Coming ‘Home’ to (post)Colonial Medicine: Treating Tropical Bodies in Post-War Britain

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Summary. While investment and popular enthusiasm have fuelled significant growth in the history of medicine since the 1980s, it remains by some metrics well outside of the historical mainstream. Yet developments in the history of medicine could offer traction to historians more generally. Through its close critical attention to power, embodiment and hegemonic institutions and knowledges, the history of medicine also presents a unique perspective from which to interrogate ‘postcolonialism’. Here, post-war British examples demonstrate the potential of a medical and postcolonial lens for historians exploring policy making, immigration or identity. In this period, civil servants, biomedical researchers, policy makers, and publics including migrants actively shaped medical and governmental responses to an apparently novel phenomenon: the mass migration to Britain of its former tropical subjects. Postcolonial analysis uncovers new models of community, and highlights the importance of the late twentieth-century and the post-imperial city as sites of historiographic and theoretical development.

Keywords: policy making; ethnicity; immigration; postcolonialism; tropical medicine

Biomedicine has grown extravagantly since the Second World War, not just in the wealthy global North, but in the developing global South. Biomedical language and modes of interpreting human, social and natural phenomena pervade the practices and technologies of governance, particularly in the post-war era, and as such should be of interest to a wide range of historians. Yet the history of medicine remains curiously distinct from the wider discipline. Even the flourishing and incisive literature now produced to document and explore colonial medicine and its aftermath is under-used by scholars in adjacent historical fields—historians of empire, for example, or of gender, or ethnicity.

Thus the power and pervasiveness of medical discourse in the lives of those excluded from as well as those included within its fluid boundaries remains under-examined.1 Here, I argue that exploring biomedicine through a postcolonial lens could not only sharpen the insights of medical history, but might also contribute new tools to the

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1This point has also been recently made by Warwick Anderson and Hans Pols, ‘Scientific Patriotism: Medical Science and National Self-Fashioning in Southeast Asia’, CSSH, 2012, 54, 93–113.
wider discipline of history. These could include forms of analysis that foreground the interdependency of local and global networks of knowledge; that better integrate material and cultural interpretations of the quotidian interactions between physical bodies and environments; that account for a spectrum of empowerment between the poles of ‘agent’ and ‘subaltern’ (without ignoring consistent patterns of disparity and their effects); and that recognise communities of interest and action, regardless of the degree to which they are self-aware. A postcolonial approach using such tools should allow biomedicine to be assessed in conjunction with other hegemonic forces that (arguably) transcend states, societies and cultures.

But what is a ‘postcolonial approach’ and how might the empirically-grounded, case study-oriented methods of historical analysis contribute to its articulation? Although definitions remain contested, the transdisciplinary literature highlights certain areas of consensus. First, a postcolonial approach decentres European and North American perspectives, integrating these regions within a global whole constituted through processes such as colonialism and decolonisation. Second, postcolonial history depends less on conventional periodisation, emphasising instead the continuity of attitudes, relationships and entities through different regimes. Third, postcolonialism places power—its circulation and appropriation, its agents and objects, its forms and tools of expression, and its limits—at the heart of historical analysis. Finally, postcolonial analysis militates against binarisms and dichotomies, and often rejects straightforward divisions between ‘subalterns’ and ‘agents’.

Adopting the suggestions of imperial historians Catherine Hall, Sonya Rose and Wendy Webster, I argue that the late twentieth-century post-metropoles are particularly rich contexts within which to assess ‘postcoloniality’ as an analytical lens. If postcolonial history demands that scholars explore geographies and nations as they exist in dynamic relation to each other, then no twentieth-century historian can safely ignore the former metropolitan centres of empire and their globally influential institutions. Moreover, the extended temporal boundaries of postcolonial periodisation offer a more realistic timeframe—stretching backward into the period of colonisation and empire building, and forward through decolonisation and into the near contemporary—within which to assess these global sites. Cultures interpellated by colonialism were not suddenly dis-integrated by the wind of change, and imperial power relations cast long shadows.

Can such a postcolonial approach facilitate historical exploration at the intersections of governmentality, expertise, and culturally plural societies, and bring the history of medicine into the scholarly mainstream? After a brief summary of existing ‘postcolonial history’ in the field, I will test the limits of postcoloniality as an analytical tool for understanding relationships between biomedicine and its subjects in the late twentieth century through three historical case studies: the post-colonial re-situating of ‘tropical medicine’; the British response to the racialised genetic conditions, sickle cell anaemia and thalassaemia; and the impact of ‘Asian rickets’ on British nutrition science and policy. Together

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2 ‘Biomedicine’ is itself a contested term; here, I refer to the complex of materialist epistemologies; knowledge-making agents and practices; and governmental, institutional and corporate bodies which characterised ‘organised medicine’ in the developed world in the twentieth century. See Roberta Bivins, *Alternative Medicine? A History* (Oxford: Oxford University Press, 2007), 1–40.
these cases expose medicalised institutional, political, and social responses to effects of decolonisation; they also offer exemplary sites for testing postcolonialism’s claims to explanatory power.

**A postcolonial history of medicine?**

In 1998, historian Warwick Anderson asked ‘Where is the postcolonial history of medicine?’ For more than a decade, as I will discuss below, historians of medicine have responded to this question and the challenge posed by postcolonialism, in the process reframing and often expanding the territory occupied by the field. Such developments notwithstanding, Anderson’s essay remains a key entry point for students and scholars alike interested in the conjunction of postcoloniality and medical history and merits close attention. Expressively, his was a question in three modes. First, it noted a sense of historiographic and disciplinary expectation unfulfilled. Despite increasing appreciation for the sophisticated bio-power generated by medicine in empire, historians of colonial medicine, Anderson argued, still privileged western knowledge and perspectives, and assumed simple unidirectional (or even bilateral) relationships between ‘centre’ and ‘periphery’. The history of colonial medicine had therefore failed to colonise the history of medicine as a whole through identifying ‘what is colonial about Western medicine in any setting’. Nor had historians of colonial medicine used the considerable traction offered by their case studies to address the emerging questions preoccupying history as a wider discipline. Instead, they continued to write ‘a minor literature’, focused on intellectual history and sometimes narrowly internalist. Their emphasis on the agency of (medical) ideas, institutions and expatriate professionals assumed a passive colonial ‘receptacle’, rather than a context rich in actors and politics of its own.

In its second mode, Anderson’s interrogative ‘where’ suggested that ‘postcolonial history of medicine’ would have a location, that it would arise from and be situated in particular geographical (and disciplinary) spaces. He envisioned the colonies themselves, and the new nations which emerged from decolonisation, as prime sites for the development of a postcolonial history of medicine. He also hinted that western medicine might be ‘colonial at home’, annexing an even wider territory for postcolonial historians. Not only might medical practices developed for and deployed in colonial settings influence medicine in the metropolitan centres (as subsequent studies have certainly illustrated), but there might be something intrinsically colonising about western medicine’s rhetorical

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3Warwick Anderson, ‘Where is the Postcolonial History of Medicine?’, *Bull Hist Med*, 1998, 72, 522–30, 523.

4This critique, like others in Anderson’s piece, is no longer justified: historians of colonial medicine are alert to the competing interests and multi-layered professional and social contexts in which medical practitioners worked, created and received knowledge: Ryan Johnson, ‘“An All-white Institution”: Defending Private Practice and the Formation of the West African Medical Staff’, *Med Hist*, 2010, 54, 237–54; Niklas Jensen, ‘... For the Benefit of the Planters and the Benefit of Mankind...’ The Struggle to Control Midwives and Obstetrics on St. Croix, Danish West Indies, 1818–1848’, in Juanita De Barros, Steve Palmer and David Wright (eds), *Health and Medicine in the Circum-Caribbean, 1600–1900* (London: Routledge, 2009), 19–39; Richard Keller, ‘Taking Science to the Colonies: Psychiatric Innovation in France and North Africa’, in Sloan Mahone and Megan Vaughan (eds), *Psychiatry and Empire* (Houndmills: Palgrave, 2007), 17–40.

5Such a history would explore relationships between medical and other agents of biopower, placing investigations of practice and routine on a par with those of knowledge and theory.

6Anderson, ‘Postcolonial History’, 524.
claims of modernity, and its universalist ambitions. In this case, a postcolonial history of medicine would equally explore ‘colonial medicine’ in London, New York and Paris as well as Lahore, Manila and Dakar.

Finally, and perhaps unintentionally, Anderson’s question suggested that ‘the postcolonial history of medicine’ might be located in time as well as place. About what periods could ‘postcolonial history’ be written? Would it address (as more conventional histories of medicine still have not) colonial medicine’s early- and mid-twentieth-century iterations and epicycles? Or would its pioneers break ground in the ‘post-colonial period’—the then-terra incognita of the late twentieth century? On revisiting Anderson’s call-to-arms, I was surprised that it never mentioned decolonisation, or the (arguably) postcolonial world which emerged after the Second World War. The presence of that world is perhaps assumed, but the thrust of Anderson’s argument is directed elsewhere. As historians have increasingly turned their attention to the second half of the twentieth century, however, the search for a ‘postcolonial history of medicine’ has taken on new urgency. Later in this paper, I will therefore explore ‘postcolonial medicine’ as it existed specifically in post-war Britain, among emerging communities of ex-colonial researchers, clinicians, civil servants and members of the newly metropolitan populations who attracted the gaze and insisted on the engagement of medical power and its putative agents.

Anderson’s question directed scholarly attention towards developing an approach which assumed neither the priority of European perspectives, nor the passivity of the extra-European world. In the years since his article was published, Anderson and other historians of medicine have sought to create such a history within the colonial stronghold of the idea. So what has the postcolonial history of medicine begun to look like?

As Anderson anticipated, historians of the colonial—and particularly the late colonial—period most swiftly adopted questions and approaches associated with ‘postcolonial history’. Within the history of medicine, as in the wider discipline, this has meant the blurring of national boundaries, often through examination of trans-national environmental factors or population movements. The emerging postcolonial history of medicine has likewise increased attention to chronic, nutritional and occupational diseases, reproductive health, and degenerative conditions in the colonies, former colonies, post-colonies,

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7 Anderson expanded David Arnold’s suggestion in Colonising the Body: State Medicine and Epidemic Disease in Nineteenth Century India (Berkeley: University of California Press, 1993), 9.

8 The periodisation of the postcolonial (or post-colonial) is contested across the disciplines engaging with ‘post-coloniality’. Dispensing with rigid, politically defined milestones, scholars debate whether the conditions of postcolonialism apply from the moment of colonisation or the moment(s) of its ending. Moreover, some use the term to describe a theoretical and interpretive approach to a past and ongoing cultural moment, while others use it exclusively to denote a period or a political, cultural and/or socioeconomic state. Here, the unhyphenated form, ‘postcolonial’ denotes the historiographic approach and the (contested and reflexive) socioeconomic and cultural state; ‘post-colonial’ refers to the period after political decolonisation.

9 Clare Anderson, Legible Bodies: Race Criminality and Colonialism in South Asia (Oxford: Oxford University Press, 2004); Alison Bashford, Imperial Hygiene: A Critical History of Colonialism, Nationalism and Public Health (Basingstoke: Palgrave, 2004); Alison Bashford, Medicine at the Border: Disease, Globalisation and Security, 1850 to the Present (Basingstoke: Palgrave, 2006); Jean Kim, ‘Objects, Methods and Interpretations: Imperial Trajectories, Haunted Nationalisms and Medical Archives in Asian American History’, J. Asian American Studies, 2011, 14, 193–219.
and among ex-colonial diasporic populations. Such topics were previously overlooked by historians of colonial medicine, as by the colonial states on which they focused. In such settings, chronic conditions emerged less as a function of declines in acute disease, than as an enduring aspect of medical research and provision beyond the state controlled sector. As I demonstrate below, their sporadic and delayed visibility in state medicine contrastingly provides a sensitive barometer of metropolitan public feeling towards the imperial relationship.

Perhaps these postcolonial approaches to colonial medicine have not achieved all of their goals; in particular, many have struggled to escape the confines of traditional national history. Nonetheless, discarding the already threadbare ‘centre–periphery’ model of relations between colonising and colonised territories and peoples, scholars have uncovered fluid and multilateral networks of exchange, and have crafted histories of medical knowledge and practices as simultaneously international and idiosyncratically local. Importantly, the geographic territory of ‘colonial medicine’ has also been expanded to include the imperia of East Asia and the Antipodes. Examining colonial practice has revealed a broader range of historical actors, including missionaries and indigenous healers, leaders, communities and patients. This in turn has encouraged explorations of hybridity—the ‘localisation’ or ‘vernacularisation’ not only of practice and agency,

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10 Sunil Amrith, Decolonising International Health: India and Southeast Asia, 1930–1965 (Basingstoke: Palgrave, 2006); Sunil Amrith, ‘Food and Welfare in India, c. 1900–1950’, Comparative Studies in Society and History, 2008, 50, 1010–35; David Arnold, ‘Diabetes in the Tropics: Race, Place and Class in India, 1880–1965’, Soc Hist Med, 2009, 22, 245–61; David Arnold, ‘British India and the “Beriberi Problem”’, 1798–1942’, Med Hist, 2010, 54, 295–314; Anne-Emanuelle Birn, ‘Doctors on Record: Uruguay’s Infant Mortality Stagnation and its Remedies, 1895–1945’, Bull Hist Med, 2008, 82, 311–54; Roberta Bivins, ‘“The English Disease” or “Asian Rickets”? Medical Responses to Postcolonial Immigration’, Bull Hist Med, 2007, 81, 533–68; Jill Briggs ‘“As Fool-proof as Possible”: Overpopulation, Colonial Demography, and the Jamaica Birth Control League’, The Global South, 2010, 4, 157–77; Chie Ikeya ‘The Scientific and Hygienic Housewife-and-Mother: Education, Consumption and the Discourse of Domesticity’, J Burma Stud, 2010, 14, 59–89; Lynette Schumaker, ‘Slimes and Death-Dealing Dambos: Water, Industry and the Garden City on Zambia’s Copperbelt’, J South Afr Stud, 2008, 34, 823–40.

11 However, see Warwick Anderson, The Collectors of Lost Souls: Turning Kuru Scientists into Whitemen (Baltimore: Johns Hopkins University Press, 2008), and Amrith, Decolonising. It is quite possible to write postcolonial history in a specific national context—but the nation state constituted and considered in such histories is necessarily much changed.

12 Arnold, ‘The “Beriberi Problem”’.
but of medical knowledge and epistemologies—and both the extent and limits of medical power.¹⁵

Historians of international (and latterly, global) health have challenged conventionally bounded national histories of medicine, and are beginning to address non-western agency.¹⁶ Yet it is in the post-metropoles that Anderson’s question can most readily be answered in all three of its modes: temporal, spatial and historiographical. Moreover, a postcolonial exploration of medicine in the post-metropoles could provide an opportunity for the wider disciplinary development I discussed above. Within my post-war British case studies, a postcolonial optic reveals apparently silenced communities harnessing and reshaping elite biomedicine through their demands as well their bodily distinctiveness; blurs any distinction between colonial and post-colonial medicine; and captures ‘local knowledge’ authoritatively critiquing ‘global’ expertise.

Was post-colonial metropolitan medicine postcolonial? The case studies

Medicine in the post-war period had certainly moved beyond Westphalian models of sovereignty and external non-intervention in domestic affairs. Empire, and later the warning signs of its disintegration, ensured this transition: trans-national identities and models of imperial citizenship had destabilised the territorial singularity of the nation state, dispersing its commercial, political and social interests across geographies more readily conceivable in a global context. Well before the Second World War, non-governmental philanthropies joined late-imperial states in funding research programmes and institution building across the tropics, eroding the exclusive claims of the nation state to the ‘civilising mission’ and even ‘modernity’. Meanwhile, imperial subjects moved ever more fluidly across global terrains with the rise of mass migration by sea and later, air. Not only did this traffic reverse the traditional tides of population movement within empires, it undermined the logic of enclavism in medicine as in politics. Epidemiologically and demographically, biomedicine from the interwar period onwards addressed itself to global

¹⁵Stacey Langwick, ‘Geographies of Medicine: Interrogating the Boundary between “Traditional” and “Modern” Medicine in Colonial Tanganyika’, in Tracy Luedke and Harry West (eds), Borders and Healers: Brokering Therapeutic Resources in Southeast Africa (Bloomington: Indiana University Press, 2006); Projit B Mukharji, Nationalizing the Body: The Medical Market, Print and Daktari Medicine (London: Anthem Press, 2011). On power and medicine, see Mukharji, 10–11; Megan Vaughan, Curing Their Ills: Colonial Power and African Illness (Stanford: Stanford University Press, 1991); on power more generally, Bill Ashcroft, Post-Colonial Transformation (London: Routledge, 2001), 171–5.

¹⁶Sanjoy Bhattacharya, Expunging Variola: The Control and Eradication of Smallpox in India, 1947–1977 (New Delhi: Orient Longman, 2006); Sanjoy Bhattacharya and Sharon Messenger (eds), The Global Eradication of Smallpox (Hyderabad: Orient Blackswan, 2010); Anne-Emanuelle Birn, Marriage of Convenience: Rockefeller International Health in Revolutionary Mexico (Rochester: University of Rochester Press, 2006); Marcos Cueto, Cold War, Deadly Fevers: Malaria Eradication in Mexico, 1955–1975 (Baltimore: Johns Hopkins University Press, 2007); Mariola Espinosa, Epidemic Invasions: Yellow Fever and the Limits of Cuban Independence, 1878–1930 (Chicago, University of Chicago Press, 2009); John Farley, To Cast Out Disease: A History of the International Health Division of the Rockefeller Foundation (1913 –1951) (Oxford: Oxford University Press, 2004); Anne Perez Hattori. Colonial Dis-Ease: U.S. Navy Health Policies and the Chamorros of Guam, 1898–1941 (Honolulu: University of Hawaii Press, 2004); Steven Palmer, ‘Migrant Clinics and Hookworm Science: Peripheral Origins of International Health, 1840–1920’, Bull Hist Med, 2009, 83, 676–709. The impacts of international health movements on medical practice and perceptions of health and disease in the global North remain unexplored.
populations. Decolonisation demanded that medicine do so in a novel geopolitical framework, invoking ‘development’, ‘indigenisation’ and ‘independence’ alongside fiscal conti- nence, structural reform and the continued—but incomplete—dominance of biomedicine over competing medical systems. For the post-colonies, historians are increasingly comfortable in asserting that this new framework was transformative: that ‘colonial medicine’ became ‘postcolonial’ at least in its rationale and rhetoric.\(^{17}\) In some places, too, medicine in the post-colonies became hybrid—incorporating indigenous agents, medical systems, practices and norms, often visible in local co-option and adaption of international health agendas.\(^{18}\) Elsewhere, however, much like the arrival of germ theory, the arrival of postcoloniality in medicine seems initially to have produced less change in practice than in theory.\(^{19}\)

On the ground, therefore, it remains easier to recognise medical postcoloniality (like colonial medicine before it) through specific instances than to extract from those cases a fixed idiom that distinguishes ‘postcolonial medicine’ from other forms of post-war medical practice.\(^{20}\) However, historians of empire have convincingly argued that the experience of empire shaped colonising no less than colonised cultures and peoples.\(^{21}\) If this is the case, then ‘postcolonial medicine’, if it exists, must operate in the post-metropoles as well as the post-colonies. In these intensely scrutinised and meticulously documented contexts, from which empire has receded only gradually, it may be easier to isolate and recognise the ‘postcolonial’. Such research will bring medical history closer to the goal of decentring European perspectives and experiences, by acknowledging the ways in which Europe too has become a hybrid and colonised space.

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\(^{17}\) Randall Packard, ‘Postcolonial Medicine’, in Roger Cooter and John Pickstone (eds), Companion to Medicine in the Twentieth Century (London: Routledge, 2003), 235–45.

\(^{18}\) Studies of population control, and particularly fertility control offer clear examples: Matthew Connolly, Fatal Misconception: The Struggle to Control World Population (Cambridge, MA: Harvard University Press, 2008); Amy Kaler, ‘A Threat to the Nation and a Threat to the Men: The Banning of Depo-Provera in Zimbabwe, 1981’, J South Afr Stud, 1998, 24, 347–76.

\(^{19}\) New case studies describe a distinctive medical discourse in these diverse contexts: Warwick Anderson, ‘From Subjugated Knowledge to Conjunctured Subjects: Science and Globalisation, or Postcolonial Studies of Science?’ Postcolonial Studies, 2009, 12, 389–400; Timothy Burke, Lifebuoy Men, Lux Women: Commodification, Consumption and Cleanliness in Modern Zimbabwe (Durham: Duke University Press, 1996); Paul Farmer, AIDS and Accusation: Haiti and the Geography of Blame (Berkeley University of California Press, 1992); Randall Packard, ‘Post-Colonial Medicine’ in Cooter and Pickstone (eds), Companion, 97–112; Lynette Schumaker and Virginia Bond, ‘Antiretroviral Therapy in Zambia: Colours, “Spoiling”, “Talk” and the Meaning of Antiretrovirals’, Soc Sci Med, 2008, 67, 2126–34.

\(^{20}\) Shula Marks, ‘What is Colonial about Colonial Medicine?’, Soc Hist Med, 1996, 10, 207–19.

\(^{21}\) Catherine Hall, Civilising Subjects: Metropole and Colony in the English Imagination, 1830–1867 (Cambridge: Cambridge University Press, 2002); Catherine Hall and Sonya Rose (eds), At Home with Empire: Metropolitan Culture and the Imperial World (Cambridge: Cambridge University Press, 2006); Andrew Thomson, The Empire Strikes Back? The Impact of Imperialism on Britain from the Mid-Nineteenth Century (Harlow: Pearson Longman, 2005); Wendy Webster, Englishness and Empire, 1938–1965 (Oxford: Oxford University Press, 2005). For empire’s impact on metropolitan science: Roy MacLeod, ‘On Visiting the “Moving Metropolis”: Reflections on the Architecture of Imperial Science’, Hist Rec Aust Sci, 1982, 5, 1–16; Paolo Palladino and Michael Worboys, ‘Science and Imperialism’, Isis, 1993, 84, 91–102; Alexis de Greiff and Mauricio Nieto Olarte, ‘What We Still Do Not Know About South–North Technoscientific Exchange: North-centrism, Scientific Diffusion and the Social Studies of Science’, in Ronald Doel and Thomas Soderqvist (eds) The Historiography of Contemporary Science, Technology and Medicine: Writing Recent Science (London: Routledge, 2006), 239–59.
Tropical medicine, which emerged as a considered response to the exigencies of empire, offers a logical starting point: if any field of metropolitan medicine has been affected by the end of empire, surely it will be the one that focused on the geographies, the epidemiologies and the pathologies of colonised and colonisers alike. By the end of the Second World War, tropical medicine was flourishing both in the global metropoles and in the decolonising tropics. Its subspecialties incorporated approaches from the microbiological to the environmental, and its research workers abidingly engaged with key intellectual engines of imperial power: hierarchies of race, models of imperial citizenship, and the spread of civilisation/modernity. These discourses were gradually reframed in the post-colonial period to consider ethnicity, nationalism and development. However, their medical and material objects—and their networks of research, funding, and policy-making—remained much the same.

While ‘coloniality’ endured in such aspects of practice, tropical medicine’s elite also recognised and discussed anticipated and actual changes following de-colonisation. In his 1961 presidential address to the Royal Society of Tropical Medicine, George McRobert ruefully acknowledged: ‘Any attempt by the United Kingdom, however wise and far-sighted and commonsense may be our motives, to carry the colonial apparatus forward into the era of independence is likely to be self-defeating.’ In the United States too, researchers were preoccupied by the passing of tropical medicine’s colonial mandate. Their language was tellingly critical of European imperialism and laudatory of internationalism:

In the era which has just passed the great colonial powers supported extensive programs of research in large institutes of tropical medicine and hygiene as an aid to the development and exploitation of the areas under their control. … Colonialism is now rapidly passing into history and the future of the tropics is becoming more and more the concern of the people who inhabit them, and of the united nations of the world …

As colonial medicine became international health, and imperial institutions were re-engineered to serve the expanding domestic commitments and reduced global sway of the post-imperial states, tropical medicine too was re-vamped. Newly ‘domestic’ populations came under its purview, while ex-colonial sites of research saw a narrowing of investigative focus, and reductions in staff and discretionary budgets. The case of the genetic haemoglobinopathies, in Britain, a minor tropical research preserve until the rise of both medical genetics and mass migration in the 1950s and 1960s, illustrates the emergence of a distinctive metropolitan ‘postcolonialism’ in medicine. ‘Asian rickets’—the re-appearance in Britain of nutritional rickets among the children of South

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22On tropical medicine: Anderson, Colonial Pathologies; Arnold, ‘Diabetes in the Tropics’; Arnold (ed.), Imperial Medicine and Indigenous Society (Manchester: Manchester University Press, 1988); Douglas Haynes, Imperial Medicine: Patrick Manson and the Conquest of Tropical Disease (Philadelphia: University of Pennsylvania Press, 2001); Michael Worboys, ‘Germs, Malaria and the Invention of Mansonian Tropical Medicine: From “Diseases in the Tropics” to “Tropical Diseases”‘, Clio Med, 1996, 35, 181–207.
23George McRobert, ‘Presidential Address: Empire to Commonwealth’, Trans R Soc Trop Med Hyg, 1961, 55, 485–6, 489.
24Alfred Sabin, ‘Preface’, Tropical Health. A Report on a study of needs and resources, Pub 996, National Academy of Sciences, National Resource Council, Washington DC, 1962.
Asian immigrants—offers a perspective on the postcolonisation of a familiar, rather than a novel, health condition, and demonstrates the ways in which British medical history too may benefit from adopting a postcolonial gaze. By contrast, examining the role of returned medical officers and tropical nutrition researchers in formulating UK nutrition standards and public health practices presents a postcolonial medicine in which ‘metropolitan’ populations, practices and exigencies are assessed by ‘colonial’ standards.

From tropical medicine to racial medicine

In 1969, a subcommittee of the Medical Research Council (MRC)’s Tropical Medicine Research Board (TMRB) met for the last time. The Abnormal Haemoglobin Variants Committee’s final recommendation to the Board called for further research into the haemoglobinopathies, particularly in the emerging medical research centres of Africa. The MRC in turn suggested that the Overseas Development Ministry (ODM) fund epidemiologist P. J. S. Hamilton, ‘to visit Africa in order to investigate and co-ordinate’ African research on sickle cell anaemia (SCA). The ODM duly supported a tour of five TMRB funded centres in three countries. This rather mundane episode is of interest because it coincided with the emergence of SCA as a public health problem and cutting edge research topic in the UK. With the arrival of West Indian immigrants in the 1950s and 1960s, the ‘first molecular disease’ became an accessible medical research object in Britain itself. Thus, in funding Hamilton’s African expedition (itself reminiscent of high colonial medicine), the MRC and ODM were also funding research on a problem newly imported to the post-metropole. Colonial medicine always served the aims and ambitions of the colonising power; however, the insistence that research investments in the ex-colonial world should be specifically tailored to address Britain’s health problems was a novel feature of its post-colonial successor.

The ODM’s response to Hamilton hints at a governmental desire to re-inscribe SCA, a politically sensitive illness, with a tropical identity by distancing it from the UK. This is, of course, entirely consistent with wider political attitudes of the late 1960s, and particularly successive governments’ extreme ambivalence about the permanent presence within Britain of South Asian and West Indian ethnic populations. Thus, Hamilton was funded only to investigate and coordinate work in Africa, rather than, as he had originally proposed, ‘to mount co-operative studies’ between workers in Africa, Jamaica and Britain. In contrast, the MRC—keen to compete with the USA in the new field of molecular biology—eagerly identified the genetic haemoglobinopathies as a domestic concern, and a suitable subject for UK research.

Hamilton’s interest in SCA was shaped by his work in an MRC-funded research clinic at Uganda’s Makerere University College Medical School. By 1969, however, the MRC was withdrawing from the business of long-term funding for sickle cell (and other) research programmes abroad. Its resources were instead to be deployed principally at home. With this change of regime, British researchers faced a transition from the familiar

25The TMRB succeeded the Colonial Medical Research Committee, which disbanded in 1961 as decolonisation eroded its remit.
26The National Archives, UK [TNA] FD23/1656, A.M.B. to B Lush, 27 November 1969.
27TNA FD 23/1656, P.J.S. Hamilton to B. Lush, MRC 28 January 1970.
28TNA FD 23/1656, B. Lush, ‘Discussion with Professor A.W. Woodruff’, 12 November 1969.
world of colonial tropical medicine to its unknown post-independence successor. Numerous keynote addresses and editorial leaders in contemporary medical journals commented on the insecurity faced by such returnees. However, as they established themselves within institutions like the London and Liverpool Schools of Hygiene and Tropical Medicine, the MRC specialist research units, the medical civil service and in urban teaching hospitals, these transplanted medical workers brought with them hybrid networks: collegial connections that spread across the post-colonies, incorporating both their international expatriate peers and the rapidly ‘indigenising’ institutions that Britain left behind. They brought, too, a heightened awareness of and interest in once-tropical diseases and populations. This earned awareness represents another key ‘postcolonial’ feature of post-war medicine in the UK. It is a characteristic shared by the diverse group of elite practitioners and researchers who were (and saw themselves to be) ‘colonised’ by their ethnically marked patients/research subjects in the 1960s and 1970s. Not coincidentally, it also proved for some to be the fulcrum of their future research and clinical careers.

So what happened when tropical diseases and populations, as well as tropically conditioned experts, came home to the metropole? In part, expertise once defined by climate and place became defined instead by culture and race. In a shift echoing tropical medicine’s early twentieth-century rhetorical transformation in response to microbiology, post-colonial tropical medicine became ‘racial’ or ‘ethnic’ medicine when it was redeployed for the benefit of transplanted ‘tropical’ populations rather than to protect white colonial enclaves (and to a lesser degree indigenous workforces). While colonial medicine was certainly attentive to racial difference, this change in valence reveals a transformative aspect of the shifting geographies and demographics of biomedical postcoloniality.

Conditions and diseases that were in the tropics a part of the pervasive medical environment, affecting a majority population—albeit one under-served by colonial medicine—became medically relevant only to a marginalised minority. The fact that these populations, like their colonial predecessors, were confined to marginal environments (urban, over-crowded, economically deprived) influenced only a minority of researchers in the post-metropoles.

As the haemoglobinopathies became for Britain (as SCA had long been in the USA) diseases that illustrated and embodied a particular ‘race problem’—in this case ‘coloured immigration’—they stimulated the emergence of another distinctively postcolonial phenomenon. The genetic haemoglobinopathies were at the cutting edge of medical research in the late 1960s and 1970s, offering a clinical platform and justification for

29 C. V. Foll, ‘Medical Aid to the Developing World—Can Britain do More? Reflections on the Ditchley Park and its Follow-up Meeting’, Trans R Soc Trop Med Hyg, 1973, 67, 130–41.
30 Warwick Anderson, ‘Disease, Race, and Empire’, Bull Hist Med, 1996, 70, 62–67; compare Anderson, ‘Immunities of Empire: Race Disease and the New Tropical Medicine, 1900–1920’, Bull Hist Med, 1996, 70, 94–118 with Mark Harrison, “‘The Tender Frame of Man’: Disease, Climate, and Racial Different in India and the West Indies, 1760–1869”, Bull Hist Med, 1996, 70, 68–93.
31 Ian Whitmarsh, ‘Hyperdiagnostics: Postcolonial Utopics of Race-Based Biomedicine’, Med Anthrop, 2009, 28, 285–315 argues for a similar effect when elite biomedicine is transplanted to tropical post-colonies, and postcolonial bodies in the tropics become proxies for racial bodies in the post-metropoles. The ‘racialised genome’ (307) discursively created in this encounter is intended as a tool for redressing inequality—but produces no health benefits.
32 On SCA and race in the USA, Keith Wailoo, Dying in the City of the Blues; Sickle Cell Anemia and the Politics of Race and Health (Chapel Hill: University of
‘molecular medicine’. In this guise, they represented an opportunity for Britain’s biomed- ical elite, who argued that basic research on these diseases would boost Britain’s threat- ened national prestige in the medical sciences, while addressing a genuine health need. The political impact of SCA and thalassaemia research, however, was magnified by the ways in which they had been rendered representative diseases of ‘racial’ groups; this association prompted media attention, and thus attracted funding.33 Equally, it offered a rare foothold for patients (and their communities) to clamber back onto medicine’s stage. The groups and individuals thus rendered politically and medically visible, and contingently empowered, were not just any patients. Working intimately with the British medical elite, pushing for both diagnostic and therapeutic advances, were colonial medicine’s sub-alterns—now post-colonising, racialised ‘ethnic’ patients.34 Regarded in a postcolonial light, this exemplifies the ‘productive’ potential of biomedical power to overcome admin- istrative inertia and the marginalisation of ‘minority’ health concerns.

Scrutinising such unexpected relationships can reveal the different—but equally postco- lonial—pathways through which medical professionals and postcolonial migrant and ethnic communities formed mutually beneficial alliances. Returned colonial researchers like P. J. S. Hamilton took the most straightforward of these. For both professional and personal reasons, they quickly took up roles as advocates for better funded (elite, biomedical) research into once-tropical diseases. In a continuation, rather than an echo, of colonial medicine, they argued that most basic research and virtually all coordination and standardisation should be done in the global North: ‘[t]he highest grade of research work can be carried out only in cool invigorating climates: air-conditioning is not an adequate substitute’.35 Research workers in the global South’s post-colonies were, however, recognised as essential collaborators.36

Military medicine, as in the colonial period, also drew medical professionals from the post-metropoles into postcolonial medicine. David Weatherall (like Hamilton) was first exposed to the haemoglobinopathies during National Service in the late 1950s, while treating the thalassaemic children of Gurkha soldiers.37 His experiences drove him to study the conditions, and to promote their research on his return to the UK. By the early 1970s, the UK’s Department of Health and Social Services (DHSS) saw Weatherall as ‘the prime mover’ behind professional calls for a UK policy response to SCA and thalassaemia.

Meanwhile, as Britain’s cities experienced reverse colonisation, some established urban consultants were drawn in by the changing demographics of their practices. Those who lent their cultural capital to their postcolonial patients, like London paediatrician Eric Stroud, were often marked by transformative colonial experiences. In 1958, Stroud was seconded from Great Ormond Street Children’s Hospital to Makerere University in North Carolina Press, 2001); Melbourne Tapper, ‘An “anthropathology” of the “American Negro”: anthropology, genetics and the new racial science, 1940–1952’, Soc Hist Med, 1997, 10, 263–89.
33TNA BN13/41, FD10/260.
34Bernadette Modell, Interview by author, 26 February 2007, and below. See also Helen Valier and Roberta Bivins, ‘Organisation, Ethnicity and the British National Health Service’, in Jenny Stanton (ed.), Innovations in Health and Medicine (London: Routledge, 2002), 37–64.
35McRobert, ‘Empire to Commonwealth’, 492.
36Weatherall, Interview, and McRobert, ‘Empire to Commonwealth’, 492.
37David Weatherall, Interview by author, 26 October 2004.
Uganda, where he was notable both for learning Swahili and for his active involvement with scattered rural hospitals. In Uganda, he first encountered both malnutrition and SCA. Returning in the 1960s, he found the same conditions in the thronging waiting rooms of a large London hospital. In 1965, Stroud directed medical attention to what he termed ‘the new environment’ produced by mass immigration, pointing both to novel conditions like the genetic haemoglobinopathies and the return of once-conquered diseases, including rickets.\(^\text{38}\) Reproducing in Britain the pattern he established in Uganda, Stroud became an important locus of support for health activism among Brixton’s racialised immigrant communities, using his position and networks to pressure the DHSS for action in relation to once ‘tropical’ but now ‘ethnic’ diseases.

Comparison elicits an interesting difference between these two elite professionals. Working in Liverpool and then Oxford, Weatherall never practised among a population significantly affected by the haemoglobinopathies he studied. In their absence, he became preoccupied with basic molecular research on the conditions, maintaining a clinical connection to thalassaemia almost entirely through visits to tropical research centres in South and South East Asia. He thus practised postcolonial tropical medicine almost exactly as it had been envisioned in 1961 where ‘[h]igh-power workers in temperate climates’ periodically visited the tropics ‘to keep in touch with actuality’.\(^\text{39}\) By contrast, Stroud returned from Uganda to an urban hospital ten minutes walk from the UK’s largest African-Caribbean community and greatest concentration of SCA. He therefore remained an active clinician in a community where he witnessed postcolonial life at its most quotidian. While both men were profoundly affected by their colonial experiences, their activities were also shaped by their post-colonial contexts. Where Weatherall pushed for research funding and policy changes, Stroud promoted the interests of nascent community activist groups and argued for better service provision.\(^\text{40}\)

A third group of medical professionals also emerged later in this period as allies and advocates of patient-driven initiatives: workers like then-Senior Paediatric Registrar Bernadette Modell at University College Hospital London. Such NHS clinician researchers were the next generation. They did not personally experience colonial medicine; instead their interests arose directly from postcolonial conditions. Living and working in the ethnically diverse post-metropoles, they interacted with postcolonial populations—people, whether born abroad or in the UK, whose contact zones integrated cities throughout the tropical world with Britain.\(^\text{41}\) Finally, reshaping a long colonial tradition, first and second generation African Caribbean and South Asian medical professionals trained in or recruited to serve a chronically understaffed NHS—including often over-looked specialist nurses and community health workers—agitated for and mediated between the communities, the NHS and the state. An identifiably postcolonial style of practice and interaction is perhaps most evident among these groups—both paid explicit attention to the transnational communities to which their patients belonged, and drew upon them for resources when facing apathy or resistance in their home medical institutions and

\(^{38}\)C. E. Stroud, ‘The New Environment’, Postgrad Med J, 1965, 41, 599–602, 599.
\(^{39}\)Weatherall, Interview; McRobert, ‘Empire to Commonwealth’, 492.
\(^{40}\)TNA MH159/121.
\(^{41}\)Mary Louise Pratt, Imperial Eyes: Travel Writing and Transculturation (London: Routledge, 1992).
Moreover, they credited patient ‘push’ as an active force shaping political and biomedical responses to particular conditions, and balanced career- and curiosity-driven research agendas with therapeutic and diagnostic drives.

What marks these generations of professionals and practices as distinctively postcolonial is the way in which they became part of communities that were resolutely ‘unimagined’ (to corrupt Benedict Anderson’s powerful phrase), often even by their own members. A postcolonial approach, looking for connection and complexity prompts attention to the emergence of such unimagined communities, in this case, communities that comprised elite practitioners, researchers and clinicians, ethnically marked health professionals and immigrant and British ethnic minority communities. It highlights too, the abiding strength and agency of colonial associations (both mental and social) and networks. Their durability becomes even more apparent in relation to nutrition research and policy.

Transplanting the tropics: nutrition research and ‘Asian rickets’

Britain’s tropical colonies supplied vital ‘clinical material’ to British metabolic and nutritional research. They also provided a stage where partisans in the debates that transfixed British nutritional science and policy—debates about whether research on nutritional interventions should focus on aetiology and metabolic biochemistry or on social and environmental factors—could test their convictions in practice. Thus the colonies served as laboratories for both technical and structural approaches to the problems of malnutrition and hunger. Nutrition researchers have celebrated their colonial training and endeavours. Based on their pioneering work, such researchers often achieved dominant positions in Britain’s domestic medical hierarchy on their return from the colonial tropics. For example, Roger Whitehead began his career in nutritional research in Uganda and went on to direct the MRC’s highly influential Dunn Nutrition Unit. Looking back in 1992, he praised ‘[t]he invaluable role that working in the old colonial territories and now the third world has played as a training ground for British nutritional science’. As Whitehead suggests, the role of the tropics as sites of research did not end with formal empire. Nor was the impact of such research felt only, or even primarily in the post-colonies; returning researchers described their experiences as ‘priceless’ for shaping nutritional programmes in Britain. In fact, the ‘basic investigative philosophies’ of post-war nutritional science evolved in a specifically colonial context. In other words, just as the disputes of British biomedicine between the wars were played out in colonial medical research and service, so debates that emerged from late colonial and international health found expression in postcolonial Britain. However, while many experts trained in

42 Modell, Interview; Valier and Bivins, ‘Organisation, Ethnicity and the NHS’, 52–6.
43 Bivins, ‘“The English Disease” or “Asian Rickets”’; Michael Worboys, ‘The Discovery of Colonial Malnutrition between the Wars’, in David Arnold (ed.), Imperial Medicine and Indigenous Societies (Manchester: Manchester University Press, 1988), 208–25 at 221; Anne Hardy, ‘Beriberi, Vitamin B1 and World Food Policy, 1925–1970’, Med Hist, 1995, 39, 61–77.
44 Some also followed the preceding professional generation into international health: Elsie Widdowson and John Mathers (eds), The Contribution of Nutrition to Human and Animal Health (Cambridge: Cambridge University Press, 1992) and Amrith, Decolonising, 26–36.
45 R. G. Whitehead, ‘Kwashiorkor in Uganda’, in Widdowson and Mathers, Contribution of Nutrition, 303–13, at 303.
46 Whitehead, ‘Kwashiorkor’, 303.
the colonies argued that interventions and techniques pioneered in the affluent developed world required adaptation for use in the developing tropical world, few acknowledged that the reverse might also be true. 47

Not all commentators shared Whitehead’s enthusiasm for the persistence of colonial tropes in domestic British nutritional research and policy. In the colonies, ‘cost realism’ and the emphasis on ‘lay care’ necessitated by economic exigencies could be clothed in rhetoric of modernity and empowerment, as fighting pathogenic ‘ignorance and superstition’ and obviating ‘feelings of dependency’. Tropical nutrition researchers might safely argue that ‘the health awareness of the community was adversely affected by the conventional hospital operating along curative doctor-dominated lines’. But back in the UK, similar claims—particularly emanating from a cash-strapped Ministry of Health—provoked scepticism from their medical peers. 48

As displaced colonial researchers returned to Britain, they revitalised what had been a shrinking field. However, they also began to re-shape and re-imagine the post-war consensus. 49 Researchers from the postcolonial generation sharply critiqued the ‘tropical interests’ and ‘population perspective’ brought home by the wind of change. They argued that such approaches in Britain ‘meant considering only the vulnerable groups, such as babies and children as worthy of interest’. 50 In their analysis, population-based approaches compromised a proper focus on individuals (increasingly valorised not just in medicine, but in society as a whole), and resuscitated an old-fashioned moral emphasis on ‘deserving’ groups.

The Nutrition Unit of Britain’s Ministry (then Department) of Health, in particular, was dominated by ex-colonial researchers. It was in this context that attitudes fostered in Britain’s tropical colonies—about what constituted a problem of nutrition, who was ‘vulnerable’, and what interventions were suitable—drove research and policy responses, successfully pushing an agenda focused on child health and under-, rather than over-nutrition. The staff of the Nutrition Unit, under ex-Ugandan doctor Sylvia Darke, showed little interest in obesity or diseases of affluence. Nor did these problems of nutrition initially interest other prominent ex-colonial researchers, despite growing concern among the wider medical community. 51 From this perspective, at least, coloniality came ‘home’ to shape a new and distinctive postcolonial agenda for research and state interventions in population health and feeding.

Nutritional rickets was one of the ‘problems of Asian immigrant populations’ which critics felt unduly preoccupied the department’s ex-colonial staff. Elsewhere, I have used post-war biomedical responses to this condition to interrogate the idea of a ‘postcolonial medicine’. 52 Here, I will look instead at ‘Asian rickets’ as a case study through which

47Hardy, ‘Beriberi’, 74–5.
48Whitehead, ‘Kwashiorkor’, 309.
49Defined by John Stewart, ‘Ideology and Process in the Creation of the British National Health Service’, J Policy Hist, 2002, 14, 113–34, 114 as ‘a broad agreement between both major political parties on the need to preserve the post-1945 social and economic settlement—in effect, the triumph of social democracy’.
50W. P. T. James and A. Ralph, ‘Translating Nutrition Knowledge into Policy’, in Widdowson and Mathers, Contribution of Nutrition, 340–50, 345. James worked with Waterlow in Jamaica, returning to a post at Dunn, and then the Rowett Research Institute in Aberdeen, where he became Director.
51James and Ralph, ‘Translating Nutrition Knowledge’, 345.
52Bivins, “‘The English Disease” or “Asian Rickets”’. 
to assess the value of a postcolonial lens in historical research, as well as the impact of the transplanted colonial gaze on (post)metropolitan populations and institutions.

In the early 1960s, prominent British paediatricians and metabolic researchers saw vitamin D deficiency rickets—entirely avoidable and cheaply curable in an affluent society—as one of ‘visiting imigrants [sic] from backward countries’.53 Yet by the mid-1960s, researchers in Glasgow and other British cities were producing evidence of startlingly high incidence among the children of Indian and Pakistani immigrants. In a 1968 address, W. T. C. Berry, the Ministry of Health’s Principal Medical Officer for Nutrition, acknowledged the problem, but downplayed its significance and severity: ‘[r]ickets excites great emotion’ because its reappearance was taken as ‘a sign of social regression’. He argued that rickets had never entirely disappeared from Britain, and asserted that the popular wartime fortification programmes which had so diminished its incidence had come at the price of iatrogenic disease—hypercalcaemia.54 Berry’s comments did little to ease increasing professional concern over rickets not just as a medical anachronism, but as an emblem of governmental indifference to the problems of ethnic minority populations and reluctance to act positively on a national basis.

Elite researchers in metabolic medicine, on the other hand, were captivated by the possibilities presented by this newly local population—racially and culturally distinctive, but metabolically ‘normal’—in which to explore the mechanisms of vitamin D metabolism. Clinicians, captured by the persistence of an easily cured deficiency disease, focused on exactly the technical solutions—supplementation and fortification—of which Berry was so critical. In particular, they promoted the mandatory fortification of ethnically associated foodstuffs with vitamin D. The Ministry of Health (from 1968, the DHSS), however, adamantly opposed fortification. The reasons proffered for this opposition included concerns about a resurgence of hypercalcaemia; legal constraints on food additives; anxieties about the cultural appropriateness and suitability of fortified foods; a conviction that the gradual assimilation of South Asian ethnic groups into the British mainstream would naturally eliminate the problem; and a strong preference for educational and voluntary approaches to dietary change.

It is in interpreting this overdetermined resistance to fortification that postcolonial analysis is most incisive. When I examined ‘Asian rickets’ within the context of post-war, post-rationing, and post-imperial Britain, the characteristic persistence of colonial entanglements of culture and race, and annexation of medical evidence to assimilative agendas were easily identifiable. But a postcolonial approach to the example of ‘Asian rickets’ necessarily situates the British case in a wider chronological and geopolitical context: understanding this national response demanded attention both to the colonial past of nutrition studies and its international context. Thus it revealed another aspect of the policy making process.

Berry, like Darke, was a former colonial researcher, deeply involved in early nutrition surveys in Nyasaland. So were other key figures on both sides of the ‘Asian rickets’

53Wellcome Library PP/CED/C.3/1/3, C. E. Dent to J. Kyle Smith, 10 September 1960.
54W. T. C. Berry, ‘Nutritional Aspects of Food Policy’, *Proc Nutr Soc*, 1968, 27, 1–8, 3, 7. Hypercalcaemia was a damaging excess of vitamin D, then attributed to over-fortification.
debate. In the colonies too, as they approached decolonisation, there had been a debate over fortification rather than consensus. As Anne Hardy has suggested, supporters of technical solutions (like fortification or enrichment of basic foodstuffs) were opposed by those interested in promoting structural change—those who saw malnutrition as a disease of poverty and underdevelopment, not just a collection of dietary deficiencies. British workers and colonial practitioners steeped in this strand of colonial research came to dominate similar areas of medical research and policy making in the UK. To their work, they brought diverse sensibilities honed by wider imperial concerns with race, culture and hygienic embodiment. Hard-learned, the lessons of discretion in confronting ‘native’ cultural practices manifested in colonial nutrition research as a preference for evolutionary change rather than ‘indiscriminately to substitute foreign ones’. These researchers had seen efforts to improve nutrition through popular education succeed while technical fixes failed, often through insensitivity to local dietary preferences and economic circumstances. Approaches developed with the colonies in mind stressed avoiding ‘unnecessary disturbance of traditional dietary habits’ and advocated instead education promoting local dietary resources. Moreover, at least some colonial researchers were made acutely conscious of the political sensitivity of their research. Retelling the experiences of his mentor, who controversially proposed protein deficiency as the cause of kwashiorkor, Whitehead wrote ‘The concept of a protein deficiency in a British Protectorate was deemed politically objectionable. Infections were unavoidable …; vitamin deficiencies were new and thus … defendable; but something as basic as a lack of protein was quite unacceptable!’

In opposing fortification, the DHSS frequently cautioned against imposing dietary change, suggesting that fortification and supplementation would not be ‘acceptable’ to the ex-colonial communities most at risk of rickets. Their claims were not based on qualitative or quantitative studies of the disparate South Asian populations of the UK. Instead, faced with the seemingly familiar combination of a tropical population with a nutritional deficit disorder, the ex-colonial experts at the DHSS relied on the certainties of colonial nutrition research and policy. They advocated education-only interventions except in cases of clinical need, and argued that assimilation to British norms of diet and dress would ‘naturally’ resolve the problem. Despite their change of location, Britain’s newcomers remained for these researchers ‘natives’ whose ‘traditional ways’ could not encompass the benefits of the new nutrition. From this perspective, DHSS resistance to fortification is visibly embedded in the complex colonial history of nutritional interventions across the tropical world, as well as the immediate politics of health spending, liberalisation of the food sector, and political fears about race-related social tension in a rapidly diversifying nation.

55 B. S. Platt and S. Y. Gin, ‘Chinese Methods of Infant Feeding and Nursing’, Arch Dis Child, 1938, 13, 353–4, 434.
56 E. Burnet and Wallace R. Aykroyd, ‘Nutrition and Public Health’, Quarterly Bulletin League of Nations Health Organisation, 1935, 4, 323–495, 430, in Hardy, ‘Beriberi’, 66. See also the Economic Advisory Council’s report Nutrition in the Colonial Empire, published in 1938–9.
57 Whitehead, ‘Kwashiorkor’, 305.
58 TNA MH 148/623, S. J. Darke to Dr. G. A. H. Elton, 13 February 1975; TNA MH 148/623, H. M. Goodall, ‘Background notes and draft answer’, 7 May 1976.
59 In fact, a Glasgow programme demonstrated community enthusiasm for fortified chapatti flour.
Can this persistence of ‘coloniality’ into the post-imperial period tell us anything new either about colonial or about postcolonial medicine? First, it is worth appreciating the ways in which the durability of these ties reflects the power of colonial medicine as a vehicle of professional identity and advancement for its practitioners. Here, alongside individual doctors’ compassion for individual patients, we also see a postcolonial outgrowth of elite, top-down ‘colonial’ medical research. Junior figures, by contrast, have described their interest as coming from the excitement of molecular biology in conjunction with exposure to immigrant populations in clinical settings. Yet they too showed an intense focus on the impacts of research and clinical events in the developing world. Their gaze was returned—and not in silence; indigenous experts in the post-colonies both contributed to research and offered fierce critiques of British failures in treatment and racialising assumptions.60

As in the post-colonies, state medicine in postcolonial Britain became increasingly insular and explicitly driven by national politics, concerns and self-interests. This retrenchment was viewed with considerable alarm by medical elites involved in trans-national research in the tropical world. Strategies in which ‘domestic’ populations affected by ‘tropical’/*racial* diseases justified the continuation and expansion of both basic science and public health endeavours were a common response. A postcolonial history of medicine should therefore begin with the recognition of the changes, as well as the continuities, in the complex network of relationships that constitute medical culture. Clearly, it will move beyond rigidly national or regional histories, since the historical actors of medicine (whether disease entities, technologies, sufferers or medical professionals) have always operated across and around them. Even the capacious borders of empire (successive post-imperial structures) fail to capture entirely the phenomena we may seek to understand. In the colonial period, their boundaries were regularly breached by international sanitary bureaux, and by private bodies like the Wellcome Trust and the Rockefeller Foundation, operating across imperial mandates as well as through them. After the First World War and during decolonisation international governmental and non-governmental organisations with broad remits (e.g. the WHO, PAHO and Médecins sans Frontières) also emerged. Consequently, the historiography of medicine—like history in general—is rapidly normalising approaches that recognise the porous boundaries of nation states as interwoven by the agents and aspirations of ‘internationalism’ (or globalism) as a hallmark of ‘modernity’.

Postcolonial approaches to the history of medicine must likewise acknowledge the role of patients as agents and resources for professional change and development, as David Arnold has recently done in relation to ‘tropical’ diabetes in India.61 Equally, they will recognise that the ways in which biomedicine works to maintain its imperium over the human body are changing. As chronic diseases, and ‘diseases of progress’ become increasingly prevalent (and remain intransigent to direct medical intervention) patients, their families, and their communities are recruited ever more insistently as medical actors in the struggle for health. There are similarities here both to humoural concepts

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60For example, F. I. D. Konotey-Ahulu, ‘Anaesthetic Deaths and the Sickle-Cell Trait’, *Lancet*, 1969, 292, 267–8; F. I. D. Konotey-Ahulu, ‘Treatment and Prevention of Sickle-Cell Crisis’ *Lancet*, 1971, 298, 1255–56.

61Arnold, ‘Diabetes’.
of regimen, and to the early twentieth-century’s germ crusaders—but today’s ‘activated patients’ engage with an intensely expert and technological world. And unlike their predecessors, they do it without the benefits of a shared medical culture, whether as recent immigrants, or simply as members of a laity barred from biomedicine’s inner sanctum by a century of uncommunicated—if not incommunicable—scientific knowledge. This is another aspect of postcolonial medicine’s dependence on what I’ve termed ‘unimagined communities’—networks of individuals, groups and communities working together towards a shared agenda or agendas, without developing a shared identity.

Moreover, postcolonial histories (including those of medicine) should trace and evaluate the reflexivity of relationships between different research sites—‘tropical’, ‘temperate’ and ‘metropolitan’, for example—and conceptualise the power differentials in more accurate ways. While in some aspects, my case studies of postcolonial migration suggest the emergence of ‘portable colonies’—for instance, newly enfranchised tropical populations re-colonised by elite medical research post-migration—in others, they show the impact of postcolonising expertise and agency redefining the relationship between researchers and their research ‘subjects’ by refocusing the medical gaze and making use of its continued authority.

Conclusions

As the generation of scholars who successfully broadened the history of medicine’s remit and widened its institutional footprint nears retirement, some are considering the intellectual future of their discipline. Historians of medicine have been criticised (often by their peers) as theoretical magpies, combining fragments of analytical and methodological invention piecemeal to apply a trendy intellectual gloss to resolutely empirical case studies, or bankrupt grand narratives.62 Some are concerned that the ‘cultural turn’ has stripped medical history of its political thrust, others worry about ‘festishising the marginal’.63 Meanwhile, applying scientometrics to medical history’s main Anglophone journals, scholars have depicted an insular and parochial discipline.64

Without adjudicating these claims, it seems to me to that ‘postcoloniality’ is an area where the history of medicine is uniquely well-placed to speak to the wider discipline of history. The importance of colonial science and colonial discourses of the body to explorations of imperial and post-imperial power make colonial medicine an ideal prism through which to explore social control and resistance; networks of knowledge making; embodiment and identity; concepts of race and gender; and other topics central to the postcolonial endeavour.65 Medical and scientific knowledge and networks

62 Recently, Roger Cooter, “Framing” the End of the Social History of Medicine’, in Frank Huisman and John Harley Warner (eds), Locating Medical History: The Stories and their Meanings (Baltimore: Johns Hopkins University Press, 2004), 309–37; George Weisz, ‘Making Medical History’, Bull Hist Med, 2006, 80, 153–9; more positively, John Pickstone. ‘Medical History as a Way of Life’, Soc Hist Med, 2005, 18, 307–23. Also Rosemary Stevens, ‘Charles E. Rosenberg and the Multifaceted Promise of Medical History’, J Hist Med Allied Sci, 2008, 63, 414–22; Rhodri Hayward “Much Exaggerated”.

63 Mary Fissell, ‘Making Meaning from the Margins: The New Cultural History of Medicine’, in Huisman and Warner, Locating Medical History, 364–89, 364.

64 Olga Amsterdamska and Anja Hiddinga, ‘Trading Zones or Citadels? Professionalisation and Intellectual Change in the History of Medicine’, in Huisman and Warner, Locating Medical History, 237–61.

65 See for example, Anderson and Pols, ‘Scientific Patriotism’. The End of the History of Medicine’, J Contemp Hist, 2005, 40, 167–78.
have, since the nineteenth century, been centrally involved in creating the normative models of race, gender, sexuality and ability that marginalise and pathologise difference. Social and cultural historians of medicine productively adopted the project of highlighting their contingency and excavating strategies both of compliance and resistance to biomedicalised norms. Postcolonial historians of medicine can further elucidate the networks and patterns of exchange which, as I have shown here, interpellate groups, spaces and forms of knowledge, and disrupt expectations based on established hierarchies. Thus instead of ‘fetishising the marginal’, we can test the basic premise of marginality: that those on the margins are separate and distant from those at the given or assumed ‘centre’ (or norm). In London, Birmingham and Manchester, my examples have shown that apparently marginal postcolonising populations were at the heart of elite biomedicine, and that assumptions rooted in distinctively colonial spaces shaped national nutrition policy in post-metropolitan Britain.

In my research, using a postcolonial lens brings into sharp focus three aspects of (medical) responses to post-war immigration: first, it insists on the continuities between these phenomena and those of imperial and colonial medicine. This usefully challenges contemporary perceptions of post-war immigration (and its medical sequelae) as disturbingly novel, and destabilises the convention that such migration represented a cultural ‘turning point’. Second, postcoloniality draws attention to unexpected sources, expressions and disparities of power between individuals and groups of historical actors. It allows me to look at the ways in which media-soaked politics of ‘race’, for example, became a source of power for some (health) activists, whilst simultaneously limiting the official repertoire of responses to (health) problems among racialised immigrant communities. Finally, a postcolonial approach demands attention to networks and relationships that cross, transcend or establish new boundaries.

Here it is worth reflecting briefly on the still contentious topic of ‘postcoloniality’: what is it, and what special traction, if any, does it offer to the historian or the reader of history? Since the 1990s, historians have adapted the language of ‘postcoloniality’ from the discourse of literary theory, and advanced its phenomena as a new area for historical investigation. Certainly historians have, for some time, been addressing the specific phenomena of decolonisation, nation-building, and post-imperial identity though studies of national, trans-national and global histories. But some scholars have asserted that ‘postcoloniality’ should be seen as analogous to analytical tools like class, gender, race and sexuality. In this vein, postcolonial history embodies an approach to the past
that both highlights and sifts complexity, hybridity and ambiguity, and that is focused on exploring submerged, erased, or silenced historical perspectives and actors and ‘unimagined communities’.

The logic of such a ‘postcoloniality’ in historical research demands that users integrate the concept’s temporal, spatial and epistemological questions. The postcolonial historian must respond to the particularities of each colonial context: every ‘postcolonial’ phenomenon emerges from and must be considered in the light of its own set of colonial contingencies. For this reason, it again strikes me that the once and future centres of ‘coloniality’ will be productive sites for exploring ‘postcoloniality’. The former imperial centres or ‘post-metropoles’ remain hubs of global exchange, intimately interwoven (in ways both obvious and obscure) with their post-colonies. We certainly cannot regard them as immune from postcoloniality. Moreover, if one hallmark of the ‘postcolonial’ is either hybrid or incomplete ‘modernity’, then finding such phenomena in the birthplaces of the modern will shed valuable light on abiding assumptions about the connections between, for example, technology, secularism, consumerism, corporeality and modernity.

Acknowledgements

I am grateful for the constructive and insightful comments of David Arnold, Alison Bashford, Margot Finn and Hilary Marland, the SHM editors, and three anonymous referees. This work was supported by Wellcome Trust [grant 072160].

68 For ‘coloniality’, Barnor Hesse and S. Sayyid, ‘Narrating the Political Postcolonial and the Immigrant Imaginary’, in N. Ali, V. Kalra and S. Sayyid (eds), A Postcolonial People: South Asians in Britain (London: C.Hurst, 2006), 13–31, at 17.