

Leprosy in Colonial South India: Medicine and Confinement

Review Number:

285

Publish date:

Wednesday, 31 July, 2002

Author:

Jane Buckingham

ISBN:

9780333926222

Date of Publication:

2001

Price:

£75.00

Pages:

248pp.

Publisher:

Palgrave

Publisher url:

<http://www.palgrave.com/products/title.aspx?is=0333926226>

Place of Publication:

Basingstoke

Reviewer:

Mark Harrison

The historiography of disease and medicine in colonial India has tended to concentrate on epidemic diseases and particularly those that have produced the greatest political upheavals. On the assumption that epidemic crises expose latent social tensions, historians have tended to treat epidemics as 'windows' through which to observe broader social and political trends. In a number of studies, historians such as David Arnold, Ian Catanach and Ira Klein have done important work that unravels the connection between disease, colonial hegemony and indigenous resistance to British rule.

But epidemics are, by their nature, untypical events and medical interventions during periods of crisis bore little resemblance to those taking place every day in hospitals and dispensaries in British India. The overwhelming bias of the historical literature towards epidemic disease may therefore have distorted our view of what 'colonial medicine' meant to most people in India, especially given the tendency to concentrate on the most serious outbreaks of disease and at times of great political strain. But even an epidemic disease like cholera appears, over the long term, to have produced little social unrest. Similarly, while smallpox vaccination met localised resistance throughout the period of British rule (and afterwards), the demand for vaccination steadily increased and, in some cases, vaccinators were unable to meet demand. Resistance to hospitalisation, which has been observed during some periods of heavy-handed government intervention (such as during the plague epidemic of 1896-8), also masks a general upward trend in the demand for in- and out-patient care in hospitals and dispensaries during the late nineteenth and twentieth centuries. In short, we should be wary of generalising about attitudes to disease and medical care on the basis of a few epidemic crises.

The great merit of examining a chronic disease like leprosy is that we see more of the everyday experiences of patients and practitioners, and how these changed slowly in response to government policy. In contrast to the government's response to plague, for example, the attempt to control and treat leprosy revealed the fragmented nature of colonial authority and the lack of any clear policy towards the disease. The closer one examines the implementation of policy, the more diffuse colonial power seems to have become, and the more amenable to compromise. This is the main argument advanced in Jane Buckingham's study. In the case of leprosy, at least, colonial medicine lacked the legal power and financial support to become an effective 'tool of empire'. At each remove from Britain, the capacity of Western medicine to act as an expression of colonial power became weaker and subject to negotiation. This was true, she argues, even within leprosy asylums, which were a far cry from Foucault's 'Panopticon' or Goffman's 'Total Institutions'. Most leprosy patients were able to negotiate the terms of their confinement, having some impact upon regimes of treatment, diet and so forth (something also stressed in recent work on Indian mental asylums). Nor were most leprosy sufferers actually confined. Even after legal provisions for confinement were made at the end of the nineteenth century, the legislation was interpreted conservatively and the bulk of those entering leprosaria came of their own volition.

Leprosy hospitals in southern India began, as in other parts of India, as private charitable concerns and were few in number. Gradually, as in the case of other hospitals, most leprosaria were taken over by the provincial government. By the 1840s, medical arguments were being put forward for segregation of leprosy sufferers, although notions of contagion were not clearly defined. A little later, there were also moves to segregate leprosy sufferers in institutions such as lunatic asylums and prisons. But there was no attempt to confine leprosy sufferers in general. Only those who were vagrants and without family and friends to support them were subject to forced confinement; even then, confinement was haphazard. By the 1840s, the Madras government was intervening in the running of asylums to prevent over-zealous medical officers from retaining patients against their will.

After the identification of the bacillus causing leprosy in 1873, and the well-publicised death of the Belgian priest, Father Damien, from leprosy in 1889, medical opinion began to shift. Leprosy was now seen less as a constitutional disease and more as a contagious disease, spread by human contact. There were even fears that leprosy would return from the colonies to infect Britain and other countries. Demands for compulsory segregation began to grow louder, but the colonial state's commitment to confinement remained half-hearted. The All-India Leprosy Act of 1898 (modelled on an act passed in Bengal the year before) was amended substantially by the Madras government after consultation with local Indian elites. The government also used great discretion in employing the legislation and it was not applied to the whole of the province until 1913. Very few leprosy sufferers were therefore affected by it and, although confinement increased, it was mostly due to voluntary admissions. By the early twentieth century, the Madras government was also beginning to work more closely with charitable groups like the Mission to Lepers, to which the care and treatment of leprosy patients was substantially devolved. This was hardly the act of a government bent on confinement and control.

The most that can be said about leprosy sufferers in colonial India is that they occupied an ambiguous status, somewhere between that of a patient and a prisoner. However, one would have to distinguish between different kinds of patient: between those who came voluntarily to leprosaria, often for short periods or as outpatients, and those without financial and family support who had fewer alternatives to life in the asylum and who were more likely to be detained against their will. Inmates of prisons and insane asylums were in a different category again. The ambivalent status of the leprosy sufferer was evident, too, in the ways in which they were treated whilst in the asylum. A degree of control over the lives of patients was considered necessary for effective management but controls were generally lax. Buckingham notes that the architecture of the leprosy asylum bore no relation to that of classic total institutions and that it was not conducive to effective surveillance. Similarly, although there were repeated attempts to control the diet of patients for therapeutic reasons, diets were sometimes modified in the light of patients' dissatisfaction. Segregation on the lines of caste, race and gender, was enforced in line with other institutions, although provisions for caste were generally inadequate and deterred many of high caste from entering.

Buckingham also argues that patient resistance influenced medical treatment. Although demand for Western medicine was increasing during the late nineteenth century, for most Indians, the first port of call was a local healer. Western medical attention was often a last resort, to be sought only after more familiar treatments had failed. The inmates of leprosy asylums may therefore have been wary of the treatments stipulated by medical officers, though it is clear that some were attracted by reports of new and supposedly effective remedies. One such was gurjon oil, a treatment developed by Surgeon Dougall of the Madras Medical Service in the early 1870s. Dougall began to use the oil after reports that leprosy had been effectively treated in Venezuela by the application of cashew nut oil. Gurjon oil was derived from the wood of a tree native to south India and was rubbed onto the skin. It was, however, soon superseded by another indigenous remedy: chaulmugra oil, which was the dominant form of treatment for leprosy until the introduction of sulphone drugs in the 1940s. The oil was already a noted component of ayurvedic remedies for skin diseases but the British promoted it as a 'specific' treatment for leprosy, incorporating it into their peculiar regime of diet and hygiene.

Chaulmugra was preferred to gurjon oil, in part, because patients regarded its action as milder and because it left the skin softer. However, some patients could or would not rub in these external preparations on a regular basis; many left the asylum and did not continue their treatment because they did not have the inclination or means to obtain the preparations. Some also appear to have regarded the constant emphasis upon specific cures as too secular and continued to call upon divine assistance, in the belief that the disease was partly a spiritual disorder.

By the end of the nineteenth century, chaulmugra oil was being used to treat leprosy throughout the British Empire, despite the fact that there was little evidence that it was effective. Its transition from a local to a global remedy was indicative of the fact that leprosy was now a matter of general imperial concern. Leprosy research and treatment had been receiving a good deal of attention since the mid-1870s, following Hansen's

discovery of the bacillus. His discovery had generated a debate about whether the disease was contagious and about the desirability or otherwise of isolating leprosy sufferers. As a result, the Government of India began to take an interest in, and began to support, leprosy investigations, such as those undertaken by Dr H. V. Carter of the Indian Medical Service. Carter was greatly influenced by Hansen's research and by the policy of isolation followed in Norway. However, his work was questioned by some within the Sanitary Department of the Government of India, who were fearful of the political consequences of enforced isolation and who continued to see most diseases within a multi-causal framework.

There are clear parallels between these debates over leprosy and the controversies that surrounded the causation and prevention of cholera, in which a similar split occurred between those who emphasised contagion and those who saw it as secondary to sanitary conditions. Narrow, contagionist ideas went against the grain of medical thinking in India, which had always stressed the environmental causes of disease. However, the environmentalist orientation of some of India's medical officers was eclipsed by the report of the Leprosy Commission that visited India at the beginning of the 1890s. The Commission, composed largely of experts from outside India, reported that the disease was contagious, though not highly so. It proposed that leprosy should be controlled by hygienic laws rather than by confinement, and by concentrating legal restrictions on vagrants and certain occupations. The report lent authority to those within India who saw the disease as contagious and gave impetus to the leprosy acts, but its recommendations were sufficiently moderate to calm the nerves of those who were wary about heavy-handed intervention.

Leprosy, then, provides many useful insights into the broader social and political dynamics of imperialism. It illustrates the growing sense that disease was an imperial problem, rather than merely a local one, but it also shows that imperial policies were significantly modified by local circumstances. Buckingham skilfully weaves together these threads to produce a coherent and nuanced account of leprosy in colonial South India. As well as considering the evolution of leprosy policy from various levels, her account manages to incorporate a discussion of the medical, political, legal and cultural dimensions of the disease. In so far as it is possible to do so from extant sources, it also gives due weight to the agency of leprosy patients and sufferers.

The author's conclusions about leprosy and colonial medical policy are balanced and judicious. The control and treatment of leprosy is presented as the outcome of complex negotiations between metropolis and locality, between patient and practitioner. These conclusions serve as a qualification to the arguments advanced by some historians (for example, David Arnold), who see medicine as a powerful colonizing force. Leprosy was clearly treated differently from other diseases, however. It was never considered a threat in the same way as epidemic diseases, yet it received far more attention than other chronic diseases, such as what was then termed consumption (later tuberculosis). There were no special provisions made for tuberculosis patients in India until the early twentieth century, nor was the disease widely regarded as a public health issue until the 1890s, and then only by comparatively few. Why, then, did leprosy become such a major issue? Clearly, its biblical associations made the care of leprosy sufferers seem like a Christian duty and an obvious component of any mission to 'civilise' the empire. But the growing interest in leprosy shown at the end of the century may have been due to mounting unease about European rather than colonial society. The colonies may have seemed like reservoirs of infection, but fears about racial decline and urban conditions in Europe suggested that there was still fertile 'soil' in which the 'seeds' of leprosy could germinate.

A good deal more could and, no doubt, will be said about the general political and cultural context in which leprosy was framed as a major problem at the end of the nineteenth century. The archive on leprosy is vast and still relatively neglected by historians. This book is one of the few monographs on leprosy in the modern era and is of considerable importance for this reason, quite apart from what it has to say about colonial India specifically. Yet I wonder whether some of the analytical categories employed in the book have made the most of the rich sources tapped by the author. The concept of 'resistance' is a case in point. It is clear that patients did in some cases resist aspects of the asylum regime but some of the instances cited by Buckingham appear more like alternative courses of action. In the case of treatment, specifically, I looked in vain for instances of patients refusing to take medication on the grounds that they objected to it. The examples cited by the author consist mostly of a lack of commitment (rather than resistance) to treatment, of

patients failing to continue treatment after leaving the asylum or of complementary practices like religious rituals and pilgrimages. There appear to have been few cases of wilful non-compliance or evasion. The concept of 'resistance' therefore seems inadequate to explain why patients behaved as they did. They had their own agendas and these cannot be understood merely as the negation of the asylum regime.

There are also some curious admissions in the secondary literature, most notably the various works on leprosy in India by Sanjiv Kakar (for example, 'Leprosy in British India, 1860-1940', *Medical History*, 40:2 (1996), 215-30 and 'Leprosy in India: the intervention of oral history', *Oral History*, 23:1 (1995), 37-45). These works contain important information about leprosy in India today and about its history during the colonial period. Kakar's work provides confirmation of much of what Buckingham has to say about patient agency, for example, as well as considering additional dimensions, like the role of Indian elites as a lobby for the confinement of vagrants with leprosy. Kakar's oral history work also shows that leprosy sufferers continue to be stigmatised in some parts of India, by contrast with the area and period studied by Buckingham, in which there was remarkably little stigmatisation.

But these are relatively minor criticisms. *Leprosy in Colonial South India* has many important things to say, both about the colonial medical encounter and about attitudes towards leprosy in Indian society. This book should be read by anyone interested in the history of leprosy or in the medical aspects of colonial rule.

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