The art of medicine

Diagnosing the medical history of British imperialism

In the past two decades, particularly, the gross inequities and violence of British colonialism have increasingly featured within popular and academic histories. Yet despite the innumerable wrongs inherent in imperialism, surely the history of the western colonial medicine provides one example of colonial governance having had its heart in the right place? From the mid-19th century, the British empire saw the regular dispatch of thousands of doctors and nurses into remote areas which until that point had had little systematic contact with western biomedical treatments and public health initiatives. For all the blood on British hands politically, were the hospitals built, the drugs distributed, and the research money ploughed into tropical disease research not defensible imperial beneficences?

Critical histories of empire have existed for decades and recently have become ever more live within mainstream debates. Stimulated by the Black Lives Matter movement, statues of empire leaders are questioned, libraries and institutions are renamed, and public exhibitions confront old imperialistic narratives. Popular books and television shows have added further perspectives and exposed the sinister underbelly of empire, reaching new audiences in their direct challenge to embedded national orthodoxies. In the UK, this work is perhaps most prominently exemplified by popular authors such as David Olusoga and Sathnam Sanghera, both of whom have encouraged critical public understanding of how the British empire operated. Among his many instructive contributions, Olusoga has highlighted the important and overlooked roles of Indian, African, and Asian troops in fighting for British empire during World War 1 and the crucial and hidden histories of many minority ethnic workers in the UK's National Health Service. Sanghera's 2021 book, *Empireland: How Modern Britain is Shaped by its Imperial Past*, examined the empire's enduring influence on British culture within national borders. As argued by Sanghera, the exploitation, violence, and inequities that the British empire routinely meted out still shape the self-identification of Black and Brown British people today and they live on in the power structures of many of the UK's legal, judicial, policing, and health institutions. This racism, sadly still alive and kicking within numerous quarters, Sanghera argues, can be traced directly to the British colonial past.

So what have the findings of professional medical historians added to these debates? Have they been able to reveal colonial health provisions as being, if not uniformly positive, then at

least less overtly politicised than other colonial interventions? The short answer is no. Indeed, colonial medical historians too have shown that the primary role of medicine in the colonies was to serve the empire, not the colonised communities.

One starting point when rethinking the role of colonial medicine is an acknowledgment of the integral way colonial power was historically entwined with the rise of tropical medicine. Although other specialties, such as epidemiology, public health, and surgery, were mobilised to serve in the colonial context, tropical medicine was developed with the explicit intent of facilitating and extending colonisa-tion. When Joseph Chamberlain (1836–1914), the Secretary of State for the Colonial Office in the UK, called for the establish-ment of the London School of Hygiene and Tropical Medicine in 1899, he did so pragmatically, rather than philanthropically, because he realised that the success of the British empire relied on having healthy imperialists governing it.

The story of how tropical medicine came to be championed as a government priority is instructive; it was partly down to the influence of Patrick Manson (1844–1922) who, by the 1890s, was established as a leading researcher within this burgeoning medical field through his research on filariasis. Since 1895, Manson had been delivering lectures on the topic at St George's Hospital, London, UK, and he soon gained Chamberlain's ear—and an appointment as the Consulting Physician to the Colonial Office—persuading him that "constructive imperialism" involved establishing a training school for doctors about to embark on careers in colonised countries. As described in my 2007 book *Practising Colonial Medicine*, the tropical medical career did not typically recruit top-flight physicians but was attractive to middle-class, masculine, sporty types, with less cerebral propensities. As the prominent Indian Medical Service doctor, Havelock Charles (1858–1934), pointed out in 1910: "The best kind of man to go to the tropics is the good ordinary type of Britisher, with a clear head 'well screwed on', an even temper, not over intellectual." It is not hard to imagine the motives of some of these doctors: middle-ranking men acquired considerable power and privilege, often working within huge regional jurisdictions. Conditions were far from easy, but it nevertheless represented a career route with steady pay and a good pension. It also meant playing one's part in an important national expansionist project, and engagement in an emerging specialty where little research had yet been done and where it might be possible to make a name for oneself. With new diseases, parasites, cases, and an underpinning racist ideology that did not prioritise participant consent, colonised countries were exploited as a living laboratory for research.

The medical practices that were undertaken in colonial postings also shed light on some aspects of colonial encounters. Situations varied between colonised territories, but the picture before the 1920s was one in which medical treatments were often selectively deployed. In line with the racist ideologies of the time, the best treatments and the best facilities were accorded to the European colonisers, followed by allocations to those that were deemed useful to the colonial state. Furthermore, the act of colonisation itself facilitated disease spread. Big bush and land clearance campaigns undertaken to build colonial infrastructures involved the forcible, and often violent, movement of people from their homes. Labourers, porters, builders, and hauliers were obliged to live in horrendous disease environments as they were forced to build the British empire. Furthermore, these incursions exposed people to new diseases by mingling populations who had previously lived separately. They also disrupted fragile ecosystems and encouraged the movement of parasites. A series of epidemics of human African trypanosomiasis (sleeping sickness) that began in Uganda from 1901, for example, was substantially caused through the bush clearances around Lake Victoria, which disrupted the natural habit of the tsetse fly. Similarly, in other colonised parts of Africa the situation of new settlements by stagnant water pools encouraged malaria through siting populations near to mosquito breeding places.

And these injustices are not just confined to the early years of empire. Certainly, in British-ruled Africa even after World War 1 when colonial medical provision expanded to rural areas—culminating in the Colonial Development and Welfare Acts of the 1940s—the methods deployed by colonial doctors continued to be racist and inequitable. Medical treatments were often enforced, people were moved with little explanation away from their families and homes, and local people who had infectious diseases were sometimes instructed to carry health passports and had differential access to health facilities. Indigenous medical beliefs were derided as superstitious and non-efficacious with little cultural sensitivity, and local people were sometimes coercively and often unwillingly involved in medical research projects.

Colonial psychiatry was also problematically deployed to legitimise colonial violence. When the Mau Mau resistance against the colonial state occurred in Kenya in the early 1950s, far from recognising this as an understandable uprising against colonisation, the British Government employed a psychiatrist, John Colin Dixon Carothers (1903–89), to medically explain the activity of the Kikuyu protesters. His work advanced concepts of African racial

inferiority. Shocking to the modern eye, Carothers's 1954 paper, *The Psychology of Mau Mau*, argued that the postwar socio-economic changes in Kenya had created a cadre of "Africans in transition", who found western modern changes too quick and dramatic to handle. The result of this culture shock was essentially implied as manifesting as a mass violent psychosis. In short, the Mau Mau uprising was not a rational resistance against political domination: these "rebels" were collectively diagnosed by Carothers as mentally ill.

Over time the agency of local people has been recognised within the medical historiography, recentring older top-down narratives of colonial medicine that tended not to engage in detailed analyses of reception. Increasingly, insights have revealed a picture of highly adaptive agentic engagement. As shown by Laurence Monnais, for example, for many colonised people the boundary between "western" and "traditional" medicine was permeable. As one of many options in the medical marketplace, western medicine was to be deliberatively considered, its pros and cons weighed up. Furthermore, it might be taken alongside traditional remedies, or combined with local community-centred sources of health support. These inventive processes of adaptation and appropriation could only happen, however, in instances where people were allowed choice.

Nor should we forget that colonial medicine was not always willingly or gratefully received. Patients and targeted populations sometimes resisted. Indeed, resistance or the threat of mass resistance acted as an important check on the roll-out of certain, unpopular, medical policies. In many colonial contexts, public health campaigns were curtailed precisely because the authorities feared rebellion. Colonial medicine, however efficacious, represented the medicine of a state that saw itself as inherently racially superior and oppressed the populations it ruled.

Colonial medical history should not be let off the hook because the western biomedical model ultimately gained cultural ascendancy. Although colonial medicine saved lives, it is important to remember that old models of medical paternalism were racist. Furthermore, many of the global health inequities still faced today, as well as the racism experienced by patients and health professionals in medical settings, are rooted in this history. Medicine was far from neutral and was wielded as an instrument of colonial hegemony, with all its dangerous, attendant assumptions.

Anna Greenwood,

Department of History, University of Nottingham, Nottingham NG7 2RD, UK

anna.greenwood@nottingham.ac.uk