Until fairly recently, historians and the public alike believed that leprosy-affected people in medieval Europe were uniformly excluded and stigmatised.¹ This chapter explains how these notions of medieval leprosy were invented for the modern world, and why leprosy’s medieval past became a matter of interest and relevance for nineteenth-century Europeans. While scholarship on leprosy in the nineteenth and twentieth centuries has flourished, scant attention has been paid to connections between medieval and modern leprosy, or to the early histories of medieval leprosy that have so influenced popular and historical understandings of stigmatising societal responses to leprosy in medieval Europe.² Yet in the nineteenth and early twentieth century, leprosy’s medieval past was a source of inspiration for, and a counterpoint to, contemporary approaches to leprosy and its management.

This chapter investigates the exploration and relevance of leprosy’s medieval European past through three avenues: medicine, empire and philanthropy. To medical professionals in the early 1850s, medieval medical writers were considered colleagues who had experience in dealing with the same disease. Medieval leprosy in Europe then became an object of interest in and of itself, with nineteenth-century medical practitioners mapping the rise and fall of the disease in the Middle Ages, as well as gathering facts about responses from medieval society, and practices of care and regulation within individual medieval European leprosaria. Since the disease had apparently disappeared from medieval Europe,³ finding the reasons why was seen as key to figuring out how to act in the present global situation. Some nineteenth-century practitioners
connected the disease with backwardness. They argued that leprosy ultimately disappeared from medieval Europe because of increased civilisation, and used this case to justify colonisation in their present time. Others pointed to medieval segregation of people with leprosy, and argued that similar measures must be reiterated in the modern world.

By the 1890s, however, the relevance of medieval leprosy had come under attack. The medieval sources could be interpreted to support a wide range of disease models, and increasingly physicians started to question the accuracy of medieval diagnosis and whether claims about the number of leprosy sufferers at this time were inflated. The advent of bacteriology spread further doubts about the actual incidence, and relevance, of medieval leprosy. The medieval physicians had not had access to microscopes or other modern equipment for diagnosis. As the use of bacteriological tests as the ultimate standard for making a diagnosis increased from the turn of the twentieth century, this argument only strengthened. With medieval records increasingly surrounded by doubts, new, current evidence about leprosy was deemed more accurate, in particular national patient records and what these revealed about how the numbers of people with leprosy changed over time.

As medical interest in medieval leprosy declined, popular interest in leprosy rose with the ‘leper scare’ of 1889, occasioned by the death of a Belgian missionary afflicted with leprosy in Hawaii: Father Damien. Re-encounters with leprosy in the tropical empire, and the death of a famous European with leprosy, led to fears of leprosy’s return to European soil. These anxieties, as well as a desire to distance ‘civilised’ Europe from its ‘backward’ colonies, and therefore also from Europe’s medieval, diseased past, led to the denigration of medieval Europeans, whose backwardness was deemed responsible for leprosy, and whose gradual civilisation was believed to have led to its decline. This supposed trajectory, from ‘primitive’ to ‘civilised’, provided an ideal justification for segregating leprosy patients in in-patient settlements, in order to guide them through a similar ‘civilising’ process. Though impractical, leprosy settlements were the standard European policy for managing leprosy in the colonial world until the 1950s.

Yet leprosy’s perceived medieval past was not only a source of fear, alienation and a desire to control: it also served as inspiration
for philanthropy towards those supposedly suffering from leprosy. Philanthropists consciously drew on biblical and medieval stories of love and charity towards people affected by the illness to guide their own actions. Drawing on journals, newspapers, medical texts, popular texts and mission archives from across Europe, with a particular emphasis on British sources, this chapter argues that nineteenth- and twentieth-century Europeans both looked towards and reinvented their medieval past to understand how leprosy was spread and controlled, to justify medical policies, to support their identity as ‘civilised’ European colonisers and to serve as inspiration for charity towards leprosy-affected people.

Medical perspectives on medieval leprosy

The first nineteenth-century medical monograph that saw medieval leprosy as directly relevant to contemporary encounters with the disease was Om spedalskhed (On Leprosy) from 1847, written by the Norwegian physicians Daniel Danielssen and Carl Wilhelm Boeck. In 1855, the work won the Prix Monthyen from the Academy of Sciences in Paris for clearly separating leprosy from other afflictions of the skin, and according to the famous German pathologist Rudolf Virchow, the monograph ‘laid the foundation for modern leprology’. The accompanying coloured atlas by artist Johan Ludvig Losting ensured that the work remained a reference for clinical diagnosis for half a century. The first part, written by Boeck, opened with a chronological list of literature on leprosy, starting with the Bible and Hippocrates, followed by almost forty references to medical texts written in the medieval period. At first glance, the goal was simply to be comprehensive and authoritative, through listing references to as many known works on leprosy as possible. A closer reading suggests that the references to medieval leprosy served at least three further functions. First, they showed that the disease, which at the time affected some 2,800 individuals in Norway, had a long and continuous presence in human history. In Norway, the Viking laws that pre-dated Christianity exempted likthraa-Mænd (leprosy sufferers) from military service. Second, medieval scholars were treated as former colleagues with relevant expertise, particularly when it came to remedies and treatments.
In other words, there was knowledge to build on in the search for a cure. Third, the medieval works on leprosy showed the hopes and pitfalls in how past societies had dealt with those affected by the disease: leprosy had been widespread in medieval Europe, most experts had believed it was contagious, and segregation in specialised institutions known as leprosaria had been the norm. This latter point held an important lesson for the present: the example of medieval leprosy showed that through active measures the disease had disappeared previously from much of Europe and, therefore, that it could be eliminated again.

Indeed, Boeck wrote: ‘Most of Europe has in an earlier period been terribly affected by the disease, but managed through severe precautions to rid itself of it. Now we are faced with the same disease as other countries in medieval times, and need to choose a similar path if we want to avoid the populations in certain areas perishing from the disease.’ However, the message did not come without a warning: the cost to those affected had been vast and unnecessary. According to Boeck’s presentation of medieval leprosy, ‘lepers’ had been forced to live outside the city gates and could only enter town on special days; they had to wear distinctive clothing and shake a ‘leper clapper’ to warn others of their presence; they were excluded from church services, considered ‘dead among the living’ and lost their legal status; and some were even burned, or buried alive.

The ‘cruel and inhumane’ policies in medieval Europe all boiled down to a mistaken belief that leprosy was contagious. To Danielssen and Boeck, leprosy was a ‘family disease’ (of 213 cases they had examined in Norway, 189 were considered due to heredity, while only 24 had appeared spontaneously), and the disappearance of the disease had merely been a side effect of discouraging those affected from spreading it through having offspring. Probably, Boeck’s selective reading of medieval texts, highlighting the cruelty of how people with the disease were treated by medieval society, was aimed at ensuring that the message struck home: society should react, but treating people affected by leprosy as contagious inadvertently led to inhumane and cruel treatment. The index even had its own entry on ‘The cruel persecution that they [leprosy sufferers] were exposed to’.

The book also discussed the specialised houses that had been erected for those suffering from the disease: ‘Misellaria, Mezelleries,
Ladreries, Maladreries, Lazaretti, Aussatshäuser, Malanterie, Leper-Hospitals, leprosarier'. In the centuries following the establishment of a leprosarium in Charolais, France, in 571 CE, the number of such institutions in Europe grew rapidly. Around 1250, Matthew Paris estimated that there were 19,000 leprosaria in the Christian world, 2,000 of them in France. Stressing that the numbers should be taken with a big grain of salt, Boeck nonetheless argued that leprosy had been relatively widespread.

Danielssen and Boeck’s publication, with its references to medieval leprosy, had direct political implications. In Norway, which was highlighted at the First International Leprosy Conference in Berlin in 1897 as the only country that had succeeded in getting a modern leprosy epidemic under control, the State built a research hospital for Danielssen in Bergen, charged with finding a cure (Lungegaardshospitalet). In 1850, based on the premise that the disease was hereditary, it was suggested that leprosy sufferers and their families should be denied the right to get married, but this failed after protests from the Church. In 1856, Norway instead established a national patient registry and three institutions to provide ‘good homes’ for those affected by the disease. The rationale was partly to alleviate the expenses for municipalities with high prevalence, and partly to ensure that those affected did not need to depend upon having children to take care of them when they were old, thereby breaking the hereditary taint.

Elsewhere, the reception of Danielssen and Boeck was radically different. In Iceland, where leprosy was also prevalent in the nineteenth century, all four leprosaria were abolished in 1848, with reference to new science that now showed the disease not to be contagious. In the British Empire, after reports that leprosy had been encountered in the colonies and amid worries that it might be contagious, the Colonial Office issued a Report on Leprosy (1867), which concluded that leprosy was ‘essentially a constitutional disorder’, best tackled by improving the health, diet and living conditions of indigenous populations. The disease posed no risk to European colonialism and, referring to Danielssen and Boeck, the report concluded that ‘any laws affecting the personal liberty of lepers ought to be repealed, [and] any action of the Executive Authority not enjoined by the law, ought to cease’.
Rudolf Virchow visited Danielssen in 1859, after being invited to evaluate the Norwegian leprosy campaign, and returned to Berlin with a firm belief that there were too many unknowns about medieval leprosy in central Europe. Inspired both by what he had seen in Norway, and by the Scottish physician James Young Simpson’s archival work on leprosy in medieval England and Scotland published in 1841–42, Virchow initiated a collaborative project on the history of medieval leprosy on the European Continent. He asked the readers of his medical journal for help gathering information on the following questions: what leprosaria existed, when they were erected, how many patients they admitted, what the conditions and rules for admission were, what forms of the disease were observed, and what causes were thought to be responsible. The questions were reprinted in several medical journals, and resulted in responses that were compiled into four lengthy articles based on replies from physicians and historians in Holland, Portugal, Russia, Finland, Greece, Switzerland and Germany. However, as Philip Kalisch has pointed out, while the resulting papers had extensive citations from original documents, showing a wide variety of responses ranging from religious rituals for the ‘living dead’ to the elaboration of rules and regulations regarding leprosy, there were no attempts at overarching syntheses of the material collected.

The general picture remained that leprosy had been present in Europe since antiquity, and had increased sharply between the eleventh and thirteenth centuries, particularly after the crusades. From the fifteenth century onwards, with some differences from country to country, the disease had declined and was only left in remote pockets along the coast, such as in Norway, Greece and the Iberian Peninsula. The figures stating that France had at one point had 2,000 leprosaria and that 19,000 of these institutions existed in the Christian world as a whole were repeated, but this time without any scepticism. The numbers were used in various places to support the argument that immediate action had to be taken in the present situation. If not, the disease would proliferate and get out of control.

From the 1870s, however, the relevance of medieval leprosy increasingly turned from fact-gathering to interpretation, as more
and more physicians started to question the validity of the depiction of a rise, peak and fall of medieval leprosy. According to August Hirsch (1817–94), professor of medicine at the University of Berlin, the apparent increase between the eleventh and thirteenth centuries was not due to heightened prevalence, but was because an ‘increased scientific spirit’ in the medieval world had led physicians to take more notice of the disease.25 A similar argument, that the leprosaria made leprosy more visible, had been made some years earlier to defuse worries about an apparent dramatic increase in leprosy on Hawaii:

The apparent rapid increase of leprosy began to be noticed, too, coincidently in point of time with the establishment of the Queen’s Hospital and Dispensary, the number of lepers who applied for relief at the hospital augmenting year by year. The truth may be that the presence of the leprous amongst the population at large was only more clearly perceived on account of their seeking relief in greater number at the hospital as this became better known.26

Having debunked the idea that leprosy had increased, Hirsch questioned the notion that the disease later declined. The ‘decline’ of leprosy in medieval Europe was in fact due to more precise diagnosis, which caused the number of individuals diagnosed with leprosy to fall by the end of the fifteenth century.27 In other words, the earlier ‘peak’ was to a large extent due to misdiagnosis. While not everyone shared Hirsch’s interpretation, it illustrated the increasingly apparent problem with using medieval sources: they could be interpreted in different ways to support a wide range of disease models.

The relevance of medieval leprosy was further challenged by new techniques in medicine, in particular Gerhard Armauer Hansen’s argument that the disease was caused by a bacillus and was therefore contagious.28 Since the medieval medical authors had not had access to laboratory techniques and other diagnostic tools, it was increasingly difficult to present them as colleagues facing the same disease. In the perspective of contagion, the history of leprosy was rewritten into a grand narrative of a disease that since antiquity had spread around the world through time and space. In 1879, William Munro, late Medical Officer to Saint Kitts in the West Indies, argued that the disease had first occurred in Egypt,
Post-medieval perspectives

Africa, India or China, and dated the introduction to western Europe from Greece and the Middle East to early medieval times. Leprosy’s disappearance from medieval Europe, he argued, was a direct consequence of ‘lepers’ being kept strictly apart from the healthy. The disease was then introduced to the New World by the transatlantic slave trade. Similarly, leprosy was transported over the Pacific as a stowaway with the importation of Chinese labour to both Hawaii and Australia. While Munro did not mention the bacillus – only that the disease was contagious – the leprosy bacillus would fit hand-in-glove with the new narrative.

The laboratory revolution in medicine was not the only reason why medieval leprosy lost relevance as a basis for policy advice. New genres for epidemiological studies based on patient registries were also important. When Hansen became head of the Norwegian leprosy apparatus in 1875, he re-examined the national patient registry. Instead of looking for family connections, he compared districts that had different practices when it came to ‘evacuating’ those affected to the State leprosy institutions. His conclusion was that even partial segregation led to a reduction in new cases.

When the annually updated registry was first established in 1856, there had been 2,874 cases in Norway; in 1874 the numbers had been reduced to 1,852. Although not everyone agreed with Hansen’s explanation, the records were considered more reliable and verifiable than scattered and uncertain medieval sources. As Hansen successfully argued for increasingly strict leprosy legislation in Norway in 1877 and 1885, medieval leprosy was given a new meaning. To Danielssen and Boeck, the medieval practices had been a warning that a belief in contagion led to cruelty. This had entailed a selective interpretation of the medieval texts, highlighting the coercion and brutality under which ‘lepers’ had been treated. Hansen had a different perspective, firmly believing that the image of strict medieval segregation was proof that the policies of the past had succeeded in reducing the number of cases. At the same time, however, by presenting medieval segregation practices as abusive, the ‘modern’ approach to segregation was put in a favourable light. Echoing the same argument, Alexandre Kermogant, from 1906 Inspector General of the French colonial health services, argued that increased travelling made leprosy in the colonies a growing
We have noted the danger and it is growing every day following the expansion of all colonial peoples, the growing number of relationships with other countries, and facilities provided to passengers to travel the world. In these circumstances would it not be prudent to consider, not the leper colony – that would be medieval – but sanatoriums or nursing homes to isolate lepers who come to us from beyond the sea … Remember, in any case, nothing is more dangerous than the failure of any prophylactic measure vis-à-vis a scourge that threatens us. Caveant consules!\textsuperscript{32}

The last major study of medieval leprosy in the nineteenth century was conducted under the auspices of the British National Leprosy Fund, the trustees of which, in 1895, published the winning contributions to their essay competition on ‘Conditions under which leprosy has declined’. From a comparative study of diet and sanitary conditions in medieval Britain and contemporary China, India and Iceland – places where the disease still existed – the British physician George Newman concluded that the rise and fall of medieval leprosy in Europe boiled down to changes in diet and lifestyle. ‘The whole weight of historic evidence is opposed to the supposition that contagion was the cause of the spread of the disease, and that segregation was therefore the cause of its decline.’\textsuperscript{33} Instead, famine and plague, by significantly reducing the population in medieval Europe, led to marked improvements in social and hygienic conditions. Furthermore, he suggested that segregation of those affected had never been total, and could therefore not be part of the explanation of the decline in cases.\textsuperscript{34} Thus, he concluded:

The disease being diffused neither by contagion nor heredity, has under favourable hygienic circumstances a tendency to die out. Hence, the decline and final extinction of endemic leprosy was due, not to segregation, but to this general tendency under favouring circumstances, viz. to a general and extensive social improvement in the life of the people, to a complete change in the poor and insufficient diet ... and to agricultural advancement, improved sanitation and land drainage.\textsuperscript{35}

Newman’s Danish co-winner Edvard Ehlers, however, basing his argument on documents from Iceland, argued that the disease had
been prevalent in medieval times, but had declined in the eighteenth and nineteenth centuries because of ‘popular dread of contagion’. The main support for the theory was that after the leprosaria in Iceland were closed in 1848, the prevalence of leprosy increased once more:

Surely the hospitals played but a slight part in the combat against the disease, but it must not be left out of consideration that their existence indicated that the disease was still to be feared. On the contrary, the abolishing of the hospitals and the administration’s throwing up the game could not help giving the population the idea, which Iceland’s superior physicians persistently maintained, that the disease was on the point of becoming extinct spontaneously, and that it no longer deserved any interest.36

The studies of Newman and Ehlers illustrate the tendencies in the medical debate on medieval leprosy at the end of the nineteenth century to tailor strategies, arguments and conclusions to specific disease models and policy recommendations that were then current. For those, like Newman, arguing that leprosy was caused by poor diet and insanitary conditions, the sanitary improvements in late medieval Europe both explained the past and gave a mandate for policies in the colonies in the present. This rationale had a strong support base in Britain, which only had a handful of cases at home, but possibly hundreds of thousands of individuals affected in the colonies. For those arguing that the disease was contagious, like Ehlers, the key to the decline of medieval leprosy was segregation, and this solution was equally valid in the present. This line of reasoning was especially strong in Scandinavia and other countries where the disease was ‘home-grown’, and from the 1880s it became increasingly entangled with the disease model that claimed that leprosy had a bacteriological origin.

As the bacteriological disease model started to gain hegemony around 1900, particularly with the establishment of the journal Lepra bibliotheca internationalis with Ehlers as the main editor, references to medieval leprosy were more or less limited to those sceptical of the new paradigm.37 The British physician Jonathan Hutchinson, who repeatedly stressed that the disease had disappeared despite segregation never having been complete, pointed at foodstuffs (badly cured fish) as the original culprit in the Middle Ages.38 Zambaco
Pacha, one of the last champions of a hereditary disease model, likewise criticised contemporary segregation for being ‘medieval’, meaning too strict and inhumane.  

In the decades that followed, medieval leprosy lost its relevance to most medical discussions. In monographs on the disease, its medieval impact remained part of the historical account, but only in order to connect earlier occurrences with the present situation. For physicians, reinterpretations of medieval leprosy were now based on backdating new insights into the aetiology of the disease, not on revisiting the medieval sources.

Imperial perspectives on medieval leprosy

In the nineteenth century, medical professionals were not the only individuals looking to medieval history to inform perceptions of leprosy in the present. Leprosy seized Europeans’ attention: with the expansion of empires, Europeans came into contact with greater numbers of people affected by the condition. In 1889, a ‘leper scare’ swept across Europe, and fears about the possible resurgence of leprosy prompted people to seek answers about why the disease had declined in the Middle Ages, in hope of finding reassurance and potential solutions with regard to the situation that faced them in their own present. The spectre of empire loomed in almost all discussions and studies of leprosy in the nineteenth and early twentieth century, and some more recent debates over the history of medieval leprosy still reflect the legacy of an imperial past.

Generally speaking, leprosy had disappeared from western Europe by the end of the eighteenth century, and as such was considered a disease of the past. But when Europeans began encountering leprosy again in the nineteenth century, both in their colonies abroad and in small numbers at home, they needed to reconcile the leprosy of Europe’s past with the present, especially because the disease afflicted the ‘primitive’ peoples of the tropics. Writers and medical practitioners sought explanations for the spread and decline of leprosy that drew parallels between medieval Europe and the contemporary tropics, while differentiating both settings from modern Europe. Colonisers branded leprosy as a tropical disease, thus distancing themselves from their own epidemiological
post, because of the special threat that leprosy, as a disease of the ‘primitive’, posed to the civilised identity of Europe. In Britain, as in other countries, diseases of the tropics posed a special threat to ‘civilisation’ and the national psyche. The word ‘civilisation’ was repeated frequently in British writings, as though it was a safeguard against disease, indicating the deep anxiety with which British people perceived the world that commerce and imperialism had brought to their doorstep.42

European interest in leprosy rose dramatically in 1889 when Father Damien, a Belgian Catholic missionary, died with leprosy at the Molokai leprosy settlement in Hawaii. News of Father Damien’s death on 15 April that year spread rapidly across the globe; photographs of him on his deathbed sold by the thousands in London, and one photo displayed in a shop window in Birmingham caused such a crowd that police were called to clear the streets.43 Upon his death, the priest was an immediate sensation, drawing ‘the gaze of the world’ to the issue of leprosy.44 For the next three months, newspapers teemed with articles about the spread of leprosy, for in his death, Father Damien was perceived as a role model for the charity and compassion due to leprosy victims; as evidence of the contagiousness of leprosy and the possibility that white Europeans could be infected with it; and as a reminder that medical practitioners still knew little about the causes and treatment of the disease.

Father Damien’s death, in drawing the attention of the media and thus the public to the issue of leprosy, lent credence to a small body of alarmist literature warning that, because of colonial expansion, leprosy was once more a threat to Europe. Agnes Lambert, who wrote extended articles about leprosy for the literary magazine The Nineteenth Century, was one of the earlier voices in the popular press proclaiming Britain’s vulnerability to leprosy, which ‘has not ceased to be of living interest and concern to Englishmen; that, with the expansion of England, it has been brought back to our very doors’.45 Archdeacon Henry Press Wright was far more outspoken in voicing his fears regarding leprosy:

He is a craven creature who is afraid to speak out boldly, when he believes that there is a cause for warning against a threatening trouble ... All this applies particularly to leprosy, and to those who
declare that the disease is greatly on the increase; and thus, unless due precautions be taken, it will ... become again, and that speedily, a common scourge throughout Europe.  

Sir Morrell Mackenzie, a physician whose voice joined Wright’s, supposed that ‘most people, I imagine, were till lately in blissful ignorance of the fact that leprosy still walks the earth in all its original hideousness’. These individuals, doctors and laypeople alike, felt that leprosy was a present and grave threat to the ‘civilised’ world, and wrote books, articles and letters to newspapers to warn others that colonialism and commerce meant that leprosy was no longer a disease of the past to which Europe was now invulnerable. These publications were part of a wider trend in which topics in science and medicine were introduced to the public via the popular press, and through periodicals in particular, though as one doctor wrote: ‘As for leprosy in England, we certainly do not share the alarm of Archdeacon Wright, and still less do we consider sensational newspaper articles on the subject justified.’

Many of those who were caught up in the ‘leper scare’ believed that the best means of controlling the threat of leprosy was to isolate its sufferers, and they looked to medieval history – and in particular the histories written by contagionist leprologists – for evidence that segregation was the key factor that had led to leprosy’s decline in Europe. It was ‘thanks to measures of strict isolation adopted during the middle ages, [that] leprosy began to decrease in Europe’, and if ‘[l]eprosy has ceased to exist in some lands; what was done there with such success can it not be done again?’ In an article in The Nineteenth Century, Dr Mackenzie went so far as to suggest that those who believed that leprosy was not contagious and advocated against segregation were to blame for the purported return of the disease:

The whole system of medical police by which leprosy was finally driven out of Europe was based on the notion that it was contagious, and no measures not based on that principle have ever had the slightest effect in checking its ravages. The alarming spread of this loathsome pest in recent years is in my opinion due to the fact that for some time the opposite doctrine gained the ascendancy, and held captive the minds of men.
Leprosy was ‘the great disease of mediaeval Christendom’, and histories of medieval leprosy abounded with descriptions of the harsh treatment of medieval sufferers.53 ‘Harshly, indiscriminately, and imperfectly as was this separation carried out in those dark days’, it was nevertheless considered primarily responsible for leprosy’s decline, and as the prolifically alarmist Archdeacon Wright wrote, ‘What was done in darker times can surely be done in these bright days of advanced science’.54 Initially, the segregation of leprosy patients in medieval Europe was mobilised as evidence to support contagionist theories of the disease’s spread, and as a theory of how to bring about its decline. As European fears of its resurgence heightened during the ‘leper scare’, a belief that medieval ‘lepers’ had been totally isolated became a means of assuaging that fear. The narrative about the decline of leprosy in Europe’s past was deeply comforting. If segregation was imposed in the present, this would protect Europeans from the terrifying possibility of a widespread recurrence of leprosy.

One of the debates over medieval leprosy, which preoccupied medical practitioners and laypeople alike, was what had led to its decline. Many attributed that decline to the supposed isolation of leprosy patients in medieval Europe. The segregation of leprosy sufferers was thus championed by many, especially in the late nineteenth century by those medical professionals who argued for leprosy’s contagiousness, and by those in the midst of the ‘leper scare’ who believed that seclusion was ‘the only sure means of really coping with the greatest and most mysterious of the maladies that afflict mankind’.55 The other major rationale for leprosy’s progressive decline between the late Middle Ages and the end of the early modern period was Europe’s advancing civilisation, which involved improved nutrition, hygiene and sanitation, and less overcrowding. This argument was generally promoted by anti-contagionists, who argued that the segregation of leprosy-affected people had never been absolute.56 By the late nineteenth century, most medical professionals writing on the history of medieval leprosy at least included advancing civilisation alongside segregation in their explanations for the disease’s decline, though they often privileged the importance of segregation:
The fact remains that cases of leprosy became less and less frequent in Europe in the fifteenth and sixteenth centuries, and that the decline of the disease was in proportion to the rigour with which isolation was enforced upon the sufferers. Other causes, doubtless, co-operated in producing the effect. During the middle ages, and even at a much later date in some countries in Europe, the articles of food consumed by the people in general were for the most of an unwholesome and innutritious character ... The habitations and surroundings of the people presented many conditions in the highest degree favourable to the spread of epidemics; water was generally scarce and often bad; the arrangements for the disposal of excreta were of the rudest character.

Slowly, but surely, a progressive improvement took place in many respects. The food of the poorer classes became more varied, more abundant, and more nutritious in character, and some advance was made in the art of cookery; while, owing to the increasing spread of commerce with other countries, bad harvests were no longer followed by wide-spread famine. Social conditions in general were thus rendered much more favourable than at any previous time, and it is highly probable that the disappearance of leprosy was in some measure due to the improvements thus briefly specified. The isolation of the sick was, however, the most potent factor.57

It was not until the 1920s that the balance began to shift in favour of advancing civilisation, over segregation, as the main explanation for leprosy’s decline. As the British leprologists Leonard Rogers and Ernest Muir argued:

Enforced residence of the few infective cases outside a town or village must have played some part in the reduction of new infections. On the other hand, compulsory powers, even yet, often fail to discover and isolate cases before they give rise to new infections, and would scarcely have been more effective in early days ... The end of the fifteenth and the beginning of the sixteenth century marked the end of the Dark Ages ... Moreover, a general improvement in the conditions of living ... was doubtless an important factor in reducing the overcrowding so favourable to ... infection. That a high degree of civilization is inimical to the spread of leprosy is indicated by the practical absence of infection from imported cases in Great Britain, France and the temperate areas of the northern United States of America.58
Many leprologists agreed that ‘the history of [leprosy’s] prevalence, increase, and decline in different regions of our globe, is interwoven with that of civilisation itself’.59

Rogers and Muir had many reasons, practical and ideological, for emphasising civilisation over compulsory segregation. The British Empire reached its height in the interwar period, and leprosy humanitarianism experienced growth as a secular, imperial endeavour, though it still continued to flourish as a missionary one. In the 1920s, Rogers and Muir were involved in the founding of the British Empire Leprosy Relief Association (BELRA), and across the British Empire – and other European empires – hundreds of new leprosy settlements were founded in the 1920s and 1930s. Some experimented with the compulsory segregation of leprosy patients, but segregation on such a scale proved impracticable. The incidence of leprosy could not be decreased unless the disease’s sufferers could be separated from others during the period that they were infectious, and most colonial medical authorities found this kind of segregation ‘impossible’ and undesirable.60 It required a staggering amount of financial resource, and Rogers and Muir argued that compulsion was the worst way to effectively control the spread of leprosy, as it often pushed leprosy sufferers into hiding, where they could continue to spread the disease.61

Leprosy settlements that patients could be persuaded to enter voluntarily were a more ideal solution, not least because as residential, relatively segregated facilities they offered missionaries, charities and colonial governments an opportunity to attempt to engineer ‘civilised’ communities that integrated ‘traditional’ customs with aspects of ‘civilisation’ and modernity that Europeans found desirable.62 This ‘civilising’ mission was an important justification for colonialism and missionary work, and was premised upon the idea that Europeans (especially the British and French) were inherently superior to the people of the tropics, and that it was therefore their right and responsibility to promote those traits that defined the ideal citizen, for the benefit of their ‘primitive’ colonial subjects.63 The emphasis on segregating patients in colonial leprosy settlements for this purpose is all the more notable given that, in practice, these settlements were too expensive to reach all infectious leprosy patients.64 As leprosy specialists began to perceive compulsory segregation as a less
effective tool for controlling leprosy, and the imperial, ‘civilising’
endeavour of leprosy control expanded, doctors such as Rogers
and Muir began to alter the way in which they wrote about
medieval leprosy.

In order to heighten the contrast between medieval and modern
Europe, many writers emphasised the poor and unhygienic living
conditions of the Middle Ages, and then compared those medieval
conditions to life in the tropical colonies, thus underlining
the distinction between ‘civilised’ modern Europeans and the
‘primitive’ colonised. Doctors and historians writing about
leprosy co-opted some particularly colourful descriptions of life
in medieval Europe: ‘The sediment of the town population in
the Middle Ages was a dense slough of stagnant misery, squalor,
famine, loathsome disease and dull despair such as the worst
slums of London, Liverpool, or Paris know nothing of.’65 ‘The
Normans did not bathe and wash as much as the Saxons, they
lived in close unventilated hovels, the diet was poor, and shameful
intemperance and immorality prevailed extensively.’66 For the
most part, European leprosy specialists and missionaries in the
twentieth century made no link between leprosy and immorality
or sexuality – instead they linked leprosy in the colonies to lack of
hygiene and civilisation.67 However, missionary and Government
belief in the ‘primitive’ immorality of colonial subjects, especially in
Africa, certainly did influence their perception of disease across the
Empire, and the desire to distance Europe’s medieval past from the
colonial present.68 Leprosy was considered to be ‘a consequence of
the filthiness of our ancestors. People never washed in the Middle
Ages; therefore leprosy was the result of a spontaneous generation
in the dung-hill on which society was rotting.’69 ‘This disease,
which one almost considers as prehistoric, can strike root ... where
Hansen’s bacillus refinds its favourite soil of uncleanliness, bad
nourishment, and filthiness, under hygienic circumstances which
have not altered in many respects since the Middle Ages.’70 Such
sensational statements were meant to reinforce the conviction that
leprosy afflicted ‘primitive’ races that lived in filth and ignorance;
‘civilised’ individuals were clean, moral and knowledgeable enough
about hygiene to be insusceptible to leprosy. European society as a
whole had progressed beyond the point of danger, for leprosy was
a disease of the ‘uncivilised’.71
The desire to differentiate nineteenth- and twentieth-century Europe from medieval Europe and the tropics was so strong that when leprosy was encountered in modern Europe, the contradiction was resolved by ascribing primitive characteristics to those Europeans who contracted the disease. Within Europe, leprosy was thought to be most prominent in Norway, and one doctor wrote of Norway that:

The peasants of that country are unspeakably dirty. Most of them never take a bath; and only once a week wash their face and hands, their feet once a year, their body remains untouched by water from birth till death. Their clothes are generally of wool, and they never take them off in going to sleep; they are never washed, and these same clothes, as long as they are not absolutely rotten, are transmitted from generation to generation. Norway is the ‘classical land of leprosy’.72

Other Europeans, anxious to dissociate themselves from the disease’s presence close to home, branded Norwegians as economically backward, primitive, and therefore the ‘classic’ victims of leprosy. The British in particular were able to remain comfortable in their conviction that any leprosy that lingered in Europe was a relic of a primitive past, whereas in their colonies, leprosy was a contemporary problem that assailed societies that seemed centuries behind Europeans.

The contrast between ‘civilised’ modern Europe and its ‘primitive’ medieval past was part of an attempt to preserve the superior and ‘civilised’ identity of European nations, which served as a partial justification for the colonisation of the ‘primitive’ peoples of the tropics. Imperialism was justified with the argument that colonisers were providing the colonised with services and opportunities that they could not otherwise provide for themselves. The fundraising propaganda of BELRA stated that ‘It is a patriotic duty to try and make every part of the Empire as healthy as possible’, and its aim was to ‘arouse the public conscience’ to this responsibility.73 Leprosy was ‘overshadowing the fairest spots of earth and the most fruitful territories of our commonwealth’.74 Incorrectly assuming that leprosy sufferers were universally stigmatised, colonisers believed that in providing care for leprosy patients they were offering a relief from stigma, and a medical service that their colonial subjects could not have provided for themselves – if they stayed on colonial soil.
Leprosy sufferers supposedly had even more reason to be grateful for their colonisation than the colonisers themselves, as Agnes Lambert commented in 1884 in relation to the recent addition of Cyprus to the British Empire: ‘Whatever Englishmen may have felt and feel about it, the leper at least is thankful that Cyprus has become part of the British Empire.’ Moreover, Europeans could gradually ‘civilise’ their colonial subjects, until they too reached the standards of living in modern Europe that had caused leprosy to disappear. In 1930, Joseph Attard, a native of Malta, was admitted to the Infectious Diseases Hospital in Cardiff, shortly after his immigration to Great Britain. For the next four years there were various attempts to repatriate Attard, as evidenced by two large files in the British National Archives full of letters between various hospital and Government authorities, each attempting to avoid the expense and inconvenience of Attard’s presence. No one wished to care for Attard, for as his attending physician at the ‘Saint Giles Home for Lepers’ (see below), where he was eventually moved, wrote, he was ‘not a satisfactory patient. He is of a different type and race to the others … He is a Maltese; it seems illogical that he should remain here.’ In spite of their best efforts, however, attempts to deport Attard were ultimately unsuccessful because there was no law that could force him, as a British subject, to leave the country unwillingly. Attard is a rare example of leprosy entering Britain in the body of a colonial subject, and an unwelcome one, for it was much preferable to practise love and charity towards leprosy patients in the Empire, where colonial subjects could be gradually ‘civilised’ until they too reached the standards of living in modern Europe that had caused leprosy to disappear, than at home.

The great fear of leprosy in Britain was linked to a supposedly medieval prejudice against it. Several cases involving leprosy ended up in British courts, the most publicly documented being a suit in which Mr Humphreys, a lodging-house keeper, claimed damages against the relations and doctor of Mr Miller, a deceased man with leprosy who had lodged in Mr Humphreys’s house, for alleged breach of warranty, fraudulent misrepresentation and conspiracy. Humphreys asserted that all three parties knowingly concealed Mr Miller’s diagnosis of leprosy, and in so doing breached the warranty that Mr Miller was fit to occupy lodgings. Further, Humphreys claimed not only that his family had been put in danger by residing
in the same house as a leprosy patient, but also that once it was discovered that a ‘leper’ had resided in his lodging house, it was impossible for him to let any of the rooms. He had been forced to destroy all of the furniture in Mr Miller’s room and repaper the walls, for such was the dread of leprosy that, even after the man’s death, no one would enter the room for fear of contagion. Sir Leonard Rogers, leprologist, attributed these cases of prejudice to the Middle Ages:

To progress in dealing with this dread disease by the ignorant prejudice of medical as well as laymen, chiefly due to the extraordinary survival from the Middle Ages of utterly false ideas of the great contagiousness of leprosy, such as quite recently led to the flight from an American court of justice, on the appearance of a leper in it, of nearly all those present, including the ‘judicial ermine’ …

In the case against Mr Miller’s estate, even when presented with clear evidence from medical experts of leprosy’s negligible contagion in England, and warned not to fall under the sway of long-popular prejudice towards the disease, the jury could not overcome their conviction that leprosy was contagious and dangerous, and the judge had to overrule the jury’s guilty verdict.

The need to differentiate ‘modern’ Europe from its ‘primitive’ colonies and medieval past also affected nineteenth-century debates over the incidence of leprosy in medieval Europe, as discussed in the previous section, and over whether leprosy had been a disease only of medieval peasantry, or also of royalty. Authors of leprosy history, whether medical professionals or historians, initially based their estimates of the number of leprosy sufferers upon the number of ‘leper’ hospitals that they believed to have existed. While some were happy to repeat Matthew Paris’s medieval estimate of 19,000 leprosaria in Europe, others claimed it was an over-estimate based on a mistranslation, and even posited that the incidence of leprosy in the Middle Ages had been quite low, and that ‘the high figures often given for the number of leprosy houses is attributable mainly to the misguided enthusiasm of romantic historians of modern times’. A few even argued that ‘the extent and importance of the disease were exaggerated out of measure by ecclesiastical example and precept’ in the Middle Ages, and were guided by ‘religious fervour’ and ‘extravagances’, ‘misunderstanding’ and
‘exaggeration’. These historiographical debates had implications beyond the medical. Some were at pains to point out that the incidence of leprosy in medieval Europe was not higher than its incidence in the contemporary, colonial world. In order to preserve imperial Europe’s ‘civilised’ identity, it was important that Europe’s more ‘primitive’ ancestors be no more prone to leprosy than the colonised denizens of the tropical world. The implication was that the ‘romantic’ historians who emphasised great numbers of leprosaria and, by extension, of people with leprosy, were influenced by a desire, medieval and contemporary, to aggrandise the medieval religious and philanthropic tradition of healing the leprosy sufferer.

**Philanthropic perspectives on medieval leprosy**

Leprosy has long been a disease of contradictions, and while modern Europeans were casting medieval Europeans in a negative light to suit their own medical, social and political agendas, they were also looking to their medieval ancestors for positive inspiration to philanthropy. Many of the same authors who wrote about the isolation, stigmatisation and cruel treatment of leprosy sufferers in medieval Europe also wrote about the religious calling of people with leprosy and the philanthropy that was directed towards them. As Agnes Lambert wrote, ‘The history of leprosy touches the loftiest heights of heroic self-denial and generosity; it goes down into the lowest depths of the most pitiful selfishness and brutal cruelty and greed of which the heart of man is capable.’ Some authors resolved this disparity by blaming the cruel treatment of medieval leprosy sufferers on secular authorities and human nature, which the Church sought to counteract:

> Whilst the civil power, animated by a selfish fear of contagion and infection, accomplished little with its stern measures of repressive legislation, the Church, without running counter to what was sound in the principle of such measures, mercifully legislated for the well-being of the whole community ... and with the true instinct of charity inspired the kings and queens, the bishops, nobles, and burgesses in the middle ages, who founded or endowed hospitals throughout the land for the shelter and seclusion of the leper.
Casting the Church and charitable nobility as the counter-actors of a cruel populace and Government allowed modern historians to paint a picture of the humane segregation of leprosy sufferers, which was particularly important to those authors who advocated segregation as the best means of controlling leprosy. It created the possibility of the argument that ‘segregation if properly carried out, is the best thing for the sufferers themselves’. 87

Christianity, specifically Christ’s call to ‘cleanse the lepers’, was one of the most important motivations to leprosy philanthropy in modern Europe, as it had been in the Middle Ages, and in writing about the Church’s history of care towards leprosy sufferers, non-medical authors in particular were celebrating a history of Christian philanthropy to leprosy, and suggesting a repetition of the same endeavours. 88 It was argued that leprosy patients need not be segregated only out of fear of their contagion: if donors supported leprosy sufferers in their isolation it could be a humane and charitable repetition of the medieval Church’s successful charity. Archdeacon Wright, who wrote so alarmingly about the return of leprosy to the civilised world in the midst of the ‘leper scare’, wrote that ‘Lepers in the middle ages were on the whole duly protected and comforted. And great was the reward, for it was that wise and generous provision for the afflicted which by degrees removed a foul and torturing disease from our own and other lands.’ 89 The Revd Mulhane, who wrote a contemporaneous volume on Leprosy and the Charity of the Church, credited the inception of Christianity with the inception of organisations to care for unfortunate leprosy sufferers. 90 He agreed with Wright’s statement that:

It is commonly supposed that leprosy died out, expended itself; that it came no one knew how and went away no one knew why. Better far to say gratefully that our present freedom from the greatest and oldest scourge of man is chiefly due to the Church, especially to its Christ-loving fraternities, which while they carefully supplied bodily and spiritual wants to the leper, kept him strictly within certain limits well apart from the strong and healthy. It was this close segregation that removed leprosy from our midst. 91

One of the fraternities to which he referred was the Order of Lazarus, a knights’ order for leprosy sufferers alone, and of this time and order Mulhane exclaimed: ‘Glorious age of Christianity! What power! What sacrifice’. 92
This ‘humane segregation’ was enacted through the creation of model leprosy settlements. These colonial settlements were often organised as ‘model villages’, carefully designed to reflect the colonial vision for a ‘civilised’ world, from the site, layout and construction of the settlements and their buildings, to the social, political and economic organisation and facilities that were provided for residents. To a certain extent these ‘civilising’ goals were shared by the missionaries, Government officials and charities who cooperated to maintain colonial leprosy settlements, but the religious traditions of philanthropy and care for people affected by leprosy that so strongly influenced missionaries sometimes put them in conflict with the colonial Government. For example, in the British protectorate of Uganda, missionaries tended to prioritise the admission of patients in the more advanced, debilitated stage of the disease, rather than patients in the infectious, early stages. The colonial Government – echoing the opinion of leprologists – wanted missionaries to admit ‘infectious cases and active cases likely to be benefitted by skilled anti-leprosy treatment’. Their perspective on ‘benefit’ was a model of in-patient treatment for infectious patients to be segregated early to reduce the contagion of leprosy; for debility to be prevented; and for discharge to take place in a matter of years, rather than decades, so that more space would be available for new patients. For missionaries, healing leprosy patients was about much more, for ‘God gives a special compensation and consolation to those who suffer’, and none suffered more than the person affected by leprosy. People with leprosy were capable of a relationship with God to which missionaries could only aspire, and the greater their suffering, the greater the value of their conversion to Christianity. It is hardly surprising, then, that missionaries were particularly inclined to admit patients whose suffering they perceived as greatest. Physical suffering was characterised by one missionary as:

Poor little bodies maimed and legs doubled under ... [An] old woman ... literally smothered from head to foot in large patches of leprosy. Another woman, with her poor old face eaten away ... I am afraid that there are some people elsewhere who think that it is much nicer to treat the acute sufferers, who quickly respond to treatment, in preference to these poor creatures.
Drawing on the Old Testament, their understandings of medieval leprosy and their own senses, missionaries firmly believed that leprosy was and always had been universally stigmatised, and thus people affected by leprosy also suffered emotionally. These sentiments were also echoed in popular culture and fundraising literature for leprosy, and donors tended to share the missions’ priorities. The missions were reliant on these donors, and colonial governments, for funding; as in other areas of colonial medicine, missionaries were the dominant providers of healthcare before the Second World War.

For many of the missionaries who devoted their lives to leprosy work, the example of medieval saints was just as important to inspiring their religious calling as the desire to follow in Christ’s footsteps. Saint Francis of Assisi, in particular, was an exemplar for many Catholic missionaries, and even for the formation of Britain’s Catholic leprosy charity, the Saint Francis Leprosy Guild. In East Africa, a number of leprosy settlements were founded and run by the Franciscan Missionary Sisters for Africa (FMSA). When the FMSA missionaries wrote of a role model for compassion and love towards the leprosy sufferer, they usually pointed to Saint Francis. One of Francis’s many recorded attributes was his compassion towards people with leprosy. His hagiographers wrote of his Christ-like ability to transcend his physical abhorrence of the leprosy sufferer’s disfigured condition in order to kiss or embrace the ‘leper’. In overcoming his revulsion to embrace the leprosy sufferer, Francis was re-enacting Christ’s love for those affected by leprosy and symbolically embracing Christ himself. Mother Kevin, the founder of the FMSA and of two leprosy settlements in Uganda, wrote that leprosy work ‘is our Franciscan Heritage’, and the FMSA missionaries who followed in her footsteps added that ‘we also felt proud that Our Lord had chosen us to be His instruments in fostering this work of charity so dear to the heart of Our Holy Father, St. Francis’.

Saint Francis’s modern-day counterpart in heroic self-sacrifice for the salvation of the leprosy sufferer was Father Damien, whose contraction of leprosy and following death ignited the ‘leper scare’. Even before his death, Father Damien was cast in the popular and medical press as a heroic martyr. Agnes Lambert wrote in The Times that: ‘One heroic priest after another has cut himself
off from his kindred and all that makes life glad, in order to devote himself to their service ... But at last he has himself fallen a victim of the terrible disease.'

Months before his death, the British Medical Journal reported that:

Father Damien will soon be no more, as he is falling a victim to his charity. ‘In England and America’, writes his devoted colleague at Molokai, ‘they call him the Hero Martyr ... If you could only seem him as he lies, in his room, on the floor, upon his bed of suffering ... People call it a sacrifice to live with lepers; but, only on seeing oneself a leper, and nothing but lepers around, then only does the extent of the sacrifice become apparent ... The unfortunate priest ... in the pursuit of the duties of his high calling, is suffering a martyrdom beyond comparison more cruel than any that befell the martyrs of the early Church.’

‘The heroic sufferer in the leper isle of Molokai closed his life of self-denial and devotion’, and the ‘noblest of Christian heroes’ became an inspiration for self-sacrifice for the salvation of leprosy sufferers, whether through donations or mission. Even ‘the least among us’ could follow his example and ‘help to give some little solace to the sad lives of the doomed exiles of Molokai’. There were calls to ‘take a humble advantage of the momentary romantic grief ... [to] effectually stamp out this curse from off the face of the earth’, and charities in Father Damien’s name were founded across Europe.

In the years following his death, ‘Heroism and self-sacrifice in the interest of humanity, like that displayed by the brave Father Damien, are, happily for the human race, by no means of unusual occurrence.’ In fact it was a far more usual occurrence that women, rather than men, volunteered as missionaries to leprosy-affected people, and quite a number did contract the disease, but these women’s sacrifices were hardly ever mentioned in the popular or medical press.

One of the reasons that Europeans were so ready to admire Father Damien was because his life – and death – in Hawaii was so remote that it never posed a risk or a threat to them. While his death did raise fears of leprosy’s contagion and potential return to Europe, some medical professionals pointed out that Father Damien and Sir George Turner, the Europeans best known for contracting leprosy, ‘BOTH were known to be notoriously careless, not washing after handling lepers, and it is most significant that
although four of the brotherhood contracted the disease in Hawaii, not one of the nursing sisters handling and dressing the lepers, but trained in cleanly methods, got leprosy.'\textsuperscript{112} Father Damien had, quite literally, sacrificed himself in the name of God. A sonnet appeared in the Jesuit magazine \textit{The Month}, and an excerpt from that sonnet indicates the martyr’s role in which Father Damien was cast:

\begin{quote}
Dead, say they? of thine own sweet accord,  
Who thro’ long years a dying life didst lead ...  
Oh, lepers’ friend, who didst—’twas all they care—  
Nurse their vile bodies and their souls make fair,  
Them loving for dear love sake of they Lord.  
Hero and martyr, of that glorious band  
Of saints immortal, where few greater are,  
For greater love than thine, sufferance more grand,  
Few mortals proved ...\textsuperscript{113}
\end{quote}

In some senses, Father Damien was following in the footsteps of medieval holy men and women who asked to be given leprosy, so that through their suffering they might assure the redemption of others.\textsuperscript{114}

Europeans were not nearly so loving and charitable when it came to other Europeans whose contraction of leprosy was not a result of their heroic dedication to the salvation of leprosy sufferers, and who brought their infection back to Europe with them. In the 1940s, one doctor proposed that Britons who had acquired leprosy in the colonies would be best suited to entering a leprosy settlement exclusively for whites in Southern Rhodesia (now Zimbabwe).\textsuperscript{115} Britain’s first home for leprosy-affected people in centuries was opened in 1914, after many years of difficulties – not least in raising funds from philanthropists. The founders of the ‘Saint Giles Home for Lepers’ were unwilling to make a public appeal, lest it attract too much publicity and, more alarmingly, patients from other countries.\textsuperscript{116} When the \textit{Daily Chronicle} published the first news of the opening of Saint Giles in June 1914, the founders were considerably annoyed, having gone to great effort to keep the nature of the Saint Giles Home a secret from the community.\textsuperscript{117} The plans submitted to the Chelmsford Rural Council were described as ‘plans of cottages and homes for chronic invalids’, without mention of leprosy, and were passed as such.\textsuperscript{118} The Home’s first patients
were snuck in ‘under the cover of night to avoid creating alarm among the local residents’, and the County Medical Officer was asked to use his influence to ‘keep the whole thing quiet’.  

The founders were right to be so wary; far from welcoming these men and women with Christian charity, the local community expressed ‘great horror and indignation’. A local Parish meeting was held in protest, and in the following weeks the issue was brought up at meetings of the Essex County Council and other local parishes, and in the local newspapers. Having leprosy-affected people ‘planted in their midst’ as ‘un fait accompli’ suggested to the local community that they were living under an ‘official tyranny’, betrayed by those Government officials who should have protected them. Fears of leprosy contagion aside – though they were strongly felt – ‘the fact remained that the popular idea was still strong that such an institution should be entirely isolated at sea … If the institution remained there the property immediately adjoining it must deteriorate in value and the owners of it would suffer heavy pecuniary losses.’ Although a number of protestors professed sympathy for ‘those who were trying to do good and minimise the suffering of their fellow creatures who were afflicted with an odious disease’, they considered the welfare of the county more important, and had ‘no burning desire to be known in the future as the Home for Lepers in England!’ The public recognised the contradiction inherent in their perception of leprosy at home and abroad, but while charity was laudable when leprosy was a distant danger, compassion was unthinkable when that danger was local.

Conclusion

Physicians, philanthropists and writers in the popular press in the nineteenth and early twentieth century were preoccupied with the impact of leprosy in medieval Europe for a number of reasons. As the disease was encountered in the colonies and in certain parts of contemporary Europe, information was sought about the prevalence of leprosy in medieval Europe and why it had ultimately largely disappeared. This material was used to shape policy regarding the disease in those European countries still affected, such as Norway and Iceland, although it became less relevant to medical and policy
Post-medieval perspectives

discussions after the advent of germ theory. Information about
medieval leprosy was also deployed to justify the colonial endeavour,
which offered care to leprosy sufferers and, it was believed, would
ultimately eradicate the disease by ‘civilising’ the colonised. At the
same time, the medieval example of Christian charity towards the
leprous motivated Christian missionaries in the colonies, and was
understood to have brought about the elimination of leprosy in
the Middle Ages through the humane segregation that it entailed.
Doctors, scientists, philanthropists and journalists reshaped the
past, in search of answers and in search of fodder to justify their
attempts to control people of colour, whom they perceived as lesser
than themselves, even as that control was cast as a humanitarian
and philanthropic endeavour. While the agency and resourcefulness
of nineteenth- and twentieth-century leprosy patients meant that in
leprosy settlements Europeans had to negotiate rather than control,
it is worth remembering that the ways in which medieval histories
of leprosy were written, and continue to be understood by people
today, are part of a troubling imperial legacy.124

Notes

1 See the Introduction to this volume, p. 1.
2 There are two notable exceptions: P. A. Kalisch, ‘An overview of
research on the history of leprosy. Part 1. From Celsus to Simpson,
Circa. 1. A.D. Part 2. From Virchow to Møller-Christensen, 1845–
nineteenth- and early-twentieth-century perspectives on medieval
leprosy, see also Rawcliffe, Leprosy, Chapter 1.
3 See the Introduction to this volume, pp. 4–5.
4 D. C. Daniellsen and C. W. Boeck, Om spedalskhed (Christiania: Chr.
Gröndahl, 1847). The monograph was translated into French in 1848
with the title Traité de la spedalskhed ou éléphantiasis des Grecs.
A British summary by Erasmus Wilson was published as a series of
eight articles in the Lancet in 1856 under the title ‘On the nature and
treatment of leprosy’. R. Edmond, Leprosy and Empire: A Medical and
5 O. K. Skinsnes, ‘Notes from the history of leprosy’, International

7 Danielssen and Boeck, *Om spedalskhed*, p. 98. This fits the timeline presented by F.-O. Touati in Chapter 2 of this volume.

8 ‘Den største Deel af Europa har i en tidligere Periode været frygtelig hjemsøgt af Spedalskheden, men har ved sine kraftige Forholdsregler befrig sig for den. Hos os staæ vi, hvad denne Sygdom angaaer, paa det samme Punkt, som ved andre Lande i Middelalderen, vi maa slaae ind paa en lignende Vej som i hine Tider, om vi ikke ville see enkelte Egnes hele Befolkning tilintetgjøres ved denne Sygdom.’ Danielssen and Boeck, *Om spedalskhed*, pp. 85–6.

9 *Ibid.*, pp. 94–100. On the clapper, see L. Demaitre, Chapter 8 in this volume.

10 Danielssen and Boeck, *Om Spedalskhed*, p. 263.


20 Deutsche Klinik, 25 April 1860, 159–60; Medical Times and Gazette, 28 July 1860, 93–4; Lancet, 28 July 1860, 90.


22 Kalisch, ‘Overview of research’, p. 133.

23 On ideas about the importation of leprosy to the West as a result of the crusades, see Touati, Chapter 2 in this volume.


28 G. A. Hansen, ‘Indberetning til det Norske medicinske Selskab i Christiania om en med understøttelse af selskabet foretagen reise

29 W. Munro, *Leprosy* (Manchester: John Heywood, 1879). See also Touati, Chapter 2 in this volume.

30 Jo Robertson has examined how seeing leprosy as a foreign threat (a ‘yellow peril’) in colonial Queensland, Australia, linked the disease to racism. J. Robertson, ‘In a state of corruption: Loathsome disease and the body politic’, Ph.D. dissertation (University of Queensland, Brisbane, 1999).

31 Hansen, ‘Indberetning’.


40 See, for instance, L. Rogers and E. Muir, *Leprosy* (Bristol: John Wright, 1925).


not use leprosy as a specific example, he offers a framework for the understanding of British fears of tropical diseases, abroad and at home.


44 *London Times*, 13 May 1889.


54 Wright, *Leprosy and Segregation*, p. 92.


60 Kew, The National Archives (TNA), CO 685/6, Uganda Medical Department Annual Report, 1923, p. 7.


67 Rogers and Muir, Leprosy, p. 51.


72 Roose, Leprosy and Its Prevention, p. 11.


Post-medieval perspectives

75 Ibid.
76 TNA, MH 55/324, letter from Pirrie to Shaw, 1934.
77 TNA, MH 55/324, minute sheet, Cardiff County Borough, 1933.
86 Ibid., 488.
88 Matthew 10:8.
89 Wright, Leprosy and Segregation, p. 92.
90 Mulhane, Leprosy and the Charity of the Church, p. 73.
91 Wright, Leprosy and Segregation, p. 92.
92 Mulhane, Leprosy and the Charity of the Church, p. 74. On the Order of Saint Lazarus, see R. Hyacinthe, Chapter 10 in this volume.
94 Uganda, Jinja District Archives, Medical Leprosy, letter from District Medical Officer Busoga to District Commissioner Busoga, 19 April 1944.
95 Vongsathorn, ‘Public health or public good?’, pp. 43–66.


100 Vongsathorn, ‘Gnawing pains’.


103 ‘Round the mission’, *Day Star in Africa*, 12 (January 1949), 10.


105 ‘The lepers of Molokai’, *British Medical Journal* (23 October 1886), 778.


108 ‘The lepers of Molokai’.


TNA, MH 55/554, memo from Sir Arthur Downes, 1914.

*Daily Chronicle*, 2 June 1914; *Essex County Chronicle*, 26 June 1914.

*Essex Weekly News*, 10 July 1914.


*Essex County Chronicle*, 10 July 1914.

Ibid.
