

Viewpoint

Cholera 1832/Covid-19 2020: We Have Been Here Before

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The arrival of Covid-19 in Britain brought massive changes to everyone's lives. The population faced unprecedented mortality, there was a real threat that health services would be unable to cope with the patient load, and people faced severe restrictions on work and movement. But pandemic disease was not new: from the plague to repeated outbreaks of cholera in the nineteenth century and Spanish flu in 1918, the Scottish population have survived massive disease outbreaks. For a historian, there were strange and unsettling parallels between Covid and earlier pandemics. I joked with a colleague about whether we would have crosses painted on the doors of infected homes, as in the plague of the 1660s. While that did not happen, in both 2020 and in 1666 food was left on doorsteps for isolated inmates. So have we, in some ways, been here before? This essay explores some correspondences and contrasts in the reaction to Covid and to cholera in 1832 in Scotland. Cholera might seem an odd choice for such a comparison – Spanish flu seems a much closer counterpart, both in terms of the disease and of chronology – but flu was a familiar disease whereas cholera, like Covid, was a novel infection. Both required governments, local authorities and individuals to devise new ways of dealing with a potentially fatal illness.

Covid-19 spread around the world at alarming speed. Reports of a pneumonia-like disease occurring in the Chinese city of Wuhan began to appear in January 2020. By the end of the month, cases were identified in France and Germany, and the WHO was warning of a 'public health emergency'. The first confirmed case in Scotland came on 1 March, and by 5 April the disease had caused over three hundred deaths. By early summer, Covid had been linked to over four thousand deaths. Covid-19 spread rapidly thanks to global air travel: cholera travelled by ship and spread far more slowly. The disease began to move out of India in 1829 and by 1831 had reached mainland Europe with the first Scottish case of cholera reported in Haddington in late December 1831. Thereafter the disease travelled rapidly – to Edinburgh, through the Borders and to Glasgow, and northwards to Wick by late July. In total, the outbreak caused around 10,000 deaths.

By the time Covid-19 was confirmed in Scotland, there was a considerable body of knowledge about the virus, the clinical symptoms were well documented and diagnosis could be confirmed by testing. Most patients recovered, but severe

cases required treatment in intensive care units using oxygen or mechanical ventilation. By contrast, doctors in 1832 struggled to get to grips with an unfamiliar disease. Victims of Asiatic cholera were struck down with stomach cramps, violent vomiting and diarrhoea. Death often occurred within a matter of hours and doctors were helpless to treat patients, or even to alleviate their symptoms. However, it proved tricky to separate Asiatic cholera from the similar, but much milder ‘British cholera’, or even diarrhoea or food poisoning. Not surprisingly, there were often debates as to whether Asiatic cholera had genuinely arrived in a community until the severity of the disease and the high mortality rate left little doubt. There was even more debate about how cholera was spread. Practitioners were split between whether cholera emerged spontaneously in dirty environments or was contagious and spread by contact with infected individuals and materials contaminated with body fluids. There was general agreement that certain behaviours rendered individuals susceptible to cholera – excessive drinking, immorality and even fear of catching the disease. Hence, cholera was associated with specific social groups: vagrants, criminals, prostitutes, drunkards were its natural victims, and sometimes cited as proof that cholera was a form of divine retribution for sin. In practice, of course, the disease was never so selective.¹

In 2020, Covid was a national emergency. The progress of the outbreak was tracked through national figures of the number of cases and of deaths, and governments in Westminster and the nations (largely) co-ordinated their responses. The NHS was mobilised to treat large numbers of patients, with capacity expanded by sizeable temporary hospitals and also a rapid increase in laboratory testing facilities. The main strategy to limit the spread of infection was the restriction of movement. Governments ordered businesses and schools to close and travel was curtailed. The public was urged to act responsibly, in their own interests and those of the wider community. By staying at home, washing or sanitising hands, and self-isolating, we were all charged with saving lives and protecting the NHS.

By contrast, cholera was perceived to be a fundamentally local problem, and was managed as a series of local outbreaks of disease. Newspapers reported the arrival, increase and then decrease in the number of cases and of deaths within specific communities. A typical account from the *Inverness Journal* for August 1832 announced:

Cholera has at length really appeared at Wick and Thurso, where there have been, we understand, about 20 cases, though few deaths ... At Dingwall there were no new cases yesterday, but the cholera continues there and at Nairn. In Helmsdale nearly thirty individuals have been affected, seventeen of whom died. Golspie is now clear of the disease, but it still lingers at Hilton of Cadboll, Ballintore, and Shadwick.²

¹ C. Hamlin, *Cholera: The Biography* (Oxford, 2009) provides an excellent overview of cholera in Britain and Europe.

² *Inverness Journal*, 17 August 1832.

In 1832, central government's role in public health was limited to organising the quarantine of shipping when threatened by an outbreak of yellow fever. Faced with the approach of cholera, the Westminster government set up a Central Board of Health, which in turn recommended the creation of local boards of health within towns and cities, responsible for taking action within their communities. Such local boards of health drew on the expertise at hand in dealing with disease: they included medical practitioners, members of town and burgh councils and of charities, which dealt with outbreaks of 'fever' (probably typhoid fever and typhus).

The Central Board also issued regulations on controlling the spread of cholera with the main strategy deployed being the cleaning of public spaces. Like the more familiar fever, cholera was linked to filthy conditions, so to prevent the emergence of the disease and reduce its spread, local authorities in towns and cities rolled out tried and tested strategies. Local boards of health organised inspections to identify insanitary areas which might be the breeding-grounds for disease, and councils arranged for streets to be cleaned, dunghills removed and the houses of the poor washed with lime. In Edinburgh, three thousand extra cartloads of filth were removed from houses and cellars, and three thousand rooms, closes and passages were cleaned and whitewashed.³ Residents were encouraged, nagged and threatened into getting rid of their pigs, and removing all accumulations of dung and filth from businesses such as tanneries and slaughterhouses. While larger centres had the resources to carry out additional cleaning, much less was done in smaller towns and in rural areas. In Perth, for example, though nuisances were quickly identified, it was some time before improvements were made.⁴

To curtail the spread of infection, local boards recorded and treated cholera patients, and instituted measures to avoid contamination from victims. All medical practitioners were required to report cases of cholera to the local board of health, who in turn sent returns to the Central Board. For those residents unable to afford to pay for care, local boards appointed medical officers to attend all cases in their area free of charge. Medicines were given to anyone suffering 'premonitory symptoms' of cholera – any form of diarrhoea – in the hope that early treatment would prevent patients developing the full-blown disease. Just as local authorities had set up temporary fever hospitals, cholera hospitals were established where victims could be isolated and treated. Glasgow created five temporary hospitals in warehouses and mills, although only one was used. While it was hoped that large numbers of patients would request admission to hospital when suffering from early symptoms, relatively few came forward for treatment, and most were very seriously ill. Not surprisingly, mortality was

³ R. Christison, 'Account of the Arrangements Made by the Edinburgh Board of Health, Preparatory to the Arrival of Cholera in That City', *Edinburgh Medical and Surgical Journal*, Supplement to vol. 37 (1832), ccliv–cclxxxviii.

⁴ Perth and Kinross Council Archives, B59/24/7/19, Papers relating to the Perth Board of Health for prevention of cholera, Reports of districts.

high: in the Glasgow hospital 318 of 455 patients died.⁵ To prevent infection from cholera corpses, the bodies had to be buried within twenty-four hours of death, patients' clothing and bedding burnt, and homes fumigated. While these measures applied in theory to all cholera patients, they were primarily aimed at the poor. Better-off patients were expected to isolate themselves at home, and to make their own arrangements for the cleaning and fumigation of household goods. The printed forms for reporting cases of cholera which survive in Inverness state that where there were objections to 'publicity' only the initials and no address could be given, ensuring that middle-class patients were saved the opprobrium linked to cholera victims.⁶

While local agencies led the fight against cholera, private citizens played a central role by funding these measures. Initially, the work of local boards of health was paid for through voluntary donations. In Aberdeen, citizens contributed £2,000, while in Edinburgh inhabitants gave £7,900 and in Huntly £40 was subscribed. Local gentry provided financial support: the Duke of Roxburgh gave 100 guineas to pay for cholera prevention in Kelso, and the Duke and Duchess of Buccleuch provided a building for use as a cholera hospital and paid for cholera measures in Dalkeith.⁷ However, donations never raised enough and, using powers under two cholera acts, local authorities imposed special rates.

Private donors also funded another anti-cholera measure – the distribution of food and clothing to the poor, intended to give them the strength to fight off the disease. In Tranent, the heritors distributed 154 carts of coals, 360 yards of flannel and bedclothes to the poor before cholera arrived.⁸ Later, the Board of Health set up soup kitchens to give out supplies. In Edinburgh in one day in February 1832, soup kitchens distributed 6,500 quarts of soup and almost 10,000 loaves. They also handed out 16,000 articles of clothing and bedding to around 3,000 poor families. Such efforts were widely praised as having had a significant effect in controlling outbreaks of cholera.⁹

Control of movement – the key plank of anti-Covid measures – was rarely used against cholera. A number of towns, including Edinburgh, Cupar, Macduff and several in Berwickshire attempted to set up *cordons sanitaires* by keeping out travellers, especially vagrants, who might carry the infection. Elsewhere, common lodging houses, used by the poorest travellers, were closed or were thoroughly cleaned and customers limited to staying for one night. In Edinburgh, theatres were closed and evening services in the city's churches were stopped.¹⁰

⁵ J. A. Lawrie, 'Report of the Albion Street Cholera Hospital', *Glasgow Medical Journal*, 5 (1832), 309–31.

⁶ Highland Archive Centre, Inverness, PA/13/M – 73/1, Cholera return 1832.

⁷ *Caledonian Mercury*, 28 January 1832; 2 February 1832.

⁸ *Caledonian Mercury*, 21 January 1832.

⁹ Christison, 'Account of the arrangements', cclxiii–cclxiv. A particularly detailed account of the work of the soup kitchen has survived in the Perth and Kinross Council Archives, B59/22/1, Perth Minutes of the Board of Health, vol. 1, 1831–32.

¹⁰ *Caledonian Mercury*, 30 January 1832.

In Dumfries, a town hit particularly hard by cholera, many of the shops shut for lack of trade.¹¹ However, given the lack of any financial support, it seems that most people continued to go to work, and to shop.

Individuals were encouraged to take responsibility in avoiding infection. Posters, handbills and newspaper articles advised keeping bodies, clothes and homes clean. People should eat their usual diet but avoid ‘indigestible’ foods such as fresh fruit. Alcohol was to be avoided at all costs: intoxication would almost certainly result in an attack of cholera. Regular hours of sleep would help to prevent the disease. People should stay at home where possible and if not, ensure that they had breakfast before setting out. Finally, ‘a cheerful mind’ would reduce the chances of succumbing to the disease.

Accounts of the 1832 cholera epidemic and of Covid-19 in the press give a largely positive image of people and communities pulling together in the face of terrifying disease. In 2020, the public proved willing to abide by regulations: to stay home, wear masks and keep their distance from people outside their own households. Restrictions on the number of mourners at funerals were unpopular, although widely accepted as necessary, with families finding alternative ways to express their respects. In 1832, it is impossible to judge how well the recommendations on private actions or public cleanliness were followed (or how effective they might have been against the disease). There was clearly public support for those actions taken against cholera, with funding for local boards of health and for charitable help to the poor.

Pandemics also provoked tensions, especially around the fear of infection. In 1832 local boards of health found landlords unwilling to rent out suitable properties for use as cholera hospitals. Neighbours were understandably nervous about the creation of hospitals close to their homes, with the prospect of cholera patients being carried through the streets in ambulances, or miasmas spreading out from the building to infect nearby homes. Few reactions to the risk of infection were as extreme as those of residents in Inveraray and in Inver, near Tain, who fled the towns and lived rough in the surrounding countryside.¹² The bodies of cholera victims provoked contradictory responses. They were feared as a potential source of infection and the men appointed in Perth to conduct funerals refused to carry out their duties.¹³ At the same time, the regulations requiring bodies to be buried within twenty-four hours and limits on the numbers allowed to follow the coffin in the graveyard meant that family and friends were unable to pay their final respects. They also raised the gruesome prospect of comatose patients being buried alive (‘early internment’ as it was tactfully described in the *Caledonian Mercury*).¹⁴

The work of medical practitioners during the pandemics also aroused conflicting reactions. In 2020, the staff of the NHS were widely (and literally)

¹¹ *Aberdeen Journal*, 17 October 1832.

¹² *Caledonian Mercury*, 14 June 1832; 10 September 1832.

¹³ Perth and Kinross Council Archives, B59/22/1, Minutes of the Board of Health, 1831–32, 15 March 1832.

¹⁴ *Caledonian Mercury*, 16 February 1832.

applauded for their care of the sick and their role in standing between the public and the infectious bodies of Covid patients. There was widespread anger when health workers were not provided with the necessary protective equipment, and the public stepped in by sewing masks and scrubs, and contributing to NHS charities. In 1832, doctors were also praised for their courage in attending cholera patients. However, they were also the target of a small number of cholera riots, when hospitals were attacked by mobs of poor people. These incidents have been interpreted as a sign of resentment against intrusive local government policies, but the disturbances were in fact inspired by fears of bodysnatching and the dead being used for anatomical dissection. Rioters believed that cholera was a cover for a new way of acquiring cadavers. In Wick, where the idea that doctors were killing cholera patients arrived with the herring fleet, an Edinburgh practitioner sent to run the cholera hospital became the focus of fear. According to the *Inverness Journal*, one of the fishers:

accosted the Doctor to the following effect: – ‘Are you here too, you butcher – many a poor creature did you kill and poison at Fisherrow and Musselburgh.’ This incensed the mob very much: and the Doctor was assailed with most violent and threatening language. They required that he should leave Wick by the first coach; and it was intimated to him that if he did not, his life would be in danger.¹⁵

In 2020 there was a strange and troubling echo of the earlier mistrust of doctors. As it emerged that BAME patients were more likely to die of Covid-19 than their white counterparts, rumours began to circulate that hospital staff were failing to treat or actively harming patients from BAME communities.¹⁶

The pandemic of 2020 then, seems both familiar and unfamiliar. Confronted by a frightening and strange disease, ordinary people did what they could to reduce the risks to themselves, their families and local community, and lent their support to efforts to control cholera and Covid-19. In both cases, agencies with perceived experience and expertise in fighting disease played a leading part in devising and implementing strategies of prevention and control. Whereas cholera was fought with cleanliness, with restriction of movement applied in only very limited ways, the response to Covid-19 has been distinguished by lockdown – the strict limiting of movement. It reflects how much public health has become a matter of private responsibility in the twenty-first century.

Does cholera suggest what might lie in the future? In 1832 at the end of the outbreak, there was a metaphorical sigh of relief. Cholera hospitals were closed, and boards of health dismantled, only to be reinstated in 1848, 1854 and 1866. By time of the fourth outbreak, cholera must have seemed like a regular occurrence and was hardly even newsworthy, with far less coverage in the press. Perhaps that is the future for Covid-19.

¹⁵ *Inverness Journal*, 27 July 1832.

¹⁶ Coronavirus doctor's diary: 'Fake news makes patients think we want them to die', *BBC News*, 19 April 2020, <https://www.bbc.co.uk/news/health-52337951>.