

doi:10.1017/mdh.2013.6

Pratik Chakrabarti, *Materials and Medicine: Trade, Conquest and Therapeutics in the Eighteenth Century* (Manchester and New York: Manchester University Press, 2010), pp. xi + 259, £60.00, hardback.

There is a line concluding the sixth chapter of Pratik Chakrabarti's arresting book under review that in many ways cuts to the heart of his effort. 'The scientific practices of the colonies were no less creative or meticulous than that of the metropolis, but the determinants of modern science, and thereby its truth, lay elsewhere' (p. 198). At once, we have an intelligent indictment of conventional accounts that inform us of the primacy of European/Western metropolitan knowledge vis-à-vis the dribs and drabs of putative primitive contributions that seep out sporadically from colonial peripheries and are worthy at best of passing patronising attention. Confessedly, in the wake of significant decolonisation after the Second World War, thoughtful treatises have emerged from the citizenry or the diaspora thereof of countries once under European thrall that have sought to question the vector of the transference of knowledge. Such endeavours, however, have in the main sought to inflect accounts, rather than attempt wholesale overhauls, recognising the power-equation and consequent inequality that attend coloniser-colonised dyads. Chakrabarti's offering does not diverge from this pattern. What he does achieve, however, is a sustained and oftentimes searing critique of colonialism through the lens of medical practice.

The book is divided into seven chapters, given almost equally to the two areas under study, Jamaica and India. Rather disconcertingly, the introduction leaps to a brief discussion of chapters 4 and 5 after chapter 1, without leading us through the intervening second and third, and we are left to ford our way through those sections in order to see how the arguments cohere in the overarch of the sustenance of narrative. Fortunately, the chapters themselves are arranged in such a manner as to afford us such an opportunity.

When Chakrabarti writes of trade and treatment in both Jamaica and Madras (chapter 1), he makes a bold claim. He suggests that, contrary to customary approaches to maritime economies where the production of over-the-counter drugs led to a general commercialisation by the end of the seventeenth century, medicine in eighteenth-century European colonies was in fact forged by quite different imperatives – minerals and spices. For Jamaica, he takes the reader through the world of privateering, piracy and buccaneering, with Port Royal as the original Spanish base, to plantation colonies where Kingston was now capital and the British were in charge. In India, the Portuguese had matched their Iberian fellows in the New World by opening up European trade, in which they were in time joined by the Dutch, the Danish, the English and the French. In 'country trade', thus denominated to express the commercial relations transacted locally in South and Southeast Asia, the author points out three significant characteristics of Euro-Asian commerce: 'the interest in spices, the exploration of Asian bazaars by European merchants and the predominantly private nature of the trade' (p. 33).

The second chapter focuses exclusively on the settlement of Jamaica. Themes resident in the first chapter continue to be developed here, with a definite vector towards the establishment of imperial hospitals, not least to cater to the needs of the navy, and situated such that the sea breeze might provide a therapeutic effect. A comparable story may be seen on the Coromandel Coast (chapter 3) where the establishment of Fort St George in Madras and militaristic activity involved in its defence and beyond was crucial in the

development of medical infrastructure. There was racial separation, with the fort becoming the area of the White Town housing only those of European descent and the adjoining region given over to those of other origins, thus named Black Town. Such rationalisation was critical to the colonial project – the development of military hospitals in colonies was not devoted to the humane care of Europeans alone, but as ‘symbols and foundations of colonial power’ (p. 105).

Local formulations continue to be a significant trend as the author tackles *materia medica* in India (chapter 4). The focus however shifts from the military to missionary activity, particularly Moravian and German Lutheran, and the efforts of the ‘Orientalists’, both of whom the author describes as dissenters from the normal exercises of empire. It is they who valorised the use of indigenous medicines and practices, believing them of crucial importance. Quite a different aspect marked Jamaican plantations (chapter 5) where over twenty per cent of the plant species were foreign to the region, with the majority attending the colonial project. In this regard, the natural history of the region was mediated through white masters and black slaves, with the native population largely excluded. Despite missionary activity in Jamaica (again by Moravians) and large-scale conversions, there was tremendous distrust towards Europeans. Unsurprisingly, plants were also put to use as poisons. The author is stark in his assessment regarding the history of medicine within Jamaican society. ‘On the one hand, it was a discourse of European search for prosperity, health, salvation and regeneration. On the other, it entailed a history of appropriation, rebellion and violence’ (pp. 164–5).

For chapter 6, Chakrabarti focuses on three different forms of medical knowledge in the colonies: plants (one in Asia and Africa generally called ‘columba’ and an Indian offering scientifically named *Swietenia febrifuga*); natural objects (bath waters in Jamaica); and indigenous medical preparations (Tanjore pills from India). In each of these cases, the claim of an alternative approach to cure was mooted, be it a riposte to famous kids on the block (for instance, quinine from the *Cinchona* tree), a recuperative immersion (with different results and treatments accruing to hot and cold waters) or an antidote to snake bites. The ultimate reception of these therapies was largely based on acceptance or the lack thereof in European metropolitan circles and the development of new approaches in science itself. In such a situation, the knowledge systems that produced the products were deemed ineffective because they were not commensurable with European practices in the metropole and the products themselves were either absorbed and translated in a different idiom or relegated to a world of curiosities.

Whither then colonial medicine? This is the subject of the concluding section (chapter 7). The author draws attention to the work of many scholars who have sought to make sense of the relationship of European and non-Western knowledge, be it collaborative (such as seen in Christopher Bayly and Richard Grove) or decentralised (as expressed by Kapil Raj). Chakrabarti himself contends that the ‘history of colonial localities is . . . a history of hinterlands, vitalised, redefined and reconfigured to provide tributes to an increasingly insatiable centre’ (p. 206). In this regard, he suggests that the local functioned within imperialism along two vectors, absorption and marginalisation. The result was as straightforward as it was lamentable. ‘While . . . local colonial sites developed intricate and sophisticated systems and networks of production of knowledge, they did not create equally sophisticated and localised sites of modern science and medicine’ (p. 217).

Pratik Chakrabarti has written a simmering book, one of controlled anger against the excesses of empire. At the same time he has afforded respect and credit to those colonial

functionaries who sought to understand and work with local systems, even if results did not always match the benignity of intent. The argument is profoundly persuasive, the scholarship exemplary, the conclusions saddening. They are not new. Yet they have been cast in a manner that resists forgetting.

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doi:10.1017/mdh.2013.7

Ida Blom, *Medicine, Morality and Political Culture: Legislation on Venereal Disease in Five Northern European Countries, c. 1870–c. 1995* (Lund: Nordic Academic Press, 2012), pp. 192, £26.95, paperback, ISBN: 9789185509737.

This volume usefully investigates the strategies employed in the Nordic countries to control venereal diseases and provides valuable nuance to assumptions that there was a common Scandinavian approach, by considering in more detail the cases of Norway and Denmark. Significant work has already been done on Sweden, which has been assumed to embody a typically Nordic approach: this is now demonstrated to be an over-generalisation on the basis of its specific public health regime.

Blom sets her findings in a broader comparative context defined by the different approaches of Great Britain and Germany. These countries have already been much studied, but provide an interesting basis for comparisons of different approaches as well as common concerns over time.

Blom indicates that, in spite of some differences of timing due to local political, social, cultural and economic factors, the three Nordic countries under discussion did have numerous basic similarities in their political regimes. By around 1900 she suggests that, although not full-blown social welfare systems, they were ‘social-assistance states’. However, there were also specific differences: not until 1947 did all three have in place the same central governmental statutes relating to free (though compulsory) treatment, mandatory notification of sources of infection, imprisonment for infecting others, and police assistance in contact tracing.

Forms of regulationism – that is, the licensing and mandatory inspection of prostitutes, and sometimes other ‘dangerous bodies’ such as soldiers, vagrants and itinerants – were the basis of approaches throughout most of the nineteenth century, subject to an increasing challenge from the abolitionist movement during the later decades. However, in Sweden a ‘contain and control’ policy affecting the whole population was already embodied in royal ordinances requiring notification of cases (or suspected cases) and their contacts, with funds for treatment provided through a special tax on citizens, even though only certain stigmatised elements within the population were seen as responsible for actually circulating the diseases. Denmark had even earlier instituted free treatment (with measures of compulsion) for ‘the common people’, subsequently made mandatory for all social groups, but a royal edict also initiated regulation of prostitution in Copenhagen, and this strategy continued to be extended during the nineteenth century.

Norway, previously under Danish rule, was ceded to the Swedish king in 1814 and did not become fully independent until 1905, although domestic policy was dealt with by the Norwegian parliament. There was no universal national legislation on venereal disease (VD), which instead continued to be dealt with under local municipal by-laws,