Leprosy in England

The following interesting item written by the Rev. R. J. E. Boggis, Torquay, appeared in ' The Times ' of December, 14, 1935.

" Although the will of Thomas de Bytton, Bishop of Exeter, who died in 1307, has not been preserved, the extraordinary full account of the executors is extant and gives a detailed conspectus of his very ample estate and of his numerous and varied legacies. His diocese comprised the two counties of Devon and Cornwall, and among the legatees were numbered as many as 40 leper-houses, whose benefactions ranged from 33s. (pre-War equivalent £32) at Tavistock and 30s. (£29) at Exeter and Launceston (evidently the largest establishments), down to 1s. (19s.) at Denbury and 6d. at Sancreed. Here is a revelation of the common prevalence of this terrible malady and also of the widespread efforts to care for the poor sufferers—as many as 17 lazar-houses in Devon and 23 in Cornwall, and the provision of separate hospitals in places so close together as Barnstaple and Pilton, or St. Madron and Sancreed and Mousehole."

Further enquiry from Mr. Boggis elicited the following complete list of the 40 leper houses in Devon and Cornwall, and the amounts of the benefactions :—

	s.	d.
Exonic versus Wondford	30	0
Okhamptone	10	0
Tavistok	33	0
Sutton	11	0
Plymptone	27	0
Clove	16	0
Modburi	16	6
Chadelyngton	2	6
Dertemuth	5	0
Tottone	27	6
Honeton	25	0
Teignemuth	18	0
Nyeweton ferers ...	5	0
Toffesham	2	6
Deveneburi	1	0
Barnum et Pylton ...	40	0
Lancetone	30	0
Tremeton	7	6
Sancto Germano ...	9	6
Liskpet	20	6
Dynmur	22	6
Bodminia	17	0
Lanford	14	0
Fowy	12	6
Ponsmier	15	0
Schiefstalle	12	6
Resureghy	20	0
Coygon	3	0
Truru	12	0
Argel	8	0
Helleston	15	6
Glas	9	0
Mousehole	13	6
Madern	6	0
Sancto Sancredo ...		6
Redruth	9	0
Sancto Brisco ...	12	6
Oldestowe	6	0
Medeschole	14	0
Expenses re above ...	23	1¼
Total ...	£29	4 1¼

Mr. George M. Doe of Great Torrington has kindly furnished the following account: ' One little chapel is situated in the hamlet of Taddiport or "Addiport" and connected with the Borough of Great Torrington by an ancient bridge across the Torridge. It is now used in connection with the parish of Little Torrington as a Chapel-of-Ease. Many towns have had these leper establishments, e.g., Plympton, Totnes, Plymouth, Tavistock, Barnstaple, Crediton and Honiton. Very frequently dedicated to St. Mary Magdalene and often separated from the town, as in the case of Taddiport, by a river or stream so as to make it an isolation hospital.

' In the register of Bishop Stapledon is recorded the institution of Sir Richard de Brente, priest, on the 2nd February 1311-12, to the chantry of St. Mary Magdalene— " juscta Ponlem de Chepyngtoritone."

In the register of Bishop Grandisson are two references evidently to this chapel.

> " Cantaria Capelle Beate Marie Magdalene in Parochia de Parva Toritone, to which Sir John de Mollonde, priest was instituted on the 29th December, 1344; the other Verig ";
>
> " Cantaria Capelle de Parva Toritone to which Sir Roger de Putteforde, priest; was instituted on the 15th May, 1349."

' In his will of the 8th June, 1418, Thomas Reymound left (inter alia) to the Leper House at Torrington the Sum of " 40d."

' In one of the lists compiled between 1540 and 1570 and now in the Public Record Office, relating to persons ejected from religious houses, is the following entry :—

> " Nicholas Newcourte, Incumbent;
> " Freechapel of Tadyport in Toryton.
> " [3.5]—39s."

' The Devonshire historian Risdon mentions an hospital at Little Torrington founded by the pious charity of Ann, daughter of Thomas Butler, Earl of Ormond, and wife of Sir James St. Leger, Knight; and Westcote states that at Tadiport is a hospital said to be built by Ann, daughter to Thomas Boteler, Earl of Ormond. Both these historians say that she endowed the hospital with allowance and maintenance for a minister of a chapel thereto belonging.

' In the year 1665 there seem to have been no lepers in

the hospital, and articles of agreement were made between the " Guardian " of the Hospital at Taddiport or Addiport of the 1st part; the Recorder and one of the Aldermen of the Town of Great Torrington of the 2nd part, and Joseph Coplestone and Ananias Nill, and the Church Wardens and overseers of the poor of Little Torrington of the 3rd part; for the Hospital, profits and revenues in the vacancy of lazaras or leprous people, to be equally divided towards the relief of the poor of the said town and parish. Provision was made for any lepers as formerly, if sent to the Hospital; and for the provision of a " Governor " and a " Reader " in the Chapel. By a deed in the same year, Tristram Arscott, the "hereditary sole and perpetual guardian" of the Hospital gave to the Mayor, etc., of Great Torrington, and the Churchwardens and overseers of Little Torrington, the Hospital and lazar house and messuages, etc., for such uses and purposes as to the rents and profits as declared in the articles named. (These two documents are fully quoted in the Report of the Charity Commissioners of 1823).

' All traces of the Mansion House and Lazar Houses have disappeared, though there are entries of them in the rental of the Magdalen Lands of 1729.'

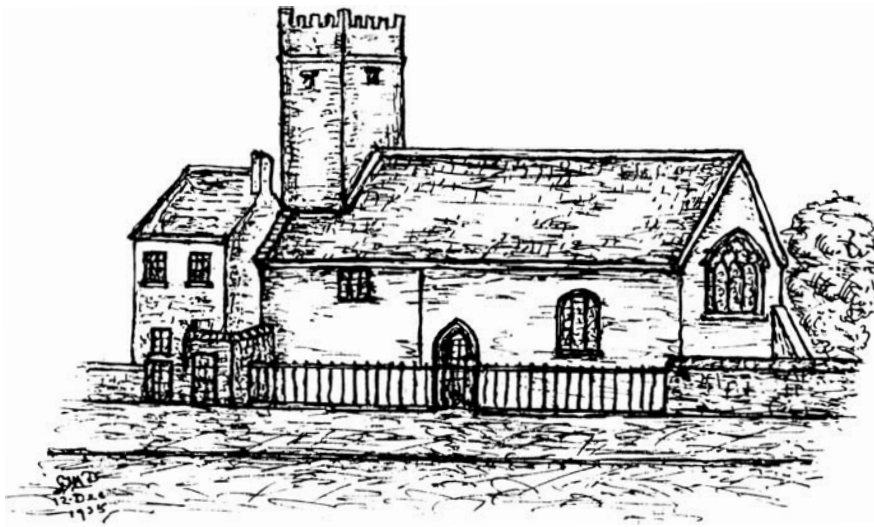
Mr. Doe has also kindly furnished a sketch and plan of the chapel which we reproduce here.

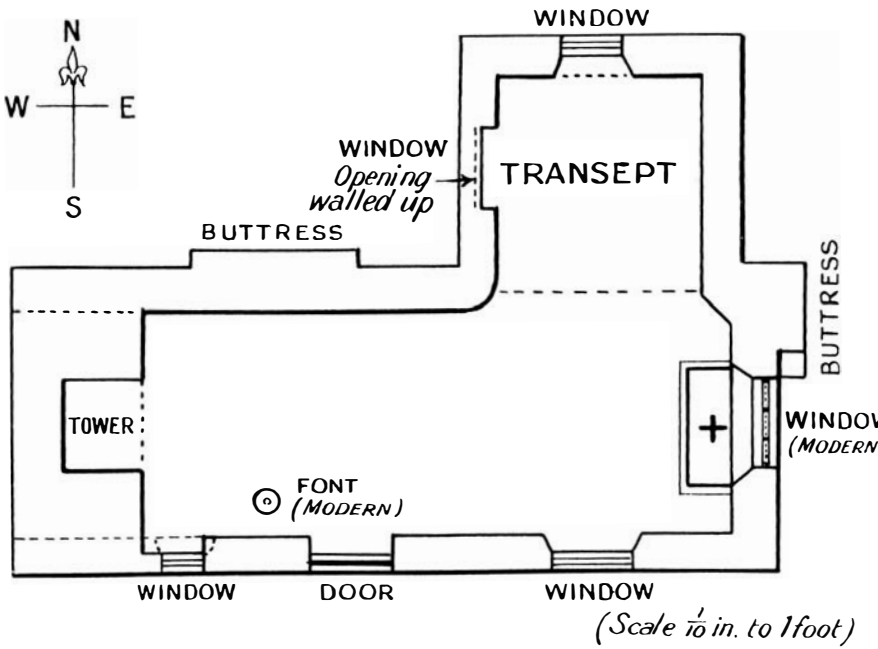
It would appear that leprosy, so common in this country in the middle ages, lingered on in distant parts of our islands such as Devon and Cornwall, Orkney and Shetland, after it had almost disappeared from the main portions of the land. Similarly, it lingered on in the fishing villages of Norwegian fiords long after it had become rare in the towns of Norway. In India we have found foci of leprosy in out of the way valleys of the Himalayas and in backwaters untouched by the flow of civilisation. For leprosy belongs to a certain stage of human progress and tends to linger on in places far removed when the country as a whole advances beyond that stage.

One of the problems which has engaged attention in recent years is the reason why leprosy, in spite of its frequent introduction from the dominions, colonies and dependencies of our Empire, does not spread and become a serious menace. In the slums of our cities overcrowding, underfeeding and insanitation, the conditions favourable for the spread of leprosy, still prevail. Some have suggested that this is because by a process of elimination our race has rid itself of susceptibility to the disease. In this way we have built up a

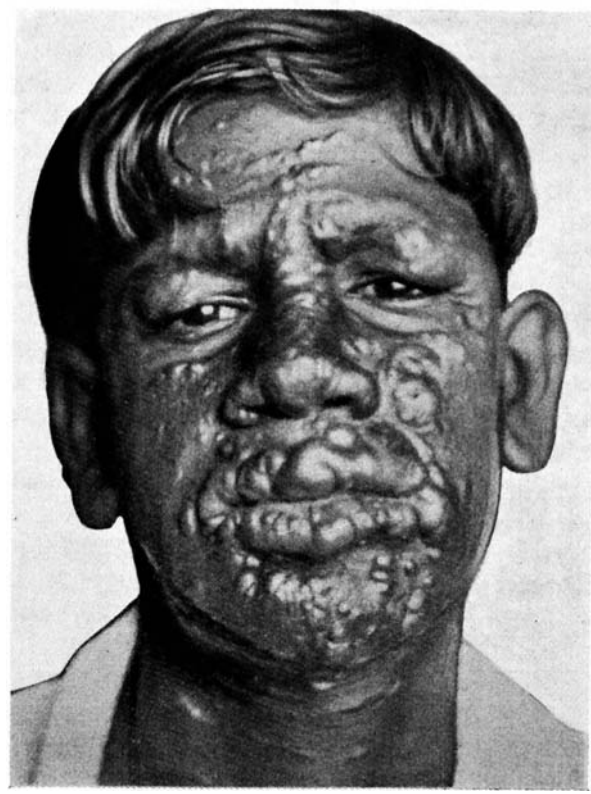
CHAPEL OF ST. MARY MAGDALENE,

AT TADDIPORT, LITTLE TORRINGTON, DEVON.





(Sketch and Plan by Mr. G. M. Doe).



Dermal Leishmaniasis, Resembling Leprosy.

See Review on page 96

comparative immunity to such diseases as measles, which is no longer the fatal disease that it was when first introduced to the virgin soil of the South Sea Islands.

But it is questionable whether leprosy was ever sufficiently widespread in this country to bring about such an effect. Many of the supposed cases of leprosy in the middle ages were probably syphilis and other disfiguring diseases. It was only when the treatment of syphilis by mercury was introduced that this disease was at all clearly differentiated from leprosy. Even today with all our modern methods, eminent physicians both in this country and India frequently fail to recognise leprosy. How much more likely was a mistaken diagnosis to be made in the middle ages.

For the last few years we have come to realise that the leprosy problem centres round the child. The first few years of life show low resistance to the disease, and while the majority of adult infections are comparatively slight and do not become infectious, child infections are much more serious and supply the severe cutaneous cases which carry on the infection from one generation to another.

It is probably in this fact that we find the best explanation of why the frequent re-introduction of leprosy into this country does not create a serious menace. The great majority of those who become infected during their sojourn in the endemic areas of our Empire, and return to this country suffering from leprosy, are adults and are therefore less likely to become infectious cases. Some are infectious, but they do not as a rule belong to the class that lives in our slums; they are chiefly males and are seldom likely to come in close contact with young children, the more so as they are generally people of education and are aware of the danger of spreading infection.

Hansen, when he visited the Norwegian leprous emigrants to the Middle West States of America, found that under the better sanitary conditions that obtain there they had not spread the disease to any of their associates. A few isolated cases of infection have occurred in this country in recent years, but our present stage of sanitation and civilization, though much room still remains for improvement, is well above the leprosy level.