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# Health, sovereignty and imperialism: The Royal Navy and infectious disease in Japan's treaty ports

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ABSTRACT

During the 1860s and 1870s, the British Royal Navy was a major presence in Japanese treaty ports and influenced the development of public health in those cities in significant ways. This paper compares the Navy's response to two of the major infectious disease issues in the treaty ports—cholera and venereal disease—with that of the Japanese. Its aim is to determine whether the presence of foreign powers that enjoyed significant extraterritorial rights served to stimulate or frustrate sanitary intervention. It is argued that while there was common ground between the approaches advocated and taken by the British and the Japanese in relation to venereal diseases, the British presence proved disruptive when it came to the control of cholera during the epidemic of 1877; an epidemic that appears to have originated on a British naval vessel.

KEYWORDS

cholera, venereal disease, Royal Navy, Japan, treaty port, sovereignty

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## Introduction

From the 1850s onwards, Japan was forced into a series of unequal treaties with a succession of Western countries, which opened six of its ports—Shimoda, Hakodate, Hyogo (Kobe), Nagasaki, Kanagawa (Yokohama) and Niigata—to trade. These ports grew rapidly and became notorious not only for their cosmopolitan atmosphere but also for vice and disease (Hoare 1995). Most of the foreigners were men and an industry of prostitution developed to service them, giving rise to concerns about the spread of sexually-transmitted infections,

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then known as venereal diseases. At the same time, the treaty ports experienced outbreaks of other infectious diseases, including cholera, which caused great devastation and created tensions between the Japanese and foreign powers, including Britain, the United States (US), Germany, The Netherlands, France, and Russia. British and Japanese efforts in controlling infectious diseases, however, also offered opportunities for cooperation and cross-cultural translation, in which, according to Robert Peckham, "'the foreign and the native' were co-produced" (2016a, 45). This paper examines the extent and nature of these interactions as may be observed in the control of venereal disease and the cholera epidemic of 1877.

Although cholera and venereal disease have been studied in some detail, the majority of historians who have examined the Japanese treaty ports have focused on a single disease. This approach allows for detailed analysis but it inhibits broader engagement with the entangled histories of public health, foreign influence, and extraterritorial rights. Focusing on the Royal Navy, this paper argues that Britain's naval presence served as both a catalyst and a hindrance to the development of public health in Japan. As Peckham has argued, the control of infectious diseases offered opportunities for exchange of knowledge but these were limited by conflicting priorities, especially the British refusal to countenance any infringement of their rights.

Britain's Navy was the most significant foreign force in Japan in the 1860s and 1870s, and had an important influence on the Japanese authorities' response to infectious disease. This is already well documented in the case of venereal disease control (see the works of: Ion 2010; Tomobe 2008; Fukuda 2005, 2004; Ōkawa 2000, 2005); but historians differ substantially in their accounts of the engagement between British and Japanese authorities. Ōkawa contends that the Japanese granted permission to foreign powers to establish lock hospitals for essentially diplomatic reasons, with medical concerns only becoming paramount in the twentieth century (2000, 2005). However, Tomobe argues that the Japanese government had concerns similar to those of foreign powers, as it considered venereal disease a threat to military efficiency as well as an obstacle to social and economic modernization (2008). This paper argues that both these concerns were evident (at least from the early 1870s) but were buttressed and held together by other considerations, namely the effects of prostitution on the economy and on the image of Japan in Western eyes. These factors combined to provide a powerful incentive for the medical regulation of prostitution, which was informed by interactions with the British and other foreign powers.

Although the Japanese and the British developed similar views on the importance of controlling venereal diseases, the question of how to do so remained contentious for it was bound with matters of sovereignty and affected by competition among foreign powers. These issues become even more apparent

in the control of other infectious diseases, the most important of which was cholera (see for example: Proshan 2018; Fuess 2014; Ichikawa 2008, 2011; Tsukata and Tsuchimoto 2004). As an "alien" disease, cholera demonstrated Japan's vulnerability in the context of its relations with the West. The time-honored response to such diseases—quarantine—also raised the issue of sovereignty in a most acute way, for it was a matter on which the Japanese and foreign powers often had fundamentally different views. As far the British were concerned, the cholera epidemic of 1877 was of particular significance because the Japanese attributed its importation to the British vessel, HMS *Lily*. British authorities' responses to these accusations, and to the measures subsequently taken by the Japanese, reveal both parties' conflicting priorities. The Japanese regarded control over infectious disease as essential to the modernization of their country and the untrammelled use of quarantine was considered vital in this respect. The top priorities of the British in Japan, however, were the protection of key personnel and the freedom of navigation. When these priorities came into conflict, the latter typically triumphed. Acting in accordance with these principles could also produce different results depending on the nature of the problem. Whereas dealing with venereal disease necessitated extensive cooperation with Japanese authorities, Britain's intervention in the 1877 epidemic was essentially disruptive. British insistence on freedom of navigation hindered Japanese efforts to control the spread of cholera and illustrated in a dramatic manner Japan's subservience to foreign powers.

## Venereal disease

The Royal Navy's efforts to protect its personnel in ports such as Yokohama, Hyogo, and Nagasaki date from 1863, when the British, allied with the French and the Dutch, were engaged in a series of battles to control the Shimonoseki Straits. The Royal Navy was also involved in an independent action at Kagoshima in 1863. After these battles, more British naval and military personnel were stationed in Japan; and between 1863 and 1875, there were approximately 1,000 British and French servicemen stationed in Yokohama alone (Ion 2010, 716). As Britain's presence grew so did concerns about venereal infection. The Crimean War (1854–1856) and the Indian Rebellion of (1857–1858) stoked fears of the impact of disease on military efficiency. In both campaigns, epidemics ravaged Britain's forces and the sanitary inquests that followed also showed chronically high levels of venereal infection. These cases led many military men and politicians to agitate for the introduction of measures to control these diseases, resulting in the passage of the first British Contagious Diseases Act (CD Act) in 1864. The CD Act and subsequent legislation of a similar nature mandated the registration of prostitutes in naval ports and garrison towns, as well as medical inspection and forcible treatment of infected women in lock hospitals. Similar though mostly

short-lived measures had been introduced from time to time in Britain's colonies. The Hong Kong Contagious Diseases Ordinance in 1857, for instance, was the first significant British intervention to control venereal diseases in its colonies at that time, predating the Indian Contagious Act of 1866. (Wald 2014; Levine 2003). The CD Acts introduced in India and some other colonies from 1866 became a turning point in the systematic control of these diseases. Such legislation tended to result in more repressive and extensive measures than those implemented in Britain (Levine 1994).

Although Japan was not a British territory, the risk of British personnel becoming infected in Japan's ports was said to be high. Indeed, some other powers had begun to take action even before the British arrived. The first compulsory examination of prostitutes in Japan was instituted at the behest of the Russian Navy, in 1860, when a military brothel was built in Nagasaki for sailors of the Russian warship, *Posadnik*. Although many of the Russians already suffered from syphilis they still lobbied for regular inspection of prostitutes (Fukuda 2005, 140–43). British medical practitioners made similar recommendations. In 1863, Royal Naval surgeon, David Lloyd Morgan, reported that syphilis was the most prevalent and "troublesome" disease in Yokohama and that it was to be found there in its "worst form", typically exhibiting infected chancres and sores. Morgan noted, however, that Japanese doctors had a good understanding of these infections and of their treatment by using mercury like the British. As a result, Morgan thought that cooperation between the British and Japanese authorities might be possible (1863, folios 35, 41–2). The British legation doctor, William Willis, held similar views and proposed the medical regulation of brothels and compulsory treatment of infected prostitutes (Ion 2010).

In the 1860s, the Japanese were less concerned than the British with the spread of venereal diseases and did not have any plans to control them through the regulation of prostitution. By the late 1860s, however, they began to accede to British requests for such measures to control venereal disease in the treaty ports. The first hospital to treat prostitutes for venereal disease was established as a result of appeals by the British in August 1868, in Yokohama. This hospital and a number of medically regulated brothels were established at the behest of the Royal Navy and staffed by a naval surgeon, George Newton, who, along with the British envoy to Japan, Harry Smith Parkes, had pushed for their creation. Newton argued that all nations had a responsibility to control venereal diseases and advocated not only the creation of lock hospitals but also the prohibition of unlicensed prostitution (Fukuda 2004, 2005; Ōkawa 2000). The inspection of prostitutes and their incarceration for treatment, however, were opposed by many brothel owners, the reasons for which are unclear, although one may surmise that it was due to women being unable to earn during their period of incarceration. Another reason may have been the feelings of the women themselves. Inspections

were invasive and demeaning and the treatments administered were painful and unpleasant. The treatment of syphilis normally involved "mercurial fumigation" or repeated inhalation of small doses of mercury until ptyalism (salivation) was induced. Nitric acid and other substances were also applied to sores from infection with syphilis and gonorrhoea. These treatments were similar to those administered to sailors but unfamiliar to most of the women (Messer 1867, folio 40). Newton did what he could to calm the situation and, within a year, was confident that opposition to the treatment was decreasing (Parkes 1869). He was also pleased with the results. At the end of the hospital's first year of operation he estimated that inspection had prevented at least 33,497 men from being infected, a calculation based on the number of women referred to the hospital and a conservative estimate of one man per woman per day (Newton 1870a).

Each female resident in the *yoshiwara* (brothel quarter) was compelled to attend the lock hospital for examination once every seven days unless prevented from doing so because of sickness. If these women were also found to be suffering from venereal disease, they were detained in the hospital until cured. As the *yoshiwara* contained 101 brothels and over a thousand prostitutes, the staff at the hospital, which included some "native doctors" and nurses that Newton himself trained for the work, were invariably busy (Newton 1870a, 4–6). While this system emphasized the inspection of women, it also included the medical inspection of sailors and troops on board British, French, American and Dutch warships. Each man was required to undergo examination before being granted shore-leave, although it is unclear how extensively these checks were carried out and for how long the arrangements continued. While they lasted, Newton believed that these inspections contributed to a decrease in cases of venereal disease among both sailors and prostitutes; and he praised the system of ship-board inspection for affording "excellent opportunities for pointing out the various diseases of the genito-urinary organs to the native assistants" (Newton 1870a, 8).

The growing demand for prostitutes from foreign sailors, soldiers, and other transient visitors, however, rapidly increased the number of prostitutes. The number of women employed in the Yokohama brothels rose from just over a thousand in 1869 to 1,327 by October the following year (Newton 1870d). In view of this, Newton requested permission from the Japanese government to extend the hospital in order to provide three more wards (Newton 1870d). Parkes applauded these moves and stressed their importance in what were considered hubs of disease. Writing to British consuls in 1870, he stated, "I hardly need point out to you the importance of such services in the open ports of Japan which are frequently visited by ships of all nations." Indeed, Parkes was happy to report that Newton was about to travel to the ports of Hyogo and Nagasaki in an effort to induce local governors to adopt measures identical to those in Yokohama (Parkes 1870a).

The Navy, however, did not get its way on everything. An issue that arose in 1870 over the imminent arrival of a steamer of the Pacific Mail Company, *Sybil*, carrying a large contingent of Chinese laborers from San Francisco to China is a case in point. The laborers' status as "voluntary", as opposed to indentured, entitled them to disembark and mingle freely with others until their ship set sail on the final leg of its voyage. This worried some naval officers who assumed that most of the Chinese, who they believed to be saturated with venereal infection, would visit local prostitutes. Newton had warned of this possibility for some time and attributed the apparently higher infection rates at Yokohama's larger brothels to the fact that many of the smaller brothels refused to admit the Chinese (Newton 1870d). The prospect of another shipload of Chinese laborers brought the matter to a head. Newton believed that the Japanese welcomed these ships because they derived revenue from the vessels, which paid anchorage charges. He also stressed both the likelihood of infection from the Chinese and how their regular arrival would result in the growth of prostitution in the port.

After hearing of Newton's unease, the Navy's commander in the region, Vice Admiral Henry Hellett, consulted Parkes on the matter and asked him whether the Japanese government was "aware of the pernicious consequences, which result from not prohibiting the landing of Chinese passengers at Yokohama without medical inspection" (Hellet 1870). Hellett also mentioned that the Lords of the Admiralty wanted more information having been alarmed by Newton's observations on the Chinese in his annual health report. In accordance with their wishes, Newton confirmed to Hellett that "The arrival at this port [Yokohama] of Chinese in great numbers undoubtedly influences prostitution and is also the means of introducing the contagions of Venereal Diseases", adding that it had been proved that brothels frequented by them had a higher percentage of diseased prostitutes than those which had refused admission to the Chinese (Newton 1870c). Parkes, however, was less sympathetic than Hellett had expected. He acknowledged that the Chinese presented a significant problem but pointed out that it would be politically difficult to prohibit Chinese passengers from landing or even to introduce medical inspection on their ships. Parkes told Hellett that the Chinese were usually orderly and that the Japanese government would not be inclined to subject them to what he described as "an arbitrary and most distasteful rule." The Chinese had the same rights as other international passengers and there was no legal basis on which to inspect them and not others. Moreover, any attempt to enforce inspection and detention would be resented by the US Pacific Mail Company and American diplomats in Japan and could create friction that might be damaging to British navigation. In any case, he added, the Japanese had nowhere near enough medical officers to carry out such inspections. The only option, in his view, was to extend the existing system of inspection (Parkes 1870b).

Discussions on the establishment of lock hospitals in other ports were already under way and in November 1870 these dialogues progressed. The British acting-consul in Nagasaki A.A. Annesley (in office 1870-1) and Newton met with the governor of Nagasaki, Nomura Morihide, who was reportedly receptive to Newton's proposal and permitted him to install a lock hospital inside the general hospital. Its superintendent, a Dutch physician, Constant George van Mansvelt, also appeared to be enthusiastic about what Annesley described as a "philanthropic scheme" (1870). Annesley's observation seems to have been correct, for in December (1870) the Japanese government sanctioned the creation of lock hospitals in both Nagasaki and Hyogo where, according to Parkes, "in the interests of foreign shipping it was felt to be much needed." In order to achieve this result, Parkes had prepared the ground diplomatically, gathering some of the leading figures in the government of port cities in Edo (Tokyo) a few months before. In Edo, the governors were introduced to Newton who described to them the operation of the scheme at Yokohama (Parkes 1870c).

Gaining approval for the extension of the lock hospital system to other ports was relatively easy at first but there were certain factors that complicated the issue. There was opposition from brothel owners who objected to the regular weekly inspections of prostitutes in their establishments. Such opposition had existed in Yokohama but seems to have declined after the first year (Parkes 1869). In Nagasaki, the situation was more complicated. There were three brothel districts and while half of the women in two of these districts (Naminohira and Tomachi), voluntarily submitted themselves for inspection there was more resistance in the other, Maruyama (Newton 1871a). Opposition from brothel owners in Maruyama also seems to have been more vociferous than in Yokohama, and some opponents spread rumors to the effect that prostitutes had committed suicide because of the intrusive nature of the inspections (Newton 1871b). Newton dismissed these rumors and blamed them on "rabble rousers" whose aim was to bring the new system into disrepute. He denied that any woman employed at the brothels had committed suicide or had objected strenuously to the inspections. Regardless of the truth of the matter, opposition from brothel owners gave pause to the *gon-chiji* (*kenchiji* in British documents), the acting governor of the province, and the system of inspection was terminated. The previous governor, Normura Morihide, had apparently appreciated the civic importance of checking venereal infection, but his successor, Miyagawa Fusayuki, was opposed to the system, for he was allegedly susceptible to the blandishments of brothel owners who resented the practice (1871b). As a result of these conflicts, the lock hospital and the lock hospital ward in the general hospital were closed.

Newton was unable to persuade Miyagawa to change his mind and decided to contact Adam Hill, the British Chargé d'Affairs in Japan, and the consuls of other foreign nations in Nagasaki, to urge the re-opening of these establishments.

A conference on this issue was held in the city on 28 July, attended by most of the foreign consuls and the *gon-chiji*. At this meeting Newton explained the "urgent necessity" of reopening the hospital and was apparently supported by all the consuls, although Miyagawa "steadfastly refused" to do so for the moment. He did, however, undertake to reopen the building later in 1871. In the meantime, Newton proposed that a separate brothel district be created solely for the use of foreigners (1871b). There is no sign that the latter was established but a new lock hospital was opened on a temporary basis in 1871; and a permanent one focusing more on treatment than inspection was opened in 1874. Newton had also managed to establish medically regulated prostitution (which he referred to as the "sanitary surveillance scheme") in other treaty ports, including Yedo (Tokyo), Osaka, and Hyogo (Kobe) (1871b).

Despite the opposition the scheme had faced in Nagasaki, the Japanese were increasingly inclined to accept regulation for a number of reasons. Although it appears that venereal disease was not regarded as a substantial threat to public health in 1868, as Ōkawa contends, the government was becoming more concerned with the Western perception that Japanese society was morally lax (2000, 2005). Within a few years of the founding of the first lock hospital there was vigorous crackdown on unregulated or "vagrant" prostitution, which was not confined to the treaty ports. In 1872, for example, there was a ban on unregulated prostitution in Tottori prefecture. Although the order applied only to Yonago and Sakai, it is important to note that these were relatively small ports that were not subject to treaties with foreign powers. This move appears to have been a response to the notorious 9 July 1872 María Luz Incident, in which Chinese indentured laborers had been deceived and detained against their will (Putsey 1872). The ensuing trial resulted in a diplomatic victory for Japan and the release of the laborers was ordered, to the annoyance of most other countries except Britain. Nevertheless, this event also highlighted the existence of the involuntary servitude of women and girls in Japan for the purpose of prostitution. This unwelcome attention resulted in the Emancipation Edict for Female Performers and Prostitutes (*geishōgi kaihōrei*), which freed prostitutes from bondage and prohibited them from living in their employers' houses or places of business (Botsman 2011; Lie 1997; Satow 1925; *YHS* 1872a). Later in 1872, the Japanese Ministry of Law promulgated regulations banning the sale or purchase of pornographic paintings and goods, along with tattooing, mixed bathing, and mixed sumo wrestling. These regulations were made in consideration of decency and to some degree with public health in mind, but were designed primarily to alter foreign perceptions of the Japanese. Indeed, the same rules prohibited the Japanese from living with foreigners (*YHS* 1872c) and forbade Japanese women from coloring their teeth or shaving their eyebrows (which had long been a practice of the nobility) because Westerners laughed at these "strange customs" (*YHS* 1872b).

There were some within the British administration who may have welcomed these measures but there were others who were unhappy with the consequences. William Putsey, Assistant-Surgeon with the Royal Marine battalion in Yokohama, claimed that the restrictions the Japanese had introduced worsened the problem of venereal disease. The fact that women were no longer allowed to reside in brothels meant they could leave the *yoshiwara* and "attach themselves" to grog shops elsewhere in the town. There, they were officially registered as domestic staff but were actually "kept for entirely immoral purposes." Others became mistresses or roamed the streets, homeless. As Putsey opined, "No one can doubt that the Japanese authorities were actuated by anything but the best of motives in liberating these girls, but most will agree with me in thinking them very wrong in being so precipitate in abolishing the old system before they had devised a new one. " He continued, "I need scarcely add that since this event . . . venereal diseases have increased in number" (Putsey 1872).

Newton did not live to see the results of the new legislation, for he died in Nagasaki on 11 July 1871. Surgeon Henry Sedgwick formerly of HMS *Salamis* replaced him as the medical officer in charge of the lock hospitals (Capt. HMS *Salamis* 1871). As with his predecessor, Sedgwick's chief task was to manage the expansion of regulated brothels and lock hospitals beyond Yokohama. This raised problems of staffing and whether Japanese practitioners should supplement the naval surgeons. Newton had often praised his three able "native assistants" whom he had trained to do the work of venereal inspection and had proposed that "native doctors" should be permitted to do the work of medical examination. The Japanese authorities were happy to accept this proposition. Hellett, however, opposed any scheme that placed naval personnel under medical staff from other countries. He was doubtful of the professional ability of Japanese doctors and even disliked the idea that those from other Western countries should have charge of hospitals that British servicemen frequented. Despite these concerns, the Admiralty was reluctant to offer Newton or his successor any assistance. These onerous duties took their toll on Newton and possibly contributed to his death.

After Newton passed away, the Japanese Ministry of Foreign Affairs awarded one thousand yen (¥1,000) to his family in appreciation of his effort to build the lock hospital (Eikoku kōshi he Ōkan 1871). While this may be seen as a diplomatic gesture, it could also be interpreted as a sign that the Japanese government was beginning to think along parallel lines with Newton. The Japanese were now far more concerned about the medical threat from venereal diseases, syphilis in particular, chiefly because of the creation of a standing army in 1871 (conscription followed two years later). Fears that syphilis would reduce military efficiency were apparent from the outset (Tomobe 2008). In 1871, the Dajōkan or Grand Council of State also ordered the Minbushō (Ministry of Popular Affairs) to prohibit the opening of new brothels in order to stem what seemed

to be an increasing number of prostitutes. Two reasons were given for this. First, too much money was being spent on prostitutes and this wasteful use of resources harmed household budgets and the broader economy. Second, syphilis spread by prostitution would be inherited by the offspring of those infected (Dajōkan 1871). The order thus went on to stress the importance of building lock hospitals for medical and economic reasons.

It is clear that Japanese interest in medically regulated prostitution was more than diplomatic. Japanese officials were evidently concerned about how their country and customs appeared to Westerners. Moreover, the introduction of conscription and broader concerns with the negative impact of disease on Japan's people and its economy brought a significant degree of convergence between the attitudes of the government and those of the British. By 1876, this was already apparent in the introduction of legislation that closely resembled the British CD Acts. In the same year, the Department of Home Affairs issued an order for the compulsory examination of prostitutes that local governments licensed (see Fukuda 2005; Fujino 2002; Satow 1925, 179–84). Naval surgeons visiting the treaty ports were impressed by the fact that the police now used "full force" in the inspection, registration, and treatment of prostitutes. Yet ports such as Kobe and Yokohama remained notorious for having a large number of unlicensed prostitutes who plied their trade at the grog shops. While the system had become tighter and ostensibly more efficient, remarkably little had changed (Siccama 1876).



## Cholera

In 1858 a cholera epidemic affected all the main islands of Japan, leaving tens of thousands dead. According to the records of J. L. C. Pompe van Meerdervoort, a Dutch physician in Nagasaki, the epidemic originated in that city but had been brought there from China by the US warship *Mississippi* (Janetta 1987). More cholera cases were reported over the next few years but it is unclear whether they arose from existing foci of infection or were newly imported. In light of these experiences it is hardly surprising that the Japanese wanted to quarantine vessels from infected ports. Some foreign officials, particularly the British, however, were reluctant to allow the Japanese to do so. In 1873, alarm was sounded in several Japanese ports when cholera was reported in Shanghai. After British and Japanese consuls in that city noted its presence, the Japanese Ministry of Foreign Affairs ordered Ōe Taku, the governor of Kanagawa prefecture, which included Yokohama, to draw up preventive regulations. The Ministry also established a commission to construct a permanent quarantine system in Japan. On 19 August 1873, the new regulations were issued but foreign governments protested against them, saying that these regulations gave the Japanese authorities the right to quarantine any vessel they chose. In response, the Ministry agreed to allow foreign

consuls to sit on the commission, alongside prefectural governors, and their permission was required before Japanese naval vessels were able to restrict the movement or anchorage of foreign ships (Takano et al. 1926). These concessions were sufficient for most foreign governments and the envoys of the USA, France, Germany, the Netherlands, Russia, and Spain eventually agreed. Parkes, however, did not reply, effectively blocking the arrangement (Utsumi 1992).

Parkes (1828–85) was appointed Envoy Extraordinary and Consul-General, the most senior British diplomat in Japan in 1865, and held that post until 1883. Prior to that, he spent several years in China as a commercial clerk and translator until he was appointed consul to Canton, where he and the Governor of Hong Kong, Sir John Bowring, played a major role in instigating the Second Opium War. Both Bowring and Parkes were keen to open China to further trade (Daniels 1996). Bowring was a passionate free-trader and in his former career as a Radical member of parliament was known for his outspoken views against quarantine on moral, commercial, and scientific grounds (Harrison 2012, 96). Parkes adopted a similar stance in Japan, viewing quarantine as harmful to British interests.

Cholera did not arrive in Japan in 1873, but the issue of quarantine resurfaced in 1877, when the disease was reported in China. In June of that year, Marcus O. Flowers, the British consul in Nagasaki (1867–1877; on leave in 1870–1871), sent a letter to the city's governor complaining of the state of Japanese temporary hospitals in the foreign settlement. Similar complaints followed from a number of foreign residents, including a British doctor, William Renwick. The odor emanating from the hospitals was clearly unpleasant, chiefly, it seems, as a result of sewerage problems; but Japanese authorities claimed that it presented no immediate danger to health. Nevertheless, the prefectural governor, Kitajima Hidetomo, remedied this defect (Flowers 1877b). These actions were taken as anxiety mounted over the possible spread of cholera from China, the Japanese consul in Amoy, Fukushima Kyūsei, having reported to the Ministry of Foreign Affairs on 7 July that the disease had been present in the city since about 27 June (Gordon 1884, 135). The warning was repeated in late July, following the spread of cholera in that port. Kyūsei urged the Japanese government to immediately implement quarantine and to build an infectious diseases hospital in Yokohama (*YMS* 1877a).

Japanese authorities were clearly anxious about the spread of cholera from Amoy but Parkes was more concerned with impediments to navigation. On 23 July he met with the Minister of Foreign Affairs Terajima Munenori and inquired whether the Japanese would seek to implement quarantine according to the 1873 regulations. Parkes advised against jumping to the conclusion that the epidemic was indeed "Asiatic" cholera (as opposed to a supposedly milder form of the disease) and stated that he had asked the British governor of Hong Kong, Sir Arthur Kennedy, whether the cholera in Amoy posed a significant threat. Parkes

also resolved that unless he received a reply in the affirmative he would argue that quarantine was unnecessary, adding disingenuously that if the disease was "true" cholera British and other foreign powers would most likely permit their vessels to be used for quarantine purposes (MFA 1992a). Parkes's declaration is significant because the Japanese would have faced great difficulty in implementing such measures by themselves, most of their ships having been dispatched to Kyushu in an attempt to suppress the Satsuma rebellion.

While Parkes awaited news from Hong Kong, the British consul in Amoy, William Pedder, announced that Patrick Manson of the Chinese Customs Service had declared the disease to be "Asiatic cholera", which he believed to have spread from Singapore. This was not the news that Parkes had hoped for. The Japanese Home Ministry accordingly activated the rules for cholera prevention and sent them to the foreign ministry so that its representatives could discuss arrangements with foreign envoys. As far as the British were concerned, the situation became urgent on 2 August when one of their ships carrying several cases of infected Chinese arrived in Kobe (*YS* 1877). The crew and passengers of the ship landed without the knowledge of the authorities, prompting Kobe and Yokohama to take emergency measures including the construction of temporary isolation hospitals (MFA 1992d). It seemed that all British vessels sailing from China would now be subjected to quarantine.

Parkes and Terajima (Japanese Foreign Minister) met again to discuss the matter and Parkes told him that doctors in Hong Kong had already informed him it was unnecessary to impose quarantine despite the announcement of the British consulate. Based on this information, Parkes requested that the 1873 cholera prevention regulations be reviewed. In addition to restrictions on naval vessels, he feared that such measures would cause an "unnecessary" disturbance of trade. Parkes also disagreed with the British consul in Kobe, who told the governor of the city that foreign cholera patients should be sent to isolation hospitals. Although Terajima replied that this had only been done in the case of Chinese inhabitants, Parkes insisted that it was unjust because it contravened the treaty which governed the ports. In deference to Parkes's concerns, Terajima postponed the implementation of those clauses related to the quarantine of foreign vessels but had left open the possibility that such measures might be used in the future (MFA 1992b). In fact, the Health and Medical Bureau was already preparing to introduce quarantine in all its ports and Kobe showed no sign of suspending the measures it had taken. Parkes and British members of the treaty port boards of health continued their protest and insisted that quarantine for all foreign persons was unnecessary, claiming that the evidence from Hong Kong showed that cholera cases were confined to the Chinese. Under pressure from the British the Japanese government backed down and quarantine in Kobe was suspended on 13 August (MFA 1992c).

Later in the same month, cases of cholera began to appear among the civilian population near the port of Nagasaki. These were first noticed in a small village half a mile from the city among the washermen who attended to foreign shipping. On the same day, according to the US consul to Nagasaki C.L. Fischer, the disease had appeared on a British warship moored in the harbor; he claimed there were four cases, two of which were fatal. Three days later, cholera broke out on a US naval vessel and there were other cases in the merchant ships. Although the origins of the disease were still unclear, Fischer believed that "the close appearance of the same on shore and on the English man-of-war gives a shadow pointing to its importation by that vessel." The captains of three steamers in the Japanese government's transport service also believed that cholera had been brought to Nagasaki by a British naval vessel that had arrived from Amoy. An unnamed German official had informed them that 13 or 14 sailors on board the British ship had died from cholera, at least one of whom had been buried at Ōura Creek. A Japanese officer visited the ship and was apparently informed by a British sailor that at least one man on his ship had died from cholera (*Naimushō Eiseikyoku Zasshi* 1878). Although accounts of the number of cholera cases varied, rumors that a British ship introduced the disease were widespread in Nagasaki and were later repeated in historical accounts such as that written by Duane B. Simmons, physician and surgeon to the *Ken* (Prefecture) Hospital in Yokohama, physician to the city's cholera board, and Chairman of Yokohama Foreign Board of Health. Although Simmons did not state explicitly that a British naval vessel had brought the disease to Nagasaki, he concluded that it had been introduced from southwest China and considered Fischer's account to be reliable (Simmons 1880, 8).

This was not the first time that a foreign ship had been blamed for importing cholera into Japan nor would it be the last. The *Lily*, however, was the only Royal Naval vessel that seems to have acquired this dubious distinction and for that reason the epidemic of 1877 was of enormous significance to the British. The immediate response of the British was denial. The resident staff surgeon at the British naval hospital in Yokohama, John Lambert, insisted that the only case of cholera that had occurred on a British vessel was on HMS *Juno* on 8 September (1877), long after the first reported cases in Nagasaki. The man in question had apparently contracted cholera after breaking his leave in the port where he had been exposed to noxious influences. Consular dispatches, which show that several cases of cholera had occurred earlier at the HMS *Lily*, which was already notorious for having a particularly high rate of venereal infection, contradicts Lambert's account. Flowers laid the blame squarely on unsanitary conditions ashore, particularly in Ōura Creek, which seamen frequented on account of its bars and brothels (1877b and c). The *Lily's* commander, however, played down all cholera reports whether in ships or in the city, referring to "vague rumors" to that effect,

even after several of his crew had succumbed to the disease (Bradley 1877). Naval surgeons Adam Brunton Messer and David Lloyd Morgan, however, confirmed the presence of cholera in Nagasaki and, with Flowers, they argued that the disease had originated there rather than having been imported (1877). While this was clearly an attempt to evade blame for the cholera outbreak, the Navy's position was also consistent with Messer's and Morgan's opinion, the two having visited Nagasaki and other treaty ports before 1877; their journals had made much of the "filthy" state of these cities and the sewage contamination of water supplies (see Morgan 1863, folio 35). The water-borne theory of cholera transmission, however, took a long time to gain traction in naval circles. After visiting several Japanese ports in 1870, the naval surgeon John Buckley noted that "with reference to the choleraic poison which many attribute in a very absolute manner to the use of water tainted with the human excreta", there were astonishingly few cases of the disease, despite the fact that the wells in and around Kobe were contaminated with human waste that was being used as fertilizer in the rice paddies (Buckley 1870, folio 44b). As far as most naval surgeons were concerned, cholera could rarely be ascribed to any single factor or medium of infection. The prevailing opinion of that time was that cholera developed from some malign conjunction of unsanitary and meteorological conditions.

These views did not conform to medical opinion in Britain, which had largely embraced the water-borne theory of cholera by the late 1860s. However, parts of Britain's eastern empire still adhered to the belief that cholera could be transmitted through the atmosphere and this became the mantra as far as the outbreak of 1877 was concerned (Harrison 1996). One can see these views reflected in Parkes's comments as he dealt with the Japanese central and prefectural governments, in which he highlighted the supposedly local causes of disease in order to draw attention away from the Navy. In particular, Parkes referred to the unsanitary conditions in the foreign settlement at Nagasaki, which he blamed for the spread of cholera; a view that seems to echo that of a British medical practitioner in the city, possibly Lambert (*YS* 1877b). However, Parkes, who was based in Tokyo, took little interest in matters of sanitation until September 1877, when he received correspondence from Flowers. Replying to Flowers, he wrote: "I regret to hear of this mismanagement which appears to me inexcusable, as it is evidently attributable to neglect, and the want of ordinary precaution." He went on to state that the prefectural governor or *kenrei* (referred to as *kenlei* in British documents), Kitajima Hidetomo, had done little to remedy the situation since it was first brought to his attention. In this respect, Parkes differed from Flowers who thought that Kitajima had shown considerable resolve. Parkes also criticized Flowers for not acting sooner after receiving complaints about the hospital and told him that he had officially written to Kitajima insisting that the

situation be rectified, to which the latter replied that "all cause[s] of complaint shall be promptly removed" (Parkes 1877a).

Parkes was aware of complaints regarding the hospital as early as July, when he aired his concerns verbally to Kitajima, but had not followed up on the matter. Flowers, in contrast, had been quite energetic and had informed other foreign consuls in Nagasaki on 14 August that he had brought the matter to Kitajima's attention "without loss of time", indicating his willingness to cooperate with them if further action was needed (Flowers 1877a). These hospitals were eventually closed and the patients were moved to a new military hospital in early October at the edge of the "native town" (i.e. the area within the port inhabited by Japanese) (1877d). In the meantime, Parkes was able to refer to the temporary hospitals as possible sources of cholera and thus divert attention from the risks that foreign shipping posed. The death toll, however, was mounting in other major cities, including the ports of Yokohama and Kagoshima. It was also widely believed that cholera had spread to these cities from Nagasaki. The arrival of cholera in Kagoshima was particularly unfortunate because this was a concentration point for forces sent to quash the Satsuma rebellion. With the end of these operations, troops who returned from Kagoshima infected many other parts of Japan (Gordon 1884, 133–5).

Faced with the almost impossible task of containing the epidemic, the Japanese Home Ministry implemented its rules for the prevention of cholera insofar as it was able. These permitted local authorities to take vigorous action in ordinary ports, although the situation in the treaty ports was more complicated. In the former, captains of ships with cholera cases on board or which had experienced such cases in the previous ten days had to report them to local quarantine officers or the governor of each district. During this time, they were also required to anchor their ship in a designated area and should have no contact with the public. Persons who were infected or thought to have been were moved to quarantine facilities on land (*YHS* 1877b). Similar regulations were implemented in the treaty ports but these required consultation with foreign consuls before they could be implemented. In theory, this allowed vessels from different countries to be exempted from the regulations; in reality, the regulations did not distinguish between foreign and Japanese cases. Each hospital was divided into three rooms or huts for patients with: light symptoms, severe symptoms, and convalescents. No separate provisions were made for patients of different races or nationalities. Chinese, Japanese, and theoretically Europeans and Americans could be detained in these hospitals. Once interred, patients were outside the control of foreign authorities (*YHS* 1877b). Many foreign consuls were therefore reluctant to let the Japanese have any authority over their nationals and thus hampered efforts to control the spread of cholera.

In other respects, the measures taken by the Japanese Home Ministry were as rigorous as those in any Western country. Potential cases of cholera were medically examined before they were officially recorded and only then were quarantine and other measures for disease prevention imposed. If cholera was deemed present, municipal governors were compelled to report it to neighboring towns and to the Home Ministry on a weekly basis or daily if the number of cases was high. Shop owners were also ordered to report any case on their premises to district governors or police within twenty-four hours; the same applied to military bases and schools. Families with cholera cases in their homes were to be isolated as far as possible and if they died the family were to disinfect the body or face punishment; they were compelled to hold the funeral within ten days. Public events, including religious rituals, were also prohibited if cholera was prevalent. If cases were numerous, local governments were also expected to construct temporary hospitals to enable patients to be removed from their houses. Houses and ships where cholera cases occurred had to notify the public to prevent anyone from entering the infected area (*YHS* 1877c). These regulations were strictly enforced. For example, on 16 September, after cholera had broken out among the police dispatched to Kagoshima the chief of the General Staff, Aritomo Yamagata, ordered cholera cases to be sent to an isolation hospital in Chiringashima (RDSSDYS 1877; *Tokyo Nichinichi* 1877b).

Extensive use of disinfection was combined with the imposition of controls on movement. Public health authorities carried out disinfection and its use was encouraged among families. The poor were given disinfectants free of charge but the latter were sold to others at a standardized price determined by the government. In these respects, the Japanese were emulating the British and other Western powers, which had used disinfection extensively during cholera outbreaks in the 1840s and 1850s. Disinfection was also the habitual resort of the Navy when epidemics affected its ships. The Japanese, however, had a slightly different view of the utility of disinfectants than most British doctors. Whereas the latter usually emphasized the potential infectivity of fecal matter, the Japanese believed that the "poison" causing "Asiatic cholera" could originate in vomit as well as diarrhea: not fresh vomit and feces, but that which had been allowed to rot (Nishino 1877; *YMS* 1877d). If stale excreta and vomit were mixed with other human waste, it was thought that the disease was likely to spread, entering the human body through drinking water or the consumption of fish, shell-fish, and other animals that had eaten human waste in water or in the form of night soil used as fertiliser. Disinfection was regarded as the most important measure to prevent cholera because it was the best way of ensuring that the poison was killed or attenuated (*YHS* 1877a and 1877d). People were also warned not to indiscriminately dispose of ejecta from cholera patients and to avoid water likely

to be contaminated with cholera, unless the former was boiled (*YMS* 1877b). Infection was thought to occur by swallowing, touching or breathing in infected material (Nishino 1877; *YMS* 1877d).

Cholera regulations were introduced into one city after another as the disease spread throughout Japan. Rumor and uncertainty abounded as to the source of infection and no possibility was excluded. However, there was a common thread to the rumors, for cholera was supposed to appear first in foreign settlements (see *YMS* 1877e). Despite this qualification, Japanese authorities scoured all localities. When cholera reached Yokohama on 12 or 13 September (1877), quarantine officers and police began to inspect the port and the area around it; a doctor was attached to each district office. Police undertook house-to-house searches with doctors to check for cases of cholera in those areas and provided carbolic acid for use as a disinfectant. All potentially infected persons were sent to the hospital and families and friends were advised not to visit them unless absolutely necessary (*YHS* 1877e; *YMS* 1877c). Similar measures were taken in other ports, the infection often being traced to ships, which had left Nagasaki (*YHS* 1877f).

As the treaty ports became the focal points of Japanese sanitation efforts, some foreign officials became concerned that the exemptions they had so far enjoyed might cease; foreigners would be subjected to the same rigorous measures as the Japanese. With pressure mounting on the foreign consuls, Parkes again sought assurance from the Japanese government that it would not impose quarantine against foreign ships. On 18 September, he met Terajima (the Minister for Foreign Affairs) and criticized the Home Ministry for having issued orders to prefectural governors, which included the implementation of quarantine and construction of isolation hospitals. Although these had so far been applied solely to the Japanese, the provisions gave no guarantee of exemption and left open the possibility that foreigners, including naval personnel, could be placed in quarantine if foreign consuls agreed. As chief British envoy, Parkes had also thought that he should grant permission himself; not the consuls (*YHS* 1877f).

The following day (19 August), the Japanese Home Ministry asked Terajima to ensure that the rules would be discussed with foreign envoys. Despite this concession, Parkes met with Terajima himself on 24 September and stressed that the rules were unnecessary as ordinary sanitary precautions were sufficient. He reiterated that cholera in Nagasaki was worse than the other parts of Japan because of the mismanagement of the temporary hospitals in the settlement (MFA 1922e). Throughout his discussions with the Japanese, Parkes denied that the disease had been imported, maintaining that cholera was already present in Nagasaki and that it arose chiefly from unsanitary conditions. He did so despite mounting evidence of the spread of the disease between Japanese ports and the appearance of cholera in many Chinese ports from August to September 1877.

The Chinese ports included Shanghai and the Fort at Taku, near Tienjin, which British warships frequented (Takano et al. 1926).

Parkes's dealings with the Japanese reflected and reinforced the opinions of naval surgeons in Nagasaki, such as Messer and Morgan, and varied little during his time in Japan. However, it is interesting to note a degree of inconsistency in British opinion as the epidemic drew to a close. Despite having opposed any measures against British nationals, Parkes and some other British consuls urged the Japanese to enforce quarantine against their own people. On 3 October, when over 6,000 soldiers landed in Kobe after returning from Kagoshima, Flowers, the British consul in Nagasaki, recommended that strict quarantine be implemented before the next contingent of some 10,000 men arrived in the city. Parkes similarly pressed the central government to order "such stringent directions as the case demands" (Parkes 1877b). His insistence in this matter contrasts not only with his stance on quarantine up to that time but also with his reluctance, in November, to agree to new sanitation arrangements in Niigata port. The acting governor of Niigata prefecture, Nagayama Moriteru, wanted to impose quarantine on ships of all nationalities, which the German consul supported. Such measures, however, were impractical to implement for German vessels alone; the consent of all foreign envoys was necessary if these were to be imposed. Although the Japanese were able to confer with the British consul in Niigata, the decision was ultimately for Parkes to make. As in 1873, he simply ignored the governor's request (MFA 1992f). This reluctance to endorse any restrictions on foreign navigation established a pattern, which continued through the more serious epidemic of cholera in 1879 (Fuess 2014, 131–2).



## Conclusion

By late 1877, the epidemic of cholera in Japan had come to an end, leaving a total of 13,722 recorded cases and 7,967 deaths (Gordon 1884, 135–6). The immediate danger to British naval and commercial interests had passed and so had the *kenrei,* Kitajima Hidetomo. Kitajima had probably contracted the disease after visiting the cholera hospital in Nagasaki, to ensure that its military and naval patients were properly attended to. Contrary to Parkes's insinuations, Flowers (British consul in Nagasaki) insisted that Kitajima had "always appeared anxious to fulfil his duty" and was popular among his own people, having their interests at heart (Flowers 1877d). His tragic end serves as a metaphor for the fate of Japan during these years. The protection of sanitary conditions for British naval and military personnel was one of the tasks with which the Japanese authorities were expected to comply but British naval and commercial interests prevented them from extending protective measures from domestic to treaty ports. This most likely served to impede what was otherwise a concerted and thorough attempt to deal with cholera. While the Japanese employed a wide range

of preventive measures, closely resembling those in European cities, the Navy and British representatives maintained that cholera was not communicable. This reflected a view that was common throughout the eastern stations in which the Navy operated. For most of the nineteenth century, quarantine was imposed selectively in treaty ports and even in formal colonies such as Hong Kong or in British India (Peckham 2016b; Harrison 2012, 138–58, 166–71). The aim was to minimize interruption of commercial navigation, naval operations, and the flow of military and civilian personnel. In the Japanese treaty ports, this stance was replicated not only for similar reasons but also because of the reputational issues involved; namely, accusations that the Navy was responsible for importing disease. In Japan, as in other Asian ports, the British emphasized the role of poor sanitary conditions and climate in order to reduce the perceived need for quarantine and to place blame on local authorities. For Parkes, this was a matter of expediency rather than of intellectual conviction.

In the case of venereal disease, the situation was rather different because there was more collaboration between the Japanese and the British. Both favored intervention centered on women's bodies and particularly those designated as prostitutes, although the British and some other foreign powers placed certain restrictions on their own personnel. The chief differences lay in the motives of the Japanese and British and the extent to which the former were willing to implement the measures the British desired. Whereas the British were almost exclusively concerned with preventing the infection of their personnel, Japanese motives were more complex. Their moves to accommodate the British may initially have been propelled by diplomatic considerations, as Ōkawa has argued, but the Japanese government soon became concerned with venereal disease for other reasons. They were continually subjected to Western criticism for their customs and morals, and took steps, from the beginning of the 1870s, to counter these impressions. Ironically, as in the liberation of women from the *yoshiwaras*, these measures were not always to the liking of foreign officials. But, in other respects, their interventions were more compatible with foreign interests. From 1871, with the creation of a standing army, the Japanese began to advocate the medical regulation of prostitutes, for reasons of military efficiency and national advancement. In this respect, their motives were firmly aligned with those of the British, some of whom, like Newton, believed that contagious diseases legislation was a fundamental duty of modern states. Yet the dynamics of the treaty ports served to constrain British naval influence over some aspects of regulation, as can be seen in Parkes's decision to block naval demands for the exclusion from brothels of Chinese transit passengers. The likely impact of such a measure on US-Japanese relations meant that it was unacceptable to the Japanese as well as being a source of potential conflict between the British and the Americans. As always, Parkes was concerned with averting any situation that might adversely affect British shipping.

In view of these complexities, public health developed differently in Japanese treaty ports than in similar contexts. In Chinese treaty ports, the development of public health was directed, for most of the nineteenth century, by foreign powers, and the reformist agendas of nationalists were not linked explicitly to hygiene until the twentieth century (Bu 2017, ch. 1; Rogaski 2004). The same could be said of the treaty ports in Korea, where Japan was the dominant power (Kim 2013; Kim 2012): only gradually did health and hygiene become a focus of national renewal. In addition, the situation in Japan was different because there was a concerted effort to improve public health and assimilate Western medical knowledge from the late 1860s, as part of a concerted drive to modernization (Anesaki 2008). By the early 1870s, this could be seen in measures to combat cholera and also to some extent in attempts to prevent venereal disease. By 1876, the campaign against venereal disease was every bit as vigorous in Japan as it was in Western countries. It was also evident in Japan's own treaty concessions in Korea, where the Japanese Consul-General issued venereal disease regulations for Busan, Wonsan, and Incheon in 1881 to 1883 (HGPW 1972). After it was able to free itself from foreign influence in the 1890s, Japan also made extensive use of the quarantine regulations it had been prevented from implementing in the 1870s, and did the same in its overseas settlements (Kim 2013). These measures provide further illustrations of the ways in which Japan simultaneously assimilated and exported modern Western modes of governance (Eskildsen 2002) or, more particularly, the technologies of surveillance, policing, and bureaucracy (Dandeker 1994).



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## Abbreviations

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| HGPW | Hanguk Gyeongchalsa Pyeonchan Wiwonhoe [Korea Police History Publication Commission] |
| MS | Manuscript |
| NDL | National Diet Library, Tokyo |
| MFA | Ministry of Foreign Affairs |
| RCPL | Royal College of Physicians Library, London |

| | |
|---|---|
| RDSSDYS | Rikugunshō Dainikki Seinan Sen'eki Dan Yon Shidan [Record of the 4th division, Japanese army, during the Satsuma rebellion] |
| TNA | The National Archives, UK |
| YHS | *Yūbin Hōchi Shinbun* |
| YMS | *Yokohama Mainichi Shinbun* |
| YS | *Yomiuri Shinbun* |

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