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Cholera and Venereal Disease

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The nineteenth century saw the rapid development of towns and cities in Britain. Higher population density without adequate amenities led to increasing squalor and deteriorations in health. Issues of public health were therefore very important in this period, and cholera and venereal disease highlight differing aspects of policy and debates at this time.

Cholera is often seen as the characteristic nineteenth-century disease. It was a powerful challenge to existing beliefs and structures and was 'a shock disease' (Morris, 1976). Asiatic cholera is caused by the *Vibrio cholerae*, which is spread by contaminated water and food. Once ingested, the bacillus can multiply quickly, causing 'devastating and unstoppable' (Dobson, 2007) diarrhoea, rapid dehydration and a shrunken 'corpse-like' (Barnard, 1990) appearance. Death often ensued, with an average case fatality rate of 40-60%. The disease could progress with terrifying rapidity; with individuals dying hours after the first symptoms were observed. However, the more usual progress of the disease was death after several days of symptoms. The fact the disease could strike quickly, seemingly at random and possibly in public, combined with the nature of the symptoms, acted to give cholera a social terror as well as the terror of the disease itself.

Cholera originated in India, but was of limited geographical range before 1817 when it spread throughout Asia. Nevertheless, it took until the 1820s for the disease to reach Western Europe, arriving in England in late 1831. Other epidemics followed in 1848-49, 1853-54 and 1866. Britain largely escaped outbreaks after this date, with only limited numbers of

cases localised around seaports. Compared with other diseases such as tuberculosis, cholera death tolls seem relatively low: 32,000 in 1831-32, 53,000 in 1848-49, 23,000 in 1853-54, and 14,000 in 1866.

The history of cholera has focussed on John Snow and Robert Koch as the heroes of disease prevention. In reality the story was more complicated. When cholera appeared in Europe, various theories of causation were put forward, with great confusion over which was most accurate. The most common theories concentrated on whether cholera was contagious or caused by local environmental conditions. Breakthroughs came later in the century. John Snow's 1853 experiment with the Broad Street Pump (limiting spread of the disease by preventing access to the affected water supply), so symbolic in retrospect, did not cause a revolution in ideas about cholera, largely because he could not identify the causal agent at work. Pacini had identified the cholera bacillus in 1854, but this went unrecognised until repeated by Koch in 1883. The debates about the cause of cholera continued during the 1860s and 1870s. Koch's discovery of the cholera bacillus in 1883 significantly bolstered germ theory. Nevertheless, this did not halt debates on the causation of cholera, as some people remained sceptical about whether this fully explained its transmission.

The treatments offered for cholera were within existing medical practices. These included bleeding, purges, patent medicines, and alcohol and opium. All of these were ineffective, although lengthy arguments about their efficacy accompanied all cholera outbreaks. Potentially effective saline fluids treatments were

experimented with from the 1830s onwards with mixed results, but these were not generally accepted throughout the nineteenth century. There were no effective treatments for cholera in this period. Thus, although developments in medical knowledge aided understanding of the nature of cholera, they did not completely resolve debates about the disease.

Attempts to halt the progress of cholera were varied. Different European regimes attempted various preventative measures, from a contagionist emphasis on quarantine to a sanitarian emphasis on cleaning up filth. The problems of preventing the spread of cholera in Britain became more pressing with the arrival of the disease in Sunderland in 1831. After initial attempts to enforce quarantine, policy shifted to smaller goals, with isolation of patients, disinfection of infected areas and attempts to clean up nuisances. Local areas were empowered to set up Boards of Health to manage these goals, leading to diversity in efforts.

The 1848 outbreak had more influence over public health policy, overshadowing the 1848 Public Health Act and helping to promote a longer-lasting commitment to reform. Subsequent outbreaks helped to further the public health agenda, although they were not the only driving force behind reform. By 1870, a neo-quarantinist system based on strict supervision of ports, and notification, isolation and disinfection of infected vessels had been developed. This was paralleled by improvements in the water supply, sewerage and general cleanliness of towns. This two-pronged approach was arguably very important in halting the progress of cholera and was generally

beneficial to health, so that despite the continuation of cholera pandemics in the later nineteenth century, Britain remained clear of major outbreaks. Through preventative measures, Britain was actually able to free itself of cholera before the cholera bacillus was properly identified.

The public reaction to cholera is also important. Unsurprisingly, there was fear and apprehension about the disease, and shock and grief about the resulting suffering and deaths. However, in 1831-32 there were numerous riots both in stricken and unaffected areas. These incidences of civil disorder, over thirty in total, were frequently linked to the activities of medical practitioners. The removal and isolation of patients did little to improve survival rates, and the rapid burial of the victims prevented normal burial customs taking place. Earlier scandals surrounding body snatching, and the 1832 Anatomy Act led many to be suspicious. Medical treatment could thus provoke riots. Nevertheless, after the first outbreak there were relatively few disturbances. Cholera retained its shock value throughout the nineteenth century but was never again the focus of violent public reaction.

The impact of cholera on nineteenth-century society was significant, varied and patchy. Initially a source of civil disturbances, later outbreaks provoked more muted reactions. Similarly, although the 1848 outbreak helped the passage of the 1848 Public Health Act, and the fear of cholera provoked intensifications in policy in the rest of the century, cholera did not have a major impact on the development of public health legislation, or on medical developments. Nevertheless, the

shocking nature of the disease gave it symbolism and interest, even when its impact was otherwise small.

Venereal disease (VD) posed a very different challenge for Victorian society than cholera. The term "venereal disease" refers to a range of different infections, both bacterial and viral, which are primarily spread by sexual contact. However, in the context of Victorian literature, VD usually meant syphilis and gonorrhoea. Syphilis had been active in European populations from at least the fifteenth century, and from ancient times in the case of gonorrhoea. As with cholera, the diseases and the social response to them highlighted various aspects of Victorian attitudes to health and morality.

Syphilis and gonorrhoea are bacterial infections, usually transmitted by sexual contact with an infected person, although they can also be passed via other means. The diseases have distinct patterns of symptoms. Syphilis causes a complex range of symptoms, grouped into primary, secondary and tertiary stages. These include skin lesions, fever, bone aches, infertility and in advanced cases of the disease, progressive destruction of the body's skin, mucous membranes, bones and internal organs. There can be prolonged asymptomatic periods between stages of the disease, and not all cases progress to the tertiary stage. Gonorrhoea is frequently asymptomatic or causes minor symptoms. However, it can cause sterility in women, and can spread to the bloodstream causing skin lesions and arthritis. The symptoms of the two diseases, although different, have enough similarities that they can be confused with one another and with other diseases. Although from the early nineteenth century they were acknowledged to be separate

diseases, this was not confirmed until later in the century, and diagnosis remained problematic. The gonorrhoea bacterium was described by Albert Neisser in 1879, and the syphilis bacterium identified in 1905 by Fritz Schaudinn and Erich Hoffmann. No effective treatments for either disease were available in the nineteenth century, and although there was some emphasis on the development of new remedies such as arsenic, therapeutics tended to remain centred around traditional approaches of mercury, purgatives and lifestyle advice. The periods of remission, common in cases of syphilis, and the frequently asymptomatic nature of gonorrhoea meant that it was unclear whether patients had been cured.

Attempting to estimate levels of VD amongst the population is extremely problematic. The socially sensitive nature of the diseases meant that they were never included within policies of compulsory notification (with the exception of ophthalmia neonatorum, an eye disease of infants born to gonorrhoea-infected mothers, which was made notifiable in 1916.) There are no reliable estimates of the incidence of VD for the first half of the nineteenth century. However, there are some estimates of the prevalence of VD among members of the armed forces from the 1860s onwards. In 1863, one-third of the cases of sickness in the army were attributed to VD. The figure was one in eleven in the navy. Civilian estimates vary: Smith (1990) claims that rates of gonorrhoea fell from 951 per million in 1871 to 809 in 1891. John Simon's contemporary estimates show a 7% prevalence rate among the population at large, with later estimates claiming 10% of the urban adult population were infected. Nevertheless, the taboo nature of venereal

diseases, the enigmatic symptoms and the difficulty of making a conclusive diagnosis mean that reliable prevalence levels in Victorian society are difficult to ascertain

Official policies for the prevention of venereal disease in Victorian Britain initially took the form of coercion. Baldwin claimed that this ended in England after the repeal of the Contagious Diseases Acts, in 1886. Nevertheless, short term compulsory or coercive measures which dealt with particular "at risk" groups remained throughout the late nineteenth century. The Contagious Diseases Acts of 1864, 1866 and 1869 established a system of surveillance of prostitutes working in garrison towns, and subjected them to inspection and treatment. Rising levels of venereal disease among the army and navy had become a cause for concern in the 1850s and 1860s, and the events of the Crimean War had increasingly cast a spotlight on the health of the army in general. Given the high rate of sickness in the armed forces in 1864 attributed to venereal disease it was vital to control this cause of incapacity. The Acts aimed to reduce the incidence of VD among the main sexual "resource" available to military men, namely prostitutes. The main policy of prevention of venereal disease therefore focused on the "classic" locus of infection, illicit sexual encounters.

The system attracted increasing levels of opposition throughout the 1870s and 1880s, eventually leading to the suspension of the Acts in 1883, and their repeal in 1886. A coalition of pressure groups opposed the Acts, objecting to the "double standard" of inspecting only women, and to the apparent legalization of prostitution,

but also claiming that a generalized return to higher standards of morality for men as well as women was the key to preventing venereal disease. This fed into the later "social purity" movement, which attempted to suppress prostitution amongst other "social ills" such as fornication. Nevertheless, other policies targeted wider groups within society. Medical inspection remained a sporadic policy in the armed forces in this period. Private medical practitioners often attempted to convince their VD-infected patients to submit to treatment to avoid infecting their spouses or future children, and hospitals identified children with congenital syphilis. In this way, official policy against venereal disease concentrated on particular groups. Campaigns concentrated on prevention and emphasized the importance of sexual continence and morality in the avoidance of venereal disease. In order to be completely successful this approach had to be adopted permanently by both partners.

As with cholera, venereal disease had a significant effect on Victorian society, but in different ways. VD was a familiar problem, with an established range of remedies and ideas which were supplemented during this period. However, the nineteenth century saw increasingly directed attempts to control the disease by targeting particular high risk or "vulnerable" groups, and the resulting campaigns against these measures, leading to the eventual focus on mostly voluntary measures. In this way, attempts to control VD can be seen as part of wider attempts to improve health, and as narratives of social control. Both cholera and VD therefore demonstrate the problems Victorian society faced when dealing with incurable diseases.

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