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**Intercepting Infection: Quarantine, the Port Sanitary Authority and
Immigration in Late Nineteenth and Early Twentieth Century Britain**

**Doctor of Philosophy
History of Medicine**

**University of Glasgow
August 2001**

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Abstract

This thesis is an investigation into infectious disease prevention in British ports in the latter part of the nineteenth century and the introduction of medical restrictions to immigration at the beginning of the twentieth century. It examines the processes which led from the imposition of human quarantine toward the implementation of sanitary inspection at British ports. Central to this development was the influence of international pressures and demands and their incorporation into British domestic port policy. These pressures and demands resulted from the differing systems of prophylaxis and related medical theories favoured by other European imperial powers. They were discussed at the numerous International Sanitary Conferences of the nineteenth century and related particularly to shipping and commerce.

British use of quarantine for the prevention of the 'exotic' diseases, cholera, yellow fever, and plague was brought to an end with the repeal of the Quarantine Act in 1896. However, exclusionary methods were not banished from the ports but remained in place for the prevention of diseases introduced by foreign migrants. The prevention of disease among immigrants, as a distinct process in port health, increased during and after the cholera epidemic of 1892, and was largely a reaction to American port health measures.

Immigration restriction appeared to contradict the general opposition to exclusionary prophylaxis at British ports. However, the fundamental difference between the exclusion of immigrants who were regarded as a potential health risk and the temporary exclusion of a vessel through quarantine, was that the detention of an immigrant vessel, and exclusion of immigrants, was not disruptive to trade.

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ABBREVIATIONS

BBL	British Brothers' League
<i>BMJ</i>	<i>British Medical Journal</i>
<i>Bull. Hist. Med.</i>	<i>Bulletin of the History of Medicine</i>
CLRO	Corporation of London Records Office
<i>DNB</i>	<i>Dictionary of National Biography</i>
LGB	Local Government Board
LL	Londoners' League
LMA	London Metropolitan Archives
<i>Lon. Med. Gaz.</i>	<i>London Medical Gazette</i>
<i>Med. Times & Gaz.</i>	<i>Medical Times and Gazette</i>
NARA	National Archives and Records Administration (Washington)
NMM	National Maritime Museum
<i>N.Y. Med. Jnl.</i>	<i>New York Medical Journal</i>
PJTS	Poor Jews' Temporary Shelter
PRO	Public Record Office
<i>Proc. Madras. San. Comm.</i>	<i>Proceedings of the Madras Sanitary Committee</i>
PSCM	Port Sanitary Committee Minutes
PSCP	Port Sanitary Committee Papers
RCAI	Royal Commission on Alien Immigration, 1903
SRA	Strathclyde Regional Archives
<i>Trans. Epid. Soc. Lond.</i>	<i>Transactions of the Epidemiological Society of London</i>
WHO	World Health Organisation



“BACK!”

INTRODUCTION

“Back!”, cries Britannia, holding up her trident and blocking with outstretched arm the progress of the approaching figure. The cadaverous apparition of cholera moves across the gangplank followed closely by a wretched mass of people pushing their way off the ship and into England. A deep chasm between the ship and the dock separates the two figures, articulating the distance between that which is British and that which is foreign. Britannia, standing in front of the viewer, as he flicks through the September 1892 edition of *Punch*,¹ forces the disease back, preventing it from making the final step onto British soil. The disease and the racially stereotyped people with whom it has shared the voyage cannot advance. This encounter between Britannia, who here represents the gatekeeper to Britain and the public health, and the figure on the gangplank, attempting to slink through the defence, is the subject of this thesis.

By the late nineteenth century Britain’s imperial prosperity and power were at their peak. The empire stretched around the globe, sustained militarily, by the wealth accrued through trade, and through British maritime superiority. Steam and sailing ships departed and arrived into British ports daily, loaded with goods from around the world. By the 1870s an estimated 25,000 vessels entered the Port of London each year, which was said to be ‘the wealthiest, most populous, and worst arranged port in the world’.² The ports and harbours of the late nineteenth century were not the run-down terminals of today, where freight-ships and ferries pass by the many empty docks of Liverpool, London, or Glasgow, overseen by a skeleton staff of customs and port officials. Victorian ports were a picture of industry and commerce, of heaving docks and busy waters, swarming with vessels large and small. Yet, they also harboured disease. Sanitary conditions in the ports and on board vessels were often appalling, with little regard given to even the most basic standard of modern cleanliness; and along with the wealth of imported goods which arrived on each tide

¹ *Punch*, Sept. 10, 1892, p. 115. The cartoon was drawn by John Tenniel, ‘First’ cartoonist to the magazine, (1864-1901).

² *Half Yearly Report of the Medical Officer*, Port of London, December 1873, p. 4; and *Lancet*, vol. 2, (1871), p. 270, quoted in A. Hardy, ‘Cholera, Quarantine and the English Preventative System’, *Medical History* (1993), 250-269, p. 257.

were often diseases, silently travelling³ among the merchandise, sailors and passengers who entered the bustling ports.

Although much scholarship has been devoted to maritime history and the history of public health in Victorian Britain, there has been, surprisingly, very little written about the important link between these two subjects. It has long been acknowledged that devastating epidemics of diseases such as cholera were imported into Britain and subsequently killed large numbers of the population in the most painful and degrading fashion. But, most scholarly investigations which have been undertaken into the effects of imported epidemics have focused upon the spread and consequences of the diseases after they had taken hold within the country.⁴ Public health developments in the prevention and control of infectious disease have been studied in relation to sanitary reform and vaccination, and through the examination of medical innovations in the understanding of disease aetiology. The work of Medical Officers of Health has also been given increasing attention. Yet, the policies and practices which operated to intercept the importation of infectious diseases at the ports have attracted little more than passing remark and a handful of articles and sections of book chapters.⁵ These texts have contributed to the basic understanding of port health in late nineteenth century Britain, showing that the sanitary system of public health extended to the ports, that the health of the ports was, in the last quarter of the century, overseen by

³ Alan Kraut, *Silent Travelers: Germs, Genes, and the 'Immigrant Menace'*, (Baltimore: Johns Hopkins University Press, 1994).

⁴ For example, Michael Durey, *The Return of the Plague: British Society and the Cholera, 1831-2*, (Dublin: Gill and Macmillan, 1979); Norman Longmate, *King Cholera: The Biography of a Disease*, (London: Hamish Hamilton, 1966); R.J. Morris, *Cholera, 1832: The Social Responses to an Epidemic*, (Croom Helm, 1976); M. Pelling, *Cholera, Fever and English Medicine 1825-1865*, (Oxford: Oxford University Press, 1978); and William Coleman, *Yellow Fever in the North: The Methods of Early Epidemiology*, (Madison: University of Wisconsin Press, 1987), pp. 139-167.

⁵ P. Baldwin, *Contagion and the State in Europe, 1830-1930*, (Cambridge: Cambridge University Press, 1999); Jeanne L. Brand, *Doctors and the State: The British Medical Profession and Government Action in Public Health, 1870 - 1912*, (Baltimore: Johns Hopkins University Press, 1965); G.C. Cook, *From the Greenwich Hulks to Old St Pancras: A History of Tropical Disease in London*, (London: Athlone Press, 1992); A Hardy, 'Public Health and the Expert: London Medical Officers of Health, 1856-1900' in: R. MacLeod, (Ed.) *Government and Expertise - Specialists, Administrators and Professionals, 1860-1919*, 128-142, (Cambridge: Cambridge University Press, 1988); Hardy, 'Cholera'; J.C. McDonald, 'The History of Quarantine in Britain in the Nineteenth Century', *Bulletin of the History of Medicine*, (1951), 22-44.; D. Porter, *The History of Public Health and the Modern State*, (Amsterdam: Editions Rodopi B.V., 1994).

Other less scholarly accounts include: "Waterman", 'Guardians of the Port's Health. Part I: The Defence Against Communicable Disease', *The P.L.A. Monthly: Being the Magazine of the Port of London Authority*, (1964), 402-405; E.W. Hope, *Health at the Gateway: Problems and International Obligations of a Seaport City*, (Cambridge: Cambridge University Press, 1931); P. O'Driscoll, "'Against Infection and the Hand of War...'" The Early Years of the Port Health Service', *Port of London: Magazine of the Port of London Authority*, (1991), 65-69.

medical officers similar to those who worked in towns and cities, and that quarantine was widely detested and rarely used in the latter half of the century. However, no scholarship has to date focused singularly on late Victorian and early Edwardian port health as a separate phenomenon within the development of public health and infectious disease prevention. It is this deficit which I will endeavour to remedy in this study.

The realisation that this important aspect of British public health had attracted so little attention from medical historians came about while I began to investigate the original focus of this thesis – the medical examination procedures and restriction of immigration at the ports in the period between 1881 (the beginning of large-scale East European migration) and 1905 (the passing of the Aliens Act, Britain's first immigration law). Historians of late-nineteenth-century immigration into Britain⁶ have tended to concentrate more specifically on the economic effects, responses, and restrictions to immigration. There has been an increasing amount of scholarship addressing issues of immigration and health in Britain in this period, but these studies have focused on the health of immigrants after arrival and during residency in Britain. Historians such as Lara Marks and Bernard Harris have examined comparative infant mortality rates, life expectancy and instances of disease.⁷ However, these studies have not been concerned with the medical inspection of immigrants as they arrived into British ports or how perceptions of risk, relating to immigration, affected existing practices in port prophylaxis. Studies relating to the medical reception and infectious disease screening of large numbers of migrants and refugees have been undertaken in

⁶ G. Aldermann and C. Holmes, *Outsiders and Outcasts - Essays in Honour of William J. Fishman*, (London: Gerald Duckworth & Co, 1993); G. Aldermann, *London Jewry and London Politics 1889-1986*, (London: Routledge, 1989); K. Collins, *Second City Jewry: The Jews of Glasgow in the Age of Expansion, 1790-1919*, 1st edn., (Glasgow: Scottish Jewish Archives, 1990); Cecil Bloom, 'The Politics of Immigration, 1881-1905', *Jewish Historical Studies - Transactions of the Jewish Historical Society of England*, vol. xxxiii, (1992-1994), 187-214; D. Feldman, *Englishmen and Jews: Social Relations and Political Culture 1840-1914*, (Yale: Yale University Press, 1994); J.A. Garrard, *The English and Immigration 1880-1910*, (London: 1971); L. Gartner, *The Jewish Immigrant in England 1870-1914*, (London: 1960); C. Holmes, *John Bull's Island: Immigration and British Society 1871-1971*, (London: Macmillan Press Ltd, 1988); P. Panayi, *Immigration, Ethnicity, and Racism in Britain 1815-1945*, (Manchester: Manchester University Press, 1994); K. Lunn (Ed.), *Hosts, Immigrants and Minorities: Historical Responses to Newcomers in British Society, 1870-1914*, (Folkestone: Dawson, 1980); Aubrey Newman (Ed.), *The Jewish East End, 1840-1939*, (London: Jewish Historical Society of England, 1981)

⁷ W. Ernst and B. Harris, *Race, Science and Medicine, 1700-1960*, (London: Routledge, 1999); B. Harris, 'Anti-Alienism, Health and Social Reform in Late Victorian and Edwardian Britain', *Patterns of Prejudice* (1997), 3-34; L. Marks, 'Ethnicity, Religion and Health Care', *Social History of Medicine* (1991), 123-128; L. Marks and M. Worboys, *Migrants, Minorities and Health - Historical and Contemporary Studies*, (London: Routledge, 2000).

relation to United States public health. Recognising a conspicuous lack in the equivalent British history, I endeavoured to take up the task embarked upon by various historians of American immigration who have examined medical reactions to immigration in ports such as New York.⁸ In the United States medicine and public health at the ports were closely linked with the policies and ideologies of immigration. As Alan Kraut remarked, 'reliance on quarantine, coupled with an innate distrust of foreigners, suggested to the native-born that regulation of immigration was crucial to safeguarding the health of the nation'.⁹ Similarly, Howard Markel has written that immigration and medical restrictions at United States ports were reflections of both medical and nativistic concerns.

In many respects, the movement to restrict immigration to the United States during this period was a call for quarantine in its broadest sense against undesirable immigrants. The reasons for such a call were not always specifically stated using the language of disease and medicine, but its results were remarkably similar to the medieval quarantines against plague:

Foreigners perceived to be dangerous to the community were prevented from entry.¹⁰

Although I had not expected British responses to immigration to exactly mirror those in the United States, which received over ten times more migrants than settled in Britain, I anticipated a similar reaction more comparable with the scale of immigration in Britain.

⁸ Kraut, *Silent Travelers*; Kraut, 'Plagues and Prejudice: Nativism's Construction of Disease in Nineteenth- and Twentieth-Century New York City', Rosner (Ed.) *Hives of Sickness: Public Health and Epidemics in New York City*, (New Brunswick: Rutgers University Press, 1995), 65-90; A. E. Birn, 'Six Seconds Per Eyelid: The Medical Inspection of Immigrants at Ellis Island, 1892-1914', *Dynamics*, (1997), 281-316.; D. Hoerder and H. Rössler, *Distant Magnets: Expectations and Realities in the Immigration Experience 1840-1930*, (New York: Holmes & Meire Publishers, Inc., 1993); H. Markel, 'Cholera, Quarantines, and Immigration Restriction: The View from Johns Hopkins, 1892', *Bulletin of the History of Medicine* (1993), 691-695; H. Markel, "'Knocking out the Cholera": Cholera, Class, and Quarantines in New York City, 1892', *Bulletin of the History of Medicine* (1995), 420-457; H. Markel, *Quarantine! East European Jewish Immigrants and the New York City Epidemics of 1892*, (Baltimore: Johns Hopkins University Press, 1997); H. Markel, and A. M. Stern, 'All Quiet on the Third Coast: Medical Inspections of Immigrants in Michigan', *Public Health Reports*, (1999), 178-182; J. Parascandola, 'Doctors at the Gate: PHS at Ellis Island', *Public Health Reports*, (1998), 83-86; C.E. Rosenberg, *The Cholera Years - The United States in 1832, 1849, and 1866*. With a New Forward edn., (Chicago: University of Chicago Press, 1987); R.T. Solis-Cohen, 'The Exclusion of Aliens From the United States for Physical Defects', *Bulletin of the History of Medicine*, (1947), 33-50.

⁹ Kraut, *Silent Travelers*, p. 30.

¹⁰ Markel, *Quarantine!*, p. 5.

However, I was initially dismayed to discover that only a relatively small amount of the vigorous debate surrounding immigration to Britain in the very last years of the nineteenth century was medical in content. The highly medicalised response to immigration in the United States and the inclusion in the British Aliens Act of a clause prohibiting entry to immigrants who 'owing to any disease or infirmity were likely to become a charge upon the rates or otherwise a detriment to the public', suggested that a medical panic had arisen in Britain in response to immigration. This did not appear to have been the case. It was clear, through numerous articles in *The Times*, *British Medical Journal*, and *Lancet*, for instance, that there had been concerns about the role of immigration in the importation of cholera and other infectious diseases. The arrival of 'Russian Jews', these publications declared in unison 'constituted a danger to public health'.¹¹ Yet, these concerns were not echoed in parliamentary debates nor were they central to the demands of anti-immigration political groups. The cartoon in *Punch*, while indicating popular fears directly related to immigration and disease, also appears to be relatively atypical, and is the only example of such commentary in the magazine.

Unlike in America the reception and transmigration across Britain of thousands of migrants in the period 1881-1905 was not answered with a call for strictly enforced medical inspections or quarantines at the ports. The relative lack of medical rhetoric in anti-immigration campaigns, particularly when immigrants were clearly not disassociated from disease importation, suggested that something else was going on at the ports in relation to disease prevention. It was at this point that it became clear that there was very little written about the policies and practices which operated to prevent the importation of infectious diseases at the ports; and that the questions which needed to be asked were not so much about the medical restriction of immigration, nor whether there was a medical panic, but what restrictions were in place more generally for the prevention of imported infections?

The focus of the thesis was gradually shifting from an investigation singularly concerned with the medical inspection and restriction of immigrants toward a more

¹¹ *Lancet*, Feb. 18, 1893, p. 375; see also, for example, 'Destitute Jews', *Lancet*, Sept. 17, 1887, p. 599; *BMJ*, Sept. 10 - Oct. 15, 1892; 'The Immigration of Undesirable Aliens', *BMJ*, Aug. 22, 1903, p. 173; *Times*, Nov. 6, 1901, p. 12f; 'Trachoma Among Aliens', *Lancet*, June 3, 1905, p. 1525.

general examination of port prophylaxis in the second half of the nineteenth century. What procedures were in place for the medical reception of vessels arriving from around the world into British ports? What role did the traditional method of infectious disease prevention – quarantine – play in late nineteenth century ports? And how did alternative systems work? The answers to these questions would help to answer the question I had initially posed – why was immigration not responded to in Britain with the same medical rhetoric of exclusion as in America?

Suspecting, therefore, that immigration control was not as central a motivation in British port health practice and administration as it evidently was in the United States, it was necessary to examine what factors had influenced the development of British public health structures at the ports. Anne Hardy has argued, in her 1993 article for *Medical History*, ‘Cholera, Quarantine, and the English Preventive System, 1850-1895’, that in the final decades of the nineteenth century a system of infectious disease prevention was established at the ports based on the sanitary system of public health. This system, which differed from methods of disease prevention at European and American ports, was the Port Sanitary System, established under the 1872 Public Health Act. It was also called the ‘English system’.¹² Although it was called the ‘English system’ the term also applied to Scotland and Wales. It differed from other methods of port infectious disease control by taking the monitoring and isolation of infectious cases away from the port (which I have called sanitary surveillance), through its reliance on the sanitary condition of the ports, as well as its interdependence with inland sanitary districts.¹³ It was developed with the dual motive of preventing the introduction and spread of cholera, which had been pandemic in Europe in 1830-2, 1847-9, 1853-4, 1865-6, 1873, 1884 and 1892-3, and to provide an alternative to quarantine, which had proved incompatible with Britain’s political and economic commitment to free trade. The success of this system – the Port Sanitary System – was, Hardy explained, ‘widely admired by contemporaries’, and was responsible, in addition to the general sanitary improvement of British towns, for ‘holding repeated cholera attacks at bay’.¹⁴ She argued that the success and ‘professional cohesion’ of the sanitary system at the ports, led to ‘public

¹² For contemporary use of this term see, for example, W. Collingridge, ‘The Milroy Lectures. On Quarantine’, Part II, *BMJ*, March 20, 1897, p. 713.

See Chapter One

¹³ Hardy ‘Cholera’, p. 268

complacency', despite greater awareness, about repeat attacks of cholera in the closing decades of the nineteenth century. This reflected a public 'confidence in the sanitary service' even though the disease remained of grave concern to medical officers.¹⁵ By the 1880s this concern about a possible return of cholera was beginning to be linked in the medical press to the large number of migrants who passed through British ports each year, and calls were made to provide special arrangements for the arrival of migrant vessels. Hardy's article runs for only nineteen pages and covers a period of nearly fifty years. She therefore only manages to draw brief attention to the connection that was made between migration and disease at the ports, and similarly, outlines only the major developments in the creation, and consequences of the 'English System'. However, she emphasises the belief in and assertion of security provided by the Port Sanitary System. This is a significant point which will be developed and analysed in this thesis.

Before the introduction of the 'English system', quarantine was employed in response to certain imported diseases. It was imposed in European and American ports until the end of the nineteenth century, and was based on the principle of complete non-intercourse with infected cases. This extended to anyone or anything which had contact with the disease. Any vessel which had a case of infection on board or had been in contact with an infected person or place was prohibited on arrival at a port from any contact with the shore. The period of non-intercourse varied from the original forty days – from where the word quarantine originates – to a period of around five days at the end of the century.

From early in the century the severity of quarantine restrictions was berated in Britain as 'anti-commercial, anti-social, and anti-Christian'.¹⁶ By the 1870s quarantine was widely opposed primarily for economic reasons - it was 'regarded as a mere irrational derangement of commerce'.¹⁷ It was also opposed on the basis that it did not appear to prevent disease, but rather encouraged its spread. Furthermore, it was argued that the diseases it was directed at were not contagious and therefore could not be prevented by the physical separation of quarantine. The 'English system', on the other

¹⁵ *ibid.*, p. 263.

¹⁶ *Hansard*, 1825, vol. XII, p.993, quoted in, McDonald, 'The History of Quarantine', p. 26
BML, Oct 8, 1887, p. 778

hand, was heralded as a more 'rational' approach to the problem of imported infectious disease. It was argued that

quarantine is condemned not merely, and not chiefly, because it is injurious to trade, but because it has been proved again and again, in almost every country which has resorted to it, to be not only useless but mischievous, whereas the system of medical inspection and isolation [the 'English system'] has been found almost uniformly effective.¹⁸

Despite these arguments, what emerges from a closer examination of the development of the 'English system' is that it was not, as Hardy indicated, a mere extension of the internal sanitary system. Nor, as most previous scholarship has indicated, was quarantine simply discarded with the emergence of a more politically and economically exigent system. In chapter one I discuss the establishment of the Port Sanitary Authority and its relationship with quarantine. Much of the chapter is devoted to outlining the administration, personnel, and particular duties of the two authorities. It serves to provide the structural background of infectious disease prevention at the ports, which, while elaborated in other parts of the dissertation, sets the scene for later chapters, and adds to previous scholarship relating to late nineteenth century port health. Slight variations occurred in the administration of the Port Sanitary Authority in England and Wales, and in Scotland. However, quarantine was applied under the same law throughout the kingdom, and the Port Sanitary Authority in Scotland was based on the same principles that were applied to the relevant Public Health Acts of England and Wales. While I draw upon examples from individual ports, this thesis represents a national approach to the history of port health. Variations will doubtless appear in more detailed local studies.

Quarantine regulations remained on the statute books until 1896 and retained a significant influence over the operation of port health until the end of the century. Yet, throughout the historiography of public health and infectious disease prevention in Britain there is a resounding unanimity about British opposition to quarantine from the early nineteenth century.¹⁹ This is echoed in many contemporary sources.²⁰ Why

¹⁸ *BMJ*, May 23, 1885, p. 1068.

¹⁹ See footnote 5.

then did quarantine remain for so long on the statute books when there was, as Hardy points out, such official and public support for the 'English System'?²¹ And, to what extent did the mere legal retention of quarantine actually impact upon day to day practices at the ports? Quarantine represented a principle of intervention and exclusion that was rejected both by the British economic and political commitment to free trade, as well as by the new 'rational' system of sanitary inspection. The contemporary term, the 'English system', defined the sanitary system of disease prevention at the ports as something particular to Britain, as something which could be defined merely by reference to England. Quarantine, on the other hand could more easily be universally applied. This reflects the suggestion made by historians such as Erwin Ackerknecht and George Rosen that the heavy-handed intervention of quarantine corresponded to the authoritarian political instincts maintained on the Continent, while sanitation conformed with the liberalism of Britain.²²

Understanding the reasons behind the retention of the unpopular and seemingly redundant quarantine system in Britain exposes the particular circumstances of the ports which distinguished their methods, policies and theoretical background to disease prevention, from the public health authorities inland. The particular location of the ports geographically and in relation to British political and economic interests differentiated them from the practical and theoretical models of public health inland and placed their development on a slightly divergent trajectory. It was these differences which allowed for the anomaly of retaining, even minimally, what was almost unanimously referred to in Britain as the 'antiquated' and 'unnecessary' system of quarantine. Quarantine Officers and the Port Sanitary Authority were Britannia in the *Punch* cartoon - the gatekeepers of the internal public health system, ensuring that no diseases were introduced from beyond British shores. What this meant was that the systems which operated at the ports were as much outward, as

²⁰ For example, *Report on the Mortality of Cholera in England, 1848-49*, (London: HMSO, 1852), p. c.; *Lancet*, Sept. 16, 1882, p. 473; *Times*, June 2, 1885, p. 9; *Med. Times & Gaz.*, June 20, 1885, p. 820; John Chapman, *Cholera Curable: A Demonstration of the Causes, Non-Contagiousness and Successful Treatment of the Disease*, (London: J. & A. Churchill, 1885); *Lancet*, Feb. 20, 1886, p. 367; *BMJ*, Oct. 8, 1887, p. 778; John Sykes, *Public Health Problems*, (London: Walter Scott, Ltd., 1892), pp. 171-185; William Collingridge, 'Practical Points in the Hygiene of Ships, and Quarantine', *Ship Masters Society, London*, 33, (1894).

Opposition to quarantine from the beginning of the nineteenth century is discussed in Chapter One

²¹ Hardy, 'Cholera', p. 268.

²² Rosen, *A History of Public Health*, (Baltimore: MD, Johns Hopkins University Press, 1993), p. 266. E.H. Ackerknecht, 'Anticontagionism Between 1821 and 1867', *Bull. Hist. Med.*, 22 (1948), 562-93, p. 589. and Baldwin, *Contagion and the State*, pp. 24-36.

inward looking. While disease prevention relied upon the health and conditions of people and the environment within the nation, so that any imported disease which did penetrate the 'first line of defence' would be less likely to spread inland, it was also dependant upon the health of ports and cities beyond Britain. With the arrival and departure of vessels from around the world, the prevention of infectious disease at the ports - particularly the traditionally 'quarantineable' diseases of plague, yellow fever and cholera - was essentially an international issue. It required international communication and a level of internationally standard or recognised methods of prevention. Port prophylaxis, while developed and administered domestically by British trained medical practitioners, lawyers, politicians, clerks and so on, could not be done entirely intramurally. As ships which departed British ports would soon dock in a foreign port, or vice versa, it was necessary to know not only of the presence of infectious disease in any port but also the method by which an attempt had been made to arrest its progress.

This tension between conditions outside and inside the country, of foreign ports and domestic ones, and of foreign people and foreign vessels confronting British practices, is a central theme of this thesis. The interaction between British agendas, medical theories and practices, and the policies, demands and perceptions of other countries has become a primary component of this study. Unlike other spheres of medical practice and government policy where an awareness of international affairs was useful, but not essential, the ports, as the geographic and often political meeting point between foreign and domestic, were inextricably linked to issues of disease control beyond British shores. It is for this reason that, although the Port Sanitary System was closely connected with the internal sanitary system, it occupies a different place in the history of public health in Britain.

To elaborate this point and to explain the most significant aspects of this difference between the internal and port sanitary systems, I have focused primarily, in this thesis, on cholera. Although the particular catalytic effect of cholera on nineteenth century society has been questioned by historians such as Charles Rosenberg²³ it was, as Richard Thorne Thorne, Medical Officer to the Local Government Board, said in 1888 'very intimately associated with the story of progress in the department of public

health and of sanitary medicine'.²⁴ Richard Evans argues that in Hamburg 'the shock of cholera in 1892 ... generated massive social pressures for social and political reform'.²⁵ The same was not the case in Britain, which avoided any significant invasion of the disease in 1892. Nonetheless it did have some important implications. Its effect at the ports was particularly apparent.

Infectious diseases were divided into two categories in port prevention. The first category referred to 'exotic' diseases, also called 'exoteric',²⁶ which referred specifically to plague and yellow fever. These diseases originated outside Britain and could only occur when imported. Quarantine was the traditionally applied method of prophylaxis when there was a risk of 'exotic' disease being imported. The other category of disease was 'indigenous' disease, which was also called 'esoteric' disease. These were diseases which were endemic to Britain, 'in other words, which are commonly about everywhere, varying simply according to the health for the time being of the neighbourhood'.²⁷ They included, for example, smallpox, typhoid, and scarlet fever. These diseases were not traditionally prevented by quarantine measures. Although cases of smallpox or scarlet fever, for instance, could be brought on vessels into British ports and consequently spread throughout British towns and cities, they continued to be categorised as 'indigenous' diseases. The terminology which was used to delineate the categories varies in contemporary texts. Throughout this thesis I will use the terms 'exotic' and 'indigenous'. I will also employ the terms 'quarantineable' and 'non-quarantineable', which were used by contemporaries in reference to the distinct methods of prevention used for the two categories of disease at the ports.

Cholera, because it only occurred in Britain when imported, was an 'exotic' disease. The way it was approached politically and medically therefore was different from diseases which were deemed 'indigenous'. It penetrated the 'first line of defence' in numerous epidemics during the nineteenth century, ravaging British towns and cities.

²⁴ C. Rosenberg, 'Cholera in Nineteenth Century Europe: A Tool for Social and Economic Analysis', *Comparative Studies in Society and History*, vol. viii, (1965-66), 452-463, p. 453.

²⁵ R. Thorne Thorne, *On the Progress of Preventive Medicine During the Victorian Era*. (London Shaw & Sons, 1888), p. 53.

²⁶ Richard Evans, *Death in Hamburg: Society and Politics in the Cholera Years, 1830-1910*. (Oxford Clarendon Press, 1987), p. 478.

²⁷ See for example, Letter from the Customs Solicitors Department to the Attorney General, Nov. 16, 1891, PRO CUST46/95/25308.

The local public health authorities were at this stage responsible for the control and treatment of the disease. Yet prevention of cholera epidemics was initially always the task of the port authorities, whose duty it was to hinder the disease from progressing inland from the ports. Plague and yellow fever were also categorised as 'exotic' diseases, and were, as such, traditionally associated with quarantine. However, in the period after the introduction of the Port Sanitary Authority and before the repeal in 1896 of the Quarantine Act of 1825, cholera was the only 'exotic' disease to have threatened invasion of Britain. Before the Port Sanitary Authority was created, prevention of 'exotic' diseases at the ports was solely under the administration of quarantine. Yet, once the Port Sanitary Authority was established, responsibility for preventing the introduction of cholera was shared between the two systems. This was the result of both ambiguities in the law and the external demands of other maritime nations. The latter were voiced at the International Sanitary Conferences, ten of which were held between 1851 and the turn of the twentieth century. Although yellow fever and plague were discussed at the conferences, particularly with reference to the Mecca pilgrimages and after 1900, the primary focus of the conferences was cholera and the appropriate methods which should be adopted in order to control its spread. This generally amounted to a discussion about quarantine. As W.F. Bynum remarked,

despite the title of the series of conferences, the first seven or eight could have been called International Quarantine Conferences, as they were primarily concerned with quarantine, and overwhelmingly about cholera.²⁸

Although these conferences have been extensively reviewed by Norman Howard-Jones in a series of articles for the *WHO Chronicle*²⁹ and are the subject of other historians' work, I discuss them, in chapter two, from the particular perspective of the British and the development and application of preventive systems in British ports. In particular I address the presentation of British medical theories of cholera aetiology as they applied to the ports. These theories, while not always consistent with general

²⁷ *ibid.*

²⁸ W.F. Bynum, 'Policing Hearts of Darkness: Aspects of the International Sanitary Conferences', *History and Philosophy of the Life Sciences*, 15 (1993), 421-434, p. 428.

²⁹ Howard-Jones, N., 'The Scientific Background of the International Sanitary Conferences, 1851-1938', 1-5, *WHO Chronicle*, 28 (1974); see also: Neville M. Goodman, *International Health Organisations and Their Work*, (Edinburgh: Churchill Livingstone, 1971; World Health Organisation, *The First Ten Years of The World Health Organisation*, (Geneva, 1958); Mariko Ogawa, 'Uneasy

trends in British disease theory,³⁰ were particularly applied in relation to the economic and political exigencies of the ports as essential mechanisms within the machinery of imperial trade. In this chapter I examine the relation between British trade and imperial interests and the medical theories of disease aetiology which supported British policy regarding infectious disease prevention at the ports. These interests and disease theories, maintained by British, and later Anglo-Indian,³¹ delegates to the conferences identified and defined the 'English system' as particularly British. It was these interests and theories which supported British opposition to quarantine, and which separated it from the majority of other nations at the conferences. I propose to examine how European responses to the singularity of British methods of port prophylaxis, within international discussion and the necessity of international conformity in respect of disease prevention, influenced the maintenance of quarantine in Britain. As Evans wrote, 'no system of rule is ever free from contradictions; nor has any capitalist society, not even that of Victorian England, ever existed in isolation from the forces of the world economy and the international diplomacy of the states surrounding it'.³²

Another reason why I place a particular importance on cholera, although obviously other diseases were cause for concern at the ports, is because it played a particular role in immigrants becoming a growing focus of port health. Although there had been some attention to immigrants as disease carriers earlier in the century, emphasis on the entry of this particular group into the ports massively increased during the 1892 cholera epidemic. In chapter three I examine responses to the perception of immigrants as a primary factor in the spread of cholera from Eastern to Western Europe and America. Britain responded by implementing inspection methods specifically focused on steerage class migrants, which, as was commented outside Britain at the time, constituted in some ways a level of immigration restriction. This chapter links the first two chapters which concentrate entirely on the Port Sanitary Authority and Quarantine, with the final two chapters which focus on the development of medical restrictions to immigration at the ports. The temporary

Bedfellows: Science and Politics in the Refutation of Koch's Bacterial Theory of Cholera', *Bulletin of the History of Medicine*, 74, (2000), 671-707.

³⁰ see Michael Worboys, *Spreading Germs – Disease Theories and Medical practice in Britain, 1865-1900*, (Cambridge: Cambridge University Press, 2000).

³¹ I will use the term 'Anglo-Indian' in reference to representatives of the Government of India

³² Evans, *Death in Hamburg*, p. 563.

measures which were put in place to monitor and prevent cholera among immigrants in 1892 continued until 1895 but had far reaching implications. Yet, even though immigrants were seen as a source of infection, the 'proper' implementation of a tightly operating and efficient sanitary system was all that was deemed necessary to protect British public health from this 'alien menace'. A Justice of the Peace wrote an article for the very respectable *Gentleman's Magazine* in 1892, in which he highlighted the popular confidence attached to the 'English system'.

Another question closely connected with the cholera epidemics, and demanding attention, is that of the immigration of foreign pauper aliens. With a relaxation of the strict rules enforced during the cholera visitation the danger will return in full force, and the crowding together of these foreigners, with their dirty habits and horror of soap and water, in our large towns, especially in London, increases the risk of cholera, and most certainly intensifies the attack when it comes.... A better argument in favour of rigorous sanitary inspection cannot be desired. Without giving further details the writer trusts that he has proved this case in support of preventive measures, and that his readers are satisfied beyond doubt that a proper system of sanitary precautions, worked by capable medical officers who are neither hampered by want of means nor thwarted by conflicting authority, *can* successfully prevent the importation of cholera from foreign countries.³³

How far does the writer's proposition go toward explaining British attitudes to the medical restriction of immigration? Did public confidence in the port sanitary system, re-enforced by Britain's virtual avoidance of cholera in 1892, reduce demands for a restriction of immigration on medical grounds?

Britain had been highly critical of the European and American application of quarantine during the epidemic, particularly the imposition of twenty-days quarantine on all immigrant vessels arriving in New York. Yet, despite British criticism about preventive methods in New York during 1892, medical inspection policies for immigrants at American ports were beginning to draw the attention of Medical Officers and government departments in Britain. In chapter four I discuss British

attitudes toward American immigration policy and practice. The international obligations and influences on the ports which are examined in chapter two in relation to quarantine and the Port Sanitary System, are also examined in chapter four. In this chapter I discuss the influences of American port immigration controls on the introduction of medical restrictions to immigration in Britain. The majority of migrants who entered British ports were what is referred to as transmigrants. That is, they transited in Britain on their journey west to America. Scrupulous American medical inspections and application of the right to refuse entry had particular ramifications in Britain. This was primarily because migrants who were rejected by American immigration officers could be returned to British ports. Others also temporarily remained in Britain en route to America in order to seek medical attention for ailments which would prevent entry into the United States.

The number of references which were made to the United States in discussions about the health of migrants in Britain indicates that American port immigration controls were a major factor in the inclusion of medical restrictions in the 1905 Aliens Act. The events which led to the passing of the Act are the subject of chapter five, as well as how the clauses relating to medical inspections at the ports were implemented once the Act came into operation in 1906. After the Act was passed, the Port Sanitary Authority took on the additional role of immigration medical inspection and ensured its role as sole authority responsible for the prevention of infectious diseases at the ports. Economic concerns were the primary impetus to the final introduction of Britain's first immigration Act, and although parliamentary debates, anti-immigration propaganda, and investigations into immigration all centred around its economic consequences, what medical concerns were voiced referred, in general, to the effects and example of American policy. Yet, as the author of the 1892 *Gentleman's Magazine* article explained, it was believed that 'proper sanitary precautions' were adequate to prevent imported disease, whatever the source. The opinions of the medical professionals who gave evidence to the Royal Commission on Alien Immigration in 1903 will be examined to determine whether the desire of the anti-alienists to restrict immigrants on medical grounds was shared by the profession. How did Medical Officers of Health respond to these exclusionary measures, which echoed the restrictions and heavy-handed intervention of quarantine? Was the medical

Francis H. Candy, F.P., 'The Prevention of Cholera.' (Reprinted from *The Gentleman's Magazine* for

restriction of immigration so different to the impositions of quarantine, and how was it integrated into the sanitary system at the ports?

As the Aliens Act was introduced primarily in response to the immigration of East-European Jews anti-Semitism was, not surprisingly, also a conspicuous element of the anti-immigration campaign. Ideas of race and disease were certainly a component of the debate, and it is not possible to discuss the introduction of the Aliens Act without reference to anti-Semitic motivations. The *Punch* cartoon I have used at the beginning of this thesis – which depicts obviously racially stereotyped Jews crowded behind the figure of cholera - immediately identifies the association which was drawn at the time between Jewish migrants and disease. Yet, although anti-Semitism was a conspicuous element in the anti-Alien debate generally, and was particularly apparent in discussions focused upon the East End of London, it was not as central to the medical discourse within these debates. The cartoon in *Punch*, while indicating an element of racial prejudice in ideas of disease importation is, surprisingly, unrepresentative of British responses to the public health threat posed by migrants. Certain diseases were identified particularly with Jewish migrants, however, these associations were less inspired than other parts of the debate by anti-Semitism specifically. I am aware that these prejudices were an important aspect of the general call to restrict immigration in this period, but in my more focused study on the introduction of medical restrictions to immigration, I have avoided, for these reasons, participating in much discourse about nineteenth century British anti-Semitism. Not only would I not do it justice within a study which is primarily focused on developments in port health, but I also feel that it is a subject which has already been competently addressed.³¹

This thesis in no way represents a comprehensive analysis of port health in the late nineteenth century, but examines the central development of the Port Sanitary Authority as the 'first line of defence' in the prevention of imported infectious disease. I have not examined the additional duties undertaken by the authority, such as the sanitary inspection of the ports with regard to houseboats and barges, nuisances,

December, 1892). *CLRO PSCP* (Oct. - Dec., 1892).

³¹ See for example: A. Cowen, and R. Cowen, *Victorian Jews Through British Eyes*. (Oxford: Oxford University Press, 1986); C. Holmes, 'Hostile Images of Immigrants and Refugees in Britain', in J. Lucassen and L. Lucassen (Eds.), *Migration, Migration History, History: Old Paradigms and New Perspectives*. (Berne: Peter Lang AG, European Academic Publishers, 1997); C. Holmes, *Ann*

sewerage outpours and so on. These duties, while an essential component of the 'English system' were primarily the responsibility of the Port Sanitary Officer, as opposed to the Port Medical Officer, who is a focus of this study. Similarly, I have not explored the extensive examination and disinfection of rags, livestock and produce, which constituted a large amount of their work. Similar debates and struggles to those concerned with human quarantine occurred in respect of animal inspection and quarantine. Quarantine for animals was deemed more desirable than it was for humans and was more strongly supported by veterinarians than human quarantine was by physicians. While presenting many interesting parallels and contrasts, particularly with regard to aetiological theories of infectious diseases, animal quarantine is beyond the scope of this thesis and is not discussed in reference to human quarantine.³⁵ The operation of the port and floating hospitals, while discussed briefly, has not been given a great deal of attention. Furthermore the separate operation of the seamen's hospital, discussed by G.C. Cook,³⁶ and naval health measures have been avoided. This study is more specifically concerned with the driving forces behind the development of the Port Sanitary Authority, including its interaction with quarantine, and the introduction of medical restrictions to immigration. Although the inquiry is national, and I discuss various ports such as Liverpool, Glasgow, Hull and Southampton, I have concentrated particularly on London partly due to the sources available to me and also because it was the largest and most international port in Britain. It was also the focus of the anti-alien campaign.

The primary sources that inform this study are many. They include: medical and medical society journals; newspapers; the annual and monthly reports of Medical Officers of Health and the Local Government Board; contemporary treatises and pamphlets; parliamentary papers and debates; and the reports of specially commissioned investigations. Letters and memoranda from and between government departments have been extensively used to complement official documents. The archives of the Poor Jews' Temporary Shelter and the Board of Guardians of British Jews provide a balance with anti-immigration texts and a number of individual government reports concerned with immigration and transmigration. Personal letters

Semitism in British Society, 1876-1939, (London: Edward Arnold, 1979); C. Holmes, 'Joseph Banister's Anti-Semitism', *Patterns of Prejudice*, vol. iv, (1970), 29-32.

³⁵ See Worboys, *Spreading Germs*, Chapter 2, 'Veterinary Medicine, the Cattle Plague and Contagion, 1865-1890'.

³⁶ Cook, *From the Greenwich Hulks*.

from Richard Thorne Thorne at the 1885 International Sanitary Conference have been used in conjunction with official, press, and other personal accounts of the conference. One of the most utilised sources is the rarely examined minutes, letters and papers of the Port Sanitary Committee, which oversaw the administration of the Port Sanitary Authority. This enormous, uncatalogued archive at the Corporation of London Records Office includes letters between the Committee and government departments, charitable institutions, Jewish groups, shipping companies, and embassies and consuls. It has allowed an insight into the operation of the Port Sanitary Authority which has enabled me to reveal the particular professional interests of the Port Medical Officers of Health, as well as the recondite relationship between the Authority and the quarantine service in the period 1872 to 1896.

This thesis examines the way the 'English System' of disease prevention advanced and supported the commercial interests of the ports, while at the same time securing the public health. British opposition to exclusionary practices at the ports, motivated primarily by commercial concerns and validated by theories of infectious disease aetiology, is a central theme; as is the examination of external influences on the development of policy and practice at British domestic ports. The 'exotic' disease cholera is also a focus of this study. I will examine both the amalgam and the conflict between external and internal factors as a primary influence in the way port health was shaped during the late-nineteenth and early-twentieth centuries. These factors are summarised in the table below which is divided under the headings 'domestic' and 'foreign'.

TABLE I:

FOREIGN	DOMESTIC
'Exotic' Disease – cholera, yellow fever, plague	'Indigenous' Disease – smallpox, scarlet fever, typhus, trachoma etc
Quarantine – concerned only with 'exotic' disease; based on the condition of foreign ports; supported by the majority of states represented at the International Sanitary Conferences of the nineteenth century – except Britain; (contagion)	Port Sanitary Authority – concerned only with 'indigenous' disease (prior to 1896); reliant upon domestic sanitary conditions and co-operation with internal sanitary authorities; (anticontagion)
Immigrants	Native Population

Essentially this thesis is a discussion about the interaction of these factors. It examines the development of the Port Sanitary Authority within established systems of disease prevention at the ports and the development and import of ideas which encouraged the introduction of medical restrictions to immigration as one feature of disease prevention in late nineteenth century Britain. Ports were the focus of international commerce, the movement of large numbers of people, and the transmission of infectious diseases. The protection of political, commercial, and public health interests, both nationally and internationally, converged at the ports. This littoral meeting place is the central focus of this thesis.

CHAPTER ONE: 'The First Line of Defense...'

Throughout the nineteenth century quarantine was an issue which roused an enormous amount of debate and discussion. It was closely associated with trade and the empire and with the contentious medical theories of contagion and anti-contagion. It also through the century distinguished Britain from other Continental powers by the strength and consistency of the opposition it invited. The policy of isolation and exclusion which quarantine demanded - prohibiting people and goods on board infected vessels from any intercourse with the shore for up to thirty days¹ - was declared to be in conflict with British liberal principles.

England imposes no restrictions upon intercourse between one and another community – town and town, nation and nation...She would dispense, in land and sea traffic alike, with those detentions known as quarantines, having found them in practice to result rather in hazardous concealments and evasions than in any effectual exclusion of [disease].²

The apparent inability of quarantine to prevent the importation of disease and its obvious interference with maritime trade led to a general and growing resistance towards it, which was manifest from the early decades of the century through to the last.

More sympathetic to British requirements was what became known as the 'English System' of disease prevention, administered by the Port Sanitary Authority. This system, established in 1872, required that only those ships with visible signs of disease on board, as determined by a medical inspector, should be disinfected, the sick removed to an isolation hospital, and other crew and passengers who displayed no symptoms of disease be monitored after disembarkation. Unlike under the quarantine system, Bills of Health³ (upon which pratique, or freedom of movement was granted)

¹ By the nineteenth century quarantine periods had been reduced from the medieval forty day period (George Buchanan, *Fifteenth Annual Report of the LGB, 1885-6 – Supplement Containing Reports and Papers on Cholera Submitted by the Board's Medical Officer*, (London: Eyre and Spottiswoode, 1886) [C 4873], p. ix.

² According to *Butterworth's Medical Dictionary*, (London: Butterworth's, 1978) a 'Bill of Health' is, 'An authenticated certificate concerning the health of a ship's company and of the seaport, regarding

were issued on the basis of the presence of disease on board a vessel, rather than on the presence of disease in the port from which it had last departed. The English System also, importantly, combined the medical and sanitary regulation of shipping with 'internal' sanitary regulations – urban and rural public health. Within an ever-developing public health system, professional groups and particular expertise were formed. The most important for the prevention of imported infectious disease were the Port Sanitary Authority and the Port Medical Officers of Health. Yet until 1872 quarantine had been the only official nation-wide system of prevention and regulation for the import of infectious disease. Although often widely arraigned both for its inability to check the spread of disease, and for the costly interruptions it inflicted on maritime trade, quarantine remained in the statute books and continued to be practised, albeit rarely, for over twenty years after the establishment of the Port Sanitary Authority - this apparently favourable system for preventing the importation and spread of infectious disease.

Quarantine in the nineteenth century

As contemporary commentators insisted, before embarking on any discussion of quarantine systems, the term must be properly defined. Indiscriminate usage of the word can be, we are told, troublesome. As an account in *The Practitioner* of 1873 suggests, 'the evil arising from this growing loose use of a defined term was very aptly illustrated at the discussion of the Epidemiological Society; for the vague and inaccurate use of the word quarantine at the commencement of the discussion caused a loss of time which could not be recovered'.⁴

Two definitions from the late nineteenth century should serve this purpose. The first was written in 1873, immediately following the establishment of the Port Sanitary Authority, and provides the more technical meaning of quarantine; while the second, written immediately following the repeal of the Quarantine Act, defines quarantine in contrast to the English System, as less discriminating and less 'scientific'.

infectious disease, which the master has to obtain before he may leave the port. The certificate is 'clean' when there is not any infectious disease at all, 'touched' or 'suspected' when there are rumours of infection, and 'foul' when infection is certified'.

⁴ 'Quarantine in Relation to Cholera', *The Practitioner: A Journal of Therapeutics and Public Health*, V.3 XI July to December, 1873, 222-229, p. 224.

Quarantine is a technical term having a precise well understood definition, and it is desirable that it should be limited to its proper meaning. Quarantine, the noun, according to the last edition of Websters, signifies – ‘specifically, the term, originally of forty days, but now of undetermined length, during which a ship arriving in port, and suspected of being infected with a malignant, contagious disease, is obliged to forebear all intercourse with the shore; hence, restraint or inhibition of intercourse to which a ship is subjected, on the presumption that she may be infected’. Quarantine, the verb, according to the same authority signifies – ‘to prohibit from intercourse with the shore, to compel to remain at a distance, as a ship from the shore when suspected of having contagious disease’.⁵

[Quarantine comprises] ...preventative measures designed to prevent the importation of disease into a country by means of maritime commerce, it may be defined as ‘the enforced detention and segregation of vessels arriving in a port, together with all persons and things on board, believed to be infected with the poison of certain epidemic diseases for specific periods’ The essential point of quarantine at its earliest inception up to its fully developed existence at the present day is that it estimates the danger, and thereupon the precautions to be taken, according to the state of health of the port from whence the vessel has arrived, and has no reference to the condition as regards health or sickness of the vessel and its inhabitants.⁶

Quarantine was imposed on ships which were deemed either ‘infected’ or ‘suspected’. Suspected ships were those which had proceeded from an ‘infected’ port, or which had had some contact with the infection. They did not necessarily have any cases or suspected cases of the disease on board yet were quarantined in the same way as a vessel with an infectious cases on board. Because the essential act of maritime quarantine was to detain and isolate ships with little discrimination being made between the sick and the healthy, it was both feared and resented. It was feared because it could mean that healthy passengers were confined on board a vessel with

⁵ ibid

⁶ William Collingridge, ‘The Milroy Lectures – On Quarantine’, Part I, *BMJ*, March 13 1897, 646-649, p 646

patients infected with contagious disease; and it was resented for the costly delays enforced on ships involved with trade. By the early nineteenth century the latter of these two vexations had taken over as the primary concern associated with quarantine. Shipping was an essential instrument in Britain's growing empire, generating enormous wealth and securing British dominance. Quarantine was a problematic factor within British maritime trade, potentially adding by the turn of the nineteenth century over thirty days onto the duration of a journey. During this month of detention another trip might have been completed (depending on where the ship had travelled from), perishable goods may have decayed, if not been destroyed, and a hefty quarantine duty had to be paid. The imposition of quarantine was accused of being 'a barbarous encumbrance, interrupting commerce, obstructing international intercourse, periling life, and wasting, and worse than wasting, large sums of public money'.⁷

However, the fundamental principle upon which quarantine rested was the idea of contagion and until, at least, the mid-nineteenth century this essentially outweighed the grievances uttered against the cost. If a disease could be communicated from one person to another, the only way to stop it was to 'break chains of transmission, interrupting the circulation of carriers by means of cordons, quarantines and sequestration'.⁸ By isolating or excluding the infection it could be excluded from a community. The traditional period of forty days initially would have covered the time needed to ensure that the disease was neither incubating or still extant in any virulent form. With changing understanding of different diseases, this period of confinement was brought by the end of the eighteenth century down to around twenty to thirty days. While a disease was considered to be contagious, quarantine was the only method that could be applied against it. However, if a disease was not considered to be contagious, but rather was generated and contracted by people by some means other than person to person (or object to person), quarantine would be of little use. It was this theory, called 'anticontagionism', which gained much support in Britain throughout the nineteenth century and was a primary tool used in arguments opposing the institution and practice of quarantine.⁹ However, it was not until the middle of the century that anticontagionist theories began, in Britain, to significantly threaten the conceptual basis upon which quarantine had been built. Until then quarantine

General Board of Health - Report on Quarantine, 1849, [1070], p. 17
Baldwin. Contagion and the State, p. 4.
See Chapter Two.

maintained a secure place in legislation and as a prophylactic strategy, relied upon by the nation to protect it from invading infections.

The first quarantine act of the nineteenth century (40 Geo. III. c.80) passed in 1800, called for the building of a lazaretto (maritime quarantine station) on Chetney Hill near Dartford, and required 'that the cost of Quarantine be borne by incoming ships'. The building of the lazaretto was unduly prolonged due to a variety of practical problems, and within a few years of its completion it was found to be ineffectual. Yet, smaller quarantine stations were maintained in the major ports, and a special lazaretto was constructed at Milford as 'a foul Bill [of Health] station – for ships to the western part of the Kingdom'.¹⁰ Another 'Foul Bill station' in Liverpool served the 'eastern part'. Goods which arrived on an infected ship were aired on deck from three to six days before being removed to the lazaretto.¹¹ There bales and packages were opened and the process of airing was continued for up to a further 40 days. Passengers and crew were required to remain on board the vessel for up to 30 days after all the goods were removed. The whole process, for a ship arriving with a foul Bill of Health, could take up to 60 to 65 days.¹²

It has been argued that Liberal ideas in England following the defeat of Revolutionary France in 1815 formed the initial bases of the two main objections to quarantine:¹³ firstly, that quarantine imposed unnecessary and costly constraints on the free flow of commerce; and secondly, that the theory of contagion, the fundamental principle underlying quarantine, was unfounded.¹⁴ At the beginning of the nineteenth century, the main opponent of quarantine, on the grounds of the anticontagious nature of disease, was Charles Maclean (1788-1824). Maclean was a physician who had been employed for most of his career as a surgeon with the East India Company and the Levant Company, and lectured to the East India Company on the diseases of hot

¹⁰ Evidence of William Matthias, Acting Superintendent of the Quarantine at Milford, *Select Committee on Means of Improving and Maintaining Foreign Trade - Second Report (Quarantine) 1824*, [417], p. 98

¹¹ This process could take up to 15 days. Usually the contents of the hold could only fit on deck in parts and thus airing need to be completed in stages. The first batch would be aired for six days and all subsequent batches for only three days.

¹² Matthias, *Select Committee (Quarantine)*, 1824, p. 99-100.

¹³ See *ibid.*; and Ackerknecht, 'Anticontagionism', p. 589.

¹⁴ Ackerknecht, 'Anticontagionism', p. 24.

climates.¹⁵ He was convinced that plague, the primary target at which quarantine measures were aimed, was not contagious but rather 'dependant on atmospheric influences'. During the period 1817-1824 particularly he published a number of medical books and pamphlets in opposition to quarantine such as, *Evils of Quarantine Laws, and Non-Existence of Pestilential Contagion Deduced from the Phenomena of the Plague of the Levant, the Yellow Fever of Spain, and the Cholera Morbus of Asia*, (London, 1824).¹⁶ He argued, summing up the main points maintained in opposition to quarantine throughout the century, that quarantine was 'really the cause of 19/20 of all epidemics by enforcing confinement in pestilential air; producing concealment of the disease, desertion of the sick, and deadly terror. Quarantines were amoral, ineffective, and the source of enormous gratuitous expenses and vexation'.¹⁷

In 1819 the government appointed a Select Committee, with not a little of Maclean's influence,¹⁸ to 'investigate the validity of the doctrine of contagion in plague'. The Committee concluded that plague was indeed contagious, passing directly from person to person and thus that there was no reason to question the principles upon which quarantine was based. Another Select Committee in 1824, this one employed to consider how foreign trade might be improved, concluded that as quarantine and contagion were inseparable, all information on the subject, as prudence dictated, should be taken from medical witnesses with known contagionist leanings. Not surprisingly, they all concluded that the present quarantine regulations were sufficient and that quarantine was necessary for preventing the import of epidemic disease.

(The) Committee have called before them several medical men of eminence, whose opinions appeared the best calculated to assist them in pursuing the object of their inquiry, and coming to a satisfactory conclusion. In making

¹⁵ In 1798 Maclean was ordered to leave India for making an insinuation in an Indian newspaper against a magistrate. He left the East India Company after failing to make promotion and travelled for the Levant Company in 1815-17, *Concise DNB – Part One from the Beginnings to 1900*, (Oxford: Oxford University Press, 1983), p. 820; see also, Mark Harrison, *Public Health in British India: Anglo-Indian Preventive Medicine, 1859-1914*, (Cambridge: Cambridge University Press, 1994), pp. 42-3; Pelling, *Cholera, Fever and English Medicine*, pp. 27-30; McDonald, 'The History of Quarantine', pp. 22-44; Ackerknecht, 'Anticontagionism', pp. 582-5; and Roger Cooter, 'Anticontagionism and History's Medical Record', in P. Wright and A. Treacher, *The Problem of Medical Knowledge Examining the Social Construction of Medicine*, (Edinburgh: Edinburgh University Press, 1982), pp. 96-7.

¹⁶ Other texts include, Maclean, *Suggestions for the Prevention and Mitigation of Epidemic and Pestilential Diseases; Comprehending the Abolition of Quarantine and Lazarettos*, (London, 1817)

¹⁷ Ackerknecht, 'Anticontagionism', p. 584.

¹⁸ Collingridge, 'On Quarantine' [Part I], p.647

their selection ... they have confined themselves to those whose attention had not only been directed to this subject, but whose opinions were understood to be in favour of the received doctrine of Contagion: their reason for this was, that it being their object to ascertain the degree of relaxation in the present regulations that might be safely adopted, consistently with the experience of danger, no advantage could arise from having recourse to the opinions of those who entirely disbelieve the possibility of Contagion, and considered every precaution to guard against it misplaced and unnecessary.¹⁹

While the Committee were somewhat critical of a few of the European methods and regulations for quarantine, it recommended that 'ships with foul or suspected bills of health should unload into a lazaretto in Stangate Creek, and there undergo a quarantine of 21 days; ships with clean bills should await permission for free pratique in the lower Thames; all quarantine charges should be borne by the public; and all existing laws repealed and incorporated in a single act'.²⁰ A Bill was drawn up which embodied the recommendations. Maclean petitioned the government complaining that the 'anti-commercial, anti-social, and anti-Christian quarantine laws' should be rejected²¹. He and other anti-contagionists vehemently objected to the Bill on the grounds that neither the 1819 nor the 1824 Select Committee had taken evidence from any supporters of anti-contagionism, despite the fact that this theory of disease was continuing to attract the support of a growing number of medical men. However, the government was determined to err on the side of caution and despite the objections concluded that it was more prudent to continue with the Bill. Furthermore, in terms of trade, when, at this stage, the rest of Europe, if not the world, were firmly in favour of quarantine, Britain could ill afford the loss of trade incurred if her ports were deemed dangerous because of an absence of quarantine laws.

Thus, in 1825 the Quarantine Act (6 Geo. III c.78) was passed.²² The Act applied to, 'all vessels, as well as His Majesty's Ships of War... coming from or having touched at any place from whence His Majesty, his Heirs or Successors, by and with the advice of his or their Privy Council, shall have adjudged and declared it probable that

¹⁹ *Select Committee. (Quarantine) 1824*, p. 8.

²⁰ McDonald, 'The History of Quarantine', p. 26.

²¹ *ibid*

²² Maclean died before the Bill was passed through to legislation.

the Plague or other infectious disease or distemper highly dangerous to the health of His Majesty's subjects may be brought.' as well as 'the Yellow Fever or other highly infectious distemper [which] prevails on the Continent of America, or in the West Indies ... No..person, goods, wares, or merchandise, or other articles as aforesaid... shall, either before or after the arrival of such vessels or boats at any port or place in the United Kingdom, ...come or be brought on shore, or go and be put on board any other vessel ...in order to ...be brought on shore,' and that they 'be obliged to perform Quarantine in such place ... for such time, and in such manner as shall from time to time be directed by His Majesty, his Heirs or Successors, by his or their ... Orders in Council'.²³

The Quarantine Act was placed within the authority of the Privy Council. Its implementation at the ports was placed within the duties of the Customs Service, and it was not long before the new law was put to the test. In 1830-31 western Europe was confronted with its first epidemic of Asiatic Cholera - the 'exotic' disease originating from India - which had been brought west with growing European mercantile and industrial development. It flourished in the expanding urban environment of industrialisation and in the exceptionally warm summer of that year.²⁴ In April 1831, after learning that cholera had arrived in St Petersburg and was slowly pushing westward, the Admiralty ordered in anticipation of the approaching disease that a strict quarantine of at least 14 days be imposed on all ships arriving from foreign ports.²⁵ By June the Privy Council moved to temporarily include cholera under the existing quarantine laws and a consultative Central Board of Health was established to oversee its implementation. The Privy Council then issued regulations in October 1831 in which strict quarantine was to be imposed on both sea and land. However, on October 9 the first case of cholera was reported in Sunderland.²⁶ Not only did the disease claim thousands of lives in its first great scourge of the United Kingdom in 1831-32, but its violence and rapidity were almost unprecedented. Richard Evans details the horrific course of the disease which, unlike other epidemic diseases such as tuberculosis (which Evans describes as spreading 'at a leisurely pace'), whirled through towns and cities with devastating effect.

²³ Quarantine Act, 1825 (6 Geo. III c.78) II & III.

²⁴ Evans, *Death in Hamburg*, p. 226.

²⁵ Baldwin, *Contagion and the State*, p. 101.

²⁶ Longmate, *King Cholera*, p. 24-5.

It began to affect the victim through a vague feeling of not being well, including a slight deafness. This was followed fairly quickly by violent spasms of vomiting and diarrhoea, vast and prolonged in their extent, in which the evacuations were usually described as being like 'rice-water'. In this stage up to 25% of the victim's body fluids could be lost. This led, not surprisingly, to a state of collapse in which, in effect, the blood coagulated and ceased to circulate properly. The skin became blue and 'corrugated', the eyes sunken and dull, the hands and feet as cold as ice. Painful muscular cramps convulsed and contorted the body. The victims appeared indifferent to their surroundings, though consciousness was not necessarily lost altogether. At this stage death would ensue in about half the cases from cardiac or renal failure, brought on by acute dehydration and loss of vital chemical and electrolytes, or the victim would recover more or less rapidly. The whole process of the symptoms from start to finish could take as little as 5 to 12 hours, more usually about 3 to 4 days.²⁷

Local boards of health were instructed to ensure the administration of the Act, and record all instances of infection. Infected towns were quarantined, and individual houses marked with signs of 'CAUTION' or 'SICK'. The quarantine period was not less than 20 days, and applied to the sick, those who had been in contact with them and those who had any ill-timed bouts of quite harmless diarrhoea. All incoming ships from foreign ports were also placed in quarantine for not less than 20 days. Infected or suspected ships were moored to floating lazarettos, where all goods on board were aired and treated with chlorine fumes; passengers and crew were forced to remain on board. The sick and the healthy were confined together, often without any medical assistance.²⁸ Although a variety of problems were associated with the quarantine regime, a great reliance was placed on it for assuring the safety of Britain.

To the quarantine now in operation we last week adverted, and we again recur, as affording the only hope which remains of excluding the disease from England; and if the regulations could be rendered as complete in practice as they are in theory, our hopes would be by no means faint; but with so

²⁷ Evans, *Death in Hamburg*, p. 227.

extensive a coast to act upon, with so many temptations, and so many opportunities afforded by smuggling, of evading the sanitary precautions, we fear that much reliance is not to be placed on their efficiency. While, however, a chance of success remains, it behoves the press to co-operate with the government in carrying those measures to effect. True, they are injurious to trade, but what of that? the profits of the merchant must give place to the safety of the public: true they are detrimental to the revenue; but surely it would be better, if need be, to levy a tax upon the purses of liege subjects than upon their lives. Besides, the period of doubt cannot last long: *if the disease come, why then farewell to further quarantine, at least by sea: if it be kept out, then the measureless benefit of its exclusion will reconcile the most prejudiced and discontented to the temporary inconvenience.*²⁹

Yet, despite the extent and rigours of quarantine measures which were put in place, cholera did arrive on British shores and continued to spread inland throughout 1832. This was, as the author of the above statement feared, partly due to the fact that smuggling had increased with a gusto to match the rigidity of the quarantine regulations, and also because, particularly during this first epidemic, the disease was so little understood. The rapidity and violence of the new disease, along with its mysterious aetiology, terrified the public and sent the medical profession into a frenzy of observing and theorising. As the disease appeared to follow neither the 'normal' paths of human intercourse nor any patterns of climate,³⁰ methods of prevention for plague were applied. Methods of treatment varied greatly. One Dr. Knapp of Musselburgh wrote a letter to the editor of the *London Medical Gazette*, during the epidemic, detailing 'ghastly' cases of the disease he had attended.

In the worst cases of cholera, where the disease comes on so suddenly as almost instantly to threaten annihilation, it has occurred to me that the Spiritus Ammoniae Succinatus might be the best stimulant, reasoning from its well known efficacy in rousing dormant vital powers after the injury sustained by them from the bite of the rattle snake.³¹

²⁹ McDonald, 'The History of Quarantine', p. 28.

³⁰ *London Medical Gazette*, November 5, 1831, p. 159, (my italics).

³¹ Pelling, *Cholera, Fever and English Medicine*, p. 2.

London Medical Gazette, November 13, 1831, p. 187.

The containment of cholera was largely unsuccessful, and during 1831-2 it was estimated that 30,900 people died from the disease in England.³² It was this failure of quarantine procedures to protect the British public from the importation of cholera during this first epidemic and those of the following two decades, which encouraged a more widespread opposition to the system. It was a combination of this and developing sanitary reforms from the 1840s that also led to precocious suggestions of an extension of sanitary methods to the ports.

It does not appear that the Quarantine has been of any avail in cholera.... A sanatory [sic] maritime police is therefore indispensable; into which it would be advantageous to convert all the quarantine officers of Europe. The futile, superstitious practices of the lazarettos are as contemptible in the eyes of science as they are injurious to commerce.³³

In the General Board of Health's 1849 *Report on Quarantine*, there was a clear opposition to quarantine. It also displayed and advanced growing support for anti-contagionist theories in respect of quarantine. The importance of this report was emphasised by Margaret Pelling who noted its effect in 'arousing the latent opposition of the medical profession'.³⁴ Co-written by Carlisle, Ashley, Chadwick and Southwood-Smith, the report set about proving through accumulated 'evidence' and 'experience' that not only were 'epidemic' diseases not contagious but also that quarantine had failed to prevent imported infection. It sought to reveal 'whether quarantine can prevent the extension of epidemic diseases, whatever may be their nature, whether contagious or not'.³⁵ Essentially the report was a manifesto on the non-contagious nature of epidemic disease, and the subsequent importance and superiority of sanitary methods over the misinformed and ineffectual practice of quarantine.³⁶

The substitution of general sanitary regulations to ships in port, for the existing quarantine regulations, would far more effectually extinguish

³² *Report on the Mortality of Cholera*, p. xlvii.

³³ *ibid.* p. c.

³⁴ Pelling, *Cholera, Fever and English Medicine*, p. 64

³⁵ *Report on Quarantine, 1849*, p. 17.

³⁶ See Chapter Two

epidemic disease, and afford better protection to the uninfected on ship board, whilst it would relieve passengers and crew from grievous inconvenience, abate the motives to concealment of sickness and to false representations as to its nature, greatly lessen commercial expenses and remove obstructions to the free transit of goods and uninfected persons which the existing system of quarantine occasions.³⁷

Quarantine, however, was still widely in use for the reception of cholera patients, and it continued to display its devastating deficiencies. In William Farr's 1850 *Report on the Epidemic Cholera of 1848 and 1849*, there was a noted disparity in the morbidity and mortality of the 1831-32 and 1848-49 epidemics. The significant increase in the late 1840s epidemic was, however, not attributed to any relaxation of quarantine, but as support for more miasmatic theories of disease aetiology grew, to the worsening of conditions in industrial towns and cities.³⁸ 'Miasma',³⁹ disease poisons found in conditions such as overcrowding, dampness, lack of ventilation and drainage, and filth, were beginning to be held to blame as both the exciting and predisposing causes of the disease, rather than strictly contagion.⁴⁰

Little was still known about the cause of the disease. By the late 1850s the waterborne theory was given some support, others favoured miasmatic theories, while numerous variations on these were also used to account for its transmission.⁴¹ Meanwhile, quarantine was losing widespread support, both because of its failure to prevent the 1832, 1848 and 1854 epidemics – 'it does not appear that the Quarantine has been of any avail in cholera'⁴² – and its incompatibility with Britain's commitment to the ideology of *laissez faire*. The latter was the main point which distinguished Britain from other European countries in formulating preventative measures against the disease. In the second half of the nineteenth century Europe responded to repeated

³⁷ *Report on Quarantine, 1849*, p. 126.

³⁸ *Report on the Mortality of Cholera*, p. xlvii. See also, Christopher Hamlin, *Public Health and Social Justice in the Age of Chadwick: Britain, 1800-1854*. (Cambridge: Cambridge University Press, 1998).

³⁹ 'The term 'miasmatic' is one of the most ambiguous terms in the history of nineteenth century medicine', Worboys, *Spreading Germs*, pp. 38-42; see also, Margaret Pelling, 'Contagion / Germ Theory / Specificity', W.F. Bynum and R. Porter (Eds.), *Companion Encyclopedia of the History of Medicine*, vol. 1, 309-333, (London: Routledge, 1993).

⁴⁰ See Chapter Two.

⁴¹ See Baldwin, *Contagion and the State*, pp. 147-49; Worboys, *Spreading Germs*, pp. 35-42 & 113-15; Pelling, *Cholera, Fever and English Medicine*, pp. 48-63; and Christopher Hamlin, *A Science of Impurity: Water Analysis in Nineteenth-Century Britain*, (Bristol: Hilger, 1990), pp. 105-07

⁴² *Report on the Mortality of Cholera*, p. c.

cholera epidemics by organising a number International Sanitary Conferences aimed at collective prevention. The first of these was held in Paris in 1850-51. Britain, at the time of greatest national support for anti-contagionist theory, was unable to persuade the other nations to reject quarantine and a policy of uniformity was adopted which fixed a minimum and maximum period for the quarantining of cholera, plague, and yellow fever.⁴³

Britain was obliged to conform somewhat with international requirements but continued to develop an approach to cholera prevention which was more compatible with the doctrine of free trade, so important to her economic and political structure. Throughout the 1850s and 1860s Britain responded to the threat of cholera with sanitary improvements and increasing professionalisation and legislation in the area of public health.⁴⁴ By the mid-1860s Britain had effected considerable advancements in the general sanitation and sanitary organisation of London and other major cities. However, in 1866 epidemic cholera struck Europe yet again, this time originating in Egypt. The epidemic was the last to have any significant effect in Britain – killing 7 in every 10,000 of the population⁴⁵ - and demonstrated that British defences were lacking in two key areas, the cleanliness of the water and the sanitary regulation of shipping.⁴⁶

From the beginning of the 1860s there were further enquiries in Britain into the efficacy of employing quarantine as the chief method of cholera prevention. In 1861 the 'Social Science Quarantine Committee' submitted a report, published by the Board of Trade, recommending, importantly, that when a vessel arrived in a port and had been inspected by the Quarantine Medical Officer any cases of illness should be removed to hospital but 'the healthy should not be detained'.⁴⁷ Similarly in 1868 'a strong deputation, representing the medical profession, presented a memorial to the Privy Council, in which they urged that the subject of quarantine had for the past twenty years been under the notice of the public, and that the present system had

⁴³ See Chapter Two.

⁴⁴ Christopher Hamlin, 'State Medicine in Great Britain', Porter (Ed.), *The History of Public Health*, 132-164; and D. Porter, 'Public Health', W. Bynum & Roy Porter (Eds.), *Companion Encyclopedia of the History of Medicine*, vol. II, (London: Routledge, 1993), 1231-1261.

⁴⁵ R. Thorne Thorne, 'On Sea-Borne Cholera: British Measures of Prevention v. European Measures of Restriction', *BMJ*, August 13, 1887, p. 340.

⁴⁶ Hardy, 'Cholera. Quarantine and the English Preventative System', p. 255.

⁴⁷ Collingridge, 'On Quarantine', [Part I], p. 648.

utterly failed during its trial in 1832, and had moreover been productive of great inconvenience'.⁴⁸

The development of the country's national sanitary system of public health provision and monitoring was, from the 1850s, well underway, and Medical Officers of Health had overseen the public health of a number of local areas since the passing of the 1848 Public Health Act. However, the role of the Medical Officers of Health whose districts touch upon rivers, ports and harbours was, from the late 1860s, beginning to be questioned. This issue was raised at the 1869 Royal Sanitary Commission and it was revealed that ships lying within a harbour were 'considered under no sanitary authority'.⁴⁹ While giving evidence, the Medical Officer of Health for Southampton, J.R.Slebbing, informed the Commission of particular difficulties associated with cholera prevention at the ports. He explained that because the disease did not fall strictly within the wording and possible remit of the Quarantine Act – being neither plague or yellow fever - the landing of a case of cholera had proved to be highly problematic. Firstly, while the case was on board a vessel within the harbour it was not within the boundaries of either a sanitary authority or parish or borough, therefore it was unclear under whose responsibility and, importantly, whose expense, it should fall. If, on the other hand, the case – while within the quarantine period - was landed it would, under international agreements relating to the definition of an 'infected port',⁵⁰ mean that any ship subsequently sailing from the port would not be granted a clean Bill of Health.

The present law imagines that those who are well and have undergone a medical examination may be landed, and those that are sick should be placed in some hospital. But the moment we land a person with cholera we place every ship from Southampton in quarantine all over the world, and very seriously affect the packet service of the country... [However], you cannot put them in quarantine; it is a very unsafe thing to land the passengers, and it is a

⁴⁸ *ibid.*

⁴⁹ *Second Report of the Royal Sanitary Commission - Vol.I The Report.* (London: HMSO, 1871), [C 281], p 51.

⁵⁰ See Chapter Two

serious thing to keep them out in the water with the germs of the disease on board.⁵¹

Southampton illustrated the problem that although, as Slebbing pointed out, 'we have sometimes upwards of 1,000 emigrants that come on board foreign ships into our port in a week',⁵² no official means existed for ensuring a thorough medical examination of each ship; there was also no means for dealing with any illness found on board which was not specified under the Quarantine Act. Vessels could be detained by Customs only if a case of plague or yellow fever was suspected, or if a cholera epidemic threatened and a General Order had been issued with specific regard to vessels arriving from infected ports. Otherwise, the Customs Service was not responsible. Yet, ships infected with non-quarantineable disease ('indigenous' disease) also lay beyond the jurisdiction of the local urban sanitary authority and the local poor law parishes or boroughs. The Harbour Commission which governed various aspects of the Port of Southampton, like similar bodies in other ports, did not employ a medical member and its 'jurisdiction in sanitary matters would be a very questionable thing'.⁵³ Thus, in effect no authority had jurisdiction over or responsibility for cases of non-quarantineable disease which was brought on board a ship into a British port.

Subsequently, and in response to these difficulties, the Commission recommended that any urban or rural sanitary authority adjacent to a harbour should extend its powers and those of its representatives to act 'for sanitary purposes in the harbour'.⁵⁴ It was also recommended that the sanitary authorities which incorporated the harbours should work co-operatively with the quarantine service and attend to ships which carried on board cases of infectious disease not touched by the Quarantine Act – 'indigenous' disease.

Quarantine has hitherto been imposed and administered by the Privy Council, with the assistance of the local Custom House staff. It is looked upon in this country mainly as a subject connected with trade or political considerations.

⁵¹ Evidence given by J.R.Slebbing, [5911], *First Report of the Royal Sanitary Commission with the Minutes of Evidence up to 5th August, 1869*, (London: HMSO, 1870), [C. 281], p. 330.

⁵² *ibid.*

⁵³ *ibid.*

⁵⁴ *Second Report of the Royal Sanitary Commission*, p. 133.

We make the following recommendations, with a view to bringing quarantine arrangements ... into harmony with the future general sanitary administration which we have proposed.

Should our recommendation that there should be a Local Authority, with a health officer in and for every place or district of England and Wales, be carried out, all adjacent British waters should be declared to be within the district of such Authority, who could carry out quarantine regulations either in case of emergency, or systematically when quarantine is enforced for political or other reasons.⁵⁵

These recommendations were incorporated into the Public Health Act of 1872, which required the appointment of a Medical Officer of Health to each of the newly established urban and rural sanitary districts which covered the entire country. Among these districts were port and riparian sanitary districts to which the local authority appointed sanitary and medical officers – the Port Medical Officers of Health.

The Port Sanitary Authority and the application of sanitary methods of prevention at the ports thus became the basis of the 'English System'. This system and the professional groups established for it were developed both as a means to providing a more comprehensive system for the reception of infected vessels and as an alternative to quarantine. Quarantine was more widely arraigned in the second half of the century than in Maclean's day and was, among a range of other indictments, condemned as 'injurious to trade'.⁵⁶ British commitment to free trade could not sustain a system which enforced the periodic restriction of movement on all incoming shipping. It was the pressures which prolonged detention and isolation of vessels placed on commercial interests that was at the core of British opposition to quarantine, particularly with regard to vessels travelling between Britain and various parts of the Empire. Whenever quarantine was raised in discussion, whether in parliament, general or medical periodicals, newspapers, or international conferences, the impact of quarantine on trade was never far from consideration. Quarantine, which isolated the sick and healthy alike, was deemed to be more of a hazard in the spread of disease than a solution, but even this persuasive argument seemed to be made with commercial interests very much in mind. However, whilst conflicting with the

⁵⁵ *Ibid* p. 49

interests of many, quarantine continued to be supported well into the nineteenth century.

Bringing Port Health Within the Sanitary System: The Establishment of the Port Sanitary Authority (with special reference to the Port of London)

The Sanitary Commission and the 1872 Public Health Act provided the legal requirement and foundations for a sanitary system of prevention and offered an alternative to quarantine. The deficits in 'indigenous' disease control at the ports was also rectified.

But what is our alternative system? Having deliberately abandoned the system of quarantine,⁵⁷ we began, many years ago, to organise the system of medical inspection with isolation. The medical inspection comes first into operation on our coasts... The medical inspection is thus followed by isolation of the sick. Unlike a quarantine system, this process does not interfere with the healthy, or expose them to risk by herding them together with the sick, but the names of the healthy and the places of their destination are taken down, and the medical officer of health of the districts in question are informed of the impending arrivals. This part of our system has been named our first line of defence...⁵⁸

This first line of defence brought together the independently operating, localised authorities which dealt with cases of imported 'indigenous' disease prior to 1872. Although remaining within local administration, disease and sanitary control of the ports was brought under the central, standard agency of the Local Government Board. For example, before 1872 a selection of independently operating *ad hoc* authorities protected the Port of London from the introduction of sea-borne infectious diseases. These included: the Thames Shipping Inspection Committee, representing riverside parishes in the prevention of cholera; forty-six individual riverside authorities; the Thames Conservancy; and Her Majesty's Customs Service. Similar joint authorities

⁵⁷ *BMJ*, May 23, 1885, p. 1068.

⁵⁸ Quarantine was actually still operational both in law and in practice, however rarely, when this quote was written in 1887.

⁵⁹ Thorne Thorne, 'On Sea-Borne Cholera', p. 340.

operated in other ports around the country although no organised system consolidated the methods of prevention practised around Britain's coastline.⁵⁹ With the passing of the 1872 Public Health Act 'the Local Government Board constituted certain of the Customs ports, or parts of such ports, into Port Sanitary Districts, appointing the pre-existing local sanitary authorities (urban or rural, as the case might be, and singularly or in combination) Port Sanitary Authorities for the administration of business appertaining to health'.⁶⁰ The effect was to standardise the approach to port prophylaxis and, as Anne Hardy has pointed out, bring a 'systematic supervision of entry to the country'.⁶¹ Generally, the port authorities were modelled on the existing structures of urban and rural sanitary districts. The Port Medical Officer of Health was usually a part-time post undertaken in addition to other employment. Very often in smaller ports the Port Medical Officer became an extension of the role and duties of the position of Medical Officer of Health for the local sanitary district. London and Liverpool were exceptional in that the Port Medical Officer was employed on a full-time basis. In London, due to the size and heterogeneous nature of the business of the port, various medical and sanitary officers were employed to oversee the health of the port. Yet, both the smaller more remote ports and the sixty-nine mile jurisdiction of the Port of London Sanitary Authority

had for their object the twofold purpose of – (1) forming in concert with the Customs authority the first line of defence against the introduction of and spread of dangerous infectious disease, and (2) the preservation of the health of crews and passengers by securing that vessels should be kept in a wholesome condition.⁶²

Port of London Sanitary Authority was established in 1872 under the local administration of the Corporation of London. The London Port Sanitary Committee was appointed by the Court of Common Council 'to make the necessary arrangements to put in force the Public Health Bill when the same shall have received the Royal

⁵⁹ For arrangements made at individual ports in anticipation of cholera in 1871 see: Appendix 47. 'First report of the Local Government Board, 1871-2'. *British Parliamentary Papers – House of Commons 1872*, 36296, vol. xxviii, p. 334 – 336.

⁶⁰ 'Report by Dr. Blaxall on the Sanitary Survey of Port and Principal Riparian Sanitary Districts, 1885-6'. *Fifteenth Annual Report of the LGB, 1885-6*, Appendix No. 8, p.129.

⁶¹ Hardy, 'Public Health and the Expert', p.135.

⁶² 'Report by Dr. Blaxall...1885', p. 129.

assent'.⁶³ The Committee first met on July 29, 1872 and Royal assent for the Act was issued in late August 1872. It was a full year later when the committee advised the Corporation to appoint a Port Medical Officer of Health and Sanitary Inspector. During the eleven intervening months, the committee worked through the various logistical requirements of putting the Act into practice.

One of the first achievements of the new Sanitary Authority in London was to acquire a hospital ship to receive cases of infectious disease as they arrived in the port. The old man o'war hulk *H.M.Ship Rhin*, which had already been used by the Seamen's Hospital Society for the hospitalisation of cholera patients, was acquired with ease from the Admiralty. Prior to 1872, cases of cholera, arriving into London, were sent to the Hospital Ship *Dreadnought*⁶⁴ which was maintained by the Metropolitan Asylum Board.⁶⁵ On the establishment of the Port Sanitary Authority, the Metropolitan Asylum Board relinquished this responsibility and handed it and the ship over to the Port Sanitary Authority. The Admiralty granted Sanitary Authority permission to take the ship for isolation purposes. However, the decision was made to abandon use of the *Dreadnought*, and acquire the *Rhin*.⁶⁶ Alterations were made within it, and a permanent mooring, with the ascent of the Thames Conservancy, was established for it at Gravesend.⁶⁷ The ship was provided with two shipkeepers who were required to live on board the vessel with their wives, who acted as nurses to the patients and cleaners of the six bed hospital.

Months before the appointment of the first Medical Officer of Health for the Port of London, the committee employed a medical officer to run the *Rhin*, care for the patients, and oversee the maintenance of sanitary conditions on board the ship. The man appointed to this position was Dr Philip Whitcombe, a 'medical gentleman'⁶⁸

⁶³ CLRO, *PSCM*, vol. 1. 'Commencing 21 Aug. 1872 – Ending 15 Oct. 1873', Aug. 21. 1872

⁶⁴ The *Dreadnought* had begun as a war ship, and had been used in the Battle of Trafalgar. It was put in the service of the Seaman's Hospital Society in 1831 and was used as an isolation ship by the Central Board of Health during the cholera epidemic of 1831-32. It was used for the same purpose in 1848-9 and 1853. Cook, *From the Greenwich Hulks to Old St Pancras*, pp. 39-54.

⁶⁵ 'The Metropolitan Asylum Board had been set up in 1867 to provide and maintain hospitals and institutions in London for many branches of medicine, including infectious diseases', *ibid.* p. 51.

⁶⁶ CLRO *PSCP*, 1872. Letters from the Metropolitan Asylum District to the Port Sanitary Committee. Guildhall -- dated 3 August, 1872, and 26 August, 1872.

⁶⁷ Gravesend was the location of the Customs Authority and, from 1872, the Port Sanitary Authority. It marked the furthest point on the River Thames to which a ship could sail on any tide.

⁶⁸ Whitcombe was licensed by the Society of Apothecaries, London, in 1839, and became a Member of the Royal College of Surgeons, London, also in 1839.

working and residing in Gravesend. Patients from vessels who displayed symptoms of 'indigenous' infectious disease were referred by the Customs authority into his care; although from a report in the Port Sanitary Committee Minutes in mid-1873, it appears that the Customs service had, in these early years, required reminding of the co-operation necessary between the two authorities.

a reply [was] sent to the... Secretary to Her Majesty's Customs stating that the ship *Rhin* has been placed at Gravesend for the reception of cholera, small-pox and other patients suffering from contagious disease. Also that the Port of London Sanitary Authorities will feel obliged by instructions being given to the Officers of H.M. Customs at Gravesend to communicate with Dr Whitcombe should any of the contagious diseases be found on board any vessel arriving at Gravesend in order that the necessary steps may be taken for the prevention of the spreading of contagion.⁶⁹

Whitcombe also filled the role of Port Medical Officer until the position could be otherwise filled – the cut off date for which was originally March 25, 1873. However, it was not until July 1, 1873, that the committee resolved to advise the Corporation of London,

to appoint a Medical Officer to take charge of the whole of the Port of London, including the Hospital Ship *Rhin* at Gravesend. Under the Public Health Act of 1872 until the 25th of March next – that the salary be at the rate of £400 per annum and that this Committee do select three qualified persons from which the Court of Common Council shall elect such Medical Officer. Also that an inspector be appointed to act under the Medical Officer, to assist in carrying out the provisions of the Public Health Act 1872, and that he be paid a salary of £120 per annum.⁷⁰

The Corporation of London instructed that the Port Medical Officer of Health should be a 'legally qualified Medical Practitioner', but that the Sanitary Officer, or Port

⁶⁹ CLRO, *PSCM*, vol. 1, July 3, 1873.

⁷⁰ *ibid.* July 1, 1873.

Inspector of Nuisances, was only required to be a 'competent person'.⁷¹ Thus, when the two positions were advertised the Sanitary Officer's position appeared in the *Daily Telegraph*, *Daily News*, *The Times*, *Standard*, *City Press* and *Shipping Gazette*, while the Port Medical Officer of Health situation was also posted in the *Lancet* and *Medical Times*, (although surprisingly, not in the *British Medical Journal*). Interviews for both positions took place on July 16, 1873. On July 28 the Court of Common Council appointed Harry Leach, who had previously worked at the Seaman's Hospital and as a medical advisor to the Board of Trade, as the first Port Medical Officer of Health and William Henry Lewis as the Port Sanitary Officer.

The duties of the Port Medical Officer of Health conformed from the beginning with the basic tenets of the 'English System'. This system worked on the sanitary and hygiene principles of disinfection and isolation. In the *Vide Report of the Port of London Sanitary Committee, 1873*, the duties of the Medical Officer included:

To enquire into the water-supply of all vessels in the Port, and advise as to its proper sources and storage.

To superintend the immediate removal from a vessel of any person suffering from a contagious or infectious disease to the hospital set apart for the purpose of the Sanitary Authority, or if the sick person is not in a condition to be removed, to isolate the vessel. (see 29th and 30th Vict., cap.90, sec 29.)

To superintend the disinfection of all clothing of seamen who have died from an contagious or infectious disease and to grant a certificate accordingly.

To inspect, before landing, all emigrants that arrive in the port from the Continent for purposes of transshipment, and to isolate all suspected cases.

To carry out, under the direction of the Port Sanitary Authority, all special Orders in Council relating to the prevention of cholera, or other epidemic diseases.

CLRO: *Assignment of Powers to the Corporation of London as the Sanitary Authority for the Port of*

To obtain all possible information as to, and keep a close account of, all foreign ports infected with, or suspected of, cholera, and with the aid of the Customs Officers, to inspect all vessels as they arrive from such ports.

To communicate and co-operate in all sanitary matters with officers of Her Majesty's Customs, the Marine Department of the Board of Trade, the Harbour and Dock Authorities, the river Police, and all other authorities concerned in the official business of the port.⁷²

The duties of the Sanitary Officer related primarily to the inspection and maintenance of sanitary conditions on board vessels, such as ensuring the cleanliness of closets and latrines, that the crew and passenger quarters were sufficiently ventilated, and that adequate cubic space was provided per person on board. He was also responsible for carrying out disinfection, cleansing and fumigation on vessels, goods and clothing where instructed by the Medical Officer.⁷³ Both the duties of the Medical and Sanitary Officer were carried out in co-operation with the Quarantine Officer of the Customs Service.

It is evident from these duties that from the outset a primary responsibility of the Port Medical Officer of Health and his staff was to protect the ports from the importation of infectious disease. Co-operation with the Customs service was also emphasised in the duties, particularly in relation to cholera, while the position of the Port Sanitary Authority as a separate and important organisation within the port was also confirmed. However, what most clearly demonstrated the establishment of the Port Sanitary Authority as the new, additional and alternative system of disease prevention was the appointment of Whitcombe and the acquisition of the *Rhin* as hospital to the Port Sanitary Authority. While the Sanitary Committee acted with a degree of leisure in appointing a Port Medical Officer of Health and Sanitary Officer to oversee the health and sanitary condition of the port, the same leisure was not afforded to the establishment of the infectious disease hospital or to the appointment of its medical officer. The ship was a physical presentation of the new authority in the port and

London, 7 Sept, 1872. (Misc. MSS. 40. 1).

⁷³ CLRO, *Return of Corporation Appointments, 1879*, (London: Charles Skpper & East Printers, 1879)

p. 115

ibid

demonstrated the Port Sanitary Authority's appropriation of responsibility over the prevention of imported 'indigenous' disease. Located near the Customs Pier the *Rhin* displayed the new authority as a counterpart to the role of the Customs Service and Privy Council in disease prevention at the port. The Port Sanitary Authority co-operated with the other authorities still operating in the port such as the Customs Service and Seaman's Hospital Society. However, the appointment of Whitcombe and the massive display of the new hospital ship immediately represented the authority of the new Port Sanitary system and the distinctive methods it would employ.

After the appointment of Lewis and Leach as Port Medical Officer and Port Sanitary Officer, Philip Whitcombe was maintained as physician on board the *Rhin*⁷⁴ with the official title of *Medical Officer of the Rhin stationed at Gravesend for the reception of patients suffering from contagious diseases*. A summary of some of his duties upon the hospital ship further demonstrates the role of the Port Sanitary Authority from its inception. These duties overlapped with those of the Port Medical Officer particularly because of the delay which occurred between the appointments.

To inspect every vessel at Gravesend reported by the authorities of H.M. Customs as unclean or infected, and order the removal of all cases of contagious disease to the Hospital Ship 'Rhin' for medical treatment.

To give personal attendance to every case admitted on board the 'Rhin' once in every twenty-four hours, and at other times when specially summoned.

Upon admission of any case of acute febrile nature, or one in which the occurrence of delirium may be expected, to appoint a Resident Assistant Medical Officer to remain on board the 'Rhin' until such case or cases may become convalescent.⁷⁵

⁷⁴ Thus the employees of the Port of London Sanitary Authority from 1873 were:
Medical Officer of Health, (from July, 1873)
Port Sanitary Officer, (from July, 1873)
Medical Officer of the *Rhin*, (from September, 1872)
Shipkeeper of the *Rhin* x2, (from September, 1872).

⁷⁵ *Return of Corporation Appointments*, p. 115.

Although being subject to constantly changing General Orders, the basic duties of the three key occupations within the Authority did not alter much for the rest of the century.

The authority of the Port Medical Officers in overseeing the sanitary standards and reception of infectious diseases in the port and riparian districts was finalised with the passing of the Public Health Act 1875.

The Local Government Board may, by provisional order, permanently constitute any local authority whose district or part of whose district forms part of or abuts on any part of a port in England, or the waters of such port, or any conservators commissions or other persons having authority in or over such port or any part thereof, (which local authority conservators commissioners or other persons are in the Act referred to as a 'riparian authority,') the sanitary authority of the whole of such port or of any part thereof (in this Act referred to as the 'port sanitary authority') ...⁷⁶

Whereas the 1872 Act had bestowed the authority of assigning the powers and duties of the Port Sanitary Authority on the Local Government Board, the 1875 Public Health Act granted the separate Port Authorities greater autonomy, although they ultimately still remained within the mandate of the Local Government Board.⁷⁷ A particularly important aspect of the 1875 Act was Section 130 which permitted the Local Government Board to alter or revoke any regulations in order for the Port Sanitary Authority to prevent the spread of cholera.⁷⁸ The powers of the Port Sanitary Authority were further extended by the Disease Prevention Act of 1883 which declared the Port of London Sanitary Authority to be an Urban Sanitary Authority, 'and giving the Local Government Board the power of assigning to them any such powers, rights, duties, capacities, liabilities and obligations as might appear to the Board to be required'.⁷⁹ The Public Health (Shipping) Act 1885 extended this and enabled the Port Medical Officers to act with more autonomy. It also enabled them to

⁷⁶ Public Health Act, 1875 [38 & 39 VICT.], Section 287.

⁷⁷ *ibid.*, Sections 287-90.

⁷⁸ *ibid.*, Section 130.

⁷⁹ William Collingridge, *The Duties of the Port Inspectors of Nuisances*, for the Association of Public Sanitary Inspectors, (Whitechapel: Thos. Poulter & Sons, 1887) p. 29.

impose fines on shipping companies and captains who withheld information about possible infections.

On December 13, 1879, Dr Harry Leach, the first Medical Officer of Health to the Port of London, died at the age of 43 of tuberculosis after a long period of illness. He was replaced in 1880 by William Collingridge M.D., D.P.H., a physician who had been employed in private practice for the previous two years and had served as a volunteer surgeon with the Serbian army during the Turko-Serbian war of 1875.⁸⁰ Collingridge also had a B.A., M.A. and LL.M. from Cambridge, indicating that the full-time position of Medical Officer to the Port of London was prestigious enough at this time to attract a man of Collingridge's calibre.⁸¹ He remained in the post until replaced by Herbert Williams M.D., D.P.H. in 1901 who had been employed in the Port Sanitary Authority as 'Medical Officer for Boarding purposes' since 1892. An indication of the volume of their work, during the first twenty years of the Port Sanitary Authority, is evident in Table II, which shows the number of vessels inspected, cleaned, fumigated and the number of confirmed infectious cases received.

By 1883 it was beginning to become apparent that both a more permanent and more suitable port isolation hospital was necessary in London. It was put to the Court of Common Council in a report from the Port Sanitary Committee that not only did the poor ventilation on board the *Rhin* 'retard recovery', but that the old hulk was in such an unsound state of disrepair, 'her upper works being so very rotten and defective', that a lengthy and expensive period of dry docking would be required for the Admiralty to 'put the ship in something like a serviceable condition'.⁸² Furthermore, it was argued that the *Rhin* incurred an unnecessary expense which a land hospital would avoid. The average annual repair costs of the floating hospital were over five times greater than they would be maintaining a land hospital, insurance premiums were more costly, while the *Rhin* incurred the additional cost of running and maintaining the boat required to take patients and the Medical Officer to and from the

⁸⁰ See also, O'Driscoll, 'Against Infection and the Hand of War.', p. 68.

⁸¹ Collingridge was paid £500 per annum when appointed in 1880. His pay was increased to £700 per annum in 1884. When Williams was employed his salary began at £650 per annum. This was increased to £800 per annum in 1906. CLRO, *Return of Corporation Appointments, 1886*, (London: Charles Skipper & East Printers, 1886); *Return of Corporation Appointments, 1908*, (London: Charles Skipper & East Printers, 1908).

⁸² CLRO, *Hospital at Gravesend - Report to the Court of Common Council from the Port of London Sanitary Committee*, April 26, 1883, Printed Reports Index, A114F, p.4.

hospital ship. Finally, if and when it became necessary to replace the *Rhin* another hulk, with the cost of purchasing and then adapting it for the requirements of a hospital, would amount to significantly more than the cost of acquiring the desired land and erecting a new hospital.⁸³ Thus, with the advice and supervision of the Medical Officer of the Local Government Board, the Corporation of London purchased a piece of land on which the hospital was built. The site lay at Denton, close to Gravesend and the old Customs House and covered one and a half acres, with a river frontage of 100 feet. The new hospital, which contained an administration block, one ward for ten patients and a small single ward for 'better class patients or other specific purposes',⁸⁴ was formally opened on April 17, 1884.

Putting the Port Sanitary Authority into Practice and the Problems of Dual Authority

In late July, 1873, almost immediately upon the appointment of Leach to the position of Medical Officer to the Port of London, a vessel arrived in the Port of London full of European emigrants en route to New Zealand. It had two cases of cholera on board. This was the first case of infectious disease since the establishment of the Port Sanitary Authority. The ship *Iris* had taken on board emigrants from Hamburg, Kiel, and Copenhagen, and arrived in London with the appearance of a clean Bill of Health. However, six to eight hours after the emigrants reached their respective temporary lodgings in Whitechapel, two of the ship's passengers, a man and child, were attacked by the 'undoubted' symptoms of cholera. The child died not long afterwards and the man was immediately isolated. The remaining 80 emigrants were temporarily removed from their lodgings, with the assistance of the Whitehall and Whitechapel 'local authorities', to the *Rhin* for isolation and observation. The healthy were separated from the sick and were accommodated on board the *S.S. Osprey*, chartered by the emigration agency in charge of their passage to New Zealand. They remained on the *Osprey* until August 17 when they were released back to the emigration agency. During this period, seven more emigrants developed symptoms of the disease and were admitted to the *Rhin*. When the infection was first detected the *Iris* was placed in selected moorings off Deptford Creek. It was disinfected by the Port

⁸³ *Ibid.* pp. 5-6.

Sanitary Officer and released again within a few hours, causing 'a minimum of distraction to commercial interests'.⁸⁵

In response to the *Iris* case and the possibility of further outbreaks of cholera, a 'temporary arrangement [that] all vessels that arrive from 'suspected' ports shall be systematically examined at Gravesend'⁸⁶ was put in place. However, despite the fact that a German line of passenger steamers had decided to 'make London their port of call instead of Harve (*sic*) where the authorities have established a three day quarantine',⁸⁷ the only other cases of suspected cholera which were referred to the *Rhin* that Summer were two seamen in mid-August and late September (only one of whom was recorded as suffering from cholera, while the other turned out to be merely a bad case of diarrhoea).

The *Iris* was the first case of imported infectious disease dealt with by a Medical Officer of the Port of London. It marked a departure from procedures previously employed at the port and demonstrated a number of features particular to the 'English System'. The two most characteristic of these features were the co-operative working of the Port Sanitary Authority with local, inland, sanitary authorities; and the separation of the sick, as well as passengers believed to be at risk, from the ship on which they arrived. A peculiarity of the 'English system' was that the health of the port was not separated from internal health - that is, the provision and administration of health and preventative systems in localities outside port and riparian sanitary jurisdiction. The 'English system' depended on communication and co-operation between port, riparian, urban and rural sanitary districts. Each separate branch of the sanitary system, although under local administration, operated within a national framework overseen by the Local Government Board. Throughout the century these relationships became increasingly complex but were based from this early stage on the idea of sanitary surveillance. The idea was that if individual cases of disease could be monitored within and between localities, and the sanitary conditions of these localities were maintained at a high standard, the disease could not spread.

⁸⁵ Patricia O'Driscoll, 'Against Infection and the Hand of War', p. 67.

⁸⁶ CLRO, *PSCM*, vol. 1, July 31, 1873, Harry Leach, 'Special Report on Cholera'.

⁸⁷ *ibid.*

⁸⁸ *ibid.*, Sept. 2, 1873

What was particularly important in distinguishing the 'English system' from other preventative systems was that the isolation of infectious cases, as well as suspected cases (where there had been some contact with the disease but no manifestation of it) did not occur on board the vessel upon which they arrived. Infectious cases were removed as soon as possible to the isolation hospital maintained either by the port or riparian authority or local urban or rural authority. The sick were separated from the healthy, who were observed elsewhere. The vessel they arrived on was not detained for a period any longer than it took for it to be thoroughly disinfected, including, importantly, its bilge-water which was subsequently discarded. It was of great importance, as the case of the *Iris* demonstrates, that the presence of infection on board any vessel should cause only a modicum of delay to maritime traffic, and thus, 'a minimum of distraction to commercial interests'. This also explains the importance attached to maintaining high levels of co-operation between the port and internal sanitary authorities. Usually, the infectious disease hospitals provided or used by the port authority accommodated only those who displayed symptoms of infectious disease. Yet, until the incubation period of the disease had elapsed,⁸⁸ other people on board the vessel could still be regarded as 'at risk'. The 'English system' insisted on the separation of the sick from the healthy and rejected the notion of incarcerating the healthy during this period. It was generally only the sick who were kept and isolated by the Port Sanitary Authority. Anyone who did not manifest symptoms indicating the presence of disease was free to disembark once details of his or her intended residence over the following days were recorded. These details were dispatched to the relevant local sanitary authorities who, for the known incubation period, observed the health of the passengers and crew of the vessel. The detention of the *Iris* passengers on board the *Osprey* for 18 days was thus not representative of the 'English System'. No separate vessel or large lazaretto, such as those provided at Pisa, Marseilles, and Venice, was maintained at the port to house shiploads of people for a period of observation. Their health was monitored by the relevant local authority and required only a minimum extension to the duties of the local medical and sanitary officers. This allowed the Port Sanitary Authorities to conduct their duties in such a way as to maintain the efficiency required at a busy and congested port, such as London.

⁸⁸ Incubation periods for different diseases - particularly cholera - remained variable for much of the rest of the century.

However, from very early in the history of the Port Sanitary Authority, the efficacy of the system was called into question. It was a problem that ensued for twenty years and yet was at the heart of the Port Sanitary Authority's role. Essentially, the predicament was that quarantine remained a legal obligation for the reception of vessels carrying plague and yellow fever and, as the law ambiguously stated, '*other infectious disease or distemper*⁸⁹ highly dangerous to the health of His Majesty's subjects'. This meant, in practice, that the Customs Service was legally obliged to approach the master of every ship entering a British port and make enquiries into the health of all persons on board.

The primary duty of the Customs officer is to guard the revenue; but he is further required to exercise certain functions in respect of the health of ships. Besides such duties, hardly more than nominal, imposed on him by the Quarantine laws, he has more important duties in respect of indigenous infections and cholera. He has to make inquiry as to the health of the port whence the vessel has come, and as to the health of the crew and passengers during the voyage home, and at the time of arrival. In the event of infectious sickness being reported to him, he is, in compliance with instructions from the Commissioners of Customs, to acquaint the local authority (Port or Riparian as the case may be) of the circumstance. Upon this authority will then devolve the responsibility of taking steps to prevent the introduction and spread of the disease.⁹⁰

Thus, the first boarding authority on all ships was the Customs Service, operating under the Quarantine Law of 1825. The Port Medical Officer of Health did not examine the passengers or crew of a ship unless the Quarantine Medical Officer referred him to the ship. The Quarantine Officer questioned the master of the vessel and only sent for the Port Medical Officer if he discovered that an infectious disease, beyond the jurisdiction of the Quarantine Law, was present. It was only then that an employee of the Port Sanitary Authority boarded a ship unless, as shall be demonstrated, particular circumstances prevailed. The Port Sanitary Authority had jurisdiction only over those diseases deemed to be 'indigenous' to the British Isles.

⁸⁹ My italics.

⁹⁰ 'Report by Dr. Blaxall...1885', p. 130.

Diseases which were classified as 'exotic' were the responsibility of the Customs Service.

A Quarantine Medical Officer did not always board vessels with the Customs Boarding Officer. If a Customs Officer, while boarding a vessel alone, discovered a disease which was thought to be 'exotic', the Quarantine Medical Officer was brought to the ship to examine the case. In clearly 'indigenous' cases the Port Medical Officer would be summoned. Sometimes the nature of the disease was unclear and it was only after the arrival of the Quarantine Medical Officer that the Port Medical Officer was summoned. The length of time this naturally took compounded the problems of dual authority.

The precise meaning and limits of the term 'other infectious disease or distemper' was what proved most problematic. When the Quarantine Act was passed in 1825 the only 'exotic' diseases at risk of being imported into the UK were plague and yellow fever. The first occurrence of cholera arrived some six years after the passing of the Act, in 1831. Subsequently, it was unclear exactly how the disease was to be dealt with. While the Quarantine Act remained the sole national system of port health, cholera was entirely the responsibility of the Customs Service – as during the epidemics of 1831-2 to 1866. However, responsibility and jurisdiction over cholera infected ships became an increasingly complicated issue after the establishment of the Port Sanitary Authority.

Reduced to its most simplistic terms, cholera could not be regarded as entirely within the jurisdiction of the Quarantine Service because it was not specifically named under the law, as plague and yellow fever were; and it was unclear whether it could be included under the provisions of '*other infectious disease or distemper*'. If cholera did not fall strictly within the Quarantine Act, was it within the remit of the Sanitary Authorities? This was one of the predominant difficulties which the two authorities at the ports faced - who was responsible for dealing with the arrival of a cholera infected vessel? Charles Follet, of His Majesty's Customs Solicitors' Department, when writing to Mr Suft at the Privy Council later in the century, claimed that 'taking the [Quarantine] Act as it stands by itself ... that word [ie. 'infectious'] has only, in my

opinion, the limited meaning of quarantineable disease'⁹¹ - by which he meant specifically plague and yellow fever. Yet, Customs impressed upon the Attorney General that the 'diseases intended to be touched by the Quarantine Acts' relate to 'plague and yellow fever because those are the diseases against which the Act was intended, but not meaning to exclude any other infectious exoteric [ie. exotic] diseases, as for instance, Asiatic Cholera'.⁹² This problem of jurisdiction remained until the repeal of the Quarantine Act in 1896. Until then cholera infected vessel generally required clearance from the Customs Service to enter a port and isolation and medical treatment of cholera cases was the responsibility of the Port Sanitary Authority. However, this process altered at different times and sometimes in different ports making it impossible to define a single procedure for cholera in the period 1872-1896.

The problem of dual authority at the ports, shared between the Port Sanitary Authority and Customs Service, was not confined to the ambiguity of jurisdiction over cholera. Difficulties were also encountered with regard to the identification, notification and inspection of other diseases. While the Customs Service, for example, had the authority to detain vessels with an actual or suspected case of plague, yellow fever or cholera on board, it did not have the power to detain any other vessel. Even if, for example, a vessel was found by a Customs Boarding Officer to have a case of smallpox on board, the Officer could not legally order the detention of the vessel. This meant that the vessel could not be forced to remain at Gravesend by a Customs Officer while the Port Medical Officer of Health was informed of the presence of the disease and was brought to the ship to undertake his own inspection. Subsequently a vessel which carried an infectious disease could sail beyond Gravesend and into London, taking the disease with it. In 1882 the Port Sanitary Committee in London sent a letter to the Marine Department of the Board of Trade to express their concern.

The Port of London Sanitary Committee have recently had under serious consideration the question of the existing quarantine protection of the Port of London and have arrived at the conclusion that in one point the defence of the Citizens of London against that importation of infectious disease is in some degree defective.

Nov. 1891. PRO PCS 447/67807.

It appears that when a vessel has on board a case of infectious disease (other than cholera) and such case has been reported to the Medical Officer of Health of the Port of London, the Officer of H.M. Customs has no power to detain such vessel, until the arrival of the Medical Officer.

As the Port Sanitary Authority have not only a Medical Officer stationed at Gravesend (Dr. Whitcombe) but also a hospital ship, (the 'Rhin') it seems to them most undesirable that such cases should be allowed, under any circumstances, to pass up the River, increasing thereby, as it necessarily must, the danger of the importation of disease.⁹³

This was not the first complaint of this nature that had been forwarded by the Port Sanitary Committee to the Board of Trade. The Committee offered solutions in order to improve the situation, including a serious recommendation for an extension to the powers of the Quarantine Officers. They suggested, in late 1882, that the Quarantine Boarding Officers should have the power to detain vessels which carried any infectious illness for a 'reasonable period (say, six hours)',⁹⁴ to allow time for communication with, and the arrival of, the Medical Officer. The reply from Whitehall was negative, stating firstly that the laws of Quarantine were not cause for concern at the Customs Office, and secondly that it was not the place of the Sanitary Committee to 'take the initiative in proposing any alteration in the law..., that in the opinion of the Board of Customs any further restrictions than those at present in force would cause very serious inconveniences to the shipping interests'.⁹⁵ The Local Government Board supported this view and correspondingly sent a letter to the Committee. They agreed that any alteration to the law which increased the amount of time and number of vessels detained in the port would cause significant and unwanted 'inconveniences' to maritime traffic 'and, as the Board understand, the Medical Officer of Health is promptly informed by telegraph of any case of infectious disease on board ship which comes to the knowledge of the officers of Her Majesty's Customs. The board may add that they are advised that coasters and river vessels, which are not boarded by Customs Officers, are probably more likely to introduce infection than vessels from foreign ports'.⁹⁶ Some serious issues were raised here in

⁹³ Nov. 1891, PRO CUST46/95/25308.

⁹⁴ Sept. 22, 1882, PRO MT10/375/H7298.

⁹⁵ *Ibid.*

⁹⁶ March 7, 1883, PRO MT10/375/15710/83.

⁹⁷ *Ibid.*

relation to the limitations of the Customs Service and the effectiveness of disease prevention under dual authority. However, because the suggested solutions would cause delays in maritime traffic the issue was dismissed.

The key problems in defining the respective roles of the Port Sanitary Authorities and the Customs Service continued to relate to the ambiguous position of cholera and the notification of disease between authorities. The effectiveness and role of the two authorities remained ill-defined well into the 1890s for two principal reasons. The first related to whether or not the failure of a master to report a case of 'indigenous' disease to a Customs Officer could result in prosecution. A master was required to give information about 'any sickness' which had occurred on board during the 'homeward' passage. Although withholding this information would mean 'indigenous' cases were not referred to the Port Sanitary Authority, Customs Officers were only concerned with quarantineable diseases. Masters could be prosecuted under the Quarantine Act if they failed to report an 'exotic' disease to the Customs Officer, but not if they withheld information about an 'indigenous' disease. The second reason related more specifically to cholera. To which authority should cholera be assigned? Although it was classified as an 'exotic' disease, cholera had not been specifically named under the Quarantine Act. Could the Act be applied to cholera infected vessels; or should a Customs Officer refer cases of cholera to the Port Sanitary Authority?

The first of the two problems came to the attention of both authorities with the arrival into the East India Dock in May 1887 of a ship called *Star of Austria*. An inspector from the Port Sanitary Authority examined the vessel having received information about a fatal case of remittent fever that had occurred on board during the voyage from India. On arrival at Mauritius the ship was placed in quarantine for three days and the quarters of the deceased crewmember were thoroughly cleaned and disinfected with sulphur. However, a case of cholera also occurred on the vessel while it was still in Calcutta. Before the vessel departed the man was removed to hospital and his belongings were destroyed. When the vessel arrived in London the master of the vessel omitted to give the Customs Boarding Officer information either about the case of remittent fever or, more importantly, the cholera.

Although the vessel is not liable to Quarantine, the master would have to truthfully answer the preliminary verbal (sic) questions as to 'whence from', 'state of health', 'any infectious illness during voyage', and the like. And he could be prosecuted under the Quarantine Act for untrue answers to these questions.

If he had a case of cholera during the voyage or, as the words are, 'in the homeward passage' I should not hesitate to advise his prosecution, but his cholera case was all disposed of, bed and bedding and all, at Calcutta, with a clean Bill of Health there – while the case 'on the homeward passage' was only a feverish attack.⁹⁷

It was argued that the master had not broken the law either by omitting the case of cholera, or by failing to inform the Customs Officer of the fatal case of fever which had occurred in the 'homeward passage'. The case of cholera occurred before the vessel undertook the voyage and thus the master was not required to declare it. It was also questionable whether the case of remittent fever was 'infectious'. Either way it remained uncertain whether the master had broken the law. If it was an infectious disease it was regarded as an 'esoteric or indigenous disease' and therefore not the responsibility of the Customs Service. As Collingridge wrote in a report to Customs, the Quarantine Act 'only related to exoteric diseases and especially plague and yellow fever'.⁹⁸ If the case of remittent fever was not infectious, the master was not compelled to report it. Collingridge explained that there was neither any actual evidence of the infectiousness of the fever, nor was it considered to have posed any 'serious' threat to the public health.⁹⁹ However, the important point to be extracted from the *Star of Austria* was the ambiguity surrounding the conditions under which a master was required to declare an illness to the Customs Boarding Officer and subsequently which authority then took charge of the case.

I know that the preliminary questions, often put in the wind and rain and with some difficulty are not put very formally, and the question, 'have you any infectious disease &c'. (sic) has grown into the question, 'any sickness', but

⁹⁷ *Quarantine Regulations – Instructions to Service, 1887-1895*. PRO CUST46/95/12717

⁹⁸ *ibid.*

⁹⁹ *ibid.*

the question is more or less a statutory one and the master is only bound to answer it truthfully according to its statutory limit.¹⁰⁰

This 'statutory limit' was at the heart of the ambiguity. The law was particularly unclear regarding the absolute boundaries of these 'limits'. The problems of infectious disease categorisation and the boundaries of Port Sanitary and Customs authorities, which the *Star of Austria* exposed retreated from discussion for a few years, but came to the fore again in 1891 with the arrival of another ship, the *S.S. Memphis*. This vessel presented a similar array of problems to those encountered in 1887. In this case the diseases involved were enteric fever and typhoid fever. Again the problem lay primarily in the question of whether or not a master was obliged to declare cases of 'indigenous' diseases, such as these, to the Quarantine Officer.

It is very doubtful whether there could be a prosecution in this case as it is doubtful whether the Preliminary Quarantine Question as to 'infectious disease' can be held to apply to esoteric or indigenous diseases, and whether even an infectious disease other than plague or yellow fever need be mentioned in answer to these questions ... the Solicitor refers to an opinion given some years ago by the Law Officers of the Crown that 'infectious', in deciding the question of Quarantine or not, means foreign and not indigenous disease, and considers that it may be doubted whether a master would be liable if his answer made no mention of an indigenous disease which happened to be, or have been on board.¹⁰¹

In this case it was feasible that unless changes were made in the law, or with regard to the Port Medical Officers of Health as a boarding authority, imported cases of 'indigenous' disease could pass through the 'first line of defence'. The problem was put to the Solicitor's Department of Her Majesty's Customs yet no definite solution was forthcoming.

¹⁰⁰ *ibid.*

¹⁰¹ PRO CUST46/95/11940.

Part of this draft letter was crossed out but remains legible. It displays some disagreement about the infectious nature of some 'indigenous' disease

...[it is understood] that Dr Collingridge is prepared to give an opinion that typhoid fever is infectious, although it is believed to be the opinion of certainly the great majority of medical men that this illness is not infectious, and that it prevails only epidemically in certain localities by each case having its origin in the same evil cause.

As a matter of fact, my view has been this, viz. – that under the Quarantine Act it is exceedingly doubtful whether any sickness of an indigenous character need be mentioned in answer to the [quarantine] questions, even if it is not perfectly certain that they need not; but that it is very probable that the scope of the Quarantine Act, in this respect, is altered by some references to it in the Public Health Acts, and that is why I say that ‘I am disposed to think’ that any infectious disease should be mentioned.¹⁰²

However, this did not clarify the position of the law on what diseases should be mentioned in reply to the Quarantine questions, nor the responsibility under the law of the Customs Officers in determining the presence of disease, as the first boarding authority, for the officers of the Port Sanitary Authority. The solution became even less clear with receipt of a second letter from the Solicitor’s Department five days later.

When, in a question under that Act [Quarantine Act, 1825], you ask a man if there is any infectious disease on board his ship, he is entitled to understand the word in the meaning which that Act gives to it. If he does, he is answering truthfully; and, in that respect, is bound to answer truthfully, just in the same way as you say he is bound to answer truthfully when he is asked where he has come from.¹⁰³

The lawyer dealing with the case at the Solicitor’s Department of Customs, Charles Follett, was unable to decipher what specifically was meant by ‘other infectious disease or distemper highly dangerous to His Majesty’s subjects’. He asked the Attorney General what these diseases referred to in relation to the practical application of the Quarantine Act and the Public Health Act. According to the Privy Council, Follett explained, quarantineable diseases referred only to plague and yellow fever, although he maintained that these diseases were only the principal diseases against which the Act was aimed, and that the Act was ‘not meant to exclude any other infectious, exoteric disease, as for instance, Asiatic Cholera’.¹⁰⁴ He suggested

¹⁰² Nov. 14, 1891, PRO PC8/447/67807.

¹⁰³ Nov. 19, 1891, *ibid.*

¹⁰⁴ Nov. 16, 1891, PRO CUST46/95/25308.

that the ‘other infectious disease[s] or distemper[s]’ could be a reference to ‘infectious diseases placed under the charge of the Public Health Act’. This would solve the problem of what diseases masters were obliged to report. It would require ‘an extension by Parliament of the meaning of the word ‘infectious’ in the Quarantine Act’ and would ‘enlarge its meaning beyond what has, for many years been attached to it’.¹⁰⁵ However, the reply from the Royal Courts of Justice, did little more than bring the problem almost full circle –returning it to the point from which it had begun.

We have considered the points which you suggest, but we still think that if in fact there exists on board the ship a disease or sickness which would fall within the plain language of the questions addressed to the master, he is liable to a penalty if he does not answer them correctly.¹⁰⁶

Again, the problem was what was meant and what were the legal obligations within the ‘plain language of the questions’? Another problem associated with the Quarantine Questions was the necessity it placed on laymen to diagnose illness if there was no surgeon on board. The master of a vessel, with no medical knowledge, informed the Boarding Officer of any disease on board. Being a layman, incorrect statements about the nature of the disease often occurred. This ignorance of medicine was, however, also used as an excuse to conceal infectious diseases which, if discovered, might cause costly delays.

The main object to the provision as to ‘any illness’, which the Privy Council were so strong for, was to prevent a serious illness on board being, for the sake of keeping the ship unfettered, called intentionally and deceptively something which it was not – something, neither fever, or contagious, nor infectious; as for instance scarlet fever might deceitfully by the master be called delirium tremors, and no notice be taken of it. There have been instances where masters had tricked the health requirements in this way, and yet where it was hard to penalise them, for they could always plead, (if they had no surgeon on board) that they really didn’t know, and believed the illness to be what they said.¹⁰⁷

¹⁰⁵ *ibid.*

¹⁰⁶ PRO CUST 46/95/25309.

¹⁰⁷ Dec. 27, 1893. SRA CL:60/1/89 p. 256.

The use of Quarantine facilities by the Port Sanitary Authority in cases of cholera was also problematic. As the disease was 'exotic', could quarantine hospitals be used by Medical Officers of Health; and what authority did relevant sections of the Public Health Acts have over Quarantine for the reception of this disease?

In 1887, for example, the Privy Council on behalf of the Local Government Board appealed to the Law Officers' Department of the Royal Courts of Justice, requesting advice as to whether or not the two quarantine hulks, moored in the Motherbank at Southampton, could be used, 'for purposes other than strictly quarantine purposes, viz. For the reception of cholera patients'.¹⁰⁸ The reply from the Law Officers' Department was negative, suggesting only that, either a new order be formed under the Public Health Act or the quarantine laws should be reassessed with the purpose of broadening the scope of quarantineable diseases. As cholera was not strictly a 'quarantineable' disease, use of facilities maintained specifically for such diseases was not, under the law, allowed. 'In our opinion,' they replied, 'the Local Government Board have no power under the existing laws, to make the orders proposed ... It seems to us that the order proposes to mix up the functions of the Customs Authorities, under the Quarantine Act, and of the local authorities under the Public Health Act, and we doubt very much whether Section 130 [of the Public Health Act 1875] or any other sections of the Public Health Act, would justify the provisions of the order'.¹⁰⁹ (Section 130 referred to the power of the Local Government Board to alter or revoke any regulation in order to prevent the spread of cholera.) Interestingly, the letter demonstrates that not only were the powers of the sanitary authorities, under section 130, insufficient in allowing them to utilise quarantine facilities in the prevention of cholera, but also that cholera was considered sufficiently beyond the jurisdiction of the Quarantine Act for any of its facilities to be used in the prevention of the disease. Yet, although it may appear clear here that cholera was no longer felt to be the responsibility of the Customs Service, the example cited of the problems caused by the *Star of Austria* along with various others demonstrate that the nature and definition of cholera under the law remained ambiguous.

¹⁰⁸ PRO PC8/377/59669.

¹⁰⁹ *ibid*

The Port Sanitary Authority was established alongside an existing system of prevention at the ports which was very specifically focused in law and practice on one tightly defined category of disease. Adding the sanitary system for the prevention of 'indigenous' disease at the ports meant, however, a necessary level of accommodation by the quarantine authorities which was difficult to achieve within the constraints of the law. Dual authority did not merely mean the addition of the Port Sanitary Authority as a separate entity within disease prevention but required mutual co-operation and compromise where there was an overlap in the function of the two authorities. As seen the overlap in the boundaries and jurisdiction of the two authorities was an area which lacked legal clarity. On the whole this did not ultimately cause great problems in the actual implementation of prophylaxis but caused an expense and waste of time which could not be accepted at the ports.

What was not ambiguous was that plague and yellow fever remained solely within the jurisdiction of the Quarantine Act. In June 1889 the *S.S.Neva* arrived in Southampton from Brazil. On board was the body of one of three deaths from yellow fever which had occurred on the homeward voyage, as well as a further surviving acute case on board. On arrival the Customs Officer and Quarantine Medical Officer came alongside, and learning of the cases ordered the vessel back out to sea to bury the body and then to return to the Motherbank in quarantine. Under orders from the Privy Council the infected man, with the ship's surgeon and two attendants, was removed to another vessel, the *Menelaus*, while the remaining passengers and crew were confined upon a third vessel, the *Edgar*. The *Neva* was disinfected with 'nitrous fumes' after which the crew was returned to it in order that it remained on its moorings. A special night watch was established to 'prevent intercommunication with those in quarantine', while precautions were made to ensure that personal contact was avoided when letters and provisions were delivered to each of the three vessels. Letters which were passed from the ships were fumigated before being despatched. The infected man – Andrews, the waiter - died two days after the vessel arrived in Southampton on June 13. No further cases were reported on either the *Neva* or *Edgar* and on June 19 the passengers and crew were released 'with great rejoicing, cheering, guns firing, and the like'. The surgeon and attendants were released from the *Menelaus* on June 21.¹¹⁰

¹¹⁰ Blaxall, 'Report on the Steamship *NEVA* in Quarantine at the Motherbank, June 1889, on Account of Yellow Fever', *Nineteenth Annual Report of the LGB, 1889-90 - Supplement Containing the Report of the Medical Officer*. (London: HMSO, 1890), [C. 6141-1], Appendix A No. 15, p. 139-41

Although isolated, this case not only demonstrates the procedures which were carried out on quarantined vessels in the late nineteenth century, but also indicates that the practice had not entirely ceased to exist in British ports. Had more cases of yellow fever, or indeed plague, occurred prior to 1896 and after the establishment of the Port Sanitary Authority similar procedures would have been employed. Yellow fever and plague remained firmly under the Quarantine Act and, as the *Neva* demonstrated, the act was still enforced in the (rare) occurrence of these diseases during this period. Where Britain differed from other nations was that it did not apply the same quarantine procedures in instances of cholera infected vessels.

The only two published texts which deal specifically with the demise of the quarantine system in Britain in the late nineteenth century and the rise of the Port Sanitary Authorities are by J.C. McDonald and Anne Hardy.¹¹¹ While providing a thorough outline of the key events and debates in this history, both imply a fairly linear progression from the rise of the 'English System' to the subsequent dissolution of quarantine. They imply that the quarantine system faced an inevitable fall in the face of the successes of public health reform and that any problems faced by the English preventative system were smoothly and efficiently remedied once it had achieved the consensus of government and medical opinion. They ignore the fact that the respective roles of Quarantine and Port Sanitary Authorities remained ambiguous into the middle of the 1890s, and that despite opposition, the role of quarantine remained prominent within the operation of port prophylaxis. Hardy, for instance, argues that 'the procedures for the detention of imported disease on incoming ships continued unsatisfactory [sic] until the Shipping Act 1885'.¹¹² However, as the above examples illustrate, this was not the case. Similarly, McDonald has suggested that the move to include cholera under the Quarantine Act in 1831 became a permanent arrangement,¹¹³ where in fact it was only a temporary measure.

Disease prevention at the ports remained 'two-pronged'.¹¹⁴ While Peter Baldwin, in his extensive book, *Contagion and the State in Europe, 1830-1930*, recognises this

¹¹¹ See, Hardy, 'Cholera', and MacDonald, 'The History of Quarantine'.

¹¹² Hardy, 'Cholera' p. 260 (* my italics).

¹¹³ MacDonald, 'The History of Quarantine', p. 28.

¹¹⁴ Baldwin, *Contagion and the State*, p. 149.

duality he underestimates the continuation of quarantine as a working component of prophylaxis. 'The British did not abandon the protection of quarantine until they felt secure behind the bulwark of their hygienic reforms'.¹¹⁵ Baldwin dates this achievement around 1884, and although it might be argued that security in 'hygienic reforms', which Hardy also emphasised, had been realised by the 1880s, quarantine remained. Although it was an isolated case, the *Neva* exemplified the fact that the Privy Council still retained the power to enforce quarantine in cases of 'exotic' disease at least until 1889. Other factors also compelled Britain to retain the presence of quarantine authorities at the ports particularly in relation to cholera.

What none of these authors take into consideration in their assessments of port prophylaxis in this period was the international pressures which were exerted on Britain with regard to quarantine. Although Britain had established a system of sanitary control for infectious disease which enabled the country to be less reliant on quarantine as the first and only line of defence, British port prophylaxis could not be separated from contemporary quarantine policies, practices and theories which existed beyond British shores.

The way that Britain dealt with the arrival of vessels carrying infectious disease was greatly determined by the external pressures put on her by European powers and the large imperial shipping and trading companies. As I have indicated in this chapter, one of the key, if not most important, factors which influenced British opposition to quarantine was its effect on trade and commerce. While the enormous expense caused by quarantine and the apparent futility of the system as an effective method of prophylaxis were weighty reasons for Britain to abolish the use and legal obligation of the practice particularly from the 1870s when an apparently superior method of prevention had been established, external pressures to maintain quarantine at any cost were such that the difficulties of dual authority continued in the ports into the middle of the 1890s. Hardy, McDonald and Baldwin, in overlooking the importance of international opinion and other external pressures, have been unable to account for the continued presence of the Customs Service in port prophylaxis into the 1890s and have subsequently ignored the complexities and ambiguities which the continued dual authority entailed.

¹¹⁵ *ibid* p. 150.

TABLE II:

Return of Vessels Inspected, Cleaned, Fumigated and Number of Infectious Disease Cases Dealt With – Port of London, 1873-1893

<i>Year</i>	<i>Number of Vessels Inspected</i>	<i>Number of Vessels Cleaned</i>	<i>Number of Vessels Fumigated</i>	<i>Number of Infectious Disease Cases Dealt With</i>
1873	1,999	338	9	83
1874	13,846	2,330	10	54
1875	14,847	1,788	5	120
1876	13,839	1,384	4	1
1877	14,310	754	10	3
1878	13,463	407	12	1
1879	14,804	516	6	-
1880	16,341	563	9	4
1881	22,315	428	30	28
1882	22,333	506	29	36
1883	26,833	1,102	22	19
1884	25,333	1,598	24	48
1885	24,327	1,819	33	32
1886	23,207	1,670	21	-
1887	21,855	1,744	23	110
1888	19,743	1,005	25	82
1889	19,396	606	19	36
1890	15,446	679	37	85
1891	15,341	402	27	76
1892	14,472	426	54	114
1893*	8,773	341	42	82
Total	362,823	20,416	451	1,057

* (to end of July)

Source: CLRO, *Royal Commission 1893 – City of London: Statement as to the Origin, Position, Powers, Duties, and Finance of the Corporation of London*, (Guildhall: 1893), p. 231-2.

CHAPTER TWO: 'Theoretical Opinions...': Contagionism/Anticontagionism, Cholera, Bacteriology and Empire

The Contagion / Anticontagion Debate

The medical theories of contagion and anticontagion have long been associated with the policy and practice of quarantine, forming an essential part of any debate concerning the implementation of various methods for the prevention of imported infectious disease. Although the origin of the debate between anti-quarantine anticontagionism and pro-quarantine contagionism (to begin with a simple dichotomy) predates the particular period to which my work refers, I will necessarily have to rely upon some of this earlier material to inform my discussion. Much has been written about the contagion/anticontagion debate of the early nineteenth century and its relevance to quarantine. The key discussion concerning this relationship has been continued over a thirty-five year period, from Erwin Ackerknecht (1948), to Margaret Pelling (1978), and Roger Cooter (1982).¹ The first to draw attention to the association between contagionism and quarantine, was Ackerknecht's publication, 'Anticontagionism between 1821 and 1867'. This paper, a key text in history of medicine and social constructionism, argued that prior to Pasteur, Koch, and the germ theory, contagionism was devalued and widely rejected as a theory of disease aetiology, while anticontagionism was, particularly in the middle decades of the century, accepted and endowed with scientific respectability. Yet, this ascendancy of one theory over another did not relate merely to medical knowledge, but coincided with the rise of liberalism - as later the acceptance of contagionism did with the 'victory of reaction'.² As Cooter wrote in his critique of the paper, 'contemporary discussion was not, in Ackerknecht's opinion, merely theoretical or even medical but, rather, was animated by "powerful social and political factors". In particular, contemporary discussion centred on contagionism's material expression: the quarantines and their bureaucracy'.³

¹ Ackerknecht, 'Anticontagionism'; Pelling, *Cholera, Fever and English Medicine*; Cooter, 'Anticontagionism'.

² Ackerknecht, 'Anticontagionism', p. 589.

³ Cooter, 'Anticontagionism', p. 89.

Ackerknecht's paper has been generally unquestioned by medical historians; indeed it has left a great body of scholarship in its wake, yet Margaret Pelling in her book, *Cholera, Fever and English Medicine, 1825-1865*, challenged Ackerknecht's association of anticontagionism and liberalism and even questioned the validity of the terms 'contagionism' and 'anticontagionism'. She objected to Ackerknecht's claim that anticontagionism was a dominant theory among medical men in this period, and to the suggestion that medicine was more politically than scientifically informed in this period than in any other. Her objections, as clearly laid out by Cooter, were threefold:

- 1) the epidemiological theory that was developing in the first half of the nineteenth century was no less 'scientific' than the germ theory that appeared later.
- 2) the majority of the English medical profession by the mid-1840s were not anticontagionists, but were *contingent* contagionists, holding that the cause of epidemic diseases were multifactoral, though related to the environment.
- 3) the terms 'contagionist' and 'anticontagionist' are entirely inadequate, for they misleadingly summarise the contemporary concern with epidemic diseases in terms of simple opposites when in fact medical reality was highly complex and multifaceted.⁴

Cooter acknowledged the value and scholarship of both papers but reduced Pelling's interpretation to a 'dichotomised positivist framework'⁵ and argued that, 'by conflating anticontagionism with one of its prime rationalisations (quarantine abolition), Ackerknecht eliminated the inherent status of the knowledge, rendering it merely an epiphenomenal reflex to socioeconomic interest'.⁶ That is, Ackerknecht's model reduced anticontagionism to merely a response to the interests of quarantine abolition. Instead, Cooter concluded that 'anticontagionism as a knowledge product can be seen as mutually constitutive with the historical conditions that gave rise to the social context in which the knowledge was called forth'.⁷

⁴ *ibid.* p. 90.

⁵ *ibid.* p. 92.

⁶ *ibid.* p. 93.

ibid. p. 100.

Baldwin also entered into the debate in his 1999 monograph. Like Cooter, he challenges Ackerknecht's model 'that nations have chosen prophylactic strategies in line with their political proclivities – for reasons ... that have as much to do with their nature as with the epidemic faced'.⁸ His analysis of prophylactic strategies employed on both sea and land in Europe over the period of a century includes not only sanitary cordons but also vaccination and the regulation of prostitution. Baldwin argues that the simple model where autocracy and restriction, and liberalism and anti-intervention go hand in hand, and where 'prophylaxis is a continuation of politics,'⁹ does not work. He argues that the 'Ackerknechtians all-explaining single cause was doubtless important, but alone it is insufficient'.¹⁰ Although he concedes that a close connection did exist between prophylaxis and politics, other factors such as geoepidemiology need to be included within the model. However, although a broader approach is welcome, Ackerknecht's model was not intended to apply to all prophylactic measures and all contagious disease. Rather, Ackerknecht discussed the particularly strong and inextricable link between politics, policy and the restraints quarantine enforced on free movement and trade.

These works offer a range of conclusions relating to the social construction of, and motivation behind, the theory of anticontagionism. Ackerknecht argued that anticontagionism, although 'based on a wrong scientific theory', was conceived not merely to deal with a medical problem but also social problems. He argued that 'anticontagionists were thus not simply scientists, they were reformers, fighting for the freedom of the individual and commerce against the shackles of despotism and reaction'.¹¹ It was the anticontagionists' association with social reform, Ackerknecht argued, that was as, if not more, appealing than its scientific merits to the large majority of the medical profession in the early nineteenth century. The social reform Ackerknecht particularly pointed to was the abolition of quarantine. Cooter, on the other hand, argued that anticontagionism was more of a general theory which supported an increased control over the new, industrialised urban environment. Rather than the randomness that contagion and the 'contagious agent' presented,

⁸ Baldwin, *Contagion and the State*, p. 24.

⁹ *ibid.* p. 35.

¹⁰ *ibid.* p. 242.

¹¹ Ackerknecht, 'Anticontagionism', p. 567.

anticontagion presented individuals with a means to take control over their own health and existence. Anticontagionism 'moralised' that individuals could be spared the evils of disease through a purification of their environment.

Looked at this way, the knowledge of anticontagionism can be seen not as casually linked to the economy nor simply as a direct reflection of it, but rather, as a mystified mediation of the constitutive changes in social relations of production contingent upon the advance of urban industrial capitalism.¹²

Similarly, Pelling criticised Ackerknecht for his over reliance on economic concerns, and for his dichotomised interpretation of nineteenth century disease theory. She concluded that:

the overriding crises of the nineteenth century were social and political, to which medical men, not as a single class, but as members of a range of classes in society, responded according to their different convictions and interests. The intellectual response to crisis is not necessarily, or even generally dogmatic. In nineteenth century epidemiology the social and the scientific very plainly meet, and I would argue that the main product of mid-nineteenth century epidemiology was a kind of compromise; not essentially an area occupied by moderates and the non-committal, but an intelligent position consistent with interest, experience, and methodology alike.¹³

Yet, despite Cooter and Pelling's persuasive arguments and alternative models, Ackerknecht's thesis should not be discounted. The principal premise of his paper that 'the whole discussion was... never a discussion on contagion alone, but *always on contagion and quarantine* [his emphasis]'¹⁴ appears to be well supported in the contemporary literature. As Richard Evans observed:

Pelling disputes the validity of the miasmatic / contagionist distinction; but while her objections may be justified in terms of scientific theory alone, the

¹² Cooter, 'Anticontagionism', p. 99.

¹³ Pelling, *Cholera, Fever and English Medicine*, p. 310.

¹⁴ Ackerknecht, 'Anticontagionism', p. 567.

distinction was clear enough to contemporaries, not least because it was always understood in terms of its implications for quarantine.¹⁵

This is a key point which Pelling, and to a lesser extent Cooter, ignores. In the earlier part of the nineteenth century to which their work refers, the terms 'contagionism' and 'anticontagionism' were widely used especially by members of the medical profession. They were distinct labels applied by physicians to identify themselves and others, and as such, purposefully created dichotomies. Later in the century, as we shall see, the distinctions were not so frequently or directly used; yet they undoubtedly remained. Part of the distinction which identified those physicians who subscribed to contagionist, or anticontagionist theories of the spread of infectious disease, was without a doubt the position they adopted on the much discussed issue of maritime quarantine. Neither Cooter nor Pelling take much time to address the important issue of quarantine in their review of Ackerknecht's work, or in their analysis of medical theories of infectious disease aetiology. As Ackerknecht maintained, any attempt to discuss the various medical theories relating to quarantine cannot be done without considering their economic and political composition and implications. Whether the discussion is focused on the pre-germ theory period of contagionism / anticontagionism, or on the squabbles of the immediate post-bacteriology period, this consideration remains the same.

By the last quarter of the century the terms 'contagionist' and 'anticontagionist' had begun to take on slightly different meanings. Being 'contagionist' meant that one believed in the theory of disease aetiology which held that a specific disease entity, or 'germ', independent of locality, was the causative agent of disease,¹⁶ and that this organism could pass from one person to another either through exhalations or excreta. Although in the early 1880s these organisms had not all necessarily been specifically identified, they were according to this theory nonetheless responsible for the spread of disease.¹⁷ The opposing theoretical camp, no longer exactly the 'anticontagionist' 'miasmatisists' of earlier decades, were called by contemporaries 'non-contagionists'. Between these theories lay, as Pelling has shown, the 'contingent contagionists'. Theories which occupied this 'middle-ground' generally did not dispute the

¹⁵ Evans, *Death in Hamburg*, p. 268 n. 36.

¹⁶ Worboys, *Spreading Germs*, p. 35-6.

¹⁷ *Ibid.*, p. 148.

possibility of an infective agent, but required for a disease to take hold the predisposing factors of an individual's general 'sickly' constitution and, most importantly, an environment of filth, bad ventilation, and general uncleanness. It also depended upon meteorological and climatic conditions. Thus, essentially, the non-contagionists and contingent contagionists of the late nineteenth century shared with the anticontagionist of the early and mid-nineteenth century, the belief that the maintenance of a sufficient standard of cleanliness and sanitation was essential in protecting a locality from the ravages of infectious disease. The dominance of this 'middle ground' is evident throughout the medical discourse of public health. In the Annual Report of the Local Government Board in 1885, for example, George Buchanan, Chief Medical Officer of the Board, wrote that 'when a case of cholera is imported into any place, the disease is not likely to spread, unless in proportion as it finds, locally open to it, certain facilities for spreading by *indirect infection*'.¹⁸ Ackerknecht, despite Pelling's criticisms, did discuss the role of a 'large centre of moderates ... the so-called contingent contagionists', in the period between 1821 and 1867. Yet, although Ackerknecht accepts a wider interpretation of medical theories than the simple dichotomy of contagion and anticontagion, his argument, and mine, is that the polarisation lay not in medical theory but in the practical application of prophylaxis at the ports – quarantine or sanitary inspection.¹⁹

However, even this dichotomy may be challenged. Michael Worboys argues in his monograph, *Spreading Germs*, that the practical applications of disease theories in preventative public health were divided into 'inclusive' and 'exclusive' programmes. 'Inclusive' practices focused entirely on prevention through environmental improvements and adhered to anticontagionist, miasmatic theories of disease. 'Exclusionary' methods were any which aimed to prevent the transmission of disease from person to person, and used, for example, disinfection or isolation.²⁰ The latter focused on individuals rather than the environment in preventing disease. As Worboys points out, historians generally place the transition of public health from environmentally centred policies to those focused more on individuals to around the late 1880s and 1890s. Yet he argues that increasing emphasis on the 'exclusive'

¹⁸ George Buchanan, 'Precautions Against Cholera', *Fourteenth Annual Report of the LGB, 1884-5 Supplement Containing the Report of the Medical Officer*, (London: Eyre and Spottiswoode, 1885), Appendix A, p. 24, [C.4516], (original emphasis).

¹⁹ Ackerknecht, 'Anticontagionism', p. 569.

²⁰ Worboys, *Spreading Germs*, p. 109-110.

methods of isolation, notification and disinfection through the 1870s, 'shows that person-centred approaches were ... used much earlier'.²¹ Indeed, the duties assigned to Leach and Whitcombe in London at the inception of the Port Sanitary Authority in 1873 were particularly focused on the use of disinfection and isolation of the sick. This example both further enforces Worboys's claim for an earlier introduction of these practices and also demonstrates that 'exclusion' was integral to the 'English system' through its incorporation of practices aimed at preventing person to person infection. However, the 'English system' also relied heavily upon the 'inclusionary' preventive methods of continuing and maintaining environmental improvements in the port, in internal sanitary districts and aboard vessels. The simple dichotomy of sanitary inspection versus quarantine at the ports as a divide between environmental sanitary methods and exclusionary quarantines, does not, therefore, work in Worboys's model. The 'English system' sits therefore as a practical application of the same 'middle ground' occupied by contingent- (or non-) contagionist theories. However, although neither the medical theoretical nor practical prevention of infectious diseases can be easily dichotomised, for the purpose of both my argument and the argument of those involved in the nineteenth century, some polarisation is necessary.

Ackerknecht's model, in contrast to Cooter and Pelling, argues that anticontagionism was a theory which was essentially and directly developed in response to socioeconomic concerns relating to 'quarantines and their bureaucracy'. The origins of anticontagionism in the earlier part of the century have been sufficiently explored by Ackerknecht, Pelling, Cooter, and Baldwin. In the late nineteenth century contingent and non-contagionism was also, at the ports, interdependent with the economic and political interests of the maritime trade. Although there were shifts within the structures of public health in the 1880s and 1890s in response to developments in bacteriology and laboratory medicine,²² the politically important implications of infectious disease aetiology at the ports maintained notions of non-contagionism well into the so-called 'bacteriological era'. This allied the ports more

²¹ *ibid.*, p. 131.

²² *ibid.*, Chapter 7.

toward the theories of disease transmission maintained in India,²³ than those which were developing within Britain.

This was most clearly demonstrated at the International Sanitary Conferences of the second half of the nineteenth century, where it was clearly illustrated that those theories exhibited by the British and Anglo-Indian delegates were those which unequivocally supported their economic and political interests regarding maritime trade and trade routes. Despite various developments in understandings of infectious disease aetiology made during the second half of the century, Britain's political and medical position at the conferences was almost entirely without modification between the first conference held in 1851 and those held in the late 1880s and early 1890s. The non-contagious nature of cholera, and to a lesser extent plague and yellow fever, was the basis of Britain's objection to quarantine at both a domestic and international level. Non-contagious disease theories, and those which were contingent on location, provided medical justification against maritime quarantine and were maintained unwaveringly by British delegates over five decades of international conferences, despite the often overwhelming resistance of other representative states.

The International Sanitary Conferences 1851-1881

To understand the significance of contagionism, non-contagionism, or contingent contagionism in the development of prophylaxis at British ports it is essential to examine how Britain responded to issues relating particularly to cholera, as they occurred beyond her own shores and those of her colonies. It is also important to address the pressures placed on Britain by other states, such as France and Germany, in an analysis of the development of British quarantine policy and practice. The International Sanitary Conferences began in 1851 (see TABLE II) and were the principal stage upon which international tensions concerning the scientific and political implications of quarantine in relation to cholera were played out. It was here that the importance of international maritime sanitary cordons were shown to have direct bearing on the development of policy and practice in Britain's domestic ports,

²³ Jeremy Isaacs, 'D. D. Cunningham and the Aetiology of Cholera in British India, 1869-1897', *Medical History*, 42 (1998), 279-305, p. 291-294; Harrison, *Public Health in British India*, p. 111-16

and on the scientific theory of contingent contagionism maintained in Britain in relation to the ports.

The proceedings and scientific background to the conferences have been exhaustively covered in a series of papers written by Norman Howard-Jones for the *WHO Chronicle* in 1974.²⁴ Neville Goodman, W.F. Bynum and a subsequent World Health Organisation publication have provided small additions to Howard-Jones's work,²⁵ and I, like them, will not attempt to traverse all of the same ground so amply covered by Howard-Jones. However, as the period covered by, and the length and complexities of, the conferences are so extensive, I will rely on these previous works to summarise the early conferences before discussing the conferences from 1881 in a manner more directly related to my own research. It is important to recount some of the details of these earlier conferences in order to place British attitudes towards the end of the century within the context of three decades of conferences.

Britain was, until the closing decade of the nineteenth century, very much alone in her opposition to quarantine as an appropriate prophylaxis for cholera and similarly alone in her unerring adherence to a non-contagionist theory of cholera aetiology. As Joseph Fayrer observed in 1888,

measures of prevention and quarantine have been the subject of international conferences held at Constantinople in 1866, Vienna in 1874, and Rome in 1885. The theories on which the measures recommended are grounded have undergone little change since the conference at Constantinople in 1866; the basis on which all conferences with regard to preventive measures are built is still, as it was then, the theory of contagion.²⁶

Fayrer was President of the India Office Medical Board and medical delegate representing the government of India at the International Sanitary Conference in

²⁴ Howard-Jones, 'The Scientific Background', 1-5, *WHO Chronicle*, 28 (1974).

²⁵ Goodman, *International Health Organisations*; Bynum, 'Policing Hearts of Darkness'; WHO, *The First Ten Years*.

²⁶ Joseph Fayrer, *The Natural History and Epidemiology of Cholera*, (London: J & A Churchill, 1888), p. 65

1885.²⁷ He was particularly averse to any theory or practice which even slightly resembled contagionism.²⁸ However, his assertion that 'the theory of contagion' was 'the basis' of the early conferences did not constitute much of an exaggeration. It may be said, at the risk of generalising, that where cholera was concerned, most of Europe was unanimous in adhering to more contagionist theories - both in methods of prophylaxis and with regard to its origin. Nonetheless, the purpose of the conferences was to determine the present state of knowledge on cholera - although some also included plague and yellow fever - and agree on the best means of preventing its spread. International opinion differed in these matters and political tensions filtered through the discussions, as for example between the German and French delegates following the Franco-Prussian War, and between the British and French after Britain's unilateral termination of dual control of Egypt.²⁹ However, there remained an acceptance that cholera was an international problem which could only be dealt with by the arrival at some manner of international agreement regarding its prevention.

It was thus that, as *The Times* reported on September 20th 1851, the principal questions to be addressed by the first conference were:

Is the cholera contagious? Are the quarantine regulations against this disease necessary for public safety? In the case of plague, is it safe to adopt the system practised by Austria of allowing the quarantine to commence from the date of the sailing of the vessel from its last port, instead of that of its arrival at the port of destination? Is it advisable to form a general sanitary board representing all the maritime powers, and to appoint for each port where a quarantine shall exist a medical officer of health who shall represent not merely the country in which he resides but all the maritime powers, and whose declaration shall be conclusive, unless it be set aside by the decision of the board on the remonstrances to which it shall give rise.³⁰

²⁷ Fayrer (1824-1907) became President of the India Office Medical Board in 1872. He became personal physician to the Prince of Wales and president of the Epidemiological Society in 1879. He was made Companion of the Order of the Star of India in 1868 and a baronet in 1896. For more biographical information see, Harrison, *Public Health in British India*, p. 260, nt. 87.

²⁸ *ibid.*, p. 54-6 & 111-2.

²⁹ See *ibid.*, p. 125-6.

³⁰ Report from the *London Medical Gazette*, which appeared in, *The Times*, September 20, 1851, p. 8c

The first International Sanitary Conference was attended by representatives of twelve European states (including Turkey), with the purpose of reaching international agreement on quarantine regulations and the contagiousness of the quarantinable diseases, plague, yellow fever and particularly cholera. There was a growing trend for international discussion on all number of relevant issues of the day such as the regulation of postal communications, patents and copyright, labour regulations and railway freight transportation. In the year of the first great International Exhibition held in London, international public health arose as an issue in response to the growing need for greater international co-operation which accompanied the improvements of industrialisation to transport and communications. After a few abortive attempts by the British and French governments in the 1830s and 1840s, in the wake of Europe's first encounter with epidemic cholera, to bring together an international conference on quarantine, the first conference was opened on July 23rd 1851. The central agenda of the conference was to fix a minimum requirement for maritime quarantine in order, as the President of the Conference explained in his opening speech, to render 'important services to the trade and shipping of the Mediterranean, while at the same time safeguarding the public health'.³¹

The conference, which was attended by a diplomatic and medical representative from each of the represented states, lasted six months and consisted of 48 plenary sessions and numerous committee meetings. By the close of proceedings on January 19, 1852, a convention containing 137 articles of international sanitary regulations had been produced in draft form and signed by all 24 delegates (two from each country). However, only four of the twelve states signed the final draft of the convention and of these only France and Sardinia ratified the agreement.³² Part of the problem was that voting was undertaken by individual representatives rather than by country. Fundamental difficulties resulted from trying to reconcile the opinions, not only of the different governments, but of the diplomatic representatives and the physicians who often disagreed on the efficacy of imposing sanitary cordons on infected or suspected ships.³³

³¹ WHO. *The First Ten Years*, p. 6.

³² *ibid.*, p. 6-7.

³³ The medical and diplomatic representatives of each country had a separate vote. Very often the two representatives voted differently, essentially cancelling out the vote of that nation. This problem was rectified in later conferences by allowing only one vote per country.

Whether cholera was 'epidemic', 'infectious' or 'contagious' was one of the most debated issues of the conference despite it having been agreed from the outset that 'scientific theories should not be discussed but practical solutions sought'.³⁴ Loosely defined in contemporary understanding of the terms, 'epidemic' disease was determined by particular meteorological conditions or conditions of the soil, striking large numbers of people but not transmitted from person to person. 'Infectious' disease was transmitted from one person to another through exhaled poisons or miasma; while 'contagious' disease was transmitted by 'morbid matter' from person to person directly or indirectly, or through fomites, either as a 'living' entity or not.³⁵ Britain firmly maintained the position throughout the proceedings that quarantine, for any of the three diseases categories, was unnecessary. For instance, plague was a modified form of typhus and both diseases arose from an 'infected atmosphere'.³⁶ British opposition to quarantine as an unnecessary hindrance to commerce was firmly established from the beginning of the conference, and it was a position which was maintained throughout the century. 'It follows that we propose the entire discontinuance of the existing quarantine establishments in this country, and the substitution of sanitary regulations'.³⁷ Furthermore, the commitment to anticontagionist sanitary measures, which was at this stage of the century so significant in Britain,³⁸ also remained as the basis of the British argument in subsequent conferences.

In England it was widely believed, wrote Britain's diplomatic representative to the conference, Anthony Perrier, that 'contagion is not a fact, but an hypothesis invented to explain a number of facts that, without this hypothesis, would be inexplicable'.³⁹ France adopted a position more in favour of compromise, while the delegates of the remaining countries argued for a greater or lesser degree of some form of quarantine, depending very much on whether they were a medical or diplomatic representative. As Goodman argues, regardless of whether or not the medical delegates had been able to reach some sort of agreement on the mode of cholera or plague transmission, each

³⁴ Goodman, *International Health Organisations*, p. 44.

³⁵ WHO, *The First Ten Years*, p. 10; see also Worboys, *Spreading Germs*, p. 38.

³⁶ Goodman, *International Health Organisations*, p. 45.

³⁷ *ibid.*, p. 46.

³⁸ Sheldon Watts, *Epidemics and History: Disease, Power and Imperialism*, (New Haven: Yale University Press, 1997), p. 197-200.

³⁹ Howard-Jones, 'The Scientific Background of the International Sanitary Conferences, 1851-1938', *WHO Chronicle*, 28 (1974), 159-171, p. 164.

of the diplomatic representatives had been sent with the particular political and commercial agendas of their respective governments concerning quarantine. This neither necessarily accorded with current medical theories, nor the opinion of the medical representative. Thus, with no agreement reached after six months of discussion either on the mode of transmission, or the duration or conditions of quarantine, the conference ended without resolution. None of the regulations drawn up in the convention were either ratified or otherwise adhered to and so, despite the fact that the conference set a precedent for further international discussion and co-operation, it was completely unsuccessful in achieving any of its initial aims. As the President of the Epidemiological Society of London, Professor J.L. Notter, reminisced in an address to the Society in 1898,

for all practical purposes the results of this conference were unsatisfactory; there was little unity of opinion, and no system of International control was possible under the circumstances.⁴⁰

The second conference, held again in Paris eight years later, was an endeavour to salvage some of the collaborative work of 1851. In an attempt to simplify the text and the proceedings of the second conference, and in order to try and reach a more mutually agreeable and manageable convention, only diplomatic representatives were invited to attend the conference. Surprisingly this did not prevent fierce debates dividing the contagionist and anticontagionist camps. Although the majority of discussion during the five months of the conference contained a minimal medical content, the general trend which followed was that those countries with Mediterranean shores tended to support strongly the establishment of sanitary cordons for cholera, based on contagionist reasoning; while those European states positioned further north argued that as cholera was not contagious, quarantine was an unnecessary precaution in preventing the spread of the disease. This point has been made by Baldwin who concluded that geography as well as politics played an important role in determining public health strategies. He argued that 'those nations closest to the sources, perceived or real, of infection were more inclined to be quarantinist than those, especially Britain, whose greater remove allowed a degree of insouciance'.⁴¹ British attitudes to

⁴⁰ J.Lane Notter, 'International Sanitary Conferences of the Victorian Era', *Trans. Epid. Soc. Lond.*, vol. XVII, (1897-98), 1-14, p. 2.

⁴¹ Baldwin, *Contagion and the State*, p. 552.

European quarantines reflect Baldwin's suggestion. As the British delegate explained, experience had

more and more shown that [cholera] is not contagious at all, and that, from another point of view, the development of European railway networks in the meantime today renders illusory any system of quarantine against arrivals by sea from cholera-infected places.⁴²

The conference again produced a draft convention, which attempted to consolidate the apparent impasse. Again, it was not signed or ratified and each individual country continued to protect its ports and frontiers in the manner which best suited them.

The next two conferences held in Constantinople in 1866 and Vienna in 1874 followed a similar pattern to the first and second conferences. That is, the Vienna conference was essentially a review and reworking of the resolutions of the Constantinople conference. Both conferences were devoted entirely to the examination of cholera and the best means of preventing its spread. This meant that they were more medically based than the 1859 conference and that the current aetiological and epidemiological theories of the disease were more central to the discussion.

The third conference was held toward the end of one of Europe's worst encounters with epidemic cholera in 1865-66. The disease had for the first time arrived in Europe by sea from Egypt. Previous epidemics had arrived largely overland from Eastern Europe, brought west from India to the Middle East by Hadj pilgrims. One of the most significant resolutions of the third conference was the almost unanimous conclusion that cholera had originated in India, that man was the principal agent in the transmission of the disease and that, despite the fact that previous epidemics had almost certainly arrived in Western Europe via land routes, maritime communications were the foremost means of disseminating the disease, followed by railway contact.⁴³ The only abstention from this conclusion came from Dr. E. Goodeve, one of the British delegates. The Government of India was not permitted to send a representative

⁴² *ibid.* p.171.

⁴³ Howard-Jones, 'The Scientific Background of the International Sanitary Conferences, 1851-1938', *WHO Chronicle*, 28 (1974), 229-247, p. 236.

to the conference but 'found a champion' in Goodeve, who had held a senior position at Calcutta Medical College.⁴⁴ Not surprisingly, he and the other British delegates were resistant to the implication of the resolution; that cholera had been brought to Europe on steamships travelling under the British flag. The suggestion that as India was the recognised origin of cholera an international medical team should be sent there to investigate the disease also met with British objections. The sovereignty of Britain in India was, according to the British, being questioned.⁴⁵ Yet, they conceded that there was some British responsibility toward arresting the further spread of the disease and examples of sanitary work already underway in the ports of Bombay, Calcutta and Madras, were provided.

One of the strongest theories penetrating the discussion at both the third and fourth conferences was that of Max von Pettenkofer (1818-1901). His theories at this stage suggested that the principal vehicle for the spread of cholera by man was the air, but that water was also a possibility. It was unanimously agreed at the conference that, 'the routes by which the toxic agent penetrates into the economy are principally the respiratory tract and very probably also the digestive tract'.⁴⁶ What was most appealing about Pettenkofer's theory was that it stood mid way between a contagionist and anticontagionist understanding of disease transmission. He claimed that in order for cholera to develop, both the importation of the 'germ' into a locality, and particular local meteorological and soil conditions and constitution were required. He conceded that disease could be transmitted from one locality to another, but not from one person to another. Pettenkofer's theories clearly demonstrate the artificiality of rigid boundaries so often placed between contagionism and anticontagionism as mutually exclusive theoretical paradigms, and point more toward the 'contingent contagionism' spoken of by Pelling.⁴⁷ His proposals at this conference and later conferences, even after the publication of Koch's findings in Calcutta in 1884, were successful because they in some way accommodated both the medical and political rationalisations for contagionism and anticontagionism. It was, thus, with much of his influence that the conference concluded that while a quarantine of up to ten days would be necessary for vessels with a foul Bill of Health, *Cordons sanitaires* were

⁴⁴ Harrison, *Public Health in British India*, p. 118.

⁴⁵ E. Goodeve, 'On the International Sanitary Conference, and the Preservation of Europe from Cholera', *Trans. Epid. Soc. Lond.*, vol. III, (1866-67), 15-31

⁴⁶ Howard-Jones, 'The Scientific Background, 2.', p. 238.

⁴⁷ Pelling, *Cholera, Fever, and English Medicine*, p. 283-4.

pointless in highly populated, filthy urban areas (which might have included most of the world's major ports) and that improving the sanitary conditions – provision of clean water and preservation of the purity of the air – of ports and towns was an important determinant in the prevention of epidemic cholera.

In the eight intervening years between the third (1866) and fourth (1874) conferences Pettenkofer further clarified his theory of the aetiology of cholera. According to his theory, the interaction of three factors - *x*, *y* and *z* – was the cause of epidemic cholera.⁴⁸ These factors - the germ, the local and seasonal conditions and an individual's predisposition - were all required in the development of the disease, but the most important, according to Pettenkofer, was the environment, particularly the condition of the soil. Theoretically, therefore, cholera could be imported but only if the seasonal conditions and soil, and the constitution of the local population, were such that the disease could 'take hold'. The germ itself, Pettenkofer argued, was incapable of causing cholera.⁴⁹ However, although Pettenkofer had many followers within Britain at this time, theories with a more anticontagionist slant still carried great favour. (John Simon, Medical Officer of Health to the Privy Council, for example, attributed the propagation of cholera, and other 'infectious' diseases, to 'filth' of all varieties).⁵⁰ However, Pettenkofer's abstention, at the Fourth International Sanitary Conference, from the same conclusion made at the third conference that cholera was always imported to Europe from India, won him much support in Britain and India. The political expediency of his theory meant that Britain and India adopted it at this conference and those which followed, providing the necessary scientific rationale and support of British maritime trade interests to and from India. As Harrison has argued in relation to the Government of India's use of Pettenkofer's scientific expertise, his 'aetiological positions did not so much determine, as provide a justification for, existing sanitary policies'.⁵¹ Pettenkofer argued strongly that local conditions were essential to the propagation of cholera and, such was the weight of his argument in Vienna in 1874, that the representatives of this

⁴⁸ Isaacs, 'D D Cunningham', p. 282.

⁴⁹ Baldwin, *Contagion and the State*, p. 143.

⁵⁰ Pelling, *Cholera, Fever and English Medicine*, p. 247-8; Worboys, *Spreading Germs*, p. 115

⁵¹ Mark Harrison, 'The Identity of Cholera in British India, 1860-1890', D. Arnold (Ed.), *Warm Climate and Western Medicine: The Emergence of Tropical Medicine, 1500-1900*, (Amsterdam Rodopi, 1996), p. 111

largely contagionist conference voted unanimously on a resolution which took some account of Pettenkofer's theories.

The Conference accepts the transmissibility of cholera by man coming from an infected environment; it considers man as able to be the specific cause only outside the influence of the infected locality; further, it regards him as the propagator of cholera when he comes from a place where the germ of the disease already exists.⁵²

As had been the result of the previous three conferences, there was no ratified convention signed at the end of the proceedings, despite very strong moves having been made toward establishing a permanent International Sanitary Commission in Vienna with the remit of studying epidemic diseases. What did come out of the 1874 conference, however, was a unanimous resolution that, as no mutually acceptable agreement on maritime quarantine could be reached, each country would have the right to choose between either a system of quarantine or sanitary medical inspection. This was of great significance to Great Britain who had only just established the Port Sanitary Authority, based on a system of medical inspection. Richard Thorne Thorne (Deputy Chief Medical Officer to the Local Government Board and British medical delegate at the conference)⁵³ reminisced about the importance of this resolution after

⁵² *ibid.*, p. 244.

⁵³ Sir Richard Thorne-Thorne, (1841-1899), was born in Leamington. He began his medical career as an apprentice to a medical practitioner in Leamington, afterwards entering as a student at St. Bartholomew's Hospital, London. In 1863 he was admitted a member of the Royal College of Surgeons of England, and served the office of midwifery assistant at St. Bartholomew's Hospital. In 1865 he became a licentiate of the Royal College of Physicians of London, and in the following year he graduated M.B. at the London University, with first-class honours in medicine and obstetric medicine. From 1869 to 1871 he was assistant physician to the London Fever Hospital. He became a member of the Royal College of Physicians of London in 1867, and was elected a fellow in 1875; he acted as an examiner 1885-89, and was a member of council 1894-96. In 1891 he delivered the Milroy lectures, 'Diphtheria: its Natural History and Prevention'. He began to lecture on hygiene at the medical school of St. Bartholomew's Hospital in 1879, and was formally appointed there the first permanent lecturer on public health in 1891. He became a supernumerary inspector in the medical department of the Privy Council in 1868, and in this capacity he conducted several investigations in connection with outbreaks of typhoid fever with such marked ability that in February 1871 he was appointed a permanent inspector. He rose gradually from this position until in 1892 he succeeded to the post of principal medical officer to the Local Government Board on the retirement of Sir George Buchanan. Thorne's knowledge of French and German, 'no less than his polished manners and courtly address', soon made him especially acceptable to his political chiefs, and he was repeatedly selected to represent this country in matters of international hygiene. Thus he was the British delegate at the International Sanitary Conferences held at Rome in 1885, at Venice in 1892, at Dresden in 1893, at Paris in 1894, at Venice in 1897; and was Her Majesty's plenipotentiary to sign the conventions of Dresden in 1893, Paris in 1894, and Venice in 1897, the last convention being very largely drawn up under his guidance. In 1895 he succeeded Sir John Simon as Crown nominee at the General Medical Council, and in 1898

the Sixth Conference held in 1885, where the decisions had been 'of a retrograde character' compared with the conference of 1874. He explained, 'I undertook to give the Commission some notion of the sanitary work that had been effected in this country since the system of medical inspection had, with the approval of the Vienna Conference in 1874, superseded all attempts at quarantine both on our shores and inland'.⁵⁴

Seven years later the fifth conference was convened in Washington, making a departure from the Eurocentricity of preceding conferences. Although the United States had been invited to the previous two conferences, they had declined to attend. This time they hosted the conference and it was attended by not only European states, together with Turkey and Egypt, but also several North and South American nations as well as China and Japan, making it one of the most internationally representative conferences of the nineteenth century. Although cholera and yellow fever had attacked the Americas during the century, issues regarding the quarantining of these diseases had been discussed at the first four conferences only with reference to Europe, the Middle-East (particularly in relation to the Mecca pilgrimages) and the Indian sub-continent. However, with the increase of trade and migration between the Old World and the New, the threat of these diseases taking hold in both hemispheres prompted the United States to enter into discussions concerning international quarantine procedures. A joint resolution of the Senate and the House of Representatives agreed upon America's need to join an international sanitary agreement and submitted that America should host the fifth conference. The two key points to be discussed at the conference were

- A. The establishment of a reliable and satisfactory international system of notification as to the existence of contagious and infectious diseases, more especially cholera and yellow fever.

honorary degrees were conferred upon him by the University of Edinburgh, the Royal University of Ireland, and the Royal College of Physicians of Ireland, while his services to public health were recognised by his selection as an honorary member of the Royal Academy of Medicine at Rome, corresponding member of the Royal Italian Society of Hygiene, and foreign associate of the Society of Hygiene of France. He was president of the Epidemiological Society from 1887 to 1889. He was made C.B. in 1892, and K.C.B. in 1897. He died in December 1899.

DNB, Suppl. Vol. 3, (1901), p. 382; 'Obituary', *Trans. Epid. Soc. Lond.*, vol. XIX, (1899-1900), p. 210

⁵⁴ R. Thorne Thorne, 'On the Result of the International Sanitary Conference of Rome, 1885', *Trans. Epid. Soc. Lond.*, vol. V, (1885-86), pp. 135-149, p. 144

- B. The establishment of a uniform and satisfactory system of Bills of Health, the statements in which shall be trustworthy as to the sanitary condition of the port of departure and as to the condition of the vessel at the time of sailing.⁵⁵

Further to the USA's desire to include a greater representation of the world's major trade routes in the pursuit of internationally agreed quarantine procedures, and to examine the possibility of reaching international agreement on the above, they summoned the assemblage for motives of more domestic importance. Howard-Johns asserts that 'the sole objective of the USA in convening this conference was to obtain international assent to a piece of domestic legislation that would otherwise be unenforceable'.⁵⁶ The National Board of Health Act was passed in 1879 to protect against 'the introduction of contagious or infectious diseases into the United States', and required specifically that 'all merchant ships and vessels sailing from a foreign port where contagious or infectious disease exists, for any port in the United States, must obtain from the consul...at the port of departure...a Bill of Health'.⁵⁷ The provisions of the Act were such that all ships departing from a foreign port bound for America were required to be in possession of a Bill of Health and 'sanitary history' endorsed by a United States Consular Official working in that foreign country. This required the Consular Official to inspect the ship, as well as the Port Officials of the country of departure. 'It is hardly surprising', Howard-Jones points out, 'that difficulties arose in the enforcement of such a law, and it was evidently the realisation on the part of Congress that the Act must necessarily remain a dead letter unless other nations could be persuaded to agree to it that led to the idea of an international conference'.⁵⁸ This motive for convening the conference was never disguised by the United States. In fact, the necessity for obtaining international co-operation in order to achieve the aims of a piece of domestic legislation was announced in the conference's opening speech.

The action of the government in calling this conference was suggested by the practical difficulties encountered by the national sanitary authorities in their

⁵⁵ *National Board of Health Bulletin*, vol.2, no.7, August 14, 1880, (Washington), p. 485.

⁵⁶ Howard-Jones, 'The Scientific Background of the International Sanitary Conferences, 1851-1938, 2', *WHO Chronicle*, 28 (1974), 369-384, p. 370.

⁵⁷ *National Board of Health Bulletin*, vol.1, no.1, June 28, 1979, (Washington), p. 3.

⁵⁸ Howard-Jones, 'The Scientific Background...3', p. 370.

efforts to obtain, by the agencies of the American consuls in various foreign ports, such information as was necessary for the satisfactory administration of the law of June 2, 1879 [the National Board of Health Act], to prevent the introduction of contagious and infectious diseases into the United States from foreign countries.⁵⁹

The proposal was opposed by a majority of representative countries for numerous reasons including the belief, put forward by Italy and Spain, that a medical inspection and certificate of health provided by officials of the port of departure would be sufficient proof in assuring the absence of disease and that the request for independent examination suggested otherwise. Britain again raised the issue of sovereignty and rejected the proposal on the grounds that it would be both impractical and an infringement on sovereign power. The United States was not successful in attaining the international assent and co-operation required to fulfil the objectives of the Act.⁶⁰ The conference was, as a result, more concerned with managerial and administrative matters than with scientific concerns or the latest innovations in infectious disease prevention, although some discussion about the aetiology of yellow fever was conducted.

The Sixth International Sanitary Conference at Rome, 1885

It was, in part, due to the lack of scientific discussion at the Washington conference, that only four years later the next conference was held, again in Europe, this time in Rome. Again, at this conference the United States tried to pursue its agenda relating to the inspection of vessels by US consular officers in the country of departure. However, again it was rejected by a majority vote.⁶¹ There were other issues of much greater significance being discussed at the Rome conference. This conference was of extreme importance for a number of reasons. As the *British Medical Journal* reported, 'there will be a great temptation to some of the other Powers to introduce political questions into the discussions. If the conference is to be of any scientific value

⁵⁹ *Proceedings of the International Sanitary Conference Provided for by Joint Resolution of the Senate and House of Representatives in the Early Part of 1881*, (Washington: Government Printing Office, 1881), p. 16.

⁶⁰ Goodman, *International Health Organisations*, p. 62; see also chapter four

⁶¹ *Med. Times & Gaz.*, (London), May 30, 1885, p. 734.

whatever, it will be needful that these should be rigidly excluded from the beginning'.⁶² However, more than any previous conference the sixth conference was the most politically motivated and it may be argued that Britain's stance throughout was particularly so.

For the first time Britain had successfully argued for a separate delegation of Anglo-Indians, and after a brief postponement due to the fact that 'some opposition was made in certain quarters to the delegates of the Indian government being allowed to vote',⁶³ the conference got under way on May 20, 1885. William Guyer-Hunter (Surgeon-General and former commissioner to Egypt in 1883), and Richard Thorne Thorne represented Britain, while the government of India was represented by Fayrer and Timothy Richard Lewis, who had been a student of Pettenkofer and was 'special scientific assistant to the Indian government'.⁶⁴ As Harrison pointed out, 'Lewis and Fayrer were almost certainly chosen because of the congruence of their views with the political objectives of the Indian administration,' however, they were not 'untypical of medical opinion in India'.⁶⁵

Within the first few days of the conference the medical delegates separated from the diplomatic representatives and formed what was known as the Technical Committee. This was to ensure the achievement of the conference's dual objectives: *technico-scientific* and *diplomatico-administrative*.⁶⁶ Thorne Thorne wrote to his friend and superior, George Buchanan, that this departure was made both 'to prepare all the work and then to submit our conclusions to the Conference as a whole (every non-medical delegate having the right to attend the meetings of the Technical Committee if he chooses)', and because the elected president of the conference was thought to be a 'garrulous dotard, making a speech every time a delegate spoke and then proceeding to act the dictionary by giving lengthy expositions of the several words he had used'. A 'conspiracy' was formed by several of the medical delegates against the elderly bore and the Technical Committee emerged.⁶⁷

⁶² *BMJ*, April 4, 1885, vol. 1, p. 708.

⁶³ *BMJ*, May 16, 1885, vol. 1, p. 1013.

⁶⁴ Harrison, *Public Health in British India*, p. 56; see also Isaacs, 'D.D. Cunningham', and Manko Ogawa, 'Uneasy Bedfellows', p. 692.

⁶⁵ Harrison, *Public Health in British India*, p. 127.

⁶⁷ Howard Jones, 'The Scientific Background...', p. 382.

During the previous year the German Cholera Commission to India, led by Robert Koch, announced the 'discovery' of the causative agent of cholera, the *comma bacillus*. However, within reports and discussions surrounding the conference in contemporary British medical journals, there is little or no reference to scientific discussion concerning the bacteriological aetiology of cholera. Such discussion had from the beginning been subverted at the conference and in the proceedings of the Technical Committee by the British and Anglo-Indian delegates. Fayrer, particularly, threatened to withdraw previous votes he had made if, when Koch began discussing the incubation period of cholera with regard to the bacillus, 'questions of the aetiology of cholera and the theory of incubation were admitted to the discussion'.⁶⁸ Indeed, as the *Medical Times and Gazette* reported on June 20, 1885,

the resolute determination of the British and Indian delegates, announced boldly from the first, to adhere to the question in its practical bearings, and abstain from all discussion on points opening up theoretical differences of opinion, was productive of good in many ways. It led to the avoidance of squabbling; it saved valuable time; it enabled the results of long practical experience to be put on record, and committed the Conference to no rash or ill considered action based upon *doubtful theoretical opinions which may not stand the test of time*.⁶⁹

Britain, as noted above, confined their aetiological discussion to that which relied upon more 'practical experience': clinical, epidemiological experience and statistical documentation. Cholera was not contagious, they argued, nor was it related in any way to shipping. Rather than directly addressing Koch's bacteriological findings, the British and Anglo-Indian medical delegates challenged members of the congress to provide examples of British ships which had brought the disease directly from India to Europe or indeed any occasion where cholera had been introduced from Britain to Europe via shipping. They demanded epidemiological evidence in support of notions of contagion which threatened to implicate Britain in the spread of cholera.

⁶⁸ Letter dated, May 25, 1885, PRO MH113/22.

⁶⁹ Howard Jones, 'The Scientific Background...', p. 382.
Med Times & Gaz., June 20, 1885, p. 820 (my italics).

Dr Brouardel and Prout, representing France, insist, as many other members of the Congress do, that cholera always originates in India and that it is conveyed thence by means of ships to Europe, although no reply was given by any member of the Congress to Professor Lewis's inquiry whether any delegate knew of a single instance of cholera having been imported into Europe by an English ship; the non-contagionists, among whom were the English representatives, Professor Lewis and Sir William Guyer Hunter, affirm, if I am not mistaken, that cholera is capable of originating *de novo* in any locality where suitable conditions for its generation coexist, and that it is not brought from India to Europe, but that its foci of independent origin are probably as numerous in Europe and America as are the places in which it appears.⁷⁰

No retort was forthcoming. Meanwhile the British delegates cited against the transmissibility of cholera via maritime trade links, what they believed to be the consummate example of Australia - '...although cholera always prevailed in India, a country with which Australia was in constant communication,...the disease had never been conveyed to Australia'.⁷¹

At the same time that Koch's theory of cholera aetiology was so adamantly rejected as an appropriate topic for discussion, many references were made by the British and Anglo-Indian delegates to Pectenokean theories of cholera. They referred, for instance, to its 'taking root [in] the soil'.⁷² As one contemporary commentator asked,

how can any rational action for the attainment of these objects issue from a Conference of such heterogeneous and chaotic elements as those which constituted the International Sanitary Conference Rome in June, 1885? For example, one member of the Conference, representing Germany (Dr. Koch), affirms that a single comma-bacillus, gaining access to the alimentary canal of a man, is sufficient to kill him; another member, representing England, affirms that inasmuch as various microscopic organisms are found in cholera dejecta, the selection of the comma-shaped bacilli as the *materies morbi* of cholera

⁷⁰ Chapman, *Cholera Curable*, p. 85-6.

⁷¹ *Lancet*, June 6, 1885, vol. I., p. 1053.

⁷² *BMJ*, June 13, 1885, vol. I., p. 1222.

appears to be entirely arbitrary, and that comma-shaped bacilli are ordinarily present in the mouths of healthy persons.⁷³

The British and Anglo-Indian delegates, however, made it clear that they were not interested in talking about the findings of the German Cholera Commission, evading all 'scientific' discussion beyond how 'English sanitary science' afforded protection against the importation and spread of disease. What concerned them most was how adamantly the rest of the represented countries adhered to the doctrine of quarantine, particularly in relation to the Suez Canal.

It was nonsensical, Britain and India argued, to impose quarantines in the Suez Canal, or elsewhere on the route from India, and instead they argued that what was required were sanitary improvements similar to those which had been introduced in the United Kingdom. Yet, a central allegation of the majority of states represented at the conference was that cholera had been introduced from India to Europe via the Middle East and North Africa and into the Mediterranean via sea links through the Red Sea and Suez Canal. Quarantine, they argued, was the only way to prevent this spread.

This was the first time that the issue of quarantine in the Canal had been raised at a conference. Surprisingly, the opening of the Canal had not been mentioned at the 1874 conference in Vienna. The conference was convened five years after the Canal had opened in 1869, yet the epidemiological significance of this considerably faster route between India and Europe was not discussed, even though the conference had again focused on India as the origin of cholera. The absence of the Canal in discussions at the Vienna conference is curious; its constant role in the discussion at Rome, explosive. Considering the importance of the Canal in British, French and German imperial politics in the years leading up to 1885,⁷⁴ it is not surprising that issues relating to it were hotly debated.

A primary concern at the 1885 conference was that four-fifths of the vessels which traversed the Canal each year were British. A large proportion of these sailed from Indian ports, principally Bombay, in which cholera was endemic. Yet, unless the disease became epidemic in Indian ports, ships sailing from them were issued with

⁷³ Chapman, *Cholera Curable*, p. 85.

clean Bills of Health. The conference recommended that all ships from Indian ports should be subject to sanitary control at Suez and it was proposed that an 'independent' medical officer, appointed by an international commission, would inspect all vessels intending to traverse the Canal. If a vessel was found to be 'infected' or 'suspected', all passengers and crew would be landed and it would be detained for five days under observation. The proposal was carried by a large majority but was vehemently opposed by Britain and India. Britain argued that this called into question the objectivity and authority of British medical officers – Thorne Thorne, 'refused to allow that any locally appointed medical officer should supersede a British medical officer in deciding whether anyone on board an English ship was suspected of having some choleraic affection or not'.⁷⁵ Furthermore, he argued, any 'dirty and ill-kept' lazaretto maintained in Egypt was bound to be more hazardous to the spread of disease than the free pratique of a well sanitised British vessel.⁷⁶

Any desire to maintain science as a basis of discussion at the conference could not be, and was not, sustained while Suez was a focus. Even the Technical Committee, which was intended to deliberate on the 'scientific' bases of sanitation versus quarantine in the Canal and elsewhere, could not extricate itself from the politics of maritime quarantine.

Although often using the language of medical or sanitary science, cholera prevention became almost a secondary issue to the more immediate political issues surrounding the Canal. The simultaneous proceeding of the Suez Canal Commission in Paris was of particular importance to the way in which the British and European delegates discussed prophylaxis in the Canal. There was, as an article in *The Times* affirmed on June 2, 1885, a significant connection between this and the extensive and political content of, discussions surrounding the Canal in Rome.

It is impossible not to discern a political connexion, more or less direct and certainly not without grave significance, between the proposals adopted by the Committee of the Sanitary Conference, mainly at the insistence of the French delegates, and the provisions of the draft treaty at present under consideration

⁷⁴ See Ogawa, 'Uneasy Bedfellows'.

⁷⁵ *BMJ*, May 16, 1885, vol. 1, p. 1013.

⁷⁶ Howard Jones, 'The Scientific Background...3', p. 383.

of the Suez Canal Commission now sitting in Paris. In both cases may be traced the working of that unfriendly and unaccommodating spirit towards this country which has long pervaded the Egyptian policy of France, and now seems to have *infected* the policy of other European Powers.⁷⁷

France, particularly, was wary of supporting Britain's interests in the Canal, angered by Britain's unilateral termination of British and French dual control of Egypt, and apprehensive of the Canal being reduced to an appendage of the British Empire.⁷⁸ The Paris convention was thus convened with the purpose of reaffirming the international character of the Canal and asserting its neutral status with the establishment of an international Canal Commission. Britain vehemently opposed this, wanting instead to limit the restraints of international control which they anticipated would hinder free movement through the Canal. However, Britain was, at the Paris conference as at the Sanitary Conference, alone in its plans for the Canal, and a convention, 'largely directed against Britain', was drawn up in early Summer 1885 imposing international laws upon passage through the Canal.⁷⁹ Much of the deliberations of the Paris convention were led by the French and the animosity felt between France and Britain in Paris was mirrored in the proceedings at Rome, along with the manner in which it was reported and received in Britain.

Thorne Thorne, who kept regular correspondence with Buchanan, wrote often about the hostility he felt from the French representatives, and the politicised nature of the discussions of the Technical Committee. He wrote:

It was quite intelligible...that Austria, Italy and other countries in close proximity to Egyptian ports should, under the apprehension of cholera and in view of the exaggerated opinions held by their population on the subject, be desirous of the enforcement in Egypt of extreme measures or precaution for the relief and security of their outposts. But I did not understand how it should happen that the French Representatives should be the prime movers in advocating a system of observance and quarantine which if rigidly carried out

⁷⁷ *Times*, June 2, 1885, p. 9d.

⁷⁸ D.A.Parnie, *East and West of Suez: The Suez Canal in History, 1854-1956*, (Oxford: Clarendon Press, 1969), p. 329

⁷⁹ *ibid* p. 330

would probably have the effect of driving British commerce with the East to take the route round the Cape of Good Hope to the detriment of the Suez Canal in which France had such an interest.⁸⁰

In medical journal and newspaper reports written at the time of the Rome conference it was generally implied that the motivation of the other representative countries, particularly France, in proposing quarantine in the Canal, was to 'fetter.. in some degree our great Indian commerce'.⁸¹ It was also reported that other European powers believed that Britain's objection to quarantine in the Suez Canal was motivated purely by commercial concerns.

English readers have been dismayed during the week to find all the nations conspiring against English commerce, and proposing restrictions on the passage of ships through the Suez Canal, which might very easily be made to tell only on those flying the English flag. It is sad, of course, to see scientific men making their views square with political exigencies...⁸² *Medical Times and Gazette*

Dr Thorne Thorne, after alluding to the general idea prevailing abroad, that Great Britain had given up the quarantine system simply from the selfish motive that her enormous commerce was too much hampered by it, pointed out that, since the date of the Vienna Conference, England alone had spent twenty-seven millions of pounds on the improvement of local sanitation...⁸³ *British Medical Journal*

In resisting the proposals of the Conference ... we are not withstanding the dictates of science or the teaching of experience in the selfish interests of our own trade. We are often accused of doing this, but we may safely disregard the malicious and ignorant accusation, in view of the fact that our maritime commerce is the widest in the world, and that cholera has never of late years

⁸⁰ Letter dated, June 3, 1885. PRO MH113/22.

⁸¹ *Med. Times & Gaz.*, June 13, 1885, p. 798.

⁸² *Med. Times & Gaz.*, June 6, 1885, p. 747.

BMJ, June 13, 1885, p. 1222.

reached our own shores nor been imported into Europe in an English ship.⁸⁴

The Times

This was not merely the result of British neurosis, France and Germany, particularly, were convinced of the British commercial motivations behind the objections to quarantine, as this translated extract from *Marseille Medical* demonstrates.

The English, who are protected by their climate from the influence of cholera – the English aristocracy of which forms a class apart, and which knows well that by means of hygiene and comfort (when they are to be had) it is possible to ensure safety from cholera, ... would consent *without compunction* [*sans douleur*] that the whole universe should enjoy the benefits of endemic cholera, provided that every obstacle to the transport of their products be removed. This though, raised to the height of an economic system, induced them to licence the Sanitary Council of Alexandria in 1883, and induced them to declare that the cholera in Egypt during that year, which destroyed not less than 50,000 victims, was a local epidemic of no importance.

It is the same thought which has induced them to promote the spread and adoption of the belief that cholera has now disappeared from Calcutta, Madras, Pondichery, Bombay, &c., in short, from all the great ports the exports from which concern their industry, and which, from the beginning of last year, has made them carry on in Europe a campaign against quarantine. Is it not demonstrated that, according to the English, cholera ceases to exist from the moment that the aristocracy and the great manufacturers do not die of it.⁸⁵

It appears, therefore, that many of the debates and resolutions of the Rome conference were more related to political demands and reactions concerning relations between Britain, Europe and the Canal, than they were with the pursuit of internationally agreed methods of cholera prevention. Regardless of whether the central focus was concerned with political control of the thoroughfare, as at Paris, or, as at Rome, the epidemiological and medical effects of this speedier route between Europe and the East, the issues and responses were the same. Britain argued for the maintenance of

⁸⁴ *Times*, June 2, 1885, p. 9d

free movement either through limiting international control or through preserving the free pratique of British ships sailing from all ports; while France, for example and for a variety of reasons, wished to see these restrictions imposed on Canal traffic.

Commercial pressures on Britain to ensure the limitation of costly delays in the Canal were immense. While both the Rome and Paris conferences were taking place 'the principal Eastern steamship lines' held a meeting in London.

In consequence of the serious loss and inconvenience which have been occasioned to shipowners by the vexatious quarantine restrictions imposed at the Suez Canal, representatives of the principal Eastern steamship lines met in London on Wednesday to concert measures for the protection of their interests, and it was resolved by them to amend their bills of lading in order that on the imposition of quarantine steamers homeward bound from an infected port should be at liberty to proceed by way of the Cape, and so avoid delay at Suez. It is found by experience that in the case of large vessels of modern construction the loss of time by the Cape is almost compensated for by the saving of the canal dues, and that a few days' detention at Suez would remove all advantages now existing in favour of that route.

A telegram from Port Said yesterday states that it is believed that Canal will be blocked for 12 days.⁸⁶

While interest in the Rome conference and discussions surrounding its possible implications were the topic of a numerous shipping company meetings and journal and newspaper articles and editorials, there was no mention of the highly contentious proceedings of the International Sanitary Conference at Rome in the Port of London Sanitary Committee papers or minutes in the years 1884-5. Nor did the committee discuss Koch's work. That Koch's 'discovery' of the cholera bacillus is not mentioned, is perhaps not so surprising. If the British and Anglo-Indian medical delegates at the conference refused to speak of it even in Koch's presence and with other European and American delegates eager to discuss its implications, it is not so difficult to understand why the domestic sanitary authorities in Britain did not feel it necessary to introduce into their business. However, that an international conference,

⁸⁶ 'Marseille Medical', October 30, 1884, in Chapman, *Cholera Curable*, p. 87.

singularly concerned with cholera prophylaxis at major ports and having particular relevance to the arrival of infected ships from Britain's colonies, was not mentioned in the papers of Britain's principal – and central – Port Sanitary Committee, is quite surprising. Since the Committee were in regular correspondence with Richard Thorne Thorne, it might be expected that some news of Rome would be found in the papers; but, no special correspondence regarding the conference was received by the Port Sanitary Committee from him, or anyone else - although Thorne Thorne had written to Buchanan throughout his time in Rome⁸⁷.

Some of the proposals made by the British and Anglo-Indian delegates at the conference had direct and important ramifications for British ports. It was, for example, proposed that rather than imposing quarantine on British ships as they traversed the Suez Canal, these vessels could sail through without having contact with the shore; that they 'should always be allowed to pass through the Suez Canal as through an arm of the sea'.⁸⁸ If the ships sailed directly to Britain from India without docking, quarantine, they argued, would not be necessary.

We maintained that no British vessel passing from India to England had ever yet conveyed cholera to Europe, and hence that we could not, merely because other countries did not wish vessels from the East to enter their ports without first undergoing a period of detention, admit the right of anyone to say that British vessels coming to our ports and touching nowhere else should be otherwise than unhindered in their course.⁸⁹

However, this would in effect have meant that ships from 'infected ports' - as cholera was endemic in ports such as Bombay and Calcutta – would arrive in London having had no quarantine or even disinfection since it had embarked. While the incubation period was believed to have been less than the time taken for the journey from India, the jury was still out. Even so, this issue – the arrival of vessels direct from India - was similarly absent from Committee discussions; as were discussions about the incubation period of cholera. The possibility that the conference could have resulted

⁸⁶ *Times*, June 12, 1885, p. 6d.

⁸⁷ See PRO MH 113/22.

⁸⁸ Thorne Thorne, 'Results of the International Sanitary Conference of Rome', p. 138.

⁸⁹ *ibid*

in an international convention requiring minimum and maximum periods of quarantine at all ports into which 'infected' or 'suspected' ships sailed, had direct relevance for the workings of the Sanitary Committee, yet remained unmentioned; as did the possibility that vessels might begin to arrive from India which, having had no land contact, sailed directly from an 'infected' port.

Even though Britain did not experience a cholera epidemic between 1872 and 1892, cholera featured as an important issue at British ports in the mid-1880s. The committee papers and minutes of the Port Sanitary Committee clearly demonstrate an anxiety about the presence of cholera in Italy, Spain and France, and the almost certain 'recrudescence of cholera on the Continent'⁹⁰ anticipated in the Spring/Summer of 1885. As well as anxieties about cholera being imported from the Continent, and about ensuring that the sanitary authorities were fully prepared for its arrival, the arrival of a number of ships from India, during 1884 and 1885, which had had cases of cholera on board during the voyage, were also cause for concern. Yet, it was because the Committee and Medical Officers knew that vessels which arrived from India had invariably undergone quarantine and disinfection before sailing into the Port of London, that they were not anxious at their imminent arrival.

On the 29th May, owing to an intimation from the Customs, I visited the *S.S.Nivia* from Calcutta, one of the crew on board having died from cholera during the voyage – The death occurred on 20th April, the corpse was at once buried at sea and the bedding, clothing and everything used by the deceased during his illness destroyed – on arriving at Ceylon the passengers were landed and the ship was thoroughly fumigated and disinfected – Again on reaching Port Said the passengers were put on shore, the ship was placed in Quarantine for seven days, fumigated and disinfected twice over – There was no other case of infectious disease on board during the voyage – *Under these circumstances* no further sanitary action was deemed necessary – the vessel was released and saved her tide up the River.⁹¹

⁹⁰ CLRO, PSCP, (Jan – June, 1885), letter from Collingridge to PSC, March 23, 1885.

⁹¹ CLRO, PSCP, (Jan – June, 1885), 'New Hospital – Gravesend – Medical Report, June 11, 1884' (my italics)

Another ship, *The Queen of Scots*, arrived into Gravesend from Calcutta in September 1885 with the clothes of a man who had died of cholera on board. As the disease had been present in the 'homeward' passage, it was deemed infectious and 'ought therefore to have been detained at Gravesend', but, as the disease – or the clothes – had not been reported, the master of the vessel was fined £20 and the Committee set about establishing measures which would ensure such an occurrence was not repeated.

Thus, the absence of any discussion about proposals put to the 1885 conference regarding the passage of vessels direct from India to Britain is peculiar. The Port of London Sanitary Authority only appeared to be at ease with the *S.S.Nivia* after it was made clear that she had already undergone extensive disinfection and a period of quarantine on the homeward journey, and *The Queen of Scots* caused such a stir because it had not. This indicates that part of the ease with which Medical Officers dealt with these cases, was due to their knowledge that, in most cases, by the time a vessel reached Britain she would already have undergone one, if not several, periods of isolation and disinfection. The absence in the Port Sanitary Committee papers and minutes of any reference to the conference or the British proposal to have vessels sail directly from India without docking suggests either that they were unaware of the deliberations of the conference, despite considerable press coverage, or that the day-to-day running of the ports demanded all of their attention. Perhaps one may also speculate that the Port authorities did not anticipate any resolution being passed which would be ratified by the British government. Before it began the conference was well known to be stacked in favour of quarantine and against British interests, and it was well known that Britain would not endorse any international agreement calling for minimum periods of medical detention. In terms of how things operated at domestic ports, the likelihood of change was minimal. As it was, the conference again resulted in no ratified agreement and quarantine continued to operate on a nation to nation basis.

Koch's Comma Bacillus and the Problem with Bacteriology

Britain's reluctance to enter into any discussion regarding a specific infective agent for cholera at the 1885 conference followed the pattern of previous conferences. Britain consistently stood apart from other European states in its total allegiance to the non-contagious nature of cholera and other imported diseases. It also reflected the general way in which Koch's 'discovery' was received in Britain. Although, as already indicated, British physicians did not entirely reject the notion of a contagious agent in the transmission of infectious disease, environmental factors, as suggest by Pettenkofer who was still in the late 1880s regarded to be 'the greatest living authority on the aetiology of cholera',⁹² always played a more prominent role in British aetiological theory. Koch's theory proposed, on the other hand, that the comma bacillus was the singular cause of cholera and that environment played no 'miasmatic' role in the spread of the disease.

Koch's *vibrio cholerae* was 'discovered' while 'Germany's leading bacteriologist'⁹³ was working for the German Cholera Commission in Calcutta in 1884.⁹⁴ Despite the acclaim Koch received in Berlin after it was announced that he had discovered the cause of the disease, his assertion that the comma bacillus was the source of cholera hinged on precarious evidence. Since the 1870s a sequence of rules dictating the necessary criteria for determining whether a particular micro-organism was the cause of a disease had been clearly laid out by Koch's teacher, Helne, and refined by Koch himself.

They dictated that the agent or micro-organism had to be isolated from a diseased subject. It then had to be used experimentally to induce the same disease in an animal. Next, the micro-organism had to be isolated from the diseased animal. The experiment had to be repeatable. The micro-organism had to be present in all diseased subjects.⁹⁵

⁹² Klein, E., *The Bacteria in Asiatic Cholera*, (London: Macmillan and Co., 1889), p. viii; also Klein and Gibbes, *An Inquiry into the Etiology of Asiatic Cholera*, (London: 1885), p. 1.

⁹³ Evans, *Death in Hamburg*, *ibid.* p. 265.

⁹⁴ See, Ogawa, 'Uneasy Bedfellows'; William Coleman, 'Koch's Comma Bacillus: The First Year', *Bulletin of the History of Medicine*, 61, (1987), 315-342; Evans, *Death in Hamburg*, p. 265-71.

⁹⁵ Evans, *Death in Hamburg*, p. 265.

The main weakness in Koch's argument was that although the bacillus found in the intestines of cholera victims was isolated and a pure culture produced, Koch was unable to reproduce the disease in animals. Although he successfully demonstrated the existence of the bacillus and its association with cholera, he did not fulfilled the criteria required to prove that it was the *cause* of the disease; it could quite as reasonably have been a *consequence* of it.⁹⁶ It was this shortcoming which was at the heart of much of the scientific opposition in Britain to Koch's findings. While, as one of Britain's leading bacteriologists, Edward Klein, noted 'with few exceptions most Continental pathologists consider the comma-bacilli of Koch as being the cause of cholera', most British physicians and scientists working on the disease 'differ from the proposition that Koch's comma-bacilli have been satisfactorily proved to be the cause of cholera', and that the 'prevailing opinion [was] that the comma-bacilli of Koch [were only] an important diagnostic guide'.⁹⁷

British physicians argued that epidemiological and clinical experience demonstrated the close association between environment and disease and that the methods of prophylaxis developed and employed according to these theories were successful in preventing the spread of disease. Sir William Gull, physician extraordinary to the Queen, observed that, 'we may in fact be able to defend ourselves against the invasion of cholera before science has discovered the essential cause of the disease. This happened very largely in the case of ague, where, by drainage and other matters, the occurrence of miasmata has been prevented'.⁹⁸ The scientific value and validity of Koch's 'discovery' was examined during the sitting of a committee which was called by the India Office to discuss the report 'An Inquiry into the Etiology of Asiatic Cholera' by English bacteriologists, Klein and Gibbes. The Committee's conclusions were published in a report called, unambiguously, 'The Official Refutation of Dr. Robert Koch's Theory of Cholera and Commas',⁹⁹ in which Koch's 'discovery' was rejected on several grounds. These included: firstly, that the bacillus could not be used to reproduce cholera in lower animals; secondly, that comma shaped bacillus were

⁹⁶ Harrison, *Public Health in British India*, p. 112.

⁹⁷ Klein, *The Bacteria in Asiatic Cholera*, p. vii-viii.

⁹⁸ 'Proceedings of a committee which assembled at the India Office ... for the purpose of considering a Report entitled 'An Inquiry into the Etiology of Asiatic Cholera', in Klein and Gibbes, *An Inquiry*, p. 15

said to be ordinarily present in the alimentary tract during health; and, because water tanks which had been contaminated with the faeces of cholera victims, and contained the comma bacillus, had failed to produce cholera in the villagers who consumed the water.¹⁰⁰ However, this final objection required clarification, as Buchanan wrote in a supplementary report to the Annual Report of the Local Government Board, 1886,

I should wish to give a caution against a presumption which appears to have gained ground among Koch's opponents, that their [the Committee's] objection to his inferences respecting the relation of cholera to comma-bacilli present in tank-water, justifies any defection from the doctrine formulated by Snow in 1849, and now based on abundant experience, that cholera ... may be produced by means of water polluted with cholera evacuations.¹⁰¹

'Scientific' – bacteriological – classification and aetiology of cholera was resisted because of its apparent shortcomings, but also because of the strong allegiance to non-contagionism and clinical practice in Britain. Furthermore, a bacterial cause of cholera had important implications for the policy and practice of public health and port prophylaxis. Essentially, and on the face of it, it appeared to undermine the whole non-contagionist theoretical background of the sanitary system, and as such was considered, potentially, to be a 'dangerous' idea.

The doctrine of contagion... is still maintained by many influential authorities on the Continent and here; the former loudly insisting on quarantine and charging us with conniving at the introduction of cholera to Europe, rather than interfere with our own mercantile interests... That a bacillus in association with cholera has been detected there need be no question... but that the cause of cholera has been discovered any more than it was before... I believe to be a dangerous and unverifiable statement, inasmuch as it will tend to emphasise the views of contagion and the importance of quarantine already so much insisted upon.¹⁰²

¹⁰⁰ 'The Official Refutation of Dr. Robert Koch's Theory of Cholera and Commas', *Quarterly Journal of Microscopical Science*, 26 (1886), 303-16; see also, Ogawa, 'Uneasy Bedfellows'.

¹⁰¹ 'The Official Refutation', p. 316.

¹⁰² Buchanan, *Fifteenth Annual Report of the LGB, 1885-6*, p. xvi.

¹⁰³ 'Proc. Madras San. Comm.', no. 42 1884, quoted in, Harrison, *Public Health in British India*, p. 112

The highly politicised reaction to the bacterial cause of infectious disease was not only expressed in response to Koch's comma-bacillus. This is demonstrated in a letter written by the physiologist, William Carpenter (1813 –1885) to Sir Benjamin Ward Richardson (1828-1896)¹⁰³, in reaction to a letter published in the *Daily News* by John Tyndall (1820-1893). Tyndall was a physicist and polemicist who rejected the theory of spontaneous generation and was the first person to link the 'cholera-fungus, ideas on contagia and Lister's septic germs'.¹⁰⁴ His public addresses and publications were widely rejected by the medical profession. The letter, dated August 27, 1883, archived at the Royal College of Physicians, London, illustrates the strong reaction with which the bacteriological construction of infectious disease was met.

Have you seen Tyndall's absurd letter in the *Daily News*? He out-buds Budd, maintaining that cholera and typhoid can only be propagated by the introduction of their germs into the alimentary canal; so that if a man's water supply be pure and he does not take in the intestinal dejecta of a cholera or typhoid patient with his food or drink, he may live close to an open sewer, or over a choked-up cess-pool, or have his house filled with sewer gases, without any danger of taking these diseases! He says I belong to an 'antiquated school', because I do not agree with him. His authority with the public is such that I consider it necessary to show that this is a matter on which he is not to be trusted.¹⁰⁵

It was the theoretical implications of a specific causative agent in diseases such as cholera and typhoid, rather than any identified microbe, which was considered highly problematic. Whether before or after the culpable microbe had been identified, the theoretical basis of bacteriology was associated with 'old-school' contagionism, which allowed for the transmission of disease irrespective of environment. 'Old-school' contagionism, as has been shown, had direct implications for Britain's maritime trade, and thus the development of bacteriology was, among those involved

¹⁰³ Richardson is described in the *Concise Dictionary of Scientific Biography*, (New York: Charles Scribner's Sons, 1981) as: '...an eminent physician and active reformer in temperance, public hygiene, and sanitation'.

¹⁰⁴ Worboys, *Spreading Germs*, p. 125 & p. 279.

¹⁰⁵ 'Letter from William Benjamin Carpenter (1813-1885) to Sir Benjamin Ward Richardson' AUG 27, 1883, Royal College of Physicians, London. (original emphasis)

with port prophylaxis, considered a 'theory' which could, potentially, cause much harm. Whether Koch's 'discovery' was considered legitimate or not – with regard to the validity of Koch's scientific procedure - was less important than the acceptance of the theoretical basis of the comma bacillus. The acceptance of contagionism, 'proven' or 'unproven', meant the acceptance of the principles of quarantine. This was clearly demonstrated in the reaction of the British and Anglo-Indian delegates at the Rome. It was also evident within the vast number of British publications, of greater and lesser medical content, which emerged in the years after 1884.

Further to these publications, the scribbled notes of a meeting held at the Royal College of Physicians in May 1889, illustrates with particular clarity British hostility to Koch's comma bacillus in the years following the 'discovery'. The Colonial Office, with an attached dispatch from the Governor of Barbados, had approached the Royal College with an inquiry as to the appropriate 'periods of detention for purposes of Quarantine in Yellow Fever, Cholera and Small-pox'. The assembled Committee of four, including Fayerer, delivered its conclusions in a one-page report, including the following, most unsurprising, recommendations.

That the incubation period of Yellow Fever and Cholera is uncertain, and the Committee is of opinion that it is unwise to impose Quarantine restrictions in the case of these diseases.

The Committee is further strongly opposed to such restrictions generally, which it considers harmful and vexatious.¹⁰⁶

Most illuminating are the barely legible short-hand minutes, scratched onto the back of a Royal College circular letter. They reveal the strong aversion to a bacterial cause of cholera developed among many high level physicians in Britain in the years immediately following the 'discovery' of the comma bacillus. As might be expected from a committee attended by Fayerer, quarantine was harshly opposed. Indeed the minutes begin with Fayerer calling for a 'general protest against Quarantine'. The committee discussed how it would be, 'absurd to Quar[antine] a ship wh[ic]h comes f[rom] an infected place and one wh[ic]h has chol[era] on board', and that, 'all

¹⁰⁶ *Report of the Quarantine Committee*, Royal College of Physicians, London, [22/8/2]

precautions except sanitary ones and medical inspection are useless, these precautions should be such as are adopted in this country & not suffering the laws of Quarantine'. Again, these comments do not particularly surprise. Yet, the few comments relating to the incubation period and cause of cholera and yellow fever are what particularly stand out in the notes. According to these eminent fellows of the Royal College, 'the incub[ation] period of Yell[ow] fev[er] & chol[era] is undefined / uncertain & the cause'. Considering that the meeting took place in 1889, five years after the 'discovery' of the cholera bacillus, and the subsequent acceptance of the theory on the Continent, the statement was particularly pointed. Rather, all the members of the committee rejected bacterial contagion and concurred that the diseases were 'affected by climate – just as is affected in sewerage'. Fayrer concluded:

Sir J. Fayrer.

They wanted to do away with Quar[antine] in Roman conference – Thorne & I & Hunter opposed it – & to good effect.

Others wanted to return to the System. Whole of Europe deranged by fear of bacillus – Koch did all that.¹⁰⁷

After the moderate headway made by Britain in reducing European reliance on quarantine during the 1874 conference, the announcement of a specific contagious agent in 1884 appeared to have had a regressive effect. It was much more difficult for Britain to argue, in an international forum, that the maintenance of a sanitary urban environment could provide sufficient protection from epidemic cholera after a germ had been identified which could, theoretically, produce the disease regardless of local conditions. Non-acceptance of Koch's bacillus was directly related to the implications it had for quarantine. Britain could ill-afford to concede that an infective agent could be imported and take hold in a port regardless of the sanitary environment which had been created there. It had grave implications for imperial trade and, as such, for Britain's domination of the Suez Canal. By denoting the contagious nature of cholera, it medically justified the requirement of quarantine stations at either end of the Canal and at ports throughout the Mediterranean. Furthermore, as the 1866 conference had

¹⁰⁷ 'Notes for the Quarantine Committee, May 1889', Royal College of Physicians, London, [2248/3]. For similar response see, Fayrer, 'The Origin, Habits and Diffusion of Cholera, and What May be Done to Prevent or Arrest its Progress, and Mitigate its Ravages', (1886), *Addresses and Papers, 1868-1888*, p. 302, RAMC Collection (Wellcome Institute Library); and Fayrer, *The Natural History and Epidemiology of Cholera*, p. 32.

highlighted, accepting cholera as a contagious disease was to accept that cholera was imported to Europe from its origin in India. By a process of simple logic, this implicated Britain and British ships in Europe's numerous encounters with cholera since 1830.

Maintaining that cholera was non-contagious suited Britain's commercial and political interests but was also well supported by numerous epidemiological investigations into the disease carried out in both Britain and India.¹⁰⁸ Experience had demonstrated overwhelmingly, after the 1866 epidemic, that the British system of public health sufficed in precluding any great extension of the disease from individual cases which arrived into British ports, while the unsanitary ports and lazarettos of the subcontinent, Lavant and Mediterranean were culpable, rather than any infective agent, for their numerous and devastating epidemics of cholera. Non-contagionism was thus not merely maintained because it supported the commercial requirements of free trade and movement, but also because it was supported by half a century of epidemiological investigations, clinical research and experience.

However, regardless of Britain's strong political and medical objections to quarantine, the majority of the rest of Europe, to varying degrees throughout the second half of the nineteenth century, supported the need for quarantine in cases of cholera, plague and yellow fever. Britain's position was well known, and, as indicted, her commercial motives were particularly commented upon by the principal European naval and imperial powers. As no ratified agreement was made at any of the conferences until the 1890s, Britain was thus free to perform any means of prophylaxis within her own ports. However, it would have been unwise for the United Kingdom to have removed, earlier than the mid 1890s, quarantine from the statute books. Regardless of problems that were caused in having the dual authority of quarantine and the Port Sanitary Authority, Britain could not, while Europe adhered to various contagionist theories of infectious disease, and demanded quarantine, be seen

¹⁰⁸ For further reading on these investigations see: Pelling, *Cholera, Fever and English Medicine*; Christopher Hamlin, 'Politics and germ theories in Victorian Britain: the Metropolitan Water Commissions of 1867-9 and 1892-3', MacLeod (ed) *Government and Expertise*, pp. 110-127; Hamlin, *A Science of Impurity*; Anne Hardy, 'On the Cusp: Epidemiology and Bacteriology at the Local Government Board, 1890-1905', *Medical History*, (1998), 42, pp. 328- 346; Chapman, *Cholera Curable*; A.J.Wall, *Asiatic Cholera: Its History, Pathology, and Modern Treatment*, (London: H.K.Lewis, 1893); Thorne Thorne, *On the Progress of Preventive Medicine*; Klein and Gibbes,

to have abandoned quarantine entirely. While it was not necessarily practised to any great degree in British ports, the fact that quarantine remained, if in appearance only, as a principle of British law, allowed British vessels and vessels travelling from British ports, to participate fully and effectively in international trade. A port, such as London, if it did not quarantine ships that were found to carry, or have carried, a case of cholera, would according to most European states, have been regarded as an 'infected' or 'suspected' port. The quarantine which would have been imposed on British ships in other European and European-run ports, if Britain did not legally maintain quarantine, would have been both constant and severe. While it might have been acknowledged that in practice Britain protected her ports almost entirely with sanitary measures, officially quarantine remained as a legal obligation and was still required of ships infected with 'exotic' disease which arrived into British ports.

It is here then that the consequence of foreign pressures on British domestic policy is witnessed, and the significance of the ports as the meeting place of foreign and domestic policy is clearly illustrated. Britain, in the manner of how she managed prophylaxis in domestic ports could not overlook foreign opinion or demand. The fact that the 1825 Quarantine Act remained law, despite the apparent success of the Port Sanitary Authorities since 1872 and the obvious difficulties which lay in dual authority, was largely to do with the weight of international demand, clearly demonstrated at the International Sanitary Conferences. The exigency of accommodating, within British domestic policy, the overwhelming desire of European powers to quarantine, was essential if Britain, despite its naval and imperial supremacy at the end of the nineteenth century, was to participate more or less unhindered in international trade. Thus, paradoxically, in order for Britain to maintain freedom of movement of British ships and trade around the world, she had to maintain, domestically, the one system which embodied exactly the opposite of this.

TABLE III:

Representative States at the International Sanitary Conferences 1851-1907:¹⁰⁹

First Conference – Paris, 23 July 1851- 19 January 1852

Austria, the Two Sicilies, Spain, the Papal States, France, Great Britain, Greece, Portugal, Russia, Sardinia, Tuscany and Turkey

Second Conference – Paris, 9 April 1859 - 30 August 1859

Austria, France, Great Britain, Greece, the Papal States, Portugal, Russia, Sardinia, Spain, Tuscany, and Turkey. Representatives of the Ionian Islands were sent as observers.

Third Conference – Constantinople, 13 February 1866 – 26 September 1866

Austria, Belgium, Denmark, France, Spain, the Papal States, Great Britain, Greece, Italy, Netherlands, Persia, Portugal, Prussia, Russia, Sweden and Norway (then political unified) and Turkey. The USA was invited but did not attend. Egypt, the under Turkish Sovereignty, observed.

Fourth Conference – Vienna, 1 July 1874 – 1 August 1874

Austria-Hungary, Belgium, Denmark, Egypt, France, Germany, Great Britain, Greece, Italy, Luxembourg, Netherlands, Norway, Persia, Portugal, Roumania, Russia, Serbia, Spain, Sweden, Switzerland, Turkey. The USA was invited but did not attend.

Fifth Conference – Washington, 5 January 1881 – 1 march 1881

Argentina, Austria-Hungary, Belgium, Bolivia, Brazil, Chile, China, Colombia, Denmark, France, Germany, Great Britain, Hawaii, Haiti, Italy, Japan, Liberia, Mexico, Netherlands, Portugal, Russia, Spain, Sweden and Norway, Turkey, USA, and Venezuela. Canada, and Cuba with Porto Rico sent medical delegates only.

Sixth Conference – Rome, 20 May 1885 – 13 June 1885

Argentina, Austria-Hungary, Belgium, Brazil, Chile, China, Denmark, France, Germany, Great Britain, Greece, Guatemala, India, Italy, Japan, Mexico, Netherlands, Peru, Portugal, Roumania, Russia, Serbia, Spain, Sweden and Norway, Switzerland, Turkey, USA, Uruguay. Egypt is given as attending although did not send a delegate.

Seventh Conference – Venice, 5-31 January 1892

Austria-Hungary, Belgium, Denmark, France, Germany, Great Britain, Greece, Italy, Netherlands, Portugal, Russia, Spain, Sweden and Norway, Turkey (including Egypt). Representatives of the Quarantine Board at Alexandria were also sent.

Eighth Conference – Dresden, 11 March 1893 – 15 April 1893

Austria-Hungary, Belgium, Denmark, France, Germany, Great Britain, Greece, Italy, Luxembourg, Montenegro, Netherlands, Portugal, Roumania, Russia, Spain, Serbia, Sweden and Norway, Switzerland, and Turkey.

Ninth Conference – Paris, 7 February 1894 – 3 April 1894

Austria-Hungary, Belgium, Denmark, France, Germany, Great Britain, Greece, Italy, Netherlands, Persia, Portugal, Russia, Spain, Serbia, Turkey and the USA.

¹⁰⁹ See, Goodman, *International Health Organisations*; and, Howard Jones, 'The Scientific Background'

Tenth Conference – Venice, 16 February 1897 – 19 March 1897

Austria-Hungary, Belgium, Denmark, France, Germany, Great Britain, Greece, Italy, Luxembourg, Montenegro, Netherlands, Portugal, Roumania, Russia, Spain, Serbia, Sweden and Norway, Switzerland, and Turkey. Bulgaria and Egypt were also present although not 'officially' independent.

Eleventh Conference – Paris, 10 October 1903 – 3 December 1903

Argentina, Austria-Hungary, Belgium, Brazil, Denmark, France, Germany, Great Britain, Greece, Italy, Luxembourg, Montenegro, Netherlands, Persia, Portugal, Roumania, Russia, Serbia, Spain, Sweden and Norway, Switzerland, Turkey, and the USA.

L'Office International d'Hygiene publique – 'The Paris Office' – 1907

Establishment of first permanent, worldwide body dealing with international health – primarily quarantine.

CHAPTER THREE: 1892

Cholera Moves West Along the Migration Route

Despite the strong opposition to quarantine which had developed in Britain from as far back as the 1820s and certainly from the 1850s, the final decade of the nineteenth century witnessed, only a few years before the repeal of the 1825 Act, a short period in which shipping companies and medical and sanitary officers rallied to demand that ships from certain Continental ports 'be quarantined'.¹ Port Medical Officers of Health sought to detain vessels for up to seven days and demanded various powers previously maintained exclusively by the quarantine service. At the same time, the problems encountered in the maintenance of dual authority at the ports appeared to be worsening. The renewal of power to detain vessels was not, however, sought by the Customs service, but rather, was at the request of the Port Sanitary Authorities. The panic which led to this curious insistence on a renewal of strict quarantine procedures was the result of the cholera epidemic seen rapidly approaching Britain from the east in the summer of 1892.

The Western European and North American cholera epidemic of 1892 had, according to contemporary observers, two origins from whence it began its march westward.² The first was in the outskirts of Paris, where the disease was identified in late March. It was believed to have been a recrudescence of former cholera epidemics in the area, which then extended down the Seine valley to the Le Havre by July 5th and northwards into Belgium by July 20th.³ The second origin was in Asiatic Russia 'which ... received its infection as the result of an exceptional epidemic of cholera in British India during 1891; this being followed in the early months of 1892 by a recrudescence along the Indo-Afghan frontier'.⁴ From Asiatic Russia the first case reported in European Russia was said to have occurred in Astrakhan on June 24th,

¹ R. Thorne Thorne, *Twenty-Second Annual Report of the LGB, 1892-3 - Supplement Containing the Report of the Medical Officer*, (London: HMSO, 1894), [C. 7412.], p. xxv.

² A third origin, responsible for the East African epidemic, was identified as the 'Arabian' epidemic of 1890-91, which followed pilgrim routes to the 'Somali coast' of Africa, in the early summer of 1892. It was reported to have been re-imported, later in the year, back to Arabia. Thorne Thorne, *Annual Report LGB 1892-3*, p. xvii.

³ F.W. Barry, 'Report on the Origin and Progress of the Western Diffusion of Cholera During the Year 1892', *Annual Report of the LGB, 1892-3*, Appendix A, No. 12, p. 117.

reaching St Petersburg on August 1st and Moscow on August 5th. It was in Poland before the end of the second week of August and at Hamburg, one of the busiest ports in the world, by August 16th. Within the month it had reached the United Kingdom, followed a couple of weeks later, in September, by its arrival in the United States.

What made this epidemic particularly frightening to contemporaries was the manner by which it spread across the Continent. Previous epidemics, such as the last major epidemic to attack Britain nearly thirty years earlier in 1866, primarily arrived with trade from Egypt and the Mediterranean. The speed with which the 1892 epidemic travelled across Europe was quickly associated with the westward migration of tens of thousands of East European Jews fleeing persecution in Russia and the Pale of Settlement. The disease was not arriving on board trading vessels, among crew and their small numbers of passengers, but in the massively overcrowded steerage holds of steamships. Although the epidemic of 1866 had arrived in Britain on trading vessels from Egypt and the Mediterranean, the source of the disease remained sufficiently far removed; this time, in 1892, those people who were seen to be responsible for importing the disease were congregating in ports on the western edge of Europe; some, having made the crossing to Britain remained and settled within the country. The disease was on the doorstep. The transportation of thousands of migrants from Russia, west through Europe and ultimately, for most migrants, to the United States, was big business, quickly and on the whole efficiently operated. It was the numbers and speed with which the migrations appeared to move across Europe as well as the accompanying prejudices associated with the cultural, religious and physical difference of the migrants, which was particularly frightening to contemporary observers of the 1892 epidemic.

The migration principally began in 1881 when the assassination of Tsar Alexander II ignited a wave of anti-Semitic retaliatory pogroms against Jews across Russia and the Pale.⁵ One of the Tsar's assassins had been a Jewess - reason enough to provoke

¹ Thorne Thorne, *Annual Report LGB 1892-3*, p. xvii.

⁵ Other immigrant groups settled in Britain at this time. Irish immigration, although not near to the scale of the 1840s and 1850s, was still ongoing. German clerical workers constituted a large proportion of immigrant numbers up until the late 1880s. Italians also immigrated, and Lithuanians were a proportionately significant immigrant group into Scotland. These immigrant groups, and others, continued to enter Britain from the early 1880s but, by the 1890s were mostly eclipsed by the number of East European Jewish immigrants. Other European migrants often shared with the Jewish migrants the steerage accommodation of the migrant steamships.

violence where prejudice already existed. Unrecorded numbers were killed, thousands injured, and Jewish property suffered hundreds of thousands of pounds worth of damage. Following the violence, only months after the widespread devastation of the pogroms, the new Tsar introduced legislation which severely restricted the liberty of Jews. The so-called Temporary Laws (although they remained in place for over thirty years) forbade Jews to live outside designated towns within the Pale, to purchase property, to access secondary or higher education, or to vote. The Jewish community was forced to submit a far greater proportion of its population to extended military service, during which only the lowest ranks of the army were available and promotion or advancement was impossible.⁶ These conditions and numerous other anti-Semitic laws and pogroms continued over the following decades and encouraged many who were subsequently constrained or persecuted to seek refuge in the reputedly more liberal west. Some settled in Western Europe and Great Britain, although most – almost half a million by 1892⁷ – migrated to the United States. Those en route to America, when travelling through Europe and Britain, were termed ‘transmigrants’.

Although East European migration continued on a large scale through the 1880s till around 1914, 1892 and 1893 were particularly busy years. The social, political and religious persecution suffered by Russian Jews since the beginning of the 1880s was compounded from 1891-2 by severe famine and by a new, and especially rampant, epidemic of cholera which in the Summer of 1892 claimed an estimated 300,000 lives in Russia and affected a total of 620,000 people.⁸ Limited access for Jews to medical services in Russia and the potency of peasant superstitions about the illness and the medical profession⁹ meant that public health efforts were generally ineffectual and the disease spread with frightening rapidity.¹⁰ Thus, the number of people fleeing Russia increased significantly, as riots and panic escalated. Emigrants headed West both to

Holmes, *John Bull's Island*, p. 20-31.

⁶ Leonard Shapiro, ‘The Russian Background of the Anglo-American Jewish Immigration’, in Colin Holmes (ed), *Migration in European History*, vol. 1, (Cheltenham: Elgar Reference Collection, 1996)

⁷ Markel, *Quarantine!*, p. 141.

⁸ *ibid.*, p. 86.

⁹ *ibid.*: Contemporary sources in Britain also perceived ‘peasant superstitions’ as a factor which contributed to the rapid spread of cholera in 1892. ‘Some extraordinary examples of the savage ignorance of the Russian peasants are given ... showing the ferocity with which the doctors were attacked owing to the conviction of the peasants that the doctors were poisoning the patients, and that the peasants were buried alive...’ *BMJ*, Sept. 10, 1892, p. 606.

¹⁰ Markel, *Quarantine!*, p. 86.

settle in the more liberal regimes of Western nations and to escape the 'degrading violence'¹¹ of one of the most dreaded diseases of the nineteenth century.

However, despite the migrants' attempts to flee infection, cholera moved west with them, following the routes they travelled en route to America. The principal routes were west from Russia and the Pale, through Germany to Dutch, Belgian or German ports, or from Baltic ports, particularly Libau. As the Chief Medical Officer for the Port of London, William Collingridge, wrote in August 1892,

the present epidemic of cholera on the Continent is remarkable for the terrible rapidity with which it has travelled... By the Jewish emigrants it was carried to Hamburg where for some time its existence was denied. From Hamburg it gradually infected Altona, Antwerp, Harve [sic], Paris, Amsterdam, Rotterdam, Roven, Bremen, at the present moment every port from St Petersburg to the Seine must be considered as dangerous¹²

The busiest migrant – and trade - port in Europe was Hamburg and it was there that cholera had its most devastating effect in Western Europe. The first case occurred in a sewerage worker on August 14th who died the following day. Each successive day saw the disease extend to more and more people. Two more cases were reported on the 16th, four on the 17th, twelve on the 18th and thirty-one by the 19th.¹³ From one of the cases on August 17th a sample was taken for bacteriological testing. However, the tests did not produce a pure culture of comma bacillus until the 22nd. The Imperial Government in Berlin was informed on August 23rd and by August 26th the number of newly reported cases occurring in the city that day had reached one thousand.¹⁴ Yet, officials did not announce to the world that Hamburg was an infected port until August 26th, 1892. Anxious to rid the busy port of the rapidly increasing and expensive number of migrants accumulating in the city, the President of the Hamburg Medical Board, Senator Gerhard Hachmann, and his colleagues withheld the information and allowed the departure of a number of infected ships bound for America.¹⁵ Once domestic and foreign quarantines were imposed on the city, the

¹¹ Evans, *Death in Hamburg*, p. 230.

¹² Collingridge, 'Route of Cholera, 1892', *CLRO, PSCP*, (July – Sept. 1892).

¹³ Evans, *Death in Hamburg*, p. 286.

¹⁴ *ibid.* p. 292.

¹⁵ *ibid.* p. 316

emigrants stranded in Hamburg would become the financial burden of the Hamburg Senate. In all, three overcrowded Hamburg-America Line ships departed Hamburg for direct passage to New York with clean Bills of Health between August 17th and 25th. The Port of New York was the second largest port in the world. The first ship to arrive carrying the cholera bacillus was the *SS Moravia*. Hachmann had assured the American Vice-Consul in Hamburg that no cholera was present in the city and the steamship departed on August 17th with a clean Bill of Health.

Although the Imperial Government did not officially announce the presence of cholera until August 26th, the British Consulate in Hamburg telegraphed London on August 25th that the disease had arrived in the port. By then cholera had already crossed the North Sea. The first case of cholera to reach Britain appeared in Grangemouth on the East Coast of Scotland on August 19th. On August 25th a vessel carrying Russian Jewish transmigrants from Hamburg arrived in Leith. They boarded a train to Glasgow, where they were to pick up the boat to America, and it was there that two of the passengers began to display some of the symptoms of cholera. 'The patients, when received into Belvidere,¹⁶ had the cold extremities, the livid fingers and toes, the stricken expression, the sighing hollow voice, and the profound prostration so characteristic of true cholera'.¹⁷ In London a vessel carrying three fatal cases of cholera, all Russian Jewish emigrants en route to America from Hamburg, arrived on August 25th, having sailed from Hamburg after it was known that cholera was present in the city but before it was officially announced. In Liverpool, on August 29th, three cases of cholera were identified among a group of immigrants who had arrived by train from Hull.

The emigrants referred to in my telegram were removed from the emigrants house in accordance with our instructions, as soon as suspicious symptoms were manifested, to the city hospital, Park Hill, on Saturday and Sunday last. The subsequent progress of the cases leaves no doubt that they are cholera, but they are progressing favourably. The closest supervision is maintained over the emigrant house in question as well as over the other emigrant houses and no sickness or ailment of any kind has been discovered...¹⁸

¹⁶ Belvidere, opened in 1870, was Glasgow's central municipal fever (infectious disease) hospital. *Glasgow Medical Journal*, vol. 38, no. 3, Sept., 1892, p. 208.
¹⁷ PRO MH55/897.

Britain had been making preparations for the imminent arrival of cholera well before the disease arrived in Hamburg or appeared in British ports. As Richard Thorne Thorne wrote in the *Annual Report of the Local Government Board, 1892*, the spread of the disease into Western Europe was, from the beginning of the Summer, expected to accompany Eastern European migrants.

And, when the disease was evidently about to invade those provinces of Russia which are within the Pale of Settlement for the Jews, and from which emigration of Russian Jews across Germany and thence to this country was at the time in rapid and continual progress, it became necessary at once to warn the authorities of those English Ports at which these immigrants and trans-migrants were landing.¹⁹

Compared with the devastation which the 1892 epidemic caused throughout Europe, America, the Middle East, and parts of Northern Africa, British precautions proved comparably effective. St Petersburg and Hamburg, for example, suffered thousands of deaths in late August and early September 1892, while the *British Medical Journal* was able to report confidently that only twenty-four cases of undoubted cholera were reported in England and Wales in the same period.²⁰ Nevertheless, Britain remained poised, defences in place, alert to the possible danger. Particularly because the epidemic was following the main migration route from East to West, concern about prevention focused on the potential risk associated with the tens of thousands of Eastern European emigrants making their journeys during the summer of that year.

From the first appearance of the cloud not bigger than a man's hand in the East, the march of the disease was carefully watched from Whitehall, and as soon as it was seen to be approaching the provinces in Russia within the pale of settlement from which the emigration of Jews is constantly taking place into and across this country, inspectors were sent by the Local Government Board to all the ports on the east coast to warn the local authorities of the probable advent of cholera, and to urge them to complete their sanitary defences in time to repel the threatened invasion ... The danger was in the present instance

¹⁹ Thorne Thorne, *Annual Report LGB 1892-3*, p. xxiii.

greatly aggravated by the character of the people conveying the infection ...
There is reason to believe that the enemy has been successfully repulsed for
the time, but it is important to realise that the danger is not yet over.²¹

Cholera was considered in the West to be essentially a 'foreign disease'²² and in 1892
East European emigrants 'the chief source of danger'.²³

Paul Weindling has disputed the claim that Jews were responsible for the spread of
cholera from Eastern to Western Europe and North America. He claims that 'given
that transmigrants did not 'cause' cholera in other port cities, notably Bremen, to
accept that Russian Jews had to be the primary cause and carriers of cholera would be
to swallow the anti-Semitic prejudices of the time'.²⁴ He argues that the assumption
made by scholars such as Richard Evans that cholera was brought to Hamburg and
subsequently west by *Ostjuden*, was more a case of 'conjecture rather than
epidemiologically proven'.²⁵ Despite widespread belief among the authorities in
Hamburg that the transmigrants were in fact responsible for the outbreak of the
epidemic, Weindling insists that 'such prejudices did not infect expert opinion',²⁶ - ie.
Koch's. Rather, Koch's expertise allowed him to see beyond any anti-Semitism
present in Hamburg during the epidemic and recognise that cholera had spread
because of the failure of the Hamburg authorities to disinfect the waste water from the
migrants' lodgings at the port.²⁷

Whether or not the failure to maintain sanitary conditions at the ports was the actual
reason why cholera was transmitted so extensively throughout the city, however, is
irrelevant. Overwhelmingly, contemporaries in both Europe (including Britain) and
America blamed Jewish migrants for the disease, and much of the fear which existed
in relation to the 1892 epidemic was a direct reflection of this. Retrospectively,
Weindling may be perfectly correct in stating that epidemiologically East European

²⁰ *BMJ*, Sept. 10, 1892, p. 604.

²¹ *ibid.*

²² Markel, *Quarantine!*, p. 87.

²³ *BMJ*, Sept. 17, 1892, p. 658.

²⁴ Paul Weindling, 'A Virulent Strain: German Bacteriology as Scientific Racism, 1890-1920', in Ernst and Harris (Eds.), *Race, Science and Medicine, 1700-1960*, (London: Routledge, 1999) p. 226

²⁵ Paul Weindling, *Epidemics and Genocide in Eastern Europe, 1890-1945*, (Oxford: Oxford University Press, 2000), p. 62.

²⁶ *ibid.*, p. 63.

²⁷ *ibid.*

Jews were not entirely culpable for the spread of the disease. However, Weindling develops this analysis purely from the retrospective gaze. Its value lies in clarifying the anti-Semitic nature of much of the response in Hamburg and other infected ports to the transmigrants as disease carriers.

Russian Jews were scapegoated for the failure of the Hamburg authorities to provide filtration. But there is no conclusive proof for the view held at the time by anti-Semites that Russian Jews caused the Hamburg cholera epidemic.²⁸

But, as Weindling himself states, 'the view held at the time' was that 'Russian Jews caused the Hamburg cholera epidemic', as well as the New York epidemic and the introduction of cholera into the Port of London. What is important in a historical study of the 1892 epidemic is not the legitimacy of contemporary fears and accusations, nor the distaste they may leave in the mouths of twenty-first century observers, but how they affected, in 1892, popular perceptions, the implementation of policy and medical practice, and the contemporary texts through which we can observe these processes. Indeed, much of the fear and panic of 1892 was due, in part, to the fact that those people identified as carriers of the disease were Eastern European Jews. Many of them embodied a physical difference and 'exoticness' which enabled easy association with the notoriously 'exotic' disease, and any other fears associated with their arrival were easily projected onto their supposed role as cholera carriers.

For decades Britain had felt secure with the preventive structures erected at her ports. The Port Sanitary Authority, in co-operation with the local Sanitary Authorities, the entire infrastructure of sanitation, as well as the Customs service, had full public and government support in its ability to provide the necessary precautions against any threatened invasion of imported infectious disease.

There has always been, as you are aware, a considerable divergence of views between the teachings put forward by the medical authorities and accepted by public opinion in England and in India, and that which has prevailed upon the

²⁸ *ibid*

Continent, as to the efficacy of quarantine as a safeguard against the contagion of cholera and some other diseases. The tendency of English opinion has been rather to look to measures of sanitary improvement as the best prophylactic against cholera, and to rely on the application of quarantine for that purpose only to a very limited degree.²⁹

However, in the summer of 1892 the almost complacent attitude which had developed in Britain toward diseases such as cholera³⁰ was replaced by quite visible anxiety among public health officials, as they saw the disease advance into Western Europe. The comfortable confidence in the 'English Preventative System' which had accompanied British delegates to the International Sanitary Conferences and allowed for such assured defiance of quarantine, was suddenly forgotten.

It has been assumed by some sanitary authorities that the mere fact of our system of 'medical inspection' exhibiting certain interstices through which cholera might creep was sufficient to warrant them in crying out for a return to quarantine restrictions, some wishing that all vessels from infected places should be kept in detention two days, others three and four days, and others five days. As to this demand, we would ... point out that the English system never laid claim to any infallible pretensions to keep cholera altogether out of the country.³¹

Her Majesty's Government can scarcely refuse to recognise its obligations in a case like this, and the protection of the nation from the invasion of a Continental epidemic, which has proved so terrible a scourge, is surely no less a matter of Imperial policy than the invasion of our shores by a foreign navy. It is a matter on which the country must make its voice heard with no uncertain sound, so that there can be no excuse for official vacillation.³²

But what caused this change of heart, and waning of confidence? Despite what Weindling argues, it had much to do with the fact that the perceived source of the

²⁹ Letter from Lord Salisbury to Thorne Thorne and E.H. Philips, May 17, 1892, PRO FO 116/3316

³⁰ See Hardy, 'Cholera', p. 263-268.

³¹ *Lancet*, Sept. 10, 1892, p. 614.

³² 'The Prevention of Cholera'—reprinted from the *Gentleman's Magazine* for December, 1892, CLRO PSCP, (Oct. - Dec. 1892).

disease was the often bedraggled, 'exotic' looking East European Jews, arriving in their thousands at ports across Western Europe. Although the contagiousness of cholera that this implied had crept back into British ideas about the aetiology of the disease in 1892, the idea that the migrants could bring with them disease was easily accommodated into existing medical theories, which still resisted Koch's bacillus. As an article in *The Lancet* explained, the migrants did not import the disease through any process of contagion, as was articulated in contagionist models of cholera aetiology, but were seen within the Pettenkofean model of disease, in that they brought with them the 'locality' within which disease could generate.

A number of immigrants arriving from an infected district – possibly dirty as regards their persons, and still more so as regards their clothes – may be provisionally regarded as so many minute migratory fragments of the locality whence they came.³³

Although somewhat extreme, this example demonstrates the significant place Pettenkofean theories still occupied in British cholera aetiology. These theories were gradated between the extreme localism of the above, and the notion that 'if it be true that the disease is caused by a living organism, whatever it may be, it is certain that the organism goes out in the bowel discharges of the patient'.³⁴ Both ways, 'it [was] not cholera so much that [had] to be feared, it [was] rather the filth which may serve as a breeding-ground for imported infections'.³⁵ Invariably, migrants and transmigrants were described and prefaced with the word 'filthy'. During 1892 the association of the word 'filth' with regard to cholera was often closely associated with steerage class migrants – 'the very class that might be picked out as most likely to spread the disease'.³⁶

What thus needed to be targeted in devising prophylactic strategies at the ports in 1892 was this 'filth' and these 'migrating localities' of disease – the East European immigrants and transmigrants. This may appear, as Weindling argues, to be 'swallowing the anti-Semitic prejudices of the time', but in order to understand the

³³ *Lancet*, Sept. 3, 1892, p. 592.

³⁴ *BMJ*, Sept. 10, 1892, p. 608.

³⁵ *Lancet*, Sept. 10, 1892, p. 614.

³⁶ *Times*, Sept. 1, 1892, p. 4a.

particular and additional preventive measures put in place during 1892, and the subsequent effects the epidemic had on British port health, it is necessary to acknowledge the strength of these contemporary fears.

The primary precaution put in place to avoid the importation of cholera in 1892, was, in fact directed particularly towards the migrants. The General Cholera Order, issued by the Local Government Board on September 6th 1892, extended the powers of the previous Cholera Order of August 28th 1890. Under the 1890 Order the Customs Boarding Officer had determined cases of cholera and then reported these to the Port Sanitary Authority. With the apparently increased danger from the 1892 epidemic, the Local Government Board altered this Order to ensure that, in London at least, a Medical Officer of the Port Sanitary Authority would visit every ship which arrived into the port, accompanying the Officers of Customs on the boarding of every vessel. An article in the *British Medical Journal* from August 1893 described the new procedure,

Since August 18th, 1892, every vessel entering the Port of London has been boarded by a medical officer. One at least of these officers is on duty day and night.³⁷

The necessity had arisen for the Port Medical Officer of Health to board a vessel in the company of the Customs Quarantine Officer.

It ... becomes absolutely necessary that every vessel should be boarded and the passengers suspected of the [cholera be medically inspected]. This can only be carried out by the Authority having a medical man always on the Customs hulk ready to go off in the launch whenever a vessel is boarded by the Quarantine Officer.³⁸

If the Medical Officer of Health boarded a vessel before the Quarantine Officer had arrived to undertake his own inspection, he was actually, under the Quarantine Act, forbidden to leave the ship until granted a formal Quarantine clearance by an officer

³⁷ *BMJ*, Aug. 5, 1893, p. 342.

³⁸ Letter to the Port Sanitary Committee from Collingridge, Sept 1st, 1892. *CLRO PSCP*, (July – Sept., 1892)

of the Customs service. 'The 17th Section of the Quarantine Act rendered them liable to imprisonment if they left a vessel before it was discharged from quarantine'.³⁹ Indeed, as the Act clearly stated, 'every such pilot or other person so quitting such vessel so liable to Quarantine shall for every such offence suffer imprisonment for the space of six months, and shall forfeit and pay the sum of three hundred pounds'.⁴⁰ Every vessel suspected of being infected by cholera thus came initially within the governance of the Quarantine Act until formally cleared and passed over to the Port Sanitary Authority. By boarding vessels with the Quarantine Officer, clearance could be granted on the spot and the Medical Officer could continue with his work without restriction.⁴¹

Articles 2 and 3 of the 1892 Cholera Order were most specifically focused on the arrival of migrants into London. They ordered the refusal of permission to land to any passengers without a correct address in the city or means to support themselves.⁴² Although Medical Officers of Health previously obtained addresses when they attended infected or suspected ships and forwarded the addresses to local sanitary authorities, this Order actually prevented the landing of those passengers whose address could not be fully verified.

I am directed by the Local Government Board to state that it appears that large numbers of aliens in a filthy and otherwise unwholesome condition are now being brought into this country, and that the danger of the introduction of cholera is thereby increased. Under these circumstances the board have thought it desirable to issue an order altering the Cholera regulations made by them on the 28th Aug. 1890, so as to impose certain restrictions on the landing of persons from ships bringing passengers of the class referred to... The order confers power on the Medical Officer of Health in the case of any ship which has on board passengers of the class above mentioned, to certify that in his opinion, with a view to checking the introduction or spread of cholera, the

³⁹ *Cholera Precautions for 1893 - Conference of Port Medical Officers*. Reprinted from the 'Shipping and Mercantile Gazette' of the 17th December, 1892, By Order of the Port of London Sanitary Committee, p. 6, CLRO MISC MSS/337/3.

⁴⁰ Quarantine Act, 1825 (6Geo. III c.78) XVII.

⁴¹ *Cholera Precautions for 1893*, p. 76, CLRO MISC MSS/337/3.

⁴² This applied to all classes of passengers arriving from foreign ports. However, the addresses of 1st and 2nd class passengers were not questioned.

persons on board would not be allowed to land until they satisfy him as to their names, places of destination and their address at such places.⁴³

Those immigrants whose addresses could not be verified were 'returned in the ship',⁴⁴ and the masters of vessels landing passengers who had not been discharged by a Medical Officer could be fined up to £50. An article titled 'The Importation of Filthy Aliens' which appeared in the *British Medical Journal* in the late Summer of 1892 is demonstrative enough of this point to relate in full:

On September 11th the S.S. *Ellida* was boarded at Gravesend by the medical officer to the Port Sanitary Authority, who found twenty-six passengers from Libau, in Russia, a place infected with cholera, who were in a filthy condition. He served the captain with a notice requiring him not to allow any of them to leave his ship. Nevertheless, it was discovered the next day that they had all been landed, without the addresses of any of them having been sent to Dr. Collingridge. The captain was fined £25, and we may express the opinion that he got off very lightly for an offence by which he exposed London to the risk of cholera, and set at naught regulations framed specially for cases such as his, the carrying out of which costs the sanitary authority many thousands a year.⁴⁵

Firstly, intended addresses were verified against a list of registered lodging houses to establish whether the address existed. A 'careful investigation' had apparently been carried out which informed the Local Government Board that 'there is difficulty ... dealing with the Jewish immigrants', and that 'about 25 or 30 % of the addresses given are untrustworthy'.⁴⁶ Addresses were also checked against a list of lodging houses recorded as 'unsanitary'. The rule although primarily concerned with the residences of 'Jewish immigrants', applied to all steerage-class passengers. The German Young Men's Christian Association complained formally to the Port Sanitary Committee when they discovered they had been placed on the 'unsanitary lodging house' list.

⁴³ *Cholera Regulations*. Local Government Board, Whitehall, Aug. 29, 1892. PRO MH19/244

⁴⁴ 'Monthly Report of the Port Medical Officer of Health', Oct., 1892. CLRO PSCP, (Oct. - Dec., 1892).

⁴⁵ *BMJ*, Sept. 24, 1892, p. 708.

⁴⁶ *ibid*

The Medical Man, who has the charge of calling on the steamboats on their arrival in London coming from the Continent (Hamburg and Rotterdam) in order to make sure if the passengers are in good health and to find out to what Hotel or private house they intend to go, has on several occasions (which have come to our notice) forbidden that passengers should come to our Hotel at the above address [Finsbury Sq., London] saying that the sanitary condition of it does not give satisfaction.⁴⁷

The German YMCA, which had three 'hotels' in London, was unaware that their property had been placed on the 'unsanitary' list. Their complaints were an attempt to gain some compensation for the losses incurred and to have the property removed from the list. Despite the assistant Medical Officer being quoted as remarking 'I'm afraid, Captain, that Hotel is on my black list' – referring to a page in his pocket-book – Collingridge claimed that no instructions regarding the hotel had ever been given to the Medical Officers. Instead, he explained 'all that this implies either is that there is some doubt as to the passengers themselves or that there is some difficulty in verifying the address'.⁴⁸ A solicitor representing the German YMCA investigated the case and interviewed a number of Masters of vessels and passengers. These testimonies provide a valuable insight into how the inspections were carried out.

All the passengers were summoned to the Cabin and I was the first who arrived. In the Cabin were the Captain, the Doctor, a Policeman, and the ship's Steward. I understand English sufficiently to know what is being said but I do not speak it well. The Captain's name was Broesen (who acted as interpreter between the Dr., who spoke English, and the passengers who spoke German). The Captain presented to the Dr. a list of all the passengers with the address of their proposed destinations, reading my name with 28 Finsbury Square as my proposed address. This address did not appear to be satisfactory to the Dr. but the Captain urged very strongly that the address was quite suitable and the Dr. asked me thro' the Captain from whom I got the address and I replied, from a similar home in Hamburg. The Dr. shrugged his shoulders and said I can't

⁴⁷ 'Complaints of the German YMCA, London', letter dated, Apr. 24, 1893, *CLRO PSCP*, (June Aug., 1893)

⁴⁸ Letter dated, Apr. 27, 1893, *ibid.*

pass your address, but gave no reason. He said tomorrow another Dr. will come and give you a final decision.⁴⁹

This particular witness was eventually granted permission to land,⁵⁰ but not all such migrants were so fortunate. In October 1892, for instance, four vessels which had arrived in London carrying European migrants were forced to return to the Continent with a number of these unfortunate migrants still aboard.⁵¹

Throughout 1892-3 the *British Medical Journal* printed extensive articles and reports about the progress of the epidemic, on treatment, and increasingly on the constant potential of the disease's importation into Britain via the huge stream of East Europeans and other steerage class migrants. Concern was met with occasional assurance, as the Medical Officer of Health for the Whitechapel District reported in September: 'although inhabited by many foreigners of the alien class, this district has been altogether free from cholera. The doubtful cases which were landed from Hamburg, and attended to in the London Hospital, proved to be severe enteritis'.⁵² However, during the potential crisis of 1892-3, most attention directed toward European immigrants was negative and provocative. Greater than with any of the previous instances of widespread Asiatic Cholera, the 1892-3 epidemic instigated a very focused reaction toward immigrants as, almost exclusively, the cause.

Despite increased activity at the ports by both the Port Sanitary Authorities and Customs Service (who monitored the arrival of every ship from the extensive list of 'infected' ports during the epidemic) their authority was limited with regard to their ability to detain 'suspected' vessels. The only way that they could restrict the movement of the perceived risk group was through questioning the legitimacy of their address.

⁴⁹ Letter dated, May 17, 1893, *ibid.*

⁵⁰ No further information about this witness is provided beyond the testimony given here.

⁵¹ 'Monthly Report of the Port Medical Officer of Health', Oct., 1892, *CLRO PSCP*, (Oct - Dec, 1892).

BMJ, Sept. 10, 1892, p. 607.

The 'S.S. *Gemma*'

The treatment of the steamship *Gemma*, which arrived in Gravesend, London, from Hamburg on August 25th 1892 was in many ways typical of the general process of prevention that operated in the Port of London in 1892. Yet it was also, in many ways, atypical of the procedure which had been established since 1872. The *Gemma* had sailed from Hamburg around midday on August 24th. All the passengers were in good health on departure but after coming alongside the light ship *Sunk* [?] the following morning, one of the adult passengers became extremely ill. Within a few hours two more passengers, both also third class immigrants, were similarly afflicted. On the ship's arrival at Gravesend, the attending Customs Boarding Officer determined that there was illness on board and, being unable to contact the Quarantine Medical Officer, which was normal procedure, he contacted the Acting Port Medical Officer of Health for Gravesend, Dr Whitcombe. Whitcombe examined the passengers and concluded that they were infected with Asiatic cholera. He was shortly joined by Dr Collingridge, who had anticipated the arrival of the *Gemma* as a suspected ship and who was able to confirm Whitcombe's diagnosis. Customs then gave clearance for the vessel to be released into the care of the Port Sanitary Authority. The three infected immigrants were immediately removed to the Denton Isolation Hospital, a mile east of Gravesend, along with all of their bedding and personal effects, which were subsequently burned. All three died within the following 24 hours. Collingridge and Whitcombe medically examined the remaining crew and passengers, and finding no cholera among them, the crew and first and second class passengers, all of whom could provide a precise and verifiable address where they were staying in London, were permitted to leave. Their luggage remained at the port with the third class immigrant passengers who were required to remain on board the *Gemma*. The report concludes:

next morning, Friday August 26th, no further cholera cases having developed on board the *Gemma*, Dr Collingridge set to work to overhaul the clothing affects of the immigrants, organising at the same time a general wash of their bodies and of such articles of clothing as he did not on account of filthiness condemn to be burned ... Also Dr Collingridge sought through the skipper of the *Gemma* to obtain from Craven and Co. a spare ship for accommodation of

the immigrants after their washing and disinfecting was accomplished, and until they could supply him with satisfactory statements as to their future addresses in London to which all were bound.⁵³

Being unable to obtain another vessel on which to detain the remaining passengers, 'finally the Port Sanitary Authority determined to have the immigrants disposed in tents on a spare couple of acres at the Port Sanitary Hospital site'.⁵⁴

Once the migrants left their accommodation at Denton on August 31st their progress continued to be closely monitored. Despite the six-day detention they had undergone, concern was still attached to them as possible carriers of disease. The Secretary to the Local Government Board in London received a telegram from the Town Clerk for Salford on September 1st and despite the precautions which had been put in place in London, panic was rising.

This day's papers state Russian immigrants from steamer *Gemma* landed at Gravesend and have come to Manchester. This no doubt will include Salford. We have had no notice what should be done, we hear today several persons belonging to Salford are arriving at Grimsby from Hamburg. They should not be allowed to come on here.⁵⁵

The Local Government Board had not known that some of the *Gemma* migrants were travelling on to Manchester but were informed the next day that indeed three had been 'found' in Manchester, but that all 'are in good health at present moment'. In response the Manchester sanitary authorities 'passed a series of resolutions by a special meeting of our hospital committee', including the immediate publication 'of a handbill of sanitary precautions against cholera and choleraic diarrhoea, printed in Hebrew, together with a translation in English language'.⁵⁶

A number of interesting and illuminating points are observable in the case of the *Gemma*. Firstly, during the 1892 epidemic cholera was deemed to be a quarantineable

⁵³ PRO.M1155/897.

⁵⁴ Barry, 'Report on the Origin and Progress', p. 182.

⁵⁵ PRO.M1155/897.

⁵⁶ *ibid*

disease, and was thus at this stage not fully incorporated into the authority of the sanitary system. The Customs Officer, who, in usual practice was the first boarding authority, was required to contact the Quarantine Medical Officer in the first instance. This officer being unobtainable his *second* choice was to contact the Port Medical Officer. The Quarantine Medical Officer was responsible for diagnosing, in the first instance, a case of cholera on board a vessel. He then gave clearance for the Port Sanitary Authority to assume responsibility for the disinfection and subsequent 'care' of the passengers and crew.

Secondly, although Whitcombe remarked in his report of the incident that 'the ship was placed in quarantine',⁵⁷ the detention and observation period imposed on the migrants was not strictly quarantine because they were removed from the vessel they arrived on and were accommodated in the grounds of the land-based infectious disease hospital. Yet, the detention resembled quarantine more than it did the 'English system', which professed only to incarcerate those people who displayed symptoms of disease; and it is interesting that Whitcombe made this distinction even if only through the terminology he chose to employ. Evenso, the period of detention under which the *Gemma* migrants and other such passengers were placed was widely supported - despite Britain's accepted opposition to any form of quarantine. An article in the *Lancet* in October 1892 reported that:

having regard to the extremely suspicious circumstances surrounding the remainder of the passengers, they and the vessel were detained afloat in the river, under observation for several days; after which they were temporarily provided for in an encampment by the port authority. This later action went beyond the powers actually conferred under the Cholera Order of the Local Government Board then in existence, but the judicious action taken in this matter under the initiative and personal superintendence of Dr Collingridge, the Port Medical Officer, received its justification a few days later when an additional order was issued to meet the case of such passengers as these - that is to say, of persons whom it is impossible to keep under observation on arrival from an infected place or infected vessel, for the simple reason that

⁵⁷ 'Medical Report from Hospital, Gravesend', *CLRO PSCP*, (July - Sept., 1892), Sept. 6, 1892.

they have no home or destination. Dr Collingridge's action at the time received full public support ...⁵⁸

This period of observation marked a significant departure from the general opposition to detention espoused under the 'English system'; and it reveals an undercurrent of thinking among medical officers such as Collingridge and Whitcombe, which was not entirely satisfied with the sanitary system. By insisting on the detention of the *Gemma* migrants at the port, Collingridge displayed a level of distrust in the system, either with regard to the methods of diagnosis, or the local sanitary authority, or both. He clearly was not willing to release the passengers who had come into contact with the three infected immigrants. Collingridge's actions reflected the anxiety among medical officers at the ports about the arrival of infected ships. Despite the 'official line' which rejected quarantine procedures, this anxiety could not, in the summer of 1892, be allayed by the operation of the sanitary surveillance alone and demanded detention. In public lectures and publications, both before and after 1892, Collingridge declared his opposition to the principles of quarantine and imposed detention. Yet, during that summer he wrote to the Port Sanitary Committee on a number of occasions about his frustration at being unable to isolate and detain infected vessels. As he wrote at the end of August 1892:

although obviously it would have been easier to have detained the vessel with the emigrants on board there are many difficulties.

Firstly, if they are detained for a short time, say two or three days, and no further disease appears, it is probable that no further spread is likely to occur, all the same there is no certainty until the period of incubation has passed and there is at present no definite medical opinion on this point. I have been obliged to fix a period as guiding my action and have determined to consider 7 days as a safe term.⁵⁹

The three passengers on the *Gemma* who displayed symptoms of the disease were removed to the Port Sanitary Authority infectious disease isolation hospital at Denton. However, the only recourse available to Collingridge to keep the other immigrants detained for further observation was to insist that the information they supplied about

⁵⁸ *Lancet*, Oct. 1, 1892, p. 783.

their addresses in London was unreliable. Collingridge was unwilling to entrust the *Gemma* migrants to the local authorities, as was the usual procedure, but rather insisted that they remain under his supervision at the port. On August 25th, as the vessel arrived into London, Collingridge telegraphed Hugh Owen, Secretary to the Local Government Board, informing him of his plans for the *Gemma* migrants.

Gemma from Hamburg arrived three cases cholera on board have taken these to port hospital will fumigate effects and detain emigrants for observation.⁶⁰

The legitimacy of the addresses supplied by the steerage passengers was inconsequential since the decision to detain them had already been made. Surprisingly, Owen replied with much support for the idea.

Board appreciate your energetic action. When emigrants leave ship most important that they should be kept together and under observation. Could not port sanitary authority utilise some building or make other provision for this, meantime emigrants should be detained on ship as long as circumstances permit.⁶¹

Indeed, as *The Times* reported, while being careful to note that any extension of the period of detention for healthy passengers was *not* a return to quarantine procedures, the circumstances of 1892 appeared to require a prolongation of the present period and method of observation.

The Local Government Board have been desirous of meeting to a certain extent the numerous representations which they have received in favour of strengthening the existing restrictions; and while rejecting altogether the notion of reviving the exploded and discredited system of quarantine, they may have been willing somewhat to extend the plan, not of detaining healthy persons, but of taking measures to keep them under observation, if they arrive in suspicious circumstances ...⁶²

⁶⁰ Appendix Report on *Gemma*, CLRO PSCP, (July – Sept., 1892), Aug. 1892.
⁶¹ Telegram, Aug. 25, 1892, PRO MH55/897.
⁶² Telegram, Aug. 26, 1892, PRO MH55/897
Lancet, Sept. 9, 1892, p. 4b.

The third point illuminated by the case of the *Gemma* was that the two Medical Officers had determined the presence of Asiatic Cholera without recourse to bacteriological testing. This demonstrates that not only was Koch's theory of the bacterial cause of cholera not integrated into medical practice relating to the disease in Britain at this stage but also that diagnostic testing for the disease in the laboratory was still not carried out in Britain as it was in Germany or the United States. Indeed, bacteriological testing for cholera at the ports did not appear until late 1894, when Klein confirmed the presence of cholera in the post-mortem examination of a sailor off the steamship *Balmore*. The examination showed 'in microscopic specimen and cultivation typical cholera'.⁶³ Even then, bacteriological confirmation only arrived at the Local Government Board nine days after the *Balmore* had sailed into the Port of London from St. Petersburg. The six other sailors who displayed symptoms of the disease were immediately removed to Denton on arrival into London. Specimens were also taken from them, which confirmed cholera, although by the time the results were received by Thorne Thorne, four were dead and the remaining two were convalescing.

British medical officers still relied primarily on clinical judgement in determining cases of cholera. Diagnosis by observable symptoms was clearly demonstrated in notes of the cholera cases which arrived in Glasgow's Belvidere Infectious Diseases Hospital in late August 1892. The Superintendent of the Hospital, Dr. James Allan, published his case notes in *The Lancet*, on September 2nd.

There are at present two cholera cases in Belvidere. The patients (a man and a woman) are Russian (Jew) emigrants, who reached Glasgow by Hamburg and Leith. The male patient was admitted to hospital at 1 o'clock on the morning of the 27th ult... *The patient's appearance was a confirmation of the diagnosis (cholera)*. The pinched face, cold, dark, shrunken hands, which were feebly tossed about, and the husky moaning voice conveyed a sufficiently dismal impression.⁶⁴

And finally, the passengers on the *Gemma* who were in 'quarantined' were only the third class immigrants, none of whom, according to the report, could provide

⁶³ Telegram from Klein to LGB, Aug. 8, 1894, PRO MH19/236

Collingridge with satisfactory information as to their address in London. One might argue that this was because the cholera victims had all travelled within the steerage accommodation of the *Gemma* and the other passengers from this part of the ship presented more of a risk of infection. However, as has been shown, immigrants were perceived to be the primary source of infection during the epidemic, and thus their containment was a primary focus of prevention. 'This inspection is necessary not only for the detection of infected persons but also to prevent the importation of pauper aliens with the danger attendant thereon'.⁶⁵

The Impact of 1892

CHOLERA A POSSIBLE BLESSING IN DISGUISE

Dr Collingridge, of the Port of London, is one of those men who can discern a 'silver lining' to even the dark cloud of epidemic cholera. He is reported in one of the London papers to have said, in substance: In fact the cholera is *the best thing* that can happen to us. If we did not get a scare about once in three years, our sanitation would soon get neglected. Cholera passed our first great Public Health Act. It formed our port sanitary regulations and authority. These acts have saved more human lives than ever cholera destroyed since the world began. If the cholera experience of the Port of New York in 1892 can do for us something intelligent, humane, or even human, in the way of sanitary legislation, these squalid immigrants, who have excited so much harsh comment, may prove to be angels in disguise to 'a plenitude of generations yet to come'.⁶⁶

The immediate aftermath of the 1892 cholera epidemic saw the respective roles of the Port Sanitary Authorities and Quarantine service thrown into question. The Port Sanitary Authority began to insist on the permanent transferral of many of the powers they had been issued with temporarily to deal with the epidemic; while the role of quarantine in British ports was again thrown into question. Having experienced no

⁶⁴ *Lancet*, Sept. 3, 1892, p. 593 (my italics).

⁶⁵ Letter from Collingridge to Port Sanitary Committee, CLRO *PSCP*, (January - March, 1893), Jan. 3, 1893.

⁶⁶ *N.Y. Med. Jnl.*, Oct 1, 1892, vol.56, p. 385.

real threat of a large-scale cholera epidemic since the Public Health Act of 1872, the Port Sanitary Authority had not had any previous opportunity to prove the effectiveness of the system with regard to cholera. As cholera was a primary factor in the establishment of the Port Sanitary System and this system had been defended by Britain at the International Sanitary Conferences as the only viable alternative to the antiquated system of quarantine, the 1892 epidemic was an important demonstration of how successful it actually was. Having affirmed the efficacy of sanitary practice over quarantine - with cholera in Britain during the epidemic not extending beyond the 35 individual cases brought into the ports, as opposed to near 17,000 cases which were reported in quarantined Hamburg – the Port Sanitary Authorities and Local Government Board began asserting their control over the ports.

On December 17th 1892, a conference, titled *Cholera Precautions for 1893 – Conference of Port Medical Officers*, was attended by 122 delegates from 42 Port Sanitary Authorities around England and Wales, including Port Medical Officers of Health, Medical Officers of Health, Port Sanitary Authority Chairmen, Mayors, Inspectors of Nuisances, and Town Clerks. The conference was convened at the Mansion House in London, with the purpose of reviewing the manner by which the cholera epidemic of that Summer had been managed and how best to prepare the ports for the subsequent epidemic anticipated for the following summer. The Lord Mayor of London on opening the conference

said he was proud to meet ... gentlemen who had so much in their hands the health of the people. In the Port of London they had endeavoured during the late scourge to keep clear from contagion, and in that he thought they had perfectly succeeded. What they had to do now was prepare for the future. He was quite sure that gentlemen coming from other ports were equally energetic, and he congratulated them on coming there into Conference in order that they might arrange matters among themselves so as to carry on the work in an intelligent and uniform manner. He might, perhaps, at the same time, be permitted to say that whilst they should be careful to prevent disease entering our ports, they should at the same time remember that it was necessary to exercise their powers with gentleness and without severity...⁶⁷

⁶⁷ *Cholera Precautions for 1893*, p. 1, CLRO MISC/MSS/337/3.

The subjects which were opened up for discussion were divided into eight categories: 1) medical inspection; 2) quarantine; 3) addresses of destination; 4) disinfection &c.; 5) disposal of infected corpses; 6) disposal of other infected articles not capable of disinfection (perishable cargoes &c.); 7) hospitals; and, 8) other difficulties experienced or anticipated.⁶⁸

It is worth exploring the discussion surrounding the first two subjects in some detail. The delegates agreed, firstly, that night inspection was not possible in some ports such as Bristol, Swansea, Hull and Plymouth because of particular features of the port, but 'in London it must undoubtedly be kept up by night as well as by day'.⁶⁹ If this meant the appointment of further staff during crises such as 1892, then so be it. The procedure would be to inspect all trading vessels, and those 'vessels carrying emigrants requiring special inspection, requiring an inspection for an hour, or an hour and a half' would always be visited last in order to 'prevent vexatious delays and expensive detention of the [other] vessels at the cost of shipowners'.⁷⁰

The delegates also agreed that the identification of infected ports was a prerequisite for inspection. In order to inspect every vessel that had sailed from an infected port it was necessary to know which ports were 'infected' and subsequently when they were declared free of infection. However, as the Port Medical Officer for Newcastle-upon-Tyne noted,

The meaning of the word 'infected' at present is not defined at all. It stands alone and is the only word used in cholera regulations. For the time being the definition of 'infected' must rest entirely on the Authorities in each case. There is not provision for 'suspected'; therefore, anyone interpreting 'infected' must interpret it to mean either known to be infected or suspected of being infected.⁷¹

⁶⁸ *Cholera Precautions for 1893*, CLRO MISC/MSS/337/1.

⁶⁹ *Cholera Precautions for 1893*, p. 2-3, CLRO MISC/MSS/337/3

⁷⁰ *ibid.* p. 54

⁷¹ *ibid.* p. 66-67

Although it appeared necessary to issue the Port Sanitary Authorities with an official list of 'infected' ports, the difficulties of providing this in practice were quickly realised. Firstly, if information about the presence of disease in a port were to emanate from British Consuls (assuming they were informed of the presence of cholera in the port), the process would take too long to reach all the Local Authorities for it to be of any use. Furthermore, and more importantly, the possible implications any such *official* list would have for trade would be too detrimental. As Collingridge explained to the conference,

an official list published by the Local Government Board is theoretical and imaginary. It is impossible to carry it out. No government could undertake it, and no government would undertake it. At present the whole of the littoral from St Petersburg to Lorient is infected with cholera. If any Government Department issued a notice that all those ports are infected, where should we be with regard to British commerce? Hamburg is officially declared free from Cholera, but there are cases of Cholera from Hamburg now. If you are to have a list of infected ports – and such a list is desirable for our own purposes – it must be issued on our own responsibility, because the Government would not, and could not, declare Hamburg to be infected at the present moment, although everybody knows that it is.⁷²

Thus the delegates agreed that, rather than having to rely upon 'newspaper reports,'⁷³ the Port Sanitary Authority of London would issue its own *unofficial* list which would be forwarded to the other Authorities. As such there would be a uniform 'private list of 'dangerous' ports – you may keep out the word "infected"'.⁷⁴

The next item for discussion, and one which demonstrates the particular effect of the 1892 epidemic on the Port Sanitary Authorities, was concerned with those ships arriving from infected ports which had migrant passengers on board. These ships were deemed to require special attention and thus, particularly in those ports where the Port Medical Officer could not board vessels arriving by night or where several arrived in the same day, the conference agreed that authority was needed to detain vessels for

⁷² *ibid.* p. 4-5.

⁷³ *ibid.* p. 19.

⁷⁴ *ibid.* p. 69.

whatever period was necessary. As the Port Medical Officer for Liverpool, Dr. J. S. Taylor, explained,

sometimes one, sometimes two and sometimes three vessels would come up in a tide. Unless these vessels were immediately boarded by the Customs Officers, who would land the Assistant Medical Officer on them, they would pass up the river and enter our docks. You will understand the length of our dock frontage is about 6 miles, and that the only boarding station we have in Liverpool is at the Dock Entrance, so that during high water the Dock Gates are open and a vessel can steam directly into the Docks, and is only boarded by the Customs Officer.⁷⁵

Although vessels could only enter the dock after they were granted a quarantine clearance, no other restrictions were placed on them. If the medical officer had a number of ships to attend to there was no way he could not deter anyone from disembarking until he returned and could record the names and addresses of those on board. Particularly in the case of migrant ships this process was deemed to be of the utmost importance and was a central focus of the preventive measures put in place during 1892. The Medical Officers at the conference argued unanimously that they would require more powers if they were to continue to carry out their duties in protecting the ports from imported cholera, particularly with regard to cholera on migrant ships. The powers they wanted included those which were at that time confined to the Customs Officers acting under the Quarantine Act. This coveted authority included the power to detain a vessel until such time as the Port Medical Officer of Health had undertaken a thorough inspection. It was agreed that a proposal should be put to the Local Government Board to authorise a period of detention of six hours, three hours before inspection and three hours afterward, for all vessels sailing from an infected port. The 'Quarantine Certificate' which permitted clearance to enter the dock was argued to be 'given as a mere matter of form, and was therefore useless'.⁷⁶ Rather than being issued by the Customs service it was argued that this clearance should be issued by a Medical Officer of Health after he had made his own examination. Similarly, it would be put to the Local Government Board that full authority be granted to both the Port Sanitary Authority and Customs Service to

⁷⁵ *Ibid.* p. 49.

severely penalise – up to £200 - anyone who provided false answers during an inspection. The Port Sanitary Authority beyond London had no such power, and the authority of the Customs Service to do this was at that time being examined by the law officers of the Crown.⁷⁷ Significantly, the overwhelming conclusion of the conference, with regard to the medical inspection of vessels was, as the Chairman, Collingridge, pointed out:

What we are doing here is gradually to remove the present quarantine powers. Everything suggested today is in the direction of removing the onus of medical inspection from the Customs to the Port Sanitary Authority – a most desirable change.⁷⁸

However, the Chairman also noted that,

in London it would not have been possible to carry out the Cholera Regulations without the co-operation of the Customs. He had, therefore, great pleasure in moving: 'That this conference gladly recognises the very valuable assistance that Port Medical Officers of Health have received, and are still receiving, from H.M.'s Customs and other public bodies having jurisdiction in the various ports, and tenders to such Authorities its cordial thanks'.⁷⁹

The Port Sanitary Authorities of Scotland did not attend the conference in London. While almost identical to the English and Welsh authorities, the Scottish Port Sanitary Authorities had been established under the separate Public Health (Scotland) Acts. No similar conference, following the 1892 epidemic, was convened in Scotland. One reason for this was because the dual authority of Customs and Port Sanitary Authority did not appear, in Glasgow and Greenock at least, to have created the same problems as were encountered elsewhere. Of course, the same difficulties arose with regard to jurisdictional boundaries, yet the issues relating to detention and notification were more satisfactorily attended to in Scotland, particularly immediately after the 1892 crisis. An Order in Council of 1893 conferred greater powers on both the Customs

⁷⁶ *ibid.*, p. 6.

⁷⁷ See chapter one.

⁷⁸ *Cholera Precautions for 1893*, *ibid.* p. 8.

⁷⁹ *ibid.*, p. 17.

Service and the Port Sanitary Authorities of Scotland 'than the corresponding order of the Local Govt [sic] Board applicable in England and Wales gives to Officers there'.⁸⁰

The practical effect of this provision is, practically, to put it in the power of the Medical Officer of Health at any Scotch port to define, at his pleasure, as 'infected' any foreign port, and then to invoke the aid of this department [Customs] for the detention of any vessel coming from a port so defined by him, and merely on that ground.⁸¹

Any vessel, therefore, which arrived in a Scottish port from a port which the Medical Officers of Health deemed to be infected with cholera,⁸² could be detained by Officers of the Customs Service until the Medical Officer was informed and brought to the ship. Even if the vessel held a Clean Bill of Health, issued at the port of departure, the fact that the ship departed from a port which the Scottish Medical Officers deemed 'infectious' was sufficient for Customs to detain it.⁸³

Although a level of co-operation was reached between the two authorities in Scotland, this was not the case in England and Wales, and the London conference of Port Medical Officers became the domestic setting for the beginning of cautious proceedings aimed at the abolition of quarantine in all British ports. It occurred as a direct result of the cholera epidemic as 1892 demonstrated what had already been known but had never been illuminated with such clarity, that having dual authority in the ports hindered the efficient working of both authorities. During a crisis as potentially large as the 1892 epidemic, the cracks in the system were brought into sharp relief. As no threat on the scale of that posed in 1892 had arisen in the previous twenty years of the Port Sanitary Authority's existence, the problems and rivalries between the authorities could be accommodated for the appeasement of foreign demands (as discussed in the previous chapter). Yet, what was most politically fortuitous was that the 1892 epidemic also clearly demonstrated that the quarantine employed in other countries to prevent the import of the disease had not proved

⁸⁰ Oct. 3, 1893, SRA CE60/1/89 p. 197.

⁸¹ *ibid.*

⁸² In September 1893 the ports listed as 'infected' by the Glasgow and Greenock Sanitary Authorities were: Antwerp, Palermo, Nantes, Rotterdam, Hamburg, Leghorn, Brest, Bilbao. [various ports in] Algeria, St. Petersburg, and San Sebastian. *ibid.* p. 194.

⁸³ *ibid.* p. 201.

successful. Thus, Britain provided the ultimate example of the superiority of the 'English system' over quarantine, just as it had argued at the International Sanitary Conferences over the previous four decades.

Before the outbreak of cholera in Western Europe, another International Sanitary Conference had been held in Venice in January 1892. The conference again discussed cholera, but with particular – almost exclusive – reference to the Suez Canal. For the first time an agreement was composed which was signed by all the representative nations. Although it was somewhat compromising to Britain's desire for completely free pratique in the Canal, it was a welcome concession within the increasingly impossible impasse which had developed between British and French interests in the Canal. As was noted in *The Times*, in February 1892,

this is the first international sanitary conference which has adopted definite and complete regulations to improve the present state of things and safeguard the interests of trade conjointly with those of public health.⁸⁴

In response to the 1892 epidemic another International Conference was convened in Dresden in March 1893, and Britain was in a prime position, having been the least effected by the epidemic, to persuade the 'Quarantine States' to reconsider the 'English system'. It meant that as far as Britain was concerned 'the conditions for the summoning of a Sanitary Conference were far more favourable than had been the case on former occasions'.⁸⁵ Furthermore, the 1892 conference, concerned more with Suez and having found an agreeable compromise on prophylaxis in the Canal, had set a precedent for consensus which had previously proved unattainable. The final ratified convention, resulting from the 1893 conference, saw further minor concessions to Britain's formerly uncompromising position, but the British generally regarded it as having sufficiently incorporated the 'English system' into international prophylaxis. Minimum and maximum periods for a 'quarantine of observation' were applied to healthy passengers from infected vessels, but because this 'observation' was not required to take place on board the vessel 'it will require no alteration whatever in the

⁸⁴ *Times*, Feb. 1, 1892, p. 5e.

⁸⁵ *Correspondence Respecting the Sanitary Convention, Signed at Dresden on April 15, 1893*, (London HMSO, 1893), [C 7156] p. 37.

cholera Regulations under which our ports are at present administered'.⁸⁶

Furthermore, only merchandise defined as 'susceptible' to 'contamination by choleraic matter', such as bed linen and clothing, was required to be detained or destroyed; and as such 'the convention offer[ed] advantages as regards the landing of merchandise which we trust will tend to free our commerce from some of the vexatious restrictions to which it has hitherto been so often subjected'.⁸⁷ However, despite these favourable outcomes, Britain remained firmly committed to many of the same issues which had distinguished her from other nations in previous decades.

One such issue was the application of bacteriological methods for procuring a diagnosis in the case of cholera. Eight years had passed since the notorious 1885 conference at which it was made clear that the British would not entertain the practical – or political – implications of bacteriology. These methods were becoming much more widespread by 1893, but Britain remained resolute. The 1892 epidemic had further demonstrated to British physicians that the principles and practice of bacteriology could not prevent the import or spread of the disease. In Hamburg, for example, where bacteriological testing was employed from almost the first cases, more than 8,500 people died of the disease within the first month.⁸⁸ In Britain, on the other hand, the reliance on clinical diagnosis and on sanitary measures proved more successful in effectively preventing the disease. Thorne Thorne, again sent to represent British interests at Dresden (but by this time also in his role as Chief Medical Officer of the Local Government Board) wrote to the Foreign Office in February 1893, to clarify the position which would be adopted by Britain at the conference.

The verification by bacteriological examination and on the spot, of the precise nature of first 'choleraic' attacks is a requirement which Her Majesty's Government may hesitate to accept as a definite 'obligation'. Apart from possible questions as to its value from a scientific point of view, the interval of time involved in making the necessary investigation is more than likely to become associated with a delay in the adoption of the necessary measures of

⁸⁶ 'Report of the British Delegates to the International Sanitary Conference of Dresden', *Twenty-Third Annual Report of the LGB, 1893-94 – Supplement Containing the Report of the Medical Officer*, (London: HMSO, 1894), [C. 7538], Appendix A No. 20, p. 455.

⁸⁷ *Ibid.*, p. 456.

⁸⁸ Evans, *Death in Hamburg*, p. 295, Table 4.

prevention, such as may be of serious import. For the purposes of notification and of prevention every case of choleraic diarrhoea should be regarded as one of cholera, and be forthwith dealt with as such.⁸⁹

Again, the primary interest represented by the British delegates was the avoidance of any delays imposed on maritime trade due to the medical prevention of cholera. Lord Rosebery at the Foreign Office addressed a letter to the three British delegates at Dresden before the opening of the conference reinforcing the position which they were to take.

Her Majesty's Government would not be likely to assent to any important alteration in the practice now in force in the United Kingdom. There would, for example, be serious difficulties in the way of introducing a system of permits, or verification cards, to be used by passengers; and apart from scientific questions, the adoption of any system of bacteriological examination must, in the event of administrative action being dependent upon its results, create delay.

Her Majesty's Government further deprecate any general rules with respect to quarantine or the detention of vessels.⁹⁰

Following the month of discussions and the eventual approval of the government back in Britain, the delegates signed a convention which did in fact allow for the detention of some vessels. Ships, having sailed from a cholera infected port but not having on board any cases of the disease, ie. 'suspected' vessels were to be given free pratique. They could, however, be detained at the discretion of the local authorities, but for no longer than a period of five days from the date of sailing. The passengers and crew of a vessel which had a case of cholera on board within the previous seven days, ie. an 'infected' vessel could be detained for a period of up to five days after the date of arrival. It was, however, included within the ratified agreement that 'no persons arriving in Great Britain in cholera-infected vessels, other than those who are actually sick on arrival, will be compulsorily detained'.⁹¹ The detention, for purposes of

⁸⁹ Letter from Thorne Thorne to Foreign Office, Feb. 13, 1893, PRO MH19/238/1-4844/93.

⁹⁰ 'Letter from Lord Rosebery to the British Delegates to the Dresden Sanitary Conference', March 7, 1893, *Correspondence Respecting the Sanitary Convention*, p. 5.

⁹¹ *ibid.* p. 38.

medical observation, of any crew and passengers of 'infected' vessels was to occur, 'if possible', after disembarkation.

It appears that the application of the Convention will, in the more backward countries, meet with opposition from populations that have hitherto trusted to Quarantine Regulations, in the old sense of the term, to preserve them from cholera. In such countries the adoption of the Convention by Her Majesty's Government would, no doubt, be of value in strengthening the hands of those who are in favour of the sanitary system so long followed with success in this country, and it would afford to those countries a knowledge of security that their trade will, in the United Kingdom, continue to enjoy that freedom from useless restrictions which is guaranteed by the Convention.⁹²

As *The Times* reported, the Dresden convention had finally achieved the general aims that Britain had advocated 'alone' since the first conference in 1851, and persuaded other European states to substitute 'the haphazard and arbitrary action of individual states and local authorities' for 'measures compatible with the necessities of international intercourse and commerce'.⁹³

There was, however, one exception to the free pratique of healthy passengers off non-infected vessels – migrants. Before departing for the conference, Thorne Thorne wrote to the President of the Local Government Board saying that, while he and his colleagues would object at all levels to quarantines and detentions which would disrupt the free movement of maritime traffic, he felt that it might, on the other hand 'be undesirable to interpose objection to restriction of some sort being imposed... as regards special classes of traffic'. The classification of these 'special classes of traffic' was clarified by the example of 'restrictions...aimed at preventing the undesirable immigration of destitute aliens from cholera stricken districts'.⁹⁴ Indeed, the conference agreed that local authorities would be granted 'the power to enact special

⁹² Letter from 'Foreign Office to Local Government Board' – as well as Board of Trade and Admiralty – dated May 11, 1893, *ibid.* p. 37.

⁹³ *Times*, April 20, 1893 p. 5d.

⁹⁴ Letter from Thorne Thorne to the President of the Local Government Board, dated Jan. 1, 1893, PRO MH 19/238/664/93.

Regulations in the case of vessels which carry emigrants, which are overcrowded, or are in a bad sanitary condition'.⁹⁵

Yet, as the detention of migrant passengers was conducted by the Port Sanitary Authority, and required detention of the vessel only until the arrival of the Medical Officer of Health, it could not be regarded as an imposition of quarantine. It did not come within the administration of the Quarantine Act, nor did it contradict Britain's other tradition of providing asylum. It was merely, as the *British Medical Journal* reported in August 1893, 'but a first line of defence' against 'the importation of pauper aliens, who [are] usually of the lowest class, coming from the most unsanitary districts'.⁹⁶ The detention of steerage class migrants for observation at the ports, rather than releasing them into the responsibility of the local sanitary authorities, was, as the article continued, necessary for the following reasons:

[they] are exceedingly likely to bring germs of disease, which, on account of the short passage, might not develop until they had left the ship, and they themselves had been lost sight of, in the poorest and most crowded portions of London. Since the present system has been in working order, this dangerous class has practically ceased to enter the port.⁹⁷

The cholera epidemic of 1892 brought to the fore the issue of restricting entry to the United Kingdom to those immigrants whose standard of health was such that it could be detrimental to the public health. An article for the *British Medical Journal* from September 1892 titled, 'Cholera and Pauper Aliens: A Point of Law', extracted from a piece written by the London Correspondent of the *Manchester Guardian*, claimed that:

the revolutionary demand being made ... to exclude all pauper aliens from entry to this country is not likely to meet with any active response, for the simple reason, if no other, than it constitutes an attempted invasion of the rights of Parliament. 'The Crown', says Professor Dicey, 'cannot except,

⁹⁵ 'British Delegates to the Dresden Sanitary Conference to the Earl of Rosebery', dated April 18, 1893, *Correspondence Respecting the Sanitary Convention*, p. 10.

⁹⁶ *BMJ*, Aug. 5, 1893, p. 343.

⁹⁷ *ibid.*

under statute, expel any alien from England, nor can it refuse him asylum here, and there is no statute in existence which confers such power ... Although for the moment the steps taken by the Local Government Board to prevent the landing of 'filthy and unwholesome' persons coming from foreign ports may pass unchallenged, it is by no means clear that the Board have not exceeded their powers... The Board now seeks to prevent aliens from landing unless they can satisfy the medical officer of health as to their place of destination in England, and the intention is that as they have no destination in England, but are going across the country to ship for America, they shall not be allowed to do so.⁹⁸

Indeed, as had been stated at the Cholera Prevention conference in late December 1892, the strict enforcement of the Cholera Regulations was intended to deter the arrival of immigrants, where no other authority under the law was able. Although none of the constraints on migrants applied at the ports by the Medical Officers of Health were as harsh as some of those imposed on the Continent or in the United States, they appeared to succeed in deterring migration through Britain (although this was more than likely due more to the severe restrictions of these other countries).

COLLINGRIDGE: [The] arrangement had had the desired result, and one effect had been to check Jewish pauper immigration... When the form was filled up it was sent to the Sanitary Authority of the district in which the person said he resided, and that Authority was informed that he was detained on board the ship pending verification of the address. The passengers were kept on board the ship practically as prisoners until an answer received from the Sanitary Authority by post or by wire.

DR. ARMSTRONG (PMOH Newcastle-on-Tyne): That system will soon stop the immigration of Jewish paupers.⁹⁹

Indeed in the United States, these 'arrangements' at British ports established during the cholera epidemic of 1892 were claimed to constitute a policy of immigration restriction. As the *New York Medical Journal* reported in September 1892, the

⁹⁸ *BMJ*, Sept. 17, 1892, p. 659

insistence on verifiable addresses of immigrants as they arrived in the port was 'virtually a prohibition of immigration, as the question can hardly be answered by the average immigrant unless he is very carefully coached'.¹⁰⁰ Indeed, as the example of the *Gemma* demonstrated, whether satisfactory or unsatisfactory, migrants' addresses were inconsequential to the decision made to detain them.

The 1892 epidemic thus not only brought changes – or at least provided a definite impetus to change – to the operation of port prophylaxis, it also began in Britain a new attitude to the restriction of immigration on medical grounds. These restrictions sat uncomfortably between a commitment to free pratique, a tradition of asylum and the desire to restrict the entry of undesirable and potentially disease-carrying migrants. Although Britain remained committed after 1892 to the tenets of free movement of trading vessels, unhindered by the costly delays of maritime quarantines which had informed her position at each International Sanitary Conference of the nineteenth century, the detention of vessels carrying third or steerage class migrants was an exception Britain was more than willing to concede.

¹⁰⁰ *Cholera Precautions for 1893*, p. 12-13, CLRO MISC/MSS/337/3.

¹⁰¹ *N.Y. Med. Jnl.*, Sept. 3, 1892, vol. 56, p. 251.

CHAPTER FOUR: External Pressures: The Impact of United States Port Health and Immigration Legislation on the Operation of British Ports

As has been shown, migrants were perceived in 1892 to pose a particular risk in the spread of cholera. This response developed as cholera was seen rapidly approaching Britain from Eastern Europe in the early summer. Temporary modifications were made during and after the crisis in preventive measures at the ports which targeted this risk group and which prompted moves toward more permanent alterations. Yet, just as the ports responded to both internal and external pressures in the implementation of policy and practice for quarantine and the 'English system', the reception of migrants as a health issue at the ports was similarly influenced. Where the demands of European imperial powers, such as France and Germany, and the 'Quarantine nations' influenced domestic policy regarding the arrival of an infected vessel, the development of immigration and quarantine policies in the United States also affected British responses to immigration.

Greater than any other external source, the operation of port prophylaxis and immigration restriction (particularly after 1891) in the United States influenced Britain's approach to port health and the 'alien problem'.¹ There were two key reasons why this occurred. Firstly, port prophylaxis and immigration restriction were closely linked in the United States. Systems of disease prevention were central tools in the screening of 'undesirables' and were occasionally employed in order to reduce drastically the number of migrants attempting to gain entrance to the United States. An estimated one million, of the 2.4 million Russian and Polish migrants who settled in the United States between 1881 and 1914,² transmigrated through and departed for the United States from ports in the United Kingdom.³ However, the stricter

¹ M.J. Landa, *The Alien Problem and Its Remedy*, (London: P.S. King & Son, 1911).

² Between 1881 to 1914 an estimated 22 million immigrants arrived in the United States - the majority originating from mainland Europe. It is estimated that 2.4 million of these migrants were Jews who emigrated from Eastern Poland and Western Russia - the Pale of Settlement. Exactly how many Jews did migrate cannot be ascertained due to the ambiguity of the US Immigration records which did not record the number of Jewish immigrants prior to 1899. British Customs statistics are similarly problematic as although some records were kept for the number of Russian and Polish 'immigrants' their period of stay in the UK was not documented; nor were Jew and Gentile distinguished prior to the 1905 Aliens Act.

From, Nicholas J. Evans, *European Migration via the United Kingdom, 1836 - 1914*, (Ph.D., University of Hull, - To be submitted 2002).

³ Transmigrants to the United States arrived and departed from London, or arrived into one of the East coast ports (eg. Hull) and were transported by trains brought right into the port, to departure ports on the West coast (eg. Liverpool). Not all transmigrants through the United Kingdom were en route to America. Others travelled to Australia, Canada, South Africa and South America. Approximately one

immigration laws of the United States – which could prevent the entry of migrants who did not satisfy its medical, financial or moral requirements – often encouraged migrants who fell short of the entry requirements to stay in Britain, either temporarily or on a permanent basis. More significantly, in British consciousness, a number of migrants who were rejected by United States immigration officials were returned to Britain by the shipping companies under whose liability they fell.

Secondly, the United States influenced the way that Britain dealt with the perceived health problems posed by immigrants by way of example. As the United States received by far the greatest number of migrants, the pressure to create legislation for monitoring or restricting their arrival appeared earlier in America than it did in Britain. Thus American legislation served as an example in Britain either to be emulated or altered, or, as John Garrard has suggested ‘to assume the importance of a blue-print for anti-alien agitators in England’.⁴ Similarly, where certain diseases, namely trachoma, were regarded in America as analogous with steerage class migrants and grounds for deportation, Britain began to make the same associations. If trachoma were grounds for rejection in an American port, it might become grounds for a migrant to remain in Britain. Consequently the otherwise relatively unimportant disease became a focus of British Port Medical Officers and those pushing for legalised immigration restriction in Britain.

Just as Britain observed with care the progress and consequence of American policy and practice, America also closely monitored the conditions of British ports. As millions of migrants intending to reside permanently in the United States were spending a number of days prior to their Trans-Atlantic voyage in some of Britain’s busiest and most overcrowded port cities, the health of these ports and the manner by which disease was prevented in them were of great interest to America. Indeed, America’s desire to implement its own independent observation of ports from which vessels departed for the United States was one of the main reasons why it hosted the International Sanitary Conference in 1881.

third of those Jewish migrants who settled in Australia, for example, had spent enough time in the United Kingdom for them to have learned a small amount of English by the time they arrived in Australia.

S. Rutland, *Edge of the Diaspora – Two Centuries of Jewish Settlement in Australia*, Second Revised Edition, (Sydney: Brandl & Schlesinger Pty Ltd, 1997) p. 77.

⁴ Garrard, *The English and Immigration*, p. 24.

Thus, just as it has been important to examine the proceedings of the International Sanitary Conferences in order to understand the policies and practice of disease prevention in British ports, it will be necessary to conduct a similar examination of American management of immigration and health, as it related to the United Kingdom.

Immigration and Medical Inspection at United States Ports

The first federal legislation regarding immigration in the United States was passed in 1819. It required masters of all vessels entering American ports to provide Customs Officers with a complete list of the number of passengers on board, their names, sex, age and occupations.⁵ Until the 1880s further laws were enacted which did little more than redefine and clarify the Act of 1819 - although a number of other laws were passed during this period which regulated the conditions on board passenger vessels travelling both to and from the United States. An Act of 1855 defined more clearly the sanitary conditions on board passenger vessels and was particularly concerned with controlling overcrowding in steerage (however this law was never completely successful in its execution).

The first federal law in the United States which restricted a specific class of people from entry to the country was passed in August 1882. It stated that 'it shall be unlawful for aliens of the following classes to immigrate to the United States, namely, persons who are undergoing a sentence for conviction in their own country of felonious crimes other than political or growing out of or the result of such political offences, or whose sentence has been remitted on condition of their emigration, and women imported for the purposes of prostitution'.⁶ The Act did not limit the immigration of these three classes to people of Chinese or Japanese origin only, but that these nationalities were the focus of the restrictions was more than apparent. This was clearly illustrated ten years later when the Republican President Benjamin Harrison endorsed the 1892 Chinese Exclusion Act, which built upon the 1882 Act and imposed severe quotas on Asian immigration.⁷

⁵ Roy L. Gars, *Immigration Restriction - A Study of the Opposition to and the Regulation of Immigration into the United States*, (New York: Macmillan, 1927), p. 83.

⁶ Gars, *Immigration Restriction*, p. 87.

Markel, *Quarantine!*, p. 144.

Beyond the 1882 Act, there existed no 'all-inclusive' federal immigration law for the United States, and any further restrictive legislation existed only on a state level. The Act which eventually codified the hotchpotch of laws relating to immigration was the Immigration Act, 1891 (26 Stat.1084). The Act was passed during the second session of the 51st Congress and was the result of a bill, sponsored by the Joint Committee on Immigration and Naturalisation, entitled 'In amendment of the various acts relative to immigration and the importation of aliens under contract or agreement to perform labor'.⁸ Within only a month of being presented to the House of Representatives in Bill form, the Act passed by a vote of 125 to 48 and was approved by President Harrison within days. It expanded the range of restricted classes of immigrants set out in the 1882 Act and included:

idiots, insane persons, paupers or persons likely to become public charges, persons suffering from a loathsome or dangerous contagious disease, persons convicted of a felony or other infamous crime or misdemeanor involving moral turpitude, polygamists, persons whose tickets were paid for with the money of another, or who are assisted by others to come, unless it is affirmatively and satisfactorily shown that they do not belong to one of the excluded classes, or to the contract labor class.⁹

In order to extend the category 'likely to become public charges', it ordered the deportation of any immigrant who became a 'public charge' within one year of arriving in the United States.¹⁰ All immigrants rejected by United States inspectors, including those deported after arrival, were required to be returned to their port of origin by the steamship company which carried them to America.

The passing of the 1891 Immigration Act, however, did not entirely satisfy those who campaigned for a tightening of immigration restriction. President Harrison, in his final State of the Union address in December 1892 before he was superseded by the Democrat Grover Cleveland, still appeared to consider the restrictive measures put in

⁸ E.P. Hutchinson, *Legislative History of American Immigration Policy 1798-1965*, (Philadelphia: University of Pennsylvania Press, 1981) p. 100.

⁹ *ibid.*

¹⁰ *ibid.* p.102.

place by the 1891 Act inadequate, particularly in relation to the threat of infectious disease importation.

We are particularly subject in our great ports to the spread of infectious disease by reason of the fact that unrestricted immigration brings to us out of European cities, in the overcrowded steerages of great steamships, a large number of persons whose surroundings makes them the easy victim of the plague. We have, I think, a right and owe a duty to our own people, not only to keep out the vicious, the ignorant, the civil disturber, the pauper, and the contract laborer, but to check the too great flow of immigration now coming by further limitations.¹¹

Immigration restriction, with particular reference to possible contagion brought to the United States by an undesirable class of migrants, was part of the platforms offered by all parties in the 1892 Presidential election campaign. Although arguments about the social and economic threats posed by the immigrants were heavily employed in the campaign, the health risks associated with immigration had a particularly poignant role to play in the orations of that Summer.

The year 1892 began in New York with the arrival in late January of the *S.S. Massilia*, a Russian emigrant ship infected with typhus. By the beginning of April 200 cases of typhus had been identified: 138 among *Massilia* passengers, as well as 49 New York residents, 11 nurses/helpers, and 2 policemen.¹² The disease was confined to the Lower East Side and although there were only 24 deaths, more than 2,600 people residing in the area and from incoming steamships were quarantined. They were almost exclusively Russian Jewish immigrants. One ship, for example, the *Nevada*, which had departed from the typhus free port of Liverpool, was declared by the Health Officer of the Port of New York, Dr William Jenkins, to have not the 'slightest suspicion' of typhus on board. Yet, the 30 Russian migrants on board were placed in quarantine, while Scandinavian passengers of the same class and all other passengers and crew were free to land without delay.¹³

¹¹ Benjamin Harrison, 'Fourth Annual Address to the Congress, December 6, 1892', in Markel, *Quarantine!*, p. 145.

¹² *ibid.* p. 66.

¹³ *ibid.* p. 74.

Quarantine was enforced under the Quarantine Act of 1878 (20 Stat., 37) until the passing of the National Quarantine Act in early 1893. The 1878 Act was the first attempt at applying a national approach to quarantine and had been established in response to an epidemic of yellow fever.¹⁴ Any immigrant or vessel infected with a contagious disease, or proceeding from an infected port, was under the Act prevented from entering any United States port without first undergoing a medical inspection and a period of quarantine where required. Although it was a federal act it could not under ordinary circumstances supersede or interfere with sanitary procedures or quarantine systems already in operation in any given state or municipal authority. Thus, the implementation of any quarantine measures ultimately remained under the regulation of state or municipal authorities.¹⁵ Nevertheless, the 1878 Act permitted the federal government to enforce additional quarantine regulations at any specific port in the event of an emergency. These powers were further enforced by the passing of the National Board of Health Act, 1879, which, although providing little other real authority to the Board of Health, permitted this federal agency to take over the quarantine responsibilities of any state if their own laws proved ineffectual.¹⁶

The National Board of Health Act was primarily concerned with preventing 'the introduction of infectious and contagious diseases', with specific reference to the 'extensive prevalence of yellow fever in certain parts of this country during the past two years, and the almost continual existence of the danger of the introduction of such contagious or infectious diseases as yellow fever and cholera by vessels coming to this country from infected ports abroad'.¹⁷ The provisions of the Act were such that all ships departing from a foreign port bound for America were required to be in possession of a Bill of Health and 'sanitary history' endorsed by a United States Consular Official or Medical Officer working in the foreign country. The Act stated that, 'it shall be the duty of the National Board of Health to obtain information of the sanitary condition of foreign ports and places from which contagious or infectious diseases are or may be imported into the United States, and to this end the Consular Officers...shall make weekly reports of the sanitary condition of the ports and places at which they are respectively stationed'.¹⁸ This required the Consular Official to inspect the ship and port of departure, as well as any Bill of Health or inspection

¹⁴ *ibid.* p. 95.

¹⁵ *ibid.* p. 96.

¹⁶ Kraut, *Silent Travelers*, p. 51.

¹⁷ Howard Jones, 'The Scientific Background, 3', p. 370.

which had been made by a port official belonging to the country of departure. It was believed that this would render Bills of Health more reliable as the authorities of the country of departure might possibly conceal epidemic infections in order to protect their own commercial interests.¹⁹

As discussed in Chapter Two, in order to implement this essential feature of the National Board of Health Act, the United States required international sanction – to which end the 1881 Washington International Sanitary Conference was called. The focus of the conference was to reach an agreement which would ensure a level of cleanliness and sanitation on board vessels before they departed from a port. The United States delegates framed their argument in terms of preventing obstructions to commerce through the time-consuming and costly enforcement of quarantine in America which would necessarily be applied to ships whose health status was questionable due to unsanitary conditions on board. The success of their argument was, however, limited. Britain was one of the chief opponents to the American proposal, labelling it impracticable. Again, as at the 1866 and 1874 conferences, the British argued that the suggestion of an ‘independent’ medical inspection of vessels greatly undermined and questioned the authority of British Medical Officers, and they would thus not support the proposal. In the end no effective resolutions or international agreements were reached, except that United States consuls were permitted to endorse Bills of Health prepared by health officials of the country of departure. Although this had not been the ideal outcome of the conference from the American point of view, it did allow the United States to oversee foreign departures and maintain most of the clauses under the National Board of Health Act and the 1878 Quarantine Act.

United States Immigration and Infectious Disease Laws and the United Kingdom

These American laws (both federal and state), which operated against the import of infectious disease and restricted immigration, had a significant effect on British attitudes to immigration and health at British ports. One of the most notable ramifications of American law for Britain was the authority both state and federal laws had for returning migrants deemed ‘undesirable’ to their last port of departure.

¹⁹ *National Board of Health Bulletin*, vol. 1, no. 1, June 28, 1879, p. 2.

²⁰ Goodman, *International Health Organisations*, p. 61.

Undesirability was measured both by economic and medical factors although neither was grounds for rejection under British law. When immigrants were rejected, either on arrival in the United States or for offences committed within a year of arrival, the steamship company which brought them to America was responsible for returning them to their port or frontier of origin. Frequently, in order to avoid the full cost of the passage back to Eastern and Central Europe, companies economised by returning the migrants to their last port of departure at less distant British ports. This point was noted some years later in the evidence of a Medical Officer and Ophthalmic surgeon to the Royal Commission on Alien Immigration in 1903.

...cases had been referred to me which had been returned from America, aliens who had gone to America, and had been examined by the immigration officers at certain ports in America, and sent back, not to Poland, but to London. So that there is a possibility of them accumulating in this country, on account of the fact that the shipping companies find it cheaper to send them back to London than to Poland.²⁰

The passage back to the United Kingdom was not only cheaper but also, as an investigation undertaken by the Poor Jews Temporary Shelter in London discovered, better for business.

If they went back to their own countries rejected by the United States it would considerably affect [the shipping agent's] business in those countries; and as a result they come to England and learning from the agents here that they can get to America through Canada they either take this course or remain in London.²¹

Aware of the frequent expensive liability they incurred, shipping company owners undertook to enforce medical inspections of their own before departure and refused to carry migrants who would not, on arrival in the United States, pass the increasingly rigorous requirements of entry.

²⁰ Evidence of Dr. F.A.C. Tyrrell, Medical Officer to the London School Board, and Surgical Officer to the Royal London Ophthalmic Hospital: *Minutes of Evidence Taken Before the Royal Commission on Alien Immigration, 1903*, vol. II. (London: HMSO, 1903), [Cd. 1742], 3670.

²¹ I.M.A. Board of Deputies of British Jews, ACC/3121/B02/01/003.

While at the boarding-house [in Liverpool], the immigrant is under constant medical surveillance; for the shipping companies employ a medical man (some companies employing a special 'shore doctor' others sending the surgeon of the ship in which the immigrants are to sail), whose duty it is to pay a daily visit to the boarding-houses and to inquire into the health of their inmates. One principal object of this medical inspection is to avoid all risk of shipping persons whose state of health might cause danger or inconvenience to their fellow passengers. But the inspection serves at the same time to enable the discovery of persons who are likely to be treated as ineligible by the American immigration authorities by reason of their state of health²²

The return to British ports of migrants who had been deemed not fit to settle in the United States was perceived in Britain not only as a financial burden, but also as a threat to the public health. Yet, despite the great concern raised by this issue, the actual impact of return migrants, in terms of numbers, was minimal. In an 1893 Board of Trade report on alien immigration into the United States,²³ David Schloss included in the concluding chapter of his report on the efficacy of American immigration policy and practice a subsection titled, *Effect of United States Laws Upon Ratepayers in United Kingdom*.²⁴ The inquiry examined to what extent persons debarred or expelled from the United States within a year of settlement and returned to the United Kingdom, subsequently sought the assistance of public relief. Schloss presented

²² 'Report by Mr Schloss: - American Legislation and Practice', *Reports to the Board of Trade on Alien Immigration, 1893*, (London: HMSO, 1893), p. 10.

²³ In 1893 the Board of Trade appointed two men, John Burnett and David Schloss, to compile a report on,

the laws relating to the immigration of foreigners into the United States, the practical methods of enforcing those laws, the state of opinion in the United States with reference to restrictions on immigration, the proposals on the subject before Congress, and the nature and economic effect of the immigration of destitute foreigners from the eastern parts of Europe. (p. iii)

The report was commissioned both on the impetus of parliamentary discussion on the issue of alien immigration into the United Kingdom, and because the duty bestowed on the Board of Trade to compile statistics relating to immigration had, during the course of numerous inquiries, left the Board of Trade with 'a great deal' of information regarding immigration to the United States. The fact that so much information on American immigration had been unintentionally collected in the process of compiling UK statistics, demonstrates further that any investigation into immigration into Britain must be accomplished with reference to the United States.

The report gives a detailed account of the 'sifting process' of immigrants both at the ports of departure and at the major immigration ports in the United States, particularly New York. Although the majority of the report concerns itself with the internal workings of American immigration policy, there are several interesting references made to the relationship between these policies and their reference to and implications for the United Kingdom.

²⁴ *ibid.*, p. 87-89.

Board of Trade statistics for immigrants returned to the United Kingdom during 1892.²⁵

According to the report, a total of 118 immigrants from New York, Boston and Philadelphia, both rejected on arrival and returned during the year 1892, were conveyed to ports in the United Kingdom at the expense of the steamship companies.²⁶ Of the 85 returned from New York, 65 had migrated from Russia or Poland, 12 from Germany, 6 from Sweden and the rest from other Northern European countries such as Finland. As TABLE III clearly illustrates both the actual number returned to British ports and the percentage this represented of the total arrivals into the three American ports, was very low.

TABLE IV:²⁷

1892	New York	Boston	Philadelphia	Total: NY, Bost. Philadelphia
Total No. of Alien Steerage Arrivals	374,741	29,709	29,292	433,742
No. Returned to UK Ports from US	85	27	6	118
Percentage of Total Arrivals Returned to UK Ports	0.02	0.09	0.02	0.03

The 85 immigrants returned to Britain from New York during 1892 were only 3% of the 2574 who were debarred or returned within a year of arriving in New York.²⁸ The 2489 who were not returned to Britain were taken back to European departure ports. A similar proportion was returned to the Continent from Boston and Philadelphia. Furthermore, as Schloss noted, ‘a very considerable proportion’ of the migrants who were returned to British ports was subsequently returned to their respective

²⁵ Although Schloss’s figures are of particular interest, they must be placed within the context of 1892 conditions. It must be remembered that these figures might be wholly unrepresentative of other – non-epidemic – years. The regulations put in place in 1892 in response to the cholera epidemic drastically reduced the number of immigrants crossing the Atlantic. The over-all figures for the number of steerage class immigrants arriving into the Port of New York during the 1892 calendar year were down 13% on the previous year, and during the last quarter of 1892 figures were down between 55 and 87 % on 1891 figures.

²⁶ Schloss, *On Alien Immigration, 1893*, p. 87.

²⁷ *ibid.* p. 87; TABLE II – (New York); TABLE III – (New York); and TABLE XVIII – (All Ports)

²⁸ *ibid.* TABLE II – (New York)

continental ports of origin.²⁹ According to Board of Trade reports for England (not including London) only three returned immigrants, all in Liverpool, became reliant on public relief in institutions maintained by the local rates. In Scotland, although total numbers are not given, four returned immigrants sought public assistance in 1892, all within the Parish of Govan Combination.³⁰

Application for poor relief by returned migrants was infrequent, and once a claim was made the expense was often reimbursed by either the shipping company or, in the case of Jewish migrants, by local Jewish charitable organisations. Yet, regardless of their infrequency, as described by Schloss and demonstrated through an examination of poor relief applications in Glasgow,³¹ the belief that migrants, who were unwanted by America, were publicly supported in Great Britain was a powerful one. Two examples will suffice demonstrate the type of relief afforded to this conspicuous few.

Goldie Friedman, a 27 years old Russian Jewish woman was brought before the Glasgow Parish of Govan Combination with an application for poor relief by State Line Company Officials on the 23rd of February 1886:

this woman was an emigrant on her way to America and turned insane on board the vessel. She was three weeks confined in an asylum at Staten Island, America, and was handed back to the State Line Company, who now applies for her removal to asylum. She having arrived at Mavis Bank Quay on board the *S.S. State of Georgia*. Her husband is in Baltimore. Sent to Merryflats [asylum] and removed on 12th March by order of the board.³²

She remained in the asylum for nearly three weeks, the cost of which was claimed from the State Line Company.³³ Similarly the Allan Line Company met the cost of five days spent in the Poorhouse by Abraham Wahlhandler in October 1891. He had been in America for four months but had been 'Returned by authorities from New York'. His only ailment appears to have been a sprained ankle, yet he was 'refused at

²⁹ *ibid.* p. 88.

³⁰ *ibid.* p. 88.

³¹ Krista Maglen, *Investigating the Immigrant Experience: Poor Relief Applications, Computer Analysis and European Immigrants in Glasgow, 1881-1896*. (MPhil Dissertation, Glasgow University, 1997-8)

³² SRA D-HEW 17/291 - 81277.

³³ Her subsequent fate was not recorded.

Royal Infirmary not requiring surgical treatment' and thus applied for [outdoor medical] poor relief.³⁴

So, although American policy to return to shipping companies any immigrant expelled on grounds of health or likely to become a public charge attracted both popular and some official concern in Britain, the quantitative evidence is unable to account for the strength of the reaction. Part of the reaction was due to Britain having to accept (there being no recourse to refuse an immigrant entry) people who had been rejected by the United States for failing to satisfy its requirements for permanent settlement - being physically, morally or economically undesirable. These undesirables were without difficulty allowed not only to enter the United Kingdom, but to settle, work and claim relief. An article in the *British Medical Journal* in 1896 complained that 'hundreds of thousands of wretched paupers...are crowded together in the cities of the Pale until life becomes intolerable. Then they escape in hordes in the hope of reaching the free West. The stronger and more able-bodied manage to reach America, but the less fit stay behind in England'.³⁵

This notion that Britain received those immigrants who United States immigration officials rejected came to the fore in the British medical press in 1892 and remained contentious over the following decade. Part of the concern, despite the preventive system established at British ports, was that no medical inspection was undertaken on vessels departing American ports for Britain and Europe. While inspections – established under the National Board of Health Act – were carried out on all vessels bound for the United States before embarkation, none were on those returning. As a Medical Inspector working with the United States Consul in Britain wrote to the Board of Trade in 1896:

passengers leaving the other side are not required to undergo an examination at all, as the object of the American Government is simply to prevent disease being imported into their own country, and they apparently do not care what disease may break out in the ship or may be imported into this country.³⁶

³⁴ SRA D-HEW 17/358 - 1073.

³⁵ *BMJ*, Sept. 12, 1896, p. 700.

³⁶ Letter dated Aug. 4, 1896, PRO MT9/559/13197.

In the United States the new Immigration Act of 1891, combined with state quarantine laws, was put into practice with the arrival of cholera from Europe. It had particular consequences for Great Britain. While Britain anticipated the arrival of cholera, watching its progression across Europe 'from Whitehall' with limited alarm and urging local authorities 'to complete their sanitary defences in time to repel the threatened invasion',³⁷ America responded with considerably less optimism. As in Britain the source of the disease was seen to be East European migrants, and America responded with great vigour by initially focusing prevention almost exclusively on this group.

With the danger of cholera in question, it is plain to see that the United States would be better off if ignorant Russian Jews and Hungarians were denied refuge here... These people are offensive enough at best; under the present circumstances, they are a positive menace to the health of the country. Even should they pass the Quarantine officials, their mode of life, when they settle down makes them always a source of danger. Cholera, it must be remembered, originates in the homes of this human riff-raff.³⁸

The first cases of cholera arrived in New York on August 30th aboard the steamship *Moravia* sailing from Hamburg. The vessel was at once placed in quarantine with all passengers, regardless of health, detained upon it. With the arrival of more infected vessels immanent, President Harrison summoned a meeting with the Attorney General, Secretary of the Treasury and Supervising Surgeon General of the Marine Health Service. They agreed to impose from September 1st an extended period of quarantine – twenty days – on all vessels from an infected port which carried 'Russian Hebrew' immigrants. The period of quarantine applied only to immigrant steerage passengers; other passengers of cabin class would be released. The 1878 Quarantine Act permitted the federal government to impose periods of quarantines on vessels arriving in American ports during emergencies. Using this authority Harrison issued a circular which placed all responsibility for the importation of cholera on steerage class immigrants and the vessels which carried them. The circular referred specifically to the 'prevalence' of cholera in 'Russia, Germany and France, and at certain ports in

³⁷ *BMJ*, Sept. 10, 1892, p. 604.

³⁸ *New York Times*, Aug. 29, 1892, p. 1a.

Great Britain' and that 'immigrants in large numbers are coming into the United States from the infected districts aforesaid'.³⁹ It ordered,

that no vessel from any foreign port carrying emigrants shall be permitted to enter any port of the United States until the said vessel has undergone quarantine detention for a period of twenty days.⁴⁰

As Markel points out, this quarantine and the circular which enforced it 'had nothing to do with bacteriological concepts of cholera culture diagnosis or incubation periods. It was explicitly conceived as a financial brake to halt steerage immigration'.⁴¹ With developments in bacteriological understanding of cholera in the United States, the estimated time deemed appropriate for the isolation of people who had been in contact with the disease was five to eight days.⁴² Indeed, at the beginning of September 1892 the Advisory Medical Council of the Chamber of Commerce in New York⁴³ recommended that 'the period of quarantine detention of healthy persons ... should be five days in case no cholera occurs among them'.⁴⁴ However, President Harrison made it clear in his final two addresses to Congress that he strongly supported restrictions on the immigration of Russian Jews. The twenty day quarantine period on all steerage passengers and the vessels they arrived in was imposed, as Markel explains, not simply to provide New York with the greatest level of protection against cholera, but to drastically limit the number of immigrants who arrived. By enforcing such extended delays it would not be economically viable for steamship companies to continue to run the Trans-Atlantic migrant routes. The scheme worked. Steamship companies which had first and second class bookings began to refuse to take on board steerage class immigrants and were subsequently spared the imposition and expense

³⁹ [Circular. 1892. Department No. 150] *Quarantine restrictions upon immigration to aid the prevention of the introduction of cholera into the United States*, (Treasury Department, Office of the Supervising Surgeon-General, U.S. Marine Hospital Service, Sept. 1, 1892), NARA S. exdoc. 52 (52-2) Congressional Series Set, vol. 3056., also see, *BMJ*, Sept. 10, 1892, p. 606.

⁴⁰ *ibid.*

⁴¹ Markel, *Quarantine!*, p. 98.

⁴² *ibid.* p. 104. The Medical Officer of the Port of New York, Jenkins, wrote in his 1892 Annual Report that the known incubation period of cholera was two to five days.

⁴³ Members of the Council included T.M. Prudden and Hermann Biggs, who had both studied in Germany under Koch and who both 'played major roles in the introduction of bacteriological research to the United States', Elizabeth Fee and Evelyn Hammonds, 'Science, Politics, and the Art of Persuasion: Promoting the New Scientific Medicine in New York City', Rosner, *Hives of Sickness*, 155-196, p. 157-164.

⁴⁴ *Journal of the American Medical Association*, Oct. 22, 1892, p. 505.

of quarantine.⁴⁵ In an attempt to re-establish steerage passage the steamship companies proposed to the United States Consul in Liverpool an expansion of the steam disinfection facilities for cleansing steerage-class clothing and baggage in order to eliminate cholera. But this

experiment proved that to continue the steaming properly would necessitate great enlargement of the plant at considerable expense, and as it was believed that even with this precaution the twenty days' quarantine at United States ports would still be required, the steamship companies concluded to abandon it.⁴⁶

After the failure of this proposal all steerage passengers already booked aboard vessels sailing from Liverpool to America were removed from ships carrying first and second class passengers and, 'the emigrants thus shut out with others whom the companies had already contracted to carry are being sent over in special ships with no other passengers'.⁴⁷ The Consul at Liverpool then issued orders to all steamship companies operating out of the port not to book steerage emigrants until further notification and to 'avoid taking first and second class passengers from infected ports'.

If the cessation of European immigration was Harrison's intention in imposing such a severe and focused quarantine policy, his scheme proved successful. Russian Jewish immigrants arriving in New York averaged approximately 3,800 per month during the early months of 1892, but between October and December, after the application of immigrant quarantine, this average fell to around 270 a month.⁴⁸ The policy was not entirely successful in preventing the spread of the disease into the city of New York but unlike previous epidemics, such as the epidemic of 1849 which killed 5017 New

⁴⁵ Letter from T. Sherman (Consul, Liverpool) to W. Wharton (Assistant Secretary of State, Washington) No. 180. Sept. 15, 1892, NARA Consular Correspondence, Dispatches From Consuls – Liverpool, Jan 1, 1891 – Dec 1, 1896 (States Department Central Files, Record Group 59, National Archives Microfilm Publication M141, roll T-52) Archives II.

⁴⁶ *ibid.*

⁴⁷ *ibid.*

⁴⁸ Markel, *Quarantine!*, p. 140.

Yorkers within three months,⁴⁹ there were only nine deaths from Asiatic cholera reported in the City of New York during September 1892.⁵⁰

The decline in the number of migrant passengers arriving in New York in September 1892 corresponded with and contributed to a decline in the number of migrants who arrived in Britain. Medical officers working at British ports and for the Local Government Board – Thorne Thorne and Collingridge for example – saw the decline in numbers arriving into British ports in 1892 as a reflection of the Local Government Board's Cholera Orders of that Summer.⁵¹ However, the rigid restrictions placed on migrant passage in United States and at European ports together with border controls⁵² were probably more responsible for the decline. As the *British Medical Journal* remarked,

if evidence were needed of the effect produced by the drastic measures of quarantine adopted by America during the prevailing cholera epidemic upon the flow of Russo-Jewish transmigrants from Hamburg across Great Britain on their way to the West, it may be found in the return of the Board of Trade as to the number of aliens arriving at ports in the United Kingdom during the past month. In place of the 5,615 aliens who landed on our shores from Hamburg *en route* for America in September of 1891, there was not one such entry in the same month of the present year. It is thus seen how effectually America has done for England that which she herself did not see her way completely to accomplish, and certainly not in the manner in which America has deemed necessary to her safety.⁵³

Watching closely the progress of cholera vessels in New York Harbour, British responses were favourable, for reasons shown above, yet were critical of the extreme restrictions of the twenty-day quarantine.

⁴⁹ Rosenberg, *The Cholera Years*, p. 114.

⁵⁰ This reduction may also be accounted for in improved sanitary conditions in New York. See Charles Rosenberg, *Explaining Epidemics and Other Studies in the History of Medicine*, (Cambridge: Cambridge University Press, 1992), pp. 219-229; and John Duffy, *The Sanitarians: A History of American Public Health*, (Chicago: University of Illinois Press, 1990), p. 177-181.

⁵¹ See Chapter Three.

⁵² see Evans, *Death in Hamburg*, p. 372-379.

⁵³ *BMJ*, Oct. 15, 1892, p. 861.

The United States have made vast progress in public health, some of their advisers are men of the highest eminence, and it may be that some system of quarantine is that which will best meet the possible importation and diffusion of cholera in the case of their country. But, however this may be, its educational effect is of the worst.⁵⁴

For many, the twenty-day quarantine period clearly demonstrated the 'evils' long associated with quarantine: its essential ineffectiveness and its ability to incite panic. The New York epidemic did not extend much beyond the end of September, but during those 30 or so days seven ships heavily infected with cholera arrived in New York Harbour. 120 people died on board the seven vessels and thousands more on other vessels were quarantined. By September 5th, with the threat of cholera growing ever greater, the Health Officer of the Port of New York, Dr Jenkins, extended the scope of quarantine to passengers of all classes. Two days earlier, two ships from Hamburg, the *Rugia* and the *Normannia*, arrived in the harbour with cholera on board. On the same day, more passengers aboard the *Moravia* succumbed to the disease. Jenkins, his small staff and resources desperately over-stretched, decided to place the entire population of the *Normannia*, 1355 people, under quarantine, despite a number of eminent individuals on board, including a U.S. Senator and the British music hall star, Lottie Collins, about to begin her debut American tour.⁵⁵ The cabin class passengers were detained for 11 days, while the steerage class immigrants were interned for 16 days. During this time all 1355 people were moved to what was considered more appropriate quarantine accommodation on Fire Island, thirty miles east of New York City and away from the overcrowded quarantine facilities in New York Harbour. However, on arrival at Fire Island the passengers of the *Normannia* were forced to remain on the pleasure boat which had ferried them from New York. For three days a combination of bad weather and irate local residents on Long Island prohibited their landing at the temporary quarantine barracks, and they had to remain on board without even the most basic amenities.

Between the peril of the voyage, the fear of a mob of armed and frenzied men, and the misery of being confined all night in a small steamer without provision

⁵⁴ *Lancet*, Sept. 17, 1892, p. 672.

⁵⁵ Markel, *Quarantine!* p. 101.

or opportunities for eating or sleeping, the passengers had a pitiable experience, and their hardships reached a climax.⁵⁶

The incident caused national and international outrage and the world's press seized upon the affair. It was extensively covered in *The Times* although criticism seldom went beyond the following:

Loud complaints are being made by cabin passengers at their unreasonable detention at the New York quarantine station. A relaxation is demanded of the strictness of quarantine provided that the passengers can provide where they were living for ten days before embarking.⁵⁷

Medical journals such as *The Lancet* were more straightforward in their condemnation of the New York quarantine and the consequent fiasco at Fire Island.

If healthy people are, in the eyes of the [United States] Government, such a danger to a community because they come from an infected port, or because cholera has occurred on board the ships in which they travel, that they must be kept away for ten or twenty days, although this may involve the greatest cruelties, indecencies and danger of death, then why complain of the action of people such as those who, in the Fire Island case, armed with clubs, pistols, boat-hooks and rifles, and were deaf to the entreaties, tears and pleadings of helpless women and children, who, though healthy, had been labelled by the quarantine system as dangerous?⁵⁸

The incident provided the ultimate, dramatic evidence against quarantine. It had all the necessary ingredients to demonstrate the claims Britain had been making throughout the century against the system. Once British faith in the sanitary system was restored after the brief brush with temptation to revert to quarantine in response to the immanent arrival of cholera in early 1892, British attacks on quarantine resumed with full force. By mid-September 1892 the *Lancet* gave those in Britain who still advocated the detention of vessels arriving from cholera infected ports and carrying 'diseased' immigrants the example of the *Normannia* to heed.

⁵⁶ *Times*, Sept. 13, 1892, p. 3a.

⁵⁷ *Times*, Sept. 1, 1892, p. 3c.

We would urge people who are thus pressing the [British] Government [to 'authorise a reversion to the ancient, useless, and cruel system known as 'quarantine'''] to read again the intelligence from Fire Island, and also note that the practical outcome of the New York quarantine system is an announcement on authority of the Board of Health that five cases of genuine Asiatic Cholera have already occurred in New York.⁵⁹

The *Normannia* incident came to be used in Britain as a graphic example of the 'evils' of quarantine. For example, at a meeting of the Ship Masters' Society in London in 1894 after a lecture by Collingridge on the 'Hygiene of Ships and Quarantine', one ship captain offered the *Normannia* incident as evidence that 'quarantine, as carried out in many places is a cruel, cowardly and sometimes barbarous imposition'.

Before me are the Quarantine Regulations current in most ports in the colonies, also French, Turkish &c. &c. [sic]. These regulations are reasonable enough generally speaking, but the trouble comes when carrying them out. We all remember the *Normannia's* case, in which, at Fire Island, 400 people, young and old, of both sexes, were kept huddled together on board a small vessel without proper food, bedding, or other necessities of life for a number of days because 'a mob of armed and frenzied men' refused to let them land.⁶⁰

The cholera epidemic of 1892 in the United States, as in Britain, was a catalyst to further debates and developments in immigration restriction and quarantine laws. Yet, rather than discouraging the use of quarantine as it had in Britain, the epidemic instigated a debate in the United States which led to the passing of the 1893 Quarantine Act, which extended the use of quarantine under federal, rather than state, law.

In general, British and American positions regarding the effectiveness and desirability of quarantine were at odds with each other. In Britain the application of quarantine was thought to be to be archaic and ineffectual, while in the United States it was believed to be the safest and most assured means of preventing the importation of

⁵⁸ *Lancet*, Sept. 17, 1892, p. 672.

⁵⁹ *ibid.*

infectious disease. Current medical opinion in either country cannot always account for this difference. As Markel points out with regard to the approach taken toward cholera in New York, 'it was not Jenkins' (or any other health official's) scientific understanding of cholera that would primarily guide the management of the epidemic. Bacteriological knowledge had far less to do with the proceedings of the 1892 epidemics than politics and nativistic sentiments'.⁶¹ In the simplest of terms, the issue of quarantine in the United States became an important part of the immigration debate. Any discussion about quarantine in the 1890s was not only a discussion about how to prevent the importation of disease, but also about how to prevent the importation of a certain class of immigrant. As Markel argues, quarantine and the restriction of immigration were closely linked.

Vibrant and colorful in its expression, but often blurred at the edges, the medical profession's debate [about quarantine] had less to do with the victory of germ theory and the institution of the laboratory in public health than with the bitter fight over U.S. immigration policy.⁶²

So closely did the issues of quarantine and immigration restriction become bound together that the 1893 Quarantine Act was largely perceived, then and now, as both an attempt to prevent disease and an attempt to place a ban on undesirable immigrants under the more palatable guise of public health.⁶³ The final report of the National Board of Trade's Quarantine Committee in January 1893 stressed that the two issues needed to be kept separate.

The general question of immigration, and whether it has the same value for our country as in past decades, is foreign to the subject, and care should be taken under the pretense and cover of quarantine laws that the opponents to immigration, as such, be not permitted to effect their purpose contrary to the will of the majority of the people of several states. That classes of immigrants shall be admitted to this country is one question; what system of quarantine and sanitary inspection of vessels, cargoes and passengers shall be adopted is

⁶⁰ Collingridge, 'Practical Points in the Hygiene of Ships', p. 27.

⁶¹ Markel, *Quarantine!*, p. 104.

⁶² *ibid.* p. 153.

⁶³ *ibid.* p. 170.

another question, and it is the opinion of this Committee that the best results will be attained by separating the two subjects in legislation.⁶⁴

The Act which was eventually passed brought the implementation and administration of quarantine under central, federal control. Ironically, given the policy during the 1892 epidemic, it was based less on a policy of total isolation and non-intercourse than existed under the previous system of separate state regulations. Instead, the Act transformed United States quarantine into a system that appeared to mirror more closely the British system of 'medical inspection, rigid sanitary regulations, and the isolation of those found to be ill with a contagious disease based on bacteriological concepts of disease incubation and transmission'.⁶⁵ As a concession to the immigration restrictionists the Act also included a clause which allowed the President to put a stop to all immigration if the threat of imported contagion appeared imminent. This clause was never employed.

Those individuals in the United States who were in favour of sanitary control, rather than quarantine as the best means to preventing the importation and spread of infectious disease drew from the British both their model and illustrative examples. Not only was the arrangement in Britain to be emulated but also India was used as an example of how British administration could implement simple sanitary precautions which drastically reduced the risk of infectious disease spreading in notoriously filthy cities. Night-soil collection was one such sanitary precaution which could prevent disease. According to a contributor to the *North American Review*, this was the type of reform which was required in cities such as New York if sanitary prevention was to be relied upon. 'Now, in civilized cities, whether in India or England, it is the rule to remove all filth during the hours of night, and before sunrise, and if the Health Department of this city of New York do not see the necessity of such an arrangement they have certainly not learned the initial principles of sanitation'.⁶⁶

In the United States British dedication to free trade was seen to be of prime importance in any discussion of medical inspection and disease prevention at British ports. The driving force perceived to be behind British policy was to find the least

⁶⁴ *ibid.* pp. 171-2, from 'Report of the Special Committee of the New York Board of Trade and Transportation on Quarantine, Adopted January 6, 1893, with the Correspondence'.

⁶⁵ *ibid.* p. 180.

⁶⁶ Thomas P. Hughes, 'Sanitation Versus Quarantine', *North American Review*, 1892, vol.155, p. 638.

expensive and most efficient method of intercepting infection in accordance with the 'worship of the Mammon of pounds, shillings and pence'.⁶⁷ Most discussion in America reflected European opinion that the British approach to protecting its ports from cholera stemmed from its trade interests. In an article entitled 'The Ability of the State to Prevent an Epidemic of Cholera' which appeared in the Philadelphia journal, *Medical News* in September 1892, Benjamin Lee, the Secretary to the State Board of Health of Pennsylvania, offered a blunt reading of British motives in responding to the threat of cholera.

The system of seacoast quarantine in Great Britain, as has long been known to American sanitarians, is defective in the extreme. Recent disclosures have developed the fact that there is really no power in the Government to enforce quarantine. The great British doctrine of free trade seems to have been pushed to its utmost limit to include disease as well as other commodities.⁶⁸

Lee went on to admit that throughout the previous weeks while the United States had struggled to keep down the number of cholera cases breaking through the barriers of quarantine, the British system had proved more successful in preventing the spread of the disease. However, such a system, where 'everything [was] in such an admirable condition of cleanliness and [had] such strict enforcement of local precautions that the germs will quickly die', required 'a complete and thorough sanitary organisation of the country so that no foot of ground escapes frequent sanitary inspection and no accumulation of filth is allowed to remain on its surface or beneath the surface for an hour'. Within two paragraphs of having admonished Britain's ulterior motives for rejecting quarantine as an effective preventative system, Lee shifted his position to one of admiration as he lamented the deficiencies of the American system. 'Such, unfortunately, is not the sanitary organisation of the States of this Union'.⁶⁹

More forceful and less relenting in his disapproval of the English system was S.T. Armstrong, a visiting physician to the Harlem Hospital who wrote an article for the *New York Medical Journal* in September 1892, entitled 'Quarantine and the Present

⁶⁷ *N.Y. Med. Jnl.*, 1892, vol.56, p. 355.

⁶⁸ *Medical News*, (Philadelphia) 1892, vol.61, p. 322.

⁶⁹ *ibid.*

Status of Quarantine Laws'.⁷⁰ Armstrong asserted that, in contrast to Britain 'the welfare of the many must be given precedence over the inconvenience of the few'.⁷¹ He argued that the system which operated in the United Kingdom was in no way superior to the system of quarantine in place in the United States.

They profess to base their indifference to a quarantine in general to the improved sanitary conditions of their cities, towns and villages. And yet it is difficult to understand a sentiment that professes to ignore a maritime quarantine, and yet provides a maritime inspection service, with crude appliances for caring for the sick who are detained from an infected vessel.⁷²

Arguing that the British sanitary system of disease prevention was little more than a second-rate alternative to quarantine, Armstrong's key point was that quarantine was still used and indeed favoured as a preventative measure in Britain where there were no consequences for trade. He cited the example of the quarantine of school children who had been exposed to infectious disease and asked how the British could support this when they frowned upon maritime quarantine.

The code of rules of the English Medical Officers of Schools Association provides that a quarantine of from twelve to twenty-one days, according to the disease, with thorough disinfection on the pupil's return to school, be required of all pupils exposed to an infectious disease. If such methods are deemed desirable to prevent an epidemic in a school, in consequence of one or more of the pupils having been exposed to an infectious or contagious disease, why is not the principle just as applicable to the prevention of an epidemic in a city, in consequence of one or more of the passengers on a vessel arriving at that place having been exposed to one of what may be considered the epidemic diseases? To ask this question seems to me to answer it affirmatively.⁷³

These responses to Britain's apparent preference to commerce over public health were similar to those expressed by the French and German delegates to the International Sanitary Conferences and in the French medical press during the 1880s and 1890s.

⁷⁰ The paper was read before the Section in Public Health of the New York Academy of Medicine, September 19, 1892.

⁷¹ *N.Y. Med. Jnl.*, 1892, vol.56, p. 355.

⁷² *ibid.*

The United States was determined to continue its own medical inspections - overseen by consular officials - in British ports. While some Americans believed British methods to be successful, despite the assumed motivations, the Americans did not have the systems in place to rely entirely on her own or British sanitary means. Consequently, the Americans subjected vessels which arrived in the United States from British ports to as rigorous a medical inspection as vessels which departed directly from Hamburg, for example. Quarantine and the strict exclusion of those who displayed symptoms of infectious disease became the preferred method of the United States.

Just as the sanitary system supported the British 'worship of the Mammon of pounds, shillings and pence', the quarantine system supported American nativism and the increasingly rigorous requirements for entry.⁷⁴ Conciliation to commercial interest appeared in America to account for Britain's rejection of quarantine during the cholera epidemic and British willingness to release potentially infected immigrants into the community. In the United States the situation was reversed. Economic concerns were sacrificed to the creation of barriers to the entry of 'infected' immigrants. The twenty-day quarantine detention period was particularly harmful to trade coming into New York and to the business of many American steamship companies, but it was successful in reducing the average number of migrants who arrived into New York each month by up to 93%.⁷⁵

In the more palatable language of public health Americans argued that strict quarantine, although detrimental to the economic interests of maritime trade, was no more damaging to commerce than the label of 'infected port' which would be applied should a contagion be imported.

It will be admitted by all that the sanitary interests of the United States call for the exclusion, by proper restrictive measures, of all exotic, pestilential diseases; and it can be shown that even from an economic point of view, a

⁷³ *ibid.*

⁷⁴ See Markel, *Quarantine!*; Kraut, *Silent Travelers*; and Higham, *Strangers in the Land*.

⁷⁵ Markel, *Quarantine!*, p. 140.

single wide-spread epidemic of yellow fever or cholera costs more than our commerce with permanently infected ports is worth.⁷⁶

Whether or not economic concerns or immigration restriction was prioritised when dealing with imported infection, scientific medicine, bacteriology and new diagnostic techniques, were only employed at the ports when they could reinforce or justify these priorities. During the 1892 epidemic, bacteriological testing was only employed in the United States to prove that Asiatic cholera had entered the country and thus justify the use of extreme quarantine measures. Thereafter only a small number of bacilli cultures from the ports were cultivated, and the knowledge derived from bacteriology that the incubation period for cholera was only five to eight days was ignored.⁷⁷ As Charles Wilson of the New York Board of Health wrote, 'all that science can do, has been done in the way of preparation should the pest come; all that science can suggest to lessen the evil effects of the pest, should it break out, is either finished or now in the course of completion'.⁷⁸ In American, as in British, ports there was a subordination of laboratory medicine to political agendas. In the United States the primary political agenda which selectively employed and ignored the bacterial aetiology of cholera was the nativistic resistance to the immigration of poor East European Jews.

With the passing of any immediate threat from cholera after 1892-3, other diseases began to replace cholera in perceptions of immigrant contagion. The narratives which redefined certain diseases as 'immigrant diseases' or 'contagions' generally emanated from the United States and were quickly adopted for the same purpose in the United Kingdom. By the turn of the century Ellis Island⁷⁹ and other facilities for the reception of immigrants in America had implemented systems of inspection which could process up to 5000 people each day at Ellis Island alone. Easily visible and identifiable diseases associated with poverty and overcrowding such trachoma, the contagious eye disease, and favus which affected the scalp were incorporated into

⁷⁶ George Sternberg (Major and Surgeon, U.S. Army), 'The Reconciliation of our Commercial and Sanitary Interests', *Reports on the Sanitation of Ships and Quarantine – Prepared by the Supervising Surgeon-General, U.S. Marine Hospital Service, for the Use of the International American Conference* (Washington: Government Printing Office, 1890), p. 19, NARA S.exdoc. 58 (51-1), Congressional Serial Set vol. 2685.

⁷⁷ Markel, *Quarantine!*, p. 105; see also, Fee and Hammonds, 'Science, Politics and the Art of Persuasion', p. 161-2.

⁷⁸ 'Safe-Guards Against the Cholera', *North American Review*, 1892, vol. 155, p. 491.

⁷⁹ Opened in late 1892.

immigration law and popular perceptions of the contagious 'nature' of immigrants.⁸⁰ Trachoma was especially associated with immigrants from 1897 when the Supervising Surgeon General of the U.S. Marine Hospital Service declared it to be a 'dangerous, contagious disease... seldom seen except among recent immigrants from the eastern end of the Mediterranean, Polish and Russian Jews'.⁸¹ The identification of trachoma became the most common reason for immigrants to be debarred on medical grounds, constituting an estimated 80% of cases rejected under the classification of 'dangerous and loathsome contagious disease' between 1897 and 1902.⁸² Nine out of every ten migrants who were diagnosed with trachoma on arrival were refused entry.⁸³ The American Public Health Association reported at its Annual Meeting in 1903 that

the ordinary quarantinable diseases were eliminated by efficient quarantine methods, but certain communicable maladies, classed as loathsome or dangerous contagious diseases, existed among immigrants, and constant vigilance and considerable skill were necessary on the part of medical inspectors of immigrants to detect these cases and separate them from the healthy immigrants. The most important of these diseases, because of its frequency, was trachoma. Of the total number of cases of loathsome or dangerous diseases found in immigrants, 87% were due to trachoma and 10% to favus.⁸⁴

Although trachoma was a highly infectious disease which if untreated could result in blindness, it was no more prevalent among immigrants than other infections and much less widespread than tuberculosis, for example. Trachoma was a disease which was easily transmitted in the overcrowded conditions of steerage accommodation and as the development of symptoms occurred around five to twelve days after infection - not much less than the time needed to cross the Atlantic - evidence of the disease was often manifest on arrival. The disease inflamed and reddened the eyes making them weep and form pustules; it was unavoidably visible. It could be quickly diagnosed among the hundreds of immigrants who lined up for inspection after the arrival of a vessel and thus became branded as the most notorious disease of immigration. While

⁸⁰ See Birn, 'Six Seconds Per Eyelid'; and Markel, 'The Eyes Have It'.

⁸¹ Markel, 'The Eyes Have It', p. 533.

⁸² *ibid.* p. 535.

⁸³ *ibid.* p. 531.

tuberculosis presented a significantly larger problem in terms of numbers, the visibility of trachoma's unsightly symptoms meant that immigrants wore their 'undesirability' on their face. For these reasons trachoma was, what Markel has called, a 'central character' on the 'stage of infectious diseases and immigration'.⁸⁵

Since 1892 particularly American port health controls were perceived in Britain to contribute to the risk of disease in British migrant port towns. This idea gathered speed in the early years of the new century. Yet, before 1897 there was no specific connection made in Britain between immigration, issues of port health, and trachoma. Indeed, it was not until the issue of immigration restriction began to be seriously considered by the British government in the first years of the twentieth century that trachoma began to emerge in port papers and related medical articles. In the 1889 Select Committee on Emigration and Immigration⁸⁶ evidence regarding the health of migrants referred only to their sanitary condition on arrival into British ports and their general propensity to contagious disease. The annual reports of the Port Medical Officers of Health during the nineteenth century referred to the number of cases of the 'exotic' disease cholera⁸⁷ and 'indigenous' diseases, such as scarlet fever and measles which arrived on incoming vessels; they did not specifically identify cases of trachoma until the turn of the century. The inclusion of trachoma in British port medical reports coincided with the move toward the legal restriction of immigration. It was a disease which was adopted by immigration restrictionists for the same reason as it was adopted in the United States: it was easily visible. Markel points out that 'the stigma of trachoma became an essential consideration in the East European Jewish immigrant's calculus of migration' as it 'permeated the experience at almost every point along the journey'.⁸⁸ In British ports, United States consular or shipping company officials checked for trachoma among hundreds of migrants who lined up for the notorious eye examination before embarking for America. It was a primary reason why a proportion of migrants were debarred from entering the United States and were returned to the United Kingdom or remained in Britain for some time before attempting to enter America. By the turn of the century, the American stigmatisation

⁸⁴ *American Medicine*. (Philadelphia), 1903, vol. 6, p. 771.

⁸⁵ *ibid.* p. 528.

⁸⁶ *Report from the Select Committee on Emigration and Immigration (Foreigners) – Together with Proceedings of the Committee, Minutes of Evidence and Appendix*, (London: Hansard, 1889), [311].

⁸⁷ Only the case of yellow fever on the *Neva* in Southampton, 1889, was reported and plague appeared in the reports from 1899.

⁸⁸ Markel, 'The Eyes Have It', pp. 528 & 560.

of immigrants as a particular source of trachoma had also become an integral part of British perceptions of the immigrant as disease carrier. The Royal Commission on Alien Immigration⁸⁹ in 1902-3 took evidence from ophthalmic physicians about the disease. Anti-immigration provocateurs began to target the disease in their literature and newspapers. The *Daily Mirror*, for instance, ran an article on the 'Alien Scourge – Disease Stricken Immigrants' which highlighted Britain's role as 'dumping ground' for those migrants who had trachoma and were thus medically unfit to enter the United States.

Recent investigations have shown enormous prevalence of the highly contagious eye disease known as trachoma among recent immigrants. Trachoma subjects are rigidly barred from entering the United States, where it is admitted that many of the Russian Jews, now transmigrant in London, are bound. At the Royal Ophthalmic Hospital in City Road it was stated that during the last week or so the Russian Jews suffering from incipient or developed trachoma have been flocking for advice and treatment. On one day, out of 160 new patients, 102 were aliens, mostly with eye disease... Most of them follow the same formula: 'Can I go to America?' They do not want the treatment so much as expert advice on the possibility of passing the medical examination at the ports of arrival. Once told that the disease would cause them to be sent back they disappear. They know their forward voyage is impossible, and seem to take no interest in curing the disease. Thus they remain in metropolis to become a source of infection for others.⁹⁰

Britain followed America's lead in identifying trachoma as a disease of East European Jewish immigrants. Just as cholera had represented the contagious nature of immigrants in the early 1890s, by the turn of the century trachoma, and to a lesser extent favus, came to represent all that was pernicious in the arrival of migrants in both Britain and America. The trachoma-stricken immigrant not only threatened to spread the contagious microbe which caused the disease, but also embodied the contagion which threatened the well-being of the body politic.

⁸⁹ See Chapter Five.

⁹⁰ *Daily Mirror*, Dec. 6, 1904, Home Office cutting, PRO HO45/10303/117267.

Throughout the nineteenth century Britain developed a system of protection at the ports which had full public and government support. Vessels and people from around the world arrived daily, causing no more difficulty than the odd altercation resulting from the dual authority of the Port Sanitary Authority and Customs Service at the ports. At the International Sanitary Conferences Britain displayed complete confidence in the safety of the systems which had been established to prevent the importation of infectious diseases into the ports. Yet, two factors in the early 1890s led to marked changes in the operation of the port health system over the next dozen years. The first, as we have seen, was the cholera epidemic of 1892 and the idea that its source was a particular class of migrant from Eastern and Central Europe. The second was the solution the United States adopted to the shared idea that immigrants were the carriers of disease. Britain was certainly effected by the 1891 Immigration Act and the extreme measures implemented in America in response to the 1892 epidemic. As Schloss showed, these did not have a numerically significant effect on the number of migrants returned from America to Britain. The impact was important in the ways it altered British ideas about immigration restriction. America and Britain were linked through the western migration of East European Jewish refugees, as well as the eastern movement of those migrants who were expelled from America under ever tightening definitions of 'desirability'. The fact that relatively few migrants were expelled and returned to Britain from the United States does not diminish the great concern felt in Britain and its political impact. The identification of trachoma as an immigrant disease in America filtered into British perceptions of East European migrants and subsequently to the notice and into the reports of the Port Medical Officers. Eye examinations prior to departure for America took place at British ports and failure to pass the United States' examinations meant that those who displayed symptoms of the disease were liable to return or remain in the United Kingdom.

The experience of the 1892 cholera epidemic and subsequent American policies heightened awareness in Britain of both the presence of transmigrants and the lack of powers to refuse entry to anyone who arrived with a 'dangerous and loathsome contagious disease'. Britain had assured the world throughout the second half of the nineteenth century that the arrival of contagious disease did not pose a risk to the public health if sanitary measures and controls were meticulously administered. Yet the fear in Britain that it was becoming the home of 'diseased' migrants not 'good

enough' for the United States led Britain to reassess, from the mid-1890s, the procedures surrounding the entry of certain groups of migrants and transmigrants and their implications for public health at the ports. Thus, the policies of a foreign country indirectly exerted pressure to change procedures at British domestic ports. Should changes be made to the port health system regarding these migrants? How would existing structures be operated under any such alteration of the prized port sanitary system?

Just as in America, port health in Britain was beginning to be related more to immigration but imperial trade still remained at the forefront of the concerns of British port management. However, placing this growing concern and desire for immigration restriction within the structures developed over the nineteenth century was becoming increasingly necessary in Britain.

CHAPTER FIVE: The Aliens Act and the Port Sanitary Authority: Bringing Immigration within the Sanitary System

In 1896 the Quarantine Act of 1825 was repealed. The barrier was removed to the Local Government Board and Port Sanitary Authority's complete control of port health. Britain's success in averting the spread of cholera in 1892 and its subsequent attainment of European acquiescence regarding the superiority of port sanitary measures over extended quarantines, hastened the legal removal of quarantine from the statute books, for all diseases. Yet the question of health at the ports remained open. The increasing belief that migrants – immigrants and transmigrants – were a source of imported infectious disease in Britain resulted in the introduction of legislation specifically restricting the entry of any migrant who arrived displaying the symptoms of disease.

The primary focus of the anti-alien debate¹ which developed with particular force in Britain during the first years of the twentieth century was not, however, the health but the economic considerations of this East European immigration.² Those arguing for immigration restriction emphasised the problems of an extended workforce, inadequate housing, and the production and introduction into the market of cheap goods. Overcrowding in the unsanitary streets of London's East End or the Liverpool dock areas, for example, where the migrants dwelt was described in detail and perceived as a direct manifestation of the immigrant 'problem'. The health problems this caused and nurtured in the urban slums of port towns were integral to the economic debates of anti-alienism, because they led to migrants becoming a charge upon the public funds and a drain on the resources of urban sanitary authorities. Diseases brought into the ports with the migrants both put pressure upon the resources of the sanitary authorities and posed a threat to the health of the rest of the population.

¹ 'Alien' was the contemporary term used to describe foreigners in or arriving into Britain. In this period it referred particularly to Eastern and Central European migrants and migrant Jews. Arnold White (1848-1918) - described as 'Author: Interested in the Question of Alien Immigration' (see also: *Who Was Who: Vol.II, 1916-1928*, p. 1116) – defined *alien immigrant* in his evidence to the RCAI as, 'a non-naturalised person with a domicile in a foreign country settling in this country'. , *RCAI, Minutes of Evidence*, vol. II, 1109.

² For further reading on the economic effect and reaction to immigration see Feldman, *Englishmen and Jews*; Garrard, *The English and Immigration*; Gartner, *The Jewish Immigrant in England*; Harris, 'Anti-Alienism, Health and Social Reform'; Holmes, *John Bull's Island*; Anne J. Kershen (Ed.), *London: The Promised Land? The Migrant Experience in a Capital City*, (Aldershot and Vermont: Avebury, 1997); Lucassen (Eds.), *Migration, Migration History, History*; and Panayi, *Immigration, Ethnicity, and Racism in Britain*.

Although the link between immigration and disease was an important part of the anti-alien debate and found a place within the legislation resulting from it, it did not occupy as central a place in British concerns over immigration or excite the same fervour or vivid imagery as it did in the United States. Throughout the debate leading up to the new immigration legislation, the Aliens Act 1905, the Port Sanitary Authority fiercely defended its ability to sufficiently prevent the introduction and spread of infectious disease and its complete control over diseased vessels and individuals arriving into British ports, so recently acquired from the Customs Service.

This final chapter will examine how those arguing for immigration restriction used the issue of disease; how the example of American policy and practice played an important role in this part of the debate; and why ultimately infectious disease did not occupy a place on the centre stage of anti-alien propaganda as it did in the United States. The Port Medical Officers of Health, and those involved with their work were among the first to encounter the migrants when they arrived in Britain. The concerns they voiced among themselves about the threat of infection accompanying the migrant vessels remained evident after 1892 but when giving evidence to the Royal Commission on Alien Immigration in 1902-3 and in official testimony relating to immigration legislation, these officers assured the relevant authorities that the risk was minimal. They displayed their confidence in the Port Sanitary System and in the competency of inland sanitary structures and systems. The primary concern of the Medical Officers was ensuring that migrants remained within these systems and under the observation of the sanitary authorities. Information about the identity and intended destinations of migrants which would ensure the success of sanitary surveillance was acquired at the ports but was for a variety of reasons unreliable. Between 1892 and 1905 sanitary surveillance was the primary means of managing immigration, but because reliable information was not always easy to obtain its affect was limited.

The Abolition of Quarantine

During the years 1892-95 the Port Sanitary Authorities retained the powers granted under the Local Government Board General Cholera Orders during the epidemic. These Orders included additions to their powers and an extension to their jurisdiction

with regard to cases of cholera. The rigorous investigation of passengers' forward addresses (which will be discussed later in this chapter) was continued. However, once the threat of cholera had again retreated, the special authority of the General Orders was removed and power to deal with cases of cholera, along with yellow fever and plague, was once again placed within the jurisdiction of the Customs Service.

From late 1893 the immediate danger from cholera had passed, and serious discussion finally began in the Houses of Parliament regarding the abolition of quarantine. Before legislation could be passed to repeal the 1825 Quarantine Act and the associated authority of the Privy Council and Customs Service over port health, it was necessary to discuss the implications for trade of removing the legal 'safety-net' of quarantine. Departments, including the Board of Trade, Local Government Board, and Treasury Chambers, exchanged anxious notes to check and double-check that no harm could befall British foreign trade if the Quarantine Act was removed. Despite Britain's confidence in the sanitary system after its success in the cholera pandemic of 1892 and the submission of European states to the British system at the 1893 International Sanitary Conference, there remained a serious concern that difficulties might await British vessels when 'they go to countries which believe in quarantine'.³ However, the Board of Trade and Foreign Office gave assurances that no such obstacles would hinder the movement of British trading vessels once quarantine had been abolished.

My Lords have reason to believe that the Local Government Board attach no importance to the maintenance of this Service in the interests of Public Health, and it only remains to consider whether its abolition would injuriously affect our trade with foreign countries.

Upon this point My Lords are informed by the Secretary of State for Foreign Affairs that he has no objection to offer to the abolition of Quarantine on the ground of Conventions with Foreign Powers, or of hindrance to our Foreign Trade.⁴

³ Memorandum from Marine Department of the Board of Trade, end April, 1894, PRO MT9/512/M7865.

⁴ Letter from Treasury Chambers to Board of Trade, April 19, 1894, PRO MT9/512/H3435.

With these assurances the Public Health Act 1896⁵ quickly passed through both Houses of Parliament and ‘the remarkable anomaly of one disease being dealt with by one Authority and another by a second Authority at the same time and under the same conditions’⁶ was brought to an end. The Act came into force on November 7, 1896 and applied to the whole of the United Kingdom. It altered the role of the Local Government Board and Port Sanitary Authority in a number of ways. Primarily, the Act transferred all the authority previously in the possession of the Privy Council with regard to instances of cholera, yellow fever, and plague over to the Local Government Board. As the powers of the Privy Council only applied to these three diseases, the Local Government Board could not extend any of its new authority to other – ‘indigenous’ - diseases. However, as Collingridge remarked in 1896,

the practical results of these Regulations [was] to make the Port Sanitary Authority (subject to the control of the Local Government Board) the actual Health Authority of the Port, and [gave] to their Medical Officers discretionary power as to the detention of vessels infected, or suspected, of either of the three diseases above mentioned.⁷

The Act ensured that no person was permitted to disembark an ‘infected’ vessel until the Port Medical Officer had examined it. The definition of an ‘infected’ vessel was extended to apply to cases of ‘exotic’ disease on board, up to and including departure from its last port, rather than ‘after it had left’. It also included two new provisions. The first recognised the expertise of the ship’s surgeon,

and requires him to give a responsible professional certificate as to whether there has been any case on board. The Master’s certificate was, strictly speaking, of no value, as he certified to a matter of which he had no expert knowledge, whereas a Medical Certificate is of a known and definite worth.⁸

⁵ Public Health Act, 1896 [59 & 60 VICT.], ‘An Act to make further Provision with respect to Epidemic, Endemic, and Infectious Diseases, and to repeal the Acts relating to Quarantine’.

⁶ ‘Sanitary Report – Port of London Sanitary Committee with the Half-Yearly Report of the Medical Officer of Health for the Port of London, to 31st Dec, 1896,’ *Port of London Sanitary Reports, 1896-1901*, p. 11, CLRO 565B.

⁷ *ibid.*, p. 12.

⁸ *ibid.*, p. 13.

The second gave power to the Port Medical Officer to require the Master of a vessel to bring his ship 'to' or to moor or anchor the vessel in a place convenient for undertaking a thorough medical inspection. This remedied a weak element in the previous law which called on the Master of a vessel to *permit* [sic] his vessel to be boarded and examined.⁹ Furthermore, 'as to the necessity for detention, and of the length of such detention, the Medical Officer of Health [was] the sole judge'.¹⁰

Thus, after more than half a century of serious endeavour to do away with the burdensome and exorbitant obligations of quarantine, the system was finally removed from the statute books and the Local Government Board and its Medical Officers was alone responsible for the health of British ports. Within four years the responsibility for dealing with the reception of previously quarantineable disease was placed firmly within the hands of the Port Sanitary Authorities during the pandemic of plague, 1899-1900. Plague reached Britain in August 1900, first in Glasgow where its effects were worst,¹¹ and then numerous cities around England and Wales. Customs officers still boarded vessels under the Customs Consolidations Act of 1876 which regulated the importation of goods. Although they no longer had any jurisdiction over the health of ships, during the threatened and actual arrival of plague in 1899-1900 Customs officers were instructed to assist the Medical Officers of Health in all matters relating to inspection and to ensure that the Port Sanitary Authority was aware at all times of the arrival of vessels from infected ports. The Port Sanitary Authority enforced isolation of the sick and sanitary surveillance of healthy passengers from infected vessels both at and away from the port in much the same way it had during the 1892 cholera epidemic.

However, prevention of plague in 1900 differed from cholera prevention eight years earlier. Unlike 1892, bacteriological testing was used to confirm or deny the existence of plague in suspicious cases.

⁹ *ibid.*

¹⁰ *ibid.* p. 14.

¹¹ 'Altogether there were recognised 36 cases of plague in Glasgow from the beginning of August to the end of September, 1900. Of these 16 proved fatal, a case mortality of 44.4 percent,' Bruce Low, 'Summary of the Progress and Diffusion of Plague in 1900,' *Thirtieth Annual Report of the LGB, 1900-01 - Supplement Containing the Report of the Medical Officer*, Appendix No. 18, (London: HMSO, 1902), [Cd. 747], p. 276.

At each port visited by the Medical Inspectors a copy of directions for obtaining and sending to the Board material from suspected plague cases for bacterioscopic examination was left with the Medical Officer of Health for his guidance. The Board made arrangements with Dr. Klein, F.R.S., of St. Bartholomew's Medical School, to examine any such material forwarded, along with the necessary particulars, to the Board by any Medical Officer of Health.¹²

In England and Wales four cases - two at London, one at Liverpool, and the other at 'the Tyne port' - were confirmed as plague by bacteriological testing. In Glasgow 36 cases were confirmed in the laboratory. A second way in which the plague epidemic of 1900 differed from the 1892 cholera epidemic (in terms of the administration of port health) was that Glasgow was declared to be an infected port under the convention drawn up at the International Sanitary Conference in Venice in 1897. This meant that although sanitary precautions, rather than quarantine, could be used in British ports, foreign ports could impose quarantine on any vessel which had sailed from Glasgow. Experts from around the world descended on the city to observe the disease and the preventive systems employed there, which prevented the extension of the disease beyond the boundaries of Glasgow.¹³ The classification of Glasgow as an infected port lasted only until October, and the city was congratulated by the Local Government Board for its success in controlling the epidemic through the combined efforts of the sanitary authorities. Finally, the 1900 plague epidemic differed from the cholera epidemic in that, although it focused attention and prevention upon the arrival of vessels from infected ports, it did not direct particular attention toward any specific group or class of people. The co-operation between port and local sanitary authorities which controlled plague in 1900 had been cemented during the 1892 cholera epidemic and the methods of observation were the same. People who had departed from plague infected ports were put under sanitary surveillance away from the port and infected individuals were isolated. However, this prevention was not aimed primarily at migrants. The spread of plague was not associated with migrants, nor did it follow

¹² 'Memorandum on Precautionary Measures taken in 1899 to Prevent the Importation of Bubonic Plague into England and Wales ...,' *Twenty-Ninth Annual Report of the LGB, 1899-1900 - Supplement Containing the Report of the Medical Officer*, Appendix No. 15, (London: HMSO, 1901), [Cd. 299], p. 345.

¹³ *Sixth Annual Report of the Local Government Board for Scotland, 1900*, p. xxxvii.

specifically migration routes.¹⁴ The prevention of cholera, on the other hand, was so directly associated with migrants that it not only relied upon the sanitary authorities, but was also depended upon the co-operation of migrant aid organisations for control of the disease. Control of the 1892 epidemic involved both the control of disease and the control of a certain 'class' of people.

'The Duty of Keeping These Aliens Under Supervision..'¹⁵

It is now necessary to return briefly to 1892 to explain the particular methods and problems involved with the sanitary surveillance of migrants. These began in 1892 and continued until the introduction of the Aliens Act. The Local Government Board Cholera General Order of 1892 caused great difficulty for many migrants entering Britain during the epidemic.¹⁶ As highlighted in a number of American journals at the time the Order was Britain's only means of refusing immigrants entry. Addresses unverified by the local sanitary authorities frequently demanded the detention of migrants at the port and occasionally their return to Continental Europe. Many of the migrants had booked their passage with agents who organised the various stages of the journey from Eastern Europe to the United States. These agencies often had offices at the European departure ports of Hamburg, Bremen or Rotterdam, for example, as well as in the transmigration towns of Britain, such as London and Hull. Yet, not all were scrupulous in the running of their businesses and some exploited the naiveté and desperation of many of the migrants. Agents in Europe often produced tickets only as far as London, where the migrants were instructed to collect the onward ticket from their agency office. But, the London addresses provided by dishonest agents in Europe were often fictional. As a result the migrants arrived with nowhere to stay and no ticket to collect for completing the journey they had paid for to America. The temporary residences agents provided were also frequently in the most wretchedly overcrowded and unsanitary lodging houses. The Port Medical Officers questioned the agency addresses for these reasons and many migrants found

¹⁴ Plague first became cause for concern in Britain when it appeared in Jeddah, Port Said, and Alexandria in the first half of 1899. 'It was not, however, until August that the Board became at all disquieted about this disease.' In August official information 'was received' of the presence of plague in Oporto, Portugal. *Twenty-Ninth Annual Report, 1899-1900*, p. xiv.

¹⁵ Theodore Thomson. 'Cholera and Alien Immigrants Arriving in the Port of London', (1905), PRO MH19/237

themselves unable to land. With no other connections in Britain nor the funds to find alternative lodgings the migrants fell into the hands of the agencies and sanitary authorities.

In addition to the problems caused by invalid agency addresses, other difficulties awaited the émigrés at the landing stations of the major migration ports, particularly London. Recognising the vulnerability of the arriving migrants various groups gathered at the 'landing places of the riverside' anxious to take advantage of the bewildered arrivals. In his memoirs Abraham Mundy, who was Secretary of the Poor Jews Temporary Shelter between 1897 – 1946, recalled and described the chief offenders:

crimps of the worst type were abounding at every landing place, who took charge of the emigrants, presumably to conduct them with their baggage to friends or lodgings. They were, however, in many instances taken to undesirable lodging houses where they were robbed of all their belongings, whilst their young women-folk were decoyed to places of ill repute and shame.¹⁷

The watchful eyes of the missionaries propagating Christianity amongst the Jews were mainly focused on these people, who they were anxious to ensnare... These 'soul-snatchers' were usually lying in wait at the landing places of the riverside, and on the disembarkation of each load of immigrants from the Continent, they poured upon them and distributed their religious tracts and insidious literature amongst them, inviting them at the same time to their centres to listen to their religious services and preaching, and offering them as a bait assistance in kind.¹⁸

The Poor Jews' Temporary Shelter was established in October 1885 in Leman Street, Whitechapel to provide immediate aid to poor immigrants and transmigrants in

¹⁶ See Chapter Three.

¹⁷ *Memoirs of Abraham Mundy – Secretary to the Jews' Temporary Shelter, 1897-1946*, vol. 1, chpt. 1, p. 1-2 (Jewish Museum, Finchley, Memoirs Box I); See also evidence of Stephen Moore, Chief Inspector of the Thames Police, *Minutes of Evidence – Select Committee on Emigration and Immigration (Foreigners)*, (1889), 1841-1846.

¹⁸ *ibid.*, chpt. 10, p. 1.

London.¹⁹ In 1893 the Shelter signed an agreement with the Port Sanitary Authority which offered an alternative to the fictional or notoriously unsanitary lodging houses provided by agents, and would protect migrants from the 'dangers' awaiting them at the landing stations. The Shelter, in accordance with the wishes of the Board of Deputies of British Jews, wanted to have a presence at the docks to give advice to the arriving migrants and to protect them from the 'crimps' and 'missionaries' who awaited them.

The agreement originated after the 1892 epidemic at the initiation of the Port Sanitary Authority. Collingridge contacted the Poor Jews' Temporary Shelter in London because the notoriously unreliable addresses provided by agents were making the work of the Port Medical Officers, and their counterparts in local sanitary districts more difficult and time consuming. In 1893 the Shelter and Port Sanitary Authority reached an agreement in which the Shelter would ensure the whereabouts of all Jewish immigrants in London for seven days after arrival 'on condition that Collingridge undertook to hand over all immigrants to the Shelter and not part only, the others especially not to be handed over to missionaries or other irresponsible persons'.²⁰ After much negotiation, during which Collingridge conceded only 'to do his best'²¹ with regard to the Shelter's provisions, they signed the agreement. It stated that it was the right of the Port Medical Officer to detain any immigrant arriving into the Port of London. Rather than kept at the port until the local Sanitary Authorities reviewed their addresses, those migrants detained for questionable addresses were handed over to an officer of the Shelter with a 'nominal roll' drawn up by the Port Medical Officer. The migrants were taken to the Shelter where a further roll was taken of their names and their intended addresses which were subsequently examined by officers of the Shelter. Once the Shelter verified their addresses, an officer of the Shelter personally escorted the migrants to the residence. The roll and details of anyone who subsequently left the Shelter to board another vessel within seven days of arrival into London was forwarded to the Port Sanitary Office at Greenwich. The Port Sanitary Office also agreed to furnish the Shelter with a list of all immigrant vessels

¹⁹ The Shelter was the principal immigrant aid organisation in London, through which, by 1903, 95% of the total number of Jewish immigrants arriving into London passed. Similar organisations operated in Hawich and Grimsby. See Evidence of Herman Landau, President of the PJTS, in *RCAI, Minutes of Evidence*, 16273.

²⁰ General Committee Minutes, PJTS, April 30, 1893.

²¹ *ibid.*

due to arrive into the port so that the presence of a Shelter officer could be assured at the riverside.²² By placing migrants with questionable addresses in the care of the Shelter, the Port Sanitary Authority relieved itself and the officers of the local Sanitary Authorities from the arduous responsibility of visiting each of address, making enquiries and conducting an investigation. They asked, “were these people known there, or were they expected to arrive there”. If they reply “Yes”, they were immediately liberated to go to that address’.²³ Furthermore, the agreement meant that should the address not be *bona fide*, the migrant could remain at the Shelter until the seven day period had elapsed without costing either the Sanitary Authorities or the shipping companies any more time or money.

The agreement did not always operate smoothly. The Port Sanitary Authority was disappointed with the frequent ‘disappearance’ within the seven day period of migrants placed within the care of the Shelter; while the Shelter complained that a lack of Port Sanitary Authority vigilance was allowing ‘the Missionaries to entice away a number of Jewish new arrivals, to unknown addresses, making it difficult for the Shelter and the authorities to trace them’.²⁴ The Port Sanitary Committee made the first official complaint against the Shelter in February 1894 stating that they were ‘not satisfied from information which [had] reached them that proper care [was] taken by the Committee of the Poor Jews’ Temporary Shelter to carry out on their part the agreement which was entered into’.²⁵ The Port Sanitary Authority worried that migrants were disappearing on the way to the Shelter and that the Shelter was not properly inspecting and verifying migrant residences, nor personally escorting the migrant to the addresses, nor returning to the Port Sanitary Office complete and accurate registers of all the migrants handed over to their care.²⁶ As a result, the Local Government Board convened a conference at which ‘the Board, the Port of London and the Whitechapel Sanitary Authorities (represented by their Medical Officers) and the Jewish Board of Guardians by the President and members of the Committee [of the Shelter] were present’.²⁷ Under some pressure from the Medical Officers, the

²² *Memoirs of Abraham Mundy*, vol. 1, chpt. 13, p. 1-2; and *Jewish Immigrants*, Supplement to the PMOH Monthly Report, May 1894, CLRO PSCP, (March – May, 1894).

²³ Evidence of Dr Herbert Williams, MOH Port of London, RCAI, *Minutes of Evidence*, 6189.

²⁴ *ibid.*

²⁵ Letter from PJTS to the Town Clerk, Guildhall, Feb. 13, 1894, CLRO PSCP, (March – May, 1894).

²⁶ Williams, RCAI, *Minutes of Evidence*, 6189.

²⁷ *Jewish Immigrants*, Supplement to the PMOH Monthly Report, May 1894, CLRO PSCP, (March – May, 1894).

Shelter agreed that they alone had not properly carried out their part of the original agreement, while stating that the Port Sanitary Authority had been consistent in honouring their side of the agreement. With the Shelter having taken responsibility for the problems which occurred, a new agreement was signed which barely differed from the original except for the inclusion of a further article requiring that the name of the vessel on which migrants arrived be registered on the roll of names and addresses. This way it would be easier to trace individuals from the same vessel should it later be discovered to be infected.

The agreement terminated in 1895 when the General Order of 1892, which specified the medical inspection and registration of all immigrants, was withdrawn because the importation of cholera no longer posed a threat. Although not officially continued, Collingridge and the Shelter's Executive Committee agreed to continue the arrangements established between their two organisations on an unofficial and less stringent basis.²⁸ Yet, with the end of the threat of cholera and the Order removed, the Port Sanitary Authority retained no specific authority over the arrival of immigrants as distinct from other passenger arrivals.

The General Order focused on the arrival of migrants because they were considered to pose a particular threat during the cholera epidemic. As the 'English system' was based primarily on the principle of observation after disembarkation, the public health threat which resulted from the disappearance of passengers from an infected vessel was great. If possible sources of infection disappeared from view, it became extremely difficult to maintain control over the spread of infection. In specifying migrants and migrant vessels the 1892 General Order reflected prejudices against this group as a particular class and, to an extent, as Jews. It also reflected a genuine concern for public health. Distrustful migrants gave, for a variety of reasons, false information to the authorities. The false names, plans and destinations not only, as we shall see, drastically distorted immigrant statistics, giving fuel to the anti-alien campaign, but also meant that the Sanitary authorities could not monitor the health of migrants who travelled from an infected port for the seven day incubation period. Not knowing where migrants were in the days after disembarkation from an infected, or suspected vessel, meant that an infection could spread before local medical officers

²⁸ Executive Committee Minutes, PJTS, June 18, 1895.

could identify and isolate cases where they occurred. The reticence of migrants in providing correct information about their intended whereabouts fostered the belief among sanitary workers that migrants were not to be trusted and so posed an additional threat to the public health. Migrants were thought particularly likely to disappear after disembarkation. Within the established sanitary system this disappearance was a serious problem which had to be addressed; and although there was a strong element of prejudice present in all mandates directed specifically at migrants, there was also a strong epidemiological basis to the registration of migrants in this way. For these reasons it was essential that the Port Sanitary Authority maintained full and accurate information about the identity and whereabouts of migrants. It was equally essential to Jewish organisations, such as the Poor Jews' Temporary Shelter, that Jewish migrants presented, and were perceived to present, no risk to the public health. In this matter (as in other issues relating to East European immigration and transmigration in Britain) the Jewish organisations wished to prevent migrants from providing any ammunition which might potentially excite latent anti-Semitism, nor did they wish to see their co-religionists fall into the hands of the 'crimps' and 'missionaries' readily awaiting their arrival. Thus the General Order, while singling out the migrants, encouraged a system by which representatives of Jewish organisations could be present in a semi-official capacity alongside the Port Medical Officers at the moment the migrants' arrived.

As well as protecting newly arrived migrants, the Poor Jews' Temporary Shelter and other Jewish organisations in Britain, such as the Board of Deputies of British Jews, were often able to obtain more accurate information from the migrants with regard to their intentions. Many of the migrants were frightened of the uniformed Medical Officers and other officials they encountered at various stages of their journey. Stories and scraps of information filtered through the waves of migrants moving Westward about what might happen if one told 'them' this or that piece of information; experience had shown that it was often more prudent to conceal the truth. Migrants frequently lied about the amount of money they possessed, for example, 'because in Russia, if he told an official he had money, the official would have it'.²⁹ However, the Jewish organisations posed no such threat and were able to acquire information from the migrants. This information was then passed on to the Port Sanitary Authorities and

²⁹ Landau, *RCAI, Minutes of Evidence*, 16283.

the Board of Trade. Nevertheless, despite the advantages Jewish organisations had over the Port Sanitary Authority and Board of Trade for obtaining information, migrants continued to 'disappear' and migration statistics remained drastically distorted.

These statistics had a particular bearing on the development of anti-alien sentiment within government circles. Popular discontent about the presence of immigrants in towns and cities such as London, Liverpool, Hull and Grimsby, chiefly focused upon the perceived economic privations brought about by the extended workforce, overcrowding in working class urban neighbourhoods, and the idea that immigrants produced goods which undercut the prices of goods produced by native manufacturers.³⁰ Ultimately, however, it was the number of migrants perceived to be 'swarming' into the country which was the impetus to changing the law with regard to the regulation of immigration. Attempts were made in 1894, 1896 and 1897 to pass legislation against the growing number of immigrants. Yet, Bills drawn up in 1894 and 1897 went no further than one or two readings, with campaigners such as Lord Salisbury unable to gain sufficient support. Britain's legal and moral tradition which ensured liberty of movement and of asylum hindered the support the Bills needed in parliament at the early stages of the debate. Legal discussions were frequent and difficult, as an article in the *Law Quarterly Review* titled, 'Alien Legislation and the Prerogative of the Crown', demonstrated in 1897:

from a legal and historical point of view the most interesting issue raised is whether or not the Crown, acting for the public welfare, possesses an inherent right, apart from legislation, to exclude or expel aliens whose presence it considers objectionable on public grounds...

There are doubtless groups of persons with strong opinions on moral, scientific, and trade questions, who would collectively furnish reasons for the exclusion of almost every kind of alien, but in dealing with legislation which affects the liberties of foreigners, if we desire to maintain a reputation for

³⁰ For extended discussion of the economic impact of immigration in this period and its role in the rise of anti-alien sentiment see texts cited in footnote 2 of this chapter.

liberality and common sense, we must act on such grounds as will be generally recognised as common sense.³¹

By 1898 the desire to place restrictions on the number and type of immigrant allowed to enter the United Kingdom was beginning to gain political momentum. A Bill which called for the exclusion of anyone deemed to be 'an idiot, insane, pauper', likely to become a public charge, having symptoms of a loathsome or contagious disease, or 'a danger to good order',³² entered parliament and was carried through to the final reading of the House of Lords before being discarded. What enabled the Bill to get further than any previous attempt was the strong arguments made by the Earl of Hardwicke and his supporters during the second reading of the Bill in the House of Lords. Hardwicke argued that 'the stream of alien immigration which struck the noble marquis [of Salisbury] as so dangerous in 1894 had increased in volume'.³³

The Board of Trade under the authority of the 1836 Aliens Registration Act,³⁴ collected official statistics relating to immigration into Britain – including both immigration and transmigration. The Act did not place any restrictions on entry into Britain, but rather was concerned solely with registration. It had never been vigorously enforced until it was revived in 1890 on the recommendation of the 1889 House of Commons Select Committee on Immigration and Emigration. The Committee was not prepared to recommend restrictive immigration legislation at that time but, 'contemplate[d] the possibility of such legislation becoming necessary in the future', and felt that it would be necessary to 'ascertain with greater accuracy, and more frequently than the decennial census provides, the number of aliens that remain in this country'.³⁵ These statistics collected by the Board of Trade were an important indication of the number of migrants who arrived in and departed Britain and were considered more accurate and up to date than the census. Yet the particular problems which were encountered during the collection of these statistics were problems that also had a particular bearing on the sanitary authorities. Where migrants were lost statistically, they were also lost to sanitary surveillance.

³¹ Tomas Haycraft, 'Alien Legislation and the Prerogative of the Crown', *Law Quarterly Review*, vol. XIII, (1897), pp. 165-186, p.165 & 170.

³² Bill 55, 1898, [61 VICT.], 'A Bill to Regulate the Immigration of Aliens'.

³³ *Times*, May 24, 1898, p. 8a.

³⁴ Aliens Registration Act, 1836, [6. WILL. IV].

³⁵ *Report from the Select Committee on Emigration and Immigration (Foreigners)*, (1889), p. xi.

The Master of each vessel which arrived in a British port³⁶ was required to submit a list of all 'aliens' on board. According to the statute he was obliged to include 'Christian' name, surname, profession, sex, and native country.³⁷ An officer of the Customs Service who counted the aliens and checked the details recorded by the Master verified this information in around one in ten cases.³⁸ The most important information statistically, and the one which caused the greatest discussion, related to whether or not the migrants were 'stated to be en route'. This information formed the basis of the Board of Trade statistics, so important in the immigration debate, that indicated the number of aliens who remained in Britain and those destined to travel on to America or another country, ie. entering Britain on a strictly temporary basis. The numbers of migrants 'en route' and remaining were determined by the number of alien passengers who could on arrival produce 'through' tickets to places outside the United Kingdom, and those who could not. Those who could were 'stated to be en route' and those who could not were 'not stated to be en route'. As the Deputy Comptroller-General of the Board of Trade declared in evidence to the Royal Commission on Alien Immigration, the production of a through ticket was the sole method used to determine these figures because 'there is no such thing as a statistic of intention. There must be some fact to go by'.³⁹ Thus only those who could produce a through ticket were recorded as being transmigrants while every other migrant disembarking in a British port was recorded as an immigrant intent on remaining in Britain.

This was the fundamental flaw in the statistics produced by the Board of Trade relating to immigrant and transmigrant numbers. Firstly, the statistics did not account for those migrants who had arranged with their agents to collect an onward ticket from a correspondent in Britain; and secondly, as pointed out by one of the Royal

³⁶ Ports at which Aliens Lists were collected: Aberdeen, Belfast, Blyth, Bristol, Cardiff, Dover, Dublin, Folkestone, Glasgow, Goole, Grangemouth, Granton, Greenock, Grimsby, Harwich, Hull, Kirkcaldy, Leith, Liverpool, London, Middlesbrough, Newcastle, Newhaven, Newport, North Shields, South Shields, Southampton, Sunderland, West Hartlepool. *RCAI, Appendix to Minutes of Evidence*, vol. III. [Cd. 1741-I], Appendix IV.

³⁷ Evidence of H.Llewellyn-Smith, Deputy Comptroller-General, Board of Trade, *RCAI, Minutes of Evidence*, 159.

³⁸ In Llewellyn-Smith's evidence it was stated that an Officer of the Customs boards every vessel from Hamburg, Bremen, Rotterdam, and Libua – the major Continental migration ports for East Europeans. *ibid.*, 146.

³⁹ *ibid.*, 155.

Commission, steamship tickets bore no identification of ownership, therefore they could be exchanged and used for the purposes of the Alien list more than once.⁴⁰

The patterns which emerge from the statistics clearly demonstrate that tickets determined figures in the Aliens List. The Northern ports of Hull, Grimsby and Leith generally accommodated the 'package' passages of steamship companies which worked in association with the railways in transporting migrants across Britain to West coast ports where vessels were waiting to sail across the Atlantic. Passengers who arrived in these Northern ports usually possessed a ticket paid through to the United States for which Britain was only part of a larger single journey.⁴¹ Such transmigration 'packages' were rarely available through London, and thus smaller numbers arrived in London who could be recorded as 'stated to be en route'. In 1895, for example, the Board of Trade recorded 13,413 aliens who arrived into London as 'not stated to be en route' and only 141 as 'stated to be en route'. In contrast 2,289 were 'not stated to be en route' in Hull and 23,376 displayed the through tickets which classified them as 'en route'. Similarly in 1902, London recorded 33,046 'not stated to be en route' and only 14 'en route', while Hull reported 2,540 and 70,082 respectively.⁴² The Board of Trade were aware, however, that some migrants statistically recorded in London as 'not stated to be en route' did actually leave Britain shortly after arrival.⁴³

There was one major cause of a dramatic distortion in the Board of Trade statistics. It also had an important impact on the sanitary surveillance of migrants. During the second half of the 1890s⁴⁴ nine of the major transatlantic shipping companies – Allan Line, Allan State Line, American Line (Liverpool – Philadelphia), American Line (Southampton – New York), Anchor Line, Beaver Line, Cunard Line, Dominion Line and the White Star Line –⁴⁵ agreed a minimum fare scale for passage to the United States from the Continent. The arrangement, called the North Atlantic Conference, was intended to stop competitive pricing 'with a view to raising the fares, which at

⁴⁰ *ibid.* 167-168.

⁴¹ See Evans, *European Migration via the United Kingdom*.

⁴² *RCAI, Appendix, TABLE V.*

⁴³ Llewellyn-Smith, *Minutes of Evidence, RCAI*, 122-130.

⁴⁴ The precise date on which the arrangement was entered into is unclear.

⁴⁵ Letter from PJTS to Board of Deputies, Nov. 8, 1898, LMA ACC/3121/B02/01/003.

one time sunk down to about 26s'.⁴⁶ The £3 profit made from each transatlantic steerage ticket from the Continent was thereafter pooled and divided among the constituent companies. At the end of 1898 the price of a steerage class journey from the Continent to the United States was fixed at £7.15s for Europeans travelling to the United States. However, if the ticket was purchased in London after having taken a separate journey from Hamburg to London, for instance, passage to the United States only cost £5.16s. This fare was only available to purchase in Britain and was restricted to British residents. There was a saving to be made of around £2 by taking this latter route.⁴⁷ The same was true in 1903 when evidence was taken at the Royal Commission on Alien Immigration. By then the price for a voyage from a Continental to an American port was £8.10s., while the price for a ticket from London was only £5.10s., plus the 15s. to 24s. required for the journey from Hamburg or Bremen to London.⁴⁸ In order to make sure that Continental steerage passengers travelled direct from the Continent, thus providing the £3 profit from their tickets to the pool, passengers booking with any of the North Atlantic Conference companies were unable to purchase a ticket from an English port to America, unless they had been resident in Britain for at least five weeks. In terms of the Conference, this period officially constituted British residency and thus classified a migrant as an 'English passenger'.

Hardly fool-proof, the system ensured that a great deal of fraud took place to secure the cheaper fare. Emigration agents operating in Europe sold migrants tickets to London and advised them to declare that Britain was their intended destination. This was then entered with their name and nationality in the Board of Trade's Alien List as 'not stated to be en route'. The agent then advised the migrant to temporarily change his or her name, declare that he or she had been resident in Britain for any period over five weeks and then purchase a ticket from the agent's correspondent in Britain which would take them from London or another British departure port to the United States. Thus, the migrant would have been registered on the Aliens List as immigrating into Britain. At the same time the migrant gave information to the Port Sanitary Authority about his or her intended address in Britain. He or she would then depart, under a

⁴⁶ Landau, *RCAI, Minutes of Evidence*, (16285).

⁴⁷ Letter from the Board of Deputies to the Board of Trade, late 1898 (draft letter, undated). LMA ACC/3121/B02/01/003.

⁴⁸ Landau, *RCAI, Minutes of Evidence*, (16286).

different name, for the United States within hours or days of arriving, stating that he or she had been resident in Britain for over five weeks, and indeed often stating periods of up to two years.⁴⁹ Consequently, as the Board of Deputies and the Poor Jews' Temporary Shelter argued, the figures recorded by the Board of Trade for the Aliens List, and used by those wishing to impose restrictions on immigration to demonstrate the 'alarming' and increasing number of immigrants arriving into Britain every year, grossly misrepresented the number of migrants who entered the country and stayed.

The Board of Trade attempted to compensate for the discrepancies caused by migrants' attempts to defraud the North Atlantic Conference. They compiled yearly statistics relating to the number of migrants whose name was noticed to occur both on the Alien list and on lists compiled of departing emigrants.

TABLE V:

YEAR	Not Stated To Be En Route	Stated to Be En Route	Ascertained to be en Route in Addition to Aliens List
1893	31,056	79,518	420
1894	28,682	35,512,	2,166
1895	30,528	44,637	2,074
1896	35,448	40,036	2,961
1897	38,851	32,221	2,676
1898	40,785	32,177	2,336
1899	50,884	49,947	2,889
1900	62,505	71,682	3,972
1901	55,464	79,140	3,879
1902	66,471	118,478	*7,964

* Provisional figure, subject to slight amendment

*Appendix to Minutes of Evidence, RCAI, TABLES V & VII*⁵⁰

⁴⁹ *ibid.* (16284-16288 & 16410-16414); and Letter, late 1898, LMA ACC/3121/B02/01/003.

⁵⁰ *RCAI, Appendix*, TABLE VII titled, 'Statement of the number of aliens ascertained to have been *en route* to places out of the United Kingdom... in addition to those described in the Aliens List'. The figures represented in both TABLE V & VII represent all migrants to all British ports. In TABLE V these figures are also broken down to represent London, Grimsby, Hull, Tyne Ports, Leith and Grangemouth, Newhaven and Dover. Similarly, the different nationalities of the migrants are broken down with regard to the number *not stated to be en route*. These are: Russians and Poles; Norwegians, Swedes and Danes; Germans; Dutch; French; Austrians and Hungarians; Italians; Roumanians; Other Nationalities.

However, the number of migrants 'ascertained to be *en route* in addition to the Aliens List' only represented those migrants whose name was noticed on departure to correspond with one recorded on the arrivals list. These migrants probably departed for the United States on one of the few non North Atlantic Conference vessels which sold steerage tickets to European migrants from British ports. These migrants had not chosen to change their names. Because of the conditions imposed by the Conference few who purchased an onward ticket to the United States within five weeks would not have changed their names. The figures represented in the table above only represent migrants who kept their name and who happened to be recognised by a Customs officer on departure. No systematic cross-referencing took place.

We do not attempt to trace the correspondence of names until the officer of Customs has stated that he has reason to believe them to be going on. We never attempt to compare the alien list as a whole with the passenger outward list as a whole. We should probably find a great many more correspondences if we did.⁵¹

In 1902, for example, the 12% initially 'not stated to be *en route*', who were later recorded by the Board of Trade to have departed for 'other countries', represented only a small percentage of those actually departed, as a majority hid their identity in order to defraud the North Atlantic Conference.

The Board of Deputies of British Jews and the Poor Jews Temporary Shelter were aware of the methods migrants engaged in in order to obtain a less expensive ticket to America. Similarly aware of how these methods distorted official statistics relating to the number of immigrants who remained in Britain, these organisations wrote to the Board of Trade to rectify the inaccuracies. However, their calculations were only based on approximations and figures they derived from the Board of Trade. The alternative figures provided by these Jewish organisations related specifically to East European Jews. Religion was not recorded by the Board of Trade and nationality was the only indication of religious affiliation. Russian or Polish 'Hebrew' was, however, often used. It is thus difficult to determine the accuracy of Jewish organisations'

⁵¹ Llewellyn-Smith, *Minutes of Evidence, RCAI*, 123.

figures as nationality⁵² was also not always analysed separately in the statistics produced by the Board of Trade. Thus the figure of 1,700, estimated to be the number of migrants who remained in England [sic] in 1898 in excess of 'foreigners' recorded to have left, is impossible to verify. The Poor Jews' Temporary Shelter insisted that although this might be an accurate figure for the number of East Europeans recorded to have remained, they argued that because an estimated 30,000 migrants departed England registered under false names, and as such as 'English residents', there was an actual deficit of 28,300 migrants for the year 1898, rather than a 1,700 increase.⁵³ Yet it was also impossible to know, they argued, of more than one case in ten and the numbers represented by the Board of Trade were more misleading than was initially apparent.

The result [of the fraud] is most serious and makes the Board of Trade Returns of the number of foreigners leaving England absolutely inaccurate.⁵⁴

The distortion of immigrant statistics was the primary and most important consequence of the fraud. These statistics were paraded by the anti-alien campaign to demonstrate the extent of the 'influx' and was a substantial piece of evidence against unrestricted immigration. Another consequence of the fraud however, was that the sanitary authorities were less able to maintain a surveillance over migrants. When migrants presented false names and destinations they undermined the ability of sanitary authorities to monitor passengers from infected ports or vessels. However, the 'disappearance' of the migrants was a response not to the requirements of the sanitary system but to the fixed pricing of the North Atlantic Conference on passage from the Continent to the United States.⁵⁵

⁵² As religion was not recorded at this stage one must assume that migrants from 'Russian and Poland' were, on the whole Jewish refugees fleeing from the Pale of Settlement and the restrictive laws relating to Jews there.

⁵³ Letter from the Board of Deputies to the Board of Trade, late 1898 (draft letter, undated), LMA ACC/3121/B02/01/003.

⁵⁴ *ibid.*

⁵⁵ See Hawkey, Customs Officer, *Minutes of Evidence, RCI*, 1422-1554

The Royal Commission on Alien Immigration

Immigration restriction was an issue which, although crossing party lines, was dominated by Conservative politicians. Two main organisations provided the link between popular opinion - 'the public' - and government: the British Brothers' League (BBL) and the Londoners' League (LL). Both were closely linked to the Conservative Party through their leadership and initial membership. The LL, established in 1901 following a meeting of the East London Conservative Association, discussed housing problems associated with the increased immigrant population in London's East End. It was formed to lobby the government for the introduction of restrictive immigration legislation⁵⁶ and, as *The Times* reported in 1901,

for the purpose of collecting information and organising interest and opinion upon subjects of importance to South and East London, and it represents... 17 constituencies, which together contain nearly 150,000 electors and a million and a half inhabitants.⁵⁷

The BBL, formed on February 25, 1901, was 'founded officially with great publicity on 9 May, 1901, at Stepney Meeting House'.⁵⁸ Membership was drawn from the East End and the Conservative Party 'so that at its inaugural meeting it could claim the support of East End Conservative MPs such as Spencer Carrington (Mile End), Murray Guthrie (Bow), Thomas Dewar (Tower Hamlets), and Major William Eden Evans-Gordon (Stepney)'. The last of whom the *Eastern Post and City Chronicle* claimed had, 'no small share in the formation of the league'.⁵⁹

The main objection to immigration among Conservatives was that the immigrants damaged the 'nation's health and efficiency'.⁶⁰ The issue of immigration restriction

⁵⁶ Feldman, *Englishmen and Jews*, p. 91.

⁵⁷ *Times*, Aug. 1, 1901 p. 2f.

⁵⁸ Holmes, *Anti-Semitism*, (1979) p. 89.

⁵⁹ Published, Nov 9, 1901, from *ibid*.

Evans-Gordon served in the Foreign Department of the Government of India from 1876-1897. In the General election of 1900 he became a Member of Parliament for the Stepney Division of Tower Hamlets. 'With a view to obtaining information at first hand on the subject [of immigration] he made tour to the Jewries of Eastern Europe, visiting St. Petersburg, Dwinsk, Riga, Libau, and Wilna'. He was knighted in 1905. 'Obituary', *Times*, Nov. 11, 1913, p. 11d.

⁶⁰ Feldman, *Englishmen and Jews*, (1994) p. 287.

was an issue which could cross party lines and class, as its foundations were rooted in ideas of home and country - unified against 'the other'. However, the non-parliamentary individuals within the leadership of the BBL and LL, such as J.L.Silver and William Stanley Shaw, objected to the political aim of using the issue of immigration to increase Conservative Party membership and support and which threatened to push East End politics in a more radical direction. Shaw claimed that the 'politicians refused to support me unless I became a tool in their hands',⁶¹ and he resigned as President of the BBL.

At its first annual general meeting the BBL claimed to have a membership of 12,000, but its support was even greater as a BBL petition in 1902 amassed 45,000 signatures in favour of its demands. Two massive public meetings of over 4000 people at the Peoples' Palace, the first in January 1902 under the auspices of the BBL and the second in November 1903 under the LL, demonstrated the growing popular support in London for the restriction of immigration. Drawing on the increasing pressure of popular activity in the East End, Conservatives such as Evans-Gordon and S.F. Ridley (Bethnal Green), argued in Parliament for reform. A deputation of the LL met with the Home Secretary, the President of the Board of Trade and the President of the Local Government Board, impressing on the three gentlemen the 'urgent need of legislation with reference to overcrowding in South and East London and to the constantly increasing influx of pauper aliens'.⁶² Evans- Gordon was present and together with two other Conservative Members of Parliament, Guthrie and Cust, the demands of the League were presented. The deputation received a sympathetic hearing and was assured that the matter would be supported and presented to both Cabinet and at the next Session of Parliament.

In January 1902 the BBL made several requests to Gerald Balfour, President of the Board of Trade, to receive a deputation to discuss alien immigration. After several letters Balfour replied,

Dear Sirs, - In reply to your letter of yesterday's date on the subject of alien immigration, I beg to inform you that I have been in communication with Major Evans-Gordon, from whom you will no doubt hear in due course. It is

⁶¹ *ibid.* 288.

proposed to raise the question in an amendment to the Address, and, for the present, at all events, I do not think any public purpose would be served by receiving the proposed deputation.⁶³

Indeed, on the 30th January 1902, *The Times* reported a speech made to Parliament by Evans-Gordon in which he expressed great disappointment that no mention of alien immigration had been made in the King's speech at the opening of Parliament. He emphasised that alien immigration had become a prominent and 'urgent' issue which required 'legislation to regulate and restrict the immigration of destitute aliens into London and other cities in the United Kingdom'.⁶⁴ As MP for Stepney, he pressed the issue of overcrowding and unemployment, but he also stressed that as 'the American law was going to be strengthened ... it was a mathematical certainty ... that the flow must go down the channels that were open. There was only one channel really open now, and that was the channel which led to these shores'.⁶⁵ He argued that the desire to regulate was based entirely on 'social and economic grounds', and that any claims that anti-alien movements were motivated by anti-Semitism was unfounded.

I know it has been said by some people that this is a racial question, and that we are trying to stir up anti-Semitic feeling. I will not detain the House going into such a question. The reverse is the fact. No one deplores more than I do the attitude taken up by some foreign countries towards the Jews... It is unfortunate that the racial question should be introduced into the matter, but it is difficult for us to enlighten the uneducated classes of this country upon the subject. All they know is that they are being turned out of their homes and the neighbourhoods in which they are obliged to live, in order to carry on their work, and that their places are being taken by Russian and Polish Jews, and you cannot persuade them that it is not a racial question. They naturally take a hatred to the Jewish people. It is for the Government to prevent that anti-Semitic feeling which, if something is not done to check the influx of aliens into this country, must inevitably result in an outbreak of very grave proportions.⁶⁶

⁶² *Times*, Aug. 1, 1901, p. 2f.

⁶³ *Times*, Jan. 23, 1902, p. 7f.

⁶⁴ *Times*, Jan. 30, 1902, p. 5e.

⁶⁵ *ibid.*

⁶⁶ Hansard, *House of Commons Debates*, Jan. 29, 1902 [101], 1283.

He argued that the Anglo-Jewish community shared his beliefs and supported his call for restriction in attempting to stem the 'grave risk of an anti-Semitic colour being imparted to this controversy'.⁶⁷ Yet, despite his claims to the contrary, Evans-Gordon's anti-Semitism shone through in his frequent use of anti-Semitic imagery when illustrating a point. In explaining to the House of Commons, for example, why it was important to introduce national immigration legislation when the problems encountered with the immigration of East European Jews were confined to the East End of London, and while their numbers were so insignificant in relation to the rest of the British population,⁶⁸ Evans-Gordon chose to employ an analogy with obvious overtones: 'Ten grains of arsenic in 1000 loaves would be unnoticeable and perfectly harmless, but the same amount if put into one loaf would kill the whole family that partook of it'.⁶⁹ Other examples of this tactic appeared in numerous speeches, and in his book, published in 1903, *The Alien Immigrant*, where he likened the 'influx' of immigrants to a plague of locusts.⁷⁰ Evans-Gordon was committed to the anti-alien cause and the need to introduce immigration legislation, yet the issue could not be one of overt anti-Semitism. Although, anti-Semitism was often at the foundation of the anti-alien debate, expressions of overt anti-Semitism were not tolerated; indeed, the desire to quell an increase in anti-Semitism was an important factor in the decision to order a Royal Commission. Feldman argues that the Royal Commission on Alien Immigration was appointed in order to stem the growing agitation and anti-Semitism of the anti-alien movement roused by the BBL, LL and the popular East End press such as the *East London Observer*.⁷¹ Evans-Gordon was a central player in both in the Conservative Party and the BBL, acting as agitator and as conciliator. 'It was largely due to his efforts that a Royal Commission, of which he was a member was appointed to consider the alien question'.⁷²

In January 1902, Evans-Gordon concluded an address to Parliament with the request:

⁶⁷ *ibid.*

⁶⁸ 'It may be argued that though the foreign population is large and increasing, it still remains small in proportion to the total population of London and insignificant in proportion to the population of the United Kingdom'. Hansard, Jan. 29, 1902 [101], 1274.

⁶⁹ Hansard, 1274; Parallels may be drawn here with the 'blood libel' in which it was accused that the blood of murdered Christian children was used by Jews in the making of *matzah* (unleavened bread eaten at Passover).

⁷⁰ William Eden Evans-Gordon, *The Alien Immigrant*, (London: William Heinemann, 1903) p. 13.

⁷¹ Feldman, *Englishmen and Jews*, p. 288.

⁷² 'Obituary Sir William Eden Evans-Gordon', *Times*, Nov. 3, 1913, p. 11d.

will they [the House] repeat the promises of legislation so often given, and, pending that legislation, will they appoint a Royal Commission to report, as early as possible, on what form a restrictive measure should take?⁷³

The request was seconded and 'agreed to'.

Only one real objection to legislation was voiced to Parliament in response to Evans-Gordon. The President of the Board of Trade, Gerald Balfour, with whom both the BBL and the LL frequently communicated, foresaw no need to legislate, but welcomed further inquiry. Previous Bills attempted to mirror the American model of immigration legislation which restricted entry of individuals likely to become a public charge, a lunatic, or suffering from a contagious disease. He noted, however, that while these restrictions were strictly enforced in the United States, only one percent of those who arrived were refused entry. 'It stood to reason that the great evils of immigration would not be removed in any measure by mere exclusion of persons suffering from disease who could not number more than a few hundred in the course of a year'.⁷⁴

It is of course possible (I do not wish to prejudice the inquiry) that the conclusion to which any Committee or Commission might arrive would be to show that these particular aliens could only be dealt with, not by restrictive provisions at the ports of entry, but by increasing the powers of the local authorities under the Public Health Acts.⁷⁵

Despite Balfour's reservations, Parliament agreed to an inquiry into the 'character and extent' of immigration and on March 21, 1902 the Royal Commission was appointed. The task of the Royal Commission was to inquire into and report upon:

- 1) the character and extent of the evils which are attributed to the unrestricted immigration of aliens, especially in the metropolis;

⁷³ Hansard, Jan. 29, 1902 [101], 1281.

⁷⁴ *Times*, Jan. 30, 1902, p. 5e.

⁷⁵ Hansard, Jan. 29, 1902 [101], 1288.

- 2) the measures which have been adopted for the restriction and control of alien immigration in foreign countries and British colonies.⁷⁶

Lord James of Hereford (1828-1911), who had been Attorney-General 1873-4 and 1892-5 was the Chairman of the Commission. The other members included: Lord Rothschild, banker and philanthropist, regarded as 'the lay head of the [Anglo-Jewish] community';⁷⁷ Alfred Lyttleton, a lawyer and MP; Sir Kenelm Digby, an Under Secretary of State to the Home Office; Henry Norman MP; William Vallance, Clerk to the Guardians of Whitechapel; and Evans-Gordon.⁷⁸

The examination of 175 witnesses⁷⁹ began on April 14, 1902. Among the 175 were nine Medical Officers of Health, the Chief Sanitary Inspector of Bethnal Green, two Vaccination Officers, a Customs Examining Officer, and physicians specialising in ophthalmic medicine. All except Dr Hope, Medical Officer of Health for Liverpool, and James Niven, Medical Officer of Health for Manchester, worked in London. Only one Port Medical Officer of Health was called to give evidence - Herbert Williams, of the Port of London.⁸⁰ Investigations into the health threat posed by immigrants were undertaken with a particular focus upon the issue of overcrowding. Generally the

⁷⁶ *Report of the RCI*, vol. I, [Cd. 1741] p. v; also see *The Times*, March 22, 1902, p. 11f.

⁷⁷ 'Rothschild, Sir Nathan Meyer, 1840-1915', *DNB, 1912-1921*, p. 480

⁷⁸ F.E. Eddis was Secretary to the Commission.

⁷⁹ All witnesses were classified under one of the following groups:

1. *Census Authorities* – enumerators and the Registrar General, Reginald McLeod
2. *Clergy* – including Rev. Stewart Headlam, then Chairman of the Evening Continuation Schools Committee: London School Board
3. *Connected with Education* – including Head Masters and members of the School Board
4. *Connected with the Jewish Board of Guardians and other Charitable Institutions* – including L. Cohen, President of the Jewish Board of Guardians.
5. *Magisterial and Police* – mostly magistrates of police courts and high ranking police officers, one of which was from Manchester.
6. *Manufacturers* – representing the manufacturing industries most associated with immigrants, ie. shoe, cigarette, and clothes making. Two of the thirteen in this category were from Glasgow.
7. *Connected with the Mining Industry* – all five of whom were connected with the Lanarkshire / West of Scotland coal mining industry.
8. *Officials* – medical professionals and local government officials of various capacities, eg. Town Clerk, inland revenue, etc. Including Sheffield and Liverpool.
9. *Workers in Sundry Trades in the East End* – tradesmen and small-scale retailers.
10. *Representatives of Trades Unions* – including trades union representatives from Leeds and Sheffield.
11. *Tradesmen in the East End* – from undertaker to umbrella-maker.
12. *Witness not Specially Classified* – including, for example: a midwife, the Mayor of Reading, agents of shipping companies, publishers, authors, Zionists, architects, local residents, the Ex-Mayor of Reading, an insurance agent, Ex-Deputy Chairman of the British Brothers' League, and a 'Distressed English Jew'.

⁸⁰ Williams succeeded Collingridge as Medical Officer of Health for the Port of London in 1901, and held the post until 1916.

examination of Medical Officers of Health, Sanitary Officers, and Vaccination Officers concerned overcrowding and the laws and bye-laws which legislated for its prevention. Questions directed at Medical witnesses initially focused not so much on their professional opinions and observations of medical and sanitary issues associated with immigrants, but on their opinions and observations of the current Registered Tenement Houses Bye-Law under the Public Health (London) Act 1891 and the laws which enabled sanitary authorities to deal with overcrowding. Via this line of inquiry the housing and sanitary conditions of both the newly arrived, 'green', and more established immigrants were extensively described, and their health and lifestyle illuminated in detail.

Although a majority of evidence taken with regard to the health of immigrants was concerned with their health and living conditions once they had settled in London's East End as well as Liverpool, Manchester and Glasgow, the Commission also gathered evidence regarding the condition of immigrants on arrival. This reflected the allegations made 'in respect of these Alien Immigrants', which focused primarily on economic issues but which also claimed

that on arrival they are (a) in an impoverished and destitute condition, (b) deficient in cleanliness, and practice insanitary habits, (c) and being subject to no medical examination on embarkation or arrival, are liable to introduce infectious diseases.⁸¹

Since only one Port Medical Officer of Health was questioned, with limited enquiry made of the other medical professionals about health and disease at the ports, the issue was not deemed to be as central an issue in British immigration as urban health and overcrowding. The evidence presented to the Commission regarding the health of immigrants on arrival and the occurrence of infectious disease amongst them revealed that although generally unclean, the migrants did not present any great threat of infection. What was most evident in the testimony of the medical professionals involved with immigrant arrivals was the notion that with greater authority, the Port Sanitary Authority, co-operating with the local Sanitary Authorities would be able to ensure that immigrants posed no threat at all. All that was required, they argued, was

⁸¹ *Report of the RCAI*, p. 5 item 38.

more complete authority to detain vessels other than those suspected of carrying 'exotic' disease and to enforce a minimum standard of health and cleanliness in steerage accommodation.

One of the problems which most concerned the Commission was that if there was 'no suspicion or whisper of any epidemic or disease',⁸² the Port Medical Officer would not board a vessel, nor would he inspect any of the passengers or crew. The Medical Officer would only board in the case of vessels arriving from ports known to be infected with 'epidemic' disease, or in cases when there was a positive reply to the question, 'Any sickness?'. As there was a Port Medical Officer on duty 24 hours a day in London, on board the Customs launch which met the arrival of all vessels, he would be able to immediately attend any case of sickness which was reported.⁸³ However, since the cessation of the General Cholera Order in 1895 there were no special powers relating to the inspection or observation of 'aliens'. Also since the abolition of the Quarantine Act, any special powers which the Port Sanitary Officer had obtained with regard to the enforced halting and detaining of vessels, applied only to cases known or suspected to be cholera, yellow fever or plague. 'Exotic' disease remained distinctive from 'indigenous' infectious disease in the operation of port health, and retained with it particular jurisdiction.

7030. (*Chairman*) You board in order to find whether there are infectious diseases on board? – (*Williams*) We only board and inspect everyone on board when they come from places where there are exotic diseases.

7031. It is the question of exotic diseases and the class of diseases that come from specific ports; but is has nothing to do with alien immigrants? – No, not *per se*.⁸⁴

It was not the authority to board and examine all immigrants that Williams, as representative of the Port Sanitary Authority, suggested to the commission, but rather the extension to all serious infectious diseases such as smallpox, scarlet fever, measles and diphtheria, of those powers which related only to 'exotic' diseases. He argued that

⁸² Evidence of Thomas Hawkey, Examining Officer of Customs, London, *Minutes of Evidence, RCAI*, 1398.

⁸³ *ibid.* 1387-1403.

⁸⁴ Williams, *Minutes of Evidence, RCAI*, 7030-7031.

although smallpox, for example, was an 'indigenous' disease, the last serious epidemic which occurred in England had, without doubt, been imported from Paris the previous June or July. 'That seems to me an example of how a disease existing in this country in a slight form might be added to or the effect increased by introduction from abroad'.⁸⁵

The evidence given to the Royal Commission reveals that the sharp distinction between the treatment of 'indigenous' and 'exotic' infectious disease continued to limit the powers of the Port Medical Officers of Health, as it had in the days of Quarantine. Although they now had jurisdiction over cholera, yellow fever, and plague, the Port Sanitary Authority remained bound to remnants of the old system and continued to operate with one set of rules for one disease and one set for another. The power to order a vessel to 'come to', and most important to the Port Medical Officer of Health, the authority to detain a vessel on his own discretion, only applied to cases of 'exotic' disease. The powers of the Medical Officer were limited in cases of 'indigenous' disease, in comparison to those he possessed for 'exotic' disease. He could not detain a vessel on the mere suspicion of smallpox, for example; rather the master, a layman, would have to report an illness first – a case of cold or lumbago often indicating the onset of an infection such as smallpox⁸⁶ – before an inspection could take place. The Medical Officer could not detain a vessel in order to inspect the passengers when no illness had been reported or the ship had sailed from a port which was not infected with an 'exotic' disease. The inspection of immigrants, merely because they belonged to a certain class, was nowhere accommodated for under the law.

Williams made the point that his role was to inspect vessels coming from an infected port or where a case of illness had been reported; beyond this he did not have the 'power to inspect with regards to individuals'.⁸⁷ Thus, unless immigrants arrived on a vessel that fit either of the above two categories, the Port Medical Officer of Health could and would not examine them. Even if they arrived in a 'filthy and unwholesome condition' covered with vermin, without illness there would be no inspection. Williams explained that vermin were neither particular to migrants – 'our soldiers in

⁸⁵ *ibid.* 6241.

⁸⁶ *ibid.* 6092-3.

⁸⁷ *Chairman, ibid.* 6130.

South Africa',⁸⁸ for example, were infested with vermin – nor were lice an 'exotic' disease.⁸⁹ The responsibility of the Port Sanitary Authority was to prevent the importation of infectious diseases, not to ensure the general health and cleanliness of persons entering the port. He suggested to the Commission that if it wished to improve the health of migrants arriving into the United Kingdom, then the regulations relating to sanitation on board British vessels, legislated for under the Merchant Shipping Act, 1894, should be extended to foreign vessels arriving in Britain. Since the cholera epidemic of 1892 the conditions on German and Dutch vessels had greatly improved. However the condition on board vessels from Libau, the main 'Russian' departure port,⁹⁰ remained 'abominable'. In 1902, according to Board of Trade statistics 34,918 aliens⁹¹ arrived in Britain from 'Russian ports', which was generally translated as Libau.⁹² Not only were the conditions highly unsanitary but, in order to maximise profits, migrants were crammed, for the duration of the three to four day journey, in the tightly overcrowded lower decks of the vessels.

On the 21st May [1902] the *SS. Hengest* [sic] of Aarhus, from Libau, arrived at Gravesend with 171 Russian immigrants. The vessels left Libau on the 17th May. The immigrants were carried in the main 'tween decks ... an area of 2.3 square feet only per head being available... The quarters occupied by the immigrants were in a filthy condition, the floors being strewn with all kinds of refuse, and offensive liquid from the horses carried on the same deck had leaked through into these quarters. No attempt had been made at cleansing this space since the vessel had left Libau. Two temporary closets were provided, and both were used indiscriminately by the sexes. The only ventilation provided was by means of the bunker hatchways, and by two 12-inch ventilators, one of which was without a cowl, and closed.⁹³

Such conditions, he argued, presented the greatest threat to the public health in Britain and increased the possibility of imported infectious disease. Williams recommended two solutions to the problem. Firstly, that a medical inspection of all persons on board

⁸⁸ *ibid.* 6145.

⁸⁹ *ibid.* 6165.

⁹⁰ Libau was the Latvian port also known as Liepaja.

⁹¹ This figure represents both migrants *en route* and *not stated to be en route* in the Aliens List. *RCAI, Appendix, TABLE VI.*

⁹² See report of Evans-Gordon Report on visit to Eastern Europe, *Minutes of Evidence, RCAI, 13349.*

ships bound for Britain should be undertaken at the port of departure, similar to United States procedure; and secondly, that the sanitary condition on board foreign vessels⁹⁴ should be brought under the standards of 'English' law.⁹⁵ In these ways the health risk of migrants arriving into British ports could be minimised.

Yet, as both the Chairman and Evans-Gordon pointed out, the conditions on board foreign vessels were outside British jurisdiction. 'Clearly our jurisdiction', Lord Hereford remarked, 'would come in as not allowing the reception of people, but that penalty would fall heavily on the immigrants. They would have to stop on board, or go back'.⁹⁶ Evans-Gordon, who had examined the American legislation, believed that carrier liability had greatly improved conditions on board vessels bound for the United States. He suggested that the ability to refuse entry to Britain 'would have a further effect on the condition of the ship, because they would not bring them'.⁹⁷ Williams indeed conceded that by prohibiting the landing of filthy aliens, the conditions under which they travelled and therefore their condition on arrival would probably be improved. However, he remarked that uncleanness and vermin could easily be remedied by washing and disinfecting their bodies and clothes, and that ultimately, in his experience, aliens did not pose any particular or increased threat of infection.⁹⁸

Generally all the medical witnesses who gave evidence to the Commission, related that in their experience immigrants were no more harm to the public health than the native population of the same class. Although they lived in overcrowded and unsanitary conditions, on board the vessels which they arrived in and in their dwellings once they had settled in Britain, immigrants generally displayed better results than the native population of the same class in population health indicators such as infant mortality, height and weight. What required reform, they repeated one after the other, was the authority of the Sanitary Authorities. Increase the power of the Medical Officer, they argued, and the perceived health problem presented by immigrants would be satisfactorily addressed. This argument did not pertain to the

⁹³ Williams, *Minutes of Evidence, RCAI*, 6176.

⁹⁴ Migrants rarely, if ever, arrived into Britain from the Continent on British owned vessels. *ibid.* 6218.

⁹⁵ *ibid.* 6208.

⁹⁶ *ibid.* 6219.

⁹⁷ *ibid.*

⁹⁸ *ibid.* 7131-7142.

problem of overcrowding that medical officers frequently pointed out, although this was a problem that they acknowledged existed even without immigration. With few exceptions the evidence the London, Liverpool and Manchester Medical Officers and professionals gave stressed that the core concerns of the Commission relating to health were not specific to the alien but were 'really a question of surroundings – poverty, and so forth'.⁹⁹

The most extreme position on the non-distinction of aliens from the native 'English' population was adopted by the most senior Medical Officer summoned to the Commission, Dr Shirley Murphy (1848-1923), the Medical Officer of Health for the Administrative County of London. He had been a member of the Royal Commission on Tuberculosis 1901, and was the medical witness most extensively examined by the 1902-3 Royal Commission. He was thoroughly questioned about overcrowding and the sanitary conditions of immigrants in the East End of London as well as in the port. The Commission asked him the unusually direct question: did he believe that anyone should be refused entry on the grounds of poor health? Murphy rigidly maintained, despite a barrage of challenges from Henry Norman, that any person, regardless of nationality, should be treated equally. If an alien arrived into the Port of London with any infectious disease, he ought to be taken to Denton and treated for the disease in the same way as an Englishman would be treated; and once recovered he should be free to go, as would the Englishman. He unequivocally opposed the refusal of entry upon medical grounds.

5011. (*Norman*) Do you, as the sanitary authority, see any reason, or not, for excluding on arrival a person whose physical condition would be such as to render him an undesirable member of the community? – (*Murphy*) If he is going to be a source of danger to the community, I should put him under restrictions on arriving here, that is to say, if the law would apply to similar people in this country – people suffering from the same malady.

5012. (*Norman*) What sort of disease would you put under these restrictions, which is not an exotic disease? – (*Murphy*) Smallpox and scarlet fever, for instance; people suffering from these diseases are not allowed to mix with other patients.

⁹⁹ Evidence of Edward Hope, Medical Officer of Health for Liverpool, *Minutes of Evidence, RCAI*.

5025. (*Norman*) You realise that many people coming in in this condition would naturally become a public charge? – (*Murphy*) If, as the result of enquiry, some national danger can be shown by numbers of people coming over here, something different from what we already know of these diseases now, no doubt the point would have to be considered on its own merits, but I am speaking of these things as we see them, and in such a proportion as we know them to exist at the present.¹⁰⁰

The isolation and observation of people with infectious disease, as opposed to restrictions which implied a ‘dangerous’ interference ‘with people’s liberty’,¹⁰¹ was the foundation of the sanitary system – the ‘English system’. As previously discussed, this system had developed over the second half of the nineteenth century in opposition to the interference of liberty imposed by quarantine, and Murphy’s testimony reflected his belief in this as the essence of the British sanitary system. The basis of the ‘Sanitation versus Quarantine’ debate throughout the nineteenth century, at the International Sanitary Conferences, and prior to the abolition of quarantine in Britain was that,

the Government ... depend for their safety upon the rational system of medical inspection at the ports and the first line of defence, and upon the maintenance of an increasingly high standard of sanitation throughout the length and breadth of the land for the second line of defence in the event of the first line being broken through.¹⁰²

Murphy expressed the essential axiom on which the Port Sanitary System was developed and which fundamentally differentiated it from quarantine. It held that regardless of the disease, or its origin, the same rational system of medical inspection, isolation of the infected and unobtrusive observation of the healthy by internal sanitary authorities was sufficient to provide a comprehensive barrier to the importation and spread of infection. By highlighting this *modus operandi* Murphy

21466.

¹⁰⁰ Evidence of Shirley Murphy, *Minutes of Evidence, RCAI*, 5011-2 & 5025.

¹⁰¹ *ibid.* 5005.

¹⁰² Collingridge, ‘The Milroy Lectures of Quarantine’, Part II, *BMJ*, March 20, 1897, p. 711.

illuminated the inconsistency that medical restriction of immigration at the ports had after over thirty years of the 'English system'. The physical exclusion of aliens in the proposed restriction of immigration was a counterpart to the physical exclusion of infected vessels enforced by quarantine. This time, however, exclusion was not based upon particular 'exotic' diseases but had been replaced by a particular 'exotic' class of people. Just as Sanitarians of the previous century had argued that 'exotic' disease could be assailed with the same stratagem as 'indigenous' disease, Murphy reasoned that the 'exotic' immigrant could be treated in the same way as the 'indigenous' population.

The authority of the Port Sanitary Authority to act upon cases of 'exotic' disease did not apply to cases of 'indigenous' disease, and the Commission argued that consequently 'indigenous' disease among 'filthy aliens' was capable of slipping through the first and second lines of defence. In response, Williams and Murphy proposed that the powers granted to them after the abolition of quarantine with respect to 'exotic' disease, such as the authority to stop a vessel and detain it for medical inspection, should be extended to 'indigenous' disease. In this way practices similar to those conducted during the cholera epidemic could become the general practice. Any infection, such as measles, found present among a group of immigrants could be isolated. The remaining passengers could be kept under observation at the discretion of the Port Sanitary Authority, until they were released to the local Sanitary Authority of the district into which they moved.

How would such diseases be classified? At the time of the Commission these particular and 'absolute' powers only applied to cholera, yellow fever, and plague.¹⁰³ What 'indigenous' diseases would be included if the jurisdiction of the Port Sanitary Authority were extended? Williams believed that complete authority to inspect and detain, and the other powers particular to 'exotic' disease, should be applied to possible cases of smallpox, scarlet fever, measles and diphtheria, but not whooping cough or vermin, for example.¹⁰⁴ Murphy also included smallpox, scarlet fever and syphilis, on the understanding that foreigners should be isolated under the same conditions as would a member of the 'native' population, but he would exclude from

¹⁰³ 'I have absolute power when there is exotic disease,' Williams, *Minutes of Evidence, RCAI*, 6082.

¹⁰⁴ *ibid.* 6165 & 6239-41.

the list 'ophthalmia' (trachoma),¹⁰⁵ and consumption (tuberculosis),¹⁰⁶ as members of the 'native' population suffering from either of these diseases were not legally required to be isolated.

Trachoma, following the American example, was given a key role in the investigations of the Commission in relation to health. During the examination of a number of witnesses the enquiry would return to the question: 'Should you say that the alien population is more subject to [trachoma] than the native?'¹⁰⁷ Generally the reply was negative.

4706. (*Vallance*) I should like to ask whether in your practice as medical officer you have found in visiting that children of the alien poor suffer more from ophthalmic diseases than the children of the native poor? – (*Loane*) Proportionally to the population, I do not think so; that is not my impression.¹⁰⁸

The issue of trachoma among alien immigrants was so important to the Commission that evidence was taken from two ophthalmic experts: William Lang, President of the Ophthalmological Society of the United Kingdom, and Francis Tyrrell, Surgical Officer to the Royal London Ophthalmic Hospital and Medical Officer to the London School Board. Although Tyrrell, following receipt of a letter he sent explaining his work to the Commission, was summoned to give evidence, Lang volunteered to speak before the Commission in order, specifically, to refute the testimony of Tyrrell. Tyrrell claimed, when called before the Commission in May 1902, that granular ophthalmia – trachoma - was a disease particularly prevalent in the alien population and the restrictive laws focusing upon the disease in America had, along with the general uncleanliness of the alien population, exacerbated the problem in London. He stated that the Jewish Board of Guardians had sent him aliens suffering from trachoma who had been returned from the United States for this reason. The aliens had travelled directly from the Continent to America but had been returned to Britain

¹⁰⁵ Murphy, *Minutes of Evidence, RCAI*, 5013-5.

¹⁰⁶ *ibid.* 5016-20.

¹⁰⁷ Hope, *Minutes of Evidence, RCAI*, 21466.

¹⁰⁸ Evidence of Joseph Loane, Late Medical Officer of Health, Whitechapel, *Minutes of Evidence, RCAI*, 4706.

in order to be treated for the disease before attempting to re-enter the United States.¹⁰⁹ He claimed that cases of the disease among the native population had risen since the arrival of the aliens and that, 'the Jewish people are peculiarly prone to trachoma'.¹¹⁰ Lang, who gave his evidence a year later, in May 1903, informed the Commission that contrary to Tyrrell's view, trachoma was a curable disease and it 'is not peculiar to Jews at all; it is universal all over the world'.¹¹¹ It was a disease more dependant on conditions than on race and 'the Jews, if they do bring it over, were not the originators of the disease; and they were not spreading it'.¹¹²

The final report of the Commission was submitted on August 10, 1903, and Lang's testimony, supported by the evidence of a majority of medical professionals who were examined, was reflected in it.

In consequence of the poor living resulting from poverty there are cases of children amongst the immigrants on arrival suffering from a disease called 'granular ophthalmia'. This disease under certain conditions is contagious. It, however, appeared that the disease, which is found in the ranks of poor children generally, did not exist to an exceptional extent among the alien children, and no instance was alleged of the disease being communicated to them by others. At the same time the desirability of permitting people suffering from this contagious disease into this country has to be considered.¹¹³

Thus, it was demonstrated to the Commission that aliens were not the source of trachoma among the poor, nor were they more likely to suffer from the disease than the native population of a similar class. However, in their final report the Commissioners did not object to the designation of trachoma sufferers as undesirable for entry into the United Kingdom. This conclusion, despite the evidence received to the contrary, together with the singling out of trachoma as the only infectious disease specifically commented upon in the report, demonstrated that another agenda was served by the disease. Trachoma, with its obvious visibility, had come to symbolise

¹⁰⁹ Tyrrell, *Minutes of Evidence, RCAI*, 3671.

¹¹⁰ *ibid.* 3679.

¹¹¹ Lang, *Minutes of Evidence, RCAI*, 20590.

¹¹² *ibid.*

¹¹³ *Report of the RCAI*, p. 11, item 71.

the 'undesirable alien' in the United States and under United States immigration law. It had also, as a result, come to symbolise, as Tyrrell's evidence demonstrated, a visible display of the fear that Britain was receiving migrants deemed unacceptable for entry to America. Although, as Williams had testified, under the present system smallpox among migrants was probably a greater public health threat,¹¹⁴ trachoma had been imported from America as the symbolic manifestation of alien infection. It had become, as Markel remarked with regard to the United States, 'a powerful symbol of the threats of immigrant disease, dependency, and economic ruin against the body politic'.¹¹⁵

Although the Commission noted in its report that 'in relation to health we feel that we ought to place reliance upon the testimony of Dr Herbert Williams', particularly his statement that 'I cannot say that much infectious disease has come into the country among these people',¹¹⁶ they recommended

such orders and regulations to include provision for medical examination of Alien Immigrants at port of arrival. In cases where an Immigrant is found to be suffering from infectious or loathsome disease, or mental incapacity, the medical officer to have power to debar such Immigrant from landing, and the shipowner to be compelled to re-convey the Immigrant to the port of embarkation.¹¹⁷

This, it was claimed, would have the ultimate effect not merely of excluding those deemed undesirable on medical grounds but would, in the first instance deter them, as in the United States, from attempting to enter and, most importantly, would act as a deterrent to shipping companies from carrying unhealthy passengers. It would also reduce overcrowding and unsanitary conditions on board passenger vessels. This reflected Williams' concerns, as did the recommendation 'that further statutory powers should be obtained for regulating the accommodation upon and condition of foreign immigrant passenger ships'.¹¹⁸ Yet, the recommendation to legislate against entry on medical grounds did not coincide at all with the majority of medical

¹¹⁴ Williams, *Minutes of Evidence, RCAI*, 6239.

¹¹⁵ Markel, 'The Eyes Have it', p. 549.

¹¹⁶ *Report of the RCAI*, p. 10, items 67-8.

¹¹⁷ *ibid.*, p. 41, Recommendation, 4)g).

¹¹⁸ *ibid.*, p. 42, Recommendation, 7).

testimony received by the Commission. Indeed, this did not go unnoticed by two members of the Commission, Kenelm Digby and Rothschild, who signed the report subject to a memorandum. Digby's extended memorandum was seconded by Rothschild. He objected to 'some of the recommendations' of the Commission which he believed did not concur with either the evidence presented to the Commission, or the conclusions which had been unanimously reached by the Commissioners. Central to these objections was the recommendation to restrict entry on health grounds.

It has been proved in evidence as summarised in the Report, that there is very little illness amongst these immigrants, and that they are not found to have introduced any infectious or contagious disease. There is little or no evidence that lunatics come over with them, and the health of the immigrants after arrival here as proved by the Vital statistics given in evidence appears to be superior to that of the native population. No case therefore seems to have been made for any special measures for exclusion at the port of landing on the ground of health. Nevertheless, it seems desirable to have more definite and systematic inspection by sanitary officers, both of the ships in which the immigrants arrive, and of the immigrants themselves.¹¹⁹

Digby, seconded by Rothschild, recommended that

the remedy or mitigation of the evil is to be found in the enforcement of the ordinary sanitary law, with certain alterations and additions which experience has shown to be required.¹²⁰

Digby and Rothschild argued that the problem of alien Immigration had proved to be essentially a local one and did not require solutions on a national level. Rather, it ought to be approached via existing public departments, without the need for the creation of a separate, national, Immigration Department. A report of the Alien Immigration Committee of the Board of Deputies regarding the Commission supported the unwillingness expressed by Digby and Rothschild to accept the recommendations. In it they lamented that,

¹¹⁹ *ibid.* 'Memorandum', p. 49

it would...be most deplorable if the recommendation, made in the face of the mass of evidence to the contrary, serves to give colour to the popular impression that the diseased state of the immigrants of the past have necessitated the regulations mentioned.¹²¹

The inclusion of medical restrictions in immigration legislation was the result not of the Commission's findings but of another agenda. This agenda was similar to that which allowed the Commission to conclude that trachoma, despite expert evidence to the contrary, ought to be considered as a condition disqualifying entry. The foundations of the anti-immigration platform, both before and throughout the Commission, were based on the leading allegation that immigrants were responsible for the housing, employment and poverty problems in London's East End. Health, although not as central to the debate as social and economic factors, played an essential role in the debate, as much symbolically as literally. As Markel remarked with regard to trachoma in the United States, immigrants not only threatened the public health with imported infections, but also the health of the body politic. This was a particularly important tool utilised by the BBL and LL in the development of popular support for the immigration debate, and one which easily tapped into traditional anti-Semitic paradigms; and it was no secret that any legislation resulting from the Commission would be directed specifically at East-European Jews. As the Royal Commission published in its report, 'the excess is mainly composed of Russians and Poles who belong for the most part to the Jewish faith'.¹²² The guiding force behind the particular Jewish focus of the Commission's investigations and reports was Evans-Gordon, and it was his particular political agenda which led to the inclusion of health restrictions in the recommendations of the Commission.

Shortly after the Commission's findings were published and the first Bill resulting from the enquiry was reviewed, the Secretary to the Commission, F.E. Eddis, wrote a book regarding 'all phases of the [alien] question'. He became well versed on this issue during the period of the Commission. Before sending the manuscript for

¹²⁰ *ibid.* p. 49.

¹²¹ 'Report of the Alien Immigration Committee of the London Committee of the Deputies of the British Jews on the Report of the Royal Commission on Alien Immigration', LMA ACC3121/B02/01/001.

¹²² *Report of the RCAI*, p. 40, item 262.

publication he forwarded a copy to the Home Office acknowledging his close involvement.

Having been the Secretary to the Royal Commission I have doubted whether I could claim the independence of one of the general public in the expression of views, not only about the recommendations of the Commission but also upon the main purpose of the Bill itself.¹²³

The reaction from the Home Office was that the book was 'quite intolerable' and 'objectionable' and that it could only be supported for publication if approved by Rothschild, Evans-Gordon and Lord Hereford; hence it was never published. One reason it received such a cold reaction was that it openly criticised the recommendations of the report and revealed the biases within it.

The Commission at the outset appointed one of their members to lead the attack against unrestricted immigration of foreigners. To Major Evans-Gordon, Member of the Parliamentary division of Stepney, was assigned this post of responsibility. All must admit that he brought to bear upon the issue an energy, an ability, and a dogged determination to do full justice to his side, combined with fairness which called forth the admiration of his opponents, no less than his friends.¹²⁴

As Rothschild, who according to Eddis had been appointed to the Royal Commission as 'leader of the defence', stated to the Deputation from the Jewish Board of Deputies to the Home Secretary on the Aliens Act, 'the General idea of the Commission was to recommend that a system somewhat analogous to that in vogue in the United States should be introduced into this country'.¹²⁵ He also agreed to a point made in a letter from Arnold White¹²⁶ during the Commission that, 'Major Evans-Gordon has been a Member of Parliament for a little over a year and although his industry and tact are admirable, his interest in the subject are of political origin'.¹²⁷ In other words, Evans-

¹²³ Letter to Home Office dated May 2, 1904, PRO HO45/10241/B37811/15.

¹²⁴ Proof, Eddis manuscript, PRO HO45/10241/B37811/15B.

¹²⁵ May 19, 1904, PRO HO45/10303/117267.

¹²⁶ See footnote 1, this chapter.

¹²⁷ Letter from Arnold White to Lord Rothschild, May 17, 1902, Arnold White Papers NMM WHI/166, Bedford Estate Office.

Gordon and the Conservative Party had pledged to legislate on the issue since the previous century and the Conservative Prime Minister, A.J.Balfour, was equally committed to legislation by 1904-5. The decision to recommend the inclusion of medical restrictions in any immigration legislation was the result of the desire to replicate American legislation and also to honour the Conservative party pledge to legislate, championed primarily by Evans-Gordon.

The Aliens Act and the Port Sanitary Authority

Thus, after one failed Bill,¹²⁸ in which a number of clauses were not considered feasible,¹²⁹ a second Bill was introduced in 1905,¹³⁰ and the Aliens Act finally entered the statute books on August 11, 1905. In relation to health it stated that an immigrant would be considered 'undesirable' under the Act, if he [was] a lunatic or an idiot, or owing to any disease or infirmity appear[ed] likely to become a charge upon the rates or otherwise a detriment to the public'. It only applied to 'alien steerage passengers' and not to transmigrants in possession of 'prepaid through tickets'.¹³¹

From the moment the recommendations of the Royal Commission were published, the Port Sanitary Authority began to consider its position within the new system. Williams wrote in his monthly report to the Port Sanitary Committee in September 1903 that considering the work undertaken during the operation of the Cholera Order, responsibility for medical inspection under the Act should be given to the Port Medical Officers of Health.

Your officers have ... had much experience in dealing with such immigrants, and the machinery exists and can be put in action immediately if required, and I bring this fact before your committee for your consideration, in order that should legislation follow on the lines of the recommendation of the

¹²⁸ Bill 147, 1904 [4 EDW.7].

¹²⁹ Such as how was a 'person of notoriously bad character' to be determined and proved; see Holmes, *John Bull's Island*, p. 72.

¹³⁰ Bill 187, 1905 [5 EDW.7].

¹³¹ Aliens Act, 1905 [5 EDW.7].

Commission, that this authority should carry out the work of medical inspection of immigrants coming into the Port of London.¹³²

The second Bill did not specify who the medical inspectors employed under the proposed Act would be. The Port Sanitary Committee was sent a number of further requests in 1905 from Williams and his provincial colleagues to urge the government to amend the Bill so that all matters relating to the health of the ports would remain within their sole authority. They suggested an amendment to clause 2.(1) of the Bill, which proposed that the Secretary of State would appoint men with 'magisterial, business, or administrative experience' to posts within the new Immigration Department. Instead Williams and his colleagues suggested 'the Medical Inspector shall be the Medical Officer of Health of the Port Sanitary Authority or such other persons as the Secretary of State shall appoint'.¹³³ Although this clause was not amended in the Act, employment of the established Port Authorities was not precluded under it. The Act was passed in August 1905, but was not due to come into operation until January 1, 1906. During this period the administrative and organisational structure of the Act had to be established, and the Port Sanitary Authorities were determined to maintain their dominion in the ports with a secure role in the new department.

Opportunely by the end of summer 1905 cholera again threatened to invade Western Europe, apparently brought from the East by Russian migrants. By September 'some cases' had occurred in Hamburg among 'Jewish emigrants'. The outbreak did not appear to be a 'serious one' but precautions were nonetheless put in place.¹³⁴ Again the Local Government Board issued regulations which permitted special authority, such as had been applied from 1892-5, with regard to 'risk' vessels.

The Medical Officer ... detains on board at his discretion the passengers from 'infected' ports [ports on the Vistula and Oder, and Hamburg] and all immigrants from other ports.¹³⁵

¹³² CLRO *PSCP*, (Sept. – Dec., 1903).

¹³³ Letter from the River Tyne Port Sanitary Authority to the Town Clerk, Guildhall, June 21, 1905, CLRO *PSCP*, (May – July, 1905).

¹³⁴ CLRO *PSCP*, (Sept. – Dec., 1905)

¹³⁵ Sept. 19, 1905, CLRO *PSCP* (Sept. – Dec., 1905).

The verification of addresses was also re-introduced and the arrangement which had been entered into between the Poor Jews' Temporary Shelter and the Port of London Sanitary Authority was renewed. Throughout the 'crisis' period which lasted from September to late November (the months between the passage of the Bill and the introduction of the Act), Medical Officers were required to employ particular vigilance in boarding every vessel which arrived carrying immigrants.

The Aliens Act having been passed, duly comes into force on the 1st January 1906 and it is probable that with a view to escaping this Act, that the numbers of such aliens will be very considerable from now until the end of the year and will entail much work on the part of [the Port Sanitary] Officers in supervising them.¹³⁶

During these three months the total number of migrants detained on board vessels and only allowed to disembark 'under supervision' was 6,036. The monthly report for October/November stated that the success of the Port Sanitary Authority in controlling the disease and the migrants was demonstrated in the fact that 'only three or four were subsequently untraced'.¹³⁷

The timing of the threatened cholera invasion was particularly advantageous to the Port Sanitary Authority. A note to Hull, Grimsby, Tynemouth 'and also Dr. Leslie Mackenzie of Scotch LGB,' from the Local Government Board in London focused the activities of the Port Medical Officers particularly upon migrants, not coincidentally, at that time.

You will doubtless have noted in the papers a statement that cholera has appeared in Hamburg in the person of an Alien recently arrived from Russia. A single imported case does not of course, in view of the Paris Convention, justify this country in regarding Hamburg as an infected port, but doubtless you will be thinking it well to keep a special eye on arrivals from there particularly on low class aliens.¹³⁸

¹³⁶ *ibid.*

¹³⁷ 'Monthly Report of the Port of London Medical Officer of Health, October/November, 1905', *CLRO PSCP*, (Sept. - Dec., 1905).

¹³⁸ Sept., 1905, PRO MH19/237/104191/05.

Simultaneously, correspondences darted between the Port Sanitary Committee in London and the provincial Port Authorities, urging them to place pressure on local Members of Parliament and other local authorities in order to ensure that 'the Port Medical Officers of Health [were] nominated as Medical inspector under the Bill, also [that] members of the Port Sanitary Authority [were] included in the list of persons from whom the Immigration Board [was] to be selected'.¹³⁹

By December 1905, only one month before the Aliens Act came into force, the Secretary of State finally resolved who was to be appointed as Immigration Officers at the ports. The Immigration Officers responsible for all parts of the Act not referring to health, such as financial means and registration, were to be appointed from among the officers of the Customs Service. The duties of the Immigration Officer were to be carried out by Customs Officers in conjunction with their ordinary duties. As they ordinarily met every vessel which arrived in British ports, the role of Immigration Officer would be 'performed by Customs Officers as part of their normal duties'.¹⁴⁰

In relation to health, while the suggested amendment to the Bill had not been included in the Act, the Secretary of State ensured that medical inspection under the Aliens Act remained within the existing structures of port health. The Aliens Committee, which was convened at the Home Office in order to prepare and implement the logistics of the Act, 'stated that they thought it not desirable that two bodies should be conducting a system of medical inspection',¹⁴¹ and the Secretary of State declared that,

the Act requires the appointment of a Medical Inspector at every immigration port. The Secretary of State concurs with the view of the [Alien] Committee that the most suitable person for the post is the Port Medical Officer of Health, or, if there is no such officer, the local Medical Officer of Health.¹⁴²

It is unclear exactly what diseases were referred to in the Act. Evans-Gordon, in a memorandum to the Bill in early 1905 questioned whether 'disease or other infirmity'

¹³⁹ Letter from the London Port Sanitary Authority to the Town Hall, Hull, Aug. 22, 1905, CLRO *PSCP*, (Sept. – Dec., 1905).

¹⁴⁰ Letter from the Secretary of State to the Treasury, Dec. 9, 1905, PRO HO162/1.

¹⁴¹ Draft memo, 'Aliens', CLRO *PSCP*, (Sept. – Dec., 1905).

¹⁴² PRO HO162/1; see also Letter dated Dec. 9, 1905, CLRO *PSCP*, (Sept. – Dec., 1905).

referred only to chronic conditions or also 'meant to include persons suffering from infectious or contagious diseases?'¹⁴³ What would happen under the Aliens Act to the powers already in the possession of the Port Sanitary Authority with regard to 'indigenous' and 'exotic' disease? An employee at the Office of Parliamentary Council advised that,

it will also be necessary to draw a distinction between infectious diseases and chronic diseases. The present policy of the Local Government Board, in accordance with treaties, is rather to enforce the landing of persons suffering from infectious diseases rather than to forbid it.¹⁴⁴

The 'treaties' related to the conventions signed at the International Sanitary Conferences of 1897 and 1903, in which Britain had again argued for the landing of healthy passengers from infected ships on condition they provided verifiable addresses and that infected individuals were isolated. Medical restriction to immigration did not strictly contravene these international conventions, nor did it interfere with international treaties regarding a state's right to repatriate foreign nationals. However, it did contradict the policy of non-exclusion upon which Britain constructed its arguments against quarantine since the 1850s.

The powers granted to the Port Sanitary Authorities in 1896 with regard to the treatment of vessels infected with 'indigenous' or 'exotic' diseases were not altered under the Aliens Act. The phrase in the Aliens Act which referred to 'any disease or infirmity...likely to become a charge upon the rates or otherwise a detriment to the public', applied to all infectious disease, both 'exotic' and 'indigenous'. The two categories of disease were not separated under the Act and the Port Medical Officers could deal with cases of either type of disease onboard an immigrant vessel without distinction. The duties of the Port Medical Officer of Health at London, as the Immigration Medical Inspector were as follows:

On arrival at Blackwall, all immigrant vessels shall bring up alongside the pier for purpose of landing'

(1) undesirable immigrants detained by the Immigration Officer,

¹⁴³ Evans-Gordon, 'Memorandum on the Aliens Bill', March 4, 1905, PRO HO45/117267/30.

- (2) ditto detained by Medical Inspector,
- (3) Any immigrants that it may not have been found possible to examine before arriving at Blackwall¹⁴⁵

No examination under the Aliens Act shall take place between the hours of 8 p.m. and 8 a.m.

Vessels arriving at Gravesend after 8 p.m. shall be examined in the ordinary way by the Medical Officer on duty with a view to the detection of cases of infectious disease, leaving the detailed examination under the Aliens Act to be carried out at Blackwall where all passengers will be landed.

Masters of vessels will be responsible for ascertaining and declaring at Gravesend whether any person on board is ill or ailing. Should any case of dangerous infectious disorder necessitating disinfection of the contacts with the case, be discovered after passing Gravesend, the vessel will be required to return to Denton, the Disinfecting Station, for the purpose of thorough disinfection. In the case of immigrant vessels coming from ports infected with Plague, yellow Fever or Cholera, the medical examination of all persons on board must take place at Gravesend before the vessel proceeds to London.¹⁴⁶

The law remained the same regarding the way medical officers inspected non-immigrant vessels which were 'suspected' or 'infected' with either 'exotic' or 'indigenous' disease. The difference in inspection practices at the ports changed after the implementation of the Act only with regard to immigrant ships. The Aliens Act defined an immigrant ship as any vessel which carried 'more than twenty alien steerage passengers'. Immigration Medical Officers stopped and medically examined these vessels under the conditions of the Act, regardless of whether any illness was reported by the Master or ship's surgeon. This definition of immigrant ships ensured that those vessels which were detained and examined under the special authority of the Aliens Act were specifically 'migrant vessels'. These vessels were legally defined

¹⁴⁴ Letter from the Office of Parliamentary Council to the Home Office, March 13, 1905, *ibid*.

¹⁴⁵ Initial inspection of immigrant vessels would take place when the Customs and Medical Officer boarded the vessel at Gravesend.

¹⁴⁶ Draft memo, 'Aliens', CLRO *PSCP*, (Sept. – Dec., 1905).

in order to differentiate them from trading vessels. Trading vessels remained under the ordinary requirements of the Public Health Acts, and were detained and examined accordingly. Thus, the 'English system' - which had largely been developed with reference to the commercial considerations of the ports - was maintained where trading vessels were concerned. The only vessels which were affected by additional restrictions were passenger vessels.

Within the first year it was evident that much of the medical evidence to the Royal Commission, as well as the predictions of Rothschild and Digby's, was well-founded: the Commission had drastically exaggerated both the scale of the immigrant health problem and the reduction medical restriction would produce in immigrant numbers. In London, 18 immigrants were deported for medical reasons in the first year of the Act, while a further 22 arrivals deemed undesirable on medical grounds were, on appeal, permitted to land.¹⁴⁷ The diseases or ailments which prohibited the landing of the 18 unsuccessful immigrants, were not recorded. However, a list from Dover, where in the first months of 1906 no aliens were deported, provides some idea of the ailments which were not grounds for deportation.

So far we have not had occasion, on Medical grounds, to report to the Immigration Officer that any Alien immigrant was in our opinion a lunatic, idiot, or suffering from any disease which appeared likely to make such immigrant a charge upon the rates, or otherwise a detriment to the public. The class of immigrants has been a respectable one, and evidence of disease confined to influenza in six cases, one slight impetigo, one eczema, one ozoena, one cataract of one eye, one right inguinal hernia, one loss of single eye, replaced by a glass one.¹⁴⁸

Trachoma, which was previously absent from monthly and annual reports of the Port Sanitary Authority began to be mentioned with increasing frequency. Yet in accordance with numerous testimonies to the Royal Commission, it failed to cause any notable problems as a disease imported by immigrants. The medical evidence

¹⁴⁷ Monthly Reports of the Port Medical Officer of Health for the Port of London, 1906, CLRO *PSCP*, (all file boxes 1906).

¹⁴⁸ Letter to H.M. Inspector of Aliens from Medical Inspector and MOH Dover, May 8, 1906. PRO HO45/10327/132181/28.

presented to the Commission had not been taken into account in the Commission's report, or indeed in the creation of the Act, and after a year this had become evident. The Port Sanitary Authorities, however did succeed in attaining their requests and recommendations for extended authority over incoming vessels. While they could not apply greater authority over suspected cases of 'indigenous' disease on board non-immigrant vessels, the Port Medical Officers of Health were granted the power of full inspection and detention of immigrant vessels.

Thus, from the first decade of the twentieth century the Port Sanitary Authorities, having successfully triumphed over the quarantine system, acquired jurisdiction over imported 'exotic' disease, and secured a place within the new immigration regulations and organisation, were the sole medical authority operating within British ports. The medical restriction of immigration was included under the new Aliens Act despite the opposition of two Commissioners and the majority of medical witnesses called to testify at the Royal Commission. After over fifty years of British opposition to policies of detention and exclusion at the ports, it was not a medical panic but the combination of a strong anti-alien campaign mounted largely by Conservative politicians and the impact of stringent American immigration laws which brought about the introduction of medical restrictions to immigration at British ports.

CONCLUSION

Charles Rosenberg in his 1965 article, 'Cholera in nineteenth century Europe: A tool for social and economic analysis', argued that the European cholera experience was a 'cross-sectional phenomena' which arose in the particular industrialised urban environment of the nineteenth century and was banished by the same material culture which had encouraged its presence.¹ The disease and the way it was treated medically, politically and socially was intrinsic to the societies in which it occurred. Yet the way it has been approached by historians, he argued, has been as something 'outside of society' and therefore not related to the conditions he referred to.

There is no human crisis more compelling than an epidemic of plague, or yellow fever, or cholera. These phenomena are, indeed, so dramatic and so terrifying that most physicians and historians have tended to view them as something alien, something outside of society and contending with it.²

Rosenberg's argument accounts for the devastating spread of the disease during the nineteenth century, and its subsequent defeat. However, although it is important to examine the disease within existing social structures, it must not be forgotten that cholera was indeed 'alien' to many of the affected countries. The conditions of the working classes in overcrowded urban centres and developments in transportation were key to the cholera epidemics, and the 'medical and administrative advances' of the period 'inevitably' banished the disease.³ Yet, contemporary reactions and actions towards cholera were related precisely to the 'alien' nature of the disease. It, and the other diseases mentioned by Rosenberg, yellow fever and plague – Ackerknecht's 'big three'⁴ – were regarded as 'alien', differentiated by the law and in medical practice from other infectious diseases which were categorised as 'indigenous'.

The debates staged between sanitation and quarantine at the ports were ultimately debates about whether or not, as Rosenberg discussed, these three 'exotic' diseases ought to occupy a place outside the confines of society, or be incorporated into the

¹ Charles Rosenberg, 'Cholera in Nineteenth Century Europe: A Tool for Social and Economic Analysis', *Comparative Studies in Society and History*, vol. VIII, (1965-66), 452-463, p. 461.

² *ibid.*, p. 453.

³ *ibid.*, p. 461.

⁴ Ackerknecht, 'Anticontagionism', p. 569.

mainstream of domestic medical practice and consciousness. Furthermore, it was not merely that these diseases were 'exotic' due to their foreign origin; the way Britain dealt with them also depended upon foreign pressures. It was not sufficient for Britain to have incorporated 'the big three' into the ordinary methods of disease prevention, as applied to 'indigenous' disease, and within domestic medical and sanitary structures. The policy which determined domestic treatment of the diseases was shaped by the demands of foreign countries. The way 'exotic', as opposed to 'indigenous' diseases, were dealt with domestically was a matter for international, not just national, discussion.

'Exotic' infectious diseases were intrinsically linked to Britain's empire and thus both to maritime trade and the foreign ports through which it passed. The way Britain responded to 'exotic' disease, therefore, was always informed by more than medical concerns alone. The implications of these diseases, particularly cholera (so clearly linked with the 'Jewel in the Crown') went beyond public health. That is not to say that public health did not have its own agenda beyond the bounds of economic or political interest; but the ports and maritime trade were central to the fabric of imperial power. Protecting the congenial operation of British and colonial ports without hindering commercial interests was fundamental to the way in which 'exotic' disease was approached at the ports in the late nineteenth century.

Prophylaxis at British ports was a compromise between the often conflicting demands of national and international interests, between 'exotic' and 'indigenous' disease, and, later, immigrants and the native population. These tensions – summarised as the tension between 'domestic' and 'foreign' – in relation to infectious disease, were played out at their geographical meeting point – the ports. The separate elements within the domestic/foreign divide at the ports (which are displayed in TABLE I in the Introduction) shaped the development of port health in the late nineteenth and early twentieth century. Over the period discussed in this thesis the relationship between each of these elements altered, becoming either closer or further apart. The separation of 'exotic' and 'indigenous' diseases was emphasised during the period of dual authority of Customs and the Port Sanitary Authority. After the repeal of the Quarantine Act this separation lessened although vestiges of the divide remained with regard to the power of the Port Sanitary Authority to detain vessels carrying 'exotic'

disease. The separate categorisation of 'exotic' and 'indigenous' disease disappeared only after the introduction of the Aliens Act and only in the case of immigrant vessels. Before the 1892 cholera epidemic port prophylaxis was divided between 'exotic' and 'indigenous' disease and quarantine and the 'English system'. From 1892 steerage migrants were added to the equation which determined methods of prevention for imported infections. The separation of 'aliens' in port prophylaxis increased from 1892 until the passing of the Aliens Act. While the delineation between 'exotic' and 'indigenous' lessened considerably from 1872 to 1896 and 1905, the separation of immigrants from the native population increased enormously as a factor in port prophylaxis from 1892 to 1905.

This study began with the assumption that in the late nineteenth and early twentieth century, a 'medical panic' was focused at the ports on the arrival of hundreds of thousands of immigrants. The inclusion of a clause in Britain's first immigration law, the 1905 Aliens Act, which prohibited the entry of immigrants who 'owing to any disease or infirmity appeared likely to become a charge upon the rates or otherwise a detriment to the public', appeared to indicate, as it had in the United States, medical concerns about the introduction into the native population of a 'diseased' foreign population. Yet, by the time immigration restriction began to gain momentum in British politics in the years leading up to the Act, the central platform adopted by anti-alien agitators was not medical but economic, concerned with sweated labour, the undercutting of wages and the sale of goods, housing and rent problems. Unlike other countries which received immigrants during this period of mass migration, Britain did not respond to the arrival of thousands of aliens in the unsanitary steerage holds of merchant steamships with the same medical rhetoric of exclusion adopted with particular force in countries such as the United States. The health condition of immigrants at the moment of arrival, a powerful image in American anti-immigration propaganda, did not, particularly after 1900, play a significant role in the British anti-alien movement. However, the notion that immigrants were the conductors of disease was not absent from Britain. Indeed in the 1890s and into the twentieth century they were often considered to be the primary vector in the transmission of cholera and other infectious diseases. Yet, that immigrants posed a significant threat to British public health was never a charge used with great force in the rhetoric of anti-immigration in Britain.

Understanding why the potential medical threat posed by immigrants was not a significant part of the alien immigration debate at the turn of the twentieth century necessarily led to an investigation of port health more generally in nineteenth century Britain. Britain had maintained, particularly since the establishment of the Port Sanitary Authorities, belief in a system of port health which opposed exclusionary practices such as quarantine. Any rhetoric which engendered exclusion with regard to port health sat uncomfortably at the end of a half century of fervent anti-quarantinism. As a result, this study became an investigation not only about the methods employed in Britain to prevent imported infectious disease relating to immigration but, more specifically, the development of the new Port Sanitary Authority, as a working alternative to quarantine, and the associated protection of maritime trade interests.

The central theme which emerges from this examination of public health at the ports is that of the meeting of foreign and domestic. This theme penetrates the entire history of port health in Britain in the late nineteenth and early twentieth century. It was central to the maintenance of quarantine in Britain until 1896, and particularly the continuance of dual authority at the ports. It was also central to the introduction of medical restriction to immigration under the administration of the Port Sanitary Authorities. Through a recognition of foreign as well as domestic agency these policies, which at first sight appear curious, are more intelligible.

There has been limited scholarship examining port health in Britain in this period and as a result it has been assumed that this important aspect of public health in the late nineteenth century followed a somewhat linear development as merely an extension and 'virtual completion of the internal preventative structure'.⁵ While this was partly true, the Port Sanitary system developed very much in relation to the specific role and importance of the ports. Health issues which affected the ports, while of domestic consequence, were also of significance beyond British shores. While relying upon the internal sanitary structure of public health for the prevention of the spread of imported infections, port health was also reliant upon the health of foreign ports and international methods of prevention. It was as much externally as internally referential.

⁵ Hardy, 'Public Health and the Expert', p. 135.

One of the primary misconceptions in the small amount of previous scholarship addressing these issues has been that quarantine played no role at the ports after the establishment of the Port Sanitary Authority, and it faced an inevitable and uncomplicated decline after the 1872 and 1875 Public Health Acts.⁶ These arguments have been formulated on the basis that there were no vessels detained for plague or yellow fever under the Quarantine Act in the final quarter of the nineteenth century. This point is inaccurate in two respects. Firstly, quarantine *was* imposed after the establishment of the Port Sanitary Authority in the case of the *S.S.Neva* in Southampton in June 1889. It was an isolated case, as it was the only case of plague or yellow fever which appeared aboard a vessel in a British port during the period 1872-1896. Yet, it illustrates that where a case of 'exotic' disease (not cholera) occurred, quarantine procedures remained in place. Secondly, the absence of other vessels quarantined under the Act did not diminish the importance of quarantine remaining on the statute books, and hence as a definite presence in the practice of port health. While quarantine remained within the law Customs officers were required to attend the arrival of every vessel proceeding from a foreign port and give it clearance to dock. Until the removal of quarantine from the law, with the passing of the 1896 Public Health Act, the Port Sanitary Authority never worked independently of the Customs Service or the requirements of the Quarantine Act. On most occasions, not including the period of the Cholera Order, the Port Medical Officer only attended a vessel if the Customs Officer, while asking the 'Quarantine Questions', was informed of an 'indigenous' illness on board. Although, between 1872 and 1896, only one case of yellow fever was quarantined, the Quarantine Act still remained at the core of the 'first line of defence', singularly concerned with the interception, should a case appear, of 'exotic' infectious disease.

Cholera, which in Britain sat uncomfortably between its absence from the specific nomenclature of 'exotic' disease under the Quarantine Act, and its clear origin outside Britain, was at the heart of the quarantine/sanitation debate. It was also the principal topic of international discussion about quarantine at the International Sanitary Conferences which ultimately bound Britain to retaining a superfluous and much hated system of disease prevention at the ports. Although the Port Sanitary Authority,

under the Local Government Board General Cholera Order, undertook the reception and treatment of cholera cases and vessels within the fundamental principles of sanitation, it was necessary to retain the Customs Service as the initial boarding authority, which then handed cases of cholera infection over to the Port Sanitary Authority. Although the ambiguities in the Quarantine Act allowed for limited jurisdiction of the Port Sanitary Authorities over cholera, the 'exoticness' of the disease bound it to quarantine.

'Exotic' diseases were categorised and treated differently because of their foreign origin and because, for reasons relating to this, they were not of domestic importance only. Britain was at liberty to impose any preventative strategy against 'indigenous' disease entering the ports. Generally, those diseases which were regarded as 'indigenous' to Britain were similarly endemic in other parts of Europe. It was a case of domestic solutions to domestic problems. International problems such as cholera required international solutions, and despite Britain's singular objection to quarantine throughout the century, it was bound by the weight of international demand to maintain some form of quarantine, paradoxically, if British vessels were to sail more or less unhindered. This pressure was primarily exerted at the International Sanitary Conferences. After 1872 cholera was mostly dealt with under the sanitary system. But in terms of the health status of British ports internationally it was essential that quarantine officers were maintained as a visible component of British port health. Although it was widely acknowledged that Britain opposed quarantine and that its reasons for doing so were primarily economically based, quarantine remained within the structure of port health for more than twenty years after the establishment of a successful and more appealing alternative for disease prevention. The ultimate success of the sanitary system in preventing the disease from spreading in Britain in 1892, when cholera's effects elsewhere had been devastating, eventually permitted Britain, not without some hesitation, to abolish human quarantine.

Thus, while it may appear, on first glance, that quarantine had ended in Britain after the establishment of the Port Sanitary Authorities, it maintained a significant role, albeit essentially as a token, both in the practical workings of the ports and as a political tool in British maritime trade.

⁴ see Hardy, 'Cholera'; MacDonald, 'The History of Quarantine'; and Ackerknecht.

The second problem found in previous scholarship is the assumption that anticontagionism was defunct, medically and politically by the 1870s or early 1880s. This is due primarily to the erroneous suggestion that quarantine had no place in the operation of port health in Britain in the last quarter of the nineteenth century. Working on Ackerknecht's notable statement that, 'the whole discussion was ... never a discussion on contagion alone, but *always on contagion and quarantine*',⁷ while there remained a legal recognition of quarantine, there also remained the opposing medical and political theory of anticontagion, which was employed by Britain in the continuing international quarantine debates. Furthermore, the implications of a contagious aetiology of cholera went beyond merely quarantine; it also implicated Britain in the importation of cholera into Europe via her strong maritime links with India. Although non-contagionism – a more appropriate term for the late nineteenth century – was maintained in India, by individuals such as Fayrer, for longer than it was in Britain, the theory retained a significant foothold in Britain, particularly in areas relating to the ports, longer than is usually credited. Precisely because of the frequent debates with Europe at the International Sanitary Conferences where Britain tried to argue for a relaxation of quarantines, especially through the Suez Canal, non-contagionist theories of cholera aetiology endured. Non-contagionism was not abandoned when Koch presented the findings of the German Cholera Commission. Non-contagionist theories, supported by years of clinical and epidemiological evidence, were also maintained by a strong political and economic agenda which did not disappear the moment the comma bacillus made headline news. On the contrary, Koch's discovery had important implications for Britain both in terms of the quarantine/sanitation debate, and Britain's role in importing cholera into Europe. It was these factors which prevented Britain from allowing any discussion of bacteriology at the 1885 International Sanitary Conference. Rather, it was maintained that cholera could occur *de novo*, depending on local conditions.⁸ Well into the 1880s and indeed, into the 1890s, Pettenkofean theories of infectious disease aetiology, which allowed for the causative influence of a contagious agent only within certain conditions of environment and individual predisposition, were maintained in relation to port health. Such examples of non-contagionism can be found in medical texts and

'Anticontagionism'.

⁷ *ibid.* p. 567.

⁸ Chapman, *Cholera Curable*, p. 85.

in political statements relating to port health into the 1890s. As late as 1898 the President of the Epidemiological Society stated in his inaugural address,

for the production of an epidemic of any disease, the concurrence of three factors or groups of factors is necessary. There must be, first, the presence of the specific contagium; secondly, a favourable environment in the form of appropriate conditions meteorological, topographical, social, or sanitary; and, thirdly, personal predisposition on the part of those who are exposed.⁹

Once quarantine was removed from the statute books non-contagionism was less exigent politically. Although it did not carry the same force it had at mid-century, non-contagionism was strongly linked to medical practice at the ports, the existence of quarantine, and its consequent economic and political implications. Despite advances being made in bacteriological theories of disease aetiology, non-contagionism remained within the rhetoric of port health as long as quarantine did, if not beyond.

The tension between 'foreign' and 'domestic' in preventing the importation of infectious diseases at the ports continued beyond the abolition of quarantine. The reception and treatment of 'exotic' and 'indigenous' disease continued to be differentiated in the powers of Medical Officers relating to the examination and detention of vessels. This was a remnant of the Quarantine Act, and while British Medical Officers attended to individual cases of both 'exotic' and 'indigenous' infectious disease ultimately with the same procedures, the distinction remained with regard to their authority over a vessel. However, the demarcation between 'exotic' and 'indigenous' disease gradually dwindled once dual authority was removed. This distinction was also less marked because a number of diseases became less endemic. Vaccination policies meant, for example, that diseases such as smallpox were more likely to occur only when imported. The same methods of medical inspection, isolation of the sick and sanitary control of the healthy could be applied to both 'exotic' and 'indigenous' disease. With the exception of some remaining powers extended by the Quarantine Act over vessels from ports infected with 'exotic' disease, very little remained to distinguish the two categories of infectious disease by the turn

of the century. Instead, the conflict between 'foreign' and 'domestic' was beginning to be transferred from a categorisation of disease, to a categorisation of person. The risk was not the imported disease but the person who imported it. 'Exotic' versus 'indigenous' disease was translated, after the abolition of quarantine and during the period of mass migration which had begun in the early 1880s, to 'exotic' versus 'indigenous' persons – or the immigrant versus the native population.

This transposition of the 'foreign' and 'domestic' from disease to the diseased was also, as in the case of the quarantine/sanitation debate, both internally and externally dependent. From 1892, particularly, migrants travelling to and across Britain were implicated as the primary source and spread of cholera. The focus upon migrants as detrimental to the livelihood of British workers, the conditions of the inner-cities and the health of the nation gradually gathered momentum until it became a significant political issue by the turn of the century. Members of the Conservative Party and anti-alien East-End lobby groups, who represented the views of an increasing proportion of the population which called for the restriction of immigration, pushed for legislation. The pressure primarily emanated from the East End of London, into which the majority of those migrants who remained in Britain settled, yet extended beyond the capital. The foremost issue upon which the movement was based was economic, although an element of the anti-alien debate focused upon the perceived and potential risk posed by migrants as importers of disease and as drains upon public and medical relief. While the medical, and certainly the economic, dissatisfactions were a response to a threat perceived in the localities into and through which the migrants moved, much of the concern pertained to foreign – namely American – attitudes to immigration. This was particularly the case with medical concerns relating to immigrants.

The United States immigration law of 1891 had direct repercussions for Britain since it strictly enforced the right to refuse entry on grounds of health. From 1892 America had demonstrated its position on hindering the entry of ill and infected immigrants by its enforcement of the twenty-day quarantine order. While this was not well received in Britain, more because of the extreme imposition of quarantine than its obvious nativism, it further highlighted the connection between port health and immigration.

⁹ H. Franklin Parsons, 'Half a Century of Sanitary Progress, and Its Results', *Transactions of the*

In the United States quarantine was increasingly becoming synonymous with immigration, yet it was argued that in a much less overt manner the British Port Sanitary system, particularly during the period of the Cholera Order, was similarly directed at hindering the entry of an undesirable class of immigrant. By refusing the disembarkation of immigrants who could not provide a 'verifiable' onward address, Britain, it was argued, was following a modified version of immigration restriction, and indeed quarantine.¹⁰ However, the most influential aspect of American legislation was the perception that those migrants who had been rejected from the United States on medical and economic grounds, were returned not to their European ports of origin but to British ports. The quantifiable evidence did not support the belief that large numbers of migrants rejected by the United States returned to Britain. Nevertheless, it had a disproportionate effect on British attitudes to immigration and was of great significance. This divergence between minimal numbers and great effect first came to public attention in the *Report to the Board of Trade on Alien Immigration* published in 1893 – the first full report since the American act had been passed. The report's author argued that the problem was minimal. On the other hand, the psychological impact of Britain being the 'dumping ground' of immigrants unwanted by the United States, meant that the issue continued to be used as a strong tool in the increasing anti-alien debate. It was argued that Britain was a 'soft touch', the vacuum into which the refuse of diseased and destitute migrants, unwanted by America, would flow.¹¹

The impact of American immigration policy also extended to what diseases British medical officers associated particularly with migrants. Although cholera was still a concern at the ports, as the 1905 outbreak demonstrated, diseases emphasised in American medical inspections were beginning to infiltrate the practice of British port health. Trachoma, which did not feature at all in the reports of Port Medical Officers in the nineteenth century or occupy much space in medical or public discussion, gradually became after 1897 central to the perceived public health risk posed by immigrants at the ports and in the slums. In the United States, where the volume of immigrants who arrived into inspection centres such as Ellis Island permitted only the most superficial medical examinations, trachoma was, as a highly visible, easily detectable, and disgusting disease, fundamental to the practice of medical exclusion of

Epidemiological Society, 1898-99, pp. 37-38.

¹⁰ *N.Y. Med. Jnl.*, 1892, vol. 56, p. 355.

¹¹ *Times*, Jan. 30, 1902, p. 5c.

immigrants. It was highly contagious and spread easily around the close living quarters of steerage accommodation. However, as the Medical Officers testified at the Royal Commission on Alien Immigration, it was not a disease which appeared among immigrants in any greater degree than any other people living under the same conditions. Nor was it a particularly overwhelming problem in Britain. It was almost entirely a concept of a disease which had been imported from the United States to Britain, and became a symbol of Britain's reception of immigrants rejected from America on medical grounds. As in America, trachoma also began to represent the idea of the immigrant as a threat to both the public health and the health of the body politic.¹² Medical experts questioned at the Royal Commission argued that it was an 'indigenous' infection, common among the overcrowded working classes of the urban slums, yet it was perceived as an imported disease through its connection with immigrants. What was important in this classification was not the disease itself but the people with which it was associated.

Medical exclusion of immigrants was included under the new law in order to intercept the introduction of this new kind of 'foreign' disease, despite the protestations of medical officers, and the two dissenting Commissioners from the recommendation of the Royal Commission. Exclusionary methods for the prevention of the 'exotic' diseases, yellow fever, and plague were brought to an end with the repeal of the Quarantine Act in 1896, but were in effect reintroduced for the prevention of diseases introduced by a foreign population. However, the fundamental difference between the exclusion of immigrants who were regarded as a potential health risk and the temporary exclusion of a vessel through quarantine, was that the detention of an immigrant vessel and exclusion of immigrants, were not disruptive to trade. This separation was clearly illustrated in the Act's definition of an immigrant vessel – a vessel which carried twenty or more steerage class immigrants; only these vessels were compulsorily detained and examined under the Act. These vessels were generally more likely to have been specifically passenger vessels. Lengthy inspections and carrier liability for passenger vessels was not a hindrance to the trading interests of a port. The Act ensured, through this clause, the free movement of trading vessels, which were unlikely to carry immigrants.

¹² Markel, 'The Eyes Have It', p. 549.

Port health was as much about the protection of the interests of maritime trade, enabling trading vessels, and their goods, to move quickly in and out of the ports, as it was about the protection of the native population from imported infectious disease, both 'exotic' and 'indigenous'. Within this context, the inclusion of medical restrictions on immigration, in an essentially economically based anti-alien movement, after half a century of anti-quarantinism, can be more readily understood. After a quarter of a century the Port Sanitary Authority triumphed in demonstrating that 'exotic' diseases such as cholera, could be incorporated into the same preventive methods employed for 'indigenous' disease. However, the type of 'foreign' disease imported by immigrants, could not be so easily incorporated. Without the additional imperative of protecting commerce, this category of disease did not need to be treated within existing systems of prevention, and it was possible to introduce medical exclusion of immigrants at the ports.

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