1. *Introduction*

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In an article on 'Cholera and Society in the Nineteenth Century', published in *Past and Present* in 1961, Asa Briggs issued a 'call for further research' into the social history of epidemics. It is a call which has not gone unanswered in the thirty years since the appearance of Briggs's article, and of the book by Louis Chevalier on which he drew.[1] There have been historical monographs, not only on cholera in different towns and countries,[2] but also notably on plague,[3] many of them very much in the Briggs–Chevalier tradition, showing how societies coped with, reacted to and interpreted short-term but intense epidemic crises. One aim of the Past and Present Conference of 1989, whose papers are printed in this volume, was hence to return to the subject and survey the development of the field.

There have, of course, been many other advances in the history of medicine and disease since 1961 which have helped to enrich the

[1] *Past and Present*, no. 19 (1961), pp. 76–96; L. Chevalier (ed.), *Le Choléra: la première épidémie du XIXe siècle* (La Roche-sur-Yon, 1958).

[2] For example, C. E. Rosenberg, *The Cholera Years. The United States in 1832, 1849 and 1866* (Chicago, 1962); R. E. McGrew, *Russia and the Cholera, 1823–1832* (Madison, 1965); R. J. Morris, *Cholera 1832. The Social Response to an Epidemic* (London, 1976); M. Durey, *The Return of the Plague. British Society and the Cholera, 1831–32* (Dublin, 1979); F. Delaporte, *Disease and Civilization. The Cholera in Paris, 1832* (Cambridge, Mass., 1986); R. J. Evans, *Death in Hamburg. Society and Politics in the Cholera Years, 1830–1910* (Oxford, 1987).

[3] For example, E. Carpentier, *Une ville devant la peste: Orvieto et la peste noire de 1348* (Paris, 1962); B. Bennassar, *Recherches sur les grandes épidémies dans le Nord de l'Espagne à la fin du XVI siècle: problèmes de documentation et de méthode* (Paris, 1969); C. M. Cipolla, *Cristofano and the Plague. A Study in the History of Public Health in the Age of Galileo* (London, 1973); M. W. Dols, *The Black Death in the Middle East* (Princeton, 1977); J. T. Alexander, *Bubonic Plague in Early Modern Russia. Public Health and Urban Disaster* (Baltimore, 1980); P. Slack, *The Impact of Plague in Tudor and Stuart England* (London, 1985); A. G. Carmichael, *Plague and the Poor in Renaissance Florence* (Cambridge, 1986).

study of major pestilences in the past. They have sprung partly from that broadening of the historian's agenda which has characterised research over the past thirty years, and from a recognition that several flourishing areas of historical inquiry – from the history of population to the history of material and mental culture – share a common interest in the subjects of health and disease. The social history of diseases which are not, or not always, the cause of short-term epidemic crises – diseases which can be endemic or chronic, such as syphilis and tuberculosis[4] – has been illuminated. There has been novel and fascinating work on disease 'exchanges' between different continents and on their implications for the history of whole populations and for ecological balances between men and their environment.[5] There has been a growth of new sub-disciplines – medical anthropology[6] and the social history of medicine[7] – which have contributed massively to our understanding of disease and health-care in different societies. In European and American historiography there has been much interest in instruments of medical and social control, from hospitals to medical ideologies, and in definitions of 'illness';[8] and in English historiography there has been a welcome focus on the standpoint of the sufferer, the patient.[9]

The chapters in this volume have naturally been influenced by these various new approaches to medical history. They illustrate in particular the value of case-studies drawn from outside as well as from within Europe, and they are sensitive to the importance of

[4] For example, A. M. Brandt, *No Magic Bullet. A Social History of Venereal Disease in the United States since 1880* (Oxford, 1987); L. Bryder, *Below the Magic Mountain. A Social History of Tuberculosis in Twentieth-Century Britain* (Oxford, 1988); F. B. Smith, *The Retreat of Tuberculosis 1850–1950* (London, 1988).

[5] W. H. McNeill, *Plagues and Peoples* (Oxford, 1977); A. W. Crosby, *The Columbian Exchange. Biological and Cultural Consequences of 1492* (Westport, Conn., 1972); A. W. Crosby, *Ecological Imperialism. The Biological Expansion of Europe 900–1900* (Cambridge, 1986).

[6] See, for example, G. M. Foster and B. G. Anderson, *Medical Anthropology* (New York, 1978).

[7] The new journal *Social History of Medicine* (Oxford, 1988–) contains and reflects the exciting work now being done in this area.

[8] Inspired by the work of Michel Foucault, beginning with *Folie et déraison: histoire de la folie à l'âge classique* (Paris, 1961) and *Naissance de la clinique* (Paris, 1963), and by Susan Sontag, *Illness as Metaphor* (London, 1977).

[9] See, for example, R. Porter (ed.), *Patients and Practitioners. Lay Perceptions of Medicine in Pre-Industrial Society* (Cambridge, 1985).

'perceptions' – the ways in which disease has been interpreted or 'constructed' in the past. All of the contributions focus, however, on major epidemic episodes. For epidemics are especially susceptible to comparative study because they are common to all continents and cultures; and they raise particularly broad issues in the history of ideas because they support, test, undermine or reshape religious, social and political as well as medical assumptions and attitudes. AIDS has been a recent reminder – in countries complacent about their success in banishing the major infections – of how wide the intellectual repercussions of epidemics can be.[10] The chapters in this volume show that they had a similar 'shock effect' in the past: conflicting with Islamic notions of a benevolent all-ordaining God in Conrad's Near East, challenging bourgeois optimism in Evans's nineteenth-century Europe, highlighting what was 'coercive or implausible' in the varied intellectual orthodoxies of Ranger's Africa.[11] Past epidemics continue to throw a peculiarly sharp light on the ideologies and mentalities of the societies they afflicted.

I

Even the most cursory perusal of the chapters which follow will show that the shocks of epidemics elicited very similar responses in very different historical and geographical contexts. So much so that Richard Evans wondered, half seriously, in the course of the conference whether there was not a common 'dramaturgy' to all epidemics. Were we simply learning that there was a fundamental and often repeated human response to such biological events, a familiar set of perhaps involuntary social reflexes? Was there anything more interesting to be discovered than that apparent truism?

Almost all epidemics were seen by contemporaries, for example, as being transmitted from person to person and as arising from particular, usually filthy, local conditions: notions of 'contagion' and 'miasma', of a more or less undefined kind, were combined. Again and again 'stench' lay at the root of disease.[12] Common social responses – and intellectual justifications for them – followed

[10] See below, p. 322–3, and the special number of *Social Research*, 'In Time of Plague', 40 (Autumn 1988).
[11] Below, pp. 86, 154, 173, 268.
[12] Below, pp. 34, 36, 112–13, 154, 171, 191–3. Cf. V. Nutton, 'The Seeds of Disease: An Explanation of Contagion and Infection from the Greeks to the Renaissance', *Medical History*, 27 (1983), p. 19.

from these assumptions. Flight from an infected place was usual, and had to be defended (or attacked) since it took people away from charitable, neighbourly or political duties.[13] Carriers of disease were identified and scapegoats stigmatised: foreigners most often, as in Renaissance Italy and modern Hawaii, since epidemic disease came from outside, but also inferiors, carriers of pollution of several kinds, among whom disease had its local roots – untouchables in India and ex-slaves in Africa, for example, or Jews at the time of the Black Death (though less commonly in Europe in later outbreaks of plague).[14] For their part, the inferiors themselves thought epidemics the consequence of plots by external enemies, or governors and elites, to 'poison' the poor.[15]

If social prejudices became polarised under the stress of an epidemic, so too did attitudes toward religion. From the plague of Athens onwards, people either sought solace in religious practices or fled from Gods which had failed them to what Pullan calls 'a kind of antinomianism'.[16] The forms of religious satisfaction also repeated themselves. At one extreme was the view that God sent plague as a punishment or a martyrdom which could not be resisted, an attitude which went hand in hand with a popular fatalism in the face of disaster. At the other pole were collective ritual practices – from Merovingian and Renaissance processions to participation in ecstatic or prophetic cults in Athens and Africa – which held out the promise of effective action, even if (in gathering people together) such rites conflicted with other assumptions about the kinds of defence responses which epidemics called for.[17]

In other words, epidemics like other afflictions and disasters present and presented common dilemmas, arising from the need to explain and combat them; and the answers repeat themselves in

[13] Slack, *Impact of Plague*, pp. 41–4. See also below, p. 94.
[14] Below, pp. 113, 189, 235, 259; comments by Richard Palmer and Brian Pullan at the conference.
[15] Below, pp. 22, 116–17, 163, 224.
[16] Below, pp. 44, 121, 252.
[17] Below, pp. 77–99 *passim*, 109, 37, 241–68 *passim*; I. N. Wood, 'Early Merovingian Devotion in Town and Country', in D. Baker (ed.), *The Church in Town and Countryside*, Studies in Church History XVI (Oxford, 1979), p. 66. For processions as sources of controversy, see below p. 105; R. Palmer, 'The Church, Leprosy and Plague in Medieval and Early Modern Europe', in W. J. Sheils (ed.), *The Church and Healing*, Studies in Church History, XIX (Oxford, 1982), pp. 98–9; C. M. Cipolla, *Faith, Reason and the Plague in Seventeenth-Century Tuscany* (Ithaca, 1979), pp. 55–6; C. M. Cipolla, *Public Health and the Medical Profession in the Renaissance* (Cambridge, 1976), pp. 36–7.

history. Nevertheless, as the various forms of religious ritual indicate, intellectual and social responses assumed a different shape in different social, cultural and political contexts. Conrad shows that early medieval Islamic discussions of plague were to a large degree separate from the historical reality of the disease, which had indeed (if only temporarily) disappeared by the time many of them were written. They were 'part of a greater overarching discourse in which epidemic disease itself was not necessarily the issue of primary concern'. The same might be said about Christian discussions of identical problems of divine justice and social obligation, though they took a subtly different form.[18] Chandavarkar and Vaughan find British responses to epidemics reflecting deep-seated colonial anxieties about India and Africa, just as Crosby and Vaughan again demonstrate the importance of missionary perceptions of indigenous cultures and moralities. As Berridge says, epidemics are interpreted according to 'pre-existing agendas' of questions which arouse anxiety and debate.[19]

II

Reactions to epidemics also took different forms according to the nature of the disease involved, a topic which deserves more detailed consideration than there is space for in this volume. One significant variable is the novelty, or alternatively the familiarity, of the disease. The intellectual challenges posed by epidemics were greatest when they plainly came fresh and new from outside, like plague in fourteenth-century Europe, many of Ranger's epidemics in Africa, or AIDS in the modern West.[20] Endemic infections or persistent chronic diseases like Horden's malaria or some of Pickstone's fevers presented different problems. Some epidemic diseases, of course, change from one to the other, like syphilis and smallpox in many societies, and AIDS arguably in our own, so that the definition of an 'epidemic' may often be problematic.[21]

[18] Below, p. 81. Cf. Slack, *Impact of Plague*, pp. 36–41.
[19] Below, pp. 211, 273, 299, 182, 315. For colonial attitudes, see also D. Arnold, 'Cholera and Colonialism in British India', *Past and Present*, no. 113 (1986), pp. 118–51, and the interesting studies in D. Arnold (ed.), *Imperial Medicine and Indigenous Societies* (Manchester, 1988).
[20] Below, pp. 250, 323. Cf. p. 150–1.
[21] Cf. C. E. Rosenberg, 'What Is an Epidemic? AIDS in Historical Perspective', *Daedalus*, 118, no. 2 (1989), pp. 1–17.

A second variable is the violence of the epidemic, which can be measured in a number of ways. Total mortality and morbidity are obviously relevant. There is a distinction between epidemics of plague in European cities which often killed more than 20 per cent of populations, and those of cholera which rarely killed half that proportion.[22] We usually know less than we would like about morbidity, however, and the violence of reactions does not always follow the violence of death or sickness in any neat relationship: extreme crises may inhibit all but fatalistic responses. The intensity of an epidemic depends also on its time-scale, whether it lasts days, months or years, plague again being exceptional in late medieval and early modern Europe in the total number of casualties recorded in two or three months.

Thirdly, we need to know something about the geographical and social incidence of the epidemic in question. Agreed communal responses may be easier to find if diseases are universal, or at least random, than if they are socially selective or concentrated, as they commonly are, in towns, suburbs or slums. Socially selective afflictions, on the other hand, allow authorities to distance themselves from the phenomenon – with the result that they either pay little heed to them, as in Chandavarkar's Bombay once plague was demonstrably a disease of the poor by 1902,[23] or define them as 'problems' and identify 'targets' for attack. Most productive of all for government responses seem to be epidemics with a definable local incidence but which nevertheless – being infectious – pose a perceived threat of breaking out of their bounds and striking the elite. This was the case with plague in European cities in the early modern period, and with cholera in the nineteenth century.[24]

Finally, in order to have a rounded picture of the dimensions of an epidemic, we need to set it in its 'disease-environment', to relate it to the 'background levels' of mortality and morbidity. It is important to recognise also that patterns of mortality and morbidity may vary in different ways and not necessarily move in the same direction over time. In early modern Europe, before the stabilisation of mortality in the eighteenth century, violent epidemics and acute infections may

[22] Below, pp. 111, 170–2. Cf. Slack, *Impact of Plague*, pp. 5, 174, 308.
[23] Below, p. 209. See Slack, *Impact of Plague*, p. 240, for hints of a similar reaction to plague in Tudor London.
[24] Slack, *Impact of Plague*, pp. 192–5; A. G. Carmichael, 'Plague Legislation in the Italian Renaissance', *Bulletin of the History of Medicine*, 57 (1983), pp. 519–25; below, pp. 110–11, 157.

have gone hand in hand with – and to some extent have been responsible for – low levels of morbidity for the survivors.[25] Where background morbidity is high, on the other hand, as in colonial Africa, concentration on epidemics by contemporaries or historians may have diverted attention from chronic diseases and more important problems of background health.[26]

A stimulating article by Mary Dobson has recently shown how complex the variations in disease-patterns in different parts of the world can be, and how they can be changed by movements of infection between them. In colonial New England low background mortality combined with infrequent but intense epidemics may have contributed to a peculiar fear of death. On the other hand, the disease 'jungles' created elsewhere by Professor Crosby's 'Columbian exchange' may have led to a greater tolerance of sickness and death, as well as to the initial cultural shocks for which Crosby argues in the case of Hawaii in this volume.[27] We need to pay attention also to the ways in which different kinds of crisis as well as different diseases reinforce one another. From the plague of Athens to the epidemics of nineteenth-century Europe and Africa, war and famine have aggravated and helped spread disease, and contributed to social and ecological crises.[28]

In general the studies in this volume and other work suggest that the most radical responses may be expected to follow epidemics which are novel, violent and intense, random (at least as initially perceived), and associated with other social disturbances. A developed reaction, such as a public health 'campaign', however, depends on familiarity, though not too much familiarity. If a violent epidemic occurs only once, it produces a single shock which may quickly be forgotten: the devastating influenza epidemics of 1557–9 in England and 1918 in the USA and elsewhere are nicely comparable examples.[29] On the other hand, familiarity may breed contempt. In some relatively closed societies illnesses such as yaws or

[25] J. C. Riley, *Sickness, Recovery and Death. A History and Forecast of Ill Health* (London, 1989), p. 156 and *passim*.
[26] A point made by Paul Weindling at the conference.
[27] M. J. Dobson, 'Mortality Gradients and Disease Exchanges: Comparisons from Old England and Colonial America', *Social History of Medicine*, 2 (1989), pp. 291–2; below, pp. 175–201, *passim*.
[28] Below, pp. 26, 161, 245, 254.
[29] Slack, *Impact of Plague*, pp. 308–9; A. W. Crosby, *America's Forgotten Pandemic. The Influenza of 1918* (Cambridge, 1989), ch. 15.

malaria may be so common as scarcely to be classed as illnesses at all. Some comparison with healthier regimes or periods is needed for the identification of disease. In early modern Japan, for example, there was a much more 'cataclysmic' view of measles, which invaded in major epidemic waves, than of smallpox, which was so common that it held few terrors.[30] Developing responses over time seem to require, besides familiarity, the maintenance of tension, such as is achieved by intense, repeated, but infrequent epidemics, with a definable but not immutable selective incidence.

III

It is possible, therefore, to build up profiles of different epidemic episodes, by recognising what Charles Rosenberg has called 'the individuality of disease entities',[31] and relating them to the environments in which they flourish; and one may go on from there to look at likely intellectual responses. So superficial a feature as the symptoms of an infection may have profound social and intellectual effects: the physical horrors of plague, syphilis and cholera account in large part for the revulsion which has given them a leading place in the history of epidemics (in contrast to influenza, for example). Different diseases exist, and different micro-organisms affect their human hosts and human society in different ways. Yet epidemics are also themselves intellectual 'constructs' which, once formulated, have a history, vitality and resilience of their own. One of the chief lessons of the studies which follow is the extent to which man-made images of pestilence have shaped responses to it, whether or not they have been what we would regard as 'accurate' or 'rational' depictions of the phenomenon. The persistence of these representations is not the least consequence of that familiarity with particular epidemics which has just been referred to.

The ways in which Dark-Age dragons 'embody' rather than symbolise disease, in Horden's striking phrase, is one example, and

[30] E. H. Ackerknecht, *Medicine and Ethnology* (Baltimore, 1971), p. 141; A. B. Jannetta, *Epidemics and Mortality in Early Modern Japan* (Princeton, 1987), pp. 105, 125, 134.

[31] C. E. Rosenberg, 'Cholera in Nineteenth-Century Europe', *Comparative Studies in Society and History*, 8 (1966), p. 453, quoted in Arnold, 'Cholera and Colonialism', p. 119.

the same might be said about demons and devils in other contexts.[32] But 'plague' itself is a particularly telling case. Chandavarkar notes that bubonic plague was far from being the worst infectious disease in Bombay, though it produced the greatest scare, and the same phenomenon has been noticed in western Europe and elsewhere. Bubonic plague certainly had its own peculiar terrors; but much of the fear of it may be attributed to the wider associations of the term 'plague', as well as to collective memories of the history of the particular disease – so that the French in the 1890s were afraid of riots in Marseilles where the great crisis of the 1720s could still be recalled.[33]

Past histories may indeed shape present perceptions, as Berridge suggests in the case of AIDS. It is notable how Thucydides's description of the plague of Athens, with which this book opens, produced echoes again and again in literary depictions of later epidemics, some of whose authors may have had access to the Greek historian or to writers who borrowed from him, from Lucretius onwards.[34] Hence, one can never be entirely sure about the extent to which chroniclers of epidemics concentrated on social dislocation, the failure of doctors, flights to and from religion, rumours of poisoned wells, and similar phenomena simply because Thucydides and later writers down to Defoe taught them to look for them. It is a possibility which historians need at least to be aware of. Longrigg shows below how Thucydides's own account of plague was a carefully crafted narrative, consistent with his wider view of history and his vision of the disintegration of Greek society; and Giulia Calvi has similarly argued that official chronicles of the Florentine

[32] Below, p. 71. Cf. Jannetta, *Epidemics in Early Modern Japan*, p. 134; R. Crawfurd, *Plague and Pestilence in Literature and Art* (Oxford, 1914), p. 3.

[33] Below, pp. 202, 207 (France); Palmer, 'The Church, Leprosy and Plague', p. 79; N. G. Owen (ed.), *Death and Disease in South-East Asia. Explorations in Social, Medical and Demographic History* (Oxford, 1987), pp. 211, 235 (comparing plague and influenza in Java). For controversy over quarantine in Marseilles in 1851 because of memories of 1720, see Delaporte, *Disease and Civilization*, p. 191.

[34] Below, pp. 327, 22–7; Crawfurd, *Plague in Literature and Art*, p. 71; G. Deaux, *The Black Death 1347* (London, 1969), pp. 20, 46, 87; Dols, *Black Death in the Middle East*, pp. 14, 53, 297; Carmichael, *Plague and the Poor*, p. 154 n. 16; and for English references, W. Boghurst, *Loimographia ... 1665*, ed. J. F. Payne (London, 1894), p. 5; W. G. Bell, *The Great Plague in London in 1665* (London, 1951), p. 299. The first English translation of Thucydides was Bishop Sprat's, *The Plague of Athens* (1667). Cf. D. Defoe, *A Journal of the Plague Year*, ed. L. Landa (Oxford, 1969), p. xxxix.

plague of 1630 are discourses shaped by analogies between the city's history and 'the inevitable trajectory of the illness'.[35]

The 'pox' has similar reverberations down the centuries, and presents similar intellectual boundaries and barriers to understanding, even when redefined as a 'venereal' or 'sexually transmitted disease'. Vaughan shows that British observers of syphilis in Uganda were encumbered by the baggage of inherited assumptions about moral disintegration and dangerous female sexuality to the extent that they at first ignored the evidence that the disease was present in an endemic, non-venereally transmitted form. As she says, AIDS has been 'socially constructed' in much the same way.[36]

In short, one of the purposes of this symposium is to show that the interaction between epidemics and ideas does not proceed only in one direction – from biological challenge to intellectual response. It is much more complicated, and interesting, than that. David Arnold writes of cholera that

> Like any other disease, [it] has in itself no meaning: it is only a micro-organism. It acquires meaning and significance from its human context, from the ways in which it infiltrates the lives of the people, from the reactions it provokes, and from the manner in which it gives expression to cultural and political values.[37]

IV

A second purpose of this collection is to illustrate how Arnold's cultural and political values, the interpretations and images attributed to epidemics, have varied from context to context and how they have changed over time. Early historical accounts of 'The Conquest of Epidemic Disease' generally saw change over time as a Whiggish progress in which popular superstitions and folklore were replaced, first, by government regulation in the interests of public health, more or less informed by the theories of doctors, and then by

[35] G. Calvi, 'A Metaphor for Social Exchange: The Florentine Plague of 1630', *Representations*, 13 (Winter 1986), pp. 139–40. For an extension of this approach, see the same author's *Histories of a Plague Year. The Social and the Imaginary in Baroque Florence* (Berkeley, 1989); and also J. S. Amelang (ed.), *A Journal of the Plague Year. The Diary of the Barcelona Tanner, Miquel Parets, 1651* (New York, 1991).

[36] Below, pp. 278, 281, 299. Cf. C. Quétel, *History of Syphilis* (Oxford, 1990); S. L. Gilman, *Disease and Representation* (Ithaca, 1988), ch. 14.

[37] Arnold, 'Cholera and Colonialism', p. 151.