

# ISOLATION: THE DEVELOPMENT OF LEPROSY PROPHYLAXIS IN AUSTRALIA

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In October 1930 an article entitled 'When will Australia adopt modern prophylactic measures against leprosy?' appeared in *The Medical Journal of Australia*. In tone the article was authoritative and persuasive. It was also demanding, although not as persistently critical as the accusation implicit in the title would suggest. Nevertheless, it brought to bear on the Australian situation a decade of international research and experience which indicated that Australia was not attuned to world-wide developments in leprosy prophylaxis and was unnecessarily tardy in introducing progressive methods of treatment. The author of the article was Sir Leonard Rogers who, with his colleague and co-researcher Ernest Muir, was pre-eminent in the international field of leprosy treatment and research. As a result of twenty years' work amongst the leprosy patients of India and continued international research, he became increasingly convinced that the compulsory, total segregation of persons suffering from leprosy was not only inhumane and ineffective but counter-productive and this was the crux of his message to the Australian medical fraternity.<sup>1</sup>

In essence Rogers argued his case against the Australians on two fronts: that an isolation policy deterred leprosy patients from coming forward for treatment, and that once confined to a lazaret the standard of treatment in Australia was considerably below that available in other countries. Rogers was quick to point out that current policy had not resulted in a diminution of new leprosy cases being recorded each year; on the contrary, the incidence of the disease had continued to increase and was acknowledged to be reaching epidemic proportions in the Aboriginal populations of northern Australia.<sup>2</sup> It will be argued here that it was the racial origins of Australia's leprosy patients and their social and economic position in Australian society which was the single most influential factor in determining Australia's approach to leprosy prophylaxis.

At the time of Rogers' appeal for a more enlightened and humane approach to leprosy treatment, Australia had three main centres for the internment of leprosy patients. The most modern and comfortable of these was the small lazaret attached to the Coast Hospital in New South Wales, which was home to less than ten people. A full-time medical officer and nursing staff were in attendance and the patients, all of whom were European or Asian, were afforded the highest standard of treatment available to leprosy patients in Australia. The second institution was on Peel Island, off the Queensland coast. It also had resident nursing staff but the thirty-five patients were attended by a doctor only on a weekly basis. A little

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<sup>1</sup> In a paper read at the Pan Pacific Science Congress, Sydney, 1923, Rogers had presented similar views but had provoked no reaction.

<sup>2</sup> On 'epidemics' see Curson 1985 and for statistical data see Saunders 1986 and Davidson 1978.

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under half the patients were Aboriginal, but the next quinquennium was to see a dramatic change in the ratio of Aboriginal and European patients. The Northern Territory's leprosy patients, all of Aboriginal descent, were accommodated on Mud Island, Australia's third main institution. No nursing staff was provided and visits by a medical officer were rare; those patients desiring treatment were obliged to administer their own. Such were the conditions at Mud Island that four female patients were segregated in an isolation ward at the Darwin hospital, as internment at the lazaret was seen to be detrimental to their moral and physical well-being. A new leprosarium for the Northern Territory, situated on Channel Island in Darwin Harbour, was opened in 1931. It was to this leprosarium that seventeen Aboriginal patients from Western Australia were transferred from their temporary accommodation at Cossack in 1931, to be joined shortly after by the twenty-six patients from Mud Island and those isolated at the Darwin Hospital. In the three remaining states leprosy cases were rare and those few reported were accommodated at infectious diseases institutions.

For many years the seriousness of leprosy in Australia and the extent of its spread was greatly underestimated, but by 1930 recognition of the problem could no longer be avoided. At the fifth session of the Federal Health Council, held in 1931, leprosy was reported to be 'perhaps, the most pressing problem of the moment' in tropical medicine, with the incidence of the disease corresponding 'very roughly with the degree of prevalence of coloured persons in the population'.<sup>3</sup> While Cilento's latter statement was misleading, a steady increase in the number of admissions to leprosy institutions had been evident during the preceding decade. However, by 1927 the total number remaining in institutions had been reduced through the continued practice of repatriating those not holding Australian citizenship and the high death rate in Australian leprosy institutions.

In the following decade figures soared. In Queensland patients were admitted to Peel Island at the rate of ten per year; by 1940 the number and racial mix of the patients was thought to warrant a second institution and the Fantome Island Leprosarium for Aboriginal patients was opened in that year.<sup>4</sup> In the Northern Territory the increase was even more dramatic with admissions to Channel Island averaging twenty-four per year. In 1939 all but ten of the 129 patients isolated there were Aboriginal people. The inconvenience of transporting the increasing number of Western Australian patients to the Northern Territory resulted in the establishment of a leprosarium at Derby on the northern coast of Western Australia in 1936.<sup>5</sup> This institution was exclusively for Aboriginal people and it supplemented the small isolation unit for Europeans in the south of the state. Sixty-five Aboriginal patients were immediately incarcerated at Derby, and by 1945, a Commonwealth funded survey program had resulted in a total of 430 Aboriginal people from the north-west being diagnosed as suffering from leprosy.<sup>6</sup> Only in New South Wales was there evidence of a weakening of the endemic foci and increasingly those admitted to the leprosarium at the Coast Hospital had contracted the disease outside Australia.

In a superficial way the treatment of leprosy patients in Australia could be seen to be very similar to that in other countries, although the differences that were to become embarrassingly acute by the end of the 1930s were already in evidence a decade earlier. As in other parts of the world, leprosy patients in Australia were treated with chaulmoogra and

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<sup>3</sup> Cilento 1934.

<sup>4</sup> *Annual Reports of the Department of Health, Queensland, 1929-1940.*

<sup>5</sup> Saunders 1986:133.

<sup>6</sup> Davidson 1978.

hydnocarpus oils, vegetable derivatives of the East Indian chaulmoogra tree. This centuries-old cure had been given twentieth-century sophistication when the production of the oil had been greatly refined and intra-muscular and subcutaneous injections had been substituted for the traditional nauseating, and less effective, oral treatment. The injections were extremely painful and often associated with debilitating side effects (Channel Island patients were given regular 'holidays' from treatment) but with even the faintest hope of a cure patients were usually willing to submit to the exacting regime. Internationally, this changed treatment, when combined with early detection, a balanced diet and hygienic living conditions brought about a significant increase in the number of patients responding positively to treatment. The condition of these patients was frequently referred to as 'cured' in the medical literature of the period but could have been more accurately described as 'disease arrested', as the high level of relapses was widely acknowledged. Nevertheless, treatment was significantly better and chances of arresting the disease greatly increased.

Isolation policies, or their absence, bore a direct relationship to the success of treatment. At the Calcutta leprosy institution, where the new treatment regime had been introduced, patients had been 'rendered bacteriologically normal and uninfected by weekly injections' of the oils. The Americans' record in Hawaii and the Philippines was both well documented and impressive. Under the most favourable conditions, such as those prevailing in Hawaii, the number of patients clinically cured of the leprosy was as high as 64%.<sup>7</sup> It was an exemplary achievement, but one which could only be obtained when patients were treated during the the initial stages of the disease. Commencing treatment early was the key to success, as was illustrated by the dramatically low 8% cure rate among advanced cases at the same American institution. Australia's compulsory isolation policies determined that ideal conditions for treatment could never be obtained, as the number of patients certified as lepers while still in the very earlier stages of the disease was low indeed. Understandably, with so little hope of a cure, treatment tended to be perfunctory, with neither patients nor medical staff hoping for more than the possible chance of reducing the gross physical destruction which the disease could so readily cause. Hence, while treatment in Australia appeared to be comparable to that available in other countries, the results were significantly different.

Australia also had legislative powers over leprosy patients very similar to those in other parts of the world, but while countries such as Malaya, the Philippines and some West Indian countries either introduced legislation which granted more personal freedom, choice of institutional or out-patient treatment and greater discretionary powers for doctors and law officers,<sup>8</sup> Australia was more rigidly enforcing strict regulations or, as in the case of the Northern Territory, introducing new repressive legislation as leprosy spread through the Aboriginal population. When the first Australian case of leprosy had been discovered in Queensland in 1855, detention and isolation of lepers had been provided for under the Public Health Act. All other colonies, except Tasmania, had similar legislation. After the federation of the six Australian colonies in 1901, the new states maintained the right to administer their own health services and to develop policy, except in the area of quarantine which became a federal concern. The Northern Territory alone was subject to federal policy, as from 1911 it was controlled by the Commonwealth government, which enacted legislation specific to the Territory. By 1930, most states had expanded Public Health Act clauses dealing with leprosy, so as to more clearly define isolation provisions. Queensland and the Northern Territory dealt with the problem with specific legislation and had,

<sup>7</sup> For greater detail see Rogers c.1925.

<sup>8</sup> Saunders 1986:36-40.

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respectively, the Leprosy Act of 1892 and the Ordinance for the Suppression of Leprosy of 1928.

In Australia the enforcement of isolation policies had the same negative effects witnessed in countries with similar legislation. When the prospect of isolation, with little hope of either cure or release, was the immediate and inevitable result of a diagnosis of leprosy, patients were understandably reluctant to come forward for treatment. This was true of both European and Aboriginal patients. Europeans, fearful of the stigma and the social and economic repercussions for their families, delayed seeking medical assistance until it was unavoidable or, when a diagnosis of leprosy was mooted, refused to submit to tests which would allow a conclusive diagnosis. In New South Wales, where the majority of patients were European, legislation stipulated a patient's certification as a leper must be based on bacteriological as well as clinical proof of the existence of the disease. This was also true in Queensland but in practice applied only to Europeans. This measure was thought to be essential when the result was confinement for life in an institution, but it compounded the difficulties of treatment. Some doctors colluded with patients in avoiding an accurate diagnosis while others, whose experience made a clinical diagnosis possible but who were unable to substantiate it with bacteriological evidence, were bound to declare the person non-leprosy. In either case the result was the same: the patient did not receive treatment. For Aboriginal patients in Queensland and patients in the Northern Territory and Western Australia, a clinical diagnosis was sufficient for commitment to a leprosarium. In no state was the level of infectivity of the various types of leprosy taken into consideration, although decades later the decision to isolate a patient was often based on this assessment and during the 1930s it was an important determining factor in other countries.

The negative effects of these stringent isolation policies were twofold. Obvious even to the most ardent advocates of compulsory isolation was the fact that many people suffering from leprosy remained in the community in an infective state for a much longer period of time than if they were free to seek medical advice without the threat of internment. Where isolation was seen to be the principal means of eradicating the disease, this rendered the prophylaxis almost ineffective. Even more significant, in the light of overseas research, was the number of patients in the early stages of leprosy who went untreated. Only when the disease advanced to a stage where detection was no longer avoidable did the patient come forward, but by then the chances of successful treatment were greatly reduced. Regular examination of the patient's contacts was considered to be an essential component of modern leprosy prophylaxis but the authorities' ability to consistently screen all contacts was also seriously affected by the adverse reaction to compulsory isolation.

The Aboriginal people were perhaps even more efficient than Europeans at avoiding detection when suffering from leprosy. Unlike the white community they had no long-standing tradition of fear associated with leprosy. It was to them a new disease which they accommodated within an already developed understanding of the causes of illness generally. It was inconvenient and often debilitating but did not provoke rejection. During the 1930s, large numbers of Aboriginal people lived in isolated bush communities, usually on their traditional lands which had highly significant religious and ritual associations. Some still followed a semi-nomadic lifestyle. Bitter experience had taught that those found by the authorities to be suffering from leprosy would be sentenced to a life of imprisonment in alien country. Impending visits by medical officers or, more often, mounted policemen would often result in lepers being hidden or whole groups of people moving into inaccessible country to avoid inspection. Thus, they gained the chance to avoid or temporarily postpone the humiliating experience of being chained like a criminal and transported, often in conveyances built for animals and subject to the curious, prying eyes

of the townsfolk who made no effort to hide their revulsion, to be finally incarcerated in a total-care institution from which there was little hope of emerging alive.

Despite the evasive measures adopted by Aboriginal people, they were isolated in increasing numbers in northern leprosariums, but their predilection for escape whenever the opportunity presented itself made the selection of island sites for leprosariums a necessary corollary to the isolation policy. Hence, as island leprosariums in other countries were closed Australia established new ones: Channel Island in 1928 and Fantome Island in 1940, both Aboriginal institutions. The one notable exception was the Derby leprosarium where perhaps the disastrous experiences of the lock hospitals on Dorre and Bernier islands earlier in the century had taught that there was little to be gained from such practices.

The accusation that leprosy prophylaxis in Australia was repressive and outdated should not have been entirely unexpected as it had been foreshadowed from within the ranks of the Australian medical profession. In 1926, E.H. Molesworth published an article in *The Medical Journal of Australia* on 'The leprosy problem' in Australia.<sup>9</sup> Much of his argument was based on the theory of European racial immunity to leprosy engendered by the demise of susceptible stock, a premise not widely supported by leprologists. He also alleged that diagnosis in Australia was inefficient and haphazard, making the isolation of those detected grossly unfair. Despite the different suppositions, Molesworth concurred with Rogers' argument against compulsory isolation. In summary he wrote:

if it be conceded that we are naturally resistant and a relatively immune race, that by far the greater part of our population is outside the bounds of a climate favourable to leprosy and that our conditions of life and housing are very unfavourable to this disease, that the hope of a cure will induce more patients to come into the open than any restrictive legislation, if these or even most of them be admitted, what is the rhyme, reason or justice in continuing the existing practice and condemning fellow countrymen to an indeterminate incarceration, to a fate which they fear with some reason to be worse than that reserved for a convicted burglar or in New South Wales at least even for a convicted murderer?

The editorial of that 18 September issue of *The Medical Journal of Australia* lent Molesworth unqualified support. Claiming leprosy sufferers to be a powerless minority group, it alleged that other less infectious and more deadly diseases were not treated by isolation, an inexplicable position unless the traditional fear of ugliness and evil associated with leprosy be acknowledged. 'A leprosy infection is a misfortune, not a disgrace' it argued. 'If lepers were as common in Australia as consumptives, this measure would be refused on social, economical and humanitarian grounds.'

However, it is evident that in Molesworth's article and in the editorial, the writers referred only to leprosy in the European community with scant attention being given to the Aboriginal situation. And it was in the Aboriginal community that most leprosy patients were to be found and certainly, by 1930, in sufficient numbers to have a significant influence on policy. The preponderance of Aboriginal patients gave rise to the situation in Australia where, to the Western tradition of fear associated with leprosy, the stigma of it being a 'native disease' was added. As the Aboriginal people were seen to be socially inferior and considerably below Europeans in the evolutionary process, circumstances were ideal for the rigid enforcement of isolation policies. Moreover, Aborigines were considered to be a significant threat to the health of the European community, particularly in tropical Australia, a factor which gave added impetus to a wider policy of institutionalisation of the Aboriginal population generally. This perceived threat to European health was particularly

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<sup>9</sup> Molesworth 1926.

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prevalent in areas where the Aboriginal population was greater than the European, as was the case in the northern regions of Australia. In the Northern Territory the small, widely-scattered White population was only a fifth of the Black and was thought to be vulnerable to 'native diseases'. Thus the medical care provided to the Aborigines was dispensed with clear economic and political motives and to promote the process of colonisation; the garb of altruism with which we have traditionally draped dispensers of Western medicine of past years has worn fearfully thin.

In positions of increasing power in 1930, and consequently major determiners of leprosy policies, were two medical officers, C.E. Cook and Sir Raphael Cilento, respectively the Chief Medical Officer of the Northern Territory and Director-General of Health, Queensland. Both were vociferous isolationists to whom others less knowledgeable in the field of leprosy looked for guidance. Such was their influence that even J.H.L. Cumpston, Director-General of Commonwealth Health, who was aware of the trend away from compulsory isolation and island sites for leprosariums in other countries, and sensitive to the criticisms of his colleagues in the international arena, allowed himself to be persuaded that modern prophylaxis was inimical to the solution of the leprosy problem in Australia. This is not to suggest that Cumpston was in any way gullible or an ineffectual administrator but rather that public perceptions of the low status of Aborigines were all-pervasive and the arguments presented by Cook and Cilento powerful. Also, Cook and Cilento, both persuasive and compelling writers, validated their claims with the use of scientific data drawn from the Australian experience, which they claimed were determined by variants not replicated in other countries. The first of these was the living conditions of the Aboriginal people, among whom the greatest number of leprosy cases was to be found.

The dramatic improvement in the condition of most Aboriginal leprosy patients during the first few months of treatment, a phenomenon noted by many leading leprologists, suggested that high standards of nutrition and hygiene were imperative for successful treatment. The living conditions of Aboriginal people were abysmally poor. With the encroachment of a settled white community into Aboriginal lands, the hygiene provided by a semi-nomadic lifestyle broke down and the traditional food sources which had kept the Aborigines a healthy race for thousands of years, gave way to a diet so imbalanced that illness was inevitable. Treatment under these conditions was doomed to failure from the outset, which effectively negated any opposition to legislative measures to institutionalise all Aboriginal leprosy patients regardless of the stage, type or infectiveness of their disease.

For the same reason any system of release, discharge, out-patient treatment or parole was seen to be inappropriate for Aboriginal patients. Once removed from relatively hygienic leprosarium surroundings, where regular balanced meals were supplied, a resurgence of the disease was likely. In Australia, limited discharge was extended to European patients in New South Wales and to a lesser extent in Queensland, but only after the patient had returned negative bacteriological tests for a prolonged period of time, usually in excess of two years. In 1937 Cilento argued through the pages of the *International Journal of Leprosy* that a system of parole and outpatient treatment in Australia was not possible in 'respect to coloured persons'.<sup>10</sup> Elaboration of this statement was not made but implicit was the view that the low standard of living and education of the Aboriginal people militated against successful treatment administered other than through isolation.

Further complicating the issue was Aboriginal resistance to Western explanations of disease, a factor which continues to compound Aboriginal health problems today. Given no evidence that Western medicine was capable of curing leprosy, Aboriginal people had little

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<sup>10</sup> Cilento 1937:49.

incentive to submit to the painful process of weekly injections and nauseating tablets. Even within the leprosariums, only strict discipline ensured that all patients received regular treatment. The inability of the authorities to compel patients to undergo treatment except in an institutional setting left little doubt in the minds of the isolationists that segregation was essential.

If Cook and Cilento needed further substantiation of their case, they found it in the geographical distribution of the Aboriginal patients. The northern regions of Australia, where endemic leprosy was to be found among the Aborigines, are sparsely populated. During the 1930s, and indeed to some extent today, living conditions were primitive, transport expensive and irregular, and isolation extreme. Under these circumstances, even if Aboriginal people could be induced to report for treatment, the difficulties in establishing health clinics were thought to be insurmountable. To be effective, numerous clinics would be required, the funds for which were unattainable in the difficult economic conditions of the depression years. Nor during this period had Aboriginal welfare become an issue, and governments generally parsimonious in providing medical facilities in remote communities were even more reluctant to shoulder the responsibility of providing adequate health care for Aborigines. With the cost of supporting and treating a patient in a total care institution in the Northern Territory running at below £38 per annum, the amount increasing in other states according to the number of European patients accommodated, institutional care had economic advantages over out-patient care in remote communities.

Thus armed, Cook and Cilento were able to either persuade or over-rule anti-isolationists in Australia. They argued that successful treatment meant institutional care, but they were not able to offer the high standard of treatment which might have softened the injustices of the isolation policies. It was in the area of treatment that the Australian case for isolation broke down and the authorities continued to isolate patients in institutions which they could not, or would not, adequately fund. Indicative of this gross lack of commitment is the willingness of the authorities to allow various orders of the Catholic Church to shoulder full responsibility for the daily care and nursing of the patients in Aboriginal institutions, a duty which they discharged faithfully under conditions of great deprivation. In the Northern Territory alone were salaried staff employed, an expense which was dispensed with in 1942 when most residents living north of Adelaide River were evacuated. Among the evacuees were most of the ten European patients from Channel Island, thereafter making Channel Island almost exclusively an Aboriginal institution. When new staff was sent to the island in 1943 it was Catholic nuns who were recruited.

Long tradition ensured that isolation policies attracted wide public support and, as laudable as the anti-isolationists' sentiments were, extensive public education would be needed before they could be widely accepted. Both official and common language made use of such terms as the 'leper' whom it was thought necessary to 'arrest' and those patients reported to have 'absconded' were labelled 'escapees'. When legislation and official action lent support to popular fancies a change of attitude among all but a few was impossible. Thus, reports of escapees were not uncommon, like that of an 'escaped leper' in the Sydney area in 1944, who although 'not considered dangerous' was nevertheless described in the daily paper in great detail for easy identification.<sup>11</sup> Inevitably, the seclusion in which leprosy sufferers were treated served to heighten the mystery and, hence, the fear surrounding the disease. Those found to have the disease were whisked away to become inmates in a total-care institution and rarely afforded the opportunity to attend to personal affairs or to farewell relatives. Often the possessions they left behind were burnt and their

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<sup>11</sup> *Sydney Morning Herald*, 6 December 1944.

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departure total and final. It was not until the post-war years that the visiting of Aboriginal leprosy patients was in any way facilitated or encouraged.

Whether in support of compulsory isolation or advocating its gradual abandonment, all those of the medical profession involved in the debate agreed with two of the three components of successful prophylaxis as put forward by Cook. In response to Molesworth, Cook asserted it was 'highly desirable that a prompt and genuine effort be made:

(a) To hasten the successful termination of the system [of isolation] a thorough investigation into the incidence of the disease for the purpose of insuring the isolation of all patients deemed infective;

(b) To ameliorate the condition of those isolated by the provision of improved lazarets and inaugurating a system of leave parole for patients who have responded to treatment;

(c) To provide for the outdoor treatment of lepers found in non-infective stages and for the regular examination of contacts and discharged persons.<sup>12</sup>

It was to be through the institution of these last two policies that the Australians would seek to justify the first.

Regrettably, not even Cook's first, and sound policy (if one accepts the tradition that leprosy patients should be isolated at all) was instituted in the spirit in which it was written. Aboriginal patients, and Europeans in the Northern Territory, were isolated regardless of their infectivity. This included children suffering from the neural form of leprosy which was often self-aborting. Moreover, in the leprosariums were many 'burnt-out' cases in which the disease had run its course leaving patients incapacitated to varying degrees but no longer infective.

Nor was Cook's second and most humane policy of improvement in living conditions and parole regulations observed. Writing of this issue in 1924 Cook had admonished:

If the community abrogates to itself the right to deprive those unfortunates of their liberty and to add to the horrors of incurable disease, the miseries of lifelong imprisonment, surely it also assumes the responsibility of housing them in comfort and in endeavouring to ensure that their dragging years of decline shall pass with a minimum of suffering. Too long the leper has been an outcast and the object of public persecution rather than practical sympathy. It is to be hoped that the Lazaret of the future will be haven of refuge sought by the leper, rather than a loathsome prison to be avoided if need be by suicide.<sup>13</sup>

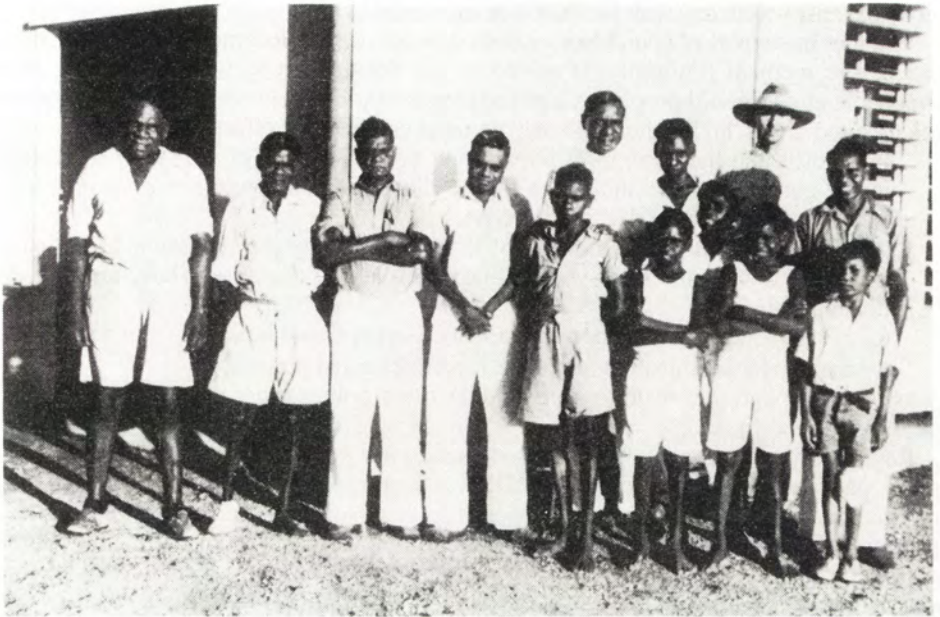
Neither the Northern Territory leprosarium, for which Cook was directly responsible from 1927 to 1939, nor any other leprosy institution in Australia during this period became anything more than a poorly equipped, prison-like detention centre in which inmates listlessly and idly passed away the days. At Channel Island some initial attempts were made to house and feed inmates at a reasonable standard, but as the leprosarium population increased government parsimony ensured that funds for extensions and maintenance were unavailable. Situated on a cheerless, low-set and waterless island surrounded by dense mangrove swamps, conditions deteriorated as the vegetation was used for firewood, the water shortage became acute and the overcrowding in the Aboriginal quarters scandalous. Patients were provided with no education, no training and, except for a few, no purposeful work. It was a place of death and only the indomitable spirit of some of the patients saved

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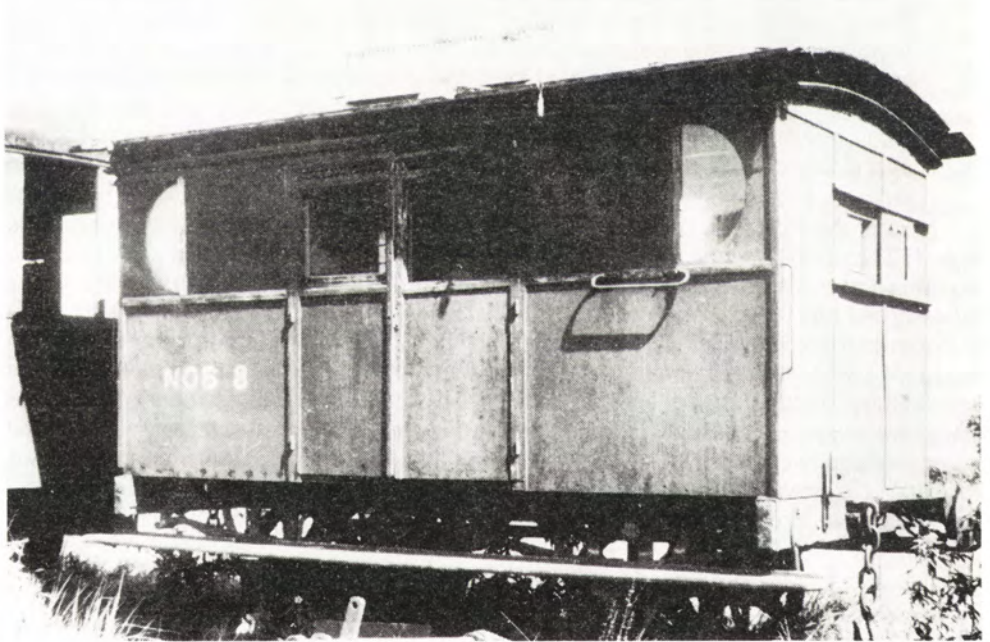
<sup>12</sup> Cook 1926.

<sup>13</sup> Cook 1924.





Aboriginal leprosy patients gather outside the recreation hall on Channel Island during the visit by a Salvation Army worker, c. 1946. Courtesy V. Pedersen.



Converted cattle truck used for the transportation of leprosy patients on the North Australian Railway until 1939. Courtesy J.Y. Harvey.

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it from being a complete hell-hole.<sup>14</sup> Peel Island Leprosarium fared somewhat better as the increased proportion of European patients guaranteed greater community awareness and involvement, and a more liberal level of government funding. Nevertheless, in comparison with institutions for the mentally ill and those for patients suffering venereal diseases, the standard of care and the facilities at Peel Island were indicative of low government commitment to much beyond interning leprosy patients. During the 1930s leprosy prophylaxis in Australia continued to focus on protection of the community rather than relief to the sufferer, a tradition which was undergoing marked change in many other countries.

The depressing living conditions endured by the patients were not alleviated by the prospect of possible release. Cook's 1926 parole scheme attracted Cilento's support, but although it operated in a limited way in Queensland amongst European patients, it was never introduced into the Northern Territory. Nor was limited release or any form of contact with families encouraged during this period. From the period 1932 to 1938, of the two hundred and twenty patients admitted to Channel Island only twenty left the island, not all of them legitimately, as included in the discharge figures are those who 'escaped' and avoided further detection.<sup>15</sup>

During the same period sixty-two patients died, providing graphic support to the popular notion amongst the patients that they had been sent to Channel Island to die. The Queensland record is a little more positive, again because of the higher proportion of European patients. For the period 1925-37, of the hundred and twenty-six admitted to Peel Island, forty-two had been discharged with ten being readmitted some time later. With thirty-four deaths, the proportion of deaths was similar to that on Channel Island.<sup>16</sup> Western Australian figures for a later date, 1937-1945, indicate that the death rate was slightly lower with one hundred and forty-six deaths among four hundred and eighty-eight admissions. Eleven per cent of patients, almost exclusively from the group suffering neural leprosy which responded most readily to treatment, had been discharged as cured, causing Dr Musso, under whose immediate jurisdiction the leprosarium fell, to comment that 'lepomatous cases have very little chance of discharge under present conditions of treatment'.<sup>17</sup>

The third component of Cook's policy, upon which the success of the entire approach was dependent, and which would go some way towards legitimising compulsory isolation, was the least effectively practised. Without exception, it was agreed by leprologists that crucial to the eventual control of the disease was a thorough, systematic and regular examination of all contacts of a recognised sufferer for a period of three to five years. The Third International Scientific Conference on Leprosy, held in Strasbourg in 1923, adopted a resolution expressing the need for such a measure and it was the one point of agreement between Rogers and Molesworth, and the isolationists Cook and Cilento. Such examinations had the benefit of minimising the period in which an infective person was unaware of his condition, and consequently not receiving treatment, thus exposing friends, family and work associates to possible infection. It also had the advantage of increasing the chance of successful treatment resulting from an early diagnosis. An isolation policy administered in conjunction with an effective survey system might have gone some way to

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14 Saunders 1986.

15 Saunders 1986: Chapter 5.

16 Cilento 1939:205.

17 Davidson 1978:178-182.



Aboriginal accommodation huts on the denuded Channel Island, c. 1937. Courtesy Commonwealth Archives.



Channel Island patients prepare for a fancy dress party, c. 1939. Courtesy Therese Puertelano.

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reducing the incidence of the disease in northern Australia, but attempts to fund and administer such a program were never seriously entertained. This resulted in the indiscriminate incarceration of leprosy patients, which afforded neither the patient nor the community protection or profit.

In the Northern Territory no regular medical surveys of Aboriginal communities were carried out until 1951. Prior to this the detection of leprosy patients was mostly a matter of chance, which involved mounted policemen to a far greater extent than it did medical officers. 'Leper suspects' were brought in, often in chains, for examination, with little or no attempt being made to trace contacts. Even where annual inspections of mission stations were conducted by medical officers, and where the relatively settled community would facilitate closer scrutiny, no systematic surveys were conducted. In Queensland, Cilento documented one incident in which 'a complete list of the families yielding suspected or proved cases has been made, and every member of these families is under examination at intervals of three months', but this was the exception rather than the rule.<sup>18</sup> More often the lack of regular surveys was explained with the disclaimer that 'it is particularly difficult to trace contacts among natives, because they rarely know their own relationships'.<sup>19</sup> It was 1938 before Musso arrived in Western Australia on Commonwealth funding to conduct a systematic survey of the endemic regions of that state; prior to this periodic 'round-ups', usually resulting from the agitations of pastoralists, had sufficed.

Molesworth, addressing the problem of leprosy prophylaxis in Australia in 1926, had suggested that 'control of the Aboriginal side of the [leprosy] problem may be impossible or impractical [and] with the rapid dying out of the Aborigines...this problem will probably solve itself'.<sup>20</sup> However, within a very short time the fallacy of the 'dying race' theory became evident, leaving Cook and Cilento with the pressing dilemma of the spread of leprosy rapidly reaching epidemic proportions across the north of Australia. It is evident that the difficulties they faced were compounded by vast distances and isolated communities, by the extreme state of poverty and ill health of the Aborigines, and by the cultural barrier which resisted the incursion of Western notions of disease and medicine. However, although claiming special circumstances Cilento and, more persistently, Cook based their arguments on the scientific grounds of epidemiology rather than face the overwhelming issue of Aboriginal welfare.

While scientific arguments were promulgated to justify isolation policies it is evident that, in Australia, to the emotive and stigmatising tradition of leprosy had been added the aspersion that it was a 'native' disease. Control of the disease through repressive legislation further intensified the stigma associated with leprosy. During the 1930s, at the height of the epidemic, policy-makers were advocating institutionalisation in various forms as a solution to the 'Aboriginal problem', and although humanitarian or paternal motives were espoused, economic and social motives usually predominated. Thus, isolation of leprosy patients provided yet another justification for the restriction of Aboriginal movement and control over the lives of those considered a social threat and an economic burden. Also, while leprosy remained a disease of the Aborigines, little professional interest would be taken in its etiology or its patients. Not only were the doctors inadequately equipped and trained to treat leprosy, but in the three large Aboriginal institutions, Channel Island, Fantome Island and Derby, doctors were obliged to combine their attendance at the leprosariums with numerous other duties, their area of responsibility often covering

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18 Cilento 1939:202.

19 Cilento 1939.

20 Molesworth 1927:389.



'Catholic staff on Channel Island at the burial of Martina, a leprosy patient from Bathurst Island'.

## LEPROSY PROPHYLAXIS IN AUSTRALIA

extensive tracts of sparsely populated country. No experts in leprosy arose from within the Australian medical profession. Treating leprosy patients generally, and Aboriginal patients in particular, was neither lucrative nor prestigious employment. Those few who evinced some interest in the disease were generally heavily committed to other fields of endeavour, as were Cook and Cilento, who were principally health administrators, and Molesworth, who divided his time between a thriving private practice and research in dermatology.

For as long as Australia remained indifferent to the welfare of its Aboriginal population, compulsory isolation of leprosy patients would continue. Leprosy prophylaxis, employed as were so many other areas of tropical medicine as a colonising tool in the north of Australia, had as its primary aim the protection of the white community and little interest was shown in the disease or those who became the victims of both disease and society. Because of the preponderance of Aborigines amongst leprosy sufferers, the Australian authorities vigorously enforced a policy which resulted in total isolation for all Aboriginal and most European leprosy patients. There can be little doubt that had Europeans been the most severely afflicted group a more humane approach would have been adopted and a higher standard of treatment offered. For almost thirty years Australia, which was internationally recognised for its progressive approach to medical research and treatment in many fields, denied leprosy patients adequate treatment and trenchantly enforced a negative and inhumane policy. This was despite the fact that neither funds nor medical expertise was available to support the high level of institutional care necessary for such a policy nor to effectively carry out the systematic surveys which were essential for success. Australia's isolation policy was finally abandoned in the 1980s and Derby, the last of the leprosariums, closed in 1986. Frequent delays in Aborigines seeking treatment for leprosy today indicate that memories of isolation linger yet.

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