COLONIAL MEDICINE ILLS

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Colonialism and medicine may seem to be separate subjects on their own, but this paper demonstrates how both subjects have interacted together in the recent modern era and produced harmful effects on diverse populations. This article reviews five sources that focus on different regions of the world. A common theme emerges from the colonial application of medicine and from the power imbalance that exploited the use of cheap labour. The combination of frenzied economically driven colonization, and the rise of modern medicine imposed European social constructs on Indigenous peoples, which caused them direct harm, and often fostered the spread of disease. Under a false concept of racial differences and implied hierarchy, European countries frequently failed their colonial subjects.

In the late 19th and early 20th centuries, European countries were at the vanguard of new technological advances in medicine. These modern advances helped strengthen national identities and allowed unprecedented economic expansion to faraway tropical lands. Competitive European imperialism is entangled with the rise of modern medicine. Alfred Reed, Chair of Tropical Medicine at the University of California, maintained that institutes like his own were the "advance agents of commerce."[1] The combination of frenzied economically driven colonization, and the rise of modern medicine imposed European social constructs on Indigenous peoples, which caused them direct harm, and often fostered the spread of disease. Under a false concept of racial differences and implied hierarchy, European countries frequently failed their colonial subjects. The journey of colonial medicine can be seen by the transition from Western self-preservation, to the growth of infrastructure that administered colonial subjects. The displacement of local populations due to economic activity furthered the spread of disease and forced the locals to live in unhealthy conditions. The reliance on the exchange of cheap labour

[1] Alfred Reed, "Organized tropical medicine in the Western United States, *California and Western Medicine* 35 (1931): 185-9, quoted in John Farley, *Bilharzia: A History of Imperial Tropical Medicine* (New York: Cambridge University Press, 1991), 130.

for profit by remote Western institutes was so far-reaching that even traditional domestic roles were colonized.

Colonialism and medicine are both comprehensive topics on their own, and the intent here is to show how both subjects have interacted together in the recent modern era and produced harmful effects on diverse populations. By restricting the number of sources to a narrow range of five articles that focus on different regions in the world, a theme emerges on the commonality of colonial medicine. Whether the location is the Texas border with Mexico, Australia, Egypt, India, or Latin America, local populations endured similar negative consequences from the power imbalance inherent in colonial settings.

In the present day it seems obvious to reflect that the colonial age was the cause of much suffering, but it may not seem apparent that medicine would be complicit with this suffering. After all, it is generally recognized that humanity has benefitted from modern medicine. However, colonization is a multi-faceted process, and it influenced the application of medicine right from the beginning. As Europeans ventured farther away from home, there was great concern for the rising mortality rates among military personnel, travellers, and colonists as they came into contact with different people and environments. Additionally, in these expeditions "European physicians, travellers and missionaries offered their medicine as lifesaving drugs or as tokens of their benevolence and superiority to the colonized races."[2]

Lifesaving drugs were typically prescribed for the protection of white people when colonizing a foreign land, especially when tropical lands were the scene of white struggles. Initially, miasmic theories (the outdated belief that disease was caused by breathing in "bad air") were prevalent, along with the perception that the soil of the land was the source of disease.[3] An example of this occurred when the British colonized Australia and struggled to cope with the severe climate in the northern tropical area. Malaria was referred to as "Colonial Fever," and the use of "quinine generally seemed to act on white constitution to counter environmental influence."[4] However, this did not solve the problem, and whites felt they needed the assistance of non-local "tropical" residents whom they saw as more suitable to working the land. This ultimately morphed into the belief that these "other people" were disease carriers, promoting the cruel medical use of quarantine through isolation, with the expectation that disease transmission to Europeans would be prevented.

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[2] Pratik Chakrabarti, *Medicine and Empire 1600-1960* (New York: Palgrave Macmillan, 2014), ix.
[3] Warwick Anderson, *The Cultivation of Whiteness: Science, Health, and Racial Destiny in Australia* (New York: Basic Books, 2003), 181.
[4] Ibid, 80.

The evolution of medicine from protecting settler's health to treating Indigenous peoples, can be seen in the development of hospitals in the colonies. John Farley notes that "before the First World War, tropical medicine was focused mainly on the health of British Colonial officials and American army personnel. But after the war, economic factors began to play an increasingly important role."[5] Hospitals were integral to improving profit because they were a way to keep cheap local labour free from disease. From a colonial point of view, hospitals were "there for purposes of development, not exploitation."[6] However, to colonial subjects, hospitals could be feared, as was the case in India where British officials were so culturally insensitive with their campaign against the plague that "people would prefer to die from the plague rather than consent or submit to the removal of their mothers, wives, daughters or sisters to the hospital."[7]

"Tropical Medicine" became a professional specialty, with governments, businesses, and educational institutes investing in research-driven initiatives. In South Africa, funding research took place over "seriously addressing the health problems of [mining] employees…[which could have been improved] by decent housing, good food, and humane policies."[8] It is cruelly ironic that the economic activities in colonial lands forced local people to work farther from their own homes, which in turn helped foster the spread of disease. The growth of colonial economies was frequently tied to the use of cheap labour. These workers would have to travel away from home and become dependent on their colonial masters for basic necessities. In Australia, colonial officials perceived Pacific Islanders as racially suited to tropical work, and "poor food, inadequate housing and medical neglect meant the Islanders…had a death rate four times higher than that of Europeans."[9]

With hindsight, it can be generally said that many disease outbreaks were caused by the unsanitary conditions that poor people were forced to live in. Although not a colonial takeover, the exploitation of migrant Mexican workers who travelled daily to work in Texas is a classic case of racial hierarchy and the short-sighted refusal to take proper steps to minimize the spread of disease. The border cities of El Paso in Texas and Ciudad Juarez enjoyed an open border for many years as Mexicans desperately sought work in part because of the Mexican Revolution, and Americans eagerly welcomed these workers for the most undesirable work.[10]

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[5] John Farley, *Bilharzia: A History of Imperial Tropical Medicine* (New York: Cambridge University Press, 1991), 116.
[6] Ibid, 117.
[7] David Arnold, "Plague: Assault on the Body." In *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India,* (Berkeley: University of California Press, 1993), 214.
[8] Farley, 124.
[9] Anderson, 84.
[10] Ibid, 121-22.

Racial themes were prevalent including the statement that "the Mexican was considered the perfect stoop laborer because he [had the right body type]."[11]

This U.S and Mexico labour exchange became threatened when incidents of typhus drove the U.S authorities to instigate harsh measures at border crossings to prevent the disease from spreading. The death of twenty-six Mexicans in a Texas jail, due to a delousing method using a gasoline mixture as a bath, illustrated the inhumanity of quarantine methods.[12] Most of the Mexicans lived in impoverished settings, and the lack of proper sanitation was the catalyst for the rise and spread of typhus. The American solution of imposing border-crossing conditions ignored the fact that, if they wanted to enjoy the benefits of cheap labour, it would have made more sense to improve Mexican workers living conditions. They did not do so, and one of the consequences was the "subsequent rise of illegal immigrants, some of whom harbored infections or feared medical examinations of any kind."[13] Although Howard Markel was writing in 2004, it is striking that the hard border concept of a wall still resonates with labour dependence issues and racial concepts by the U.S.A.

The colonial impulse to avoid direct aid to the oversupply of cheap labour is a common theme throughout the world. In South Africa, medical experts knew that the rise of Bilharzia corresponded with colonial irrigation projects.[14] However, unhealthy workers could easily be replaced, and as a result, there was no incentive to improve working conditions. In contrast, when similar impoverished living conditions of white Boer farmers sparked a Bilharzia outbreak, "the response was immediate when white children were found to be infected."[15] Authorities instigated a quarantine-like summer camp program for the white children that involved medications and education. However, no similar effort was made for Black children and "South Africans were unwilling to spend money to treat Africans infected by Bilharzia [and] they were certainly not prepared to attack the economic factors that increased the seriousness of Bilharzia and other diseases."[16]

Part of the overall problem in assessing disease in colonies, was the institute's structure and philosophy that were formed around the concept of "Tropical Medicine." John Farley discusses the United Fruit Company's working relationship with Harvard Medical School's Department of Tropical Medicine. He notes that the department was formed at Harvard because of the fear that tropical diseases

[11] Howard Markel. "Lice, Typhus, and Riots on the Texas Border." In *When Germs Travel: Six Major Epidemics That Have Invaded America Since 1900 and the Fears They Have Unleashed,* (New York: Pantheon Books, 2004), 122.
[12] Ibid, 113-14.
[13] Ibid, 139.
[14] Farley, 121.
[15] Farley, 137.
[16] Ibid, 139.

could arrive in the port city of Boston.[17] The United Fruit Company was the largest American company of its kind operating in Latin America and was very concerned about its interests in the tropics. The company felt that proper research should be done in the colonies. Harvard insisted that the real research should be done in Boston because researchers 'mental capacity could be diminished by working in the tropics.[18] As a result, remote authority could overrule local expertise and transmit incorrect theories and beliefs.

The imposition of remote authority on local agents can also be seen in British India, where the "political and social impact [of a late 19th century plague outbreak] was felt long before … mortality had reached its peak."[19] This command was caused by the governmental authorities in Britain, who formed policies in response to the fear of the plague coming to Britain.[20] Compounding this was the medical profession's self-image as "the principal agents and overseers of the British administration … and the Indian Civil Service were entrusted with overall control of plague operations."[21] British control was so overwhelming that important social structures based on caste and religion were ignored and seen as merely superstitious.[22]

As noted earlier, women in India were afraid of going to hospitals, in part because methods for preventing the spread of plague were so aggressive that "plague measures anticipated the arrival of the epidemic itself."[23] Furthermore, rumours began to circulate, and violent public reactions displayed a lack of confidence in Western medicine.[24] For Indian women, the biggest issue was that most of the doctors were male and white. Arnold points out that searching the female body for the plague was considered the equivalent of sexual molestation.[25]

The absolute failure of colonial powers to recognize social and cultural values can be seen in the British colonization of Egypt. Historian Hibba Abugideiri points out that, in the British initiative to modernize Egypt, gynaecologists extended their focus on the female body to activities in the home.[26] The Egyptian nation was generally viewed by the British as backward and in need of modernization to fulfill its potential. Egyptian doctors with their Western-based medical training were seen

[17] Ibid, 124-28.
[18] Ibid, 129.
[19] Arnold, 202.
[20] Ibid, 205.
[21] Ibid, 208.
[22] Ibid, 204.
[23] Ibid, 237.
[24] Ibid, 218-24.
[25] Arnold, 214.
[26] Hibba Abugideiri. "Egyptian Doctors and Domestic Medicine: The Forging of Republican Motherhood." In *Gender and the Making of Modern Medicine in Colonial Egypt,* (Burlington, VT: Ashgate, 2010), 187.

as vital for this transformation. Part of this transformation would be the radical role that doctors would play in modifying the domestic roles of Egyptian women. Traditionally Egyptian midwives were in the home assisting with breastfeeding and childcare, but the doctors overruled this practice and encouraged the "rethinking of the family and gender roles."[27] This domestic overhaul of Egyptian culture was based on Victorian bourgeois ethics.[28] The identity of the "Modern Egyptian Woman" was to be radically changed based on her motherhood, domestic role, grooming, and etiquette. Medical advice declared that the mother alone should breastfeed her child and the employment of midwives was prohibited.[29] It was also stated that the mother must teach and supervise her child as much as possible and oversee much of the domestic work done in the home.[30] The drive to build Egypt as an unequivocal modern state was so encompassing that the "gendered and moralistic view of doctors as regulators of women's social behaviour was a distinctly modern phenomenon."[31]

From today's perspective it certainly seems outrageous that medical professionals could have interfered so drastically into the family home. However, the real issue is about power, and women have typically had a lack of it, even to the present day. Colonialism was about power imbalance. It could dictate terms to people who were poor and impoverished. It could take advantage of people from around the world with its mantra of technologically modernizing the world by sheer force. The wrongfully obtuse construction of "racial" otherness reinforced economic imposition. Perhaps the greatest injustice was the colonizer's inability to see that it was their actions that gave rise to the spread of some diseases. It is much more than ironic, that the Hippocratic Oath, (interpreted as to do no harm or injustice to the patient), which Western medicine tries to emulate so much, was not upheld and indeed the colonial powers did much harm.[32]

[27] Ibid, 188.
[28] Ibid, 194.
[29] Ibid, 200-04.
[30] Ibid, 205-11.
[31] Ibid, 187.
[32] Markel, 140.

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