A City in Crisis:
The Human and Institutional Responses to the Bubonic Plague Outbreak of 1720 in Marseille

by

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Class of 2022

An essay submitted to the faculty of Wesleyan University in partial fulfillment of the requirements for the Degree of Bachelor of Arts with Departmental Honors in French Studies

Middletown, Connecticut

January, 2022
Acknowledgments

This essay would not be possible without the guidance and encouragement of Professor Jeff Rider. Thank you for suggesting that I turn my term paper into a senior essay despite writing it in my junior year, and for making that transition possible. I will forever appreciate and remember your kind words of affirmation throughout the writing process.

Thank you to the faculty of the French Section, especially Professors Catherine Poisson and Stéphanie Ponsavady. Professor Poisson, your feedback shaped my French reading and writing style into what it is today. Professor Ponsavady, as my pre-major advisor, you encouraged me to pursue the French major which has been a wonderful addition to my academic experience at Wesleyan. Thank you for furthering my appreciation for Le Sud this semester; this essay will not be the end of my exploration.

To my wonderful housemates Sam, Caitlin, Neff, and Noah: thank you for filling our home and our entire time at Wesleyan with love, laughter, and support. You are all unfailingly compassionate and relentlessly entertaining. I can’t imagine the past four years without you.

My most heartfelt thanks go to my parents, Jim and Cecile. Thank you for modeling perseverance and intelligence while never failing to find the humor in life. You instilled in me an excitement for discovery that has guided these last four years and will inform the rest of my life. Thank you for being my biggest cheerleaders, even from 3000 miles away.
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Introduction

When the word “plague” comes up in conversation, most people think of the bubonic plague, or Black Death, that swept through Europe, Africa, and Asia in the fourteenth century. This is not surprising, since the Black Death is the most fatal pandemic in recorded history. It is estimated that between 75 and 200 million people died from the illness across the three continents. However, this infamous outbreak was neither the first nor the last major outbreak of the bubonic plague. The first epidemic, known as the Plague of Justinian, began in 542 and spread throughout the greater Mediterranean area. The second epidemic, or the Black Death, followed in 1346. This period was the “plague” that fascinated me as a young student in history classes. Gruesome descriptions of symptoms and treatments entertained me even as I learned that the disease reduced Europe’s population by at least one third. I assumed that after the fourteenth century, the bubonic plague had vanished into thin air.

In May 2020, in a search for perspective during the depths of the COVID-19 pandemic, I dove down a Wikipedia rabbit hole reading about the plague. I discovered that contrary to my earlier beliefs, the bubonic plague did not disappear after the fourteenth century. In fact, outbreaks of the plague continued well into the nineteenth century. To my surprise, the last outbreak of the bubonic plague in Western Europe occurred in Marseille, France in 1720. Despite what I believed to be a well-developed grasp of French history, I had never heard of an outbreak in France after the devastating second plague pandemic. As I scrolled through Marseille’s Wikipedia page, I became increasingly captivated by the details and
stories from this period. I began to draw connections between Marseille’s response to the plague and the United States’ response to COVID-19 exactly 300 years later.

The more I discovered about how the inhabitants of Marseille, the local government, and the French monarchy responded to the epidemic, the more I realized that the manner in which we as humans react in times of crisis has not evolved radically. When the COVID-19 crisis began, people around me began making the occasional joke along the lines of, “well at least it’s not the plague!” The subtext of many of these jokes was that we are much better equipped to handle a pandemic in the twenty-first century than those living during the eighteenth or the fourteenth centuries. While COVID-19 as a disease is less fatal than the bubonic plague, I’ve come to realize that the inhabitants of the twenty-first century are not intellectually or emotionally superior to the inhabitants of eighteenth-century Marseille.

I began by investigating the medical response to the plague in Marseille, which seemed a logical place to start as I wanted to analyze a medical crisis. When COVID-19 began to spread in the United States, we saw doctors and public health officials spring into action by disseminating new guidelines and treatment suggestions. I wondered if a similar reaction had occurred in Marseille, even without the communication technology we have today, including the internet and social media. Did doctors share information and resources then like they do today or was treatment less standardized? The similarities I discovered between the medical responses to infectious diseases in 1720 and 2020 led me to wonder if other aspects of the human response to disease might have remained as similar as well.
As we observed with the COVID-19 pandemic, the ways in which governments, both local and national, respond to a crisis has significant ramifications on its development. In 2020, New Zealand immediately began a strict lockdown and stopped travel. As a result, they effectively eliminated COVID-19 from their nation and were able to return to an almost normal life. The United States chose the opposite approach. Poor communication and coordination between the federal government and the states caused COVID-19 to spike across the country as citizens refused to follow local ordinances, which varied from state to state. After living through a less-than-ideal government response, I was curious as to the approach executed by the local government of Marseille and the French monarchy.

When we think about institutional reactions to epidemics, we immediately consider the medical community and the government. In my mind, it is vital to include religious institutions as well. In the eighteenth century, France was a predominantly Catholic country. Catholic leaders, including the bishop of Marseille, had power, resources, and great influence over their congregants. I have included a chapter dedicated to the religious response to the plague that discusses the Catholic church, because excluding an institution with power comparable to that of the French monarchy would be a gross oversight. While researching this chapter, I discovered that most academics who write about the plague in Marseille fail to mention religion at all. They instead focus on science, medicine, and government. These facets of the response to the epidemic are integral, but I believe that the picture is incomplete without religion.
Therefore, I will discuss all of these communities and their responses to the bubonic plague in Marseille. Before diving in, I’ve included a chapter describing Marseille’s history of infectious diseases, the public health infrastructure in place, and how the plague still managed to spread in 1720. The following chapter outlines Marseille’s medical response, including key physicians, treatments, and scientific hypotheses of the time. Next, I discuss how the local and federal governments as well as the French monarchy responded to the outbreak. Finally, I explore the religious response to the plague, focusing on the bishop of Marseille during the epidemic and his work to heal the city. I’ve chosen this order because it is loosely chronological. Once the plague began to spread in Marseille, the medical community was first to react. Doctors began treating patients before the infectious disease was formally identified. The government was the next institution to respond, followed by the Catholic church. This chronology is quite similar to the one I observed at the beginning of the COVID-19 pandemic.

There has never been a more pertinent time to study past epidemics in modern memory. Gone are the days when I sat in history class wondering how it felt to watch your town become overrun with disease. By exploring the institutional response to the bubonic plague in Marseille, I hope to gain a comprehensive understanding of the scope of human reactions to a medical crisis not unlike that of the present. The exploration of the multiple sides to plague management in Marseille from 1720 to 1722 should provide a new perspective to readers currently navigating the COVID-19 pandemic.
Chapter 1: Historical Background

Marseille, a city located on a bay along the southeast coast of France, has a long history with epidemics and infectious disease. Situated on the Mediterranean Sea, its harbor is ideally located for trade with Italy, Spain, North Africa, and the Middle East. During the eighteenth century, all goods in route to northwestern Europe from the eastern Mediterranean passed through the port. Along with these economic benefits came a high risk of disease spread via trade ships.

The second epidemic of the Black Death arrived in Marseille from Constantinople via a trade ship in mid-September, 1347. The same ship that brought plague to Marseille also contaminated other centers of trade in the Mediterranean, including Alexandria, Genoa, and Venice. While the ship visited other cities in Mediterranean Europe, the spread of the disease by land began in Marseille. By March 1348, the plague had spread to the coast of Spain. The disease spread by land from Marseille to Bordeaux, a trade hub on the Atlantic coast of France, which went on to contaminate its trading partners (Benedictow 2005, 46-47). The Black Death went on to infect the rest of Europe, Africa, and Asia, killing millions of people and causing an especially dramatic reduction in the population of Europe.

Due to the city’s past history with disease, infection-preventing infrastructure existed well before the plague’s arrival in Marseille on May 25th, 1720. Marseille had a well-developed quarantine system in place by 1620, as well as hospitals for contagious diseases (Barbieri and Drancourt 2018, S6). Prior to the plague outbreak in 1720, Marseille had already experienced the second epidemic of the bubonic plague, more commonly known as the Black Death, in 1347, as well
as outbreaks of cholera and yellow fever. The most effective preventative measure in place was the lazaretto: a maritime quarantine system invented in Venice. A lazaretto, or lazaret, was an island off the coast of a port city where the crew and cargo of incoming ships were quarantined until they were determined to be free of infectious diseases, including the plague. Marseille’s first lazaretto was established in 1526 on Pomègues, an island off the coast of the city (Barbieri and Drancourt 2018, S6). In 1720, Marseille had three lazarettos in operation. The most recent had been developed between 1663 and 1683 off of the city’s west coast and was home to a small community of staff working to unload and distribute incoming goods (Devaux 2013, 172). This lazaretto was dangerously close to and accessible from the city of Marseille, an error that would contribute to the quick spread of disease from the plague ship to the city in 1720. The navy was responsible for preventing passengers and crew from escaping potentially infected ships. Detailed plans enforced the separation of those in different stages of quarantine and the cleaning of the ships themselves (Snowden 2019, 70-71).

Public health boards worked in conjunction with the lazaretto system to prevent the arrival of infectious disease in Marseille. Beginning in 1702, King Louis XIV required all ships entering the port of Marseille to submit paperwork from previous ports identifying their risk of disease (Barbieri and Drancourt 2018, S6). The captain of an incoming ship was obligated to report to the health office on the island of Pomègues, under the control of the City Council. He was required to produce letters from the health offices of each port the ship had visited and identify all passengers on board. His ship was then either issued a clean bill of health
(patente nette) or a poor one (patente brute). Quarantine and decontamination measures at the lazarettos were determined according to the health certificate assigned to the ship. A ship with plague cases or a patente brute was sent to a lazaretto twenty miles away from the city for at least half of its quarantine. Some ships and their cargo were even burned. Ships given the patente nette either by Marseille or other nearby ports were assigned to a lazaretto closer to Marseille and often had shorter or even no quarantines. The Board of Health responsible for assigning incoming ships to the appropriate lazaretto according to their risk level consisted of sixteen elected representatives chosen by merchants, traders, and doctors. Their meetings were closed to authority figures associated with the maritime economy, including the captain of the port (Devaux 2013, 174). The lazarettos and supporting patente system were very effective and failed in 1720 due only to protocol violations. Other than the plague ship that arrived in 1720 and caused the outbreak of the plague detailed in this paper, the 240 ships that arrived in Marseille and received a patente brute during the eighteenth century caused only sixteen documented plague cases and no significant outbreaks (Barbieri and Drancourt 2018, S6).

Because of its well-developed public health infrastructure, Marseille, along with Toulon, became “exclusive entry points into France from 1622 for all ships coming in from Muslim countries, and from 1669 for all ships coming from the Levant” (Barbieri and Drancourt 2018, S6). Since it was a prominent trading hub, the city was at increased risk of infectious disease, especially as its trading partners continued to have plague cases. However, in May 1720, France had gone several
decades without a plague outbreak, so health checks were becoming less rigorous and people began to bend the rules. This relaxing of public health measures proved to be fatal when coupled with a large economic incentive to move ships quickly through quarantine in preparation for the fair of Beaucaire. The fair was an annual, enormous bazaar 82 km from Marseille. A policy declaring the last six days in July to be tax-free created a market for merchants from all Mediterranean ports to sell their goods. This event was especially profitable for traders in Marseille due to their ideal importing location (Devaux 2013, 172-173). Missing this fair and the ensuing profits was unthinkable for those shipping their wares to Marseille to be sold. In 1720, the great incentive to facilitate highly profitable trade during the summer lead to a catastrophic breach of public health protocol.

The ship *Grand Saint-Antoine* was owned by one of the *échevins*, or magistrates, of Marseille. Between November 2\textsuperscript{nd} 1719 and February 5\textsuperscript{th} 1720, the ship was anchored in Lebanon at Sidon and then at Tyre to receive cargo. It left Tyre with a *patente nette* on February 5\textsuperscript{th}. Between February 20\textsuperscript{th} and April 3\textsuperscript{rd}, the *Grand Saint-Antoine* docked in Tripoli, Libya to load cargo and fifteen passengers (Signoli 2018, 4). On April 3\textsuperscript{rd}, the ship was again given a clean bill of health and set sail. Two days later, one of the passengers fell sick, died, and was thrown overboard. After the *Grand Saint-Antoine* stopped in Cyprus, seven sailors and the ship’s doctor died from a suspicious illness forcing the ship to make an unplanned stop in Livorno, Italy (Snowden 2019 72; Signoli and Tzortzis 2018, 5). The *Grand Saint-Antoine* made one final stop in Le Brusc before arriving at Pomègues on May 25\textsuperscript{th}. When it arrived at Pomègues, it brought with it very valuable cargo, including
cotton and silk (Jonas 34), to be traded in Beaucaire as well as at other markets (Devaux 174). The total value of the ship’s cargo is estimated at a colossal 300,000 livres (Signoli and Tzortzis 2018, 5). The value of one livre was set at one pound of silver, so 300,000 livres would be equivalent to over $100 million today. There were two sources of infection identified on the ship, leading to the death of eight people at sea and the contamination of Marseille. The first was a passenger from Turkey who boarded the ship in Tripoli on April 3rd and died two days later. The second was contaminated cotton from Tyre that later infected six porters responsible for unloading it in Marseille (Signoli and Tzortzis 2018, 5). Other fabrics on board came from Smyrna and Tripoli, also known to be centers of plague infection at the time (Snowden 2019, 72). A timeline of the ship’s journey is represented in Table 1. When examining the specific timeline of infection on board the Grand Saint-Antoine, it is important to note that the Turkish passenger who died two days after boarding the ship died twenty-two days before anyone else on board. This timing supports the theory that the others who died were infected by the original infected passenger, because they died much later than the passenger who was already infected when he boarded the ship. The plague has an incubation period of one to ten days, which is well within the period between the embarking of the sick passenger and the deaths of the other sailors (CDC 2019) (Federation of American Scientists 2013).
Table 1: Timeline of the infection of the Grand Saint-Antoine

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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<tbody>
<tr>
<td>November 2 1719</td>
<td>The Grand Saint-Antoine arrives in Lebanon</td>
</tr>
<tr>
<td>February 5 1720</td>
<td>The Grand Saint-Antoine leaves Tyre, Lebanon for Tripoli, Libya</td>
</tr>
<tr>
<td>February 20 1720</td>
<td>The Grand Saint-Antoine docks in Tripoli</td>
</tr>
<tr>
<td>April 3 1720</td>
<td>Passengers from Turkey board the ship in Tripoli</td>
</tr>
<tr>
<td>April 5 1720</td>
<td>One Turkish passenger dies</td>
</tr>
<tr>
<td>April 27 1720</td>
<td>First sailor dies</td>
</tr>
<tr>
<td>April 28 1720</td>
<td>Second sailor dies</td>
</tr>
<tr>
<td>May 4 1720</td>
<td>Two more sailors die</td>
</tr>
<tr>
<td>May 6 1720</td>
<td>Ship doctor dies</td>
</tr>
<tr>
<td>May 17 1720</td>
<td>Three more sailors die. The Grand Saint-Antoine arrives in Livorno, Italy but remains at a lazaretto due to its suspicious sanitary condition</td>
</tr>
<tr>
<td>May 25 1720</td>
<td>The Grand Saint-Antoine arrives in Marseille</td>
</tr>
</tbody>
</table>

The ship’s suspicious history was well known to public health authorities before its arrival in Marseille, through communication with bureaus of health around the Mediterranean. Health authorities in Livorno had specifically warned other ports about the ship’s sanitary condition (Devaux 2013, 174). In response, the health office at Marseille issued the ship a patente brute, documenting its potential for infection. Proper protocol following a patente brute would have required the ship and its cargo to be burned, and its passengers and crew quarantined. Instead, the ship’s owner, a rich merchant and échevin, convinced the health office to allow an abbreviated quarantine so the goods could be sold at the fair of Beaucaire as planned. Two days after the ship’s arrival, one of its sailors died at the lazaretto (Signoli and Tzortzis 2018, 5). On June 4th, after a petite quarantaine (Snowden
2019, 72), the ship’s still infected cargo was unloaded at the newest lazaretto which finally proved to be too close to the city. After a nine-day quarantine ending on June 13th, the passengers left the lazaretto for Marseille (Signoli and Tzortzis 2018, 5).

On June 19th, a woman named Marguerite Dauplaine fell ill and died two days later. She would later be identified as the first case of community spread of the plague. On June 28th, a tailor named Michel Crisp died, followed by his wife on June 29th. At least two more tailors and clothiers and their families died between July 5th and 8th, most likely infected by the contaminated cloth from the Grand Saint-Antoine. On July 9th, a thirteen-year-old boy died while attended by two doctors who finally identified the suspicious illness as the plague. This boy’s sister was a tailor, suggesting that he had also been infected by contaminated fabric. While this community spread was occurring on the mainland, at least six porters who had unloaded the cloth from the Grand Saint-Antoine died on the lazaretto. By mid-July, the plague was spreading quickly through Marseille; by the end of the month, almost ten thousand of its inhabitants had fled the city (Scott and Duncan 2001, 339).
Chapter 2: Medical Response

The medical response to the plague outbreak in Marseille was complex but well documented; patients presented with diverse symptoms and varied severity of sickness, and doctors disagreed on the root cause of the disease. According to Michel Signoli, a current member of the Medical Faculty of Marseille, local doctors officially declared that the disease sweeping Marseille was the bubonic plague on July 9th 1720. Because the spread of the disease was rapid and overwhelming, the king’s physician, Dr. Chirac, deployed three physicians from Montpellier on September 17th 1720 to examine the outbreak and offer their assistance. Montpellier was the hub for medicine in Europe during the eighteenth century, and its medical college, founded in the twelfth century, still operates today. These three doctors trained under Dr. Chirac at Montpellier and were soon followed by more (Williamson 1958, 237). However, even after doctors identified the disease as the plague, medical professionals were still divided between the contagionists and anti-contagionists. Many treated what they referred to as a “fièvre maligne” or a “fièvre contagieuse ou pestilentielle,” a malignant fever, or a contagious or pestilent fever. (Signoli and Tzortzis 2018, 5-6). The physicians from Marseille who had examined the first patients in the outbreak believed that it was the plague and was contagious; however, the visiting physicians were convinced that it was a noncontagious pestilent fever. This difference of opinion influenced how the doctors from Montpellier treated their patients. They visited them at home, in the streets, and in the hospital, unafraid to sit on their beds or touch their buboes (Williamson 1958, 237, 239).
The general belief held by many physicians outside of Marseille that the disease was a pestilent fever and not the contagious plague was most likely influenced by Dr. Chirac, the king’s physician. The three doctors first deployed to Marseille were all his former students and as such, tended to share his medical views. Dr. Chirac was an anti-contagionist who thought the doctors of Marseille had been incorrect in identifying the outbreak as the plague. In his mind, the devastating illness was the result of corrupt humors due to seasonal changes and bad food, and was not due to the infected Grand Saint-Antoine (Williamson 1958, 238, 241).

At least two large, impromptu hospitals were quickly constructed to centralize the treatment of plague patients shortly after the arrival of the physicians from Montpellier. One was built with timber and sail cloth in a square at the edge of Marseille and the other was in the converted Charité, or almshouse, that had previously given housing to the poor (Williamson 1958, 239).

Much of the medical information known about this particular episode of the plague comes from a document titled A Succinct Account of the Plague at Marseilles, written by the three Montpellier physicians in November 1720 to inform doctors in other countries on how best to treat this plague. The authors categorized patients into five classes in order of severity. Patients of the first class were the sickest and often died suddenly, living three days at most. They suffered from fever, inconsistent pulse, “heaviness in the head,” confusion, a white tongue which later turned black, a pale face, seizures, and an upset stomach. Those in the second class still had fevers, headaches, and stupor, but also felt overheated and
thirsty, had white or red tongues, red eyes and faces, labored breathing, buboes, and sickness to the stomach, but less than with patients in the first class. Almost all those in this class died, but they tended to live a little longer than those in the first class. Patients in the third class exhibited symptoms common in the first two classes but had much more moderate symptoms. People in the fourth class shared the symptoms of the second class, but their symptoms vanished after two or three days without medical intervention. Finally, the fifth class was comprised of infected people who exhibit buboes but no other symptoms. These patients generally did not need medical attention and easily survived (Chicoyneau, Soullier, and Verny 1721, 7, 8-10, 13-15, 32).

In addition to debating its contagiousness, physicians at the time debated the cause of the plague. One popular theory was that diseases, including the plague, were caused by seasonal and atmospheric factors that interacted with the earth to create a sick or poisoned atmosphere (Zuckerman 2004, 279; Snowden 2019, 60-61). Nathaniel Hodges, a physician in the late seventeenth century, supported this theory and proposed that the plague originated from corrupted nitro-aerial particles (Zuckerman 2004, 281). One of the most prominent British doctors at the time, Richard Mead, was a vocal proponent of the plague’s contagiousness. He published this opinion in his book *A Short Discourse Concerning Pestilential Contagion, and the Methods to Be Used to Prevent It* in 1720. Eight more editions of his text were later published, the first in 1722. In his book, Mead argues against the popular atmospheric theory by combining the theories of air and contagion. He writes that air itself cannot produce disease. Instead, the “state” of the air, either “right” or
“corrupted,” affects the distance infectious matter can travel; corrupted air contributes to the infected particles’ power, allowing them to infect people more easily (Mead 1720, 19).

The publication of A Short Discourse provoked a period of controversy and disagreement among medical professionals. Some believed that the plague could not spread interpersonally or that it originated only abroad (Zuckerman 2004, 276). Mead’s opponents argued that he had never treated the disease, but Mead drew connections between the plague and smallpox, which was known to be contagious (Zuckerman 2004, 284). In later editions, he specified that the plague could spread from sick people, goods from areas with the plague, and corrupt air (Mead 1720, 10).

To protect against the spread of disease, Mead made multiple recommendations in numerous editions of his book. These included a forty-day quarantine of certain imported goods, such as cotton and wool, in a lazaretto, and burning infected peoples’ clothes. Both of these measures could have lessened the transmission of disease by fleas (Zuckerman 2004, 288). In fact, if the textile quarantine had been followed with the Grand Saint-Antoine, the plague might not have spread so uncontrollably through Marseille.

A Succinct Account of the Plague at Marseilles describes many of the treatments recommended by French physicians during the epidemic. For patients in the first class, recalling that they had the worst infection, doctors commonly used emetics¹ and cathartics², but found them more harmful than effective. They also

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¹ Drug to induce vomiting.
² Purgative drug.
tried cordials\(^3\) and sudorific\(^4\) medicines, but these did not help the patients recover. The doctors prescribed copious amounts of cordials to attempt to soothe their patients, but noted that the disease in patients in the first class is stronger than any medical intervention. To treat patients in the second class, doctors tried blood-letting, but found that it worsened their patients. They recommend immediately giving the patient a medicine such as *Ipecacuanha* that would make them “gently vomit” along with broth, water, and tea (Chicoynneau, Soullier, and Verny 1721, 24). Following this, they suggested cathartics and laxatives, followed by cordials like those recommended for the treatment of first-class patients. Patients in the third class exhibited varied but less severe symptoms, so doctors did not have a standard course of treatment, instead addressing the most urgent symptoms using the techniques mentioned above. Fourth class patients had even milder symptoms and were commonly given cathartics, cordials, and sudorific substances. No treatment was suggested for patients in the fifth class, as they were classified as such because they did not require medical attention. The doctors authoring the book also suggested a treatment specifically for the buboes that often form on the skin of plague patients, consisting of applying a balm to the buboes, followed by more corrosive ointments, then cleaning the wound to promote healing (Chicoynneau, Soullier, and Verny 1721, 8, 10, 12, 15, 21, 25, 32-34).

During this time, many recipes were published claiming to cure the plague, often even being promoted by the government of Marseille. It is unknown if these treatments had positive effects on those who took them, but medical knowledge at

\(^3\) Soothing medicine with a pleasant flavor.
\(^4\) Drug to induce sweating.
the time had not yet identified bacteria as the cause of the disease, so these recipes
drew inspiration from other popular remedies for disease (Hammond and Sturgill
1972, 592). Some inhabitants of Marseille, including many doctors, began carrying
spices and herbs to smell as a preventative measure to protect against the poisoned
atmosphere. These herbs could be contained in a vial around the neck or in the beak
of a plague mask (Figure 1). Doctors, priests, and others who faced frequent
exposure often wore plague suits and carried rods when interacting with the
potentially infected (Figure 1). These suits featured leather pants and wax-coated
cloth gowns, as it was thought that the dangerous particles from the poisoned
atmosphere could not stick to these fabrics. The rod both ensured that patients kept
their distance and was also used to inspect the patient for buboes and other signs of
plague (Snowden 2019, 60-62).

![Figure 1: Doctor in a plague costume, Marseille 1720. Reprinted from Snowden (61).](image)
As with the Black Plague epidemic in the fourteenth century, it was widely accepted that the dead bodies of plague victims could still spread disease. Therefore, strict regulations required that corpses be disposed of as quickly as possible, without a funeral, funeral procession, or period for others to view the body and pay their last respects (Snowden 2019, 77). Even with these rules, corpses began accumulating in the streets, town squares, and by hospital gates faster than they could be buried. Although the victims had died, their bodies were still infected with contagious bacteria and thus posed a grave threat to Marseille’s inhabitants. The immediate danger caused by these bodies lead to the use of mass graves outside of cemeteries and the use of lime in preparing the deceased for burial. Twenty-seven mass graves were dug in close proximity to the main city gates by local peasants. Under normal circumstances, graves would have been required to be dug further away from the city. However, the sheer volume of deceased plague victims proved to be difficult to transport down the narrow, winding roads of Marseille. Officials even buried victims in the tombs under churches, which threatened worshippers with infection (Signoli and Tzortzis 2018, 6-7). The analysis of plague burial sites later revealed that many bodies were hastily removed from their homes buried in their clothes. Other graves feature bodies without clothes but sometimes wrapped in cloth, suggesting that they were buried by a medical institution (M. Signoli 2012, 221).

Doctors practicing in Marseille in 1720 were obviously at a great risk of infection. Even staffing the city with physicians proved to be challenging due to the high stakes. In 1720, Marseille’s Collège des agrégés, or College of Aggregates
assigned twelve doctors to treat the plague. Three of these doctors assigned to treat the people in Marseille refused to serve and instead chose to flee. Of the doctors who accepted their assignments, five became sick and two of the five died. Only three worked actively during the entire epidemic. Of the thirty surgeons in Marseille before 1720, only five were still alive after the plague (Signoli and Tzortzis 2018, 7). Miraculously, the three physicians from Montpellier who documented much of the medical response during the time period survived their contact with the disease. Even though the medical community remained divided on the nature of the plague and found few curative treatments, the medical infrastructure and resource-sharing during this period of emergency reveals an inspiringly high level of dedication to treating victims of the disease.
Chapter 3: Government Response

The local government’s response to the sudden outbreak of disease, at the time unidentified, began in early July of 1720. On July 2\textsuperscript{nd}, the government of Provence enacted a travel ban barring contact between the city of Marseille and the rest of Provence. One week later, on July 9\textsuperscript{th}, the outbreak was finally declared to be the plague. On July 12\textsuperscript{th}, ships arriving with potentially infected cargo were required to divert to the island of Jarre to quarantine (Signoli and Tzortzis 2018, 6).

The early isolation of the city was disastrous for its inhabitants who fell into a period of famine and resulting chaos. Townspeople began looting and pillaging the city or even fleeing to less infected towns. The lack of food quickened the deaths of the sick and lead to more robberies out of desperation. Overwhelmed and unable to establish order, the city magistrates requested the army’s assistance (Devaux 2013, 175, 177; Takeda 2011, 128).

By the eighteenth century, every port in the Mediterranean was equipped with a health office within the jurisdiction of that port’s government. These international health offices communicated frequently, even during war, to share advice for disinfecting goods and document plague cases. More stringent public health measures were added in late July and August to attempt to combat the rapid spread of the plague throughout the city. Valuable public health infrastructure was reformed and used aggressively, including health offices, or bureaux de santé, and lazarettos.

At the beginning of the epidemic, decisions concerning the city were in the hands of the échevins, citizens of Marseille who had amassed their power through trade.
These local officials were loyal to their city because their fortunes depended on it. The same cannot be said for those later appointed by the monarchy.

The échevins of Marseille organized the treatment and quarantine of plague victims and their families, either at home or in the hospitals. They also coordinated the removal of dead bodies, often done at night, and their subsequent burial with lime. The use of lime reduced the risk of contagion from the dead bodies and lessened the smell. The city’s convicts were originally assigned to move and bury the bodies, as it was a dangerous and undesirable task. By August, all convicts were actively employed in this job or had unfortunately died from plague exposure (Devaux 2013, 177). On July 30th, city officials ordered the imprisonment of the city’s poor and homeless population and deported about three thousand foreign beggars from the city. The gathering and banishment of those with a lower social status was arguably done to reduce the spread of disease to the rich, who held comfortable positions in local government. The same day, the Parliament of Provence explicitly forbade Marseille from engaging in trade and commerce with the rest of the region and ordered the city to close its gates (Signoli and Tzortzis 2018, 6). The new decree strengthened the no-contact order from July 2nd between Marseille and its surrounding towns.

As the plague worsened, institutional efforts to contain it became increasingly strenuous. At the advice of a doctor, local governors enacted a three day-long massive burning of infected items in the city, which began on August 2nd. They thought that burning contaminated objects in public places would decrease community transmission of the disease. The townspeople were instructed to burn
an ounce of sulfur in each room of their homes in an effort to purify the air. One doctor in disagreement with this practice stated that these decontamination measures actually worsened the air quality in Marseille (Signoli and Tzortzis 2018, 6).

After two full months of infection, the échevins of Marseille realized they needed more manpower. The citizens of Marseille were growing desperate, as there was a lack of food and income stemming from the trade bans placed on the infected city. As a result of increasing turmoil, the French monarchy began taking control of the crisis in Marseille, much to the chagrin of local officials. The Crown began to streamline these plague prevention measures by giving power and autonomy to their appointed officials instead of the locals. The monarchy’s response to the crisis focused on assigning a few individuals to lead infection-containment strategies and not overcrowding local departments with redundant officials (Takeda 2011, 123). This strategy limited the size of the local government and centralized all initiatives under the Crown. However, the échevins of Marseille believed that the lazarettos and health offices should be run locally and granted autonomy. Nevertheless, the monarchy established a new bureau of health directed by the royal Conseil de la santé, which immediately ordered Marseille to begin quarantine (Takeda 2011, 108, 116, 125-127).

As the lack of available resources increased, so did crime. In an effort to restore order, the Prince Regent of France, Philippe d’Orléans, implemented martial law and placed in charge the Chevalier de Langeron to be the new Commander of Marseille. The monarchy expanded the power of the échevins by allowing them
increased liberty to punish wrongdoers. These emergency permissions enabled municipal officials to enforce compliance with their orders. They were also used to punish the increase in crime more harshly. Langeron chose to sentence those caught stealing to death in an aggressive effort to limit the chaos. Local officials were also granted the permission to create an emergency police force by recruiting citizens as guards and spies to maintain order in the city (Takeda 2011, 132, 140; Devaux 2013, 177).

On August 3rd, the échevins named 150 men to be commissaires and supervise the five parishes of the city. These volunteer commissaires were part of the new city militia, headed by captains who were paid by the city. The emergency troops patrolled the city, identifying those committing crimes or endangering public health. They went so far as to enter peoples’ homes unannounced, searching for the sick and for dead bodies. These searchers only magnified the terror and distrust sweeping Marseille (Takeda 2011, 137-138; Snowden 2019, 75).

The aforementioned increase in punitive power granted to the échevins of Marseille resulted in what many authors describe as a reign of terror. Individuals who committed even small crimes, failed to comply with orders to dispose of the deceased, or attempted to flee were often executed. It is unknown exactly how many people were executed between 1720 and 1722, but the population of Marseille in total was reduced by fifty percent. While not executed, those who failed to follow public health rules were banished from the city. The parliament of Aix ordered all doctors in Marseille to treat plague patients and stripped medical degrees from those who left the city. General disobedience resulted in imprisonment in the
galleys of ships moored in the harbor, where prisoners were required to dispose of plague victims, or whippings for disobedient women. The most common crime was breaking into and stealing from abandoned buildings; anyone apprehended while doing so was sentenced to life in the galleys. (Takeda 2011, 132, 137, 144). Part of this terror was due to the power held by the monarchy.

By September, there were no more available convicts to assign to dispose of deceased plague victims, so out of desperation, city échevins posted a public notice. It read:

À Marseille le 3 septembre, 1720.

This translates to:

Nothing is more necessary than to remove and bury the bodies of people who died. Aldermen urge zealous persons who are in the city,
to have the goodness to come riding horses to assist in the removal and burial of the dead people, by their presence and by the orders given to those they employ. Besides the commendable work they will do and the glory they will gain of serving their country on an occasion as important, the community will give bonuses to those who will accept it, and we will reimburse all those zealous persons for all expenses they will engage for the removal and burial of dead bodies in both the urban and rural.

Marseille, September 3, 1720 (Devaux 2013, 176).

The officials emphasized the bravery and patriotism of willing volunteers and offered them payment. However, the language used in the public notice reveals their sheer desperation for help, even after the intervention of the monarchy. Unfortunately, there were simply too few people willing to risk their lives to clean the city, especially after the employment of every available prisoner.

Further travel and trade restrictions were added in September in an attempt to contain the still present disease to Marseille. The Conseil d’État of France published a decision on September 14th noting that health certificates, much like the ones used to regulate incoming ships, would be required in order to leave the city. These restrictions successfully protected other French cities from contracting the plague, either from Marseille or abroad. Some cities chose an even more aggressive approach, including Bordeaux. In January of 1721, the steward Claude Boucher of Bordeaux deployed armed guards to enforce the travel ban between Marseille and its surrounding cities. The steward was an administrative leader.
appointed by the king to oversee the city property of Bordeaux. His efforts to isolate Bordeaux from the rest of the region were successful, since Bordeaux remained safe from the epidemic (Devaux 2013, 179, 181).

By the end of September and early October of 1720, plague cases were decreasing and the epidemic seemed to be under control. City officials began cleaning the city by removing garbage, burning clothing and objects contaminated by plague victims, and thoroughly cleaned all buildings that were home to infected people. Formerly contaminated houses were whitewashed that December to represent their newfound cleanliness (Signoli and Tzortzis 2018, 7). However, this partial respite from the disease did not last long. By March 1721, 127 patients were suddenly hospitalized, eight of whom later died. The resurgence in cases prompted a drastic reaction from national officials, including the pope’s French representative, a vice-legate of the Catholic Church, who ordered the construction of a plague wall between Cavaillon and Sault in the Monts de Vaucluse. Cavaillon is a small inland town northwest of Marseille, while Sault is directly north of Marseille, near the border of the Rhône-Alpes region of France. By July, the wall was 24km long and was surrounded by a 3-meter-deep ditch. In 1724, a second wall was built 12 meters away to enforce and supplement the original. Sources disagree on the final, total length of wall, but some claim it grew to over 100km (Devaux 2013, 177-178, 181).

However, the wall and bureaucratic restrictions on travel were not sufficient to discourage some inhabitants of Marseille from attempting to flee their infected city. The army was again summoned to contain the Marseille’s potentially infected
citizens within its gates. Over one thousand troops formed a sanitary line of surveillance and had permission to shoot those attempting to cross the city limits without proper documents. These aggressive tactics proved to be effective, as very few outbreaks occurred beyond the sanitary line (Devaux 2013, 178).

The government’s response to the plague in Marseille was a combined institutional effort between the monarchy and municipal government. Throughout this period, there were also successful public health measures, including the communication between health offices across the Mediterranean, the increased use of lazarettos, and public cleaning efforts. The quarantine of the city and its isolation from its trading partners resulted in a period of famine and poverty for many residents, but was largely successful in preventing the spread of disease. As a result of the city’s isolation, crime increased, leading to the implementation of martial law on multiple occasions. Martial law, coupled with the increased severity of punishments for law-breaking lead to a period of terror in Marseille where small offenses would lead to life in the galleys or banishment from the city. The executive reaction to the plague outbreak of 1720, while unnecessarily punitive, was aggressive, centralized, and succeeded in localizing the plague to Marseille.
Chapter 4: Religious Response

The medical and governmental responses to the plague are essential to understand the lives of those in Marseille in 1720, but many scholars overlook the religious response. The Catholic church was, and still is, one of the most powerful institutions in France. As such, it is critical to include religion when studying this topic. When the plague arrived and began to spread in Marseille in 1720, authority figures in Christian institutions responded in one of two ways: either attempt to save themselves from the disease or risk their health and bring peace to their congregants through religious measures. The monks of St. Victor and St. Martin chose the first approach. They remained cloistered in their abbeys for the duration of the epidemic or fled to safety. However, three powerful religious authority figures did just the opposite. The bishop of Marseille Henri François Xavier de Belsunce de Castelmoron, Jean-Jacques Gautier, a priest of the Oratorian order, and a Jesuit priest Claude-François Milley worked tirelessly and directly with the people of Marseille (Devaux 2013, 178; Jonas 2000, 36). Michel Serre, a painter in Marseille who witnessed the plague first-hand, depicts the Bishop de Belsunce as comforting those dead and dying in the streets at great risk to himself (Figure 2, Serre 1721).
Figure 2: Portion of *Vue du Cours pendant la peste de 1720* by Michel Serre c. 1721

The representation of Bishop de Belsunce by Serre is part of a much larger oil painting, shown in full in *Figure 3* (Serre 1721). The area depicted is a wealthy residential boulevard called *le Cours.*

Figure 3: *Vue du Cours pendant la peste de 1720* by Michel Serre c. 1721
Serre even paints himself watching (Figure 4) the scene in one of the painting’s corners (Martin and Weiss 2020). He is said to often feature himself in his paintings.

![Figure 4: Self-portrait of Serre, Vue du Cours pendant la peste de 1720 by Michel Serre c. 1721](image)

The Bishop de Belsunce is present in the center foreground of the scene, anointing the sick and dying (Figure 2). The bishop is surrounded by wealthy city officials wearing elegant clothes and wigs, almost all averting their eyes from those dying in the street. An analysis of this painting by Martin and Weiss suggests that the owner of the Grand Saint-Antoine is one of the many unidentified men accompanying the bishop, unable to confront the tragedy he has brought to his city.

It is important to compare the representation of the aristocrats standing over the dying and those lying in the street. The bishop and his companions are all seemingly healthy, rich, white men. The people dying beneath them are all wearing rags or much less elegant clothes, indicating their lower economic status. They also
seem to have darker skin and hair, suggesting that they hold a disadvantaged status in society due to their race. The representation of those with a higher position in society physically standing over those they most likely consider beneath them is incredibly striking.

While there is no evidence that his companions in the painting contributed to plague relief, the bishop himself worked diligently through the epidemic to heal his city through religion. In a letter to the Bishop of Soissons, a town north of Paris, the Bishop of Marseille wrote:

We are not in a condition to express any other sentiment than that of grief. Your alms came at a very seasonable time for I was reduced almost to the last penny. I am laboring to get money […] Never was desolation greater, nor ever was any other like this […] To be sick and dead was almost the same thing […] The sick are abandoned by their own relations, and cast out of their houses into the streets […] We go into the streets full of dead bodies half rotten […] [to] give him absolution […] the Blessed Sacrament was carried everywhere to all the sick (de Belsunce de Castelmoron 1760) Letter dated September 27, 1720.

In his letter asking the other bishop for donations, Bishop de Belsunce provides first-hand insight into the state of the city in the fall of 1720. He describes his efforts to give absolution to the sick on the streets, which is illustrated in Serre’s painting. Interestingly, he later admits in his letter, “Had we not attempted to deceive the public, by assuring that the evil which reigned was not the plague; and had we
buried the dead bodies which lay a whole fortnight in the streets, I believe the mortality had ceased” (de Belsunce de Castelmoron 1760). The Bishop expresses regret for the delayed response that allowed the plague to overrun Marseille. His actions during the remainder of the epidemic support his expressed desire to help as many people as possible, even when putting himself at risk.

During the epidemic, many held the belief that the reemergence and spread of the plague in Marseille was due to the wrath of God. The disease was often seen to be a divine punishment, akin to the pestilences frequently mentioned in the Bible. Much like during the Black Death of the fourteenth century, it was thought that the people of Marseille had sinned and were now sentenced to death by a seemingly uncontrollable disease (Devaux 2013, 182). This reaction was not unique; in times of turmoil, Christians commonly believed that hardship was part of God’s plan or a consequence for their sins. This belief led religious leaders to an obvious conclusion: if the plague was a manifestation of God’s anger, then it could be cured through acts of religion and divine forgiveness (Jonas 2000, 40).

The Bishop de Belsunce believed that the most promising approach to placate God’s anger was consecrating Marseille to the Sacré-Cœur, or Sacred Heart of Jesus. He organized a procession through the city held on November 1st 1720 to pledge Marseille formally to the cause (Devaux 2013, 178). As part of their commitment, people placed Sacred Heart “safeguards” around their homes. These safeguards consisted of a heart either embroidered or attached by appliqué to wool or linen cloth. The phrase «Arrête ! Le Cœur de Jésus est avec moi !» which translates to “Stop! The heart of Jesus is with me” was often written or embroidered
along the edge of the cloth. The pieces of cloth could also be attached to one’s clothing to ward off the plague (Jonas 2000, 48).

During the fall of 1720, plague cases began to decline. As a sign of the city’s gratefulness and continued devotion to God, Bishop de Belsunce and his clergy performed a formal blessing over the city from the Notre Dame des Accoules church (Devaux 2013, 178). Even though plague cases had decreased, churches in Marseille were closed to the public until June 1721. In addition to his blessing of the city, Bishop de Belsunce chose to honor the redeeming power of the Sacred Heart on its feast day, which occurs nineteen days after Pentecost. In 1721, the Feast of the Sacred Heart fell on June 20th. Before the feast, Catholics built a massive altar at the port of Marseille. The altar was built on top of a raised platform and was wrapped in flowers and cloth. On the feast day itself, a huge procession travelled through the streets of Marseille to the altar at the port. People carried religious statues, prayed, and chanted. When the procession arrived at the altar, the Bishop lead those gathered in communion (Jonas 2000, 41-42).

Unfortunately, the decreased presence of disease in 1721 was not permanent, and cases began to increase again in 1722. Instead of viewing the resurgence as a consequence of their failed endeavors, religious leaders in Marseille presented it as a reflection of the city’s current morality. The Bishop de Belsunce specifically reprimanded the merchant leaders who did not join the procession during the Feast of the Sacred Heart the previous June. In response, multiple city leaders processed to the cathedral Notre Dame de la Major in early June 1722 and made a vow to the Sacred Heart. On June 12th, the Feast of the Sacred Heart, the
Bishop organized a similar ceremony to that of 1721, but in the plaza instead of the harbor to demonstrate the city’s continued devotion to God (Jonas 2000, 43-44).

The plague not only changed the manner in which people engaged in their relationship with God, but it also disrupted many religious traditions regarding death and the afterlife. Catholic doctrine teaches that without last rights, one is unable to ascend to heaven. However, during the epidemic, the Catholic church was unable to administer last rights to its dying congregants for multiple reasons. As discussed in Chapter 2, the people of Marseille understood that one could contract the plague through contact with a deceased plague victim. An important component of the sacrament of last rights is anointing the sick with holy water. To do so, a priest had to expose himself directly to the plague. In addition to the desire to contain the plague, there were simply too few priests to anoint all sick congregants. Many priests died from their attempts to anoint those they could (Devaux 2013, 178). The lack of the sacrament of last rights was anxiety-inducing for Catholics in Marseille. In its absence, they feared the deceased would be unable to ascend to heaven.

Adding to that anxiety was the inability to hold traditional funerals and perform burial practices. The deceased could not be laid out for viewing and instead had to be buried as quickly as possible, often in unconsecrated land, to prevent disease spread. Therefore, those close to the deceased could not see them one last time to verify their death by witnessing the early signs of decomposition (Snowden 2019, 78). Alternate measures were often used to confirm death instead of looking for signs of decay. These techniques included cutting a body’s hands or feet or
inserting pins into their fingers, then observing if the person reacts. Evidence of pin insertion was later found when researchers examined bodies in the Marseille Observatory mass grave (Devaux 2013, 183). The cumulation of these factors prompted uneasiness about the final destination of the souls of many of the departed.

The plague became less and less prevalent in Marseille until it essentially disappeared in September 1722. Before the epidemic, two hundred and fifty priests were serving the city. Two years later, fifty had died from the disease (Devaux 2013, 178). Just like the physicians who followed a documented course of treatment to attempt to heal plague patients, the Bishop de Belsunce followed his own plan to earn God’s forgiveness. He acted with immense courage in treating those he knew could infect him and in gathering with his congregants to beg for God’s forgiveness. Even though most people today understand that the plague in Marseille was bacterial and not divine, the Catholic church’s response to the plague was still incredibly meaningful in the lives of the people of Marseille.
Conclusion

My experience reading and writing about the response to the plague in Marseille in 1720 has been informed by concurrently living through the COVID-19 pandemic. I found myself looking for connections between the two medical crises and was easily able to empathize with the people of Marseille three hundred years ago. By exploring how multiple institutions responded to the epidemic, I have gained a multifaceted understanding of life in Marseille during the plague.

After learning how the plague arrived in the city and was able to infect so much of the population, I examined actions taken by the first responders to the disease: doctors. In an attempt to understand the attitudes of the medical community during the plague in Marseille, I read journals and letters published by doctors of the period. The treatments they documented are obviously different from those employed today, but the reasoning motivating their medical decision-making holds true today. Scientists and doctors now have a more comprehensive understanding of the science of disease and have more advanced technology at their disposal than their counterparts of centuries past. However, I’ve found that the general approach to controlling a pandemic has not changed dramatically in three hundred years. Doctors used their existing medical knowledge to treat patients and communicated their methods to medical communities in other towns and countries.

The approach taken by the French monarchy and the local government of Marseille was much stricter than the response we saw to COVID-19 in the United States, but was based around many of the same principles. Both outbreaks of disease resulted in quarantines, limitations on travel, and public measures to
coordinate cleaning and disinfection. During both crises, the military was deployed as emergency manpower. In Marseille, soldiers patrolled the city and enforced the quarantine by staffing the plague wall. In the United States during COVID-19, military members coordinated testing and vaccine sites. The logistical efforts employed to quarantine the infected population of Marseille are still effective today, even when executed differently.

Finally, I examined letters, art, and secondary accounts of the religious response to the plague to understand the important intersection of this crisis and Christianity. The Bishop de Belsunce is an excellent example of how people often engage differently with their religions during times of crisis. His deep desire to heal Marseille through prayer and devotion to the Sacred Heart of Jesus is an integral component of the human and institutional response to the plague. As a powerful leader in his community, the bishop’s reaction to the epidemic influenced his congregants’ responses as well. The congregants pledged themselves to the Sacred Heart and participated in processions and ceremonies to ask for God’s forgiveness. While their actions did not cure the disease, I can imagine that they helped the people of Marseille feel less powerless in the face of a devastating plague.

Over the course of my research, I have witnessed the profound effects of this crisis on the people of Marseille. In 1720, Marseille was home to 394,369 people. Two years later, when the plague epidemic finally subsided, 119,811 of its inhabitants were dead (Signoli and Tzortzis 2018, 10). In a very short period of time, the town had lost about a third of its population. While this is a higher rate of death than any country has experienced thus far during COVID-19, most people
living through the COVID-19 pandemic today can easily empathize with the fear and reactions of the people of Marseille in 1720. Almost exactly three hundred years later, we share a common experience of isolation and medical emergency.
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