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THE 1851 INTERNATIONAL SANITARY CONFERENCE AND THE CONSTRUCTION OF AN INTERNATIONAL SPHERE OF PUBLIC HEALTH

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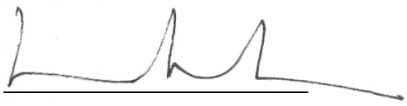
Signed: 

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Abstract

Focusing on the 1851 International Sanitary Conference, this dissertation analyses an important episode in the international regulation of health, trade, passengers, and cargo in a period of epidemic crisis. It argues that a group of diplomats and physicians appointed to represent 12 European nations instituted a new international forum that extended – and occasionally rivalled – national and local agencies for epidemic governance. Together, delegates endeavoured to establish a common sanitary policy in Europe and in the Orient. By creating shared surveillance and judicial mechanisms – while standardising definitions and practices – delegates aimed to engineer the flow of people, vessels, cargo, and diseases in the Mediterranean region. As a transnational forum, the Conference was a platform where doctors and diplomats reinterpreted models of public health and sanitary administration while creating institutions that challenged conventional concepts of borders, national policy, and state sovereignty. As a multinational event, the Conference marked the unprecedented transition from local, national and, bilateral public health policies into a coherent transnational project for the governance of epidemics.

The dissertation is based on extensive research conducted in hitherto largely unexplored medical, diplomatic, and national collections in Britain, France, Italy, Portugal, Spain, and the United States of America. Sources ranging from diplomatic correspondence to medical publications and personal diaries, tie together multiple national and professional perspectives while untangling a diversity of personal and state agendas that fundamentally shaped the foundation of international public health mechanisms and contributed towards the crystallisation of medical concepts.

Chapter one demonstrates how economic and political concerns about the impact of quarantine on international trade led to calls for international regulation and the standardization of quarantine practices in the Mediterranean region. Drawing on medical reports, pamphlets and diplomatic correspondence, the chapter exposes the multitude of quarantine practices in the Mediterranean region and a growing

international demand for prophylactic reform. These exchanges, it is shown, culminated with the organization of the 1851 International Sanitary Conference in Paris.

Chapter two argues that the Conference challenged previous diplomatic and medical protocols by including two professional groups in the process of regulating international public health. The lack of precedent allowed diplomatic and medical delegates to establish new rules for the conduct of the conference, which gave them a relatively high level of autonomy from the states they represented.

Chapter three focuses on the problems of constructing a shared aetiological classification and regulating quarantine practices. It shows that, although doctors gained progressive control over the Conference, ultimately diplomatic agendas shaped the final outcome. In addition, it demonstrates that, rather than defending the elimination of quarantines, liberal states supported the continuation of quarantine practice in the Mediterranean; albeit that they managed to severely limit its operation in practice.

Finally, chapter four examines how European and Oriental sanitary institutions were uniformly redesigned and new international judicial mechanisms created. These measures variously affected the sovereignty of the participating states by limiting their independent capacity to set national epidemic policies. However, the chapter argues that these negotiations took the shape of sovereignty bargains: by loosening control over specific elements of their sovereignty, states managed to advance their political, economic and sanitary agendas.

By looking at the International Sanitary Conference of 1851, this dissertation shows how the foundations of international public health had consequences not only for the control of epidemic diseases and the circulation of goods and people in the Mediterranean region, but also for the authority and status of the nation states. By doing so, it reveals that international public health governance resulted from the amalgamation of a particular configuration of expert and diplomatic struggles and

compromises. Moreover, the dissertation shifts the traditional local and national focus in the history of medicine to a wider and international context where local and national traditions struggled to produce coherent discourses and practices.

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INTRODUCTION

> *Gentlemen, (…) for too long we complained, and with good cause, of the diversity of sanitary regulations that in their detrimental interference with national commerce have established themselves to be a source of discomfort and, unfortunately, inequality. In a time when the industrious nations of the world seem to have forgotten their age-old rivalries and joined hands at the marvellous exhibition of London, we are putting an end to a state of affairs that was so often regrettable. (…)*
> *This we know, Gentlemen: we must reconcile, in wise measure, what is necessary for the protection of public health – even if we must make the occasional concession to ideas firmly rooted in peoples' minds (for it is often the case these same ideas can be uprooted in an instant) – with what is necessary to afford our seafarers the maximum liberty they could hope. These are indeed difficult problems to solve, and it is for this reason that we have called this meeting of luminaries, men of science, and of practical experience whose collective knowledge we hope will illuminate this conference. Gentlemen, our aims are worthy of you and the powers that you have the honour to represent. […] [Achieving these goals] would, in fact, be a great fortune and innovation: the agreement between so many powers around a topic that for so many centuries was [the] source of profound division! Gentlemen, new ways of locomotion, by sea and by land, contribute to the everyday elimination of obstacles and to bridge distances between nations. Moreover, in order to complete that magnificent project of the human spirit, no other effort can be more fruitful and powerful than a wise regulation, which, within reasonable limits, eliminates sanitary obstacles.*
> *Let us work together in order to achieve this goal and we shall deserve the esteem of civilization and humanity*.[1]

On the morning of 5 August 1851, shortly after ten o'clock, Pierre Jules Baroche, the recently appointed French Minister of Foreign Affairs, welcomed several delegates to the *Hôtel des Affaires Etrangères* in Paris. Representing several European nations, these enlightened men of science and law had been summoned to Paris in order to negotiate a common trans-national solution to deal with the epidemics that were prevalent in nineteenth-century Europe. For six months, twenty-four delegates from twelve countries met regularly at the International Sanitary Conference (ISC).[2] Each delegation, composed of a diplomat and a physician, put forward a particular model of international public health that they believed should be instituted in the Mediterranean region. After 48 regular sessions and several specially appointed commissions, the delegates produced a Draft International Sanitary Convention and

[1] Ministère des Affaires Étrangères de France, *Procès-Verbaux de la Conférence Sanitaire Internationale*, vol. 1 (Paris: Imprimerie nationale, 1852). S2:2-4.
[2] Between 1851 and 1938 fourteen conferences were organised in total. Paris was the main venue for these conferences, but they also convened in Constantinople, Vienna, Washington, Rome, Venice, and Dresden.

Regulation for their governments, which set out a common vision of the aetiological nature of epidemic diseases and detailed the prophylactic measures that should be internationally instituted in order to avoid new epidemic outbreaks. Despite the eager participation of governments and the promising results produced by delegates, only four participating states ended up ratifying the Convention; as such, historians such as Norman Howard-Jones have declared the Conference an utter failure.[3]

This dissertation will not attempt to assess the ISC's success or failure. Instead, via a close look at the debates, negotiations, and larger socio-economic contexts, the aim is to understand the state of international public health during the first half of the nineteenth century: What were the recognised problems and solutions? Who were the players? What role did science and diplomacy play in the making of the ISC? In sum, how did states aim for a common regulation of the increasing circulation of vessels, goods, and people during this period? These questions frame the *1851 International Sanitary Conference and the construction of an international sphere of public health.*

The process of creating an international approach to public health issues in Europe was neither straightforward nor without tension; rather, it was a source of intense debate and dispute. Faced with successive epidemic outbreaks of plague, yellow fever, and cholera, the European intelligentsia developed complex and conflicting visions on the nature of diseases and the mechanisms used to avoid future outbreaks. Moreover, Europe was marked by the emergence of modern states with antagonistic imperialistic ambitions both in the colonial world and within the European continent. In this sense, these powers struggled to dominate their neighbours politically and culturally. In many regards, the ISC provided a stage for these conflicts, and the resolution of Europe's epidemic issues required an adjustment of contradictory agendas.

The dual representation system practiced at the ISC – i.e. each state's appointment of a doctor and a diplomat as delegates to the conference – provides a good case study to help understand how knowledge claims and policy-making were negotiated and

[3] Norman Howard-Jones, *The Scientific Background of the International Sanitary Conferences, 1851-1938* (Geneva: World Health Organization, 1975).

produced hand in hand, given that meanings and practices debated at the ISC embodied two overlapping spheres: science and politics. This dissertation will show how international public health measures resulted from co-production exercises involving several states, professional groups, and vested interests. Moreover, in the following chapters, debates will be reconstructed and situated in order to show how knowledge circulated in nineteenth-century Europe while being negotiated on an international level. In a *quasi*-ethnographic historical approach, this dissertation will recover terminologies and practices used in the context of the ISC. However, the aim of *1851 International Sanitary Conference and the construction of an international sphere of public health* is not merely to tell the story of a conference. Instead, this is a history of delegates and states making sense of epidemic diseases and prophylactic mechanisms through extensive networks that spanned from Lisbon to Constantinople, from Naples to London. It is a history that includes a multitude of actors and institutions that strived to articulate meanings and practices internationally.

The ISC was by no means the first or the only international conference organised by several states. In fact, the early nineteenth century was the starting point of a new era of the creation and circulation of knowledge and politics in international venues. The new world order built upon the defeat of Napoleon in 1814 and the Congress of Vienna (1814-15) created the conditions for the multiplication of international conferences: in a context where warfare was considered second choice, 'civilized' states and individuals favoured outlets where disputes could be solved through negotiation.[4] However, as Jeffrey A. Auerbach has shown in his work on the 1851 Great Exhibition, these new international outlets involved much more than merely providing a venue for debate and circulation of ideas and objects. In fact, internationally organised exhibitions and conferences allowed states to exercise power and put forward specific expansionist agendas.[5] The capacity of these institutions to fulfil a multitude of functions in part justifies their success. Between

[4] F. R. Bridge and Roger Bullen, *The great powers and the European states system 1815-1914* (London: Longman, 1980).
[5] Jeffrey A. Auerbach, *The Great Exhibition of 1851: a nation on display* (London: Yale University Press, 1999).

1800 and 1870, a total of 132 international conferences were organised – and while only six conferences were organised between 1815 and 1840, there were 23 that took place in 1867.[6]

The importance and number of nineteenth-century international conferences contrasts with the lack of systematic studies of this modern phenomenon. In 1989, Jacques Julliard edited a special number of *Mil neuf cent. Revue d'histoire intellectuelle* that was exclusively dedicated to conferences. The issue presented conferences as places of intellectual exchange: places where ideas were presented, contested and negotiated.[7] However, in looking at events such as at the International Conference of Criminal Anthropology,[8] and the Conferences of International Feminists,[9] scholars appeared more interested in summarising each event's main conclusions instead of focusing on the process of establishing the decisions.

This descriptive approach to international conferences also moulded, to a large extent, the first compressive study of the ISC. In his 1975 work, *The Scientific Background of the International Sanitary Conferences*, Howard-Jones summarises the main achievements of fourteen International Sanitary Conferences organised between 1851 and 1938. In his view, the lack of knowledge about the 'true' nature of diseases compromised the success of the conferences. Howard-Jones selects what he believed to be state of the art knowledge about epidemic diseases and transports it to the space of these international events. He tells a teleological and linear history that follows the conferences' aetiological and prophylactic debates and ends with the triumphs of medicine and medical men and the eventual establishment of the World Health Organisation.[10] In his history of the ISCs, Howard-Jones portrays the conferences as places of circulation of knowledge but does not question how this knowledge was transported or which political agendas underpinned the organisation

[6] Union of International Associations, *Les congrès internationaux de 1681 à 1899* (Brussels1960).
[7] Christophe Prochasson, "Les Congrès: lieux de l'échange intellectuel. Introduction," *Mil neuf cent. Cahiers George Sorel*, no. 7 (1989).
[8] Martine Kaluszynki, "Les Congrès internationaux d'anthropologie criminelle (1885-1914)," *Mil neuf cent. Cahiers George Sorel*, no. 7 (1989).
[9] Laurence Klejman, "Les Congrès féministes internationaux," *Mil neuf cent. Cahiers George Sorel*, no. 7 (1989).
[10] Howard-Jones, *The Scientific Background of the International Sanitary Conferences, 1851-1938*.

of these events and their conclusions. Moreover, he fails to situate the ISCs within larger contexts outwith the world of scientific discoveries.

In contrast, in 1993 W. F. Bynum studied the ISC via a more sophisticated framework. Bynum was interested in teasing out the interplay between science, nationalism, and internationalism when applied to disease governance. As such, he placed the ISC within larger internationalist agendas connected with the growth of concerted international efforts. Bynum followed major debate shifts during 14 ISCs and ultimately argued that the ISC served the self-interests of powerful European and industrial countries.[11] Bynum's narrative is a clear step away from Howard-Jones' Whiggish account of the ISC.[12] However, like Howard-Jones, Bynum's scope was too large to enable him to pay close attention to individual conferences and their unique professional dynamics. His work does not explain the mechanisms that states deployed in order to set agendas and protect their interests. Finally, Bynum's contribution to a general understanding of the ISCs did not clearly address the mechanism through which science was articulated with political agendas.

More recently, Valeska Huber described the ISC as a social arena where differences and boundaries between disciplines, nations, and cultures were defined. Huber's account was built upon LeRoy Ladurie's idea of a world unified by a common market of microbes that circulate through trading networks.[13] She claimed that the nineteenth century – and the ISC in particular - marked the unification of the world through public health. In her account, the ISC established a prophylactic model that, like a membrane, allowed the flux of vessels and people while enabling the closure of borders if the sanitary safety of Europe were at risk.[14] In her analysis, Huber regarded the agreed policies as consensus shaped by particular political and economic contexts.

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[11] W. F. Bynum, "Policing Hearts of Darkness: Aspects of the International Sanitary Conferences," *History and Philosophy of the Life Sciences* 15(1993).
[12] Herbert Butterfield, *The Whig interpretation of history* (London: G. Bell and sons, 1931).
[13] Emmanuel Le Roy Ladurie, "A Concept: the unification of the globe by disease (fourteenth and seventeenth centuries)," in *The Mind and Method of the Historian*, ed. Emmanuel LeRoy Ladurie (Chicago: University of Chicago Press, 1978).
[14] Valeska Huber, "The Unification of the Globe by Disease? The International Sanitary Conferences on Cholera, 1851-1894," *The Historical Journal* 49, no. 2 (2006).

This dissertation will follow W. F. Bynum's and Valeska Huber's approaches in order to understand the works of the ISC through certain contexts that came together to build particular epistemic and practical positions. Like them, it also looks at the ISC as an important milestone in the history of public health. Hobsbawm classified the long nineteenth century as an age of revolutions, and the ISC embodied this spirit too.[15] From an international relations perspective, the ISC marked the start of a new period of international coordination of public health policies. However, the 1851 ISC was far from the first initiative to introduce a common public health programme. As early as 1652, Florence, Genoa, and the Holy See had established an international agreement to introduce common public health measures in the three harbours of the west coast of Italy. By agreeing to observe and enforce common measures while allowing the establishment of foreign health authorities in their territories for surveillance proposes, these Italian states promoted, in the words of Carlo Cipolla, a 'revolutionary and enlightened effort which, in the interest of "the common health," envisaged international controls and the voluntary relinquishment of discretionary powers by fully sovereign state in the matter of public health.'[16] Compared to the 1652 agreement, the ISC considerably expanded the number of participant states and the geographical scope designed to implement common public health instruments. In comparison with the three Italian ports, delegates to the ISC aimed to establish a common epidemic governance system for the entire Mediterranean region.[17] Finally, instead of focusing its efforts on establishing common practices, the ISC worked as a venue to crystallise meanings – namely, delegates attempted to create an international standard for representations of the aetiological nature of diseases.

These efforts were concentrated around three maladies: cholera, yellow fever, and plague. However, cholera was clearly the central point of dispute. Cholera had

[15] The long nineteenth century periodisation runs between 1779 (the French Revolution and the end of the Ancient Régime) and 1914 (the start of the First World War). See E. J. Hobsbawm, *The age of revolutions, 1789-1848* (London: Abacus, 1962).
[16] Carlo M. Cipolla, *Fighting the plague in seventeenth-century Italy* (Madison: University of Wisconsin Press, 1981).
[17] Because this system involved a careful policing of arrivals at Mediterranean ports, in practice the ISC was also applied to vessels traveling from the Americas to European destinations. In this sense, the ISC geographical scope extended far beyond the Mediterranean Sea.

arrived in Western Europe for the first time in the 1820s. Newspapers and contemporary publications painted a picture of an anxious and scared European society, and cholera aetiology and prophylactic strategies were sources of intense disagreement and controversy within European medical and political circles.[18] There was no consensus regarding the cause of cholera, and to the despair of many, the strategies for tackling the spread of this disease produced little effect.[19] Numerous theories linked cholera outbreaks to particular sanitary conditions, meteorological configurations or geophysical circumstances. However, nineteenth-century intelligentsia agreed that strict prophylactic measures were seriously compromising the profitability of commercial activities.[20]

Although cholera only made an appearance in Europe in the early nineteenth century, the references to this disease date back to the sixth century BC in Indian medical literature.[21] Nevertheless, the first largely circulated European description of cholera was produced after the arrival of Vasco da Gama in India in 1498. Gaspar Correia, the Portuguese chronicler (1495-1561), reported in his 1503 publication, *Lendas da India* [Legends of India], of the existence of a local disease named *moryxy* responsible for a high rate of mortality in the army of the Calicut sovereign.[22] Between Correia's chronicles and the arrival of cholera in Europe, Britain and Portugal had intensified their presence in India and consolidated their imperial rule. In order to manage India efficiently, these European powers had developed networks to circulate information between the metropolis and the dominated areas: officials reported regulations, specific events, and other requests from one end of the Empire to the other. These networks also extended into the medical field. Doctors and colonial officers produced, sent and received regular reports regarding the health

[18] See, for instance "Cholera Morbus: Forms Of Prayers To Be Read In All Churches," *Times*, 7 November 1831; "Cholera Morbus: Opinions And Facts Respecting The Disease," *Times*, 12 November 1831.
[19] Peter Baldwin, *Contagion and the state in Europe, 1830-1930* (Cambridge: Cambridge University Press, 1999); Richard J. Evans, *Death in Hamburg: society and politics in the cholera years, 1830-1910* (Harmondsworth: Penguin, 1990).
[20] Erwin Ackerknecht, "Anticontagionism between 1821 and 1867," *Bulletin for the History of Medicine* 48, no. 22 (1948); R. J. Evans, "Epidemics and Revolutions - Cholera in 19th-Century Europe," *Past & Present*, no. 120 (1988).
[21] Robert Pollitzer, "Cholera Studies," *Bulletin of the World Health Organization* 10, no. 3 (1954).
[22] Gaspar Correia, *Lendas da India* (Lisboa: Edição da Academia Real das Sciencias, 1859).

conditions of the regions under their administration.[23] This information was crucial not only because of its usefulness in the creation of colonial policies, but also because, in the case of cholera, it allowed European medical communities to recognise the symptoms of the disease.

Cholera, endemic in India up to the 1800s, spread globally in six successive pandemic waves from the beginning of the nineteenth century.[24] The first pandemic, 1817-23, affected the Asian continent, the Indonesian Archipelago, the Persian Gulf and the oriental part of Russia. The second wave, from 1826 to 1837, arrived in the Western states of Europe from 1831 onwards. Subsequently, cholera appeared in Europe during four other major pandemic outbreaks – 1846-1862, 1864-1875, 1883-1894 and 1899-1923.[25] Other epidemic diseases were also present in nineteenth-century Europe. However, when compared with cholera, plague and yellow fever were not as rampant in the continent. The impact of cholera on nineteenth-century societies was so profound that Charles Rosenberg and other historians claimed that responses to the disease came from all sectors of society; they transpired values and attitudes in the areas of science, religion, and governance. Epidemic diseases – and cholera in particular – provide a sampling device to help understand societies and change.[26] As this dissertation will show, the ISC, as a conference composed by state envoys, allows us to understand how states formulated national epidemic governance positions while allowing space to consider how individual agency played into this process.

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[23] The flux of communication between the two imperial poles lasted up to the last days of the empire. Anna Crozier explores the relations between the metropolis and the doctors working for the Colonial Medical Service during the nineteenth and twentieth centuries. Anna Crozier, *Practicing Colonial Medicine* (New York: I. B. Tauris, 2007).

[24] Different writers defend divergent dates of onset and duration of successive pandemics. In 1882, H. Haneser proposes four waves: 1816-37; 1840-50; 1852-60 and 1863-73. A. Hirsh (1883) also describes four major outbreaks: 1817-23; 1826-37; 1846-63 and 1865-75. Pollitzer, "Cholera Studies."

[25] The last cholera outbreak in Europe was in Portugal in 1974, when a set of contaminated bottles of mineral water was put out on the market. R. J. Morris, *Cholera, 1832: the social response to an epidemic* (London: Croom Helm, 1976).

[26] C. E. Rosenberg, "Cholera in Nineteenth-Century Europe - Tool for Social and Economic Analysis," *Comparative Studies in Society and History* 8, no. 4 (1966). Michael Durey made established a similar argument: Michael Durey, *The return of the plague: British society and the cholera, 1831-2* (Dublin : [New York] :: Gill and Macmillan Humanities Press, 1979).
Both authors based their historiographical position on Asa Briggs' invitation to look at cholera as a historical object capable of unravelling multiple social dimensions. Asa Briggs, "Cholera and Society in the Nineteenth Century," *Past and Present* 19, no. April (1961); ibid.

Since George Rosen's pioneering *History of Public Health*, historians have devoted considerable efforts in order to understand those which he considered the most important function of modern states.[27] Rosen claimed that public health, as a conceptual umbrella that covers health governance, has changed considerably throughout history.[28] Throughout time, public health has been increasingly institutionalised. The international public health agreements described by Carlo Cipolla were in part possible through the very process of institution and formalisation of public health into permanent public health organisms. In Tuscany, this process occurred during the 1600s. Facing a plague outbreak, the Florentine government formed a permanent board of health with the capacity to coordinate national epidemic surveillance by employing doctors and state officials. Based on the idea of environmental pollution, the board of health attributed epidemic outbreaks to malevolent odours generated by waste, filth, and stagnancy.[29] By looking at the dynamics between physicians and state administrators, Cipolla traced the history of formalisation of public health institutions and practices.

The institutional dimension of public health has been an important line of inquiry for historians. Mathew Ramsey has analysed how the unstable political climate of post-Revolutionary France shaped the national programme of public health. Although the first central institution for the coordination of public health initiatives was founded in 1776,[30] the first half of the nineteenth century had been marked by stronger initiatives. Medical elites forged alliances with administrative machineries such as

[27] George Rosen, *A History of Public Health*, MD monographs on medical history ; no.1 (New York: MD Publications, 1958).
[28] Ibid.
[29] Carlo M. Cipolla, *Miasmas and disease : public health and the environment in the pre-industrial age* (New Haven ; London: Yale University Press, 1992).
[30] Earlier, facing plague outbreaks in 1720 in Marseilles, the French government had tried to coordinate prophylactic measures at a national level. However, these efforts were little more than ad hoc responses to an epidemic crisis. For most of the Old Regime, Matthew Ramsey argued, France lacked a permanent institution at a national level devoted exclusively to public health. This tendency was reversed in 1776 when the Royal Society of Medicine was established in order to investigate and regulate epidemic and epizootic diseases, remedies and mineral waters. Like the Florentine Board of Health, the Society encouraged the elimination of environmental health hazards while compiling reports on the local topographical and meteorological conditions. This institutionalisation shift marked the emergence of a medical bureaucracy with jurisdiction over public health. The bureaucracy extended its control to the population of the entire kingdom, in contrast to previous initiatives, which were exclusively dedicated to urban centres. Matthew Ramsey, "Public Health in France," in *The History of Public Health and the Modern State*, ed. Dorothy Porter (Atlanta: Rodobi, 1994).

the Ministry of the Interior or the Ministry of Agriculture and Commerce in order to establish epidemiological and demographical investigations and public health programmes.[31] In addition to the founding of new institutions like the Royal Academy of Medicine and the Central Sanitary Commission to promote research, advise the central government, and design and implement prophylactic policies, a new legal framework was developed in France and in 1822 legislation granted the 'monarchy virtually dictatorial powers in times of epidemic emergency.'[32]

The centralisation quest was further advanced with the Revolution of 1848 and the creation of a new consultative body under the Ministry of Commerce and Agriculture: the Consultative Committee on Public Hygiene. The new Committee supervised a network of advisory councils of pubic health, and by 1851 was entrusted to coordinate the work of epidemic doctors.[33] French public health was increasingly centralised by the efforts of the government. In parallel, according to Ann La Berge, this institutionalisation movement was paired with the creation of a professional community of hygienists bonded by publications, training and ideologies.[34]

Dorothy Porter has shown that in England, attitudes towards public health reflected general values of society, which tried to keep the size of the state to a minimum. Within this constraint, the search for solutions to the epidemic costs of nineteenth-century economic, demographic, and urban expansion passed through the construction of bureaucratic structures that allowed the growth of public health administration. These efforts were driven by the actions of central government but mostly relied on local government for their practical application.[35] In fact, in contrast to the absolutist continental states, English counties, boroughs, and parishes were

[31] Ibid.
[32] Ibid.
[33] Ibid.
[34] Ann Elizabeth Fowler La Berge, *Mission and method: the early nineteenth-century French public health movement*, Cambridge history of medicine (Cambridge ; New York: Cambridge University Press, 1992). See also Erwin Ackerknecht, "Hygiene in France, 1815-1848," *Bulletin for the History of Medicine* 22, no. 2 (1948).
[35] Dorothy Porter, *Health, civilization, and the state: a history of public health from ancient to modern times* (London: Routledge, 1999).

responsible for their own affairs, and developed a set of traditions and institutions adapted from local circumstances and available resources.[36]

Organised around the ideas of poverty and social reform, the public health movement in England was marked by a multitude of local approaches that often lacked a coherent uniformed nexus. As such, as Christopher Hamlin has demonstrated, the legitimacy and limits of central government intervention were persistently questioned during this period.[37] In the wake of epidemic outbreaks like typhus and cholera, the central government authorised the creation of local boards of health. However, as Gerry Kearns clearly stated, not only did these boards have to compete with several other local authorities in their response to environmental problems, but their actions were also constrained by central boards of health, poor commissions, sanitary commissions, and the Privy Council, all sitting in London. From a legal perspective, public health – as a manifestation of the hygienist movement – involved laws dedicated to poverty, quarantine, trade, removal of nuisances, and others. Public health, therefore, was far from a uniform body in nineteenth-century England.[38]

In their analysis, Cipolla, Ramsey, La Berge, and Hamlin interwove legal and medical sources while providing larger philosophical contexts in order to explain the distinct processes of the formalisation of public health.[39] In addition, these authors explained the institutionalisation of public health by looking at professional dynamics in these countries. The analysis of professional discourse also allowed Charles Rosenberg and Robert Morris to show how concepts of epidemic diseases varied in time and from community to community. Priests, doctors, and state administrators produced professionally coherent discourses on the nature and cause of diseases while offering solutions for treating and avoiding future outbreaks.[40]

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[36] Christopher Hamlin, "State Medicine in Great Britain," in *The history of public health and the modern state*, ed. Dorothy Porter (Amsterdam: Rodopi, 1994).*p*134

[37] ———, *Public health and social justice in the age of Chadwick : Britain, 1800-1854* (Cambridge: Cambridge University Press, 1998).

[38] See Flinn's detailed introduction on the roots of the sanitary movement. Edwin Chadwick and M. W. Flinn, *Report on the sanitary condition of the labouring population of Great Britain: 1842* (Edinburgh: Edinburgh University Press, 1965).

[39] See also Hamlin, *Public health and social justice in the age of Chadwick : Britain, 1800-1854*.

[40] Rosenberg, "Cholera in Nineteenth-Century Europe - Tool for Social and Economic Analysis."; Morris, *Cholera, 1832: the social response to an epidemic*.

Scholars have also associated specific prophylactic discourse with a multitude of variables. In a seminal article, Erwin Ackerknecht linked individual ideologies with the support of prophylactic tools that varied in the degree to which they affected individual liberties.[41] However, in an extensive international comparative study, Peter Baldwin argued that the geo-position of a country influences its adopted prophylactic measures more than political ideologies.[42] These claims tend to be problematic since they oversimplify arguments and do not account for the multitude of co-existing positions. Margaret Pelling and Vinten-Johasen *et al* unravelled the diversity of professional aetiological and prophylactic opinions through a close look at medical and state authority discourses. Despite the fact that nineteenth-century medical positions operated in an axis that ranged between contagionism and anti-contagionism ideas, in reality, extreme positions were rarely found.[43]

By looking at quarantines as a specific prophylactic measure, historians have traditionally focused on the legal framework and the social impact of quarantine. For example, Charles F. Mullett claimed that through quarantine, the state progressively penetrated and restricted its subjects' liberties using the justification of public welfare.[44] J. C. McDonald argued that science was used in the interest of trade, to avoid the *de facto* use of quarantines in England.[45] More recently, in *Maritime Quarantine: The British Experience*, John Booker described an extensive debate between supporters and opponents of the practice of quarantine based on medical, economic, and political arguments.[46]

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[41] Ackerknecht, "Anticontagionism between 1821 and 1867."
[42] Baldwin, *Contagion and the state in Europe, 1830-1930*.
[43] Margaret Pelling, *Cholera, fever and English medicine, 1825-1865* (Oxford: Oxford University Press, 1978); Peter Vinten-Johansen, *Cholera, chloroform, and the science of medicine: a life of John Snow* (Oxford: Oxford University Press, 2003).
[44] C. F. Mullett, "A century of English quarantine, 1709-1825," *Bulletin of the History of Medicine* 23, no. 6 (1949).
[45] J. C. McDonald, "The history of quarantine in Britain during the 19th century," *Bulletin of the History of Medicine* 25, no. 1 (1951).
[46] See for example William Coleman, "Epidemiological methood in the 1860s: Yellow fever at Saint-Nazaire," *Bulletin for the History of Medicine* 58, no. 2 (1984); ———, *Yellow Fever in the North. The methods of early epidemiology* (Madison: University of Wisconsin Press, 1987); George D. Sussman, "From yellow fever to cholera a study of French government policy, medical professionalism and popular movements in the epidemic crises of the Restoration and the July monarchy" (Dissertation (PhD), Yale University, 1971).

In contrast with this nationally-bound view, historians such as Peter Baldwin have produced studies that either offer international comparisons of prophylactic practices, or elect international events as objects of research. While Baldwin's account offers a bird's eye view of what happened in Europe during a set period in terms of prophylactic policies, Valeska Huber's approach allows us to see what happens when different prophylactic strands come together in the moment of determining a position.[47]

Building on the extensive literature on the history of public health, international conferences and the social history of epidemic diseases, the aim of the dissertation is to contribute to the above described scholarly conversations by offering a comprehensive social historical account of the formation of the field of international public health through the lenses of medical knowledge and professional practices.

A theoretical approach

In order to understand how meanings and practices were negotiated at the ISC in order to create an international model of public health, this dissertation will follow a symbolic interactionist approach. Intellectually deriving from the Chicago School and created as a critical response to functionalist and quantitative sociological approaches, symbolic interactionist theory is based on the major premise that representations of reality are the result of negotiation between actors.[48] Human beings act toward things on the basis of the meaning that they ascribe to these things. Understanding meanings is central for the understanding of any social action. Thus, meaning is not a natural property of a thing; on the contrary, meaning, according to Herbert Blumer, arises from a process of negotiation between people:

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[47] Huber, "The Unification of the Globe by Disease? The International Sanitary Conferences on Cholera, 1851-1894." Bynum, "Policing Hearts of Darkness: Aspects of the International Sanitary Conferences."; Norman Howard-Jones, *International public health between the two World Wars : the organizational problems*, History of international public health ; no.3 (Geneva :: World Health Organization, 1978); ———, *The Scientific Background of the International Sanitary Conferences, 1851-1938*.

[48] On the emergence of the Chicago School between 1915 and 1940, and its singular methodologies and theoretical approaches, see Martin Bulmer, *The Chicago school of sociology: institutionalization, diversity, and the rise of sociological research* (Chicago: University of Chicago Press, 1984).

> the meaning of a thing for a person grows out of the ways in which other persons act toward the person with regard to the thing. Their actions operate to define the thing for the person. Thus, symbolic interactionism sees meanings as social products, as creations that are formed in and though the defining activities of people as they interact.[49]

In this sense, the process of interaction is not a 'neutral medium in which social forces play out their games, but the actual stuff of social organization and social forces.'[50] From an interactionist perspective, meaning and actions are not pre-determined. Science and scientific claims, understood within an interactionist perspective, depend and change according to society itself.[51]

In *Symbolic Interactionism in Social Studies of Science*, Adele Clarke and Elihu Gerson reviewed the impact of the interactionist perspective on the understanding of science and technology.[52] If the work produced within the interactionist perspective is vast in terms of elected objects, Clarke and Gerson claim that it is possible to find shared characteristics within this scholarship: for instance, a constant preoccupation with understanding social change in science and its relations with tradition and established scientific representations of reality. Instead of focusing on science as merely 'knowledge', these scholars refuse to 'divorce knowledge from interaction and social organization.'[53] They are more interested in the activities of producing knowledge and its work environment than in famous scientists or heroic physicians. In this sense, the laboratory, the museum and other formal/informal spaces of circulation of knowledge are places that create disciplines and discipline scientific practices and representations. Moreover, these are places of translation and diffusion of knowledge through different social spheres and actors that contribute to a constant

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[49] Herbert Blumer, *Symbolic interactionism: perspective and method* (Berkeley: University of California Press, 1986). *p*5.
[50] Howard Saul Becker and Michal M. McCall, *Symbolic interaction and cultural studies* (Chicago: University of Chicago Press, 1990). *p*6.
[51] S. Caroline Purkhardt, *Transforming social representations: a social psychology of common sense and science* (London: Routledge, 1993).
[52] Adele Clarke and Elihu Gerson, "Symbolic interactionism in social studies of science," in *Symbolic interaction and cultural studies*, ed. Howard Saul Becker and Michal M. McCall (Chicago: University of Chicago Press, 1990).
[53] Ibid., 180.

mutability of knowledge. The symbolic interactionist tradition in Science and Technology Studies (STS) demonstrates the 'inseparability of scientific knowledge and the work organization that produces it'.[54]

However, social interactionists have often been accused of denying the existence of reality with their radical social constructivism approach.[55] Trying to bring nature back to the STS debate, Sheila Jasanoff argued that science is the result of a process of co-production between the social and the natural world: 'society cannot function without knowledge any more than knowledge can exist without appropriate social support.'[56] Furthermore, Jasanoff used the term co-production to refer to processes that connect the production of knowledge with the organisation of policy-making. In her view, science and policy together define problems and create knowledge in the same way that they produce social problems and create solutions.[57] By avoiding both social and natural determinisms, this perspective brings an interpretive turn into social studies of science: it emphasises dimensions of meaning, discourse and textuality in the same way that symbolic interactionists do.[58] Jasanoff claims that nature limits social possibilities while multiple representations of reality can co-exist since they depend on communities of representations and practices.[59]

By following the ISC debates, it is assumed for the purposes of this dissertation that medical theories emerge under specific social conditions and that they are mobilised in relation to specific practices. Moreover, it is accepted that the practical, professional and social interests of these communities ultimately shape theories and

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[54] Ibid., 187.
[55] This debate received the label of 'science wars' and was strongly ignited by the Sokal affair (see Alan Sokal and Jean Bricmont, *Intellectual impostures : postmodern philosophers' abuse of science* (London: Profile Books, 1998); Alan D. Sokal, *Beyond the hoax : science, philosophy and culture* (Oxford: Oxford University Press, 2008).) See also Ian Hacking, *The social construction of what?* (Cambridge, Mass. ; London: Harvard University Press, 1999).
[56] Sheila Jasanoff, *States of knowledge: the co-production of science and social order* (London: Routledge, 2004). *p*2-3.
[57] Ibid.
[58] Ibid., *p*4.
[59] In the same way as ANT is well known for giving voice to scallops, this scholarship also talks about the rebellions led by river otters against humans. See T. L. Goedeke and S. Rikoon, "Otters as Actors: Scientific Controversy, Dynamism of Networks, and the Implications of Power in Ecological Restoration," *Social Studies of Science* 38, no. 1 (2008): 126.

concepts.[60] This idea allows us to understand why several actors presented different aetiological ideas at the Conference and how these strands changed during the six months so that a common agreement was eventually created. Moreover, by following the aetiological and prophylactic ideas that constituted the international public health model, this dissertation will look at the multiple identities of diseases. In this sense, the approach follows Ludmilla Jordanova's vision of social constructivism. By bringing diplomacy and state governance to the world of history of medicine, this dissertation will also look at particular images of diseases, find their roots and establish their implications.[61] By showing that diseases are not natural entities but social concepts deeply rooted in contexts, it will follow Charles Rosenberg's idea that diseases do not exist until their existence has been agreed upon, by perceiving, naming, and responding to them.[62]

Primary sources

This research is based on two types of primary resources: first, the Proceedings of the 1851 International Sanitary Conference are used to illustrate the official character of the ISC; secondly, material produced in order to support and contextualise the work of the delegates will provide a different angle on the process of constructing a model of international public health.

Printed following the end of each session in 1851-52, the proceedings offer a detailed image of the Conference's debates. Written in French, the official language of the Conference, they represent the official and final account of the ISC, sanctioned by delegates. The special collections of the University of Edinburgh, the Royal College of Physicians of Edinburgh, the National Archives in London, the Portuguese *Torre do Tombo* and *Arquivos Histórico Diplomático* allowed me to collect lost copies of

[60] Barry Barnes, David Bloor, and John Henry, *Scientific knowledge: A sociological analysis* (London: Athlone, 1996).
[61] Ludmilla Jordanova, "The Social Construction of Medical Knowledge " *Social History of Medicine* 8, no. 3 (1995).
[62] Charles Rosenberg, "Framing Disease: illness, society and history," in *Framing disease: studies in cultural history*, ed. Charles Rosenberg and Janet Golden (New Jersey: Rutgers University Press, 1991).

the individual session proceedings and combine them as a unit before the Harvard University Library's Open Collections Program digitised them.

As will be demonstrated in the dissertation, some delegates succeeded in altering the content of the proceedings in order to advance specific agendas. In a letter to the Foreign Office, Anthony Perrier, the English diplomatic envoy complained that these documents were not totally accurate.[63] In order to provide alternative sources to the Conference debates, I will combine the proceedings with the vast diplomatic correspondence exchanged between delegates and their home institutions. These documents were found at the National Archives in London, the Diplomatic Archive Centre of the French Ministry of Foreign and European Affairs, the Portuguese *Torre do Tombo* and *Arquivos Histórico Diplomático*. Because of the nature of diplomatic practices, I was also able to find a selected collection of letters sent to, or by, Austrian, Spanish, and Russian delegates and their authorities. At the Yale Francis A. Countway Library of Medicine and the University of Pennsylvania, I discovered private letters between John Sutherland, the British Foreign Office, and Edwin Chadwick.

In addition, medical publications on epidemic diseases were found at the special collections of the University of Edinburgh, the Royal College of Physicians of Edinburgh, the Royal College of Surgeons of Edinburgh, the British Library, the Wellcome Collection, the French National Academy of Medicine, the Portuguese *Torre do Tombo*, and the Lisbon Academy of Sciences. Final, additional printed material was traced through Google Books' efforts to digitise nineteenth-century collections.

Dissertation structure

The dissertation is divided into four chapters. Chapter one demonstrates how economic and political concerns about the impact of quarantine on international trade led to calls for international regulation and the standardisation of quarantine practices

[63] Perrier to Palmerston (private) Paris, 21 and 22 August 1851, TNA:PRO FO/97/210.

in the Mediterranean region. Drawing on medical reports, pamphlets and diplomatic correspondence, the chapter exposes the multitude of quarantine practices in the Mediterranean region and a growing international demand for prophylactic reform. These exchanges, it is shown, culminated in the organisation of the 1851 International Sanitary Conference in Paris.

Chapter two argues that the Conference challenged previous diplomatic and medical protocols by including two professional groups in the process of regulating international public health. The lack of precedent allowed diplomatic and medical delegates to establish new rules for the conduct of the Conference, which gave them a relatively high level of autonomy from the states they represented.

Chapter three focuses on the problems of constructing a shared aetiological classification and regulating quarantine practices. It shows that, although doctors gained progressive control over the Conference, it was ultimately diplomatic agendas that shaped the final outcome. In addition, it demonstrates that, rather than defending the elimination of quarantines, liberal states supported the continuation of quarantine practice in the Mediterranean; however, they did manage to place severe limits on its operation in practice.

Finally, chapter four examines how European and Oriental sanitary institutions were uniformly redesigned and new international judicial mechanisms created. These measures variously affected the sovereignty of the participating states by limiting their independent capacity to set national epidemic policies. However, it is argued that these negotiations took the shape of sovereignty bargains: by loosening control over specific elements of their sovereignty, states managed to advance their political, economic and sanitary agendas.

CHAPTER 1: Between diseases and desires: pursuing international regulation of public health

Quarantine in a stalling Mediterranean

In the early 1800s, Henry Matthews decided to leave Britain and explore the south of Europe. Matthews (1789-1828), the fifth son of a physician and poet from Herefordshire, was a fellow of King's College, Cambridge where he received a BA in 1812 and an MA in 1815. Like his colleagues at King's, Matthews was educated at Eton College before university.[64] Matthews decided to leave England not for sightseeing purposes, but because, being ill, he was ordered by his doctors to travel and 'run away from death'.[65] Although it is not clear what medical condition threatened his life so seriously, the rainy weather of Britain was probably considered responsible for the deterioration of his health. Like many of his British contemporaries who adventured at sea, Matthews endured the difficulties of sailing, but unlike others, he kept a diary where he registered the details of travelling during the nineteenth century and his ideas about quarantine.

On 12 September 1817, Matthews boarded the *Princess Charlotte*, a packet ship to Malta. With little sea experience, Matthews spent most of his days 'sick as a dog' and decided to disembark as soon as the ship reached Lisbon. Arriving from England with a clean bill of health, the *Princess Charlotte* received free pratique[66] straight away. Immediately, Matthews decided to explore the hilly streets of Lisbon. After a couple of days, he continued his journey to Italy on board the *Fanny*, a small trading vessel of about 140 tons burden. The sailing to Livorno took twelve long days, during which he endured the displeasures of seasickness. As soon as the *Fanny* approached Livorno, 'a boat from the Health-Office bailed [her] immediately, and

[64] Thompson Cooper, "Matthews, Henry (1789–1828)," in *Oxford Dictionary of National Biography* (Oxford: Oxford University Press, 2004).
[65] Henry Matthews, *The Diary of an Invalid: Being the Journal of a Tour in Pursuit of Health, in Portugal, Italy, Switzerland, and France, in the Years 1817, 1818, and 1819* (Paris: Baudry, 1836).p1
[66] Free pratique was the permission granted to a ship to use a port after quarantine, or on showing a clean bill of health.

[she was] ordered to perform a quarantine of ten days.'[67] The *Fanny* and her passengers

> weighed anchor, and were permitted to go within the mole into the harbour. […] And as [they] had a clean bill of health and there was, in fact, no ground for putting [them] under quarantine at all, [they] proceeded at once to this destination. Two officers of the Health-Office were put on board to prevent all intercourse with [them]. As soon as [they] were safely moored within the harbour, a boat full of musicians made its appearance under the cabin-window, and [they] were serenaded with 'Rule Britannia,' and 'God save the King.'[68]

While a group of Livornese sang '*Rule, Britannia! Rule the waves: Britons never will be slaves*', Henry Matthews thought about the very nature of quarantine. He recognised that, like any other laws, 'the quarantine laws […] though originally intended for the general good,' soon were 'perverted to private purposes.'[69] Like many other commentators of the time, he noticed that quarantine often challenged the conventional boundaries of public and private good – or the interest of general public health versus the interests of trade in a period of growing international commerce. To Matthews, the business of quarantine was no more than a formality. After all, the *Fanny* was moored next to a 'multitude of vessels of all nations packed together higgledy-piggledy, as close as sheep in a pen.'[70] Matthews wrote ironically, in his diary, that this strange way of governing diseases in Livorno was 'a rare precaution against infection.'[71] According to his account, 'the true cause of these strict regulations […] [was] the emolument derived from them by the Health-Office.'[72]

The transport of cargo and people during the first half of the nineteenth century was an expensive and time-consuming affair. On the one hand, overland transportation was directly dependent on the quality of roads and the weather.[73] On the other, sea-shipping speed was heavily dependent on weather and sea conditions. Furthermore,

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[67] Matthews, *The Diary of an Invalid: Being the Journal of a Tour in Pursuit of Health, in Portugal, Italy, Switzerland, and France, in the Years 1817, 1818, and 1819.p*24
[68] Ibid. *p*24
[69] Ibid.
[70] Ibid.
[71] Ibid.
[72] Ibid.
[73] Ann Norton Greene, *Horses at work: harnessing power in industrial America* (Cambridge, MA: Harvard University Press, 2008). See chapter 2: *A Landscape for Horses.*

the imposition of up to 60 days of quarantine increased the duration of travelling, the escalation of costs associated with the lack of commercial activity and the unpredictability of the duration of the journey. Many travellers and merchants were unsure of the duration of quarantine to which their vessel would be subjected.[74] Travellers such as Henry Matthews complained about the enforcement of this strategy, and they were not alone. Ship owners, merchants and doctors voiced their concerns with respect to these measures. In this chapter, I survey attitudes towards quarantine and demonstrate how distrust and opposition to this prophylactic technology fed an intense diplomatic debate which eventually culminated in the organisation of the 1851 ISC. I argue that quarantine was far from an exclusively medical issue. On the contrary, it affected and resulted in responses from several groups, who struggled to reconcile this sanitary technique with the situation that they witnessed in reality.

As such, this chapter will unveil national agendas and the negotiation of an international agenda of public health. It will contribute to a better understanding of the eclectic practices of quarantine within the Mediterranean Sea.

Quarantine could, perhaps, have been a profitable business for some in the nineteenth century,[75] but it was a major inconvenience for many. Furthermore, many questioned its efficiency as a prophylactic tool. However, there is also evidence of a large contingent of support for quarantine. Many doctors – and even politicians and travellers – believed that this measure was the only way to prevent diseases such as

[74] In a letter sent to the Editor of the Times, P.M., a British traveller who wished to travel to India, complained that on his departure from Constantinople he was informed that passengers arriving at Alexandria would be subjected to a quarantine of 15 days. However, on his arrival at the Egyptian port, local health authorities decreed a mandatory quarantine of 21 days. In addition to the inconvenience of an additional six days of quarantine, P.M. reported that he was forced to 'endu[r]e the misery of being incarcerated in the vilest lazaretto in the Mediterranean. The rooms are dark, gloomy, most intolerably filthy, and abounding in vermin. (...) The windows are bar[r]ed like felons' cells, and are not glazed. (...) We are treated more like criminals than gentlemen.' P.M., "Lloyd Vapore Austriaco - Egyptian quarantine and steam navigation in the Red Sea. To the Editor fo the Times," *Times*, 15 December 1838.

[75] Although at this stage I have no clear evidence that demonstrates or quantifies the profitability of quarantine, it is easy to imagine that some social groups benefited from the practice of this prophylactic tool. For instance, a busy quarantine station serving several thousand passengers per year, would have to provide accommodation, food, water, bed lined, among other services. Sold in the grounds of the lazaretto, these commodities would provide solid income to providers. In this sense, it is easy to understand quarantines as a profitable business.

plague, yellow fever or cholera spreading via disembarkation in healthy ports. Although these groups did not deny the heavy economic cost of the measure, they believed that this was the price that must be paid for the preservation of public health, and took the debate over quarantine and the enforcement of this sanitary practice as a serious matter. An episode from Matthews' travelogue offers a good example of the extent to which public health officials were concerned with even the most minor details of quarantine practice. When he arrived in Livorno, a fowl flew from his ship into a neighbour vessel; facing an unpredictable breach of quarantine, health authorities debated extensively about what should be done in order to avoid possible contamination. Finally, 'it was determined […] that the fowl [should] remain where it was, till the quarantine of [the] neighbour [vessel] had expired.'[76]

It is possible that the Livornese authorities, like most quarantine partisans, were driven by contagionist ideas. According to these theories, diseases were transmitted to humans through contact with infected people, animals or cargo. It was also held that diseases could manifest either immediately or several days after contact. Therefore, in order to assure that there was no risk to public health, it was necessitated that quarantine last for the same duration as the incubation period of diseases. In physical terms, quarantine was designed as a barrier between vessels, people, cargo and local populations. Only after the required time had elapsed would authorities allow goods and passengers to be safely unloaded.[77] In this sense, the whole purpose of quarantine was to control potential sources of contagion. A fowl flying between vessels arrested under quarantine could compromise and jeopardise the health security of populations. There was no way to know whether the fowl - or any other object or living creature – was a vector for the transmission of disease. Quarantine, as an urban institution, was an attempt to shut cities down and avoid the

[76] Matthews, *The Diary of an Invalid: Being the Journal of a Tour in Pursuit of Health, in Portugal, Italy, Switzerland, and France, in the Years 1817, 1818, and 1819*. *p*26

[77] Roger Cooter, "Anticontagionism and History's Medical Record," in *The Problem of medical knowledge: examining the social construction of medicine*, ed. Peter Wright and Andrew Treacher (Edinburgh: Edinburgh University Press, 1982); Ackerknecht, "Anticontagionism between 1821 and 1867."; Baldwin, *Contagion and the state in Europe, 1830-1930*; Alison Bashford and Claire Hooker, *Contagion: historical and cultural studies* (London: Routledge, 2001); Margaret Pelling, "Contagion/Germ Theory/Specificity," in *Companion Encyclopedia of the History of Medicine*, ed. W. F. Bynum and Roy Porter (London: Routledge, 1993); ———, "The meaning of contagion: reproduction, medicine and metaphor," in *Contagion: historical and cultural studies*, ed. Alison Bashford and Claire Hooker (London: Routledge, 2001).

spread of diseases. Closing a city down was sometimes part of a nationwide strategy: this way, a disease outbreak would not only be avoided in a particular city, but also prevented from spreading throughout the country.

During the nineteenth century, quarantine transformed from a local problem into a national and transnational issue. It was one public health technique among many others;[78] however, unlike others, it juggled local and national interests, local traditions and national directives. Often, these contradictory interests were the bases of struggle in the context of the emergence of modern states in Europe (for instance, protecting the public health could mean closing a port city to trade, thus limiting a nation's access to particular goods and depriving merchants of income). Marked by growing and complex machineries of central administration, European states in the early nineteenth century tried to create national standards across their domains; this was usually achieved either by controlling access to certain professions or creating categories of citizens. Through these strategies, states managed to impose regularity and predictability on their territories.[79] As quarantine was typically controlled by local authorities and regulated with vague legal frameworks, it defied the central imposed order.

Usually, a vessel approaching a Mediterranean port would be intercepted by health officials and have its bill of health inspected. At the same time, local officials would assess onboard sanitary conditions and the type of transported cargo. After this information was collected and depending on the place of departure, the ship could be

[78] The nineteenth century was a period marked by an increasing public health effort. Works and policies were developed in several spheres of the urban landscape in order to improve the levels of morbidity, such as new city planning with wide streets and greater air circulation, introduction of sewage systems, improvement of the quality of drinking water, control of food provisioning, etc. See, for instance David S. Barnes, *The great stink of Paris and the nineteenth-century struggle against filth and germs* (Baltimore: Johns Hopkins University Press, 2006).

[79] See, for instance Michael J. Lacey and Mary O. Furner, *The State and social investigation in Britain and the United States*, Woodrow Wilson Center series (Cambridge: Cambridge University Press, 1993); Andrew Abbott, *The System of professions : an essay on the division of expert labor* (Chicago ; London: University of Chicago Press, 1988); Michael Mann, *The sources of social power. The rise of classes and nation states, 1760-1914* (Cambridge: Cambridge University Press, 1993); Dietrich Rueschemeyer and Theda Skocpol, *States, social knowledge, and the origins of modern social policies* (Princeton, N.J.: Princeton University Press, 1996); Dorothy Porter, *The history of public health and the modern state*, The Wellcome Institute series in the history of medicine, Clio medica ; 26 (Amsterdam: Rodopi, 1994).

presented with three different scenarios: (1) Free pratique; (2) quarantine of observation or (3) full quarantine. If a vessel were granted free pratique, she would be admitted to the port without delay, and her passengers and cargo would receive immediate authorisation to disembark. If, for whatever reason, a vessel were placed under observation, the ship would be escorted into an isolated spot, close to the harbour, and a group of quarantine guards would come aboard in order to ensure that no communication occurred between the vessel and the local population. Finally, if health authorities ordered full quarantine, the vessel would be escorted into the lazaretto and purified according to local practices, along with her cargo and passengers. During this period, communication with the outside world would not be allowed.

In any case, quarantine was a long, tedious and expensive sanitary measure that both merchant and navy vessels had to endure in order to receive free pratique. In 1834, a vessel arriving at a French port from Constantinople would be subject to 60 days of quarantine. However, if the same vessel, with the same cargo, docked in Venice or Trieste, the quarantine imposed would be 34 days (see Table 1). The duration of the imposed quarantine was decided by local administrations, who not only perceived epidemic risk differently, but also developed individual strategies to secure the health of the territories under their jurisdiction.

Place of departure[80]	Place of arrival	Duration of Quarantine[81]	Linear distance km (approx)[82]
Algeria	Genova	33	984
Algeria	Malta	20	1017
Algeria	Marseille	25	749
Algeria	Trieste	21	1331
Algeria *(Average 22.6)*	Venice	14	1235
Constantinople	French ports	60	2594
Constantinople	Genova	50	2386
Constantinople	Livorno	47.5	2260
Constantinople	Malta	50	2260
Constantinople	Trieste	34	2183
Constantinople *(average 45.9)*	Venice	34	2244
Egypt (Port Said)	French ports	44	2725
Egypt (Port Said)	Genova	46	2522
Egypt (Port Said)	Livorno	32.5	2375
Egypt (Port Said)	Malta	25	1794
Egypt (Port Said) *(average 36.8)*	Marseille	47	1191
Ionian Islands	Genova	35	1186
Ionian Islands	Malta	20	597
Ionian Islands	Marseille	30	1392
Ionian Islands	Trieste	21	999
Ionian Islands *(average 25.4)*	Venice	21	1047
Mexico (Vera Cruz via Gibraltar)	Genova	50	10368
Mexico (Vera Cruz via Gibraltar)	Malta	7	10626
Mexico (Vera Cruz via Gibraltar)	Marseille	7	10065
Mexico (Vera Cruz via Gibraltar)	Trieste	21	10770
Mexico (Vera Cruz via Gibraltar) (*average 21 days)*	Venice	21	10661
New York (via Gibraltar)	Genova	23	7388
'New York (via Gibraltar)	Livorno	20	7438
New York (via Gibraltar)	Malta	7	7636
New York (via Gibraltar)	Marseille	5	7078
New York (via Gibraltar)	Trieste	18	7791
New York (via Gibraltar)	Venice	18	7674

[80] Based on Dupeyron's 'Comparative table of quarantine in several Mediterranean ports'. Dupeyron groups all departures into eight major groups – 'Constantinople, North Sea, Enez and the Dardanelles'; 'Egypt, Syria, Ottoman Empire (with the exception of the above places of departure)'; 'Ionian Islands'; 'Northern Africa (except Algeria)';'Algeria'; 'Antilles and Mexico'; 'United States of America'; 'Places infected with cholera'. For the sake of the argument, I have chosen a major port within these categories in order to calculate approximate distances. Ségur Dupeyron, *Rapport Adressé à Son Exc. le Ministre du Commerce* (Paris: L'Imprimerie Royale, 1834).

[81] Includes quarantine and purification process. Dupeyron's original data offer detailed information on the length of quarantine according to the place of departure and the type of bill of health accompanying a vessel. However, these details are only available for 'Constantinople, North Sea, Enez and the Dardanelles'; 'Egypt, Syria, Ottoman Empire (with the exception of the above places of departure)'; 'Ionian Islands'. In order to offer a comparative perspective, I computed the averages of the length of quarantine for each place of departure. For example, for departures from 'Constantinople, North Sea, Enez and the Dardanelles', a ship could face 55 days of quarantine if it arrived in Livorno with a foul bill of health, and 44 days if it presented a suspicious bill of health. Hence, the average is 47.5 days.

[82] Approximate value calculated with Google Maps. By default, this number is an underestimate of the actual distance of travelling. Nevertheless, this data offers a clear proportional distance between a point of departure and a point of arrival.

(average 15.1)			
Northern Africa (Al Hoceima)	Genova	33	1492
Northern Africa (Al Hoceima)	Livorno	20	10422
Northern Africa (Al Hoceima)	Malta	20	1655
Northern Africa (Al Hoceima)	Trieste	21	1887
Northern Africa (Al Hoceima) *(average 28.4)*	Venice	21	1773

Table 1 Duration of quarantine according to place of departure

Disparities in the practice of quarantine were well known throughout the nineteenth century. In 1839, Arthur Todd Holroyd (1806-1887), a physician, jurist and explorer, sent an open letter on 'quarantine laws, their abuses and inconsistencies' to the Board of Control, the cabinet responsible for overseeing the British East India Company's businesses. Holroyd, who had recently returned from Egypt, Syria and the Mediterranean, argued that quarantine was unjust and nothing less than forced imprisonment.[83] Born in London, with an MD from the University of Edinburgh and an MB from Christ's College, he was an active member of several medical associations and also a traveller and member of the Royal Geographical Society.[84]

His letter on quarantine was published as a pamphlet in both London and Edinburgh in 1839. That year, the Dublin Journal of Medicine published a small review article of the letter, and in 1841 the Edinburgh Medical and Surgical Journal published a longer article about it.[85] In his letter, Holroyd was determined to demonstrate that quarantine was 'useless, inefficient' and had a direct impact on people and cargo that proceeded from India to England by the way of the Red Sea, Egypt, and Malta[86] – i.e. the major commercial routes that linked Europe with Asia. Furthermore, he

[83] Arthur Todd Holroyd, *The quarantine laws: their abuses and inconsistencies; A letter addressed to the Rt. Hon. Sir John Cam Hobhouse, Bart. M.P., President of the Board of Control* (London: Simpkin, Marshall & Co, 1839). *p*3

[84] H. T. E. Holt, "Holroyd, Arthur Todd (1806 - 1887)," in *Australian Dictionary of Biography* (Melbourne: Melbourne University Press, 1972).

[85] See "The Quarantine Laws, their Abuses and Inconsistencies. A Letter addressed to the Right Hon. Sir John C. Hobhouse, Bart., MP, President of the Board of Control by Arthur T Holroyd," *Dublin Journal of Medical Science*, no. 44 (1839). And "Messrs Bowring and Holroyd On the Oriental Plague and Quarantine. Observations on the Oriental Plague, and on Quarantine, as a means of arresting its Progress. Addressed to teh British Association of Scinece, assembled at Newcastle, August 1838. By John Bowring. Edinburgh, 1838. 8vo. Pp. 45. and The Quarantine Laws, their Abuses and Inconsistencies. A Letter addressed to the Right Hon. Sir John C. Hobhouse, Bart., MP, President of the Board of Control by Arthur T Holroyd," *Edinburgh Medical & Surgical Journal*, no. 147 (1841).

[86] Holroyd, *The quarantine laws: their abuses and inconsistencies; A letter addressed to the Rt. Hon. Sir John Cam Hobhouse, Bart. M.P., President of the Board of Control.p*3

claimed that liberal legislation should be adopted without 'endangering the public safety'[87] and that it would only be possible if all parties involved with quarantine were consulted. In his view, fear should be replaced by knowledge and ideology by experience and observation.

In order to gather and accumulate persuasive evidence relating to the issue of quarantine, Holroyd consulted doctors and consuls with diplomatic positions in the Mediterranean ports. Some, like Dr Gregson, believed that quarantine was in fact responsible for the propagation of diseases instead of diminishing it.[88] Others, like Dr Clot Bey, did 'not advocate the abolition of quarantines.' In his opinion, 'they are to a certain extent useful; but I should like to seem them freed from those thousand and one fiscal practices, which are antiquated and vexatious; I should like to see the interests most important to science, commerce, and humanity unshackled by self-interest.'[89]

In his open letter, Holroyd argued that quarantine, during the 1830s, was 'unphilosophical in theory, or pernicious in practice [and full] of contradictions, absurdities, and inconsistencies kept up from ignorance or interested motives.'[90] Holroyd noted, for example, that vessels were quarantined even when they departed from disease-free ports. Additionally, there were some cases where passengers and cargo received free pratique, but the ships that transported them were placed under quarantine. Furthermore, Holroyd claimed that, during the legislative process, doctors with solid knowledge about plague or cholera were not consulted. He concluded his letter by requiring the British Government to send a medical 'commission to the Levant, thoroughly to investigate the whole question.' Such a measure 'besides having the effect of placing quarantine upon a scientific and philosophical basis, would […] end in a material alteration and reduction of

[87] Ibid.*p*3
[88] Ibid.*p*35 Dr Gregson, like many others, argued that the sanitary conditions passengers experienced in quarantine stations (see note 11) were responsible for the propagation of diseases instead of controlling its spread.
[89] Ibid.*p*35
[90] Ibid.*p*64

[quarantine's] present lengthened period.'[91] Quarantine was, in the view of Holroyd, a paramount concern for everyone who was reliant on links between the West and the East. For that reason, he recommended that all those who had private and public interests in the Levant be consulted.

Administrators of rationality

Holroyd was not alone in highlighting the multiplicity of quarantine practices in Mediterranean ports. On the instructions of the French Minister of Commerce, in 1834 Ségur Dupeyron published a report on the sanitary regimes practised along the Mediterranean coast.[92] Dupeyron, Secretary of the Superior Health Council, received direct orders from the Minister to visit the 'lazarettos of Marseille, Toulon, Genova, Livorno, Venice and Trieste' in order to learn 'all its details, the interior and distribution of these facilities; to observe the practice of purification of cargo (…) and letters, to study the organization of these institutions as an ensemble and as individual parts, in short, to learn the rules that constitute the system of quarantines.'[93]

Like Holroyd, Dupeyron was not interested in looking at quarantine from a medical perspective, but instead from a historical perspective that could provide insight into the reality of quarantine and its effects. In his view, history was a tool that would allow him to understand (1) whether the importation of plague into Europe was linked with the increase of commerce; (2) whether lazarettos had higher rates of plague than cities, and (3) whether plague was specifically linked with particular departure places in the Levant. Furthermore, he suggested, the use of history allowed him to distance himself from doctors and their approaches to make sense of reality[94].

[91] Ibid.*p*65

[92] Dupyeron's report is a 93 page long printed publication by the Royal Press. Dupeyron uses historical tools in order to offer a series of events enabling him to read and produce conclusions on the efficiency of quarantine practices. Furthermore, he synthesises his argument in tables, where he crosses variables such as place of departure, place of arrival, type of bill of health, and duration in order to measure the effects of quarantine.

[93] Dupeyron, *Rapport Adressé à Son Exc. le Ministre du Commerce.p*4

[94] Dupeyron's use of history coincided with the growth of positivism philosophy and its appropriation by the political sphere. For instance, in 1827, two French administrators from the Ministry of Justice published the first issue of the annual publication of c*ompte général de l'administration de a justice*

Doctors often used historical evidence to shed light on medical issues; however, Dupeyron claimed, they had clear vested interests that orientated the collection and analysis of data. Dupeyron's work covered a long period, between 900 and the 1830s, whereas doctors' studies typically only covered a few decades. He saw himself as the first state official – an 'agent of administration' – who studied sanitary laws, a task previously held by physicians. Dupeyron's rational method opposed typical medical methods. In his opinion, it was not enough to claim whether or not a disease was contagious; he considered this polarised debate to be limiting. He argued that only if 'scientific considerations from both sides are presented in an absolute way we can decide a question which touches upon political economy.'[95] He believed that the management and treatment of diseases were, in fact, two separate spheres that belonged to different professions, and recommended that state officials 'should study ways of applying local police and judge what can be possible to adopt in France in the case of invasion' while 'doctors should only occupy themselves with treatment and prophylactic methods.'[96]

Following a detailed analysis of plague outbreaks in Europe since the tenth century, Dupeyron concluded that the disease had its origins in the Orient[97] and that 'commerce facilitated the transport of plague.'[98] In his view, the world faced an intractable problem. On the one hand, it was impossible to eliminate quarantine and the barriers that prevented trade from flowing freely. On the other hand, it was not possible to cease international trade and thus stop the transportation of diseases. Although trade enriched national treasures, Dupeyron warned, it was still in the

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criminelle en France. Like Dupeyron, they also used tabulated data – facts – which were classified by the Minister of Justice as 'exact knowledge.' This knowledge of facts 'is one of the first needs of our form of government; it enlightens deliberations; it simplifies them; it gives them a solid foundation by substituting the positive vision and reliability of experience for the vagueness of theories.' Piers Beirne, "Adolphe Quetelet and the Origins of Positivist Criminology," *The American Journal of Sociology* 92, no. 5 (1987).

[95] Dupeyron, *Rapport Adressé à Son Exc. le Ministre du Commerce*.*p*86

[96] Ibid. *p*86

[97] The Orient, as a category used by Dupeyron, included the territories between the domains of the Saracens (from Morocco to Constantinople) and the Greek empire. After analysing the place of departure of vessels that transported plague into Europe, Dupeyron noted that 50% departed from Egypt or Syria, 35.5% from other places and only 6% from Constantinople. Ibid.*p*35.

[98] Ibid.*p*15

'interest of a country […] not to neglect preventive measures that should obey reason and not exaggerate fear.'[99]

In these senses, lazarettos or quarantine stations (the physical places where quarantines were practised) represented a good compromise. Instituted first in Venice in 1423, other European harbour-cities soon followed its lead.[100] Even if it was clear to Dupeyron that lazarettos did not offer complete protection against diseases, he had no doubts that their implementation added an extra barrier of protection to local populations. For this reason, he claimed that 'communications between infected countries and healthy countries could not continue open without danger for the latter.'[101]

Like many of his contemporaries, Dupeyron was fully aware of the contagionist and anti-contagionist debate that marked the first half of the nineteenth century.[102] However, instead of endless theoretical debates on 'medical opinions', he believed in practicalities like 'finding ways of treatment and ways of prevention [of diseases,] other than the limited ones that we deploy today.' After all, he claimed, 'Jenner did not talk about the contagiousness of small pox, he discovered the vaccine!'[103] In his view, states should shift their attention towards rational observation in order to develop and enforce good mechanisms for disease prevention, and should also find and implement efficient methods of quarantine and purification.

In Marseille, Dupeyron found a model that could be exported to the rest of the Mediterranean. There, the Board of Health (the authority in charge of quarantine in the city) was composed exclusively of local merchants. Dupeyron claimed that this professional group had specific vested interests in eliminating the barriers imposed by quarantine; nevertheless, it was one of the most radical Boards in all the Mediterranean. These merchants were 'sometimes more severe than the government

[99] Ibid.*p*18
[100] Baldwin, *Contagion and the state in Europe, 1830-1930*; John Booker, *Maritime quarantine: the British experience, c.1650-1900* (Aldershot: Ashgate, 2007).
[101] Dupeyron, *Rapport Adressé à Son Exc. le Ministre du Commerce.p*24
[102] See Ackerknecht, "Anticontagionism between 1821 and 1867."
[103] Dupeyron, *Rapport Adressé à Son Exc. le Ministre du Commerce.p*27

could wish' in enforcing quarantine.[104] The attitude of the Marseillais merchants sounds puzzling, and seems to contradict their vested interests. It is easy to presume that merchants, above all, supported the elimination of barriers responsible for slowing down commercial enterprise. However, the merchants of Marseilles may have realised that the practice of quarantine was very much embedded in local and Mediterranean traditions of epidemic control. For this reason, instead of trying to abolish quarantine, they preferred to control it according to their own rules. Perhaps, in their opinion, it was better to have a world in which they could set the rules of quarantine than one driven by the rules of doctors or politicians.

The delays imposed by inspections and quarantine imposed specific temporalities on the nineteenth century (see Table 1). Quarantine and associated purification methods also inflicted costs and losses. Purification may have only rarely destroyed full bales of cotton, but it frequently ruined silk and delicate goods. Susceptible cargo was also often exposed to aeration in the lazarettos or on board, where the humidity of the night and the exposure to salt contributed to the deterioration of manufactured products.[105]

Like the duration of quarantine, purification strategies diverged widely between the Mediterranean ports. Aeration – the exposure of goods to the atmosphere – was, in Dupeyron's view, a particularly good example. In Genova, aeration never lasted longer than six days for vessels with foul or suspicious bills of health; in Livorno, 15 days were required for vessels with foul bills. In Trieste and Venice, three days for ships with suspected bills and six for those with foul bills were imposed. Finally, any French port would enforce six days of aeration of cargo for suspected bills and twelve for foul bills. Similarly, the techniques employed in the purification of letters varied from place to place. In Marseilles, correspondence was dunked in chlorine; in Livorno, vinegar was used; in Genoa they were quickly flamed; and in Trieste and Venice they were fumed in a solution of incense, potassium and sulphur.[106]

[104] Ibid.*p*28
[105] Ibid.*p*30
[106] Ibid.*p*76. The fumigation of letters was also practiced in Naples until January 1837 when the King of the Two Sicilies, Ferdinando Carlo, abolished it due to its 'absurdity'. Temple to Viscount Palmerston. Naples, 17 January 1837. BPP *p*182

Dupeyron also noted that quarantine targets were not based on rational choices but instead on other considerations. Upon linking outbreaks of plague in Europe with the places of departure of the vessels responsible for the transport of the disease, he claimed that Egypt was the recurring source of plague. Nevertheless, he noted, French quarantine was toughest on vessels which had departed from Constantinople – all vessels arriving from there received an automatic 'foul bill of health' and were obliged to endure long periods of quarantine. In his opinion, 'foul bills of health applied to Constantinople cause[d] great inconvenience, [were] not justified by experience and indirectly attack[ed] trade.'[107] Not only did vessels from Constantinople suffer prolonged quarantine periods, but their cargo was subjected to particular purification techniques that were invasive, violent and destructive. Unlike the Board in Marseilles, local authorities in Trieste and Livorno did not impose immediate foul quarantine upon vessels arriving from Ottoman ports. Because they treated these arrivals the same as any others, it was possible for Trieste and Livorno to offer them free pratique or quarantine of observation. The system in Trieste and Livorno, which was based upon different bills of health, had direct effects on the competitiveness of these ports: vessels with clean bills of health were immediately granted free pratique, which lowered the costs of shipping. This difference is a clear reification of the high heterogeneity of practices across the Mediterranean.

Based on his systematic observations, Dupeyron concluded that (1) there was a large space for manoeuvre to improve and reform French sanitary facilities and practices, and that (2) there was little agreement between European magistrates regarding measures of purification and the duration of quarantine. In order to overcome this problem and create a standard across Mediterranean ports, Dupeyron suggested the 'organization of a meeting of delegates of all Mediterranean countries.' In this conference, 'measures to be adopted against several suspected places of departure (…)[and] a common sanitary law applicable to all cases' ought to be discussed.[108] In his opinion, it was crucial to create a system where vessels arriving from Constantinople or the Black Sea would not receive immediate foul bills of health, but

[107] Ibid. *p*38
[108] Ibid.*p*84

instead would be granted free pratique if no plague was present at the point of departure and if onboard heath conditions were adequate. Dupeyron also defended vessels which were non-susceptible to infection, claiming that they should receive immediate free pratique without quarantine or purification. He argued that Mediterranean countries should abolish the practice of aeration, without increasing the length of quarantine. Finally, he requested that all forms of quarantine be eliminated for vessels arriving with clean bills of health from the Antilles and the United States.

Doctors and quarantine

The French government did not immediately implement Dupeyron's suggestions. In fact, it was a German doctor who was credited with the idea of organising an international congress where sanitary matters could be negotiated across European states. According to a long article published in the *Journal de débats politiques et littéraires* on 10 November 1838, 'Doctor Bâtard proposed that the emperor of Russia and the King of Prussia should participate in the organization of a congress of men of state and physicians that shall be nominated by all maritime powers of Europe and shall research ways of improving sanitary measures currently employed against epidemic diseases in general and plague in particular.'[109] Bâtard's authority, he asserted, was based on long experience with plague. He claimed to have treated no less than '25 to 30.000 people and explored 400 corpses without contracting the disease.'[110] Articulating the knowledge of scholars and the experience of legislators, Bâtard aspired to solve the problem of plague in Europe, as had been done in the Orient, and thus 'make the history of plague *a dead book*'.[111] Of course Bâtard was not the first or the only medic to elaborate on the efficiency of quarantine. If we look at medical journals like the *Lancet*, the *Gazette Médicale de Paris,* or the *Archives Générales de Médecine*, it is clear that there was a long medical debate on this topic. However, Bâtard was one of the first doctors to bridge the world of medical

[109] A. Bulard, "Congres Sanitaire Europeen," *Journal de débats politiques et litteraires*, 10 November 1838.
[110] Ibid.
[111] Ibid. Italics in the original.

publication and the world of daily newspapers, by requesting the organisation of an international congress to negotiate sanitary standards.

Bâtard planned to organise a congress composed of physicians and administrators. Located in Malta, 'the congress [should] elucidate the truth of the contagion of plague and apply this knowledge into *universal* sanitary legislation.'[112] In his view, the combination of medical knowledge and systematic experimentation would allow old medical disputes to be solved, and, at the same time, enable legislation to be produced that would forever free humanity from plague. Bâtard's congress would make full use of humans for experimentation, in order to understand the aetiological, pathological, therapeutic, and prophylactic natures of plague.

In order to 'determine *the natural limits, modes of invasion, and modes of spread of the disease*', Bâtard requested that the congress make full use of historical evidence and validate any conclusions via experimentation. The collection of historical data would allow congressmen to shed light on the nature of plague, and experimentation would make it possible to clarify 'if plague spreads by immediate contagion, mediated contagion, at distance, by inoculation.'[113]

To standardise knowledge and practices, Bâtard came up with a complex agenda of experiments to be followed during the international meeting. All experiments would be repeated several times, in several places and with different subjects, in order to ensure the validity of results across countries, latitudes and peoples. He asked for the experimentation to be conducted with control populations, which would allow scientists to extrapolate from the results. Bâtard's aim was that, during the congress, subjects of any particular experiment should include, for example, foreigners and indigenous people, or vaccinated and non-vaccinated individuals, or healthy people and people infected with smallpox. Given that the very nature of the experiments would pose severe risk to human lives, Bâtard suggested the use of prisoners as subjects. After all, in his view, they owed a debt to humanity.[114]

[112] Ibid. My italics.
[113] Ibid.
[114] Ibid.

Bâtard proposed that the congress should conduct pathological experiments in order to determine 'by which ways the morbid invasion proceeds, but also to understand the nature of symptoms and lesions that compose the plague.'[115] Furthermore, he maintained that the medical delegates' task was to study therapeutic options and to 'verify all treatments and medications already considered inefficient [!]'[116] Finally, he declared, doctors should assess the 'true value of prophylactic measures and their absolute preventive properties.' The knowledge produced from the completion of the above four steps would underpin sanitary reform in the Mediterranean, inspired by 'grand humanitarian thought.'[117] Following the conclusion of the medical agenda, the international delegates should initiate the administrative work. Bâtard insisted, *ad nauseam*, that science and experimentation should form the backbone of the congress and that all decisions would be based on those two important paradigms. Nevertheless, even before the work of the conference started, he was sure that 'all European maritime lazarettos […] should be replaced by one unique central lazaretto in the middle of the Mediterranean.'[118] According to Bâtard, this new sanitary institution would not employ fuming as a disinfection technique. In his opinion, fuming letters and goods was 'ridiculous' and inefficient.[119] Bâtard did not hesitate to declare that, if his directives were followed, plague would disappear. Furthermore, he claimed, the centralisation of the system of quarantine via a single Mediterranean sanitary station would allow enhanced control over sanitary practices and avoid granting despotic individuals too much power. Interestingly enough, Bâtard links despotism with greedy local sanitary officials and boards of health, and not with a central monopoly of resources. In his view, centralisation was synonymous with the standardisation of the quarantine system in the Mediterranean and would be a tool against despotism. In opposition to travellers, but like Dupeyron, Bâtard wished to construct a rational system of quarantine based on experimentation and systemic knowledge. Neither Bâtard nor Dupeyron wished the reformed Mediterranean system of quarantine to be inspired by fear and anxiety.

[115] Ibid.
[116] Ibid.
[117] Ibid.
[118] Ibid.
[119] Ibid.

The diplomatic initiative

Bâtard did not acknowledge Dupeyron's report, instead claiming full credit for the *innovative* idea of organising an international congress to discuss sanitary practices. However, a few months before his article was published, efforts had been made to negotiate transnational legislation that would impose uniformity in the practices of quarantine and purification within the Mediterranean. Interestingly enough, the major stimulus for these negotiations did not come directly from doctors, travellers, or merchants, but from the diplomatic sphere. After all, diplomats, particularly consuls based in major overseas ports, played a major role in travellers, doctors and merchants' communication with national governments. These groups tended to address their complaints about quarantine directly to diplomats, who mobilised their resources in order to tackle problems perceived as unjust both at local and international level. For this reason, diplomats were involved in the business of quarantine from early on. In this section, I will present two distinct stories that eventually converge into a common narrative. The first, from a British perspective, is led by naval interests. The second, from a French perspective, is driven by commercial interests. Throughout this section, I will refer to diplomatic correspondence in order to show how an international agenda was constructed and how, in letter after letter, agreements and tensions were teased out. I will show how national interests were played out and negotiated in a diplomatic world marked by internationalism and finally, will demonstrate the growing importance of the business of quarantine, with several European states attempting to control the length and practices of quarantine in the Mediterranean.

On 15 April 1838, Admiral Robert Stopford, Commander-in-Chief of the Mediterranean Fleet, wrote to Major-General Sir Henry Frederick Bouverie, Governor and Commander-in-Chief in Malta from 1836 to 1843, complaining about the extraordinarily lengthy practices of quarantine on the island. For Stopford, it was incomprehensible that a naval vessel arriving from Constantinople with a clean bill of health, no sick persons on board and in 'as good and healthy a state as is possible for [a] ship to be' could be subject to the same period of quarantine as any merchant

ship, especially when his vessel carried a doctor on permanent duty.[120] Although Bouverie agreed with Stopford, neither he, as Governor of Malta, nor the Board of Health of the Island had any power to change the situation. In fact, Bouverie's hands were tied. The practice of quarantine and purification in Malta was deemed proper and efficient across Mediterranean states. For this reason, vessels departing from Malta received automatic free pratique throughout the Mediterranean. However, this *status quo* could only be maintained if merchant and naval vessels alike performed the required quarantine. In his reply, Bouverie suggested that if Malta unilaterally imposed new rules, 'the immediate consequence would be the interruption of the free pratique of the island with the continent'[121] and every vessel departing from Malta would be subject to a new quarantine at its destination. Both Stopford and Bouverie were very aware of the importance of the British navy's role in securing commercial and geopolitical interests in the Mediterranean. In carrying out this role, strength was not a sufficient tool of control and surveillance by itself. In order to control the Mediterranean, the British navy had to be able to move fast from one point to the other, and quarantine could jeopardise these operations. In fact, if a vessel was quarantined in Marseilles, it could be detained for a long period before it was able to depart for a new mission.[122]

The navy letter sent to Bouverie followed normal British bureaucratic routes and, around May 1838, reached the Admiralty in London. From there it was transmitted to Lord Glenelg, Secretary of State for the Colonies and responsible for Maltese affairs. Glenelg was in complete agreement with Bouverie and Stopford. He went as far as to condemn the imposition of quarantine upon HMS as 'repugnant.' However, like Bouverie, Glenelg saw Malta as an important piece of the complex international jigsaw of trade and quarantine, and, to the dismay of many, held that Britain could

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[120] Admiral Stopford to Major-General Sir H. F. Bouverie, Malta, 15 April 1838, Great Britain Foreign Office, *Correspondence relative to the contagion of plague and the quarantine regulations of foreign countries, 1836-1843* (London: Harrison, 1843). (henceforth, CRC) *p*5.

[121] Major-General H. F. Bouverie to Admiral Stopford, Malta, 16 April 1838, CRC *p*6.

[122] On the importance of the British navy in securing Mediterranean interests see C. I. Hamilton, *Anglo-French naval rivalry, 1840-1870* (Oxford; New York: Clarendon Press ; Oxford University Press, 1993); C. J. Bartlett, *Great Britain and sea power, 1815-1853* (Oxford: Clarendon Press, 1963); Michael Lewis, *The Navy in transition, 1814-1864; a social history* ([London]: Hodder and Stoughton, 1965); S. W. C. Pack, *Sea power in the Mediterranean: a study of the struggle for sea power in the Mediterranean from the seventeenth century to the present day* (London: Barker, 1971).

not act unilaterally; to do so would risk the right of free pratique granted by European ports to vessels departing from Malta.[123] Recognising that the issue was larger than colonial administration, Glenelg contacted the Foreign Office, which initiated negotiation with several Mediterranean states in order to decrease the duration of quarantine for naval vessels. On 11 June 1838, Viscount Palmerston, the Foreign Secretary, dispatched a letter to Frederick Lamb, Ambassador at the Court of Vienna. Palmerston was interested to know how many days of quarantine the Austrian government required from the Maltese authorities in order to continue granting free pratique to vessels departing from Malta and arriving at Trieste.[124]Additionally, the Foreign Secretary asked Lamb to persuade Austrian authorities to accept 15 days as the maximum period for which vessels could be quarantined in Malta.

Meanwhile, on 12 June 1838, Palmerston wrote to his ambassadors and consuls in France, Sardinia, Tuscany and Naples. He acquainted them with the complaints raised by the Admiralty and requested them to 'draw the attention of the Sardinian [and other] Government[s] to the marked difference which exists between a ship of war and a merchantman, with respect to liability to convey infectious diseases.' He wrote, 'the order, regularity, cleanliness, and medical attendance, which are found on board a ship of war, render such a vessel far less likely than a merchant man to have infectious disorders on board: while the sense of honour and the professional responsibility of the Commander of a ship of war to his Government give the declaration of such officer as to the state of health of his crew, a very different value from that which could attach to a similar declaration made by the master of a merchantman.' Thus, he expected these governments to decrease the length of quarantine for navy vessels to 'fifteen days, from the time of sailing from the last place of departure liable to quarantine; so that, if a ship of war shall have performed that period of quarantine at Malta, and shall come from Malta to a Sardinian [or any other Italian] port, without touching intermediately at any place, which would render

[123] Mr Stephen to Sir John Barrow, Downing Street, 25 May 1838, CRC *p*7.
[124] Viscount Palmerston to Sir Frederick Lamb, Foreign Office, 11 June 1838, CRC *p*7. Trieste was the major Austrian port in the Mediterranean.

such ship liable to quarantine, such ship shall be immediately admitted to free pratique.'[125]

On 6 July, the Foreign Office received a reply from his ambassador in Vienna. Frederick Lamb reported that, after addressing the head of the quarantine department, it was clear that Austria was not keen to change its sanitary regulations unilaterally. As in Malta, Austrian authorities feared that if they imposed new quarantine rules, free pratique rights granted by other nations would be jeopardised. That had already occurred when Austrian authorities allowed the 'premature admission to pratique of an ambassador coming from Constantinople.' Following that event, departures from Trieste were immediately put under quarantine in Toulon and Marseilles. Although Lamb and the Austrian administrator recognised that, individually, the states had no power to modify the actual system of quarantine, both agreed that, if a group of nations initiated negotiations for the development of common sanitary standards, other nations would join them since 'commercial and financial interests of the Mediterranean States, as well as those of their armed fleets, [...] demanded a general revision' of quarantine regulations. The Austrian authorities claimed that due to 'the great experience of this Government in questions of quarantine, Vienna would be the best point on which to assemble Commissioners for the purpose.'[126]

The concern about quarantine in the Mediterranean was not exclusively British. Following Dupeyron's report, France was also determined to change the practice of quarantine in the Mediterranean in order to facilitate trade, and engaged in formal negotiations with several European states. While Britain informally approached Austrian authorities, France had contacted the Austrian Empire first, in early July.[127] But even before that, French diplomats had contacted several other Mediterranean states in order to organise an international meeting at which a new sanitary system would be discussed. On 22 May 1838, roughly two weeks before the British Foreign Office ordered its ambassadors and consuls to contact several European

[125] Viscount Palmerston to Sir A. Forster, Foreign Office, 12 June 1838 in CRC Sardinia *p*162
[126] Sir Frederick Lamb to Viscount Palmerston. Vienna, 6 July 1838 in CRC Austria *p*8
[127] Baron Langsdorff to Prince Metternich, Vienna, 4July 1838, CPR *p*13.

governments, the French Minister of Foreign Affairs, Count Molé, dispatched a letter to his Ionian Islands consul, Despreaux de St. Sauveur,[128] requiring him to negotiate the participation of the government of the Ionian Islands in a future international sanitary conference. St. Sauveur received a similar letter to the rest of the French diplomats contacted by Molé. Molé noted that 'the divers[e] sanitary practices in different Mediterranean ports, the frequent variations of the adopted dispositions, and the arbitrary action that many times presides its application' made any future agreement difficult to reach.[129] Nevertheless, France wished to organise 'a meeting of delegates of all Mediterranean countries' in order to establish a common law for all nations. The French Minister of Foreign Affairs suggested that at this future conference, participants would be required to assess the current sanitary measures applied to plague, yellow fever and cholera and 'determine which [measures] we can attribute a real efficacy, we can achieve uniformity and suppress all unnecessary measure[s] that create obstacles to commerce.' Furthermore, in order to create a uniform sanitary system in the Mediterranean, France believed that the future delegates would need to debate and negotiate consensus surrounding six major points previously voiced by Dupeyron in his report:

> 1. To fix a maximum and a minimum of quarantine for arrivals suspected of plague, yellow fever, and cholera.
> 2. To determine the nature and the expense of purification, both in the lazarettos and on board.
> 3. To revise the two-fold list of commodities susceptible and not susceptible.
> 4. To regulate the use of health officials while vessels perform quarantine in national and foreign ports. And to fix the number of days which might be deducted from the quarantine of such vessels.[130]
> 5. To fix a tariff for the pay of the health officials taken during the stay in a foreign port, and for the expenses of the return of the said officials.
> 6. To determine the conditions upon which certain countries actually suspected might obtain alleviations of quarantine for arrival from them.

The list was not exhaustive. Through his consular services, Molé assured the Ionian Government that the agenda of the future conference was open to any suggestion that could 'facilitate the interests of commerce.' However, Molé was very clear on one

[128] The French Minister of Foreign Affairs sent identical letters to Malta and Vienna on 9 June 1838.
[129] Count Molé to M. Despreaux de St. Sauveur, Paris, 22 May 1838 in CRC France p.90.
[130] Point 4 is my own translation from the original French letter. Both in point 4 and 5 I opted to change the word *guard of health* for *health official*. In this particular case, the original meaning is closer to 'sanitary police' than to 'health official.' However, given that the first could be seen as a type of health official, I decided to opt for this nomenclature.

point: France was not going to accommodate commercial interests if they, in any way, compromised public health.[131]

Interestingly enough, the universalism typical of France was not fully transposed onto the organisation of these conferences. One might expect them to develop a worldwide solution to tackle a *world united by disease*.[132] However, France instead limited the agenda of the future conference to the Mediterranean. In the view of the French government, the world was not equal in its geographical characteristics. Specific latitudes demanded specific, individually tailored sanitary approaches. In order to tackle Mediterranean sanitary issues, states needed to develop strategies different from those enforced in the Americas, Africa, or in Asia. Even countries around the North Sea demanded specific actions different from the ones practiced in the Mediterranean Sea, as they were clearly within a different geographical location. Molé believed that the differences imposed by geography would not realistically allow the constitution of a 'rigorous uniform system in southern, oceanic and English Channel ports', and that countries such as Belgium and Holland had no place in the discussion of Mediterranean affairs. The inclusion of Britain was strictly linked with her Mediterranean possessions.

While this geographical argument was used to exclude north European powers, it was a religious rationale that excluded the North African states of the Mediterranean. Molé wished to extend the invitation to the conference exclusively to 'Mediterranean Christian states' represented by local sanitary administrators. By limiting the conference to *Christian* states, Molé managed to kill two birds with one stone. First, the formulation 'Mediterranean Christian states' immediately excluded North European polities, and secondly, it excluded non-Christian countries such as Morocco, Algeria and Tunisia in the north of Africa. Via these limiting factors, the participant countries were funnelled around the *latitude* of European Mediterranean

[131] Count Molé to M. Despreaux de St. Sauveur, Paris, 22 May 1838 in CRC France p.92.
[132] I borrow here Ladurie's vision of a world united by diseases since the early modern period. Coupling the development of intensive pan-continental trade with an intensive flux of travellers, Ladurie claims that diseases specific to certain ecologic environments travelled and were installed in new settings. Ladurie, "A Concept: the unification of the globe by disease (fourteenth and seventeenth centuries)."

ports. The exclusion of North African states had, most probably, little relation to questions of religious faith. More likely, the delimitation of possible participants was driven by French commercial interests. The countries in question contributed little to the profitable practice of trade during the nineteenth century.[133]

The main reason for the French, British and Austrian interests in the Mediterranean area was the fact that this sea was transformed, during the nineteenth century, into the major maritime avenue linking Europe to the profitable markets of Asia.[134] During this time, two major routes facilitated Euro-Asian trade (see Figure 1). The first route involved sailing the Atlantic, crossing the Cape of Good Hope, and travelling north to either Bombay or Madras. The Route of the Cape of Good Hope, charted during the sixteenth century by Portuguese sailors, was long, susceptible to piracy and less predictable in terms of duration of the journey (see Table 2).

Year	Departure	Arrival	Days	Miles
1791	Dunnose	Bombay	114	12,924[135]
1808	Lizard Point	Bombay	108	12,820
1813	Portland	Bombay	129	14,196
1822	Start Point	Bombay	124	14,045
1824	Lizard Point	Bombay	115	12,382
1829	Lizard Point	Bombay	127	13,479
1832	Lizard Point	Bombay	105	14,139
1832	Lizard Point	Bombay	105	14,017
1833	Spithead	Bombay	118	13,344
1833	Lizard Point	Bombay	108	13,153
1833	Lizard Point	Bombay	97	13,701
1833	Lizard Point	Bombay	96	12,942
		Average	112.8	13,428.5
		Maximum	129	14,196
		Minimum	96	12,382

Table 2 Route of the Cape of Good Hope. Journey duration between England and India

[133] See D. C. M. Platt, *Finance, trade, and politics in British foreign policy 1815-1914* (Oxford, London,: Clarendon P., 1968). Especially chapter 4.

[134] Additionally, these powers were also interested in the region as a valuable market for manufactured goods. See Roger Owen, *The Middle East in the world economy, 1800-1914*, Rev. pbk. ed. (London ; New York: I.B. Tauris, 1993). *p*84

[135] Henry Wise, *An analysis of one hundred voyages to and from India, China, &c., performed by ships in the honorable East India Company's service* (London: J.W. Norie, 1839). Wise noticed that duration of the journey, both in length and in time, was in large part affected by poor wind conditions encountered between England and India. My calculations.

	Days		Days
Bombay – Marseilless – London	56	Bombay – Falmouth – London	68[136]
	57		74
	62		62
	67		61
	53		60
	48		63
	50		52
	53		52
	49		57
	77		103
	46		60
	53		60
	56		67
	47		61
Average	55.3		64.3
Max	77		103
Min	46		52

Table 3 Overland Route. Journey duration between London and Bombay

The second option, the overland route to India, was considerably shorter and safer due to the strong naval presence of Britain in the Mediterranean (see Table 3).[137] Notwithstanding its name, the overland route consisted of two maritime sections linked by an overland road. The Mediterranean and the Indic were connected by two major alternatives: the Euphrates Route (via Scanderoon[138]) or the Red Sea Route (via Alexandria). Although shorter, the first option was only rudimentarily explored during the 1830s, and was more a dream than a reality. In fact, during that decade, Britain organised several expeditions to study the option of navigating the Euphrates, but never managed to develop a continuous communication line between Scanderoon and the delta of the river by boat or train.[139] The Red Sea Route gained growing commercial importance when, in January 1835, the British Government introduced a mail steamer between Malta and Alexandria and recommended that the East India Company provide a connection between Suez and Bombay. The overland route was considerably faster. Travelling between India and England required, on average, 55.3

[136]Ibid.
[137] See Halford Lancaster Hoskins, *British routes to India* (New York: Longmans, Green and co., 1928).
[138] Today İskenderun.
[139] See, for instance *Curiosities of communication: The road. The railway. The electric telegraph. The sail and the steamer. Ocean steamers. Foreign mails*, Travelling Hours (London: C. Knight, 1851).

days of sailing and overland journey. If a merchant instead opted to sail the Cape of Good Hope Route, the length of the journey would rise to an average of 112,8 days.[140] For this reason, control of the Middle East region was of mounting importance. Any country that held power over this region would gain a doorway to India and to her profitable market.

By restricting the participants of the conference to Mediterranean Christian states, France limited the number of future partakers. As such, they enhanced their power over the agendas and results of the conference. After all, it is possible to speculate that the number of contesting powers would proportionally increase with the number of participants; not only would a reduced number of states restrict the possibility of inter-state coalitions against a larger power, but it would also decrease the number of powerful states. As France only wished to confer with south European countries, they suggested that the venue should be located in an Italian port, 'situated, if possible, at an equal distance from the participant ports.'[141]

[140] Wise, *An analysis of one hundred voyages to and from India, China, &c., performed by ships in the honorable East India Company's service*.
[141] Count Molé to M. Despreaux de St. Sauveur, Paris, 22 May 1838 in CRC France *p*92.

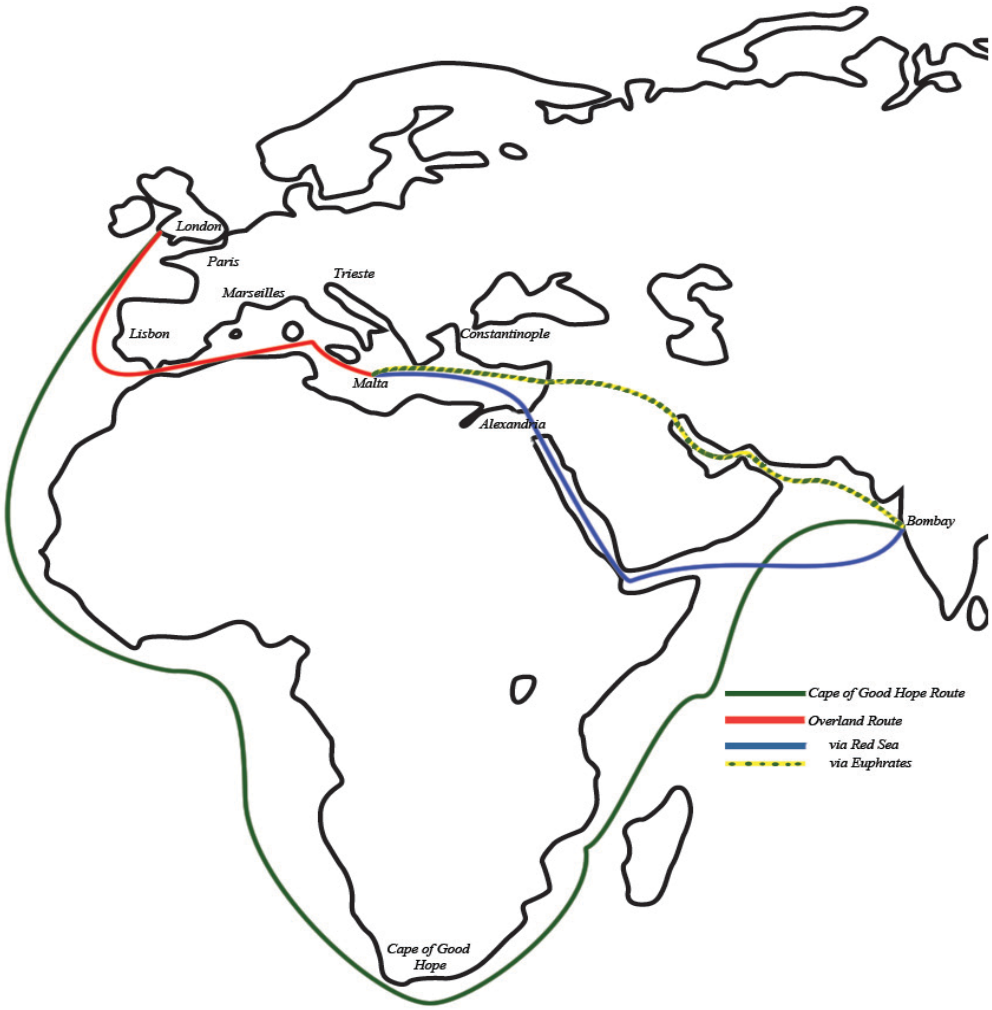

Figure 1 Major nineteenth century routes between India and Europe

In this complex game of boundary delimitation, Britain, with her Mediterranean colonies, was automatically included. However, Molé and his officials initially invited the British territories of Malta and the Ionian Islands, instead of Britain herself. Nevertheless, France informed these governments that, if they wished, the French government was ready to engage in formal negotiations with London on this matter. After all, Malta and the Ionian Islands were both formal colonies of Britain, without legal capacity to ratify diplomatic treatises. On 11 June 1838, French authorities contacted Malta through her Governor, Bouverie. Bouverie contacted the Secretary of State for the Colonies, but gave little mention to the request that he had received in April that year. For some reason, Bouverie did not make a link between the Commander-in-Chief of the Mediterranean Fleet's request to shorten the length of quarantine in Malta and the French invitation to Malta to attend a sanitary

conference discussing the rules of quarantine in the Mediterranean. In his letter, he acquainted Lord Glenelg, the Secretary for the Colonies, with the aforementioned invitation and requested further instructions. According to Bouverie, 'nothing could be more desirable for the interest of commerce, as well as for the convenience of the public health, than the establishment of a uniform system of quarantine.'[142]

Nevertheless, the Governor of Malta was fully aware that any consensus would involve intense negotiation. He also realised that the Mediterranean was marked by an enormous heterogeneity of national sanitary legislation and that local authorities often ignored national directives and imposed random regulations that they had decided on the spot. In his view, any attempt to create a common sanitary law would ultimately result in an impasse where consensus would not be reached and national rivalries would escalate. Nevertheless, Bouverie fully supported Molé's idea. After all, he observed, it would only be through a general conference on the subject, attended by persons thoroughly acquainted with the details of quarantine, that any alleviation of its frequent and unnecessary oppression could be achieved. If the result of such a meeting was the reduction of quarantine and the creation of a rational and uniform system, then the Governor of Malta had no doubts that the conference would perform a great service to society. As such, he requested formal authorisation from London to appoint 'two civil officers, well versed in matters of quarantine, on the part of this Government, to attend the conference.'[143] No doubt, Bouverie was excited about the prospect of creating a uniform system of quarantine for the Mediterranean. From the moment that Glenelg was informed of the French intentions, he used his office to study the agenda proposed by Count Molé. However, due to lack of communication between governmental offices, Britain pursued two independent and parallel lines of action regarding the sanitary conference: the Foreign Office attempted to organise their own future international quarantine conference, and the Secretary for the Colonies studied the possibility of taking part in the sanitary conference organised by France.

[142] Henry Frederick Bouverie to Lord Glenelg, Malta, 11 June 1838 in CRC France *p*80
[143] Ibid *p*81

On receiving Bouverie's letter, Glenelg ordered J. Lewis, a clerk for the Secretary for the Colonies, to study the French proposal and elaborate on interests that the British Government ought to defend. Like many others, Lewis viewed 'quarantine regulations [as] the main obstacles to maritime intercourse in the Mediterranean, especially between its eastern and western extremities.' He pointed out that Britain's naval presence in the Mediterranean, the value of Mediterranean trade, and the new line of British steamers between Gibraltar, Malta, Corfu and Alexandria were reasons enough for Britain to participate in the attempt to negotiate 'quarantine regulations in the Mediterranean.' Furthermore, 'these regulations should not be unnecessarily restrictive.' In his internal *Memorandum*, Lewis stressed what I have previously called the *domino effect* of the Mediterranean quarantine system:

> If the English Government should change the Quarantine Regulations of Malta and its other colonies in the Mediterranean, without previously obtaining the approbation of the sanitary authorities of the neighbouring countries, the pratique granted in those colonies would not be received elsewhere; and vessels coming from any of those colonies would be subjected to a quarantine of observation. [...] The latter liability would attach to ships of the Royal Navy; as well as to merchant-vessels; so that no ship of war sailing from Malta, could communicate with any part of France, Italy, or Austria, without being previously subjected to a quarantine of Observation.[144]

Unilaterally, Britain could do very little, and any change could ultimately produce 'inconveniences far greater than those arising from the existing system.' He argued that Malta might suffer more than any other British colony: 'its transit trade [would] be almost completely destroyed […and] it would lose its importance as a quarantine station.[145] Its importance as a quarantine station is now daily growing, on account of the establishment of the French steamers to the Levant, and the use of the overland

[144] Memorandum respecting Quarantine Regulations in the Mediterranean by Mr. Lewis, London, 26 June 1838, CRC *p*85

[145] This reinforces the idea that quarantine was a source of power and even income. Only a few quarantine stations in the Mediterranean offered quarantine standards recognised by other ports as valid. If a boat went through the process of quarantine in any of these stations, it would not require further quarantines so long as it was travelling directly to a major European port. The stipulation of the duration of quarantine was, for this reason, an important tool to manage the flow of trade in the Mediterranean. If, for instance, two vessels arrived with the same cargo at a given sanitary station, local authorities had the power to determine the duration of quarantine for each vessel with regard to its particular conditions. If different lengths of quarantine were applied to the two vessels, the one arrested for the shortest duration would enjoy optimum conditions when dealing with the market, as it would be able to offer its products without the competition of the second vessel, which would still be enduring quarantine. Furthermore, each arrival at a quarantine station was marked by the payment of sanitary fees according to the size of the vessel and transported cargo. Given the limited number of recognised quarantine stations, large numbers of vessels converged into three major Mediterranean quarantine stations and generated considerable revenues for the sanitary authorities.

journey to India. It would, however, cease to be a quarantine station if its pratique was not received by the Board of Health at Marseilless [sic], and by the other sanitary authorities of the Mediterranean.' For this reason, Lewis suggested to Lord Glenelg that Britain would only be able to change the actual system of quarantine by inviting France and Austria to attend a conference where these issues could be discussed.[146] The fact that Lewis wished to protect Malta's position as an important quarantine station in the Mediterranean is not surprising. After all, Bâtard, in his article published in the *Journal des débats politiques et littéraires*, had already claimed that a central quarantine station should be established in the Mediterranean. Although Lewis did not justify his suggestion, his attitude reinforces the argument that quarantine was a source of power.

During the first half of the nineteenth century, there were only a limited number of quarantine stations in the Mediterranean internationally recognised as practising quarantine to the required standards in order to avoid the transmission of diseases between vessel, cargo and people and the port of arrival. If a vessel was quarantined in any of these given stations, it would not require further quarantines if travelling directly to a major European port. As such, the stipulation of the duration of quarantine was an important tool in managing the flow of trade in the Mediterranean. If, for instance, two vessels arrived with the same cargo at a given sanitary station, local authorities had the power to determine the duration of quarantine for each vessel with regard to its particular conditions. If different lengths of quarantine were applied to the two vessels, the one arrested for the shortest duration would enjoy optimum conditions when dealing with the market, as it would be able to offer its products without the potential competition of the second vessel, which would still be enduring quarantine. Furthermore, each arrival at a quarantine station was marked by the payment of sanitary fees according to the size of the vessel and transported cargo. Given the limited number of recognised quarantine stations, it is easy to assume that local governments collected large amounts of revenue out of the practice of quarantine. However, if you take a close look at the balance sheet of the Malta quarantine station, it appears that this was not the case (see Figure 2). In fact, John

[146] Memorandum respecting Quarantine Regulations in the Mediterranean by Mr. Lewis, London, 26 June 1838, CRC *p*83.

Booker notes that throughout the first half of the nineteenth century, quarantine caused great losses to the Maltese authorities.[147] Nevertheless, it is without question that governments were interested in maintaining the existing quarantine stations. Two reasons, not mutually exclusive, justified this attitude; first, it was truly believed that quarantine was an efficient prophylactic tool, and secondly, profits were indirectly generated from the practice of quarantine. Certainly, the last premise implies that quarantine was a tool of power that influenced patterns of trade. However, it is not possible to quantify the profit derived from quarantine policies at a merchant level.

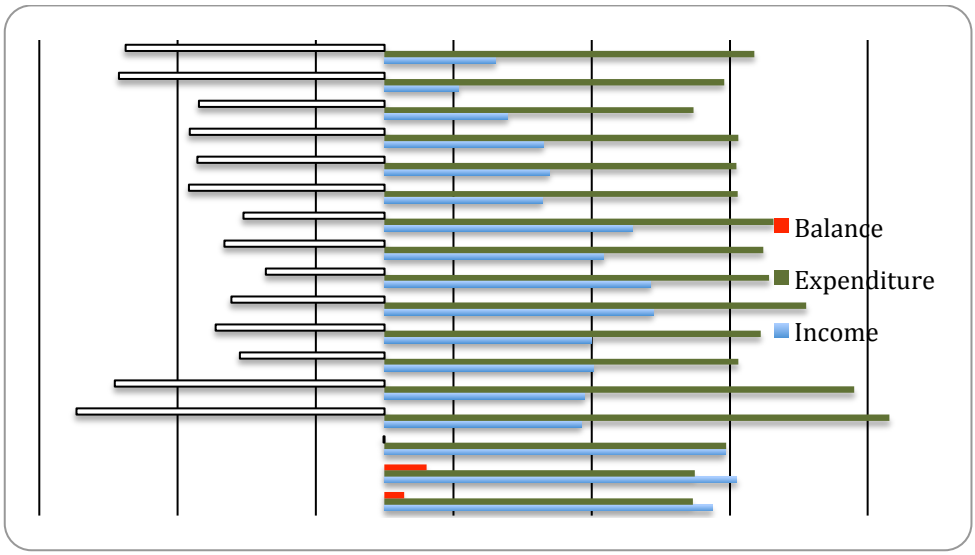

Figure 2 Income, expenditure and final balance of quarantine in Malta between 1824 and 1850.[148]

The British Foreign Office only learnt on 2 July 1838 that France was also organising a conference to solve sanitary problems in the Mediterranean. When the British ambassador to Paris, the Earl of Granville, invited the French government to take an active part in the British initiative, Count Molé informed him that his government was already organising a congress to reform quarantine practices in the Mediterranean. The congress, 'free from arbitrary power,' would be composed of 'special delegates' who would challenge and settle old quarantine disputes. In his letter, Molé informed Granville that French authorities had already contacted both Malta and the Ionian Islands, and that these local governments supported the French

[147] Booker, *Maritime quarantine: the British experience, c.1650-1900*. See Appendix 5 and 6.
[148] Data compiled from Booker's appendix 5 and 6. Ibid..

initiative. Similarly, 'courts of Turin and Florence have already given their full and entire consent.' For these reasons, Molé had no doubt that Britain 'will also partake of the views which have guided us in this business, and will show itself perfectly disposed to favour its execution; particularly by addressing to the Lord High Commissioner of the Ionian Islands, and to the Governor-General of Malta, such instructions and powers as the state of things may render necessary or proper.'[149] Due to the French success in establishing a base of participants for a future conference, Britain had to accept the French invitation or else be excluded from the future meeting. If the latter option were chosen, it would jeopardise London's dominance of the Mediterranean, as Britain's voice would not be taken into account when negotiating the new rules of quarantine.

The French enterprise expanded its tentacles and on 4 July 1838, Baron Langsdorff, the French Chargé d'Affaires at Vienna, informed Prince Metternich, the Austrian Minister of Foreign Affairs, that 'the French Government wished to see the European States bordering upon the Mediterranean concur in one common system of quarantine, which should put an end to the abuses and inconsistencies of the present practice.' Through Lagsdorff's letter, Metternich learnt that Italian courts had already been contacted about this matter, but that France wished Vienna and Paris to coordinate their efforts and use the conferences as a platform for their national agendas.[150]

Both Molé and Lagsdorff were perfectly aware that creating a uniform system of quarantine was not going to be easy, because of conservative opinions and the 'greater or less attachment which exists in different countries for ancient customs, and established regulations, but also on account of the diversity of opinions predominating in this or that country on the question of contagion or non-contagion, which it is impossible to exclude entirely from the consideration of sanitary measures.'[151] In order to ease the process of negotiation, Molé thought it best to

[149] Count Molé to Earl Granville, Paris, 2 July 1838, CRC p.79.
[150][150] Baron Langsdorff to Prince Metternich, Vienna, 4 July 1838, CRC *p*13.
[151] Count Molé to Baron Langsdorff, Paris, May (?) 1838 Great Britain Foreign Office, *Correspondence relative to the contagion of plague and the quarantine regulations of foreign countries, 1836-1843*.16

avoid any medical discussion that could jeopardise possible agreed solutions.[152] The French minister, like Ségur Dupeyron (see section *Administrators and rationality)*, believed that only a strict comparative approach to the different protective strategies would differentiate efficient mechanisms of disease prevention from non-efficient ones. In his opinion, these comparisons would allow the participant states to find solutions for avoiding future outbreaks of plague, yellow fever and cholera in the Mediterranean. Clearly, Molé was convinced that quarantine and sanitary measures were mere administrative issues and not medical problems. Sanitary problems, like any other problems that modern states faced, could be solved by a rational approach involving the collection of data and its analysis.[153]

Langsdorff acquainted the Court of Vienna with Molé's agenda. In a letter to Langsdorff (13 June 1838), Metternich, the Austrian Minister of Foreign Affairs, saw in the future commission - not congress as the French suggested[154]– a 'service rendered to humanity' and progress. He informed the French ambassador that he had already been contacted by Britain, but that all three states should probably cooperate to create a new quarantine practice that would serve the interests of commerce and industry. Metternich noted that plague tended to be endemic in non-Christian polities of the East because of their non-use of sanitary practices. However, the Ottoman Empire had recently started to adopt new sanitary practices imported from the 'European civilization.' In fact, he continued, many Austrians were now employed in Turkey by the Sultan Mahoud, working to construct a better and more efficient quarantine service. For these reasons, Vienna was interested in extending the invitation to the congress 'to all the Governments directly interested in the establishment of quarantine.' In addition to France and the Italian states, Austria specifically desired to include Britain, Greece and Russia. The reason for including Britain, as mentioned above, was her direct control over the Ionian Islands and Malta, while Greece and Russia were added to the list because of several occasions in the past where they had acted as gateways to the invasion of Europe by plague.

[152] Ibid.16
[153] Theodore M. Porter, *The rise of statistical thinking, 1820-1900* (Princeton, N.J.: Princeton University Press, 1986); ———, *Trust in numbers: the pursuit of objectivity in science and public life* (Princeton, N.J.: Princeton University Press, 1995).
[154] This point will be further explored in the last section of this chapter.

Furthermore, Russia had extensive possessions on the Black Sea coast and was in-between Europe and Asia. For all these reasons, the conference could not exclude or ignore any of the above powers. However, it is interesting to note that neither Portugal nor Spain was mentioned among the list of potential participants. Certainly, Portugal, unlike Spain, was not a Mediterranean country. Nevertheless, both countries, due to their Atlantic trade, were important pieces in the South European quarantine puzzle. Furthermore, Portugal was used by Britain as a commercial hub that linked the Mediterranean with the British Islands.

Although Vienna recognised that the six points suggested by the French Minister of Foreign Affairs were crucial to the constitution of common quarantine standards, Metternich was not in full agreement with France and her agenda. In his view, 'in order to arrive most expeditiously, and with the greatest certainty at the desired result, the Commission ought to found its work only upon known bases [i.e. solid knowledge], and which have already acquired the sanction of experience.'[155] The nature of cholera and yellow fever were not clear, and no consensus had been reached among medical communities. For that reason, only plague should be addressed in any future meeting, otherwise it would be difficult to 'obtain positive results.'

In Britain, on 28 July 1838, the Board of Trade (which had been previously acquainted with the French idea of organising a international sanitary conference) informed the Foreign Office that the French plan was 'highly desirable' for Britain. The Board looked at the French conference as an opportunity to create 'general and uniform rules, less restrictive in their operation upon trade for future practice.' The Board of Trade wished the Governor of Malta to appoint two civil officers to attend the meeting; however, the Board was also of the opinion that Her Majesty's Government should 'adjoin some English medical man to the Maltese officers.' Finally, the Board suggested that all European powers, especially Sweden, Russia, Prussia and Denmark, should also attend the conference, with the purpose of 'establish[ing] a uniform system of quarantine for the north as well as for the south

[155] Great Britain Foreign Office, *Correspondence relative to the contagion of plague and the quarantine regulations of foreign countries, 1836-1843*.30

of Europe.'[156] However, this last idea was dismissed by the Foreign Office on 22 August, because, according to Lord Palmerston, including northern European states could jeopardise the success of the conference. Like the French, Palmerston probably feared that if the invitation were extended to other north European states, the balance of power could play against British interests. After all, the larger the number of participants, the harder it would be to negotiate consensus.[157] With the support of the Board of Trade, Palmerston contacted the Secretary for the Colonies on the same day and urgently requested him to authorise the colonies to accept the French invitation to attend a sanitary conference.[158] Although he wished Glenelg to pressure the colonies to accept the French invitation quickly, it was not until November that he was able to communicate to the French Ambassador in London, Count Sebastiani, that her Majesty's Government was ready to 'accede to the proposal in question.'[159] The fact that the British appeal to cut the length of quarantine was refused by all Italian states perhaps contributed to this outcome. After a long wait, neither Sicily, Tuscany nor Sardinia accepted the British request to decrease the length of quarantine of navy vessels arriving at Malta from Constantinople to 15 days.[160]

France clearly took the lead; Paris set agendas, selected participants and chose venues. By October 1838, several European states were convinced that an international conference would soon start and a new system of quarantine would emerge. In a letter to the British Ambassador to Vienna on 30 November, Palmerston informed Lamb that Britain was ready to join the conference and had already appointed its delegates.[161] However, for some reason that is not entirely clear, the conference never happened. France appears to have forgotten to organise and open the event, and little explanation was given to the previously invited states. In fact, in a letter of May 1840, the Sardinian Ambassador reported to Palmerston that in a conversation with Count Solar de la Marguerite, the Sardinian Minister of Foreign

[156] Mr Denis le Marchant to the Hon. W. Fox Strangway, Office of Committee of Privy Council for Trade, Whitehall, 28 July 1838, CRC *p*87.
[157] Hon. W. Fox Strangway to Mr le Marchant, Foreign Office, 22 August 1838, CRC *p*92.
[158] Hon. W. Fox Strangway to Mr Stephen, Foreign Office, 22 August 1838, CRC *p*93.
[159] Viscount Palmerston to Count Sebastiani, Foreign Office, 3 November 1838, CRC *p*100.
[160] See Mr Kennedy to Viscount Palmerston, Naples, 2 August 1838, CRC p.200. Mr Aubin to Viscount Palmerston, Florence, 14 August 1838, CRC p.244. Sir A. Foster to Viscount Palmerston, Turin, 10 September 1838, CRC *p*165.
[161] Viscount Palmerston to Sir Frederick Lamb, Foreign Office, 30 November 1838, CRC *p*23.

Affairs, the latter confessed that 'the proposal which came from France two or three years ago […] failed [and] he never knew why.'[162]

Lazarus, raising a conference from the dead

The conferences that both Britain and France devoted effort towards organising during the 1830s were a dead idea by 1840. During a period of ten years, neither country – nor any other European state – made any effort to create a uniform system of quarantine in the Mediterranean. Although the causes for the abrupt interruption of negotiations are not clear – it was not even clear to the involved parties – we can and should devote some space to speculation. In *Maritime Quarantine*, John Booker links the sudden demise of the conferences with the necessity of further enquiries into the nature of plague. Booker claims that the lack of consensus surrounding the contagiousness of plague jeopardised the formation of an international conference. After all, the goal of the conference would drastically vary depending on the nature of the disease: 'if plague were proven non-contagious, then any conference should consider the dismantling of quarantine rather than the conformity of procedure.'[163] Although the quest for aetiological certainty was an important issue during the late 1830s and throughout the 1840s, this debate was by no means settled by the 1850s, which was when the first International Sanitary Conference took place. Given that aetiological consensus was lacking throughout the three decades leading up to the opening of the 1851 ISC, Booker's approach does not seem sturdy enough to hold full explicative value.

By contrast, the international events that occurred between 1839 and 1840 within the boundaries of the Ottoman Empire, the *Eastern Question*, offer valuable insight into our problem. As shown above, the control over the Middle East became a crucial issue, as countries relied on guaranteed access to India and Europe.[164] Furthermore,

[162] Sir A. Foster to Viscount Palmerston, Turin, 11 May 1840, CRC *p*173.
[163] Booker, *Maritime quarantine: the British experience, c.1650-1900*.
[164] The dynamics between the Levant and the overland route to India are not yet fully understood by historians. In a 2007 article, Bayly notes that her paper 'is the first publication [that has] ever dedicated a discussion to analys[ing] the comparisons, contrasts, and connections between nineteenth-century British Indian Empire and the later Ottoman Empire.' The literature on this topic tends to focus its analysis on internal politics of the Ottoman Empire, the collapse of this polity, and the

from a naval perspective, both France and Britain tried to achieve a maritime hegemony in the Mediterranean in order to protect their national overseas interests.[165] Although the European struggle for the Near East was not new by the end of the 1830s, the escalation of the issue coincided with the abrupt end of negotiations over the construction of a uniform system of quarantine in the Mediterranean. The dispute over this region was not exclusively confined to European nations. Muhammad Ali – the Egyptian ruler under the Ottoman Empire - was determined to declare Egypt autonomous and expand its territory over Syria. In 1831-2, he deployed his army first to Syria and then to Konya in the centre of Turkey, and so the Ottoman Empire requested help from European powers. Both Britain and Russia developed strategies to oblige Muhammad Ali to return to Egypt and thus preserve the integrity of the Ottoman Empire. When, in April 1839, Turkey finally advanced on Egyptian troops in order to regain control over Syria and destroy Muhammad Ali's imperial dream, the Ottoman Empire suffered a massive defeat. Through the eyes of European states, the tension between Cairo and Constantinople was a source of opportunity to assert power in the region. France, Britain and Russia were ready to mediate the conflict, but these countries did not produce a concerted strategy. London and St Petersburg aligned with Constantinople, while Paris supported Cairo. Since the Napoleonic invasion of Egypt in 1789, France had toyed with the idea of gaining a base of influence in the Middle East. As such, the conflict between Egypt and Turkey looked promising in terms of securing a settlement in the Near East – providing that Egypt would be able to win the war.[166] The French-Egyptian ambition was not well received in Europe. In June 1839, Britain deployed her navy to block all sea-lanes between Egypt and the Levant, and, in articulation with Russia and Austria, prepared a draft proposal for the diplomatic resolution of the conflict. Egypt was requested to return the occupied territories and recognise the authority of the Ottoman Empire. However, with the support of Paris, Muhammad

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formation of new Middle East states. See for instance Malcolm Yapp, *The making of the modern Near East, 1792-1923*, A History of the Near East (London: Longman, 1987)., Efraim Karsh and Inari Karsh, *Empires of the sand: the struggle for mastery in the Middle East, 1789-1923* (Cambridge, MA: Harvard University Press, 1999)., G. H. Bolsover, "Lord Ponsonby and the Eastern Question (1833-1839)" *The Slavonic and East European Review* 13, no. 37 (1934).

[165] Hamilton, *Anglo-French naval rivalry, 1840-1870*.

[166] See Yapp, *The making of the modern Near East, 1792-1923*. and Karsh and Karsh, *Empires of the sand: the struggle for mastery in the Middle East, 1789-1923*. See also Hoskins, *British routes to India*. *p*279

Ali refused to accept the terms of the draft agreement. Due to this hostile attitude, Britain, Russia and Austria initiated a joint military operation in Beirut and Lebanon in September 1840. These actions culminated with the arrival of the British fleet at Alexandria in November. Cairo finally agreed to call the troops back to Egypt and return the Syrian possessions to Constantinople. France, facing the humiliation of the Egyptian defeat, had to join the above European powers in condemning Muhammad Ali's imperial dream. In *Anglo-French Naval Rivalry*, Hamilton notes that it was clear that if a serious clash between the two forces [France and Britain] emerged in the Mediterranean – as almost happened in the Egyptian affair – the repercussions to France and Britain would be far more severe than losing the Mediterranean links with India.[167] In fact, Hoskins claims that both Britain and France were close to starting a European war.[168] Certainly, during the Egyptian affair, French and British navies never came into direct confrontation. However, the tense diplomatic climate in the Middle East suggests that the clash of French and British interests influenced other diplomatic issues such as the organisation of an ISC. Similarly, Schroeder argues that the Eastern crisis affected Anglo-French relations and European politics in general through the 1840s.[169] Moreover, it is unlikely that, post-Egyptian humiliation, France would join their diplomatic efforts with Britain towards the construction of a uniform system of quarantine in the Mediterranean. Given the similar timing between the end of diplomatic negotiations and the escalation of the Middle East conflict, it is likely that this issue played an important role in the sudden end of quarantine negotiations in 1839.

However, eleven years later, on 12 November 1850, Louis-Napoléon Bonaparte, then President of the French Republic, announced France's intention to summon European states to create a uniform system of lazarettos and quarantine. After this announcement, Jules Baroche, French Minister of Foreign Affairs, contacted several European ambassadors in France, inviting their countries to participate in what would later be called the 1851 International Sanitary Conference (ISC). Like many

[167] Hamilton, *Anglo-French naval rivalry, 1840-1870*. *p*10
[168] Hoskins, *British routes to India*.
[169] Paul W. Schroeder, *The transformation of European politics, 1763-1848* (Oxford: Oxford University Press, 1994). *p*739.

other diplomats, Paiva, the Portuguese ambassador in Paris received a letter from Baroche on 16 April 1851 with details of this future conference. As with many other European states, there is no record of Portugal ever being contacted during the 1830s diplomatic exchange on the negotiation of a uniform system of quarantine in the Mediterranean.[170] However, Baroche now wished Portugal to appoint delegates to attend the upcoming conference. Influenced by a preliminary study by François Mêlier[171] and previous negotiations held within European diplomatic circles, Baroche was convinced that maritime relations in Europe would improve.

The name *International Sanitary Conference* was not decided randomly. By choosing the term *conference* instead of *congress*, the French government was trying to ensure that these meetings would not provide a venue for empty theoretical debates or inflamed political discussions. The aim of the conference was 'practical' consequences.[172] 'Health and only health' was the concern of the meetings.[173] Above all, Baroche saw no point in holding a medical congress where 'like in an arena, one fights for an opinion or a doctrine without acknowledging any correction to its proposed idea or doctrine.'[174] For this reason, it was crucial that each participant country appoint two delegates: a doctor and a diplomat. 'The first should represent the scientific element, the second the administrative, commercial and maritime element.'[175]

The demarcation of boundaries between politics and science was again reinforced in a letter sent by France to the British Government on 19 April 1851. According to this dispatch, countries 'must not take into the conference the political conflicts with rival powers. The conferences *are not* a scientific convention; the invited scientists are present to help countries reach the best solutions on dealing with cholera. Doctors are present to facilitate the process regarding technical questions. The ultimate goal is to

[170] Baroche to Paiva, 16 April 1851, Arquivo Histórico Diplomático, Leg./Emb. Paris, Maço 6.
[171] Although this important study is referred to as an important basis for the 1851 ISC, I was not able to find it in any consulted archive either in Paris, Lisbon or London. However, Mêlier's main conclusions are described in the abovementioned French letter.
[172] Correspondence from the Legação de Portugal em Paris [Portuguese Legation in Paris], 1851, MNE box 609.
[173] Ibid. Underlining in the original.
[174] Ibid
[175] Ibid.

protect the interests of the population and the commercial enterprises'.[176] Both science and politics appeared to be sources of contention for the French government, as French state administration was based on a practical and rational model. In order to facilitate the achievement of these grand goals, France decided to appoint C. E. David, General Consul of France in Genova and François Mêlier, a fellow of the National Academy of Medicine and member of the Consultative Committee of Public Hygiene, as delegates.

Baroche wanted France to be the venue for the conference. Although the French government did not 'have any concrete idea', his preference oscillated between a 'sea-port' location and an inland city. On the one hand, a place like Marseilles or Port Vendres could offer 'a useful base of observation to the members of the conference.' On the other hand, cities like Paris or Montpellier 'offered numerous advantages' such as 'libraries and scientific institutions.' Montpellier, for instance, was the centre of a famous medical school that could offer valuable library resources during the course of the conferences. At the time, Montpellier was connected to Marseilles by railways, which could be used by delegates to visit the city and learn *practical* issues of quarantine. There, delegates could see, experiment, and test their ideas.[177] Wherever the chosen venue, Barroche believed that the conferences would start by the end of June 1851, and requested that Portugal cooperate so as to make that possible.

With his letter, the French Minister of Foreign Affairs included a document entitled 'Bases for the Sanitary Conferences with Indication of Questions that should be Addressed and Solved.' In a 21-point list, France presented an international agenda of public health, marked by specific French national experiences, problems, interests and idealisms. Barroche aimed above all to create a new international system of quarantine that did not 'compromise the sacred interests of public health' but at the same time allowed 'free commerce' to emerge.[178] The future ISC would produce a

[176] Letter (19th April 1851). Foreign Office Papers, FO 97/210. Emphasis is my own.
[177] Correspondence from the Legação de Portugal em Paris [Portuguese Legation in Paris], 1851, MNE box 609.
[178] Ibid.

‘Mediterranean Official Sanitary Law’, to be declared ‘mandatory by all and for all.’ Although France saw these conferences as crucial events in the ordering of world trade and world public health, it was recognised that the aims were rather ambitious. For this reason, it was declared that local interests would be considered when finalising any international legal document, and that, more importantly, no matter what the outcome of the delegates’ negotiations during the meeting, national governments would always be able to reserve the right to ratify or reject resolutions.

During the conference, international delegates would decide whether sanitary measures ought to be applied exclusively to people and cargo that arrived by sea or should also be enforced on overland arrivals. The diplomats and doctors present at the ISC would limit their discussion to specific diseases. France suggested that they should address sanitary measures for ‘Oriental plague,’ ‘American yellow fever,’ and ‘Indian cholera.’ Although it was recognised that ‘army typhus’ was also an important disease, France had reservations as to its inclusion in the agenda of the ISC.

It was intended that once the delegates had arranged a clear framework of discussion, they would immediately evaluate the current sanitary system by assessing whether the measures practiced were too severe or remained crucial for the protection of public health. Doctors and diplomats would also determine the deciding factors for when diseases became sporadic or endemic. Barroche noted that the French Academy of Science considered ‘that plague was not seen as importable except when it reigns in an epidemic state.’ For the sake of public health, the French government adopted this faceted vision of diseases when producing their national policy on public health. France only applied sanitary measures when plague was epidemic, and suggested that all states should adopt the same strategy in order to simplify the flow of trade by avoiding unnecessary sanitary practices that detained vessels. If this was agreed, delegates would be invited to decide the appropriate sanitary measures that should be applied during epidemic outbreaks of diseases. In France’s view, four major approaches were possible: ‘quarantine, lazarettos, isolation or general

measures of hygiene.'[179] In any case, the delegates would also decide whether the measures should only be applied to people or should also be enforced on vessels, cargo, letters and diplomatic dispatches. Finally, they were required to create a common list of susceptible and non-susceptible products.

Barroche was also interested in liberalising the state of bills of health applied to vessels departing from the Orient. He believed that people arriving from healthy places in Egypt or Turkey should not be considered health hazards in Europe. As such, he asked delegates to debate this possibility and produce clear rules governing the necessary conditions for free pratique at arrival: i.e. a minimum amount of travelling time and a possible imposition of a permanent onboard presence of doctors.

Travelling in the Mediterranean was marked by a multiplicity of heterogeneous sanitary authorities and legislation. Each local authority typically held sway over assessing and securing heath security within its jurisdiction. However, these local authorities were not isolated; in fact, they belonged to national consular and medical networks, and together certified, issued and validated bills of health. During the nineteenth century, a large number of these networks co-existed: after all, Sicily did not want to entrust their national health security to Austria, just as Sardinia would not feel comfortable depending on Britain to secure epidemic safety in Sardinian domains. Nevertheless, France was optimistic that a singular multinational system of epidemic prevention could be established within the Mediterranean. Barroche suggested that governments could share a common network of consuls – or a mixture of consuls and doctors – that would grant bills of health to departing vessels. These documents would have universal validity and for that reason would be accepted in all Mediterranean ports. The new system would require necessary mechanisms of forgery prevention and reliability of information contained in the bills of health.

After deliberating on the above issues, the conference was to focus its attention on the creation of a uniform system of quarantine. Barroche hoped that the duration of

[179] Ibid

quarantine could be framed around maximum and minimum periods shared by the whole Mediterranean – though always keeping specific local circumstances in mind – and that delegates would decide whether the duration of traveling would count within the period of quarantine or not. During quarantine, vessels, cargo and people should be subject to a uniform rule of aeration and purification. Similarly, the treatments practised in Mediterranean lazarettos ought to be uniform from place to place. Furthermore, France proposed that sanitary fees should be consistent, only charged in order to cover expenses associated with public health, and never used as tax revenue.

In setting the agenda for the conference, France was interested in creating a universal system of quarantine that would overcome the local diversity experienced in the Mediterranean. A new international law, transversal to all quarantine stations in the Mediterranean, would create a world unified by rationality.

In terms of public health administration the French agenda was, again, internationalist and with a focus on creating and managing common resources. Thus, the conference was requested to create a common sanitary law that all port boards of health in the Mediterranean were to follow. These boards were also to be subjected to new regulations: Paris hoped that the new law would oblige the boards to include foreign consuls alongside local members. But even more radical was the idea of introducing an international tribunal to arbitrate future disputes.

The process of organising an international sanitary conference in the first half of the nineteenth century was long and full of obstacles. Although several sections of European society requested the reform – or even the annihilation – of the Mediterranean system of quarantine, it was soon understood that individual states could do little to change the *status quo*. In fact, every time that a state attempted to change national rules of quarantine unilaterally – like Vienna once did – it was soon punished by other sanitary authorities, who would refuse to recognise the validity of its process of quarantine, and enforce further – and lengthy – quarantine on all vessels departing from that state. Quarantine and sanitary practices within the

Mediterranean transformed from a local and national issue into an international problem marked by a multitude of agendas and conflicts of interests.

At the same time, the centre of gravity of the power and interests surrounding quarantine shifted. Power shifted between states until France finally used it to organise the 1851 ISC. But power was also juggled between professional groups; three major groups disputed the jurisdiction over the problem of quarantine. First, doctors, who claimed that quarantine was a prophylactic tool and hence a medical issue ruled by medical rationales. Secondly, state administrators, who suggested that quarantine in the Mediterranean was heterogeneous and probably inefficient. They also held that one of the principal reasons for this chaotic system was the endless medical disputes over the nature of plague, cholera and yellow fever. For this reason, state administrators demanded that doctors be excluded from the process of reforming the Mediterranean quarantine system. In their view, only rationality, observation and experience would provide answers to construct a new and efficient way of preventing diseases to spread in Europe. Thirdly, diplomats, who were involved in the business of quarantine from early on. European diplomatic machineries were in charge of surveying local health conditions and reporting them to their central authorities. Furthermore, diplomats, mainly consuls, often issued bills of health that accompanied vessels from the departure to the arrival port. As the overseas representatives of government, they often received complaints from merchants about unfair quarantine practices. Diplomats had a formal network of resources that could be easily mobilised to organise international initiatives. For all these reasons, they managed to secure the affair of international negotiation over quarantine under their own jurisdiction.

Interestingly enough, throughout the period of organisation of an international meeting to reform the system of quarantine in the Mediterranean, merchants never managed to secure an effective place at international level.

CHAPTER 2: Between diplomacy and medicine: the ISC as a multi-professional event

> *Should we vote by country or by individual? Should the vote be exclusively secret? Or should it be secret only certain cases while ostensive in others? Should it be done by standing up or through voting cards?*
>
> *(...)*
>
> *Before continuing the discussion, Mr Segóvia requests Mr President to let the Conference know if there is any precedent regarding th[ese] question[s].*
>
> *Mr President answers that [according to diplomatic protocol], congresses generally vote by country. However, given that in congresses there is only one element, the diplomatic element, any analogy would evidently be unfair.*[180]

Soon after 11am on 23 July 1851, C. E. David, the plenipotentiary minister representing France, opened the first session of the International Sanitary Conference (ISC). 24 delegates were waiting to join him at the French Ministry of Foreign Affairs in Paris in order to construct an international sanitary system. Each delegate was expected to contribute his own personal expertise in the governance of epidemics and to defend the interests of the country that he represented – countries that included Austria, England, France, Greece, Portugal, the Roman States, Russia, the Kingdom of Sardinia, Spain, Turkey, Tuscany, and the Kingdom of the Two Sicilies.

Recent cholera outbreaks, epidemic threats of diseases such as plague and yellow fever, and myriad contradictory and tedious prophylactic policies practiced in European ports underpinned the organisation of the ISC. The conference aimed to create a common epidemic policy in Europe through the construction of standard shared meanings and public health practices. These objectives were clearly stated in an invitation letter and in the detailed conference programme circulated by the French government in April 1851: delegates were convened in order to create a

[180] *Procés-verbaux de la conférence sanitaire internationale, ouverte à Paris le 27 Juillet 1851*, vol. 1, 7 August 1851, *pp*2–3 (President and Segóvia).

uniform system for the lazarettos and quarantines already existing and operating in the Mediterranean Sea.[181]

In order to avoid the debate being unduly influenced by special commercial interests, France prohibited governments from appointing merchants and ship owners as their representatives.[182] Instead, each participant state was invited to appoint a doctor and a consul that could, respectively, contribute scientific and administrative knowledge, and maritime and commercial expertise.[183] This conflation of professional expertise, I argue in this chapter, represented an original international medico-diplomatic product – an event without precedence. However, by creating this institution, the ISC struggled to find usable precedents and protocol that could guide its efforts. Conventionally, diplomatic conferences were uni-professional, and the protocol framing such experiences failed to guide the regulatory initiative that combined doctors and diplomats in the same negotiation space.

Divided into two parts, this chapter will examine the process of appointing delegations and the construction of a protocol to guide the works of the Conference. In part one, I will explore two delegation episodes in light of national financial, commercial, and scientific agendas. In doing so, I will look at the role of expertise in the selection of delegates while investigating how states established mechanisms in order to limit the agency of those selected to represent them. In part two, I will look at the form of the ISC through the lenses of previous international events and contemporary diplomatic *modus operandi*. After establishing the professional originality of the Conference, I will focus on the Conference's protocol, created to assist scientists and diplomats in co-navigating the process of regulating international public health.

[181] Barroche to Paiva, 16 April 1851, Arquivo Histórico Diplomático, Leg./Emb. Paris, Maço 6. For the English version of the invitation letter see: French Embassy in London to Palmerston, 19 April 1851, The National Archives of the UK (TNA): Public Record Office (PRO) FO97/210.
[182] French Embassy in London to Palmerston, 19 April 1851, TNA: PRO FO97/210
[183] French Embassy in London to Palmerston, 19 April 1851, TNA: PRO FO97/210

I

Delegating

In the morning of 23 July 1851, ten delegates congregated in the library of the Ministry of Foreign Affairs in Paris. Opening the proceedings of the conference was C. E. David, who had been mandated by the French government to represent its interests and oversee the logistics of the Conference. David welcomed the delegates, on behalf of his government, and reminded them that they had been convened 'to provide important services to trade and navigation in the Mediterranean while safeguarding the public health' of the participating states.[184] The ISC, he stressed, was to be a forum of conciliation – a social locale – where, for the sake of humanity, national agendas, professional interests, scientific theories, and commercial vested interests were expected to come together. Despite this ambitious agenda, only half of the expected delegates attended the first session of the Conference – and many were not seen at all during the two months that followed the official opening. Although some delegates may have been delayed by unpredictable problems, the majority were absent because they had become entangled in complex bureaucratic webs that failed to appoint them in time to attend the first session.

Portugal: delegating in harsh political and economic conditions

Portugal, like all the participants, received a formal invitation to attend the ISC in April 1851. Following initial inquiries, the French ambassador to Lisbon, Adolphe Barroche, eagerly reported to his government that Portugal was interested in taking part in the Conference and actively participating in the creation of common international sanitary policy. The envoys of Portugal, he affirmed, could be expected to arrive in Paris by the end of June. However, despite Barroche's assurance, the Portuguese delegates had still not appeared by early July.[185] In fact, they only managed to join the Conference in September. In the meantime, French and English

[184] *Conférence sanitaire internationale*, vol 1, 27 July 1851, *p*2 (David).
[185] Barroche to Minister of Foreign Affairs, 28 May, Archives des Affaires étrangères: 1851 Legation de France a Lisbonne, tombe 67, 294

diplomats were pressuring the Portuguese government to appoint a delegation, while national political and economic variables disrupted their efforts.

In its invitation letter, Paris clearly stated that countries were to appoint 'an envoy among consuls that resided in one of the several ports of the [French] Republic.'[186] The aim of this specification was to ensure that those selected were familiar with quarantine practices and the problem of epidemic diseases. Despite these recommendations, Portugal decided to appoint the Secretary of the Portuguese Legation in London as its diplomatic envoy.[187] The reasons underpinning this defiant Portuguese decision are not clear. It is possible that during his diplomatic career, the Portuguese Secretary developed unique skills and expertise that were perfectly aligned with his country's national agenda. Even if the Portuguese Secretary did not handle quarantine affairs on a daily basis in London, the delegate-to-be may have been exposed to – and even participated in – the prolific prophylactic debates held by English medical and political elites during the first half of the nineteenth century. As such, the Secretary may have developed a clear political standpoint on the use of quarantine as a tool to control epidemic outbreaks.

More importantly, the decision to challenge the French request may have been due to issues of trust. International Relations scholars have long argued that delegated agents pursue their own interest, despite constraints imposed by the decisory power. Since the agendas of the delegator and delegated are rarely perfectly aligned, conflicts between parties are likely to emerge.[188] Those who appoint delegates must surely try to select persons who fit the agenda to be defended; however, a limited pool of possibilities can constrain their choices. Delegating necessarily involves the consideration of delegates' individual characteristics. These characteristics – necessarily linked with agency – are often dealt with via mechanisms that limit the behaviour of delegates, but, as Hawins and Jacoby argue, delegates can also develop

[186] Barroche to Paiva, 16 April 1851, Arquivo Histórico Diplomático, Leg./Emb. page 3
[187] Barroche to French Minister of Foreign Affairs 8 June 1851, Archives du Ministère des Affaires Etrangères, Correspondance Commercial Lisbonne, tombe 67, 294.
[188] D. Roderick Kiewiet and Mathew D. McCubbins, *The logic of delegation : congressional parties and the appropriations process*, American politics and political economy series (Chicago: University of Chicago Press, 1991).

a multitude of strategies to enhance their autonomy.[189] For this reason, trust is a crucial aspect when selecting representative envoys.

In addition to appointing a diplomat that did not reside in France, Portugal also hoped to circumvent the structure of the delegation as originally envisaged. In an effort to avoid the additional cost of sending a second delegate, Portugal inquired about the possibility of being represented in Paris by a single diplomatic envoy.[190]

Since the turn of the century, the national economy had suffered chronic financial problems, and successive governments had tried to contain the increasing state expenses. The invasion of Portugal by Napoleonic forces in 1807 had eroded the country's economy and political governance.[191] This problem had been further aggravated by the arrival of English military forces that had converted the country into a *de facto* protectorate. Without concrete political programmes to revive national economy, internal and colonial trade had been paralysed and political instability was growing.

In 1822, the economic problems of Portugal had intensified with Brazil's declaration of independence. Colonial gold and taxes had stopped flowing, and Portugal was left bankrupt and insolvent.[192] The incapacity to generate income was extreme, and international credit markets refused to buy national sovereign debt until 1851.[193]

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[189] Ibid.

[190] Barroche to French Minister of Foreign Affairs 8 June 1851, Archives du Ministère des Affaires Etrangères, Correspondance Commercial Lisbonne, tombe 67, 294.

[191] Facing the imminent arrival of the Napoleonic forces at Lisbon, the royal family and its court fled to Brazil at the end of 1807. In a case of inverted colonialism, continental Portugal was ruled from the colony, a move that deprived the country of its elite and left the territory ungoverned. For a colourful description of this inverted colonialist experience, see: Patrick Wilcken, *Empire adrift: the Portuguese court in Rio de Janeiro, 1808-1821* (London: Bloomsbury, 2004). See also D. D. Horward, "Wellington and the Defense of Portugal," *International History Review* 11, no. 1 (1989).

[192] Jorge Miguel Viana Pedreira, "From Growth to Collapse: Portugal, Brazil, and the Breakdown of the Old Colonial System (1750-1830)," *Hispanic American Historical Review* 80, no. 4 (2000).

[193] Maria Fátima Bonifácio, "1834-42: a Inglaterra perante a evolução política portuguesa (hipóteses para a revisão de versões correntes)," *Análise Social* 20, no. 83 (1984); ———, "«A guerra de todos contra todos» (ensaio sobre a instabilidade política antes da Regeneração)," *Análise Social* 27, no. 115 (1992); ———, "Costa Cabral no contexto do liberalismo doutrinário," *Análise Social* 28, no. 123-4 (1993); ———, "Segunda ascensão e queda de Costa Cabral (1847-1851)," *Análise Social* 32, no. 142 (1997); ———, "A 'causa' de D. Maria II (1826-1834)," *Análise Social* 39, no. 172 (2004); José Miguel Sardica, *A Regeneração sob o signo do consenso: a política e os partidos entre 1851 e 1861* (Lisboa: ICS, 2001).

At the same time as the economic and financial crisis, Portugal had struggled to maintain a stable political regime – civil wars, popular revolts, coups d'état, and military uprisings had marked the first half of the century. In total, between the turn of the century and 1851, seven royal heads had ruled Portugal and a succession of governments had formed cabinets, each introducing contradictory policies on the economy and other matters.[194]

Facing overwhelming internal issues, the Portuguese government may have seen the appointment of a second delegate as superfluous. The country could have its voice represented well in Paris, even by a single individual. Moreover, the decision would allow Portugal to save considerable sums relating to salaries, accommodation, and travelling. The plan suited Portuguese needs and so a formal request was submitted to the French Minister of Foreign Affairs. In response, the Minister reaffirmed that the aim of the appointment of two delegates was to secure a professional balance between doctors and diplomats and an equal representation of medical and administrative expertise in the Conference. Nevertheless, he did not object to the Portuguese decision, provided that the choice was made in accordance with the full agreement of the Portuguese government.[195]

Despite this support from France, Portugal struggled to appoint the London Secretary as its envoy. On 8 July, Adolphe Barroche reported to Paris that his diligence had failed due to a cabinet reshuffle that dismissed three ministers, including the Minister of the Interior – the only authority with the power to appoint delegates.[196] Nevertheless, the French ambassador hoped to secure a resolution shortly: the continuing Minister of Foreign Affairs promised to personally intervene by speaking to the new Minister of the Interior, forcing a prompt appointment. Barroche

[194] Stanley G. Payne, *A history of Spain and Portugal*, 2 vols., vol. 2 (Madison: University of Wisconsin Press, 1973); Raymand Carr, "Spain and Portugal, 1793 to c. 1840," in *War and Peace in an Age of Upheaval 1793–1830*, ed. C. W. Crawley (Cambridge University Press, 1965). See chapter two.
[195] French Minister of Foreign Affairs to Barroche 21 June 1851, Archives du Ministère des Affaires Etrangères, Correspondance Commercial Lisbonne, tombe 67
[196] Barroche to French Minister of Foreign Affairs 8 July 1851, Archives du Ministère des Affaires Etrangères, Correspondance Commercial Lisbonne, tombe 67.

concluded that, if no obstacles were found, a delegate could depart from Lisbon the following day.[197]

Despite successive promises, the Portuguese government failed to appoint a delegate during July. By mid-August, 24 days after the official opening of the ISC, the efforts of the French Ambassador finally paid off, and a delegation was appointed. As Barroche confessed, this feat was not his sole responsibility, instead resulting from the collaborative work between the French and English ambassadors to Lisbon. The unification of diplomatic synergies around a conference that aimed to establish a common sanitary policy in the Mediterranean region reveals the importance that the two countries attributed to the event. Moreover, the joint efforts developed by France and England – and perhaps the agenda of the new Minister of the Interior – reshaped the final structure of the Portuguese delegation. Portugal decided to send two delegates, in accordance with the model initially proposed by the organisers.[198]

This shift indicated that for the new cabinet, the international regulation of quarantine was an important issue that justified investing in two delegates. Moreover, the government decided to comply with the original delegation structure suggested by France. João Mouzinho da Silveira, a key member of the Portuguese embassy to Paris, was appointed as the diplomatic envoy. Although he did not reside 'in one of the several ports of the [French] Republic,'[199] as initially suggested by France, Mouzinho da Silveira was well acquainted with maritime law and quarantine. In a highly centralised country, public health policy was increasingly a Parisian affair.[200] As such, the Portuguese diplomat must have been familiar with quarantine practices in French ports such as Marseille, and their impact on

[197] Barroche to French Minister of Foreign Affairs 8 July 1851, Archives du Ministère des Affaires Etrangères, Correspondance Commercial Lisbonne, tombe 67.
[198] Barroche to French Minister of Foreign Affairs 16 August 1851, Archives du Ministère des Affaires Etrangères, Correspondance Commercial Lisbonne, tombe 67.
[199] Barroche to Paiva, 16 April 1851, Arquivo Histórico Diplomático (AHD), Leg./Emb. Paris, Maço 6. 3
[200] See chapter four.

Portuguese merchants. Regarded as zealous and intelligent by Barroche,[201] Mouzinho de Silveira was considered a good fit to represent Portugal.

Appointed as the medical delegate, José Maria Grande was an accomplished doctor who had been elected president of both the Lisbon Society of Medical Sciences and the Lisbon Royal Academy of Science. Grande started his career as an army physician, but soon devoted himself to horticulture and botanical sciences. In 1841 he was made professor of botany at the Polytechnic School of Lisbon, and head of the Botanic Garden of Ajuda – also in Lisbon. In 1849 Grande published the *Cultivator's Guide and Manual*,[202] and, soon after returning from the ISC, he continued to explore these agricultural interests by starting to reorganise the teaching of agricultural practices in Portugal.[203]

As they did not involve epidemic diseases, it was probably not Grande's research interests that played an important role in his appointment, but instead his political career probably contributed towards his selection. Soon after finishing his degree in medicine at the *Universidade de Coimbra*, Grande had joined the liberal forces and started a political career as a civil governor.[204] Later, in 1838, he was elected as member of the national parliament, a position that, except for short intervals, he held until 1852. As an MP, Grande participated in several permanent parliamentary commissions, including one devoted to public health issues (1839-1846), where he may have contributed towards national quarantine policies.[205] When writing to his

[201] Barroche to French Minister of Foreign Affairs 16 August 1851, Archives du Ministère des Affaires Etrangères, Correspondance Commercial Lisbonne, tombe 67

[202] José Maria Grande, *Guia e manual do Cultivador ou elementos de agricultura* (Lisboa: Impressão da Epoca, 1849).

[203] Maria Filomena Mónica, *Dicionário biográfico parlamentar : 1834-1910*, vol. 2 (Lisboa: Imprensa de Ciências Sociais, 2005). Vol 2 *pp*366-9

[204] The civil governor was an important administrative figure in charge of representing the central government at a district level. Coincidentally, this role was created by José Mouzinho da Silveira, the father of the Portuguese diplomatic envoy to the ISC.

[205] Americo Costa, *Diccionario chorographico de Portugal continental e insular: hydrographico, historico, orographico, biographico, archeologico, heraldico, etymologico*, 12 vols. (Porto1929). *p*832 Unfortunately, prior to this date, no further details on Grande's participation in the Public Health permanent parliamentary commission were found.

Minister of Foreign Affairs, Barroche described Grande as 'one of the most distinguished and influential men of the country.'[206]

Overall, both delegates satisfied the French ambassador, who noted that the selection demonstrated a genuine interest in the sanitary agenda of the Conference.[207] More importantly, the selection pleased the Portuguese government, which trusted the two men to voice and defend its position. From an individual perspective, both delegates enjoyed extensive contact networks that contributed towards their appointments: Mouzinho da Silveira had been educated in France and was an insider within the Portuguese diplomatic world, while Grande's professional and political career made him a well connected man.

The complex appointment episode forced a heavy delay to the arrival of delegates in Paris. Mouzinho da Silveira and Grande only joined the ISC almost a full month after its start. Nevertheless, they were still able to participate fully in the important debates of the Conference, since these were repeatedly adjourned until the majority of delegates arrived in Paris. Ultimately, the process of appointing Portuguese delegates reflects the impact of national political and economic realities, while highlighting the role of social networks and trust.

England, internal policy and external delays

Similarly to Portugal, other countries also faced issues when appointing delegates, and originally selected teams were frequently subject to alteration. In the case of England, the appointment of the medical delegate was problematised by the rivalry between two state agencies that were attempting to make their own agenda the national one through the voice of a delegate. On 24 January 1851 – months before an official invitation letter was sent by France – the London Medical Gazette announced that Dr. Benjamin Guy Babington (1794-1866) 'had been nominated by Lord

[206] Barroche to French Minister of Foreign Affairs 16 August 1851, Archives du Ministère des Affaires Etrangères, Correspondance Commercial Lisbonne, tombe 67.
[207] Barroche to French Minister of Foreign Affairs 16 August 1851, Archives du Ministère des Affaires Etrangères, Correspondance Commercial Lisbonne, tombe 67.

Palmerston to act for and represent the British Government at the *Quarantine Congress* which is shortly to [be] held at Leghorn [Livorno].'[208]

In 1851, Benjamin Babington was an accomplished London physician who had just been elected the first president of the Epidemiological Society. After a brief civil service career in India, Babington had returned to England where, in 1820, he had started his medical studies at Cambridge. In 1831 he had joined the Royal College of Physicians as a fellow, and ten years later had given the prestigious Croonian lecture at the same institution.[209] More importantly, Babington was very familiar with the ISC's subject of inquiry: in 1832, he had gained first-hand experience of cholera during its first outbreak, and, according to the *Transactions of the Epidemiological Society of London*, 'he devoted much attention to the investigation of the phenomena and pathology.'[210] Continuing his interest in epidemic diseases, Babington had translated and published a seminal German work on the medieval experience of the Black Death,[211] which, the *Transactions* claimed, 'was well received by the profession, and unquestionably gave an impulse to epidemiological inquiry among our countrymen.'[212]

In 1848-49, new cholera outbreaks were registered across Europe. As with the 1832 outbreak, medical communities did not have a common understanding of the nature of the disease and could not agree on strategies to prevent new epidemic outbreaks. However, this second epidemic coincided with important steps taken towards the formalisation of epidemiology as an autonomous scientific discipline in England. Until 1850, medical professionals interested in epidemiological data depended on papers published by the Royal Statistical Society; however, they were starting to feel that it was necessary to carve out a singular space where doctors could produce and circulate original epidemiological knowledge. These preoccupations eventually

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[208] "The Quarantine Congress," *London medical gazette* 47, no. 24 January (1851). My italics
[209] J. F. Payne, "Babington, Benjamin Guy (1794–1866)," in *Oxford Dictionary of National Biography* (Oxford University Press, 2004).
[210] Gavin Milroy, "Memoir of Benjamin Guy Babington M.D., F.R.S., etc," *Transactions of the Epidemiological Socieity of London* 2(1867). *p*473
[211] See J. F. C. Hecker and Benjamin Guy Babington, *The black death in the fourteenth century* (London,: A. Schloss, 1833).
[212] Milroy, "Memoir of Benjamin Guy Babington M.D., F.R.S., etc." *p*473

resulted in the creation of the London Epidemiological Society in 1850, and in the election of Benjamin Babington as its founding president – just a few months before the start of the ISC.[213]

In the initial preparation meetings for the Society's official opening, Babington noted that cholera alone could justify its establishment. He was fully aware of the 'painful' reality 'that up to [this] day we know neither the real cause, the means of prevention, nor the cure, of this awful malady.'[214] However, he hoped that under the sponsorship of the Society, 'the combination of talent in all branches of the [medical] profession meeting together under one roof, formed into one body for one good – one national cause, that what it is possible for man to effect, shall not much longer remain a mystery.'[215]

In order to produce sound knowledge on epidemic diseases, Babington envisioned the Society as an international hub for the circulation of data, coordination of research, and production of solid prophylactic policies capable of avoiding future epidemic outbreaks. In this sense, the Society was to play a crucial role in making its members 'acquainted with the scientific researches of men of other countries'[216] and in 'making inquiries in all parts of the world, to organize scientific investigations in different departments and in various parts of the globe, and to give publicity to the result of its manifold labours.'[217] Babington's cosmopolitan agenda was to profit from a favourable European political outlook, since the lack of military conflicts provided a unique opportunity for 'the interchange of scientific information among medical men of different countries.'[218]

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[213] D. E. Lilienfeld, ""The greening of epidemiology": sanitary physicians and the London Epidemiological Society (1830-1870)," *Bulletin of the History of Medicine* 52, no. 4 (1978).
[214] "Epidemiological Society: the address of Dr. Babington on his proposing the establishment of this society, at the general meeting held at the Hanover Square Rooms, July 30, 1850," *The Lancet* 56, no. 1412 (1850).
"Epidemiological Society: Monday, Dec 2 1850 - Dr Babington, President," *The Lancet* 56, no. 1423 (1850).
[215] "Epidemiological Society: Monday, Dec 2 1850 - Dr Babington, President."
[216] Horward, "Wellington and the Defense of Portugal."
[217] Ibid.
[218] "Epidemiological Society: Monday, Dec 2 1850 - Dr Babington, President."

Research and circulation of knowledge was to be the central focus of the Society, since, according to Babington, only a correct understanding of the nature of diseases could provide a basis for the formulation of efficient prophylactic measures. The fact that medical communities did not fully understand the nature of cholera meant that Babington was loath to recommend clear prophylactic policies. Despite the immediate economic benefits that would result from such a decision, the lack of solid evidence for the inefficiency of quarantine as a prophylactic practice meant that it would be premature. He feared that if this decision was to be taken, humanity would face serious risks: 'the seeds of death [could be spread] into the heart of populous cities, and the most awful results, the destruction of myriads of human being[s], [could] follow such [a] mistake.'[219]

According to Babington, unnecessary epidemic risks must be avoided at all cost: quarantine policies should not result from unscientific administrative decisions but instead from research developed at an international level and coordinated by the newly formed Society. Under the Society's direction, diseases would be classified according to their levels of contagiousness, and once a final list was produced, quarantine would be exclusively applied against diseases considered to be contagious. By restricting the use of quarantine to this reduced number of diseases, commerce would no longer suffer avoidable delays and costs. Babington's internationalist mission was, in many ways, similar to the ISC agenda. The striking difference was the professional division of labour as proposed by Babington: the creation of an international epidemic governance scheme should be the exclusive competence of doctors, not diplomats as planned by the ISC.[220]

As a prominent leader of the English epidemiologist movement and a supporter of the international circulation of knowledge, Benjamin Babington was, in many ways, the perfect delegate to represent his country at the ISC. In March 1851, several weeks after the *London Medical Gazette*'s announcement, the French doctor who was entrusted to manage the scientific programme of the conference – François

[219] "Epidemiological Society: the address of Dr. Babington on his proposing the establishment of this society, at the general meeting held at the Hanover Square Rooms, July 30, 1850."
[220] Ibid; "Epidemiological Society: Monday, Dec 2 1850 - Dr Babington, President."

Mêlier[221] – contacted his minister of foreign affairs to confirm the accuracy of the news. Moreover, Mêlier requested further details of the quarantine congress that Babington was supposed to attend in Livorno – could it be possible that two international congresses were to take place at the same time to address the same problems?[222]

As already demonstrated in the previous chapter, several European states competed to be the first to organise an international congress to standardise the practice of quarantine in Europe. Mêlier may have been confused, not knowing whether a parallel conference was being organised by England when France was planning to issue official invitation letters to the ISC. Moreover, according to intelligence already secured by the French government, England was to appoint John Sutherland as the envoy to the ISC – not Benjamin Babington. In the light of such confusing intelligence, Jules Barroche, the Minister of Foreign Affairs, decided to ask his General Consul in London, Adrien Louis Conchelet, to clarify the situation.[223]

Upon receiving Barroche's letter, Conchelet paid a visit to Edwin Chadwick – the Commissioner of the General Board of Health – who confirmed that six months earlier he had been asked about a possible quarantine congress taking place in Italy, but that the project had fallen silent soon afterwards. The *Gazette's* announcement may have been an editorial mistake resulting from a lack of updated information – or a conscientious editorial effort to put forward Babington's name as delegate to a future sanitary conference.

Chadwick was not surprised by the circulated rumours. Babington was clearly at odds with the anti-quarantine policy defended by the Board and its publications;[224] as

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[221] An important French public health official, François Mêlier was eventually appointed medical delegate to the ISC. See further biographical details in chapter four.
[222] Mêlier to Jules Baroche 27 March 1851, Archives du Ministère des Affaires Etrangères, Correspondance Commercial Londres, tombe 36.
[223] Jules Baroche to Louis Conchelet 1 April 1851, Archives du Ministère des Affaires Etrangères, Correspondance Commercial Londres, tombe 36
[224] See Edwin Chadwick, *Report on the sanitary condition of the labouring population of Great Britain: a supplementary report on the results of a special inquiry into the practice of interment in towns, made at the request of Her Majesty's principal secretary of state for the Home Department*

such, Chadwick interpreted the attempt to promote Babington to be a strategy to challenge the growing power of the Board and restore pro-quarantine policies in England and abroad. As shown in chapter one, the creation of the General Board of Health in 1848 had sparked an era of competition where two governmental institutions struggled to secure a monopoly on public health policy in England. The Quarantine Act of 1825 had granted the exclusive power to decree quarantine in England to the Privy Council.[225] However, the failure of the Council to prevent the 1848 cholera outbreak had led to a progressive transfer of power to the General Board of Health.

From a legal perspective, under the Nuisances Removal and Disease Prevention Act, the Board of Health was sanctioned to 'provide for the cleansing of streets, houses, & removal of nuisances, and interment of the dead' if 'any part of the United Kingdom shall appear to be threatened with or affected by any formidable epidemic, endemic, or contagious disease.'[226] However, these powers could only be mobilised once the Privy Council had deemed them necessary and issued an order granting the Board temporary powers to oversee policy relating to epidemic governance in the state. Facing the uncontrollable spread of cholera in the country, in October 1848 the Council had given the Board powers for six months and paved the way for Chadwick to secure, temporarily, the control of a further aspect of public health in England.[227]

In addition, the publication of the 1849 *Report on Quarantine* by the Board of Health further undermined the existence of the Privy Council as the gatekeeper of the epidemic safety of England. Instead of agreeing with the Council's traditional support of quarantine practice, the Board of Health suggested a policy shift based on the removal of nuisances that fostered the development of epidemic, endemic and contagious diseases.[228] In other words, with the publication of the *Report on Quarantine*, the Board of Health tried to reduce the power of the Privy Council to

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(London: Her Majesty's Stationery Office, 1843). And General Board of Health, *Report on quarantine* (London: W. Clowes & Sons for H.M.S.O., 1849).

[225] Quarantine Act 1825 (6 George IV c. 78)

[226] Disease and Prevention Acts 1848 (11 & 12 Victoria c. 123) sections 9 and 10.

[227] Richard Albert Lewis and Henry R. Viets, *Edwin Chadwick and the public health movement, 1832-1854* (London ; New York: Longmans, Green, 1952). *p*190

[228] General Board of Health, *Report on quarantine*. *p*127

introduce quarantines in England and highlighted the importance of the sanitary agenda, already spelt out in the Nuisances Removal and Disease Prevention Act, that transformed the Board of Health into the main caretaker of public health in the country.

Within the ideological, theoretical, and institutional conflict, the appointment of Babington emerged as a final attempt on the part of the Privy Council to protect a pro-quarantine policy and to set it as official policy both in England and abroad. After all, as Chadwick noted, the quarantine department of the Privy Council saw 'its existence threatened as [a] result of the anticontagionist principles of the board of health.'[229] Facing this risk, the Privy Council tried to find 'partisans of the ancient doctrines in the College of Physicians of London and Dr Babington was chosen to defend' quarantine and the Council.[230] Chadwick concluded that whatever ideas Babington would put forward, they would be 'less advanced than those of the Board of Health.'[231]

In the context of the above struggle, it was no coincidence that Conchelet visited Edwin Chadwick – and not the Privy Council – to gather intelligence on the selection process for the English delegation. First, the General Board of Health was gaining momentum in setting the public health agenda for England. Secondly, as R. A. Lewis concluded, the 'voice of the Board was the voice of Chadwick.'[232] Thus, Chadwick was expected not only to hold privileged information but also to influence the process of appointing delegates. In this sense, the Babington episode was a residual – and failed – attempt to restore the lost power of the Privy Council and to secure a pro-quarantine agenda in England and in the Mediterranean region.

The choice of Babington as a potential delegate to an international conference was finally ruled out with the official appointment of John Sutherland (1808-1891) on 2

[229] Adrien Louis Conchelet to French Minister of Foreign Affairs 5 April 1851, Archives du Ministère des Affaires Etrangères, Correspondence comercial Londres, tombe 36.
[230] Adrien Louis Conchelet to French Minister of Foreign Affairs 5 April 1851, Archives du Ministère des Affaires Etrangères, Correspondence comercial Londres, tombe 36.
[231] Adrien Louis Conchelet to French Minister of Foreign Affairs 5 April 1851, Archives du Ministère des Affaires Etrangères, Correspondence comercial Londres, tombe 36.
[232] Lewis and Viets, *Edwin Chadwick and the public health movement, 1832-1854*. *p*184

July 1851. After graduating in 1831 from the University of Edinburgh, Sutherland had settled in Liverpool where, in addition to his medical practice, he had edited several medical journals devoted to the sanitary improvement of the region.[233] Later, in 1848, Sutherland was invited to join the General Board of Health where, under direct instructions from Edwin Chadwick, he conducted a special inquiry on cholera. Initially, this inquiry was to have taken place in Germany but, on the eve of his departure (26 September 1848), Sutherland was instead directed to go to Hull 'in consequence of the appearance of several cases of the disease on board a vessel in the port.'[234] This detour marked the start of a larger investigation conducted by the Board of Health, which enabled Sutherland to observe the local circumstances causing outbreaks of cholera in England and Scotland. Eventually, Sutherland's observations were published as a 164-page long appendix to the *Report of the General Board on the Epidemic Cholera of 1848 & 1849*, an appendix that had largely shaped the main report signed by Ashley, Edwin Chadwick and Southwood Smith.[235]

Sutherland believed that 'the health, the well-being, and the duration of the life of man [were] intimately connected with the observance of the natural laws of the universe in which he dwells',[236] and unsurprisingly, he attributed the causes of cholera to local characteristics 'by virtue of which the epidemic obtains such power over the resisting vital forces of individuals, as to produce that class of phenomena usually ranked under the general designation of cholera.'[237] Furthermore, Sutherland argued that 'overcrowding; dampness; filth; want of ventilation and atmospheric pollution, proximity to graveyards (…), pigsties, offensive sewers (…); narrow, closely-built, and confined neighbourhoods, bad water [and] the impregnation of the

[233] Sutherland edited *The Liverpool Health of Towns Advocate* in 1846 and the *Journal of Public Health and Monthly Record of Sanitary Improvement* from 1847 and 1848.
[234] John Sutherland and Great Britain. General Board of Health., *Appendix (A) to the Report of the General board of health on the epidemic cholera of 1848 & 1849* (London,: W. Clowes & sons, 1850). *p*1
[235] General Board of Health, *Report of the General Board of Health on the epidemic cholera of 1848 & 1849* (London,: W. Clowes, 1850).
[236] Sutherland and Great Britain. General Board of Health., *Appendix (A) to the Report of the General board of health on the epidemic cholera of 1848 & 1849.p*3
[237] Ibid.*p*4

subsoil of towns with organic matter from filthy streets, cesspools' were examples of 'local defects' frequently linked with fatal outbreaks of the disease.[238]

Because local circumstances were the major cause of epidemic diseases, Sutherland believed the use of quarantine to be useless and injurious. In the case of vessels arriving from affected ports, no arrangements were made to ascertain the existence of on-board cholera cases, let alone treat them. In fact, assistance would be sent only when the disease was fully developed, which, in many cases, meant that it was too late to avoid the inland spread of cholera.[239] More problematically, while the application of quarantine to cholera presumed the disease to be contagious, Sutherland's experience suggested that the disease could not become 'epidemic unless certain conditions prevail which must be existing for some time before any case of the disease can occur.'

In summary, Sutherland understood that the development of cholera was due to pre-existing local circumstance. For this reason, quarantine was useless – if not dangerous – and only an effort to remove the local nuisances could secure the epidemic safety of populations. This aetiological and prophylactic model, defended by Sutherland, was similar to the one presented by the Board of Health in its *Report on Cholera and on Quarantine*. For this reason, the endorsement of Sutherland by Chadwick must have been a natural step to secure a continuous defence of the public health agenda of the Board, both nationally and internationally.

Because of either economic matters or aetiological beliefs, the Foreign Office, the Board of Health, and John Sutherland defended the elimination of the practice of quarantine in England and Europe. In a letter sent by Palmerston to Sutherland, the Secretary of Foreign Affairs affirmed that 'the main object which Her Majesty's Government have in view of sending delegates to attend [the ISC was] to assist in simplifying and liberalizing, as much as may be found practicable, the whole system of Quarantine, and especially to endeavour to relieve commerce from the weight and

[238] Ibid.*p*7
[239] Ibid.*p*10

vexatious obstructions which the existing quarantine system prevalent in most of the countries of Europe imposes upon it.'[240]

John Sutherland's stance represented a common ground, where the aetiological and prophylactic premises of the Board and the commercial interests of the Foreign Office could meet without conflict, and generated mutual advantages for the two institutions: Palmerston saw his commercial agenda supported by the scientific expertise and credibility of Sutherland, while the Board of Health gained access to a powerful international platform where the *official* position of England could potentially be moulded according to its own agenda. As such, the Board also saw its agenda legitimised by the Foreign Office, an ally that could be advantageously mobilised in the future.

While the space of the ISC was inhabited by doctors and diplomats, the conference was primarily the product of several diplomatic machineries. For this reason, the Foreign Office instituted a set of mechanisms to control its delegates, in particular John Sutherland. In this sense, any possible intention of the Board of Health to control the agenda of the conference was prevented by Palmerston, who invited John Sutherland to attend his office 'in order that [he could] receive any further instructions with which it may be found requisite to furnish [him] in regard to the conference.'[241]

In addition to the agenda personally conveyed to the British delegate in London,[242] a letter sent by Palmerston on 10 July supplied further instructions. Sutherland was expected 'to discuss fully the various questions which may be brought forward at the Conference.' However, at the same time, he was not to 'commit Her Majesty's Government to any decision with respect to any question without express orders

[240] Palmerston to Sutherland, 10 July 1851, Inclusion in the Procès-verbaux de la Conférence sanitaire internationale ouverte a Paris le 27 juillet 1851, Yale University: Cushing/Whitney Medical Library 19thCent RA422 In8 1851+
[241] Foreign Office to John Sutherland, 8 July 1851, Inclusion in the Procès-verbaux de la Conférence sanitaire internationale ouverte a Paris le 27 juillet 1851, Yale University: Cushing/Whitney Medical Library 19thCent RA422 In8 1851+
[242] No records were found detailing the meeting between Palmerston and Sutherland.

from Her Majesty's Government.'[243] Sutherland was also required to produce periodic reports on the works of the conference in collaboration with his fellow diplomatic delegate. Finally, the medical envoy was asked to maintain constant communication with the English ambassador to Paris for further guidance. If doubts existed, Sutherland was to represent the Secretary of Foreign Affairs and not the Central Board of Health.

Surprisingly enough, when John Sutherland was appointed to attend the ISC, no diplomat had yet been selected to join him in France. Although sources do not fully document the process of the selection of this second delegate, the official proceedings of the conference show that the diplomatic envoy missed the first session – despite residing in France. This delay suggests that bureaucratic problems may have occurred at the Foreign Office: occasionally, diplomatic correspondence was lost or delayed, requiring new orders to be sent when an expected answer did not arrive.

The fact that a doctor was the first delegate to be appointed to attend a sanitary conference should not be understood as a manifestation of a world dominated by medicine (rather than diplomacy). As shown above, the actions of Sutherland were carefully circumscribed by diplomatic instructions, and, more importantly, the ISC was an event organised by diplomats who endeavoured to maintain tight control over the works of the conference. The primacy of appointing Sutherland over the diplomatic envoy may instead denote a concern about recruiting non-diplomatic personnel to attend a diplomatic event. Palmerston may have sensed that selecting a doctor might require time-consuming negotiations in order to address both the complex vested interests within the medical profession and medical bureaucracy and the competing agendas between institutions such as the Board of Health and the Privy Council. In contrast, appointing a diplomat would take no more than an internal and ordinary decision of the Secretary of Foreign Affairs, and did not require the endorsement of any other institution or professional group.

[243] Palmerston to Sutherland, 10 July 1851, Inclusion in the Procès-verbaux de la Conférence sanitaire internationale ouverte a Paris le 27 juillet 1851, Yale University: Cushing/Whitney Medical Library 19thCent RA422 In8 1851+

On 10 July, the English consul at Brest, Sir Anthony Perrier, was finally appointed as England's diplomatic envoy.[244] Perrier was an experienced diplomat and regarded by the Foreign Office as an asset in the pursuance of an international anti-quarantine policy. First, as the consular official of a major Atlantic port, Perrier was familiar with the practice of quarantine in France, and its costs and problems. In a report published in 1860 by the House of Commons, Perrier remarked that before 1850 'quarantine measures were frequent and rigour[ous] at Brest…[where] ships from all quarters often underwent long and expensive quarantines on slight grounds.'[245] Secondly, as the English envoy to the 1839 and 1843 International Commission for the regulation of fisheries on the coasts of Newfoundland and France, Perrier had been trusted to negotiate the delicate details of a new agreement on the fishery practices of those coasts. The double experience of representing England in international events (as opposed to the local commitments that consuls typically undertook) allowed Perrier to gain an important insight into the world of international policy-making.[246]

As with the Portuguese delegation process, in choosing representatives, England tried to create the perfect alignment of delegator and delegate agendas. As such, trust was again crucial, and, in the case of the medical delegate, his scientific profile and networks paved the way to Paris. In this sense, divergent medical views on epidemics were seen by the Foreign Office to have important political implications, thus making the ISC a political as much as a medical arena.

[244] Palmerston to Perrier, 10 July 1851, The National Archives of the UK TNA: PRO FO97/210. The next letters show that Perrier received an allowence of £1/day on top of his normal salary and Sutherland £4/day for the duration of the ISC.
[245] *Quarantine laws. Abstracts of returns of information on the laws of quarantine which have been obtained by the Board of Trade. p5; 1860 (568-I) LX.191.*
[246] For a summary of Perrier's contributions towards an international agreement on fishing practices see: United States Permanent Court of Arbitration, *North Atlantic Coast fisheries arbitration. Appendix to the Counter case of the United States before the Permanent Court of Arbitration at The Hague under the provisions of the special agreement between the United States of America and Great Britain concluded January 27, 1909* (Washington 1909).

Twenty-four odd characters

When all 24 delegates finally joined the conference, they brought a unique set of expertise built by a multitude of professional backgrounds, institutional affiliations, and aetiological and prophylactic positions.

As previously noted, the French invitation mentioned that countries were requested to appoint a consul already residing in a French port. In addition to Portugal, several other governments ignored the French suggestion and appointed diplomats based in other countries: Tuscany and Greece delegated their agendas to consuls based in Mediterranean ports highly exposed to quarantine – Genoa and Malta – while Spain appointed its consul in Singapore. Finally, the Kingdom of the Two Sicilies selected its consul in Brussels. Out of eleven diplomats expected to reside in a French port,[247] only three did so; four were based in non-port towns in France, and four elsewhere.

While the appointment of some consuls with substantial quarantine experience can be easily understood, the choices of Spain and the Kingdom of Two Sicilies are less immediately comprehensible. Segóvia, the Spanish consul in Singapore, had finished his diplomatic mission there and returned to Spain to receive a new post in Latin America just prior to the start of the ISC. Underpinning the Spanish decision, perhaps, was an interest in the views of a diplomat experienced in distant markets and the impact of quarantine on long haul trade. The periodic circulation of diplomats may also shed light on the decision to appoint Louis Falcon as the Sicilian delegate: before being stationed in Brussels, it is possible that he had held office in a large Mediterranean port and thus developed expertise on quarantine matters. However, his poor attendance at the ISC suggests that he may have been appointed only to satisfy the French delegation requirements: Falcon participated in a mere 16 out of 48 sessions of the ISC. Moreover, the contrasting activity of Dr Giuseppe Carbonaro, his medical counterpart, suggests that the Sicilians regarded the defence of public health as a medical affair and not a diplomatic business.

[247] In this calculation, the French delegate was excluded since he was one of the organisers of the conference.

Medical delegates to the ISC were characterised by a close association with the regime they represented. For example, the Turk, Dr Bartoletti, was a member of the Constantinople Superior Board of Health, while the Sardinian, Dr Carbonaro, was the Secretary of Naples' sanitary authority. Another Sardinian, Bô, held a chair in medicine at the University of Genoa and presided over the national medical society. Likewise, the Russian, Spanish, French, and Roman medical envoys held leading positions in national health authorities in charge of regulating quarantine and other public health affairs.

In addition, most of the doctors had developed a parallel research career with extensively published work on epidemic diseases and quarantine. Carbonaro,[248] Betti[249], and Capello[250] had published works on local cholera outbreaks, and preventive and curative strategies against the disease; Bô's work had focused on yellow fever and French quarantine policies;[251] while Mêlier,[252] Monlau[253] and Sutherland[254] had located the hygienic causes of diseases.

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[248] Giuseppe Carbonaro, *Epitome sul cholera-morbus asiatico osservato in Livorno nel 1835* (Napoli: Trani, 1836); ———, *Intorno al cholera-morbus; osservazioni pratiche fatte in Napoli nel 1836 e 1837* (Napoli: Trani, 1849); ———, *Intorno al Rapporto su la peste e le quarantene, fatto a nome di una commissione alla Reale Accademia di medicina di Francia dal dottore Prus; osservazioni* (Napoli: Cataneo, 1847); ———, *La peste orientale relativamente al sistema delle quarantene* (Napoli,: Cataneo, 1845).

[249] Pietro Betti, *Cenni sul modo di preservarsi dal cholera-morbus e per amministrare i primi, e i piu pronti soccorsi a chi ne cadesse malato coll'aggiunta di un'istruzione sul modo di purificare gli individui, e disinfettare le stanze, e le robe, che hanno servito al ricovero, e all'uso delle persone affette dalla stessa malattia* (Livorno: Bertani, 1835).

[250] Agostino Cappello, *Risposta ad alcuni articoli stranieri intorno il cholera - morbus di Ancona* (S.L., 1836); ———, *Esame critico sopra la officiale relazione del corso e degli effetti del cholera morbus in Parigi e ne suoi d'intorni : pubblicata dal governo francese nel 1834 / di Agostino Cappello* (Rome: Boulzaler, 1835); Agostino Cappello and Achille Lupi, *Storia medica del cholera indiano osservato a Parigi da Agostino Cappello e da Achille Lupi cola inviati dal Sommo Pontefice Gregorio 16. nell'anno 1832* (Roma: Stamperia Camerale, 1833); Agostino Cappello, *Esperimenti pel cholera morbus* (Roma: Tip. Belle Arti, 1838); ———, *Cholera morbus, ossia, Della febbre pestilenziale colerica* (Rome: Presso Antonio Boulzaler, 1851).

[251] Angelo Bo, *Sulle quarantene contro la febbre gialla d'America e sulla inefficacia degli ordinamenti quarantenari della Francia: Relazione di una commissione creata dal Consiglio Generale di Sanita Marittima sedente in Genova* (Genova: Tipogrfia dei Fratelli Pagano, 1850).

[252] François Mêlier, *De la Santé des ouvriers employés dans les manufactures de tabac, rapport lu à l'Académie royale de médecine, dans sa séance du 22 avril 1845* (Paris: J B Baillière, 1845).

[253] Pedro Felipe Monlau, *Elementos de higiene privada* (Barcelona: Imprenta de D. Pablo Riera, 1846).

[254] Sutherland and Great Britain. General Board of Health., *Appendix (A) to the Report of the General board of health on the epidemic cholera of 1848 & 1849*.

In all, the vast majority of medical and diplomatic delegates were highly regarded professionals with vast experience in epidemic surveillance and management. For this reason, the ISC was a heterogeneous social arena where official national scientific and political positions were circulated, debated, and negotiated. Moreover, due to the specialisation of delegates, delegators such as the English Foreign Office imposed mechanisms to control their actions abroad. In this sense, delegators established rules and determined the margin of discretion with which delegates were able to negotiate, while at the same time imposing rigorous reporting proceedings. Delegates were to represent their nations and not their own vested interests.

II

Order and protocol

Soon after the start of the conference, delegates concluded that no existing protocol could provide proper guidance to the ISC. By the 1850s, diplomatic conferences were an established genre with crystallised forms of conduct. Likewise, international professional meetings had become a frequent phenomenon, even if guided by incipient protocols. At a crossroads where diplomacy met medicine, the ISC failed to fit into a clear recognisable nineteenth-century model of international congregation. This section will look at the strategies that delegates developed in order to establish a protocol to flexibly guide the works of the ISC in a way that satisfied all involved parties, and assess how the instituted rules contributed towards a peculiar power distribution among the professional groups.

From chaos to order in the diplomatic world

In the aftermath of the havoc caused by the Napoleonic wars, European powers convened in Vienna to establish a new political order. The Congress of Vienna resulted from the surrender of the Napoleonic forces in 1814 and the signature of the Treaty of Paris. This treaty settled the terms of peace and stipulated that ‘all powers engaged on either side in the present war, [should] within the space of two months,

send plenipotentiaries to Vienna, for the purpose of regulating, in General Congress, the arrangements which [were] to complete the provisions of the present treaty.'[255]

The agenda of the Congress of Vienna was loosely defined via secret agreements between participants and a few other documents that were made public. A conservative attempt to restore and legitimise the power of the old order of European royal houses, the Congress aimed to redraw the European political map by creating a German Federation, establishing new borders between Poland and Germany, extending the possessions of the Kingdom of the Netherlands, and constructing a neutral Switzerland. Equally ambitious were the Congress' intentions to regulate the navigation of rivers on an international basis and introduce social reforms to abolish and outlaw slavery.[256]

According to the Treaty of Paris, all nations were to participate in the Congress as equal partners, regardless of whether they were on the winning or losing side of the war. However, pre-existing agreements between Austria, England, Prussia, and Russia (the Quadruple Alliance) established two classes of participants: the first were countries that, through their political and economic power, were able to determine the agenda of the Congress, while the second were countries that did little more than legitimise the event.[257] Moreover, the inequality of participants was further aggravated by the lack of guidelines regarding the composition of delegation teams. While Portugal decided to send an ambassador, England was represented by the Secretary of Foreign Affairs, and Russia by the Tsar himself. The diversity of participants' social and diplomatic status reinforced the dynamics of subservience and inequality.[258]

This lack of clear organisation also materialised in other dimensions of the Congress. Scheduled to open on 1 October 1815, it was continuously postponed without ever

[255] Treaty of Paris, art 32. British and Foreign State Papers Vol 1 1812 1814 p 169
[256] C. K. Charles Kingsley Webster, *The Congress of Vienna, 1814-1815* (New York: Barnes & Noble, 1963). *p*55
[257] Ibid. p64. See also Bridge and Bullen, *The great powers and the European states system 1815-1914*. *p*208
[258] See Harold Nicolson, *The Congress of Vienna : a study in Allied unity 1812-1822*, Cassell history (London: Cassell, 1989).

being officially opened – despite the fact that work had started in September 1814. Moreover, the organisers of the Congress only allowed one specific venue where delegates could convene and negotiate. These two limitations resulted in unofficial and non-transparent events. Thus, the works of the Congress developed in unconventional venues such as ballrooms, hunting parties, private residences and even boudoirs, where the participants were chosen according to the interests of the organisers.[259] Understandably, the Congress of Vienna never appointed an official such as a president or a secretary that could act as an official steering committee. Instead, the Congress operated though tacit agreements between participants, and with committees created ad hoc under the leadership of England, Austria, Prussia, Russia, and France.

Interestingly enough, the lack of an official opening did not preclude an official closure of the Congress, where all participating powers convened in order to sign the Final Act of 9 June 1815. Between the start of the non-official works and the official closer, the Congress lasted over half a year. Tim Chapman argues that drafted documents, circulated before the start of the Congress, and the existence of secret agreements between the Quadruple Alliance members, led participants to believe that a final act would be signed after a few weeks of work.[260] But a congress primarily organised around the social capital of the participants, who preferred the informality of the boudoirs to the space of an open congress, cost – among other things – time. In fact, the inexistence of formal protocol was a result of an old diplomatic order, composed of a restricted number of actors armed with diplomatic *savoir faire* that allowed the emergence of ad hoc fluid rules.

Between 1815 and the start of the ISC in 1851, the diplomatic world changed, as practice was increasingly codified and formalised. The effects of the Congress of Vienna were indeed extensive. For a start, it was only the first in a series of congresses, which aimed to keep European peace and solve international disputes.

[259] Downer Hazen, The Congress of Vienna *p*34
[260] Tim Chapman, *The Congress of Vienna : origins, processes, and results* (London ; New York: Routledge, 1998). *p*26

These congresses were organised in order to stabilise the political map of Europe while suppressing attempts at revolution that would undermine the *status quo*.[261]

While some of these congresses were still dominated by informality and fluid praxes, by 1851, the crystallisation of diplomatic practice was evident. On the eve of the ISC, Charles de Martens[262] published the fourth edition of his *Diplomatic Guide* in Paris. This book aimed to 'systematically expose the laws and customs of diplomacy' for students intending to initiate a diplomatic career or individuals with an interest in the mechanisms of diplomacy.[263] Although the accuracy and influence of this publication is uncertain, the fact that the *Guide* was already in its fourth edition in 1851 suggests that the book was a popular manual for aspiring diplomats and reflected the diplomatic protocol practised in mid-nineteenth century Europe. Arguably, Martens' publication translated a diplomatic world marked by set models and hierarchies.[264]

Non-diplomatic conferences

According to the *Union des Associations Internationales*, during the first half of the nineteenth century, 26 international non-diplomatic conferences and congresses were organised in Europe – and by the end of the century, the number rose to 1,000.[265] Organised by different professional and interested groups, international conferences and congresses were used as venues to debate physics, naturalism, slavery, peace, prisons, economy, and agriculture – to name just a few topics. The extensive list of events denotes a clear burgeoning of a new social phenomenon, linked with processes of circulation of knowledge, standardisation of social practices and the creation of transnational political movements. Delegates from all over the world

[261] See William Mulligan, "Restrained Competition: International Relations," in *A Companion to Nineteenth-Century Europe*, ed. Stefan Berger (Oxford: Blackwell, 2006).
[262] Also known as Karl von Martens.
[263] Karl von Martens and Ferdinand de Wegmann, *Le guide diplomatique: Précis des droits et des fonctions des agents diplomatiques et consulaires; suivi d'un traité des actes et offices divers qui sont du ressort de la diplomatie, accompagné de pièce et documents proposés comme exemples*, 2 vols., vol. 1 (Paris: Gavelot Jeune, 1851). *p*xii
[264] This publication will be further analysed in the next few pages.
[265] Union of International Associations, *Les congrès internationaux de 1681 à 1899: liste complète* (Bruxelles: Union des associations internationales, 1960).

converged on cities such as London, Brussels, and Paris, and during set periods of time negotiated common meanings and future practices.

In *Colloques et sociétés,* Claude Tapia develops a typology in order to grasp the multitude of nineteenth-century congresses. In his view, international congresses were divided into seven major categories: political meetings of heads of states or governments; economic and monetary meetings; ecclesiastic assemblies; trade union meetings; meetings of political organisations; international, scientific, technical, literary and artistic conferences; and professional meetings.[266] The common link, Tapia argues, is that conferences and congresses served as forums for the circulation of knowledge, coordination of policies, strengthening of ideologies, reinforcement of administrative machineries, and regulation of social life.

The 1846 World Temperance Convention and the 1847 Congress of Economists were two examples of international events emerging from the greater nineteenth-century world of international congresses and conferences.[267] Unlike diplomatic events, congresses which were connected with political movements, social reform, and professional groups had no capacity to regulate the matters within their scope of debate. The lack of an official state representation and mandate to act in the name of governments limited the action – but not the ambition – of participants. Individuals who took part in these events merely represented particular scientific and academic societies, private and religious groups, or their own persona.

Emerging three decades after the Congress of Vienna, the World Temperance Convention and the Congress of Economists were marked by a formal and transparent organisation. Before the start of the event, organisers drafted agendas, determined the duration and venues of the event, and internationally circulated invitations to participants. Lasting four days, both events accommodated a large number of participants, arriving from all over the world. Opening in London, the

[266] Claude Tapia, *Colloques et sociétés : la régulation sociale*, Publications de la Sorbonne. N.S. Recherches (Paris: Publications de la Sorbonne, 1980). *p*23
[267] See Douglas Maynard, "Reform and the Origin of the International Organization Movement," *Proceedings of the American Philosophical Society* 107, no. 3 (1963).

Temperance Convention registered 301 participants – mostly priests and doctors – interested in elevating society's moral qualities and creating a coherent political programme to curb the world's alcohol consumption levels.[268] In Brussels, the Congress of Economists assembled 175 European and American delegates – including Karl Marx and Adolphe Quetelet. Together, and 'in [the] name of science and humanity,' delegates looked at the advantages of free trade and produced guidelines for future trade policies.[269]

Unlike the Congress of Vienna, the Temperance Convention and the Congress of Economists elected officers (a presidential and secretariat team) that managed the event and moderated debates. Convening daily, at set times, participants were invited to participate fully in the debates. Although 'no member was allowed to speak twice' at the Temperance Convention due to the high number of participants,[270] no limitation was ever imposed at the Congress of Economists. Both events sponsored the printing and distribution of copies of the detailed conference proceedings and lists of participants. These documents transformed the events into objects, capable of being mobilised and circulated, while standardising knowledge into crystallised forms. In this sense, printed proceedings allowed international events to gain a temporal and geographical scale that surpassed their ephemeral limitations. Ultimately, the mobility of discourses contributed towards the unification of political and scientific programmes.

The formalisation differences between the Congress of Vienna and the non-diplomatic events of the 1840s should not be seen as an inherent characteristic of professional events. Instead, the difference marks an organisational shift that eventually normalised the running of international congresses. Organised in order to

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[268] See list of delegates: Convention World's Temperance and Thomas Beggs, *The proceedings of the World's Temperance Convention : held in London, August 4th, and four following days, with the papers laid before the convention, letters read, statistics and general information presented, &c., &c* (London: C. Gilpin, 1846). *p*131

[269] Association belge pour la liberté commerciale, *Congrès des économistes réuni à Bruxelles par les soins de l'Association belge pour la liberté commerciale* (Bruxelles: Imprimerie de Deltombe, 1847). *p*1

[270] World's Temperance and Beggs, *The proceedings of the World's Temperance Convention : held in London, August 4th, and four following days, with the papers laid before the convention, letters read, statistics and general information presented, &c., &c*. *p*15

facilitate the circulation of political agendas and the circulation of knowledge, international congresses and conferences were platforms of intellectual exchange, where political and epistemic communities were constructed and reaffirmed.[271] Moreover, these international events established temporary centres for the coordination and planning of socio-political and economical life through the re-invention of political boundaries, the creation of common discourses, or the collection of scientific evidence used to support given initiatives. In order to do this, the organisers of these events increasingly imposed codified orders, translated through protocol. Because of this use of protocol in the regulation of international congresses and conferences, the professional boundaries between groups were clearly maintained. This was particularly true in the case of diplomatic initiatives that locked other groups out of proceedings, until the organisation of the ISC.

Building the format of the International Sanitary Conference

The French decision to invite participating countries to be jointly represented by a diplomat and a physician marked the end of an era in which diplomats claimed exclusive access to diplomatic events. Certainly, this transition occurred progressively and in a controlled way: doctors did not invade the space of the conference. Instead, under a specific set of rules and mechanisms of surveillance, they were invited to share their expertise. Nevertheless, the introduction of a second professional group into an already established diplomatic sphere imposed new problems and challenges to existing diplomatic protocol. The new professional ecology, established by the ISC, required the reinvention of previous conference models and the adoption of explicit rules to facilitate the peaceful and productive cohabitation of doctors and diplomats.

The intention of creating a bi-professional conference was detailed in the pre-programme that was circulated before the conference started. Authored by François Mêlier, this document, following common diplomatic practices, detailed the terms of

[271] See Prochasson, "Les Congrès: lieux de l'échange intellectuel. Introduction." Anne Rasmussen, "Les Congrès internationaux liés aux Expositions universelles de Paris (1867-1900)," *Cahiers Georges Sorel* 7(1989). and Nico Randeraad, *States and statistics in the nineteenth century* (Manchester: Manchester University Press, 2010).

reference that delegates were expected to address during the conference.[272] In the document, Mêlier stressed that the ISC should use science as a guide for the protection of public health and international trade. Nevertheless, he did not determine how the professional groups should be ranked in the conference. As science was to play a role in the works of the Conference, did Mêlier expect doctors to lead the ISC, or were they to be subordinated to the diplomats who were ultimately responsible for the organisation of the event? Alternatively, Mêlier may have envisioned a conference where doctors and diplomats were to act as equal delegates, but was it expected that doctors would be treated equally in the process of constructing common international law? In order to solve these tensions, conventional diplomatic protocol had to be adapted to the particular challenges imposed by the ISC.

As a creation of European diplomatic machineries, the ISC operated, to a certain extent, within diplomatic canon and protocol. Charles de Martens's *The Diplomatic Guide*, mentioned earlier, dedicated a section to congresses and conferences, two distinct diplomatic artefacts that varied in the type and number of participants as well as the outcomes typically produced.[273] According to Martens, conferences were meetings between two governments, represented by plenipotentiary ministers, and took place 'under the meditation of a third power.'[274] In contrast, *congresses* were 'assemblies of plenipotentiary ministers nominated by their respective governments to negotiate peace or to produce solutions for general political questions that divided the assembled states.'[275] From the perspective of diplomatic protocol, the nature of

[272] The pre-circulation of a conference programme was a standard diplomatic option to facilitate debate and reduce the duration of the meetings. According to Martens, these articles were tendentially short, clear and precise in the stipulation of the bases of any proposed treaty to be signed by the participating parties. Martens and Wegmann, *Le guide diplomatique: Précis des droits et des fonctions des agents diplomatiques et consulaires; suivi d'un traité des actes et offices divers qui sont du ressort de la diplomatie, accompagné de pièce et documents proposés comme exemples*, *p*1.
[273] Fifteen years later, in the fifth edition of the *Guide Diplomatique*, Martens dropped the distinction between the two objects and concluded that 'there is no precise distinction between congress and conference. In general, the name congress is given to very important meetings that leads to a general treaty.' Charles de Martens, *Le guide diplomatique. Précis des droits et des donctions des agents diplomatiques et consulaires*, 5 ed., vol. 1 (Paris: A. Durand, 1866). *p*179
[274] Martens and Wegmann, *Le guide diplomatique: Précis des droits et des fonctions des agents diplomatiques et consulaires; suivi d'un traité des actes et offices divers qui sont du ressort de la diplomatie, accompagné de pièce et documents proposés comme exemples*, 1.vol 1 *p*200
[275] Ibid.vol 1 *p*194

the ISC was closer to the format of a congress: no mediator was present, and delegates were invited to address a specific problem, the standardisation of sanitary practices.

The name of the ISC was a deliberate decision on the part of the organisers. As the previous chapter notes, the French administrator who first suggested the articulation of sanitary policies in the Mediterranean argued for a simple meeting of delegates [*réunion de députés*][276] to produce a desirable solution. The semantic change, implied in the French decision to organise an *international sanitary conference,* was an attempt to 'define, in the most simple way, the nature of the practical deliberations that should be agreed on instead of abstract theories.'[277] For the same reason, France rejected the organisation of a *congress* – 'a word that could imply a political character that, it was thought, would not be properly attributed to the meeting in question.'[278] Thus, the ISC was not, according to the French government, a political arena.

Although the name chosen for the ISC challenged diplomatic protocol, the selection of a venue to host the conference followed the conventional model described by Martens, who suggested that conferences and congresses should be located in the 'city (…) better situated to allow [delegates] to communicate as quickly as possible with their [governments].[279] By the time that countries were invited to attend the conference, the French government had yet to decide the final location of the ISC. In the letter of invitation, the French authorities indicated Paris and Port-Vendres as the most likely cities to host the conference.

With the support of the participating countries, Paris (specifically the Ministry of Foreign Affairs) was selected for its accessibility and centrality.[280] In addition, as the

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[276] Dupeyron, *Rapport Adressé à Son Exc. le Ministre du Commerce*: *p*84.
[277] French Embassy in London to Palmerston, 19 April 1851, The National Archives of the UK TNA: PRO FO97/210.
[278] Barroche to Paiva, 16 April 1851, Arquivo Histórico Diplomático, Leg./Emb. Paris, Maço 6.
[279] Martens and Wegmann, *Le guide diplomatique: Précis des droits et des fonctions des agents diplomatiques et consulaires; suivi d'un traité des actes et offices divers qui sont du ressort de la diplomatie, accompagné de pièce et documents proposés comme exemples*, 1. Vol 1 *p*196
[280] Palmerston to Marescalchi, London, 8 May 1851, TNA:PRO FO/97/210 .

administrative and intellectual capital of the French empire, Paris was, according to Palmerston, the city 'best adapted for the purpose [of the conference] inasmuch as it [was] the place where all kinds of information connected with the subject matter of inquiry might most easily be obtained.'[281] Historians and sociologists of science have noted the importance of space in the production and circulation of science, and argued that local circumstances condition particular projects.[282] The ISC was no exception. Paris was the ideal locale to procure and circulate data that could inform an effort to create international sanitary regulations. The proximity to governmental institutions connected to the governance of public health, and the existence of rich libraries, offered abundant resources that could be mobilised in order to assess the value of quarantine and inform aetiological and prophylactic discussions.

The same geography that enabled the procurement and circulation of knowledge also limited the nature of the conference: hosted at the French Ministry of Foreign Affairs, delegates had no direct access to victims of epidemic diseases or places for scientific experimentation. However, this restriction was in line with the Conference's pre-programme, which forbade the ISC to become a scientific congress devoted to experimentation and endless academic debates.[283]

The pre-programme invited countries to send their delegates to Paris, in time for the opening of the conference, by 'the end of June' in 1851.[284] The lack of a precise date for the opening of the ISC was a common practice in the organisation of international congresses – the Congress of Vienna, for example, was expected to convene three months after the signature of the Treaty of Versailles. This option served to

[281] Palmerston to Marescalchi, London, 8 May 1851, TNA:PRO FO/97/210 .
[282] David Livingstone, *Putting Science in its Place: Geographies of scientific knowledge* (Chicago: University of Chicago Press, 2003); David N. Livingstone, *Science, space and hermeneutics: Hettner-lecture 2001*, Hettner-lectures; (Heidelberg: Dept. of Geography, University of Heidelberg, 2002). For a summary of the importance of space and its impacts on science, see Finnegan for a good review of the spatial turn in STS. Diarmid Finnegan, "The Spatial Turn: Geographical Approaches in the History of Science," *Journal of the History of Biology* 41, no. 2 (2008).
[283] See Baroche to Paiva, 16 April 1851, Arquivo Histórico Diplomático (AHD), Leg./Emb. Paris, Maço 6.
[284] In a new letter sent to the English Government in June 1851, the French Embassy in London invited England to send its delegate to Paris between 25 and 30 June for the start of the ISC. French Embassy in London to the Foreign Office, London, 13 June 1851, Foreign Office Papers, FO 97/210. French Embassy in London to the Foreign Office, London, 19 April 1851. Foreign Office Papers, FO 97/210.

accommodate the need of delegates to travel long distances and to minimise, as much as possible, the impact of notoriously unreliable transport systems. By setting the start of the ISC at the end of June 1851, France, in their view, gave delegates enough time to arrive in Paris. Moreover, the French organisers anticipated that the timing of the ISC would allow participants sufficient time to implement the recommendations of the Conference before the summer of 1852, when a fresh outbreak of epidemic disease was anticipated, associated with the hot weather.[285]

Arriving on 11 July, John Sutherland was one of the first delegates to reach Paris, and soon consulted C. E. David regarding the details of the ISC. David stated that 'a sufficient number of delegates had not yet arrived to enable a meeting to be called.'[286] A week later, David observed that some delegates were still to arrive in Paris; however, those already in the city desired to start the conference as soon as possible. Thus, David proposed opening the conference on 21 July but deferring any important decisions until all the delegates had arrived.[287] Like Sutherland, other delegates arriving in Paris visited David, not only to present their official credentials but also to gather detailed information about the future of the ISC. These visits were, indeed, expected by David as an integral part of the diplomatic protocol.[288]

The ISC eventually opened its doors on 23 July,[289] and after a short welcome speech by David, Joseph Lavison, the Austrian general consul at Marseille and the senior delegate present, proposed the appointment of the French diplomat as the president of the conference. After a quick consultation, all the members attending supported Lavison's proposal.[290] The selection of David – and not a medical delegate – as the

[285] French Embassy in London to the Foreign Office, London, 19 April 1851. Foreign Office Papers, FO 97/210
[286] Sutherland to Perrier, 14 July 1851, The National Archives of the UK TNA: PRO FO97/210
[287] Sutherland to Perrier, 17 July 1851, The National Archives of the UK TNA: PRO FO97/210
[288] Martens and Wegmann, *Le guide diplomatique: Précis des droits et des fonctions des agents diplomatiques et consulaires; suivi d'un traité des actes et offices divers qui sont du ressort de la diplomatie, accompagné de pièce et documents proposés comme exemples*, 1. Vol1 *p*147
[289] On 20 July, Sutherland received a letter from David informing him that the first session would take place in three days. David to Sutherland, 20 July 1851, The National Archives of the UK TNA: PRO FO97/210
[290] According to the instructions received by Dr Sutherland, the English envoy, the appointment of David as the president of the ISC was intended to honour the hosting country and was a 'proper compliment to the French Government.' Palmerston to Sutherland, 25 July 1851, Inclusion in the

president reinforced the diplomatic ideology that oriented the organisation of the conference, while following traditional diplomatic protocol. It is not surprising that Palmerston directed Sutherland to vote for David: 'the conference [was] held in Paris [and] it would seem to be a proper compliment to the French government that M. David (…) should be chosen [as] president.'[291]

As the newly appointed president, David declared the conference constituted, and introduced Ernest Baroche, Jules David and Désormeaux, the secretaries directly appointed by the Minister of Foreign Affairs and the Minister of Agriculture and Commerce to assist delegates and write up the proceedings of the conference. Incidentally, this appointment transformed the ISC into a quasi-family enterprise: Jules David was the son of C. E. David and Désormeaux the son-in-law of Dr François Mêlier, the second French delegate.[292] This nepotism on the part of the French ministers introduced an important element of control to the works of the conference, and allowed David and Mêlier to use their advantageous position to shape the proceedings of the ISC according to specific agendas.[293]

Each session started with the reading of the proceedings of the previous day. Delegates could request the correction of any mistakes and, once satisfied with the final product, the proceedings were approved and signed. The text was then forwarded to the *Imprimerie Nationale* (the French official press house) to be printed and subsequently distributed among delegates. Finally, in addition to private reports, delegates forwarded a copy of the proceedings to their governments, which used the information to scrutinise the work of their envoys and to dispatch further orders. The constant flux of correspondence between the delegates and their governments contributed to the extended duration of the conference. During the six months for which the ISC was convened, delegates requested and waited for precise orders to

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Procès-verbaux de la Conférence sanitaire internationale ouverte a Paris le 27 juillet 1851, Yale University: Cushing/Whitney Medical Library 19thCent RA422 In8 1851+.

[291] Palmerston to Sutherland, 25 July 1851, Inclusion in the Procès-verbaux de la Conférence sanitaire internationale ouverte a Paris le 27 juillet 1851, Yale University: Cushing/Whitney Medical Library 19thCent RA422 In8 1851+.

[292] On the family links of Désormeaux see J. Bergeron, "Êloge de M. Mêlier. Lu dans la séance du 11 Décembre 1888," *Mémoires de l'Académie de Médecine* 36(1891). *p*28

[293] An analysis of the impact of David-Mêlier family network can be found in the next chapter.

arrive, a time-consuming process. In 1851, Paris was still not connected to other European capital cities through a telegraphic network, and so all correspondence was transported by sea or overland.[294] According to the 1855 edition of *Bradshaw's General Railway and Steam Navigation*, the distance between Paris and London could be covered in 13 hours – providing that the ferry or the two trains were not delayed.[295] Of course, correspondence between Paris and distant cities such as Istanbul required additional time. Furthermore, frequent letters circulated with requests for information, which meant that further time was required to organise the official national position put forward by delegates.

After several postponements, the ISC eventually established an operational routine. Unlike the Congress of Vienna, the ISC was officially opened and held in a room at the Ministry of Foreign Affairs, dedicated to the proceedings. In addition, like the Temperance Convention and the Congress of Economists, the ISC employed a president and an administrative team that contributed towards the efficiency, transparency and accountability of the conference. The expected outcomes, meanwhile, followed the Congress of Vienna's model: the ISC aimed to produce a document which would legally bind participant states to a piece of international law. Finally, like previous diplomatic initiatives, the ISC received the patronage of the hosting political elite: the Minister of Foreign Affairs, his director of consulate and commercial affairs, the Minister of Agriculture and Trade and his chief of interior trade made regular visits to the conference and were directly involved with its works.

Both ministers attended the second session of the ISC and, as the Minister of Foreign Affairs noted, 'the [existing] diversity of sanitary regulations plagued [Europe and] damaged commerce between different nations.'[296] Delegates were reminded that the ISC was underpinned by the ultimate necessity of finding common solutions for the protection of public health. At the same time, it was emphasised that these measures

[294] Daniel R. Headrick, *The invisible weapon: telecommunications and international politics, 1851-1945* (New York ; Oxford: Oxford University Press, 1991). *pp*12-15
[295] Departure from London at 20:30, from Calais at 2:50 with arrival to Paris at 9:50). See "Bradshaw's general railway and steam navigation guide, for Great Britain and Ireland," (London: Bradshaw's Railway Information Office, 1855).
[296] Conférence sanitaire internationale, vol 1, 5 August 1851, *p*3 (French Minister of Foreign Affairs).

should not ignore the need for swift international circulation of goods, indispensable for the proper 'development of peoples and industry.'[297] More candidly, the Minister of Agriculture and Trade concluded that 'time [was] money' and unnecessary sanitary obstacles to commercial transactions inflicted considerable losses, which should be avoided.[298] Both ministers stressed the need for the priorities of public health and commercial freedom to be balanced, and hoped that this would be achieved through the scientific knowledge and diplomatic expertise of delegates.

Doctors and diplomats alike were expected to contribute towards the construction of a sanitary system, through complex processes of negotiations and compromises that often challenged national agendas. Foreseeing problems ahead, the ISC president decided to clarify the format of the conference and to create rules capable of 'accelerating [future] deliberations.'[299] It was expected that debating and voting would be two crucial activities undertaken at the ISC. Regarding the process of discussion, delegates agreed not to interrupt speakers and to avoid presenting proposals or opinions identical to those already under debate. The agenda of each session was to be determined by the president, who also had the power to conclude the debate and order a final vote of the proposals under discussion; this would require the support of an absolute majority in order to be passed. Finally, due to the importance of the debates and the necessity of voting on each presented proposal that was presented, delegates were required to attend all sessions of the conference – except if formal authorisation had been granted beforehand.

Procedures for voting were critical to the success of the ISC in producing resolutions, and this issue was to generate heated debate amongst the delegates. In order to construct a voting system capable of gaining the participants' support, David invited the envoys to decide whether votes were to be counted by country, as was usually the case in diplomatic conferences, or by individual, as with professional conferences and congresses. The decision on this matter could potentially shape the outcome of

[297] Conférence sanitaire internationale, vol 1, 5 August 1851, *p*3 (French Minister of Foreign Affairs).
[298] Conférence sanitaire internationale, vol 1, 5 August 1851, *p*4 (French Minister of Agriculture and Trade).
[299] Conférence sanitaire internationale, vol 1, 7 August 1851, *p*2 (David).

the conference and would determine the status, legitimacy and power of each professional group. It would establish whether or not medical and diplomatic expertise were indeed equal in a conference organised through diplomatic mechanisms. One necessarily wonders whether doctors – without diplomatic training, experience, and affiliation – could be trusted to shape future international laws. Similarly, diplomats were required to deliberate on specific sanitary issues despite having no formal medical training. Could the construction of a sanitary code be trusted to professionals with limited aetiological and prophylactic knowledge? According to David, diplomatic protocol dictated that delegates should vote by state, yet previous diplomatic initiatives were reserved to diplomats. The lack of a clear precedent allowed delegates to decide the concrete rules of the ISC, and potentially to change the future of diplomacy by creating a precedent.

Starting the voting debate, Pietro Betti (the Tuscan doctor) reminded the Conference that France had invited countries to 'send *two* delegates and not *a* delegation.'[300] In his particular case, he had not 'receive[d] an imperative mandate' from his government and believed the ISC to be a platform where free ideas could be exchanged. Betti expected votes to be counted individually: 'each delegate had a unique character and his convictions c[ould], with no inconvenience, differ from his colleague's.'[301]

In contrast, Segovia, the Spanish diplomatic envoy, argued that the terms of reference given to delegates were not just a matter of individual responsibility. Delegates were acting on behalf of governments, and it should be expected that diplomatic and medical representatives would vote together. If delegates voted individually and against each other, governments would see their representation neutralised and jeopardised.[302] In a similar vein, Perrier added that individual voting could harm the equal representation of states in cases when one of a country's delegates was unable to attend the conference, as only one vote could then be cast by that country. Furthermore, Dr Sutherland of England pointed out that, although

[300] Conférence sanitaire internationale, vol 1, 7 August 1851, *p*4 (Betti).
[301] Conférence sanitaire internationale, vol 1, 7 August 1851, *p*5 (Betti).
[302] Conférence sanitaire internationale, vol 1, 7 August 1851, *p*5 (Segóvia).

delegates were expected to represent two different elements, he trusted that diplomats and doctors would be in permanent agreement. For this reason, votes should be cast on a delegation basis and not individually.[303]

Submitting the matter to the floor, the two voting scenarios were submitted to ballot. Delegates decided that all future voting was to be counted on an individual basis.[304] Each delegate would vote by raising his hand, but, if a third of delegates requested it, voting could be made secret. Finally, if voting results were even, the vote of the president would determine the outcome.[305] The voting method introduced by the delegates distinguished the ISC from traditional diplomatic congresses, which had typically relied on nation-based voting systems.

Tensions between traditional diplomatic protocol and innovative solutions that met the needs of the ISC could also be found in the debates on the Conference's expected outcome. In the programme pre-circulated by the French government, countries were invited to send two delegates to attend the Conference in order to produce an *Official Sanitary Code for the Mediterranean*. However, delegates such as the Tuscan diplomat feared that governments would not support a treaty based on individual votes rather than national directives. Thoughtfulness, he claimed, was required, and he stressed that the final outcome should modestly be titled *draft sanitary regulation* and submitted, in due time, to further negotiations between national governments and their offices for foreign affairs.[306]

In contrast, Perrier defended a bold initiative. He argued that, as participating states reserved the right not to ratify the ISC's outcomes, delegates should set themselves ambitious aims: a sanitary convention to be submitted for final approval from the governments. This option would also save precious time, since a draft regulation

[303] Conférence sanitaire internationale, vol 1, 7 August 1851, *p*6 (Sutherland).
[304] Conférence sanitaire internationale, vol 1, 7 August 1851, *p*6
[305] Conférence sanitaire internationale, vol 1, 7 August 1851, *p*8
[306] The exact name suggested by Cecconi was *Projet de règlement sanitaire maritime*. Conférence sanitaire internationale, vol 1, 9 August 1851, p.3 (Cecconi).

would require governments to organise a new conference and to appoint new delegates who would then compose a final convention.[307]

Deciding upon the name of the final document to be produced by the ISC was a complex matter, which required an unequivocal agreement on the potential impacts of the conference. According to the Spanish diplomat, three major options were available: first, the conference could produce a declaration of principles to guide future sanitary legislation; secondly, delegates could create a regulation detailing future sanitary practices; and thirdly, a convention could be signed and secure the standardisation of sanitary practices in the region.

The discussion on the outcomes of the ISC ended when Lavinson, the Austrian delegate, reminded delegates that the pre-circulated programme was clear regarding the matter: a sanitary code for the Mediterranean was the ultimate goal of the conference. In order to achieve this, he suggested that they formulate both a convention and a detailed sanitary regulation entitled *Draft Convention Followed by a Settlement for its Implementation*.[308] The precision of this debate derived from a diplomatic effort to produce a recognisable product compatible with diplomatic tradition.

Conclusions

This chapter has shown that appointing delegates was a complex process that involved the recruitment of persons whose individual and professional agendas were closely aligned with national sanitary agendas. In a context of representing a nation abroad, trust was a crucial factor in selecting envoys. However, delegators made sure to issue detailed instructions and request the production of periodic reports in order to keep delegates under control.

As a new international institution that gathered together diplomats and physicians, the ISC revisited diplomatic protocol in order to regulate its works. By introducing a

[307] Conférence sanitaire internationale, vol 1, 9 August 1851, *p*3 (Perrier).
[308] Conférence sanitaire internationale, vol 1, 9 August 1851, *p*5 (Lavinson).

voting system that privileged individual expertise, delegates carved a space for debate that, to some extent, separated themselves from their states when drawing up a draft sanitary convention and regulation. Although states maintained their decision-making capacity and power, delegates defined their role as determiners of medical and administrative matters. Though diplomatic institutions tried to secure a tight control over the works of the conference by limiting the autonomy of their envoys, delegates used their expertise to secure a space for debate that was autonomous from diplomatic interests.

CHAPTER 3: Between science and practice: quarantine and politics of classification of diseases

> 'Now, it is clear that quarantines and sanitary cordons are not efficient against diseases that are exclusively epidemic because these precautions cannot form a barrier that avoids the introduction of the epidemic constitution importable by winds, probably by magnetic currents which cross our globe and possibly by electricity that travels around it imperceptibly and in all directions.'[309]

> 'You say that quarantines are impossible and illusory but you accept them for plague and yellow fever! You say that they are contrary to their aim: I do not understand you.'[310]

A few minutes after opening the fifth general session of the International Sanitary Conferences (ISC), C. E. David, the elected president, invited all the participating delegates to address what he thought to be the most serious, central, and urgent matter of the conference: the selection of the diseases that were to be subjected to sanitary measures.[311] Other delegates also viewed the imminent debate as crucial to the very success of the ISC: Anthony Perrier, the diplomat sent by London, privately reported to Lord Palmerston, his Foreign Secretary, that the issue under discussion was 'one of the most important points'[312] because delegates were in reality deciding the future of quarantine in the Mediterranean Sea.

Stakes were indeed high for all participants. Changes in the practices of quarantine had the potential to reshape international public health, to distress trade, and to introduce new navigation practices in the Mediterranean region. As I argue in this chapter, the debate on quarantine was situated at the crossroads between medical

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[309] *Procés-verbaux de la conférence sanitaire internationale, ouverte à Paris le 27 Juillet 1851*, vol. 1, 27 September1851, p. 28 (Dr Grande)
[310] *Conférence sanitaire internationale*, vol 1, 23 September1851, p. 9 (Dr Carbonado)
[311] In this chapter I use *sanitary measures* synonymously with quarantine. This option is in line with the usage of the terms by the delegates themselves.
[312] Perrier to Palmerston (private), 25 September 1851, The National Archives of the UK TNA: PRO FO97/211

knowledge, diplomatic interests, and individual convictions. Furthermore, I will claim that the decision on the number of diseases that were to be subject to quarantine was a classificatory exercise; during the course of the ISC, delegates distinguished between two sorts of diseases – diseases that required quarantine and those that did not.

The classification of cholera was particularly complex and, in many ways, followed national controversies on the aetiological properties of the disease and the prophylactic value of quarantines. From an aetiological perspective, the debate navigated around two axes: endemic and epidemic diseases; and contagious and anticontagious diseases. According to the 1849 Beaude's *Dictionnaire de médecine usuelle* and the 1832 Adelon's *Dictionnaire de médecine*, endemic diseases developed in specific locations due to causes inherent in those places.[313] Moreover, because inherent causes tended to be permanent, endemic diseases were also permanently registered during specific periods and seasons.[314] Meanwhile, Adelon's dictionary described epidemic diseases as 'affections produced by general causes that temporar[il]y reigned over a great number of individuals.'[315] The origins of these causes were usually seen as exogenous to the local outbreak.

Underpinning the contagionism and anticontagionism axes were concepts connected to the causes of the disease's manifestation. Pure contagionists believed that the disease-causing matter was produced in the body of sick persons and transmitted by touch, fomites (clothes, bedding, and general objects that entered into contact with the sick and that were capable of conserving the poison and transmitting it during a period of time), or infection (produced by the sick, these viruses were released into the immediate atmosphere and inhaled by the healthy). On the contrary, non-contagionists believed that the causation of diseases was matter in the atmosphere

[313] Jean Pierre Beaude, *Dictionnaire de médecine usuelle è l'usage des gens du monde*, 2 vols., vol. 1 (Paris: Didier, 1849).vol 1 *p*584
[314] Adelon et al., *Dictionnaire de médecine ou Répertoire général des sciences médicales considérées sous le rapport théorique et pratique*, Deuxième édition, entièrement refondue et considérablement augmentée ed. (Paris: Béchet et Labé, 1832), Texte imprimé. Vol 12 *p*15
[315] Ibid. vol 12 *p*130

and physical environment (miasma). Once inhaled through the lungs, the matter entered the blood and disrupted the physiological balance of individuals.[316]

Despite being useful as provisional and initial navigation concepts, clear-cut definitions and oppositions between contagionism and anticontagionism have been largely criticised by scholars of history of medicine. These concepts accumulated layers of connotations over time. Each period added its own attempts at definition, but was inevitably affected by previous histories of the concept. Hence, the 'historian's difficulty in arriving at workable definitions even within a specific historical context is often a reflection of contemporary lack of precision.'[317]

As Margaret Pelling showed, mid-nineteenth-century English doctors and state officials produced no clear opposition between contagionism and anticontagionism. Instead, the two terms were used as limits in order to produce particular aetiological views and to originate a set of adaptable, malleable and in-between positions such as the idea of contingent contagionism. Although complex and even contradictory, these positions resulted from compromises 'consistent with interests, experience and methodology alike.'[318] Furthering this idea, Christopher Hamlin demonstrated that contagionism and anticontagionism explanations were not mutually exclusive, essentially opposed or even incompatible.[319]

The fluidity of concepts described by Pelling and Hamlin was also true in the case of the ISC. By framing the debate around the axes of epidemic/endemic and contagious/anticontagious, doctors and diplomats defined and classified diseases such as cholera.[320] However, unlike earlier debates, which shaped national quarantine policies and eventually led to the organisation of the Conference, the ISC

[316] The literature on contagionism and anticontagionism is extremely vast and the problem itself is a classical historiographical subject in the field of history of medicine. The above distinction is a simplification based on Vinten-Johansen, *Cholera, chloroform, and the science of medicine: a life of John Snow*. See chapter 7 Cholera theories.
[317] Pelling, "The meaning of contagion: reproduction, medicine and metaphor."*p*16
[318] ———, *Cholera, fever and English medicine, 1825-1865*. *p*310
[319] Christopher Hamlin, "Predisposing Causes and Public Health in Early Nineteenth-Century Medical Thought," *Social History of Medicine* 5, no. 1 (1992).p47
[320] Schematically, four grand positions could be expected. Disease could thus be: 1. epidemic and contagious; 2. epidemic and non-contagious; 3. endemic and contagious; or 4. endemic and non-contagious.

itself was composed of a restricted number of actors trusted by their countries to defend national agendas and to produce a common sanitary policy for the Mediterranean region. As a social arena shared by the two professional groups of diplomats and doctors, the ISC allows us to understand the international dynamics of classification of diseases and the process of constructing a common public health policy through efforts to balance public health ideals and international trade interests.

More specifically, in this chapter I look at the process of establishing quarantine as a valuable tool in the quest to protect public health and trade, and argue that judging the value of quarantine was an exercise of power, space, aetiology, history, and diplomacy. The first and second parts of this chapter deal with the limitations of the existent historical models used to explain the nineteenth-century prophylactic choices of European polities, and suggest that to understand the ISC, a deeper understanding of state agendas and state delegation is required. Underpinned by the *Edinburgh Strong Programme*, the third section of this chapter builds a theoretical framework based on the act of classification. By introducing a model that carefully merges the two bases of science and politics for the co-production of reality, this chapter challenges the previous understanding of nineteenth-century international epidemic control policies.

Section IV, V and VI of this chapter deal with the process of establishing a shared classificatory system in the space of the ISC, thereby grounding the analysis empirically. Section IV focuses on the power of diplomacy, particularly the Programme Commission appointed by the president of the ISC and composed of a selective group of delegates. Section V addresses the issues of individual agency and expertise in the space of the Conference by looking at the reception of the classificatory report presented by the Programme Commission. Finally, section VI looks at the power of numbers and the political negotiations used to create a majority in support of a common classificatory rule of *diseases to be quarantined*.

I

Classification of diseases as a historically and geographically situated problem

On 14 August 1851, Guglielmo Ménis — the Austrian medical delegate — opened the debate on diseases and sanitary measures, and reminded his colleagues that before the start of the ISC, a provisional program had been circulated between all participants. This document invited European states to create a sanitary system to prevent the importation of *contagious* diseases in the Mediterranean region.[321] Because delegates were allowed to address contagious diseases only, Ménis saw no reason to debate cholera, a disease that he believed to be epidemic.[322] He argued that plague and yellow fever – true contagious diseases - should be the only diseases under consideration, since sanitary measures such as quarantine were only effective when trying to prevent this disease category.

Likewise, Dr Angelo Bô, the Sardinian delegate and author of several studies on quarantine and contagious diseases,[323] argued that sanitary measures should be reserved for diseases like plague and yellow fever. Unlike Ménis, he viewed cholera as a contagious and importable disease – one that travelled from India to Europe and the Americas. However, he noted that smallpox, syphilis, and many other diseases were similarly contagious. Moreover, in his view, these other diseases 'acquired, after many centuries, the right of residency' and no sanitary measure was ever applied against them. He therefore asked why Europe should enforce quarantines against cholera if this disease shared the same contagious properties as smallpox and syphilis and was already endemic in Europe.[324]

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[321] *Conférence sanitaire internationale*, vol 1, 27 September 1851, *p*6 (Ménis). My italics

[322] Throughout this paper, I use cholera, cholera morbus, Asiatic cholera and Indian cholera not as synonymous but in the same way delegates used it.

[323] See, for instance, Angelo Bo, *Sulla dottrina dei contagi e delle malattie contagiose considerata ne' suoi rapporti colla pubblica preservazione: commentari* (Genova: Tipografia dei Fratelli Pagano, 18--). See also, ———, *Sulle quarantene contro la febbre gialla d'America e sulla inefficacia degli ordinamenti quarantenari della Francia: Relazione di una commissione creata dal Consiglio Generale di Sanita Marittima sedente in Genova*.

[324] *Conférence sanitaire internationale*, vol 1, 27 September 1851, *p*7 (Bô)

Although the two delegates both contested that cholera should not be subject to future quarantine measures, Ménis and Bô used different sets of arguments to justify their positions. In other words, as I argue in this chapter, despite the fact that both delegates classed cholera as a disease that should not be quarantined, each used a different set of auxiliary classifications to support their final classification. Ménis wished to avoid the use of quarantine measures because cholera-morbus was a non-contagious disease. On the other end of the spectrum, Bô considered cholera to be a contagious disease, but, due to other factors, also wished to avoid the introduction of quarantine for cholera.

Not all delegates shared the anti-quarantine views of Ménis and Bô. In fact, while trying to construct a unified way of classifying diseases, the ISC became the stage of a diplomatic and medical controversy, which would only be solved by a long international debate on the value of quarantine and the nature of diseases. More importantly, the conclusions of this debate shaped the future of international public health policy-making by establishing rules, agendas and professional dynamics.

Aetiological debates were far from an alien subject among medical communities during the first half of the nineteenth century. The mere existence of the ISC was the consequence of the failures of these communities to establish a largely shared definition of cholera perceived as true and valid. Since the first outbreak of cholera between 1829 and 1832, doctors had developed a set of strategies in order to establish the nature of cholera. In Poland, for instance, in 1831, Dr Foy 'practised on himself some most daring and disgusting experiments' in order to demonstrate that cholera was not 'propagated by immediate contagion.' Foy 'tasted the vomited matter, inspired the breath of patients labouring under the disease in its most violent form' and even 'inoculated himself with the blood drawn from one of the victims.'[325] During the same period, Nicolas Chervin proposed a similarly radical solution, although not by risking his own skin in the process. He suggested that the French government procure 'bed linen, garments, beds, &c., just taken from the dead and dying of' cholera in the Baltic region while securing '60 to 100 volunteers of

[325] "Experiments on the mode of propagation of the cholera," *The Lancet* 16, no. 409 (1831).

different ages and temperaments and habits' to be clad, exposed and 'imposed [to the] fomites of the contagious' during a maritime expedition to end 'in one of the least populous districts of the north-west of France.' Conclusions could then be drawn regarding the *true* nature of cholera and the ways to avoid future outbreaks:

> if the hundred individuals thus situated escape unharmed, restrictions are nugatory [sic], and are prejudicial to one of the first interests of nations. If, on the other hand, the disease explodes amongst the experimentalists, uncertainty will be at an end, and the philanthropic merchant will learn to submit with resignation to the restrictions imposed on commerce for the safety of his fellow men.[326]

A few years later, in 1849, John Snow claimed that cholera was spread through water supplies. To prove it, he initiated a methodical process of relating statistical epidemiological data on cholera to the London systems of water distribution and sewage disposal. Snow suggested that healthy people swallowed the poison of cholera through soiled water or hands and for this reason the disease 'might be checked and kept at bay by simple measures that would not interfere with social or commercial intercourse (…) It would only be necessary for all persons attending or waiting on the patient to wash their hands carefully and frequently (…) Or, if that cannot be accomplished, to have the water filtered and well boiled before it is used.'[327] In France, and elsewhere, doctors employed microscopes to look at the excrement of cholera patients. In 1849, Pouchet described the existence of small animalcules – *vibrio rugula* – in rice water excretions, while the London Royal College of Physicians published a report on cholera through which, with detailed microscopic observations, the College tried to find 'cholera bodies.'[328]

In sum, doctors around Europe used several methods and rationales to produce theories explaining the nature of cholera and to develop strategies that would prevent any future outbreak of the disease. The number of aetiological theories was such that

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[326] "The Cholera," *The Lancet* 16, no. 413 (1831). *p*572

[327] John Snow, *On the mode of communication of cholera* (London: John Churchill, 1849). *p*30 See also ———, "On the pathology and mode of communication of cholera," *London Medical Gazette* 44(1849).

[328] Pouchet, "Infusoires das les déjections des cholériques (extrait d'une lettre de M Puchet)," *Compte Rendu des séances de l'académie des sciences* 28, no. 1 (1849). Royal College of Physicians of London, *Report on the nature and import of certain microscopic bodies found in the intestinal discharges of cholera* (London: J. Churchill, 1849). Outside of Europe, doctors also registered several microscopic observations of cholera. See, for example James H. Cassedy, "John L. Riddell's Vibrio biceps: Two Documents on American Microscopy and Cholera Etiology 1849-59," *J Hist Med Allied Sci* XXVIII, no. 2 (1973).

some medical journals, such as the *Lancet*, refused to publish any more articles on cholera in 1849.[329] Inevitably, this continuing lack of professional agreement on the nature of cholera and on the research methodologies severely constrained the work of ISC delegates when they tried to produce a common quarantine policy for the Mediterranean region.

Moreover, the number of avenues available to resolve this controversy was limited by the programme set for the ISC. Under French influence, delegates decided to avoid transforming the ISC into a scientific venue and 'discussions of pure science and theory' were ruled out.[330] The agreed aim of the ISC was to produce solutions of practical application, rather than research. However, delegates were asked not to avoid the use of scientific deductions, observations or results – those were considered 'the best guides to follow' and their exclusion would be a 'true heresy', as the Programme Commission noted.[331]

[329] [*the editor*], "To correspondents," *The Lancet* 54, no. 1366 (1849).
[330] *Conférence sanitaire internationale*, vol. 1, *Resume Analytique,* Annex 2 to Proc. 7, 6 September 1851 *p*2
[331] *Rapport* ISC vol 1 s7 attachment 1*p*6.

II

From Ackerknecht to Paris: the problem of national agendas

Despite representing two different states, Dr Ménis from Austria and the Sardinian Dr Bô jointly opposed the use of quarantine as a prophylactic tool to control the spread of cholera in Europe. These delegates were not alone: also against the use of quarantine were the French and English delegations as well as other individual delegates. As will be shown below, a variety of reasons underpinned these positions, among which matters of national traditions and practices played important roles. During the first half of the nineteenth century, European states developed different prophylactic strategies to control epidemic diseases. While certain countries privileged quarantine, others opted for hygienic strategies to improve local conditions that were deemed responsible for the development of epidemic diseases.[332] In order to understand this national variation, Erwin Ackerknecht developed a model based on individual political ideologies.[333] In his model, prophylactic measures reflected particular aetiological approaches and were associated with political and economical interests: contagionist actors defended the application of quarantine while anti-contagionists proposed non-quarantine measures to control epidemic outbreaks. While anticontagionism was 'motivated by the new critical scientific of their time',[334] contagionism, he noted, was so old that is seemed never to have been submitted to rational examination. Contagionism and quarantine were, in Ackerknecht's view, associated with old bureaucratic powers and suspect to all liberals who were trying to reduce state interference to a minimum.

In *Anticontagionism between 1821 and 1867*, Ackerknecht claims that associations between ideology and prophylactic measures were never made at a state level but instead from an individual perspective. For example, rather than focusing on the

[332] As Margaret Pelling demonstrates, this distinction is far from unproblematic. Even in the case of England – traditionally seen as an anti-quarantine country – it is not possible to find a unified discourse condemning the use of this prophylactic practice. See Pelling, *Cholera, fever and English medicine, 1825-1865*.
[333] Ackerknecht, "Anticontagionism between 1821 and 1867."
[334] Ibid. *p*567

position of the French state, he looked at the discourse of French doctors. After a careful analysis of medical debates in France and England, Ackerknecht concluded that 'intellectually and rationally the two theories balanced each other too evenly.'[335] Support for contagionist or anticontagionist theories – or in other words, support for or opposition to the application of quarantines – was the result of individual trajectories, economic outlooks and political loyalties: 'these, being liberal and bourgeois in the majority of the physicians of the time brought about the victory of anticontagionism.'[336] In this sense, he suggested that 'the ascendency of anticontagionism coincide[d] with the rise of liberalism, [and] its decline with the victory of the reaction.'[337]

This idea was re-interpreted by Peter Baldwin who claimed, in *Contagion and the State*, that Ackerknecht connected politics and prophylaxis at a level of states.[338] In this sense, Baldwin argued, quarantine, as a traditional tool against epidemic diseases, was favoured by absolutist, autocratic or conservative regimes; meanwhile, 'liberal, democratic systems, reluctant to interfere with individual freedom, [which] sought less intrusive strategies (…) preferred to forego preventive interventions altogether.'[339] This geo-political association is far from simple, as Baldwin noted. First and foremost, it is difficult to produce a clear-cut list of autocratic and liberal states: Baldwin presents Britain as a liberal country and Austria and Russia as continental autocracies. However, he places France somewhere in-between the two political spheres, and leaves the remaining European countries uncategorised, with the exception of Prussia. Given the political complexity of the post-1848-Revolutionary Europe, Baldwin's analysis is not surprising. According to Jonathan Sperber, there were two large models of European political organisation in the 1840s, and little had changed before the start of the ISC.[340] The first was demonstrated by the constitutional monarchies of France, the Netherlands, Belgium and some Scandinavian and German states, which exercised political power using a

[335] Ibid. *p*589
[336] Ibid. *p*589
[337] Ibid. *p*589
[338] Baldwin, *Contagion and the state in Europe, 1830-1930*.
[339] Ibid. *p*12
[340] Jonathan Sperber, *The European revolutions, 1848-1851*, 2nd ed. ed. (Cambridge University Press: Cambridge, 2005).

fundamental law that limited, to some regard, despotic measures. The second was epitomised by the remaining continental European states – particularly the Italian polities, Prussia and the Austrian Empire – which practiced a political absolutism where no fundamental rights were granted to subjects.[341] With this constitutional divide in mind, we can infer that the majority of states that participated in the ISC were absolutist, autocratic or conservative regimes.

Recognising the inability of this model to explain the quarantine practice of nineteenth-century Europe, Baldwin argued that national prophylactic policies also depended on the geographical position of a given country in relation to the epidemic route of transmission of a disease. In the case of cholera, which travelled from India to Russia and from Russia to western European states, he claimed that countries further away from the original epidemic centre had the opportunity to learn from past prophylactic experiences and adapt their own strategies when facing an epidemic outbreak. 'In a more general sense, the importance of geography is revealed in the basic split between the Mediterranean countries, in close contact with the Orient founts of cholera, and the Atlantic nations at a further remove.'[342] In theory, a map of this model would divide the prophylactic attitude of the participant countries into two distinct groups – a group of countries closer to the Orient who supported the practice of quarantine and a group of countries closer to the Atlantic who would defend sanitary measures.

However, the national strategies developed during the first half of the nineteenth century to control the spread of cholera reveal too many exceptions to this model, such as Russia and Austria, both with vast territories, who tried to impose quarantines on their eastern frontiers but did not adopt such practices in the western parts of their territories. In the Italian Peninsula, some states supported the use of quarantine while others despised it. Despite these exceptions, Baldwin suggests that Europe was divided 'between Mediterranean and Atlantic, north and south' and that this basic geographic dichotomy highlights 'fundamental geo-epidemiological

[341] Ibid. *p*47
[342] Baldwin, *Contagion and the state in Europe, 1830-1930*. *p*212

blocs.'[343] Although the prophylactic histories of these blocs were marked by a variety of twists and tergiversations, Baldwin argues that a common prophylactic history can be traced.

Assembling the representatives of twelve European states with the aim of creating a common sanitary policy for the Mediterranean region, the ISC was an arena for states to put forward their official prophylactic visions. For this reason, the ISC is an ideal ground to test Baldwin's model and to understand how different states, through their delegates, articulated the necessity of protecting their domains with the range of available prophylactic measures. As this chapter will show, the ISC reveals a more complex history than the one presented by Peter Baldwin. By using the state as a unit of analysis, Baldwin downplays the important role of individual agency and neglects the fact that states simply cannot be represented without people. In the case of the ISC, this approach raises obvious problems: each participant state depended on their envoys to defend *national* agendas. However, long distances separated Paris from the envoys' diplomatic centres; furthermore, in 1851 there were no major telegraphic connections between these centres, and delegates and their governments depended on time consuming overland or sea couriers to transmit and receive updates. As will be shown below, the surveillance and control of delegates became a major issue during the conference, and some delegates used the states' weak surveillance and power technologies to impose personal agendas. In this sense, despite the fact that doctors and diplomats received direct orders from their national governments, these agents enjoyed certain levels of independence when judging and classifying cholera within the prophylactic framework designed at the ISC. Furthermore, under certain conditions, individual envoys had the capacity to challenge the terms of reference trusted upon them, and even used their networks of influence to shape new national prophylactic agendas. After all, classifying is an act of exercising power. Outside the direct sphere of surveillance from their states, delegates developed strategies to impose private agendas and align national mandates according to their interests. These national and individual agendas had a direct impact on the process of deciding

[343] Ibid. *p*212

which diseases should be subject to quarantine in the new international sanitary system.

III

Problems of classification of diseases

The ISC is an extremely interesting case study for understanding the process of classification of diseases. With the shared goal of creating a common and singular quarantine policy for the Mediterranean region, several European states, professional groups and individuals used the conference as a social arena to fight for the imposition of a classificatory system that best suited their interests. For this reason, the involved actors had to produce *visible* agreements, both at the level of creating a common disease classificatory system and on the rules to sort out diseases accordingly. The set of classes was rarely a problematic issue –almost all delegates agreed that diseases were to be classified either as *diseases to be subjected to quarantine measures* or as *diseases not to be subjected to quarantine measures*. However, delegates struggled, for two months, to agree upon rules of classification. During this process, they mobilised a battery of resources both inside and outside of the conference in an effort to pursue their national agendas and individual conviction. Ultimately, delegates battled to impose their desired conceptual framework.

Matters of classification[344] have long fascinated historians and sociologists of science. David Bloor, Barry Barnes and John Henry – among other members of the Edinburgh School – developed a framework for the analysis of the social process of categorisation, based on what they termed *finitist* conceptions of reality. Bloor argued that 'all systems of knowledge (...) are constituted by the divisions that are drawn between kinds or sorts of things' and he revisited the idea of Durkheim and Mauss that the 'classification of things reproduces the classification of men.'[345]

[344] I use the terms *classification* and *categorisation* synonymously throughout this chapter.
[345] David Bloor, "Durkheim and Mauss revisited: classification and the sociology of knowledge," *Studies in History and Philosophy of Science* 13, no. 4 (1982). *p*267

Ordering and ascribing properties to things is never a natural or objective activity. On the contrary, classifying is a crossroad between nature, society and individuals. By looking at the classification work of Boyle and Newton in the practice of seventeenth-century physics, Bloor claims that both physicists arranged 'the fundamental laws and classifications of their natural knowledge in a way that artfully aligned them with their social goals.' Within their specific interests, Newton and Boyle could produce a myriad of classifications – they just needed to use their imagination. However, in a Wittgensteinian sense, creativity is not a stray phenomenon but instead a tamed social product. Creativity is constrained by circumstances which impinge upon the individual – instincts, biology, past experiences, social interactions, training, and anticipations of and response to sanctions.[346] As such, the act of classification of a particular set of entities or instances is bounded to specific circumstances.

Underpinning the theoretical work developed by the Edinburgh School is the idea of *meaning finitism*: meaning is always open-ended and is created in a step-by-step fashion. Meaning follows usage, cannot independently exist from it and never settles in definitive forms - meaning can always be contested.[347] Furthermore, to understand the meaning of a concept, actors must learn and understand a set of connected concepts used in a process of classification. For example, in the process of classifying *diseases to be quarantined* and *diseases not to be quarantined*, actors may use concepts such as epidemic, endemic, and contagion, to name just a few. This constellation of attributes conveys the sense in which all members of the category resemble each other and are *correctly* classified together.[348] Classification is the process of examining the instances of a given term: to learn to classify is to learn to employ the classifications of some community or culture.[349] In other words, classifying a given disease as a *disease to be quarantined* results from previous experiences – if disease *x* was previously classified as *to be quarantined*, and if *y*

[346] See Bloor, David, *Wittgenstein, Rules and Institutions* (London: Routledge, 1997). *p*20
[347] Bloor, David, "Idealism and the Sociology of Knowledge," *Social Studies of Science* 26, no. 4 (1996). *p*850
[348] Barnes, Bloor, and Henry, *Scientific knowledge: A sociological analysis*.
[349] Barry Barnes, "On the conventional character of knowledge and cognition," *Philosophy of the Social Sciences* 11(1981). *p*305

resembles *x*, it follows that *y* should also be a *disease to be quarantined* (I shall return to this point below).[350] However, determining the level of resemblance between diseases is far from simple. In fact, Barnes et al. noted that asserting similarities is a process of outweighing inevitable differences – no two things are completely the same.[351] For this reason, if a new disease is compared with diseases already classified either as *to be quarantined* or *not to be quarantined*, one will invariably find that the new disease will have both similarities to and differences from the members of any pre-established categories.

Of course, the categorisation of something is not exclusively made by comparing it with the existing members of the category/ies that it may be classed under. In fact, the process often relies on complex operations of establishing relations between the thing to be categorised and a constellation of other concepts – concepts which are categories themselves. For instance, *diseases to be quarantined* might be those that (1) spread in a regular and predictable fashion and are (2) epidemic in their nature. Links between the categories can, in some cases, be formalised in a set of rules: for example, 'all *epidemic diseases* are to be classified as *diseases to be quarantined*.' However, the constellation of connected categories does not in itself completely determine the meaning of the first category, because each member in the constellation also can have indeterminate meaning.[352] The meaning of 'epidemic' is subject to change as much as the set of diseases used to classify it. In parallel with the set of descriptive categories used to classify a given thing, the classification process depends on resemblance judgments between new particulars and the existing members of a category.

From a schematic perspective, classification requires two non-separable elements: an infrastructure of classification – a set of categories – and the rules for *sorting things out* into those categories. In most of the cases, as Bowker and Star note, classifying is

[350] This process of classification is what Barnes, Bloor and Henry call classification by ostension. See ibid.p 306 and Barnes, Bloor, and Henry, *Scientific knowledge: A sociological analysis*. *p*50
[351] ———, *Scientific knowledge: A sociological analysis*. *p*51
[352] Ibid. *p*52

an intuitive, invisible and unproblematic process. [353] Due to individual and collective histories of classification, both infrastructure and the act itself of sorting things is crystallised in everyday life. For example, for most individuals it would be unproblematic to sort two piles of books – the first for books with yellow covers and the second for books with blue covers. Classification problems emerge when new things to be classified are found which do not clearly fit into existing classes (for instance, books with both yellow and blue on their covers), or when the classification system is renegotiated (e.g. books should be sorted according to the fonts on their covers or – as we will see in the case of the ISC, the rules of disease classification are revised). In these situations, the act of classification can lose its invisibility and may even become the focus of heated dispute. After all, as Foucault shows, the capacity of ordering the world is a strong source of power and an efficient way of protecting and exploiting resources.[354] For this reason, while exercising the power of imposing classes of diseases, delegates faced resistance from those who did not agree with the rules of classification.

IV

The diplomatic turn and the classification of diseases

The first classificatory struggle over cholera arose soon after Ménis and Bô expressed their anti-quarantine views. Through a rhetorical move that exposed the classificatory rules of diseases, Dr Carbonaro, the medical envoy from the Two Sicilies, concluded that cholera must be classed among *diseases to be quarantined*. To reach this conclusion, he first looked at plague and noted that this disease was quarantined because it was importable, travelled from person to person and because of the 'preventive influence of isolation.'[355]He then noted that cholera resembled plague in all these aspects: it had departed from Asia and found its way down to

[353] Geoffrey C. Bowker and Susan Leigh Star, *Sorting things out: classification and its consequences*, Inside technology (London: MIT Press, 1999).
[354] See Michel Foucault, *The order of things: an archaeology of the human sciences* (London: Tavistock Publications, 1970); ———, *The archaeology of knowledge* (London: Routledge, 1989); ———, *The Birth of the Clinic. An archeology of medical perception* (New York: Vintage Books, 1994).
[355] *Conférence sanitaire internationale*, vol 1, 15 August 1851, *p*9 (Dr Carbonaro).

Italy, and when quarantines were established, such as in Persia in 1822 or around the Russian imperial palace of St Petersburg, outbreaks had been avoided.[356] For these reasons, Carbonaro expected cholera to be classified among diseases like plague and yellow fever, i.e. a disease to be subjected to quarantine measures.

A fervent opposition to Ménis and Bô's proposed classification grew among the delegates and caused a true impasse in the development of the ISC. In order to resolve the conflict, C. E. David (the French diplomat and president of the Conference) suggested the creation of a special commission to study, coordinate and prepare a possible classificatory rule capable of gaining a majority of support among the delegates. Furthermore, in order to make the most efficient use of the ISC's time, the Programme Commission[357] was requested to create a detailed agenda and guideline for the Conference and a draft sanitary system for the Mediterranean. David appointed the Programme Commission at the end of the fifth general session. He envisioned a commission composed of a restricted group of members, who could work 'with calm and maturity' and develop a document to be openly scrutinised in subsequent general sessions.[358]

Headed by Betti, the Tuscan medical delegate, the Commission contained three other physicians and three diplomats:[359] medical delegates represented France, Sardinia and Greece, while diplomats represented Austria, England and Spain. According to the proceedings of the conference and the available diplomatic sources, the selection of this group was smooth and unproblematic. Although uncontested, David's selection of names raises important questions of representation, power and orchestration of agendas.

Considering the majority of doctors among the commissioners, one could argue that the classification of diseases was under medical jurisdiction and, consequentially,

[356] *Conférence sanitaire internationale*, vol 1, 15 August 1851, *p*9 (Dr Carbonaro).
[357] Hereafter *Programme Commission, Commission or* PC.
[358] *Conférence sanitaire internationale*, vol 1, 15 August 1851, *p*9 (David)
[359] According to the report sent by the English delegates to their Foreign Office, 'these delegates then withdrew to another room and constituted themselves into committee appointing Dr. Betti to be their chairman and Dr. Mêlier their reporter. Sutherland and Perrier to Palmerston, Paris, 14 August 1851 TNA:PRO FO/97/210.

that diplomats were mere advisors in the process of constructing a common sanitary policy for the Mediterranean. However, upon close attention, the choice of commissioners reveals a possible diplomatic scheme devised to secure control over the agenda of the conference. In fact, David's selection guaranteed the majority of commissioners who supported the French classificatory agenda: the French, Austrian, English, Sardinian, and Spanish commissioners believed that cholera should be classed among non-quarantined diseases. This left the Tuscan and Greek doctors alone in their quest to defend cholera as a disease that should be quarantined. As will be shown below, this diplomatic machination in the appointment of commissioners paid off. France managed to secure the Commission's presentation of a programme tailored to its needs.

Having appointed the Commission, David secured a room at the French Ministry of Foreign Affairs where the new commissioners could meet daily, uninterrupted. A final report was expected within a week, but due to the complexity of the mandate, the final document was actually presented to the ISC two weeks after the expected deadline. Curiously, the report that was read to the delegates revealed an uncommon level of agreement among commissioners. In fact, no apparent disagreements or tensions between them can be found in the report presented to the Conference. However, the lack of controversy may have resulted from the French strategy to silence opposition and make the process of disease classification as invisible as possible. François Mêlier, the French medical delegate, now appointed as the Commission's secretary and reporter, suggested that 'proceedings of the Commission [should] neither be printed, copied, nor communicated in extenso to the other delegates'[360] until the principles laid down in the French government's programme had been fully discussed and conclusively modified, rejected or adopted. In other words, what happened in the Commission was to stay in the Commission.

Although the commissioners agreed with Mêlier's secrecy policy and no proceedings were ever published, many, like Anthony Perrier — the English diplomat — rushed to report privately on the state of affairs of such an important organ of the ISC to

[360] Perrier to Palmerston (private) Paris, 21 and 22 August 1851, TNA:PRO FO/97/210. Original underline.

their Foreign Offices.[361] Through these reports, we can get a glimpse of the processes by which an initial compromise was struck on the question of categorisation. In early September, the Commission presented a 41 page long printed report on the *Questions of the Programme and their Solutions*. According to Perrier, the report was 'masterly' in its production by Mêlier, who used his writing and negotiation skills to bring 'round those who at first opposed his measures' and agendas. In fact, his *procès verbaux* were so 'very ably drawn out' that they could not 'fail to carry conviction to many in the general conference as they have already done in the committee.'[362] Mêlier had already confided to Perrier that he held the power to manipulate the composition of the proceedings. On one occasion, when the two had the opportunity to dine privately, Perrier confessed his discontent with the fact that the ISC was marching towards a situation where quarantines had to be applied against cholera, as this was against his mandate as the diplomatic envoy of England. In response, Mêlier asked for patience: 'you will see that in my composition I will modify all those things.'[363]

Mêlier indeed had the capacity and power to influence the proceedings of the ISC according to his own agenda and this ability eventually shaped, to some extent, the report presented by the Commission. The report reminded delegates that the problem of the decision about which diseases required sanitary measures was not confined to what Mêlier described as 'the civilized world', but instead that 'all humanity [was] interested in its solution.'[364] The aim of the report was to design a sanitary system for the Mediterranean where public health was 'before and above all' things. Public health, it claimed, was a 'sacred interest, sacred like life, inviolable like it.'[365] However, the *needs* of humanity and civilisation were not exclusively public health needs. Mankind required free communications. After all, the 'period of great civilization' lived by delegates was characterised by 'ceaseless exchanges, faster and multiple relations' and for the sake of civilisation these had to be

[361] Perrier wrote several private dispatches to Palmerston while sitting at the Programme Commission.
[362] Perrier to Palmerston (private) Paris, 21 and 22 August 1851, TNA:PRO FO/97/210.
[363] Perrier to Palmerston (private) Paris, 17 August 1851, TNA:PRO FO/97/210.
[364] *Conférence sanitaire internationale*, vol. 1, *Rapport a la Conférence sur les questions du programme et leur solutions,* Annex 1 to Proc. 7, 6 September 185, *p*2
[365] *Conférence sanitaire internationale*, vol. 1, *Rapport a la Conférence sur les questions du programme et leur solutions,* Annex 1 to Proc. 7, 6 September 185, *p*2.

protected. Governments, delegates and the Commission were required to reconcile public health, free communications and trade. The ISC should be 'inspired by high values of public good.'[366]

The Commission's report asserted, in line with the previous views of delegates at the ISC, that the first step to producing a sanitary system was to 'determine which diseases regarded as importable from a country to another, should be the object of sanitary measures.'[367] Before addressing this problem, the Commission imposed certain rules to guide both its works and the general ISC. By setting these rules, the Commission hoped to secure the successful construction of a uniform international sanitary system.

For this reason, politics was to be excluded from the conference. Scientific and theoretical discussions were to be avoided too: the ISC was practical in its nature and not a venue for research. In light of this decision, the use of words like *contagion* or *infection* was to be restricted since, according to this body, they did not contribute towards practical outcomes. Moreover, by attempting to restrict the role of politics and science, the Commission hoped to ease the process of building a flexible and uniform system of practices capable of being adapted to local climates and geographical realities. Needless to say, politics and science were, in fact, the major operators of the ISC.

After establishing this framework, the Commission was ready to present the list of *diseases to be quarantined*. Although France had invited European states to consider whether diseases like plague, yellow fever and cholera belonged to the common category of *diseases to be quarantined*, the Commission noted that the inclusion of cholera in this list was a mere formality intended to 'demonstrate deference and respect for the opinions of' all states.[368] Unequivocally, the Commission declared

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[366] *Conférence sanitaire internationale*, vol. 1, *Rapport a la Conférence sur les questions du programme et leur solutions,* Annex 1 to Proc. 7, 6 September 185, *p*2

[367] *Conférence sanitaire internationale*, vol. 1, *Rapport a la Conférence sur les questions du programme et leur solutions,* Annex 1 to Proc. 7, 6 September 185, *p*3. My italics.

[368] *Conférence sanitaire internationale*, vol. 1, *Rapport a la Conférence sur les questions du programme et leur solutions,* Annex 1 to Proc. 7, 6 September 185, *p*8.

plague and yellow fever as *diseases to be quarantined* while cholera – due to its aetiological nature and prophylactic history – should be placed among *diseases not to be quarantined*.

From an aetiological perspective, the Commission recognised that cholera had an exotic nature external to Europe and that it was 'susceptible of importation.'[369] Furthermore, cholera shared the spreading characteristics of other diseases that the Commission classed as *to be quarantined*. However, no available knowledge was at hand to help fully understand the nature of cholera and predict its spread or outbreaks. Equally problematic was the fact that the disease was now 'acclimatized in Europe' and its seeds could be found everywhere.[370] For these reasons, quarantine, as a tool to break the process of cholera transmission, was hopeless: no barrier could be efficiently erected to protect a place already contaminated with the disease. In particular, a continent where cholera was already endemic would profit little from the practice of quarantine. As such, cholera should be classed accordingly as a *disease not to be quarantined*.

Moreover, according to the Commission, the prophylactic history of cholera proved that quarantine increased the epidemic risk of cholera. Quarantines had a perverted and contradictory effect as they encouraged future outbreaks by concentrating passengers onboard vessels or in lazarettos where the disease could be freely spread. The Commission maintained that the nature of cholera required particular conditions to nourish, only found in certain foci of corruption and infection.[371] By not classifying it among *diseases to be quarantined*, the Commission hoped that the future Mediterranean sanitary system would provide an incentive for states to eliminate these foci either by abolishing quarantine stations, or by cleaning and ventilating houses and vessels.

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[369] *Conférence sanitaire internationale*, vol. 1, *Rapport a la Conférence sur les questions du programme et leur solutions,* Annex 1 to Proc. 7, 6 September 185, *p*9.
[370] *Conférence sanitaire internationale*, vol. 1, *Rapport a la Conférence sur les questions du programme et leur solutions,* Annex 1 to Proc. 7, 6 September 185, *p*9.
[371] Further explanation on *foci of corruption*. Add here reference to Vinten-Johansen, *Cholera, chloroform, and the science of medicine: a life of John Snow*.

Interestingly enough, the justifications underpinning the proposed classificatory system mirrored ideas summarised by the English Board of Health in several past reports. This particularity may have derived from the diplomatic efforts of Anthony Perrier in aligning the ISC programme with that of his own country, which were perceived by the Commission as 'perfectly rational.'[372] In this sense, the Commission argued, in addition to the negative prophylactic effects of quarantines, classing cholera as a *disease to be quarantined* would inflict severe costs to commerce and would not promote free trade among nations – an effort that nations like France and England had endorsed since the early 1800s by negotiating (or imposing) reformed bilateral tariff arrangements that facilitated the distribution of their products in Europe and elsewhere. The politics of trade seemed to inform the scientific reasoning of the Commission.

Passed by five out of seven commissioners, the report finally proposed a sanitary system where cholera was classified as a *disease not to be quarantined*. Although the ISC aimed to establish a standard sanitary practice in the Mediterranean region, the Commission granted some flexibility to local authorities in dealing with the epidemic risk of cholera. While they did not allow the employment of quarantines, local authorities were authorised to isolate specific vessels perceived as hazardous. In a first analysis, the empowerment of local authorities contradicts the internationalist aim of the ISC. However this strategy was no more than a diplomatic attempt to rule out quarantine in Europe completely, in a legitimate and standard way. To facilitate this, the Commission forbade local authorities to decree mandatory isolation to all vessels arriving from a specific location – this would be no more than a camouflaged quarantine and a perversion of the isolation power. In any case, the Report appeared, to all participant states and sanitary authorities, to be guided by a spirit of responsibility, humanity, and hospitality when dealing with embarkations feared to be infected with cholera. In order to protect local populations, authorities could isolate a vessel but never repel it: nations were asked to embrace the treatment of the sick through a system of lazarettos. Old quarantine stations were to be converted from isolation locales to open treatment outlets.

[372] *Conférence sanitaire internationale*, vol. 1, *Rapport a la Conférence sur les questions du programme et leur solutions,* Annex 1 to Proc. 7, 6 September 185, *p*10.

After establishing the aetiological bases of plague, yellow fever and cholera and assessing the success of quarantine in preventing these diseases, the Commission determined that only plague and yellow fever could be efficiently prevented with this sanitary measure. It was now time for the Commission to work out the details of the application of quarantine against these diseases. The commissioners were to decide whether quarantines should be enforced as soon as an individual case of plague or yellow fever was reported or only when the diseases reached an epidemic stage. Alternatively, quarantines could be permanently practiced in order to avoid any potential risk of contamination. The Commission also had to decide whether two diseases with distinct aetiological natures could be tackled with a common quarantine programme or the international sanitary policy for the Mediterranean should prescribe distinct procedures for each disease.

Similarly, the process of determining the specificities of quarantine was underpinned by aetiological assumptions and the prophylactic history of quarantine. This time, commissioners were particularly interested in the epidemic risk of plague and yellow fever, the customary practice of quarantine and its efficiency in securing the epidemic safety of Europe.

In the specific case of plague, the Commission based its resolutions on the 1846 Report on Plague published by the French Academy of Medicine.[373] Like the French Academy, the Commission argued that from an aetiological perspective, the sporadic and epidemic status of plague was problematic in its identification, given that the number of affected people was not enough to correctly distinguish the two realities.[374] In order to do so, other characteristics had to be taken into consideration; however, the Commission avoided any further consideration of the matter. They claimed that whether it was sporadic or epidemic, plague could potentially spread and risk the epidemic safety of Europe, given that even 'a sporadic outbreak in one

[373] Renés-Clovis Prus, *Rapport a l'Académie royale de médecine sur la peste et les quarantaines* (Paris: Chez J.-B. Bailliére, 1846).
[374] *Conférence sanitaire internationale*, vol. 1, *Rapport a la Conférence sur les questions du programme et leur solutions,* Annex 1 to Proc. 7, 6 September 185, *p*13.

locality could perfectly become epidemic in another [place] if displaced and transformed.'[375] Through travel, sporadic plague could hypothetically find optimal conditions to develop into epidemic outbreaks. In the face of such a catastrophic scenario, the Commission could only defend the use of quarantine and the mobilisation of any other possible protections. No resources were to be spared when protecting public health!

The apparent commitment of the Commission to using quarantine as a prophylactic tool was no more than an illusion. After establishing an epidemic model where an individual case of plague could potentially jeopardise the epidemic safety of Europe, the Commission devised an astonishing mechanism to avoid quarantines for this disease. The premise was relatively simple: although in theory a single case of plague was enough to originate an epidemic, this case had to exist in order for the disease to spread. Or, to put it differently, if plague did not exist, no epidemic risk existed. Hence, no quarantine measures were required to protect European populations. This extraordinary argument again led commissioners to mobilise French medical literature in an effort to clarify the risk of plague in Europe. By looking at studies on oriental plague by Prus, Willemin, Suquet, and Fauvel – all reputed French physicians – the Commission noted that Egypt registered its last plague epidemic between 1841 and 1842. More surprisingly, based on the vast French medical literature, the Report concluded that the Orient was a plague-free region and the absence of the disease was 'an acquired fact.'[376] Logically, if plague did not exist in the Orient, no scientific grounds justified the existence of expensive quarantine and purification of cargo.[377]

[375] *Conférence sanitaire internationale*, vol. 1, *Rapport a la Conférence sur les questions du programme et leur solutions,* Annex 1 to Proc. 7, 6 September 185, *p*13.
[376] *Conférence sanitaire internationale*, vol. 1, *Rapport a la Conférence sur les questions du programme et leur solutions,* Annex 1 to Proc. 7, 6 September 185, *p*15.
[377] The Commission noted that quarantines inflicted the cost of 'considerable sums of […] more than one million of francs' in the whole Mediterranean Sea *Conférence sanitaire internationale*, vol. 1, *Rapport a la Conférence sur les questions du programme et leur solutions,* Annex 1 to Proc. 7, 6 September 185, *p*15.

Astonishingly, despite such conclusions, the majority of commissioners voted that 'plague, even if sporadic, [should] be the object of sanitary measures.'[378] The same report that claimed that plague was nonexistent, and that sanitary measures against it were useless, proposed a system based upon quarantine. This incongruous and schizophrenic outcome is hard to understand, but it may have resulted from the direct intervention of François Mêlier, who was in charge of writing the final report. As seen above, Anthony Perrier, the English diplomat, had already praised the persuasive and writing skills of Mêlier. The contradictory ideas defended in the Commission's report may have been the result of Mêlier's power (and hope) to manipulate future debates in the general sessions of the ISC according to personal or national sanitary agendas. Mêlier may have had the power to impose his sanitary model in the Report, but was unable to control the vote of all the commissioners.

In an effort to rationalise the use of quarantine against yellow fever, the Commission compared the prophylactic history of the preventive models practiced in Spain and in Genoa. By doing so, they hoped to create a universal model of quarantine capable of eliminating all unnecessary – and costly – measures. In Genoa, the Commission noted, quarantine was decreed for both sporadic and endemic cases of yellow fever. In addition, all vessels were visited by a doctor trusted to inspect and certify the sanitary condition of the embarkation – this was even applied to ships arriving with clean bills of health. If judged necessary, medical inspectors or the Genovese sanitary authorities had the power to declare quarantine at any point. In contrast, Spain practised seasonal quarantines for yellow fever. Despite the fact that Spanish ports were in constant communication with colonies where yellow fever was endemic, Spain only demanded quarantine in three situations: during summer time, in periods of intense heat, or when yellow fever was epidemic in the Americas. During the remaining time, Spain granted free pratique to vessels arriving from its American colonies.

The Commission noted that both systems had proved to be efficient in avoiding yellow fever outbreaks. However, in the quest to trim all unnecessary and expensive

[378] *Conférence sanitaire internationale*, vol. 1, *Rapport a la Conférence sur les questions du programme et leur solutions,* Annex 1 to Proc. 7, 6 September 185, *p*16.

sanitary measures, thus helping the free flow of trade, people and military movements, they decided to adopt the Spanish model as the future sanitary standard for the Mediterranean region: unanimously they agreed to 'confine sanitary precautions to epidemic yellow fever and reject them against sporadic yellow fever.'[379]

In conclusion, based on aetiological suppositions, prophylactic histories and diplomatic efforts, the Commission constructed a sanitary model for the Mediterranean based on two classes of *quarantinable* diseases. Crucial for this enterprise was the restricted and controlled number of commissioners that were in charge of building such sanitary code, and their capacity to make parallels between the Commission's programme and their national sanitary agendas. In fact, from a set of seven commissioners, only the Tuscan and Greek doctors defended a pro-quarantine agenda, leaving the majority of the European map dotted with anti-quarantine supporters; this defies Baldwin's geo-epidemiological model (see Figure 3).

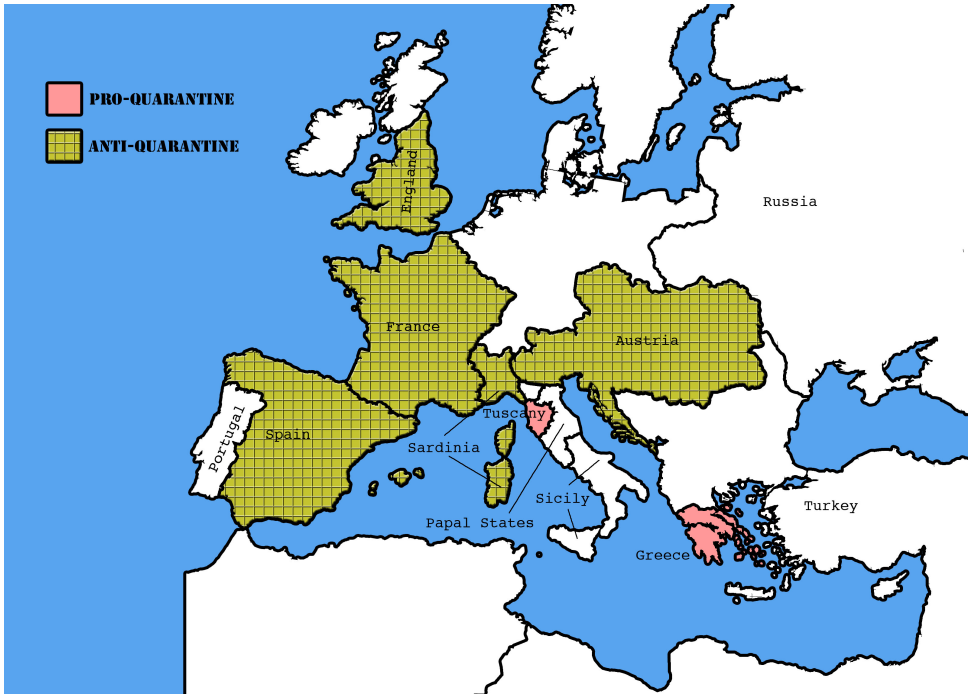

Figure 3 Distribution of quarantine votes in the Commission

[379] *Conférence sanitaire internationale*, vol. 1, *Rapport a la Conférence sur les questions du programme et leur solutions,* Annex 1 to Proc. 7, 6 September 185, *p*18.

V

Between states and expertise. The power of individual agency

On Saturday 6 September, delegates were summoned, at 10:15, to attend the seventh general session. In total, twenty delegates were present at the meeting and heard François Mêlier reading the Commission's report for over two hours. Delegates were now expected to approve the work of the Commission, produce the final version of the International Sanitary Code for the Mediterranean, bring the ISC to an end, and return home as soon as possible. However, the pace of the following sessions was anything but speedy. Delegates revolted against the classification of diseases proposed by the Commission, and, instead of approving their draft, battled for the imposition of a classification that satisfied their agendas. These conflicts were located both inside and outside the space of the conference, and culminated in some delegates defying national missions in order to protect personal agendas.

The group of delegates who listened to the Commission's Report included the recently arrived Dr Agostino Cappello[380] and C. Escalon, the Papal States (or Roman) envoys. In a private letter to London, Anthony Perrier confided that these delegates appeared to 'have special instructions from the *Roman Sanita* on each and all the articles in Dr Mêlier's programme, and have orders not to yield on any point.'[381] More problematically, the Roman agenda was not aligned with Perrier's mission: Cappello was a 'staunch contagionist' and Escalon, who was considerably more liberal, was 'under Cappello's domination.'[382] The pair, Perrier feared, were ready to mobilise and organise other delegates and to challenge the Commission's classification of cholera as a *disease not to be quarantined*. In fact, to Perrier's astonishment, the Romans were fully prepared to initiate a pro-quarantine campaign.

[380] In the ISC proceedings, Cappello's name appears printed as Capello. However, in the last page of the second volume of the ISC hold at the Medical Historical Library, Yale, Cappello signed his name with two Ps. I use this form throughout this chapter.
[381] Perrier to Palmerston (confidential), Paris, 8 September 1851.TNA:PRO FO/97/211.
[382] Although not clear, it seems Perrier was surprised by this inversion of power. The ISC was organised within diplomatic circles and Cappello, who was the Roman Consul General at Marseilles, was under the influence of a medical man. Perrier to Palmerston (confidential), Paris, 8 September 1851.TNA:PRO FO/97/211.

Soon after Cappello's arrival at the conference he distributed 'a printed notice to all the delegates, containing instances of cholera having been transmitted by contagion' and stressing that the Roman States had been spared from cholera outbreaks thanks to the enforcement of strict sanitary measures.[383] Although Perrier was apprehensive, David was not concerned with the Roman offensive. In fact, the French diplomat was convinced that the most powerful nations had enough resources to control the results of the ISC: the support of England and the 'influence of France and Austria [was] sufficient to get greater points carried through' and institute a liberal sanitary system in the Mediterranean.[384] Little did Perrier know that the first attack on the liberal agenda was soon to arrive from an ally: John Sutherland, the English medical delegate.

Without consulting his government or his fellow delegate, Sutherland launched a heavy attack on the rules of classification of diseases set forth by the Commission. In his opinion, the classification of *diseases to be quarantined* was not 'in accordance with scientific truth.'[385] The system proposed by the Commission was 'neither more nor less than the practice of the greater part of Europe, (even Spain) in 1832,'[386] the time of the first cholera outbreak, and since then, science had demonstrated that quarantine was useless 'to stop the march of diseases reputed as transmissible,' i.e. plague, yellow fever and cholera.[387] In accordance with the latest publications of the English Board of Health that he had co-authored, Sutherland urged the ISC to replace quarantine policies in the Mediterranean with hygienic measures.[388]

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[383] Perrier to Palmerston (confidential), Paris, 8 September 1851.TNA:PRO FO/97/211.
[384] Perrier to Palmerston (confidential), Paris, 8 September 1851.TNA:PRO FO/97/211.
[385] *Conférence sanitaire internationale*, vol 1, 23 September 1851, p3 (Sutherland).
[386] Sutherland to Palmerston, Paris 25 September 1851. TN:PRO FO/97/211.
[387] *Conférence sanitaire internationale*, vol 1, 23 September 1851, *p*3 (Sutherland).
[388] As the author of the Appendix A to the Report of the General Board of Health on the Epidemic Cholera, John Sutherland suggested that quarantine was unreasonable when applied to contagious diseases: 'It is one of the absurdities of the system of quarantine, when applied to cholera, that it is directed against the introduction of a disease presumed to be contagious, and which experience has proved cannot become epidemic unless certain conditions prevail, which mist be existing for some time before any case of disease can occur.' According to Sutherland, these local conditions were, for example, overcrowding, dampness, filth, want of ventilation and atmospheric pollution, among many others. In this sense, Sutherland claimed, in order to prevent epidemic diseases, local actions should be developed in order to remove the topical causes which preceded and accompanied these diseases. Sutherland and Great Britain. General Board of Health., *Appendix (A) to the Report of the General board of health on the epidemic cholera of 1848 & 1849*. *pp*7-10, 41.

Pragmatically, the English doctor recognised that the ISC was not a 'scientific academy' but a venue where 'consideration other than scientific should be taken into account.'[389] In fact, Sutherland agreed that the classificatory system proposed by the Commission 'offered the best possible [diplomatic] arrangement', but as a man of science, he could not support a system that so deeply contradicted scientific postulations.[390] While the model proposed by the Commission made too little use of quarantine for the Papal States's delegates, it was over-dependent on this prophylactic tool for Sutherland, and for this reason, he believed that his duty was to abstain from voting on any quarantine matter and challenge the orders received from London.

What was intended as an ultra-liberal attempt to classify all diseases as *diseases not to be quarantined* resulted in an unintended attack against the anti-quarantine party. By not supporting the Commission's classificatory model, Sutherland risked jeopardising the machinations of Perrier and Mêlier, who had skilfully worded a Report that to a large extent abolished the use of quarantine and protected the economic interests of the liberal parties. The abstention of Sutherland reduced liberal voting power, and weakened the capacity of England, France and Austria to control the outcome of the ISC. To the great surprise of the English Foreign Office and Anthony Perrier, Sutherland was 'unwilling to concede any thing that would in any manner detract from the principles laid down by the Board of Health' or to follow orders from London.[391] Perrier considered Sutherland 'too sensible a man to sacrifice the reality for a shadow',[392] but, torn between the Foreign Office and the Board of Health, Sutherland decided to abstain from voting; at stake were his scientific principles and convictions.

Problems with loyalty were not exclusively English. As already shown in Chapter 2, the ISC had developed a voting system that allowed 'delegates of some of the Mediterranean powers […] to vote according to their convictions without being

[389] *Conférence sanitaire internationale*, vol 1, 23 September 1851, *p*3 (Sutherland).
[390] *Conférence sanitaire internationale*, vol 1, 23 September 1851, *p*3 (Sutherland).
[391] Perrier to Palmerston (private), Paris, 25 September 1851.TNA:PRO FO/97/211.
[392] Perrier to Palmerston (private), Paris, 25 September 1851.TNA:PRO FO/97/211.

exposed to the censure of their government'[393] and reduced the capacity of governmental control. In accepting these rules, governments and the organisers of the conference underestimated the power of individual agency and empowered delegates such as Sutherland to pursue personal agendas.

However, voting was not the only way in which delegates could protect their personal interests. In fact, delegates like the Spanish diplomat, António Segóvia, successfully explored parallel avenues in order to impose his classificatory rules of diseases upon the ISC and even upon his own government. Like other delegations, the Spanish envoys did not agree on a single strategy to classify diseases regarding its quarantine status.[394] Although the Spanish doctor, Dr Monlau, eagerly defended the classificatory agenda received from his government, Segóvia bluntly disagreed with the pro-quarantine policy imposed by Spain.

In an attempt to promote his personal classificatory agenda and secure the help of possible allies, Segóvia contacted David soon after the Report had been read. He informed the President of the ISC that through the Ambassador to Paris, he had received orders from the Spanish government 'to withdraw from the conference, under protest, should quarantine measures against cholera not be adopted.'[395] Incidentally, the Spanish Ambassador also disagreed with the Spanish agenda and immediately requested new instructions from his government in Madrid in an attempt to allow Segóvia to join the anti-quarantine party. A reply from Madrid was expected to arrive in five or six days, the time available for Segóvia to mobilise all his resources to secure the elimination of quarantine in the Mediterranean region.

Fearing that a possible Spanish abandonment could jeopardise the success of the ISC, David contacted Anthony Perrier. He hoped that together they could use their countries' influence in Madrid to manipulate the Spanish government and protect the classificatory system proposed by the Commission. Not knowing about David's

[393] Perrier and Sutherland to Palmerston, Paris, 7 August 1851. TNA:PRO FO/97/210.
[394] According to Perrier's private reports this was also the case of the Roman and the Tuscan delegation. See Perrier to Palmerston (confidential), Paris, 23 October 1851.TNA:PRO FO/97/211.
[395] Perrier to Palmerston (private), Paris, 25 September 1851.TNA:PRO FO/97/211.

initiative, Segóvia also contacted the English diplomat and requested England to use its diplomatic machinery to influence his government in Madrid directly. In private, Segóvia exposed in detail the 'actual position of sanitary affairs in Spain' and elaborated a complex plan to change the Spanish national agenda on quarantine.[396] So audacious was his plan that Segóvia 'consented to put his opinions in writing.'[397] After clearly exposing the relationships and missions of Spanish major sanitary actors, Segóvia suggested that foreign diplomats should specifically lobby the Minister of the Interior and two other influential members of the Spanish Board of Health. Although it is not possible to follow Segóvia's diplomatic plotting in more detail through the available sources, it is certain that his efforts eventually paid off. Spain never abandoned the ISC, and her delegates started to defend an agenda closely aligned to Segóvia's classificatory model.

Afraid that his diplomatic efforts might not produce the desired effects, Segóvia devised an alternative plan based on the linguistic particularities of the Report. Aware of past conflicts that originated from quarantine classificatory disagreements, the Spanish diplomat tried to neutralise the blunt classification proposed by the Commission. Instead of internationally classifying cholera as a disease to not be quarantined, Segóvia produced a model that he hoped would satisfy all parties. The solution was simple: the ISC would return the classificatory decision on diseases to national governments. By doing so, all polities would regain the power to perform quarantines on vessels arriving from countries where cholera was epidemic. This attempt to maintain the sanitary *status quo* apparently challenged the ISC aspiration to construct a uniform sanitary practice in the Mediterranean region, which was the very reason the ISC was called into existence. However, Segóvia introduced an important caveat: quarantine could only be applied to specific vessels; it could not be decreed against a specific country or region.

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[396] Perrier to Palmerston (confidential), Paris, 23 October 1851.TNA:PRO FO/97/211.

[397] Segóvia allowed Perrier to copy his letter and even share the authorship details with Palmerston. However, the Spanish delegate requested that the Spanish government should not learn about these details. In order to preserve his anonymity, Segóvia did not sign the letter and always referred to himself in the third person. Perrier to Palmerston (confidential), Paris, 23 October 1851.TNA:PRO FO/97/211.

The linguistic trick proposed by the Spanish diplomat did not greatly differ from the Commission's report. Both proposals struggled to impose a concept of individual isolation or quarantine and revoke the orthodox practice of quarantines against entire regions and states. However, by retaining the word quarantine, Segóvia hoped to reassure pro-quarantine governments and local populations from the Mediterranean shores long 'accustomed to consider quarantine as the only safeguard against infectious diseases'[398] This twisted attempt at a consensual solution for the classificatory problem of cholera was short lived. After his idea was presented to the Austrian envoys, Segóvia was informed that this delegation would never consent to any type of quarantine measure, whatever its nature.

Between successes and defeats, delegates mobilised a multitude of resources inside and outside of the ISC in order to protect individual agendas and to align national mandates with their own convictions. In this sense, the ISC reveals an interesting compromise between individual agency and national delegation strategies. In many cases, states seem rather inefficient and powerless to survey the actions of their appointed delegates. In the same way, national agendas, like that of the Spanish, appear to be like sandcastles, capable of being reengineered by the right tools. The fluidity of national agendas seriously compromises Baldwin's geo-epidemiological model when applied to the ISC. First, it is hard to ascertain the official national voice in a delegation composed of two people of different backgrounds and agendas, with equal voting capacity. Secondly, the easy transformation of national agendas undermines the validity of a solid epidemiological model supported by geographical categories.

[398] Perrier to Palmerston (private), Paris, 25 September 1851.TNA:PRO FO/97/211.

VI

Numbers against diplomatic dreams and individual agendas

Although England feared the aggressive pro-quarantine pamphlets distributed by the Papal envoys, the first serious assault against the Anglo-Austrian-French agenda was made by another Italian delegation. On 23 September, Dr Betti from Tuscany opened the tenth general session, and argued that the Commission's decision to class cholera as a *disease not to be quarantined* was based on a bad comparison between cholera and diseases like syphilis and smallpox. In actual fact, the Commission had never established a relationship between cholera, syphilis and smallpox, but Betti's claim sparked and reshaped the classificatory debate. Moreover, it opened new avenues for pro-quarantine delegates to protect and put forward their agendas.

According to Betti, the Commission's classificatory decision was based on two principles: first, that cholera, like syphilis and smallpox, spread in an unpredictable way; secondly, that all three diseases were acclimatised to Europe or, to put it differently, were endemic in Europe. Thus, Betti noted that the Commission assumed the incapacity of quarantine to control the spread of cholera and classified the diseases as *not to be quarantined*. However, he pointed out, the Commission had failed to acknowledge that the spreading properties of cholera were similar to those of plague and yellow fever. In fact, Betti thought both diseases spread erratically, because when cities were newly infected, certain districts, houses and individuals were randomly spared. Likewise, Dr Carbonaro, the Sicilian physician, recalled that cholera jumped from London to Paris without contaminating intermediate locales because the distance between the two cities had been travelled during the incubation period: a 'healthy-looking man from London could carry the morbid principle that develops [only] in Paris.'[399] Cholera, like plague and yellow fever – all transmissible diseases – 'spread through maritime communications, caravans, armies, pilgrims,

[399] *Conférence sanitaire internationale*, vol 1, 23 September 1851, *p*9 (Carbonaro).

isolated individuals and [material] things'[400] and, for the sake of uniformity and rationality, should be classified as a *disease to be quarantined*.

The two Italian doctors also contested the Commission's classificatory scheme from an endemic perspective. Carbonaro recalled that 24 outbreaks of yellow fever 'during the course of 120 years' had not been enough to declare the disease 'acclimatised to Spain',[401] but the Commission was happy to judge cholera as endemic based on two single outbreaks. Moreover, Betti argued that no serious argument could sustain the classification of cholera among diseases like syphilis and smallpox, when the former had been continually present in Europe for over 12 centuries and cholera for no more than two decades. Once again the two Italian delegates demanded the reclassification of cholera as a *disease to be quarantined*, like plague and yellow fever.

Not surprisingly, the main opposition to the reclassification effort of cholera came from Dr Ménis, the Austrian physician and member of the Commission. Although he agreed with his government's official classificatory position, Ménis did not agree with the reasons that underpinned the Austrian decision. According to Vienna, cholera was a *disease not to be quarantined* because of its epidemic and non-contagious nature. However, as a physician with a vast cholera experience gained in Brescia between 1836 and 1849, Ménis believed that the disease spread through a 'sui generis principle, called *contagion, miasma or infection.*'[402] This principle was 'volatile and easily escaped barriers erected to contain [the spread of the disease].'[403] This had been the case when in 1831, despite rigorous sanitary cordons, cholera entered Austrian Galicia through Russia and from there travelled to Hungary and finally to Vienna, where even a double sanitary cordon failed to protect the city. At the same time, the 'capricious' cholera never reached cities like Mantua, Cremona, Lodi and Milan – even when their neighbouring city of Brescia registered a cholera outbreak and the free communication of people and cargo was unrestricted by quarantine. The manner by which cholera spread, Ménis concluded, could underpin

[400] *Conférence sanitaire internationale*, vol 1, 23 September 1851, *p*9 (Carbonaro).
[401] *Conférence sanitaire internationale*, vol 1, 23 September 1851, *p*9 (Carbonaro).
[402] *Conférence sanitaire internationale*, vol 1, 23 September 1851, *p*15 (Ménis).
[403] *Conférence sanitaire internationale*, vol 1, 23 September 1851, *p*15 (Ménis).

both pro and anti-quarantine arguments, thus '*post hoc, ergo propter hoc* argumentation had no value.'[404] His practice and experience with the disease led him to determine that quarantine measures were ineffective against cholera. If cholera was contagious and quarantine was useless against it, then it must share the same properties as diseases like smallpox, measles, and scarlet fever, and no government or doctor, he argued, 'ever thought to impose quarantines against these disease despite there was no doubts that they were contagious.'[405]

Regarding the attempts to make a specific link between plague and cholera based on their shared contagious nature, Ménis stated that such efforts were supported by bad scientific evidence. According to the Austrian delegate, while the two diseases shared a contagious nature, the specificities of each contagion were distinct and produced different ways of 'marching, affecting the human fibre, and predilection for victims.'[406] Unlike cholera, the march of plague, or to put it another way, the spread of plague, was fully understood and predictable. Moreover, plague had 'a big affinity with the human fibre',[407] with the capacity to annihilate entire populations, while cholera rarely killed more than two or three per cent of a given population – even in the worst epidemic cases, it never affected more than five per cent. In fact, cholera was a selective disease that 'exclusively attacked the scum of the society: the immoderate, drinkers, fornicators, decrepit, sick, alienated, imprudent, and the timorous.'[408] For this reason, unlike with plague, the moral condition of populations was crucial to the development, prevention or treatment of cholera: 'courage, resignation, a calm spirit and faith 'were the adequate weapons to fight cholera, a disease that should remain classed as *not to be quarantined*. Ménis, like other doctors, progressively transformed the ISC into a medical forum where aetiological questions were extensively debated and linked with prophylactic strategies. Moreover, Ménis, like many other delegates, used an accumulation of anecdotal

[404] *Conférence sanitaire internationale*, vol 1, 23 September 1851, *p*16 (Ménis).
[405] *Conférence sanitaire internationale*, vol 1, 23 September 1851, *p*16 (Ménis).
[406] *Conférence sanitaire internationale*, vol 1, 30 September 1851, *p*12 (Ménis).
[407] *Conférence sanitaire internationale*, vol 1, 30 September 1851, *p*12 (Ménis).
[408] *Conférence sanitaire internationale*, vol 1, 30 September 1851, *p*12 (Ménis).

evidence to attempt and defend tentative correlations between facts, medical theories and the design of epidemic prophylaxis.[409]

The discourses from delegates within both classificatory parties were, in the opinion of Dr Costi, the Greek delegate, 'remarkable'.[410] However, he could not find 'anything new, anything that had not been repeated by physicians' in countries where cholera outbreaks had been registered.[411] In a nutshell, certain delegates claimed that cholera was a contagious disease and presented countless cases where the imposition of quarantines avoided outbreaks, while other delegates listed numerous cities where cholera never appeared despite free communication of people and goods. Costi wondered how delegates would choose between the two classificatory positions and create a 'rational, uniform and not illusionary' international system of public health.[412]

The construction of such a system required, in the opinion of the Spanish doctor, Monlau, a consensual agreement on the contagiousness of cholera. However, a definite and absolute position on the matter was unreachable: *Asiatic cholera-morbus* was not constantly, essentially and universally contagious. Moreover, 'it was contagious or became contagious in circumstances that human science was not able to determine with certitude.'[413] On the one hand, impartial observations of facts demonstrated that cholera was sometimes contagious, or behaved in the same way as contagious disease. On the other hand, the same observations demonstrated that in many cases the disease was not contagious. Facing this reality, an 'impartial man could not, and should not, declare himself exclusively contagionist or anti-contagionist.'[414] However, neither could an impartial man deny that, in many cases, quarantine was sometimes effective against cholera. To abolish its use for this disease was not 'sensible and in certain countries such abolition would be cruel because it would steal an illusion […] an illusion that reassures the spirits, an illusion

[409] I borrow the idea of 'accumulation of anecdotic evidence' from David S. Barnes, *Lazaretto, epidemics, politics, and quarantine in a nineteenth-century city* (forthcoming).
[410] *Conférence sanitaire internationale*, vol 1, 27 September 1851, *p*25 (Costi).
[411] *Conférence sanitaire internationale*, vol 1, 27 September 1851, *p*26 (Costi).
[412] *Conférence sanitaire internationale*, vol 1, 27 September 1851, *p*26 (Costi).
[413] *Conférence sanitaire internationale*, vol 1, 27 September 1851, *p*14 (Monlau).
[414] *Conférence sanitaire internationale*, vol 1, 27 September 1851, *p*14 (Monlau).

very close to the reality and as consequence, an illusion that protects.'[415] Besides, he continued, 'in certain countries and localities, the abolition of quarantine would be much more than risky, much more than cruel: it would be impossible.'[416]

Instead of simply classifying diseases as *to be quarantined* and *not to be quarantined*, Monlau explored the meanings of these classifications beyond the practice of quarantine. By classifying cholera as a *disease not to be quarantined*, the Commission was not only granting permission for sanitary authorities to isolate vessels but also allowing them to perform *hygienic* measures. According to the Spanish doctor, hygienic measures included cleansing, aeration and ventilation, dispersion of people, purification of vessels and cargo, and in certain conditions, the isolation of vessels. Surprisingly, this was no different from Monlau's conception of *sanitary* and *quarantine* measures which likewise involved 'cleansing, aeration, ventilation, dispersion of people, purification of cargo and, if judged necessary, isolation.'[417]

In the face of these similarities between sanitary and hygienic practices, Monlau endeavoured to convince the ISC to reform the classificatory system and mark diseases as either *diseases not to be subjected to hygienic quarantines* or *diseases to be subjected to hygienic quarantines.* Quarantine would no longer be synonymous with its old etymological meaning, implying dreadful quarantine stations and their mistakes, suppositions, fiscal demands and out-dated, ridiculous and vexatious practices. Instead, Monlau wished to class cholera, plague, yellow fever and 'all other transmittable diseases' under a 'rational system of precaution' concerned with foci and vehicles of infection, ports and populations capable of developing diseases. In shaping these classificatory categories, Monlau aimed to ease consensus among delegates by linking the practice of quarantine with the typical hygienic measures set forth by the Commission.

[415] *Conférence sanitaire internationale*, vol 1, 27 September 1851, *p*15 (Monlau)
[416] *Conférence sanitaire internationale*, vol 1, 27 September 1851, *p*16 (Monlau)
[417] *Conférence sanitaire internationale*, vol 1, 27 September 1851, *p*17 (Monlau)

The efforts to create new classificatory frameworks never gained momentum. Instead, through the development of debates, delegates became increasingly aware that the majority did not support the Commission's classificatory solution, and were instead defending the classification of cholera as a *disease to be quarantined*. Delegates from Tuscany, Sardinia, the Papal States, Sicily, Spain, Portugal and Turkey had already requested the introduction of either mandatory or optional quarantines in the Mediterranean region. In an attempt to conciliate the two classificatory parties, the Portuguese doctor, Dr Grande proposed 'mandatory, as much as possible, the most rigorous hygienic measures and to leave quarantines optional.'[418] Grande believed that hygienic measures like ventilation, cleansing, dispersion of the sick, draining of marshes, cleaning of ports, cities and villages, and performing sanitary inspections of homes and vessels should be the pillar of any action aiming to mitigate 'cholera and zymotique diseases'.[419]

Grande also understood quarantine to be a crucial tool of international public health. However, he was aware that if it were made mandatory, the works of the ISC would not gain the support of northern and central European states, while if it were simply prohibited, southern nations would never consent to the decision or put it into practice. At first glance, this geographic division by Grande seems consistent with Baldwin's geo-epidemiological model. However, according to the Portuguese doctor, it was the physical geography of a place that was directly connected to the success or failure of quarantine. He claimed that 'Portugal, for example, has still a great number of islands: Azores, Cape Verde, etc., and in most of them there is only one or two disembarkation ports. It is therefore unnecessary to say that quarantines can be extremely efficient against the contagion' of cholera.[420] Alongside Portugal, there were other southern European countries such as Greece and Sicily, whose territories were also composed by islands, who regarded quarantine as essential to the protection of public health. Although Grande defended a model where states could classify cholera either as a *disease to be quarantined* or *not to be quarantined*, he thought it best to limit the power of states and sanitary authorities by not allowing

[418] *Conférence sanitaire internationale*, vol 1, 27 September 1851, *p*30 (Grande)
[419] *Conférence sanitaire internationale*, vol 1, 27 September 1851, *p*31 (Grande)
[420] *Conférence sanitaire internationale*, vol 1, 27 September 1851, *p*31 (Grande)

quarantines against cholera to be longer than those in cases of yellow fever. In this sense, the geographical argument presented by the Portuguese doctor was radically different from the one made by Peter Baldwin in *Contagion and the State*. The crucial factor in defining the prophylactic policy of a given country was not its position on the globe, but the topography of its territory.

Although Dr Rosenberger was not authorised by the Russian government to vote on any matter related to quarantine, his mandate did not restrict him from fully engaging in the debates. By quickly comparing the number of causalities caused by the 1829-32 cholera epidemic, when quarantine had been used, with the 1846-9 epidemic, when it had been abolished, Rosenberger concluded that the number of cholera cases was three times higher in the period without quarantine. Like Grande, Rosenberger believed that the success of quarantine was constrained by geographical factors. For that reason, 'island[s], peninsulas separated from the continent through an isthmus […] and al[l] maritime ports'[421] should perform mandatory quarantines for the sake of building a uniform system of international public health. However, unlike Grande, Rosenberger believed it was not enough to declare that the duration of cholera quarantines should be shorter than those of yellow fever. He specified that the incubation period of the disease did not exceed five days, and so quarantines should not last longer than that.

Facing a majority of delegates who defended the classification of cholera as a *disease to be quarantined*, David, in the capacity of president of the ISC, ordered the Commission to reconvene and produce a new classification of cholera in accordance with the classificatory ideas so far presented. One hour later, the Commission announced that, under specific conditions, cholera was to be classed as a *disease to be quarantined*. All departures from places where cholera had been declared were to be subjected to observation quarantines of up to five days if the duration of the travel was shorter than that period. Finally, the Commission suggested that places of

[421] *Conférence sanitaire internationale*, vol 1, 30 September 1851, *p*5 (Rosenberger)

departure that neighboured cholera outbreaks or were used as intermediary travelling stops would also be subject to observation quarantines of up to three days.[422]

In the vote on the Commission's classificatory proposal, out of 23 present delegates, 15 voted in favour. Surprisingly enough, as will be further explored below, several delegates, who had passionately defended the classification of cholera as a *disease not to be quarantined*, shifted their position and supported the creation of an international system of public health based on the practice of quarantine. Four delegates voted against and four others abstained. In the end, from north to south, and east to west, the majority of European states legitimised the use of quarantine in the Mediterranean (see Figure 4).

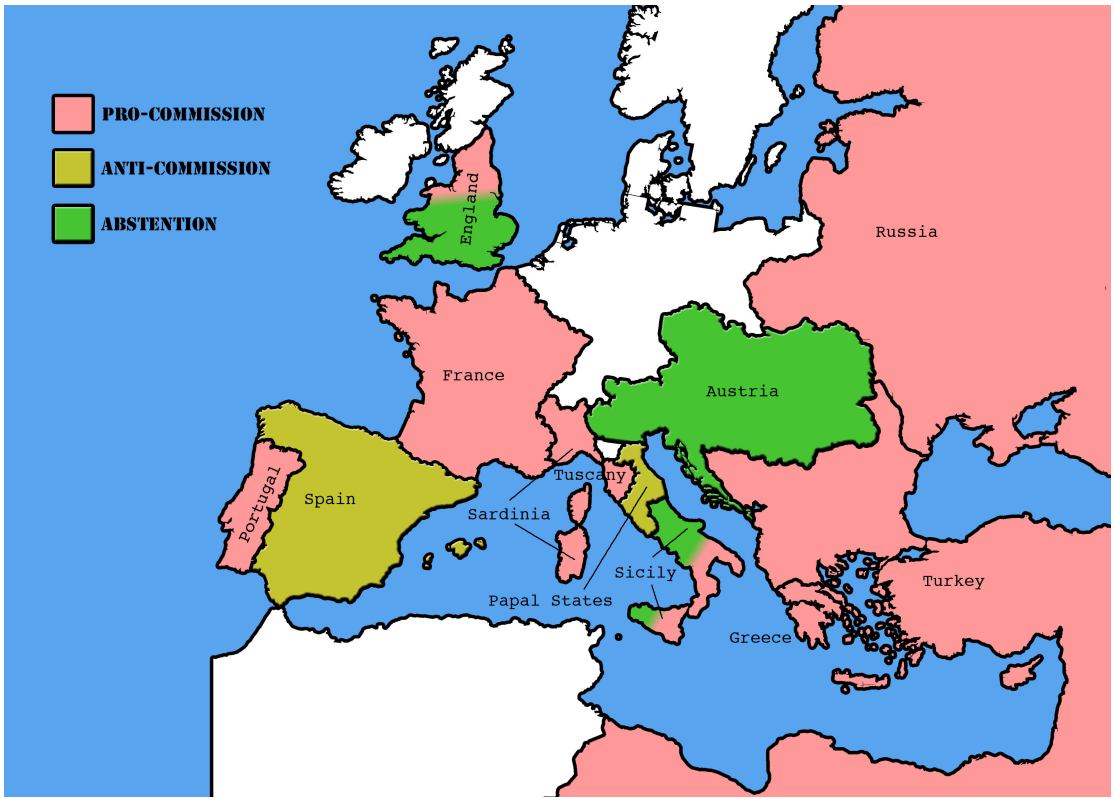

Figure 4 Distribution of votes after the pro-quarantine classification of cholera by the Commission

[422] *Conférence sanitaire internationale*, vol 1, 4 October 1851, *p*12 (David)

Underlying the abstentions and anti-Commission votes were three main reasons: scientific reputation, rigidity of the model proposed by the Commission and the strategy to tame the practice of quarantine in the Mediterranean region. Dr Sutherland defied orders received from London and abstained in order to avoid jeopardising his scientific reputation. The Sicilian, Dr Carbonaro, found the system proposed by the Commission too rigid – although he agreed with the classification of cholera as a *disease to be quarantined*, he considered that the five day limit imposed by the Commission was not sufficient to avoid the spread of the disease. Similarly, this temporal limitation motivated the delegates from the Papal States and Spain to vote against the Commission. Like Carbonaro, the Roman doctor, Dr Capello, and the Spanish doctor, Dr Monlau, believed in the classification of cholera as a *disease to be quarantined*; however, the Spanish and Roman delegates found themselves obliged to vote against the Commission. As a physician and as the Roman representative, Cappello understood that quarantine limits decreed centrally could potentially jeopardise the actions of local sanitary authorities when local epidemic safety required more than five days of quarantine.[423] As for Monlau, he argued that these limits contradicted the rigorous quarantine traditions practiced in Spain – a practice that his country did not wish to abandon.[424] In both the Spanish and Roman cases, the delegates noted, the Commission could easily secure their support if the practice of quarantine was not framed within rigid temporal limits. However, this policy directly threatened the aim of the ISC – the construction of a uniform system of public health in the Mediterranean – and did not receive the support of other delegates.

The articulation of the Spanish delegates' votes against the Commission's classificatory agenda unravels and encapsulates different motives and quarantine agendas. As shown above, the two Spanish delegates defended two distinct classifications of cholera. Segóvia, the diplomatic envoy, mobilised a set of resources to reshape the pro-quarantine mission received from Madrid, while Monlau persistently defended the imposition of rigorous quarantines in the Mediterranean region. Ultimately, both delegates voted against the classification of cholera as a

[423] *Conférence sanitaire internationale*, vol 1, 4 October 1851, *p*11 (Cappello)
[424] *Conférence sanitaire internationale*, vol 1, 4 October 1851, *p*11 (Segóvia)

disease to be quarantined, but their reasoning differed. Monlau, as already mentioned, did not support the relaxation of quarantine practices. Segóvia, meanwhile, disagreed with the introduction of a system based on quarantine. However, because Segóvia voted with Monlau and did not reveal his motives publicly, he managed to avoid direct confrontation with the government of which he was an envoy, and successfully compromised his individual agenda with the agenda of his country.

The third reason for abstention – presented by the Austrian delegates – was intricately connected with the swing in attitude of the English diplomat and the French delegation – the delegates that most strongly insisted on the elimination of the practice of quarantine in Europe. During the classification debate, Dr Ménis and Lavison threatened, under the orders received from Austria, to abandon the conference if cholera was classified as a *disease to be quarantined*. Nevertheless, despite the Commission's decision to classify cholera as such, neither delegate left the Conference. Moreover, the Austrian delegates did not vote against the new classification of cholera. Instead, by abstaining, Ménis and Lavison legitimised the use of quarantine in the Mediterranean region, just as Perrier, David and Mêlier did by supporting the new classification of cholera. The contradiction between the agendas previously defended by these delegates and the final result of the classificatory process could be seen as a setback against the elimination of quarantine in Europe and the diplomatic efforts of England, France, and Austria. However, this contradiction is in fact no more than a powerful chimera that camouflages the victory of the anti-quarantine party. Certainly, these countries did not manage to discard the use of quarantine in the Mediterranean region. However, by limiting and regulating its uses, they produced a uniform and accountable public health system and removed the costs associated with the uncertainty of the duration of travel. If ratified by the participant governments, the system produced by the ISC would allow passengers, merchants and shipping companies to plan the duration of journeys more accurately by limiting the capacity of local sanitary authorities to decree random values of quarantine against passengers, crew, cargo and vessels. Traders, passengers and

vessel owners would have the option to move between ports quickly in order to shorten the duration of travelling and maximise investments.

Conclusions

The end of the classificatory debate over cholera marked the legitimisation and regulation of the use of quarantine in the Mediterranean region. Throughout the debate, doctors became increasingly important in defining the prophylactic model that was to be enforced in Europe against epidemic diseases. Although the use of science was pronounced to be limited by the ISC, doctors continued national aetiological debates and shared anecdotal evidence on the triumphs and defeats of quarantine in Europe. Nevertheless, these debates were always framed by diplomatic rules and goals that were, to a large extent, achieved by the dominant powers at the ISC. In fact, the classification of diseases according to the use of quarantine entangled medicine and politics in a complex scheme, where two professional groups each tried to monopolise the jurisdiction over the classificatory problem. Thus, the final result encapsulates the tensions between doctors and diplomats, politics and medicine, and individual and national agendas.

Moreover, the detailed analysis of the negotiation of an international system of public health contradicts the conventional understanding that scholars have previously produced on quarantine and political ideologies. The geo-epidemiological model put forward by Peter Baldwin in *Contagion and the State* is far too simplistic to understand the nuances and political stratagems staged during the ISC. The so-called liberal states were, to a large extent, interested in an international prophylactic policy against epidemic diseases based on quarantine – as long they were regulated, accountable and foreseeable.

CHAPTER 4: Between public health and state sovereignty: clashes of concepts and boundaries

Gentlemen, is it only in the Levant that sanitary institutions are not perfect? What are we doing here? Why are we assembled here if not to improve the sanitary institutions in our countries?

Bô, Séance 35

Mr Vitalis does not think that the current Egyptian Board [of health] gives enough guarantees because foreign delegates [to the Board] only have consultative voices, unlike in Constantinople where they enjoy deliberative powers.

Vitalis Séance 39

What?! You want me – an independent state – to be subjected to a congress of doctors and foreign consuls? [A congress] that will declare which are the diseases against which I should protect my country as if my doctors did not know it? [A congress] that will talk about the convenience or inconvenience of quarantines as if they could protect the public health of my people better than me, their governor. (…) What does it matter to a Russian or a Turk if Cadis or Malaga are devastated by yellow fever? And will those foreigners also address my commercial interests and the ways to protect them? All this, my dear gentlemen, is what we would certainly had said a century ago however in 1851 we have not replied like this. And where we are here together – we foreigners – to find a solution to these important questions.

Segóvia, Séance 43

By mid-December, winter had fully arrived in Paris. After several months of debate over common aetiological and prophylactic meanings, delegates were finalising the practical details of the future transnational sanitary system. Some argued that the system of protection in Europe should make use of the sanitary engineering of the Orient and the erection of prophylactic walls capable of preventing the flow of diseases westwards. Others – like the Sardinian, Dr Bô – saw an opportunity to reform sanitary practices across Europe: from East to West, from North to South, new common policies would protect public health in a singular and united fashion.

Both strategies required careful analyses of each country's epidemiological and prophylactic reality as well as an assessment of their levels of epidemic risk. In other words, each region was to be submitted to the scrutiny of delegates to decide if the guarantees were sufficient to grant the region a place in the exclusive club of nations connected through free pratique: an elite among which common sanitary practices and mutual trust were prerequisites to a world without quarantine. But the extent to

which nations would sacrifice their independence in order to belong to this world remained an open question.

As this chapter will show, the transnationality of epidemic governance clashed with modern ideas of sovereign states. Despite Segóvia's overall optimism, delegates to the ISC argued that the Conference was exceeding its competencies by removing the power of states to deal with national epidemic issues, imposing the views of foreigners on the structure of national sanitary institutions, and even suggesting the creation of international sanitary courts capable of disputing national legal decisions. In other words, the ISC planned to control and govern sanitary structures traditionally placed under the exclusive sovereignty of states.

Sovereignty bargains

Instead of viewing national sovereignty as a legalistic concept, the chapter follows a recent social constructivist wave in the field of International Relations, which explores sovereignty as 'an aggregated concept that varies according to historical and social circumstances.'[425] More than a monolithic concept, sovereignty is seen (according to this view) as a practice that states perform in order to assert autonomy, control, and legitimacy both inside and outside their borders.

The performativity of sovereignty allows ample space for negotiation. States can engage in what Bruce Byers calls sovereignty bargains. In these bargains, 'some obligations that limit state sovereignty are voluntarily accepted in order to enhance the effectiveness of sovereignty.'[426] The negotiations involve rights, capacities, and responsibilities in three realms: those under a state's jurisdiction; those under other states' jurisdiction; and those in the commons. In each bargain, the three elements are modified in order to produce common, transboundary solutions. Yet Karen Litfin warns against the overuse of Byers's concept: 'the term sovereignty bargain should be used with a good dose of caution because it connotes a certain degree of

[425] K. T. Litfin, "Sovereignty in World Ecopolitics," *The International Studies Review* 41, no. 2 (1997). *p*169 [if it is a wave, you will need to add a few more titles to the footnote]
[426] Bruce Byers, "Ecoregions, State Sovereignty and Conflict," *Security Dialogue* 22, no. 1 (1991). 72

intentionality on the part of a unitary actor that may not actually exist.'[427] Nevertheless, this is a valuable starting point in understanding the kind of trade-offs and concessions associated with the international negotiation of a sanitary system aiming to govern epidemic diseases across Europe.

History and the national-international nexus

In a 2006 article, Valeska Huber explores the tensions within 'a world [that] was growing together to an unprecedented extent due to new means of transportation.' It was also a world that faced new epidemic challenges due to its increased interconnectedness. Looking specifically at the ISCs as the first attempt to tackle the problem of transactional propagation of diseases through interstate cooperation, Huber shows that the delegates endeavoured to establish transnational standards and to create sanitary 'membranes' that could halt the progression of epidemic diseases while allowing the flow of vessels, trade, and passengers. One of the most salient projects that delegates pursued was the conversion of heterogeneous and localised quarantine practices into uniform and preventive hygienic ones, that boosted the speed of communications in the Mediterranean region. For this purpose, 'delegates proposed specific administrative, technological and scientific techniques, the categorisation of border crossers into dangerous and non-dangerous groups and new concepts of borders.'[428] As such, the internationalist project proposed by the ISC included the reform of Ottoman sanitary structures in light of European-style sanitary organisations and the creation of standard travelling documents that were validated and accepted by all participants.

Although Huber looks at several issues that directly affected the autonomy, control, and legitimacy of participating states, this chapter explicitly shows that the Conference emerged as a relevant social locale where, under the lens of public health, state sovereignty was negotiated. By furthering Huber's analysis, this chapter will demonstrate that states negotiated their sovereignty and partook in specific

[427] Ibid.p171
[428] Huber, "The Unification of the Globe by Disease? The International Sanitary Conferences on Cholera, 1851-1894." *p*471

bargains in order to advance internationalist interests such as the promotion of public health and trade in the Mediterranean region, while protecting specific national goals. Ultimately, the design and enforcement of surveillance apparatus required governments to standardise their practices and bureaucratic structures in order to simplify proceedings, eliminate epidemic risks and raise overall confidence in the international system's capacity. At the same, the legitimate opportunity to redesign models of epidemic governance raised fears about the possibility of states loosing control over their domestic affairs. As the chapter suggests, under the flag of constructing a safer epidemic word, the ISC was used to enhance the political control of certain countries' sanitary machineries

This chapter will highlight the success and nuances of parallel interventionist agendas by focusing on the advantages that states expected to extract by bargaining away their sovereignty. Because states faced different national problems, they valued the advantages of the debated policies differently. For some, it was more important to profit from the outcomes of these policies than to secure the control and autonomy of their resources. Leaving aside the cost/benefit formula of these policies, delegates tended to find it easier to organise their neighbours' sanitary organisations than allow the ISC to have a say in the way their governments should protect the population's health. Throughout this chapter, the contexts and rationales surrounding the bargaining process will be untangled in order to demonstrate how certain states profited from allowing the sacrifice of certain elements of their sovereignty.

As the ISC approached its end, delegates completed two documents to be submitted for ratification by their governments. While the Draft Sanitary Convention set major guidelines in matters of international sanitary governance, the Draft International Sanitary Regulation detailed precise rules to be executed in the Mediterranean and the North Sea. Together, the documents substituted local heterogeneities with transnational regularities in the form of international law.[429] The deal was tempting:

[429] This was a wider trend initiated during the eighteenth century to bring regularity and precision to modern world's chaos. Either through the standardisation of currencies, measurements and time, local peculiarities progressively eroded and gave space to wider conventions that facilitated regional, national and international exchanges. Ken Alder, *The measure of all things : the seven-year odyssey and hidden error that transformed the world* (New York: Free Press, 2002); Peter Galison, *Einstein's*

the ISC promised to protect public health and further commercial and maritime relations for the price of some international control over national policies and resources. The measures that the participating countries were asked to accept had the potential to improve health conditions and make sanitary systems uniform, while relieving navigators from unnecessary impositions.[430] This could easily be perceived as a win-win situation, but as this chapter will show, a complex web of interests underpinned the negotiations of a novel international system of public health.

Divided into two sections, the chapter first looks at mechanisms developed to standardise public health institutions in Europe in order to support the claim that the interventionist ISC agenda was received with apprehension by delegates. Although most envoys agreed that changes to the organisational structure and competencies of sanitary institutions were needed, they also appreciated the need to protect their countries' autonomy, control and legitimacy over public health affairs.

The second section focuses on negotiations between Europe and the Ottoman Empire to secure free pratique for all Oriental departures. Through a process of controlling sanitary policies and even institutions, European powers managed to secure a strong presence in the Ottoman Empire using the excuse of epidemic safety. Together, both sections show a double interventionist standard. However, by putting the difference in context, it highlights the advantages that nations gained from allowing the ISC to intervene in their domestic affairs.

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clocks and Poincaré's maps : empires of time, 1st ed. (New York: W.W. Norton, 2003); M. Norton Wise, *The Values of Precision* (New Jersey: Princeton University Press, 1995).

[430] *Procés-verbaux de la conférence sanitaire internationale, ouverte à Paris le 27 Juillet 1851*, *Projét de Convention Sanitaire,* vol. 2, Annex to Proc. 44, 19 December 1851

I

A continental quest for autonomous and legitimate national legal systems

After a long weekend's break, delegates congregated once again in the Ministry of Foreign Affairs. On the agenda for that day, Tuesday, 9 December 1851, was the organisation of sanitary authorities. France had invited governments to make sanitary organisations as uniform as possible. While Paris wished to take 'laws and practices of each country' into consideration, the French requested that delegates consider the feasibility of instituting a new sanitary organisation, composed of agents (to be appointed by central governments) and local personalities. The aim was to conciliate the necessity of imposing a central authority that was able to offer sanitary and administrative guarantees, while allowing a certain degree of flexibility in order to satisfy local requirements.[431] In addition, France wished to open sanitary councils to foreign consuls as an attempt to break discriminatory practices against foreign vessels and allow free information flow between all interested parties. Under the form of 'international law', consuls would be summoned every time decisions that concerned their nations were to be made locally.[432] These proposals were strikingly similar to the organisation of the French sanitary system, which France attempted to impose as a template to be applied elsewhere in Europe.[433]

[431] Baroche to Paiva, 16 April 1851, Arquivo Histórico Diplomático (AHD), Leg./Emb. Paris, Maço 6.
[432] Baroche to Paiva, 16 April 1851, AHD: Leg./Emb. Paris, Maço 6.
[433] The use of the French organisational system as a model was not new. Charles Tilly notes that after the Revolution, 'the French used their own new [governance] system as a template for the reconstruction of other states. As revolutionary and imperial armies conquered, they attempted to build replicas of [the direct rule] system elsewhere in Europe. Napoleon's government consolidated the system and turned it into a reliable instrument of rule. The system survived the Revolution and Empire in France and, to some degree, elsewhere; Europe as a whole shifted massively towards centralized direct rule with at least a modicum of representation for the ruled.' Charles Tilly, *Coercion, capital, and European states, AD 990-1990*, Studies in social discontinuity (Oxford: Blackwell, 1990). *p*110
In the particular case of sanitary affairs, in 1768 the Duke of Praslin – the French Secretary of State of the Navy – argued that 'it was desirable for the communication between nations and for the wellbeing of humanity and navigators that all quarantine stations in the Mediterranean should be modeled upon [assimilés] Marseille.' *Archive départmentales des Bouches-du-Rhone, C4464* cited by Françoise Hildesheimer, "Marseille, Capitale Sanitaire de la France," in *110 Congrès national des sociétés savantes* (Montpellier: Histoire Modern, 1985).

Soon after the start of the Conference in July, the Programme Commission accepted and reinforced the French proposal by judging the uniformisation project to be an 'excellent idea.' The Commission argued that 'the presence of consuls in [sanitary] councils could not be more advantageous' and invited delegates to consider the right number of consuls for local councils and to grant foreign members deliberative powers.[434] The goal was to create efficient and responsible sanitary organisations.

In mid-October, a new commission was appointed. Headed by François Mêlier, the Commission on the Organisation of Sanitary Magistracies or Authorities included diplomats from England, Russia, Tuscany, Spain and two doctors from Portugal and Sardinia. One month later, the final report was read to the ISC and in its eleven pages the commissioners presented further details of a new model for governing sanitary authorities in Europe.

The problem, simply put: Mediterranean sanitary authorities were heterogeneously designed and their structure varied not only internationally but also within national territories. Often, these institutions – like the Marseille Intendancy – enjoyed considerable autonomy and were not accountable to central governments.[435] Alone, they designed and imposed policies, performed sanitary inspections, and enforced sanctions on offending captains, crews, merchants, and passengers. The concentration of power within regional authorities undermined the efforts to create coherent national sanitary programmes by favouring local interests. Moreover, the dispersion of power across local authorities contradicted modern ideas of central governments as power and policy brokers.[436]

Facing these problems, the ISC Programme Commission – in line with initial French recommendations – suggested rearranging sanitary authorities by placing them under the direct control of the central government. While the directors of new local sanitary authorities would be directly appointed by the government, the Programme

[434] *Procés-verbaux de la conférence sanitaire internationale, ouverte à Paris le 27 Juillet 1851*, *Report,* vol. 1, Annex to Proc 7, 6 September 1851, *p*35
[435] Hildesheimer, "Marseille, Capitale Sanitaire de la France."
[436] See Stefan Berger, *A companion to nineteenth-century Europe, 1789-1914*, Blackwell companions to European history (Oxford: Blackwell Publishing, 2006).

Commission would allow local concerns about sanitary matters to be heard by instituting consultative local boards of health. Combined, the two measures aimed to resolve the dichotomy between centralisation of sanitary governance and local sanitary interests.[437]

According to the Commission, important commercial ports were expected to establish a sanitary station headed by a Director of Health. This governmental agent – 'active leader of the service' – was required to direct subordinate staff; execute sanitary laws and regulations; assess the sanitary status of arriving vessels; deliver bills of health to departing ships; and survey the sanitary conditions of the port and region under his jurisdiction. Given these requirements, the Commission judged doctors to be the most suitable professionals to head sanitary stations. Moreover, to secure accountability and loyalty while curbing potential corruption, the Commissioners supported the compensation of Directors of Health with a fixed salary paid by central governments.[438]

The Commission also set guidelines for uniformising the structure of local councils. According to these guidelines, the councils were to be composed of civil and military leaders, notable local citizens, members of local administration, merchants, doctors or chemists, and, of course, the Director of Health. The commissioners recommended the inclusion of a good number of men of science in order to secure the implementation of hygienic measures.[439]

Although local in their nature, the Commission believed that local councils would profit from opening themselves up to local diplomatic communities. By inviting local consuls to elect a delegate to the councils, they hoped to improve international trust in local measures. As witnesses, consuls could offer valuable accounts of sanitary conditions abroad while sharing local sanitary conditions and policies. The double flux of knowledge circulation, it was expected, would improve sanitary surveillance and raise confidence in the system. However, in order to avoid international

[437] *Conférence sanitaire internationale*, vol. 2, Annex to Proc. 32, 15 November 1851.
[438] *Conférence sanitaire internationale*, vol. 2, Annex to Proc. 32, 15 November 1851.
[439] *Conférence sanitaire internationale*, vol. 2, Annex to Proc. 32, 15 November 1851.

interference in local interests, consul-delegates were deprived of any deliberative power. Instead, they were exclusively invited to observe council meetings and offer their advice when requested. In addition, in cases where local authorities were considering the imposition of quarantine against a given country, the diplomatic representative of that country would also be invited to attend the council. By increasing dialogue between local and international authorities, the Commission aimed to minimise mistakes resulting from long-distance communication problems.

The ideology of centralisation proposed by the Commission was in line with the political system that post-Revolutionary France had built and often tried to impose elsewhere through warfare, diplomacy, or other economic and cultural initiatives.[440] Since 1792, French central administration had undergone a revolution: staff numbers expanded, and a rigid bureaucratic structure took shape.[441] The professionalisation of state affairs in France was made possible through the reorganisation of the territory, cities, taxation structure and collection, new model of justice enforcement, and new transportation network that established Paris as the political and economical centre of France. From an organisational perspective, the centralisation impulse resulted in the introduction of a new administrative model based on three institutional levels: the local municipal entities, the regional *départements*, and the national central ministries based in Paris. In this system, a strict chain of command was established: administrative chiefs of the *départements* were directly appointed by the emperor and responsible for the implementation of orders from Paris.[442] Paris, as the bureaucratic head of France was transformed into the 'capital of modernity' through the expansion of state functions and the development of a rational bureaucracy. However, the centralisation of Paris was a result of international aspirations. During the nineteenth century, the French attempted to construct Paris and France as the centre of the civilised world.[443]

[440] Jörn Leonhard, "The Rise of the Modern Leviathan: State Functions and State Features," in *A Companion to Nineteenth-Century Europe*, ed. Stefan Berger (Oxford: Blackwell, 2006).
[441] Tilly, *Coercion, capital, and European states, AD 990-1990*.109
[442] Leonhard, "The Rise of the Modern Leviathan: State Functions and State Features." *p*142
[443] David Harvey, *Paris, capital of modernity* (New York: Routledge, 2003).

The sanitary governance model introduced by France directly influenced the administrative restructuring proposed by the ISC. In this sense, it is important to understand the historical evolution of these authorities and the increasing centralisation of sanitary affairs in order to grasp the Commission's proposals. By the turn of the nineteenth century, the jurisdiction over health-related issues was dispersed and shared between several ministries such as the Ministry of Agriculture and Commerce and the Ministry of the Interior. According to Matthew Ramsey, Napoleon was 'well aware of the potential benefits of public health measures [… but] made only a limited contribution to developing the administrative apparatus to implement them.'[444]

Interestingly enough, the major institutional innovation of the Napoleonic years was not the creation of central government sanitary authorities but the establishment of the local Health Council of the *Département* of the Saine by the Paris prefect of police in 1802. Certainly, municipal health boards were not unheard of in France. On the contrary, these sanitary institutions survived the Revolution in major port cities. The innovation introduced by the Parisian prefect of police – and later used by the ISC as a model – was the permanent character of the council and the employment of salaried staff recruited from among leading public health professionals. However, unlike the reform proposed by the ISC, the Health Council remained an advisory body without powers to establish local or national sanitary policies. In contrast, the Council was responsible for analysing typical nineteenth-century sanitary issues associated with increasing urbanisation, circulation of people, and the insalubrity of modern cities. Moreover, as early as 1815 the Parisian Council aspired to break with its localist nature and coordinate a nationwide system of health councils; however, these plans never materialised.[445]

Post-Revolutionary France continued the centralisation efforts sketched out by the Parisian Council. In 1820, the Restoration established the Royal Academy of Medicine as a central public health institution to respond to all governmental public health inquiries. The consultative capacity of the Academy was reconsidered after

[444] Ramsey, "Public Health in France." *p*54
[445] La Berge, *Mission and method: the early nineteenth-century French public health movement*. *p*144

the 1821 yellow fever outbreak in Spain and the later creation of a special Commission to oversee the national practices of quarantines, sanitary cordons, and sanitary stations. The success in avoiding yellow fever in France paved the way for new legislation and a new permanent national institution. In 1822 the French Government created the High Council of Health under the direct responsibility of the Ministry of the Interior, no longer ruled by a professional organisation.[446] The High Council was trusted to implement a new sanitary code and oversee a provincial network of sanitary commissions. Despite several administrative problems, the 1822 legislation 'did reorganise and effectively nationalise the system of sanitary protection of the frontiers.'[447] The legislation even managed to restrict the traditional autonomy of the Marseille Intendancy of Health and place it under the direct control of the Minister of the Interior – just as the ISC now wished to place sanitary institutions under the control of central governments.

Conflict between national and local sanitary governance emerged in 1850 with cholera outbreaks in Malta. Fearing possible contagion in France, the Marseille intendants imposed a five-day quarantine on all vessels arriving from the Mediterranean island. Disagreeing with this measure, on 20 July the central government dispatched a telegram ordering the immediate suspension of quarantine and the reestablishment of free pratique to vessels arriving without on-board sick or dead. Defiant, the Intendancy maintained its quarantine policy. Paris issued new orders, and Marseille continued to ignore them. After three days of correspondence, the central government had had enough. Paris issued a decree that exonerated the Intendancy and appointed François Mêlier as its Extraordinary Commissioner to Marseille.[448]

[446] Sussman, "From yellow fever to cholera a study of French government policy, medical professionalism and popular movements in the epidemic crises of the Restoration and the July monarchy."; ibid.
[447] Ramsey, "Public Health in France." *p*56
[448] Hildesheimer, "Marseille, Capitale Sanitaire de la France." *p*141

Centralisation models

As a senior state agent, Mêlier epitomised the centralisation shift that marked France during the first half of the nineteenth-century. Thus, it is not surprising that as the author of the ISC programme, a member of the later Programme Commission, and head of the Commission on the Organisation of Sanitary Magistracies or Authorities, Mêlier imposed a centralisation ideology on the ISC project. In the particular case of sanitary authorities, central states were expected to attain control over its operation through the appointment of health directors. In the same move, the over-influence of local interests was to be curbed through the creation of new boards of health with exclusive consultative capacities.

When delegates met to debate these measures, Ebeling, the Russian envoy, announced that he was forced to abstain from voting on any measure that obliged his Empire to reorganise sanitary institutions. Ebeling's declaration caused some surprise. After all, the Russian diplomat had been an active member of the Commission where he had shown personal support for the reformist agenda. However, as described in the previous chapter, delegates often struggled to choose between national and individual agendas. More importantly, the fact that the model under discussion resulted from an international institution immersed states in a conflict between international efforts of standardisation and the protection of national sovereignty.

Russia was not the only state to be apprehensive about the Commission's interventionist agenda. Austria refused to support measures that contradicted its own sanitary policies, while the Two Sicilies and Portugal had reservations about an international engendering of national sanitary affairs.[449] Although the Austrian, Dr Ménis, appraised the standardisation measures developed by the ISC, he strongly disagreed with a common organisational model. In his view, the Conference should limit itself to issuing guidelines that states could then use if they wished to reform their unique sanitary systems. Forcing mandatory organisational changes, Ménis reckoned, directly intervened in private state affairs. Moreover, 'each government

[449] *Conférence sanitaire internationale*, vol. 2, 9 December 1851 (Lavison).

ha[d] its administrative principles, its particular rules to manage state administration' that resulted from populational, geographical and climatic peculiarities.[450] If an international reorganisation of sanitary authorities did not account for local realities, it was destined to failure. No state would adopt or execute it. For Ménis, it was pointless to work out details of a common model of sanitary organisation since the nations were destined to maintain their heterogeneous practices of administration.

While Austria had reformed its sanitary system recently, this did not seem to impact its resistance position as much as the necessity of allowing administrative practices to serve local needs and the fear over international interventionism that jeopardised national autonomy. The reforms introduced in Austria, between August 1841 and September 1847, created a system in many ways similar to that now proposed by France: sanitary affairs were placed under the jurisdiction of the Ministry of Trade, which, through its Central Maritime Sanitary Council, regulated health affairs and quarantine practices.[451] The Central Council also coordinated a network of subordinate offices, each composed by one state agent and a controller.[452] The major difference between the two organisations was the role of foreign consuls: if France wished to open local health councils to foreigners, Austria was determined to avoid their presence.

Facing opposition, Dr Mêlier tried to highlight the similarities between the Austrian system of organisation and the one now under discussion. In addition, he stressed that the Conference's strategy for uniformisation was designed in a way that allowed states to preserve their autonomy over sanitary organisation.[453] In parallel, English and Spanish delegates openly voiced their pro-reformist and interventionist position. Together, they repudiated Austro-Russian attempts to preserve the *status quo* in a

[450] *Conférence sanitaire internationale*, vol. 2, 9 December 1851 (Ménis).
[451] See Ronald E. Coons, "Steamships and Quarantines at Trieste, 1837–1848," *Journal of History of Medicine and Allied Sciences* 44, no. 1 (1989).
[452] During the debate on sanitary administration, Ménis exposed its national system in some detail. See *Conférence sanitaire internationale*, vol. 2, 9 December 1851 *p*8.
[453] Surprised by the opposition to the Report, Dr Mêlier tried to convince his opponents that the Commission did not wish to impose anything except a Health Director and Local Councils. All details would be left up to national governments: 'the choice of the director was free, and the same [was valid] for the composition of the council.' The Commission, he believed, did not limit governmental action but instead created the necessary conditions for national governments to control all sanitary authorities' details. *Conférence sanitaire internationale*, vol. 2, 9 December 1851 (Mêlier).

venue justly organised to promote change. As Segóvia concluded, 'if each [country] was to stay in the same way, it was useless to discuss [any uniformisation agenda].'[454] Spain stated that any reformist action would require a gradual implementation, but change was still needed if uniformisation was to be achieved.

At first glance, the English pro-centralisation position may appear rather contradictory, given that traditional localist sanitary initiatives were developed during the first half of the nineteenth century. By the 1850s, Whitehall had developed policies and infrastructures to supervise and impose national sanitary standards within the framework of local autonomy. Thus, centralisation was, with some exceptions, more of a political consequence rather than a political objective in itself. In the particular case of public health governance, the 1848 Public Health Act was a clear attempt to impose a public health central supervision body.[455]

The act created a sanitary structure that included a set of new local authorities and a Central Board of Health under the direction of Edwin Chadwick. The local boards of health were mandated to administer public health in the regions under their jurisdiction, and the Central Board of Health was created to regulate them and supervise the application of the above-mentioned 1848 Act. Although Chadwick was a strong believer in the power of centralisation, the Board was not able to establish full control over local authorities. As Robert Gutchen synthesised, 'Chadwick was the centraliser, but the system under the Public Health Act was not one of centralisation.'[456]

As a major collaborator with Chadwick, John Sutherland, the English medical envoy to the Conference, had close affinities with his mentor. After all, Sutherland had worked closely with Chadwick and both his professional and personal considerations

[454] *Conférence sanitaire internationale*, vol. 2, 9 December 1851 (Segóvia).
[455] Robert M. Gutchen, "Local improvements and the centralization in nineteenth-century England," *The Historical Journal* 4, no. 1 (1961). See also E. T. Stokes, "Bureaucracy and Ideology: Britain and India in the Nineteenth Century " *Transactions of the Royal Historical Society* 30(1980).
[456] Gutchen, "Local improvements and the centralization in nineteenth-century England." *p*88

played a crucial role in securing his appointment as English medical delegate.[457] Even if some divergences of opinion may have existed between the two men (in particular, the role of doctors and medicine in the improvement of sanitary conditions), John Sutherland supported the development of central government institutions that could efficiently regulate and inspect local public health initiatives. Likewise, Anthony Perrier, the English diplomat, regarded the system proposed by the ISC as a positive strategy, accommodating the promotion of central control while allowing local interests to be taken into consideration. However, as he eventually revealed, his country strategy was marked by a double standard: England only intended to reform the organisation of the sanitary institutions of its Mediterranean territories. Mainland affairs, it appears, were to remain the exclusive responsibility of the national government. No international organisation should aspire to intervene in the autonomy, control, and legitimacy of the English state.[458] The capacity to demarcate territorial boundaries as subject to uneven doses of international intervention was not available to all countries. For instance, in contrast with England, the geopolitical reality of Austria resulted in the likelihood of the subjugation of national health authorities to international decisions. The sacrifice of autonomy would be felt in its most tangible territory, not in some rather distant possession that already enjoyed a certain level of political autonomy.[459]

Foreign consuls

As mentioned above, the reform of local councils (in which their deliberative powers were removed) included the appointment of consuls in charge of representing local diplomatic community. From the organisers' perspective, this measure allowed local and international interest to be easily taken into account by opening new communication channels. The consul-delegate would be able to offer official

[457] Correspondence exchange between the two men illustrate this personal consideration and professional alligment. See Edwin Chadwick, *The Papers of Sir Edwin Chadwick, 1800-1890* (Brighton, Sussex, England: Harvester Press Microform Publications, 1983).
[458] See *Conférence sanitaire internationale*, vol. 2, 11 December 1851 (Perrier).
[459] If this argument is explored to its full extent, one can perhaps see the ISC as an opportunity for the English government to claim and gain legitimacy so as to further control and order its overseas territories. Under the general veil of international sanitary reforms and the specific ISC mandate, England was 'obliged' to intervene in its Mediterranean possessions. These policies could even be claimed as humanitarian and not as a Whitehall autocratic measure, in an effort to reduce animosity against them.

documentation that proved the sanitary status of departure ports while directly observing and reporting on local initiatives in order to curb epidemic risk. In a nutshell, the presence of an international observer would raise trust levels and potentially shorten – perhaps even avoid – costly quarantines both locally and abroad.

In many ways this measure was not new. France and Sardinia already practiced such a system, and both Perrier and David sat in local sanitary councils as consul-delegates. Even in countries where councils where not open to foreigners, consuls were heavily involved in their work. As the Turkish diplomat summarised, consuls certified bills of health, facilitated the process of cargo quarantine, and witnessed the opening of letters and official correspondence: they were a constant presence.[460] The novelty of this proposal was its formal character. If accepted, a foreigner would legitimately have the right to a permanent presence on the council without depending on the good will of its members.

As with the international engineering of sanitary structures, the point of conflict resulted from the attempt to formalise a strategy that could directly degrade national autonomy and control over territories and issues of sanitary governance. Seven major points underpinned the reason of disagreement against this measure. First, as Ménis noted, the inclusion of consuls in an official national body – even if local in its nature – was illegal in countries like Austria where 'the exercise of public functions [was] interdicted to foreigners.'[461] Secondly, he continued, the presence of foreign citizens on these boards would have serious local consequences: introducing foreign elements into institutions that, first and foremost, had been designed to protect local interests would compromise the trust placed in them by local populations. How could they be sure that their interests were properly protected when foreigners often had conflicting agendas imposed by the states and merchants they represented?[462] Thirdly, because local consular communities were to elect a delegate, the measure did not allow 'perfect reciprocation.' For these reasons, a state with powerful diplomatic apparatus

[460] *Conférence sanitaire internationale*, vol. 2, 9 December 1851 (Halphen).
[461] *Conférence sanitaire internationale*, vol. 2, 9 December 1851 (Ménis).
[462] Ibis

could, in theory, secure the election of its consuls all over the Mediterranean while those less powerful might fail to secure any seats at all. According to the Sardinian, Magetto, this would work against the national dignity of represented states, as it potentially reified their inequality.[463] Fourthly, Vitallis voiced his concerns that there could be a breach of national security if foreigners were allowed to freely survey the works of important governmental bodies.[464] Fifthly, the Portuguese diplomat pointed out that smaller countries, like his own, risked the undermining of their sanitary policy by foreigners if they were to have the same power as national authorities.[465] Sixthly, the Roman diplomat contended that many of the affairs under discussion in these authorities should not be disclosed to foreigners due to their confidentiality.[466] Finally, as the Sicilian, Carbonaro, put it, political reforms should result from a recognisable need for change that was not present in this initiative: resident consuls were already called every time that local councils needed them. To reserve a mandatory seat for a consul-delegate did not offer sanitary or organisational advantages but imposed extra layers of problems.[467]

The concerns voiced by the opposition were dismissed by Mêlier and Segóvia as out of tune with reality. Segóvia reminded his fellow delegates that the ISC had already redefined the structure of sanitary authorities. The new model removed the executive and deliberative powers of local councils in order to give them a new role as advisors to a state-appointed director of health. Thus, these bodies' lack of power immediately restricted the capacity of foreign councils to influence national sanitary policies.[468] Furthermore, in a more idealistic manner, Mêlier argued that foreign consuls would not jeopardise national security or interest since they acted on good will: health, a matter that concerned everyone, was not susceptible to national interest.[469]

[463] *Conférence sanitaire internationale*, vol. 2, 9 December 1851 (Magetto).
[464] *Conférence sanitaire internationale*, vol. 2, 9 December 1851 (Vitallis
[465] *Conférence sanitaire internationale*, vol. 2, 9 December 1851 (Mouzinho da Silveira).
[466] *Conférence sanitaire internationale*, vol. 2, 9 December 1851 (Escalon).
[467] *Conférence sanitaire internationale*, vol. 2, 9 December 1851 (Carbonaro).
[468] *Conférence sanitaire internationale*, vol. 2, 11 December 1851 (Segóvia).
[469] *Conférence sanitaire internationale*, vol. 2, 9 December 1851 (Mêlier).

To bypass the controversy, delegates used mechanisms often deployed during the Conference.[470] While some envoys requested the proposal to be withdrawn, others, led by the Portuguese, Mouzinho da Silveira, defended the optionality of the measure. Both positions privileged the existing *status quo* by resisting change. Eventually, delegates decided to grant states the ultimate decisive power by agreeing to a voluntary application of the measure. If desired, just as before the Conference, states could allow the presence of consuls in local councils. Equally interesting is the fact that, like all measures decided by the ISC, the consul-delegate question was properly framed in the Draft Sanitary Regulation under article eight.[471] However, unlike standard Conference proceedings, the introduction of consul-delegates – a measure eventually unanimously approved – was never properly regulated in the Draft Sanitary Regulation. The fact that this document exhaustively detailed the composition and competencies of sanitary authorities – as it detailed all other matters decided by the ISC – makes the omission rather evident.[472] It is clear that as it figured in the Draft Convention, the measure was not withdrawn at all. However, this option (to apply the measure voluntarily) openly reduced the prominence of foreign consuls as members of local boards of health. Perhaps the choice was made after delegates were made aware of growing concerns from the governments they represented. Or, alternatively, the attempt to downplay the international opening of sanitary institutions may have reflected the fact that there was no concrete change, apart, of course, from the formalisation act that allowed foreign consuls to be members of local boards of health. In any case, as previous examples demonstrated, conference documents were carefully crafted to avoid an escalation of conflict that could compromise the ISC's future and were produced with the intent of opening new policy avenues.[473] Keeping this in mind, abandoning (to a certain extent) the idea of introducing foreign consuls may have been more profitable than trying to impose it.

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[470] An identical example is explored in the previous chapter when delegates define the aetiological nature of diseases.
[471] *Conférence sanitaire internationale*, vol. 2, *Project de Convention Sanitaire,* annex 2 to Proc. 44, art. 8, *p*5.
[472] *Conférence sanitaire internationale*, vol. 2, *Project de Réglement Sanitaire International,* annex 2 to Proc. 46, arts 101-11, *p*18-9
[473] See chapter 3.

The international tribunal

The progressive escalation of conflict between delegates reached its peak when a debate started on the creation of arbitral tribunals composed of foreign consuls with jurisdiction over all sanitary disputes. If implemented, this measure would undermine the autonomy and legitimacy of national legal systems while jeopardising state control over internal judicial affairs. In this sense, the system would produce a paralegal institution, outside of national governmental jurisdiction, and with capacity of rule over crimes practised in national territory.

In the programme circulated prior to the beginning of the ISC, France succinctly requested delegates to consider the creation of an 'Arbitration Tribunal [*Tribunal Arbitral*] in charge of hearing and ruling [sanitary infractions].'[474] Unlike with previous proposals, the Programme Commission found it necessary to compose a three-man sub-commission to assess immediately the viability of the measure. Together, A. Perrier, A. Segóvia, and J. Lavison questioned whether the ISC had a mandate to debate the creation of an institution composed by foreign consuls with potential power to rule in national sovereign territories. If instituted, these tribunals could become paralegal bodies capable of 'decid[ing] upon governmental decisions, or at least, to recriminate their actions.' It was crucial, they concluded, to ascertain whether the Conference was authorised to pronounce upon such paramount issues.[475]

It was clear to the sub-commissioners that all participating states had received the pre-circulated programme of the Conference and that this document had been instrumental in the decision of sending a delegation team to the Conference. Therefore, members of the sub-commission presumed that all delegates were authorised to engage in such discussion, since they were each chosen and mandated by their respective governments based on information provided in the conference program. Moreover, ignoring debate about these matters – as some delegates suggested – would contradict the expectations of the organisers and participating governments, the sub-commissioners argued.

[474] Baroche to Paiva, 16 April 1851, Arquivo Histórico Diplomático, Leg./Emb. Paris, Maço 6.
[475] *Conférence sanitaire internationale*, vol. 1, *Rapport Particulier sur la question du tribunal ou jury arbitral international*, annex 1 to Rapport de la [Programme] Commission, 1

In any case, the sub-commission suggested changing the name of the proposed arbitration tribunal to 'arbitration court'.[476] Each major port would hold a seat on a court composed of consuls belonging to the high contracting parties and residing locally. This court, after considering evidence on sanitary misconduct, would be empowered to settle pecuniary compensation. Nevertheless, all parties were allowed to appeal to local justice if not satisfied with the verdict of the court. More importantly, the court would only have jurisdiction over questions of sanitary regulation, since infractions to the international sanitary convention stipulations would remain 'the responsibility of contracting governments.'[477]

Upon reading the sub-commission's report, the Programme Commission also classified the problem of creating common arbitration institutions 'as the most difficult and delicate' question to be addressed by the ISC.[478] Proportional to its difficulty was its importance: as a member put it, it was impossible to prevent sanitary infractions in their totality.[479] The ISC, therefore, had to develop mechanisms that enhanced regulation compliance and punished offenders including merchants, crews, individual passengers, and even states themselves. Connecting the diversity of potential infractions was the international nature of the crimes. How to prosecute them? Where to prosecute them? If central governments were involved, should the matter be dealt with through diplomatic channels or in normal foreign tribunals? The first option was time-consuming and often inefficient; the second option was impractical since no foreign government would sit in a foreign tribunal to be judged under foreign law. In fact, as the Commission concluded, only new institutions could offer a solution to the problem. The creation of international arbitral courts aimed to institute a space where disputes between governments, corporations, and individuals could be settled.[480]

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[476] This semantic shift will be further analysed below.
[477] *Conférence sanitaire internationale*, vol. 1, *Rapport Particulier sur la question du tribunal ou jury arbitral international*, Annex 1 to Rapport de la [Programme] Commission, 2
[478] Conférence sanitaire internationale, vol. 1, Rapport de la [Programme] Commission, annex to season 7, *p*35
[479] The Commission Report did not name *intervinients*. See Conférence sanitaire internationale, vol. 1, Rapport de la [Programme] Commission, annex to season 7, *p*36
[480] Conférence sanitaire internationale, vol. 1, Rapport de la [Programme] Commission, annex to season 7, *p*36

The international sanitary court idea was inspired by a similar institution created in 1815 by the Congress of Vienna. While setting principles for free navigation in the Rhine, the Treaty of Vienna created an international institution (the Central Commission for the Rhine Navigation) charged to regulate navigation, administer and maximise the river's transportation capacity and to act as a court of appeal for cases initially brought before Riparian state navigation courts.[481] According to D. Collinson, in the case of Rhine navigation, the correct execution of international law was crucial in order to guarantee free circulation of cargo and people in the river and improve trade and taxation profitability.[482] The Central Commission for the Rhine Navigation offered a concrete answer to the problem.

Despite being a second instance of appeal, verdicts issued by the Commission for the Rhine were not final if involved parties were not satisfied with the result. In these cases, new appeals could be launched with superior national courts.[483] Likewise, verdicts read by the ISC sanitary courts could be subject to appeal. Nevertheless, the proposed sanitary courts differed significantly from the Commission for the Rhine in three aspects. First, sanitary courts were designed as first instance institutions to solve all sanitary disputes. Secondly, instead of one single court, several sanitary courts were to operate across Europe. Mandated to settle sanitary disputes committed within their jurisdiction, the courts were to be staffed by either five or seven judges elected from foreign consuls, and would convene in the residence of an elected president under diplomatic protection. Finally, the sanitary court was qualified to impose financial compensation for damages derived from sanitary regulation infringement.[484]

As shown above, the ISC concluded that debating the definition and introduction of sanitary courts was a legitimate and mandated requirement. However, the Programme Commission struggled to anticipate whether participating states would

[481] Council of Europe, "Commission Centrale pour la Navigation du Rhin," *European yearbook* 14(1966). *p*38
[482] D.S. Collinson, "The Rhine Regime in Transition--Relations between the European Communities and the Central Commission for Rhine Navigation," *Columbia Law Review* 72, no. 3 (1972).
[483] Ibid.
[484] Conférence sanitaire internationale, vol. 1, Rapport de la [Programme] Commission, annex to season 7, *p*39

ever accept the institution of such a measure. The Commission was fully aware that the proposed internationalist idea would face 'problems and perhaps [even] aversion.' But 'if governments represented in the Conference sincerely wished to achieve [international sanitary protection], they should [also] wish for the means. They should want [to dispose of the tools that] assured the loyal and complete execution of the convention and regulations.'[485]

The need to create an institution that satisfied participating countries may justify the struggle to name and define it. France initially suggested the creation of a singular Arbitral Tribunal [*Tribunal Arbitral*] while the sub-commission recommended the foundation of a set of International Arbitral Courts [*Jury Arbitral International]*. To put it simply, the semantic variation differentiated a scenario where an international tribunal equalled (and possibly competed with) national state tribunals in terms of legitimacy and power from a situation were conflict was mediated by an institution recognised as legitimate by the involved parties but did not compete with national legal systems.

Delegates reacted to the interventionist agenda of an international court with either negativity or reluctance. Opening the debate, David, the ISC president and diplomatic envoy of France – the country that first introduced the idea of establishing an international sanitary tribunal – reminded delegates that introducing such a judicial body could infringe on 'the letter and spirit of all existing treaties by which consuls were limited to exercise judicial authority in foreign countries.'[486] In overt opposition, Dr Ménis of Austria demanded the immediate revocation of any attempt to introduce an international tribunal disguised as a court. In his view, regarding the prevention of law infraction, states already possessed legal codes that framed methods of prosecution according to national principles.[487] National legal systems were legitimately autonomous, thus they should maintain the monopoly over institutions that legally solved sanitary disputes occurring within their territories. To

[485] Conférence sanitaire internationale, vol. 1, Rapport de la [Programme] Commission, annex to season 7, *p*37
[486] *Conférence sanitaire internationale*, vol. 2, 13 December 1851 (David) *p*10.
[487] *Conférence sanitaire internationale*, vol. 2, 13 December 1851 (Ménis) *p*16.

interfere with national justice matters would offend the dignity of all represented governments.

For Magnetto, the Sardinian diplomat, the problem of introducing international sanitary courts was not centred on moral grounds but instead on the very impractical character of the measure. The imposition of such courts would not be accepted by absolutist states as they feared such intervention would jeopardise their authority and control over all national affairs. In these cases, the simple word 'court [jury] produce[d] the same horror as that of Holy Office in France and in England.'[488] Secondly, he thought that the introduction of international sanitary courts carried the underlying message that local authorities were incapable of providing justice to their citizens and only the work of foreign consuls would suffice. Finally, he doubted that states would ever accept an international court judging their actions and those of their representatives. For all these reasons, Magnetto announced that he would vote against the establishment of 'a special international tribunal to judge sanitary matter infractions.'[489]

In addition to the presented arguments, the Tuscan and Greek diplomats explored the impact of such a measure in the legal landscape of their nations. Cecconi of Tuscany argued it had 'been demonstrated that an international arbitral court [was] incompatible with the fundamental laws of most represented states.' Thus, he concluded that the discussion was simply useless. More precisely, Costi of Greece pinpointed the legal issues of international courts: first, according to the legislation of several represented states, citizens had the right for their legal disputes to be solved by their own national judges. Secondly, the introduction of international sanitary courts required the creation of new judicial procedures, each directly aligned with the national law of the participating country. Facing the multiplicity of legal traditions and landscapes, this would be a challenging mission likely to end in illegal measures. Thirdly, if sanitary courts were illegal, then, Costi elaborated, the majority of verdicts would be subjected to appeal. Finally, in an attempt to guarantee the fair outcome of judgments produced by sanitary courts, the Programme Commission

[488] *Conférence sanitaire internationale*, vol. 2, 13 December 1851 (Ménis) *p*18.
[489] *Conférence sanitaire internationale*, vol. 2, 13 December 1851 (Cecconi) *p*21.

ruled that consuls of nations whose citizens or interests were under trial should not be part of the judging collective. The good intentions of the Commission created a legal loop with no solution. The international courts would likely have to judge situations where a vessel was registered in one country, while the captain was the citizen of another. The transported cargo could belong to merchants from third and fourth countries, while passengers potentially represented the whole spectrum of nations present at the ISC. The cosmopolitan nature of sanitary affairs made international courts illegal or impracticable: foreign consuls would not be able to judge matters, either because it was against national laws or because fair-judgment regulations would make them ineligible to judge.[490]

The Portuguese delegates furthered the point of independency and legitimacy of national law facing international institutions, by noting that merchants who opened businesses in a foreign country were obliged to follow the law of that country. At the same time, 'when governments ratified the international sanitary convention, [the convention would] have the force of law, [delegates could not and should not] suppose that each of their countries would not execute promulgated laws.'[491] Thus, if merchants acted against ISC agreements they would first and foremost commit infractions of national law. Facing this, 'the right to judge infraction of laws [was] a liberty that should be allowed to each government. Above all this was a guaranty of order and national independency.'[492] Moreover, as a diplomat, Silveira did not trust other diplomats to judge these matters while proper regulated tribunals existed. He appealed to the ISC to 'respect the liberty of powers: that justice judges, and diplomacy develops good international relations and produces good treaties. That [diplomacy] doesn't intervene where it cannot service or it risks failing its noble mission.'[493]

The support for the introduction of international sanitary courts was limited to two countries: Spain and England. Responding to the criticisms of delegates, Ségovia of

[490] *Conférence sanitaire internationale*, vol. 2, 13 December 1851 (Ménis) *p*21.
[491] *Conférence sanitaire internationale*, vol. 2, 13 December 1851 (Silveira) *p*23.
[492] *Conférence sanitaire internationale*, vol. 2, 13 December 1851 (Silveira) *p*23.
[493] *Conférence sanitaire internationale*, vol. 2, 13 December 1851 (Silveira) *p*23.

Spain began by recalling that the idea of creating such an institution came directly from France, which was now vacillating in providing the required support. As for the uselessness of the measure – which had been claimed by Cecconi and other delegates – Segóvia noted that 'the current state of affairs, laws, tribunals, and existing penalties [did] not satisfactorily meet proposed aims.' It had already been proven by the ISC, Segóvia claimed, that 'infractions to sanitary rules resulted in countless complaints and endless diplomatic correspondence extremely embarrassing to governments. Finally, [sanitary infractions] were rarely judged to the satisfaction of parties. In reality, wrongly or rightly, one of the parties always felt injured.' In order to provide a solution to this problem, the ISC proposed the 'creation of a different kind of new tribunal, a tribunal composed of foreign consuls.'[494]

Segóvia was certainly aware that delegates were hesitant to empower foreigners to 'issue an opinion or judgment on infractions committed by compatriots or state officials.' He rooted the distrust in the fact that delegates 'forgot about the special nature of state affairs and had an exaggerated deference to a certain legal disposition.' Regarding the latter, governments had the right and resources to modify national laws for the sake of public interests. On the subject of the role of foreigners in justice provision, Segóvia traced prejudice against them back to ancient Roman civilisation, but noted that those times were long gone. In his view, 1800s Europe was a modern and civilised continent where the degree of 'distrust and antipathy against *foreigners* was inversely [proportional] to the civilisation of the people.' Foreigners were members of states united by a community of interests and uniform principles that produced a common justice framework: whatever was 'unfair to a Frenchman, to a Spaniard, or to a Russian, would not be honest or fair to an Englishman, a Portuguese, or an Italian.' Thus, Segóvia concluded it would be 'neither monstrous nor absurd to request the opinion of a *foreigner*.' After all, infractions of sanitary matters violated commonly established laws and regulations and were an international affair of interest to all. In this sense, the foreigners that the ISC were trying to invest as judges were not governmental envoys that blindly protected national interests. On the contrary, the group of consuls that would

[494] *Conférence sanitaire internationale*, vol. 2, 13 December 1851 (Segóvia) *p*11.

compose international sanitary courts were mandated to facilitate international commerce and relations between nations and peoples. These modern men 'studied the laws and customs of the country' of residence; they learned the language, established families, and worked towards national prosperity. They even mourned the victims of public calamities while helping survivors. In the eyes of Segóvia, foreign consuls were part of a singular class of humanity that could be reciprocally empowered to judge sanitary infractions.[495]

Despite Segóvia's passionate speech, the opposition to international courts was overpowering. Together, 19 delegates voted against the creation of an institution that visibly compromised the autonomy, control and legitimacy of national legal systems. In the end, only delegates from Spain and England supported the measure, and in a letter to the Foreign Office Perrier and Sutherland concluded that 'the advantages of an Arbitral Tribunal, composed of consuls, was admitted by almost all the members, but the dread of foreign influence, and the desire to keep secret their motives for imposing quarantine measures, caused a most strenuous opposition from the delegates of all the petty states.' [496] Even France, which introduced the idea of courts composed of foreign consuls, ended up voting against the measure. 'Mr David –' the English delegates informed '- joined the opponents and stated his belief that France would not admit of any foreigner jurisdiction within Her Territory.'[497]

[495] *Conférence sanitaire internationale*, vol. 2, 13 December 1851 (Segóvia) *pp*11-15
[496] Perrier and Sutherland to Palmerston, 15 December 1851, The National Archives of the UK TNA: PRO FO97/212
[497] Perrier and Sutherland to Palmerston, 15 December 1851, The National Archives of the UK TNA: PRO FO97/212

II

Intervening in the Ottoman Empire

As the interventionist agenda of the ISC resulted in attempts to engineer and control the legal machineries of participating states, the delegates expressed discomfort and fear that the ISC would dilapidate their states' autonomy, control, and legitimacy to deal with crimes committed within their sovereign territories. However, although the idea of changes to the sanitary and penal organisation of European nations was met by protests, it was quite different when delegates focused their attention on Ottoman sanitary services.

While organising the ISC, France invited participating countries to consider whether Oriental[498] arrivals should be granted free pratique in European ports. The French government recognised that 'Egypt and Turkey now had sanitary institutions that allowed nations to relax [quarantine practices].' Although it was only a few years since the abolition of quarantines was thought 'impossible or reckless,' France believed that the recently introduced sanitary policy in the Orient allowed European powers to reduce quarantines against the Ottomans. After all, France was already granting free pratique to Oriental arrivals providing they had sailed for more than eight days, carried a clean bill of health and kept a permanent on-board physician. The French wanted to know whether the anti-quarantine policy could be immediately expanded throughout Europe in a uniform way, or which conditions – 'guarantees', as it was framed - European countries would demand in order for free pratique to be granted in the future. [499]

The French relaxation of quarantines resulted from two major changes. First, in 1838, the Ottoman Empire started to create sanitary institutions within its territory.

[498] As Said demonstrated, the concept of the Orient has been particularly prevalent throughout history. Its boundaries were constantly negotiated as its meanings diverged in space and time. See Edward Said, *Orientalism* (London: Penguin, 1985 [1978]). Delegates to the 1851 ISC used the concept of the Orient mostly as synonymous with the Ottoman Empire, in particular when referring to Turkey and Egypt. The term Levant was used in the same fashion.
[499] Baroche to Paiva, 16 April 1851, AHD: Leg./Emb. Paris, Maço 6.

Secondly, in 1847, France instituted a network of physicians trusted to survey the health conditions in the Orient. In other words, France relied on both Ottoman institutions and its own resources placed in the Orient. Together, these measures increased French trust in the epidemic safety of the Levant and consequently led to a more permissive system of quarantine.

Ottoman institutions with European flavour

Since the 1830s, European powers had managed to influence Ottoman sanitary affairs. By securing either consultative or deliberative powers, European consuls were able to conduct surveillance through their direct access to the workings of Ottoman boards of health. This was already a step forward from the failed motion of introduction of consul-delegates to European local boards of health discussed above. Before the ISC opened, European powers had already secured agents with intervention capacity within the Ottoman Empire's governmental apparatus.

With the institution of the Constantinople Superior Board of Health [*Conseil Supérieur de Santé de Constantinople*] in 1838, Turkey created a system of quarantine mechanisms and epidemic surveillance. As the central sanitary coordination institution, the Constantinople Board aimed to survey public health conditions, prevent plague outbreaks, and, in cases where the disease had already been introduced to the Empire, to develop measures to prevent its propagation and eventually eradicate it.[500] Under the symbolic presidency of a Minister of the

[500] This section on Oriental sanitary institutions reflects the conclusions of the ISC Commission on the Organisation of the Sanitary Service in the Levant. In this document, the reporters detailed the history and organisation of Oriental sanitary institutions, based, they claimed, on the following sources: Turkish Quarantine Regulations and attachments; Memorandum on the need for a sanitary service in Turkey addressed to S. A. Ahmed-Féthi-Pacha by the Constantinople Superior Board of Health, 1846; Mission in the Orient, report by M. Ségur-Dupeyron, 1846; Memorandum by Dr Raffalowich on the sanitary conditions in Egypt, Marseille, 1848; Letter on the organisation, staff and result of the sanitary and hygienic service of Egypt by Dr Prus, Alexandria, 1848; Data on the reform of quarantine institutions by Dr Gobbi, Vienne, 1849; Note on the Turkish quarantine organisation by Dr Leval, member of the Constantinople [Board of Health], *Gazette médicale de Constantinople*, November 1849; General Report of the Turkish Commission sent to Egypt in 1849, Constantinople, 1850; Memorandum on the Orient Sanitary Service (Gobbi project), addressed by the Austrian government to several European powers; Instructions to French sanitary doctors by the Minister of Commerce and Agriculture and Academy of Medicine of Paris (and the King's decree of 18 April 1847 regarding the institution of doctors in the Orient); Reports by French sanitary doctors addressed to their government by Dr Fauvel, Burguières, Willemin, Prus, Suquet and Camascasse; Report on the sanitary service in

Sublime Porte,[501] the Board was divided equally between government agents and delegates from Austria, Belgium, France, England, Greece, Prussia, Russia, Sardinia and Tuscany. Like the Ottoman members, these foreign delegates had a deliberative voice and shared all other rights that the others enjoyed.[502] Surprisingly enough, by 1851 the Board still had no legal existence as no law had ever proclaimed its creation or framed its actions. Nevertheless, the Board controlled 63 local boards of health (*offices de santé*) that 'surveyed public health conditions […] executed or made executable sanitary regulations, and [enforced] any other decision communicated [by the Constantinople Board].'[503] Despite the lack of legal framework, the Board issued a set of regulations that the ISC Commission on the Organisation of the Sanitary Service in the Levant thought to be 'shaped upon the best European models and adapted to the particularities of the country.'[504]

In context, the sanitary innovations instituted in the Ottoman Empire were not an isolated policy. In fact, they resulted from a complex number of policies instituted since 1826 by the Sultan Muhamad II, which progressively built a modern centralised state within the Ottoman territory.[505] The need for reform derived from an inherent military and economic weakness that was evident to all and had resulted in numerous military fiascos, unreliable infrastructures and a lack of an internationally

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Turkey by Pekarsky, addressed in 1848 to the minister of internal affairs of the Russian Empire; Twelve reports regarding the condition and sanitary service of Turkey and specially Syria and Egypt by Dr Raffalovitch, addressed in 1846, 1847, and 1848 to the same Russian minister; Memorandum by R Fauvel - address in July 1851 to the Minister of Commerce and Agriculture; Two memoranda by Pezzoni, delegate of the Russian government to the Constantinople Board of Health addressed to Dr Rosenberger in July 1851; Note on the Egyptian Sanitary Service sent to Cerrati, Sardinian general consul by Henricy, adjunct to the president of the Alexandria Intendancy in 6 October 1851; Lists of consuls residing in the Orient.

[501] Although formally an Ottoman ministry was the president of the Council, in practice the vice-president of the Council performed his role.

[502] The presence of foreigners as full board members is further discussed below.

[503] *Conférence sanitaire internationale*, vol. 2, *Rapport sur l'organisation du service sanitaire dans le Levant au nom d'une Commission composée de MM. Magnetto, Président, Bartoletti, Carbonaro,, Grande, Rosenberer, Sutherland et Vitalis*, Annex 1 to Proc. 29, *p*6

[504] *Conférence sanitaire internationale*, vol. 2, *Rapport sur l'organisation du service sanitaire dans le Levant*, Annex 1 to Proc. 29, *p*10

[505] Lewis wrote extensively on the first wave of Ottoman reforms. See Bernard Lewis, *The Emergence of Modern Turkey* (London: Oxford University Press, 1968).

competitive industry.[506] The political reform gathered momentum, with new legislation issued in 1839 (the *Tanzimat* reforms) that transferred the power once monopolised by the Sultan into the hands of bureaucrats and, among other things, reorganised the financial system, abolished slavery, and instituted a legal code for commerce and trade. The new ruling elite, with close European contacts, saw the establishment of Western institutions as the only viable strategy for avoiding the decline of the Empire.[507]

Although an integral part of the Ottoman Empire, Egypt had grown progressively autonomous from Constantinople during the first half of the nineteenth century. Under the ruling of Muhammad Ali, styled Viceroy of Egypt, the country went through radical reforms. Muhammad Ali refashioned the armed forces, reorganised the administration and installed a centralised bureaucracy, changed the patterns of landholding and agricultural production, introduced heavy industry, and conquered an empire that by the 1830s included northern Sudan, the western coast of Arabia, all of Greater Syria, and parts of southwestern Anatolia.[508] By doing so, he secured autonomy from the Ottoman Empire while establishing close commercial and diplomatic contacts with European powers.

From a sanitary perspective, in 1831 the Egyptian government allowed the creation of a Board of Health in Alexandria. The Board was exclusively composed of foreign consuls who, on the eve of its constitution, declared that 'quarantine service [and all future sanitary establishments] should be controlled, directed and manned by Europeans, since this was the only way to achieve the success desired.'[509] The European-dominated board soon became a venue of intrigue where personal and national agendas were protected. More problematically, the Board instituted a discriminatory policy that often granted free pratique to European vessels while

[506] Murat Gül, *The Emergence of Modern Instanbul. Transformaton and modernisation of a city* (London: I.B. Tauris Publishers 2009).
[507] Afaf Lutfi Al-Sayyid Marsot, *Egypt in the Reign of Muhammad Ali* (Cambridge: Cambridge University Press, 1984). *p*26
[508] W.L. Cleveland and M.P. Bunton, *A history of the modern Middle East* (Boulder, CO: Westview Press, 2009). *p*66
[509] LaVerne Kuhnke, "Resistance and Response to Modernization: Preventive medicine and social control in Egypt, 1825-1850" (Dissertation (PhD), The University of Chicago, 1971). *p*159

imposing quarantines on Ottoman ships sailing under the exact same circumstances. Together, the lack of international agreement and the practice of discriminatory policies dictated the end of the Board, which in early 1840 was nationalised and locked away from foreigner intervention.[510] Eventually, after considerable diplomatic influence in Cairo and Constantinople (the head of the Ottoman Empire), foreign consuls regained access to the Board. In fact, a new decree of November 1843 reorganised the body into a Sanitary Administration to which Consuls General of Austria, France, England, Greece, Prussia, Russia, and Sardinia were invited to send delegates with consultative or advisory status.[511]

French doctors in the Orient

In addition to sanitary institutions engineered by the Ottoman governments, France also developed its surveillance capacities within the Empire. In 1847, a network of French physicians was established. These doctors –expected to facilitate the work of their consuls by assessing health conditions – had permanent residence in Constantinople, Smyrna,[512] Beirut, Alexandria, Cairo and Damascus. As part of their mission, the French physicians in the Levant were mandated to 'meticulously report on the health conditions of the countries; to issue, for the convenience of French consuls, [medical] certificates [that underpinned] dispatching bills of health; to observe the health conditions of passengers, crews, and vessels departing to France; and to study, in general, the country regarding its climate, [and] diseases.'[513]

While France established a network of sanitary physicians, Austria also developed medical institutions in the Ottoman Empire.[514] With the help of the Austrian government, the Ottomans established a Western-style medical school in the late 1830s and Metternich's personal physician was entrusted to procure Austrian

[510] Ibid. *p*162-3
[511] Ibid. *p*164
[512] In English, the city was called Smyrna until the Turkish Postal Service Law of 28 March 1930, upon which the name Izmir (sometimes İzmir) was adopted in English and most foreign languages.
[513] *Conférence sanitaire internationale*, vol. 2, *Rapport sur l'organisation du service sanitaire dans le Levant*, Annex 1 to Proc. 29, *p*28
[514] The Ottoman government also welcomed French assistance in military and educational fields. See M. Raccagni, "The French Economic Interests in The Ottoman Empire," *International Journal of Middle East Studies* 11, no. 03 (1980).

teachers (and directors) for the new Constantinople school. The increasing presence of Austrian physicians as medical professors and the development of close ties between Austrian doctors and the Sultan led to public health initiatives marked by a distinctive Austrian flavour.[515] The efforts developed by France and Austria to improve Ottoman health conditions and impose epidemic surveillance mechanisms were part of larger national quarantine projects. Through the intervention in the Ottoman Empire, both countries – like those with seats on the Constantinople Superior Board of Health – tried to transfer Europe's first line of defence against plague to the Orient so that quarantines at their homeports could be safely reduced.[516]

The Commission's assessment

European powers were increasingly infiltrating Ottoman sanitary affairs and already controlled important surveillance resources in the Orient. Presided over by the Sardinian consul, Magnetto, the ISC Commission for the Organisation of Levant's Sanitary Service presented its report on 11 November 1851.[517] In a total of 35 pages plus two attachments, the Commissioners considered existing sanitary conditions and institutions and designed a set of measures to be implemented in order to secure permanent free pratique with the Ottoman Empire.

In general, the Commission was happy with the outcomes of the sanitary reforms instituted in Turkey and Egypt. In their eyes, by including foreign consuls with deliberative powers, the Constantinople Superior Board of Health had developed services in a progressive and regular way. More importantly, it was capable of detecting and correcting sanitary errors committed by local authorities. The results

[515] Marcel Chahrour, "'A civilizing mission'? Austrian medicine and the reform of medical structures in the Ottoman Empire, 1838-1850," *Studies in History and Philosophy of Science Part C: Studies in History and Philosophy of Biological and Biomedical Sciences* 38, no. 4 (2007).
[516] This idea was initially developed by Ronald Coons and later elaborated by Valeska Huber under the lens of membrane mechanism, capable of opening to let trade pass while closing to avoid the propagation of epidemic diseases. See Coons, "Steamships and Quarantines at Trieste, 1837–1848." and Huber, "The Unification of the Globe by Disease? The International Sanitary Conferences on Cholera, 1851-1894."
[517] In addition to Bagnetto, the Commission was composed of six other delegates: Dr Bartoletti of Turkey, Dr Carbonaro of the Two Sicilies, Dr Grande of Portugal, Dr Rosenberger of Russia, Dr Sutherland of England, and the Greek consul Vitalis.

were telling: for a period of five years, the Council had managed to make 'the scourge disappear throughout the extent of the Empire.'[518]

As for Egypt, its 1843 sanitary reforms inspired less confidence from the Commission. Certainly, the reforms introduced included the institution of a central sanitary administration in Alexandria responsible for designing and overseeing quarantine, hygienic and medical policies in the region. However, commissioners frowned upon two organisational details. First, the Commission disapproved of the consultative nature of foreign consuls in the sanitary administration of Egypt. Secondly, the Egyptian autonomy within the Ottoman Empire resulted in the Alexandrian sanitary authority being outwith the control of Constantinople. The two factors enhanced the self-governance of Egypt and created a scenario where Europe had no 'direct action on the development of [Egyptian sanitary] affairs.'[519]

Nevertheless, the Commission recognised that the Egyptian authorities had developed important epidemic changes. First and foremost, plague had been eradicated from Egypt. According to several medical sources consulted by the Commission, the last plague outbreak had been registered in 1844. Moreover, Egypt had managed to impose an active hygienic surveillance of its territory; quarantine service worked, with some exceptions, without problems, and the causes of death were correctly established through systematic post-mortem observations. Finally, it concluded that 'the capacity of Egypt's sanitary service men, their zeal and courageous perseverance added [further] guaranties that Europe [needed] to relax its rigorous [quarantine practices] against this country.'[520]

Despite the general optimism, the Commission was not yet ready to grant free pratique to the Ottoman Empire. Before that could happen, Turkey, Egypt, and the European powers would have to introduce new measures that curbed sanitary risks

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[518] *Conférence sanitaire internationale*, vol. 2, *Rapport sur l'organisation du service sanitaire dans le Levant*, Annex 1 to Proc. 29, *p*12
[519] *Conférence sanitaire internationale*, vol. 2, *Rapport sur l'organisation du service sanitaire dans le Levant*, Annex 1 to Proc. 29, *p*19
[520] *Conférence sanitaire internationale*, vol. 2, *Rapport sur l'organisation du service sanitaire dans le Levant*, Annex 1 to Proc. 29, *p*25

and instituted ultimate guaranties for European public health. The Commission required the Sultan himself to issue a law that maintained the current organisation of the Superior Health Council of Constantinople, where 'interested European powers continued to be represented […] by delegates in equal number to Ottoman officials, all with deliberative voice.'[521] In both its interior and littoral territory, Turkey was expected to appoint more doctors and institute local sanitary boards. The government was also invited to finish the construction of four quarantine stations and start work on two others. In addition, the Commission proposed the creation of new regulations inspired by the work of John Sutherland,[522] a penal code and a special tribunal to deal with sanitary infractions. Finally, the Commissioners wished to elevate the Constantinople Superior Board of Health to the *de facto* top hierarchical sanitary institution of the entire Ottoman Empire, Egypt included.[523]

Regarding Egypt, the presented measures were no less interventionist. The Alexandria sanitary authority was to be replaced by a new Board of Health organised like the Superior Health Council of Constantinople. Foreign consuls were expected not only to hold seats, but to possess deliberative powers in all Egyptian sanitary matters. In addition, inspectors and doctors working for the sanitary services would need to hold a degree conferred by a European university.[524]

One thing was certain in the Commission's view: by itself, the Orient was unable to offer the necessary guaranties to institute free pratique, and so European powers should be involved beyond the Ottoman institutional coordination. The ancient network of consuls already established in the Orient issued bills of health used by European port authorities as epidemic surveillance tools. While these documents had initially been based on consuls' private consideration, more recently, the

[521] *Conférence sanitaire internationale*, vol. 2, *Rapport sur l'organisation du service sanitaire dans le Levant*, Annex 1 to Proc. 29, *p*1
[522] A list of hygienic measures to be instituted in the Orient, authored by John Sutherland, was also attached to the Commission's report. See *Conférence sanitaire internationale*, vol. 2, *Indication des mesures hygiéniques proposées pour le Levant comme complément de son système de quarantine*, Annex 1 to *Rapport sur l'organisation du service sanitaire dans le Levant,* , Annex 1 to Proc. 29
[523] *Conférence sanitaire internationale*, vol. 2, *Rapport sur l'organisation du service sanitaire dans le Levant*, Annex 1 to Proc. 29, *p*3
[524] *Conférence sanitaire internationale*, vol. 2, *Rapport sur l'organisation du service sanitaire dans le Levant*, Annex 1 to Proc. 29, *p*3

establishment of sanitary authorities and European doctors in the Ottoman Empire offered concrete epidemic evidence that consuls were issuing bills. In the case of France, consuls had already been instructed to base their bills on medical certificates produced by French physicians in the Orient. According to the Commission, these doctors also contributed towards the improvement of local health conditions by providing enlightened advice to local authorities and improving sanitary institutions. In sum, overseas doctors provided 'incontestable services not only to their countries of residence but to all Europe' and their number should be expanded.[525] In total, the Commission suggested the institution of 26 doctors: six in Egypt, four in Syria, and 16 more spread throughout the remaining Ottoman territory. These sanitary doctors would be required to survey the health conditions in the area under their jurisdiction. Although this could potentially profit all ISC participants, the autonomy and freedom of doctors was crucial. On the one hand, Ottoman authorities should not try to condition the judgments of physicians; on the other hand, participating nations should understand that foreign doctors were only accountable to their respective national governments.

If all interventionist measures were enforced by the Ottoman Empire and participating European nations, the Commission proposed to 'allow free pratique to the whole Levant, without establishing a difference between Turkey, Syria and Egypt.'[526] While the only cost to Europe was the salary of its doctors posted in the Orient, the Ottoman governments would compromise their autonomy, legitimacy and control over sanitary affairs within its territories.

The debate

When delegates started discussing the Commission's report, their opinions ranged from the immediate establishment of free pratique to the internal postponement of the measure. While delegates like the Sardinian, Dr Bo, wished to revoke quarantines immediately as a sign of appreciation of Ottoman efforts to improve health

[525] *Conférence sanitaire internationale*, vol. 2, *Rapport sur l'organisation du service sanitaire dans le Levant*, Annex 1 to Proc. 29, *pp29*-30
[526] *Conférence sanitaire internationale*, vol. 2, *Rapport sur l'organisation du service sanitaire dans le Levant*, Annex 1 to Proc. 29, *pp*3-6

conditions and epidemic surveillance,[527] more pessimist delegates like the Austrian envoys stressed the imperfection of the Ottoman sanitary system, which did not offer guarantees for the introduction of free pratique.[528] Slowly, delegates agreed that it was crucial to the epidemic safety of Europe that the Ottoman Empire introduce measures like the constitution of a legal framework for the Constantinople Superior Board of Health. However, since approved measures needed to figure in the final Draft Sanitary Convention, caution was required. Often, international convention involved reciprocal exchange of rights and Europe did not wish to see Ottoman officials in its central sanitary authorities, enjoying deliberative powers.

Details were indeed important. The Commission requested the Ottoman government to provide a legal framework for the Constantinople Board of Health and at the same time demanded that its present structure, where foreign consuls were allowed to deliberate on Ottoman sanitary affairs, was preserved. The aim was that all interested European powers would be represented. However, as Segóvia of Spain noted, the present organisation of the Board did not include consuls from all ISC countries. Spain, Sardinia, Portugal, the Roman States and the Two Sicilies were interested in securing a seat on the Board and wished to have their claim recognised in the future treaty. Although the ISC found itself fully legitimised to engineer local sanitary organisations in Europe, its President now feared that the Conference had no capacity to dictate the number of consuls that would hold seats on the Constantinople Board of Health. This, he stated, was a problem 'of convenience that should be left to the decision of interested governments and the Sublime Porte'.[529]

The introduction of a penal code and a special tribunal for sanitary infractions was well received by delegates. Anthony Perrier of England noted that the creation of sanitary tribunals had already been suggested by the French and hoped that delegates would vote for their establishment in Turkey. However, the Austrian doctor believed that the Commission's suggestion 'exceeded […] the limits of respect due to the

[527] *Conférence sanitaire internationale*, vol. 2, 25 November 1851, *p*14 (Bo)
[528] *Conférence sanitaire internationale*, vol. 2, 27 November 1851, *p*7 (Ménis)
[529] *Conférence sanitaire internationale*, vol. 2, 1 December 1851, *p*3 (David)

Sublime Ottoman Porte.'[530]A proposal such as the one under debate would have a character of obligation and an international conference had no power to make such requests of a sovereign nation. In line with the Commission and the English diplomat, Dr Rosenberger of Russia emphasised the mandatory character of the proposal. The Constantinople Board of Health itself had already requested the Sultan to introduce these measures and the ISC was ready to support this stance.

This chapter began with the claim that state sovereignty is not static but constantly negotiated. The argument has been made that states strike sovereignty bargains that allow them to enhance, or protect, certain elements of their autonomy, control, and legitimacy for the sake of others. This begs a crucial question: what did the Ottoman Empire gain by allowing European states to shape and even control important Ottoman public health mechanisms? At a first glance, the issue of free pratique was only in the interest of European powers. After all, it was their merchants who profited from the economic advantages of quicker sailing times within the Mediterranean. Not only did they manage to transport people and cargo faster but, from a logistics perspective, the eradication of quarantines improved the turnaround time for vessels to start new trips and potentially increased the volume of transported cargo and passengers. Finally, the end of quarantines implied the end of quarantine fees charged in lazarettos and contributed to the lowering of commercial costs. Certainly, if ISC measures were to be enforced, Europeans would increase transportation speed while enhancing epidemic surveillance and safety. In addition, they would secure a voice in the administration of Ottoman public health while decreasing the costs of sailing and trade.

As with Europeans, Ottoman merchants would also profit from the eradication of quarantines. Although their fleets were smaller, the gains derived from faster transportation speed were obvious. Furthermore, for the price of losing some autonomy and control over national sanitary affairs, the Ottoman Empire gained many other advantages. First, merchants were able to turn their vessels around quicker, which had potential positive effects on the Ottoman treasury: if vessels

[530] *Conférence sanitaire internationale*, vol. 2, 4 December 1851, *p*4 (Ménis)

increased the annual volume of transported cargo, it was likely that they would pay more import/export taxes to the Empire. Secondly, these gains in productivity made the Mediterranean trade route even more competitive compared to the time-consuming Atlantic route between India and Europe. Thirdly, by allowing the infiltration of European consuls and physicians into Ottoman sanitary bodies, the Ottoman Empire profited from the circulation of scientific and organisational knowledge. Finally, by allowing foreign doctors to survey its territory, the Ottoman Empire benefited from a network of highly trained professionals without having to pay for them. All in all, the Ottoman Empire fostered its economy while making Turkey and Egypt safer epidemic places.

In summary, the ISC developed efforts to engineer the sanitary organisation of the Levant, while also imposing a network of foreign doctors within the Ottoman territory, in order to control Oriental sanitary policies and survey its epidemic conditions. The contrast with the measures imposed on European sanitary organisations was striking. First, although the ISC tried to organise sanitary administration structures both in Europe and in the Ottoman Empire, most European powers held similar views to England, which informed the Conference that it would only adopt changes within its Mediterranean possessions. Its mainland was autonomous and control over its sanitary policies should remain under the exclusive competence of Her Majesty's Government. Secondly, the introduction of consuls with deliberative power in Turkish and Egyptian boards of health was established without issue. However, when delegates tried to secure the presence of a foreign consul-delegate as a consultative member of the (also consultative) local boards of health, the majority voted against the measure. Finally, the ISC secured the creation of a special tribunal for sanitary affairs in the Ottoman Empire, but failed to institute it in Europe.

CONCLUSIONS. Or, the end of a conference and the beginning of an international public health movement: some concluding remarks

> *I come to announce that you have gloriously accomplished your mission. You have overcome adversity, triumphed over entrenched prejudice, and - under the light of science - you have restored trade's freedom, which for years has languished in vain obstacles.*
>
> *Gentlemen, I thank you from the bottom of my heart in name of commerce that you have freed; and in name of humanity that your wisdom has contribute[d] to facilitate international exchanges without scarifying measures necessary to protect public health.*[531]

On 19 January 1852, delegates convened for one last meeting. Received by the Marquis Turgot, Minister of Foreign Affairs, and Noël Lefebvre-Duruflé, Minister of Agriculture and Trade, delegates arrived to bid their farewells and to prepare, slowly, for their journey home. After six months of work, the European envoys finalised a Draft Sanitary Convention and a Draft International Sanitary Regulation. The two documents not only synthesised the ISC as an event aiming to regulate international public health but also sowed the roots of a movement that would increasingly internationalise public health practices and discourses. This final chapter details the end of the ISC and positions the Conference within a larger post-1851 movement of public health internationalisation. Via this analysis, concluding remarks will be drawn that illustrate the consequences of this internationalisation of public health during the first half of the nineteenth century.

Optimism closes the Conference

In the midst of the applause that interrupted his passionate speech, Lefebvre-Duruflé summarised the main achievements of the ISC. In his view, delegates had managed to discard all political and scientific questions in favour of more practical matters. As a result of their work, the participant states had decided that public health should result from common agreements and that any future sanitary measure should be duly uniformed within all participant countries. More specifically, delegates to the ISC had introduced regulations that limited sanitary measures to three exclusive diseases – plague, yellow fever, and cholera – and relaxed the use of quarantines. In future,

[531] *Procés-verbaux de la conférence sanitaire internationale, ouverte à Paris le 27 Juillet 1851*, vol. 2, 19 January 1852, p. 3 (French Minister of Foreign Affairs, Marquis Turgot).

arrivals from the Orient carrying clean bills of health were to receive free pratique in European ports as soon as certain conditions had been met. In order to further Europe's capacity for epidemic surveillance, a network of physicians was to be established in the Orient, while the presence of a doctor was to be required onboard steamers. In order to simplify proceedings and standardise practices, delegates created a common template for bills of health with two exclusive classes – clean and foul. Likewise, cargo was reclassified by delegates based on its epidemic risk, in order to unify the heterogeneous classification systems practiced in Europe.[532] More importantly, the Conference reduced 'the duration of quarantines henceforth proportional to the period of incubation of diseases,' and abolished, in principle, all taxes applied to sanitary measures.[533] Finally, delegates agreed to place sanitary authorities under the direct control of central governments.

In light of this elaborate list of achievements, Lefebvre-Duruflé congratulated delegates: 'everything that humanity and represented nations [had] expected from [the Conference, they saw it] accomplished.' To further celebrate, a banquet was organised for delegates and ambassadors while Louis-Napoléon Bonaparte awarded the National Order of the Legion of Honour to each delegate.[534] A last farewell dinner, organised by the envoys, also took place in Paris, and according to an article published in 1860 by the Spanish medical delegate Pedro Monlau, the event was highly enjoyable. The meal was followed by 'toasts, speeches, verses and cheers' 'to the health and prosperity of represented monarchs and nations, to the noble hospitality of France, and to the perpetual peace and harmony among world countries.'[535] To perpetuate the memory of the Conference, delegates decided to have a medal minted and to collect money for donation to the poorest child born on the last day of the Conference in the district where the meetings took place. Eduardo Mitriquiris – the 'legitimate and natural son of Andrés Mistriquiris, coachman and

[532] Although it was an important aspect of the ISC, this dissertation does not look at classification of cargo due to space limitations. For further details on classification of cargo see Barnes, *Lazaretto, epidemics, politics, and quarantine in a nineteenth-century city*.
[533] *Procés-verbaux de la conférence sanitaire internationale, ouverte à Paris le 27 Juillet 1851*, vol. 2, 19 January 1852, p. 7 (French Minister of Agriculture and Trade, Lefebvre-Duruflé).
[534] *Procés-verbaux de la conférence sanitaire internationale, ouverte à Paris le 27 Juillet 1851*, vol. 2, 19 January 1852, p. 4 (French Minister of Foreign Affairs, Marquis Turgot).
[535] Pedro Felipe Monlau, "Congresso Sanitario de Paris en 1851-52," *El Monitor de la Salud de las Familias y de la Salubridad de los Pueblos* 3, no. 1 (1860).

Paulina Ripaud, washerwoman'[536] – was selected and named the adopted son of the ISC. The Conference would gain life outside its walls and Eduardo could expect to receive his funds on the day he turned 18 years old.

The festive mood and the sense of triumph perhaps overshadowed the less optimistic words that were delivered by the French ministers in the above-mentioned speeches just prior to the final celebrations. The Minister of Foreign Affairs opined that delegates had a mission beyond the ISC. With the end of the Conference, they were to be the 'apostles of the doctrine [they] produced and each of [them], armed with the arguments of all (…) would know how to overcome misconceptions and make [sanitarian] truth triumph.'[537] Enemies would certainly emerge and try to defeat the progress made in Paris, and for that reason, the Minister of Agriculture and Trade reminded delegates that their efforts should still 'be submitted through diplomatic channels to ratification. Perhaps – he continued – [the process of ratification] would find adversaries among men to which [delegates'] work was unknown! Conceivably serious apprehension would emerge against the new [sanitary] code.'[538] Passed from generation to generation, prejudice against modern sanitary conceptions was rooted in fear and in old traditions. Listing perils and strategies to guarantee the successful ratification of the drafted Convention and Regulation, the Minister of Agriculture and Trade declared his utter belief that all states would eventually adhere to their delegates' decisions.

When delegates left Paris, the success of the Draft Sanitary Convention and Regulation was promissory. Back in their own states, national bureaucratic machineries initiated a process to assess their delegates' work and formalise the ratification of the international treaty. Despite initial positive reactions, however, the majority of participants – including England – never ratified the Draft Convention and Regulation. Optimism and support gave way to apprehension and discontentment.

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[536] Ibid.
[537] *Procés-verbaux de la conférence sanitaire internationale, ouverte à Paris le 27 Juillet 1851*, vol. 2, 19 January 1852, p. 4 (French Minister of Foreign Affairs, Marquis Turgot).
[538] *Procés-verbaux de la conférence sanitaire internationale, ouverte à Paris le 27 Juillet 1851*, vol. 2, 19 January 1852, p. 7 (French Minister of Agriculture and Trade, Lefebvre-Duruflé).

The next section focuses on the particular process that the English state developed in order to finalise its ratification position, as it gives an insight into the reasons that certain states eventually decided against the Drafts and the ways that international public health was thoroughly dependent upon national states. The wealth of available sources for the English decision allows the reconstruction of a complex process that involved the coordination of several governmental bodies and colonial authorities while maintaining communication with other potential contracting parties.

Problems with protocol

In England, the Foreign Office sent copies of the Draft Convention and Regulation to the Privy Council, the Board of Health, and the Board of Trade, and requested their opinion regarding the quality and implications of the international sanitary project.[539] By mid-February the first replies started to arrive. Despite their consideration that there were minor issues with particular points, the Board of Health stated their unconditional support for the adoption of all provisions contained in the Draft Convention.[540] Likewise, the Board of Trade found no objections and communicated its satisfaction with the proposed changes that promised to discard the inconveniences and disadvantages that injured international commerce.[541]

Supported by the Boards of Health and Trade, the Foreign Office was prepared to sign the Convention. France – as host – was also ready to organise the final ceremony where contracting parties could proceed with the signature of the documents.[542] In a letter to the Foreign Office, Count Walewski, the French Ambassador to London, informed them that Sardinia and several other states had already nominated Plenipotentiaries to sign the Convention and invited England to do the same. Count Walewski also mentioned that his government had introduced

[539] *Memorandum relative to the Negotiation respecting the System of Quarantine in the Mediterranean* (confidential), 11 April 1853, The National Archives of the UK TNA: PRO FO97/215
[540] *Minute of the General Board of Health on the Convention proposed by the Sanitary Conference at Paris, 13 February 1852,* TNA: PRO FO97/213. See objections below.
[541] Office of Committee of Privy Council for Trade to Henry Addington, Permanent Under-Secretary of State for Foreign Affairs, 20 February 1852, TNA: PRO FO97/213
[542] Count Walewski, French Ambassador to London, to Earl Granville, Secretary of State for Foreign Affairs, 6 April 1851, TNA: PRO FO97/213

two changes to the Convention in order to expedite the ratification process: unilaterally, a new article had been added that obliged parties to accept the Convention and Regulation as a single document. In addition, the terms of ratification had been altered. Instead of obliging contracting parties to ratify the Convention within three months of the conclusion of the Conference, Paris now encouraged powers to exchange ratifications 'in the shortest time possible' but without a set temporal limit.[543]

A few weeks after receiving Count Walewski's invitation, news arrived at the Foreign Office through Anthony Perrier. According to the former delegate to the Conference, further modifications had been made to terms previously agreed in the ISC. In this sense, the Drafts of Convention and Regulation would not be subject to additional negotiation or changes. They were final documents ready to be transformed into an international treaty through the process of signature and exchange of ratification. However, this process would not be conducted according to traditional diplomatic praxis: France had decided that, instead of organising a single ceremony where all contracting parties would come together to sign and ratify the agreement, a standard copy would be made available to Plenipotentiaries to sign whenever ordered by their governments to do so.[544] This process was clearly at odds with the proceedings described by Charles de Martens in his *Guide Diplomatique.*[545] According to the *Guide*, the act of ratification consisted of a document, signed and sealed by a sovereign, through which he or she approved the contents of the treaty made in his or her name and promised to execute the agreed points in good faith.[546] With these documents, ambassadors from all parties would convene to exchange ratifications and would conjunctly sign the Convention in their sovereign's name. Accordingly, the ratification ceremony obliged each ambassador per party to sign a copy of the Convention and keep another copy, signed by all participants, to return to

[543] Count Walewski, French Ambassador to London, to Earl Granville, Secretary of State for Foreign Affairs, 6 April 1851, TNA: PRO FO97/213
[544] Memorandum, 11 April 1853, TNA: PRO FO97/215
[545] More on this source in the previous chapter.
[546] Karl von Martens and Ferdinand de Wegmann, *Le guide diplomatique: Précis des droits et des fonctions des agents diplomatiques et consulaires; suivi d'un traité des actes et offices divers qui sont du ressort de la diplomatie, accompagné de pièce et documents proposés comme exemples*, 2 vols., vol. 2 (Paris: Gavelot Jeune, 1851). p154

his government. In opposition to this practice, Perrier complained, Paris had arranged it so that 'each Plenipotentiary retain[ed], in order to send to his Court, a copy signed only by himself and the French Plenipotentiary, while the only copy signed by all Parties would be that to be kept at Paris.'[547]

On 6 April 1852, the Earl of Malmesbury, the British Secretary of Foreign Affairs, wrote to his Ambassador to Paris expressing his discontent with the French resolutions. Not only did he find no reason to deviate from the normal diplomatic course, but he also disagreed with the introduction of articles that denied the possibility of negotiating the Convention and Regulation before its signature. Despite complaints, Paris refused to compromise, leaving Malmesbury with no other alternative than to instruct his ambassador to collect signatures from all contracting parties for his copy of the agreement.[548]

English diplomatic history and its particular traditions introduced protocol difficulties that required close consideration. From a formal perspective, an international treaty was first and foremost a contract between sovereigns as persons and only secondly an agreement between sovereigns as states. The Sanitary Convention was thus a treaty to be established between Queen Victoria and other heads of state, including the Pope (styled as His Holiness, the Pope). Following centuries without official contact, diplomatic relations between England and the Roman States had been reestablished and regulated by the 1848 11 & 12 Vict., c. 108 Act.[549] This legislation carried an important caveat that only allowed diplomatic affairs with the Pope as the sovereign of the Roman States, never as the head of the Catholic Church.[550] Seeking to avoid an invalidation of the treaty on legal bases, the Foreign Office requested the Law Officers' opinion. In order to avoid potential problems, the Law Officers suggested that the Pope should receive no other title than that of 'Sovereign of the Roman States' in any document signed by the two

[547] Memorandum, 11 April 1853, TNA: PRO FO97/215
[548] Earl Granville to Earl Cowley, English Ambassador to Paris (draft letter), 6 April 1852, TNA: PRO FO97/213
[549] H. A. Smith, "Diplomatic Relations with the Holy See, 1815-1930," *Law Quarterly Review* 48, no. July (1932).
[550] 11 & 12 Vict., c. 108

powers.[551] Additional modifications to the Draft Convention and Regulation were thus required.

England was not alone in taking issue with the French protocol decisions. Austria and Tuscany also protested against the introduction of these unorthodox practices.[552] In addition, Austria, Russia, Sicily, Spain, Turkey, and Tuscany requested changes to be made; however, the French position, states were informed, was final.[553] No alterations were to be allowed, due to the fact that shortly after introducing protocol changes to the Convention, France, Sardinia, and Portugal had signed the international treaty, precluding changes to the text. In addition, Paris considered the Draft Convention final because it had been produced by delegates representing governments.[554] While the first argument surprised the protesting states – London, for example, was unaware that states had already started signing the Convention – the second argument generated clear opposition. England disputed the final character of the work of its delegates since they had been appointed 'to discuss, for the information of their respective Governments, the ameliorations which it might be possible to introduce in the system of quarantine in the Mediterranean' – not to make a treaty.[555] London expected an opportunity to fine-tune the work of its delegates and to introduce any changes deemed necessary. The Foreign Office argued that its position was supported by the Preamble of the Convention, which stated that the contracting parties 'have resolved to negotiate and conclude a special Convention, followed by a Regulation, and have for that purpose named Plenipotentiaries,' but the French Government was acting as if the Convention had already been negotiated by Plenipotentiaries, rather than by mere delegates who were not invested with full powers.[556] The Convention, England claimed, existed only as a draft, and while Paris insisted that the Drafts must be accepted or rejected without alteration, the French

[551] Law Officers (Doctor's Commons) to Foreign Office, 18 March 1852, TNA: PRO FO97/213
[552] Anthony Perrier to Earl of Malmesbury, 8 July 1852, TNA: PRO FO97/214
[553] This changes were connected with the Convention and Regulation contents and will be further explored below.
[554] Memorandum, 11 April 1853, TNA: PRO FO97/215
[555] Earl Cowley to Earl of Malmesbury, 31 August 1852, TNA: PRO FO97/214
[556] Memorandum, 11 April 1853, TNA: PRO FO97/215.

Government had been the first to act upon a contrary principle by unilaterally adding an article after the Drafts had been settled by the delegates.[557]

Problems with content

In addition to growing protocol complaints, the very content of the Convention and Regulation was also a matter of increasing concern. The English Board of Health and Board of Trade, requested to consider the Draft Convention and Regulation in January 1852, concluded that the Foreign Office should proceed with the signature and ratification of the treaty. The Board of Health noted that public health protection was still over-centred on quarantine practices that could be further liberalised. The Board also regretted that the ISC had failed to institute juries of consuls to solve quarantine disputes, but considered these two issues minor when considering the advantages derived from ratifying the International Sanitary Convention and Regulation.[558]

English criticisms of the ISC emerged with a letter from the Privy Council to the Foreign Office on 5 February. The Council objected to the plan to appoint European medical officers in the Levant and to make the expansion of such a network a main condition of free pratique for arrivals from the Orient. According to the ISC, French doctors in the Levant had contributed towards the extinction of plague. The Conference expected that additional European physicians would help to improve epidemic conditions in the Orient. However, arguing that plague had been extinct in Egypt nearly three years before the French arrival, the Council dismissed the over-ambitious safety claims of the Conferece. [559]

More importantly, since 1845, England had granted free pratique to all arrivals from the Orient carrying a clean bill of health. Proposed by the Privy Council, this measure had proved considerably advantageous to trade, but would be put to an end if the Regulation was signed. The ISC had decided to grant free pratique to Oriental

[557] Memorandum, 11 April 1853, TNA: PRO FO97/215.
[558] General Board of Health to Foreign Office, 13 February 1852, TNA: PRO FO97/213
[559] Privy Council to Earl Granville, 29 January 1852, TNA: PRO FO97/213

arrivals, providing, among other conditions, that the network of European physicians was fully established in the Levant. Until then, England was required to reimpose quarantines on these arrivals in order to comply with international sanitary regulations.[560]

Despite initial support, the Board of Trade reconsidered its position of *support without reservations* a month after issuing its first report. On 6 April, the Board forwarded a letter by William Pym, the Superintendent General of Quarantine, to the Foreign Office, and recommended a careful appreciation of the impact of new fees to be introduced with the Regulations.[561] According to Pym, the Convention's article seven declared that new charges would be levied in all Mediterranean ports upon vessels, people, and cargo, and allowed each government to determine the final charges providing that they raised sufficient money to cover the sanitary expenses. Pym and the Board of Trade recommended that the final charges should be made known to the British Government before ratification took place, in order to avoid adding unpredictable costs to trade. [562]

In a letter dated 5 May, the Secretary of State for the Colonies communicated to the Foreign Office that, regarding Gibraltar, Malta, and the Ionian Islands, the Colonial Department supported the signature of the Draft Convention and Regulation. However, as in the case of the Board of Trade, the Department dispatched a new letter a few weeks later expressing its concerns.[563] Forwarding a letter from the Governor of Malta, the Secretary alerted the Foreign Office to the malign consequences that the Convention and Regulation would inflict upon the island's trade.[564] Governor Sir William Reid claimed that the Regulation stipulated a period (inclusive of voyage and quarantine) of 8 to 10 days as a condition for pratique to arrivals from the Levant. The period was clearly longer than the three days required of vessels arriving from Egypt, let alone the short 24 hours imposed on arrivals from

[560] Privy Council to Earl Granville, 29 January 1852, TNA: PRO FO97/213
[561] Board of Trade to Foreign Office, 6 April 1852, TNA: PRO FO97/213
[562] William Pym, Council Office, 3 April 1852, attached dispatch to Board of Trade to Foreign Office, 6 April 1852, TNA: PRO FO97/213
[563] Memorandum, 11 April 1853, TNA: PRO FO97/215
[564] Secretary of State for the Colonies to Foreign Office, 22 May 1852, TNA: PRO FO97/214

Turkey. Vessels facing lengthy quarantines, the Governor feared, would avoid stopping in Malta. Instead, they would opt for Trieste and other distant ports so as to make the voyage long enough to fulfil the ISC-stipulated period without finding themselves subject to additional quarantines.[565]

Facing growing anxieties about the Draft Convention and Regulation contents, the Foreign Office reexamined the documents. Doubts emerged regarding the power of the executive government to carry out the stringent hygienic measures necessary to enjoy the advantage of the new sanitary system. In particular, it was questioned whether the Parliament would grant the necessary authority to implement the sanitary reforms proposed by the Conference.[566] A new wave of apprehension emerged at the end of May, when the new international Bill of Health was finally received in London.[567] According to Section II (Departure Measures) of the Draft Regulations, bills of health were to be issued after careful inspection of vessels, crew (including clothes and bedding), passengers, and food and water provisions. Conducted by local boards of health, the inspection had to be carried out within the 48 hours before departure.[568] For these new documents, the Foreign Office once again requested the opinion of the Board of Trade, the Board of Health, and the Privy Council. Was the international bill of health aligned with English interests, asked the Secretary of Foreign Affairs?[569]

A week later, the Board of Health communicated its satisfaction with the proposed Bill of Health.[570] However, the Privy Council argued against its adoption. In their opinion, the existing bill of health in England was simpler and required less information than the one under consideration, while still sufficient to establish the

[565] William Reid, Governor of Malta, to Secretary of State for the Colonies, 8 May 1852, TNA: PRO FO97/214
[566] Memorandum, 11 April 1853, TNA: PRO FO97/215
[567] Article 24 of the Draft Regulation stated that a model of Bill of Health was annexed to the regulations, but in fact, this important document never accompanied it. In fact, France only made this document available on 26 May when it was sent to the British Ambassador to London. Earl Cowley to Earl of Malmesbury, 27 May 1852, TNA: PRO FO97/214
[568] See *Procés-verbaux de la conférence sanitaire internationale, ouverte à Paris le 27 Juillet 1851*, vol. 2, Draft International Sanitary Regulation, Annex to 16 January 1852
[569] Foreign Office to Board of Trade, the Board of Health, and the Privy Council (draft), 1 June 1852, TNA: PRO FO97/214
[570] General Board of Health to Foreign Office, 9 June 1852, TNA: PRO/FO87/214

sanitary state of a departing vessel and its epidemic risk.[571] In addition, the Privy Council pointed out logistic issues that required the attention of the government if the new bill of health was adopted. A report by the Board of Customs, annexed by the Privy Council, stated that English local boards of health did not conform to the sanitary regulations produced by the Conference. Thus, extensive reform was required in order to institute local boards of health in each port from which vessels departed to the Mediterranean. Furthermore, the Board of Custom claimed that the model of vessel inspections proposed by the ISC was too meticulous and would generate considerable inconvenience and annoyance to all involved parties. Merchants, in particular, were expected to complain and resist the new measures. Facing inevitable domestic problems, the Board of Trade, like the Board of Customs, concluded that the proposed bill of health and adjacent sanitary regulations should not be adopted. To do so would be impracticable and unwise.[572]

The unconditional support from the Board of Health clearly contrasted with the positions of the Privy Council, the Board of Trade, the Board of Customs, and the Secretary of State for the Colonies. As a pet project of the Board of Health, the ISC, as seen in chapter two, was a unique opportunity to implement a particular sanitary project. The Board, under the guidance of Chadwick, had secured the appointment of a medical delegate that embodied its agenda. With a few concessions, John Sutherland was capable of regulating and reducing quarantines in the Mediterranean region. The consequences of a possible lack of support for the Convention and Regulation by the Board were greater than simply failing to back up one of its key members of staff. Due to its close involvement with the ISC, a refusal to sign the Convention and Regulation would both undermine the Board's national and international sanitary authority and challenge its future capacity for influencing the regulation of sanitary affairs.

The contradictory domestic opinions on the Draft Convention and Regulation meant that the Foreign Office's task of issuing orders regarding the signature and

[571] Privy Council to Foreign Office, 12 June 1852, TNA: PRO/FO87/214
[572] Custom House to Privy Council, 9 June 1852 attached dispatch to Privy Council to Foreign Office, 12 June 1852, TNA: PRO/FO87/214

ratification of the documents was arduous and often incoherent. Between January and May, the Foreign Office instructed its Ambassador to Paris to negotiate and sign the Convention (February); to sign and exchange ratifications without negotiation but with the caveat that a complaint had to be formally made regarding the protocol imposed by France (April); and to sign the Convention without annexing the Regulation to it as a unified treaty (May). According to a memorandum produced by the Foreign Office, 'much embarrassment [had been] felt as to the proper mode of dealing with the [process].'[573]

However, a final report by the Board of Trade, sent on 23 January 1853 (a year after the conclusion of the ISC), made the British position final. The Board took the opportunity to analyse documents produced during the ISC as well as the vast correspondence exchanged between the Foreign Office and other national and international authorities. The Board concurred with the critical opinions previously expressed by the Privy Council and other state agencies: if England were unsuccessful in obtaining reasonable modifications of the Draft documents, the stipulations would cause considerable damage to national commercial interests.[574] The Board was aware of the consequences of such a rupture. If Britain did not ratify the Convention, vessels sailing under its flag would suffer harsh quarantines and sanitary measures; parties that distanced themselves from the arrangements could hardly expect favourable treatment from those who had joined it, the Board argued. However, the International Sanitary Convention and Regulation contained 'measures so pregnant with palpable evil' that its adoption would cause even worse hardships.[575] To the Foreign Office, it was clear that the signature of the treaty was conditional on changes to the Convention and Regulation.

England was not alone in its quest to introduce alterations to the two documents. In April 1852, the English ambassador to Paris informed London that out of the twelve parties involved in the Conference, it was expected that seven, namely England, France, Sardinia, Turkey, Greece, Portugal, and Tuscany, would accept the

[573] Memorandum, 11 April 1853, TNA: PRO FO97/215
[574] Board of Trade to Foreign Office, 28 January 1853, TAN: PRO FO97/215
[575] Board of Trade to Foreign Office, 28 January 1853, TAN: PRO FO97/215

Convention as it stood; of the other five, Austria and Russia were uncertain, and Naples, Rome, and Spain were not expected to concur.[576] Three months later, Anthony Perrier communicated further details. Portugal and Sardinia had already ratified the Convention, but five other states had serious reservations that impeded them from accepting the proposed international treaty. Spain rejected the proposed quarantines against cholera; Sicily refused to ratify the Convention as the Government opposed the requirement to construct a quarantine station; and Austria and Tuscany took issue with several measures as their implementation required considerable inconvenience and injury to trade, and also objected to the French model of signature and ratification. In addition, the Russian Government disagreed with certain resolutions since they were at odds with official positions that Perrier saw as contrary 'to the enlightened views of England and France.[577] Greece and the Ottoman Empire, Perrier claimed, were ready to ratify but had decided to wait until the Great Powers had agreed to the Convention before doing so.[578]

Spain claimed that its extensive coastline and its climate's susceptibility to certain diseases required coercive measures that the ISC aimed to outlaw. The Spanish government requested modification of the documents regarding quarantines against yellow fever and cholera. In their opinion, the maximum term of seven days of quarantine in cases of yellow fever, a disease that had prevailed in Spain for 20 years, was insufficient. Likewise, Madrid wanted to secure tougher measures against cholera, which had been kept out of Spain for some time by quarantine but had broken out once those measures had been relaxed.[579]

Austria voiced its discontent with the Draft Convention and Regulation via a detailed list of 17 points that required alteration before Vienna would adhere to the treaty. For instance, they wanted to continue practicing contemporary sanitary policies (contrary to the ISC) for all arrivals from Oriental ports. In addition, it was requested that

[576] Earl Cowley to Earl of Malmesbury, 22 April 1852, TAN: PRO FO97/214
[577] Anthony Perrier to Earl of Malmesbury , 8 July 1852 TAN:PRO FO97/214
[578] The Ottoman Empire also imposed the condition that Egypt should not figure in the Convention (as was the case) as an independent state, but as a part of the Ottoman Empire. Anthony Perrier to Earl of Malmesbury , 8 July 1852 TAN:PRO FO97/214
[579] Spanish Legation in London to Foreign Office (translation), 5 April 1853, TAN:PRO FO97/215

when in foreign ports, Austrian vessels would only be subject to hygienic measures if Austrian consular services explicitly invited local authorities to carry out these tasks. Another demand was that steamers belonging to companies legally recognised by the Austrian government must be treated as war vessels and therefore enjoy exemption from all quarantine practices.[580]

Russia, meanwhile, requested the introduction of a five-year grace period during which the Draft Sanitary Regulation would be implemented on a voluntary basis. In addition, the Russian Government requested the organisation of a new meeting where delegates could finalise details regarding the Draft Convention and Regulation. Saint Petersburg was especially keen to retain the right to develop prophylactic policies outside the strict Sanitary Regulation in periods of epidemic crisis.[581]

Final remarks

Despite several formal and informal requests, France never allowed alterations to be made to the documents. During the first half of the nineteenth century, states had invested extensive resources in organising the Conference, appointing delegates, and guiding their envoys through complex and long negotiations. Moreover, complex domestic processes had been used to scrutinise closely the impacts of the ISC on domestic trade and epidemic capacity. National official positions resulted from laborious inquiry and coordination efforts. Nevertheless, out of 12 participants, only four states signed the International Sanitary Convention or Regulation: France, Portugal, Sardinia, and Turkey. The others gradually allowed the 1851 ISC to die.

Howard-Jones, in *The Scientific Background of the International Sanitary Conferences*, claimed that 'ignorance of the causes of the epidemic diseases under discussion proved an insuperable barrier to international agreement.'[582] Moreover, he concluded that 'from the point of view of practical results, the first International

[580] French Ministry of Foreign Affairs to Foreign Office, 20 October 1852, TAN:PRO FO97/214
[581] Anthony Perrier to Earl of Malmesbury , 8 July 1852 TAN:PRO FO97/214
[582] Howard-Jones, *The Scientific Background of the International Sanitary Conferences, 1851-1938*. *p*99

Sanitary Conference was a fiasco. Everyone went on doing in their own way what they had done before.'[583] But is 'fiasco' the right word? Underpinned by the principle that judgments, as discourses, are temporally and geographically located and constrained, this dissertation has shown that following repeated attempts to regulate public health internationally, the ISC successfully managed to bring together 12 states that created a common sanitary system for the international community. The arrival of yellow fever and cholera in Europe during the first half of the nineteenth century, as well as the growing international circulation of vessels, cargo, and people, resulted in the realisation that public health needed to be regulated internationally in order to keep diseases at bay and maintain the flow of trade.

This dissertation has detailed the process through which public health regulation was transformed into an international affair. In this sense, it is not a comparative history of public approaches but instead an analysis of the very process of internationalisation: a process where antagonistic political and scientific agendas came together. By following complex negotiations between medical and diplomatic delegates, the dissertation has shown how European governments built a particular model of public health requiring the standardisation of aetiological concepts, prophylactic practices, and administrative institutions.

Inspired by the Edinburgh Strong Programme, four thematic chapters showed how science, diplomacy, and state bureaucracy were closely interwoven during the negotiation process. In fact, in the quest for legitimacy in the adoption of controversial solutions, science, diplomacy, and state bureaucracy worked together to justify choices. Nevertheless, as was shown in the first chapter, the early days of international public health were not monopolised by doctors, diplomats and state administrators. These professional groups certainly played an important part; doctors collected epidemic data and theorised upon the nature and causes of epidemic diseases. Armed with aetiological definitions, they created prophylactic guidelines that individuals, cities, and states could enforce in the hope of avoiding future outbreaks. Diplomats, on the other hand, were the true embodiment of epidemic

[583] Ibid. *p*16

surveillance machinery. Based in the world's most important political, commercial, and economic cities, ambassadors, consuls and other diplomatic staff composed and circulated regular epidemic reports on the areas under their jurisdiction. Moreover, they were responsible for issuing bills of health that certified the condition of vessels departing from their ports, and also had the resources to operate bureaucratic machineries and allow states to function through the institution of practices and routines.

Merchants, ship owners, governmental administrators, and passengers also played an important role in the initial process of making public health international. These groups lobbied governments and published books, pamphlets, articles, and diaries that contributed towards the shaping of agendas and the crystallisation of axis of debate. Experiencing first hand the inconveniences and costs of quarantine policies, they successfully voiced their discontentment. However, without the capacity to organise representation and gain access to the corridors of policy-making, their role eventually faded away. The process of internationalising public health relied on expertise, political networking, and enough resources to maintain and materialise a coherent project like the ISC. Doctors, physicians and state administrators secured the gatekeeper position of the international public health movement by playing their different expertises to their advantage. Slowly, they eliminated competing social groups from the policy-making process. For this reason, merchants, ship owners, governmental administrators, and passengers played little or no part in either the ISC itself or the consecutive ratification process.

Organised by the French Minister of Foreign Affairs, the International Sanitary Conference hosted a total of 24 diplomatic and medical delegates. Chapter two showed that these envoys were carefully selected to ensure that their diplomatic and medical agendas were aligned with those of the states they represented. This was an important affair, since diplomats and doctors came in all shapes and sizes regarding their aetiological and prophylactic positions.

In the case of physicians, their position was based around two operative axes: contagionist/anti-contagionist; and pro-quarantine/anti-quarantine. Pure contagionists believed that disease-causing matter could travel and was transmitted through the communication of people and objects, while anti-contagionists believed that atmospheric and physical environments – miasmas – caused diseases when inhaled by humans. In this sense, contagionists believed in the power of quarantine to establish a barrier between contaminated and healthy bodies, while anti-contagionists argued that only the improvement of atmospheric and physical environment could prevent the emergence of diseases. Scholars have long argued that in reality these concepts were fluid and that physicians positioned themselves at various points along the two axes. Delegates to the ISC not only embodied the fluidity of categories, but also showed the extensiveness of this argument by their ability to compromise their aetiological and prophylactic stands. The International Sanitary Convention and Regulation were not underpinned by pure contagionist or anti-contagionist arguments but by that which resulted from the negotiations between actors diversely positioned along these axes.

As a pioneer event that opened the diplomatic world to another professional group, the ISC struggled to establish a protocol. Despite their aim to create a common sanitary system in the Mediterranean, organisers and delegates alike argued that the ISC was not a space for scientific and political discussion. Instead, the works of the Conference were to be commanded by a practical sense, allowing delegates to create a rational quarantine system that both prevented public health threats and enabled the speedy circulation of vessels, people, and cargo. In many ways, the boundary work, that was developed to separate the ISC from scientific debate, was carried out in order to confer credibility to the Conference. By declaring the ISC as a space outwith scientific production, organisers aimed to distance themselves from numerous scientific establishments (such as medical academies and societies) that struggled to secure aetiological and prophylactic consensus when embarking in *ad nauseam* missions to accumulate anecdotical epidemic evidence. The ISC was not meant to be a place of research but instead a place for circulation of practical knowledge. In addition, the ISC was not concerned with individual subjects of epidemic diseases:

the programmes did not address such issues, and delegates did not acknowledge the existence of individuals searching for medical relief in cases of disease.

The ISC, its delegates and the participating states constructed international public health as a world of international regulation. This is clear from looking at the expected products of the Conference: an international sanitary convention that would institute international policy guidelines and an international sanitary regulation that would detail the internationalisation of public health in the Mediterranean region. Expectations regarding the role of delegates in this process were less clear. Were doctors to be subordinate to diplomats, since the ISC ultimately aimed to produce an international treaty, or should diplomats hold an inferior position due to the medical expertise of physicians? The answer to this question once again encapsulated an important problem: was international public health a medical or diplomatic affair? The voting system adopted by the Conference sheds light on this problem. Delegates to the ISC decided that instead of voting by country, each delegate would have a vote. Thus, doctors and diplomats held equal representation power. However, delegates operated under national instructors, and were also part of professional groups interested in influencing the international public health agenda. As such, delegates were governed by different – and sometimes conflicting – loyalties. They owed loyalty to their sovereigns, governments, and foreign offices; to their professional institutions; and, at the same time – as legitimate professionals – to their own convictions. Aware of these conflicting loyalties, states devised ways of coercing delegates to protect their specific agendas.

The practical dimension of the ISC was further highlighted in chapter three, where the thin boundaries between politics and science were exposed. Most delegates arrived at the ISC with clear aetiological models, but for the sake of common agreement, these beliefs were subjected to extensive negotiations. Rather than defining the nature of diseases, it was considered more important for delegates to focus their efforts on establishing the value of quarantine in the context of an international public health system. This effort, the chapter showed, resulted from the capacity of states to assert their power while delegates were mobilising scientific and

political arguments in the debate in order to substantiate their choices. Based on these efforts, the ISC declared that only three diseases – plague, yellow fever, and cholera – should be classified as subject to quarantine. This decision narrowed the scope of international public health, since its actions were limited to quarantining the above diseases. In this sense, international public health was not designed to create better urban settings, educate people, or provide clean water and construct efficient sewage systems, as anti-contagionists would have preferred. Instead, it was imagined as a set of mechanisms created to prevent three diseases from reaching European territory. However, the Conference products were not rooted in contagionist concerns alone. Delegates planned detailed inspections of vessels, crew, passengers, and cargo in order to certify that no nuisances were present to initiate the development of diseases.

The last chapter looked at the struggle between national and international interests. For the sake of European public health, delegates developed careful administrative proceedings and reorganised sanitary institutions in accordance with a unified model. As an internationalist movement, the ISC found that self-legitimacy interfered with the governance of national affairs for the sake of the common good. Actions such as the introduction of standard sanitary administrations were controversial, but allowed states to strike bargains and put forward their agendas. By allowing the ISC to regulate their private businesses, states secured additional advantages in return. This may have been symbolic of the belief that the changes would contribute to a safer world, but it could also allow for claims-making in spheres other than public health.

As in all aspects of social life, negotiation power was not equally shared among participants. In fact, though European states only agreed to a network of local boards of health placed under the direct control of central states, in the case of the Levant, the ISC imposed a powerful interventionist strategy that included – in many regards – the legitimate colonisation of Oriental public health institutions. In many ways, this decision was made with the aim of building a protective ring around Europe that would block the circulation of epidemic diseases. Participants believed that with the establishment of such a protective ring, quarantine would be eliminated in Europe

and vessels, trade, people, and cargo would be able to circulate without disruptions. This promoted the stereotype of the Orient as a black hole of disease and death that permanently threatened Europe. International public health, as constructed by the ISC, was a complex phenomenon that involved sentiments of superiority and civilisation, both of which justified direct interventions.

Ultimately, the model of international public health designed by the ISC was never implemented. States found that the advantages of the model were not great enough to consider compromising their autonomy and control over sanitary policies. However, the legacy of the ISC reached far beyond the printed proceedings of the Conference. In 1859, a new ISC was convened in Paris, and prior to 1938, eleven further International Sanitary Conferences were organised in cities such as Constantinople, Vienna, Rome, and Washington. Not only did the topics under analysis change over the years, but also the type of expectations, rules, and outcomes. However, as the first ISC, the 1851 meeting served as a foundation for the international public health movement regarding practices, rules, and aims.

BIBLIOGRAPHY

Primary sources

-. "Bradshaw's General Railway and Steam Navigation Guide, for Great Britain and Ireland." London: Bradshaw's Railway Information Office, 1855.

[*the editor*]. "To Correspondents." *The Lancet* 54, no. 1366 (1849): 494.

Adelon, Louis Florentin Calmeil, Jean-Jacques Cazenave, Jean Marc Gaspard Itard, Pierre-Nicolas Gerdy, Dance, Delmas*, et al. Dictionnaire De Médecine Ou Répertoire Général Des Sciences Médicales Considérées Sous Le Rapport Théorique Et Pratique*. Deuxième édition, entièrement refondue et considérablement augmentée ed. Paris: Béchet et Labé, 1832. Texte imprimé.

Beaude, Jean Pierre. *Dictionnaire De Médecine Usuelle È L'usage Des Gens Du Monde*. 2 vols. Vol. 1, Paris: Didier, 1849.

Bergeron, J. "Êloge De M. Mêlier. Lu Dans La Séance Du 11 Décembre 1888." *Mémoires de l'Académie de Médecine* 36 (1891): 1-37.

Betti, Pietro. *Cenni Sul Modo Di Preservarsi Dal Cholera-Morbus E Per Amministrare I Primi, E I Piu Pronti Soccorsi a Chi Ne Cadesse Malato Coll'aggiunta Di Un'istruzione Sul Modo Di Purificare Gli Individui, E Disinfettare Le Stanze, E Le Robe, Che Hanno Servito Al Ricovero, E All'uso Delle Persone Affette Dalla Stessa Malattia*. Livorno: Bertani, 1835.

Bo, Angelo. *Sulla Dottrina Dei Contagi E Delle Malattie Contagiose Considerata Ne' Suoi Rapporti Colla Pubblica Preservazione: Commentari*. Genova: Tipografia dei Fratelli Pagano, 18--.

———. *Sulle Quarantene Contro La Febbre Gialla D'america E Sulla Inefficacia Degli Ordinamenti Quarantenari Della Francia: Relazione Di Una Commissione Creata Dal Consiglio Generale Di Sanita Marittima Sedente in Genova*. Genova: Tipogrfia dei Fratelli Pagano, 1850.

Bulard, A. "Congres Sanitaire Europeen." *Journal de débats politiques et litteraires*, 10 November 1838, 3-4.

Cappello, Agostino. *Cholera Morbus, Ossia, Della Febbre Pestilenziale Colerica*. Rome: Presso Antonio Boulzaler, 1851.

———. *Esame Critico Sopra La Officiale Relazione Del Corso E Degli Effetti Del Cholera Morbus in Parigi E Ne Suoi D'intorni : Pubblicata Dal Governo Francese Nel 1834 / Di Agostino Cappello*. Rome: Boulzaler, 1835.

———. *Esperimenti Pel Cholera Morbus* Roma: Tip. Belle Arti, 1838.

———. *Risposta Ad Alcuni Articoli Stranieri Intorno Il Cholera - Morbus Di Ancona*. S.L., 1836.

Cappello, Agostino, and Achille Lupi. *Storia Medica Del Cholera Indiano Osservato a Parigi Da Agostino Cappello E Da Achille Lupi Cola Inviati Dal Sommo Pontefice Gregorio 16. Nell'anno 1832*. Roma: Stamperia Camerale, 1833.

Carbonaro, Giuseppe. *Epitome Sul Cholera-Morbus Asiatico Osservato in Livorno Nel 1835*. Napoli: Trani, 1836.

———. *Intorno Al Cholera-Morbus; Osservazioni Pratiche Fatte in Napoli Nel 1836 E 1837*. Napoli: Trani, 1849.

———. *Intorno Al Rapporto Su La Peste E Le Quarantene, Fatto a Nome Di Una Commissione Alla Reale Accademia Di Medicina Di Francia Dal Dottore Prus; Osservazioni*. Napoli: Cataneo, 1847.

———. *La Peste Orientale Relativamente Al Sistema Delle Quarantene*. Napoli,: Cataneo, 1845.

Chadwick, Edwin. *The Papers of Sir Edwin Chadwick, 1800-1890*. Brighton, Sussex, England: Harvester Press Microform Publications, 1983.

———. *Report on the Sanitary Condition of the Labouring Population of Great Britain: A Supplementary Report on the Results of a Special Inquiry into the Practice of Interment in Towns, Made at the Request of Her Majesty's Principal Secretary of State for the Home Department*. London: Her Majesty's Stationery Office, 1843.

"The Cholera." *The Lancet* 16, no. 413 (30 July 1831): 572.

"Cholera Morbus: Forms of Prayers to Be Read in All Churches." *Times*, 7 November 1831, 4.

"Cholera Morbus: Opinions and Facts Respecting the Disease." *Times*, 12 November 1831.

Correia, Gaspar. *Lendas Da India*. Lisboa: Edição da Academia Real das Sciencias, 1859.

Curiosities of Communication: The Road. The Railway. The Electric Telegraph. The Sail and the Steamer. Ocean Steamers. Foreign Mails. Travelling Hours. London: C. Knight, 1851.

Dupeyron, Ségur. *Rapport Adressé À Son Exc. Le Ministre Du Commerce*. Paris: L'Imprimerie Royale, 1834.

"Epidemiological Society: Monday, Dec 2 1850 - Dr Babington, President." *The Lancet* 56, no. 1423 (7 December 1850 1850): 639-42.

"Epidemiological Society: The Address of Dr. Babington on His Proposing the Establishment of This Society, at the General Meeting Held at the Hanover Square Rooms, July 30, 1850." *The Lancet* 56, no. 1412 (21 September 1850): 354-55.

General Board of Health. *Report of the General Board of Health on the Epidemic Cholera of 1848 & 1849*. London,: W. Clowes, 1850.

———. *Report on Quarantine*. London: W. Clowes & Sons for H.M.S.O., 1849.

Grande, José Maria. *Guia E Manual Do Cultivador Ou Elementos De Agricultura*. Lisboa: Impressão da Epoca, 1849.

Great Britain Foreign Office. *Correspondence Relative to the Contagion of Plague and the Quarantine Regulations of Foreign Countries, 1836-1843*. London: Harrison, 1843.

Hecker, J. F. C., and Benjamin Guy Babington. *The Black Death in the Fourteenth Century*. London,: A. Schloss, 1833.

Holroyd, Arthur Todd. *The Quarantine Laws: Their Abuses and Inconsistencies; a Letter Addressed to the Rt. Hon. Sir John Cam Hobhouse, Bart. M.P., President of the Board of Control*. London: Simpkin, Marshall & Co, 1839.

Martens, Charles de. *Le Guide Diplomatique. Précis Des Droits Et Des Donctions Des Agents Diplomatiques Et Consulaires*. 5 ed. Vol. 1, Paris: A. Durand, 1866.

Martens, Karl von, and Ferdinand de Wegmann. *Le Guide Diplomatique: Précis Des Droits Et Des Fonctions Des Agents Diplomatiques Et Consulaires; Suivi D'un Traité Des Actes Et Offices Divers Qui Sont Du Ressort De La Diplomatie, Accompagné De Pièce Et Documents Proposés Comme Exemples*. 2 vols. Vol. 1, Paris: Gavelot Jeune, 1851.

———. *Le Guide Diplomatique: Précis Des Droits Et Des Fonctions Des Agents Diplomatiques Et Consulaires; Suivi D'un Traité Des Actes Et Offices Divers Qui Sont Du Ressort De La Diplomatie, Accompagné De Pièce Et Documents Proposés Comme Exemples*. 2 vols. Vol. 2, Paris: Gavelot Jeune, 1851.

Matthews, Henry. *The Diary of an Invalid: Being the Journal of a Tour in Pursuit of Health, in Portugal, Italy, Switzerland, and France, in the Years 1817, 1818, and 1819*. Paris: Baudry, 1836.

Mêlier, François. *De La Santé Des Ouvriers Employés Dans Les Manufactures De Tabac, Rapport Lu À L'académie Royale De Médecine, Dans Sa Séance Du 22 Avril 1845*. Paris: J B Baillière, 1845.

"Messrs Bowring and Holroyd on the Oriental Plague and Quarantine. Observations on the Oriental Plague, and on Quarantine, as a Means of Arresting Its Progress. Addressed to Teh British Association of Scinece, Assembled at Newcastle, August 1838. By John Bowring. Edinburgh, 1838. 8vo. Pp. 45. And the Quarantine Laws, Their Abuses and Inconsistencies. A Letter Addressed to the Right Hon. Sir John C. Hobhouse, Bart., Mp, President of the Board of Control by Arthur T Holroyd." *Edinburgh Medical & Surgical Journal*, no. 147 (1 April 1841): 491-519.

Milroy, Gavin. "Memoir of Benjamin Guy Babington M.D., F.R.S., Etc." *Transactions of the Epidemiological Socieity of London* 2 (1867).

Ministère des Affaires Étrangères de France. *Procès-Verbaux De La Conférence Sanitaire Internationale*. Vol. 1, Paris: Imprimerie nationale, 1852.

Monlau, Pedro Felipe. "Congresso Sanitario De Paris En 1851-52." *El Monitor de la Salud de las Familias y de la Salubridad de los Pueblos* 3, no. 1 (January 1860): 4-8.

———. *Elementos De Higiene Privada*. Barcelona: Imprenta de D. Pablo Riera, 1846.

P.M. "Lloyd Vapore Austriaco - Egyptian Quarantine and Steam Navigation in the Red Sea. To the Editor Fo the Times." *Times*, 15 December 1838.

Pouchet. "Infusoires Das Les Déjections Des Cholériques (Extrait D'une Lettre De M Puchet)." *Compte Rendu des séances de l'académie des sciences* 28, no. 1 (1849): 555-6.

Prus, Renés-Clovis. *Rapport a L'académie Royale De Médecine Sur La Peste Et Les Quarantaines*. Paris: Chez J.-B. Bailliére, 1846.

"The Quarantine Congress." *London medical gazette* 47, no. 24 January (1851): 175.

"The Quarantine Laws, Their Abuses and Inconsistencies. A Letter Addressed to the Right Hon. Sir John C. Hobhouse, Bart., Mp, President of the Board of

Control by Arthur T Holroyd." *Dublin Journal of Medical Science*, no. 44 (1 May 1839): 278.

Quarantine Laws. Abstracts of Returns of Information on the Laws of Quarantine Which Have Been Obtained by the Board of Trade. P5; 1860 (568-I) Lx.191.

Royal College of Physicians of London. *Report on the Nature and Import of Certain Microscopic Bodies Found in the Intestinal Discharges of Cholera*. London: J. Churchill, 1849.

Snow, John. *On the Mode of Communication of Cholera*. London: John Churchill, 1849.

———. "On the Pathology and Mode of Communication of Cholera." *London Medical Gazette* 44 (1849): 745-52M 923-29.

Sutherland, John, and Great Britain. General Board of Health. *Appendix (a) to the Report of the General Board of Health on the Epidemic Cholera of 1848 & 1849*. London,: W. Clowes & sons, 1850.

United States Permanent Court of Arbitration. *North Atlantic Coast Fisheries Arbitration. Appendix to the Counter Case of the United States before the Permanent Court of Arbitration at the Hague under the Provisions of the Special Agreement between the United States of America and Great Britain Concluded January 27, 1909*. Washington 1909.

Wise, Henry. *An Analysis of One Hundred Voyages to and from India, China, &C., Performed by Ships in the Honorable East India Company's Service*. London: J.W. Norie, 1839.

World's Temperance, Convention, and Thomas Beggs. *The Proceedings of the World's Temperance Convention : Held in London, August 4th, and Four Following Days, with the Papers Laid before the Convention, Letters Read, Statistics and General Information Presented, &C., &C*. London: C. Gilpin, 1846.

Secondary sources

Abbott, Andrew. *The System of Professions : An Essay on the Division of Expert Labor*. Chicago ; London: University of Chicago Press, 1988.

Ackerknecht, Erwin. "Anticontagionism between 1821 and 1867." *Bulletin for the History of Medicine* 48, no. 22 (1948): 562-93.

———. "Hygiene in France, 1815-1848." *Bulletin for the History of Medicine* 22, no. 2 (1948): 117-55.

Alder, Ken. *The Measure of All Things : The Seven-Year Odyssey and Hidden Error That Transformed the World*. New York: Free Press, 2002.

Association belge pour la liberté commerciale. *Congrès Des Économistes Réuni À Bruxelles Par Les Soins De L'association Belge Pour La Liberté Commerciale*. Bruxelles: Imprimerie de Deltombe, 1847.

Auerbach, Jeffrey A. *The Great Exhibition of 1851: A Nation on Display*. London: Yale University Press, 1999.

Baldwin, Peter. *Contagion and the State in Europe, 1830-1930*. Cambridge: Cambridge University Press, 1999.

Barnes, Barry. "On the Conventional Character of Knowledge and Cognition." *Philosophy of the Social Sciences* 11 (1981): 303-33.
Barnes, Barry, David Bloor, and John Henry. *Scientific Knowledge: A Sociological Analysis*. London: Athlone, 1996.
Barnes, David S. *The Great Stink of Paris and the Nineteenth-Century Struggle against Filth and Germs*. Baltimore: Johns Hopkins University Press, 2006.
———. *Lazaretto, Epidemics, Politics, and Quarantine in a Nineteenth-Century City*. forthcoming.
Bartlett, C. J. *Great Britain and Sea Power, 1815-1853*. Oxford: Clarendon Press, 1963.
Bashford, Alison, and Claire Hooker. *Contagion: Historical and Cultural Studies*. London: Routledge, 2001.
Becker, Howard Saul, and Michal M. McCall. *Symbolic Interaction and Cultural Studies*. Chicago: University of Chicago Press, 1990.
Beirne, Piers. "Adolphe Quetelet and the Origins of Positivist Criminology." *The American Journal of Sociology* 92, no. 5 (1987): 1140-69.
Berger, Stefan. *A Companion to Nineteenth-Century Europe, 1789-1914*. Blackwell Companions to European History. Oxford: Blackwell Publishing, 2006.
Bloor, David. "Durkheim and Mauss Revisited: Classification and the Sociology of Knowledge." *Studies in History and Philosophy of Science* 13, no. 4 (1982): 267-97.
———. "Idealism and the Sociology of Knowledge." *Social Studies of Science* 26, no. 4 (1996): 839-56.
———. *Wittgenstein, Rules and Institutions*. London: Routledge, 1997.
Blumer, Herbert. *Symbolic Interactionism: Perspective and Method*. Berkeley: University of California Press, 1986.
Bolsover, G. H. "Lord Ponsonby and the Eastern Question (1833-1839)." *The Slavonic and East European Review* 13, no. 37 (1934): 98-118.
Bonifácio, Maria Fátima. "1834-42: A Inglaterra Perante a Evolução Política Portuguesa (Hipóteses Para a Revisão De Versões Correntes)." *Análise Social* 20, no. 83 (1984): 467-88.
———. "A 'Causa' De D. Maria Ii (1826-1834)." *Análise Social* 39, no. 172 (2004): 519-45.
———. "Costa Cabral No Contexto Do Liberalismo Doutrinário." *Análise Social* 28, no. 123-4 (1993): 1043-91.
———. "«a Guerra De Todos Contra Todos» (Ensaio Sobre a Instabilidade Política Antes Da Regeneração)." *Análise Social* 27, no. 115 (1992): 91-134.
———. "Segunda Ascensão E Queda De Costa Cabral (1847-1851)." *Análise Social* 32, no. 142 (1997): 537-56.
Booker, John. *Maritime Quarantine: The British Experience, C.1650-1900*. Aldershot: Ashgate, 2007.
Bowker, Geoffrey C., and Susan Leigh Star. *Sorting Things Out: Classification and Its Consequences*. Inside Technology. London: MIT Press, 1999.
Bridge, F. R., and Roger Bullen. *The Great Powers and the European States System 1815-1914*. London: Longman, 1980.
Briggs, Asa. "Cholera and Society in the Nineteenth Century." *Past and Present* 19, no. April (1961 1961): 76-96.

Bulmer, Martin. *The Chicago School of Sociology: Institutionalization, Diversity, and the Rise of Sociological Research*. Chicago: University of Chicago Press, 1984.

Butterfield, Herbert. *The Whig Interpretation of History*. London: G. Bell and sons, 1931.

Byers, Bruce. "Ecoregions, State Sovereignty and Conflict." *Security Dialogue* 22, no. 1 (1991).

Bynum, W. F. "Policing Hearts of Darkness: Aspects of the International Sanitary Conferences." *History and Philosophy of the Life Sciences* 15 (1993): 421-34.

Carr, Raymand. "Spain and Portugal, 1793 to C. 1840." In *War and Peace in an Age of Upheaval 1793–1830*, edited by C. W. Crawley. 439-61: Cambridge University Press, 1965.

Cassedy, James H. . "John L. Riddell's Vibrio Biceps: Two Documents on American Microscopy and Cholera Etiology 1849-59." *J Hist Med Allied Sci* XXVIII, no. 2 (April 1, 1973 1973): 101-08.

Chadwick, Edwin, and M. W. Flinn. *Report on the Sanitary Condition of the Labouring Population of Great Britain: 1842*. Edinburgh: Edinburgh University Press, 1965.

Chahrour, Marcel. "'A Civilizing Mission'? Austrian Medicine and the Reform of Medical Structures in the Ottoman Empire, 1838-1850." *Studies in History and Philosophy of Science Part C: Studies in History and Philosophy of Biological and Biomedical Sciences* 38, no. 4 (2007): 687-705.

Chapman, Tim. *The Congress of Vienna : Origins, Processes, and Results*. London ; New York: Routledge, 1998.

Cipolla, Carlo M. *Fighting the Plague in Seventeenth-Century Italy*. Madison: University of Wisconsin Press, 1981.

———. *Miasmas and Disease : Public Health and the Environment in the Pre-Industrial Age*. New Haven ; London: Yale University Press, 1992.

Clarke, Adele, and Elihu Gerson. "Symbolic Interactionism in Social Studies of Science." In *Symbolic Interaction and Cultural Studies*, edited by Howard Saul Becker and Michal M. McCall. 286 p. Chicago: University of Chicago Press, 1990.

Cleveland, W.L., and M.P. Bunton. *A History of the Modern Middle East*. Boulder, CO: Westview Press, 2009.

Coleman, William. "Epidemiological Methood in the 1860s: Yellow Fever at Saint-Nazaire." *Bulletin for the History of Medicine* 58, no. 2 (1984): 145.

———. *Yellow Fever in the North. The Methods of Early Epidemiology*. Madison: University of Wisconsin Press, 1987.

Collinson, D.S. "The Rhine Regime in Transition--Relations between the European Communities and the Central Commission for Rhine Navigation." *Columbia Law Review* 72, no. 3 (1972): 485-516.

Coons, Ronald E. "Steamships and Quarantines at Trieste, 1837–1848." *Journal of History of Medicine and Allied Sciences* 44, no. 1 (1989): 28-55.

Oxford Dictionary of National Biography. online edition ed. Oxford: Oxford University Press, 2004.

Cooter, Roger. "Anticontagionism and History's Medical Record." In *The Problem of Medical Knowledge: Examining the Social Construction of Medicine*, edited

by Peter Wright and Andrew Treacher. 87-108. Edinburgh: Edinburgh University Press, 1982.
Costa, Americo. *Diccionario Chorographico De Portugal Continental E Insular: Hydrographico, Historico, Orographico, Biographico, Archeologico, Heraldico, Etymologico*. 12 vols Porto1929.
Council of Europe. "Commission Centrale Pour La Navigation Du Rhin." *European yearbook* 14 (1966).
Crozier, Anna. *Practicing Colonial Medicine*. New York: I. B. Tauris, 2007.
Durey, Michael. *The Return of the Plague: British Society and the Cholera, 1831-2*. Dublin : [New York] :: Gill and Macmillan Humanities Press, 1979.
Evans, R. J. "Epidemics and Revolutions - Cholera in 19th-Century Europe.". *Past & Present*, no. 120 (AUG 1988): 123-46.
Evans, Richard J. *Death in Hamburg: Society and Politics in the Cholera Years, 1830-1910*. Harmondsworth: Penguin, 1990.
"Experiments on the Mode of Propagation of the Cholera." *The Lancet* 16, no. 409 (1831): 417-48.
Finnegan, Diarmid. "The Spatial Turn: Geographical Approaches in the History of Science." *Journal of the History of Biology* 41, no. 2 (2008): 369-88.
Foucault, Michel. *The Archaeology of Knowledge*. London: Routledge, 1989.
———. *The Birth of the Clinic. An Archeology of Medical Perception*. New York: Vintage Books, 1994.
———. *The Order of Things: An Archaeology of the Human Sciences*. London: Tavistock Publications, 1970.
Galison, Peter. *Einstein's Clocks and Poincaré's Maps : Empires of Time*. 1st ed. New York: W.W. Norton, 2003.
Goedeke, T. L., and S. Rikoon. "Otters as Actors: Scientific Controversy, Dynamism of Networks, and the Implications of Power in Ecological Restoration." *Social Studies of Science* 38, no. 1 (February 2008): 111-32.

Greene, Ann Norton. *Horses at Work: Harnessing Power in Industrial America*. Cambridge, MA: Harvard University Press, 2008.
Gül, Murat. *The Emergence of Modern Instanbul. Transformaton and Modernisation of a City*. London: I.B. Tauris Publishers 2009.
Gutchen, Robert M. "Local Improvements and the Centralization in Nineteenth-Century England." *The Historical Journal* 4, no. 1 (1961): 85-96.
Hacking, Ian. *The Social Construction of What?* Cambridge, Mass. ; London: Harvard University Press, 1999.
Hamilton, C. I. *Anglo-French Naval Rivalry, 1840-1870*. Oxford; New York: Clarendon Press ; Oxford University Press, 1993.
Hamlin, Christopher. "Predisposing Causes and Public Health in Early Nineteenth-Century Medical Thought." *Social History of Medicine* 5, no. 1 (1992): 43-70.
———. *Public Health and Social Justice in the Age of Chadwick : Britain, 1800-1854*. Cambridge: Cambridge University Press, 1998.
———. "State Medicine in Great Britain." In *The History of Public Health and the Modern State*, edited by Dorothy Porter. vii, 439 p ; 23cm. Amsterdam: Rodopi, 1994.
Harvey, David. *Paris, Capital of Modernity*. New York: Routledge, 2003.

Headrick, Daniel R. *The Invisible Weapon: Telecommunications and International Politics, 1851-1945*. New York ; Oxford: Oxford University Press, 1991.
Hildesheimer, Françoise. "Marseille, Capitale Sanitaire De La France." In *110 Congrès national des sociétés savantes*, 135-49. Montpellier: Histoire Modern, 1985.
Hobsbawm, E. J. *The Age of Revolutions, 1789-1848*. London: Abacus, 1962.

Holt, H. T. E. "Holroyd, Arthur Todd (1806 - 1887)." In *Australian Dictionary of Biography*. 441-2. Melbourne: Melbourne University Press, 1972.
Horward, D. D. "Wellington and the Defense of Portugal." *International History Review* 11, no. 1 (Feb 1989): 39-54.
Hoskins, Halford Lancaster. *British Routes to India*. New York: Longmans, Green and co., 1928.
Howard-Jones, Norman. *International Public Health between the Two World Wars : The Organizational Problems*. History of International Public Health ; No.3. Geneva :: World Health Organization, 1978.
———. *The Scientific Background of the International Sanitary Conferences, 1851-1938*. Geneva: World Health Organization, 1975.
Huber, Valeska. "The Unification of the Globe by Disease? The International Sanitary Conferences on Cholera, 1851-1894." *The Historical Journal* 49, no. 2 (2006): 454-76.
Jasanoff, Sheila. *States of Knowledge: The Co-Production of Science and Social Order*. London: Routledge, 2004.
Jordanova, Ludmilla. "The Social Construction of Medical Knowledge ". *Social History of Medicine* 8, no. 3 (1995): 361-81.
Kaluszynki, Martine. "Les Congrès Internationaux D'anthropologie Criminelle (1885-1914)." *Mil neuf cent. Cahiers George Sorel*, no. 7 (1989): 59-70.
Karsh, Efraim, and Inari Karsh. *Empires of the Sand: The Struggle for Mastery in the Middle East, 1789-1923*. Cambridge, MA: Harvard University Press, 1999.
Kiewiet, D. Roderick, and Mathew D. McCubbins. *The Logic of Delegation : Congressional Parties and the Appropriations Process*. American Politics and Political Economy Series. Chicago: University of Chicago Press, 1991.
Klejman, Laurence. "Les Congrès Féministes Internationaux." *Mil neuf cent. Cahiers George Sorel*, no. 7 (1989): 71-86.
Kuhnke, LaVerne. "Resistance and Response to Modernization: Preventive Medicine and Social Control in Egypt, 1825-1850." Dissertation (PhD), The University of Chicago, 1971.
La Berge, Ann Elizabeth Fowler. *Mission and Method: The Early Nineteenth-Century French Public Health Movement*. Cambridge History of Medicine. Cambridge ; New York: Cambridge University Press, 1992.
Lacey, Michael J., and Mary O. Furner. *The State and Social Investigation in Britain and the United States*. Woodrow Wilson Center Series. Cambridge: Cambridge University Press, 1993.
Ladurie, Emmanuel Le Roy. "A Concept: The Unification of the Globe by Disease (Fourteenth and Seventeenth Centuries)." In *The Mind and Method of the Historian*, edited by Emmanuel LeRoy Ladurie. Chicago: University of Chicago Press, 1978.

Leonhard, Jörn. "The Rise of the Modern Leviathan: State Functions and State Features." In *A Companion to Nineteenth-Century Europe*, edited by Stefan Berger. Oxford: Blackwell, 2006.
Lewis, Bernard. *The Emergence of Modern Turkey*. London: Oxford University Press, 1968.
Lewis, Michael. *The Navy in Transition, 1814-1864; a Social History*. [London]: Hodder and Stoughton, 1965.
Lewis, Richard Albert, and Henry R. Viets. *Edwin Chadwick and the Public Health Movement, 1832-1854*. London ; New York: Longmans, Green, 1952.
Lilienfeld, D. E. ""The Greening of Epidemiology": Sanitary Physicians and the London Epidemiological Society (1830-1870)." *Bulletin of the History of Medicine* 52, no. 4 (Winter 1978): 503-28.
Litfin, K. T. "Sovereignty in World Ecopolitics." *The International Studies Review* 41, no. 2 (1997): 167-204.
Livingstone, David. *Putting Science in Its Place: Geographies of Scientific Knowledge*. Chicago: University of Chicago Press, 2003.
Livingstone, David N. *Science, Space and Hermeneutics: Hettner-Lecture 2001*. Hettner-Lectures;. Heidelberg: Dept. of Geography, University of Heidelberg, 2002.
Mann, Michael. *The Sources of Social Power. The Rise of Classes and Nation States, 1760-1914*. Cambridge: Cambridge University Press, 1993.
Marsot, Afaf Lutfi Al-Sayyid. *Egypt in the Reign of Muhammad Ali*. Cambridge: Cambridge University Press, 1984.
Maynard, Douglas. "Reform and the Origin of the International Organization Movement." *Proceedings of the American Philosophical Society* 107, no. 3 (1963): 220-31.
McDonald, J. C. "The History of Quarantine in Britain During the 19th Century." [In eng]. *Bulletin of the History of Medicine* 25, no. 1 (Jan-Feb 1951): 22-44.
Mónica, Maria Filomena. *Dicionário Biográfico Parlamentar : 1834-1910*. Vol. 2, Lisboa: Imprensa de Ciências Sociais, 2005.
Morris, R. J. *Cholera, 1832: The Social Response to an Epidemic*. London: Croom Helm, 1976.
Mullett, C. F. "A Century of English Quarantine, 1709-1825." *Bulletin of the History of Medicine* 23, no. 6 (Nov-Dec 1949): 527-45.
Mulligan, William. "Restrained Competition: International Relations." In *A Companion to Nineteenth-Century Europe*, edited by Stefan Berger. Oxford: Blackwell, 2006.
Nicolson, Harold. *The Congress of Vienna : A Study in Allied Unity 1812-1822*. Cassell History. London: Cassell, 1989.
Owen, Roger. *The Middle East in the World Economy, 1800-1914*. Rev. pbk. ed. London ; New York: I.B. Tauris, 1993.
Pack, S. W. C. *Sea Power in the Mediterranean: A Study of the Struggle for Sea Power in the Mediterranean from the Seventeenth Century to the Present Day*. London: Barker, 1971.
Payne, J. F. "Babington, Benjamin Guy (1794–1866)." In *Oxford Dictionary of National Biography*. Oxford University Press, 2004.
Payne, Stanley G. *A History of Spain and Portugal*. 2 vols. Vol. 2, Madison: University of Wisconsin Press, 1973.

Pedreira, Jorge Miguel Viana. "From Growth to Collapse: Portugal, Brazil, and the Breakdown of the Old Colonial System (1750-1830)." *Hispanic American Historical Review* 80, no. 4 (2000): 839-64.

Pelling, Margaret. *Cholera, Fever and English Medicine, 1825-1865*. Oxford: Oxford University Press, 1978.

———. "Contagion/Germ Theory/Specificity." In *Companion Encyclopedia of the History of Medicine*, edited by W. F. Bynum and Roy Porter. 292-308. London: Routledge, 1993.

———. "The Meaning of Contagion: Reproduction, Medicine and Metaphor." In *Contagion: Historical and Cultural Studies*, edited by Alison Bashford and Claire Hooker. London: Routledge, 2001.

Platt, D. C. M. *Finance, Trade, and Politics in British Foreign Policy 1815-1914*. Oxford, London: Clarendon, 1968.

Pollitzer, Robert. "Cholera Studies." *Bulletin of the World Health Organization* 10, no. 3 (1954 1954): 421-61.

Porter, Dorothy. *Health, Civilization, and the State: A History of Public Health from Ancient to Modern Times*. London: Routledge, 1999.

———. *The History of Public Health and the Modern State*. The Wellcome Institute Series in the History of Medicine, Clio Medica ; 26. Amsterdam: Rodopi, 1994.

Porter, Theodore M. *The Rise of Statistical Thinking, 1820-1900*. Princeton, N.J.: Princeton University Press, 1986.

———. *Trust in Numbers: The Pursuit of Objectivity in Science and Public Life*. Princeton, N.J.: Princeton University Press, 1995.

Prochasson, Christophe. "Les Congrès: Lieux De L'échange Intellectuel. Introduction." *Mil neuf cent. Cahiers George Sorel*, no. 7 (1989): 5-8.

Purkhardt, S. Caroline. *Transforming Social Representations: A Social Psychology of Common Sense and Science*. London: Routledge, 1993.

Raccagni, M. "The French Economic Interests in the Ottoman Empire." *International Journal of Middle East Studies* 11, no. 03 (1980): 339-76.

Ramsey, Matthew. "Public Health in France." In *The History of Public Health and the Modern State*, edited by Dorothy Porter. Atlanta: Rodobi, 1994.

Randeraad, Nico. *States and Statistics in the Nineteenth Century*. Manchester: Manchester University Press, 2010.

Rasmussen, Anne. "Les Congrès Internationaux Liés Aux Expositions Universelles De Paris (1867-1900)." *Cahiers Georges Sorel* 7 (1989): 23-44.

Rosen, George. *A History of Public Health*. Md Monographs on Medical History ; No.1. New York: MD Publications, 1958.

Rosenberg, C. E. "Cholera in Nineteenth-Century Europe - Tool for Social and Economic Analysis." *Comparative Studies in Society and History* 8, no. 4 (1966): 452-63.

Rosenberg, Charles. "Framing Disease: Illness, Society and History." In *Framing Disease: Studies in Cultural History*, edited by Charles Rosenberg and Janet Golden. New Jersey: Rutgers University Press, 1991.

Rueschemeyer, Dietrich, and Theda Skocpol. *States, Social Knowledge, and the Origins of Modern Social Policies*. Princeton, N.J. ; Chichester: Princeton University Press, 1996.

Said, Edward. *Orientalism*. London: Penguin, 1985 [1978].

Sardica, José Miguel. *A Regeneração Sob O Signo Do Consenso: A Política E Os Partidos Entre 1851 E 1861*. Lisboa: ICS, 2001.
Schroeder, Paul W. *The Transformation of European Politics, 1763-1848*. Oxford: Oxford University Press, 1994.
Smith, H. A. "Diplomatic Relations with the Holy See, 1815-1930." *Law Quarterly Review* 48, no. July (1932): 374-93.
Sokal, Alan, and Jean Bricmont. *Intellectual Impostures : Postmodern Philosophers' Abuse of Science*. London: Profile Books, 1998.
Sokal, Alan D. *Beyond the Hoax : Science, Philosophy and Culture*. Oxford: Oxford University Press, 2008.
Sperber, Jonathan. *The European Revolutions, 1848-1851* [in English]. 2nd ed. ed. Cambridge University Press: Cambridge, 2005.
Stokes, E. T. "Bureaucracy and Ideology: Britain and India in the Nineteenth Century ". *Transactions of the Royal Historical Society* 30 (1980): 131-56.
Sussman, George D. "From Yellow Fever to Cholera a Study of French Government Policy, Medical Professionalism and Popular Movements in the Epidemic Crises of the Restoration and the July Monarchy." Dissertation (PhD), Yale University, 1971., 1971.
Tapia, Claude. *Colloques Et Sociétés : La Régulation Sociale*. Publications De La Sorbonne. N.S. Recherches. Paris: Publications de la Sorbonne, 1980.
Tilly, Charles. *Coercion, Capital, and European States, Ad 990-1990*. Studies in Social Discontinuity. Oxford: Blackwell, 1990.
Union of International Associations. *Les Congrès Internationaux De 1681 À 1899*. Brussels1960.
———. *Les Congrès Internationaux De 1681 À 1899: Liste Complète*. Bruxelles: Union des associations internationales, 1960.
Vinten-Johansen, Peter. *Cholera, Chloroform, and the Science of Medicine: A Life of John Snow*. Oxford: Oxford University Press, 2003.
Webster, Charles Kingsley. *The Congress of Vienna, 1814-1815*. New York: Barnes & Noble, 1963.
Wilcken, Patrick. *Empire Adrift: The Portuguese Court in Rio De Janeiro, 1808-1821*. London: Bloomsbury, 2004.
Wise, M. Norton. *The Values of Precision*. New Jersey: Princeton University Press, 1995.
Yapp, Malcolm. *The Making of the Modern near East, 1792-1923*. A History of the near East. London: Longman, 1987.