

# Crossing Colonial Historiographies



Crossing Colonial Historiographies:  
Histories of Colonial and Indigenous  
Medicines in Transnational Perspective

Edited by

Anne Digby, Waltraud Ernst  
and Projit B. Mukharji

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P U B L I S H I N G

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## INTRODUCTION

# CROSSING HISTORIOGRAPHIES, CONNECTING HISTORIES AND THEIR HISTORIANS

ANNE DIGBY, WALTRAUD ERNST  
AND PROJIT B. MUKHARJI

Over the last couple of decades, the history of medicine has established itself as a recognised field among historians. Those working on colonial medicine occupy a prominent niche that has enjoyed considerable expansion, driven to some extent by a more general focus among historians, social scientists and political campaigners on issues related to “globalisation”. Current scholarship on colonial medicine in different parts of the world during the “age of empire” shares particular features. “Empire” usually implies, in truly Eurocentric and modernist fashion, a focus on western nations’ colonial transgressions since the (European) Enlightenment period and the subsequent unfolding of capitalism across the globe. Whilst united by this problematic spatial and temporal framework, there is also great diversity.

Engagement with different kinds of colonialism (including settler, imperial, indirect, French, British, American) and a focus on diverse indigenous socio-political cultures, not to mention very distinct indigenous therapeutic traditions, have led to a wide range of approaches to varied colonial medicine(s) and indigenous modes of healing. Consequently, increasingly distinct historiographic traditions of colonial and indigenous medicines in the various regions formerly ruled by different colonial powers have developed quite independently from each other. The current state of scholarship in the history of medicine in colonial and post-colonial contexts testifies to the diversity of colonial experiences and indigenous actions; but it is also characterised by compartmentalisation. Geo-cultural divides have been reinforced and a regrettable lack of conceptual interaction prevails between those working on different regions in the world. Moreover, conceptual and methodological debate between scholars

specialising on Belgian, British, Chinese, Portuguese, Spanish, Dutch, Russian, German colonial contexts rarely occurs. Historical journals tend to focus on specific minority world traditions and researchers at medical history conferences find themselves usually streamed into separate groups and panels (for example, Asian or South African, Chinese or South Asian, South American or Eastern European). The lack of actual dialogue between the scholarship produced on these different colonial contexts has made it difficult to gauge the extent to which the established differences are a historical reality or, alternatively, an artefact due to the varied analytical approaches deployed.

In recognition of the apparent lack of crossovers between the medical histories of different regions (and its historians), the principal aim of the conference preceding this book was to bring together scholars working within separate historiographic traditions. The resulting engagement with the varied histories and historiographies of different colonial and indigenous medicines offered the opportunity to explore new conceptual perspectives and facilitated critical reflection on how scholars' embeddedness in specific palimpsests and approaches to the history of medicine and healing affects their research. In a similar vein, this collection intends to facilitate a move towards greater intellectual dialogue. A wide spatial lens is deployed to break down area specialisms and geo-cultural divides, enabling broader comparative analyses with fresh political and cultural mappings of medicine. This is important also in view of the manifold exchanges, connections, crossovers and entanglements between different modes of healing within and beyond the boundaries of nation states and colonial territories.

A number of themes emerged during discussions at the conference and in subsequent exchanges between authors. The most challenging of these require further investigation and centre on the difficulty of historians trained and working within one particular (temporal and spatial) context to fully appreciate the insights, generalities and specificities outlined in the work produced by colleagues working within another such context. To adapt to the realm of history a Kuhnian contention on the incommensurability of worlds: "Practicing in different worlds, [...] two groups of [historians] see different things when they look from the same point in the same direction."<sup>1</sup> While Kuhn's focus was mainly on incommensurability over time, incommensurability arises also over space if historiographic traditions are too isolated from each other—as has largely been the case with the histories of colonial medicine.

It is difficult enough to reconcile work on one particular region (say, South Asia) produced by scholars located within different academic

contexts, historiographic traditions and methodological approaches (such as colleagues based at Harvard and Chicago, Oxford and London, Delhi and Hyderabad, Berlin and Heidelberg). How much more challenging is it then for a South Asia specialist to relate to and learn from colleagues working on medicine in colonial Mexico, the Kazhak steppe or East Africa? Even the historiographies of Portuguese India (often collectively referred to as Goa), of British India and of Princely India have by and large developed with but rare crossovers—no doubt partly due to language divisions but also because of the different regional and scholarly connections of its academics.<sup>2</sup> The cultural, academic and conceptual worlds from within which we produce our work frame our perspectives and may hinder the scope for methodological and conceptual crossovers and engagement with other worldviews. Despite these constraints, a dialogue between different historiographic traditions and the varied histories resulting from them not only opens up new perspectives and insights on other worlds outside our specialisms but also brings the scope and limitations of our own world and work into sharp relief. New insights on the particularities and universal features that characterise our historical investigations *and* our historiographic context will be the result. By connecting distinct traditions of historical enquiry and their research findings, it becomes possible to identify larger shared patterns.

The aspiration to break out of narrow and conventional geo-political boundaries in our historical research has become a central tenet of many academic networks. “Self-reflexivity”, or the injunction that a discipline’s methodological tenets ought to apply equally to the discipline itself, has been allotted a central role by anthropologists, sociologists and historians of science ever since Popper enshrined it as an important principle.<sup>3</sup> There are two related yet differently focused ways in which reflexivity can be deployed. One concerns itself with critical reflection on the boundaries that contain and restrict historians’ mental maps, namely the methodological frameworks and historiographic traditions they employ. The other relates to the definition and delimitation of historians’ subject matter and its temporal and spatial confines. The latter aspect has received much attention in recent years. Scholars, both within and outside the realms of history of medicine, have attempted to break free of the artificial boundaries of conventional temporal and geo-political remits. Sweeping periodisations that cut up typically linear and Eurocentric Whiggish histories into convenient and seemingly clear stages have become less prominent since the advent of postcolonial writing and Said’s *Orientalism*.<sup>4</sup> The “spatial turn” has made it more difficult for historians to

use, by default, the geo-political maps drawn up by dominant powers during the “industrial revolution” and the “age of empire”.<sup>5</sup>

Coming from different historiographic traditions and driven by varied sets of practical research questions, historians have proposed a wide range of different terms and affiliated paradigms to circumscribe crossovers, connections, networks and circulation, such as “connected histories”, “global history”, “transnational history”, “comparative history” and “histoire croisée”.<sup>6</sup> Such a proliferation of related endeavours at a particular time suggests that these are firmly grounded in, and fuelled by, present-day economic, political and cultural processes.<sup>7</sup> Some of these paradigms constitute merely a plea for a new set of research questions and a certain willingness on the part of historians to let their sources drag their research beyond narrow and conventional spatial markers and boundaries, such as “nation”.<sup>8</sup> Others have been more ambitious in trying to theorise the politics and nature of networks that defy conventional temporal and spatial units.<sup>9</sup>

Despite the multiplicity of approaches and the lack of consensus on how to map the various networks and connections, historians have clearly acknowledged that *trans*-local, *trans*-regional and, in particular since the nineteenth century, *trans*-national connections have had a significant impact on historical developments in particular localities. Most existing histories of colonial medicine remain caught up in current national and geo-political boundaries and risk—often inadvertently—reifying the “nation”. Yet, nations, as Benedict Anderson has so aptly shown, are “imagined communities” and hence require historians to be wary of the implications of using “pre-established national formatting” as their analytical framework.<sup>10</sup> Transnational histories tend to sidestep such reification by instead focusing on a “network of dynamic interrelations” within and between nations as well as in relation to other socio-political structures and processes.<sup>11</sup> The strength of a transnational approach is its ability to puncture the petty parochialism of nations and open them up for more nuanced historical scrutiny.

Despite the critical value of the transnational perspective, questions emerge about its potential limitations. First, if we agree with Anderson that nations are a relatively recent phenomenon in world history, can we then employ a transnational approach to study epochs prior to their emergence? Some suggest we can, while others contend that such endeavour is inherently anachronistic and misleading. Second, by focusing on the porosity of national boundaries, a transnational analysis may be seen to follow global capitalism a little too closely for the comfort of those yet to make their peace with it. At the same time, the nation has for a

variety of reasons remained relevant in modern times. It has become the rallying point for a range of political constellations, including ultra-nationalists, xenophobes and fascists—as well as anti-globalists. These tendencies often grow out of precisely the kind of economic, social and cultural dislocations that are produced by global, transnational connections. It is not yet clear if or how a transnational history needs to respond to these kinds of issue.

The ambition of the present volume is to focus on the scope for crossovers and connections between scholars working within different methodological and historiographic traditions. The contributions to this collection show that a diverse array of societies can be characterised as “colonial”, alongside those that have traditionally been considered as such. British India, Portuguese Angola and Dutch Indonesia therefore figure in this volume together with Yucatan, Soviet Central Asia and parts of Qing China. This extension of the term “colonial” to a much wider range of societies makes the category “colonial” itself more heterogeneous. The chronologies and types of modernity found in different “colonial” societies emerge as varied, characterised by a multiplicity of older and more recent patterns of connections, and continuities and discontinuities over time and space. While some of the contributors look at new patterns of connections being fostered through colonialism, others show how preceding ones are modified. Colonialism in its varied stripes does not usher in a period of connectedness (as opposed to an earlier period of isolation), but rather fosters diverse patterns of connections that dynamically interact with older ones.<sup>12</sup>

It is in regard to this more multifaceted view of colonialism and the dynamic interaction of older and newer patterns of connectedness that this volume differs from existing works on globalisation and colonial medicines.<sup>13</sup> By connecting historians working on diverse sets of societies described as “colonial”, the present collection’s intention is to showcase the range of and interactions between different types of modern and earlier connections. It is hoped that this will engender further reflection and exploration, leading to a more nuanced and critical appreciation of the variedly connected pasts of our “global” present.<sup>14</sup>

This collection also widens intellectual horizons in going beyond historians’ previous emphasis on the antithesis of core and periphery to provide more relativist and sensitive interpretations involving the trans-imperial. This is most evident in those chapters taking a transcontinental standpoint, such as Guy Attewell’s illuminating discussion of the transregional trade and reconfiguration of knowledge of a drug with an ambiguous identity—*tiraq al faruq*—between Europe and Asia. From this

transnational perspective a deeper understanding of the drivers of transformation is thus gained.

What is in the toolkits of this volume's contributors? The kind of sources employed can heavily influence the outcomes of research in source-driven interpretations since, as David Sowell argues, an over-dependence on, for example, Rockefeller Foundation documents highlighting medical centres can impede a more nuanced region-based interpretation. The exclusive dependence on the written record can also privilege certain historical actors, thus giving a restricted or exclusive viewpoint. Several chapters—such as those by Jo Wreford, Jorge Varanda and Markku Hokkanen—emphasise the counterbalancing importance of oral histories in gaining a more multifaceted understanding derived from a more diverse set of actors. Without such testimonies the viewpoint of healers, auxiliaries and patients would be marginalised. Equally importantly, insight into the convoluted processes, as well as the outcomes, of healing arguably would be impeded.

New conceptual perspectives in this volume arise from authors engaging innovatively with diverse historiographies of colonial and indigenous medicine. Whilst there is little emphasis in this collection on Foucaultian power as an explanation of colonial agency, the models of medical pluralism developed for Asia (notably by Kleinman and Leslie), or for Africa (particularly by Janzen and Vaughan) continue to be found relevant. However, by crossing historiographical faultlines and challenging the division of disciplines through using insights from related disciplines such as the history of medicine, anthropology, etymology, ethnopharmacology and experiential ethnography, authors find opportunities to explore and reconfigure. For example, Walter Bruchhausen aims “to make the history of colonial medicine more anthropological and the anthropology of traditional medicine more historical” in his chapter on East Africa. And, for Goa, Cristiana Bastos warns against “the conceptual trap of reifying the Portuguese experience as an essentially hybridizing one” in her interpretation that departs from a conventional depiction of colonial society.

Varied chapters prompt reflection on the extent to which spatial factors shape (or limit) the historian's perceptions. Should imperial boundaries, colonial or national frontiers be used, or should a more innovative frame of reference be applied? Authors have therefore interrogated the relevance or “fit” of these different models. A prime example of this is Jorge Varanda's innovative study of the Diamang Company situated in a remote position near the north-east frontier of the Portuguese colony of Angola. His chapter prompts the reader to consider what spatial focus is

appropriate by showing how Diamang broke away from a nationalist-colonial and metropole-centred framework into “a network of relations of knowledge, exchange of goods and ideas outside” the Portuguese empire. This was constructed to access the latest drugs and medical technologies in order to improve the health of the employees of a diamond producing company. Through reconceptualising relations within, and between, the Portuguese, Belgian and British empires this chapter presents a useful perspective on cross-colonial exchanges in which global networks operated *across* empires through Lisbon, Brussels and London. Varanda suggests that such intercolonial contacts indicated a mosaic or collage of empire.

Historiographical enquiry is broadened in a distinctive manner by Carla Nappi, Guy Attewell and Thomas Williamson in their respective discussions of the intricacies of medicines and medical conditions. Guy Attewell’s paper investigates the “transregional, transcultural and transnational connections and displacements” in the history of the generic commodity of *tiryāq-al-faruq* (alternatively known as “Venetian treacle”). The variants, aliases and connected histories of this medical commodity (once included in the *British Pharmacopoeia*, although expunged in 1788), are used to interrogate what may be labelled as indigenous (whether Indian or Islamic), colonial, or “western” and hence to question compartmentalisation into supposedly unproblematic categories.

Carla Nappi seeks “to draw the process of the historical identification of national, ethnic, and indigenous categories into the field of historiographical inquiry” and to explore the plural histories of ingredients of drugs. She problematises “Chinese-ness” through interpreting early modern Chinese medicine as a colonial practice. In a pathbreaking paper she focuses on the caterpillar fungus of “winterworm, summer grass” or *dongchong xiacao*. Analysing the remarkable historical transformations of this Chinese medical drug, Nappi’s historical lens reveals important geographical and epistemological shifts, raising questions over its allegedly Chinese character, and revealing its shape-shifting nature (whether half-plant, half insect, plant or fungus.) She problematises *dongchong xiacao* as a history of likenesses rather than the history of an object and, in drawing attention to the “inherent instability of translations”, she forces us to reconsider the equivalence of terms for *materia medica*.

Thomas Williamson’s paper on researching amok in Malaysia crosses a different set of research boundaries with his use of etymology as well as documentary sources in showing the construction of amok as a cultural category within hardening colonial usage. Medical interrogation found it an elusive category yet frequent general reference to it in English signified

cultural and racial difference. In contrast in Malay other configurations were possible including amok as a descriptor of the behaviour of modern things, which was increasingly used in a collective rather than individual sense. Amok stories for the 1950s and 1960s linked it to political and social unrest, whereas from the 1970s amok was psychologised within a burgeoning Malaysian discourse on health. Amok continued to shift in meaning with present-day everyday usage spanning babies' tantrums to the behaviour of rogue elephants. As Williamson concludes, amok had an "infinity of variables", a "series of enactments" that point to scholars studying "not things but processes, processes in which they themselves are implicated".

Whilst certain chapters offer fresh perspectives through adopting a broad lens featuring crossovers and networks between empires, others develop new insights by way of a more constricted standpoint. Rather than focusing on the metropole and colonial urban centres, several authors prefer to look at the regional and the rural. In each case, this accompanies novel insights into internal colonisation—an intriguing but neglected topic. Carla Nappi shows the regional hybridity of physical treatments of the body within the transforming space of early modern colonial China. In two other studies—that of David Sowell on the Yucatan peninsula in Mexico, and Anna Afanasyeva on the Kazakh steppes—a sensitivity to the context of distance leads on to a consideration of issues of isolation and of difference. Both chapters look at the way in which medicine was used as part of a modernising and centralising project of internal colonisation by the state, and in each case public health was a central feature of modernisation.

Anna Afanasyeva's case study of medicine in the Kazakh steppes under successive political regimes highlights the issues of the nature of colonial empire and the significance of borderlands within it, and then through these subjects she explores the character of internal colonisation. This has added interest because the boundary between "us" and "them" in the region was less clear cut than in maritime empires, and because local elites within the empire were co-opted into the Russian nobility regardless of their ethnicity or creed. Afanasyeva paints a complex portrait of a largely ignored medical history topic through her representation of Russian medicine as a tool of empire from the early nineteenth century, when Russian doctors in remote hospitals brought western medicine to the Kazakh population, and thus helped combat their perceived backwardness. Remarkably, the efficacy of traditional Kazakh healing in the form of local herbs and animal products, together with mud or salt baths was also recognised at the time. Afanasyeva argues that the achievements of



Russian imperial medicine in the region were at first denied by the succeeding Soviet regime until Stalinist historians reinterpreted earlier medical advances as an enlightened and beneficial medical development, although impeded by Tsarist administrative inefficiency. But, following the break-up of the Soviet Union, a more problematical historiographical interpretation developed, which again elevated the importance of Kazakh ethno-medicine and the skills of local folk doctors. This changing historiography reminds the reader of the relevance of contemporary political changes in altering perspectives and evaluations of past colonial medical practices.

In a second essay on internal colonisation, David Sowell sets out to combat the neglect of such peripheral histories through analysis of the biomedical transformation of a region, and in so doing exposes the tensions between regional and national health agendas. He focuses on how public health programmes advanced biomedicine in twentieth-century Yucatán as developed by both state and federal governments in their modernisation projects. Earlier Spanish colonisation had effectively created a Yucatec Maya or Indian identity as well as producing medical pluralism through the interaction of Hispanic and indigenous healing. After the Mexican Revolution (1910-17) the revolutionary state aimed to enhance its authority through advancing healthcare so that federal public health campaigns made biomedicine a powerful colonising agent in weakening “traditional” medical practices (with the notable exception of midwifery.) Tensions resulted between Mexican federal and Yucatec state governments within a context of rapidly changing economic conditions. Whilst in Latin America generally, public health programmes spread biomedicine, exceptionally in Yucatán the regional state took the lead by developing health initiatives within the henequen<sup>15</sup> economic zone, whilst federal bodies followed in advancing public health in the corn zone. In this multilayered analysis Sowell elucidates multiple colonisation and its differential impact on regional medical practices, as well as highlighting connections between medicine and political economy.

A focus on peripheries naturally leads into concern over borders, their porosity or otherwise, and a movement of healthcare knowledge with migration of people from village communities to towns, mines, plantations and missions. In his study of colonial central Africa Markku Hokkanen notes the porous boundaries of Anglophone south-central Africa (covering the modern nation states of Malawi, Zambia and Zimbabwe), with their common but rich indigenous healing culture of therapy management groups, healers (*nyangas*) and regional shrines. He emphasises the dynamic and intertwined nature of indigenous and western medicine in the

area, arguing that medical middles—African medical assistants, hospital clerks and midwives sometimes drawn from the families of healers—were important brokers between the two. Hokkanen views them as “important agents of medical pluralism in colonial societies” by demonstrating the porous dividing line between two medical categories. Another issue raised in this chapter is the social life of colonial drugs. This area of investigation includes the appropriation of indigenous knowledge or material into colonial medicines, a clear example being *Strophanthus*—a Malawian arrow poison that became a colonial heart medicine before finding its way into the *British Pharmacopoeia*. As such it was for a short time a quite valuable export for Malawi.

The economic history of medicine has been relatively neglected so it is a welcome feature in several chapters. In Walter Bruchhausen’s discussion of health care in south-east Tanzania during colonial and post-colonial times, he stresses the role of the market in patients’ agency within medical pluralism. He gives a valuable insight into the extension of the medical market for the African during the colonial period, both as a result of the plans of German colonisers and, even more, of African agency through their demand for European-based hospital care. In relation to African traditional healers in the market for medicine, Bruchhausen helpfully suggests the complexity of their role, both in relation to consumers’ ambivalent expectations and in a context of contradictory evidence for and against medical services as a business.

Hybridity is a central focus of the chapter on the colonial Dutch East Indies from 1850 to 1910 by Liesbeth Hesselink. She interrogates the assumption that the local population in need of healthcare, whether Javanese, Europeans, Chinese, went to healers of the same ethnicity. Her case study of plural medicine on Java discusses whether *doekoens* in the Javanese community, *sinses* in the Chinese community, and physicians, pharmacists, midwives and dentists in the European community took sole care of their fellows. Ample space for this kind of patient pluralism would have been given by the indirect nature of colonial Dutch rule although there were Dutch medical initiatives such as a Dutch medical school to train auxiliary doctors, and a more short-lived midwifery school. Hesselink asks how much “healer hopping” took place and argues that availability and superior expertise were influential drivers within a complex context where there were varied medical crossovers. In childbirth European women frequently used *doekoen baji* (native midwives) or western-trained Javanese midwives, and also sought help from *doekoen baji* to procure an abortion or to increase fertility. In addition, for cases of syphilis or diphtheria the Chinese *sinse* might be consulted. In turn the

Javanese sought “European” medicines such as quinine or cholera antidotes, the Chinese used indigenous herbs, whilst European physicians might employ indigenous herbs or Chinese medicines. So a situation of partial but selective hybridity had developed.

Walter Bruchhausen suggests that the powerful connotations of concepts we employ shape our view of phenomena, and takes the use and misuse of pluralism as a case in point. He emphasises the plurality both of colonial medicine and of traditional medicine. David Sowell argues that in Yucatán healers or *H-menes* developed pluralistic medical practices through a fusion of Spanish humoral concepts with indigenous hot/cold concepts whilst, in the twentieth century, a second phase of medical pluralism resulted from choices between indigenous herbs and biomedical medicine for different kinds of illness. He concludes that the colonial process itself “altered indigenous medical practices in subtle and lasting ways.”

Two chapters encapsulating both a colonial and a post-colonial element complete the coverage of the volume. In her discussion of the emergence in 1842 of the medical school within Portuguese Goa, a minuscule territory often overlooked in the medical history of South Asia, Cristiana Bastos provides a revisionist interpretation. Interrogating the view of the school as the creation and the tool of the Portuguese empire, Bastos challenges conventional wisdom in arguing that, in the interplay between local and colonial initiatives, local agendas from a diverse community were the more important. Rather than being a “tool of empire”, the institution existed in the interstices of colonial power, with the school’s activities often being in tension with the colonial administration’s efforts. Exemplifying this complexity were contrasting depictions that ranged from the laudatory to the anti-colonial, on the changing role of its graduates in the health services of the Portuguese empire in Africa.

In her chapter on contemporary South Africa Jo Wreford reflects on “the web of connections and disconnections between colonial medicine and traditional health practitioners” and the prejudicial and divisive bequest left by this. She interrogates the alleged dichotomy between knowledge and belief as represented by an unequal relationship between scientific biomedicine and indigenous healing, together with the frequent inaccurate association of healing with witchcraft. This legacy led to deleterious effects on a divided provision of healthcare for HIV/AIDS patients. As a trained healer, Wreford describes as a participant observer an alternative scenario in the potential for partnership and constructive dialogue with healers through an innovative, recent healthcare initiative (project HOPE) in the Western Cape. Here local healers (*amagqirha*) have

demonstrated their desire to understand the HIV/AIDS virus from a biomedical perspective, have built up bonds with clinic staff, and have shown that they wish to work cooperatively. Some difficulties remain, including different patient expectations, dissimilar forms of patient-practitioner encounters, and unidirectional referrals. However, Wreford perceives in the project the potential for “adaptation, alteration and even hybridisation” in a way that could transcend the past.

In this collection authors have deployed rich empirical material in focused but nuanced studies and through conceptually and theoretically informed approaches have tried to avoid the pitfalls endemic in the genre of colonial medical history, whether of essentialism, reductionism, or dichotomising paradigms between the modern and the traditional or the indigenous and the biomedical. Instead of one-dimensional perspectives contributors have presented multilayered interpretations, emphasising commonalities and interconnections as well as contrasts. They have interrogated misleading labels, problematised older certainties and juxtaposed the familiar and unfamiliar. With its wide spatial lens this collection of essays should thus assist in integrating and reconfiguring the colonial historiography of medicine.

## Notes

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<sup>1</sup> Kuhn’s original: “...the proponents of competing paradigms practice their trades in different worlds. One contains constrained bodies that fall slowly, the other pendulums that repeat their motions again and again. In one, solutions are compounds, in the other mixtures. One is embedded in a flat, the other in a curved, matrix of space. Practicing in different worlds, the two groups of scientists see different things when they look from the same point in the same direction.” Thomas Kuhn, *The Structure of Scientific Revolutions* (Chicago: University of Chicago Press, 1970 [1962]), p. 150.

<sup>2</sup> For a plea for “connected histories” and reflections on the danger of area studies to become parochialist see: S. Subrahmanyam, “Connected Histories: Notes towards a Reconfiguration of Early Modern Eurasia”, *Modern Asian Studies* 31, 3 (1997): 735–62. See also: R. W. Strayer (ed.), *The Making of the Modern World: Connected Histories, Divergent Paths, 1500 to the Present* (New York: St. Martins Press, 1989).

<sup>3</sup> See also: A. Giddens, *Consequences of Modernity* (Oxford: Polity Press, 1990); U. Beck, A. Giddens and S. Lash, *Reflexive Modernization* (Oxford: Polity Press, 1994); H. Putnam, *Renewing Philosophy* (Cambridge, MA: Harvard University Press, 1992); H. Putnam, *Reason, Truth, and History* (Cambridge, MA: Harvard University Press, 1982); I. Hacking, *The Social Construction of What?* (Cambridge, MA: Harvard University Press, 1999).

<sup>4</sup> There are some prominent exceptions, such as: C.A. Bayly, "'Archaic' and 'Modern' Globalization in the Eurasian and African Arena, Circa 1750-1850", in A.B. Hopkins (ed.), *Globalization in World History* (New York: W.W. Norton, 2002), pp. 45-72.

<sup>5</sup> For recent publications on the spatial turn see: D.A. Finnegan, "The Spatial Turn: Geographic Approaches in the History of Science", *Journal of the History of Biology* 41 (2008): 369-388; C.W.J. Withers, "Place and the 'Spatial Turn' in Geography and in History", *Journal of the History of Ideas* 70 (2009): 637-658; B. Warf and S. Arias (eds), *The Spatial Turn. Interdisciplinary Perspectives* (London and New York: Routledge, 2008); M. Middell and K. Naumann, "Global history and the spatial turn: From the impact of area studies to the study of critical junctures of globalization", *Journal of Global History* 5 (2010): 149-170.

<sup>6</sup> Work in these fields is plentiful. For select examples, see: M. Werner and B. Zimmermann, "Beyond Comparison. Histoire croisée and the Challenge of Reflexivity", *History and Theory* 45 (2006): 30-50; M. Werner and B. Zimmermann, "Vergleich, Transfer, Verflechtung: Der Ansatz der *Histoire croisée* und die Herausforderung des Transnationalen", *Geschichte und Gesellschaft* 28 (2002): 607-636; G. Therborn, "Entangled Modernities", *European Journal of Social Theory* 6 (2003): 293-305; S. Randeria, "Entangled Histories of Uneven Modernities: Civil Society, Caste Solidarities and Legal Pluralism in Post-Colonial India", in Y. Elkana et al. (eds), *Unraveling Ties: From Social Cohesion to New Practices of Connectedness* (Frankfurt: Campus Verlag, 2002); Z. Bauman, *Liquid Modernity* (Cambridge: University Press, 2000); J. Kocka, "Comparison and Beyond", *History and Theory* 42 (2003): 39-44; M. Espagne, "Sur les limites du comparatisme en histoire culturelle", *Genese* 17 (1994): 112-121; M. Detienne, *Comparer l'incomparable* (Paris: Le Seuil, 2000); H.-G. Haupt and J. Kocka, "Comparative History. Methods, Aims, Problems", in D. Cohen and M. O'Connor (eds), *Comparison and History* (New York: Routledge, 2004), pp. 23-40; J. Osterhammel and N.P. Petersson, *Geschichte der Globalisierung* (Muenchen: C.H. Beck Verlag, 2003); A. Iriye, *Cultural Internationalism and World Order* (Baltimore: Johns Hopkins University Press, 1997); S. Khagram, J. V. Riker and K. Sikkink (eds), *Restructuring World Politics: Transnational Social Movements, Networks, and Norms* (Minneapolis: University of Minnesota Press, 2002); G. Metzler, *Internationale Wissenschaft und Nationale Kultur: Deutsche Physiker in der Internationalen Community, 1900-1960* (Goettingen: Vandenhoeck and Ruprecht, 2000).

<sup>7</sup> See also the introduction to G. Budde, S. Conrad and O. Janz (eds), *Transnationale Geschichte. Themen, Tendenzen und Theorien* (Goettingen: Vandenhoeck and Ruprecht, 2005), p. 12.

<sup>8</sup> See, for example: P. Chatterjee, "Beyond the Nation? Or Within?", *Social Text* 56, 16 (1998): 57-69; A. Appadurai, *Modernity at Large: Cultural Dimensions of Globalization* (Minneapolis: University of Minnesota Press, 1996).

<sup>9</sup> For a case study see J. Flores, "Distant Wonders: The Strange and the Marvelous between Mughal India and Habsburg Iberia in the Early Seventeenth Century", *Comparative Studies in Society and History* 49 (2007): 553-81.

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<sup>10</sup> Benedict Anderson, *Imagined Communities. Reflections on the Origin and Spread of Nationalism* (London: Verso, 1991 [1983]); Werner and Zimmermann, “Beyond Comparison”, p. 46

<sup>11</sup> Werner and Zimmermann, “Beyond Comparison”, p. 43

<sup>12</sup> On the suggestion that crossovers between particularistic developments and universal processes engender “negotiated universals”, see J. Kocka, in D. Sachsenmaier, J. Riedel with S. N. Eisenstadt (eds), *Reflections on Multiple Modernities* (Leiden: Brill, 2002), 119-128.

<sup>13</sup> See also: J. Alter (ed.), *Asian Medicine and Globalization* (Philadelphia: University of Pennsylvania Press, 2005); L. Pordie, *Tibetan Medicine in the Contemporary World: Global Politics of Medical Knowledge and Practice* (New York: Routledge, 2008); K. Raj, *Relocating Modern Science. Circulation and the Construction of Knowledge in South Asia and Europe, 1650-1900* (London: Palgrave Macmillan, 2007); H. Cook, *Matters of Exchange. Commerce, Medicine, and Science in the Dutch Golden Age* (New Haven: Yale University Press, 2007); A. Bashford (ed.), *Medicine at the Border. Disease, Globalization and Security, 1850 to the Present* (London: Palgrave Macmillan, 2007); S. Sufian, “Colonial Malariology, Medical Borders, and Sharing Scientific Knowledge in Mandatory Palestine”, *Science in Context* 19 (2006): 381-400.

<sup>14</sup> The current volume constitutes a first step towards the envisaged “crossing of colonial historiographies”, namely a deeper engagement of historians of medicine with the “processes of historicization” and “interweaving of the empirical and reflexive dimensions”. As outlined by Werner and Zimmermann in their plaidoyer for *Histoire croisée*, this involves a “double hermeneutic” that considers both the empirical and epistemological construction of the object, combining empirical and reflexive concerns. Werner and Zimmermann, “Beyond Comparison”, pp. 38- 40

<sup>15</sup> An agave plant whose long leaves are the basis of fibre for twine.

## CHAPTER ONE

# INTERWEAVING SUBSTANCE TRAJECTORIES: *TIRYAQ*, CIRCULATION AND THERAPEUTIC TRANSFORMATION IN THE NINETEENTH CENTURY

GUY ATTEWELL

This study analyses an encounter in the nineteenth century between British colonial anxieties over an elusive medical condition considered typically ‘tropical’ (beriberi), which was prevalent in parts of India, Ceylon and the East Indies, and a medicinal commodity (*tiryaq al-faruq*), whose therapeutic value became reconstituted through this encounter. It draws attention to the roles of multiple actors, and to transregional movements of people, things and ideas in the making and remaking of a substance’s therapeutic attributes. In so doing, it makes interventions in two main directions. First, by foregrounding an entwined historical perspective, the trajectories of *tiryaq* resonate with a growing body of studies which question the meaningfulness of ‘colonial’ and ‘indigenous’ as self-evident analytical categories.<sup>1</sup> This paper intersects with some of the recent historiographical trends associated with *histoire croisée*, as for instance discussed by Michael Werner and Bénédicte Zimmermann.<sup>2</sup> It responds to the need to understand configurations of healing knowledge with historical depth and beyond presentist compartmentalized geopolitical domains, such as ‘Europe’ or ‘Asia’ and how their histories may be approached. The intention here is to complicate an interpretation of encounters through categorizations of reified cultural systems (colonial, indigenous, Islamic, Indian), while pointing to particular socio-political conjunctures, agency and medical concerns which allowed for the reconfiguration of knowledge about this drug.

Second, writings on the Eurasian drug trade, especially from an economic history perspective, tend not to problematize therapeutic use and

wider social meanings of substances in trade and use. This study will point to some of the conditions of possibility which allowed for reconstitutions of the meanings and uses of a substance. There are a number of studies, some recent some less so, which have centre-staged ‘things’ and indeed drugs or remedies in historical and anthropological narrative. Among them are the volume *Biographies of Remedies*,<sup>3</sup> which explores Dutch and Anglo-American healing cultures through the perspectives afforded by a variety of medicinal substances. In the present study of theriac/tiryac I am keen to avoid the conceit of anthropomorphic identity conveyed by the term ‘biography’ in order to precisely relate the labile and unstable qualities of substances in movement that transgress an ‘identity’. I will be focusing on one such moment of reconfiguring through encounter. Of significance for this study are Arjun Appadurai’s seminal approaches to commodities and commodification.<sup>4</sup> Appadurai emphasized the cultural construction of value, which was largely absent in literature on commodities and consumption. In effect he was inserting the realms of culture and politics into the appreciation of a commodity’s value in exchange over and above a straightforward economic analysis of supply and demand.<sup>5</sup> In the case of theriac, its historiography has conventionally focused on a European experience, narrowly conceived.<sup>6</sup> The rise and fall of theriac within European spheres of production and consumption is a prominent theme in this literature. This paper explores the (re-) construction of therapeutic value by shifting the discussion of theriac to interconnected locales of use and the production of knowledge that tied in ‘European’ centres of production to widely dispersed but connected locales. In this way, I am moving against a drug trade narrative which presumes the stability of the drug as an entity in processes of exchange. There are clear resonances here with Kapil Raj’s insight on the process of circulation itself as a site for the production of scientific knowledge.<sup>7</sup>

The prelude to this study is an end point of sorts - the pages of an authoritative mid nineteenth-century medical dictionary published in Philadelphia in 1874. The dictionary was compiled by Robley Dunglison – personal physician to Thomas Jefferson, one time Chair of Materia Medica at the University of Maryland, Baltimore,<sup>8</sup> the so-called ‘father of American physiology’ and America’s most prolific medical author of his time. The 1874 *Lexicon* was a new and thoroughly revised edition of his 1848 dictionary and was published posthumously.

On page 1053, we find two entries for medicinal compounds which appear just a few entries apart from each other.

‘Treac’le. (τρηιακα) (F.) *thériaque* (Old E.) Triacle, Molasses, Theriaca – t. English, *Teucrium chamaedrys* – t. Venice, Theriaca.



Treeak Farook. A native nostrum, used in India for beriberi. Its composition is unknown. It is a thick extract into which some terebinthinate enters, and it is said, by regular practitioners in India, who have used it, to lower the pulse.<sup>9</sup>

The first entry, for *Treacle*, includes derivations in Greek and French, and alternative names – we can note that English treacle referred to a medicinal plant known as a remedy for snake-bites, commonly known as *Wall Germander*, as well as molasses, and that Venice treacle is referred to as *theriaca*. The second entry ‘*Treeak farook*’, is termed a ‘nostrum’, which would denote a ‘secret’ remedy, or a specially prepared patent medicine of questionable benefit. Treeak farook is of ‘unknown composition’; it is ‘native’ to India; it is used for the treatment of beriberi. Terebinthinate is a distillation of wood resin, most likely in this case aromatic opobalsam. ‘Regular practitioners’ means to my mind those who have a recognized professional standing from Dunglison’s perspective – it would not here refer to ‘local’ Indian practitioners, hakims and so forth. ‘It is said’ distances the author from the claim for its clinical effects; in this case the pulse is highlighted. Notice as well that the first definition has a subtle historical narrative, through derivations; in addition further information about uses is lacking, primarily, perhaps, because treacle-theriac was one of the most famous drugs of European-language pharmacopeia, even if discredited in many circles by this time, as we will discuss below. By contrast, the second entry, ‘treeak farook’, is dehistoricized – there is no derivation or other historical placement. It is a mysterious drug indigenous to India, whose value, if any, lies in the now of 1874, and in a specific circumstance – a case of beriberi. The presentation of these definitions leads us to believe that treacle-as-theriac and treeak farook are two different drugs, but what we will see is that they both belong to the same species of drug – they are in fact synonymous. As we find out how the same drug became split into two different entities, we will reflect on tiryaq’s trajectories along multiple pathways of circulation and transmission, displacement and translocation in which the medical / therapeutic and social lives of tiryaq were interwoven in patterns of migration, trade and local contexts of application.

## Beriberi

In 1835 John Grant Malcolmson, assistant surgeon in the Madras medical service in eastern colonial India, published the results of his researches on a medical condition which confounded medical opinion on causation and treatment – beriberi.<sup>10</sup> This work, entitled ‘A Practical Essay on the

History and Treatment of Beriberi', rapidly gained a certain renown. It was written as a response to an advertisement in the Fort St George Gazette in May 1832, announcing that a prize by the Madras medical board would be given to the best dissertation on the 'disease called beriberi' and on rheumatism.<sup>11</sup> The Madras medical board wanted more systematic information on beriberi and how it could be treated. Rheumatism was often confounded with beriberi, although its prevalence among the native infantry was, in Malcolmson's view, second only to fevers among all the diseases from which they suffered. Malcolmson's work won the substantial prize of 500 Rupees or its equivalent in a gold medal. In the following years this work gained wide circulation for his discussion of a disease that was reported to cause high morbidity, and in many cases swift death, among the military and naval personnel of European imperial powers through south and south-east Asia, as well as among plantation labourers, prisoners, seafarers and, later in the century, among the Japanese navy and Chinese miners. For much of the nineteenth century a large number of European writers considered beriberi a form of dropsy, on account of oedematous swellings. Late nineteenth-century debates, entertained into the twentieth century, presented theories of contagious organisms and bacteriological causation, alongside dietetic causation.<sup>12</sup> In the first decades of the twentieth century, consensus among medical circles slowly grew that beriberi was caused by a nutritional deficiency, later identified as a deficiency in vitamin B1 (thiamin). A focus among an international network of researchers was on the role of polished white rice as a contributing factor in producing symptoms that characterized beriberi.<sup>13</sup> However, right into the 1920s there was much contestation about beriberi as a specific disease as such, or as denoting a group of interrelated conditions, about its etiologies, means of prevention and appropriate methods of treatment. The conjuncture of these two facets, the threat of the disease to colonial projects, to political, economic and military situations in coastal Asia coupled with the lack of confidence in diagnosis, prognosis and treatment for it among colonial officials, laid the ground for the interest in Malcolmson's researches from the 1830s.

In the early nineteenth century, J. G. Malcolmson was just one of a number of military and medical personnel stationed in districts of eastern coastal India who drew attention to a presentation of symptoms characteristically including swelling, anaemia, numbness of the extremities, partial paralysis, emaciation and extreme lethargy and weakness, the successful treatment of which confounded them at every turn. Their attention was primarily focused on cases in the military and in jail

populations, though also intermittently on cases among civilians.<sup>14</sup> Contemporary reports for prison populations in Madras Presidency noted deaths from beriberi could account for half of all deaths,<sup>15</sup> although the value of any statistical appreciation is mitigated by the problems in differential diagnosis, and thereby retrospective diagnosis.<sup>16</sup> Malcolmson collectivized this symptomatic constellation as *barbiers/beriberi* (which had been considered different diseases by some observers), using terminology that had been current in writings on disease in the Indian Ocean zones in Portuguese, French, Dutch and English since at least the time of the seventeenth-century Dutch physician Jacob de Bondt (Bontius). ‘Beriberi’ was speculatively derived from Sinhala for debility,<sup>17</sup> or sheep gait in Hindustani, although Malcolmson noted that neither of these terms appeared to be current ways of denoting beriberi in these languages at the time.<sup>18</sup> Malcolmson sought to make a correlation between beriberi and a disease conveyed by a local Hindustani term, *suj bha’ee*, although it is not clear whether local people saw this constellation of symptoms as a single correlated condition, or as separate presentations of weakness, swelling, debility and paralysis. This is an important point to bear in mind when we come to discuss therapeutic innovation below.

## Masulipatnam

It is clear that demand for treatment for the problems of debilitation, swelling, and paralysis above was pressing among the populace of the Northern Circars division of the Madras Presidency, where Malcolmson was stationed during the 1830s. Observers noted the association of localities within this division, especially Masulipatnam, with outbreaks of beriberi through the nineteenth century.<sup>19</sup> Malcolmson attempted to formulate a ‘law’ for the occurrence of beriberi in the region as not extending more than forty miles inland, although he struggled both to explain why this should be so, as also to account for the exceptions to the law which he listed. A correlation that was made, but not in any way insisted upon, and at times argued against, was that of the quality and quantity of diet and the occurrence of beriberi.

Masulipatnam, for some centuries an important trading port on India’s north Coromandel coast, was in a region which had suffered frequent famines from the 1750s — especially hard-hitting were those of 1790-1792, 1807 and the Guntur famine of 1832-3, which decimated the peoples of Guntur and Masulipatnam districts.<sup>20</sup> Large sectors of the population working in agriculture in the hinterlands of the port had already suffered under exploitative revenue collection systems under the legacy of fading

Mughal power in the mid eighteenth century, and were vulnerable to erratic rains. The East India Company took control of five of the Circar districts in 1765, and the British introduced the Permanent or Zamindari Settlement of 1803-04, by which they sought to systematize revenue collection. According to the study of G. N. Rao, the chaotic revenue system in the coastal Andhra country took little account of annual variations in productivity relating to seasonal weather patterns. Cultivators accordingly bore the brunt of adverse conditions and a mismanaged revenue collection structure.<sup>21</sup> Cultivators in the first half of the nineteenth century, in the analysis of P. Swarnalatha, were also undermined by the trend of falling grain prices until the 1860s (despite the peaks in times of famine), which forced many to seek alternative employment as labourers or coolies.<sup>22</sup> The large-scale import of low-grade, cheap Arrakan rice from Burma by the British is understood to have exacerbated the price falls, and contributed to destitution among agricultural labourers. The connection between the quality of food and its scarcity and the symptomatic pictures of beriberi was made in reports on beriberi compiled at the time. But Malcolmson and several of his contemporaries in the British medical and military establishment, while considering the importance of diet and food quality, dismissed the idea that diet could alone account for the debilitation of stout men bearing the characteristic symptoms of this condition. The mystery that enshrouded the cause of these symptoms for the British was paralleled in their many and varied methods of treatment, and this was where Malcolmson sought to make his main contribution.

In accordance with the pragmatic goals of Malcolmson's text, a large part of his discussion was devoted to treatment modalities and efforts to evaluate effectiveness. The two most prominently discussed treatments were locally prescribed remedies, and a discussion of these 'native' remedies was actually stipulated on the Madras Medical Board advertisement for the prize essay – such must have been their renown or intrigue by this time. Several people figured prominently in Malcolmson's account in bringing to wider notice the usefulness of these remedies for the treatment of some of these symptoms. The first of these was William Geddes, a surgeon for the native infantry. Geddes had, by his account, quoted by Malcolmson, 'exhausted every resource' in his attempts to treat his patients. He then followed the advice of two other doctors, who recommended calomel in scruple (1.2 gram) doses with opium and to continue until prolific salivation took place.<sup>23</sup> Without effect, he pursued other conventional lines, including bloodletting, blisters to the loins, purging with jalap, the administration of calomel, opium and squills, the prescription of diuretics and warm baths. However, as he wrote,

‘notwithstanding [...] all that I could do, the fatal dropsy supervened and killed my patients [...] Being completely at a stand’, he continued, ‘I consented the request of my patients to be allowed to try a native medicine, which they stated had cured some them, when affected on a previous occasion’ – this native medicine ‘treak farook’ was considered, according to Geddes, ‘a most sovereign remedy’ ‘by natives throughout the country’. In this narrative, apart from Geddes, another prominent mediator and agent in the dissemination of the use of treak farook to wider publics was a Dutch surgeon, Gerhard Herklots, stationed in Madras and periodically in Chicacole (Srikakulam in coastal Andhra), who became well-known as the translator of a work on the customs of Muslims in India.<sup>24</sup> Herklots valued the local use of treak farook, as well as many other prescriptions which he had, apparently, learnt from local practitioners and which were represented in Malcolmson’s text, although Herklots thought more highly of another remedy. This he referred to as *oleum nigrum*, a black oil, (known in Hindustani as *roghan malkangani*), based on the seeds of the shrub *malkangani* (Hindustani, *Celastrus paniculatus* (Willd.) widely used as a medicine in India’s healing traditions, and currently marketed for pain relief. The use of the seeds of this plant is detailed in Persian and Urdu pharmacopeia for the treatment of nervous dispositions, weakness and memory loss.<sup>25</sup> Herklots claimed ‘astonishing success’ of this *oleum nigrum* in the treatment of beriberi, although this success was apparently not entirely replicated in the trials of Malcolmson, who mentioned how Herklots’s position had been ridiculed – Herklots had learnt the local languages and had been taken into confidence by the people, which had in Malcolmson’s mind, affected his appraisal of the usefulness of the oil and led him to believe too strongly in the curative powers of native remedies ‘in their nature evidently absurd’. In spite of Malcolmson’s open reservations over Herklots’ position in relation to local knowledge, Malcolmson, by his own admission, promoted the use of *malkangani* oil in Madras Presidency for the treatment of beriberi by either supplying the drug or giving instructions on how it was to be made.

While Malcolmson also had reservations about treak farook, he sought out reports about its good effects on the oedema, the racing pulse and debilitating effects of beriberi. He found out that it was a sought after medicine prescribed by ‘hakims’, local physicians, mostly Muslim but also Hindu, in the vicinity of the port of Masulipatnam, where it came through trade. Local practitioners had told him that Arab traders brought it to Bombay. Seeking more information, he went and spoke to the traders who had brought it into the port of Masulipatam. These, he noted, were Moghul traders, who told him that the treak farook was brought ‘from beyond

Istamboul [*sic*]’ via the Red Sea. He found out that the treeak farook was also traded inland to Hyderabad, where it was in demand for numbness and rheumatism and also as an aphrodisiac, in Malcolmson’s illuminating comment, ‘as usual amongst them with unknown remedies’.<sup>26</sup> That treeak farook was ‘unknown’ to local peoples was entirely Malcolmson’s supposition, and in part contradicted by his very own sources. Moghul (Indo-Persian) traders had been present in Masulipatnam since the late sixteenth century when it had been the principal port for the Qutb Shahi dynasty of Golconda, and had continued to serve the subsequent Hyderabad Nizams of the Asif Jahi dynasty. Masulipatnam was therefore a highly significant node in a long established trading network linking Shiite dynasties in the landlocked Deccan plateau with oceanic trade, to the east and west.<sup>27</sup> The port was apparently severely damaged by a tropical storm in 1800,<sup>28</sup> but clearly continued to function as a port subsequently. Swarnalatha’s study points to the continued importance of Moghul traders operating out of Masulipatnam in the chintz trade until the 1840s, which the British attempted successively to undermine, and the trading links between Masulipatnam and Hyderabad evidently remained, as Malcolmson witnessed with the passage of treeak farook.

Malcolmson’s enquiries led him to view the product leaflets accompanying the consignments of treeak farook in Masulipatnam. These were in Italian with some ‘Turkish’ labelling.<sup>29</sup> The brochure stated – ‘Alla Testa d’Oro’ – ‘treeak farook’ the theriac of Andromachus, prepared by John Baptist Sylvestris, near the Rialto Bridge in Venice. A Venetian product marketed in India using a ‘native name’ – was the trade in treak farook merely another example of European pharmaceutical expansion across the waters? Malcolmson himself believed that the Venetians had used a Perso-Arabic name in order to encourage sales, and that trade in this drug was recent (on the grounds that he could find no mention of treeak farook in Persian and Hindustani dictionaries, and that he did not find that the use of the drug was widely dispersed in the region). Other patent medicines that were marketed in India in the nineteenth century included Dover’s powder (a combination of opium and the South-American origin medicinal ipecacuanha), and later, Holloway’s pills, which Thomas Holloway began to trade in the 1830s and which became a marketing phenomenon throughout the British Empire.<sup>30</sup> But the trajectory of treak farook did not fit this pattern of ‘European’ commercial enterprise along colonial networks. Malcolmson’s researches alluded to Venetian interest in the production of this drug in sixteenth-century Ottoman Egypt – another commercial centre, but the linkages between places, peoples, texts, materials and cultures of use go still deeper. We have to ask: – what