Plague, Quarantines and Geopolitics in the Ottoman Empire

Bulmus, Birsen

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One day in the summer of 2004 I wandered down to the shores of Istanbul’s Golden Horn and saw a peculiar sight: a grand, yellow, nineteenth-century building sitting directly on top of one of the district’s most famous mosques. Right next to it was an equally elegant red-brown office, directly on the shores of the bay. International travellers to the city who come by boat have to go to these buildings even today in order to undergo medical inspection to see if they have contracted any epidemic disease. Certainly, most travellers to Istanbul before the mid-twentieth century would almost certainly have been familiar with the compound, as ships were the mode of overseas travel.

After learning from the guards that the buildings were constructed in the mid-nineteenth century, I, as a student of the history of medicine in the Middle East, wondered why the Ottomans had waited so long. Travellers began to complain of plague spreading from the district’s docks to the surrounding city shortly after Sultan Mehmed II’s conquest of the city in 1453, and yet it took about 400 years for a quarantine to be built. I wondered, then, to what extent geopolitical and cultural influences explained this development.

I remembered that the Ottomans essentially remained a premodern state until Napoleon’s conquest of Egypt in 1798 forced the Sultanate to embark on modernising reform in order to save the empire from disintegration. Istanbul and the realm’s other major port cities had relatively few Muslim merchants and a comparatively weak navy, and relied on non-Muslims and foreigners to develop their overseas trade. The result was a lack of both a politically conscious Muslim middle class and a lively press culture that expressed interest in modernising reform and economic development.

I had the impression from the Ottoman primary sources that I looked at
over the next few months that the Istanbul quarantine facility was one of many innovations partially inspired by the Europeans. Anton Lago, an Austrian doctor who worked for the Ottoman Sultan Muhmud II, wrote a famous work in 1836 that argued that the Ottomans should construct the quarantine facilities. Like most European advocates of quarantine until that time, Lago maintained that the plague was an ether-like substance that spread to humans either by person-to-person contact or by exposure to plague-infested materials such as wool and cotton. I also realised that Ottoman writers centuries before Lago’s time were aware of the European experience with epidemic disease. İlyas bin Abram Al-Yahudi (d. 1513), a Jewish refugee who fled from the Reconquista to offer services to the Ottoman court, wrote a medical treatise on his experience with the plague in Spain. İdris-i Bitlisî (d. 1520) similarly wrote about how the Europeans used mercury to cure the plague and urged his Ottoman audience to do the same.1

Europeans had also written extensively about plague in the Ottoman Empire. A number of key English authors blamed the great plague of London in 1665 and the 1720 Marseille outbreak on unregulated imports of plague-infested cotton and wool. These accusations helped to justify the construction of quarantines by the late sixteenth century that not only guarded borders against disease, but also gave their sovereigns greater control over foreign trade and any monopolies associated with it. The quarantine had the potential to help to promote domestic production in the name of public health and, thus, could be of great institutional importance in promoting mercantilism. Quarantine reform was also often used to categorise certain groups that were more likely to spread the plague. These reforms empowered state officials to medically police the poor and immigrant populations in thriving port cities like London from the sixteenth to the early twentieth centuries.2

Until 1838, British critics of these measures pointed to the Ottoman Empire as a positive example, since there was no quarantine there. In their opinion, the quarantine and sanitary police were cruel and unnecessary measures that hindered trade and humiliated many. It was no coincidence that liberal British writers would condemn the Ottomans after 1838 for repeating their own ‘mistake’.3

I still wondered, however, whether there was more to this story of the Ottoman quarantine than simply Mahmud II’s acceptance of Lago’s European-style quarantine in 1838. I had also read the treatise of Hamdan Bin El-Merhum Osman Hoca (1773–1840), a contemporary of Lago who also wrote a key text in 1836 advocating quarantine reform to the sultan. Hamdan, an Algerian notable who fled to the Ottoman Empire in the wake of the French occupation, was mainly concerned with convincing Muslim elites within the empire about the necessity of the reform.4
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One key argument for Hamdan was that the new institution was fully justified according to Islam. He often referred to earlier Ottoman plague treatise writers. These included famous sixteenth-century figures. Bitlisi vigorously defended his avoidance of plague in Damascus after performing his ritual pilgrimage to Mecca in 1512 from his critics. Ebussuud Efendi (1491–1574), the single most influential Ottoman Islamic jurist of the sixteenth century, also supported flight from plague as a justifiable precaution. Bitlisi and Ebussuud – and Hamdan – could also cite pre-Ottoman Islamic thinkers to support their opinions. They would at times mention Lisaneddin Al-Khattib (d. 1375), an Islamic scholar who advocated medical precautions after witnessing the 1348 outbreak of the Black Death, and the famous Sufi mystic, Abu Hamid Ghazali (1058–1111), who wrote of the need for human compassion for plague victims. They would reference Caliph Umar (634–44), who also fled the plague, as well as selected sayings of Muhammad, to justify their positions. In addition, Hamdan cited earlier Ottoman medical treatises on plague that justified medical treatment. Such earlier works not only dealt with flight – the most controversial of topics during the sixteenth century – but also with prescriptions and fumigation. These treatments often paralleled those of premodern European medical writers on plague.

Hamdan was different from many of these earlier writers in at least one key respect: he did not ever view plague in mystical terms and shunned the use of magic or ritual prayer to ward off the disease. Writers like Bitlisi, Ebussuud Efendi and Kemaleddin Taşköprüzade (d. 1621) included such elements within their treatises as one of many ways to fight the disease. Ahmed Efendi Müneccimbaşı bin Halil er-Rumi (d. 1748) had gone so far as to write an entire work on plague and the elemental magic of talismans in 1667–8. Hamdan, like most modern European plague reformers, abandoned magic in favour of empirically proven scientific principles.

One European innovation that Hamdan did not introduce was the use of quarantine as a social disciplinary tool to police the poor or other subject groups. Hamdan, like Turhan Pasha (d. 1914), a later Ottoman medical reformer, may have opposed the measure out of religious conviction, as such policing treated segments of the population as virtual subhumans. It is also quite likely that he recognised that medical policing might lead to authoritarian tendencies in government: a problem for the Europeans who first developed the sanitary police. In fact, no major Ottoman quarantine official embraced discriminatory measures until 1894 – including the famous former chiefs Ahmed Midhat (1844–1912) and Besim Ömer (1862–1940).

Hamdan and his audience were concerned about increasing foreign penetration. While many Muslims were afraid that the Ottoman Empire might share Algeria’s fate as a colony, others pointed to the increasing influence of
British and French loans and commercial influence, while yet others pointed to European support of Muhammad Ali of Egypt (1769–1849) as a rival to their own sultan. Hamdan implied that quarantine would help to defend Ottoman sovereignty in resisting these tendencies. Quarantine could potentially assist the native textile producers by controlling British and other European imports as ‘suspected goods’, affording the Ottoman authorities the possibility of taxing or even banning these goods.8

Unsurprisingly, the Europeans – particularly the British – protested that the establishment of the Ottoman quarantine in 1838 was clearly contrary to the Ottomans commitment to free trade. Lord Ponsonby (1770–1855), the British ambassador to the Sublime Porte, having imposed the Balta Liman unequal trade agreement on the Ottomans that year, succeeded in forming the Constantinople Superior Health Council, an international body, to supervise the quarantine. The British would also prompt other major European powers to gather a series of international sanitary conferences to which the Ottoman quarantine would also be subject. As these developments indicate, the Ottoman and foreign governments would struggle during the ensuing eighty years over who would ultimately control the quarantine, its policies and revenues.

The French and British reacted to the 1838 Ottoman quarantine by embracing a new understanding of plague as infectious in places where filthy and unhygienic conditions propagated the disease. This understanding, pioneered by French doctors Antoine Clot (1793–1868) and Louis Aubert-Roche (1810–74) in Egypt in 1841, was in contrast to the previous view of plague as being spread from person to person or through infected goods. They advocated increased medical policing of at-risk populations, such as Egypt, India, China and the Ottoman Empire – all non-European countries. Advocates of this new school of thought argued that the Ottoman quarantine was not enough to get rid of the disease. They supposed that only the Europeans themselves had the means and technological know-how to improve sanitation, building codes, sewage and water supply systems in order to transform the infested areas into hygienic living space. These views helped to justify colonial control of public health in Egypt, often humiliating the native population as coming from an inferior, diseased culture.9 The British institutionalised these practices in Egypt’s major cities and in medical inspection stations set up along the Suez Canal after they declared Egypt a protectorate in 1882.

The British and French held a number of international sanitary conferences in 1892, 1894, 1897 and 1903 to institutionalise medical inspection procedures with regard to the annual Muslim pilgrimage to Mecca. The Europeans claimed the pilgrimage routes – often with crowds of over 100,000 pilgrims per year – were unsanitary and spread plague and cholera. Many of the pilgrims were from
colonised countries, and the ruling European powers believed that the colonisers and the colonised were both at risk. The Europeans sought strict regulations on the pilgrim traffic. Every pilgrim would not only have to pre-pay his or her ticket, but would also have to undergo a series of medical inspections at the Suez Canal and along the Red Sea, and also before and after departure to the Hijaz, the Ottoman province of western Arabia. Alexandre Yersin’s discovery of the bubonic plague bacilli as the biological cause of plague in 1894 only slightly changed these regulations to include inspection and fumigation for rats and rat-infested materials. The medical officials at the time believed unhygienic conditions and poor sanitation were responsible for spreading plague from rats and fleas to human populations.

The conferences did not resolve the underlying political tensions between the Ottomans and the European powers. The British, in control of the Suez Canal, the sea lanes and major shipping companies, gained greater leverage over distant Ottoman territory, leading Muslims to question whether the Empire retained its sovereignty as the premier Sunni Muslim state. The Europeans also had political considerations in mind. Knowing that Sultan Abdulhamid II (r. 1876–1909) promoted a message of pan-Islamist unity in the face of European colonialism, they feared that colonial subjects who visited might be incited to rebel at home.

Kasim İzzeddin (1859–1926), the leader of the Ottoman sanitation effort after 1894, made the fateful decision to adopt medical inspection methods. In contrast to Hamdan and his successors, İzzeddin would not only maintain maritime quarantines in the major ports of the Ottoman Empire, he would also oversee new urban plans, construct new water supplies, sewage systems, hospitals, urban shelters and – very importantly – police the poor and the pilgrims.

İzzeddin’s reforms targeted two critical frontier districts: the Hijaz, home to Mecca and Medina; and southern Iraq, where the Ottomans oversaw an annual pilgrimage of Shia Muslims from Persia and Russia. These efforts embittered the relationship of the Ottoman central authority with local populations. Both the Bedouins of the Hijaz and the Shia of southern Iraq felt that they were being systematically discriminated against, and may well have questioned the value of their continued loyalty to the Ottoman state. İzzeddin, a Lebanese Sunni Muslim who also feared foreign encroachment of the Arab lands of the Ottoman Empire, thought that centralisation through sanitation reform would help to consolidate Ottoman rule once railway lines had connected Mecca, Baghdad and Basra to the main Ottoman grid. Oddly enough, these efforts won considerable international support, particularly from the British. İzzeddin and the Ottomans would be dependent on British coal, machinery and transportation and this increased British leverage in these frontier areas; at least until the railway was established,
when these materials could be sent over land and not by sea through British-dominated waters.

After November 1914, when the Ottoman and British empires found themselves at war, the British cut off this technical and logistical support, and İzzeddin’s efforts were doomed to failure. The local Bedouin population rebelled in the Hijaz, and the Shia of southern Iraq put up no major resistance against the British when they invaded in 1916.

After the First World War and the brief British occupation of Istanbul and the Straits, Atatürk and the new Turkish Republic asserted its control over the quarantine facilities in Turkey. The new regime abolished all foreign oversight, but kept its administrative headquarters in the Golden Horn complex I first saw.12

This book will elaborate on the long and intricate geopolitical history of plague, national sovereignty and quarantine in the Ottoman Empire from 1300 until the end of the First World War by delving into the writings of the main actors in this drama. These treatise writers included not only Hamdan and his contemporaries, but also other Ottoman thinkers and statesmen throughout this time period. I will additionally consider works by British, French and other pertinent Western travellers, doctors, diplomats and scholars that influenced or were analogous to Ottoman conceptions of plague and the quarantine and sanitary reform movement.

Indeed, historians have highlighted plague’s role in the rise and fall of empires and states in the Middle East and eastern Mediterranean. As Lawrence Conrad has shown, the first outbreak of plague occurred in 541–2 during the time of the Byzantine emperor Justinian, and had a devastating impact on the sedentary population of the fertile crescent, key to maintaining Constantinople’s rule in the area. Plague deaths in major cities like Antioch and their grain-producing hinterland weakened the Byzantines’ economic and military ability to retain the province. The Byzantines soon came to rely upon the trading and military skills of the Bedouin, who moved into the area from the nearby Arabian Peninsula. The Bedouin, like the Ottoman Turks nearly seven centuries later, would use their predatory skills to found an empire of their own. The early Islamic empire, founded by Muhammad and his companions, would dominate the region until the end of the Umayyad dynasty in 750. Oddly enough, a second great outbreak of plague may well have hastened the end of the dynasty, since the newly entrenched Arab elites in Damascus had themselves become sedentarised and therefore more vulnerable to an epidemic.13

The importance of plague to the rise of the Islam, as Conrad illustrates, can even be seen in the Quran itself. In the 105th chapter, Al-Fil (The Elephant), the Quran talks about the fate of an Abyssinian army that sought to subject Mecca and take over the Kaba on the eve of Muhammad’s birth:14
Hast thou not seen the people of the elephant, how dealt with them the Lord? Did not He make their plot to end in ruin abhorred? When He sent against them birds, horde on horde, and stones of baked clay upon them poured, and made them as leaves of corn devoured.

Conrad postulates that these lines are, in fact, a metaphorical reference to an outbreak of plague that was visited upon the Abyssinians by divine intervention, an immediate sign of God’s presence in history. The common traditional Muslim attribution of plague to the work of angel-like genies (jinn), and the view that those who died from plague were martyrs to God also coincides with this belief.

Yet Conrad also demonstrates that Muhammad and his companions sometimes advocated taking physical precautions to avoid the disease. Muhammad commanded at one point that ‘if it (plague) is in a land, do not enter it’. He also alluded to flight as an option to avoid contagious disease when he instructed the faithful to ‘flee from the leper, as you would flee from a lion’. Admittedly, Muhammad made other injunctions to the contrary, positing that there was no contagion, that one should not leave a plague-infested area, and that God was the ultimate cause of disease. Still, all of these statements need to be put in their proper context. Conrad points out, for example, that Muhammad’s assertion of ‘no contagion’ was likely part of a broad condemnation of nature worshipers, who saw contagious disease as divine. Conrad shows that popular beliefs in contagion continued to persist, stating: ‘the Umayyad poet Jarir sang of a “spreading contagion quickly communicated [to others]”, while his rival Farazdag spoke of how “contact with her infects the healthy”.

This ambivalent attitude towards contagious disease was most famously displayed after the outbreak of plague in Amwas, a town near Damascus, where, in 638, Abu Ubaydah, one of Caliph Umar’s commanding generals, was ordered to leave the vicinity to go to the more distant town of Serag after plague was discovered in the area. Ubaydah argued against fleeing, saying it was God’s will for him to stay. Umar then told him through a parable that God had ordained that he should take precautions:

Yes, we are fleeing from the will of God, to the will of God . . . Suppose you have camels which come into a valley with two slopes, one lush with pasturage and the other barren; if you graze them on the lush slopes, would that not be by the will of God, and if you graze them on the barren slope, would that not also be by the will of God?

Authors from this time onwards would cite this exchange as demonstrating the righteousness of their cause. Those who argued for precaution referred
to Umar’s parable, his leadership as caliph and the fact that Abu Ubaydah ultimately obeyed his command. Others countered that Abu Ubaydah’s initial protest was valid, and that he in fact regretted obeying Umar.

My work is aimed in large part at explaining this tension throughout Ottoman history, following Conrad’s call for greater elaboration on the subject: ‘To assert that “Islam” denies contagion is therefore to miss the essence of what was in fact a complex and difficult debate that has continued through most of Islamic history, involving contributions by individuals too numerous to consider here.’

Conrad’s work is also influential for establishing that early Muslim physicians differentiated plague from other contagious diseases. According to Imam Nawawi (1234–78): ‘Every plague (taun) is a pestilence (waba), but not every pestilence is a plague.’

Conrad, early Islamic physicians saw taun as a physical reference to buboes, a clear proof that the disease was indeed bubonic plague, whose biological agent was discovered by Alexander Yersin and Kitasato Shibasaburo in Hong Kong in 1894.

\textit{Yersina pestis} was a seemingly harmless non-motile cell that, in the right conditions, quickly and uncontrollably reproduced in the warm, moist blood of its victims. The bacilli was largely confined to populations of black rats (\textit{rattus rattus}), which Conrad argues were prevalent in the premodern Middle East both in urban areas and their agricultural hinterlands. Moreover, fleas, particularly the variety \textit{Xenopsylla cheopis}, which was particularly fond of black rat blood, had a tendency to pass on \textit{Yersina pestis} to other rats. Although \textit{Yersina pestis} almost always peacefully co-existed with its rat and flea hosts, rare outbreaks of the disease could occur. When they did, \textit{x. cheopis} fleas became particularly virulent, as the \textit{Yersina pestis} gathered and multiplied in its black rat blood-filled stomach. This would ‘block’ the flea from swallowing more food, making it bite its victims much more frequently, dramatically increasing the chance it could pass on the disease. While for most of the time the affected rat population was isolated from humans, disaster would strike when people came into close proximity with infected fleas, as flea bites were the most common means of contracting the plague. \textit{Yersina pestis} would then grow uncontrollably in the bloodstream, where its gel-like shell prevented it from being eaten by ‘the human body’s normal defences’, the bacilli-eating phagocytes.

If the body’s lymphatic system carried the \textit{Yersina pestis} cells to exterior lymph nodes, ‘the hordes of bacilli collected in these nodes and created a case of bubonic plague with characteristic swellings or “buboes” in the groin and armpits and behind the ear’, reflective of an unrestricted growth of cells that usually killed the victim within six to eight days. If the bulk of the \textit{Yersina pestis} were instead transmitted to interior lymphatic nodes, as was usual in 5–15 per cent of cases, the victim would die from septicemic plague without
swellings, as the cells would quickly block the circulatory system, fatally damaging the heart and other vital organs. Rarely, \textit{Yersina pestis} was inhaled directly into the victim’s lungs, without contact with a flea, eventually causing suffocation from pneumonic plague.\textsuperscript{22}

According to Conrad, tracing the disease according to premodern Muslim sources would always be problematic, given the inability of the authors to understand the disease’s biological origin. Thus, they might be able to decipher the buboes, fever and other bodily symptoms, but would not recognise the bacilli as the cause of the disease or rats and fleas as its vectors. Instead, they looked at the plague as a materialistic phenomenon that originated in an elemental-based miasmatic eruption that could be transmitted by corrupted physical elements.

In contrast to Conrad, Michael Dols’ account of the 1347–8 outbreak of the Black Death in Mameluke Egypt posits that Islamic societies in general reacted to the plague passively, believing that it was sinful to interfere with the disease as it was God’s will. Dols argued that this dogmatic perspective triumphed over the immediate post-1348 accounts like those of Ibn Al-Khatimah (d. 1369) and Al-Khatib, who, like their western European counterparts, shared a miasmatic understanding of the disease.\textsuperscript{23}

In Dols’ opinion, the Islamic belief that God created a spiritual agent, a genie (\textit{jinn}), who caused the plague to strike, was essential to suppressing miasmatic accounts. This otherworldly view became widely pervasive within a generation of the 1347–8 outbreak, and continued to dominate legal scholars, rulers and the population at large until the modernising reforms of the nineteenth century, which abandoned Islamic law in favour of secular Western-inspired models. To Dols, even later Ottoman accounts like Taşköprüzade’s were essential to illustrating how this orthodoxy promoted popular practices, such as the use of ‘number magic’ and ritual prayer instead of taking physical precautions, like fleeing, or fumigation or other medical remedies. The result, in his view, was the overall decline of the Mamlukes, the Ottomans and other Islamic societies – a key contrast to the West, where views on plague transmission led to extended debate, and the continuing push for reform. He even goes so far as to claim that Western religious treatises on plague, which argued that the disease was God’s punishment for sin, was a motivation for moral reform; yet another sign of the Europeans’ activist approach towards natural disaster. In his opinion, this activist drive for reform was fundamental to the Western conquest of the disease, progress which culminated in the discovery that the plague was, in fact, caused by \textit{Yersina pestis}.\textsuperscript{24}

Heath Lowry’s recent article on the plague in the Ottoman Empire in the fifteenth and sixteenth centuries largely confirms Dols’ views. Lowry seconds
the notion that Islamic societies, particularly the ‘core Arabic lands’, were dominated by a fatalistic view of Islam that persisted in the succeeding centuries. To Lowry, the Ottomans were an exception to this rule from Osman’s founding of the empire in 1300 until Sultan Selim’s incorporation of these lands in the wake of the Battle of Çaldıran in 1517. Until this time, ‘practical’ rulers like Mehmed II, known as ‘the Conqueror’ of Constantinople in 1453, took activist measures, such as seizing the strategic island of Lemnos – the source of ‘Lemnian earth’, a popular ingredient in plague medicines – as well as continually repopulating his new capital after it was devastated by the disease. After 1517, however, the Ottomans embraced orthodox Islam and abandoned an activist approach:

One might well query what, if any, preventive measures did the Ottomans [post-1517] come up with in an attempt to thwart the periodic ravages caused by the plague? The answer is: none whatsoever. It was only in the 1830s that they finally adopted a quarantine regime, a practice which had been in place throughout Western Europe for over 200 years.

Lowry bases these conclusions, like Dols before him, on narrative literature, particularly fifteenth-century Byzantine chroniclers and sixteenth-century Western traveller literature and diplomatic accounts. They coincide with the general claim that the Ottoman Empire, considered by most of its European neighbours to be the gravest threat to Christendom from Mehmed’s conquest of Constantinople until Suleyman the Magnificent’s siege of Vienna in 1528, had entered a period of stagnation, military defeat, socioeconomic decay and gradual dismemberment that would characterise its history until its ultimate dissolution in 1923.

The most influential work on Ottoman plague during the eighteenth and nineteenth centuries, Panzac’s *Le Peste dans l’Empire Ottoman* (1985), almost entirely fits within the historiographical framework that Dols and Lowry have laid out. Panzac argues, on the basis of extensive French and British consular records and traveller accounts, that the Ottomans adopted the maritime quarantine only after extensive European pressure to do so. This European influence was felt in both diplomatic and medical circles. The Europeans, particularly the Habsburgs and the French, apparently suggested both maritime and domestic quarantine in order to combat plague and cholera, a newly emerging epidemic menace in the 1830s. European-trained doctors and newly available published European medical literature popularised quarantine among Ottoman reformers. Panzac concludes that, regardless of Ottoman hesitations, the empire’s adoption of the maritime quarantine in 1838 led to the end of this state’s dubious distinction as the ‘sanctuary of plague’.

Two key works that have explicitly dealt with the critical question of how
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early nineteenth-century Islamic governments implemented maritime quarantine reform are LaVerne Kuhnke’s *Lives at Risk: Public Health in Nineteenth-century Egypt* (1990) and Nancy Gallagher’s *Medicine and Power in Tunisia, 1780–1900* (1983). Kuhnke’s work illustrates that it was Muhammed Ali, and not the British or French ambassador to Cairo, who initially implemented the maritime quarantine, and, at the same time, the Egyptian Academy of Medicine. These indeed, were key institutions in Muhammad Ali’s grand projects of modernisation. The Ottoman sultan Mahmud II, who carried out a similar modernisation programme and implemented the maritime quarantine in Istanbul some seven years after Muhammed Ali’s foundation of one in Alexandria, very likely followed the same pattern. Just as Muhammed Ali hired foreign medical experts like Clot, so too Mahmud II employed the Frenchman Sade de Galliere, the Viennese Karl Ambroso Bernard, and the Austrian Anton Lago to help implement the medical reforms. Kuhnke does not discount the fact that the Egyptian medical school, like its Ottoman counterpart, trained new generations of native-born graduates to continue the medical reforms. They may have initially been trained in French, but the language of instruction quickly shifted to Arabic in Cairo and Ottoman Turkish in Istanbul. Despite the gradual decline of these institutions after both the Egyptian and Ottoman governments faced European financial and diplomatic pressure, Kuhnke’s findings lead us to believe that the maritime quarantine reform might have been an example of Western-inspired reform. However, the Egyptian maritime quarantine was part of a project of native-led state formation fundamentally distinct from colonial-imposed Westernisation.

Gallagher’s work alludes to a similar situation in Tunisia, where the local governor Hamuda Bey (1782–1814) initiated a maritime quarantine in 1784–5. Interestingly, Hamuda Bey launched the quarantine with a host of other measures that restricted French influence over Tunisian exports and imports, all in the name of public health. These mercantilist policies met firm resistance by the French, who publicly protested them by 1828 to Husayn Bey (1824–35), one of Hamuda Bey’s successors. While Gallagher, like Kuhnke and Panzac, documents her study with western European language sources, she also makes a serious effort to include relevant Arabic primary source materials, such as Husayn Bey’s response to the French protest in 1828, that speak to the issue of quarantines as part of a nativist response to colonial intervention.

This book has benefited tremendously from this historiographical debate, beginning with Conrad’s arguments that there was no prevalent dogmatic attitude towards plague among Muslims and that one needs to look at the particular circumstances of each author. Dols’ counter-argument that Muslim plague treatises almost universally favoured a fatalistic view has justified the tendency to
examine Western travellers, diplomats, politicians and physicians as the primary historical sources about outbreaks in the region.

However, as Gallagher has shown, the most engaging sources were often written by Muslim medical thinkers and statesmen, who hoped to use quarantines and other preventative measures as part of a countrywide policy of modernisation. Unsurprisingly, these reformers would often run into opposition by their western European counterparts, who were frequently attempting to dominate the politics and economy of the region. The common European refrain that the Muslim reformers failed to grasp a truly scientific understanding of the disease often revealed a political subcontext that begs further explanation.

This book seeks to contribute to this scholarship by first looking at the history of plague in the Ottoman Empire prior to 1838 and exploring its relevance to the quarantine reform movement. Chapter 2, ‘Conceptualising Plague in Ottoman Islamic Thought’, examines how Hamdan’s religious justification for the 1838 reform related to prior Islamic thinkers. Hamdan’s arguments and the opposition to them were also similar to religious debates on plague and public health in seventeenth- and eighteenth-century England. Chapter 3 ‘Plague and Ottoman Medical Thought’, compares Ottoman medical conceptions of plague with that of Europe. The chapter explores the ties between England, which developed the quarantine in the late sixteenth and seventeenth centuries, and the Ottoman Empire, which did not pursue similar efforts. Chapter 4, ‘Magic and Plague in the Ottoman Empire’, looks at the continued Ottoman practice of religious ritual and magic to combat plague in contrast to early modern Europeans – particularly the English – whose press culture and religious wars led to increasing repression of individualistic mystical beliefs that defied centralising authority.

The next chapters are dedicated to describing how quarantine reform affected the Ottoman history of plague from 1838 until the end of the empire. Chapter 5, ‘Hamdan Bin El-Merhum Osman and the Ottoman Plague Reforms’, deals specifically with Hamdan’s efforts to establish the quarantine, and contrasts his views to that of British and American writers with regard to sanitary policing. Chapter 6, ‘Plague and Quarantines in the Colonial Era’, highlights the continuing struggle between the Ottoman authorities, who maintained Hamdan’s vision for the quarantine, with that of the British and French, who fundamentally reformulated their conception of plague and the medical institutions connected with them. Chapter 7, ‘Plague, Sanitary Administration and the End of Empire’, details Izzeddin’s final gambit of accepting European social disciplinary methods as part of quarantine reform, underlining how his alienation of the Bedouin of the Hijaz and the Shia of southern Iraq led in part to the disintegration of the Sultanate. Chapter 8, ‘Towards a New Understanding of Plague and Quarantines in the Ottoman Empire’, wraps up the book with a concluding analysis of the
legacy of the quarantine reform movement – Istanbul’s maritime quarantine – evident in Golden Horn facilities to the present day.

NOTES


2. John Howard, An Account of the Principal Lazarettos in Europe; with Various Papers Relative to the Plague; Richard Mead, A Short Discourse Concerning Pestilential Contagion, or the Plague, with the Methods to be Used to Prevent it; Richard Mead, A Discourse on the Plague; Sir James Porter, Observations on the Religion, Law, Government, and Manners of the Turks. The Second Edition, Corrected and Enlarged by the Author. To which is; Patrick Russell, A Treatise of the Plague: Containing an Historical Journal, and Medical Account, of the Plague, at Aleppo, in the Years 1760, 1761, and 1762.

3. Anonymous, The Plague as It Affects England from Official and Other Sources; Gavin Milroy, Quarantine and the Plague: Being a Summary of a Report on these Subjects Recently Addressed to the Academy of Medicine in France: With Introductory Observations, Extracts from Parliamentary Correspondence and Notes.


5. Manfred Ulmann, Islamic Medicine, p. 94.


9. Anonymous, Plague; Milroy, Quarantine and the Plague.


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28. Halil İnalcı, with Donald Quataert, An Economic and Social History of the Ottoman Empire, 1300–1914, pp. 400–7; Bernard Lewis, The Muslim Discovery of Europe, pp. 33–45; Bernard Lewis, What Went Wrong? Western Impact and Middle Eastern Response, pp. 7–17.
30. Panzac cites Nöel Biraben’s conclusions on this matter, pp. 11–13.
37. Timothy Mitchell’s Rule of Experts: Egypt, Techno-Politics, Modernity has looked at the legacy of colonialism and native reaction in public health policy in Egypt from the 1940s until today.