

COLONIAL STATE HEALTHCARE IN TRINIDAD, 1845-1916.

BRITISH COLONIAL HEALTHCARE IN
A POST-EMANCIPATION PLANTATION SOCIETY: CREOLISING PUBLIC HEALTH
AND MEDICINE IN TRINIDAD, TO 1916.

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ABSTRACT

This study examines the advent of state public health and medical services in Trinidad in the post-emancipation colonial period, to 1916. Britain's sugar-producing plantation societies were structured to allow the small white Creole plantocracy to exploit the labour of the African and East Indian lower orders and keep the people in a perpetual state of poverty. Trinidad established the Government Medical Service (GMS) in 1870 in response to an edict from the Colonial Office. The civilising mission had clearly gone awry and state-provided western medical services would henceforth be mandatory to mitigate the excessive mortality and morbidities amongst the subject peoples.

The GMS rapidly evolved into a major provider of medical care services. However, the form and function of the GMS remained contested terrain, due to the enduring disagreements about the causes of the widespread impoverishment and ill-health amongst the people. The Creole plantocracy used the poverty and poor health of the Africans as proof of their regression into barbarism after emancipation. Conversely, some British officials believed that plantation society colonialism created adverse conditions of life, thus obligating the state to alleviate its effects. The Afro- and Indo-Trinidadian people emerged as a powerful force in the process of creolising the colonial state's social policies, as tens of thousands of sufferers sought assistance from the government doctors each year. The GMS thus developed as a distinctly creolised West Indian entity providing western public health and medical services to the African and East Indian residents.

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– Chapter 1 –

Introduction, Historical Context, Historiography, and Thesis Overview

This study investigates the development of the colonial state's policies and services for public health and medical care in the post-emancipation British West Indian colony of Trinidad, to 1916. In 1870, in response to a Colonial Office edict to its plantation colonies, Governor Arthur Gordon enacted several health-related ordinances to mitigate the conditions causing high mortality amongst the indentured East Indian population. Since 1845, the government had sponsored the migration of Indians each year to replace the formerly enslaved labourforce on the sugar estates.¹ Gordon's reforms created Trinidad's Government Medical Service (GMS), which rapidly developed into a large two-tiered system. The secondary tier provided medical care to indentured Indian men and women in the private hospitals on the plantations. The primary tier provided institutional and out-patient health care to a notable percentage of the free Indo- and Afro-Trinidadian residents each year.² The constantly increasing costs and number of public GMS patients stimulated protracted struggles between the white Creole plantocracy and sojourning British officials about the colonial state's obligation to be involved in maintaining the health of the free Africans and Indians, who embraced state healthcare and relentlessly demanded services from the GMS doctors.

Plantation societies were purposefully organised to allow the small Creole plantocracy to retain the wealth created through the exploitation of its subject peoples. This form of colonialism created poor living and working conditions, which had profoundly negative effects on the health and well-being of the people.³ The Colonial Office's edict signified that Britain's mission to civilise its subject peoples would henceforth require its plantation societies, including Trinidad, to provide western public health and medical services to the people. However, the terms of the form and function of the GMS were nebulously defined in the metropole and without precedent in the Empire, and thus subject to interpretation. This study examines the tensions shaping the evolution of Trinidad's policy on state public health and medical services: the lower classes demanded assistance to relieve their poverty and ill-health, which the Creole elite insisted was proof of the Africans' regression into barbarism, while some British officials and the GMS doctors insisted that the problems were rooted in the plantation economy.

¹ Trinidad's Coolie Immigration Ordinance 13 of 1870 stipulated extensive healthcare and medical measures to be provided by the plantation owners to the indentured East Indians. Gordon also introduced several other Ordinances related to public health and medical care. Ordinance 2 of 1869 created the Surgeon-General's department. Ordinance 15 of 1870 empowered the governor to hire District Medical Officers. Ordinance 5 of 1869 and 1870 defined the management for the Port-of-Spain Hospital and San Fernando Hospital.

² The 'Indo-Trinidadians' or 'East Indians' include the locally-born people and the immigrants brought to the colony under indenture. The terms 'African' or 'Afro-Trinidadian' refer to the peoples of African ancestry, including those of pure and mixed parentage, who were born in the colony or migrated to Trinidad as slaves or as free migrants after emancipation.

³ De Barros, Palmer, and Wright recently argued that these adverse conditions characterised the circum-Caribbean region and the health of the people. This thesis establishes that plantation society colonialism created the poor health conditions in Trinidad and then struggled to define its obligation to deal with the effects. Juanita De Barros, Steven Palmer, and David Wright, "Introduction," in *idem*, eds., *Health and Medicine in the circum-Caribbean, 1800-1968* (New York: Routledge, 2009), 2.

The amalgam of the peoples of African, Asian, and European ancestry makes the history of the circum-Caribbean region extremely interesting, but complex. Many different peoples brought their cultures of healing and medical practices to the Americas and adapted their healthcare strategies to the existing resources and local customs. Steven Palmer, Juanita De Barros, and David Wright recently established that the diverse inhabitants throughout the region commonly combined creolised and traditional forms of healthcare during the colonial period. They encouraged scholars to investigate these histories, which are in their infancy for this region, while suggesting the need for studies of institutional healthcare: little is yet known about the organisation and operation of the numerous large medical institutions created by the various colonial governments.⁴ This study addresses this historiographic lacuna by investigating the state's social policies and its GMS organisation in post-emancipation Trinidad, to 1916. The GMS provided public health and medical services in the community and through its institutional network, caring for poor Trinidadians gratuitously, or for token sums. Although the Colonial Office mandated the creation of the GMS, the medical service did not replicate Britain's model of state healthcare, although some commonalities did materialise, nor did it displace traditional medical practices. The GMS evolved through conflicts, negotiations, and adaptations, while coexisting with a vibrant marketplace of traditional Afro- and Indo-Trinidadian cultures of health and healing.

Plantation Colonies and Imperialism's Civilising Mission

From the seventeenth century, Britain established or acquired sugar-producing plantation colonies in the British West Indies and Indian Ocean, including Trinidad, Jamaica, British Guiana, Natal, and Mauritius. The prosperity of the imperial plantation colonies had historically depended on slave labour and protective tariffs on sugar. As part of the post-Enlightenment reforms, the Imperial parliament dismantled these artificial constructs, abolishing slavery, in 1838, and disbanding the tariff protections on sugar as part of the introduction of free trade in the 1840s.⁵ The high profits from sugar dissipated, requiring Britain to resuscitate its economically ailing plantation societies, until the colonies regained their economic viability through agricultural diversification late in the century.⁶ For the duration of the century, the West Indian colonies made decreasing economic contributions to the Empire until they represented an insignificant portion of Britain's trade.⁷ Despite the on-going economic troubles in the sugar-producing colonies, the structures of their politico-economies did not change in any

⁴ De Barros, Palmer, and Wright, "Introduction," *Health and Medicine*, 2, 11.

⁵ Walton Look Lai, *Indentured Labour, Caribbean Sugar. Chinese and Indian Migrants to the British West Indies, 1838-1918* (Baltimore: Johns Hopkins Univ. Press 1993), 3.

⁶ Curtin argued that the Sugar Duties Act of 1846 did not cause the decline in prosperity in the West Indian colonies. The Act eliminated protection against market forces, but the "technological backwardness," the development of the foreign beet sugar industry, and the West Indian failure to organize a free labour market after emancipation contributed to the uncompetitive nature of these economies. Philip D. Curtin, "The British Sugar Duties and West Indian Prosperity," *The Journal of Economic History*, 14, 2 (1954): 158.

⁷ Porter calculated that the West Indian colonies represented 17.6% of Britain's economic trade in 1815, valued at £15.4 million. By 1913, West Indian products had declined to .47% of Imperial trade, worth £6.6 million. Andrew Porter, ed., *The Oxford History of the British Empire, Volume 3, The Nineteenth Century*, (Oxford: Oxford University Press, 1999), 5.

meaningful way in the nineteenth century. The plantations remained the fundamental unit of production, designed to create and channel the increasingly elusive wealth into the hands of the exceptionally small white elite.

During slavery, the estates were considered the primary agency to civilise the Africans and continued to be deemed the locus of civilisation for the African and East Indian populations in the post-emancipation period.⁸ Thomas C. Holt argued that Malthusian and Wakefieldian ideals framed the structure of the post-emancipation societies. Officials believed that free labourers needed to be directed to the production of staple and export products. The colonies created the conditions whereby the subject peoples would remain landless labourers, available to toil in the plantation economy, purposefully keeping the people nearby the agricultural estates and, therefore, within the realm of civilisation.⁹ Planters in the British West Indies insisted that the Africans would otherwise regress into barbarism: the ex-slaves needed to be “‘civilised’ and conditioned to accept the *status quo*.”¹⁰ Historians have consistently argued that each colony’s government enacted many policies to limit the opportunities for people to survive beyond the plantations. The restrictions on land and labour clearly favoured the planters by keeping the people poor and landless, which precluded the emergence of a large-scale sector of peasant proprietors.¹¹ Post-emancipation colonies could not use overt coercion to keep the people near the estates, but the purposeful restriction of their alternatives attempted to force the peoples into waged labour, rationalised as a civilising measure: the lower classes would develop the British values of industry and thrift by labouring on the estates.¹² This form of colonialism, therefore, kept the mass of the people within the plantation economy, which impoverished them, while channelling wealth to the small elite strata of the plantocracy.

The planters’ deeply-rooted racial ideologies continued to shape the colonies:

⁸ Marshall argued that officials in London accepted “for no very good reason” the planters’ argument that the survival of civilization depended on the estate structure: government policies henceforth restricted the growth of peasantries in the colonies, to protect the ex-slaves from lapsing into barbarism. Woodville K. Marshall, “Peasant Development in the West Indies Since 1838,” in H. Beckles and V. Shepherd (eds.) *Caribbean Freedom: Economy and Society from Emancipation to the Present* (Princeton: Markus Wiener, 1993), 104.

⁹ Holt provided an insightful analysis of the genesis of many of Jamaica’s far-reaching policies. Thomas C. Holt, *The Problem of Freedom. Race, Labor, and Politics in Jamaica and Britain, 1832-1938* (Maryland: Johns Hopkins Univ. Press, 1992), 73-6.

¹⁰ Brian Moore, “The Culture of the Colonial Elites of Nineteenth-Century Guyana,” in Howard Johnson and Karl Watson, eds., *The White Minority in the Caribbean* (New Jersey: Markus Wiener, 1998), 95-6. Patrick Bryan, “The White Minority in Jamaica at the end of the Nineteenth Century,” in Johnson and Watson (eds.), *The White Minority in the Caribbean*, 123-4.

¹¹ Donald Wood, *Trinidad in Transition. The Years after Slavery* (London: Oxford University Press, 1968), 91-2. Madhavi Kale, “‘Capital Spectacles in British Frames’: Capital, Empire and Indian Indentured Migration to the British Caribbean,” *International Review of Social History*, 41 (1996): 114. Look Lai demonstrated that Trinidad’s Legislative Council continued to control and depress the wage rates in the colony, setting the indentured wage rates below the subsistence level and only slightly higher for free labourers on the estates. Look Lai, *Indentured Labour, Caribbean Sugar*, 8-9, 171. The situation was similar in British Guiana. Brian Moore, *Cultural Power, Resistance, and Pluralism. Colonial Guyana, 1838-1900* (Montreal: McGill-Queen’s University Press, 1995), 9.

¹² Wood, *Trinidad in Transition*, 92.

these were not egalitarian societies.¹³ The colonial structures allowed the relative handful of white planters to maintain their privileged economic, social, and political ascendancy over their large populations of non-white residents.¹⁴ These racial beliefs were not restricted to the British West Indies. Andrew Porter argued that they dominated the Empire: official racial thinking during the century asserted that the indigenous peoples failed to progress.¹⁵ Scholars have unequivocally established that racist policies and tense racial relations characterised Trinidad.¹⁶ Patrick Bryan succinctly defined the basis of this form of racism: “a status quo ideology that favoured progress within order, moral reform, hierarchy and ‘obligation.’ Britain’s paternalist rule over the ‘subject people’ of the empire, served the function of ‘uplifting’ the subject people.”¹⁷ Scholars concur that colonial rule in plantation societies was predicated on the difference between colonial “savagery” and metropolitan “civilisation”: colonial elites portrayed the need to preserve their dominance in the struggle against “black barbarism.”¹⁸ The civilising mission intended to keep the African peoples labouring on the plantations as a measure to pre-empt their otherwise inevitable regression, while maintaining the labourforce so desperately needed to preserve the economy. Plantation society colonialism was thus predicated on the professed racial superiority of the white Creoles and Britons, who were intent on maintaining this exploitative society. A central argument of this thesis is that these deeply-rooted racial ideals and the narrowly defined civilising mission underpinned the struggles over the government’s obligation to maintain the health and well-being of its subject peoples. This study defines the post-emancipation imperial

¹³ Historians concur that the comparatively small sectors of white Creole elites functioned as oligarchies during the century, enacting many laws to restrict the livelihood of the African and Indian populations. For instance, Brereton argued that the policies of Trinidad’s white Creole elite were clearly rooted in racist ideals. Bridget Brereton, *Race Relations in Colonial Trinidad 1870-1900* (Cambridge: Cambridge University Press, 2002), 1-63. Bryan demonstrated that Jamaica’s white plantocracy used its governmental powers, laws, and economic control to ensure its continued domination of all facets of the colony. Patrick Bryan, *The Jamaican People 1880-1902. Race, Class and Social Control* (Jamaica: Univ. of West Indies Press, 2000), ix-xi. Moore and Johnson extended Bryan’s argument in their investigation of the strategies for social and cultural control instituted by Jamaica’s elite to preserve its hegemony. Brian Moore and Michele Johnson, *Neither Led nor Driven. Contesting British Cultural Imperialism in Jamaica, 1865-1920* (Jamaica: Univ. of West Indies, 2004), 1-5.

¹⁴ Bolland argued that much of the conflict between the ex-slaves and planters resulted from the policies imposing restrictions on land acquisition by the lower orders. O. Nigel Bolland, “Systems of Domination after Slavery: The Control of Land and Labor in the British West Indies after 1838,” *Comparative Studies in Society & History* 23, 4 (1981): 591-619. Johnson provided an alternate view of the forms of domination exercised by the oligarchy in the Bahamas. Howard Johnson, *The Bahamas from Slavery to Servitude, 1783-1933* (Florida: Univ. of Florida, 1996).

¹⁵ Porter, “Introduction: Britain and the Empire in the Nineteenth-Century,” 23-4.

¹⁶ The racial tensions are the central theme in many monographs. See, for instance, Brereton, *Race Relations*. Kelvin Singh, *Race and Class Struggles in a Colonial State. Trinidad 1917-1945* (Jamaica: University of West Indies Press, 1994). Wood, *Trinidad in Transition*. Holt, *The Problem of Freedom*, 215-306, especially 307-9. For a Marxist interpretation, see Dennison Moore, *Origins and Development of Racial Ideology in Trinidad. The Black View of the East Indian* (Canada: NYCAN, 1995).

¹⁷ Bryan, “The White Minority in Jamaica,” 124.

¹⁸ Catherine Hall, *Civilising Subjects: Metropole and Colony in the English Imagination, 1830-1867* (Chicago: University of Chicago Press, 2002), 10. Moore and Johnson, *Neither Led Nor Driven*, 1-5.

project in Trinidad to include a broad range of initiatives to maintain the ailing economy, while reinforcing the *status quo* and power of the white elites. The term ‘imperialist’ is periodically used to refer to the white British and Creole elites when they were unified in their objectives and acting within a shared worldview of white racial superiority. However, during the numerous conflicts between the two elites over state healthcare, each faction is referred to as either the British or Creole elite.

The need for non-white labourers remained central to plantation societies. Madhavi Kale recently admonished scholars for failing to challenge the imperial rhetoric of the post-emancipation “labour shortage,” arguing that Trinidad’s planters failed to form working relationships with the free African population, despite their claims that the Africans had regressed, after 1838.¹⁹ However, the Imperial government believed the latter and accepted the responsibility to find a large supply of cheap labourers for the estates. The Imperial, Indian, and colonial governments collaboratively agreed to sponsor the immigration of East Indians to work as bonded labourers on the plantations. Between 1845 and 1916, this multi-governmental program of migration redeployed about 1.3 million East Indians to the plantation colonies.²⁰ One-third of the so-called “Coolies” travelled to the British West Indies, chiefly to British Guiana and Trinidad, and a fewer number to Jamaica.²¹ Trinidad sponsored the immigration of 143,939 indentured men and women during this period, although women continually represented a minority of the migratory East Indians. The majority settled in Trinidad, with only a mere 29,448 people returning to India.²² In addition to providing bonded workers for the plantations, the Indian diaspora changed Trinidad’s demographics. By 1921, as the last indentured worker left the colony, Indo-Trinidadians constituted 33% of the population.²³ Chapter 2 investigates this ethno-demographic transformation, arguing that indentured migration formed the central axis of Trinidad’s policy for the growth of its population, based on the continual importation of expendable labouring bodies, while discouraging the conditions for the natural increase amongst the Indians and Africans.

Although historians of indenture have not focused their lenses on health, *per se*, they continually connect the adverse conditions of life, endemic diseases, poverty, and

¹⁹ Kale, “Capital Spectacles in British Frames,” 109-33. See also, Curtin, note 12 (above).

²⁰ David Northrup, *Indentured Labor in the Age of Imperialism* (New York: Cambridge Univ. Press, 1995): 3.

²¹ The East Indians were distributed as follows: 238,909 to British Guiana, 143,939 to Trinidad, and 36,412 to Jamaica. Grenada, St. Vincent, and St. Lucia each received less than 4,400 immigrants. Trinidad received 11,391 indentured Africans, 379 Madeirans, and 1,152 Chinese people. The recruitment of the Chinese occurred between 1852-53 and 1861-65. G.W. Roberts and J. Byrne, “Summary Statistics on Indentured and Associated Migration Affecting the West Indies, 1843-1918,” *Population Studies* 20.1 (1966): 127, 131. Indentured labourers also travelled to other colonies and countries: 453,309 journeyed to Mauritius, 152,184 to Natal in South Africa, 26,507 to Reunion, 60,965 to Fiji, 34,304 to Dutch Guiana (Suriname), 39,771 to Kenya and Uganda, 6,351 to Seychelles, 25,509 to Martinique, and 42,326 to Guadeloupe. Clem Seecharan, *Tiger in the Stars. The Anatomy of Indian Achievement in British Guiana 1919-29* (London: Macmillan, 1997), 4.

²² Roberts and Byrne, *Population Studies*, 127, 131.

²³ In 1921, the population of 366,733 included 122,605 East Indians. *Census of the Colony of Trinidad and Tobago, 1921* (Port-of-Spain: Government Printer, 1923).

harsh labour to the poor health amongst the Indians.²⁴ Most scholars have concentrated on the troublesome question of the restricted freedoms of the people. One debate has dominated the literature for more than thirty years, although the usefulness of continuing it is now in question. In 1974, Hugh Tinker criticised the redeployment of Indians throughout the globe as a new form of slavery.²⁵ P.C. Emmer acknowledged the exploitation, but argued that the people exercised agency. Women, in particular, used migration to their advantage in what Emmer termed the “Great Escape,” emancipating themselves from India’s restrictive social and caste systems.²⁶ Social and gender historians investigated the factors motivating Indians to migrate and examined their post-indenture lives in the colonies. The evidence of the exercise of agency supported the counter-argument of the “Great Escape” and the “material benefits” of migration.²⁷

With the emergence of diaspora studies and the new imperial history during the 1990s, scholars criticised the importance of this debate, while encouraging the adoption

²⁴ Bridget Brereton, “The Experience of Indentureship, 1845-1917,” in John LaGuerre (ed.), *Calcutta to Caroni. The East Indians of Trinidad* (Trinidad: Longman Group, 1974), 31. Laurence’s monograph on indenture in Trinidad and British Guiana devoted a chapter to the health of the immigrants, comparing the regulations and conditions between the two populations. K. O. Laurence, *A Question of Labour. Indentured Immigration into Trinidad and British Guiana. 1875-1917* (Jamaica: Ian Randle Publishers, 1994), 197-228. Seecharan’s analysis of Indian resistance and adaptation, between 1919 and 1929, briefly highlighted the problems of poor sanitation and health at the end of the indenture system. Seecharan, *Tiger in the Stars*, 65-87. India imposed similar requirements for housing and medical care on the foreign colonies. Hoeft’s study of Suriname established that the colonial officials instituted the minimal measures to satisfy India’s requirements. I would suggest that this minimalist approach was consistent throughout the colonies sponsoring indentured immigration. Rosemarijn Hoeft, *In Place of Slavery. A Social History of British Indian and Javanese Laborers in Suriname* (Gainesville: University Press of Florida, 1998).

²⁵ Hugh Tinker, *A New System of Slavery. The Export of Indian Labour Overseas 1830-1920* (London: Oxford Univ. Press, 1974). Hoeft, *In Place of Slavery*. Verene Shepherd, “Emancipation Through Servitude: Aspects of the Condition of Indian Women in Jamaica, 1845-1945,” in H. Beckles and V. Shepherd (eds.) *Caribbean Freedom: Economy and Society from Emancipation to the Present* (Princeton: Markus Wiener, 1993): 245-50.

²⁶ P.C. Emmer, “The Great Escape: The Migration of Female Indentured Servants from British India to Surinam, 1873-1916,” in David Richardson (ed.), *Abolition and its Aftermath: The Historical Context, 1790-1915* (London: Cass, 1985): 245-66.

²⁷ East Indians emigrated for many reasons. Seecharan provided a concise summary of the historiography on the motivations of the immigrants. Seecharan, *Tiger in the Stars*, 28-36. Reddock argued that women acted independently to improve their lives, but that these actions challenged gender ideals and caused officials to attempt to curtail their actions. The majority of the material benefits evidence involving women offers similar arguments. Rhoda Reddock, “Indian Women and Indentureship in Trinidad and Tobago 1845-1917: Freedom Denied,” *Caribbean Quarterly* 32, 3/4 (1986): 27-49. Verne Shepherd, “Gender, Migration and Settlement: The Indentureship and Post-indentureship Experience of Indian Females in Jamaica, 1845-1943,” in Verne Shepherd, Bridget Brereton, Barbara Bailey (eds.), *Engendering History. Caribbean Women in Historical Perspective* (New York: St. Martin’s, 1995): 233-57. Lommarsh Roopnarine, *Indo-Caribbean Indenture: Creating Opportunities out of Adversity*, unpublished Ph.d. thesis, State University of New York, 2002. Patricia Mohammed, “Writing Gender into History: The Negotiation of Gender Relations among Indian Men and Women in Post-indenture Trinidad Society, 1917-47,” Verne Shepherd, Bridget Brereton, Barbara Bailey (eds.), *Engendering History. Caribbean Women in Historical Perspective* (New York: St. Martin’s, 1995): 20-47.

of current analytical frameworks. David Eltis, for instance, suggested the need to ask penetrating questions about the socio-cultural values of the societies sponsoring this global diaspora.²⁸ David Northrup argued that scholars need to conduct rigorous studies prior to asserting that the oppression of indenture approached slavery.²⁹ Verne Shepherd agreed and, along with Madhavi Kale, focused on the politics of Imperial expansion involving the Indians.³⁰ Certainly, indenture was an oppressive system. However, many historians have simply perpetuated a version of the historical debate between the anti-slavery reformers and the plantocracies. These recent scholarly criticisms have influenced this study of state healthcare in Trinidad. While historians have investigated the health of the enslaved Africans, and their post-emancipation colleagues have alluded to the prevalence of ill-health amongst the indentured East Indians, there is very little information on the health of either sector once they were released from their different forms of bondage. This analytical framework situates the health experience of the African and East Indian sectors in relation to each other to compare the experience between different populations living side by side, with the objective of understanding the broad implications of colonial state healthcare in plantation society colonialism.

India ended indentured migration in 1916, unilaterally terminating the flow of Indians to British colonies and foreign countries, due to rising nationalist and anti-British agitation.³¹ Historians concur that three factors guided India's decision: the unfree state of the Indians abroad, their poverty, and the immoral life of Indian women caused by the profound gender disparity within the post-indenture Indian populations overseas.³² Until that time, indentured migration had formed a vital component of the imperial project in Trinidad for seventy-one years, providing the plantocracy with a consistent supply of bonded workers, justified within the rhetoric of the labour shortage and professing to civilise the Indians. However, the conditions of life and labour had been difficult for the Indians and, in fact, outright perilous to their health and longevity in the early years. James Patterson Smith argued that the Colonial Office recognised that the imperial project's civilising mission was encountering difficulties in the mid-1860s. In 1865, the African population rose up to challenge colonialism at Morant Bay in Jamaica, while Whitehall faced heightened political pressures about the adverse conditions of the indentured Indians in the host colonies. The Colonial Office recognised the need to change its approach to civilising the colonial "barbarian." One important reform forced the colonial governments to accept the responsibility for the health of their

²⁸ David Eltis, "Introduction. Migration and Agency in Global History," in *idem*, ed., *Coerced and Free Migrations. Global Perspectives* (California: Stanford Univ. Press, 2002), 2-4.

²⁹ Northrup, *Indentured Labor in the Age of Imperialism*, 4-6.

³⁰ Kale, "Capital Spectacles in British Frames," 109-33. Verene Shepherd, *Maharani's Misery. Narratives of a Passage from India to the Caribbean* (Jamaica: University of West Indies Press, 2002).

³¹ On 29 March 1916, the Secretary of State telegraphed Trinidad stating that India had decided to abolish indentured immigration. 1916 LC #46, *Abolition of Indentured Emigration*.

³² Look Lai argued that India's decision was not related to any particular circumstances in the West Indies, but the result of rising nationalist sentiments. Reddock argued that the condition of the expatriate Indian women, during indenture and as free colonial residents, formed an important part of the agitation. Nationalists believed that the men had been enslaved and the women were prostituted. Laurence noted all three factors. Laurence, *A Question of Labour*, 457-8, 469, 471. Look Lai, *Indentured Labour, Caribbean Sugar*, 175-8. Reddock, "Indian Women and Indentureship," 27-49.

indentured labourers and to create GMS organisations.³³ Each colony had a great deal of flexibility organising its GMS. Some colonies, such as Jamaica, integrated ailing and injured East Indians into their system of public hospitals and exercised significant control over their care.³⁴ Trinidad's Coolie Immigration Ordinance 13 of 1870 required the planters to provide a rudimentary level of health services to the immigrants, while the government absorbed the responsibility to provide travelling GMS physicians to service the estates.³⁵ The government's commitment to employ the doctors benefited the planters: the white Creole elite henceforth supported the state's obligation to provide the medical resources for this secondary tier of the GMS.

Conversely, the colonial state's involvement in providing medical services to the free or non-indentured public became a point of contention and the root of the many protracted struggles to 1916, as explored below (in Chapters 4, 5, and 6). From its inauspicious beginning in 1870, the GMS grew to become one of the government's main annual expenditures, while subsuming the meagre forms of state-provided relief within a rather convoluted introduction of selected tenets of preventive medicine in Trinidad and, after 1899, Tobago.³⁶ By 1870, Trinidad had established the Port-of-Spain and San Fernando Hospitals, Lunatic and Leper Asylums, and Coolie Dépôt Hospital.³⁷ The number of institutions and patients increased substantially in the next six decades. By the 1921 census, in addition to the lunatic, leper, orphan, convict, and police populations, the GMS treated a substantial number of poor Trinidadians gratuitously or for a token sum: 14,594 patients in nine hospitals, with 41% being paupers, and a further 40,064 poor people as out-patients at twenty-three government dispensaries and health offices.³⁸ Large Public Health, Quarantine, and Port Health departments then existed as adjuncts to the GMS. This study establishes that this large primary tier of government healthcare for the African and East Indian public became the subject of momentous controversy between the white Creole elite, the British officials in Trinidad and London, and the Trinidadian public. While the elites disagreed on the obligation of the state to provide these resources, the public remained a major force in ensuring the survival of the GMS through their tenacity to use the state's medical resources to address their health

³³ James Patterson Smith, "Empire and Social Reform: British Liberals and the 'Civilizing Mission' in the Sugar Colonies, 1868-1874," *Albion*, 27, 2 (1995): 253, 270.

³⁴ Bryan, *The Jamaican People*, 166-7. James C. Riley, *Poverty and Life Expectancy. The Jamaica Paradox* (New York: Cambridge Univ. Press, 2005), 49.

³⁵ BPP 1872 [c.523]. *The Present State of Her Majesty's Colonial Possessions. For the Year 1870*, 70-2.

³⁶ Tobago was subsumed within Trinidad as a ward. The GMS annexed Tobago's medical districts in 1899. CO 295-391 (1899) #4024. *Tobago Medical Service*. Tobago was not an equal partner with Trinidad in the GMS structure, which is consistent with Luke's analysis of Tobago's status as a ward from 1897 to 1924. Learie B. Luke, *Identity and Secession in the Caribbean. Tobago versus Trinidad, 1889-1980* (Jamaica: Univ. of West Indies Press, 2007), 101-24.

³⁷ The Cocorite Leper Asylum was the first medical facility on the island, established in 1845. The 200-bed Port-of-Spain Hospital and 120-bed Belmont Lunatic Asylum opened in 1858. The San Fernando Hospital opened a year later. Daniel Hart, *Trinidad and the other West India Islands and Colonies*, 2nd edition (Trinidad: Chronicle Publishing Office, 1866), 104, 199. 1877 LC #1. *Lunatic Asylum. Annual Report of the Medical Superintendent for 1876*, 1.

³⁸ 1922 LC #65. *Administration Report of the Surgeon-General for the year 1921*, 2, 7, 14. [Hereafter, *Surgeon-General AR*.] In 1921, the GMS also treated 828 lunatics and 643 lepers in the asylums, plus 642 inmates at the House of Refuge.

conditions, despite the many obstacles placed in their way.

Methodology: Juxtaposing the Process of Creolisation and “Tensions of Empire”

As an entity created by a plantation society in the British Empire, Trinidad’s GMS was perpetually shaped by pressures from within the colony, the pan-Caribbean region, the metropole, and distant territories, such as India. In the past decade, historians have criticised studies that do not account for the complex connections between the colony and the larger world. At the same time, scholars of the British West Indies have continued to ascertain the uniqueness of these creole societies. This study integrates both approaches in order to recognise the importance of the Trinidad’s global interconnectedness, while concurrently establishing how the process of creolisation created this distinctly British West Indian system of state medicine and public health.

The recent literature has identified several challenges in studying the local and global experiences within a single analytical framework. Scholars of the new imperial history, such as Ann Laura Stoler and Frederick Cooper, argue that the influences from multiple locations created many “tensions of empire.” They have criticised historians who fail to look beyond the axis of the colony to metropole and recognise that people, ideas, and knowledge travelled on many different routes before arriving in the colony.³⁹ Scholars in diverse specialist areas offer similar critiques of the insularity of colonial histories. Barry Higman has argued that scholars have been too intent on rewriting colonial histories which extract the British West Indies from the British Empire. He anticipated a historiographic shift as historians started to account for the numerous viewpoints and contexts of life in the Caribbean region which created the “vital creole culture ambiguously rooted in Empire.”⁴⁰ Certainly, the history of the British West Indies cannot be explained in isolation from the metropole. David Arnold recognised the opposite problem in some histories of health and medicine in the imperial world, and admonished historians who produced narratives of “Europe’s medical adventures overseas.” Western medicine was not a static and value-free body of knowledge, which simply radiated from the metropole across the Empire. Arnold directed historians to probe the trans-national linkages shaping medicine in the tropical Empire.⁴¹ Scholars examining different imperial world locales thus agree that ideas and knowledge changed and adapted as they moved throughout the Empire, as did many of the people who influenced their development.

David Lambert and Alan Lester recently argued that it is important to maintain the historical relations between the people within the vast imperial world, along with their connections to the places and contemporary events beyond the borders of the

³⁹ Ann Laura Stoler and Frederick Cooper, “Between Metropole and Colony: Rethinking a Research Agenda,” in Ann Laura Stoler and Frederick Cooper, eds., *Tensions of Empire. Colonial Cultures in a Bourgeois World* (Berkeley: Univ. of California Press, 1997), ix, 1, 26.

⁴⁰ B.W. Higman, “The British West Indies,” in Robin W. Winks, ed., *The Oxford History of the British Empire. Vol. V. Historiography* (Oxford: Oxford Univ. Press, 1999), 136-7, 144.

⁴¹ David Arnold, “Tropical Medicine before Manson,” in David Arnold, ed., *Warm Climates and Western Medicine: The Emergence of Tropical Medicine, 1500-1900* (Amsterdam: Rodopi, 1996), 11-13.

colony. They argued that multiple colonial projects existed in tandem, linking the colony to the metropole and other locations in and beyond the Empire, within what they characterise as a “networked or webbed imperial space.” A framework of an interconnected imperial world allows multiple locations to be considered at once, without privileging any particular locality.⁴² This model allows historians to recognise a colony’s place in the universality of imperialism: each colony functioned as one of many nodes on the global networks, receiving, modifying, and transmitting ideas, attitudes, and practices at the same time.

Two recent monographs on colonial Jamaica provide excellent examples of the richness of studies that reveal the complexities of colonialism and relate the events to broader developments occurring within inter- and intra-Imperial networks. During Jamaica’s transition from slavery to free labour, Diana Paton established the mutually constitutive nature of the changing definitions of crime and punishment, through Jamaica’s interactions with other circum-Caribbean colonies and the metropole. Paton encouraged colleagues to conduct detailed studies of the daily struggles in the colonies, while situating the analysis within the broader context of the Imperial and Atlantic worlds.⁴³ Similarly, Catherine Hall’s *Civilising Subjects* identified many multi-directional forces operating in the imperial world, while bringing Jamaica and Birmingham into one analytical frame. Hall’s examination of Governor Edward John Eyre’s imperial career in several colonial nodes of the imperial network, from Australia to Jamaica, encapsulated the global nature of the influences which changed the thinking about race during his colonial career.⁴⁴ The scholarship by Paton and Hall provides admirable examples of the productive results derived from connecting the universal and the local: the complexities of the struggles within Jamaica were shaped by the flow of ideas from the Imperial and Atlantic worlds, in addition to the metropole.

The histories of the West Indian colonies in the context of global forces are clearly significant but, as demonstrated by Paton and Hall, the developments within each colony continue to merit intensive interrogation. Scholars of the colonial Caribbean have established the historical importance of the processes of contestation and negotiation between the European-descended elites and African majorities, as they forged new and distinctly creole societies during the colonial period. Since the seventeenth century, the term ‘creole’ has described a diverse range of Caribbean-born entities with non-native ancestry or heritage, including the peoples, cultures, languages, ways of life, music, styles, flora, and fauna.⁴⁵ In the 1970s, Kamau Brathwaite’s pioneering studies of the development of West Indian societies challenged the model of plural societies, wherein the remnants of African traditions were situated alongside the European cultures.⁴⁶ To

⁴² David Lambert and Alan Lester, “Imperial Spaces, Imperial Subjects,” in David Lambert and Alan Lester, eds., *Colonial Lives across the British Empire: Imperial Career in the Long Nineteenth Century* (Cambridge: Cambridge University Press, 2006): 4-5, 9-10.

⁴³ Diana Paton, *No Bond but the Law. Punishment, Race, and Gender in Jamaican State Formation, 1780-1870* (Durham: Duke University Press, 2004), 1-5.

⁴⁴ Hall, *Civilising Subjects: Metropole and Colony in the English Imagination, 1830-1867*.

⁴⁵ Carolyn Allen, “Creole: The Problem of Definition,” in Verene A. Shepherd and Glen L. Richards, eds., *Questioning Creole. Creolisation Discourses in Caribbean Culture* (Kingston: Ian Randle, 2002), 48. B.W. Higman, *Writing West Indian Histories* (London: Macmillan, 1999), 6.

⁴⁶ Brathwaite was challenging M.G. Smith’s construction of the British West Indies colonies

the contrary, Brathwaite conceived of the uniqueness of creole societies, forged through centuries of struggle. He defined creole society as:

... a complex situation where a colonial polity reacts, as a whole, to external metropolitan pressures, and at the same time to internal adjustments made necessary by the juxtaposition of master and labourer, white and non-white, Europe and colony, European and African, ... in a culturally heterogeneous relationship.⁴⁷

Thus, in Brathwaite's definition, while Africans were forced to acculturate to European norms, Europeans also assimilated African cultures, and inter-acculturation between both groups proceeded apace.⁴⁸

Scholars consistently recognise the importance of the creolisation thesis, while they debate the optimum theoretical constructs for their studies.⁴⁹ Nigel Bolland, for instance, agreed that Africans did not passively accept the European cultures and that they actively exercised agency. Bolland criticised the dualism in Brathwaite's conception, and instead proposed a dialectical analytical framework, but nonetheless agreed that the creolisation is key to understanding that Caribbean societies were built by "contention," rather than homogeneity.⁵⁰ Subsequently, scholars such as Michele Johnson and Brian Moore criticised the dialectical framework's intrinsic polarisation of the conflicts, such as the struggles between hegemony and resistance or domination and subordination. Their study demonstrated the efficacy of the forces of creolisation in negotiating cultural imperialism and its "civilising mission" in Jamaica, through the complex contestations between the conservative planter elite, British reformers, and the Afro-Jamaican lower ranks. Johnson and Moore established that conflict prevailed within the elite factions and the fact that, by virtue of the sheer numbers of lower class Afro-Jamaicans, the presumed "subordinate" Afro-Creole culture dominated the landscape.⁵¹ Similarly, other scholars have confirmed that the complex creole societies cannot be comprehensively explored within the limitations of the dialectical or dualist models: creolisation often

were plural societies. Michael Garfield Smith, *The Plural Society in the British West Indies* (Berkeley: Univ. of California Press, 1965).

⁴⁷ Edward Kamau Brathwaite, *Contradictory Omens: Cultural Diversity and Integration in the Caribbean* (Jamaica: Savacou, 1974), 11. Brathwaite's earlier work offered a similar definition for the societies prior to emancipation. Edward Brathwaite, *The Development of Creole Society in Jamaica 1770-1820* (Oxford: Clarendon Press, 1971), xvi.

⁴⁸ Brathwaite, *Contradictory Omens*, 11.

⁴⁹ Verene A. Shepherd and Glen L. Richards, "Introduction," in *idem*, eds., *Questioning Creole. Creolisation Discourses in Caribbean Culture* (Kingston: Ian Randle, 2002): xi-xxvi.

⁵⁰ The emphasis is in Bolland's essay. Bolland has repeatedly criticised Brathwaite's dualistic conception of the interaction and blending of "creole" and "colonial" elements. He proposed a dialectical analytical framework, to recognise the mutually constitutive nature of the competing forces: there can be no whiteness without blackness, masters without slaves, or resistance without systems of domination. O. Nigel Bolland, "Reconsidering Creolisation and Creole Societies," in Gad Heuman and David Trotman, eds., *Contesting Freedom: Control and Resistance in the Post-Emancipation Caribbean* (Oxford: Macmillan, 2005), 179-82. *Idem*, "Creolisation and Creole Societies: A Cultural Nationalist View of Caribbean Social History," *Caribbean Quarterly*, 44, 1-2 (1998), 3.

⁵¹ Moore and Johnson, *Neither Led nor Driven*, xiv-viii, 322.

involved other ethnic and racial groups, such as the settled East Indians and Chinese, and there was on-going inter-acculturation amongst the diverse groups of white elites.⁵² Thus, while the burgeoning scholarship clearly establishes how creolisation created distinctly West Indian societies, the methodological approaches continue to evolve as scholars expand their purview of the process and effects of creolisation.

Historians have not yet considered how the forces of creolisation influenced the development of governmental social policies, legislation, and institutional structures, which had a direct bearing on the development of the West Indian societies. A central thematic argument in this study is that the forces of contestation and negotiation creolised the government's policies on public health and medicine in colonial Trinidad and shaped the contours of the GMS organisation and the services which it delivered to the residents. To be clear, the theories and praxis of western medicine in Trinidad were the same as in the metropole and there is no evidence that the GMS doctors integrated indigenous or local therapeutics into their medical practices: doctors in Trinidad practiced British medicine. The process of creolisation influenced the state policies on western medicine and, more specifically, if and how the treatments provided by the GMS would be delivered to the Trinidadian people. In this plantation society, the GMS employed the majority of the colony's European-trained medical practitioners, operated all the medical institutions, and functioned as the state authority on public health. The government therefore established and maintained almost exclusive control over the dispensation of western public health and medical care services, albeit often reluctantly, while the state's obligation to maintain the health and well-being of the subject peoples remained contested terrain.

Three distinct factions negotiated Trinidad's colonial healthcare policies: the white Creole elite, sojourning British officials, and the Trinidad public. Racial and class ideals permeated the worldview of the white elites: their discourse portrayed the Africans as failing to embody civilisation and regressing into barbarism. However, the white Creoles considered the prevalence of ill-health and poverty as proof of their claim, while some, but not all, sojourning white Britons believed that the state needed to address the poverty and ill-health created by plantation society colonialism. The alliances between the white Creoles and Britons often changed each time new officials arrived in the colony. The subject peoples were not invited to participate in the debate over the colonial state's obligation to assist them. However, the power of the lower classes devolved from the same factor identified by Moore and Johnson in Jamaica: their sheer numbers. In

⁵² For the Indians, see for instance, Rhoda Reddock, "Contestations over Culture, Class, Gender and Identity in Trinidad and Tobago. 'The Little Tradition,'" in Verene Shepherd and G. Richards, eds., *Questioning Creole. Creolisation Discourses in Caribbean Culture* (Kingston: Ian Randle, 2002). Patricia Mohammed, "The 'Creolisation' of Indian Women in Trinidad," in Shepherd and Richards, eds., *Questioning Creole*, 130-47. For the Chinese, C. Ho, "'Hold the Chow Mein, Gimme Soca': Creolization of the Chinese in Guyana, Trinidad and Jamaica," *Amerasia*, 15, 2 (1989): 3-25. In his study of white creole culture in Barbados, Lambert argued that the controversies over slavery and emancipation creolized the identities of the white planters, while creating important "tensions of empire" between the elites in and the anti-slavery reformers and officials in the metropole. Similar to this study of the struggles between Trinidad's white elites, in Lambert's monograph it is often difficult to delineate between the dominant and subordinate dialectic amongst the white elites. David Lambert, *White Creole Culture, Politics and Identity during the Age of Abolition*, New York: Cambridge University Press, 2005, 5, 37-9.

the case of healthcare in Trinidad, tens of thousands of poor people relentlessly sought medical assistance from the GMS doctors each year. The elites often distained and disparaged these lower-class sufferers, but the non-white masses remained a force to be reckoned with, because of their cumulative tenacity, and an important factor in creolising state healthcare.

This study investigates the system of state healthcare in Trinidad by examining the struggles in the colony, while situating the developments within the interconnected network spanning the metropole, pan-Caribbean region, and other imperial locations, such as British India. Trinidad creolised its social policies and the GMS as it alternatively acculturated, accommodated, and rejected pressures from within the colony and from far beyond its borders.

The Historiography of Health and Medicine in the British West Indies

To-date, historians of the post-emancipation British West Indies have not investigated each colony's formal involvement in public health and medical services, the growth of their GMS organisations and institutions, or the health of the peoples who used the system.⁵³ The meagre literature on the history of colonial health and medicine is consistent with what Johnson and Moore have repeatedly identified as the lack of social and cultural histories for the post-1865 colonial period.⁵⁴ In general, the scholarship is more extensive for the period of slavery. This trend is evident in the history of health and medicine, and the literature on slave health is exceptionally useful to contextualise the attitudes of the plantocracy about the health of its non-white subjects. A central thematic argument of this thesis is that slavery era attitudes continued to prevail throughout the period, which had a major effect in defining the politico-economy of health and shaping the contours of state healthcare in Trinidad.

Philip Curtin's seminal 1969 monograph on the Atlantic slave trade initiated vigorous scholarly interest in the health of the enslaved peoples. Curtin established that the British West Indian slave populations had never become self-sustaining populations,

⁵³ Laurence considered the public health and medical services prior to 1873 in Trinidad and British Guiana. While this was an important contribution to the early post-independence literature, it provided only a brief comparative summary. K.O. Laurence, "The Development of Medical Services in British Guiana and Trinidad 1841-1873," *Jamaican Historical Review* 4 (1964): 59-67. Riley's study of life expectancy in Jamaica included an informative summary of the public health initiatives, the GMS services, and social welfare to 1920. Riley, *Poverty and Life Expectancy*, 48-68. The absence of studies on the GMS organisations and their patients in the West Indian colonies is part of a larger deficiency in the literature on the GMS organisations throughout the imperial world. Crozier's recent monograph on the colonial government doctors in British East Africa analyses the backgrounds and careers of the doctors, without delving into the patient interactions within the medical service. Anna Crozier, *Practicing Colonial Medicine: The Colonial Medical Service in British East Africa* (New York: Tauris, 2008).

⁵⁴ Brian L. Moore and Michele A. Johnson, *'Squalid Kingston' 1890-1920. How The Poor Lived, Moved And Had Their Being* (Jamaica: Univ. of the West Indies, 2000), viii-ix. For Jamaica, the largest British West Indian plantation colony, they qualify the sparse nature of the socio-cultural literature between 1865, the year of the Morant Bay uprising, and 1938, a time of renewed violence in Jamaican society. Moore and Johnson, *Neither Led nor Driven*, xi-xiii.

and decreased in size, while slaves in the United States reproduced their numbers by natural means.⁵⁵ This revelation piqued the interest of historians, who uncovered a wealth of data about the health of the slaves. The British Parliament wanted to ensure that planters complied with the 1807 legislation abolishing the slave trade and thus mandated annual censuses of the slaves,⁵⁶ while the Colonial Office made Trinidad a test colony for the abolition of the trade.⁵⁷ The Colonial Office's distrust of the plantocracies created a large number of primary sources, which historians of slavery and historical demographers meticulously analysed to ascertain the reasons why the populations decreased in size. Their studies established that excessively high mortality rates and extremely low fertility rates caused the unnatural decrease in the number of slaves.⁵⁸

With the advent of social history, historians began to scrutinise the daily living conditions and the widespread ill-health amongst the slaves. Their examinations established clear connections between the high rates of mortality and morbidities and the brutality of the system, malnutrition, and deprivation, which persisted within the racialised political economies of health in the colonies.⁵⁹ Historians also questioned the effectiveness of the legislation enacted by Britain, in the 1820s, to ameliorate the conditions of the slaves. These scholars argue that, although the health of slaves on some plantations may have improved, the conditions tended to become worse for the majority, as emancipation drew near.⁶⁰ Unfortunately, some studies tend to use medicine to

⁵⁵ Philip Curtin, *The Atlantic Slave Trade: A Census* (Madison: University of Wisconsin Press, 1969), 69.

⁵⁶ For slave registration and the use of the data, see Barry Higman, *Slave Populations of the British Caribbean, 1807-1834* (Jamaica: Univ. of West Indies Press, 1995), 6-36, 164. Slave registration created censuses of the slave population, which provided statistical information to Whitehall and Britain's anti-slavery movement.

⁵⁷ Gelien Matthews, "Trinidad: A Model Colony for British Slave Trade Abolition," *Parliamentary History* 26 (2007): 84-96.

⁵⁸ Higman, *Slave Populations of the British Caribbean*. B.W. Higman, *Slave Population and Economy in Jamaica, 1807-1814* (New York: Cambridge Univ. Press, 1976). Richard B. Sheridan, *Doctors and Slaves: A Medical and Demographic History of Slavery in the British West Indies* (Cambridge: Cambridge Univ. Press, 1985). A. Meredith John, *The Plantation Slaves of Trinidad, 1783-1816: A Mathematical and Demographic Inquiry* (New York: Cambridge Univ. Press, 1988). Barbara Bush, *Slave Women in Caribbean Society 1650-1838* (Kingston: Heinemann Caribbean, 1990): 120-50. Hilary McD. Beckles, *Natural Rebels: A Social History of Enslaved Black Women in Barbados* (NJ: Rutgers Univ. Press, 1989).

⁵⁹ K. Kiple, *The Caribbean Slave: A Biological History* (Cambridge: Cambridge Univ. Press, 1984). K. Kiple and V. Kiple, "Deficiency Diseases in the Caribbean," *Journal of Interdisciplinary History*, 11, 2 (1980): 197-215. Richard S. Dunn, "'Dreadful Idlers' in the Cane Fields: The Slave Labor Patterns on a Jamaican Sugar Estate, 1762-1831," *Journal of Interdisciplinary History*, 17, 4 (1987): 795-822. Jerome S. Handler, "Diseases and Medical Disabilities of Enslaved Barbadians, From the Seventeenth Century to around 1838 (Part I)," *Journal of Caribbean History*, 40, 1 (2006): 1-38. *Idem*, "Diseases and Medical Disabilities of Enslaved Barbadians, From the Seventeenth Century to around 1838 (Part II)," *Journal of Caribbean History*, 40, 2 (2006): 177-214. Jennifer L. Morgan, *Laboring Women: Reproduction and Gender in New World Slavery* (Philadelphia: Univ. of Pennsylvania Press, 2004).

⁶⁰ J.R. Ward, *British West Indian Slavery, 1750-1834: The Process of Amelioration* (New York: Oxford Univ. Press, 1988), 224-5. Richard B. Sheridan, "From Chattel to Wage Slavery in Jamaica, 1740-1860," *Slavery & Abolition*, 14, 1 (1993): 13-40. Barbados remained anomalous in the British West Indies, as it was the only slave colony where the population reproduced its

critique slavery, which detracts from this important topic, and appears out of place within a literature where it is difficult to identify any current-day scholars defending the system of slavery.⁶¹ Overall, these studies provide substantial insight into the challenges faced by the slaves in their daily lives. They establish the plantocracy's brutal treatment of their slaves: these behaviours were well-accepted amongst the whites. Chapters 2 and 3 establish that these ideologies permeated the planters' consciousness as they extrapolated the notion of expendable and replaceable African bodies to the new Indian population. The prevalence of these attitudes amongst the white elite controlling the healthcare resources affected the conditions of health of the subject peoples in Trinidad.

In contrast to the active scholarly interest in the health of enslaved Africans, little attention has been devoted to the health of the colonial peoples in the post-emancipation British West Indies. Several influential scholars have noted this deficiency in the literature, including Shula Marks and Diana Paton.⁶² The literature is indeed sparse and, until recently, generally restricted to a limited number of studies on selected aspects of public health,⁶³ the practice of medicine,⁶⁴ and the ecology of certain diseases.⁶⁵ The literature thus lacks a composite analysis of health or western medicine in any colony, although ill-health may have been endemic everywhere: social and cultural historians allude to the peoples' struggles with adverse health conditions. For instance, Bryan established that widespread poverty and ill-health strained the resources of the Jamaican lower classes, forcing them to seek government assistance, but sufferers often had difficulty reaching the GMS facilities and obtaining poor relief.⁶⁶ This study reveals

numbers by natural increase. However, this should not be construed as confirmation of a healthier population. Inniss recently argued that the infant mortality rate remained high during the ameliorative period. Tara A. Inniss, "From Slavery to Freedom: Children's Health in Barbados, 1823-1838," *Slavery & Abolition*, 27, 2 (2006): 251-60.

⁶¹ The informative essays by Gosse and Jabour on the ameliorative period tend to be overshadowed by this tendency. David Gosse, "Health Conditions on Selected Plantations in Jamaica," *The Journal of Caribbean History* 40, 2 (2006): 215-34. Anya Jabour, "Slave Health and Health Care in the British Caribbean: Profits, Racism and the Failure of Amelioration in Trinidad and British Guiana, 1824-1834," *Journal of Caribbean History*, 28, 1 (1994): 1-26.

⁶² Shula Marks, "Presidential Address. What is Colonial about Colonial Medicine? And what has Happened to Imperialism and Health," *Social History of Medicine*, 10, 2 (1997): 207, passim. Paton, *No Bond but the Law*, 12. See also, De Barros, Palmer, and Wright, "Introduction," 2-3.

⁶³ Rita Pemberton, "Water and Related Issues in Nineteenth-Century Trinidad," *Journal of Caribbean History*, 40, 2 (2006): 235-52. Rita Pemberton, "A Different Intervention: The International Health Commission/Board, Health, Sanitation in the British Caribbean, 1914-1930," *Special Issue of Caribbean Quarterly*, 49, 4 (2003): 87-103.

⁶⁴ Laurence, "The Development of Medical Services," 59-67. Nadine Joy Wilkins, "Doctors and Ex-slaves in Jamaica 1834-1850," *Jamaican Historical Review* 17 (1991): 19-30. Although Clyde is a medical doctor and amateur historian, he illuminated several interesting aspects of the practice of medicine in a colony that has not received much scholarly attention. David F. Clyde, *Two Centuries of Health Care in Dominica* (Lucknow: Prom Printing, 1980).

⁶⁵ Kenneth Kiple, "Cholera and Race in the Caribbean," *Journal of Latin American Studies* 17 (1985): 157-77. Kenneth Kiple and Brian T. Higgins. "Cholera in Mid-nineteenth Century Jamaica," *Jamaican Historical Review* 17 (1991): 31-47. David Killingray, "The Influenza Pandemic of 1918-1919 in the British Caribbean," *Social History of Medicine* 7, 1 (1994): 59-87. Susan Watts, "Dracunculiasis in the Caribbean and South America: A Contribution to the History of Dracunculiasis Eradication," *Medical History* 44, 2 (2000): 227-50.

⁶⁶ Bryan identified the GMS and Poor Relief services as important health resources for the

that Trinidadians similarly exerted significant effort to obtain GMS assistance, which was the only form of relief in a colony that refused to institute a Poor Law system.

While the analytical categories of race and class have naturally dominated the few extant works, scholars have only recently started to consider the implications of gender, in the slavery and post-emancipation periods.⁶⁷ In the first anthology devoted to health and medicine in the circum-Caribbean region, published in 2009, the contributions of the four historians of British colonies concentrated on women's health, infant welfare, and midwifery.⁶⁸ These essays established that freedom and enslavement and their legacies, along with colonialism's civilising mission, determined how women experienced health, as patients and practitioners in the medical marketplace.⁶⁹ These authors provided long overdue investigations into the importance of race, class, and gender in influencing the development of social policies and state control over female bodies, and the actions and reactions of women in the British West Indies. Chapter 3 contributes to the gender scholarship, in one area where the state healthcare archival sources provided relevant data, by introducing the efficacy of gender, race, and class in defining the health conditions aboard the ships transporting indentured East Indians to the Caribbean.

The generally thin scholarly literature on health and medicine the colonial British West Indies is a curious anomaly. Historians agree that medicine played an important role in the imperial project elsewhere in the Empire.⁷⁰ However, there has been a notable

Jamaican people. As established in this thesis, Trinidad did not institute a similar system of Poor Relief, which caused the GMS to evolve to a system of medicalised relief, housing many sufferers in medical institutions, who would have been candidates for almshouses or out-door relief in other colonies. Bryan, *The Jamaican People 1880-1902*, 161-90.

⁶⁷ While earlier studies may have acknowledged gender, the use of gender as the central analytical category has only recently appeared in the literature. See, for instance, Pedro Welch, "Gendered Health Care: Legacies of Slavery in Health Care Provision in Barbados over the period 1870-1920," *Caribbean Quarterly*, 49, 4 (2003): 104-20. Churchill examined British physician Hans Sloane's medical practice during his visit to the West Indies, analysing the early gendered and racial ideals in medical diagnoses and treatments. Wendy D. Churchill, "Bodily Differences? Gender, Race, and Class in Hans Sloane's Jamaican Medical Practice, 1687-1688," *Journal of the History of Medicine & Allied Sciences*, 60, 4 (2005): 391-444.

⁶⁸ De Barros, Palmer, and Wright, *Health and Medicine in the circum-Caribbean*.

⁶⁹ Inniss considered the professionalization of midwifery during slavery, introducing the implications of freedoms and race in the competition between white, African, free, and enslaved midwives. Challenger contributed to the scholarship on Contagious Diseases Acts by analysing the former slave colony of Barbados, while McCollin considered women's struggles for health in Trinidad and Tobago's changing post-war landscape. De Barros established the influence of gendered and racial ideals in the quest of officials to supplant traditional childbirth practices with medicalised western approaches, as early-twentieth-century reformers insisted that non-white women from the lower orders had failed to adopt civilised maternal behaviours, which resulted in high rates of infant mortality. Tara A. Inniss, "'Any elderly, sensible, prudent woman.' The Practice and Practitioners of Midwifery during Slavery in the British Caribbean," in De Barros et.al. eds., *Health and Medicine in the circum-Caribbean*, 40-52. Denise Challenger, "A Benign Place of Healing? The Contagious Diseases Hospital and Medical Discipline in Post-Slavery Barbados," in *ibid*, 98-120. Debbie McCollin, "World War II to Independence: Health, Services, and Women in Trinidad and Tobago, 1939-1962," in *ibid*, 227-48. Juanita De Barros, "Improving the Standards of Motherhood.' Infant Welfare in Post-Slavery British Guiana," in *ibid*, 65-94.

⁷⁰ The comprehensive literature reviews by Marks and Anderson confirm an extensive

change in the conception of the contribution of western public health and medicine from the time when Roy MacLeod first argued, in 1988, that they functioned as powerful “tools of Empire,” becoming a trademark of imperialism.⁷¹ David Arnold responded that biomedicine became more than a mere tool, gaining the dubious honour as “one of the most enduring and, indeed, destructive or distorting legacies of colonial rule.”⁷² Scholars have increasingly separated the rhetoric from the reality to determine the extent of medicine’s influence. Continuity is evident in the literature spanning diverse imperial territories: while the rhetoric promoted public health and medicine to tame the environment and civilise the people, the politico-economy restricted the scope of these initiatives. Mark Harrison, for instance, argued that the priority of maintaining stable rule in India required extensive collaboration between the British and Indian elites, which precluded the introduction of any public health policies that would stimulate negative responses from the people.⁷³ The actions of colonisers and colonised alike meant that western medicine did not replicate the forms from the United Kingdom.⁷⁴ Arnold established that India generally reacted, rather than introducing preventive medicine or addressing endemic ill-health, because the government was disinterested or unable to assume the responsibility for so many people.⁷⁵ Although colonial medicine developed as part of imperialism’s “mission and mandate,” many factors limited its scope and influence: Michael Worboys encouraged historians to look beyond the

scholarship on the integration of colonial medicine in the development of the imperial world. Warwick Anderson, “Postcolonial Histories of Medicine,” in John Harley Warner and Frank Huisman, eds., *Locating Medical History. The Stories and Their Meanings* (Baltimore: Johns Hopkins Univ. Press, 2006): 285-306. Marks, “What is Colonial about Colonial Medicine?” The recent essays by De Barros are some of the few exceptions where health in the British Caribbean is considered within a more contemporary analytical framework. Her studies demonstrate that professionals integrated British and Guianese ideals into the practice of medicine and public health. This resulted from the entry of locally-born black and coloured residents into the medical profession and the non-white middle class adopting the rhetoric of “sanitary enlightenment” as part of their initiative to “uplift” the lower classes. Many other health personnel plausibly blurred the racialised boundaries and functioned as active medical agents in the colonial project. Juanita De Barros, “‘Spreading Sanitary Enlightenment’: Race, Identity, and the Emergence of a Creole Medical Profession in British Guiana,” *Journal of British Studies* 42 (2003): 483-504. Juanita De Barros, “Sanitation and Civilization in Georgetown, British Guiana,” Special Issue of *Caribbean Quarterly* 49, 4 (2003): 65-86. Juanita De Barros, “‘To Milk or Not to Milk?’ Regulation of the Milk Industry in Colonial Georgetown,” *Journal of Caribbean History*, 31, 1-2 (1997): 185-208.

⁷¹ Roy MacLeod, “Introduction,” in Roy MacLeod and Milton Lewis, eds., *Disease, Medicine, and Empire. Perspectives on Western Medicine and the Experience of European Expansion* (London: Routledge, 1988), x, 1-2.

⁷² David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India* (Berkeley: Univ. of California Press, 1993), 3-4, 7-8.

⁷³ Mark Harrison, *Public Health in British India. Anglo-Indian Preventive Medicine 1859-1914* (Cambridge: Cambridge Univ. Press, 1994), 3-4, 60-98.

⁷⁴ Harriet Deacon, “Racial Segregation and Medical Discourse in Nineteenth-Century Cape Town,” *Journal of Southern African Studies*, 22 (1996): 293-6.

⁷⁵ David Arnold, “Disease, Medicine and Empire,” in David Arnold, ed., *Imperial Medicine and Indigenous Societies* (New York: St. Martin’s Press, 1988): 13-15. De Barros and Stillwell identified a similar disinterest in the British Caribbean, arguing that colonial elites were unwilling to invest in public health measures: medical resources were scarce in the colonies. Juanita De Barros and Sean Stilwell, “Public Health and the Imperial Project,” *Colonialism and Health in the Tropics*. Special Issue of *Caribbean Quarterly* 49, 4 (2003): 2-3.

“tropical medicine” campaigns to understand how the people used both indigenous and western medicine as part of their usual health regimes.⁷⁶ The distorting legacies were not restricted to unwelcome interventions, but also included the discriminatory exclusion of colonial residents from participating in the systems of western medicine.

The colonial state’s attempt to restrict the public’s access to western medical services is clearly evident in this study, which poses a challenge in determining how to explore the struggles. Waltraud Ernst recently criticized scholars for continuing to frame medicine as a tool of imperialism, thematically stressing resistance to colonial hegemony, or using the history of medicine to critique colonialism. She argued that scholars have failed, for more than 20 years, to answer Roy Porter’s simple question: “What is colonial about colonial medicine?”⁷⁷ Ernst suggested examining medicine’s relationship to other social debates, such as the contention over Britain’s Poor Laws. She posited that these policies, “although not specifically ‘medical’,” shaped how decision makers treated society’s disadvantaged at both ends of the Empire.⁷⁸ Ernst’s suggestion is relevant to the analysis of a plantation society, where the structure of the colony sustained a culture of poverty and did not foster the growth of the “mixed economy of welfare,” which was so important to the metropolitan model.⁷⁹ While Britain’s 1601 Elizabethan Poor Laws (as amended over time) declared the obligations of the state to provide for the poor, and created its network of health-related organisations, plantation slave societies had never instituted similar systems. During the advent of Chadwickian public health reforms, from the 1840s, plantation colonies were consumed with their arduous socio-economic readjustments after emancipating the slaves.⁸⁰ Nonetheless, many British officials attempted to introduce the metropolitan ideology on the state’s obligation to maintain the health of the public and build the infrastructure to deliver the services. This created many conflicts between the white Creole and British elites over the obligation of the state to provide medical services and the control over those resources.⁸¹

⁷⁶ Michael Worboys, “The Colonial World as Mission and Mandate: Leprosy and Empire, 1900-1940,” *Osiris*, 15 (2001): 207-8.

⁷⁷ Waltraud Ernst, “Beyond East and West. From the History of Colonial Medicine to a Social History of Medicine(s) in South Asia,” *Social History of Medicine*, 20, 3 (2007): 505-24. Ernst explained that Porter asked the question at the Society for the Social History of Medicine (SSHM) meeting in 1986. The SSHM president reiterated the question in 1997. See, Marks, “What is Colonial about Colonial Medicine?”

⁷⁸ Ernst, “Beyond East and West,” 507-11.

⁷⁹ Historians of the British welfare state for the metropole have established the importance of the “mixed economy of welfare” in providing medical and economic relief services to the poor, through a combination of the Poor Law infrastructure, voluntary charity, and the informal sector. Bernard Harris, “Introduction: The ‘Mixed Economy of Welfare’ and the Historiography of Welfare Provision,” in Bernard Harris and Paul Bridgen, eds., *Charity and Mutual Aid in Europe and North America since 1800* (New York: Routledge, 2007), 1, 6.

⁸⁰ Historians have established that there were many readjustment struggles in the unsettled period following emancipation. David Vincent Trotman, *Crime in Trinidad. Conflict and Control in a Plantation Society 1838-1900* (Knoxville: University of Tennessee Press, 1986), 35-69. Donald Wood, *Trinidad in Transition*. Holt, *The Problem of Freedom*.

⁸¹ Cunningham and Andrews established that colonial elites and indigenous peoples could choose to adopt, ignore, or contest western medicine. Andrew Cunningham and B. Andrews, “Introduction: Western Medicine as Contested Knowledge,” in *idem*, eds., *Western Medicine as Contested Knowledge* (Manchester: Manchester Univ. Press, 1997), 1-23.

The editors of the anthology on healthcare in the circum-Caribbean, discussed above, argued that the on-going and diverse conflicts over western medicine differed from the resistance identified by historians in other parts of the British Empire. Western medicine had become firmly rooted in the Americas several centuries earlier than in Asia or Africa. The increased medical activities accompanying nineteenth-century colonialism were not a “colonizing imposition” in the Caribbean. The conflicts between the local elites and colonisers were struggles for control, rather than resistance.⁸² Trinidad’s GMS was created in this conflictive environment. It was not a simple colonial variant of the system in the metropole, but an amalgam of practices and ideas from the Caribbean, Europe, and India, influenced by the doctors’ training in British medical schools and their sojourns in other colonies.

Trinidad’s system of state healthcare did not adopt indigenous medical practices, but the system was predicated on the assumption that the public would use traditional forms of healing outside the realm of the GMS healthcare. In as much as this is the first study of post-emancipation state healthcare in a British West Indian colony, there is a similar dearth in the historical literature on indigenous medical practices although, for several decades, anthropologists and sociologists have been studying the continuity of African systems of health and healing, from slavery to the present day.⁸³ Perplexingly, in light of the importance of the Indian diaspora, these studies overlook the history of Indian systems of healing and medicine.⁸⁴ Nonetheless, despite this long-standing interest of social scientists in Afro-Caribbean systems of healing, few historians have turned their attention to indigenous medical practices during slavery,⁸⁵ although post-emancipation social and cultural historians have established the resilience of these traditional systems.⁸⁶ The colonial medical marketplace may have been much more complex than the literature leads us to believe. This study concentrates on the colonial

⁸² De Barros, Palmer, and Wright, “Introduction,” 5-6.

⁸³ Laguerre’s monograph on the persistence of African folk medicine in the Caribbean is recognised as initiating the multi-disciplinary interest in the topic. Michel Laguerre, *Afro-Caribbean Folk Medicine* (Mass: Bergin and Garvey, 1987). Payne-Jackson and Alleyne’s recent study concluded that many modern-day Jamaicans seamlessly integrate Jamaican “folk” medicine and western therapeutics into their health regimes. Arvilla Payne-Jackson and Mervyn C. Alleyne, *Jamaican Folk Medicine. A Source of Healing* (Jamaica: Univ. of West Indies Press, 2004). Brian M. du Toit, “Ethnomedical (Folk) Healing in the Caribbean,” in M. Fernandez Olmos and L. Paravisini-Gebert, eds., *Healing Cultures. Art and Religion as Curative Practices in the Caribbean and its Diaspora* (New York: Palgrave, 2001): 19-28.

⁸⁴ De Barros, Palmer, and Wright, “Introduction,” 12, *passim*. For one of the few studies available to-date, see Noor K. Mahabir, *Medicinal and Edible Plants used by East Indians of Trinidad and Tobago* (Trinidad: Chakra, 1991).

⁸⁵ Juanita De Barros, “‘Setting Things Right’: Medicine and Magic in British Guiana, 1803-1834,” *Slavery and Abolition* (2004): 28-50. Jerome Handler and J. Jacoby, “Slave Medicine and Plant Use in Barbados,” *Journal of the Barbados Museum and Historical Society*, 41 (1993): 74-98. Handler argued that the white residents viewed the indigenous slave medical practices with scepticism. Jerome S. Handler, “Slave Medicine and Obeah in Barbados, Circa 1650 to 1834,” *NWIG*, 74, 1-2 (2000): 57-90.

⁸⁶ For instance, Johnson and Moore demonstrated the complexity of Obeah’s intertwined spiritual, cultural, and medical belief system and practices, and the dependence of many Jamaicans on Obeah. Johnson and Moore, *Neither Led Nor Driven*, 14-95. Similarly, Bryan described the persistence of the Afro-Jamaican indigenous systems of healing, which he argues were often the healthcare preferred by the people. Bryan, *The Jamaican People*, 177-87.

state's system of western healthcare services which, by definition, are outside the realm of indigenous practices. However, as concluded below (in Chapter 6), Trinidadians relied extensively on non-western therapeutics: the GMS system often functioned as the alternative source of healthcare. Traditional African and Indian systems of healthcare served an important function in colonial society, although the absence of scholarly studies precludes an understanding of how the residents used these systems to maintain their health and relieve their suffering.

White Elites, Crown Colony Rule, and Trusteeship

Many of the struggles over state healthcare in Trinidad occurred within the upper strata of colonial society. Each British West Indian colony had two white elites: the native-born Creoles and the sojourning British colonial officials and bureaucrats.⁸⁷ The locally-born white Creoles are referred to as the 'Creoles' or the 'white Creole elite,' which embodies their socio-economic standing and biological moniker of 'colour' within one definition, including whites of European descent from France, Spain, Britain, Germany, and other countries.⁸⁸ In the immediate post-emancipation period, ethnic rivalries often divided the elite, such as the struggle between the Roman Catholic French-Creoles and Protestant British-Creoles over religious ascendancy, although Bridget Brereton established that the divisions had dissipated by the end of the century.⁸⁹ In the numerous struggles over the GMS, there was no discernable difference in the attitudes amongst the influential members of Creole society, who were remarkably united in matters involving state healthcare. Instead, the struggles usually pitted some, but not necessarily all, British officials and GMS doctors against the Creoles. These two factions maintained a complex relationship, which ranged from collaborative to adoptive to conflictive at times, although consensus usually prevailed on economic and political matters, which makes the enduring struggles over the GMS an important anomaly during the century.

The white Creole elites remained the dominant minority, controlling the economy, capital, land, and labour in the colonies. Despite their power to determine the fate of so many people for centuries, Howard Johnson argued that the white elites have been marginalised in the historiography and invited historians to write the upper classes back into the colonial histories.⁹⁰ The essays by scholars of Jamaica, British Guiana, and

⁸⁷ The composition of the elites differed between the colonies. For instance, British Guiana's Creole elite was mostly of British descent. Moore, "The Culture of the Colonial Elites," 96.

⁸⁸ Bridget Brereton, "The White Elite of Trinidad, 1838-1950," in Johnson and Watson (eds.), *The White Minority in the Caribbean*, 33. To simplify the terminology in this study, the taxonomy of hyphenating 'Creole' has not been adopted, although historians of Trinidad often use French-Creole, African-Creole, and Indo-Creole. The decision to restrict the use of the term 'Creole' to the native-born white elite is meant to be a simple method of differentiating the elite Creoles from the white British expatriate colonial officials and bureaucrats.

⁸⁹ Brereton argued that the animosities between the French and English Creoles were muted by 1870 and blurred by the end of the century. Brereton, *Race Relations*, 44-6. Similarly, Singh showed that cohesion and agreement prevailed on policy matters between the ruling class elites (the commercial barons, planters, and government administrators) during the period of his study, beginning in 1917. Singh, *Race and Class Struggles in a Colonial State*, xx.

⁹⁰ Howard Johnson, "Introduction," in Howard Johnson and Karl Watson (eds.), *The White Minority in the Caribbean* (New Jersey: Markus Wiener, 1998), ix-xvii.

Trinidad identified many similarities in the worldviews of the white elites. Patrick Bryan and Brian Moore characterised the white elites in Jamaica and British Guiana as wielding extraordinary power, which was the inverse of their insignificant numbers. These elites never constituted more than 2.8% of the population in their colonies: their numbers declined to below 2.0%, between 1841 and 1911.⁹¹ Trinidad's white elite is estimated to be about 1.5% of the total population in 1907, which is consistent with the statistics provided by Moore and Bryan.⁹²

The white Creole elites developed culturally rich societies.⁹³ Whiteness remained the inalienable criterion for membership. Bryan concluded that Jamaica's elite formed a closed and caste-like society to isolate themselves from the "combustible" coloured people," ostracising anyone who showed sympathy to non-whites or their causes. Ostracism represented social death in a society where the Creoles controlled the social and cultural institutions.⁹⁴ Brereton described Trinidad's white elite in a similar manner, stating that their worldviews reflected pride in their aristocratic traditions, with membership in their closed society restricted by social and racial purity.⁹⁵ Keith Laurence concurred with Brereton that the plantocracy was not only self-interested, but also disinterested in the well-being of its subject peoples.⁹⁶

The Colonial Office believed that the Creole elites would not rule impartially and interjected its own white elite into each colony: the British rulers and administrators. This set the conditions for an extraordinarily complex relationship, although the Creoles and Britons were hypothetically unequal partners. Britain instituted direct rule, from 1831 to 1925, designating Trinidad a Crown Colony with a nominated legislature.⁹⁷ As stressed by Brereton, Crown Colony rule was predicated on the principle of trusteeship: the Crown would protect the masses from exploitation by the landed class.⁹⁸ However, the ability to sustain plantation society colonialism required significant complicity between the Creole elite, British administrators, and the senior trustees: the governor and Colonial Office.⁹⁹ Porter argued that London realised that it needed to collaborate

⁹¹ White Jamaicans represented 1.88% of the population in 1911 and the white Guianese were 1.6% in 1891. Bryan, "The White Minority in Jamaica," 116-32. Moore, "The Culture of the Colonial Elites," 97, 111.

⁹² Trinidad's censuses and vital statistics did not enumerate residents by ethnicity or colour, which makes it difficult to quantify precisely the number of white residents in the colony. However, in response to a question in the House of Commons in 1908, the Colonial Office stated that a "liberal estimate" of the resident Europeans (whites) was 5,000 people during 1907. Based on the Registrar-General's statistics of about 344,000 colonial residents that year, white Trinidadians would have constituted 1.5% of the population. 1908 LC #110, *Vital Statistics. Annual Report of the Registrar-General for 1907-08*, 3. [Hereafter, *Registrar-General AR.*] CO 295-455 (1909) #10150, *Indentured Labourers*. Minutes.

⁹³ Brereton, *Race Relations*, 53-5, 60-1. Moore, "The Culture of the Colonial Elites."

⁹⁴ Bryan, "The White Minority in Jamaica," 119-21.

⁹⁵ Brereton, *Race Relations*, 53-5, 60-1. Brereton, "The White Elite of Trinidad," 32-70.

⁹⁶ Brereton, *Race Relations*, 30-1. Laurence, "The Development of Medical Services," 60-2.

⁹⁷ Hewan Craig, *The Legislative Council of Trinidad and Tobago* (London: Faber & Faber, 1951), 1.

⁹⁸ Bridget Brereton, *Law Justice and Empire. The Colonial Career of John Gorrie 1829-1892* (Jamaica: University of West Indies Press, 1997), xiv-xv.

⁹⁹ Selwyn D. Ryan, *Race and Nationalism in Trinidad and Tobago: A Study of*

with the local elites, but this cooperation did not preclude many tensions. While differences prevailed, the elites were united by their shared belief in their racial superiority.¹⁰⁰ However, Bryan and Brereton agreed that the Creoles resented the British officials, who symbolised the “visible embodiment of imperial domination.”¹⁰¹ Nonetheless, the powerful Creoles often drew the sojourning Britons into their elitist culture. According to Bryan, as a rule, “however open-minded the bureaucrat was at the time of his arrival in colonial society, his attitudes came to resemble closely those of the dominant local white segment, especially with regard to the black and coloured population.”¹⁰² If careering Britons did not share these racist opinions, they risked being ostracised from society. As established in this study, the governor often set the pace in determining the alliances between the Britons and Creoles and they changed regularly. The shifting power remained important in the struggles over the GMS, to 1916.

Brereton purposefully dispelled the illusion that Crown Colony rule protected the people from oppression. She characterised the “great myth” that “Governors and officials were impartial administrators, and at the same time, the special protectors of the poor.” Many formed close relationships with prominent Trinidadians, “making it improbable that any but the strongest-willed Governor would oppose them.”¹⁰³ David Trotman echoed this sentiment: “The herculean task of defying both implicit ideology and explicit social and economic power in order to protect the powerless required an individual with exceptional qualities.” To Trotman, the governor had to “rise above the insidious racism” at the root of the system.¹⁰⁴ Brereton and Trotman stressed that the Creole elite’s worldview continued to be framed by the traditions of slavery and plantation society.¹⁰⁵

This study establishes that autocratic governors and crusading officials and doctors periodically emerged to challenge the *status quo* in matters involving the health of the people. As such, the protracted struggles of several careering officials are often at the centre of this study: the conflicts over the function of the GMS were an important part of the creolisation of state healthcare. The Colonial Office constantly transferred colonial governors and administrators to new posts in the Empire. Hall’s study of Edward Eyre’s career demonstrated the way in which historical actors were a product of the imperial system and their experiences in many different colonies, as much as the colonies were influenced by the ideas which officials brought with them. Lester and Lambert argued that careering officials connected diverse locations in the Empire as they transported ideas to and through the colonies.¹⁰⁶ These individuals could choose to introduce new ideas and extend their work from previous colonies, or simply acculturate to the local society and have a trouble-free administration. Numerous careering officials passed through Trinidad, influencing the development of the GMS over the years, as they

Decolonization in a Multiracial Society (Toronto: Univ. of Toronto Press, 1972), 18-19.

¹⁰⁰ Porter, “Introduction: Britain and the Empire in the Nineteenth-Century,” 17. Porter made this argument in the context of the British Empire, including the West Indies.

¹⁰¹ Bryan, “The White Minority in Jamaica,” 129. Brereton characterised the tensions as an “estrangement” between the Creole elite and British officials, Brereton, *Race Relations*, 43-7.

¹⁰² Bryan, “The White Minority in Jamaica,” 129. Johnson, “The White Minority,” xv.

¹⁰³ Brereton, *Race Relations*, 24-6, 35-6.

¹⁰⁴ Trotman, *Crime in Trinidad*, 32-3.

¹⁰⁵ Brereton, *Race Relations*, 24-6, 35-6. Trotman, *Crime in Trinidad*, 35-69.

¹⁰⁶ Lambert and Lester, “Imperial Spaces, Imperial Subjects,” 2, 8-13.

imported different ideas from other colonies about state healthcare.

Trinidad's government was a single-chamber nominated Legislative Council, with the seats evenly divided between "Official" and "Unofficial" representatives.¹⁰⁷ The latter were private citizens from the propertied and wealthy class, appointed by the Colonial Office for a fixed term on the recommendation of the governor, and these men retained their seats at the pleasure of the governor. These men were almost exclusively white.¹⁰⁸ The "Officials" were senior career civil servants and usually British. The governor had limited authority over senior civil servants, lacking the power to hire or fire them, but he could suspend a senior employee pending an inquiry by the Colonial Office.¹⁰⁹ Officials and Unofficials remained subordinate to the governor and were expected to support his wishes. In the event that Unofficials attempted to pass any unpalatable legislation, the governor could veto the measure, or cast his dual vote to give the Britons a majority.¹¹⁰ However, the tendency for the Creoles and Britons to cooperate meant that the veto powers were rarely used in Trinidad.¹¹¹ The Colonial Office maintained the ultimate control through its power to disallow any law which an errant governor may have approved.¹¹² As established below (in Chapter 5), on rare occasions individual governors acted counter to the wishes of Whitehall, necessitating Colonial Office intervention.

Perhaps due to the conflicts surrounding the GMS, the Surgeon-General function did not include a seat on the Legislative Council, until the early 1890s. With no formal authority in the government, the Surgeon-General relied on the governor to represent the GMS. Senior Unofficial Dr. Louis de Verteuil spoke with authority on medical matters: he was a critic of the GMS and long-standing nemesis of the longest serving

¹⁰⁷ The constitutional structure for each government in the British Empire is summarised annually in *The Colonial Office List*. See, for instance, *The Colonial Office List for 1881, Rules and Regulations for Her Majesty's Colonial Service*, 272-3.

¹⁰⁸ The two non-white appointees on the Legislative Council were coloured barrister Henry Alcazar, appointed in 1894, and black Cyrus Prudhomme David, appointed in 1904. "Mr. David's Appointment," *The Mirror*, 15 April 1904. Samaroo's short biography of David and his legal and political career analysed David's many struggles with the Legislative Council. Brinsley Samaroo, "Cyrus Prudhomme David – A Case Study of the Emergence of the Black Man in Trinidad Politics," *Journal of Caribbean History*, 3 (1971): 73-89.

¹⁰⁹ *The Colonial Office List for 1881*, 272.

¹¹⁰ *The Colonial Office List for 1881*, 272-3. By the end of the century, Legislative Council members had grown to eleven Officials and eleven Unofficials, with the governor retaining a double vote. Craig, *The Legislative Council*, 28.

¹¹¹ Moore stated that Trinidad's governor did not need to veto any Legislative Council decisions. However, as established below (in Chapter 5), Whitehall intervened on several occasions to overturn decisions regarding the GMS. Additionally, a brief analysis of Trinidad's ordinances reveals several that the Colonial Office disallowed at least seven laws, between 1842 and 1858. Most of these ordinances involved immigration or master-servant laws. After 1858, Whitehall did not cancel any legislation, which suggests a more collaborative relationship by Trinidad's Legislative Council and the Crown trustees. For the detailed list of legislation, see, *Law Commission of Trinidad, Laws of Trinidad and Tobago. Chronological and Alphabetical Lists of Ordinances and Acts 1832-1983* (Trinidad: Law Commission, 1985). Moore, *Racial Ideology*, 146. Bryan argued that Jamaica's governors did not use their veto power to overrule that colony's white oligarchy. Bryan, "The White Minority," 118.

¹¹² The hierarchy of authority was printed each year in *The Colonial Office List*.

Surgeon-General, Samuel L. Crane (1871-93).¹¹³ Creole society could make an uncooperative expatriate socially unwelcome and their colleagues in the Legislative Council could make the official economically insecure by reducing his salary.¹¹⁴ Council thus possessed the political and social power to marginalise disobliging Britons. This control will be shown to be important during the struggles to institute medical and health reforms in Trinidad.

Overview of the Chapters

Throughout this study, the imperial project in Trinidad continued to be controlled by the white Creole and British decision makers, who alternatively cooperated or disagreed about the government's involvement in the health and well-being of its subject peoples. These struggles were constantly reshaped by trans-national forces from India, London, other colonies, and the Atlantic community. Chapters 2 and 3 examine the ideological underpinnings of Trinidad's policies for the health of its peoples, Chapters 4 and 5 consider the struggles over the form and function of the GMS, and Chapter 6 considers how the Trinidadian peoples interacted with the GMS doctors and system.

Chapter 2, *Population Manipulations: To Neither Whiten nor Blacken Trinidad*, explores the plantocracy's valuations of the bodies of its African and East Indian subject peoples, which remained at the root of the tensions over the state's involvement in their health and well-being, to 1916. Many legacies of slavery continued to define this plantation society and particularly the notion that non-white labouring bodies were expendable commodities. Trinidad's planters historically dealt with the slaves' inordinately high mortality rates by purchasing new bodies, in lieu of maintaining their human chattel in a state of health and breeding the next generation of labourers within the colony. The plantocracy's penchant to import the next generation of labourers, rather than investing in the health of the people, was facilitated by making the program of indentured immigration the central axis of the colony's policy for developing the future colonial population. This policy had significant repercussions for the East Indian and African populations, which are ascertained by a quantitative analysis of the demographic growth of each sector. This analysis addresses an important deficiency in the literature by establishing the point in time when the East Indian and African sectors recovered, demographically, from the brutality of enslavement and indenture, and overcame the systemic barriers to natural growth created by the imperial project, to become self-sustaining populations.

The migratory indentured East Indians were one of many nineteenth-century diasporas of millions of British subjects, who hoped to better their lives by travelling to new homelands. However, the ocean voyages were so perilous and unhealthy that the Imperial government legislated health protections to increase the oceanic survival rates. Trinidad's responsibility for the health of its indentured East Indians began half way across the globe in the Coolie Depots in Calcutta and Madras. Chapter 3, *Maritime Public Health: Imperial Values and Migrant Bodies, 1840-1872*, compares the health

¹¹³ L.A.A. de Verteuil, *Trinidad: Its Geography, Natural Resources, Administration, Present Conditions and Prospects*, 2nd ed. (London: Cassell and Company, 1884), 207-10.

¹¹⁴ Brereton, *Race Relations*, 27, 29, 31, 43-4.

policies enacted for two populations of assisted migrants, white Britons and indentured East Indians, as they travelled as wards of the Imperial government to the colonies. The conflation of Imperial ideas about each race's level of civilisation and capability for improvement became inexorably intertwined with the medico-moral sanitary order enacted aboard the different fleets of ships. This chapter establishes the profound difference in the attitudes of the colonial governments about the bodies of their migrants, depending if they were white British settlers or indentured Indians, and the direct connection between racial ideals and the public health frameworks aboard the ships. A quantitative mortality analysis confirms that many Indian bodies continued to be sacrificed during the journeys, as the public health measures failed to protect the health of this seaborne population.

After establishing the nature of the colonial state's attitudes regarding the health of its subject peoples, the subsequent three chapters explore the contested evolution of the Government Medical Services and the public health and medical services that it provided to the residents. Chapter 4, *"Take up the White Man's Burden ... and bid the sickness cease": Creolising Trinidadian Colonial Healthcare, 1870-80*, considers the tumultuous creation of the GMS during the 1870s, as the government struggled to define its involvement in the health and well-being of its subject peoples, amidst pressures from Imperial world governments and the Atlantic community. Trinidad accepted the Colonial Office's dictate to assume the responsibility to provide medical care for the indentured workers on the estates, as part of Britain's civilising mission. However, the plantocracy vigorously contested the imperial White Man's Burden to introduce western medical services for its population of impoverished free African and (non-indentured) East Indian peoples. The irreconcilable worldviews of the British and Creole elites and the constantly shifting alliances between them forced the GMS to evolve as a negotiated entity, which never fully satisfied the elite decision makers or the Indo- and Afro-Trinidadian public.

The economic strife caused by the severe global depression in the sugar markets and rampant ill-health motivated tens of thousands of Trinidadians to seek government healthcare services each year during the 1880s, which increased the government's expenditures substantially. The desire to reduce the GMS's expenses heightened the tensions over the state's obligation to address the endemic ill-health and poverty amongst the people, which plantation society colonialism had created. The turmoil over the GMS and the question of Poor Relief turned into a nasty conflict amongst the white elites. Chapter 5, *Imperial Trusteeship and Colonial Healthcare, 1880-1891*, investigates the escalation of these conflicts, to the point where the Colonial Office intervened and used its infrequently exercised powers of trusteeship to protect the subject peoples from arbitrary rule. The trustee's unusual intrusions resulted from the actions of two crusading officials within the colony, who challenged the *status quo*. Surgeon-General S.L. Crane's crusade is juxtaposed beside Chief Justice John Gorrie's campaign to reform the justice system. As careering imperial officials, each man's worldview and enthusiasm for the imperial trusteeship to protect the subject peoples had been shaped by their experiences in the Empire. While the form of plantation society colonialism remained unchanged, the reforms to state healthcare continued to deal with the effects of ill-health and poverty, rather than eradicating the causes.

Chapter 6, *The Civilising Mission: GMS Policies and Patients, 1891-1916*, considers the patients who were the object of the western medical initiatives in the civilising mission. It is possible to reconstruct some experiences of the caregivers and patients to ascertain the nature of their medical encounters with the colonial state's GMS organisation and its doctors. As many of these sufferers were extremely poor, this investigation probes how they obtained medical attention from government doctors by qualifying as pauper, poverty, or fee-for-service patients. While the colonial officials continually portrayed the GMS patients as paupers who had failed to embrace British civilisation and its influences, the Indian and African residents demonstrated remarkably civilised behaviours, integrating western and traditional healthcare into their strategies to cope with the effects of plantation society colonialism.

Archival and Primary Sources

The research for this project was conducted at the National Archives of Britain, Trinidad, and Scotland (Edinburgh), the Commonwealth Institute in London, England, and the Rockefeller Archives in New York. The archival collection for the Colonial Office provided extensive files of the correspondence between officials and citizens in London, Trinidad, and other colonies. The colonial administrative structure required each senior official to submit lengthy annual reports. The reports by each Surgeon-General, Registrar-General, and Protector of Immigrants recorded the major events and developments during the year and often revealed the anxieties of each administration. Trinidad's Legislative Council published voluminous reports each year on many diverse topics relevant to colonial governance. These and other archival sources have been interrogated with the knowledge that they are exceedingly useful, but often problematic. The records continually mute the voice of the Trinidadian public and patients in the GMS system, while privileging the view of the colonial officials and the Creole elite.

The British Parliamentary Papers have been an invaluable source of information about the local and global struggles which heightened to the point of meriting imperial intervention or parliamentary interest. These papers also contain the annual reports of the Colonial Land and Emigration Commission and the annual series of Blue Books. The proceedings of the numerous commissions and formal inquiries convened by the India or Imperial governments, and their associated digests of testimony by witnesses, provide many insights, often inadvertently, into the day-to-day living conditions and health of the Trinidadian public and the indentured East Indians.

The Trinidad and British commercial newspapers offered the commentaries and editorials of a diverse group of people over time. Two Trinidadian newspapers have been used at length, the anti-government paper, *The Mirror*, and the pro-government *Port-of-Spain Gazette*. GMS and private physicians often corresponded with the medical and commercial press on issues of Atlantic or imperial significance, including *The British Medical Journal*, *The Lancet*, and *The Times*. Although not numerous in quantity, the publications of residents, doctors, travellers, and other interested parties have provided important revelations on health and medical matters in the colony.

– Chapter 2 –

Population Manipulations: To Neither Blacken nor Whiten Trinidad

After the end of slavery in 1838, the Imperial, India, and colonial governments collaborated to sponsor the migration of indentured East Indian labourers to Britain's tropical sugar-producing colonies. Verene Shepherd recently reminded historians that this diaspora changed the ethno-racial composition in the host colonies and, in particular, Trinidad and British Guiana.¹ The transformation of Trinidad's population in a mere seven decades was significant. In 1825, Trinidad's residents consisted of 8% white and 92% black and coloured persons.² Between 1845 and 1916, the plantocracy sponsored the immigration 143,939 East Indians.³ By 1907, the African sector had decreased in relative numbers to represent a mere 68.5%, whites had become a smaller minority at 1.5%, and the East Indian diaspora accounted for 30% of the population.⁴ To-date, little scholarly attention has been directed to understand how migration and natural increase contributed to the changes in the Afro- and Indo-Trinidadian sectors. This chapter addresses this historiographic lacuna by exploring the policies of the white Creole elite about the development of its subject peoples, followed by a quantitative analysis of the policy outcomes, comparing the natural increase and migration of the Africans and East Indians in the forty-year period between the 1881 and 1921 censuses.⁵

Trinidad's plantocracy demonstrated little interest in encouraging the long-term growth of the African and Indian sectors. This chapter's central argument is that the colony's policies for population development intended to neither whiten nor blacken Trinidad, by concentrating on creating the East Indian sector exclusively by immigration, while marginalising Afro-Caribbean immigration, and placing obstacles in the way of natural increase for both sectors, which contravened the known principles for establishing self-sustaining populations. The traditional economic justification of slavery continued to underpin Trinidad's policies, and indentured immigration functioned as the new mechanism to satisfy the planters' insistence that it was cheaper to buy expendable labouring bodies, rather than breeding the next generation of estate workers, although planters now purchased the East Indians' capacity for labour, rather than their bodies. The white Creole elite's disinterest in investing in the health and well-being of its subject peoples is a thematic argument in this study. This chapter establishes one of the major ideological underpinnings of that disinterest, demonstrating how the political will to neither whiten nor blacken Trinidad was codified in many legal ordinances.

¹ Verene Shepherd, *Maharani's Misery. Narratives of a Passage from India to the Caribbean* (Jamaica: University of West Indies Press, 2002), 5.

² John enumerated 3,214 white and 38,960 black and coloured Africans in Trinidad in 1825. A. Meredith John, *The Plantation Slaves of Trinidad, 1783-1816: A Mathematical and Demographic Inquiry* (Cambridge: Cambridge Univ. Press, 1988), 39.

³ G.W. Roberts and J. Byrne, "Summary Statistics on Indenture and Associated Migration affecting the West Indies, 1834-1918," *Population Studies*, 20, 1 (1966): 127.

⁴ Trinidad's census did not record "race" or colour, making it difficult to quantify the size of the white minority. In 1908, the Colonial Office staff estimated the white residents at 5,000, or 1.5% of the population. Trinidad's vital statistics enumerated 344,000 residents that year. 1908 LC #110, *Registrar-General AR*, 3. CO 295-455 (1908) #10150, *Indentured Labourers*. Minutes.

⁵ The availability of annual reports by the Registrar-General, Surgeon-General, Protector of Immigrants, and the censuses determined the start date of 1881. The analysis ends at the 1921 census, which is the year when the last indentured East Indian left the colony.

This chapter makes two new contributions to the scholarship, responding to the critics of those who debate if indenture was neo-slavery or if East Indians benefited materially, as introduced above (in Chapter 1). David Eltis, for instance, counselled historians to question the values of the host colonies, while David Northrup argued that rigorous studies must be performed before claiming that the brutality of indenture approached slavery.⁶ This analysis of natural increase establishes that Trinidad's East Indian sector was constituted with an even larger gender disparity than the slave population which it replaced. The slaves' inability to become self-sustaining populations had been an important reason to end slavery, but emancipation did not eradicate the problem. Afro-Trinidadians required five decades of freedom to recover from the gender imbalance and the trauma of slavery, before experiencing a natural increase. However, Indo-Trinidadians surmounted their sexual disparity and begin to increase by natural means during the 1890s. Considerable differences existed between the two populations living side by side in one colony: East Indians and Africans had strikingly different rates of births and deaths. This study concludes that the trauma of slavery adversely affected the African bodies' capacity for natural increase for a comparatively longer period than the one experienced by the East Indians during and after indenture. Second, this study establishes that a substantial number of so-called 'free' East Indians illegally escaped from Trinidad each year. Although colonial and metropolitan officials claimed that their civilising mission created a contented and prosperous Indo-Trinidadian population, while the Africans regressed into barbarism, the migration patterns prove otherwise. Africans and East Indians alike surmounted the barriers and migrated at will, despite the laws enacted by the colony to restrict the immigration of Afro-Caribbean peoples and prevent the emigration of East Indians. Much of the wealth accumulated by the Indians was earned after their escape to other locations, notably the Spanish Main.

Ideological Underpinnings of Trinidad's Post-Emancipation Population Policies

Richard Sheridan and Philip Curtin established that slavery had been predicated on the planters' belief that importing new bodies was the cheapest way to acquire labourers, rather than breeding a population of labourers locally.⁷ Despite the pressure for pro-natalist measures during the ameliorative period in the British West Indies, Barbados was the only colony to record a positive natural increase amongst its slave population.⁸ The tenet of importing new bodies to replenish the labourforce continued to dominate the plantocracy's consciousness in the post-emancipation period. Brian Moore identified

⁶ David Eltis, "Free and Coerced Migrations from the Old World to the New," in David Eltis, ed., *Coerced and Free Migrations. Global Perspectives* (California: Stanford Univ. Press, 2002), 37-9, 48. David Northrup, *Indentured Labor in the Age of Imperialism* (New York: Cambridge Univ. Press, 1995), 4-6.

⁷ Richard B. Sheridan, *Doctors and Slaves: A Medical and Demographic History of Slavery in the British West Indies* (Cambridge: Cambridge Univ. Press, 1985), 140. Philip D. Curtin, "Epidemiology and the Slave Trade," *Political Science Quarterly*, June 1968: 215-16.

⁸ Hilary McD Beckles, *Natural Rebels. A Social History of Enslaved Black Women in Barbados* (New Jersey: Rutgers Univ. Press, 1989), 90-114. Heather Cateau, "A Question of Labor: British West Indian Plantations, 1750-1810," *Plantation Society in the Americas*, 6, 1 (1999): 65-94.

the resultant effects of the persistence of this idea in his study of British Guiana. He argued that the Guianese-born African sector did not have the ability to reproduce its numbers and thus progressively decreased in size during the five decades after emancipation. Moore attributed this unnatural depletion of the population to the policies instituted by the plantocracy, based on “antediluvian slavocratic ideas that labour was expendable and easily replaceable by large numbers of fresh importations.”⁹ Trinidad’s white Creole elite never relinquished its similar belief that African bodies were expendable commodities, which had a direct bearing on their post-emancipation policies regarding the African and East Indian populations.

In their quest to explain the universe as a series of natural laws, Enlightenment thinkers identified the two factors determining how populations increase their numbers: net migration and ‘natural increase.’ Natural increase is a population’s ability to reproduce its numbers naturally, by having an excess of births over deaths. This is normative and usually occurs, except in crises such as prolonged dearth and natural disasters. Thomas Malthus was an important Enlightenment intellectual who influenced Britain’s nineteenth-century ideologies on developing its populations in the age of imperial expansion. In *An Essay on the Principle of Population* in 1798, Malthus argued that civilisation’s recent progress and prosperity had allowed some populations to outpace the laws of natural increase and grow too rapidly, with a detrimental effect if too many people competed for limited resources. He called for governments to take action when the rapid pace of progress pre-empted nature’s checks and balances on excessive growth.¹⁰ He supported the redeployment of free populations within the Empire, but stressed that equal numbers of men and women needed to be moved to destinations where they could better their lives.¹¹ As argued below (in Chapter 3), these tenets influenced government-sponsored migration programs during the century, but would be selectively applied at times, depending on the race of the people.¹² Malthus was incensed when the pro-slavery faction used his treatise to justify slavery. He used the West Indian slave populations’ inability to reproduce their own numbers as evidence that slave owners contravened the natural laws of the universe in two important ways. The planters’ demand for males had purposefully degraded the moral conditions of the slaves by creating unnaturally male-dominated populations.¹³ The slave owners then forced their human possessions to live below normal levels of subsistence: this interfered to an

⁹ Moore connected the broader policies on land and labour to the problems in the growth of the population and the African Guianese-born population’s decrease in size, between 1841 and 1891. Brian Moore, *Cultural Power, Resistance, and Pluralism. Colonial Guyana, 1838-1900* (Montreal: McGill-Queen’s University Press, 1995), 8, 11, 18.

¹⁰ T.R. Malthus, *An Essay on the Principle of Population, as it Affects the Future Improvement of Society* (London, 1798), 1-18, 279-302.

¹¹ For an insightful explanation of the influence of Malthusian policies in defining the complex nature of “freedom,” see, Thomas C. Holt, *The Problem of Freedom. Race, Labor, and Politics in Jamaica and Britain, 1832-1938* (Maryland: Johns Hopkins Univ. Press, 1992), 71-9.

¹² As argued below (in Chapter 3), the program of assisted-migration to send white Britons to the Australian colonies was predicated on equal numbers of male and female migrants, while the programs sending East Indians to the West Indies included a minimal number of women.

¹³ T.R. Malthus, *An Essay on the Principle of Population; Or, A view of Its Past and Present Effects on Human Happiness with an Inquiry into our Prospects Respecting Future Removal or Mitigation of Evils which it Occasions*, Vol. II, first American ed. (Washington: Roger Chew Weightman, 1809), 540-1.

“excessive and unusual degree” and inhibited the slave populations’ ability to grow.¹⁴

Historians have confirmed that Malthus was indeed correct, in their arguments that slave owners created a slave society where life was unnaturally short and that the people who survived could not reproduce their numbers. David Northrup quantified the extent of the problem in the British Caribbean. There were 775,000 slaves when the legal slave trade was abolished in 1807. In 1834, the population had declined by 14% (110,000 people), because planters could not buy new bodies to replace the slaves who had died. The slave populations decreased by about 25% in Britain’s newly acquired colonies of Trinidad and British Guiana, despite the extensive immigration of planters and the corollary influx of their slaves, who the planters could legally import.¹⁵ After Curtin established that slave populations had not sustained their numbers by natural means, historical demographers questioned if this resulted from low birth rates or high death rates: Trinidadian slaves suffered from both problems.¹⁶ Meredith John found the mortality rates “extremely high” and the reproduction rates low.¹⁷ A myriad of factors contributed to the poor survival rates, including the brutality within the system, the lack of disease immunities, and poor nutrition, health, and living conditions.¹⁸ For slaves born in Trinidad, John calculated their average life expectancy to be a mere seventeen years at birth.¹⁹ Historians have identified several factors contributing to the slave populations’ unnatural decrease in size. Planters inhibited the patterns of reproduction in several ways. Curtin argued that planters believed that it was cheaper to buy slaves, rather than breeding the next generation. Their preference for male slaves resulted in imbalanced gender ratios amongst the slaves who they purchased, which affected the potential for family formation and reproduction.²⁰ Women were not valued for their reproductive roles. Owners commonly interfered with family formation and sexually abused slave women.²¹ Barry Higman estimated that only about half of the enslaved people in the Caribbean lived in family units in 1813.²² The planters were disinterested in creating the conditions to allow the slaves to reproduce their numbers.

¹⁴ The emphasis is in the original. Malthus, *The Principle of Population*, Vol. II, 540-1.

¹⁵ Northrup, *Indentured Labor*, 18.

¹⁶ As discussed above (in Chapter 1), many historians have investigated the unnatural decrease in the British West Indian slave populations. For Trinidad, see, John, *Plantation Slaves of Trinidad*. B.W. Higman, “African and Creole Slave Family Patterns in Trinidad,” *Journal of Family History*, 3, 2 (1978): 163-80. Curtin, “Epidemiology and the Slave Trade,” 213-4.

¹⁷ John, *Plantation Slaves*, 163-4, 168. John indicated that high rates of infant and child mortality rendered the overall reproduction rate very low.

¹⁸ John, *Plantation Slaves*, 101-8. Gelien Matthews, “Trinidad: A Model Colony for British Slave Trade Abolition,” *Parliamentary History*, 26 (2007): 91-2. Higman, “Slave Family Patterns,” 171-2. K. Kiple, *The Caribbean Slave: A Biological History* (Cambridge: Cambridge Univ. Press, 1984), 53. Jerome S. Handler, “Diseases and Medical Disabilities of Enslaved Barbadians, From the Seventeenth Century to around 1838 (Part I),” *Journal of Caribbean History*, 40, 1 (2006): 1-38. Jerome S. Handler, “Diseases and Medical Disabilities of Enslaved Barbadians, From the Seventeenth Century to around 1838 (Part II),” *Journal of Caribbean History*, 40, 2 (2006): 177-214.

¹⁹ A. Meredith John, “Plantation Slave Mortality in Trinidad,” *Population Studies*, 42, 2 (1988): 172.

²⁰ Curtin, “Epidemiology and the Slave Trade,” 214-5.

²¹ Higman, “Slave Family Patterns,” 170. Shepherd, *Maharani’s Misery*, xxi.

²² Higman, “Slave Family Patterns,” 170.

There is no evidence to suggest that the planters changed their attitudes about their non-white labourers in the post-emancipation period. This commoditisation of the labouring bodies as expendable continued, despite the changes to the “race” of sugar estate workers, from African to East Indian, and the modified legal relationship between workers and estates, from enslavement to indenture. Replenishing bodies continued to depend on the arrival of the next ship, although the Legislative Council now hired the ships and brought East Indians instead of Africans. In lieu of buying a slave body, planters now purchased highly-subsidised contracts of indenture from the government. For a plantation economy attuned to buying labourers, indentured migration thus became the new alternative to accomplish these transactions.

Northrup identified the importance of racial ideals in the many programs of indentured migration during the nineteenth century. He argued that officials manipulated the identities of migrants, depending on whether they were white or not, to define who would migrate freely and who would be bonded labourers. Rather than merely connecting reservoirs of labour to places of scarcity, governments jointly supervised the migration and contracts of indenture in the host colonies.²³ Madhavi Kale augmented Northrup’s argument in her study of indenture in Trinidad, establishing that the identity constructed for the East Indians depended on the similarly engineered African identity.²⁴ Historians agree that the plantocracy portrayed the Africans as the cause of their post-emancipation labour problems: officials claimed that the Africans had shunned British civilisation and regressed into barbarism when they refused to work on the estates.²⁵ Walton Look Lai characterised indentured migration as the central policy in an arsenal of weapons used by the planters to control the labour market and colonial subjects. Although the emancipated Afro-Trinidadians had reflexively withdrawn from the plantations, he found the next generation to be willing and steady workers by 1877.²⁶ Kale agreed, but demonstrated that officials in London and Trinidad continued to uphold the African identity of unreliable and unwilling workers. This assertion of the racial defectiveness was important to the claim of a shortage of labourers, which remained the fundamental justification to import Indians for the plantations. Without unresponsive Africans, there would be no labour shortage, and the plantocracy would not have been able to replenish its workforce with new East Indians each year.²⁷ There was no labour shortage, *per se*, but a shortage of labourers who would work for subsistence wages under arduous conditions.

The impermanent East Indian identity as temporary sojourners allowed the program of indentured immigration to address the labour question in the short-term, with little regard for the long-term development of the population. The program to send

²³ Northrup, *Indentured Labor*, 1-15

²⁴ Madhavi Kale, “Capital Spectacles in British Frames’: Capital, Empire and Indian Indentured Migration to the British Caribbean,” *International Review of Social History*, 41 (1996): 110, 118-21.

²⁵ Bridget Brereton, *Race Relations in Colonial Trinidad 1870-1900* (Cambridge: Cambridge University Press, 2002), 9. Kale, “Capital Spectacles,” 110, 118-21. Donald Wood, *Trinidad in Transition. The Years after Slavery* (London: Oxford Univ. Press, 1968), 62-3, 239.

²⁶ Walton Look Lai, *Indentured Labour, Caribbean Sugar. Chinese and Indian Migrants to the British West Indies, 1838-1918* (Baltimore: Johns Hopkins Univ. Press, 1993), 12-13, 174.

²⁷ Kale, “Capital Spectacles,” 110, 113, 120.

East Indians to the former slave colonies upheld the plantocracy's desire for male workers. Despite the governmental anxiety about the gender imbalance in the former slave population, the program for the Indians created an even larger gender disparity. The minimum quota of female immigrants was initially 30 women to 100 men but, in 1868, after much debate, the Colonial Office decreed that ships could not depart from India without 40 women for every 100 men.²⁸ The female quota resulted from ideas about the morality of the Indians abroad: London officials asserted that Asian migration was immoral without this number of women.²⁹ However, the gender disparity amongst the East Indians at the point when they boarded the ships to Trinidad in India was much larger than that for the earlier slave population. For instance, in 1813, Trinidad's resident slave population had about 30% more women, when compared to the quota established by the government for the female East Indian immigrants in 1868.³⁰

Northrup argued that the 1868 increase in the quota, from 30 to 40 women per 100 men, reflected the decision to change the policy of the program to permanent colonisation.³¹ However, the rhetoric of 'permanent' needs to be questioned in light of the gender imbalance created by the quota. Rhoda Reddock argued that the gender disparity reflected the unwillingness of planters to encourage female migration, because of their disinterest in investing in the local reproduction of the next generation of labourers.³² By importing 40 women for every 100 men, the government continued to create a population with unnatural sex ratios, which reduced the opportunities for family formation and the potential birth rates. Curtin calculated that the slave trade's two to one gender ratio translated to a 33% lower potential in the overall *per capita* birth rate.³³ By comparison, the Indian ratio of ten men to four women reduced the potential birth rate below that number. Although the slave populations were unable to increase naturally, even fewer Indian women were redeployed half way across the globe in the program of indenture. The governments had therefore collaboratively engineered a new population that would be less successful than the slaves in reproducing their numbers or establishing a society with a modicum of morality, according to the Enlightenment's natural laws of the universe. The quantitative analysis on natural increase, below, introduces the multi-decade struggles of the East Indians and the descendants of the formerly enslaved peoples to overcome these systemic barriers to natural increase, knowingly constructed at different times by Trinidad's plantocracy.

²⁸ BPP 1874 #314. *Mr. Geoghegan's Report on Coolie Immigration*, 52. Northrup, *Indentured Labor*, 76-7. The controversy over the gendered quota in relation to health conditions aboard the emigrant ships is discussed below (in Chapter 3).

²⁹ BPP 1866 [3679], *Twenty-Sixth General Report of the Emigration Commissioners*, 22. Despite all the anxiety over the gendered quota, as discussed below (in Chapter 3), the sources do not state how the government determined that 30 or 40 women alleviated their concerns about the moral condition of the Indian population overseas.

³⁰ John calculated the slave population to be 60% male and 40% female in 1813 (for slaves over age 15). John, *Plantation Slaves*, Table A-7, 190-1. With 40 East Indian women per 100 men, the ships left India with about 30% fewer women than the resident female slaves in 1813.

³¹ Northrup, *Indentured Labor*, 76-7.

³² Rhoda Reddock, "Indian Women and Indentureship in Trinidad and Tobago 1845-1917: Freedom Denied," *Caribbean Quarterly* 32, 3/4 (1986): 27-8.

³³ Curtin, "Epidemiology and the Slave Trade," 215.

Relational Identities and the 1909 Sanderson Commission

Northrup and Kale argued that the governments manipulated the identities of the East Indians as part of the justification of their programs of indentured immigration. The relational identities constructed for the Africans and East Indians continued to form the basis of the Trinidadian plantocracy's assertion of its success in civilising the foreign race of indentured East Indians and the concomitant failure of the Africans to respond to civilisation. The 1909 Sanderson Commission provides extensive evidence of the way that officials from the metropole and plantation colonies articulated strikingly unified and consistent evaluations of how each race fared in its march to civilisation. This analysis of the testimony of the witnesses at the commission reveals the mature phase of relational identities constructed for the African and Indian subject peoples, after the program of indenture had been in effect for more than fifty years: these identities were integral to Trinidad's policies for developing its population sectors.

In March 1909, the Colonial Secretary of State, the Earl of Crewe, appointed Lord Sanderson to review the system of indentured East Indian migration to the Crown Colonies and report on the advantages derived from the system by India and the plantation colonies. After hearing the testimony of eighty-three witnesses during seventy-three days of hearings, the commission concluded that the program benefited the colonies and India.³⁴ Trinidad's plantocracy and officials turned out in force in London to testify at the hearings.³⁵ Although the terms of reference for the commission did not ask the commissioners to ascertain if the migrants benefited from the program, witnesses commented on the progress of the East Indians and the Africans' concomitant failure to embody the values of British civilisation.

The witnesses attested to the success of the program, claiming that the immigrants improved both morally and physically after arriving in Trinidad.³⁶ Reverend John Morton, the head of the Canadian Presbyterian Mission in Trinidad, described by the commissioners as an expert witness on East Indians, insisted that indenture changed the Indians in a positive way, causing them to bear children of a "stronger and more vigorous race," with substantively more civilised habits.³⁷ Witnesses further construed an inter-generational effect of the positive British influences, pronouncing Trinidad-born

³⁴ BPP 1910 [cd 5192]. *Report of the Committee on Emigration from India to the Crown Colonies and Protectorates*, 4-5, 24-5. [Hereafter, *Sanderson Report*.]

³⁵ BPP 1910 [cd 5193]. *Report of the Committee on Emigration from India to the Crown Colonies and Protectorates. Part II. Minutes of Evidence*. [Hereafter, *Sanderson Evidence*.] BPP 1910 [cd 5194]. *Report of the Committee on Emigration from India to the Crown Colonies and Protectorates. Part III. Papers Laid before the Committee*.

³⁶ BPP 1910 [cd 5193]. *Sanderson Evidence*, 331. Trinidad Surgeon-General H.L. Clare.

³⁷ BPP 1910 [cd 5193]. *Sanderson Evidence*, 1, 339. The Canadian Presbyterian mission to Trinidad, 1868 to 1917, operated many of the schools and attempted to Christianise the East Indians. The missionaries lived in the Indian communities. The two monographs by the missionaries detail their religious activities, but do not provide any information of consequence about the health or living conditions of the East Indians. Sarah E. Morton, *John Morton of Trinidad. Pioneer Missionary of the Presbyterian Church in Canada to the East Indians in the British West Indies* (Toronto: Westminster, 1916). Kenneth James Grant, *My Missionary Memories* (Halifax: Imperial Publishing, 1923).

Indians to be even more racially improved than their parents.³⁸ The coveted British values of industriousness and thrift remained at the forefront of the comparisons. Trinidad proprietor, imperial parliamentarian, and anti-indenture proponent Norman Lamont encapsulated the prevailing sentiments plainly: “It is often said in the West Indies that while the [African] Creole can do twice as much as the Indian, the Indian will do twice as much as the [African] Creole.”³⁹ The testimony resonated with the ideals of the civilising mission. Lamont assured the commissioners that the health and living conditions of the immigrants were far better than in India.⁴⁰ The long-serving president of the powerful West India Committee, Sir Nevile Lubbock, compared the lives of Indo-Trinidadians to the people in India’s large and over-populated districts, where he insisted that the people barely survived and starved during the famines. He proclaimed that the Indians lived in “comparative luxury” in Trinidad.⁴¹

The commissioners spent a significant amount of time trying to ascertain if the East Indians prospered while in the colonies. Colonial reports consistently portrayed the immigrants as contented and prosperous people.⁴² Several witnesses insisted that the majority of this population benefited, as evidenced by their ability to accumulate large sums of money and jewellery.⁴³ In the commission’s report, Lord Sanderson concluded that the East Indian immigrants in Trinidad (and British Guiana) were well-treated, had “undoubtedly” prospered, and had “excellent prospects of acquiring competence and even wealth” after completing their sojourn of indenture.⁴⁴ The portrayal of the East Indians as prosperous people resonated as a major theme throughout the testimony. However, as established above (in Chapter 1), India would subsequently terminate indentured migration in 1916, a mere seven years after the Sanderson Commission. The Indian government based its decision on the poverty of the East Indians overseas, along with its concerns that the gendered disparity created immoral conditions of life for the

³⁸ BPP 1910 [cd 5192], *Sanderson Report*, 32, 69-70. Evidence of Sir H. Johnston, Stipendiary Magistrate Henry Huggins, and Reverend John Morton, with reference to the 1893 report by Surgeon-Major D.W.D. Comins.

³⁹ BPP 1910 [cd 5193], *Sanderson Evidence*, 301.

⁴⁰ Lamont claimed that estate conditions were “much better than they [East Indians] are accustomed to in their own homes, and certainly far better than they provide for themselves when they become free.” BPP 1910 [cd 5193], *Sanderson Evidence*, 301.

⁴¹ Lubbock was the Chairman of the New Colonial Company, which operated large estates in Trinidad and British Guiana, and Past President of the West India Committee (1884-1909). BPP 1910 [cd 5193], *Sanderson Evidence*, 86. The plantocracy routinely used India as the comparison for the improvement in the lives of the East Indians. Trinidad’s Dr. Louis de Verteuil stressed that their lives improved in his 1884 monograph and then articulated the same sentiments at the commission: East Indians were racially inferior, but responded to the civilising agency in Trinidad. Louis de Verteuil, *Trinidad: Its Geography, Natural Resources, Administration, Present Condition, and Prospects*, 2nd ed. (London: Cassell, 1884), 23-4.

⁴² See, for instance, 1899 LC #54, *Protector of Immigrants AR*, 7. 1902 LC #63, *Protector of Immigrants AR*, 9. Other colonies similarly claimed that their East Indian populations prospered. For instance, as part its justification to abolish return passages to India, British Guiana’s Court of Policy passed a resolution extolling the wealth amassed by the East Indians and the beneficial effects of the civilising influences on the people. 1891 LC #20. *Immigration. Minutes of a Meeting of the Standing Committee on Immigration*.

⁴³ BPP 1910 [cd 5193], *Sanderson Evidence*, 25, 295, 297, 347. Testimony of O.W. Warner, Protector Coombs, and Lord Stanmore. Witnesses from other colonies gave similar evidence.

⁴⁴ BPP 1910 [cd 5192], *Sanderson Report*, 99-101.

expatriate Indians.⁴⁵ Although the decision-makers in India detected little evidence of prosperity and wealth, the testimony of the colonial and metropolitan witnesses at the Sanderson Commission illustrates the ubiquitous discourse on East Indian prosperity.

The progress of the East Indians was contrasted to the failure of Africans to respond to the civilising influences. Trinidad's Surgeon-General, Dr. Henry L. Clare, described the Afro-Trinidadians as much more muscular than East Indians, but "lazy" and disinclined to work.⁴⁶ Colonial Secretary S.W. Knaggs characterized the people as lacking the instincts of materialism and frugality: although Africans could be "splendid" workers when their low subsistence-level needs stimulated irregular waged labour, their hand-to-mouth existence meant that these paupers became an immediate charge upon the government when they became ill.⁴⁷ When asked to compare the racial vigour of the Africans to the former slave population, witnesses spoke of racial deterioration. Estate manager Peter Abel insisted that slaves were "finer" physical specimens and steadier agricultural labourers, but the current-day black and coloured Africans had weakened.⁴⁸ Physiological and psychological deterioration went hand in hand. The entire race had developed a love of living so profound that it made Africans disinterested in work.⁴⁹

Arthur Gordon, Lord Stanmore, was one of the few dissenting voices about the Africans' failure to become civilised. This witness had extensive experience as the governor of several plantation colonies, including his sojourn in Trinidad from 1866 to 1870. Laurence Brown characterised Gordon as a senior careering official in the imperial world, responsible for reforming and refashioning indentured migration in Trinidad, Mauritius, and Fiji, between 1866 and 1880.⁵⁰ In his testimony at the Sanderson Commission, Stanmore did not conceive of any innate racial failure in the Africans. Instead, he believed that they would not work for Trinidad's planters because they were offered the trifling subsistence wages paid to the indentured Indians.⁵¹ Stanmore was one of the few witnesses to deviate from the rhetoric of the Africans' regression since emancipation and the representation of East Indians as happy and prosperous.

Despite Lord Stanmore's contradictory opinion, the relational identities had become universal in the elite discourse of Trinidad's officials and planters. These identities were crucial to the justification of indentured migration and Trinidad's policy

⁴⁵ K. O. Laurence, *A Question of Labour. Indentured Immigration into Trinidad and British Guiana. 1875-1917* (Jamaica: Ian Randle Publishers, 1994), 457-8, 469, 471. Look Lai, *Indentured Labour*, 175-8. Reddock, "Indian Women and Indentureship," 27-49.

⁴⁶ BPP 1910 [cd 5193], *Sanderson Evidence*, 331, 334.

⁴⁷ BPP 1910 [cd 5193], *Sanderson Evidence*, 272-3. Testimony of Samuel William Knaggs.

⁴⁸ BPP 1910 [cd 5193], *Sanderson Evidence*, 410-11, 417.

⁴⁹ Jamaica's Governor Sir Sydney Oliver stressed the innate psychological difference between the East Indians and the Afro-Jamaicans: the latter were the dominant labour force in Jamaica. BPP 1910 [cd 5193], *Sanderson Evidence*, 291-2.

⁵⁰ Laurence Brown, "Inter-colonial migration and the refashioning of indentured labour: Arthur Gordon in Trinidad, Mauritius and Fiji (1866-1880)," in David Lambert and Alan Lester, eds., *Colonial Lives across the British Empire: Imperial Careering in the Long Nineteenth Century* (Cambridge: Cambridge University Press, 2006), 204-27. Chapman's earlier biography of Stanmore is much less critical of Gordon. J.K. Chapman, *The Career of Arthur Hamilton Gordon, first Lord Stanmore, 1829-1912* (Toronto: Univ. of Toronto Press, 1964).

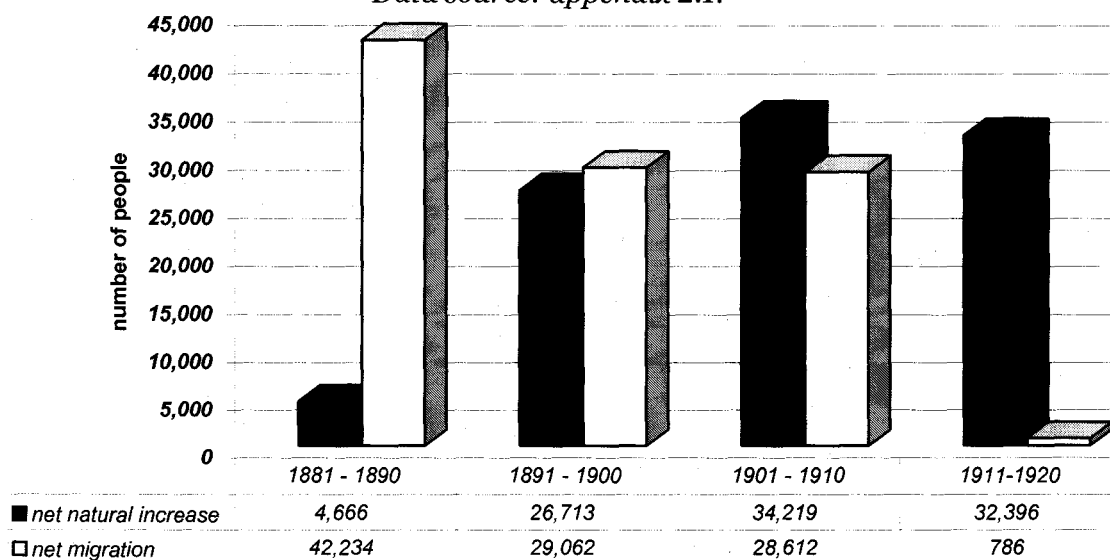
⁵¹ BPP 1910 [cd 5193], *Sanderson Evidence*, 347.

on population growth. A quantitative analysis of the outcome of the policy to neither whiten nor blacken Trinidad establishes the effects of the legacy of the slavery era ideals on the expendability and impermanence of plantation labourers in determining the demographic fate of the African and East Indian populations in Trinidad.

Population Growth by Natural Increase and Migration, 1881 to 1920.

Trinidad's program of indentured migration changed the colony's demographic composition fundamentally by introducing East Indians to the colony and then augmenting their numbers each year. By 1891, Indo-Trinidadians accounted for about one third of the colony's residents. The people under indenture represented a minority of this sector at just over 5% of all residents and about 15% of the East Indian sector.⁵² The colony continued to import a disproportionate number of males each year, maintaining the planters' preference to acquire a minimum number of females. Thus, the Indo- and Afro-Trinidadian sectors had been resolutely created with significant disparities in their sexual demographics. The effect of Trinidad's policy is examined by considering the growth of the total colonial population and then examining and comparing the details of natural increase and migration between the African and East Indian sectors. This comparison of growth by migration and natural increase reveals several different patterns for the two populations who lived side by side in Trinidad.

*Figure 2.1 – Population Growth in Trinidad 1881 – 1920.
Comparing total Natural Increase (the excess of births over deaths).
to Net Migration (the excess of immigration over emigration).
Data source: appendix 2.1.*



⁵² This calculation is based on the census data of 200,028 residents in Trinidad, including 70,242 Indo-Trinidadians. The annual report of the Protector of Immigrants recorded 10,405 indentured East Indians in Trinidad on 31 March 1891. 1891 LC #68, *Protector of Immigrants AR*, 2. *Census of the Colony of Trinidad, 1891* (Port-of-Spain: Government Printer, 1892).

Figure 2.1 illustrates the decennial growth in the colony's total population between 1881 and 1921, comparing the results of net natural increase to migration. The reversal in the method by which the population grew within this short forty-year period is striking. In the first decade, Trinidad's growth resulted almost exclusively from migration, while the population barely sustained itself naturally. This pattern reversed itself within four decades: the growth from migration rather quickly plummeted to a negligible number, while the population's capacity for natural increase reached unprecedented levels.

The profound change in the population's natural increase, starting in the 1890s, is evident in Figure 2.1. The detailed analysis of natural increase, below, identifies the decade of the 1880s as the point when the African sector recovered demographically from the traumas of slavery and its sexual disparity and began to reproduce naturally. It also identifies the 1890s as the time when the disproportionately male East Indian sector started to reproduce its own numbers, despite the on-going sexual imbalance inflicted on the population by the government's immigration program, along with the harsh conditions of indentured labour.

While the changes in natural increase made a positive contribution to the colony's population, the changes in migration patterns had the opposite effect. Figure 2.1 confirms that migration accounted for about 90% of decennial growth between 1881 and 1890. Three decades later, from 1911 to 1920, the net growth from migration plunged to a paltry 2.4%. Three factors contributed to this change: voluntary circum-Caribbean immigration declined after 1901, India terminated indentured migration in 1916, and World War I impeded travel when Britain commandeered commercial ships for the war and enemy ships patrolling the Caribbean waters made travel unsafe.⁵³

The new century thus represented an important turning point when the primary historical means of growth, by migration, reached its zenith, arrested, and then declined to become a negative factor, while the resident population's enhanced capacity to reproduce itself by natural means stopped the total population from shrinking in size. However, these changes did not occur uniformly in the African and East Indian sectors.

Growth by Natural Increase in Trinidad, 1881-1920.

The inability of slave populations to grow by natural increase had captured the attention of Enlightenment thinkers, abolitionists, and British reformers. As demonstrated above, historians and historical demographers have actively investigated this unusual state of being and skilfully quantified the extent of the problem. However, little attention has been devoted to identify when the formerly enslaved peoples and their descendants, along with the newly established East Indian sector, began to grow by natural increase. Brian Moore is one of the few historians to address this question for an Afro-Caribbean population. In his study of post-emancipation British Guiana, Moore identified that the native-born African population decreased in size between 1841 and 1891.⁵⁴ The experience of the Afro-Guianese people is a troublesome revelation in the context of the prolific growth of other world populations during the century. This analysis of the

⁵³ 1915 LC #154, *Surgeon-General AR*, 10. 1915 LC #109, *Protector of Immigrants AR*, 6.

⁵⁴ Moore, *Cultural Power, Resistance, and Pluralism*, 11, 18.

patterns of natural increase establishes that Trinidad's populations faced the same plight as the Afro-Guianese peoples, but that the Afro-Trinidadian sector recovered during the 1880s and the Indo-Trinidadians in the following decade.

The comparative statistics on the growth of the population by natural increase are presented in Figure 2.2 and net migration in Figure 2.3. The terms used in these charts to describe the populations require clarification. Trinidad's census classified the population as either East Indian or the "general" population.⁵⁵ The term "East Indian" is self-explanatory, including any person of East Indian descent, whether of pure or mixed parentage. These statistics are precise, because this sector was distinctly enumerated in the vital statistics. The "general" population is referred to as "West Indian" in the following charts. The West Indian sector includes the tiny white minority and the Afro-Trinidadian majority. As established above, white Trinidadians constituted only 1.5% of the total population by 1907.⁵⁶ Although the West Indian sector includes the white residents, their numbers were so insignificant that it should not have a measurable effect on the data on migration (Figure 2.3, below) or this comparison of the patterns of natural increase between the West Indian and East Indian sectors.⁵⁷

Figure 2.2 – Population Growth by Natural Increase in Trinidad, 1881 to 1920, Comparing the Growth of the East Indian and West Indian Sectors.

Data sources: Appendix 2.1, 2.2, 2.3.

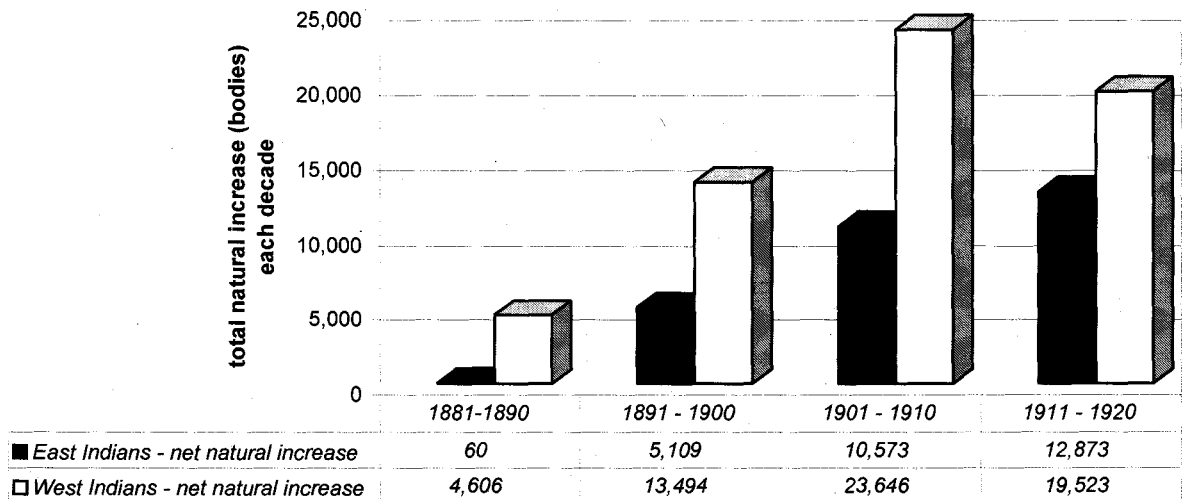


Figure 2.2 illustrates two remarkable changes in the patterns of natural increase during this period. First, in the 1880s, the West Indian sector, the vast majority of who were Afro-Trinidadians, began to increase in size naturally, just slightly ahead of the time

⁵⁵ Registrar-Generals named this sector the "General" population, but this analysis uses the term "West Indian." Reverend John Morton suggested the nomenclature of 'West Indian' and 'East Indian' at the Sanderson Commission. BPP 1910 [cd 5193], *Sanderson Evidence*, 339-40.

⁵⁶ Op.cit. See note 4, above.

⁵⁷ For instance, in 1907, the West Indian sector included the estimated 5,000 white people (1.5% of the population) and about 234,000 Afro-Trinidadians (68.5% of the population). The number of white residents was so small that it is doubtful that the handful of births, deaths, and net migration would have had a significant effect on the data in the following figures.

identified by Moore for the Afro-Guianese people. This establishes that the Afro-Trinidadians required more than two generations of freedom, or about five decades, to recover from the trauma of slavery and begin to reproduce their numbers naturally. Second, the East Indian sector began to reproduce itself naturally in the 1890s, despite the government's policy to continue to import 40 women per 100 men and the harsh conditions of life under indenture. Although the systemic barriers to natural increase remained current amongst the East Indians, this sector required a much shorter period of time to recover demographically, when compared to the African peoples. By the end of the century, both sectors had thus overcome the systemic barriers to natural increase, which had been purposefully constructed within the systems of labour that had commoditised their bodies as expendable and replaceable.

The generally improving trends shown in Figure 2.2 establish that the aggregate results of natural increase were positive during these four decades. However, this more natural state of being resulted from different factors within the West Indian and East Indian sectors. Each population had dissimilar crude birth and death rates, which measure the incidence of births or deaths per 1,000 living persons. The available statistics allow the crude birth rate (CBR) and crude death rate (CDR) to be calculated for each population: these statistics are detailed in Appendix 2.3 for the West Indian sector and Appendix 2.4 for the East Indians. In the forty years depicted in Figure 2.2, fewer West Indians died *per capita*,⁵⁸ but they also bore fewer children.⁵⁹ This sector's improved rate of growth thus resulted from the large decline in the crude death rates. Conversely, the East Indians experienced a nominal increase in their death rates,⁶⁰ but the prolific increase in their crude birth rates more than compensated for the slightly higher death rate.⁶¹ Despite the on-going perpetuation of the demographic sexual disparity, the East Indian growth was due to the increase in the birth rate. In other words, during this forty year period, fewer West Indians died, while the East Indian death rate increased: the West Indian CDR declined by 15.1% at the same time that the East Indian CDR increased by 3.1%. Simultaneously, the West Indian crude birth rate declined by 12.6%, while the East Indian CBR increased significantly, by 17.1%. These two populations living side-by-side experienced life in appreciably different ways. If such trends had continued *ad infinitum*, beyond the period of this study, East Indians would have eventually become the majority in the colony.

⁵⁸ Between 1891 and 1920, the West Indian crude death rate declined during each decade, starting at 26.97 (1891-1900), dropping to 24.61 (1901-1910), and then to 22.89 (1911-1921). This represented a net decrease of 15.1% in the CDR between the first and last decades. For the detailed calculations of the crude rates, see Appendix 2.3.

⁵⁹ The average West Indian crude birth rate declined by 12.6% during this thirty year period between 1891 and 1920. The average of the annual West Indian CBRs remained relatively constant at 36.00 in the first decade (1891-1900) and 36.18 between 1901 and 1910. It then declined to 31.48 (1911 and 1920). For the detailed crude rates, see Appendix 2.3.

⁶⁰ Between 1891 and 1920, the average East Indian crude death rates increased slightly each decade: 25.53 (1891-1900), 25.76 (1901-1910), and 26.31 (1911-1920). This represented a net increase of 3.1% in the CDR between the first and last decades. For the detailed crude rates, see Appendix 2.4.

⁶¹ The East Indian CBR increased by an average of 17.1% from 1891 to 1920. Between 1891 and 1900, the average of the annual East Indian CBR was 32.02. This CBR average increased to 36.60 (1901-1910) and then to 37.50 (1911-1920). For the crude rates, see Appendix 2.4.

Residents produced enough children after the 1890s to change the historical patterns of unnatural decrease. Unfortunately, there are no extant studies to help explain why these changes occurred at this time. The creation of the Government Medical Service (GMS) organisation in 1870 plausibly had a significant effect on helping to mitigate the death rate at times, but the provision of maternal and infant healthcare services was not a priority during the period of this study. While the different sectors finally managed to surmount the unnatural condition of not being able to reproduce their numbers, it is indeterminate at what point the colony would be poised to make a major health transformation that would have a pronounced affect on the birth and death rates. The scholarship for Jamaica and British Guiana identifies that those colonies started to make major changes around 1920, which would have had a major influence on important indicators, such as live births, infant mortality, and life expectancy. Juanita De Barros established that British Guiana pioneered the British West Indian reforms for infant and maternal health in the 1910s, which were then used by the other colonies. Trinidad did not adopt the Guianese reforms until 1918.⁶² In his study of life expectancy in Jamaica, James Riley argued that there had been no improvement in the trends for survivorship and life expectancy before 1920. Officials knew what needed to be done to reform public health and the GMS, but the government continually lacked the resources to put the plans into action.⁶³ During the period of this study, Trinidad's GMS did not tend to pioneer innovations in health and medical care, which suggests that while the GMS may have helped to mitigate the death rates somewhat, this would have only helped the Trinidadian people finally start to achieve the more natural rates of increase experienced by many other populations elsewhere.

Population Growth by Migration in Trinidad, 1881-1920.

A population's growth from migration is positive when the location has more immigrants than emigrants. Negative net migration is usually caused by a crisis, such as famine or war. Figure 2.1 established that Trinidad's net migration statistics changed significantly between 1881 and 1920, which suggests that unusual circumstances prevailed during this period. However, the migration literature for Trinidad provides little information on the emigration of the West Indian and East Indian sectors, or the inter-colonial immigration of the West Indian population. Figure 2.3 provides statistics on the aggregate migration for the West Indian and East Indian sectors.

⁶² Juanita De Barros, "'Improving the Standards of Motherhood.' Infant Welfare in Post-Slavery British Guiana," in Juanita De Barros, Steven Palmer, and David Wright, eds., *Health and Medicine in the circum-Caribbean, 1800-1968* (NY: Routledge, 2009): 170-2. The initiation of infant welfare programs occurred in other colonies around 1920. See, for instance, Margaret Jones, "Infant and Maternal Health Services in Ceylon, 1900-1948: Imperialism or Welfare?" *Social History of Medicine*, 15 (2002): 263-89.

⁶³ James C. Riley, *Poverty and Life Expectancy. The Jamaica Paradox* (NY: Cambridge Univ. Press), 48.

Figure 2.3 – Population Growth by Net Migration in Trinidad, 1881-1920, Comparing the West Indian and East Indian Sectors.

Data Sources: Appendix 2.1, 2.2, 2.3.

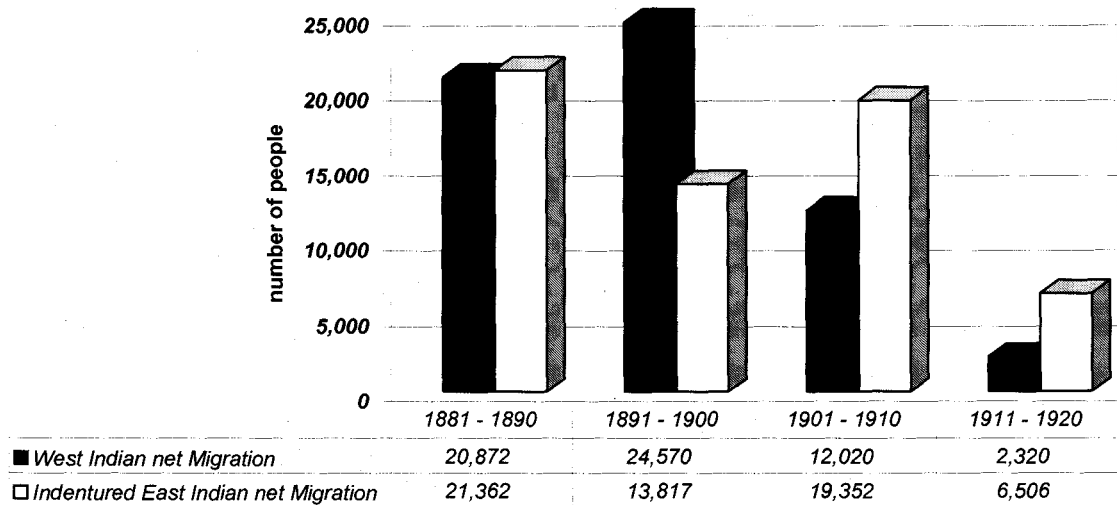


Figure 2.3 illustrates changes in the net migration of the West Indian and East Indian sectors each decade, which culminated in both sectors contributing rather negligible numbers of new migrants after 1911. The nature of these migrations differed between the two sectors. West Indians generally made voluntary migration decisions. In the first two decades, these choices helped the population to grow. Conversely, after 1901, fewer people in the West Indian sector decided to migrate to Trinidad or to remain in the colony. Between 1911 and 1920, the net growth from voluntary migration plummeted to a mere 11% of the volume three decades earlier. The major change in East Indian migration during the same decade, 1911 to 1920, occurred when India terminated the program of indentured migration in 1916. Government ships then stopped bringing the thousands of new indentured labourers who had continually replenished the plantation labour force each year during the previous eight decades. Migration between Trinidad and India then became a unidirectional outflow of repatriations to India.

Trinidad did not make any sustained attempts to “whiten” the colony. Other colonies, such as British Guiana, instituted programs to encourage white immigrants from locations such as Madeira, Cape Verde, and the Azores.⁶⁴ Between 1834 and 1918, British Guiana received 32,216 white migrants from these locations, while a mere 897 arrived in Trinidad.⁶⁵ Trinidad’s meagre attempts to stimulate migration over the years

⁶⁴ Moore argued that British Guiana’s program to encourage the Portuguese immigrants was an initiative to whiten the population. Brian Moore, *Race, Power and Social Segmentation in Colonial Society. Guyana after Slavery, 1838-1891* (NY: Gordon and Breach, 1987), 139-41.

⁶⁵ Trinidad’s brief attempts to promote indentured migration from the United States brought 1,333 people to the colony between 1835 and 1867, but the sources do not define the ethnicity and colour of these migrants. Roberts and Byrne, *Summary Statistics*, 127, 129, 131. Look Lai stated that 1,298 immigrants arrived from Madeira, Cape Verde, and the Azores. Look Lai, *Indentured Labor, Caribbean Sugar*, 16-18. For British Guiana, Wood stated that 21,811 people from Madeira arrived between 1841 and 1861, initially under indenture, but they soon

were unsuccessful. For instance, in 1889, upon learning that many countries were encouraging Azorean immigration, Governor William Robinson attempted to sponsor a program. The British Consulate for the Azores and Madeira explained that countries, such as Hawaii, offered free passages and land grants. The Legislative Council, led by Dr. Louis de Verteuil, informed the Colonial Office and British diplomats that they preferred foreign labourers to Afro-Caribbeans, who were still too degraded from slavery. However, Trinidad's offer of free land grants required the people to work as indentured labourers for up to seven years. Secretary of State Henry Holland, Lord Knutsford, responded that the Azorean people were disinterested in migrating to Trinidad.⁶⁶

Trinidad's Legislative Council rarely encouraged Afro-Caribbean migrants from other colonies and, in fact, often tried to discourage them. The mid- and late-century policies changed from the immediate post-emancipation period, when Bonham Richardson demonstrated that there were significant movements of migrants from St. Kitts and Nevis to Trinidad.⁶⁷ However, Trinidad's interest in this and other inter-colonial migration arrested when indentured East Indian migration was instituted. Many other colonies welcomed Afro-Caribbean migrants. For instance, in 1885, Antigua and British Guiana provided assistance to Barbadians and offered free land. Trinidad proposed indenture, which was emphatically declined by the Barbadian government on behalf of its people.⁶⁸ Trinidad's other rare schemes were similarly unsuccessful. Unlike other colonies, Trinidad offered little in the way of assistance to potential immigrants.⁶⁹ In his testimony to the Sanderson Commission, black lawyer and Legislative Council member C.P. David complained that his government colleagues would never encourage the migration of Afro-Caribbean peoples while indentured migration continued.⁷⁰ Trinidad's planters had developed an addiction to bonded Indian labour: its program of indentured migration remained the colony's central policy for population growth.

became free migrants. Wood, *Trinidad in Transition*, 101-6.

⁶⁶ 1890 LC #83. *Immigration. Correspondence relative to Immigration from the Azores and to the encouragement of Voluntary Immigration from the Mainland and neighbouring Colonies*. Acting Governor Henry Fowler stated that the planters only wanted East Indian or Chinese labourers. 1891 LC #32. *Despatch from the Secretary of State with reference to Immigration from the Azores*. The few instances where Trinidad attempted to encourage white migration ended unsuccessfully. CO 384-152 (1884) #3694. *Immigration from Madeira*. Ryan argued that the Portuguese were not considered 'white' in Trinidad, but were still more desirable to the Trinidad elite than the Africans already in the colony. Selwyn D. Ryan, *Race and Nationalism in Trinidad and Tobago: A Study of Decolonization in a Multiracial Society* (Toronto: Univ. of Toronto Press, 1972), 19.

⁶⁷ Bonham C. Richardson, *Caribbean Migrants. Environment and Human Survival on St. Kitts and Nevis* (Knoxville: Univ. of Tennessee Press, 1983), 81-92.

⁶⁸ 1885 LC #71. *Papers Relating to Emigration from Barbados*. Trinidad's Select Committee on emigration from Barbados stated that the planters refused to consider non-indentured Barbadian immigrants. 1886 LC #36. *Report of Select Committee on Emigration from Barbados*.

⁶⁹ For instance, in 1898, Legislative Council member A.P. Marryat attempted to recruit labourers from hurricane-ravaged St. Vincent and Barbados. British Guiana had significant success recruiting these people, because the colony offered them liberal assistance. Marryat's scheme failed as the potential immigrants were disinterested in Trinidad's restrictive terms. 1898 LC #185. *Agricultural Labourers from St. Vincent and Barbados*.

⁷⁰ BPP 1910 [cd 5193], *Sanderson Evidence*, 197-8, 216.

Nonetheless, the consistently strong flow of voluntary pan-Caribbean migration had a major effect on Trinidad. Thousands of migrants entered and left the colony each year. Although the colony welcomed people with capital and professionals, the official attitude differed about Afro-Caribbean immigrants. “Deckers” were poor people travelling on the lowest fares, on the decks of the ships, in search of work.⁷¹ Officials developed a fastidious interest in the deckers, who they believed would capitalise on the healthcare services offered by its GMS organisation. In 1882, Trinidad enacted the Infirm Pauper Ordinance to prohibit the immigration of undesirable immigrants, including those who appeared to be “vicious,” criminal, poor, or infirm.⁷² This law allowed the Harbour Master, police, doctors, and quarantine officials to reject immigrants by making subjective decisions on a person’s “likely” future potential to seek assistance from the government hospitals, asylums, or almshouse.⁷³ The Imperial world policy of free trade dictated the free movement of people and precluded the Legislative Council from erecting overt barriers to immigration. However, the ordinance provided officials with a great deal of latitude to turn away immigrants deemed as undesirable.⁷⁴

Similar to the “head tax” imposed on Asians by the anti-Chinese immigration laws, which emerged in the imperial world during the 1880s, the Infirm Pauper Ordinance required undesirable immigrants to deposit the extraordinarily large sum of £20 with the government, in this case, to be drawn upon if the immigrant used the GMS or other government services.⁷⁵ The £20 fee functioned as an expensive deterrent, rather than a reasonable deposit for future medical care. As argued below (in Chapter 6), the GMS rarely ever convinced patients to pay for their treatments at the colony’s medical institutions. The ordinance also imposed hefty fines on any ship that transported pauper migrants to Trinidad.⁷⁶ Over the years, articles and editorials in the local media complained that the law was vigorously enforced at some times and quite lax at other

⁷¹ BPP 1910 [cd 5193], *Sanderson Evidence*, 223.

⁷² First enacted by Ordinance 5 of 1882, *An Ordinance relating to the introduction of Paupers likely to become chargeable to the Colony* was amended by Ordinance 11 of 1895, 19 of 1897, and 186 of 1905, and then repealed by Ordinance 4 of 1936. The short title of the law was the Infirm Pauper Ordinance.

⁷³ Infirm Pauper Ordinance 186 of 1905.

⁷⁴ Critics of indentured migration said that the ordinance was a device to inhibit the immigration of free workers. Colonial Secretary S.W. Knaggs claimed that it kept out undesirables. BPP 1910 [cd.5193], *Sanderson Evidence*, 274. The Infirm Paupers Ordinance 5 of 1882 required paupers to deposit £20 on arrival in Trinidad, or have a resident agree to be responsible for the immigrant’s expenses for a year. CO 384-186 (1893) #20843, *Emigration Despatches*. By 1909, the deposit had been reduced to £5, but it is not clear when this change occurred.

⁷⁵ For instance, in 1885 Canada imposed a \$50 “head tax” on Asians attempting to enter the country. Canada’s restrictions on immigration remained in force from 1858 to 1968. For a summary of Canada’s exclusionary laws, see James W. St. G. Walker, “Race,” *Rights and the Law in the Supreme Court of Canada. Historical Cases Studies* (Waterloo: Wilfred Laurier University Press, 1997), 12-31. Xiaoping Li and Jo-Anne Lee, “Chinese in Canada,” in C.R. Ember, M. Ember, and I.A. Skoggard, eds., *Encyclopedia of Diasporas: Immigrant and Refugee Cultures around the World* (Springer, 2004), 646.

⁷⁶ The Ordinance allowed the ship master to be fined £50 and the owner of the vessel £100 for each rejected immigrant. The ship could be subjected to a maritime lien enforced by the Royal army and navy.

times.⁷⁷ However, in response to queries by a committee of the British parliament in 1909, Harbour Master J.B. Saunders and Governor Le Hunte had no qualms advising the parliamentarians that this law targeted “Coloured West Indians of the labouring class”: the law was readily invoked if the immigrant’s “general appearance conveys the impression” that they might one day need medical or social assistance.⁷⁸ While Trinidad could not construct overtly racialised barriers to immigration, the active discouragement of Afro-Caribbean immigration and the Infirm Paupers Ordinance helped officials maintain their long-term objective of not blackening the colonial population.

Illegal Emigration and the “Leakage” of East Indians

In direct contrast to the attempts to discourage the growth of the colony’s African population, Trinidad instituted laws to try and keep Indo-Trinidadians within the colony. For the Indians who migrated under indenture, and any children born in the colony, freedom had a particular definition. To be free meant freedom from indenture, but they were not free to leave the colony unless returning to India. The Immigration Ordinance 13 of 1870 made it a criminal offence for Indians to leave for any destination other than India without obtaining a passport from the Protector of Immigrants.⁷⁹ Trinidad’s longest serving Protector of Immigrants, William Coombs, made it difficult for applicants to obtain passports and proudly proclaimed his success discouraging the majority of applicants.⁸⁰ A further amendment to the ordinance, in 1878, made it illegal for anyone to entice, recruit, or assist an Indian to leave Trinidad.⁸¹ India formalised this restriction in the Indian Emigration Act of 1883, which prohibited foreign countries from recruiting her subjects without its approval. India obligated the Colonial Office and Foreign Office to deal with any nation that recruited Indians from a colony that

⁷⁷ “The Landing of Paupers,” *The Mirror*, 10 September 1901. “Day by Day,” *The Mirror*, 2 September 1905. “Detained on board the Statia,” *Port-of-Spain Gazette*, 20 July 1905.

⁷⁸ CO 295-452 (1909) #32738. *Distressed British Subjects*. Governor Le Hunte to Secretary of State.

⁷⁹ The Coolie Immigration Ordinance 13 of 1870 and all subsequent amendments defined the need for a passport. See, for instance, BPP 1904 [cd 1989], *Coolie Immigration, Immigration Ordinances of Trinidad and British Guiana*, 44-5. Jamaica and British Guiana also required East Indians to obtain passports before departing for foreign countries or any British territory other than India. BG Sessional Papers 1880, *Registrar-General AR*, 12. JCA Sessional Papers 1898-99, *Report of the Immigration Department for the year ended 31st December 1899*.

⁸⁰ Coombs’ actions to discourage East Indians from leaving Trinidad would have been consistent with the elite attitude that the people of this inferior “race” needed to be protected from their own actions. Moreover, the Protector’s job was to keep Indians labouring on the estates. LC #68, *Protector of Immigrants AR*. Coombs’ predecessor, Charles Mitchell, issued significantly more passports, while stating that most East Indians did not bother to obtain passports. 1895 LC #108, *Protector of Immigrants AR*, 5. In reporting the low number of passports issued each year, Coombs confirmed that there were numerous opportunities for people to “escape” to the Spanish Main and Demerara. 1906 LC #74, *Protector of Immigrants AR*, 8. 1907 LC #91, *Protector of Immigrants AR*. Yet, in 1906, in response to questions from the House of Commons about the conditions of life for East Indians, Coombs insisted that the passport laws were strictly enforced. CO 295-436 (1906) #20098. *Indentured Coolie Labourers*. Report by Protector of Immigrants W.H. Coombs. BPP 1906 #357, *Coolie Labour*.

⁸¹ Ordinance 21 of 1878 made it illegal to recruit or assist an East Indian to leave the colony. BPP 1904 [cd 1989], *Immigration Ordinances*, 44-5.

sponsored indentured migration.⁸² The laws of India and Trinidad thus allowed the colony to restrict the movements of Indians to attempt to keep them in Trinidad.

Nonetheless, many people left the colony, usually for the Spanish Main. Each Registrar-General expressed significant frustration with the large volume of free East Indians who emigrated illegally each year.⁸³ They called this well-known problem the “leakage” in the population. Officials confirmed that the high volume of leakage rendered the colony’s vital statistics grossly inaccurate in the years between each census. The “leakage” involved a large number of people who surreptitiously departed on boats destined on a short eight-mile journey to Venezuela, the gateway to the Spanish Main, or on longer trips to other Caribbean ports and the Panama Canal zone.⁸⁴ The constant volume of legal maritime traffic afforded travellers numerous transportation options to many destinations. Consequently, the large volume of people boarding small boats at unknown locations to avoid surveillance and venturing into the often perilous ocean waters suggests that the residents who leaked out of Trinidad took purposeful steps to avoid being apprehended by officials.

As an island dependant on maritime trade, Trinidad’s administration at the ports managed the high volume of traffic, monitoring the thousands of people entering and leaving the colony each year. The Indians who decided to escape from Trinidad wreaked havoc with the colony’s statistics. Officials continually expressed confidence in the reliability of their statistics on the number of immigrants arriving in Trinidad.⁸⁵ However, officials could never manage to account for the total number of Indians who left the colony.⁸⁶ Each Registrar-General invested considerable time in downwardly revising his annual estimates of the total number of residents in an attempt to account for this leakage.⁸⁷ Each subsequent census confirmed that far more people had leaked out of Trinidad than they had estimated, leaving the resident population much smaller than anticipated. Figure 2.4 depicts the decennial volume of leakage and compares it to the net migration of the West Indian sector and the legal East Indian migration to India.

⁸² CO 295-375 (1896) #25430. *Coolies enlisted for labour in Columbia*.

⁸³ See, for instance, 1921 LC #91, *Registrar-General AR*, 3.

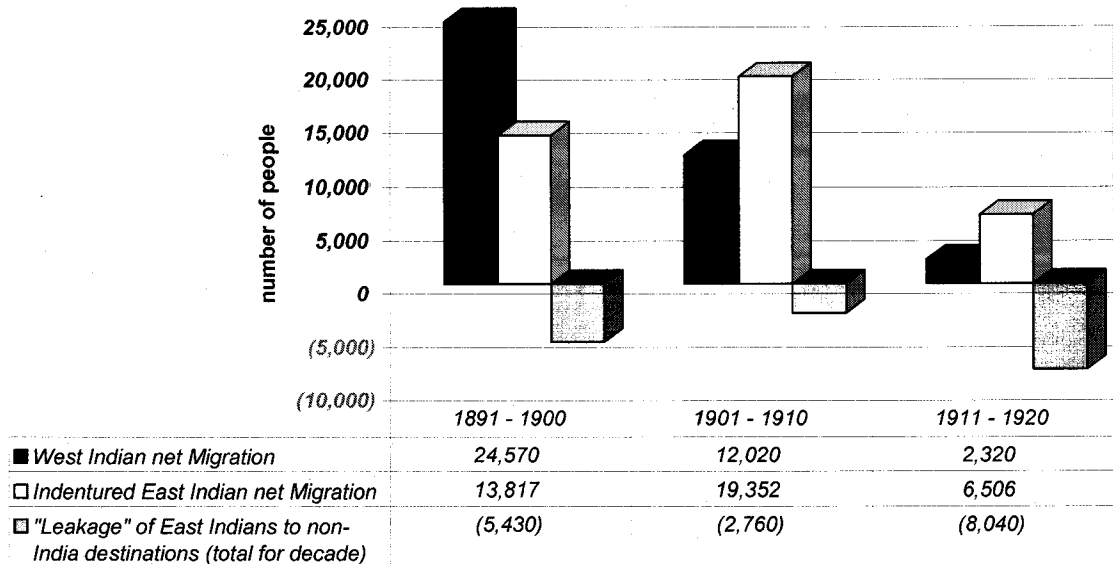
⁸⁴ 1893 LC #92. *Protector of Immigrants AR*, 3. 1894 LC #73, *Registrar-General AR*. 1895 LC #55, *Protector of Immigrants AR*.

⁸⁵ Each Registrar-General expressed his lack of confidence in the accuracy of the emigration statistics, except for the statistics on migration from Trinidad to India. See, for instance, 1902 LC #118, *Registrar-General AR*, 3. 1922 LC #86, *Registrar-General AR*, 3.

⁸⁶ Registrar-General A.C. Robinson quantified the discrepancies between the estimated and actual population in the censuses from 1891 to 1921. He confirmed that the annual estimates were “greatly exaggerated” by 6% to 10.3%. 1922 LC #86. *Registrar-General AR*.

⁸⁷ Registrars tried many methods to compensate for the inaccurate inter-colonial emigration numbers. However, they were continually unsuccessful in generating estimates that were more precise. 1891 LC #45, *Registrar-General AR*, 3-5. 18. 1898 LC #115, *Registrar-General AR*, 2. 1914 LC #31, *Registrar-General AR*, 3. 1921 LC #91, *Registrar-General AR*, 3.

Figure 2.4. – Population “Leakage” of East Indians, 1891-1920.
Data Source: Appendix 2.1



The net volume of East Indian leakage is striking in comparison to the indentured migration during the first and third decades in the chart. Between 1891 and 1900, the number of East Indians who escaped from Trinidad was equivalent to about 40% of their total net legal migration between Trinidad and India. This number decreased to about 14% in the next decade. Then, between 1911 and 1920, Trinidad lost more East Indians through leakage than it imported during the final decade of indenture. Several thousand East Indians simply disappeared from the colony each decade. As established below, many escapees commuted between Venezuela and Trinidad frequently, which suggests that the net number in Figure 2.4 would not have been the total traffic in a given decade but, instead, the net quantifiable number on the date of each census.

The official rhetoric insisting that plantation society colonialism created a prosperous and contented East Indian population rationalised that these deserters had been well-treated in the colony, but that foreigners had successfully deluded the people and convinced them to leave. Protector Coombs insisted that the stimulus for escape was “the golden vision of *El Dorado* that lies only a few hours journey across the narrow belt dividing Trinidad from the Spanish Main.” Coombs attempted to deter East Indians from leaving the colony by creating a fear of foreigners from the Spanish Main. He told the Indians that these outsiders were “evil-disposed persons anxious to take them [away],” who would then steal their possessions.⁸⁸ Coombs also insisted that many escapees returned from Venezuela as “physical wrecks” and in “a very feeble and needy condition.”⁸⁹ Trinidad’s GMS was constantly portrayed as the main reason why the escapees would want to return to Trinidad; they required the GMS’s superior medical

⁸⁸ 1906 LC #74, *Protector of Immigrants AR*, 10.

⁸⁹ 1913 LC #154, *Protector of Immigrants AR*. 1908 LC #109, *Protector of Immigrants AR*.

care after their bodies had been harmed by foreigners.⁹⁰ Some former residents did in fact periodically reappear in Trinidad “in a pitiable condition” and officials publicised their misfortune in the Spanish Main to discourage others from escaping.⁹¹ However, the Surgeon-General’s annual reports never referenced any problem with large numbers of repatriated patients arriving in pathetic condition.

Official reports confirmed that the majority of people never returned. Many escapees found their *El Dorado* in the Spanish Main, earning the high wages that enabled them to acquire tracts of land in the foreign countries.⁹² While plantation society colonialism in Trinidad purposefully attempted to keep the population as impoverished landless labourers, and rationalised these policies within its civilising mission, many Indians rejected these constraints and ventured to their own *El Dorado*. In another surprising revelation, Coombs confessed that the majority of money deposited by East Indians in Trinidad’s government bank had been earned through their labours in Venezuela.⁹³ The prosperity of many East Indians, which featured prominently in the discourse of the benefits of the civilising mission, thus represented wealth amassed after they escaped from Trinidad. These escapees also commuted between the Spanish Main and Trinidad to use the Port-of-Spain Hospital: “The distance is short and the treatment in Hospital, as a coolie described it, is ‘bahut achcha’ (very good).”⁹⁴ Former Indo-Trinidadians travelled, undetected, back and forth between their *El Dorado* and Trinidad at will, suggesting that these people were not the deluded souls portrayed by Coombs. These revelations introduce a new dimension to the debate over the “material benefits” counter argument to the neo-slavery thesis, if indeed a significant portion of the wealth possessed by East Indians had been generated outside of the colony.⁹⁵

The notion of escapees visiting Trinidad to make deposits at the bank and seek medical attention at the Port-of-Spain Hospital confirms the ineffectiveness of the government’s surveillance mechanisms. Nonetheless, the traditions of slavery and bonded labour meant that the colony had a great deal of experience dealing with absconders and escapees as the plantation society attempted to keep people in their proper places.⁹⁶ This constant volume of people leaking in and out of Trinidad is remarkable in light of the colony’s purposeful measures to apprehend them. Protector Coombs admitted that he dispatched boats to patrol the coast and placed guards on shore.⁹⁷ At other times, delegations travelled to Venezuela or Columbia to retrieve expatriates, but these foreign relations could become quite complex.⁹⁸ For instance, in

⁹⁰ For instance, see, 1908 LC #109, *Protector of Immigrants AR*.

⁹¹ 1900 LC [no number], *Protector of Immigrants AR*, 6. 1913 LC #154, *Protector of Immigrants AR*, 8.

⁹² 1895 LC #108, *Protector of Immigrants AR*, 4. 1896 LC #175, *Protector of Immigrants AR*, 8. 1921 LC #55, *Protector of Immigrants AR*, 4.

⁹³ 1896 LC #175, *Protector of Immigrants AR*, 6.

⁹⁴ 1896 LC #175, *Protector of Immigrants AR*, 6.

⁹⁵ The debate by historians if indentured migration represented neo-slavery, or if immigrants derived “material benefits,” is discussed above (in Chapter 1).

⁹⁶ In the immediate post-emancipation period, Northrup indicated that planters in Trinidad and Jamaica complained that absenteeism reduced the productivity of the ‘free’ black labour force by almost two thirds, when compared to the slavery. Northrup, *Indentured Labor*, 19-22.

⁹⁷ 1904 LC #78, *Protector of Immigrants AR*, 8.

⁹⁸ As early as 1866, Daniel Hart reported the problem with many East Indians escaping to

1896, the Colonial Office directed Trinidad's officials to retrieve a large number of East Indians from Columbia. Columbia and Britain did not have extradition treaties: Columbia respected the East Indians' claims to be free people. Despite the rhetoric that East Indians were reduced to poor and unhealthy souls without the protection of Trinidad's government, the escapees were found to be healthy and prosperous in their new homeland.⁹⁹ This initiative to repatriate the former Trinidad residents failed miserably. These interactions illustrate the tension between the residents who went to great lengths to avoid officials and a government that attempted to stop or retrieve persons who clearly did not want to live in Trinidad.

Officials dealt with this challenge to the rhetoric of happiness and prosperity in a very pragmatic way, by generally failing to admit to the problem in public forums. Nonetheless, the continued volume of leakage brought the reliability of emigration statistics into question and tormented generations of Registrar-Generals.¹⁰⁰ All inter-census vital statistics that depended on an accurate count of the total population are erroneous in the historical records. These statistics include all crude birth and death rates and the rates of natural increase and migration. Officials had to await the results of the next census to quantify the magnitude of the perpetual under-estimation of the leakage and the concomitant over-estimation of the population.¹⁰¹ Censuses allowed the Registrar-Generals to quantify, retrospectively, the total number of bodies that had leaked out during the decade. However, they did not amend their previously published and vast collection of vital statistics that depended on an accurate count of the population. As such, many published statistics in the historical records remain incorrect

Venezuela. The planters had difficulty retrieving these "fugitive apprentices," because Trinidad did not have an extradition treaty with Venezuela. Daniel Hart, *Trinidad and the Other West India Islands and Colonies*, 2nd ed., (Trinidad: Chronicle Publishing Office, 1866), 74. Forty years later, in 1903, Governor Henry Jackson indicated, in his Blue Book report, the government's intention to attempt to stop the leakage to Venezuela. BPP 1905 [cd 2238-19], *Colonial Reports - Annual. No. 442. Trinidad and Tobago*, 3.

⁹⁹ In 1896, the Colonial Office and Foreign Office became concerned about the aggressive recruiting of Indians in Trinidad and Jamaica by Columbians, because this recruitment had upset the Indian government. Over the next two years, Trinidad enlisted the support of the British Legation in Venezuela to attempt to retrieve at least fifty escapees. TDAD *Confidential Despatch* #247, 30 September 1896. CO 295-375 (1896) #25430. *Coolies enlisted for labour in Columbia*. Report by Attorney-General Vincent Brown. CO 295-375 (1896) #23257. *Coolies enlisted for labour in Columbia*. Acting Colonial Secretary C.C. Knolleys to Secretary of State Chamberlain. CO 295-393 (1897) #8533. *Return of Coolies from Columbia*. Acting Protector of Immigrants H.C. Stone reported a similar problem had occurred in 1893, although the Indians had been found to be happy and prospering in Venezuela. 1894 LC #102, *Protector of Immigrants AR*, 6.

¹⁰⁰ See, for instance, 1891 LC #45. *Registrar-General AR*, 5. 1911 LC #162 *Registrar-General AR*, 3. 1922 LC #86 *Registrar-General AR*, 3-4.

¹⁰¹ Despite each Registrar's attempt to account for this annual population leakage, each census confirmed an under-estimation of emigration. As a result, the annual vital statistics reports consistently over-estimated the population by 7% to 10% during each of the decades of this study. The 1901 census, for instance, counted 255,148 residents, although officials anticipated a population of 277,651 (an error of 8.8% or 22,503 people). This problem continued during the subsequent decades. The 1911 census enumerated 333,552 residents, which was 10.3% less than the estimate of 368,014. The 1921 census enumerated 365,913 persons, compared to the estimated 391,279. 1902 LC #118, *Registrar-General AR*, 3-4. 1911 LC #162, *Registrar-General AR*, 3. 1922 LC #86, *Registrar-General AR*, 3-4.

to 1921. Appendices 2.1 to 2.4 provide a detailed calculation of the population leakage and tables of recalculated vital statistics to revise the erroneous vital statistics published by the Registrar-Generals, which they admitted were incorrect due to the population leakage. Updated vital statistics are provided for migration and natural increase (including crude birth and death rates) statistics in the appendices, and used throughout the quantitative analysis, above.

Conclusions

Although Britain's abolition of slavery redefined Trinidadian society, many ideologies remained current amongst the members of the Creole plantocracy. Africans could no longer be enslaved, but were not considered equal citizens. Sugar workers would no longer be human chattel, but still would be a foreign race. The form of bonded labour changed from slavery to indenture, but these bodies were not those of free migrants and labourers. All these changes proceeded apace, as Trinidad continued to look beyond its borders to satisfy its demands for labour. This had major repercussions for generations of residents, not the least of which involved the questions if they would be born, die, and bear children in Trinidad.

Imperial-world intellectual currents upheld the ideals that commoditised non-white labouring bodies as both expendable and replaceable. During slavery, Trinidad's plantocracy had advanced this commoditisation philosophy to an extreme level. The Coolie Immigration Ordinance 13 of 1870 penalised planters who wantonly sacrificed too many East Indian bodies each year through poor health conditions or by working the people to death. However, the discourse on the expendability of labouring bodies simply made room for a new race of Asian labourers and then marginalised the African bodies which had once been of vital importance, but had suddenly become inconsequential to the plantation economy. The policies privileging the plantocracy's desire for a population of bonded Indian labourers put obstacles in the way of the natural growth of all sectors, as the long-standing axiom persisted that the next generation of labourers would not be born in Trinidad. These manipulations ensured that the system of indenture would continue to allow planters to buy the labour of vital importance to the plantation economy, rather than buying the bodies themselves.

The plantocracy achieved its objective of manipulating the colonial demographics to neither whiten nor blacken Trinidad. Nonetheless, the lived lives of the people proceeded in spite of the official will. For growth by natural increase, many residents hurtled the barriers to family formation and reproduction that had been put in their way. In terms of migration, innumerable people made personal decisions about immigration and emigration. Although Trinidad's elite portrayed the colony as the *El Dorado* for East Indians, many residents thought otherwise and sailed or leaked out of Trinidad because they conceived their *El Dorado* to be elsewhere across the Gulf of Paria in the Spanish Main or in the circum-Caribbean area.

The quantitative analysis of natural increase established the different decades when each sector became a self-sustaining population. For the East Indian sector, the gender imbalance was a surmountable obstacle, and natural increase began although

approximately 15% of its people still laboured under indenture, and the equivalent number of people were precluded from leaving Trinidad during the other five years of their contracts of industrial residency. By contrast, with a slightly lower sexual disparity, enslaved Africans had experienced a profoundly unnatural decrease in their numbers. Free Africans and their descendants in the post-emancipation period needed five decades to become a self-sustaining population. The difference between the indentured and formerly enslaved peoples suggests that the barrier to natural increase was much more complex than freedom and the gender ratio for the Afro-Trinidadian peoples. Certainly, the legacies of slavery continued for many decades hence, suggesting that historical demographers should continue their studies into the post-emancipation period, to examine the development of the African populations in the British West Indies, and compare those results to the other populations in the colonies. Although the unnatural decrease in the slave populations was central to the abolitionist discourse, as Brian Moore established, the problem did not end at emancipation.

The legacies of slavery continued to influence the ideologies and attitudes of the powerful white Creole decision makers in Trinidad, to 1916. By repositioning indentured immigration as the central axis of the policy on population growth, and then measuring the outcomes, this study established the disinterest of the ruling class in investing in the long-term growth of the subject peoples. This attitude had a direct correlation to the struggles over the function of the GMS organisation and the services that it provided to the public, as discussed below (in Chapters 4, 5, and 6): the Creole elite continually disclaimed the state's obligation to invest in the health of its subjects. The genesis of this disinterest is evident in the broader policies on the development of the population.

Chapter 3 continues to explore the attitudes of Trinidad's white elites, in regards to the health conditions aboard the ships transporting the Indians to the West Indies. Between 1840 and 1872, the Colonial Land and Emigration Commission supervised the state programs of assisted migration and regulated the conditions aboard the ships. In addition to indentured East Indians journeying to the Caribbean, many Britons travelled to white settler colonies at the same time, as wards of the Imperial and colonial governments. This period provides a rare opportunity to investigate how race and gender influenced the construction of very different public health and medical conditions aboard the ships carrying white settlers and indentured East Indians.

– Chapter 3 –

Maritime Public Health: Imperial Values and Migrant Bodies, 1840-1872.

While it is difficult to quantify precisely the number of migrants during the period of imperial expansion, statisticians estimate that about fifty million Europeans emigrated internationally, between 1846 and 1924.¹ Many migrants sought to improve their lives, despite the health risks associated with ocean travel. Philip Curtin characterised the “epidemiology of migration” as the movement of people between different disease environments, usually resulting in heightened mortality and morbidities amongst the migrants. He recently lamented that studies of migrant health begin after the people arrived at their destination. At present, little is known about the health of travellers during their lengthy ocean journeys.² This omission in the literature on migrant health is intriguing in light of the Imperial government’s frenzied activities to mitigate the health risks of ocean travel, by imposing health and safety legislation on ships embarking from or arriving in British ports, to protect the health of the migrants who were so vitally important to populate the Empire.

In 1840, Lord John Russell established the Colonial Land and Emigration Commission (CLEC) to reform the conditions of maritime health and safety for passengers from the lower classes, using the regulatory device of the Imperial Passengers’ Act.³ The commissioners promoted their regulations as vitally important to protect the “health, comfort, and good conduct” of the emigrants.⁴ During the CLEC’s regulatory tenure of 1840 to 1872, about 6.4 million continental Britons emigrated to the white settler colonies and United States.⁵ 325,587 of the poorest of these people travelled gratuitously to the Australian colonies in government-assisted migration programs.⁶ At the same time, another half million British Indians travelled from India to the sugar-producing plantation colonies in the British West Indies and Mauritius, to labour under indenture for five years.⁷ These two populations of impoverished white Britons and East Indians journeyed aboard ships chartered and supervised by the CLEC. A direct comparison is possible, and enlightening.

This study establishes that each population’s racial and gender demographics resulted in the creation of two different public health frameworks for assisted migrants. The regulations dictating “good conduct” conflated the migrants’ behaviours, which correlated to one’s predisposition to disease and ill-health, with a broader attempt to

¹ Walter F. Wilcox, ed., *International Migrations. Statistics*. Vol. I (New York: Gordon and Breach, 1969 ed.), 82.

² Philip D. Curtin, “The Epidemiology of Migration,” in David Eltis, ed., *Free and Coerced Migrations from the Old World to the New. Global Perspectives* (California: Stanford Univ. Press, 2002): 94, 106.

³ BPP 1840 #35, *Colonial Land Board. Copies of Commissions appointing T.F. Elliot and Robert Torrens, Esquires, and the Hon. Edward E. Villiers, Land and Emigration Commissioners*, 1-12.

⁴ BPP 1850 [1204], *Tenth General Report of the Colonial Land and Emigration Commissioners*, 6. [Hereafter, *CLEC Tenth AR*.]

⁵ BPP 1873 [c.768], *CLEC Thirty-Third AR*, 47-9, 68-9.

⁶ The Australian colonial sponsors included New Zealand, New South Wales, Victoria, West Australia, South Australia, and Queensland.

⁷ BPP 1873 [c.768], *Thirty-Third CLEC Report*, 47-9, 68-9.

civilise the future colonial residents. The medico-moral sanitary order legislated for ships transporting white Britons intended to build a better and more moral class of white settlers during the journey, while the regime for East Indians consisted of a program to civilise a foreign race. This study explores the period of ocean travel, when the Imperial and colonial governments were directly responsible for the health of the East Indian and white British assisted-migrants, to ascertain the relationship between public health and the civilising mission. Whereby Chapter 2 established the attitudes of Trinidad's white Creole elite about the long-term development of its subject peoples, this study considers how those outlooks influenced the maritime health protection policies for the Indians.

After reviewing the extant literature, this study establishes the connection between the Chadwickian health reforms introduced in continental England and the CLEC's numerous reforms to the Imperial Passengers' Act, beginning in the early 1840s. The investigation of the different medico-moral sanitary orders aboard the Australian and East Indian ships reveals the extent to which the definition of public health protections depended on the race and gender of the specific population. The outcomes of the two diverse medico-moral sanitary orders are then evaluated through a quantitative comparison of the shipboard mortality rates for each population. The legislator's zealous enforcement of the medico-moral sanitary order, to protect the morality of the future wives and mothers of the Australian colonies, resulted in low mortality rates aboard their ships. By contrast, the majority of these health protections were not instituted on the ships carrying East Indians, concentrating instead on civilising the coolie body. Many ships disregarded the requirements to provide life sustaining necessities, resulting in very high mortality rates aboard many ships travelling to Trinidad and British Guiana.

Historical Continuities: Middle Passage and Coolie Ship Mortality

Indentured East Indians travelled to their host colonies aboard ships chartered and supervised by the CLEC and their colonial sponsors. They journeyed aboard so-called "Coolie Ships," which were purpose-built boats constructed to meet the legislated standards of passenger health and safety. To-date, few historians have investigated the migrants' experience on the lengthy voyage to the West Indies, and the health of the migrants has not been their primary concern.⁸ Hugh Tinker identified a symptom of unhealthy Coolie Ships when he highlighted a few random years of excessive deaths. Tinker argued, for instance, that the 1864-65 mortality of 29.7% of passengers on the

⁸ Shepherd confirmed that historians have not studied the seaborne phase of migration extensively. Verene Shepherd, *Maharani's Misery. Narratives of a Passage from India to the Caribbean* (Jamaica: University of West Indies Press, 2002), xviii. The literature involving the migrant voyages is restricted to a handful of historians. Verene A. Shepherd, "The 'Other Middle Passage?' Nineteenth-century bonded labour migration and the legacy of the slavery debate in the British-colonised Caribbean," in *idem*, ed. *Working Slavery, Pricing Freedom. Perspectives from the Caribbean, Africa and the African Diaspora* (NY: Palgrave, 2001), 343-76. David Northrup, *Indentured Labor in the Age of Imperialism, 1834-1922* (NY: Cambridge Univ. Press, 1995), 80-103. K.O. Laurence, *A Question of Labour. Indentured Immigration into Trinidad and British Guiana 1875-1917* (Jamaica: Ian Randle, 1994), 78-103. Basdeo Mangru, *Benevolent Neutrality. Indian Government Policy and Labour Migration to British Guiana 1854-1884* (London: Hansib, 1987), 109-37. M.D. Ramesar, *Indian Immigration into Trinidad 1897-1917* (unpublished Master's Thesis, University of West Indies, Trinidad, 1973), 79-103.

Coolie Ship *Golden South* would have triggered an Imperial crisis, if these travellers had been (white) English migrants, instead of East Indians.⁹ This mortality appears excessive when compared to the frenzy elicited during the anti-slavery parliamentary debates, when William Wilberforce proffered of the unacceptable 12.5% mortality rate on Middle Passage voyages.¹⁰ In 1788, the Imperial government enacted “Dolben’s Act” to mitigate the deaths aboard the slave ships.¹¹ This contentious legislation triggered intense debates about the ship conditions, which historians interpret as the quest to assign culpability and moral responsibility for the deaths of so many slaves.¹² Pro-slavery proponents attributed the mortality to the Africans’ pre-existing health, while critics blamed the slave traders for horrific conditions and brutal treatment of their human cargos.¹³

Following Tinker, scholars unfailingly noticed the high mortality, particularly in 1856-1857 and 1864-1865.¹⁴ Basdeo Mangru and Keith Laurence questioned the death rates in light of the myriad of complex regulations created by the India, Imperial, and colonial governments.¹⁵ Laurence chronicled ever-changing and confusing rules at the immigration depots and on the ships, which leaves no doubt about the governmental activity.¹⁶ Ralph Shlomowitz and John McDonald commended Tinker for identifying the problem, while criticizing his lack of systematic quantification. Their study demonstrated a sustained pattern of high mortality, but failed to provide explanations for the deaths.¹⁷ The literature has thus established that the governments were actively involved in regulating the shipboard conditions, but many immigrants did not survive the journey.

The voice of the travelling subaltern East Indian had not been heard until Verene Shepherd investigated the brutal rape and death of female migrant Maharani in October 1885. The Colonial Office insisted that British Guiana’s Governor Henry Irving inquire into Maharani’s death, as part of its campaign to prove that ship conditions did not replicate the atrocities of the Middle Passage.¹⁸ Shepherd argued that Coolie Ships were sites of “(s)exploitation,” where many women endured abuse: sexual, physical, mental, and otherwise. Maharani and others clearly lacked confidence in Dr. Hardwicke, the government’s Surgeon-Superintendent, who Shepherd suspected was the rapist.¹⁹ Her

⁹ Hugh Tinker, *A New System of Slavery. The Export of Indian Labour Overseas 1830-1920* (London: Oxford Univ. Press, 1974), 163.

¹⁰ Herbert Klein, Stanley Engerman, Robin Haines, and Ralph Shlomowitz, “Transoceanic Mortality: The Slave Trade in Comparative Perspective,” *William and Mary Quarterly*, LVIII, 1 (2001), 97.

¹¹ Dolben’s Act was formally entitled *An act to regulate, for a limited time, the shipping and carrying of slaves in British vessels from the coast of Africa*. Richard H. Steckel and Richard A. Jensen, “New Evidence of Slave and Crew Mortality in the Atlantic Slave Trade,” *Journal of Economic History*, XLIV (March 1986), 76.

¹² Klein, et.al, “Transoceanic Mortality,” 93, 97.

¹³ Steckel and Jensen, “New Evidence of Slave and Crew Mortality,” 57-8.

¹⁴ Laurence, *A Question of Labour*, 92, 95. Mangru, *Benevolent Neutrality*, 110-12, 116, 119-20. Shepherd, *Maharani’s Misery*, 23.

¹⁵ Basdeo Mangru, “The Depot and the Voyage,” *Benevolent Neutrality*, 109-37.

¹⁶ Laurence, *A Question of Labour*, 78-103.

¹⁷ Ralph Shlomowitz and John McDonald, “Mortality of Indian Labour on Ocean Voyages, 1843-1917,” *Studies in History*, 6, 1 (1990), 36, 38-40.

¹⁸ Shepherd, *Maharani’s Misery*, xxv.

¹⁹ Shepherd, *Maharani’s Misery*, 74-5.

illumination of the gendered exploitation confronted a major problem characterising Coolie Ships, which can be missed in the cryptic references by both officials and current-day historians.²⁰ Shepherd's corrective illuminated the surgeon's questionable medical skills and the failure of British justice, thus raising questions about the effectiveness of the multi-governmental apparatus which should have protected the emigrants.

The scholarly neglect of this maritime phase of migration presents a stark contrast to the robust interest in the diaspora of enslaved Africans on the Middle Passage, who preceded East Indians as the labour force of choice in the plantation colonies. However, consistent with diaspora studies, historians studying the nineteenth-century expansion of the Empire are at present expanding their analytical frameworks. David Eltis and Robin Cohen have encouraged scholars to adopt a framework that situates the migratory peoples as the central objects in their studies and contextualises the migrations in a global setting. Eltis further counselled historians to consider the values which guided the actions of each participating community.²¹ This analysis of the health conditions aboard the emigrant ships draws upon the quantitative methods established by the historians of Middle Passage mortality, but contextualises the outcomes within a comparative study of the colonial sponsors' valuation of the bodies of their immigrant populations. As suggested by Eltis, the guiding values of the various governments had a direct bearing on the maritime public health protections enacted to protect those bodies on the different fleets of emigrant ships.

Chadwickian Public Health and Maritime Reforms

Following the precedent of Dolben's Act for the slave ships, Britain enacted the 1803 Imperial Passengers' Act to protect the poor classes of British travellers during their journeys in steerage class aboard commercial ships. In 1839, John George, Earl of Durham, complained that the antiquated Act had failed to protect the health of seaborne migrants: he identified a major problem with the unhealthy and mortality-inducing conditions on the emigrant ships.²² Durham reported that about 5% of the British immigrants travelling to Canada died during the voyages, while 20% of the survivors required hospitalisation when they arrived. These sickly and ailing immigrants drained the resources of the host colonies and imperilled the health of the settled populations.²³

²⁰ Laurence, *A Question of Labour*, 87-8. Surgeon-Superintendent Laing directed novices to beware of ship masters who exhibited "antagonistic" interests to East Indian well-being and health. CO 885-5 (1889) #75, *Hand Book for Surgeons [sic] Superintendent of the Coolie Emigration Service by James M. Laing, M.A. and L.R.C.S.E.*, 9, 43-6.

²¹ Robin Cohen, ed., *The Cambridge Survey of World Migration* (Cambridge: Cambridge Univ. Press, 1995), 1-2. David Eltis, "Free and Coerced Migrations from the Old World to the New," in David Eltis, ed., *Coerced and Free Migrations. Global Perspectives* (California: Stanford University Press, 2002), 37-3, 48. David Eltis, "Introduction. Migration and Agency in Global History," in *idem*, ed., *Coerced and Free Migrations*, 2-4, 17-8.

²² Durham was investigating rebellions in Upper and Lower Canada when he revealed this major problem with the ship conditions. BPP 1839 #3, *Report on the Affairs of British North America from the Earl of Durham, Her Majesty's High Commission, 11 February 1839*, A2. [Hereafter, *Lord Durham's Report*.] Stanley Johnson, *A History of Emigration from the United Kingdom to North America 1763-1912* (London: Frank Cass, 1966, 1913 reprint), 22, 107.

²³ BPP 1839 #3, *Lord Durham's Report*, 87-9. BPP 1839 #3-II, *Lord Durham's Report*,

Britain's initiative to redistribute labouring peoples to populate the Empire faltered every time shipboard conditions killed prospective immigrants, or when the ships arrived laden with diseased and emaciated passengers. Durham's message was clear: the commerce of migration was thwarting the progress of Imperial expansion.

In the spirit of the Benthamite reform era, Britain established the CLEC in response to Durham's exposé, intending to solve many problems in peopling the North American and Australian colonies.²⁴ Despite the advent of free trade, which included the free movement of people throughout the Empire, the Imperial government realised that it needed to intervene to protect the health of the migratory labouring classes. The CLEC henceforth reformed and managed the Passengers' Act to regulate the conditions in steerage class, so that migrants would arrive in their destinations in a healthy state. During the CLEC's regulatory tenure, about 6.4 million persons emigrated from the British Isles.²⁵ Over 5.5 million emigrants paid their own fares to North America, with the majority destined for America, and 14% arriving in British colonies.²⁶ An additional 600,000 people paid the higher fares and journeyed to the Australian colonies.²⁷ These lower class migrants could afford to pay their own fares, deciding on their destination, and then travelling aboard private commercial ships regulated by the Passengers' Act. Conversely, the other 325,587 assisted British migrants had a different relationship with the regulators and the Australian colonial governments, because they were too impoverished to afford to migrate. After passing rigorous screening tests to determine their desirability and suitability to be settlers, they travelled gratuitously as wards of colonies aboard CLEC-chartered ships.²⁸ The assisted-migration programs helped the Australian colonies attract white settlers, who were otherwise deterred by the heightened health risks of the longer journey and the higher cost of the ship fares.

The Imperial government expanded the CLEC's mandate when the post-emancipation labour problems erupted in the sugar-producing colonies in Mauritius and the West Indies. As established above (in Chapters 1 and 2), the formerly enslaved peoples refused to accept the exploitative conditions of labour on the estates and the colonial planters relentlessly predicted imminent economic disaster, unless they immediately found large numbers of labourers. Malthusian ideals facilitated the solution of redeploying indentured East Indians, which appeared utilitarian to the colonies, Colonial Office, and India. However, as the CLEC took the reins of control, the India government had recently terminated the short-lived 1836 and 1837 redeployment of the "Gladstone Coolies." India's ensuing inquiry identified the poor conditions on the ships and predicted that maritime mortality would soon approach the levels formerly experienced by the slaves on the Middle Passage.²⁹ The Indian government insisted on

Appendix (A), 11. BPP 1839 #3-III, *Lord Durham's Report*, Appendix (B), 35.

²⁴ Oliver MacDonagh, *A Pattern of Government Growth 1800-1860. The Passenger Acts and their Enforcement* (London: MacGibbon and Kee, 1961), 129-37.

²⁵ BPP 1873 [c.768], *CLEC Thirty-Third AR*, 48-9.

²⁶ BPP 1873 [c.768], *CLEC Thirty-Third AR*, 48-9.

²⁷ BPP 1873 [c.768], *CLEC Thirty-Third AR*, Appendix 1 and 10.

²⁸ BPP 1873 [c.768], *CLEC Thirty-Third AR*, Appendix 1 and 10.

²⁹ I.M. Cumpston, *Indians Overseas in British Territories 1834-1854*, 2nd ed. (London: Dawson of Pall Mall, 1969), 24, 52. BPP 1874 #314, *Mr. Geoghegan's Report on Coolie Emigration from India*, 5-8.

active civil and medical superintendence of the indentured Indians before it would reinstate immigration. Thus, in 1845, the British Parliament mandated the CLEC to supervise the transportation of the Indians aboard the Coolie Ships. This program redeployed 146,257 East Indians to the British West Indies and 352,785 to Mauritius during the CLEC's tenure, until 1872.³⁰ The CLEC was therefore responsible for the maritime health of two populations of sponsored migrants at the same time: poor Britons travelling to the Australian colonies and poor East Indians destined to be bonded workers in the sugar-producing plantation colonies.

To-date, historians have not investigated how the rapidly changing ideas on poverty and public health during the 1840s informed the Passengers' Act's emergent health protection regulations for the impoverished British subjects who migrated during the CLEC's term as the Imperial regulator.³¹ At the same time that the anti-slavery reformers succeeded in their quest to abolish slavery, several other reforming factions were interested in the health of the labouring classes, including the Benthamite reformers, Chadwickian public health disciples, and the framers of the New Poor Law. The literature on public health reform in England provides insights into the significant changes underway in Imperial world conceptions of disease causation and poverty. This was an important time in the formulation of the embryonic "sanitary idea," which characterized Britain's health reform movement for the duration of the century.³² In 1842, the Poor Law Commission's secretary, Edwin Chadwick, released his lengthy study, *The Sanitary Condition of the Labouring Population of Great Britain*.³³ Chadwick employed a vast array of statistics to establish a firm connection between morbidity and mortality and the living and working conditions of the lower classes. Dirty and overcrowded living conditions were identified as the causes of inexorably intertwined physical and moral health problems.³⁴ Anne Digby compared Chadwick's report to a modern-day "best-seller," with an estimated 100,000 copies sold to the public.³⁵ The British public was interested in the condition of the labouring classes.

Chadwick's report launched Benthamite disciples into a campaign to sanitize and rectify the overcrowded conditions of England's labouring and poor classes.³⁶ The sanitarian discourse connected overcrowding to ill-health: too many closely-knit bodies impeded the ventilation necessary to allow fresh air to diffuse the hazardous effluvia

³⁰ BPP 1873 [768], *CLEC Thirty-Third AR*, 68-9.

³¹ The two extant monographs consider the legislation within the genre of political history, stressing the growth of administrative government. Fred Hitchins, *The Colonial Land and Emigration Commission* (London: Oxford University Press, 1931). MacDonagh, *A Pattern of Government Growth 1800-1860*.

³² Pelling qualified the key period in the development of new public health ideas as the years spanning 1838 to 1850. Margaret Pelling, *Cholera, Fever and English Medicine 1825-1865* (Oxford: Oxford Univ. Press, 1978), 34.

³³ BPP 1842 #006, *Report to Her Majesty's Principal Secretary of State for the Home Department, from the Poor Law Commissioners, on an inquiry into the Sanitary Condition of the Labouring Population of Great Britain*.

³⁴ Anthony S. Wohl, *Endangered Lives. Public Health in Victorian Britain* (Mass.: Harvard Univ. Press, 1983), 287.

³⁵ Anne Digby, *British Welfare Policy: Workhouse to Workfare* (London: Faber and Faber, 1989), 40.

³⁶ Pelling, *Cholera, Fever and English Medicine*, 7.

known to cause ill-health and created the conditions where immoral behaviour flourished. The reformers' interest in free flowing fresh air remained central to the health tenets for the duration of the century, causing Anthony Wohl to characterise it as a "national obsession."³⁷ In Great Britain, reformers recognised the connection between dearth, dirt, and ill-health. They henceforth directed their attentions to the public sphere and the structures of working-class homes, including sewerage, drainage, ventilation of the homes, and potable drinking water.

The Imperial government published Chadwick's epoch-making study and enacted the CLEC's first major reforms to the Imperial Passengers' Act in 1842: the CLEC's reforms adapted this developing corpus of public health knowledge to the maritime environment, but only for the people who travelled in steerage class. Passengers in transit on emigrant vessels spent most of their time in the below-ship decks, where hundreds of strangers lived together in the exceptionally cramped steerage deck, and often did not see the light of day. The turbulent waters caused widespread seasickness, especially during the first several weeks of the voyage.³⁸ Below-deck amenities did not include privies or washing facilities. Healthy and ailing emigrants alike attempted to survive within the confines of the dark, damp, ill-ventilated, and generally filthy passenger deck. The maritime officials recognised the connection between this captive passenger environment and the high rates of ill-health amongst the travellers. Port officials watched apparently healthy people board ships, only to be ravaged in-transit by the outbreaks of diseases. The CLEC decided that the migrants' heightened susceptibility to the diseases resulted from their weakened conditions, sea sickness, malnourishment, the inability to partake of fresh air, and from a general state of post-departure "alarm."³⁹ The CLEC accumulated extensive statistics, which confirmed its concerns about the unhealthy environment on the migrant ships.⁴⁰

The CLEC enacted its first set of reforms in 1842, which introduced health protections forcing the ship owners to provide passengers with food, water, and rudimentary medical comforts, and include these health-sustaining necessities within the cost of the fare.⁴¹ However, the CLEC's obsession with keeping fares as low as possible, so not to deter intending migrants, resulted in the stipulation that ship owners had to provide only a minimal amount of food and water, and could not adequately address the overcrowding.⁴² The merchant ship operators would have liked to fill their vessels with more passengers, rather than supplies, but the Passengers' Act now mandated that each "statute adult" would receive a bread and water diet; children received half rations and infants had no entitlements.⁴³ This health innovation targeted

³⁷ Wohl, *Endangered Lives*, 285-6.

³⁸ BPP 1854 [1833], *CLEC Fourteenth AR*, 20.

³⁹ BPP 1854 [1833], *CLEC Fourteenth AR*, 20-1.

⁴⁰ BPP 1850 [1204], *CLEC Tenth AR*, 8. MacDonagh's monograph meticulously describes how the CLEC accumulated knowledge and became experts. MacDonagh, *Government Growth*.

⁴¹ *An Act for regulating the Carriage of Passengers in Merchant Vessels*, 5&5 Vic., c.107.

⁴² Passengers previously provided their own food. Many emigrants had difficulty paying the fare and could not afford to purchase enough food to last several months. BPP 1842 #567, *CLEC Second AR*, 15. BPP 1853 [1647], *CLEC Thirteenth AR*, 25. BPP 1842 [355], *Report of the Land and Emigration Commissioners on the necessity of amending the Passengers' Act*, 3-6.

⁴³ Britons became statute adults at age fourteen and Indians at twelve. Children counted as half an adult and infants were not counted. BPP 1842 #116, *A Bill (as amended by the Committee)*

the high incidence of disease vulnerability due to starvation and dehydration.

The regulations attempted to minimize the shipboard overcrowding in order to ensure that the passenger deck had a supply of fresh air, as officials implicated the putrid odours, rather than the human filth, as the root of the poor health conditions.⁴⁴ The compulsion with free-flowing fresh air initiated a long debate about overcrowding. Ship owners maximized profits by putting as many people as possible into steerage class, but critics insisted that the overcrowding was “one of the worst evils” on ships.⁴⁵ They correlated the excess numbers of people on the ships to the subsequent progress of major health problems during the voyages, believing that the presence of too many people impeded the ventilation and the fetid air caused ill-health.⁴⁶ Regulators thus limited the number of emigrants who could legally travel on a ship, to a certain extent, by specifying a statute amount of space per passenger. Ship owners naturally increased the fares.⁴⁷

The Passengers’ Act basic health protections introduced a restricted number of the fundamental mechanisms of British healthcare by requiring ships to carry medical chests and, over time, to construct rudimentary hospitals. A debate raged for decades whether the Act should compel private ships to employ a surgeon. The pragmatic problem of a lack of medical men interested in the high-risk and low status job convinced the CLEC that it was impractical to require all ships to hire a surgeon: many people, including the regulators, feared that the ships would be delayed or grounded due to a lack of medical men.⁴⁸ A matrix of changing regulations thus specified which private ships did and did not require surgeons, while the Imperial government employed physicians in Great Britain’s major ports to seek out unhealthy emigrants. Pre-boarding medical screening was difficult. Inspectors were fully aware that many migrants did not exhibit signs of ill-health, or would conceal their medical conditions, but the prevailing medical knowledge recognised that people carried the “seeds of disease” and “latent” illnesses.⁴⁹ Officials admitted that these external examinations for the invisible seeds of disease were ineffective, especially as the inspectors did not know the medical histories of transient passengers, and travellers knew better than to admit to ill-health.⁵⁰

for regulating the Carriage of Passengers in Merchant Vessels, 18 March 1842, 3, 5, 23.

⁴⁴ The sources are rife with descriptions of the putrid odours on ships. Durham claimed that residents could smell the emigrant ships before they arrived. BPP 1839 #3-III, *Lord Durham’s Report*, 87. When the smell became unbearable, crews were sent below-deck to shovel out the filth and excrement. BPP 1851 #632, *Report from the Select Committee on Passengers’ Act*, xxvi.

⁴⁵ BPP 1842 [355], *Passengers’ Act*, 15-16.

⁴⁶ BPP 1854 #349, *Second Report from the Select Committee on Emigrant Ships*, iv, viii.

⁴⁷ Engerman argued that the regulations caused the ship owners to increase the fare prices, which decreased the number of migrants. Stanley L. Engerman, “Changing Laws and Regulations and Their Impact on Migration,” in David Eltis, ed., *Free and Coerced Migrations from the Old World to the New. Global Perspectives* (California: Stanford University Press, 2002), 87.

⁴⁸ The CLEC estimated that private ships departing from Liverpool required about 100 surgeons during each quarter of the calendar. The commissioners stated that it would be impossible to find that many competent surgeons. BPP 1842 [355], *Passengers’ Act*, 5-6, 20.

⁴⁹ BPP 1854 [1833], *CLEC Fourteenth AR*, 20-1. BPP 1857 [2249], *CLEC Seventeenth AR*, 47. BPP 1874 #314, *Geoghegan’s Report*, 45. BPP 1854 #349, *Second Report from the Select Committee*, vi. Cholera and India’s typhus gaol fever were stated to be difficult “latent” diseases to detect amongst emigrants. Laurence, *A Question of Labour*, 94.

⁵⁰ BPP 1854 [1833], *CLEC Fourteenth AR*, 20-1.

Regulators were cognizant of the connection between migrants' exposure to epidemics and subsequent shipboard appearances of disease, usually in an "aggravated form."⁵¹ Officials had the power to halt departures during epidemics, but this rarely happened, due to the disruption to commercial shipping and the problems created by detaining the emigrants, who continually streamed into crowded and disease-infested ports.⁵²

The reforms to the 1842 Passengers' Act thus embodied many tensions between the medical knowledge of the day, the cost of health protections, and the CLEC's mandate to keep the migrants flowing to the colonies. These struggles resulted in the reformed Passengers' Act instituting a rudimentary level of health protections for passengers travelling in steerage class aboard the majority of ships in the Imperial world. Nonetheless, the provision of basic food and water, the reduction in overcrowding, medical chests, and the pre-boarding medical screening helped to alleviate some of the worst conditions aboard the vessels. These stipulations applied to passengers travelling in steerage class throughout the Empire. Although these basic maritime health reforms seem insufficient to the modern-day observer, they represented a significant improvement over the previous conditions experienced by the seaborne travellers. The migrants were not asked their opinions: the expectation was that they would be the passive, improved, recipients of the reforms.

The Medico-Moral Sanitary Order for Government-Sponsored Migrants

The conditions of maritime travel were different for the poor emigrants who travelled as guests of the colonial governments in the programs of sponsored migration. The CLEC-chartered ships facilitated a unique relationship between the lowest classes of emigrants and the nineteenth-century state. The colonial sponsors assumed the responsibility for the welfare of their passengers and they directly controlled the conditions aboard the ships. These ships invoked auxiliary health regulations, which intended to transform the passengers by instilling the racially and gender-specific behaviours inherent in "good conduct."⁵³ Ships transporting assisted migrants afforded an unprecedented opportunity for officials to reform the behaviours known to cause ill-health.

Acting on the orders of the colonial sponsors, shipboard officials had several months during the time at sea to reform the behaviours of their wards. Impoverished Britons sailing to the Australian colonies were aboard the ship for about twenty-two weeks.⁵⁴ The journey was a similar length for East Indians sailing to the West Indies.⁵⁵

⁵¹ BPP 1857-8 [2395], *CLEC Eighteenth AR*, 13-4. MacDonagh, *Government Growth*, 140-2.

⁵² Ships departing from epidemic-infested ports would usually be cleared for departure if no new cases of diseases appeared on the scheduled date of departure. BPP 1854 #349, *Second Report from the Select Committee*, vi.

⁵³ BPP 1850 [1204], *CLEC Tenth AR*, 6.

⁵⁴ The voyage was twenty weeks to West Australia and twenty-four to New Zealand. BPP 1852 #348, *Passengers Act Amendment Bill (as amended in committee)*, 15 Victoria, 11.

⁵⁵ The voyage from Calcutta to the West Indies took twenty to twenty-two weeks. BPP 1854 [1833]. *CLEC Fourteenth AR*, 67. BPP 1852 #348, *Passengers Act Amendment Bill*.

⁵⁵ The voyage from Calcutta to the West Indies took twenty to twenty-two weeks. BPP 1854 [1833]. *CLEC Fourteenth AR*, 67.

The medical knowledge of the day indicated that it was perilous to human health to make long sea journeys and traverse tropical climates.⁵⁶ The supplementary sanitary regulations aboard these ships thus dictated mandatory emigrant behaviours, ranging from routine schedules for eating, exercising, and taking fresh air, to the compulsory use of privies, laundry, and bathing.⁵⁷ The similarities in the moral-sanitary order then deviated sharply, depending upon whether ships carried white Britons or East Indians. The regulations reflected the sponsors' views of the status of each migrant population in the hierarchy of civilisation and savagery and their capabilities for improvement.

One of the few similarities between the fleets involved the officer responsible for passenger health and enforcing the sanitary order: the Surgeon-Superintendent. The different objectives of building better Britons for Australia and civilising the East Indians necessitated the creation of two different cadres of medical men for the ships. Historians offer brief but wide-ranging portrayals of Surgeon-Superintendents aboard Coolie Ships as diverse men, ranging from the consummate hero to the tragically incompetent, medically, morally, and otherwise.⁵⁸ The literature contrasts the lucrative remuneration paid to surgeons working on Australia-destined ships to the low pay scales offered to Coolie Ship surgeons.⁵⁹ Low pay and status, along with the working conditions, attracting sub-standard medical men, is thus implicitly a causal factor in explaining the disparity in healthiness aboard the different fleets of ships.

The cause of this remunerative disparity, however, can be interpreted as symptomatic of the value placed on the different responsibilities associated with each corps of medical men, as the job function and the employers deviated substantially between the two fleets. Both cadres of surgeons tended to passengers' medical needs. However, on Australia-bound ships, the CLEC recruited and employed these men directly. The Australian colonies placed a high monetary value upon this job. The Surgeon-Superintendent functioned as the seaborne Imperial representative and fully-empowered Medical Officer of Health. The CLEC spent considerable time recruiting and equipping Surgeon-Superintendents to perform their expansive role, and in publicizing the job as vitally important.⁶⁰ The CLEC routinely credited all beneficial ship health to its

⁵⁶ The Passengers' Act invoked special requirements for ships travelling on long journeys and those which passed through the tropics. One of the main requirements was an adjustment in the number of superficial feet allocated per passenger, which meant that fewer people could be carried on the ships. BPP 1842 [355] *Passengers' Act*, 15-16.

⁵⁷ Orders specified that all passengers were out of bed by 7.00 am and in bed by 10.00 pm. Before breakfast, passengers dressed, rolled up their beds, swept the berths, and disposed of all dirt. Each day, adult men (five per 100 emigrants) swept, scraped, and holy-stoned decks, and cleaned the ladders, round-houses, and hospitals. The men were prohibited from entering women's quarters. BPP 1850 [1163], *Papers Relative to the Emigration to the Australian Colonies. Papers Relative to Instructions for Surgeons of Emigrant Ships sailing under the Superintendence of Her Majesty's Colonial Land and Emigration Commissioners*, 224-33. BPP 1847-1848 [916], *CLEC Eighth AR*, 58.

⁵⁸ Shepherd argued that the competency of the surgeon was recognised to be crucial to the success of the voyage, but difficulties recruiting surgeons resulted in use of incompetent surgeons. Shepherd, *Maharani's Misery*, 19, 24-9.

⁵⁹ Shepherd, *Maharani's Misery*, 19. Mangru, *Benevolent Neutrality*, 36. Tinker, *A New System of Slavery*, 151.

⁶⁰ BPP 1850 [1204], *CLEC Tenth AR*, 8-10. BPP 1870 [196], *CLEC Thirteenth AR*, 13. BPP

elite corps of physicians.⁶¹ These hand-picked surgeons were essential to the job of enforcing a broadly-conceived moral-sanitary order, stipulating a regime of mandatory behaviours to ensure the cleanliness of the individual's body, mind, and morals.

In contrast, Surgeon-Superintendents on Coolie Ships had only an arms-length relationship with the Imperial and colonial governments, as the government contracts required ship owners to hire their own surgeons. This posed quite a challenge, due to the well-known and acute dearth of British-trained surgeons available at the embarkation depots in India. Historians assert that a surgeon's "availability" often functioned as the employment criteria.⁶² Captains boarded newly-graduated students, or those without formal training.⁶³ Ships travelling elsewhere in the Empire periodically hired medical staff without formal credentials. However, a much larger ratio of non-accredited doctors worked on the Coolie Ships.⁶⁴ The CLEC constructed the job in a way that was less appealing to potential surgeons. Tinker characterised the job as "lonely, monotonous, and at times arduous and dangerous," making this Surgeon-Superintendent function one that would not attract "clever and ambitious candidates."⁶⁵ The moral-sanitary order for Coolie Ships tasked the medical men to civilize this race and ensure that healthy Coolies were ready to labour in the sugar colonies. The significant disparity in the surgeon pay scales between the two fleets, then, reflected different Imperial values on the responsibilities assigned to the medical men, as the objectives and tasks of medico-moral uplift differed substantially for the two migratory populations.

Building Better Britons for Australian Colonies

Australian colonies encouraged the immigration of healthy labourers, young families with few children, and equal numbers of single men and women, in order to populate the territories with productive and reproductive labouring family units.⁶⁶ Catherine Hall described Australia's strategy for colonisation, based on Edward Gibbon Wakefield's theories of the 1830s, that the country should be systematically colonised by young English families.⁶⁷ Gendered ideals influenced the organisation of this colonisation. Lisa Chilton argued that white women were of vital importance to Britain's project to "domesticate the dominions" and civilise the inhabitants of the Empire. Chilton established that officials and female emigration societies collaborated to attract the

1850 [1163], *Instructions to Surgeons*, 102-3.

⁶¹ BPP 1850 [1204], CLEC Tenth AR, 7. BPP 1857 [2249]. CLEC Seventeenth AR, 14. BPP 1870 [c.196]. CLEC Thirtieth AR, 13. Tinker, *A New System of Slavery*, 149.

⁶² Mangru, *Benevolent Neutrality*, 123. Tinker, *A New System of Slavery*, 163.

⁶³ BPP 1874 #314, *Geoghegan's Report*, 26-7.

⁶⁴ BPP 1854-55 #293, *Return of the Number of Her Majesty's Ships and Vessels now in Commission on Home and Foreign Service*. BPP 1875 #240, *Return of Names, Ages, and Nationalities of Persons who have service in the British Merchant Service during the last Two Years as Surgeons and whose Names do not Appear in the Medical Register*. BPP 1876 #316, *Ship Surgeons. Return of Names, Ages, and Nationalities of Persons who have Served in the British Merchant Service as Surgeons whose Names do not appear in the Medical Register*.

⁶⁵ Tinker, *A New System of Slavery*, 148.

⁶⁶ BPP 1842 #567, CLEC Second AR, 18.

⁶⁷ Catherine Hall, *Civilising Subjects: Metropole and Colony in the English Imagination, 1830-1867* (Chicago: University of Chicago Press, 2002), 27-42.

“right” type of female migrants and then instituted programs to improve these women during their voyage to the white settler colonies.⁶⁸ Unmarried female migrants would perform a vital role, forming family units and then producing the next generation of colonial residents.⁶⁹

Imperial officials developed a fastidious interest in the conduct of the women, who became the prime subjects in the governmental initiative to build a better class of labouring white Britons through the CLEC’s maritime medico-moral sanitary order. In 1846, the ever cost-conscious CLEC took the unprecedented step of hiring matrons to work for the Surgeon-Superintendents as the “natural protector” of female morals.⁷⁰ Chilton defined the function of the matron as a chaperone, necessary to maintain the respectability of the women during the voyage, and thus protect the public image of female migration to the white settler colonies.⁷¹ Matrons had an extensive list of duties to “improve” the women during the journey and prepare them for their future role domesticating and civilising the Australian colonies.⁷² They conducted daily educational classes for women and constantly inspected the cleanliness of the children.⁷³ Passengers could be mustered at all hours of the night to ensure proper moral conduct by verifying that everyone slept in their proper and segregated places. Matrons were essential to the sanitary order. They had to be firm and vigilant with their female charges, and watch for misconduct from the male officers, crew, and passengers; officials continually expressed their surprise that the matrons performed their jobs so well.⁷⁴ The administrative anxieties over the female passengers precluded these ships from developing into the ‘(s)exploitative’ environments which Shepherd found aboard the Coolie Ships.

In this initiative to improve the migrants and create a better class of Britons, Australia ships appointed teachers and religious instructors to work under the direction of the Surgeon-Superintendent. Clergymen conducted daily classes for adults and children, Sunday services, and operated rudimentary lending libraries. Emigrants who conformed to the medico-moral regime were rewarded with mattresses, linens, dishes, and books for their new life.⁷⁵ Those who defied risked imprisonment or fines: each ship selected a cadre of male enforcement officers from the emigrant cohort, dressed them in much-coveted uniforms, and directed the deputized men to heed the surgeon’s directions and enforce the sanitary order.⁷⁶ Australia-bound government ships operated under the

⁶⁸ Lisa Chilton, *Agents of Empire. British Female Migration to Canada and Australia, 1860s-1930* (Toronto: University of Toronto Press, 2007), 9, 11, 71.

⁶⁹ Marjory Harper, “British Migration and the Peopling of the Empire,” in Andrew Porter, ed., *The Oxford History of the British Empire. Vol. III. The Nineteenth Century* (NY: Oxford University Press, 1999), 81.

⁷⁰ BPP 1850 [1163], *Instructions for Surgeons*, 228-31.

⁷¹ Chilton, *Agents of Empire*, 57-61.

⁷² Chilton, *Agents of Empire*, 9-10, 57-61.

⁷³ BPP 1850 [1163], *Instructions for Surgeons*, 228-31. The matron received a free fare and small gratuity, if the authorities approved of her performance during the trip.

⁷⁴ Matrons were appointed by the CLEC or Surgeon-Superintendent, recommended by the British Ladies Female Emigration Society. By 1857, at least forty-three matrons were employed. BPP 1857-58 [2395], *CLEC Eighteenth AR*, 20-1. BPP 1859 [2555], *CLEC Nineteenth AR*, 15-16.

⁷⁵ BPP 1850 [1163]. *Instructions for Surgeons*, 226-31.

⁷⁶ There was one constable for each fifty emigrants. BPP 1850 [1163], *Instructions for Surgeons*, 225.

most comprehensive regulations, where the health protections intended to change the immoral behaviours of the migrants, including their sexual habits, religiosity, parenting, and advance their education. The work of the highly valued and empowered Surgeon-Superintendent was augmented by a small army of matrons, clergymen, teachers, and constables, who were not employed by the governments on any other ships.

The Australian ships instituted one additional regulatory restriction, which differentiated this public health environment from other ships travelling in the Imperial world. The CLEC analyzed its voluminous collection of mortality statistics and decided that children and infants faced the most risk on sea journeys and were the main carriers of disease.⁷⁷ Current-day statisticians argue that these observations were correct.⁷⁸ The health risks caused the CLEC to restrict the number of infants and children allowed aboard the ships to Australia. The gratuitous transportation offered to these migrants was restricted to families with two children under seven years of age, or three children under age ten.⁷⁹ This form of demographic screening emerged, over time, as a central tenet of health on these ships. Overall, Australia-destined ships were regulated by the most comprehensive maritime public health regulations in the British Empire.

Maritime Public Health: Civilising Coolie Bodies

The medico-moral sanitary order developed for the Coolie Ships took on the decidedly different character of civilizing a non-white race; it lacked the regulatory initiatives and financial investment to build a better and healthier class of Britons. In lieu of moral uplift, the commentaries by officials portray the enforcement of sanitary measures as instilling British behaviours to civilise the East Indians.⁸⁰ However, the behaviours expected from the Indians differed significantly from the other population of assisted migrants. The extensive medico-moral measures to reform future Australians never materialised for East Indians. There were no mandatory classes on childcare, sanitation, education, or Christianity. No cadre of matrons protected the “good conduct” of the women. Instead, the Surgeon-Superintendent may have stood alone in attempting to keep his employer, the crew, and male emigrants from “(s)exploiting” the women.⁸¹ Intense struggles ensued to get passengers to adapt to the basics of this alien sanitary order, such as eating government-supplied food on a regular schedule. Unanswered questions abound whether emigrants understood what they were being told to do, and the amount of force used to encourage migrants to adopt these behaviours, as the ship officers and surgeons were not required to know any Indian languages.⁸² Not

⁷⁷ During 1849-50, for instance, on the ships travelling to Australian colonies, 75% of the recorded deaths were for infants and children. This pattern continued throughout the period of this study. BPP 1850 [1204], *CLEC Tenth AR*, 8. BPP 1866 [3679], *CLEC Twenty-Sixth AR*, 22. BPP 1854 [1833], *CLEC Fourteenth AR*, 20-21.

⁷⁸ Shlomowitz and McDonald, “Mortality of Indian Labour,” 38, 55, 65.

⁷⁹ BPP 1853 [1647], *CLEC Thirteenth AR*, 18-19.

⁸⁰ Laurence, *A Question of Labour*, 87-90. BPP 1850 [1163], *Instructions for Surgeons*, 225-28. CO 885-5 (1889) #75, *Hand Book for Surgeon Superintendents*.

⁸¹ Shepherd, *Maharani's Misery*. Laurence, *A Question of Labour*, 87-8. CO 885-5 (1889) #75, *Hand Book for Surgeon Superintendents*, 9, 43-6.

⁸² In the 1860s, the regulations required ships to carry a third officer as an interpreter, if the surgeon or captain did not speak any languages of India. BPP 1874 #314, *Geoghegan's Report*, 27.

surprisingly, Surgeon-Superintendents found East Indians reluctant to seek medical attention and needed to be vigilant in seeking out the sickliest passengers: they inflicted punishments to force the patients to eat and take medicine.⁸³

Government officials believed that the East Indian body was inherently unhealthy, although these bodies were concurrently regarded as the saviours of the labour-intensive tropical sugar plantations. Officials had low expectations for the health of the migrants during their ocean journeys. CLEC officials framed their regulations based on their belief in the Europeans' more robust physical constitution, which had a superior ability to adapt to seaborne life and withstand the rigors of the voyage: even in their healthiest state, officials believed that the Indians had a "feeble constitution."⁸⁴ The government's instructions to the Surgeon-Superintendents reflected a remarkable racialising of the prevailing health knowledge, predicated on the feebleness of these non-European bodies.⁸⁵ They also ignored cultural differences, with the exception of the need for a distinctly Indian diet. The Coolie Ship medico-moral sanitary order intended to instil the routines of civilized behaviour and otherwise strengthen and rest their feeble bodies during the voyage, such that the Coolie bodies would be in a fitful state of health to perform the gruelling plantation labour.

The medico-moral sanitary initiatives for East Indians were overshadowed by a dispute between the governments and their officials. As established above (in Chapter 2), the Colonial Office insisted that the sponsors despatch a minimum quota of females on each ship. Officials in London knew that women would not leave India without their children, but were not prepared to allow this immigration to proceed without any females, claiming it would be objectionable "on moral grounds."⁸⁶ The female quota became one of the most contentious edicts in India and aboard the Coolie Ships. This quota had significant implications for the health of the passengers, not necessarily from the women *per se*, but because these women naturally brought along their offspring. The officials at the depots in India drew attention to their statistics identifying the relationship between the high shipboard mortality and the presence of a large number of high-risk children.⁸⁷ A debate raged for decades between all parties over the appropriate quota.⁸⁸ As established above (in Chapter 2), the quota was 30 women per 100 men until

⁸³ Tinker, *A New System of Slavery*, 148. The punishments are not documented in detail. Tinker referenced comments by Dr. John Bury in his trip log to Trinidad in 1857.

⁸⁴ BPP 1871 [c.369], *CLEC Thirty-First AR*, 10. BPP 1843 #621, *CLEC Third AR*, 29.

⁸⁵ Pamphlets were issued to surgeons to instruct them on how to deal with the different physical constitutions of the various emigrants. BPP 1843 #621, *CLEC Third AR*, 32. BPP 1850 [1163], *Instructions for Surgeons*, 224-33. CO 885-5 (1889) #75, *Hand Book for Surgeon Superintendents*. Other pamphlets provided instructions for the surgeons on treating diseases in the maritime environment. For instance, India's Sanitary Commissioner Dr. J.M. Cuninghame, wrote a lengthy treatise on preventing and containing the contagious fever which plagued the emigrant ships in the 1864-65 season, although its causes eluded the medical authorities. CO 318-258 (1870) #8428, *West India Immigration*. Encl.: Instructions for the guidance of Surgeon-Superintendents of Government Emigrant Ships regarding Contagious Fever and the Precautions which should be adopted to prevent its spread, by J.M. Cuninghame, M.D.

⁸⁶ BPP 1866 [3679], *CLEC Twenty-Sixth AR*, 22.

⁸⁷ BPP 1874 #314, *Geoghegan's Report*, 24.

⁸⁸ BPP 1861 [2842], *CLEC Twenty-First AR*, 18. BPP 1874 #314, *Geoghegan's Report*, 26, 29, 52.

1868, when the Colonial Office changed it to 40 women per 100 men.⁸⁹ Officials in London ignored the implications for the potential of increased mortality aboard the ships, as documented in the statistics of their experts, when they issued their directives about the gendered female quota for the ships departing from India.

The demographic screening on the Australian and East India ships thus represented two different processes. Australian colonies desired equal numbers of male and female immigrants, to create a moral population and civilise the dominions. Officials restricted the number of children who could board the ships as part of the public health screening process. The West Indian colonies desired temporarily sojourning male labourers and were disinterested in attracting women unless they would labour under indenture. The Colonial Office set the quota as a measure to ensure morality amongst the sojourners, but the refusal by the women to migrate without their children resulted in many high-risk travellers being boarded on the ships. The female quota thus represented a compromise between the objectives of creating a moral immigrant population and containing the mortality rates aboard the ships.

Officials in London turned a blind eye to the related problem of recruiting female indentured labourers.⁹⁰ However, unlike Australian migration, where the “right” type of women received free passages, West Indian colonies did not offer free passages to encourage female migration. All adult immigrants were required to sign a contract of indenture, which obligated them to perform arduous agricultural labour. In the constant struggle to fill the quotas of women, agents in India often allegedly recruited the “sweepings of the bazaars” and confessed to loading ships with prostitutes and women they had rescued from “a life of degradation.”⁹¹ The situation was quite different compared to the moral screening of women destined for Australia. On one occasion, the *Melbourne Daily News* reported that several local gentlemen were outraged to find that six newly arrived female emigrants had disembarked from the ships and promptly went in search of employment at the local brothels. The men lambasted the CLEC for sending women who added to the local vice, rather than “good and useful members of society,” who they could employ as servants.⁹² By contrast, the emigration agents in India complained about the difficulty filling the quota, while doing whatever was necessary to get the requisite number of women on the ships. These officials allowed many sickly children aboard, because their mothers helped fill the quota.⁹³

Historians have questioned if the women were indeed prostitutes and the dregs of society.⁹⁴ The Indian nationalists who agitated to end the system in the early twentieth

⁸⁹ BPP 1874 #314, *Geoghegan's Report*, 52.

⁹⁰ Shepherd, *Maharani's Misery*, 5-10.

⁹¹ CO 295-407 (1901) #42210, *Class of Emigrants dispatched from Agency*, Trinidad Agent Stewart to Colonial Office, 189. BPP 1872 [c.562], *CLEC Thirty-Second AR*, 19.

⁹² BPP 1850 [1163], *Papers relative to the Emigration to the Australian Colonies*, Melbourne Daily News, 20 January 1849, 125.

⁹³ The willingness of the officials in India to board large numbers of children is evident into the 1880s. Shlomowitz and McDonald, “Mortality of Indian Labour,” 57. Madhavi Kale, “Capital Spectacles in British Frames’: Capital, Empire and Indian Indentured Migration to the Caribbean,” *International Review of Social History*, 41 (1996), 130.

⁹⁴ Prabhu P. Mohapatra, “‘Restoring the Family’: Wife Murders and the Making of a Sexual Contract for Indian Immigrant Labour in the British Caribbean Colonies, 1860-1920,” *Studies in*

century claimed that the prostitution of women occurred after recruitment. Rhoda Reddock argued that this sentiment gained currency and was one of the key reasons why India terminated indentured migration in 1916.⁹⁵ Certainly, during the period of this study, the emigration agents in India claimed that many of the women had questionable moral orientations.⁹⁶ Officials admitted their desperation in recruiting these potentially health-challenged mothers and their often demonstrably sickly children. As established in the mortality analysis, below, the presence of health-challenged infants and children aboard the Coolie Ships contributed to the continually high mortality rates. By ignoring the precedents for demographic and pre-boarding medical screening, the imperial regulators knowingly contradicted their public health policies mandated for other ships. The conflicting objectives in two different initiatives resulted in this compromise: the decision to use the quota to ensure the establishment of a moral expatriate population, as opposed to the public health protection minimising the number of at-risk infants and children on the ships.

There are no photographs available of the East Indian migrants during the CLEC's tenure, but the following pictures show the Indians upon arrival in Trinidad and British Guiana at about the end of the century. These pictures offer a glimpse into the result of the process to civilise the East Indians and maintain their health, so that they would be ready to labour on the agricultural estates. Figure 3.1 is a photograph of the new arrivals at Trinidad's Coolie Depot, probably at the end of the century. By this time, officials believed that the East Indians improved their health during the journeys under the jurisdiction of the Surgeon-Superintendents.

History, 11 (1995): 227-60. Conversely, Lal argued that the official view that the women were of "loose character" dominates the sources and was "repeated *ad nauseam* in virtually every account." Brij V. Lal, "Understanding the Indian Indenture Experience," *Journal of South Asia Studies*, 21, 1 (1998): 230.

⁹⁵ Rhoda Reddock, "Indian Women and Indentureship in Trinidad and Tobago 1845-1917: Freedom Denied," *Caribbean Quarterly*, 3/4 (1986): 45-6.

⁹⁶ Each colony's emigration agent in India complained to the Colonial Office. Jamaica's W.M. Anderson claimed the women were of the "vilest character." Trinidad's agent, Thornton Warner, said they were "sweeping up females of the lowest character and caste." CO 318-258 (1870) #4789. *West India Immigration*, 1-3. In 1909, at the Sanderson Commission, Colonel Duncan G. Pitcher appeared as an expert witness on immigration, based on his 1882 role as India's investigator of the system. His report criticised the quota and recommended alternatives, so that the agents would not need to "sweep in the Bazaar women." He stated that nothing had changed: recruiters in India were still sweeping the bazaars and paying little attention to the character of the females. In 1909, Pitcher was the Deputy Director of Agriculture for Oudh and the Northwest Provinces. BPP 1910 [cd 5193], *Report of the Committee on Emigration from India to the Crown Colonies and Protectorates. Part II. Minutes of Evidence*, 174-7.

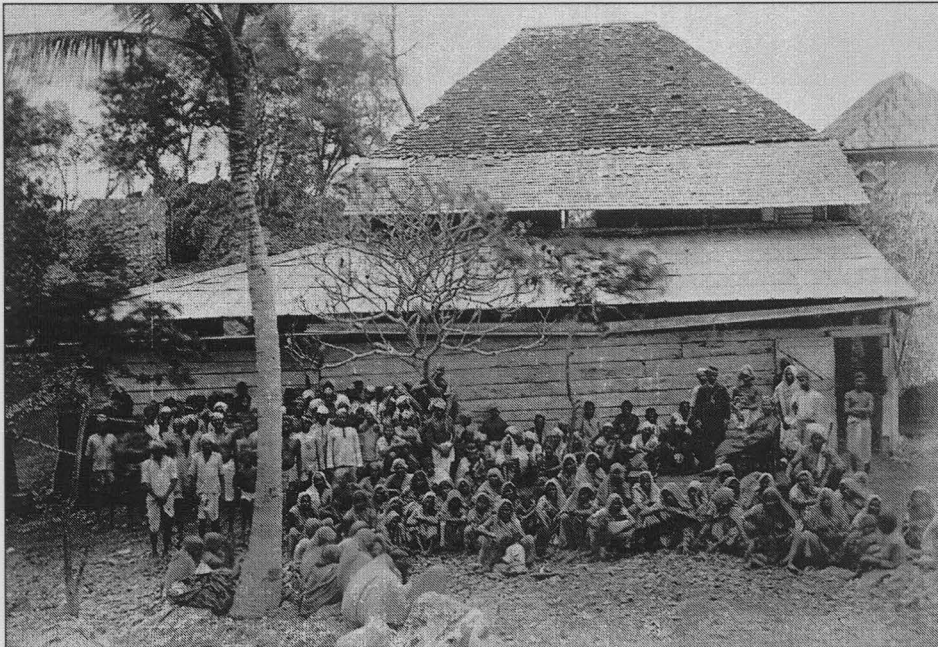


Figure 3.1 – Trinidad: “Coolies on arrival from India, mustered at depot,” [n.d.]⁹⁷
Courtesy of British National Archives. Reprinted with permission.

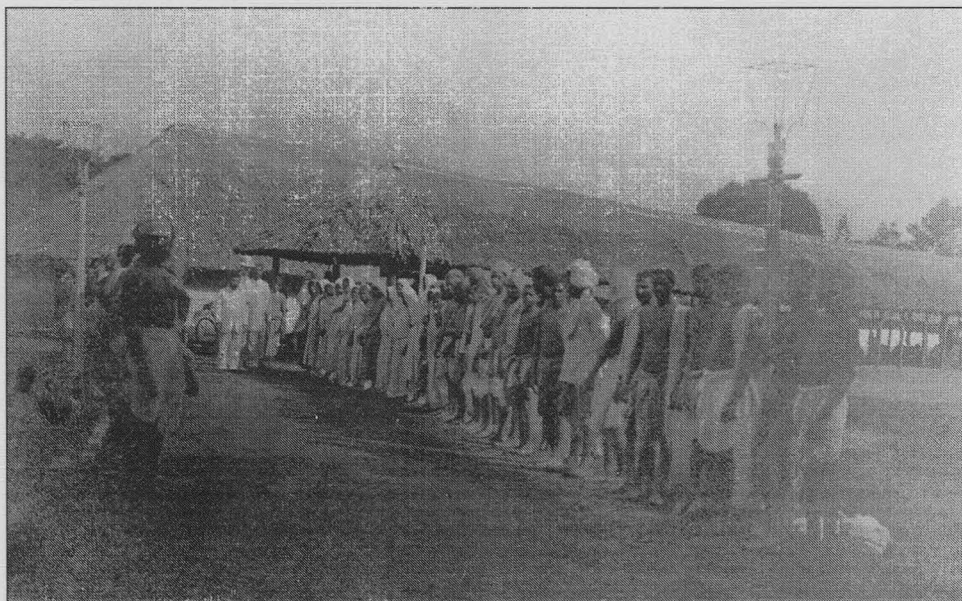


Figure 3.2 – British Guiana: “Medical examination of New Arrivals,” [n.d.]⁹⁸
Courtesy of British National Archives. Reprinted with permission.

Figure 3.2 is a photograph of the East Indians mustered for their medical inspection. There are few details available on the nature of this examination. The

⁹⁷ British National Archives, CO Photographs, CO 1069/392/15. Undated [1890 to 1916].

⁹⁸ British National Archives, CO Photographs, CO 1069/355/41. Undated [1870 to 1916.]

inspection, shown in this picture, may have been rather rapidly performed for the healthy immigrants. The healthy East Indians spent very little time at the depot. After the medical inspection, they would be assigned to their estates and transported to their new Coolie Barracks and jobs within a few days. Ailing new arrivals were sent to the purpose-built hospitals in the depots, where they would convalesce before being allotted to the estates.



*Figure 3.3 – British Guiana: “The Dépôt Hospital, for 94 patients,” [n.d.]⁹⁹
Courtesy of British National Archives. Reprinted with permission.*

Figure 3.4 depicts the new female immigrants and children receiving dinner at the depot in British Guiana, segregated from the men. This picture suggests the colonial standard of the appropriate level of civilised behaviours for East Indians when dining: the women sit outside, with their bowls on the ground, awaiting the porter. It is doubtful that the immigrant women destined for the Australian colonies were taught this form of deportment and civilised behaviours on the ships.

⁹⁹ *British National Archives, CO Photographs, CO 1069/355/46. Undated [1870 to 1916], possibly at the end of the century.*



Figure 3.4 – British Guiana: “The emigrants at their meals,” [n.d.]¹⁰⁰
Courtesy of British National Archives. Reprinted with permission.

In summary, from the 1840s, government-sponsored migrants travelled aboard ships regulated by racialised and gendered maritime health initiatives, based upon the objectives of developing two difference populations for their colonial futures. This investigation now considers the results of these policies, by comparing the human costs of relocation between the two migrant populations.

Quantitative Measurements to Analyse Oceanic Mortality

Historians use two different measurements to analyze seaborne shipboard mortality. Contemporaries used the Voyage Loss Rate (VLR), which indicates the passenger’s probability of dying during the voyage. It is a simple ratio of the number of deaths amongst the passengers who embarked on the voyage, sometimes presented as an annual average VLR for the ships that sailed during the year. The CLEC reported death rates using the VLR and historians of indentured immigration use this calculation. For instance, Tinker piqued historians’ interest in the seaborne mortality by referencing the 1864-65 VLR of 29.7% of the Indians on the *Golden South*.¹⁰¹ However, historians who study mortality on the Middle Passage criticised the impreciseness of the VLR, because it does not allow for variances in the voyage durations, and a few low mortality trips will significantly lower the annual average.¹⁰² To eliminate the statistical effects of variable voyage lengths, historians now prefer to calculate the maritime crude death rate (CDR)

¹⁰⁰ British National Archives, *CO Photographs*, CO 1069/355/42. Undated [1870 to 1916], possibly at the end of the century.

¹⁰¹ Tinker, *A New System of Slavery*, 163.

¹⁰² Klein, et.al., *Transoceanic Mortality*, 107.

per 1,000 passengers at risk, per voyage month.¹⁰³ This model appeared in the 1980s as scholars challenged the Whig assertion that the Middle Passage mortality declined as a result of legislative progress and humanitarianism. To the contrary, studies using the CDR found that the total mortality did indeed decline, but this resulted from the decreased mortality of shorter voyages.¹⁰⁴

Emigrant Ship Mortality Analysis

This analysis of migrant health concentrates on twenty-three emigration seasons, from 1850-51 to 1872-73. Reliable mortality statistics begin with the 1850-1851 migration season, by which time the CLEC had a decade of experience regulating ocean travel. It had enacted the basic health protections for all ships and further instituted the medico-moral sanitary orders for government migrants to Australia and the West Indies. The Passengers' Act, however, was again in a state of flux as cholera pandemics affected seaborne Imperial subjects, between 1847 and 1854. Emigrant ships arrived in colonies carrying diseased and dying passengers. Imperial medical officials tracked the progress of cholera,¹⁰⁵ while it created mortality crises amongst the migrants. Concurrently, two other health-related stimuli changed the patterns of migration. In India, the government terminated indentured migration, from 1848 to 1850, due to the high mortality and the concerns about the financial viability of the colonies over free trade.¹⁰⁶ In an unrelated development, the 1846 onset of famine in Ireland caused emigration to skyrocket to "gigantic proportions," as an estimated 25% of the people left their homeland.¹⁰⁷ British politicians lavished attention on the major health problems accompanying this Irish exodus. These concurrent crises resonated throughout the Imperial world.

The ships transporting white migrants to North America and the Australian colonies had low mortality rates until the cholera pandemic and Irish famine.¹⁰⁸ CLEC officials were convinced that they had contained the shipboard mortality. Reluctant to discourage the migration of the suffering Irish people, the CLEC stayed the course with

¹⁰³ Shlomowitz and McDonald define the "crude death rate per 1,000 per month" as the number of deaths "divided by the average seaboard population at risk, ... divided by the average length of voyage (in '30-day' months), and expressed as a rate per 1,000. The average seaborne population at risk is defined as the number of passengers embarked minus half seaboard deaths, plus half the seaboard births." Shlomowitz and McDonald, "Mortality of Indian Labour," 37. This formula assumes that births and deaths occurred at an even rate during the voyage.

¹⁰⁴ David Eltis, "Mortality and Voyage Length in the Middle Passage: New Evidence from the Nineteenth Century," *Journal of Economic History*, XLIV (June 1984), 301-8.

¹⁰⁵ BPP 1854 #235. *Cholera (Jamaica). Copy of the Report made by Dr. Milroy to the Colonial Office, on the Cholera Epidemic in Jamaica, 1850-51*, 2, 6-7.

¹⁰⁶ BPP 1874 #314, *Geoghegan's Report*, 65.

¹⁰⁷ BPP 1854 [1833], *CLEC Fourteenth AR*, 1. MacDonagh, *Government Growth*, 22-3. Wilcox quantified 2,088,000 Irish emigrants during these years. Walter F. Wilcox, ed., *International Migrations. Interpretations*. Vol. II (NY: Gordon and Breach, 1969 ed.), 264-7.

¹⁰⁸ The CLEC reports indicate that, between 1841 and 1846, the 173,564 Britons emigrating to North America and the Australian colonies experienced a mortality rate of less than .63%, on the ships and in quarantine at their destination. This calculation is not a VLR, because the CLEC included the subsequent post-voyage deaths. BPP 1847-48 [961], *CLEC Eighth AR*, 14-17.

its “bread and water” health protections on the private ships.¹⁰⁹ This mass exodus of too many nutritionally deficient Irish and the prevalence of cholera, however, overtaxed the merchant ship industry. The mortality on the ships travelling to North America became a major concern when reports claimed that the 1847 mortality increased twenty-fold to an unacceptable 16.3%.¹¹⁰ In fact, these allegations were overstated: 5.7% of the embarked passengers perished in 1847.¹¹¹ Thus, the death rate in this purported crisis would never reach the high East Indian mortality rates. Nonetheless, contemporaries believed that 16.3% of North America-destined migrants died during their journeys. Meanwhile, a spate of shipwrecks and philanthropist Vere Forster’s exposé of his horrific incognito emigrant ship voyage intensified the growing public relations disaster.¹¹²

Parliament quickly formed a Select Committee, which reported its findings in 1851 and 1853.¹¹³ The prevailing health knowledge continued to insist on fresh air, water, and food as the central preventive measures, but the Imperial Parliament legislated increased quantities for the passengers travelling on private ships during the flurry of major reforms, until 1855.¹¹⁴ New sanitary measures required the ship operators to provide privies and hospitals on the vessels, issue cooked provisions, and provide segregated sleeping quarters for single people.¹¹⁵ Several preventive measures from the medico-moral sanitary order from the Australian program were thus adapted for private ships. However, the CLEC was still not convinced of the value of forcing the private ships to hire doctors for the journeys. The new regulations alternatively mandated and exempted ships from carrying surgeons, until settling into a complex pattern.¹¹⁶

Figure 3.5 presents the annual Voyage Loss Rates aboard the Coolie Ships. Where the data is available, the table includes VLRs for government ships carrying British

¹⁰⁹ BPP 1847-48 [961], *CLEC Eighth AR*, 14-17.

¹¹⁰ MacDonagh, *Government Growth*, 166, 187. BPP 1847-48 [961], *CLEC Eighth AR*, 14-17.

¹¹¹ The excessive mortality was restricted to ships bound for Canada and New Brunswick, but the media over-stated the numbers. Also, although VLRs only include deaths on the ships, these numbers included post-voyage deaths in the hospitals in the colonies. There were 6,116 deaths amongst 106,812 people, which is a loss rate of 5.7%. BPP 1847-48 [961], *CLEC Eighth AR*, 15.

¹¹² BPP 1851 #198, *Emigrant Ship Washington*. BPP 1854 [1833], *CLEC Fourteenth AR*, 13.

¹¹³ BPP 1851 #632, *Select Committee on Passengers’ Act*. BPP 1854 #163, *First Report from the Select Committee*. BPP 1854 #349, *Second Report from the Select Committee*.

¹¹⁴ The new rules increased the space per passenger by 20% and mandated more nutritious diets for the passengers and required ships to install the new technology for air ventilation. BPP 1850 [1204], *CLEC Tenth AR*, 11. BPP 1851 [1383], *CLEC Eleventh AR*, 6. BPP 1855 [1953], *CLEC Fifteenth AR*, 25. BPP 1856 [2089], *CLEC Sixteenth AR*, 19-20. BPP 1854 #349, *Second Report from the Select Committee*, viii. BPP 1852 #348, *Passengers Act Amendment Bill*, 9. BPP 1854 #255, *A Return of the Names, Stations, Dates of Appointment, and Salaries*, 9.

¹¹⁵ BPP 1852 #348, *Passengers’ Act Amendment Bill*, 5, 8-9, 14.

¹¹⁶ Several factors determined whether surgeons were required on a private ship, including the number of passengers, the size of the ship, and the length of the trip. Ships going to America required a surgeon if they departed between October and January and met other conditions. In effect, most North American ships were exempt from hiring a surgeon. BPP 1854 #255, *A Return of the Names*, 17. BPP 1852 #348, *Passengers Act Amendment Bill*, 15. *An Act to amend the Passengers’ Act and to make further Provision for the Carriage of Passengers by Sea*, 10&11 Victoria, c.103. *An Act to make further Provision for one year, and to the end of the next Session of Parliament, for the Carriage of passengers by sea to North America*, 11&12 Vic., c.6. *The Passengers’ Act*, 1849, 12&13 Vic., c.33. *The Passengers’ Act*, 1853, 15&16 Vic., c.44.

emigrants to Australia and private ships carrying the poor migrants to North America.

Figure 3.5 – Annual Average Voyage Loss Rates (VLR). Government ships for East Indian and Australia migration, and self-paid British migration to North America. 1850-51 to 1872-73 seasons.

Source: statistics from the CLEC Annual Reports (BPP series).^{117 118}

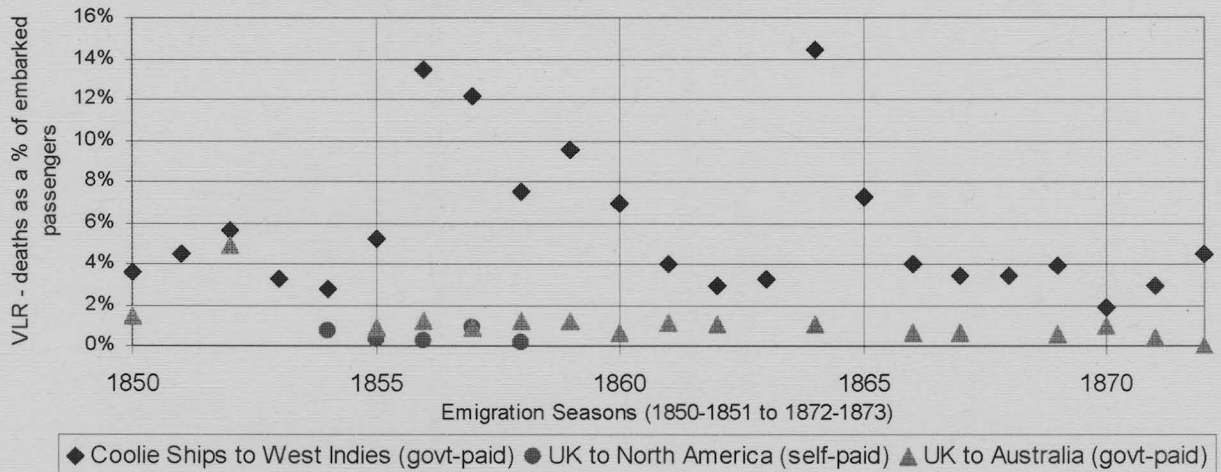


Figure 3.5 reveals a significant statistical difference in the mortality rates between ships carrying East Indian migrants to the West Indies and those conveying white Britons to the colonies. An extremely fluctuating mortality pattern persisted aboard the Coolie Ships, while the shipboard death rates for white colonists settled into a predictable and generally low range, by 1854. By 1856, the regulators indicated that the mortality problem had been brought under control on the North America-destined ships.¹¹⁹ In summary, private ships thus recorded the lowest losses of life, despite being regulated only by the slightly enhanced, but still basic, health protection measures.

Figure 3.5 establishes that Australia-destined government ships experienced slightly higher death rates when compared to the private ships travelling to North America.¹²⁰ The CLEC's explanation of the different mortality rates for these two white

¹¹⁷ The mortality statistics for the ships carrying migrants to North America are incomplete in the CLEC reports. The data is incomplete for a few years of the Australia migration. Figure 3.5 presents the annual VLRs only for the years when the data sets are complete in the CLEC reports.

¹¹⁸ These VLRs are the annual averages of all ships sailing each season. Coolie Ship VLRs are calculated for the 306 ships sailing from Calcutta and Madras to Trinidad or British Guiana, between 1850-51 and 1872-73. The data to calculate the VLRs is extracted from the CLEC annual report statistical appendices. The series of CLEC reports begins with BPP 1853 [1499], *CLEC Twelfth AR* and includes all reports to BPP 1873 [c.768], *CLEC Thirty-Third AR*.

¹¹⁹ BPP 1857 [2249], *CLEC Seventeenth AR*, 13-14. BPP 1857-58 [2395], *CLEC Eighteenth AR*, 19.

¹²⁰ The annual average VLRs generally ranged from a high of 1.5% (in 1850) to a low of 0.01% (in 1872). One exception occurred on the Australian ships in 1852, when the VLR reached 4.9%. The discovery of gold enabled the colonies to invest larger sums of money to encourage emigration, resulting in "unprecedented" numbers of British emigrants. The CLEC claimed that it

populations confirmed its belief in the connection between the slight disparity in the migrants' socio-economic standing and an acceptable mortality rate for each migratory cohort. The officials consistently related the slightly higher mortality on their ships transporting the assisted white migrants to their "inferior" class.¹²¹ Although regulated by the comprehensive medico-moral sanitary order, officials never expected their Australia-bound ships to attain the slightly lower mortality associated with the slightly better class of migrants who were able to pay their own fares.

The CLEC's use of the VLR to compare the shipboard mortality introduces the methodological problem identified by the Middle Passage historians. The journey to the Australian colonies took three times longer than the voyages to North America.¹²² However, the CLEC reports do not provide the data to calculate the more precise CDR for the private ships, which accounts for the variances in the lengths of the journeys. Plausibly, the use of the CDR would produce equitable death rates on both fleets of ships. Nonetheless, the point is that government officials believed that the slight differences in the migrants' socio-economic classes resulted in different mortality rates.

Officials expressed similar attitudes about the East Indian population. It should be noted that, while acknowledging the problems inherent in the VLR, the key variable of voyage length is generally consistent between the Australian and East Indian ships, as both journeys were about twenty-two weeks in duration.¹²³ Although the use of the VLR is not a precise measurement, Figure 3.5 revealed the striking difference on ships conveying Indians. Coolie Ship VLRs approached the low rates characteristic of white migration only once, in 1870. The erratic pattern in the graph and the continued high rates of mortality challenges the tendency of historians to concentrate on 1856-57 and 1864-65.¹²⁴ Indeed, the statistics in Figure 3.5 confirm that mortality was consistently high. Nonetheless, these death rates did not stimulate comparable political anxiety and public outcry in Britain. The ships transporting Indians experienced the highest mortality rates of any ships regulated by the Passengers' Act. Figure 3.5 demonstrated the comparatively long delay before the onset of improvement.¹²⁵ The medico-moral sanitary order designed to civilize this race did not protect the health of East Indians,

was not prepared for this onslaught of migrants. BPP 1852-53 [1647], *CLEC Thirteenth AR*, 12-20.

¹²¹ The commissioners correlated the diminutive gradations in the socio-economic class of the migrants: the ability to pay a £14 passage fare related to different expectations of mortality. BPP 1857 [2249], *CLEC Seventeenth AR*, 13-14. BPP 1857-58 [2395], *CLEC Eighteenth AR*, 19. BPP 1859 [2555], *CLEC Nineteenth AR*, 14-15. BPP 1860 [2696], *CLEC Twentieth AR*, 17. BPP 1870 [c.196], *CLEC Thirtieth AR*, 13.

¹²² In 1850, the journey by sail was thirty-five days from Liverpool to New York and forty-six days to Quebec. The voyages to Australia were about twenty-two weeks. With the introduction of steam ships to North America, by 1856 the journey from the United Kingdom to Canada was twelve days. BPP 1850 [1250], *CLEC Tenth AR*, 1. BPP 1857 [2249], *CLEC Seventeenth AR*, 38.

¹²³ For the Australian journeys, see the note above. The voyage from Calcutta to the West Indies took twenty to twenty-two weeks. BPP 1854 [1833], *CLEC Fourteenth AR*, 67.

¹²⁴ Laurence, *A Question of Labour*, 92, 95. Mangru, *Benevolent Neutrality*, 110-12, 116, 119-20. Shepherd, *Maharani's Misery*, 23. Tinker, *A New System of Slavery*, 162.

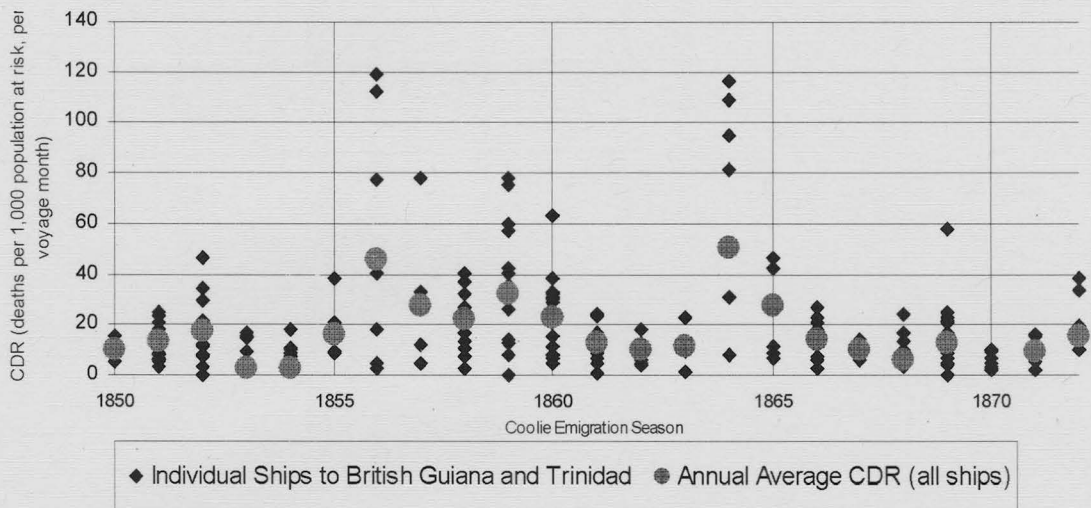
¹²⁵ Mortality decreased to an average of about 1.7% between 1881 and 1891, according to the data provided by D.W.D. Comins, *Note on Emigration from India to Trinidad* (Calcutta: Bengal Secretariat Press, 1893), 29. Shlomowitz and McDonald argued that the CDRs decreased after 1873. Shlomowitz and McDonald, "Mortality of Indian Labour," 45-8.

who clearly paid a higher health relocation cost than any other British population.

Mortality was not inevitable on Coolie Ships. The average annual mortality rates depicted in Figure 3.5 conceal that four ships made the journey without any deaths and another forty-six ships recorded rates below the 1.5% Australian average. Figure 3.2 eliminates the annual averages and presents individual CDRs for 284 Coolie Ships.

*Figure 3.6 – CDRs for 284 Coolie Ships sailing to the West Indies.
1850-51 to 1872-73 seasons.*

Source: data from CLEC Annual Reports (BPP series).¹²⁶



The mortality documented in Figure 3.6 indicates a pattern of high losses, but also confirms that mortality was neither inevitable nor consistently high. At the low end of the range, four ships made the perilous journey without any deaths at all, although two sailed during the highest mortality years.¹²⁷

If mortality could sometimes be contained, the question then arises: why did high death rates persist for several decades? The Imperial and West Indies governments did not interpret the mortality rates on the Coolie Ships against the same standards for white migration. For instance, in 1856-57, the average VLR exceeded 17% on the Coolie Ships. As introduced, above, an alleged loss rate of this magnitude in the North American migration had recently stimulated considerable Imperial attention, the Select Committee reports of 1851 and 1853, and a series of legislative reforms. This death rate for the East Indians did not garner similar attentions or actions in the Imperial metropole. Instead,

¹²⁶ The data to calculate the CDRs is extracted from the CLEC annual report statistical appendices on the passengers embarked and died during the year. This is the same data set used to compute the VLRs for Figure 3.5. The data published by the CLEC allowed VLRs to be calculated for 306 ships. However, CDRs can only be computed for 284 ships, as shown in Figure 3.6, because of missing data for certain ships, such as the duration of the voyage, the number of infant deaths, and so on.

¹²⁷ The five ships with no deaths sailed in the 1852-1853, 1859-1860, and 1869-1870 seasons.

West Indies officials initiated an investigation and expediently exonerated their health protection apparatus. British Guiana officials concluded with the *status quo* condemnation of the officials in India and accused them of filling ships with “sickly and unfit” Coolies.¹²⁸ The colonies sent the results of their inquiries to England, where the CLEC heartily supported their conclusions.¹²⁹ The commissioners rationalised the mortality by blaming the uncivilised and feeble Coolie bodies: mortality was always high because of endemic cholera, Indians’ sickly physical constitutions, and because migrants drank polluted water from Calcutta’s Hoogley River.¹³⁰ The rhetoric emanating from officials in Britain and the West Indies echoed that of the earlier anti-slavery debates, when the pro-slavery faction attributed ship mortality to the slaves’ pre-existing diseases and the conditions in Africa, while vindicating ship conditions, as discussed above. In the opinion of British officials in two corners of the Imperial world, they had done their job and the culpability should be directed eastward to India. The CLEC commissioners sent the mortality statistics to India, asking for a local inquiry, whilst doubting that the government could find a medical officer qualified to conduct an investigation.¹³¹

1857-58 represented a turning point in the history of health for Coolie Ships, although the stimulus for change did not originate from the Imperial regulators or the self-exonerating investigations in the West Indies. Instead, the change occurred as Britain instituted direct rule in India after the Mutiny/Rebellion.¹³² David Arnold and Mark Harrison have each argued that the Mutiny/Rebellion affected a more cautious government stance on some interventionist medical or public health reforms which could have provoked negative reactions from the population.¹³³ Yet, in the instance of public health for the Coolie Ships, officials zealously attacked the problem. The new Raj initiated the first of several penetrating inquiries and surprised both the CLEC and West Indian colonies by appointing well-regarded Dr. Mouat, Inspector of Gaols and Dispensaries, to lead the first inquiry. Mouat took the extraordinary step of spending three weeks travelling on Coolie Ships, perhaps the first Imperial world regulator to experience emigrant ship conditions first hand.¹³⁴

Mouat identified many momentous problems, including the complete lack of enforcement of all basic health protections.¹³⁵ Mouat took particular exception to ships filling their tanks with water from Calcutta’s polluted Hoogley River. The colonial

¹²⁸ BPP 1857-58 [2395], *CLEC Eighteenth AR*, 53-4. BPP 1874 #314, *Geoghegan’s Report*, 24-6.

¹²⁹ BPP 1857-58 [2395], *CLEC Eighteenth AR*, 53-4.

¹³⁰ BPP 1857 [2249], *CLEC Seventeenth AR*, 46-47.

¹³¹ BPP 1874 #314, *Geoghegan’s Report*, 24-6.

¹³² *An Act for the better government of India*, 21&22 Victoria, cap. 106.

¹³³ Arnold argued that political insecurity and fear of resistance caused the state to refrain from compulsory vaccination. David Arnold, *Colonizing the Body. State Medicine and Epidemic Disease in Nineteenth-Century India* (Berkeley: Univ. of California Press, 1993), 158. Harrison argued that the new Raj was reluctant to pursue public health programs which impinged on the local culture. Sanitarians restricted their civilizing mission to education on matters of hygiene. Mark Harrison, *Public Health in British India. Anglo-Indian Preventive Medicine 1859-1914* (Cambridge: Cambridge Univ. Press, 1994), 60, 87-8.

¹³⁴ BPP 1881 [c.2995], *Accommodation and Treatment of Emigrants on Board Atlantic Steam Ships*, Encl. #9. Dr. Mouat to the President of the Board of Trade.

¹³⁵ BPP 1874 #314, *Geoghegan’s Report*, 24-7.

investigation blamed the East Indians for drinking this water, but failed to mention that it was their ship personnel who provided it to the emigrants. Mouat also identified other significant problems, such as ships hiring newly-graduated surgeons, who did not speak Indian languages or understand how to treat East Indians.¹³⁶ Mouat concluded that these and other problems were not unusual in 1856-57, but had persisted for some time. He assigned fault for on-going high mortality to the ship conditions provided by the colonial sponsors of this migration.¹³⁷ India's Governor General in Council and the Secretaries of State in both the Colonial and India Offices accepted Mouat's conclusions. The CLEC commissioners changed their stance and agreed with Mouat's evidence from the Surgeon-Superintendents and ship personnel: many ships had never enforced the sanitary orders.¹³⁸ Evidently, some ship surgeons and officers had their own ideas about the civilising measures to be invoked for East Indians during the journey, which took precedent over the enforcement of the government's well-documented preventive health and disease containment measures.

Clearly, the CLEC and the Passengers' Act had not enforced the protections which the regulations claimed to offer to the East Indians, so India instituted forceful local regulations, requiring colonial sponsors to comply with the edicts or risk having their ships stopped from embarking. The new rules embodied Mouat's recommendations.¹³⁹ From this point forward, East Indians were assured of the crucial health protections of air, clean water, food, and sanitation.¹⁴⁰ Nothing would be left to the discretion of colonial officers. India instituted its own protective apparatus to protect its subjects as they travelled to distant colonies, including a staff of government emigration agents, Protectors of Emigrants, and Medical Inspectors of Emigrants. India Acts controlled the ship conditions and licensed the ships, recruiters, and depots.¹⁴¹ Another important change reflected India's desire to address Mouat's finding that the sanitary discipline of her subjects had not adhered to the government-issued directions. East Indians would henceforth be appointed to police the conformity to the program. Similar to the uniformed cadre of enforcement constables on the Australian ships, sanitary discipline became the responsibility of the Sirdars or "Chief Coolies."¹⁴² India now intervened to ensure that the basic health-maintaining measures previously instituted on the other fleets of migrant ships, fifteen years earlier, were rigorously enforced on the Coolie Ships. The locus of control vaulted from one side of the Imperial world to the other, as India no longer accepted façades of pretended enforcement. Although the Passengers' Act theoretically operated as a higher authority, officials in India simply stopped ships from embarking if the sponsors failed to uphold the locally mandated health standards.

¹³⁶ BPP 1874 #314, *Geoghegan's Report*, 26-7.

¹³⁷ BPP 1874 #314, *Geoghegan's Report*, 24-6. BPP 1857-58 [2395], *CLEC Eighteenth AR*, 13-14.

¹³⁸ BPP 1859 [2555], *CLEC Nineteenth AR*, 49-50.

¹³⁹ "Government of India-Home Department-Public Consultation, 25th March 1859. No. 83-Revised Rules for the Guidance of all Persons concerned in the Emigration of Native Labourers from Calcutta to the West Indies," in BPP 1860 [2696], *CLEC Twentieth AR*, 174-87.

¹⁴⁰ BPP 1860 [2696], *CLEC Twentieth AR*, 175-9. BPP 1874 #314, *Geoghegan's AR*, 26-7.

¹⁴¹ India Act No. 13 of 1864, *An Act to consolidate and amend the laws relating to the emigration of native labourers*. BPP 1865 [3526], *CLEC Twenty-Fifth AR*, 107-26. From 1862, medical officers were appointed to monitor the health of the emigrants in depots. BPP 1863 [3199], *CLEC Twenty-Third AR*, 45.

¹⁴² BPP 1860 [2696], *CLEC Twentieth AR*, 176-7.

One of Mouat's most emphatic proposals, however, remained contentious for decades, as he criticised the number of women and children aboard the ships. He wanted the female quota limited to 25% and special rations for infants, children, and nursing mothers.¹⁴³ The Secretaries of State for India and the Colonial Office refused to sanction Mouat's advice. East Indians in the West Indies had to be provided with women or emigration would be halted on moral grounds, despite the health precedent limiting the numbers of at-risk infants and children allowed on other ships. The direct tension between the two policies on health and morality stimulated disagreement about the number of women required. Mouat wanted 25 women per 100 male migrants, the CLEC insisted on 50, and the Colonial Office set the new quota at 40.¹⁴⁴ The only concession for this high-risk population involved rations of milk, at the surgeon's discretion.¹⁴⁵ The records do not indicate that any other measures were contemplated, such as hiring matrons to inspect the children and educate the mothers on caring for their infants.

This analysis has identified strikingly different mortality rates for three migrant populations, wherein a hierarchy of 'acceptable' mortality is evident. British emigrants able to pay their own fares, and thus from a 'better' socio-economic class, were at the top of the hierarchy. Australia bound government-assisted Britons occupied a nearby albeit slightly lower rung. Indentured East Indians experienced vastly different mortality rates. Imperial attitudes about the race, gender, and economic value of the bodies of these migrants differentiated the two white British populations at the top of this hierarchy from the East Indians at the bottom.

Conclusions

Nineteenth-century Imperial world expansion stimulated the mass migration of several British populations at a time when many broadly-conceived and diverse reform factions emerged to target the conditions of the labouring classes. The colonies sponsoring assisted migration instituted demographic restrictions on the migrants who qualified for free transportation, to ensure that their investments would attract the types of people desired for the future development of their colonies. Australian colonies valued young and healthy Britons who would form productive and reproductive family units. Demographic restrictions precluded the migration of large families, multitudes of disease-carrying children, and imbalanced gender ratios. West Indian colonies sponsored migration for the expressed purpose of providing labouring immigrants to perform the gruelling work under indenture. West Indian colonies thus valued the so-called "Coolie" bodies as temporary sojourners performing exhausting labour, with replacements for the feeble bodies on the next ship arriving from India.

Amidst these different and well-entrenched valuations of immigrant bodies, the Imperial government recognized the need to reform the unhealthy conditions aboard the emigrant ships. The emergent Chadwickian conceptions of public health underpinned

¹⁴³ BPP 1874 #314, *Geoghegan's Report*, 24-6

¹⁴⁴ BPP 1874 #314, *Geoghegan's Report*, 52.

¹⁴⁵ BPP 1859 [2555], *CLEC Nineteenth AR*, 49-50. BPP 1860 [2696], *CLEC Twentieth AR*, 180-1. Nursing mothers received a pint of milk daily. Infants and children under two years of age received the milk ration if they were orphans or if their mothers could not nurse them.

the maritime regulations determining the health conditions for lower class British subjects travelling throughout the imperial world. The controlled environment of the seaborne vessels has provided a rare opportunity to compare the racialising and gendering of a single corpus of public health knowledge. The racial and gendered ideologies allowed several different maritime public health frameworks to coexist, because the colonial sponsors valued the bodies of their immigrants differently. The essence of the strategy to build a better class of Britons to settle the Australian colonies diverged substantially from the scheme to civilize an alien race working as indentured sojourners in the West Indies. The medico-moral sanitary orders designed to execute these objectives resulted in different health outcomes. The regulators believed that the mortality was higher on the Australian ships, when compared to the North American migration. The use of the VLR to measure this mortality does not allow a firm conclusion if this was, in fact, true. Nonetheless, this perception caused the governments to make an unprecedented financial investment in the health conditions aboard the Australian ships, augmented by the demographic screening program to reduce the number of infants and children on the ships. In a striking contrast, the civilizing medico-moral sanitary order aboard Coolie Ships created the conditions where excessive mortality rates prevailed. East Indians paid a significant human health cost of migration, due to the decisions made by the emigration sponsors and their health protection apparatus. High East Indian mortality rates persisted long after the mortality problems had been addressed on ships transporting the other migrant populations.

The gendered quota for the indentured labourers created a significant tension amongst the Imperial, India, and colonial governments, due to the different objectives for the program. West Indian planters continued to demand a predominantly male labourforce. Officials in India were concerned about their ability to recruit women and continued to object to the health perils associated with boarding so many children. The Indian government and Colonial Office were anxious about the morality of the Indians in the West Indies and this policy took precedent over the medical policies to decrease mortality during the journey. Families and women may have been more inclined to migrate if women were offered free passages or exempted from indentured labour. This would have required the planters to pay wages above the subsistence level, to allow the men to support their families, which contravened the fundamental purpose of the system of supplying cheap labour for the troubled sugar industry. By 1916, when India terminated the system of migration, the government recognised that the gendered quota had not allowed moral populations to establish themselves in the colonies.

The intervention by the India government to reduce the shipboard mortality rates sent a clear message to the colonies that excessive deaths would not be tolerated. By licensing all personnel and the emigration depots, India took control over some preventable problems affecting the shipboard conditions. The planters in Trinidad had no choice but to accept the rules in India. However, the situation changed once the Indians arrived in Trinidad. Chapter 4 investigates the advent of Trinidad's Government Medical Services, created in 1870 as the result of an edict by the Colonial Office, as a response to the pressures over the excessive death rates amongst the indentured workers on the plantations. The tensions in the Empire emanating from half way across the world in British India regarding the health of the East Indians overseas had a direct effect on the form and function of state healthcare created in Trinidad.

– Chapter 4 –

*“Take up the White Man’s burden ... And bid the sickness cease”:
Creolising Trinidadian Colonial Healthcare, 1870-80.*

This chapter investigates Trinidad’s contested entry into the provision of healthcare services for the public through the creation of the Government Medical Service (GMS) in the 1870s. The British and Creole elites, representing two powerful factions of white decision makers, each possessed well-entrenched ideas about the state’s obligation to shoulder the burden of responsibility for the health and welfare of its colonial subjects. During this decade, Trinidad established two different variants of the GSM in succession, pulled in one direction by the traditions of slavery and plantation society,² and pushed in another by its responsibilities as a tropical British colony. The first variant of the GSM (1870-74) upheld the treasured values and traditions of the influential members of Creole society, who retained control over health and medical matters. During Henry Irving’s governorship, from 1874 to 1880, the pendulum swung decidedly in the opposite direction, as he energetically forced the plantocracy to confront his view of the state’s obligations to provide western public health and medical services to the non-white subject peoples, as part of imperialism’s civilising mission.

This analysis spans the reigns of three governors: Arthur Gordon (1866-70), James R. Longden (1870-74), and Henry Irving (1874-80). Longden’s unremarkable governorship could otherwise go unnoticed, if his predecessor and successor had not been autocratic governors, both of whom made important changes to state healthcare. Prior to his departure for Mauritius, Gordon enacted several ordinances establishing the GSM and defining the government’s healthcare services for indentured East Indians, while setting a preliminary direction for the form of state medical services for the public at large.³ On his arrival in Trinidad, Longden lost no time acculturating to Creole society and facilitating the plantocracy’s desire to structure the GSM in a way that retained the planters’ cherished customs and values.⁴ The initial variant of the GSM was thus created and flourished during his administration. His successor, a former staff member at the

¹ Rudyard Kipling, *The Writings in Prose and Verse of Rudyard Kipling* (Charles Scribner, 1903), 78.

² Brereton and Trotman concurred that the history of slavery, patriarchy, and plantation society framed the white elite’s worldview. Bridget Brereton, *Race Relations in Colonial Trinidad 1870-1900* (Cambridge: Cambridge University Press, 1979), 35-6. David Vincent Trotman, *Crime in Trinidad. Conflict and Control in a Plantation Society 1838-1900* (Knoxville: University of Tennessee Press, 1986), 35-69.

³ The public at large is defined to include all residents, including people born in Trinidad, immigrants, and post-indenture (free) East Indians. Indentured East Indians are excluded from the definition of the public at large, because the 1870 Coolie Immigration Ordinance 13 restricted their freedoms and civil liberties.

⁴ CO 295-342 (1892) #6356. *Application for Directorship of Sanitary Dept. Egypt*. During Longden’s absences, interim administrators upheld his policies, including W.H. Rennie (1872 to 1873), W.W. Cairns (1874), and the Creole J. Scott Bushe (1874). G. William Des Voeux stated that it was a well-accepted precedent that acting administrators would not approve legislation inconsistent with the wishes of the permanent governor. G. William Des Voeux, *My Colonial Service in British Guiana, St. Lucia, Trinidad, Fiji, Australia, Newfoundland, and Hong Kong with Interludes* (London: John Murray, 1903), 297-8. The list of acting governors is provided in *The Trinidad Official and Commercial Register and Almanack for 1882*, 37.

Colonial Office, Governor Irving, reformed the GMS into a structure that reflected his view of the colonial state's obligations to the poor.

Trinidad began the long process to creolise state healthcare during these protracted struggles during the decade. The influential Creoles believed that the poverty amongst the Afro-Trinidadians signified their regression into barbarism: the people failed to respond to the civilising initiatives, which meant labouring at subsistence wages and using their meagre earnings to maintain their health and pay for healthcare. The Colonial Office and some of its officials insisted that poverty and environmental factors stimulated ill-health: this had been proven by public health reformers in Britain. At the same time, the mass of poor residents demanded state assistance and used the GMS in increasing numbers each year. The GMS healthcare emerged as a negotiated entity which ultimately satisfied none of the factions, but began to address the demand from the lower class Trinidadians.

*Governor Arthur Gordon: Estate Healthcare and
the Creation of Trinidad's Government Medical Services in 1870.*

In the wake of the Afro-Jamaican uprising at Morant Bay in 1865, the Colonial Office realised that its civilising mission was encountering severe difficulties in the plantation colonies. James Patterson Smith argued that Whitehall recognised the need to change its approach to civilising the colonial "barbarian" and to respond to the heightened political pressures about the adverse conditions of the indentured East Indians. The Colonial Office directed its governors to create GMS organisations and make their governments responsible for the health of the labourers.⁵ As one of the few healthcare-related edicts to originate from the metropole during the century, this directive did not lay out a master plan, but allowed each governor a great deal of flexibility to organise the colony's GMS and set the parameters of government care for the indentured Indians.

In Trinidad, Governor Gordon addressed Whitehall's dictate, enacting the new Coolie Immigration Ordinance 13 of 1870, which defined the conditions of work and life for the East Indians and the parameters of state involvement in their medical care.⁶ Laurence Brown argued that Gordon's strong political support in Britain allowed the autocratic governor to codify his reforming ordinance in the colonial statutes, despite the objections from the local elite.⁷ An independently wealthy and politically well-connected member of Britain's upper ranks, Gordon did not need to cultivate the support of the local Creoles. Leading French-Creole and Unofficial member of the Legislative Council, Dr. Louis de Verteuil, commented on Gordon's tenacity: "Sir Arthur was not the man to

⁵ James Patterson Smith, "Empire and Social Reform: British Liberals and the 'Civilizing Mission' in the Sugar Colonies, 1868-1874," *Albion*, 27, 2 (1995): 253, 270.

⁶ The 1870 Immigration Ordinance was not modified substantially until the next consolidating ordinance, Ordinance 19 of 1899. BPP 1904 [cd.1989], *Immigration Ordinances of Trinidad and British Guiana*.

⁷ Laurence Brown, "Inter-colonial migration and the refashioning of indentured labour: Arthur Gordon in Trinidad, Mauritius and Fiji (1866-1880)," in David Lambert and Alan Lester, eds., *Colonial Lives across the British Empire: Imperial Careerings in the Long Nineteenth Century* (Cambridge: Cambridge University Press, 2006), 207, 210-11.

desist from measures which he considered just and fair. Unable to tame his opponents into acquiescence, he did not hesitate to crush them.”⁸

Historians of indenture consider the 1870 Coolie Immigration Ordinance an important piece of legislation.⁹ Until this time, Gordon and the Protector of Immigrants, Dr. Henry Mitchell,¹⁰ had not been too successful convincing planters to address the high mortality rates voluntarily. The ordinance thus obligated planters to provide many basic health measures, such as supplying food to the new arrivals and constructing their barracks housing to a minimum standard.¹¹ Many planters had not bothered to hire doctors to tend to their ailing or injured workers, so Gordon made medical care mandatory: the government henceforth employed Medical Visitors of Plantations to travel to each estate hospital twice a week to care for the East Indians.¹²

One of the most important health-maintaining clauses in the ordinance established a severe penalty for planters who allowed more than 7% of their indentured workers to die during the year. These planters would not be allowed to request new immigrants to replace the deceased workers.¹³ This punitive measure had an immediate effect. Mitchell reported that the mortality rate declined to an unprecedented 4.8% in 1870, although the results were not consistent throughout the estates. Mitchell refused to supply new East Indians to twenty estates in 1870, or about 17% of the total sugar plantations in Trinidad, because their mortality rates exceeded 7%.¹⁴ The following year he imposed the penalty on about 9% of the estates,¹⁵ suggesting that some planters did not embrace the principle that East Indian bodies were not expendable. The literature review, above (in Chapter 1), confirmed that high death rates had prevailed amongst the predecessors to the indentured Indian labourforce: enslaved Africans. This phenomenon re-emerged amongst the East Indians during the early years of the program of indenture. However, the immediate decline in mortality following Mitchell’s enforcement of the

⁸ L.A.A. de Verteuil, *Trinidad: Its Geography, Natural Resources, Administration, Present Conditions and Prospects*, 2nd ed. (London: Cassell and Company, 1884), 465.

⁹ Laurence stated that the passing of the ordinance was the start of the “mature” phase of the system and started his monograph coincident with the ordinance. K.O. Laurence, *A Question of Labour: Indentured Immigration into Trinidad and British Guiana 1875-1917* (Kingston: Ian Randle, 1994), x. Look Lai’s Appendix 2 reprints the consolidated summaries of major changes to Trinidad and British Guiana’s ordinance, using the 1870 law as the starting point. Walton Look Lai, *Indentured Labor, Caribbean Sugar. Chinese and Indian Migrants to the British West Indies, 1838-1918* (Maryland: Johns Hopkins University Press, 1993), 303-13. Brown, “Inter-colonial Migration,” 210-11.

¹⁰ Mitchell was appointed Protector in 1853. *The Colonial Office List, 1881*, 385.

¹¹ Planters had to provide each person over age ten with food rations for the first two years of their indenture. The recipients paid the cost of the rations. BPP 1872 [c.523], *The Present State of Her Majesty’s Colonial Possessions. 1870. 70-5*. [Hereafter, *Blue Book for 1870*.]

¹² BPP 1872 [c.523], *Blue Book for 1870*, 70-1.

¹³ Immigration Ordinance 13 of 1870, BPP 1872 [c.523], *Blue Book for 1870*, 70-5.

¹⁴ Few statistics survive for the 1870s. However, the 1877 estate inspection report recorded 118 estates in operation. The estimate of the percentage of estates which were refused new immigrants assumes that at least 118 estates were operating in 1870 and 1871. 1877 LC #22. *Immigration. Abstract of the Quarterly Returns for the year ending 30th September, 1876*. BPP 1872 [c.523], *Blue Book for 1870*, 70, 74-5.

¹⁵ Eleven estates were refused immigrants in 1871. BPP 1872 [c.523], *Blue Book for 1870*, 74-5.

ordinance confirmed that a large proportion of these deaths could indeed be prevented.

After dealing with the Colonial Office edict to address the conditions of the indentured workers, Gordon turned his attention to the associated order to establish a colonial GMS. As one of his final acts before leaving Trinidad, Gordon pleaded with the Colonial Secretary of State, the Earl of Kimberley, to appoint a Surgeon-General in England and send him to the colony at once. Creole physicians would not be suitable for this senior position in the civil administration. Gordon considered the only English candidate in the colony, Medical Officer of Health Dr. R.H. Bakewell, unsuitable because Bakewell was “at war with many of his own colonists.” In Gordon’s eyes, Bakewell had committed the unpardonable sin of allowing a disagreement with coloured physician Dr. J. Espinet to escalate into a public racial conflict. The Legislative Council did not share this sentiment and held Bakewell in high regard, having appointed him Medical Officer of Health and Vaccinator-General. Bakewell continued his work, enforcing contentious public health measures, while sporting a government-issued firearm for protection, after being tarred and feathered on the steps to Government House early in 1870.¹⁶ As this drama played out in the streets of Port-of-Spain, Gordon expressed a sense of urgency to fill the newly created senior civil service position of Surgeon-General.¹⁷

On the recommendation of the Colonial Land and Emigration Commissioners, the Colonial Office hired Dr. Samuel Leonard Crane, a sixteen-year veteran Surgeon Superintendent aboard the government’s emigrant ships.¹⁸ Crane’s maritime experience managing racial relations and the health of East Indians appeared to be the salient factors in his appointment, but these workers subsequently captured a minimal amount of his attention during his twenty-two year tenure. Planters recognised the value of having government doctors attend to their labourers at no cost to the estate. However, the much larger primary GMS tier of healthcare for the public at large quickly emerged as an object of contention. The influential in Creole society rejected the Colonial Office’s reformed outlook and new mandate to include western medicine in its mission to civilise the colonial barbarian. Surgeon-General Crane and his successors devoted the vast majority of their professional attention to this primary tier of government healthcare serving the impoverished public at large, which rapidly grew in cost and size, placing many Surgeon-Generals in conflict with Trinidad’s Legislative Council.

Colonialism and Poverty: “The Poor Ye Have Always With You”¹⁹

The Colonial Office’s directive to the plantation colonies to institute GMS organisations

¹⁶ CO 295-254 (1870) #8800 [Crane appointed Surgeon General]. CO 295-259 (1871) #2696 [Bakewell and the Justice System], 335-38.

¹⁷ Ordinance 4 of 1869 created the Surgeon-General Department. It was repealed and redefined by Ordinance 17 of 1872 and again by Ordinance 12 of 1893.

¹⁸ CO 295-254 (1870) #8800 [Crane appointed Surgeon General]. CO 295-342 (1892) #6356. *Application for Directorship*. 14 Jan 1892.

¹⁹ This quotation introduced a letter to the editor on the problems of poor Trinidadians accessing GMS healthcare. The letter was written three decades after the period of this chapter, confirming that many conflicts continued. However, by that time, the public and press vocally criticised the government’s negative attitudes about the poor. *The Mirror*, 22 April 1903.

as part of its civilising mission did not dwell on the details of the public health and medical services to be provided to the people. In Trinidad, the colonial elite rejected any sense of responsibility for the health and well-being of the impoverished Indian and African lower orders, although widespread ill-health prevailed amongst these poor residents. Waltraud Ernst alluded to the notion that the relationship between poverty and the advent of colonial medicine may be more prevalent than the scholarship leads one to expect. She encouraged researchers to examine the policies which had a bearing on medical initiatives, such as the state's attitudes to the poor and the mechanisms to deliver healthcare services.²⁰ The official policies about the poor remained vitally important in plantation society colonialism, which purposefully allowed the white minority to control the political economy. Trinidad's plantocracy had historically considered labourers to be expendable commodities, which necessitated the government's intervention with the 1870 Coolie Immigration Ordinance. By contrast, the Colonial Office and its expatriate officials had been conditioned by England's Poor Law tradition and related ideas on the responsibility of the economically secure classes to provide for the poor. These divergent worldviews set the stage for an on-going struggle over the primary tier of the GMS healthcare services for the public at large.

Historians of Britain's social welfare system have argued that major changes occurred in the beliefs on the causes of poverty and its relationship to ill-health, between 1834 and 1867. The Poor Law Amendment Act of 1834, commonly called the New Poor Law, required the poor to enter the workhouse in order to obtain relief. This policy was based on the principle of less-eligibility: in-door relief offered a standard of living lower than the lowest class of labourers could achieve. Able-bodied persons would naturally prefer any other alternative to the miserly conditions in the workhouse.²¹ Less-eligibility would thus deter the able-bodied from seeking relief, while stimulating habits of thrift and industriousness, to teach the workers to provide for themselves in sickness and old age, rather than depending on the parish for support.²² However, the framers of the New Poor Law failed account for the miserable conditions of the labouring poor. Anne Digby argued that it rapidly became apparent to officials that a public program could not reasonably reduce its citizens to living conditions below the subsistence level.²³ Nonetheless, the state enacted additional legislation to reinforce the New Poor Law's attempt to stop out-relief. The Outdoor Relief Prohibitionary Order of 1844 prohibited Poor Law Unions from relieving their poor anywhere other than the workhouse. Historians concur that contemporaries disregarded the law. By the 1860s, the majority of relief was provided by outdoor allowances.²⁴

²⁰ Waltraud Ernst, "Beyond East and West. From the History of Colonial Medicine to a Social History of Medicine(s) in South Asia," *Social History of Medicine*, 20, 3 (2007), 505-24.

²¹ Anne Digby, *British Welfare Policy: Workhouse to Workfare* (London: Faber and Faber, 1989), 31-4.

²² M.A. Crowther, *The Workhouse System 1834-1929. The History of an English Social Institution* (London: Batsford, 1981), 6, 17.

²³ Digby, *British Welfare Policy*, 31-4.

²⁴ Crowther estimated that twice as many people received out-relief, as compared to the people incarcerated in the workhouses. Crowther, "The Workhouse System," 6. Anne Digby, "The Rural Poor Law," in Derek Fraser, ed., *The New Poor Law in the Nineteenth Century* (London: Macmillan, 1976), 170.

Society's view of poverty and its causes thus underwent a radical transformation during these three decades. The New Poor Law had been based upon sentiments characterised by Lynn Hollen Lees as a "virulent hatred of pauperism" and its concomitant "faith in an ethic of self-help and individual responsibility." However, contemporaries soon realised that the economy created poverty. Rather than seeing poverty in terms of moral failure, it came to be recognised as a problem that society needed to combat.²⁵ Public health reformers popularised new explanations of the causes of poverty. Poor Law secretary Edwin Chadwick challenged the extant beliefs, demonstrating that illness caused pauperism: disease, therefore, inflicted a profound economic cost on society.²⁶ Sanitarians exposed how poor food, unsanitary conditions, poor water supplies, and other environmental factors victimised the poor.²⁷ Chadwick's 'sanitary idea' captured the attention of public health reformers and guided their reform campaigns, into the twentieth century. Derek Fraser argued that Chadwick "turned social theory on its head," by demonstrating that unsanitary conditions created social evils and moral problems ("intemperance, prostitution, delinquency, etc."). The prevailing wisdom had traditionally asserted the inverse relationship.²⁸

The New Poor Law did not make provisions for the sick poor. M.W. Flinn stated that reformers were obsessed with exterminating out-relief amongst the able-bodied poor. He argued that a "remarkable" development occurred. The rapidly constructed workhouses consistently included sick wards and infirmaries in the new buildings, although these facilities were not mentioned in the Act.²⁹ The law was soon modified to reflect the practices in the Poor Law Unions, and the provision of medical services was formalised in the General Medical Order of 1842.³⁰ Flinn concluded that the spontaneous development of a national organisation of healthcare providers and facilities was "an accident of history which only the most pressing social need could have engineered."³¹

At about the same time that the Colonial Office issued its edict for plantation colonies to create GMS organisations, Britain's Metropolitan Poor Law Amendment Act of 1867 formally recognised the importance of the massive network of medical institutions and the District Medical Officers (DMOs) in the community. This law established the state's obligation to provide hospitals and other specialised healthcare institutions for the sick poor and separated these services from the workhouse system. Flinn argued that the Act formalised "state medicine," as the workhouse infirmaries and

²⁵ Lynn Hollen Lees, *The Solidarities of Strangers. The English Poor Laws and the People, 1700-1948* (NY: Cambridge Univ. Press, 1998), 223.

²⁶ Digby, *British Welfare Policy*, 40. Chadwick recognised that Poor Law expenditures would continue to increase until the government took action to resolve the problems of poor water supplies, deficient sewerage, and unsanitary housing.

²⁷ Lees, *The Solidarities of Strangers*, 243.

²⁸ Derek Fraser, *The Evolution of the British Welfare State*, 3rd ed., (Britain: Palgrave, 2003), 68-70.

²⁹ Small workhouses created sick wards within their facilities, while larger institutions built infirmaries and engaged full-time medical personnel. M.W. Flinn, "Medical Services under the New Poor Law," in Derek Fraser, ed., *The New Poor Law in the Nineteenth Century* (London: Macmillan, 1976), 48-9, 51.

³⁰ Flinn, "Medical Services under the New Poor Law," 48.

³¹ Flinn, "Medical Services under the New Poor Law," 49.

sick wards were converted to the new system of state hospitals.³² The workhouses had transformed into a resource for institutional hospital treatments for sick and impotent non-able bodied poor people and children. With so many sick people, able-bodied and healthy paupers represented a mere 13.5% of the inmates.³³ Steven Cherry provided statistics which quantify the magnitude of this institutional care. In 1861, in England and Wales, the voluntary hospitals offered 14,800 beds, while the workhouse infirmaries and sick wards provided 50,000 beds.³⁴ In light of the rapid transformation of punitive workhouses into providers of healthcare services, the New Poor Law's fundamental tenet of less-eligibility had been overruled by the actions and practices of officials in the unions, who could not rationalise providing ailing patients with a lesser level of healthcare than the standards offered in the voluntary hospitals.³⁵

Although the New Poor Law system rapidly evolved to become an important locus for both economic and medical relief services, residents in Britain also had other alternatives for assistance. Bernard Harris established the importance of philanthropic and charitable ideals in forming the British elite's view on their obligations to the poor.³⁶ In the complex medico-social support network in England, an expansive suite of services developed over several centuries, involving the parishes, social philanthropy, Poor Law unions, charitable societies, and the national government. Scholars define this amalgam of the "mixed economy of welfare" to include four sectors: the state, voluntary charity, the informal sector, and the commercial organisations (pension plans, insurance companies, and so on).³⁷ In England, each of these sectors provided a variety of medico-social services for the poor.

The resources available to sick or poor Trinidadians differed substantively from the four pillars of the mixed economy of welfare in continental Britain. For instance, the commercial sector was not active during the 1870s.³⁸ Although there are no existing studies on the informal sector, anecdotal evidence suggests that the impoverished lower orders relied extensively on families, friends, and their community during times of

³² The Metropolitan Poor Law Amendment Act of 1867 created the Metropolitan Asylums Board. Flinn stated that a similar law for rural England was enacted the following year. Flinn, "Medical Services under the New Poor Law," 6, 64-5.

³³ Fraser provided Local Government Board statistics for 1874. Children represented 31% of the workhouse inmates, while 53.5% were sick and aged persons. The able-bodied persons were a minority at 13.5% of the residents. Fraser, *The New Poor Law*, 5.

³⁴ Steven Cherry, *Medical Services and the Hospitals in Britain, 1860-1939* (Cambridge: Cambridge University Press, 1996), 45-6.

³⁵ Fraser, *The New Poor Law*, 6. Flinn, "Medical Services under the New Poor Law," 57.

³⁶ Bernard Harris, "Charity and Poor Relief in England and Wales, Circa 1750-1914," Bernard Harris and Paul Bridgen, eds., *Charity and Mutual Aid in Europe and North America since 1800* (NY: Routledge, 2007), 19-42.

³⁷ Bernard Harris, "Introduction: The 'Mixed Economy of Welfare' and the Historiography of Welfare Provision," in Bernard Harris and Paul Bridgen, eds., *Charity and Mutual Aid in Europe and North America since 1800* (NY: Routledge, 2007), 1, 6.

³⁸ The commercial sector of welfare services included commercial pension funds, insurance plans, and so on. These organisations were not active in Trinidad during the 1870s. One of the first quasi-public pension funds was the Widow and Orphan Fund for civil servants established by Ordinance 25 of 1898. By 1901, 250 government employees made voluntary contributions to this fund. 1902 LC #23, *Widows' and Orphans' Fund*.

medical and health troubles. In his 1884 monograph, the influential French-Creole and long-serving Unofficial member of the Legislative Council, Dr. Louis de Verteuil, tempered his racially-derogatory remarks by acknowledging the Afro-Trinidadian people as “charitably disposed, and ever ready to assist the destitute.”³⁹ As concluded below (in chapter 6), after the GMS had become firmly established in the 1880s, many Trinidadians continued to use the informal sector and indigenous remedies extensively before seeking the assistance of the GMS doctors. However, the extent of this sector cannot be quantified from the surviving sources.

The voluntary sector in the mixed economy of welfare had not developed to any extent in Trinidad by the 1870s. Harris discouraged scholars from attempting to understand the motives of philanthropists, recommending that they attempt to ascertain the tangible contributions of charities to society.⁴⁰ In Trinidad, these charities were relatively small. The Port-of-Spain Anglican Church operated the Daily Meal Society, providing meals to about sixty people each day, including the aged, infirm, and patients recently discharged from the hospital.⁴¹ The Protestant and Catholic churches operated tiny asylums in town, but these facilities were so small that commentator Daniel Hart did not realise that they existed.⁴² A few private philanthropic initiatives emerged in the late 1880s in Port-of-Spain.⁴³ Charitable institutions otherwise remained scarce, to 1916. These charities did not offer medical care or long-term relief and were so small that only a few residents benefited from their services.⁴⁴

The colonial state struggled with the most basic questions involving the provision of any welfare services for decades, such as who should shoulder the burden of erecting almshouses and maintaining their residents. The borough of Port-of-Spain operated a small house of refuge with seventy-five beds, with admissions limited to those who could prove their residency in town.⁴⁵ The almshouse capacity remained severely insufficient, in perpetuity, as the town refused to expand the facility. The Port-of-Spain Hospital managed to extract a modest annual sum from the town to offset the cost of providing care to the innumerable people who would have resided in its almshouse, if a large

³⁹ de Verteuil, *Trinidad: Its Geography, Natural Resources*, 13.

⁴⁰ Harris, “Introduction: The ‘Mixed Economy of Welfare,’” 1, 6.

⁴¹ BPP 1866 [c.3719]. *Blue Book for 1864*, 78. Brereton, *Race Relations*, 57-8.

⁴² The 1866 Blue Book indicated that two small asylums existed in town, but they were so small that commentator Daniel Hart thought that the Daily Meal Society was the only charity. Hart, *Trinidad and the other West India Islands*, 129-33. BPP 1866 [c.3719]. *Blue Book for 1864*, 78. The Catholic Church maintained the sixteen-bed St. Vincent’s Asylum for Incurable Patients. *Sadlier’s Catholic Directory, Almanac and Ordo [sic], 1883, Part II, The Catholic Church in the British Provinces of North America, the West Indies, Central and South America* (NY: D.J. Sadlier, 1883), 75.

⁴³ Brereton, *Race Relations*, 57-8.

⁴⁴ In his 1897 report on a system of Poor Laws, Registrar-General C. Bourne lamented the lack of charitable organisations. He confirmed the presence of a few small charities and three old age homes operated by the churches. The Daily Meal Society continued to operate, along with “another similar dole Society.” 1897 LC #188. *Papers relating to the question of Poor Relief*, 3.

⁴⁵ The almshouse had been in operation since 1866 (at least), but little is known about it. By 1877, it hosted 65 to 75 inmates. BPP 1878-79 [c.2273]. *Blue Book for 1877*, 31. BPP 1866 [c.3719]. *Blue Book for 1864*, 77.

enough facility had existed.⁴⁶ The town promised to remove incurable and aged patients from the hospital. This never happened.⁴⁷ In terms of facilities to host the rest of the colony's destitute, old, incurable, blind, or disabled residents, the Legislative Council ignored the pressing need for a colonial House of Refuge until 1881.⁴⁸ Trinidad did not differentiate between able-bodied and non-able-bodied, deserving and non-deserving, or the ill, infirm, and aged residents in the colony. As will be established, below, the poor were an undifferentiated mass of subject peoples, whose poverty was proof of their regression into barbarism.



Figure 4.1 – Colonial Hospital, Port-of-Spain, circa 1880s.
Reprinted with permission, Rockefeller Archive Center.⁴⁹

By the end of the century, the government freely admitted that the absence of a system of Poor Laws had forced the medical institutions to absorb the function of housing the aged, disabled, destitute, and hopeless cases.⁵⁰ Yet, contemporaries proudly

⁴⁶ From 1840 to 1875, Port-of-Spain paid 1/- per person (daily) to the colonial treasury to relieve its paupers in the hospital. Ordinance 27 of 1875 changed this to a token fixed sum, reducing the town's costs from £1,500 to £750 annually. BPP 1875 [c.1183]. *Blue Book for 1875*, 86-7. 1886 LC #92. *Poor Relief. Letter from the Surgeon-General Relative to the Provision for the Maintenance of the Indigent Sick in POS.*

⁴⁷ Incurable patients were to be removed from the hospital, but Crane complained that this rarely occurred. He criticized the Borough for ignoring so many destitute patients, claiming the municipality neglected this "universally recognized obligation." 1886 LC #92. *Poor Relief.*

⁴⁸ 1889 LC #28. *Surgeon-General AR*, 69.

⁴⁹ Rockefeller Archive Center, RF Photographs, 451/116/2286/6937.

⁵⁰ 1897 LC #188. *Papers relating to the question of Poor Relief*, 2-4.



*Figure 4.2 - San Fernando Colonial Hospital, circa late in the century.⁵²
The hospital is the large complex occupying the large area and greenspace on the hill.
Reprinted with permission, British National Archives.*

British Guiana's Chief Medical Officer recognised the similar pragmatic limitations of the healthcare delivery mechanisms in his colony, the other major British West Indian sponsor of indentured labour. Surgeon-General Robert Grieve's comments, in 1888, suggested that the upper ranks of Guianese Creole society had not developed a personal or government sense of responsibility for the lower orders. Grieve reminded his government that it bore the entire cost of the colonial medical system because of the failure of a philanthropic movement to develop.⁵³ Trinidad's influential Creoles similarly rejected the responsibility, either as state-funded or philanthropic initiatives. The lack of Poor Law institutions and infirmaries, charitable hospitals, and public dispensaries restricted the options available to poor residents when ailing, disabled, or injured. If these people needed assistance beyond what could be provided by friends and family in the informal sector, their only hope was to engage with the GMS organisation.

*Elite Creole Worldviews of the White Man's Burden:
The Government Medical Services (1870-74)*

After Gordon's departure for Mauritius, the Creole plantocracy organised its GMS in a manner which reflected its deeply-held traditions, while rejecting many tenets of preventive medicine. The Creoles controlled all medical expenditures and institutions,

⁵¹ CO 295-279 (1877) #13574. *Statements against Dr. Crane and the mortality in the Colonial Hospital*. Encl. Surgeon-General to Colonial Secretary, 4 June 1877. Longden attributed the American comparison to W.G. Sewell, *The Ordeal of Free Labour in the British West Indies* (London: 1861). BPP 1871 [c.344]. *Blue Book for 1869*, 65. For the San Fernando Hospital, see Des Voeux, *My Colonial Service*, 301-2.

⁵² British National Archives, CO 1069/392/20 [n.d.] *View of San Fernando*.

⁵³ British Guiana Sessional Papers (1888), *Surgeon-General AR*, 3.

systematically retained all authority, and did not conceive of an obligation to provide Poor Relief to the public at large. The plantocracy's priority continued to be reducing the death rate amongst the indentured labourers on the estates, due to the perpetual looming threat that India or the Imperial government could intervene and terminate the flow of immigrants. Surgeon-General Crane arrived in Trinidad in the spring of 1871. He subsequently claimed that his new position had been ill-defined, involving only nebulous notions about caring for the police and indentured immigrants, and Governor Longden's edict to reduce the costs at the medical institutions.⁵⁴ Crane's complaint perhaps more accurately reflected the disparity between his views and the Creole decision makers on the function of state healthcare and the Surgeon-General's role. The Legislative Council had in fact defined precisely how it wanted the GMS to function, which precluded allowing a Surgeon-General sent by the Colonial Office to have any latitude to make strategic decisions. Council had enacted several ordinances in advance of Crane's arrival, specifying the management structure at the public hospitals and the appointment of Medical Visitors of Plantations.⁵⁵ Rather than being an ill-defined function, the governor's direction to Crane and the ordinances made the Surgeon-General subordinate to the wishes of the Legislative Council.

The medical care for indentured labourers took precedence in defining the broader contours of the GMS system. The legislators insisted on retaining the existing relationships between the planters and the handful of Creole doctors who had been servicing some estates.⁵⁶ The plantocracy drew on its historical precedent of engaging doctors through part-time contracts. Longden issued contracts to twenty-one doctors, including five patronage appointments of Medical Visitors of Plantations, and sixteen part-time positions in the urban hospitals and asylums or delivering statutory services to the public.⁵⁷ Crane's responsibilities were limited to organising the duties of the sixteen doctors, excluding the Medical Visitors, and dealing with the corollary myriad of day-to-day problems at the government hospitals and asylums, which continued to be the only locus of institutional care for poor residents.

All twenty-one doctors insisted on residing in the urban centres of Port-of-Spain and San Fernando, regardless if their contracts obligated them to work in distant rural districts each week. This would not have been viewed as an unreasonable demand by the Creole legislators, who likewise tended to be urban dwellers, although it posed a problem for a Surgeon-General who wanted to make the GMS healthcare accessible to the public. Both David Trotman and Keith Laurence established that few private physicians ever ventured beyond the urban centres to establish practices in the rural districts, well into the twentieth century.⁵⁸ Crane tried to capitalise on the travels of the five Medical

⁵⁴ CO 295-342 (1892) #6356. *Application for Directorship*, p.7.

⁵⁵ Ordinance 15 of 1870 empowered the governor to hire District Medical Officers. BPP 1872 [c.523]. *Blue Book for 1870*, 70-2. Ordinance 5 of 1869 defined the management at Port-of-Spain's hospital, as did Ordinance 5 of 1870 for San Fernando's hospital. BPP 1871 [c.334] *Blue Book for 1869*, 65-6.

⁵⁶ BPP 1872 [c.523] *Blue Book for 1870*, 71.

⁵⁷ BPP 1872 [c.523] *Blue Book for 1870*, 71. CO 295-274 (1875) #8580. *Scheme for Reorganizing the Medical Services*. Irving to Sec. of State, 6 July 1875.

⁵⁸ Trotman, *Crime in Trinidad*, 227. Laurence identified the problem in the 1860s. K.O. Laurence, "The Development of Medical Services in British Guiana and Trinidad 1841-1873," *The*

Visitors by giving them additional contracts to deliver specific statutory services to the rural public while making their rounds: public vaccinations, post mortem examinations, attending to paupers, and providing medical evidence when required by the justice system. The GMS paid the doctors handsomely to deliver statutory services.⁵⁹

Longden appointed the Medical Visitors to preserve the relationships between the planters and physicians.⁶⁰ The doctors retained their contracts at his pleasure. Longden required the Medical Visitors to report their activities each fiscal quarter to Protector of Immigrants Henry Mitchell.⁶¹ Gordon described Mitchell as one of the few officials who had “never lost an opportunity when he saw it of turning the scale in favour of the immigrant,” which may have been a difficult task in Trinidad during this decade.⁶² Mitchell had full control over the tier of the GMS which delivered services at the estates. Crane’s subsequent critique of this system of Medical Visitors revealed his powerlessness to address the problems arising when some doctors blatantly disregarded their contracts to provide statutory services to the rural public.⁶³ According to the statutes, the Surgeon-General could not hire or fire these doctors, and he lacked the power to enforce any system of accountability.

Crane was concerned that too few rural residents managed to capture the attention of the travelling doctors.⁶⁴ A rough estimate of the public’s access to the doctors confirms the problem. The colony’s obligation to India prioritised the care of the approximately 11,000 indentured workers at 118 estates dispersed throughout the island.⁶⁵ Each of the five doctors travelled twice-weekly to an average of twenty-four estates, attending about 2,200 indentured East Indians each on their rounds. In light of the difficult terrain and distances between estates, these duties undoubtedly occupied a great deal of their time. After tending to the indentured workers, the supplementary contracts paid the doctors to provide statutory services to the remaining 87,000 or so rural residents.⁶⁶ It would have been impossible for each Medical Visitor to treat an

Jamaica Historical Review 4 (1964), 273.

⁵⁹ CO 295-274 (1875) #8580. *GMS Reorganisation*. Irving to Sec. of State, 6 July 1875.

⁶⁰ BPP 1872 [c.523]. *Blue Book for 1870*, 71.

⁶¹ BPP 1872 [c.523]. *Blue Book for 1870*, 71.

⁶² Gordon made this comment during his 1909 testimony to the Sanderson Commission. BPP 1910 [cd.5193]. *Report of the Committee on Emigration from India to the Crown Colonies and Protectorates. Part II. Minutes of Evidence*, 343.

⁶³ In 1904, when the elite Creoles were trying to reinstitute the long abolished system of hiring doctors on contract, Surgeon-General James de Wolf would remind the Legislative Council that part-time doctors had no vested interest in carrying out their work on an efficient basis. Dr. de Wolf started his GMS career in the 1870s as a contract DMO. CO 295-431 (1904) #25694. *Medical Service*. Dr. J.A. De Wolf to Secretary of State. 19 July 1904.

⁶⁴ 1886 LC #104, *Surgeon-General AR*, 2.

⁶⁵ Few statistics are available for the 1870s. However, the 1877 estate inspection report indicated that 10,772 indentured East Indians resided on 118 estates. 1877 LC #22. *Immigration. Abstract of the Quarterly Returns*, 1876.

⁶⁶ The 1871 census enumerated 109,638 people, with 28,567 in Port-of-Spain and San Fernando. By 1881, the total residents increased to 153,128, with 38,193 in the two towns. An average of about 98,000 people thus lived in the rural districts. *Census of the Colony of Trinidad, 1891* (Port-of-Spain: Government Printer, 1892). 1, 7. This raw mean calculation of the ‘free’ rural

average of 2,200 indentured East Indians and another 17,400 poor rural residents during his twice-weekly travels. As a point of comparison, in England, the 1842 General Medical Order restricted the size of the population assigned to each DMO employed by the Poor Law organisation, who attended to about one-third of the number of poor in a district, when compared to Trinidad's rural Medical Visitors.⁶⁷

The tensions surrounding state healthcare involved the government's obligation to assist the majority of the population, who did not labour under indenture, to maintain or regain their health. The system of hiring part-time doctors for rural districts was predicated on the assumption that the travelling doctors would be available to the public, providing statutory services to the residents entitled to receive them, and then offering their services to everyone else as private patients on a fee-for-service basis.⁶⁸ These assumptions proved fallacious. After completing their estate duties, the GMS doctors devoted little, if any, time to the public patients.⁶⁹ Many residents could not obtain any GMS services in their communities and were drawn to the two large urban colonial hospitals in great numbers.⁷⁰ A phenomenon persisted for many decades whereby ailing and destitute residents continually 'flocked' to the towns.⁷¹ These medically-motivated pilgrimages to the San Fernando and Port-of-Spain institutions centred the plight of sick people within the gaze of the urban dwelling Creole elite. Sufferers constantly arrived at the GMS institutions and attempted to engage with the government doctors.

Crane's organisation of the GMS doctors' duties attempted to deal with this onslaught of rural and urban patients seeking treatments. In this initial variant of the GMS, sixteen part-time doctors received urban postings: twelve in Port-of-Spain and four in San Fernando.⁷² Their assignments included duties at the institutions (hospitals, asylums, and jails), maritime health services, and delivering statutory services, such as vaccinations, caring for paupers, and post-mortem examinations. The urban concentration of the GMS doctors did not necessarily mean that medical attention was more accessible to the urban poor or the rural inhabitants who made the trek to the towns. The part-time contracts restricted the time that doctors dedicated to their government work. The GMS doctors working at the urban hospitals and asylums found their terms of employment less lucrative when compared to their colleagues holding the Medical Visitor patronage appointments. The urban doctors each earned an average of about £380 annually, while their colleagues employed as Medical Visitors averaged £900

residents represents the number of rural residents, less the indentured population, with the result averaged between the 1871 and 1881 censuses.

⁶⁷ England's General Medical Order of 1842 defined that Poor Law districts could not exceed 15,000 residents of all classes. Flinn estimated that middle- and upper-class residents, who did not use Poor Law medical services, accounted for at least 50% of each district's population. Thus, the DMO attended to about 7,500 residents who also had other alternatives for assistance. Flinn, "Medical Services under the New Poor Law," 54.

⁶⁸ CO 295-274 (1875) #8580. *GMS Reorganisation*. Irving to Sec. of State.

⁶⁹ CO 295-274 (1875) #8580. *GMS Reorganisation*. Irving to Sec. of State.

⁷⁰ 1885 LC #15. *Surgeon-General AR*, 2.

⁷¹ 1885 LC #15. *Surgeon-General AR*, 2. Chapter 5 investigates this phenomenon of people flocking to the towns seeking medical assistance. The problem became so pronounced during the 1880s that the GMS doctors agitated for the Legislative Council to create rural district hospitals.

⁷² CO 295-274 (1875) #8580. *GMS Reorganisation*. Irving to Sec. of State.

from their contracts.⁷³ Urban doctors meanwhile pursued their private practices, possibly with great vigour, as they competed with private practitioners for paying patients. As such, the urban medical markets offered Trinidadians the choice of many practitioners, assuming that they could pay the doctors' fees. However, the majority of the population could not afford to engage a practitioner of western medicine.⁷⁴

The doctors working at the urban hospitals had little control over the number and types of patients admitted to their institutions. In an attempt to reduce the costs of operating the institutions, which increased each year, the Legislative Council instituted a system of dual management, which rather expediently degraded to what is more appropriately characterised as duelling management. The 1869 and 1870 Hospital Ordinances appointed both medical and non-medical personnel to run the hospitals in Port-of-Spain and San Fernando.⁷⁵ The GMS House Surgeon functioned as the medical head of each facility. Concurrently, a non-medical civil servant from the Colonial Storekeeper Department was appointed Master of the Hospital, tasked with controlling the quantity and types of supplies and provisions used within the hospital, along with all expenditures.⁷⁶ Storekeepers were expected to exercise "salutary control" over the colony's "charitable" (medical) institutions.⁷⁷ Presiding doctors had very little control over the admission of patients, the resources available to treat them, and of the operating efficiency of the institutions.

Longden claimed that this structure responded to suggestions made in an 1863-64 Colonial Office circular.⁷⁸ This despatch advised colonies of ways to improve the administration of their hospitals and asylums. It addressed the problem whereby many colonial governments assigned the responsibility to manage medical facilities to non-medical personnel, who were often found to be "extremely ill qualified" to administer the institutions. The circular encouraged each colony to appoint a senior Medical Officer to preside over each institution, vested with "paramount powers," and responsible to the colony's Chief Medical Officer (CMO).⁷⁹ Although Longden professed to implement the Colonial Office's suggestions, his administration had done the reverse by appointing non-medical intermediaries to run the hospitals. Surgeon-General Crane did not receive any "paramount powers" which would have made the doctors accountable to his office and, in turn, made Crane a CMO responsible to the Legislative Council. The Surgeon-General function thus remained powerless over the part-time doctors and no single person shouldered the responsibility for medical and health matters in Trinidad.

At each facility, the medical department had little suasion over administration and expenditures, which had a direct bearing on the quality and quantity of patient care

⁷³ CO 295-274 (1875) #8580. *GMS Reorganisation*. Irving to Sec. of State.

⁷⁴ 1886 LC #104, *Surgeon-General AR*, 1-2.

⁷⁵ Ordinance 5 of 1869 created the two departments at the Port-of-Spain Hospital, as did Ordinance 5 of 1870 for the San Fernando Hospital. BPP 1871 [c.334] *Blue Book*, 1869, 65-6.

⁷⁶ The only exception allowed the House Surgeon to purchase medicines and surgical supplies. BPP 1871 [c.344]. *Blue Book for 1869*, 65. CO 295-311 (1886) #20601. *Surgeon-General's Dept.* Sub-encl. #1. Surgeon-General. 9 March 1886.

⁷⁷ BPP 1872 [c.523]. *Blue Book for 1870*, 69.

⁷⁸ BPP 1871 [c.344]. *Blue Book for 1869*, 65-6.

⁷⁹ CO 295-311 (1886) #20601. *Surgeon-General's Dept.* Sub-encl. #1. Surgeon-General.

available at the hospitals. Despite the incessant directive to reduce the expenditures, and the patronage appointments of non-medical Creole officials to carry out that edict, the costs soared. Direct hospital expenditures on patients (excluding salaries, buildings, and capital costs) increased by 76%, from £11,116 in 1871 to £19,651 in 1874.⁸⁰ Doctors meanwhile complained that the “manifest inability” of the non-medical managers caused them a great deal of “alarm.”⁸¹ Additionally, the system of dual management allowed many abuses to prevail, as the doctors and non-medical managers remained continually at odds with each other about the way that each hospital should be administered.⁸²

In summing up this initial form of the GMS, the patronage appointments of Medical Visitors prioritised the desire to keep the planters and doctors content, as both groups represented important sectors of society. The geographic organisation of the GMS around the care of indentured workers had a broad implication in limiting the accessibility to medical services for the public. Most Trinidadians could not obtain gratuitous GMS medical attention and many could not afford to pay. The powerful in Creole society would subsequently revere this form of the GMS, selectively forgetting that costs had escalated, sick and destitute residents flocked to the towns, and the institutions could not cope with so many patients.

Trinidad's Smallpox Epidemic of 1871-72

Despite Creole society's complacency with the medical landscape, the international community intervened to challenge the state's restricted involvement in the health of its public. The stimulus for change involved the smallpox pandemic, which took hold of Trinidad and reached epidemic proportions during 1871-72. Trinidad's maritime partners and the Colonial Office exerted significant pressures on the colony to introduce contemporary preventive health measures. The Legislative Council eventually responded to these demands and expanded its limited set of public health measures to placate its critics, but remained unwilling to change the broader parameters of state medicine.

Communities throughout the increasingly interconnected globe placed a priority on containing the smallpox visitations of the early 1870s. Anne Hardy argued that a discernable shift occurred in the accepted preventive measures in England, just prior to the pandemic. After 1864, the generally adopted measures to prevent and contain smallpox combined vaccination with the processes of early notification of cases, the isolation of victims, and disinfection.⁸³ Trinidad continued to rely on its tradition of

⁸⁰ CO 295-311 (1886) #20601. *Surgeon-General's Dept.* Sub-encl. #1. Surgeon-General. The institutional costs are recorded in 1893 LC #160, *Surgeon-General AR for 1892*, 13.

⁸¹ Crane identified the “alarm” caused by the non-medical managers as the key reason to abolish the system in 1875. The sources do not detail the problems. During the subsequent 1886 and 1891 inquiries, Crane devoted significant attention to problems with the hospital food, buying supplies, and publishing objective medical criteria for admissions, suggesting that these were the key problems. 1886 LC #104. *Surgeon-General AR*, 1-2. 1885 LC #15. *Surgeon-General AR*, 3.

⁸² CO 295-311 (1886) #20601. *Surgeon-General's Dept.* Sub-encl. #1. Surgeon-General. 9 March 1886.

⁸³ Anne Hardy, “Smallpox in London: Factors in the Decline of the Disease in the Nineteenth Century,” *Medical History*, 27 (1983), 122-3.

employing vaccination as the only measure to combat smallpox, often administered reactively in response to an outbreak. For instance, when smallpox spread through the Spanish Main in 1819, the colony mandated the vaccination of all residents, and levied a £40 fine on evaders.⁸⁴ The government thereafter maintained the Vaccination Institute in Port-of-Spain, but did not make it compulsory until 1864, when authorities realised that only 7,000 residents had been vaccinated.⁸⁵ The immunisation rates did not increase in the 1870s, although the GMS doctors had been contracted to vaccinate residents. The popular local beliefs on smallpox transmission kept immunisation rates low. Pharmacist Lewis Osborne Inniss stated the Afro-Trinidadian beliefs:

... it was the popular idea that if you visited all your acquaintances who got it and were not afraid of it, you were safe, but if you tried to run away from it, you would inevitably catch it, or rather it would catch you ...⁸⁶

The government's failure to institute measures for mandatory vaccination, disinfection, and isolation allowed the smallpox visitation to reach epidemic proportions as the African public pursued its own popular measures for smallpox prevention.

The epidemic attacked with such virulence that the colony's deficient health practices became a matter of international importance. From London, *The Times* kept readers informed as British colonies and foreign countries imposed quarantines, refusing to allow ships from Trinidad to land or disembark passengers.⁸⁷ The quarantines restricted the movements of goods and especially the sugar crop which was of vital importance to the economy. High prices for sugar prevailed in Britain, and the planters had hoped to maximize their financial returns. Their expectations were dashed when ships refused to stop in Port-of-Spain and subject their cargos and passengers to subsequent quarantine.⁸⁸ The potency of the epidemic confirmed that Trinidad's preventive measures had not kept pace with contemporary practices. The epidemic reached "grave proportions," with 12,351 cases and 2,449 deaths, or almost 20% of all cases, during the lengthy visitation.⁸⁹ Trinidad appears to have fared slightly worse than

⁸⁴ L.M. Fraser, *History of Trinidad from 1814 to 1839* (Trinidad: Government Printer, 1896), 95. Niklas Thode Jensen, "Safeguarding Slaves: Smallpox, Vaccination, and Governmental Health Policies among the Enslaved Population in the Danish West Indies, 1803-1848," *Bulletin of the History of Medicine*, 83 (2009), 116.

⁸⁵ Britain's 1853 Vaccination Act made vaccination compulsory for infants. The 1867 Act included all children under age 14 and penalised parents who failed to vaccinate their children. Dorothy Porter and Roy Porter, "The Politics of Prevention: Anti-Vaccinationism and Public Health in Nineteenth-Century England," *Medical History*, 32 (1988), 231-3. Trinidad's law lagged behind Britain by a decade, as vaccination was not compulsory until Ordinance 8 of 1864. Until that time, rural residents were vaccinated only during an epidemic. BPP 1865 [c.3423]. *Blue Book for 1863*, 31. BPP 1866 [c.3719]. *Blue Book for 1864*, 73. Smallpox epidemics occurred in 1837, 1849, and 1850. Hart, *Trinidad and the Other West India Islands*, 198-202.

⁸⁶ L.O. Inniss, *Trinidad and the Trinidadians. A Collection of Papers, Historical, Social and Descriptive, about Trinidad and its People* (Port-of-Spain: Mirror Printing, 1910), 77.

⁸⁷ "The Mails," *The Times*, 30 October 1871, 4. "From the London Gazette of Tuesday, Nov. 21," *The Times*, 22 Nov 1871, 6. "The Mails," *The Times*, 28 August 1872, 7. "Transfer of Infection. Letter to the Editor," *The Times*, 15 June 1872, 11.

⁸⁸ "The Mails," *The Times*, 30 October 1871, 4.

⁸⁹ "Vaccination in Trinidad," *British Medical Journal*, 3 April 1886, 652. CO 295-342 (1892)

London, which had one of the highest death rates in the England amongst the infected population.⁹⁰ Graham Mooney correlated London's high death rate to the haphazard public health procedures and, in some locations, "blatant disregard" for the vaccination legislation.⁹¹ Trinidadians suffered as a result of the same problems, although they occurred for different reasons in the colony.

Crane had sixteen years experience as Surgeon-Superintendent aboard the Colonial Land and Emigration Commission's (CLEC) emigrant ships in the Australian and Coolie Medical Services, dealing with the most dreaded contagious diseases in the less than optimum maritime environments. This portion of Crane's career exposed him to the disease-containment measures instituted by many colonies and countries on the maritime routes from the Australian colonies through the West Indies to England and eastward to India. As discussed above (in chapter 3), the CLEC reformed the Imperial Passengers' Act in an attempt to stop ships from transporting diseased passengers to and from British ports. Crane garnered significant recognition for his professional abilities and zealotry in tending to the health of the immigrants during his career as a Surgeon-Superintendent.⁹² His medical acumen was possibly the reason why the CLEC recommended him for the job in Trinidad. Crane understood how to contain dreaded diseases in the challenging shipboard environment during medically perilous ocean voyages. He would have also experienced, first-hand, the problem of attempting to find a port amenable to landing a ship filled with passengers stricken by infectious diseases.

Regardless of Crane's experience, Longden and the government relied on the medical expertise of Dr. R.H. Bakewell, the English gun-wielding medical officer who Governor Gordon had refused to appoint as Surgeon-General. The Legislative Council did not share Gordon's negative appraisal of Bakewell and upheld his key positions as Medical Officer of Health and Vaccinator-General. Contemporaries and historians have used Bakewell's racist deportment to illustrate the complexity of race relations in the colony. Donald Wood described the public altercation between Bakewell and Espinet as the "most outrageous" incident of the era, arguing that the racism at the root of the struggle made the conflict legendary in its own time.⁹³ Dr. Espinet became the hero in this legend and Bakewell became an object of ridicule by the Afro-Trinidadians. Lewis Osborne Inniss pronounced Bakewell a "Negrophobe," noting that everyone in the community knew who had tarred and feathered the doctor, but that his assailants were never accused.⁹⁴ This very public altercation made its way into a local calypso:

#6356. *Application for Directorship of Sanitary Dept. Egypt*. 14 Jan 1892, 8.

⁹⁰ Anne Hardy provided the mortality rates for victims admitted to the isolation hospitals: 13,139 admissions as the epidemic peaked in 1871-72, with an 18.95% mortality rate. Trinidad had only 800 fewer cases in about the same time, which equates to higher infection and mortality rates per 1,000 population. For London's statistics, see Hardy, *Smallpox in London*, 134.

⁹¹ Graham Mooney, "'A Tissue of the most Flagrant Anomalies': Smallpox Vaccination and the Centralization of Sanitary Administration in Nineteenth-Century London," *Medical History*, 1997, 41 (3), 262.

⁹² Basdeo Mangru, *Benevolent Neutrality. Indian Government Policy and Labour Migration to British Guiana 1854-1884* (Hartfordshire: Hansib, 1989), 124.

⁹³ Donald Wood, *Trinidad in Transition. The Years after Slavery* (London: Oxford University Press, 1968), 250-2.

⁹⁴ Inniss, *Trinidad and Trinidadians*, 87-8.

*Bakewell, Bakewell, what is de matter? T'ree black man tar Papa!*⁹⁵

Bakewell's racist ideals had a much larger effect than simply being a "most outrageous" incident, because his official medical actions imperilled the health of the public. Decades after the 1871-72 epidemic had subsided, the GMS's Dr. Raoul Seheult cryptically alluded to the disproportionately high mortality rates amongst the Africans.⁹⁶

Trinidad's haphazard public health measures and the public's rationale to avoid vaccination can be traced to Bakewell's actions in the community, which also helped to create an international scandal. Correspondents from Trinidad informed *The Times* of their wish for the local Board of Health to bring the epidemic under control swiftly, but meanwhile doubted its ability to be successful. The Board encountered serious difficulties in its house-to-house campaign to vaccinate residents.⁹⁷ On 30 December 1870, while the pandemic made its way through Europe, Vaccinator-General Bakewell published a report claiming that vaccination was a "useless" preventive measure. He also blamed vaccinations for the person-to-person transmission of "the most loathsome diseases," syphilis and leprosy.⁹⁸ *The Times* stated that Bakewell's report had excited the lower classes and caused widespread fear of vaccination.⁹⁹

Officials had to find ways to surmount many objections to vaccination. In 1867, an anti-vaccination movement emerged in England. Naomi Williams argued that the compulsion in the laws remained contentious, as it sacrificed the tenet of individual rights for the broader good: the health of the community.¹⁰⁰ In Britain's diverse territories, governments encountered cultural and religious objections to vaccination. Mark Harrison, for instance, found that authorities in India were sensitive to the local religious taboos. Consistent with India's reluctance to institute health measures which could provoke unrest amongst its subjects after the 1857-58 Mutiny/Rebellion, the government embarked on a program to convince the people of the benefits of voluntary vaccination during the pandemic, rather than using the law.¹⁰¹ The resistance also embodied the pragmatic fear of contracting syphilis.¹⁰² Dorothy Porter and Roy Porter quantified the veracity of the syphilis fear by demonstrating that England's 1871 Select Committee on compulsory laws identified only two cases where syphilis had been transmitted by arm-to-arm vaccination.¹⁰³ However, as metropolitan doctors disclaimed the risk of contracting syphilis, Bakewell adopted the contrarian stance and heightened

⁹⁵ Anthony de Verteuil, *Surgery in Trinidad* (Port-of-Spain: Litho Press, 1996), 4. Anthony de Verteuil is a descendant of Dr. Louis de Verteuil and amateur historian. I disagree with his conclusion that the tarring of Bakewell ended racial discrimination in the medical profession.

⁹⁶ GMS employed Seheult from 1894 to the 1940s. R. Seheult, "On an Epidemic of Smallpox of Irregular Type in Trinidad during 1902-4," *Proceedings of the Royal Society of Medicine*, 1908 (1), 229-302.

⁹⁷ "The Mails. Letter from Trinidad on the 10th of October," *The Times*, 30 October 1871, 4.

⁹⁸ BPP 1873 [c.729] *Report on Leprosy and Yaws in the West Indies*. Gavin Milroy, 32-7.

⁹⁹ "The Mails. Letter from Trinidad on the 10th of October," *The Times*, 30 October 1871, 4.

¹⁰⁰ Naomi Williams, "The implementation of compulsory health legislation: infant smallpox vaccination in England and Wales, 1840-1890," *Journal of Historical Geography*, 20 (1994), 396.

¹⁰¹ Mark Harrison, *Public Health in British India. Anglo-Indian Preventive Medicine 1859-1914* (New York: Cambridge Univ. Press, 1994), 82-7.

¹⁰² Williams, "The implementation of compulsory health legislation," 396.

¹⁰³ Porter and Porter, "The Politics of Prevention," 233-4.

Trinidadians' fears of vaccination. By disclaiming the value of this preventive measure in his report, Bakewell fuelled the objections of the anti-vaccination contingent, the religious opposition of Indo-Trinidadians, and the popular Afro-Trinidadian beliefs.

Bakewell's claims also excited the upper ranks and created another racial controversy. In his December 1870 report to the Trinidadian public, Bakewell insisted that white persons could not contract leprosy by any means other than vaccination; in his opinion, the four new cases of leprosy on the island confirmed that vaccinators had used the lymph from blacks to infect the upper class whites.¹⁰⁴ Bakewell had finally gone too far, not only by publicly denying the value of vaccination, but by racialising the fear of disease transmission and the broader white fears of diseased natives. The Colonial Office, Royal College of Physicians, and several local Creole physicians refuted Bakewell's allegations and attacked his lack of scientific evidence.¹⁰⁵ Dr. Thomas Murray (Sr.), who had previously held the post of Vaccinator-General for forty years, rallied the Board of Health to contradict Bakewell's claims publicly. At Longden's instance, Dr. Louis de Verteuil waged a media campaign to discredit Bakewell.¹⁰⁶ Britain's Royal College of Physicians urged the Colonial Office to enforce vaccination to protect the lower classes, "who are too ignorant to protect themselves," dismissing Bakewell's allegations as "merely speculative." The Colonial Office then sent a confidential circular to the governors and chief medical officers in the West Indies, Sierra Leone, Ceylon, and the Cape of Good Hope, advising them to beware of such erroneous claims. Medical officers from many colonies responded to the Colonial Office and its emissary to Trinidad, Dr. Gavin Milroy, discrediting Bakewell's allegations.¹⁰⁷

The reading public, parliamentarians, and colonial governments had been informed that Trinidad's Vaccinator-General did not believe in vaccination and knowingly attenuated the already tense racial relations with his unsubstantiated claims. Bakewell was meanwhile preoccupied with verifying Venezuelan Dr. L.D. Beauperthuy's cure for leprosy, rather than leading the campaign against smallpox expected from the Medical Officer of Health and Vaccinator-General.¹⁰⁸ Correspondents to *The Times* summarized the situation in Trinidad as absurd: "we have the extraordinary spectacle of the paid Vaccinator-General of the island doing all in his power to discourage the practice of vaccination, and yet allowed by the Government to retain his offices."¹⁰⁹ The colony's economy suffered,¹¹⁰ while its deficient systems to prevent and contain diseases became a known problem in the international community.

As the epidemic raged on, colonial decision makers put their trust in their Creole medical colleagues, pitting Surgeon-General Crane in a battle with two Unofficial

¹⁰⁴ BPP 1873 [c.729] *Report on Leprosy and Yaws*, 32-7.

¹⁰⁵ CO 295-259 (1871) #8260. *Letter from Royal College of Physicians to Secretary of State*, 17 Aug. 1871. CO 295-259 (1871) #6817. *Medical Dept. of Privy Council to Secretary of State*, 11 July 1871. BPP 1873 [c.729] *Report on Leprosy and Yaws*, 32-7.

¹⁰⁶ BPP 1873 [c.729] *Report on Leprosy and Yaws*, 33.

¹⁰⁷ BPP 1873 [c.729] *Report on Leprosy and Yaws*, 33-7, 83-6.

¹⁰⁸ Bakewell's support for Beauperthuy's cure prompted the Colonial Office to send Gavin Milroy to investigate the claims. BPP 1873 [c.729] *Report on Leprosy and Yaws*.

¹⁰⁹ "The Mails. Letter from Trinidad on the 10th of October," *The Times*, 30 October 1871, 4.

¹¹⁰ BPP 1873 [c.709-II] *Blue Book for 1873*, 76.

members of the Legislative Council, Dr. Louis de Verteuil and Dr. J.V. de Boissière.¹¹¹ Crane finally marginalised his adversaries by justifying his disease-containment methods as the lowest-price alternative.¹¹² The epidemic had wreaked havoc with government revenues and the personal fortunes of many in the upper strata of Creole society. The total bill to deal with the epidemic would later be tallied up at £20,000, suggesting that the drain on the colony's ailing treasury was an important consideration.¹¹³ Uncharacteristically, the government threw its support behind Crane.

Decisive steps had to be taken to regain credibility within the Atlantic community. The Legislative Council enacted several laws in 1872 vesting the Surgeon-General with the responsibilities which maritime partners expected to be in effect. These included the public health functions of Medical Officer of Health and Secretary to the Board of Health and Quarantine Authority.¹¹⁴ The government again mandated the compulsory vaccination of infants and children and dissolved the Vaccination Department formerly managed by Bakewell.¹¹⁵ This new expansive role vested the Surgeon-General's office with the responsibility for many health-related statutory services, including vaccination and the health concerns created by the maritime traffic.¹¹⁶ For these statute obligations, the Surgeon-General thereafter retained the responsibilities, although it remained questionable, for some time, if the GMS had the requisite manpower and authority to execute the functions in a meaningful way.

In this instance of a medical disaster reaching epidemic proportions, pressure from the Colonial Office and the Atlantic community had allowed the Surgeon-General to win the battle to direct medical matters, but the prognosis for the outcome of the longer war to execute the necessary measures had not yet been decided. However, the public health and medical fiasco associated with the epidemic set the process in motion for extraordinary support from the Imperial world medical profession and the Colonial Office for the embattled Surgeon-General during future altercations. The Colonial Office's unusual intervention of sending the renowned Dr. Gavin Milroy to the West Indies to investigate Bakewell's claims initiated a long-term friendship between Crane and Milroy, based on their mutual respect of each other's medical prowess.¹¹⁷ In 1880,

¹¹¹ CO 295-342 (1892) #6356. *Application for Directorship*, 8. Drs. de Verteuil and Boissière held appointments on the Legislative Council. Brereton stated that their ancestors were the original French nobles in Trinidad. Brereton, *Race Relations*, 36-7.

¹¹² CO 295-342 (1892) #6356. *Application for Directorship*, 8.

¹¹³ BPP 1873 [c.709-II]. *Blue Book for 1873*, 86.

¹¹⁴ Ordinance 4 of 1869 created the Surgeon-General's department. Ordinance 17 of 1872 repealed it and reconstituted the Surgeon-General's duties. Crane later reminisced how the duty of Medical Officer of Health came about in the midst of the epidemic at Longden's request. CO 295-311 (1886) #20601. *Surgeon-General's Dept.* Sub-encl. #1. Surgeon-General. 9 March 1886. CO 295-274 (1875) #8580 *Scheme for Reorganising the Medical Services*.

¹¹⁵ Ordinance 23 of 1873 abolished the Vaccinator-General office. It made parents responsible to vaccinate children under age sixteen. It also defined vaccination as a statutory service provided to the public, through government-appointed district vaccinators. BPP 1873 [c.709-II]. *Blue Book for 1873*, 79-80. CO 295-342 (1892) #6356. *Application for Directorship*, 8. "Vaccination in Trinidad," *British Medical Journal*, 3 April 1886, 652.

¹¹⁶ CO 295-274 (1875) #8580. *GMS Reorganisation*. Irving to Sec. of State.

¹¹⁷ When he left Trinidad, Milroy experienced the inconvenience inflicted on the travelling public who passed through an infected port. After a four-day journey to Dominica, Milroy's ship

the *Medical Times and Gazette* would refer to Milroy's evaluation of Crane as "one of the ablest practitioners in the West Indies."¹¹⁸ The Colonial Office staff likewise held Crane's professional abilities in high esteem, going to extraordinary lengths to support him during the skirmishes between the Creoles and the GMS in the 1880s.¹¹⁹ Nonetheless, it was not a foregone conclusion that this plantation society would embrace British preventive public health or address the metropolitan concerns about the health and well-being of the lower classes. However, the socio-medico landscape would soon change, with the arrival of the new governor, reform-minded Henry Irving.

*Imperialists and the White Man's Medical Burden:
The 1875-76 Reforms to the Government Medical Service.*

During the initial five years of Crane's tenure, Trinidad had constructed its medical services organisation in a form that naturally reflected the traditions and values of Creole society. The government demonstrated that it could reconsider its involvement in matters of public health, but it tended to respond to the Atlantic community, rather than the residents. Despite the changes wrought by the epidemic, Crane indicated that the colony's poor could only access the services of the GMS medical officers in two or three districts.¹²⁰ The poor needed to make their way to the hospitals in Port-of-Spain or San Fernando, leaving many ill people to languish in their community. However, Governor Irving had a different view of the colonial state's responsibility to its subject peoples. Irving championed the Colonial Office's ideology on the importance of the GMS to the civilising mission. Although the Colonial Office had a laissez-faire attitude when Longden aligned with the Creole elite, the staff at Whitehall extended its full support to the zealous new governor. The Secretary of State and Colonial Office staff would subsequently attribute the success of Irving's governorship to his ability to resist the imperatives of Creole society, pronouncing Irving as "one of the few who are wholly indifferent to local popularity."¹²¹

Irving turned his attention to restructuring the medical service so that it could deliver on its mandated responsibilities. This new form of the GMS would remain intact for the next half century, despite the relentless pressure from the Creole elite to change the contours of the GMS back to its original structure and limited purpose. Crane and Irving collaboratively reformed the GMS through four major initiatives in 1875-76, publicly proclaimed to be a centralised structure to curtail the escalating costs and spend the government's money in a more efficient and effective manner.¹²² At the foundation of

was in quarantine for fourteen days because of the smallpox in Trinidad. David F. Clyde, *Two Centuries of Health Care in Dominica* (Lucknow: Prom Printing, 1980), 80-1.

¹¹⁸ "Observations on Yaws (A Reply to Dr. Gavin Milroy) by Dr. H.A. Alford Nicholls, MD, Medical Superintendent of the Dominica Yaws Hospitals," *Medical Times and Gazette*, 10 January 1880, 33.

¹¹⁹ This is investigated in Chapter 5.

¹²⁰ 1886 LC #104. *Surgeon-General AR*, 2. Crane did not specify which districts provided the GMS services to the poor.

¹²¹ CO 295-281 (1878) #13202. *Disreputable and inefficient state of Colonial Civil Service. Minutes.*

¹²² 1885 LC #15, *Surgeon-General AR*, 3.

the reforms was the vesting of the Surgeon-General with the accountability and authority for all health-related operations and expenditures.¹²³ In this way, the colony now had one CMO responsible for medical matters and answerable to the Legislative Council's executive, who were generally career civil servants sent to Trinidad by the Colonial Office, rather than to the general Legislative Council filled with Creole appointees.¹²⁴ This hierarchical system of accountability dispensed with the duelling medical and non-medical administrations, placing the Surgeon-General in control of the institutions and expenditures.¹²⁵ Crane appointed senior physicians to manage each facility, delegating the responsibility for their "good order and management" to the head doctors.¹²⁶ Presiding medical officers were accountable for the institution's fiscal and medical management, according to the new suite of GMS regulations.¹²⁷ Crane drew his inspiration for this hierarchical model from the Colonial Office's much earlier circular,¹²⁸ which Longden had interpreted in an oppositional fashion to solidify the system of dual management, now replaced by the reforms instituted by Irving in 1875 and 1876.

The second reform dispensed with the part-time medical officers and the patronage appointment positions of commuting Medical Visitors of Plantations. The twenty-one doctors became full-time salaried government employees, altering their relationship with their employer and, as civil servants, making physicians accountable for all duties assigned to them. Many doctors in specific functions, such as the DMOs, retained the privilege of private practice, although the caveat remained that it could not "interfere" with government duties.¹²⁹ The government's prior aversion to hiring doctors into the civil establishment had cost the colony substantially more in contract fees than it subsequently paid for doctors on permanent staff.¹³⁰

Crane modeled the structure of the doctors' remuneration on the Indian Medical Service, which he knew was well-liked by the British medical professionals employed by the British government in India. This program was designed to compensate doctors

¹²³ CO 295-432 (1905) #14856. *Government Medical Dept.* Enclosure 3 in Trinidad Despatch #106, 19 April, 1905. Minute by Surgeon-General, 23 February 1905. BPP 1877 [c.1869]. *Blue Book for 1876*, 48. The Surgeon-General received paramount powers over the institutions with the revoking of Ordinance 5 of 1869 for the Port-of-Spain Hospital, and Ordinance 5 of 1870 for the San Fernando Hospital. These ordinances were replaced by the new *Regulations for the Colonial Hospital*. CO 295-276 (1876) #1195. *Return of medical appointments under the new Scheme*. Encls.: Regulations for Medical Attendance on the Poor. 1 January 1876. Regulations for the Colonial Hospital Port-of-Spain. 31 December 1875.

¹²⁴ The Executive Council consisted of the governor, Attorney-General, Colonial Secretary, and the local Commander of Her Majesty's Forces. *The Colonial Office List for 1881*, 174. The sources do not indicate the frequency of executive meetings during Irving's governorship. However, Brown indicated that the executives rarely met during Gordon's tenure, and then only to consider measures proposed by Gordon. Brown, "Inter-colonial migration," 208 and passim.

¹²⁵ Crane later reminded the Legislative Council that Irving supported these reforms as a means to bring the expenditures under control. 1885 LC #15, *Surgeon-General AR*, 3.

¹²⁶ CO 295-311 (1886) #20601. *Surgeon-General's Dept.* Sub-encl. #1. Surgeon-General.

¹²⁷ 1891 LC #46. *Surgeon-General AR*, 1.

¹²⁸ CO 295-311 (1886) #20601. *Surgeon-General's Dept.* Sub-encl. #1. Surgeon-General.

¹²⁹ CO 295-432 (1905) #14856. *Government Medical Dept.* Enclosure #3 in Trinidad Despatch #106, 19 April, 1905. Minute by Surgeon-General, 23 February 1905.

¹³⁰ CO 295-274 (1875) #8580. *GMS Reorganisation*. Irving to Sec. of State.

commensurate with the work they performed.¹³¹ It introduced an equitable and graduated compensation program as a measure to attract and retain physicians for the medical service. All physicians joined the GMS “on the same footing” in terms of base remuneration, while salary increments and pensions rewarded doctors for remaining with the GMS over the years.¹³² Crane addressed the problems of attracting British-trained doctors to the colony and the propensity of the Creole elite to make patronage appointments by formalising a system of career paths for the GMS doctors. Junior men worked as supernumerary surgeons at the hospitals during their probationary period, receiving training from the senior doctors and temporary assignments to replace doctors who had earned a leave of absence. Doctors showing promise would then be assigned to increasingly responsible positions, starting in the rural districts, which remained the least attractive placements due to their locations, “healthiness,” responsibilities, and the low potential for income from private practice.¹³³ Urban centres offered lucrative postings for senior doctors, either managing large institutions or working as metropolitan DMOs. These changes to the method of compensating the doctors had thus fully inverted the previous structure: rural districts became testing grounds for junior men, the profitable Medical Visitor appointments ceased to exist, and doctors who served their time could merit profitable urban postings. Relatively junior doctors now dispensed the GMS’s healthcare services on the estates.

Senior GMS physician, and future Surgeon-General, Dr. James de Wolf believed this structure allowed the medical service to attract “a desirable class of men.” Doctors now considered their employment in GMS as a career, based on the four mechanisms of “a fair salary, service increment, prospects of promotion, and pension on retirement.”¹³⁴ This system set the conditions for government physicians, many of whom were Trinidad-born men, to join the ranks of the economically secure classes, and for white doctors to consolidate their position in the upper ranks of Creole society. At the same time, it also created an environment conducive to the emergence of a sense of occupational consciousness, as doctors could allow medical considerations to guide their actions, as opposed to the fear of subjective unemployment.

Civil service employment required DMOs to reside in their assigned districts. In dispensing with the slavery-era model of Medical Visitors for the plantations, Crane defined the role and responsibility for the DMOs to be very similar to the function in the Poor Law Medical Service throughout rural England.¹³⁵ Crane set the geographic boundaries of the districts by estimating the size of the resident population and their potential health needs.¹³⁶ His stated objective was to balance the workloads equitably

¹³¹ CO 295-311 (1886) #20601. *Surgeon-General’s Dept.* Sub-encl. #1. Surgeon-General..

¹³² CO 295-274 (1875) #8580. *GMS Reorganisation*. Crane to Secretary of State, 4 July 1875.

¹³³ CO 295-274 (1875) #8580. *GMS Reorganisation*. Irving to Sec. of State. CO 295-432 (1905) #14856. *Government Medical Dept.* Encl. #3 in Trinidad Despatch #106, 19 April, 1905. Minute by Surgeon-General, 23 February 1905.

¹³⁴ CO 295-432 (1905) #14856. *Government Medical Dept.* Encl. #3 in Trinidad Despatch #106, 19 April, 1905. Minute by Surgeon-General, 23 February 1905.

¹³⁵ The Poor Law DMO functioned as the key figure in the treatment of the poor in England. Flinn stated that the districts were defined to ensure that patients and doctors could reasonably traverse the distance to reach each other. Flinn, *Medical Services under the New Poor Law*, 49.

¹³⁶ DMOs were assigned to twelve rural districts: St. Joseph, Tacarigua, Arima, Mayaro, Chaguanas, Couva, Point a Pierre, North Naparima, South Naparima, Savanna Grande, Cedros,

between the DMOs. The contours of the medical districts thus took into account not only the number of indentured East Indians, but also the other residents, along with the distance to be traversed, acknowledging the onerous travel constraints in the rural districts.¹³⁷ Although doctors could not always reach the patients and *vice versa*,¹³⁸ the organisation of the medical districts attempted to make the GMS services more accessible to the public at large.

After sorting out the roles and responsibilities of the Surgeon-General and the GMS doctors, Irving's third reform, enacted on 1 January 1876, defined the conditions by which the poor and pauper populations received the GMS services.¹³⁹ This entitlement had traditionally been implied, but never clearly defined or articulated in public documents. Published widely as *The Regulations for Medical Attendance on the Poor*, the rules thereafter remained remarkably consistent throughout the period of this study, with only slight alterations in the schedule of fees for the small minority of patients who paid a token sum for their treatments and medicine.¹⁴⁰ The government deputised employees and respectable members of Creole society to certify impoverishment and determine patient entitlements to the GMS healthcare in the absence of a system of Poor Law officers tasked with determining entitlements.¹⁴¹ Wardens in each rural district, Port-of-Spain Medical Officers of Health, and the San Fernando Sanitary Inspector issued Pauper Certificates entitling destitute persons to receive gratuitous medical attention and medicines for a period of four weeks. In addition to these civil servants, the burgesses or respectable ratepayers in the towns or wards could issue a Certificate of Poverty, which was valid for a two-week period, entitling the bearer to medical attention and medicines for one shilling apiece, payable in advance.¹⁴² Any other people seeking the services of the GMS doctors were considered private patients. The GMS published a schedule of the times and places when the doctors attended to Poverty and Pauper Certificate patients.¹⁴³

and Oropouche. CO 295-274 (1875) #8580. *GMS Reorganisation*. Irving to Sec. of State.

¹³⁷ CO 295-274 (1875) #8580. *GMS Reorganisation*. Crane to Secretary of State. These criteria remained in effect when future changes were made to the GMS staffing when the colonial population increased during the next decade. CO 295-316 (1887) #11453. *Observations as to creation of new medical districts*.

¹³⁸ Trotman described the roads as "atrocious" in the rainy season. Trotman, *Crime in Trinidad*, 14.

¹³⁹ CO 295-276 (1876) #1195. *Return of medical appointments under the new Scheme*. Encl.: Regulations for Medical Attendance on the Poor. 1 January 1876.

¹⁴⁰ The regulations were reprinted each year in the Trinidad Almanac. See, for instance, *The Trinidad Official and Commercial Register and Almanack for the year of our Lord 1883*.

¹⁴¹ Flinn indicated that the Poor Law Relieving Officer determined entitlements to medical relief and treatments. Flinn, "Medical Services under the New Poor Law," 49.

¹⁴² The 1876 *Regulations* did not make provisions for poor patients to buy medicine, nor did they indicate the length of time during which the certificate was valid. The provision for patients to purchase low cost medicine was in the regulations by 1882. The two and four week validity periods were added to the regulations by 1886. *The Trinidad Almanack, 1882*, 50. *The Trinidad Almanack, 1886*, 86-7.

¹⁴³ The Port-of-Spain Hospital out-patient clinics treated patients between 11 and 12 o'clock, Monday, Wednesday, and Friday. CO 295-276 (1876) #1195. *Return of medical appointments under the new Scheme*. Encl. Regulations for the Colonial Hospital, Port-of-Spain. Made by the Governor and Executive Council Under authority of Ordinance No. 18 of 1872. Henry T. Irving, 31st December, 1875.

The fourth major reform had remarkable staying power over time, plausibly due to the pathetic state of many patients who presented themselves to the doctors. This reform was tested by the GMS doctors in Port-of-Spain in 1876. The doctors began providing a form of medicalised out-door relief to sufferers in this interesting adaptation of the tenets of preventive medicine. Prior to this time, the colonial state's preventive medicine had generally been limited to vaccinations. Concurrently, the laws required boroughs to establish and maintain almshouses, while forbidding them to offer outdoor relief.¹⁴⁴ However, as discussed above, the two small almshouses were woefully under-capacity for the needs of the population. *The Regulations* entitled the poor to receive medical attendance, but many of the people suffering from morbidities related to destitution, or perhaps just from the effects of poverty, now had an avenue for non-monetary relief, albeit very limited in scope. The GMS's new medicalised out-door relief allowed the poor to obtain medical comforts without being admitted to an institution.¹⁴⁵ This new service resulted from the doctors' recognition of the number of sufferers who needed attention to their destitute conditions. In the first year, doctors recorded that 566 recipients of medicalised out-door relief would have required institutionalisation under the previous rules. Within a year, the GMS offered medical relief services throughout the colony, which rapidly grew in popularity.¹⁴⁶ There is a remarkable parallel between the actions of the GMS doctors to provide medical relief and what Flinn characterised as the "spontaneous" development of medical services within the New Poor Law organisation in the 1840s.¹⁴⁷ The pressing need amongst the inhabitants in both Trinidad and England stimulated each organisation to provide a form of medical care that was not sanctioned in the laws. In Trinidad, as in England, the doctors did not possess the resources to alleviate the endemic destitution at the root of the pervasive manifestation of early stage maladies, but they attempted to ease the worst of its symptoms in this unique adaptation of preventive medicine.

By and large, the centralised reforms intended to instil the British idea of efficiency into the system and furthered Irving's campaign to reconstitute the civil service on the basis of accountability for job performance.¹⁴⁸ Irving had no qualms about enacting reforms striking at the heart of plantocracy control of colonial resources. He described the reformed medical service to Secretary of State Lord Carnarvon, Henry Herbert, as one designed to meet the needs of the people, rather than simply placating the powerful estate proprietors.¹⁴⁹ The Surgeon-General became accountable to the Executive Council and the non-medical persons had been removed from the decision making structure.¹⁵⁰ Astute Irving positioned the reorganisation as a quest for efficiency

¹⁴⁴ Ordinance 13 of 1852 required Wardens to establish almshouses, although Registrar-General H. Clarence Bourne remarked in 1897 that this obligation had never been fulfilled in the colony. Ordinance 10 of 1853 required Boroughs to maintain almshouses, but precluded the provision of out-door relief. 1897 LC #188. *Papers relating to Poor Relief*, 4.

¹⁴⁵ CO 295-279 (1877) #13574. *Statements against Dr. Crane*, Crane to Colonial Secretary.

¹⁴⁶ CO 295-279 (1877) #13574. *Statements against Dr. Crane*. Crane to Colonial Secretary.

¹⁴⁷ Flinn, "Medical Services under the New Poor Law," 49.

¹⁴⁸ BPP 1877 [c.1869]. *Blue Book for 1876*, 48.

¹⁴⁹ CO 295-274 (1875) #8580. *GMS Reorganisation*. Irving to Colonial Sec.

¹⁵⁰ All four members of the Executive Council were appointed by the Colonial Office, suggesting their actions would have reflected the Colonial Office position on medical matters. Executive Council members were the Governor, Colonial Secretary, Attorney-General, and the Officer in Command of local troops. *The Trinidad Official and Commercial Almanack*, 1882, 27.

and effectiveness, which was well-received by his colleagues at the Colonial Office.¹⁵¹ This variant of colonial medicine for a plantation society would subsequently be instituted in other colonies: Irving and the Secretary of State looked so favourably upon the reformed system that British Guiana would organise its GMS system on the same principles.¹⁵²

In terms of the 1875-76 GMS reforms in Trinidad, Irving and Crane had drawn a definitive line between the patients who were, and were not, the government's responsibility, but in doing so, inadvertently opened Pandora's Box. For the first time in this colony, the widely-published *Regulations for Medical Attendance on the Poor* definitively declared the government's obligation to the poor. At the same time, mandating DMOs to reside within their districts situated the medical men closer to their public, to deliver healthcare to the poor, indentured East Indians, and police, with their services also being concurrently available to other residents on a fee-for-service basis. This remained important in the rural areas where the relatively small number of people who could afford to pay for medical care discouraged private doctors from establishing practices.¹⁵³ The reforms thus attempted to address a multitude of concerns involving the public's accessibility to western medicine and the lack of poor relief. However, it is unclear if anyone realised just how many residents would qualify for government healthcare under the published rules. The number of poor residents legitimately eligible for gratuitous or low-cost GMS healthcare doubled within a decade,¹⁵⁴ and then continued to increase each year thereafter.

Conclusions

As Waltraud Ernst predicted, refocusing the investigative lens of colonial medicine to include the policies and attitudes impinging on the medical landscape enhances our ability to understand how the racial and class tensions inherent in plantation society colonialism influenced the development of state medicine. In Trinidad, the process to institute colonial medicine embodied all the other tensions generated by colonialism, perhaps in a similar manner to the struggles experienced in other imperial world plantation societies. Britain's state medicine 'at home' developed within its own distinctly unique structure, as did Trinidad's GMS. Each government's view of its obligations to the public and poor was predicated on historically divergent and incongruous ideologies. Colonialism's inherent tensions heightened in each instance where metropolitan decision makers and expatriate officials assumed the colony was in the broadest sense British, when it remained distinctly Creole on matters of public health and medicine.

In the metropole, the framers of the 1834 Poor Law Amendment Act equated

¹⁵¹ CO 295-274 (1875) #8580. *GMS Reorganisation*. Irving to Colonial Secr.

¹⁵² CO 295-313 (1887) #9405. *Treatment of Medical witnesses by chief justice*. Enclosure #5. Letter from Acting Surgeon-General B. Pasley. 30 April 1887.

¹⁵³ When the lucrative Medical Visitor arrangements shifted to government contracts, there was no incentive for private doctors to establish practices, because the rural paying patient base was so small. Laurence, "The Development of Medical Services," 67.

¹⁵⁴ CO 295-316 (1887) #4669. *Report of Commission on Surgeon-General's Department*. Minutes.

poverty with moral failure and introduced measures to deter the poor from seeking relief, but this principle had been overturned by the mid-1860s. Officials recognised that sickness and poverty often went hand in hand and that the labouring classes needed relief from the effects of economic cycles. The Metropolitan Poor Law Amendment Act of 1867 removed the stigma from Poor Law medical services and stimulated the construction of many diverse medical institutions to assist the chronically ill and geriatric populations, while providing active-care medical treatments to regenerate the labouring peoples. In Trinidad, the Creole elite never altered its attitudes about the African population, using the widespread poverty amongst the people as proof of racial regression into barbarism after emancipation. The mission to civilise the people continued to be narrowly defined to attempt to force the Africans and Indians to labour in the plantation estate economy. Paradoxically, plantation society civilisation created poverty and then blamed the victims for their misfortune.

The Colonial Office did not develop an Imperial strategy or master plan for the creation of the colonial healthcare systems in the unique environment of a plantation society. Each colony had a great deal of latitude to organise its GMS. Thus, while officials in Trinidad decided to implement distinct tiers of healthcare for the public at large and indentured East Indians, their colleagues in Jamaica organised a single tier system for their colony. In the absence of detailed studies on how and why each colonial government structured its GMS system, and the outcome of those decisions, it is not possible to compare the struggles in Trinidad with the other plantation societies. The tensions in Trinidad during the 1870s over the form and function of the GMS may have similarly occurred in other colonies and represented a natural evolution of a new system of state welfare services.

One consistent pattern characterised the struggles over state medical services in Trinidad, as the Colonial Office supported the desires of each governor, rather than encouraging a consistent imperial policy and structure for colonial medical services in plantation colonies. Within this decade, the governors who ruled Trinidad tended to overturn the decisions of their predecessor on many fundamental matters of importance to the organisation of the GMS. The governor wielded extraordinary powers and could decide to use them. As discussed below (in Chapter 5), these powers were intended to be a mechanism by which the trusteeship inherent in Crown Colony rule was used to protect the subject peoples from arbitrary decisions. However, as was evident during Longden's tenure, the gubernatorial powers could be used to for the opposite purpose. Nonetheless, while the Colonial Office actively supported the policies of Gordon and Irving, it adopted a *laissez-faire* attitude when Longden demonstrated an affinity for the Creole worldview. Thus, during the first decade of the GMS, the colony's policy often reflected the personal interests of the reigning governor, rather than a consistent colonial or imperial strategy.

The reformed GMS combined selected structures from the public hospitals and Poor Law Medical Service in England, the Indian Medical Service, and Trinidadian traditions, while addressing the unique racial and economic demographics of the lower orders of free and bonded subject peoples in the colony. This organisation of state healthcare services was the product of the tensions from both within the colony and the interconnected network in the Imperial world. The creolisation of colonial medicine thus occurred as the various elite factions continued to retain different conceptions of the

nebulously defined idea that the colony would shoulder the White Man's Burden of providing medical services to its subject peoples.

The GMS's retention of authority over medical matters and the channelling of government revenues into the well-being of the poorer classes remained contentious. During the 1880s, the small Creole upper class periodically devoted remarkable energies to attempt to regain control of the GMS. The Surgeon-General's ability to deflect those campaigns depended on his own alliances and the prevailing and often fluid coalitions between the current governor, Creole elite, and the increasingly socio-economically secure class of the GMS doctors. Chapter 5 examines the evolution of state healthcare during the tumultuous period between 1880 and 1891.

– Chapter 5 –
Imperial Trusteeship and Colonial Healthcare, 1880-1891.

During the 1870s, Trinidad had established the Government Medical Service (GMS) amidst tensions between the various officials and the Creole elite about the state's obligation to assist the poor in maintaining their health. During the economically depressed 1880s, the GMS's costs and patient numbers increased dramatically. The factions agreed that extreme measures were needed to reduce the costs, but disagreed on the course of action. Surgeon-General Crane used the tenets of preventive medicine to justify his demand for the legislators to implement a system of Poor Relief to mitigate the conditions of poverty causing so many people to need state healthcare. The Legislative Council rejected Crane's call to expand its commitment to the lower classes and instead concentrated on the dire effects of the depression on the colony's revenues, attempting to reduce healthcare spending, in 1887 and again in 1891. On both occasions, Governor William Robinson's requests for the Colonial Office to sanction the legislation arrived in Whitehall at the same time that Crane appeared in person to plead his case on behalf of the people. In contrast to the normal collaborative relations between the Creole elite and the British officials on government matters, the struggles over state healthcare and relief forced the Colonial Office to exercise its infrequently used constitutional powers of trusteeship and intervene into the disputes.

This chapter begins by reviewing the perspectives of historians and contemporaries on Crown Colony rule in Trinidad, which was predicated on the principle of trusteeship, wherein the governor and Colonial Office retained the power to abrogate colonial decisions to protect the imperial subjects from arbitrary rule. However, this power was rarely exercised, suggesting the unusual nature of the Colonial Office's interventions into the colonial disputes regarding state healthcare and Poor Relief. This study then establishes the connection between the economic depression and the demand by the public for state assistance. *The Regulations for Medical Attendance on the Poor* clarified the public's entitlement to healthcare services and the people exercised their privilege with a vengeance: thousands of impoverished sufferers flocked to the urban centres seeking medical care each year. Although the Legislative Council refused to adopt preventive health and Poor Relief measures to reduce the number of GMS patients, in 1886-87 it agreed to construct a network of district hospitals to situate the remedial medical care services closer to the rural population. Rather disingenuously, the legislators sought Colonial Office approval to build the hospitals at the same time that they launched their first attempt to retract the size of the GMS. This confused the Colonial Office. Nonetheless, Whitehall did not intervene until pushed to act by some of its sojourning officials and Trinidad's disgruntled Creole elite. This chapter concludes with an analysis of these unusual interventions into Trinidad's medical affairs in 1886-87 and 1891, when Whitehall was forced to exercise its powers of trusteeship.

These local disputes over state healthcare and relief occurred in tandem with the struggles of another career civil servant, Chief Justice John Gorrie. Bridget Brereton explained the tensions caused by Gorrie's crusade to reform the justice system between 1886 and 1892: "Gorrie's unforgivable sin, in the eyes of the planter-merchant community, was to administer justice impartially and to reform judicial proceedings in

order to open up the courts to working-class suitors.”¹ There are remarkable parallels between the actions of Gorrie and Surgeon-General Crane. Both men campaigned on behalf of the same population of poor African and East Indian subjects, believing that the civilising mission obligated the colony to provide the people with British justice and western medical services. The Creole elite vigorously attempted to marginalise Crane and Gorrie. Brereton’s chronicle of Gorrie’s tumultuous time revamping the justice system is periodically juxtaposed alongside this analysis of the controversies over state healthcare and Poor Relief. In both instances, the Colonial Office reluctantly interceded to stop the turmoil in the colony, albeit with different outcomes for each crusader. In 1887 and late 1891, the Colonial Office dictated that the GMS would remain intact and reinforced Crane’s authority. In early 1892, the Colonial Office’s Select Committee ruled against Gorrie and he was recalled to England. In losing the battle over the state healthcare, the Creoles learned a valuable lesson on how to manipulate the Colonial Office’s infrequent interventions, allowing them to triumph over Gorrie. Trusteeship remained a fluid and malleable entity in the imperialist project; Crane and Gorrie’s struggles shaped the course of history in this corner of the imperial world, momentarily, in as much as their experiences in the Empire shaped their worldviews on colonialism.

Trusteeship and Crown Colony Rule

While Britain’s civilising mission is commonly associated with the imperial attitudes about the non-white subject peoples, British officials also believed that they needed to manage their inherited populations of white Creole elites. Britain initially imposed Crown Colony rule on Trinidad to minimize the potential for an independent legislature run by the Creole elite to make any embarrassing decisions during the abolition of slavery.² Trinidad remained a Crown Colony from 1831 until 1924. During this time, the Colonial Office insisted that Britons needed to rule the colony to protect the African and East Indian subjects from the actions of the self-interested and untrustworthy white oligarchy.³ Direct rule did not simply allow the Crown to intervene, but obligated the trustees to abrogate any troublesome colonial initiatives. However, post-colonial historians have emphatically critiqued the rhetoric of Crown Colony rule and questioned the efficacy of the trusteeship in their quests to explain the legacies of colonialism in Trinidad.⁴ The Colonial Office rarely ever curtailed the actions of the reigning governor

¹ Bridget Brereton, *Race Relations in Colonial Trinidad 1870-1900* (Cambridge: Cambridge University Press, 1979), 28. Bridget Brereton, *Law, Justice and Empire. The Colonial Career of John Gorrie 1829-1892* (Jamaica: Univ. of West Indies Press, 1997), 227-314.

² Hewan Craig, *The Legislative Council of Trinidad and Tobago* (London: Faber & Faber, 1951), 16-17.

³ H.A. Will, “Problems of Constitutional Reform in Jamaica, Mauritius and Trinidad, 1880-1895,” *The English Historical Review*, 81, 321 (1966): 715. These sentiments were articulated by many British officials, well into the twentieth century, including Colonial Secretary Hugh Clifford in 1905, and Under Secretary of State for the Colonies E.F.L Wood in 1922. CO 295-435 (1905). #17402 *Colour Question in Trinidad. Memorandum on the Existing Condition of Race-Feeling in the Island of Trinidad*. Hugh Clifford to C.P. Lucas. BPP 1922 [cmd.1679]. *Report by the Honourable E.F.L. Wood, MP (Parliamentary Under Secretary of State for the Colonies) on his Visit to the West Indies and British Guiana*, 7.

⁴ Brereton, *Race Relations*. Brereton, *Law, Justice and Empire*. David Vincent Trotman, *Crime in Trinidad. Conflict and Control in a Plantation Society 1838-1900* (Knoxville: University

and usually sanctioned any resolution put forth jointly by the governor and Legislative Council.⁵ The senior imperial trustees, the governor and Colonial Office, thus tended to collaborate with the Creole elite, rendering Whitehall's interventions into the intra-colonial struggles over the GMS as anomalous events. On both occasions, in 1886-87 and 1891, the Colonial Office overrode the unanimous decision of Governor Robinson and the Creole legislators at the behest of Surgeon-General Crane, when he demanded that Whitehall act on its obligation to mitigate the conditions of its poor subjects.

Although Whig historian Hewan Craig argued that Trinidad's governor functioned as an "impartial authority" protecting the interests of all sectors of society, in the wake of decolonisation, historians vigorously attacked the rhetoric of impartiality.⁶ Their analyses established the powerful alliances between the Creole elite and various British officials over the years. In his 1972 study of race and nationalism in Trinidad, Selwyn Ryan introduced that the Creoles and Colonial Office officials shared similar economic objectives. These powerful men often acted in unison to pressure the governor to implement policies privileging the planter-merchant community.⁷ Brereton's 1979 analysis of the troubled race relations argued for the inherent power in these alliances:

It was the great myth of Crown Colony government that Governors and officials were impartial administrators, and at the same time, the special protectors of the poor. The Crown was the representative of the unrepresented masses; hence the need to keep power and responsibility in the hands of the Governor.⁸

The influential Creoles elites in the British West Indies mastered the art of drawing sojourning British officials into their society. Patrick Bryan and Howard Johnson have both argued that the white Creole plantocracies had great success convincing "open-minded" officials to adopt their racist attitudes.⁹ For Trinidad, David Trotman and Brereton stressed that this worldview continued to be framed by the traditions of slavery and plantation society.¹⁰ To Trotman, the governor had to "rise above the insidious racism" at the root of the system, while Brereton doubted that many governors had the strength to oppose the powerful Creoles.¹¹ Thus, while Crown Colony rule professed to protect the people, historians agree that it more often protected the interests of major stakeholders, as the Creoles and Britons cooperated and collaborated in an environment

of Tennessee Press, 1986). Dennison Moore, *Origins and Development of Racial Ideology in Trinidad. The Black View of the East Indian* (Canada: NYCAN, 1995). Selwyn D. Ryan, *Race and Nationalism in Trinidad and Tobago: a study of decolonization in a Multiracial Society* (Toronto: University of Toronto Press, 1972).

⁵ Brereton, *Race Relations*, 27. Brereton argued that, on matters of finance, the Colonial Office usually supported the wishes of the Creoles, because these men represented the colony's wealthy class. Craig, *The Legislative Council*, 17. Moore, *Racial Ideology in Trinidad*, 146.

⁶ Craig, *The Legislative Council*, 26.

⁷ Ryan, *Race and Nationalism*, 18.

⁸ Brereton, *Race Relations*, 25.

⁹ Patrick Bryan, "The White Minority in Jamaica at the end of the Nineteenth Century," in Howard Johnson and Karl Watson (eds.), *The White Minority in the Caribbean*, (New Jersey: Markus Wiener, 1998), 129. Howard Johnson, "Introduction," in Howard Johnson and Karl Watson (eds.), *The White Minority in the Caribbean*, (New Jersey: Markus Wiener, 1998), xv.

¹⁰ Brereton, *Race Relations*, 24-6, 35-6. Trotman, *Crime in Trinidad*, 35-69.

¹¹ Trotman, *Crime in Trinidad*, 32-3. Brereton, *Race Relations*, 24-6, 35-6.

that perpetuated racial inequality and economic exploitation.

Several governors publicly acknowledged the significant demands exerted by Trinidadian Creole society to acculturate to the dominant local values and influences. In his testimony to the 1909 Sanderson Commission, Arthur Hamilton Gordon, Lord Stanmore, reflected on the troubled times in Trinidad after his departure in 1870. He criticised the weakness of governors who bowed to the wishes of the dominant establishment, imperilling the equality and impartiality of British rule. Stanmore described the “great danger” of powerful plantocracies ruling unchecked in pursuit of their own interests, when “cowardly” Britons aligned with them, rather than exhibiting the moral fortitude necessary to curtail those tendencies.¹²

In his memoirs, G. William Des Voeux expounded on the pressure to conform to the values of Creole society during his tenure as acting governor in 1877-78. He arrived in Trinidad shortly after his testimony to the Royal Commission had substantiated the widespread abuse of indentured Indians by British Guiana’s planters.¹³ Des Voeux complained of the “frigid” reception by the Creoles and their attempts to undermine his official status, viewing the strong extant relationships as an important reason why Whitehall needed to appoint impartial non-Trinidadians to rule.¹⁴ At the same time, Des Voeux acknowledged that his tenure had been bearable only because of the excellent social life, which pushed him to the brink of financial ruin from entertaining the influential colonists and official visitors. Des Voeux claimed to balance his social priorities with impartiality on governmental matters, rather than allowing the governor’s neutrality to become subordinate to the pressures exerted by the influential Trinidadians.¹⁵ Des Voeux described the unending social activities with charming and intelligent gentlemen, such as Dr. Crane, as some of the most pleasant in his entire colonial career.¹⁶ Donald Wood juxtaposed Des Voeux hosting the elite at his posh roller skating party at Government House alongside the entertainments of children from the lower ranks, where the “bare-footed urchins” played in abysmally filthy streets in the slums.¹⁷ Certainly, Des Voeux and other officials believed that their residencies could become insufferable if ostracised from elite society. Roller skating with the rich would always be preferable to the entertainments offered by the other classes.

Some British expatriates periodically personified the ethos of trusteeship and challenged the entrenched *status quo*. As argued above (in Chapter 4), Arthur Gordon and Henry Irving used their gubernatorial powers to negotiate their medical and health

¹² BPP 1910 [cd.5193]. *Report of the Committee on Emigration from India to the Crown Colonies and Protectorates. Part II. Minutes of Evidence*, 346-53.

¹³ BPP 1871 [c.393], *Report of the Commissioners Appointed to Enquire into the Treatment of Immigrants in British Guiana*, 1-15. On 25 December 1869, Des Voeux wrote a complaint to the Earl of Granville, alleging mistreatment of indentured East Indians in British Guiana, which initiated a lengthy formal investigation. Many of Des Voeux’s allegations were confirmed.

¹⁴ G. William Des Voeux, *My Colonial Service in British Guiana, St. Lucia, Trinidad, Fiji, Australia, Newfoundland, and Hong Kong with Interludes* (London: John Murray, 1903), 293-7, 304, 310.

¹⁵ Des Voeux, *My Colonial Service*, 297, 304, 310, 318-19.

¹⁶ Des Voeux, *My Colonial Service*, 307.

¹⁷ Donald Wood, *Trinidad in Transition. The Years after Slavery* (London: Oxford University Press, 1968), 298.

reforms, despite the local opposition. Trotman argued that officials had to possess “exceptional qualities” to attempt the “herculean task of defying both implicit ideology and explicit social and economic power in order to protect the powerless.”¹⁸ This was certainly true for any reforms contemplated for public health or justice for the people. Brereton introduced Sir John Gorrie as one of these officials: “British imperialism threw up from time to time men like Gorrie, maverick officials who tried to serve the interests of the ‘subject peoples’ and to make a reality of the trusteeship doctrine.”¹⁹ Gorrie’s reforms on behalf of society’s disadvantaged had encountered significant opposition from the local Creole plantocracy in each of his colonial postings.²⁰ In Mauritius, from 1869 to 1876, the powerful Creoles considered Gorrie “Public Enemy Number Two,” surpassed only by his reform-minded leader, Governor Arthur Gordon.²¹ Brereton summarized Gorrie’s career as an untiring mission to champion the cause of plantation society’s lower orders. His reforms “inspired both bitter opposition from colonial elites and intense admiration from the ‘subject races’ in each place where he served.”²² As a careering civil servant, Gorrie’s worldview was shaped by his colonial sojourns and influential in redefining the contours of justice in the colonies where he served.

Gorrie’s personal and professional motivations undoubtedly inspired Crane. However, a senior administrator had difficulty introducing contentious reforms without strong executive support. Crane had traditionally remained in the shadow of the ruling governor, but, as argued below, surfaced as a vocal critic in his own right at the time when Gorrie arrived in the colony. The plight of the destitute patients who sought medical care from the government doctors every day provided Crane with a potent reason to agitate to change the widespread suffering in the colony. The trusteeship inherent in Crown Colony rule endowed the governor with significant powers to deal with the situations arising when disharmony prevailed. As will be shown, the individual crusades waged by the Chief Justice and Surgeon-General challenged the *status quo* during Robinson’s reign, rendering his governorship a chaotic period. The failure of the trusteeship model then became an imperial issue, necessitating that the Colonial Office exercise its power to intervene to protect the subject peoples. These struggles came to the forefront during the latter part of the decade, when the economic depression heightened the adverse conditions of the colony’s endemically poor people, with definite repercussions for their health and well-being.

Ailing King Sugar: The Economic Context of Illness

Plantation colonies were structured to allow the small white elite to retain the wealth generated by exploiting the labour of its non-white subject peoples, although wealth creation was often fleeting during the nineteenth century. The numerous changes in the global sugar markets wreaked havoc with the economies of the plantation societies and

¹⁸ Trotman, *Crime in Trinidad*, 32-3.

¹⁹ Brereton, *Law, Justice and Empire*, xi-xii.

²⁰ Gorrie’s colonial assignments included Jamaica (1865-68) in the wake of the Morant Bay uprising, and Mauritius (1869-76) and Fiji (1876-82) with Governor Gordon, and then the Leeward Islands (1883-86) and Trinidad and Tobago (1886-92).

²¹ Brereton, *Law, Justice and Empire*, 88-9.

²² Brereton, *Law, Justice and Empire*, xi-xii.

caused another major recession between 1884 and 1902.²³ The severe situation in the West Indies became an imperial problem. In 1897, the West India Royal Commission concluded that the crisis was immense and the sugar industry faced certain “extinction” in many colonies: several colonies could no longer afford the costs to administer their governments. The commissioners cautioned that these problems would amplify the suffering of the labouring classes, especially as many colonies did not have the money to provide any form of relief to the large numbers of poor people. They warned the governments to refrain from attempting to resuscitate their failing treasuries by introducing new taxes that heightened the distress amongst the poor.²⁴

Trinidad’s recurring economic crises feature prominently in the literature. Scholars have demonstrated that the plantation economy was purposefully organised to promote endemic impoverishment amongst the lower classes.²⁵ Trotman identified systemic deficiencies and vulnerabilities, ranging from crop failures and natural disasters to the “boom-and-bust cycles” of export markets. He correlated the crises to the high rates of crime, while considering how they affected the masses of people who existed on the margins of society. Trotman argued that the plantation economy created an adverse quality of life, because the people who profited the most in times of prosperity did little to mitigate the effects of cyclical and endemic dearth amongst the public at large, allowing pathetic living conditions to prevail. The Creoles remained disinterested in improving the GMS or any other services for the public, except for the apparatus of law enforcement and punishment. Trotman summarized life in Trinidad as short and “nasty.”²⁶ Kelvin Singh concurred and described the continued harsh conditions of life, to 1945. Singh argued that the elite consistently refused to recognize poverty as the cause of the physical deterioration and high rates of sickness of the lower classes. The prosperous tended to blame the victims for their misfortune, which Singh considered was a trope to justify the long-standing policies to suppress wages. Officials investigating the socio-economic conditions identified that subsistence diets and malnutrition contributed to the adverse conditions of a generally unhealthy population, symbolising the effects of a society rife with poverty and unemployment.²⁷

During the 1880s, Trinidadians suffered immensely from the economic turmoil which would eventually culminate in the Imperial government’s intervention with the 1897 West India Royal Commission. Trotman found this to be a time of high unemployment, wage reductions, and employers defaulting on wage payments.²⁸ In August 1886, Governor Robinson appointed Chief Justice John Gorrie to chair Trinidad’s Trade and Taxes Commission, tasking the committee to recommend how to

²³ Colonies in the British West Indies suffered from the effects of foreign competition by producers of bounty-fed beet sugar and protective tariffs on cane sugar by foreign countries. BPP 1898 [c.8655] *Report of the West India Royal Commission*, 69.

²⁴ BPP 1898 [c.8655] *Report of the West India Royal Commission*, 69. BPP 1898 [c.8657] *Report of the West India Royal Commission. Appendix C*.

²⁵ Trotman, *Crime in Trinidad*, 103-4. Kelvin Singh, *Race and Class Struggles in a Colonial State. Trinidad 1917-1945* (Jamaica: University of West Indies Press, 1994), 36. Brereton, *Law, Justice and Empire*, 325.

²⁶ Trotman, *Crime in Trinidad*, 103-4, 146-56.

²⁷ Singh, *Race and Class Struggles*, 36, 114-15.

²⁸ Trotman, *Crime in Trinidad*, 105-6.

increase trade and decrease the local cost of living.²⁹ Trinidad's revenues depended on high duties on agricultural exports and imports. The highly taxed imported food products and commercial goods made the cost of living 30% higher than other Caribbean colonies.³⁰ Robinson stressed the importance of lowering food prices. He was concerned about the health of the labouring classes: "this is no small question when it is remembered how such a change would affect our hospitals, poor houses and asylums." Robinson directed the commission to find a way to help the people afford the "necessaries of life."³¹ Gorrie's recommendation to abolish import duties would have reduced the cost of living, by exempting food and staple products from the high taxes.³²

Incensed by Gorrie's proposal, planters and merchants circumvented Robinson and petitioned the Colonial Office, insisting that, "the lower classes were prosperous and well able to bear indirect taxes in the form of duties on imported food and other necessities."³³ H.A. Will stated that Whitehall indicated that the Legislative Council was "unmanageable" on the proposal to eliminate the taxes on food. The government's actions on this and several other matters caused the Colonial Office staff to decline Trinidad's requests for constitutional reform, because they recognised that Whitehall had to retain the power to veto legislation passed by Trinidad's Council.³⁴ However, the Colonial Office could have passed the necessary legislation to abolish the duties, but this did not happen.³⁵ Thus, as Gorrie and Robinson insisted that the people were suffering, the influential Creoles disclaimed this assertion, and the Colonial Office retained its non-interventionist tradition. The Legislative Council increased the import duties.

Destitution sent far too many people to the GMS. Institutions operated beyond their patient capacities: doctors stuffed people in every available nook and cranny.³⁶ Residents used the GMS services at a startling rate. By the 1891 census, the primary tier for the public at large treated 47,162 patients annually:³⁷ 15,422 in hospitals, 30,768 out-

²⁹ Brereton, *Law, Justice and Empire*, 241-2.

³⁰ 1892 LC #12. *Despatch from Secretary of State respecting Expenditure on Medical Establishment and Institutions*. Minutes of discussion, 2.

³¹ 1887 LC #8. *Report of Commission on Trade and Taxes*. Minute by Governor. *Trade and Taxes Commission, Trinidad*. 1886. (Port-of-Spain: Government Printer, 1886).

³² Brereton, *Law, Justice and Empire*, 241-2.

³³ The Colonial Office's C. Alexander Harris, Secretary to the West Indies Committee, discounted the petitioner's claim that they represented a broad sector, recognizing that the 1,952 signatories were planters and merchants. Brereton, *Law, Justice and Empire*, 241-2.

³⁴ Will made this argument in the context of his review of the Colonial Office's response to the agitation for constitutional reform in Jamaica, Mauritius, and Trinidad. Other than establishing the Finance Committee in 1885, no other changes were granted to Trinidad during the period of Will's study (1880 to 1895). Will, "Problems of Constitutional Reform," 694, 715.

³⁵ Will argued that the Colonial Office insisted on keeping Trinidad as a Crown Colony, so that it could veto local laws and institute its own legislation if necessary. Will, "Problems of Constitutional Reform," 715. It is indeterminate if the Colonial Office contemplated using its powers to abolish the duties. Robinson and Gorrie would have plausibly supported the decision.

³⁶ 1885 LC #15, *Surgeon-General AR*, 3-4.

³⁷ GMS reported its usage statistics by patients. The 15,422 in-patients represented the number of admissions to the institutions. However, the out-patient numbers may not have been exact. *The Regulations for Medical Attendance on the Poor* allowed certificate patients to use the GMS for a two or four week period. *The Regulations* did not specify that each family member required a certificate; assumedly a parent would bring several children to the doctor at one time.

patients, plus 467 lunatics, 253 lepers, and 252 paupers in the House of Refuge.³⁸ This large volume of patients is remarkable in relation to the total population: the GMS treated between 25% and 29% of Trinidad's residents in 1891.³⁹ Innumerable other people used indigenous healers, Obeah, and private physicians, but these encounters in the private sector are not documented in the records of colonialism. The breadth of impoverishment amongst the government's patients remained notable, with about 80% (just over 37,000 people) qualifying for Pauper or Poverty Certificates according to *The Regulations for Medical Attendance on the Poor*.⁴⁰ In other words, the GMS treated more than one-sixth of the residents as paupers during the year. One of Brereton's early essays characterised the indentured East Indian sector as "a sick one."⁴¹ In that about 25% of the non-indentured population received healthcare within the public tier, arguably Trinidad's public at large was sickly too, as well as impoverished.

Surgeon-General Crane used statistics on *per capita* hospital treatments to compare the health of his residents to those in the metropolis. In London, 2.74 per 1,000 population obtained treatments as out-patients, while Trinidad's rate was an astounding 150, suggesting that many Londoners possessed the resources to engage private physicians and avoid hospital clinics much better than the Trinidadians. The contrast for in-patient treatments was similarly striking. London admitted 18.2 per 1,000 population, while Trinidad admitted 62.9.⁴² Crane's statistics suggest a remarkable differential in the health of the Trinidadians and the personal resources that they could devote to maintain it. With almost three and a half times as many patients needing institutional assistance in this colony, the GMS's resources remained perpetually strained and the hospitals were continually plagued by overcrowded conditions.⁴³

The onslaught of patients seeking GMS assistance drew the doctors into the broader struggle between the British officials and the Creole elite, especially as the Legislative Council constantly criticised the GMS about the overcrowded conditions of the hospitals and the high institutional mortality rates.⁴⁴ Doctors reflexively defended

³⁸ 1892 LC #113, *Surgeon-General AR*, 7-8, 11, 13-14.

³⁹ The 1891 census enumerated 200,028 residents. All 10,782 indentured East Indians received treatments during the year, along with 47,162 people from the public at large. Using a mean annual population of 202,587 (from Appendix 2.2), GMS treated 28.6% of all residents. If the indentured Indians are excluded, because they were compelled by law to be treated by the doctors, the number of voluntary patients is high: GMS treated 24.6% of the public during the year. *Census of the Colony of Trinidad, 1891* (Port-of-Spain: Government Printer, 1892).

⁴⁰ 1892 LC #113, *Surgeon-General AR*, 7-8.

⁴¹ Bridget Brereton, "The Experience of Indentureship, 1845-1917," in John LaGuerre (ed.), *Calcutta to Caroni. The East Indians of Trinidad* (Trinidad: Longman Group, 1974), 31.

⁴² 1892 LC #113. *Surgeon-General AR*, 7-8. Crane's statistics on London were obtained from *Burdett's Hospital Annual*. This lengthy annual digest published extensive statistics on hospital finances, patient treatments, and major trends in public, private, and Poor Law institutions in the United Kingdom, the colonies, and the United States. Data of this nature allowed Crane to make these comparisons. See, for instance, Henry C. Burdett, *Burdett's Hospital and Charities Annual 1895* (London: Scientific Press, 1896).

⁴³ The overcrowding in the hospitals remained a problem throughout the period of this study. Wood noted overcrowding as early as the 1860s. Wood, *Trinidad in Transition*, 29.

⁴⁴ The Surgeon-General's annual reports summarised the admissions, overcrowding, and mortality rates. However, for the approximately 31,000 out-patients each year, the reports do not

their professional abilities and attributed the problems to the lack of political will to address the conditions that created such a large patient population. This decade's significant advances in medical knowledge, such as the germ theory of disease, reinforced what doctors had known all along: ailments caused by deprivation needed to be arrested before those cases progressed to the state where sufferers needed institutional care. The doctors connected the patients' inability to obtain relief to the increasing demands for medical care. "Destitution and sickness," Crane insisted, "follow so quickly one upon the other that measures for their relief have to be considered together."⁴⁵ The GMS doctors knew that the hospital conditions facilitated the spread of disease, increased the mortality rates, compromised the patients' medical conditions, and increased the average length of stay by about 25%.⁴⁶ Patients spent an average of 41 days in the hospitals.⁴⁷ In effect, the physicians were fighting for the adoption of an earlier corpus of preventive public health knowledge, which had long since been accepted in the metropolitan hospitals and schools where they had trained.

The embattled doctors also faced criticisms from the Legislative Council over the escalating expenditures. Crane reminded the legislators of the inherent economy in the *per capita* cost of patient treatments, but argued that the expenditures would continue to increase until residents could access earlier forms of relief.⁴⁸ *The Regulations for Medical Attendance on the Poor* had clarified the public's entitlement to the services and the decade's economic troubles caused more residents to exercise their claim. The number of in-house patients doubled during the decade.⁴⁹ The new system of hospital management constituted by the 1875-76 reforms had resulted in a 15% decrease in the *per capita* cost of maintaining in-house patients, while the quality and quantity of the food, medical supplies, and clothing improved, at the same time that the GMS equipped the facilities to the current British standards.⁵⁰ Nonetheless, the doctors did not receive accolades for their efforts to treat the patients by more cost-effective means; the Legislative Council wanted and needed to spend less on GMS healthcare, while critiquing the institutional overcrowding and high mortality rates. The medical landscape in the colony had become untenable for all parties by the middle of the decade.

Crusading on Behalf of the Poor: Surgeon-General Crane and Chief Justice Gorrie

Chief Justice John Gorrie arrived in Trinidad in 1886 and immediately embarked on his

indicate how many people were refused hospital admission because of the lack of facilities. Crane confirmed that the GMS doctors did not maintain statistics of this nature. CO 295-279 (1877) #13574. *Statements against Dr. Crane and the mortality at the Colonial Hospital*. Crane to Colonial Secretary, 26 October 1877.

⁴⁵ 1885 LC #15, *Surgeon-General AR*, 2.

⁴⁶ 1882 LC [unnumbered], *Surgeon-General AR for 1881*, 1.

⁴⁷ 1886 LC #7, *Report by the Surgeon-General suggesting a scheme of out-door Poor Relief*.

⁴⁸ 1885 LC #15, *Surgeon-General AR*, 3.

⁴⁹ CO 295-316 (1887) #4669. *Report of Commission*. Minutes.

⁵⁰ 1885 LC #15, *Surgeon-General AR*, 3, 7. The Colonial Office acknowledged the positive results of the 1875-76 reforms that had vested the Surgeon-General with financial control. CO 295-316 (1887) #4669. *Report of Commission*. Minutes.

crusade to rebalance the scales of justice, opposing the upper ranks of Creole society at every step along the way. The elite decided that Gorrie posed a serious threat to their traditional control over Trinidad's society and economy.⁵¹ Brereton's conclusion encapsulates the complexity of the racial tensions and the struggles of the handful of officials who challenged the *status quo* in Crown Colonies.

... these Caribbean islands were long-settled communities composed mainly of the descendants of slaves and slaveowners [sic], with entrenched white elites who cherished racist traditions and had influential allies in Britain. Gorrie's belief in equality before the law and his willingness to defy the opinions and values of the local oligarchs generated strong and persistent opposition ... ⁵²

Although the majority of the officials employed by the Colonial Office executed their duties in an unremarkable manner, a handful of these men periodically created substantial controversy during their imperial careers. In Trinidad, it was unusual to have two reform-minded officials in the colony at the same time. Concurrent with Gorrie's arrival, Crane increasingly elevated the question of the state's legal obligations to its subjects to the forefront, demanding that the legislators act to relieve the ubiquitous poverty causing so many people to need the GMS services. Crane and Gorrie acted on their personal interpretation of their obligations as trustees of British rule. However, the Chief Justice had the authority to dispense British justice as he wished, while the Surgeon-General needed to solicit Legislative Council approval for his reforms.

In February 1886, Crane submitted a proposal to the Legislative Council to create a system of out-door Poor Relief. He wanted the government to take action on the symptomatic destitution that fostered the epidemiology of so many ailments, which could have been prevented, but instead sent so many people to the GMS.⁵³ Each district would create a Poor Relief Board, staffed by a large employer of labour and existing government officers, including the local Warden, Stipendiary Magistrate, and District Medical Officer. The boards would dispense relief according to the English system, subjecting the able-bodied poor to a labour test to ascertain their entitlement. The government would arrange employment, at reduced wages, for the people who were capable of performing manual labour, but unable to find work.⁵⁴ This proposed system of out-door workfare would have raised an important question in this plantation society: why would Trinidad need indentured migration if the government put able-bodied unemployed people to work on public works projects? The 'less-eligibility' wage rate would have been the below-subsistence earnings paid to indentured East Indians, which the free residents refused to accept.

Crane was unable to forge the necessary alliances and muster political support for his contentious proposal to reduce the number of GMS patients by providing economic relief. Crane's public statements began to reference Britain's statutes, arguing that the authorities were legally obligated to address the conditions of the poor, because the

⁵¹ Brereton, *Law, Justice and Empire*, xvii.

⁵² Brereton, *Law, Justice and Empire*, 319-20.

⁵³ 1886 LC #104, *Surgeon-General AR*, 13. 1886 LC #7, *Relief of Poor*.

⁵⁴ As with the British precedents, the proposed system delineated between the infirm and able-bodied. 1886 LC #7, *Relief of Poor*.

principles of the 1601 Elizabethan Poor Laws (as amended over time) applied to a colony ruled by British laws. Crane insisted that the laws “established the principles ‘that the impotent poor have a claim to be maintained at the public expense, and that the able-bodied poor have a claim to be employed by the public,’ principles recognized down to this day.” It was the government’s “manifest duty” to provide for the poor.⁵⁵ The enabling statutes were in place to allow the government to offer relief, but the urban and rural wards refused to assist their destitute residents.⁵⁶ The government’s position was clear through its inaction: it did not have an obligation to institute relief. Crane failed in his quest to position the government’s inaction on Poor Relief as a contravention of British law. He then resorted to insulting the elite self-conception of the superiority of Creole civilisation.⁵⁷ The Surgeon-General’s ill-fated attempt to interpret the law and his affront to the upper class did little to further his cause. Crane clearly had no suasion over the decision makers, but needed their support.

The elite would not imperil its system of indentured labour, nor would it accept any responsibility for non-indentured residents. Legislators ignored Crane’s proposal. A year later, Robinson resuscitated the plan. He traced the high costs at the hospitals to the absence of out-door relief.⁵⁸ Robinson blamed Port-of-Spain’s town council for failing to provide relief and refusing to expand its “miserably inadequate” almshouse.⁵⁹ The time was at hand for the government to “make some provision for the sick and destitute poor.” Robinson justified the plan as an initiative to reduce costs. An expenditure of £2,000 could either treat eighty-seven hospital in-patients or provide 263 people with out-door relief in food, clothing, and medical comforts.⁶⁰ Robinson encouraged the legislators to implement the system of relief, but they ignored his suggestion.

Finally, in 1890, Robinson used his authority to enact an ordinance to implement the system and create local boards in each district.⁶¹ The boards disregarded Robinson’s orders.⁶² Dr. C. Burgoyne Pasley, a senior GMS doctor, reiterated that Crane’s proposal for rural poor relief could have been successful, “had the members of the District Boards taken that earnest, personal, and real interest in the welfare and relief of the poor.” The disinterested officials justified their inactions by claiming that out-door relief would

⁵⁵ 1886 LC #92, *Poor Relief. Letter from the Surgeon-General Relative to the Provision for the Maintenance of the Indigent Sick in POS.*

⁵⁶ 1886 LC #92, *Poor Relief.*

⁵⁷ 1889 LC #28, *Surgeon-General AR*, 5.

⁵⁸ 1886 LC #86. *Minutes of the Finance Committee with reference to Estimates for 1887. Minute by the Governor Suggesting that Provision be made for the Establishment of a System of Poor Relief.*

⁵⁹ Port-of-Spain’s government was in debt and Council deemed it too “irresponsible” to receive further government money. 1886 LC #86, *Minutes of the Finance Committee.*

⁶⁰ 1886 LC #86, *Minutes of Finance Committee.* Minute by Governor. Crane calculated the cost of hospital care as three times higher than issuing food, clothing, and medical comforts by out-door relief. It cost GMS from .24¢ to .30¢ daily to treat people in hospitals. Crane anticipated that this would be reduced to .10¢ per day through out-door relief. 1886 LC #7, *Relief of Poor.*

⁶¹ *The Poor Relief Regulation, 1890*, established Poor Relief Boards in each district, along with almshouses and the provision of out-door relief. BPP 1892 [c.6563-5], *Trinidad and Tobago Blue Book*, 28.

⁶² 1891 LC #46, *Surgeon-General AR*, 10.

increase the incidence of pauperism and create a system fraught with abuses.⁶³ This assertion would have had resiliency amongst those who supported the crusade against out-door relief occurring in the metropole at this time.⁶⁴ However, Trotman argued that the local opposition was based on the white elite's traditional and consistent portrayal of the Africans' natural inclination for laziness. He found that "relief was given grudgingly in time of crisis, but that the authorities considered pauperism a crime."⁶⁵ The GMS doctors lamented the survival strategies forced upon their underprivileged patients and challenged the official stance of blaming the poor for their destitute conditions. The GMS instead issued medical comforts to out-patients. The doctors believed this intervention would reduce the expenditures in the long run, by helping their patients remain healthy and attempting to arrest maladies in the early stages.⁶⁶

Tensions thus heightened as the factions debated the relationship between state relief, healthcare, and poverty, with the Creoles insisting that state healthcare pauperised the population, and British-trained doctors retorting that poverty facilitated endemic illness and thus necessitated state healthcare. The two polarised views showed no signs of compromise. In the meantime, the problem of so many ailing poor people became an increasingly large and visible problem in the colony.

Symptoms of the Problem: Medically-Motivated Urban Migrations

The rural poor routinely swelled the numbers of impoverished urbanites. Residents knew that Port-of-Spain and San Fernando hosted the colony's medical establishments and these towns attracted many poor people.⁶⁷ Crane described their medically-motivated pilgrimages as a well-entrenched custom.⁶⁸ The 1875-76 reform situating District Medical Officers (DMOs) in the districts helped reduce some of this migration by providing decentralised services to tens of thousands of sufferers each year. The rural out-patient system was believed to be "improving daily."⁶⁹ Rural DMOs continued to send sufferers to the urban hospitals for lengthy and complex in-patient treatments,⁷⁰ but many people made the pilgrimage on their own volition. While the leper and lunatic asylums treated specific types of patients, the hospitals continued to be the only major institutions for social welfare support. Many residents competed for the restricted

⁶³ CO 295-313 (1887) #9405. *Treatment of Medical witnesses by chief justice*. Encl. #5. Letter from Acting Surgeon-General B. Pasley. 30 April 1887.

⁶⁴ England's Poor Law policies were in a state of flux in Britain at this time. Hurren and Harris argued that the policy change in the retrenchment strategy, the "crusade against outdoor relief" (1873-1900), reduced Poor Law expenditures and the investments needed for sanitary infrastructures and disease control. Elizabeth T. Hurren, "Poor Law versus Public Health: Diphtheria, Sanitary Reform, and the 'Crusade' against Outdoor Relief, 1870-1900," *Social History of Medicine*, 18, 3 (2005), 399-418. Bernard Harris, *The Origins of the British Welfare State. Social Welfare in England and Wales, 1800-1945* (New York: Palgrave, 2004), 53-6.

⁶⁵ Trotman, *Crime in Trinidad*, 108-9.

⁶⁶ 1891 LC #46, *Surgeon-General AR*, 10.

⁶⁷ Trotman confirmed the late-century migration to Port-of-Spain by many economically dislocated rural Trinidadians. Trotman, *Crime in Trinidad*, 152.

⁶⁸ 1885 LC #15, *Surgeon-General AR*, 2.

⁶⁹ CO 295-311 (1886) #20601. *Surgeon-General's Dept. Sub-encl. #1*. Surgeon-General.

⁷⁰ 1890 LC #35, *Surgeon-General AR*, 8.

resources in the hospitals, including the destitute, homeless, aged, disabled, and blind. The forms of relief they sought could have been provided more cost effectively in purpose-built special care facilities, rather than in active treatment hospitals.⁷¹ However, these unfortunates had nowhere else to go, as alternative institutions did not exist.

The political will languished to diversify the socio-medical support offered to the public, with the exception of the construction of one new almshouse, which was woefully under-capacity from the outset. In 1881, the government opened a colonial House of Refuge in St. Clair, adding 150 beds to the capacity of the GMS system. In addition to housing the destitute, inmates suffered from old age, chronic maladies, blindness, and severe physical disabilities.⁷² The pent-up demand for the facility did not relieve the overcrowding at the hospitals, as equally incurable cases filled the hospital beds as fast as doctors transferred patients to the almshouse.⁷³ Port-of-Spain and San Fernando operated small almshouses, but the few hundred beds across the three facilities remained insufficient for the population.⁷⁴ Port-of-Spain's town council minimised its expenditures on the poor by deflecting the problem to the colonial government. The destitute residents did not disappear. They reflexively went to the hospital.⁷⁵ The municipal inactions cost the colonial treasury \$5,694 annually to house the cases that belonged in the town's small house of refuge.⁷⁶ The GMS doctors put patients in every possible bed in the hospitals and asylums. The problem continued throughout the decade, causing *The Lancet* to report in 1889 that the continually overcrowded hospitals functioned as poorhouses, which contributed to the high institutional death rates.⁷⁷ The quasi-almshouse hospitals continued to capture the attention of correspondents to *The British Medical Journal* to the end of the century.⁷⁸ The GMS doctors knew that they had to find a way to redistribute these patients to facilities more appropriate to their needs.

The Trinidadian public contributed to the debate over state healthcare in a pragmatic way, by constantly presenting their health-challenged bodies to the GMS doctors. The tenacity of the residents to surmount many barriers is examined below, in Chapter 6. While the records of medical colonialism tend to consolidate the patients into aggregate statistical entities, Figure 5.1 provides a rare glimpse of one of the many patients who exerted significant effort to seek medical attention.

⁷¹ 1886 LC #7, *Relief of Poor*. 1890 LC #35, *Surgeon-General AR*, 7-8. 1891 LC #46, *Surgeon-General AR*, 10. 1882 LC [unnumbered], *Surgeon-General AR*, 1.

⁷² 1889 LC #28, *Surgeon-General AR*, 69.

⁷³ 1882 LC #19, *Surgeon-General AR for 1881 (Half Year)*, 2.

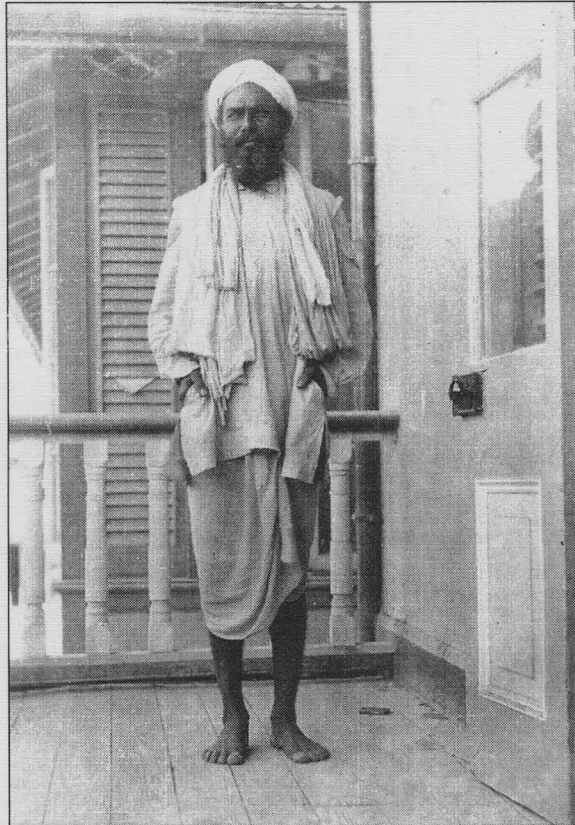
⁷⁴ The Port-of-Spain almshouse housed between 65 and 75 inmates. BPP 1878-79 [c.2273], *Papers Relating to Her Majesty's Colonial Possessions*. 1877, 31.

⁷⁵ As discussed above (in Chapter 4), during the 1875 reforms, it was decided the town would pay £750 annually in order to reduce its costs and eliminate abuses in the system. [The form of abuse was not documented.] Crane assumed that the town would transfer incurables from the hospital to the poor house. This never happened. 1886 LC #92. *Poor Relief*.

⁷⁶ Doctors at the Colonial Hospital indicated that the average forty patients treated in-house each day could have been cared for in a House of Refuge. This volume of patients cost GMS \$5,694 each year. 1886 LC #92. *Poor Relief*.

⁷⁷ "Health of Trinidad," *The Lancet*, 13 July 1889, 76.

⁷⁸ See, for instance, "The West Indies as a Health Resort. Medical Notes of a Short Cruise among the Islands," *The British Medical Journal*, 4 Sept. 1897, 611. "India and the Colonies. Trinidad," *The British Medical Journal*, 10 June 1889, 1444.



*Figure 5.1 – “East Indian who walked 60 miles to be treated.”
Courtesy of Rockefeller Archive Center. Reprinted with permission.⁷⁹*

This unidentified Indo-Trinidadian man suffered from hookworm. His sixty mile trek, on foot, suggests that he traversed a significant part of the island seeking treatment. This patient, and thousands of others, contributed to the debate amongst the elite officials in a particular way, by persistently exerting extraordinary effort to obtain medical care. During the 1880s, the congregation of sufferers in Port-of-Spain amplified the visibility of the large number of ailing destitute people. According to pharmacist L.O. Inniss, “Nearly everybody who was somebody, lived down in town.”⁸⁰ The plight of the rural and urban poor played out on the doorsteps of the Creole elite and the members of the Legislative Council. Although Crane could not convince legislators to take action on the causes of endemic destitution, he persuaded them to deal with the symptom: the phenomenon whereby so many sick residents ‘flocked’ to the towns.

District Hospitals

Crane captured the attention of the usually inattentive Creoles by demonstrating that the creation of a network of rural cottage hospitals would help to arrest the medically-

⁷⁹ Rockefeller Archive Center, *RF Photos*, 451, Box 117, 2289, P3377.

⁸⁰ L.O. Inniss, *Trinidad and Trinidadians. A Collection of Papers, Historical, Social and Descriptive, about Trinidad and its People* (Port-of-Spain: The Mirror Printing, 1910), 80.

motivated pilgrimages of the destitute ill into the urban centres. Despite continually ignoring the *per capita* cost savings of Crane's Poor Relief proposal, the notion of far distant rural institutions gained political currency amongst the urban dwelling legislators. Council agreed to spend the capital to build the hospitals, but the Colonial Office subsequently refused, twice, to sanction the expenditures, due to the colony's poor financial condition. Even well-justified projects were put on hold.⁸¹ The influential Creoles remained inflexible on their position regarding out-door relief, but momentum increased to build the cottage hospitals. Thus, during a decade of economic strife and unremitting criticisms over the GMS's increasing expenses, legislators dealt with one problem by instituting expensive institutional alternatives.⁸²

During Irving's governorship, the colony had purchased land in Princes Town with an eye to constructing a rural hospital.⁸³ The GMS started experimenting with cottage hospitals, opening four facilities in 1881, which proved so successful that their tiny capacities were quickly expanded.⁸⁴ These hospitals operated at a slightly lower cost and their mortality rates remained below those at the urban hospitals.⁸⁵ The GMS adapted existing buildings and arranged with estate owners to use a dozen or so beds for government patients at their private hospitals, such as the hospital at the St. Marie estate.⁸⁶ The district hospitals were certainly not large or grand facilities, like the urban hospitals, but they established a decentralised network of remedial care facilities within the more densely populated communities throughout the island.

⁸¹ 1885 LC #15, *Surgeon-General AR*, 4. The government traditionally did not challenge the expenditures to incarcerate lunatics and lepers. However, the colony's financial predicament caused the government to defer the costs of expanding the asylum this year.

⁸² The per capita daily cost to treat the GMS patients was .30¢ at the Port-of-Spain hospital and .28¢ in district hospitals. Crane estimated that out-door relief would have cost .10¢. 1886 LC #7, *Relief of Poor*. 1886 LC #104, *Surgeon-General AR for 1885*.

⁸³ 1885 LC #15, *Surgeon-General AR*, 4.

⁸⁴ For instance, the hospital at Princes Town started with seven beds, but expanded to thirty within a year. 1882 LC [unnumbered], *Surgeon-General AR for 1881 (Half Year)*, 1.

⁸⁵ 1882 LC [unnumbered], *Surgeon-General AR for 1881*, 1.

⁸⁶ Records on the GMS's use of the estate hospitals are minimal. In the early decade, GMS used fifteen beds at the Caroni estate. GMS later used ten beds at St. Marie estate until 1887. 1882 LC [unnumbered], *Surgeon-General AR for 1881*, 1. 1888 LC #44, *Surgeon-General AR*, 5.

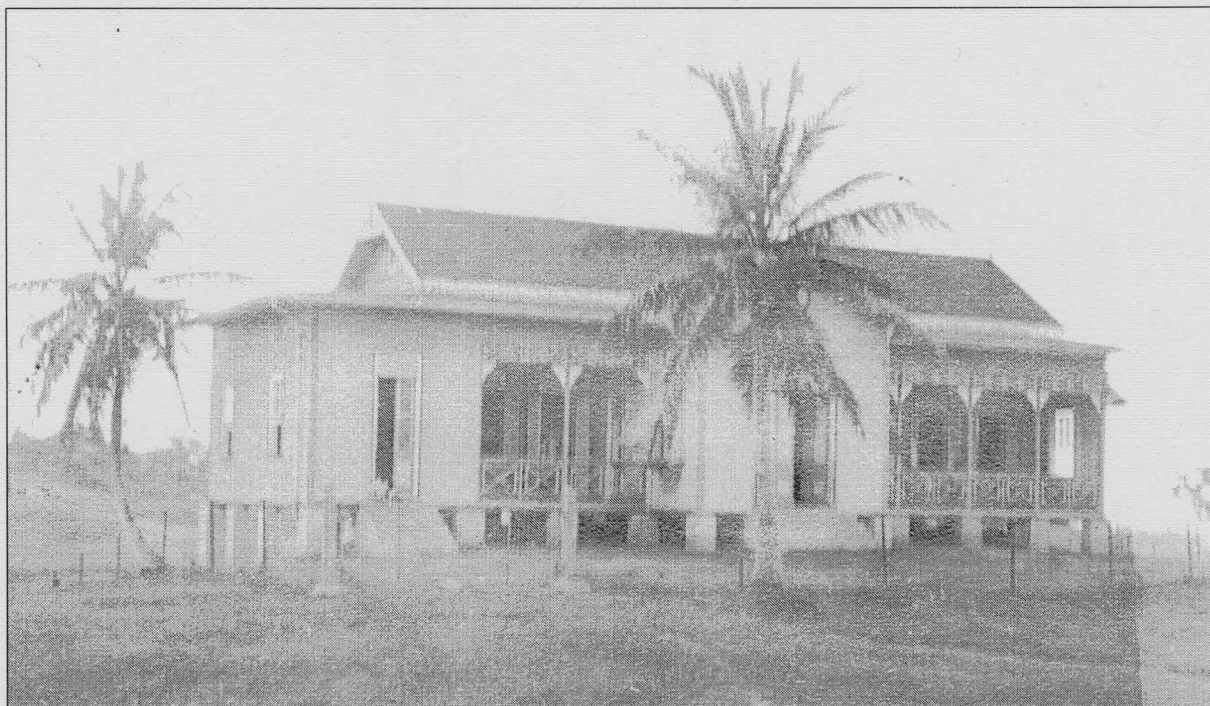


Figure 5.2 – St. Marie Estate Hospital, 1 March 1916. The GMS used ten beds at this hospital in the 1880s for public patients, before building the Cedros District Hospital. Courtesy of Rockefeller Archive Center. Reprinted with permission.⁸⁷



Figure 5.3 – Cedros District Hospital, 1 March 1916. Courtesy of Rockefeller Archive Center. Reprinted with permission.⁸⁸

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Rockefeller Archive Center, RF Photographs, 451, Box 117, 2294, P266I.

While perhaps capitalising on a form of not-in-my-backyard sentiments, doctors mobilised the tenets of preventive medicine and claimed that the hospitals helped alleviate the congestion and high mortality rates in the urban hospitals. They called for hospitals to be built in the districts sending large numbers of sufferers to the urban centres and GMS dispensaries in communities that could not justify hospitals.⁸⁹ This experimental phase meant that, in some instances, facilities opened and closed in short order.⁹⁰ Nonetheless, by the end of the decade, six district hospitals added significant capacity to the network, treating 3,010 in-patients during the year.⁹¹ Innumerable other sufferers received out-patient care. Crane described the district hospitals as “excellent institutions,” providing the sick poor with access to hospital therapeutics in their local community.⁹² Trotman argued that the Legislative Council reacted negatively to subsequent proposals to add more hospitals, claiming that the GMS services had a “pauperizing effect.” Legislators insisted that residents were now “state aided from cradle to grave,” but Trotman doubted this assertion of the breadth of the socio-medical safety net, showing instead that the continued inaccessibility of services sent many people to Obeah practitioners.⁹³

As the single reform for which Crane garnered support during the 1880s, the important but relatively expensive program to create district hospitals proceeded apace, despite encountering a major financial hurdle. The sugar depression focused London’s attention on the colony’s troubled economy. Robinson forwarded the Legislative Council’s plan to build hospitals in St. Joseph, Couva, and Chaguanas to the Colonial Office. (After resolving the tensions between Trinidad and London, these hospitals increased the GMS system capacity by 100 beds.⁹⁴) Robinson justified the expenditure based on lower per patient costs and the potential to decrease mortality rates in the districts, if sufferers could access medical care earlier.⁹⁵ The system of district hospitals was well-established in other colonies, such as Jamaica, which operated eighteen rural facilities by this time.⁹⁶ Whitehall rejected the proposal twice, demanding an explanation of how Trinidad intended to raise the £3,300 to pay for the hospital construction.⁹⁷ Trinidad had just established the Legislative Council’s new Finance Committee, which

⁸⁸ Rockefeller Archive Center, *RF Photographs*, 451, Box 117, 2294, P266H.

⁸⁹ 1885 LC #15, *Surgeon-General AR*, 2-5. They called for hospitals in St. Josephs, Couva, Chaguanas, and Princes Town, and dispensaries in Cedros, Oropouche, Toco, and Montserrat.

⁹⁰ Reports mentioned the closure of small hospitals, but is unclear when they opened; some came and went quickly. See, for instance, 1886 LC #97. *Return showing the number of Coolies in the undermentioned Government Medical Institutions on the 20th Day of November, 1886.*

⁹¹ Hospitals were situated in St. Joseph, Tacarigua, Arima, Chaguanas, Couva, and Princes Town. 1890 LC #35, *Surgeon-General Report for 1889*, 11.

⁹² 1890 LC #35, *Surgeon-General AR*, 11.

⁹³ Trotman, *Crime in Trinidad*, 227.

⁹⁴ 1888 LC #44, *Surgeon-General AR*, 5.

⁹⁵ CO 295-311 (1886) #19497. *Votes passed by Legislative Council.*

⁹⁶ James C. Riley, *Poverty and Life Expectancy. The Jamaica Paradox* (New York: Cambridge Univ. Press), 51.

⁹⁷ The minutes indicate the Colonial Office staff’s annoyance with both Robinson’s deportment and the proposal. In declining to approve the plan, the staff did not dispute the rationale, but pointed to the colony’s poor financial position. CO 295-311 (1886) #19497. *Votes passed by Legislative Council.*

was now responsible for all colonial expenditures.⁹⁸ Will argued that the local control over the spending was a concession by the Colonial Office, rather than agreeing to change the constitution of the colony, which the Council had been requesting. Whitehall feared that giving more power to the Legislative Council would result in rule by a “mischievous oligarchy,” which was clearly pro-planter, and had little regard for the lower classes.⁹⁹ The despatches from London declining to approve the district hospitals contained a clear warning to the governor and legislators.¹⁰⁰ The Colonial Office’s annoyance was multi-faceted.

Warring Factions and Imperial Interventions in 1886-87

In tandem with the Legislative Council’s request for approval to establish the district hospitals, a movement was afoot in Trinidad to silence the troublesome Surgeon-General and end his crusade. At the same time that the legislators sought approval for their plan to return the GMS to its former variant, where the Surgeon-General had no authority, Crane appeared in person at Whitehall to challenge the government’s decision. Although Whitehall immediately pronounced the Legislative Council’s actions to be contrary to the interests of the people, the staff embarked on a lengthy process to discredit the proposal submitted by the local legislature before Secretary of State Henry Holland invoked his authority to veto the plan. The Colonial Office’s action to disallow a proposal put forth by Trinidad’s governor and Legislative Council, but strongly opposed by another British official, was a protracted process.

In March 1886, Robinson appointed a committee to streamline the GMS administration. The terms of reference for the committee are unclear, but the ensuing controversy suggests that the verdict to revert the GMS to the earlier variant had been decided in advance. A shroud of secrecy enveloped the proceedings, as witnesses testified in confidence. The government acted swiftly to repeal the 1875-76 ordinance, which codified the GMS reforms, and reinstitute the 1870 law.¹⁰¹ The Colonial Storekeeper regained the responsibility to manage the institutions, while the Surgeon-General no longer had paramount accountability for colonial medical matters.¹⁰² Crane was also relieved of his responsibility as the Medical Officer of Health. These changes were portrayed as benevolent gestures to help the Surgeon-General reduce his personal workload.¹⁰³ The government changed the ordinances in direct opposition to Crane’s protests. Robinson refused to allow Crane to read the documentation of the proceedings and Council decisions, but sent it to London for official sanction. Both the despatch and Crane travelled to London in October 1886. Crane immediately registered his complaint at Whitehall about the proceedings. The Secretary of State gave the documents to Crane

⁹⁸ Craig, *The Legislative Council*, 23-7.

⁹⁹ Will, “Problems of Constitutional Reform,” 706-13.

¹⁰⁰ CO 295-311 (1886) #19497. *Votes passed by Legislative Council*.

¹⁰¹ 1886 LC #79. *Rules and Regulations*. CO 295-311 (1886) #20601. *Surgeon-General’s Dept. Encl. #2. Report of the Commission appointed to enquire into the working of the Surgeon-General’s Department*.

¹⁰² CO 295-316 (1887) #4669. *Report of Commission*. Crane to Secretary of State.

¹⁰³ CO 295-311 (1886) #20601. *Surgeon-General’s Dept. Encl. #2. Commission Report*. CO 295-316 (1887) #4669. *Report of Commission*. Minutes.

and declined to respond to Robinson until he received Crane's comments.¹⁰⁴

The Colonial Office reacted negatively to the contents of the despatch and the events in Trinidad. The staff discussed, at length, that the existing colonial ordinances codified the Surgeon-General's responsibility and authority to manage the medical service and its institutional structures. They interpreted the Council's actions as a challenge to the principle of appointing specialists to manage large government departments.¹⁰⁵ In this case, the Surgeon-General's medical and professional acumen were vitally important to the effective management of this tropical colony's public health and medical infrastructure. Whitehall recognised that the Creole elite had attempted to neutralise the functional head of a large department by abrogating the broad principle of the Chief Medical Officer's accountability for financial, operational, and professional management. The sympathetic comments of the Colonial Office staff acknowledged the underlying struggles of Trinidad's tendency to arbitrary rule and the propensity of many governors to align with the local influences during their sojourns.¹⁰⁶ The Colonial Office's lead officer on the file, C. Alexander Harris, Secretary to the West Indies Committee, counselled his colleagues to recognise that Robinson's actions were "mischievous," and that they purposefully negated the important changes made by his reform-minded predecessor, Governor Irving.¹⁰⁷

The Secretary of State and his staff unanimously agreed to disallow the ordinance and to reprimand Robinson and the Council for two reasons. First, they believed that the inquiry lacked any semblance of credibility. The proceedings involved the formality of assembling commissioners, summoning witnesses to provide the necessary evidence, and writing a lengthy report justifying the predetermined outcome. The staff discredited the credentials of the members of Trinidad's committee and expressed their frustration that Robinson had appointed officers of "obscure" standing to judge how Crane, who they held in high esteem, managed the GMS.¹⁰⁸ Indeed, the committee members did not hold influential positions in colonial governance. The Colonial Office may have been concerned about setting the precedent of allowing secondary office holders, who happened to be Creoles, judge the effectiveness of a trusted appointee.

The Colonial Office staff questioned the credibility and motives of the witnesses. The committee had ignored Crane's copious submissions and relied on information solicited from a select group of witnesses: the Colonial Storekeeper, GMS clerks, and elite GMS doctors Pasley, Fabien, De Wolf, and Knaggs. Although the committee certainly needed medically-informed evaluations about the care of institutionalised patients, the Colonial Office staff questioned the impartiality of the doctors, who

¹⁰⁴ CO 295-311 (1886) #20601. *Surgeon-General's Dept.* Secretary of State to Crane, 14 Dec. 1886. Secretary of State to Robinson, 14 Dec. 1886.

¹⁰⁵ CO 295-316 (1887) #4669. *Report of Commission.* Harris to Wingfield.

¹⁰⁶ CO 295-316 (1887) #4669. *Report of Commission.* Minutes.

¹⁰⁷ CO 295-311 (1886) #20601. *Surgeon-General's Dept.* Minute, Harris to Wingfield, 27 Nov. 1886. Harris held the position of Secretary to the West Indies Finance Committee. *The Colonial Office List, 1914*, 557.

¹⁰⁸ The committee included David Horsford (Acting Auditor General), C.B. Hamilton (Receiver-General), and D.L. O'Connor (Registrar in Bankruptcy). CO 295-311 (1886) #20601. *Surgeon-General's Dept.*

harboured “years of jealousy” over Crane’s control,¹⁰⁹ and would have benefited from the recycled variant of the GMS.¹¹⁰ The doctors would not be dismissed from the medical service, plausibly because the Colonial Office had difficulty recruiting doctors for Trinidad, but Pasley and his colleagues would spend several years re-establishing their credibility with London.¹¹¹

The second point of contention involved the committee’s selective manipulation of the data on the costs of treating patients. Trinidad’s justification to revert the GMS to its former structure revolved around the question of why the *per capita* daily costs of treating institutional patients decreased during the decade following the 1875-76 reforms. This was a relatively obscure question, as the spending on institutional supplies represented an insignificant portion of the annual budget to treat tens of thousands of sufferers each year, pay hundreds of employees, and operate the institutions. Crane quantified the reduction to be .15¢ per person daily, while increasing the food, clothing, and medical comforts provided to patients. This was a significant saving when applied to the 6,000 hospital patients in 1885.¹¹² The quality and quantity of these items, vital to patients during their recovery, had been substandard during the non-medical era of hospital management, to the point where it caused great “alarm” for the doctors.¹¹³ The GMS had also improved the patient and medical facilities in the institutions.¹¹⁴

The Trinidad committee relied on the testimony of Colonial Storekeeper O’Donnell Fitzgerald, who insisted that the savings were due to decreases in the market prices for supplies, rather than from the GMS reforms.¹¹⁵ Harris rejected this allegation. The number of patients had doubled between 1876 and 1885, while the expenditures on consumable patient items increased by only 50%.¹¹⁶ Secretary of State Holland overruled the government’s action to reinstate the Colonial Storekeeper as the managers of the medical institutions and directed Council to abolish the department.¹¹⁷

¹⁰⁹ CO 295-316 (1887) #4669. *Report of Commission*. Minute, Harris to Wingfield. Holland to Robinson.

¹¹⁰ The case of C. Burgoyne Pasley is an example of the alliances. Pasley had been hired by the Colonial Office. Creole society held Pasley in high regard, appointing him Acting Surgeon-General during Crane’s vacations. When the Colonial Office was discrediting the inquiry, Robinson and Payne tried to retain their credibility by sending further despatches to substantiate their claims of the inefficiency of GMS, which the Colonial Office staff discredited. CO 295-311 (1886) #22453. *Surgeon-General’s Dept*. Pasley to Governor Robinson, 25 Nov. 1886.

¹¹¹ After the failed attempt to discredit Crane, the Colonial Office staff observed that Pasley switched allegiances and supported Crane. CO 295-313 (1887) #9405. *Treatment of Medical Witnesses by Chief Justice*. Minutes and Encl. #5, 30 April 1887.

¹¹² CO 295-311 (1886) #20601. *Surgeon-General’s Dept*. Sub-encl. #1. Surgeon-General. 9 March 1886. CO 295-316 (1887) #4669. *Report of Commission*. Harris to Wingfield.

¹¹³ 1886 LC #104. *Surgeon-General AR*, 1-2. 1885 LC #15, *Surgeon-General AR*, 3.

¹¹⁴ CO 295-311 (1886) #20601. *Surgeon-General’s Dept*. Sub-encl. #1. Surgeon-General.

¹¹⁵ CO 295-311 (1886) #20601. *Surgeon-General’s Dept*. Encl. #2. Commission Report.

¹¹⁶ O’Donnell Fitzgerald succeeded Samuel Fitzgerald as the Chief Storekeeper during the 1875-76 reforms. Crane pronounced the department “more obstructive than useful.” In 1881, several departments recommended disbanding the Colonial Storekeeper department, but Council refused to close it. CO 295-311 (1886) #20601. *Surgeon-General’s Dept*. Harris to Wingfield. Sub-encl. #1. Surgeon-General. Encl. #2. Commission Report.

¹¹⁷ CO 295-316 (1887) #4669. *Report of Commission*. Holland to Robinson, 17 May 1887.

The committee's purposeful manipulation of evidence and statistics caught the attention of officers in other colonies. At the same time that the Colonial Office was negating the revival of the 1870 ordinance, Jamaica's Surgeon-General Dr. Mosse took up the cause of his embattled colleague in Trinidad. Mosse informed the readers of his annual report that Trinidad's Legislative Council was attempting to return its GMS system to the pre-1875 variant, which had been "abolished on the grounds of excessive cost and great inefficiency."¹¹⁸ Mosse compared the average daily costs to treat hospital patients in the three major West Indian colonies.

Table 5.4 – Comparative GMS Expenditures, 1886-87.¹¹⁹

Colony	Total Population	GMS annual expenditure	Average daily cost to treat all patients
Trinidad	153,128	£ 24,425	1s 2 ¼ d
British Guiana	252,168	£ 33,619	1s 3d
Jamaica	605,881	£ 45,057	1s 2 ½ d

Mosse's statistics established that the three colonies spent about the same amount *per capita* on patient treatments. Trinidad's total medico-social spending differed from Jamaica and British Guiana, however, because they operated Poor Law organisations, with their own equally large budgets, while Trinidad did not. As the Colonial Office staff processed the various data, the government was meanwhile ignoring Robinson's directive to create the system of Poor Relief, as introduced above. Crane ensured that Harris and his colleagues recognised the need for the Poor Relief system.¹²⁰

Holland decreed that no changes would be made to the GMS. His despatch to Robinson included a clear message that Robinson had aligned with the wrong side of local politics: Crane's position would indeed "be upheld." The Colonial Office staff criticised Robinson's deportment as the trustee: he had contravened the tenets of British fair play and justice by withholding the report from Crane.¹²¹ Although Crown Colony rule allowed Whitehall to abrogate a colonial initiative to protect the subject peoples from arbitrary rule, there were few late-century instances where it overruled the recommendations put forth by the governor and Legislative Council. This now occurred with a modicum of regularity when the controversies involved the GMS. The staff decided that Robinson had become embroiled in local politics and could not control the autocratic Legislative Council. Robinson subsequently threw his support behind Crane's crusade for Poor Relief, while his former Creole allies refused to accept defeat.

¹¹⁸ Jamaica Sessional Papers 1886-87. *Island Medical Department AR*, 163, section 20.

¹¹⁹ Jamaica Sessional Papers 1886-87. *Island Medical Department AR*. Comparative Statement of Expenditure, 163. These statistics appear to be preliminary 1886-87 numbers from each colony.

¹²⁰ CO 295-311 (1886) #20601. *Surgeon-General's Dept. Sub-encl. #1*. Surgeon-General.

¹²¹ CO 295-316 (1887) #4669. *Report of Commission*. Minute, Harris to Wingfield. Holland to Robinson.

The Conflict Continues: Imperial Interventions in 1891-92

Conflicts continued to prevail in Trinidad. By 1891, the tensions between Trinidad's elite and the crusading Gorrie and Crane escalated and necessitated further interventions from the Colonial Office. By now, Trinidad's oligarchy had simply had enough of each crusader and embarked on a program to rid the colony of these officials. On 11 May 1891, the Creole elite formalised its new attack on the GMS when Robinson sent three despatches to Secretary of State Henry Holland, Lord Knutsford.¹²² As before, the strategic objective of returning the GMS to its pre-1875 variant remained intact, although the tactics changed to make this appear to be a prudent financial decision during the difficult economic times. The justification revolved around two arguments. The first concentrated on Trinidad's total annual expenditures on medical services, which were deemed disproportionate to other colonies. The second argument positioned the cost of employing GMS physicians as excessive and as governmental interference into the operation of the free market. The legislators insisted that employing doctors in the civil service "crushe[d] out all private enterprise," making it impossible for private practitioners to earn a living. In the opinion of Trinidad's legislators, these problems could be rectified by reducing the GMS budget by 50% to 75% and ceasing to employ doctors in the civil establishment.¹²³ This plan therefore intended to reduce the medical services provided by the government to the public.

Knutsford initiated a formal inquiry, but kept this investigation within his direct control. He appointed a committee comprised of Dr. Crane, Trinidad Stipendiary Justice Llewellyn Lewis, C. Alexander Harris, and Knutsford's Assistant Private Secretary, H.W. Just.¹²⁴ Harris, it will be recalled, had been instrumental overturning the decisions of Trinidad's 1886 committee on healthcare. Trinidadians had little opportunity to influence the deliberations formally without representation on the committee, or even informally, as the committee convened in London during October 1891. The documentation regarding this inquiry did not state the terms of reference or define the scope of the committee's authority, but Knutsford subsequently accepted its decision to leave the GMS intact. Additionally, although the Legislative Council did not discuss Poor Relief in the proposal to dismantle the GMS, the committee recommended that the colony act on Crane's previously proposed system of out-door relief, and Knutsford directed the governor to do so.¹²⁵ Trinidad's legislators realised that the Secretary of State had not only overturned their decisions, but he also mandated the Poor Relief system that they had opposed.

The London committee set the stage for their recommendation to leave the GMS system intact by amassing statistical proof to counter the assertions of excessive spending. Council's charge hinged on a comparison of the annual GMS costs (£60,000)

¹²² The allegations were contained in Robinson's dispatches 164, 165, 166 of 11 May 1891. 1892 LC #12, *Secretary of State on Medical Establishment*.

¹²³ CO 295-335 (1891) #21907. *Minutes of Committee*. Knutsford to Broome. 1892 LC #12, *Secretary of State on Medical Establishment*.

¹²⁴ The job functions for Harris, Just, and Lewis are stated in the 1914 *Colonial Office List*, 557, 575, 586.

¹²⁵ CO 295-335 (1891) #21907. *Minutes of Committee*. Encl. Knutsford to Broome. 22 December 1891. 1892 LC #12, *Secretary of State on Medical Establishment*.

with those of Barbados (£16,000) and Jamaica (£35,000). Robinson insisted that Trinidad's costs should be on par with those colonies.¹²⁶ Knutsford's committee outlined the "misleading" nature of comparing costs between colonies with fundamentally different socio-medical infrastructures and population sizes. Council had again neglected to account for each colony's substantial annual expenditures to relieve the poor; £39,080 in Jamaica, £13,233 in British Guiana, £17,660 in Barbados.¹²⁷ Trinidad had not used British Guiana as a comparison, although its population most closely resembled Trinidad's, and both colonies were major sponsors of indentured immigration, incurring similar statutory medical obligations to those workers. Likewise, the relatively sparse distribution of rural residents minimised the potential for private physicians to set up medical practices in outlying districts. British Guiana's total salaries for government doctors exceeded Trinidad's costs.¹²⁸

Trinidad's annual GMS expenditure of £60,000 was on par with the combined medical and Poor Relief expenditures in other colonies. With its larger population, Jamaica spent £74,080 on its socio-medical infrastructure of relief (£39,080) and the GMS (£35,000). The much smaller colony of Barbados spent a total of £33,660 on the two systems each year, without any indentured labourers.¹²⁹ British Guiana spent about £66,000 on the GMS and Poor Relief.¹³⁰ Trinidad's total expenditures remained in the range of other West Indian colonies, although the lack of out-door relief and alternatives for institutional care meant that the colony treated fewer people in a more expensive way, when compared to the number of people who could have been assisted in a more progressively structured system.¹³¹

The proposal to reduce the GMS budget by 50% to 75% would have barely allowed Trinidad to pay for statutory services (such as vaccination, DMOs for indentured estate workers, and port health measures) and to provide a minimal level of service at the asylums, gaols, and hospitals. London identified the repeated inaction on the plight of the poor as the essential cause of the large institutional expenditures.¹³² The committee recommended that the Council should act on the relief proposals that had been submitted during the past five years. Crane confidently predicted that the Poor Relief system would allow the GMS to eliminate 500 beds from the network of hospitals and consequently reduce its annual operating costs by £10,000. These costs of maintaining the poor would shift to the municipalities, albeit at a lower *per capita* cost. The local communities would then assist the poor, similar to other British colonies.¹³³

¹²⁶ CO 295-335 (1891) #21907. *Minutes of Committee*. Encl. Minute of discussions.

¹²⁷ CO 295-335 (1891) #21907. *Minutes of Committee*. Encl. Minute of discussions. Jamaica Sessional Paper 1890-91, *Report of the Board of Supervision for the Relief of the Poor in Jamaica, for the period of Eighteen Months ended 1st March*. Appendix No. 19. Appendix No. 20.

¹²⁸ CO 295-335 (1891) #21907. *Minutes of Committee*. Encl. Minute of discussions.

¹²⁹ Barbados spent £17,660 on relief and £16,000 on the GMS, as stated above.

¹³⁰ In addition to the £13,233 expenditure on relief (as above), British Guiana spent £52,595 on its GMS, for a combined total of £65,828. BPP 1893-94 [c.6857-55] *British Guiana Annual Report for 1891*, 5.

¹³¹ CO 295-335 (1891) #21907. *Minutes of Committee*. Encl. Minute of discussions. 1892 LC #113. *Surgeon-General AR*, 6.

¹³² CO 295-335 (1891) #21907. *Minutes of Committee*. Encl. Minute of discussions.

¹³³ CO 295-335 (1891) #21907. *Minutes of Committee*. Encl. Minute of discussions.

Knutsford's committee then dealt with Trinidad's recommendation to cease employing doctors as civil servants. The Legislative Council insisted that the GMS paid excessive salaries to the doctors and that government doctors stifled the competition in the medical marketplace. It wanted to decrease the number of GMS doctors and reduce the salaries of those retaining their jobs.¹³⁴ The potential decrease in the number of doctors and the desire to set the salary rate below the levels offered by other colonial GMS organisations had serious implications for the colony's ability to attract doctors and the ability for the poor to access healthcare services in the rural areas. Knutsford's committee upheld the GMS's salary and career path structure, as originally modelled on the Indian Medical Service.¹³⁵ This decision reflected their interest in ensuring competitive wages and equity within the civil service.¹³⁶ The Colonial Office recruited doctors for Trinidad and knew that careering physicians wanted to be compensated according to the scale of salaries offered elsewhere.

The committee pointed to the health of the medical marketplace in Port-of-Spain, where twenty-seven doctors practiced: thirteen private practitioners and fourteen GMS employees. Only three GMS doctors exercised their privilege for private practice.¹³⁷ Council's complaint thus intimated that the part-time private practices of three GMS doctors made the pay-patient market uncompetitive for thirteen independent physicians. However, these private practitioners had always considered their practices more lucrative than government work.¹³⁸ The committee also noted that independent doctors would not set up rural practices because they could not earn sufficient income from the impoverished residents without the government salary and associated fees.¹³⁹ A reduction in the number of doctors and their salaries would have reduced the GMS's compliment of human resources, implying that a greater number of residents would have to find the means to pay private physicians.

The Creole's plan to dismantle the GMS did not stipulate the new structure that they intended to subsequently put in place, but comments by Crane's nemesis, Dr. Louis A. de Verteuil, reiterated their preference for the original system. Although he remained a persistent critic of the GMS, de Verteuil continued to hold several lucrative GMS contracts. The 1884 edition of his locally revered monograph on Trinidad's history and

¹³⁴ CO 295-335 (1891) #21907. *Minutes of Committee*. Encl. Minute of discussions.

Knutsford to Broome, 22 Dec. 1891. 1892 LC #12, *Secretary of State on Medical Establishment*.

¹³⁵ The number of GMS doctors did not change. The committee re-evaluated the allowances paid to the doctors and made minor adjustments in the fees for various activities (such as issuing Death Certificates), which nominally decreased costs. It also approved the doctors' request to change the seniority reward from an increase of £100 per annum after ten years of service to £50 per annum after five years and then again at ten years of service. The initial salary for new doctors was reduced from £300 per annum to £250, which was the amount that had been offered to new doctors since 1884. 1892 LC #12, *Secretary of State on Medical Establishment*, 2-3. CO 295-335 (1891) #21907. *Minutes of Committee*. Encl. Minute of discussions.

¹³⁶ CO 295-335 (1891) #21907. *Minutes of Committee*. Encl. Minute of discussions.

¹³⁷ GMS employed thirteen doctors plus Crane in Port-of-Spain. Hospital surgeons were not allowed private practice. 1892 LC #133. *Surgeon-General AR*, 3-5.

¹³⁸ Only one (unidentified) physician had expressed interest in government work, but then decided that his private practice was more lucrative. CO 295-335 (1891) #21907. *Minutes of Committee*. Encl. Minute of discussions.

¹³⁹ CO 295-335 (1891) #21907. *Minutes of Committee*. Encl. Minute of discussions.

future prospects criticised the organisation of the GMS and the career paths provided to its doctors. He argued that the doctors should be accountable to private sector physicians who had established themselves in society; elite Creole doctors would acquire appointments as visiting physicians to the hospitals.¹⁴⁰ He was thus suggesting that his elite colleagues could be enticed to relinquish part of their private practices to preside over medical matters at the institutions. Assumedly their interest would be piqued through lucrative financial contracts, as had been the norm in the GMS's early years.

Robinson and the Legislative Council had also remained silent on the fate of the multitudes of Trinidadians who would henceforth be restricted from accessing the GMS services. However, Trotman provided information that suggests the Council's solution for the African population, which was clearly portrayed as having regressed into barbarism. In 1891, officials asserted that the "African portion of the population can take care of themselves when left alone in the woods." Obeah practitioners would thus benefit from the increased number of residents seeking their services, although Trotman believed that they already conducted a brisk business in herbal therapeutics, to help Afro-Trinidadians cope with their conditions of life. Many people continued to use the herbalists, whether because of personal preference or, in Trotman's argument, the "inadequate and chaotic state" of the GMS.¹⁴¹

In London, the committee concluded its investigation at the end of October. Crane and Llewellyn Lewis returned to Trinidad. The Creole elite would have known London's decisions before Knutsford's despatch of 22 December 1891. Knutsford directed the new governor, Sir Frederick Napier Broome, to make no changes to the GMS and to proceed at once with Crane's proposed system of out-door relief. Knutsford ended his directives with an unequivocal demonstration of his support for Crane's "valuable and hearty service which he has continually rendered to the Colonial Government."¹⁴² Broome reprinted Knutsford's letter for the Legislative Council.

While waiting for Knutsford's despatch, the Legislative Council launched its attack on Sir John Gorrie. Brereton described their actions in late 1891, when the Creole legislators voted to request a formal enquiry in Trinidad about the administration of justice in the colony.¹⁴³ The failed attempt to marginalize Crane had taught the legislators a valuable lesson of relevance to their campaign to return the justice system to its former state: the Colonial Office would not remove a senior official at their behest. They realised the need to organise the trustee's intervention in a manner that would allow them to control the process by ensuring that the Imperial enquiry was conducted locally. Brereton stated that Knutsford reluctantly agreed. Four British jurists and scholars conducted the Judicial Enquiry Commission in Trinidad in the spring of 1892. Brereton established that the white Creole oligarchy stacked the evidence in its favour to ensure that this Commission had no alternative but to rule against the conduct of the "maverick"

¹⁴⁰ L.A.A. de Verteuil, *Trinidad: Its Geography, Natural Resources, Administration, Present Conditions and Prospects*, 2nd ed. (London: Cassell and Company, 1884), 207-10.

¹⁴¹ Trotman, *Crime in Trinidad*, 223-7.

¹⁴² CO 295-335 (1891) #21907. *Minutes of Committee*. Knutsford to Broome. 22 December 1891. 1892 LC #12, *Secretary of State on Medical Establishment*.

¹⁴³ Brereton, *Law, Justice and Empire*, 300-2.

judge, thus ending his tumultuous crusade.¹⁴⁴

Conclusions

The unremitting conflicts over the relationship between state obligations, poverty, and the health of residents permeated the socio-medical landscape in Trinidad throughout this decade. The ideologies of the Creole and British officials shaping the GMS remained conflictive rather than cooperative and fostered a protracted struggle over the control of financial and medical resources, until the escalating tensions necessitated imperial intervention on at least two occasions. These actions from Whitehall were unusual during a decade when many important initiatives created controversy in the colony. When the Legislative Council overturned the recommendations of the Trade and Taxes Commission and increased the duties on foodstuffs, heightening the struggles of the poor during the economic depression, the Colonial Office did not take any steps to oppose the powerful Creole elite. The Colonial Office's decision to intercede into the affairs of the GMS may have resulted from its view of the importance of the medical services, or perhaps because Crane kept arriving in person to plead the case of the Trinidadian public. His stories of the suffering and dearth amongst the subject peoples undoubtedly brought a personal dimension to the cause, which no amount of official correspondence could have possibly conveyed.

The upper strata of Creole society held considerable suasion over many British officials sent to administer the government and rule the colony. While Crown Colony government had been organised to mitigate the actions of the Creole elites in plantation colonies, in many instances in Trinidad it was difficult to ascertain who were the rulers and who were the ruled. While the British officials needed to cooperate and collaborate with the Creoles, Robinson's tenure represented a chaotic period. Although the governor had distinct ideas on what needed to be done at times, his gubernatorial powers were often impotent. This created many problems for the Surgeon-General. As with any public health crusader in the nineteenth century, Crane certainly needed local executive support for his reforms, which was not forthcoming to any extent. Gorrie faced the same situation, although his position in the justice system gave him far more latitude for action. As argued by Brereton, men like Gorrie periodically appeared within the Empire and challenged the *status quo*: Surgeon-General Crane similarly personified the principle of trusteeship. Both of these men had been influenced by their previous sojourns in other parts of the imperial world, experiencing plantation society colonialism from many different vantage points. These officials had a significant effect on their own areas of jurisdiction, even if only for a fleeting moment.

A significant portion of this study has investigated the attitudes and decisions within the upper ranks of colonial society, due to the nature of the sources relevant to the history of a state healthcare organisation. The records of colonialism infrequently capture the voices of the public and the patients of the GMS system. Although the individual patients may have been reduced to nameless statistics in the government archives, these patients remained a vitally important driving force in the creolisation of state healthcare in Trinidad. Sufferers played an important role by flocking to the towns

¹⁴⁴ Brereton, *Law, Justice and Empire*, 300-14.

and arriving on the doorsteps of the GMS doctors. The troubled economic times unquestionably aggravated their difficult lives and strained the resources which they could devote to health maintenance. With 47,000 of their numbers seeking assistance in 1891, a remarkable number by any measurement, Trinidadians were a force shaping the struggle. While the elites argued over tax rates, Poor Relief, and the GMS, the patients maintained the momentum to use their entitlements to the medical services, which may have not been in such demand if the elite factions had resolved their differences and taken action on the broader issues. As the only significant health reform during the decade, the network of district hospitals remained important to the residents and the GMS doctors, well beyond the period of this study. The hospitals helped to remove several thousands of sufferers each year from the immediate gaze of the urban-dwelling legislators in the colony's two major ports. The interconnected problems of poverty and ill-health, however, did not go away. A system of Poor Relief would have reduced the strains on the GMS organisation and assisted a larger number of people in a different way, albeit merely shifting expenditures from one government department to another. There is no way to anticipate how large the system would have become, but it may have grown as large as the GMS, if not larger. The Legislative Council reflexively justified its actions by proclaiming that the GMS services pauperised the residents, although the GMS doctors asserted that the poverty created their large patient population. Such was the nature of plantation society colonialism.

The government succeeded in its quest to avoid expanding the state welfare services, although it lost the struggle to dismantle the GMS and return it to the limited functions prior to the 1875-76 reforms. It did not act on Knutsford's directive to institute the Poor Law system and the government would not reconsider its position for another twenty-five years. The directives from the Colonial Office would imminently change, as Joseph Chamberlain became the new Secretary of State. Chamberlain's philosophy of constructive imperialism would allow the Creole elite to achieve its long-standing objective of decreasing the size of the GMS organisation. Chapter 6 examines the troubled times in Trinidad into the twentieth century, by considering the struggles of the patients to gain and retain access to the GMS system.

– Chapter 6 –

The Civilising Mission: GMS Policies and Patients, 1891-1916.

The 1803 Haitian revolution conditioned white Creoles and Britons throughout the British West Indies to the possibility that their subjects could one day rise up. This fear became a reality in Trinidad on 23 March 1903. Historians have interpreted the “Water Riot” in Port-of-Spain as an important event in the emergence of a sense of black consciousness and nationalism.¹ However, these studies overlook how many profound struggles over the political economy of health brought the 5,500 ratepayers to Government House on the ill-fated day. This study explores the complexities and connections between the civilising mission, Water Riot, and state healthcare by attempting to excavate the experiences of two of the most elusive groups in the records of colonialism: ailing residents who were denied access to the GMS services and those who became GMS patients. In the wake of the concurrent public health disasters and Water Riot, the GMS became a focal point in the public and confidential reports by government officials as they attempted to explain how and why the civilising mission had gone awry.

This study first establishes the profound changes to Trinidad’s GMS and the public health landscape, between the time when the new Secretary of State, Joseph Chamberlain, introduced his strategy of constructive imperialism in 1895, and the Water Riot in 1903. During this period, Surgeon-General Frances Lovell attempted to enhance the image of the GMS system to attract elite patients, while paring the services for the poor patients to the bone. Lovell’s reforms were predicated on the colonial elites’ unified assertion that state healthcare services had not succeeded in advancing civilisation but, instead, had pauperised the population. In brief, the subject peoples had become shamelessly dependent on the state’s benevolence. The analysis then examines, as best as possible, how the poorest people in the colony interacted with the GMS system. Contrary to the imperialist’s view of a dependent pauper population, many impoverished people could only obtain the state medical services, to which they were entitled by state policy, by exerting significant effort and tenacity. Furthermore, many sufferers did not seek assistance from the government until they had exhausted their meagre financial resources and other therapeutics in the community. Thus, while the civil disobedience at the Water Riot undoubtedly reflected an emergent sense of consciousness amongst the lower orders, it was also a public expression of discontent about the colonial state’s public health and medical care system. Moreover, an important force in the creolisation of the social policies on state healthcare - the subject peoples - had risen up *en masse* to challenge the colonial elite.

The Prelude to the Riot: Refashioning the GMS for Civilised Patients

Between 1870 and 1895, the Colonial Office had maintained a conservative position on state healthcare, providing little directional guidance, but responding to the colonial

¹ K.O. Laurence, “The Trinidad Water Riot of 1903: Reflections of an Eyewitness,” *Caribbean Quarterly*, 15, 4 (1969), 5-22. Bonham C. Richardson, *Igniting the Caribbean’s Past. Fire in British West Indian History* (Chapel Hill: Univ. of North Carolina, 2004), 175-82. Anthony Bogues, *Caliban’s Freedom. The Early Political Thought of C.L.R. James* (London: Pluto, 1997), 11.

officials when turmoil prevailed within the elite factions. This reactive department changed noticeably in 1895, when Joseph Chamberlain took the reigns of control and modified the strategy of the broader imperial project to constructive imperialism. The new political climate allowed Trinidad's Legislative Council to alter its social policies and the parameters of state healthcare services, aided by its new-found allies, Surgeon-General Frances Lovell and Governor Hubert Jerningham. Lovell proceeded to convert the Port-of-Spain Hospital into a state-of-the-art surgical facility and locus of therapeutics for the upper orders of society, while significantly reducing the number of lower class GMS patients throughout the system. These noteworthy reductions in the services available to the public represented the local manifestation of the changing metropolitan imperialist policies, which would ultimately contribute to the public's dissatisfaction and stimulate their riotous actions.

Chamberlain displayed a keen interest in the potential for western medicine to help the Empire become more productive: a modern, business-like approach would attempt to use British science and medicine to conquer microbes. In 1899, Chamberlain established the London School of Tropical Medicine (LSTM), to train colonial doctors and missionaries on the latest scientific methods and to conduct research on the tropical diseases which had traditionally thwarted the progress of the Empire.² John Farley argued that the Colonial Office staunchly supported tropical medicine to protect white imperialists in the perilous tropics, while demonstrating a notable disinterest in the health of the subject peoples.³ Chamberlain directed the governors of the West Indian colonies to make significant reductions in their GMS expenditures. He reprimanded the governments for being far too generous with the medical services provided to the public: colonies could not afford those services and the "natives" did not need them.⁴

Surgeon-General Lovell lost no time jumping on the constructive imperialism bandwagon. He re-conceptualised the GMS as an organisation providing services to a substantially smaller number of "natives," while catering to the influential citizens who were important to Chamberlain's strategy. In fact, the usual compliment of GMS patients had been thwarting Lovell's plan to attract elite patients into the system. In the metropole, a remarkable transformation had occurred in the public's perception of the hospital during the late-Victorian period. William Bynum confirmed the change in attitudes about the public hospital, which had accompanied the new medico-scientific knowledge, diagnostics, and therapeutics. Patients from the upper and middle classes used the hospitals more frequently.⁵ This change did not manifest spontaneously in Trinidad. Thus, in 1895, Lovell embarked on a campaign to refashion the urban hospitals and make them more appealing to Trinidad's elite. Lovell built private wards at the Port-

² BPP 1903 [cd.1598], *Papers Relating to the Investigation of Malaria and Other Tropical Diseases and the Establishment of Schools of Tropical Medicine*, 3-13. Seamen's Hospital Society, *London School of Tropical Medicine, Report for the Year 1899-1900* (1900), 2.

³ John Farley, *Bilharzia. A History of Imperial Tropical Medicine* (Cambridge: Cambridge University Press, 1991), 4.

⁴ CO 295-391 (1899) #8041. *Observations on Medical and Education Expenditures*. Confidential Jerningham to Chamberlain. Jerningham quoted Chamberlain's directive and use of the term "natives."

⁵ W.F. Bynum, "Ideology and Health Care in Britain: Chadwick to Beveridge," *History Phil. Life Sci.*, 10 (1988), 77-8.

of-Spain Hospital for society's upper strata. Initially, wards inside the main building were converted into private rooms, which then evolved into the detached private structures, shown in Figure 6.1. Lovell introduced other amenities to the hospital, building tennis courts and importing 200 rose bushes to adorn the grounds.⁶

*Figure 6.1 – Private Ward at the Port-of-Spain Colonial Hospital.⁷
Courtesy of Rockefeller Archive Center. Reprinted by permission.*

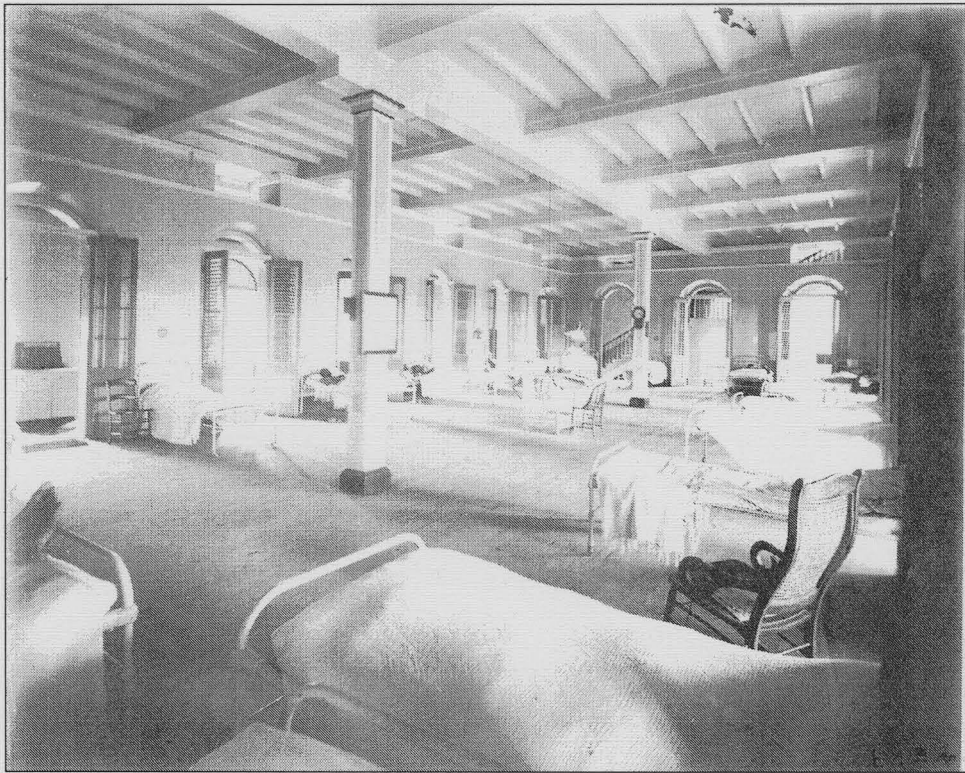


State-of-the-art surgical procedures became a priority to attract the new clientele. Patients who could afford to pay a token amount for hospital care, but who could not afford private rooms, continued to be admitted to the public wards and treated alongside the Poverty and Pauper Certificate patients, as shown in Figure 6.2.

⁶ 1895 LC #94, *Surgeon-General AR*, 10. 1896 LC #129, *Surgeon-General AR*, 26.

⁷ Rockefeller Archive Center. RF Photographs, 451, Box 116, 2286, P6936, *Port-of-Spain Hospital. Front/Private Ward*. This picture was probably taken between 1914 and 1916.

*Figure 6.2 – Male Ward at Port-of-Spain Hospital [n.d. probably 1914-16].⁸
Courtesy of Rockefeller Archive Center. Reprinted by permission.*



The Legislative Council enacted new ordinances to establish the rules to allow private patients to be admitted to the hospital. In 1895, Lovell confidently anticipated the success of his initiative to attract a more desirable class of patients to the Port-of-Spain Hospital.⁹ Although poor Trinidadians had a long history of flocking to the urban institutions, their social betters certainly did not flock to the renovated hospital. The private facilities awaited the onslaught of wealthy patients, which never materialised. Almost two decades later, in 1912-13, the statistics for the Port-of-Spain Hospital indicate that a mere sixty-one paying patients used the private wards during the year: this amounted to less than 1% of the people admitted to the hospital.¹⁰ The therapeutics remained a bargain at only 6/- per day, including major surgical procedures and intensive nursing care.¹¹ However, the segregated wards and low-cost medical care failed to transform the class of patients of the public hospitals, as had long-since occurred in the metropole.

Elite Trinidadians who possessed the financial wherewithal to choose their locus

⁸ Rockefeller Archive Center. RF Photographs, 451G, Box 116, 2286, *Port-of-Spain Hospital, P6934 [n/d], Male Ward, 1st Floor, Main Building.*

⁹ 1896 LC #129, *Surgeon-General AR*, 9. Ordinance 24 of 1895 revised the rules to allow private patients to be admitted to the hospital.

¹⁰ The hospital admitted 6,761 patients in 1912-13. 1914 LC #91, *Surgeon-General AR*, 22-6.

¹¹ The revenue from paying patients was £333. 1914 LC #91, *Surgeon-General AR*, 22, 26.

of healthcare continued to be treated either in their private residences or at institutions in “at home” in the United Kingdom. Newspaper reports confirmed that influential citizens often engaged multiple physicians when they were unwell, sometimes having one or more doctors in continuous attendance for hours on end, providing unlimited attention in their homes.¹² Many people from the upper ranks left the colony when they needed hospital treatments. The media made it their business to report on the health of society’s influential, many of whom boarded the next ship to Britain when sick. Friends and family turned out in force to bid them farewell during the continual departures of officials, merchants, planters, and doctors.¹³ The elite had confidence in the new scientific hospital treatments in Britain, but continued to shy away from the GMS facilities. Lovell failed to recognise that the hospital remained a space defined by race and class. Trinidad’s elite citizens may have been disinterested in allowing their white bodies to be treated by the predominantly non-white nursing staff, or they may have been deterred by the long-standing taint of the hospitals functioning as medicalised almshouses. Although their motives are indeterminate in the historical records, it is clear that they did not flock to the private facilities at the hospital.

Nonetheless, Lovell concentrated on reducing the number of poor patients in the system. Chamberlain’s 1899 directive to decrease medical spending provided an opportunity to cut the GMS budget significantly. Governor Jerningham immediately applauded the edict, telling Chamberlain that the GMS’s high costs resulted from the combination of “too soft hearted” governance, the high wages paid to labourers, and the colony’s history of allowing the subject peoples to rely on the government. In his opinion, the state healthcare services had only succeeded in pandering to the Africans’ “natural laziness” and had pauperised the people. He thought that the industrious and frugal East Indians represented a different sort of humanity; however, the GMS had encouraged both subject races to idleness.¹⁴ Jerningham, Lovell, and the Legislative Council slashed the GMS spending on out-patients and reduced the hospital beds in the system by at least 30%.¹⁵ These officials decided to curtail pauperism by forcing sufferers to provide for their own medical needs.¹⁶ Lovell continually claimed that the reductions did not inflict hardships on the people: they were a necessary step to train the people about thrift and industriousness. He counselled the doctors and officials that there could be “a little suffering at first until the mass learnt [sic] that they must help themselves.”¹⁷ To the contrary, after Chamberlain left the Colonial Office, the officials who inherited this legacy of constructive imperialism agreed that Lovell’s measures had taken the GMS to the “brink of a collapse” by the time of the Water Riot, in 1903.¹⁸

¹² For instance, Miss Annette Fernandez, a private elite citizen, had GMS Drs. Eakin and Fabien “in constant attendance at all hours night and day.” Obituary, *The Mirror*, 17 August 1901.

¹³ See, for instance, “Items of news,” *Port-of-Spain Gazette*, 6 Aug. 1905. “Death of Dr. F.B. Archer,” *The Mirror*, 5 Oct. 1901.

¹⁴ CO 295-391 (1899) #8041. *Medical Expenditures*. Jerningham to Chamberlain.

¹⁵ CO 295-391 (1899) #11877. *Medical Retrenchment*. Confidential Jerningham to Chamberlain. 1896 LC #129, *Surgeon-General AR*, 9. This was codified by Ordinance 24 of 1895.

¹⁶ CO 295-391 (1899) #8041. *Medical Expenditures*. Jerningham to Chamberlain.

¹⁷ 1895 LC #94, *Surgeon-General AR*, 22.

¹⁸ Governor Henry Jackson, the GMS doctors, and Surgeon-General James de Wolf agreed that the GMS was on the verge of destruction by 1903. CO 295-432 (1905) #14856. *Government Medical Dept*. Encl.: Despatch #106. Jackson to Colonial Secretary Lyttelton.

Lovell's zealous campaign to reduce the services for the lower classes reflected the elite discourse on civilizing the "natives," rather than responding to their health needs. The contradictions between the state policy and life in Trinidad imminently became clear to some GMS doctors and the public. In 1896, the presiding surgeon at the Port-of-Spain Hospital, Dr. E.A.G. Doyle, embraced Lovell's program of restricting admittance to patients needing advanced medical treatments or state-of-the-art surgeries. He proudly refused all "unsuitable cases," including the aged, chronically ill, and poor. However, Doyle asked the government to exonerate him from any future blame,¹⁹ while claiming that his actions did not inflict any suffering on the people who he ejected from the hospital or turned away at the door.²⁰ Lovell remained dissatisfied. In 1899, he directed the GMS doctors to be more vigilant turning away patients, insisting that it was vitally important to educate the people to provide for themselves, and that this did not put "excessive hardship on the sick poor."²¹ Lovell's reforms seem rather disingenuous in light of the conclusions by the 1897 West India Royal Commission. As introduced above (in Chapter 5), the commission reported that the severe sugar industry recession, now in its second decade, had put colonies on the verge of bankruptcy, with little money in the treasuries to relieve the widespread suffering amongst the lower classes.²² While Lovell and Doyle tried in vain to transform the hospital to a modern surgical facility, catering to society's better classes, the lower orders were getting poorer and needed GMS assistance even more than in the past.

By 1900, Doyle admitted that things had gone wrong at the hospital. He lamented having discharged patients too early: "Hospital meant saving them from starvation." He realised his error in turning away 1,080 people during 1899, who had arrived "only suffering from want of food and some trifling ailments," but then returned "in a worse state," or died before they could ask for help again.²³ The hospital refused admission to 2,885 people the following year, or one third of the people arriving at the door, denying medical care to many "deserving" people; doctors now attended to only "urgent" cases.²⁴ The government's refusal to provide medical care had not taught the people to embrace the values of civilised society. Rather, their untreated medical conditions became chronic or terminal.

The public health problems increased with two epidemics in short succession. The bubonic plague reached Trinidad in 1901.²⁵ Then, smallpox raged through the colony in 1903, with 5,257 reported cases and twenty-eight deaths.²⁶ The new Surgeon-General, long-serving GMS doctor James de Wolf, and the Medical Board forfeited all credibility internationally by refusing to declare Trinidad an infected port, raising the ire of Atlantic world partners, and generating attention in the international media and medical press.²⁷

¹⁹ 1897 LC #50, *Surgeon-General AR*, 31-2.

²⁰ 1898 LC #105, *Surgeon-General AR*, 31-2.

²¹ 1900 LC #58, *Surgeon-General AR*, 33.

²² BPP 1898 [c.8655], *Report of the West India Royal Commission*, 69. BPP 1898 [c.8657], *Report of the West India Royal Commission. Appendix C*.

²³ 1900 LC #58, *Surgeon-General AR*, 30, 32.

²⁴ 1901 LC #44, *Surgeon-General AR* 35, 54, 56, 64.

²⁵ 1900 LC #137, *Bubonic Plague*.

²⁶ 1904 LC #75, *Surgeon-General AR*, 4.

²⁷ "Reported Smallpox in Trinidad," *The Times*, 12 March 1903, 5. "The Epidemic in the

The GMS doctors pronounced the epidemic to be eruptive fever and chicken pox: the scientific spirit of medical discoveries had permeated the medical mind in Trinidad, as they then proclaimed their discovery of a new strain of Varioloid Varicella.²⁸ Dissenting private physician George Masson rallied the Governor of Barbados to the most unusual intervention of sending his smallpox expert to conduct an inquiry in February 1903: Dr. Bridger confirmed smallpox.²⁹ However, the Medical Board refused to accept Bridger's conclusions. The Colonial Office's medical expert, Dr. Patrick Manson at the LSTM, reprimanded the GMS doctors for overlooking that the virulence of smallpox varied from epidemic to epidemic. Trinidad was not experiencing the most devastating form of smallpox, but the disease was nonetheless serious and highly contagious.³⁰

Tensions heightened as the Atlantic community united against Trinidad. The Barbados public charged the doctors with officially conspiring to hide the facts of the epidemic.³¹ This debacle caused the West Indies colonies to create a uniform Sanitary Convention.³² Many countries and colonies henceforth distrusted Trinidad's official proclamations that the colony was free from notifiable infectious diseases. Ships would often find that the next port refused to accept a clean bill of health issued in Port-of-Spain.³³ The problem lasted for several years. In 1911, *The Lancet*, Secretary of State Lewis Harcourt, and Surgeon-General Henry L. Clare confirmed that the Atlantic community continued to harbour a "general distrust" of the colony, since the Varioloid Varicella fiasco eight years earlier. The members of the West Indian Sanitary Convention doubted that Trinidad's medical officials and government upheld the obligations of the Convention.³⁴

The international community, Whitehall, and the Trinidad public recognised that government officials and doctors masked the truth of the health conditions in the colony.

West Indies," *British Medical Journal*, 23 May 1903, 1231. "The Trinidad Epidemic," *The Lancet*, 20 June 1903, 1750-1. "The Trinidad Epidemic," *The Lancet*, 29 August 1903, 628-9. "Small-pox in the West Indies," *British Medical Journal*, 26 Sept. 1903, 779.

²⁸ The Colonial Office's medical advisors, Dr. Patrick Manson and the Local Government Board, immediately dismissed the Trinidad doctors' claim that they had 'discovered' a new form of disease. CO 295-425 (1903) #14062. *Epidemic in Trinidad*. CO 295-417 (1903) #20491. *Eruptive Fever Experiments*. CO 295-425 (1903) #30223. *Epidemic in Trinidad*.

²⁹ CO 28-260 (1903) #3831. *Chicken-pox in Trinidad*. "The Trinidad Epidemic," *The Lancet*, 15 August 1903, 496.

³⁰ CO 295-425 (1903) #14712. *Disease in Trinidad*. CO 295-425 (1903) #19555. *Epidemic in Colony*.

³¹ "The Barbadoes Papers and Dr. Bridger's Report," *The Mirror*, 19 March 1903. CO 295-417 (1903) #17127. *Epidemic of Eruptive Fever*. Encl. #3 in despatch of 22 April 1903. Minute by Surgeon-General.

³² 1904 LC #59, *Quarantine System in the West Indies*. Report of Delegates at Conference in Barbados. "The Scurrilous Trinidad Newspapers," *The Mirror*, 16 September 1910.

³³ For instance, in 1910 and 1911, plague and smallpox cases caused Jamaica, the United States, and the Royal Mail Steam Company to refuse bills of health issued in Trinidad and to quarantine ships from Trinidad. CO 295-458 (1910) #21244. *USA Quarantine on Trinidad*. CO 295-465 (1911) #16008. *Jamaica Quarantine on Trinidad*. Encl.: Chamber of Commerce to Colonial Secretary.

³⁴ "Medical Administration in Trinidad: The Vindication of Dr. H.L. Clare," *The Lancet*, 8 July 1911, 103-5. CO 295-472 (1911) #5152, *Medical Enquiry Commission*. Dr. Clare to Under Secretary of State.

In immediate weeks leading up to the riot, the deficient public health conditions and the lack of disease containment measures allowed smallpox to ravage the population. The new governor, Alfred Moloney, did not declare the presence of smallpox until 20 April, four weeks after the riot, when an exasperated Colonial Office forced him to issue the Smallpox Proclamation.³⁵ On the morning of 23 March, the day of the Water Riot, the media printed the last instalment of Dr. Bridger's report where he concluded that Trinidad's doctors had deceived the public. He pointed out the facts, which would have been painfully apparent to the residents: people were succumbing to the disease in droves in the absence of preventive and isolation measures. Bridger had witnessed the hospitals overflowing with patients and sufferers being discharged into the community while still contagious.³⁶ Residents must have been confused as all signs supported Bridger's conclusion and contradicted what their government and the GMS doctors had been telling them.

"Mournful Monday": 23 March 1903

By March 1903, the deteriorating health conditions heightened the tensions in Trinidad. The GMS no longer afforded care to many sick people and especially those who had exhausted their meagre resources during the course of their illnesses. Surgeon-General de Wolf faced unprecedented demands for medical care as sufferers sought relief from the dreaded smallpox and other maladies.³⁷ Amidst these health disasters, the only bright light on the horizon was the completion of the long-awaited waterworks system for Port-of-Spain. Residents were infuriated because the government continually turned off the water, or cut the pipes if officials suspected water wastage.³⁸ Clean water would provide relief for bathing, drinking, cooking, and cleaning away the tropical perils.³⁹ Although officials tried to restrict the public's consumption of the water, residents insisted they would use the water to clean their homes inside and out, to rid the town of "disease-spreading matter."⁴⁰ Residents believed these were good public health practices.

The Legislative Council alarmed the public by announcing that it intended to levy taxes on water by introducing meters through the planned Waterworks Ordinance. Tensions heightened with the further notice that the public would be restricted from attending the Council's meeting on the second reading of the bill. Many members of the public had clearly had enough and wanted their voices heard. The Ratepayer's Association organised a mass meeting. This photograph of the protest meeting is

³⁵ CO 295-417 (1903) #18788, *Epidemic of Eruptive Fever*.

³⁶ "Dr. Bridger's Report on the Cases of Eruptive Fever," *The Mirror*, 23 March 1903.

³⁷ 1904 LC #75, *Surgeon-General AR*, 3.

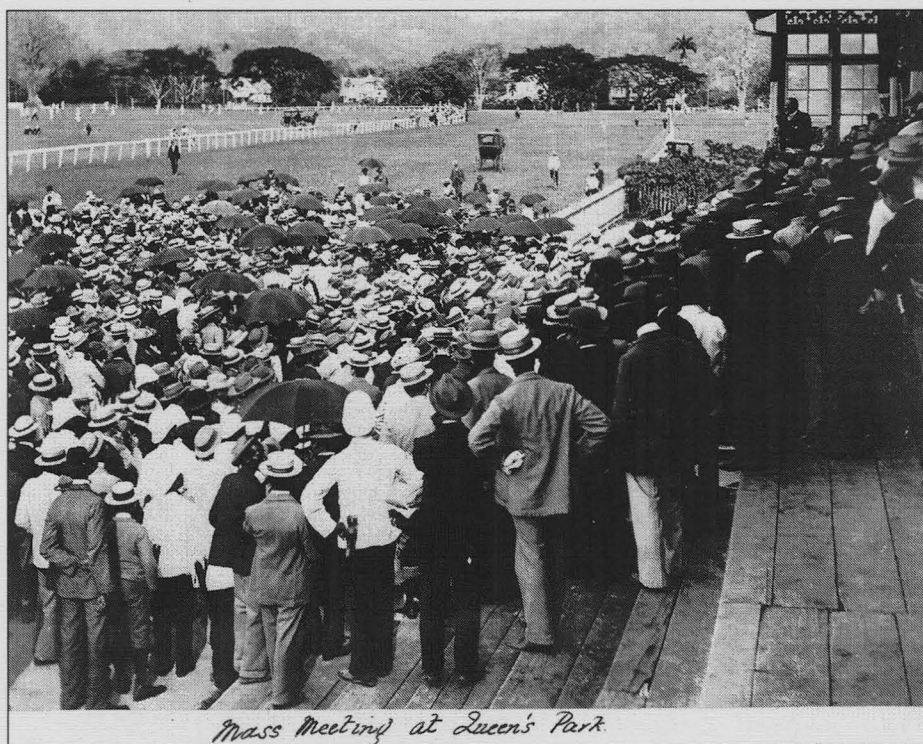
³⁸ BPP 1903 [cd.1662], *Report of the Commission of Enquiry into the Recent Disturbances at Port of Spain Trinidad*, 15, 18, 21. "Cutting off the water," *The Mirror*, 18 Feb. 1903. "The Water Question," *The Mirror*, 28 Feb. 1903. "Again at work," *The Mirror*, 7 April 1903.

³⁹ "The Water Question," *The Mirror*, 7 April 1902. "Our Failing Water Supply," *The Mirror*, 6 Feb. 1903. "Dangerous to Health," *The Mirror*, 18 March 1903. "Covered Drains," *The Mirror*, 31 March 1903. "Important to the Burgesses," *The Mirror*, 13 Aug. 1903.

⁴⁰ "Alleged Official Trickery," *The Mirror*, 23 March 1903. "The Water Supply," *The Mirror*, 4 March 1903. "Disease in the Cup," *The Mirror*, 6 June 1903. "A Threatening Danger," *The Mirror*, 13 June 1903. "The Same Old Story of 'No Water'," *The Mirror*, 16 Jan. 1903.

instructive in showing the behaviours of these supposed “uncivilised” 2,000 residents.⁴¹

*Figure 6.3 – Ratepayer’s Association. Mass Meeting at Queen’s Park, 21 March 1903.⁴²
Reprinted with permission, British National Archives.*



This photograph illustrates the orderly behaviour and civilised dress of the people as they protested two issues. The tax-paying public objected to the introduction of water meters, believing that water should be free, as it always had been, and that the charges would be unduly high. The residents also resented being excluded from the government’s reading of the waterworks ordinance, scheduled for two days later on March 23rd. Officials subsequently described these protesters as a “mob” of the “lowest class of coloured people – thriftless and lazy,” and “poor, excitable, and ignorant” people who followed the (educated) black leaders into the riot.⁴³ To the contrary, Bonham Richardson argued that they were concerned and frustrated citizens.⁴⁴ Arguably, these pictures could have shown a meeting of Britain’s better classes, were it not for the colour of the faces in the crowd. The Legislative Council refused to listen to the resolutions from the Ratepayer’s Association meeting in Queen’s Park.

On the day thereafter called “Mournful Monday,” between 5,000 and 6,000 residents arrived at Government House for the Legislative Council meeting, an astonishing gathering in a town with 6,793 registered ratepayers. The thousands of

⁴¹ BPP 1903 [cd.1662], *Water Riot Commission Report*, 23.

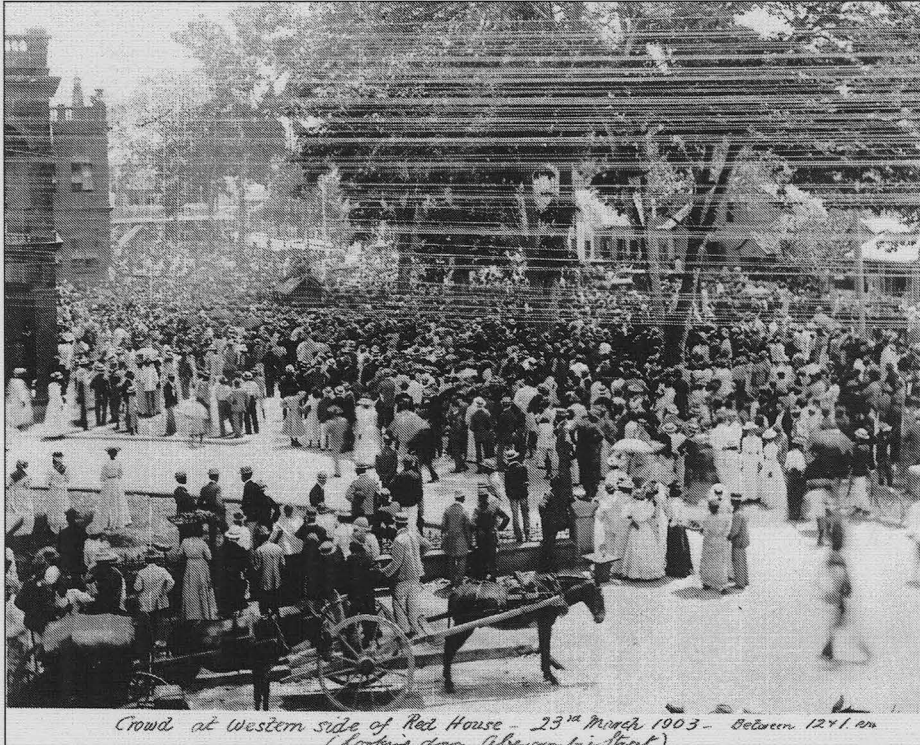
⁴² British National Archives, CO 1069/392/130, *Mass Meeting at Queen’s Park*.

⁴³ BPP 1903 [cd.1662], *Water Riot Commission Report*, 13, 26, 29.

⁴⁴ Richardson, *Igniting the Caribbean’s Past*, 178.

assembled residents waved flags and sang *God Save the King* and *Rule Britannia* for several hours, hoping to drown out the government discussion inside the building.⁴⁵ The executives of the Ratepayer's Association were refused entry to the Legislative Council meeting at about the time this photograph was taken.

*Figure 6.4 – Citizens assembled outside Government House, 23 March 1903.⁴⁶
Reprinted with permission, British National Archives.*



Though described by the Inspector General of Police as a “good-natured” crowd, tensions rose after a few hours of patriotic singing, with no signs of any concession from the Legislative Council. People started pelting the building with stones. Arsonists lit fires at 2.30. The Light Infantry, regular police, and fire brigade refused to respond to the government’s call for help. Soldiers were summoned from the HMS warship *Pallas* in the harbour.⁴⁷ The white soldiers shot into the crowd, leaving forty-eight people wounded and sixteen dead, with three people bayoneted.⁴⁸ Citizens wanted to discuss water and taxes, but the day ended with a civilian massacre and Government House in ashes.

⁴⁵ BPP 1903 [cd.1662], *Water Riot Commission Report*, 6-10.

⁴⁶ British National Archives, CO 1069/392 (128), *Crowd at Western Side of Red House. 23rd March 1903 between 12 & 1 pm (Looking down Abercrombie Street)*.

⁴⁷ The detachment of white mounted Light Infantry insisted that its jurisdiction was restricted to external threats. One detachment of armed officers appeared and left quickly when the people threw stones at them. BPP 1903 [cd.1662], *Water Riot Commission Report*, 8-10, 31.

⁴⁸ BPP 1903 [cd.1662], *Water Riot Commission Report*.

Figure 6.5 – *The Burning of Government House (the 'Red House'), 23 March 1903.*⁴⁹
Reprinted by permission, British National Archives.



Urgent telegraphs from the Chamber of Commerce's white doyens demanded that Chamberlain recall Governor Moloney and the officials at once, and send a Royal Commission of Enquiry.⁵⁰ Chamberlain appointed Sir Cecil Clementi Smith to chair the commission, which spent six weeks in Trinidad taking testimony in April and May 1903.⁵¹ On 17 April 1903, the Barbados public applauded the appointment of the commission, while suggesting that Whitehall should strike a similar commission to investigate the officials who had allowed the smallpox epidemic to rage unchecked.⁵²

The turmoil over the supply of clean and potable water had complicated the public health and medical fiascos during constructive imperialism. Chamberlain's commitment to tropical medicine to protect the white imperialists, while reducing the state healthcare services provided to the "natives," had the opposite effect than desired in Trinidad: the white elites were fearful and the heightened ill-health had created unrest.

The Civilising Mission Gone Awry

After Sir Cecil Clementi submitted his report, the Colonial Office waited a suitable period and recalled Moloney, despatching Governor Henry Jackson and Colonial Secretary Hugh Clifford to subdue the tensions. A more fearful British and Creole elite now

⁴⁹ British National Archives, CO 1069/392/138, *Burning of the Red House. 23 March 1903.*

⁵⁰ BPP 1903 [cd.1661], *Papers Relating to the Recent Disturbances at Port of Spain Trinidad*. Encl. 4: Chamber of Commerce to Chamberlain.

⁵¹ BPP 1903 [cd.1662], *Water Riot Commission Report*, 3-12.

⁵² "Trinidad Royal Commission," *The Mirror*, 29 April 1903.

claimed that they wanted to communicate with the people.⁵³ While their public expressions became more controlled, the disregard for health and well-being of the public did not change. Pushed to the brink of collapse, concerns over the GMS would feature prominently in the discussions amongst the new British officials, as they contemplated why the civilising mission had gone awry.

As part of his official role quelling the racial controversies, Clifford wrote a poignant report evaluating the failings of each subject “race”: black- and coloured-Trinidadians, East Indians, and the racially degenerating white French- and Spanish-Creole elite. His assessment of Trinidad’s ‘Colour Question’ stunned the Colonial Office. Clifford stated the extent of racial strife in the colony:

... the Colour Question is the one, all-pervading, and immensely difficult question that underlies, and affects, more or less vitally, every matter connected with the administration of the Colony. ... The Colour Question is all-pervading, and at any time may, by an accidental circumstance, be rendered acute and dangerous. The bulk of the political power is still vested in the whites who, however, have lost their prestige, and are hated and suspected while they have ceased to command admiration and are rapidly ceasing ... to command the respect which is born of fear. The black and coloured people believe themselves to be the victims of gross injustice, and claim, with some show of reason, that they are in many respect the equals, and even the superiors of many of the whites.⁵⁴

Clifford criticised the Water Riot report by his mentor, Sir Cecil Clementi Smith, for failing to mention the pervasive racial tensions, although they were clearly central in the riot and the other profound struggles in the colony.⁵⁵

Clifford undoubtedly exemplified the racist British ideals of the era, which troubled even his idolising biographer.⁵⁶ This emissary, sent by the Colonial Office to regain control over the colony, blamed the problems on the Africans’ failure to progress and embody the important moral and spiritual sensibilities of civilisation.⁵⁷ Clifford’s evaluation remained confidential amongst the white British officials. However, in his report in the public *Blue Book*, he barely concealed his disdain for the non-white residents as he explained the reasons why the GMS hosted so many patients.

... the average poverty is greater, though indigence in the tropics is robbed of many of the terrors which it has in colder climates; and there is lacking to us that strong, well-to-do middle class, which, both in France and in England, forms the backbone of the nation. ... the less wealthy have little to spare when the demands made by the high cost of living have been satisfied; the poorer classes, from whom the principal users of the Government Institutions are naturally drawn, are averse from paying for what they there receive, even when they could do so, albeit

⁵³ BPP 1905 [cd.2238-19], *Trinidad and Tobago Report for 1903-04*, 11-12 [*Blue Book*.]

⁵⁴ CO 295-435 (1905) #17402, *Colour Question in Trinidad*, Hugh Clifford to C.P. Lucas, “Memorandum on the Existing Condition of Race-Feeling in the Island of Trinidad.”

⁵⁵ CO 295-435 (1905) #17402, *Colour Question in Trinidad*.

⁵⁶ Harry A. Gailey, *Clifford: Imperial Proconsul* (London: Collins, 1982), 52-3.

⁵⁷ CO 295-435 (1905) #17402, *Colour Question in Trinidad*.

at the cost of some personal inconvenience.⁵⁸

Clifford stated that Africans resented the free medical care provided by the government for the indentured Indians in the colony: Afro-Trinidadians decided that they, too, were entitled to free medical care and had the right to use government resources, such as the hospitals.⁵⁹ In Clifford's view, the lower orders had failed to embrace British values: respectable Britons knew their taxes allowed charitable medical services to be delivered to the poor. However, these residents had confused charity with entitlements.

Clifford had misconstrued the public's vocal complaint about the state healthcare services provided by the GMS to indentured Indians. The non-elite majority had always opposed being taxed to subsidise the sugar industry, and the tensions heightened when the public was increasingly restricted from using the primary tier of GMS services.⁶⁰ The people recognised that the GMS services were not governmental charity: the colony levied taxes on imported products to pay for the system and it was the masses who shouldered the burden of taxation.⁶¹ Patrick Bryan's critique of the dichotomous nature of Jamaica's GMS suggests the magnitude of the problem in Trinidad:

Medical facilities could not solve problems which were deeply rooted in a policy of social exploitation which cynically and callously imposed taxes on the poor for their own poor relief, or taxed imported protein foods used by the poor.⁶²

Residents drew a direct connection from their taxes to the GMS doctors and hospitals, and thus considered, rationally, that they had paid for these resources. Conversely, Trinidad's imperial trustees decided that the problems with the GMS had resulted from the mistaken view of the uncivilised masses that they were entitled to free medical care. Since 1895, the official discourse exonerated colonialism from any responsibility for creating the poverty experienced by most residents. The GMS was acknowledged to be at the brink of collapse, attenuating the insufficiency of the meagre coping mechanisms of the people who needed to use the system.

Trinidad's lower classes were not passive recipients of the changing government policies. This analysis now turns to the view of the patients and, in particular, the poorest people in the colony, the GMS's Pauper and Poverty Certificate patients. As opposed to being pauperised by the system, many people struggled to obtain their entitlements, while using a variety of creolised therapeutic systems and western medicine as part of their complex survival strategies.

⁵⁸ BPP 1905 [cd.2238-19], *Trinidad and Tobago Blue Book*, 11.

⁵⁹ BPP 1905 [cd.2238-19], *Trinidad and Tobago Blue Book*, 11-12.

⁶⁰ "The Medical Service. Letter from 'A Sufferer'," *The Mirror*, 22 February 1904.

⁶¹ CO 295-395 (1899) #6998, *Industries of the Colony*. Encl. "Sugar Planters and Their Opponents. West Indians and Members of Parliament. Facts for Mr. Chamberlain."

⁶² Patrick Bryan, *The Jamaican People 1800-1902. Race, Class and Social Control* (Jamaica: Univ. of West Indies Press, 2000), 186.

*Certifying Impoverishment:
GMS Pauper and Poverty Certificate Patients.*

Poverty and Pauper Certificate patients represented the largest numbers of people in the GMS system. In 1875-76, Governor Henry Irving had systematised the criteria by which poor people qualified for services in *The Regulations for Medical Attendance on the Poor*,⁶³ which remained in force during this study. In the absence of a system of Poor Laws, and its mechanisms to authenticate poverty and medical need, the GMS deputised officials and respectable citizens to ascertain the people's entitlement to use the system, according to *The Regulations*. Before applying to the doctor, sufferers had to obtain their certificates from officials or respectable ratepayers.⁶⁴ The screening process interjected non-medical intermediaries into the patient-doctor relationship to ensure that poor patients met the criteria of being poor enough for assisted or free services.

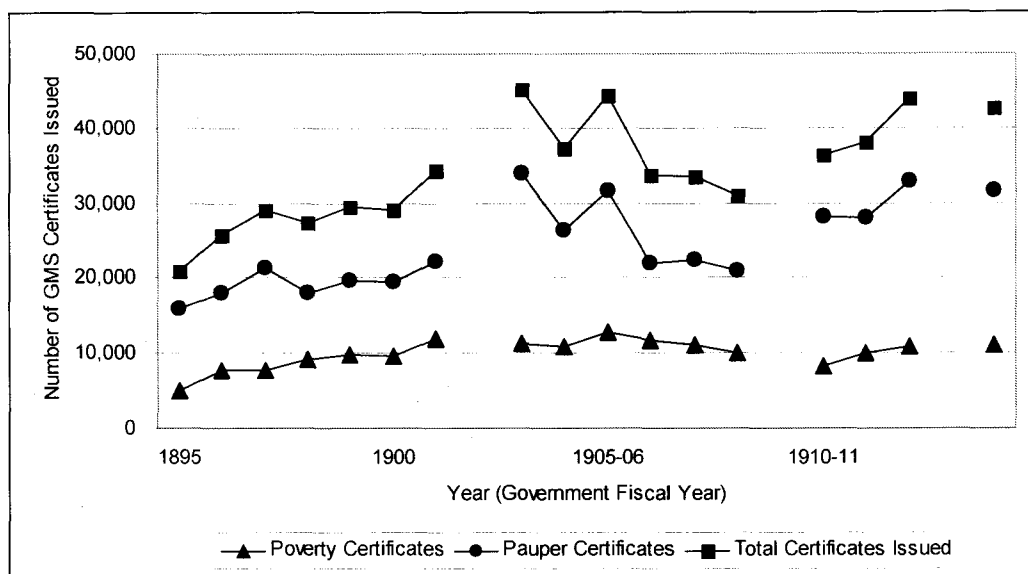
Poverty Certificates entitled sufferers to medical attention and medications during a two-week period, for a few shillings for each visit to the doctor, after a Burgess or respectable local ratepayer signed the certificate. Pauper Certificates allowed patients to receive treatments and medicines, free of charge, for four weeks. In contrast to the Poverty Certificates issued by members of the community, sufferers needing the so-called "pauper papers" had to apply to a government official, such as the local warden or health inspector.⁶⁵ Table 6.6 summarises the number of certificates issued, between 1895 and 1915, where the data is available. More than 582,289 people used certificates during the seventeen years tabulated in this graph, or an average of 34,000 people each year.

⁶³ CO 295-276 (1876) #1195. *Return of medical appointments under the new Scheme*. Encl: Regulations for Medical Attendance on the Poor. The regulations were reprinted in the annual Almanacs. See, for instance, *The Trinidad Official and Commercial Register and Almanack, 1882* (Port-of-Spain: J. Wulff, 1882), 50. [Hereafter, *Trinidad Almanack*, or *Trinidad and Tobago Yearbook* (after 1898).]

⁶⁴ *Trinidad and Tobago Yearbook*, 1898, 92-3.

⁶⁵ The regulations, enacted on 1 January 1876, did not specify limits on the validity of the pauper and poverty certificates. The published *Regulations for Medical Attendance on the Poor* in the official almanacs to 1882 did not state time limits, but the two and four week limits were in the 1886 and subsequent almanacs. It is unclear how long patients could use their certificates, prior to 1886. CO 295-276 (1876) #1195, *Return of Medical Appointments Under the New Scheme*, Encl. in Trinidad despatch #5 of 6 Jan 1876. *Trinidad Almanack for 1886*, 86-7. Sample certificates are in CO 295-335 (1891) #21907, *Minutes of Committee*, Encl: Regulations for Medical Attendance on the Poor, D. Wilson, Acting Colonial Secretary, 14 Sept. 1885. The Regulations did not change, except for variations on the token fees and the introduction of the expiry date. *Trinidad Almanack for 1882*, 50. *Trinidad and Tobago Yearbook for 1898*, 92-3. *Trinidad and Tobago Yearbook for 1899*, 185-6.

Table 6.6 – Poverty and Pauper Certificates Issued, 1895-1915.
Data Sources: Surgeon-General Annual Reports.



The statistics in Table 6.6 establish that the number of people who could afford to pay the token sum associated with Poverty Certificates constituted the minority. The larger group received Pauper Certificates, reflecting their claims to more destitute circumstances. The largest increase in patients occurred amongst the recipients of Pauper Certificates, who received medical care and medications free of charge, while the number of Poverty Certificate patients settled into a rather constant range. The total population and number of certificates issued increased substantially during this period. However, the relative percentage of the public who used certificates remained constant, averaging about 12.4% each year.⁶⁶ This trend suggests that the number of poor patients reached equilibrium during these decades, with this disadvantaged stratum remaining the same relative size, albeit large in absolute numbers.

The upward fluctuations in the number of certificate patients tended to reflect cycles of prevailing poor health, epidemics, adverse climactic conditions, or general economic distress. In some years, multiple factors caused more residents to seek assistance from the government. The GMS doctors tended to the largest number of certificate patients in 1903-04, when the small-pox epidemic and Water Riot caused an extended period of civil unrest, economic dislocation, and the public health crisis. An unprecedented 45,104 people, or 16.3% of the public, qualified for treatments as certificate patients.⁶⁷ In other years, patient numbers fluctuated geographically in response to local conditions.⁶⁸ For instance, Dr. Robert H.E. Knaggs attributed the

⁶⁶ These annual averages are calculated using the mean annual population (from Appendix 2.2) and the number of certificates issued (from Table 6.6).

⁶⁷ This is calculated for 45,104 certificate patients, in an annual mean population of 277,417 in the public at large (286,294 residents less the indentured East Indians, who did not qualify for certificates and did not use the GMS primary tier).

⁶⁸ For instance, in 1907-08 the Surgeon-General reported a decrease in patients in Port-of-

increase in the number of paupers treated in 1897 to the “general hard times” faced by the residents in his district, rather than any increase in morbidities.⁶⁹ In the St. Joseph district, Dr. Henry Alston treated each of his 2,260 certificate out-patients an average of five times that year.⁷⁰ In other years, adverse economic conditions, drought, and unhealthy public health or climatic conditions could take their toll and temporarily draw more users into the system.

The sources do not confirm how many people tried to obtain certificates and failed, or the number of people turned away without treatments. Dr. Doyle had refused to treat one third of the people seeking admission to the Port-of-Spain Hospital in 1900,⁷¹ suggesting that a substantial number of people elsewhere may have been refused certificates or treatments. Some doctors periodically considered the certificate authorities too liberal in their evaluation of the circumstances of the applicants. In 1895, Dr. R.C. Bennett waged a personal crusade to end what he believed was the “lavish and improper issue of pauper certificates.” He proudly reported his success in terminating all medicalised out-door relief in his district: “The results have been magical. All the strong, lusty, lazy loafers etc have vanished, like Shakespeare’s Witches in Macbeth ‘into thin air’.” Bennett believed that the poor in his district represented a purely “artificial construction” and insisted that there was no need for these people to reappear at his door.⁷² This pronouncement appears harsh in light of the difficult economic times in Trinidad. If these so-called strong loafers truly required medical care, they plausibly sought the services of a doctor in another district. On the other hand, Dr. Knaggs took exception to Lovell’s cutbacks and overrode the decisions of the certificate-issuing officials, making a point that he often waived the minor fee required by the Poverty Certificate.⁷³ As a member of elite Creole society, Knaggs could assert his authority to ignore the politically-motivated decisions. Hugh Clifford’s insistence that the poor Trinidadians found it a “personal inconvenience” to pay for medical care did not acknowledge that doctors, such as Knaggs, recognised that many patients had very limited resources.

Some doctors waged campaigns which failed miserably. The abject poverty of the people startled Dr. J.F. Gibbon, the DMO in Tobago. In 1899, Gibbon described the conditions throughout his district as “wretched in the extreme.” He was dismayed to find children huddled “on the floor in rags, sacking, and any refuse of clothing obtainable.” Nonetheless, Gibbon’s comments reflected the civilising discourse of elite society. He blamed the victims, insisting that the high morbidity and mortality rates would prevail until the people achieved greater “enlightenment.”⁷⁴ Gibbon soon accepted the sights which had once shocked him. He claimed that parents feigned pauperism to get free care for their children and he decided to force the development of a “healthier consciousness

Spain and Princes Town, but an increase in San Fernando and six rural districts. 1908 LC #111, *Surgeon-General AR*, 3. In the following year, patient numbers declined in Port-of-Spain and nine districts, but increased in five other districts. 1909 LC #103, *Surgeon-General AR*, 8.

⁶⁹ 1898 LC #105, *Surgeon-General AR*, 21-2.

⁷⁰ 1898 LC #105, *Surgeon-General AR*, 22.

⁷¹ 1901 LC #44, *Surgeon-General AR*, 35, 54, 56, 64.

⁷² 1896 LC #129, *Surgeon-General AR*, 24.

⁷³ 1896 LC #129, *Surgeon-General AR*, 19.

⁷⁴ 1900 LC #58, *Surgeon-General AR*, 38-9.

of individual respectability” by making paupers pay one shilling, although *The Regulations* entitled them to free care. Gibbon’s crusade failed. One shilling may have been a token sum to the doctor, but it was beyond the capabilities of many families. He subsequently lamented that his actions resulted in a “considerable and much to be regretted neglect of children.”⁷⁵ Most parents henceforth only made one ill-fated trip to Gibbon when their child was in an “advanced Cachectic state,” using the doctor to negate the need for a post-mortem inquiry into the cause of death.⁷⁶ No one held Gibbon accountable for his failed attempt to civilise the people; similar to Dr. Doyle, individual zealotry to civilise the people, by teaching them to provide for themselves, had only succeeded in sacrificing the bodies of impoverished sufferers.

Commentators took pen in hand to criticise the obstacles placed in the way of ailing people who attempted to obtain medical relief. For instance, in 1903, *The Mirror* printed a letter from ‘Truth,’ who reminded readers of the conditions of life for the lower orders. Sick people from Gran Couva’s extended geographic district made their way to town and camped out under the awning of the warden’s office, waiting for his weekly visit. The somatic conditions of these people wasting away on the street caused residents to take matters into their own hands and make the four-mile journey to the warden’s main office in another town to procure certificates on behalf of the dislocated sufferers languishing in the streets. ‘Truth’ summarised the inhumanity of forcing people into public displays of suffering as “unpleasant and reprehensible,” calling for the citizens to be deputised to issue certificates to “deserving” paupers, so that the sufferers would not be subjected to these extended periods of “human agony and distress.”⁷⁷ Gran Couva residents displayed respectable behaviours by advocating on behalf of the paupers, taking their complaint to the media when the warden and DMO did not share their sense of urgency in ensuring that the people received the medical care paid for by their taxes.

The DMO’s disinterest could become more pronounced as he progressed through the GMS career paths designed to solidify his socio-economic position in the colony. Junior physicians worked in the institutions, receiving promotions to progressively less impoverished rural districts, perhaps finally meriting lucrative postings as urban DMOs or managers of the large medical institutions.⁷⁸ DMOs retained the right to private practice and were encouraged to tend to paying patients to augment their low salaries. Doctors could readily prioritise their private practices and the health needs of their elite patients, who could engage the doctor as a private physician, rather than as a GMS doctor. A doctor’s tendency to neglect his governmental duties periodically became a matter of public controversy. In 1901, *The Mirror* criticised the selective nature of the medical practices of the DMOs in Port-of-Spain:

It is not likely that such a highly paid doctor is going to get out of his bed at night to visit poor Quashie rolling with fever in a nasty, dark hovel on the banks of the Dry River. His fee is not a certainty in that case. When Mr. Golden ... has an attack of indigestion the case is somewhat different.⁷⁹

⁷⁵ 1907 LC #123, *Surgeon-General AR*, 15.

⁷⁶ 1908 LC #111, *Surgeon-General AR*, 13.

⁷⁷ “The Poor Ye Have Always with You,” Letter to the Editor, *The Mirror*, 22 April 1903.

⁷⁸ CO 295-432 (1905) #14856. *Medical Dept. Encl. #3*, Surgeon-General, 23 February 1905.

⁷⁹ “The Medical Service,” *The Mirror*, 17 August 1901.

Editor R.R. Mole reminded readers that the GMS doctors received their salary to treat poor fevered “Quashie” and other impoverished people in their districts. However, some doctors wanted to direct their professional attention to “Mr. Golden” and other elite patients outside the GMS system. The newspaper claimed that private practitioners performed “most of the poorer and pratis work of the town,” while the government doctors continued to “compete with them for the patronage of the better classes.”⁸⁰ The records do not allow Mole’s allegation to be confirmed or denied, but the media debate over the duties of the doctors suggests that some sufferers had difficulties obtaining their entitlements to state healthcare.

The majority of interactions among doctors, intermediaries, and the 30,000 to 40,000 certificate patients each year proceeded with a surprisingly minimal amount of publicity. Contrary to the official view of the Africans and Indians as uncivilised, many patients were hard-working community-oriented people. Residents refused to be stigmatised, although Drs. Gibbon and Bennett, and Gran Couva’s warden, tried to impose shame on the patients. This presents a stark challenge to the official view that the benevolent GMS services pauperised the population: the tenacity exercised by some sufferers to receive their entitlement suggests the magnitude of medico-economic need. The officials correctly identified that the people considered the GMS services as an entitlement, but they misjudged the reasons why those people needed the help.

The Patient Experience

The government records rarely ever recorded the voice of the patient, which makes it difficult to excavate the reasons why the people used the GMS services. Roy Porter argued that the attempt to reconstruct the patterns of consciousness of the patients is one of the major challenges to writing patient-centred histories from below.⁸¹ Despite the deficiencies in the sources, it is possible to ascertain two characteristics of the patients in the system. Many people surmounted major difficulties to reach the GMS doctors. However, the GMS was not necessarily a reflexive response: a large number of people used many other forms of healing and medicine, but integrated the GMS services into their regime late in the cycle of illness. One of the repetitive complaints the GMS doctors voiced about their patients involved the large number of people who delayed seeking their services. David Trotman argued that many people did not go to the hospital until the last possible minute, because they distrusted the effectiveness of the GMS medical care.⁸² While many people may indeed have held this opinion, other laggard patients considered it an alternative to their preferred form of healthcare, or they used the system in a utilitarian way when their ailments created or amplified destitution.

Doctors continued to express great angst because so many patients did not seek

⁸⁰ “The Medical Service,” *The Mirror*, 17 August 1901. “The Medical Service,” *The Mirror*, 27 Sept. 1901.

⁸¹ Roy Porter, “The Patient’s View. Doing Medical History from Below,” *Theory and Society*, 14 (1985), 182, 185.

⁸² David Vincent Trotman, *Crime in Trinidad. Conflict and Control in a Plantation Society 1838-1900* (Knoxville: University of Tennessee Press, 1986), 148-9.

GMS assistance until their conditions became far advanced. Their reports stated that patients continually arrived in “pathetic” states, requiring months of intensive medical and nursing care, while other sufferers had progressed beyond the point where medical interventions could have a positive outcome. Physicians routinely criticized these patients for their tendency to apply for medical relief only when “far gone in illness” and in “hopeless condition.”⁸³ Patients had obviously suffered for some time, but sought the GMS doctor only after their co-morbidities or destitution, or perhaps both, finally rendered their conditions unmanageable. Doctors made a point of reporting the arrival of new patients in extremely “low” or “collapsed” conditions and often recorded their extreme states of malnourishment.⁸⁴ The physicians recognised that the impoverishment complicated the patients’ morbidities and “considerably diminished their chances of survival.”⁸⁵ Doctors pointedly admonished caregivers for failing to be proactive in summoning them. Dr. F.A. de Verteuil, for instance, insisted that he should have been called to the homes of the majority of the people who died in his hospital, “but they are brought down in hammocks and taken to the Hospital, when all chance of relief are gone.”⁸⁶ These types of complaints from the doctors became more acute during the recurrent epidemics. Chief Surgeon Dr. E.A. Turpin identified the enormous strains on the San Fernando Hospital when a local dysentery epidemic induced many long-suffering residents to seek treatments. Their extant chronic illnesses, which happened to be hookworm in many of these cases, had already rendered the patients’ bodies too weak to withstand an attack of dysentery. Turpin’s staff had little success saving many of these patients who finally sought admission to the hospital.⁸⁷

Countless patients presented themselves to doctors in weak and emaciated conditions during the final throes of illness and then promptly expired.⁸⁸ As established above (in Chapters 4 and 5), the GMS continually faced criticisms about the high institutional mortality rates. Doctors reflexively responded to these critiques by diligently recording and publishing statistics on the elapsed times between the admission and death of hospital patients. These statistics confirm the doctors’ complaints that many people arrived in ‘hopeless’ conditions. For instance, in 1901-02, more than 87% of hospital deaths occurred within one month of admission, and just over 12% of the newly admitted patients who died did so within minutes or hours of arriving at the hospitals.⁸⁹ Similar mortality rates continued throughout this period. Doctors amassed these statistics as a defensive action to exonerate their professional abilities. They attributed many deaths to the long inactions by the deceased, insisting that many people arrived “when their condition is practically beyond medical skill.”⁹⁰ Trinidad was not the only plantation colony to experience this problem. Jamaica’s GMS doctors continually voiced

⁸³ 1896 LC #129, *Surgeon-General AR*, 29. 1911 LC #130, *Surgeon-General AR*, 5. 1913 LC #8, *Surgeon-General AR*, 21.

⁸⁴ 1896 LC #129, *Surgeon-General AR*, 29. 1897 LC #50, *Surgeon-General AR*, 34.

⁸⁵ 1914 LC #91, *Surgeon-General AR*, 31.

⁸⁶ 1897 LC #50, *Surgeon-General AR*, 32.

⁸⁷ 1914 LC #91, *Surgeon-General AR*, 31.

⁸⁸ 1896 LC #129, *Surgeon-General AR*, 29. 1890 LC #35, *Surgeon-General AR*, 11. 1906 LC #100, *Surgeon-General AR*, 25.

⁸⁹ The death rates are calculated from the statistics in the annual reports. 1902 LC #57, *Surgeon-General AR*, 35.

⁹⁰ 1913 LC #8, *Surgeon-General AR*, 21.

their frustrations over the spectacle of many terminally ill and “moribund” cases arriving at their institutions.⁹¹ Similar to Trinidad, Bryan argued that many Jamaicans did not go to the hospital until their diseases were terminal: sufferers meanwhile used other therapeutic systems, with great success.⁹²

Trinidad offered a multitude of different healing systems and remedies to the public. Although we know little about the persistence of Indo-Caribbean practices, the emerging literature of Afro-Caribbean healing confirms the perseverance of traditional ideologies on health and healing, supported by an extensive array of practitioners and resources in the community, through to today.⁹³ The colony also supported a vibrant pharmaceutical marketplace. Creole pharmacist L.O. Inniss confirmed the public’s great enthusiasm for ‘Creole Remedies’ and folk treatments. Inniss and his pharmacist colleagues promoted a plethora of self-administered remedies.⁹⁴ Trotman established that Obeah practitioners and herbalist medicine retained vigorous followings in the colony, especially due to the scarcity of the GMS resources in the rural areas:

... there were no doctors within ten to fifteen miles of rural areas like Moruga, LaBrea, and Toco. There were no government health services in these areas, since the health centers outside of Port-of-Spain tended to be located only in those areas where there was a heavy concentration of indentured East Indian labor.⁹⁵

Taken together, these forms of healthcare suggest that residents capitalized on many different types of resources, and state healthcare services were simply one of the solutions. Thus, although colonial officials inherently assumed that western medicine was a superior system, many residents considered it as only one form of therapeutics. The major attraction to the GMS for patients in “pathetic” states may have in fact been the institutional facilities and medicalised relief, which helped address the problem of destitution accompanying protracted illnesses.

As suggested by Trotman, the distance between patients and physicians was a factor mitigating the potential for sufferers to use the GMS services. The problem of lengthy and arduous journeys had featured prominently in the medical rationalisation of the importance of constructing the network of district hospitals in the 1880s. Doctors characterised these rural facilities as vitally important to “save those dangerously ill from being subjected to long and rough journeys to Port-of-Spain or San Fernando,” which

⁹¹ See, for instance, Jamaica Sessional Papers 1898-99. *Report on the Public Hospital for the year ended 31st March 1899*, 1.

⁹² Bryan, *The Jamaican People*, 185-6.

⁹³ As established in the literature review, above (in Chapter 1), there are no studies on Trinidad, but the emergent literature for other British colonies suggests that many of these traditions may have been in place in Trinidad. Michel Laguerre, *Afro-Caribbean Folk Medicine* (Mass: Bergin and Garvey, 1987). Arvilla Payne-Jackson and Mervyn C. Alleyne, *Jamaican Folk Medicine* (Jamaica: Univ. of West Indies Press, 2004), M.F. Olmos and L. Paravisini-Gerbert, *Healing Cultures. Art and Religion as Curative Practices in the Caribbean and Its Diaspora* (Hampshire: Palgrave, 2001).

⁹⁴ L.O. Inniss, *Trinidad and Trinidadians. A Collection of Papers, Historical, Social and Descriptive, about Trinidad and its People* (Port-of-Spain: Mirror, 1910), 141-9.

⁹⁵ Trotman, *Crime in Trinidad*, 226-7.

had been the only location where residents could obtain hospital care until that time.⁹⁶ The network of district hospitals helped to reduce the distances travelled by some patients and doctors, but did not solve the problem for everyone. In 1905, Governor Jackson acknowledged the need for patients to travel long distances to reach the GMS facilities, at the same time that he had characterized the people as sadly lacking in industriousness, as established above. Jackson admitted that sick people often found themselves far away from medical care. Long journeys complicated their destitute conditions, “so men whom a little earlier treatment would have saved from illness, and who might even have been willing to pay a small sum for it, remain where they are until they are so ill that it needs a lengthy stay in the hospital to set them up.”⁹⁷ Doctors continued to complain about the length of the journeys faced by their patients, complicated by the colony’s primitive transportation infrastructure. The problem heightened each year when the long tropical rainy season made the poor roads generally inaccessible.⁹⁸ Dr. A.P. Lange, for instance, bemoaned the fact that “disgraceful” road conditions made it “almost impossible” for many to seek his services.⁹⁹ Unhealthy bodies lacked the physical wherewithal to make a difficult journey and could only hope that their friends and family retained the stamina to get them where they needed to be.

The death of cocoa contractor Manson Mitchell of Tamana illustrates one such example of patients who struggled with these obstacles. Mitchell died quickly after succumbing to illness, in less than a day: the police inquired into his death. As with his fellow independent peasants, Tamana residents had to travel about sixteen miles to reach the doctor at Arima. The road conditions during the rainy season were so bad that Mitchell could not get to the doctor. Death came swiftly. The rains continued to fall and the doctor could not get to Tamana to certify the death before they buried Mitchell’s body.¹⁰⁰ Distance and road conditions remained an important impediment for many sufferers other than Manson Mitchell. Arima’s DMO, Dr. F.A. de Verteuil, confirmed the magnitude of the problem. He attributed the rather high mortality of patients admitted to his district hospital to the stresses of the journeys. Many patients fared poorly during the trips and arrived “in a very deplorable condition.”¹⁰¹ Dr. F.A. de Verteuil was quick to admonish caregivers for failing to summon him in a timely fashion, but had neglected to account for the distance between himself and his patients.

Residents in this tropical climate often sought the services of a doctor as soon as they succumbed to illnesses known to require immediate attention, but there was no guarantee of finding the doctor at the end of an arduous journey. For instance, upon suddenly becoming very sick, Tobago resident Richard Jones made the 13.5 mile journey to the DMO. On finally arriving in Scarborough, Jones found that Dr. Gibbon was in Trinidad. The police intervened, but Jones expired before reaching the town’s hospital.¹⁰² Similarly, the parents of five-year old Peua Dichong became extremely concerned over

⁹⁶ CO 295-313 (1887) #9405. *Medical witnesses*. Encl. #5. Acting Surgeon-General B. Pasley.

⁹⁷ CO 295-432 (1905) #14856. *Medical Dept*. Encl.: Despatch #106. Jackson to Lyttelton.

⁹⁸ 1895 LC #94, *Surgeon-General AR*, 8. 1898 LC #105, *Surgeon-General AR*, 24-5.

⁹⁹ 1898 LC #105, *Surgeon-General AR*, 28-9.

¹⁰⁰ “A Sudden Death at Tamana,” *The Mirror*, 19 February 1902.

¹⁰¹ 1896 LC #129, *Surgeon-General AR*, 30. 1897 LC #50, *Surgeon-General AR*, 32.

¹⁰² “Tobago. Sudden Death,” *The Mirror*, 27 February 1902.

their child's health amidst a fever epidemic and wanted medical attention at once. They carried Peua from their distant village to Gran Couva two days in a row, but were unable to engage the DMO. Little Peua died without seeing the doctor.¹⁰³

Residents more proximal to the urban hospitals did not necessarily fare better in their quest. After travelling to the warden's office to get his certificate for admission to the San Fernando hospital, Ramdeen continued on his journey, only to be found dead on the road the next day. The post mortem inquiry revealed that Ramdeen died from acute pleurisy and diseased kidneys, suggesting that he suffered immensely during his trek.¹⁰⁴ The media reported similar cases of dead bodies found along the routes to the hospitals.¹⁰⁵ The experiences of these and innumerable other people confirmed the plight of sufferers who attempted, but failed, to obtain medical assistance. Trinidadians needed to possess inordinate tenacity at times to reach the medical services they desired.

Conclusions

Historians of medicine struggle to reconstruct the health experiences of sufferers in the past, encountering all the challenges of history from below. Plantation society colonialism added another level of complexity to the struggle to reveal the voice of the patient, because of the enduring disinterest in the perspectives of the people who managed the system. The most prevalent voices in the records of colonialism reflect the views of the colonial elite and doctors who organised the system. They would have us believe that Trinidad offered the potential of prosperity for industrious people, but that their benevolent GMS services had instead allowed the subject peoples to develop a bad habit of depending on charity.

When reading across the archival grain, many opposing realities of plantation society come to light. Colonialism could make the people unhealthy and continually push them towards poverty. Sufferers employed a variety of strategies to maintain or regain their well-being, and the state's healthcare services represented one of those alternatives. People who desired to engage with the GMS practitioners routinely encountered many obstacles placed in their way, but exerted considerable tenacity to extract what they desired from the system. The fact that tens of thousands of patients engaged with the state's medical services organisation each year suggests that the GMS was indeed a vital component of the colony's medico-social landscape, providing important services to many patients who made conscious decisions to employ western medical therapeutics in their quest for health. The discontinuity between constructive imperialism's version of the civilising mission and the reality of life in Trinidad played out each day as the broader tensions of colonialism continued to manifest in the struggles by the subject peoples to access and utilise state medical services.

The events leading up to the ill-fated Water Riot confirmed that the public was concerned about the politico-economy of health and well-being in their community.

¹⁰³ "Death of a Child through Want of Medical Aid," *The Mirror*, 8 May 1902.

¹⁰⁴ "Died on the Way," *The Mirror*, 8 February 1902.

¹⁰⁵ "Died on the Way," *The Mirror*, 7 Sept. 1901. "The post mortem," *Port-of-Spain Gazette*, 25 Oct. 1905.

Their demands for pure water to flush away the perils of the tropics and cleanse the smallpox-infected town represented a civilised form of behaviour. When their orderly protests were ignored, the actions of a few arsonists captured the attention of officials in the metropole and necessitated a changing of the guard in the colony. Racial tensions pervaded. However, as lamented and perpetrated by Hugh Clifford, the racial tensions were never publicly mentioned in the report by the commissioners who investigated the riot. Tense racial relations had always been at the root of the controversy over the GMS. Thus, when tens of thousands of people continually sought the services of the GMS doctors, even after the cutbacks, their power was derived from the aggregate of their numbers. The Indo-and Afro-Trinidadian people continued to have a voice, albeit muted, in the creolising of state healthcare, but only because they continued to be tenacious in attempting to get the resources which they needed to deal with the effects of plantation society colonialism.

– Chapter 7 –
Conclusions

Trinidad's Government Medical Services and its doctors experienced many challenges during the period of this study, although many of the struggles were not unique to the plantation society in this colony. The GMS doctors strove to keep up-to-date with the constantly changing medical knowledge and attempted to keep their medical practices and institutional facilities current. Similar to their colleagues in the metropole and other colonies, the government doctors participated in the broad movement for medical professionalization, while attempting to enhance their socio-economic standing. Patients presented themselves with medical conditions and diseases which puzzled the doctors and for which there were no therapeutic regimes to alleviate the suffering. In terms of the institutional structure, the GMS was constantly criticised for being too costly, but it never seemed to have quite enough resources. In these and countless other ways, colonial medicine in Trinidad shared many challenges and characteristics with other forms of organised medicine elsewhere in the world.

The Colonial Office's edict for the colonial governments to assume the responsibility for the medical care of the indentured East Indians was an anomalous development during the imperial world's transition to free trade and amidst the rise of laissez-faire government. The government's program to provide doctors and healthcare resources to the sugar estates constituted a subsidy to private enterprises. Conversely, the public health and medical responsibilities mandated for the employers by the Coolie Immigration Ordinances were plausibly without precedent in any other part of the imperial world, except for plantation colonies. These laws required private agricultural companies to provide medical and health-related services to their employees, such as hospital facilities and supplying their workers with daily rations of food. In effect, Whitehall directed its plantation colony governments to intervene into free enterprise while subsidising those same businesses to address the mortality and health problems for an identified labourforce. In Trinidad, some planters rejected these forms of governmental interference and attempted to circumvent their legal obligations. However, the plantocracy never challenged the local decision to provide the government doctors and medical services gratuitously to the indentured estate labourforce. The planters derived a benefit from this secondary tier of the GMS services, paid for from the public purse.

In Trinidad, the need for this governmental intervention was symptomatic of a more fundamental problem, which remained the most prominent determinant of the uniqueness of colonial medicine: the planters' disregard for the health and longevity of the sojourning labouring East Indians. The legacies of slavery continued to permeate the Creole elite's consciousness and attitudes about the African and East Indian subject peoples. As argued throughout this study, the labouring bodies of the lower classes continued to be commoditised and considered as expendable entities. This ideology persistently shaped the contours of colonial medicine in Trinidad and periodically incited the conflicts between the Creole and British officials.

The uniqueness of Trinidad's state healthcare and medical services involved its status as a governmental entity in a post-emancipation plantation society. The broader

tensions of plantation society colonialism constantly shaped the contours of state healthcare services. Trinidad was a racially troubled society where a tiny class of elite white Creoles retained the economic, political, and social power, and wielded an inordinate amount of authority over the lower orders of African and East Indian peoples. This consolidation of power in the hands of a few allowed this elite to determine the fate of many colonial residents, including their ability to live healthy and long lives. The colony emerged from emancipation without the broadly based medico-social infrastructure that had become so important to the British metropolitan model of the mixed economies of social welfare and the medical marketplaces. The evolution of the practice of modern medicine in the colony would be severely restricted by the lack of a diversified system of public, private, charitable, and voluntary organisations. Plantation societies were predicated on a structure of two socio-economic classes. The inordinately large lower class mass of the colonial residents did not have the economic resources to contribute to the creation of a diversified system. The upper strata of society did not conceive of a personal obligation to institute philanthropic health-related programs, thus forcing the responsibility to devolve to its members who governed the colony. As private citizens and colonial rulers, Trinidad's white Creole elite retained a restricted view of its obligation to become involved in the health and well-being of their subject peoples.

For the duration of this study, Trinidad's plantocracy maintained a purposeful strategy to create a population of impoverished peoples, in an attempt to force the people to labour in the gruelling and exploitative plantation economy. Many policies supported this program, such as the restrictions on acquiring Crown Lands, the suppression of wage rates, and the high taxation on basic foods and imported goods. The official rhetoric constantly rationalised this strategy as an important part of the mission to civilise the African and East Indian peoples, by transforming them into productive waged agricultural labourers and teaching the people the coveted British values of thrift and industriousness. The plantocracy failed miserably as agents of civilisation within the parameters of its own rather convoluted interpretation of the civilising mission. However, Trinidad's Legislative Council was exceedingly successful in achieving its objective of keeping the masses of the people impoverished. Extreme poverty characterised this colony. At the end of this period, an educated black and coloured middle class had started to emerge and would subsequently challenge the shackles of colonialism which had kept so many people poor for so long. However, for the majority of the century, very few people materialized to contest the status quo or advocate on behalf of the poor. The powerful white Creole and British elites proceeded, generally unchecked, to maintain the structure of plantation society in a form that cultivated and sustained a culture of poverty.

The rampant poverty created many problems for the GMS doctors. The government continually directed its GMS organisation to provide only the minimum amount of remedial medical care services to the extraordinarily large number of sick and ailing residents. The doctors were constantly attempting to treat the outcomes and effects of a colonial environment that lacked many contemporary public health measures and sanitary infrastructures: these had long-since become regarded as vitally necessary for disease prevention in other colonies and countries. These deficiencies had a notable effect on an impoverished population. The outcome of colonialism in Trinidad created an environment that challenged the modernising practices of western medicine, which

increasingly focused on preventive measures and surgical interventions. Many doctors would have preferred to eradicate the causes of so many problems, rather than continuing to deal with their effects. From the medical perspective, the most enduring problems faced by the GMS doctors resulted from the government's failure to come to terms with the relationship between poor health, poverty, and sanitation in a manner commensurate with the dominant medical ideals.

The post-Enlightenment reforming ethos fostered the rapid development of many different factions, intent on improving the conditions of the poor and labouring classes. In the metropole, the birth of the sanitary ideal and the public health movement in the 1840s had a major influence on the modernisation of medical science. British-trained doctors and officials would henceforth carry many of these ideas and practices with them as they travelled throughout the imperial world. However, Trinidad's plantocracy was not necessarily interested in yet another set of reforming ideals from the metropolis. It was erstwhile preoccupied with the economic and social dislocation caused by emancipation and the introduction of free trade. In the 1840s, and again at various times to 1916, Trinidad's economy was in dire straits and without the resources to finance the newly emerging health and medical reforms, if they had been a priority, which they were not. Certainly, many members of the Creole elite had discounted the importance of the ameliorative measures during the last stage of slavery, when they owned the majority of the Afro-Trinidadian people. It would be too much to expect that these former slave owners, whose opposition to emancipation caused the Colonial Office to institute Crown Colony rule, would transform themselves to an elite class which was concerned about the health of the freed African peoples. India's intervention to terminate migration in 1838 and 1839, because of the high mortality rates amongst the indentured labourers, confirmed that the plantocracy continued to view the non-white labouring bodies as expendable commodities. In times of economic prosperity, the government modernised the colony's sanitary infrastructure in very restricted areas, most notably in the two major maritime ports and urban centres, where the white Creole elite tended to reside. The majority of the population did not have the opportunity to benefit from any widespread local implementation of the broader advancements in sanitary science and public health.

The GMS doctors often criticised and agitated against the government's reluctance to adopt more proactive policies and address the widespread poverty, which they believed was causing the high incidence of disease and illness amongst their ever-increasing numbers of patients. However, the notion of alleviating poverty or providing economic relief to the lower classes contravened the fundamental tenets upon which this plantation society continued to be structured. The Legislative Council repeatedly declined or ignored the directives from the trustees of the imperialist project, including some reforming governors and the Colonial Office, to institute any form of economic relief. According to some doctors, a system of Poor Relief would have mitigated the conditions which caused the high incidence of poor health and reduced the prevalence of suffering amongst the poor. However, it is doubtful that an organised system of relief would have reduced the colony's overall expenditures. Instead, it would have simply shifted the expenditures from remedial treatments to preventive measures. The Legislative Council therefore adhered to its long-standing tradition of dealing with the outcomes of dirt and depravity, rather than adopting more current and medically-

informed initiatives to eradicate the causes of the problems. The official ideologies about the poor, who constituted the majority of the population, consistently rationalised the poverty as the outcome of racial defectiveness and the failure of the people to absorb the essence of British civilisation.

The colony continually demonstrated an affinity to institute western public health and medical practices selectively, despite the increasing tendency of many other governments to adopt the tenets of an increasingly uniform body of medical knowledge. The advances in knowledge about the optimum way to contain contagious diseases, in the 1860s and 1870s, transformed the nature of maritime quarantines and health protections, stimulating regional sanitary conventions, which developed into international initiatives and agreements by the end of the century. Medical officials and doctors in Trinidad kept current with the rapidly changing body of knowledge. However, and rather perplexingly, the local implementation of the relevant practices periodically deviated from the generally accepted norms. In the instances of the 1871-72 and 1903 smallpox epidemics, Trinidad ignored the prevailing medical knowledge and practices on isolating and containing contagious diseases, which allowed the epidemics to rage out of control and imperil the health and lives of many residents. While the high infection and mortality rates did not appear to cause great angst amongst the local authorities, the imperative to control these contagious diseases became a concern of the international community. Trinidad's Atlantic neighbours and imperial world partners exerted significant pressure on the colony to conform with the contemporary public health and disease containment measures. Although colonialism in Trinidad was predicated on the elite retaining control of this plantation society, the increasing globalisation of the medical knowledge on disease containment and eradication was a factor which it simply could not control. Trinidad's legislators eventually, although not expediently, instituted more commonly accepted measures for disease containment and protection. However, the maritime Atlantic community continued to question and distrust Trinidad's claims that the colony conformed to the prevailing procedures on disease prevention.

It is unfortunate that the records of colonialism left so little information about the individual patients and their experiences within the GMS system. The official records tended to reduce the sufferers into aggregate statistics on diseases, mortalities, admissions, certificate holders, and many other categories, which were meaningful to a medical bureaucracy with too few resources and tens of thousands of patients each year. The continually increasing number of people who used the system entrenched the GMS organisation and facilities within Trinidad's socio-medical landscape, while making its costs a perpetual sore point amongst the ruling Creole elite. Despite all the administrative anxiety about the number of patients flocking to the GMS doctors and hospitals, the tremendous momentum by the peoples to use the system provided the most formidable challenge to any governmental attempts to retract the services. Historians of the British West Indian colonies are always on the alert for evidence of acts of resistance by the subject peoples. Trinidadians certainly did not display any discernable resistance to the imperatives of western medicine or reject the colonial state's system of healthcare services. Instead, the people demanded their entitlements to the services. Trinidadians realised that they bore the burden of excessive taxation to pay for the system. When in need of the medical care, the people had no qualms about demanding the services that they believed were due to them.

Trinidadians often had to work extremely hard to become a GMS patient. Innumerable individuals traversed difficult terrains on lengthy journeys to seek medical attention, sometimes in a personally incapacitated condition, or carrying a debilitated friend or family member in a hammock or other conveyance. Some patients encountered the purposeful stigmatisation in the system as they negotiated with certificate-issuing authorities or interacted with moralising doctors. At times, the patients' maladies and discomfort must have been acute to motivate them to persist through the various obstacles. However, the GMS services were not the exclusive form of healthcare services used by the sufferers and, perhaps, not their preferred alternative. Although very little is yet known about the persistence of the African and Indian medical traditions, or the community-based cultures of healing, this study confirms that they did indeed exist and many Trinidadians relied on these resources before seeking assistance from the GMS doctors. It is hoped that future studies will reveal the nature and breadth of these forms of medical and healthcare solutions. They may have indeed been preferred by the residents in their struggles to maintain their health and address their maladies when ailing. Without detailed studies, it is difficult to ascertain where western medicine ranked in the hierarchy of therapeutics employed by the Trinidadian people. It is clear, however, that the colonial state's GMS healthcare services were one part of patients' multi-faceted and complex strategies for survival.

Statistical Appendices – Population Vital Statistics

– Appendix 2.1 –
*Quantifying Trinidad's Average Annual Net Migration
and Population Leakage*

As discussed above (in Chapter 2), thousands of East Indians illegally left Trinidad each year, in what was termed as the 'leakage' of the population.¹ Trinidad's Registrar-Generals continually struggled with the governmental inability to count the number of residents who departed from the colony each year. The consistent under-estimation of the size of the population 'leakage', and concomitant over-estimation of the number of residents during the inter-censal years, rendered many of the published statistics inaccurate, including the figures on net migration, the total and mean population, and all crude rates. However, in retrospect, the quantity of the population leakage each decade can be quantified, which then allows the necessary calculations to produce more exact statistics for the total population, and for the West Indian and East Indian sectors.

The following charts provide the detailed calculations of the 'leakage' of East Indians during three decades, from 1891 and 1920. These statistics are then applied to calculate the tables in Appendix 2.2 to 2.4.

¹ The 'leakage' of East Indians involved only the people who illegally left the colony. The problem in enumerating the departures from Trinidad did not apply to the government program of East Indian immigration and the repatriation of East Indians back to India. The government rigidly controlled the movement of East Indians between India and Trinidad (and *vice versa*) aboard the ships they chartered, producing very accurate statistics of the net annual increase from this legal form of migration.

Leakage of East Indians: 1 January 1891 to 31 December 1900 – Trinidad			
1891 census is 5 April 1891	-column 1- All residents of Trinidad (columns 2+3)	-column 2- West Indian sub- population	-column 3- East Indian sub- population
1901 census – 21 April 1901			
- less: adjustment fiscal year alignment ²	273,899	187,508	86,391
- less: adjustment for Tobago ³	(3,186)	(537)	(2,649)
	<u>(18,676)</u>	<u>(18,676)</u>	<u>0</u>
1901 adjusted population: Trinidad			
- less: 1891 census population	252,037	168,295	83,742
- equals: net growth in population	<u>(200,028)</u>	<u>(129,786)</u>	<u>(70,242)</u>
- less: net natural increase	52,009	38,509	13,500
- less: Trinidad-India migration	(18,603)	(13,494)	(5,109)
- equals: net number of immigrants/ (emigrants) during the 10 year period.	<u>(13,817)</u>	<u>0</u>	<u>(13,817)</u>
	19,589	25,015	(5,426)
- Average annual net immigration/ (emigration), exclusive of Trinidad- India migration.	1,959 immigrants	2,502 immigrants	543 emigrants

Between 1891 and 1900, the net total leakage of East Indians was 5,426 people, or an average of 543 persons each year. West Indian net migration contributed, on average, 2,502 new persons to Trinidad each year.

² The statistics for the census of 21 April 1901 require an adjustment to align the temporal period with the government's fiscal year, which was the calendar year. The adjustments are as follows for 1 January to 31 March: births (1,500 West Indians, 688 East Indians), deaths (963 West Indians, 485 East Indians), and East Indians arriving from India (2,446 persons).

³ Trinidad and Tobago were not enumerated as a united entity until 1901 and population statistics for Tobago in 1891 are not available. Thus, Tobago's population in 1901 is subtracted for this decade. Tobago's 1901 census population was 18,751, less the adjustment for natural increase (January to March 31) of 75 people, for a net population of 18,676 people. There were no East Indians in Tobago at the time of the 1901 census.

Leakage of East Indians: 1 January 1901 to 2 April 1911 – Trinidad and Tobago			
	- column 1 - All residents: T & T (columns 2+3)	- column 2 - West Indian sub- population	- column 3 - East Indian sub- population
1911 census – Trinidad and Tobago			
- less: 1901 adjusted census	333,552	222,641	110,911
- equals: net growth in population	<u>(270,713)</u>	<u>(186,971)</u>	<u>(83,742)</u>
- less: net natural increase	62,839	35,670	27,169
- less: Trinidad-India migration	(34,219)	(23,646)	(10,573)
- equals: net number of immigrants/ (emigrants) during the 10 year period.	<u>(19,352)</u>	<u>0</u>	<u>(19,352)</u>
	9,268	12,024	(2,756)
- Average annual net immigration/ (emigration), exclusive of Trinidad- India migration.	927 immigrants	1,202 immigrants	276 emigrants

Between 1901 and 1911, the net total leakage of East Indians was 2,756 persons. West Indian net migration contributed an average of 1,202 new persons each year.

Leakage of East Indians 2 April 1911 to 31 December 1920 – Trinidad and Tobago			
	- column 1 - All residents: T & T (columns 2+3)	- column 2 - West Indian sub- population	- column 3 - East Indian sub- population
1921 census population (adjusted) ⁴			
- less: 1911 census population	366,736	244,128	122,253
- equals: net growth in population	<u>(333,552)</u>	<u>222,641</u>	<u>110,911</u>
- less: Net natural increase	33,184	21,847	11,694
- less: Trinidad-India migration	32,397	(19,524)	(12,873)
- equals: net immigrants/(emigrants)	<u>6,507</u>	<u>0</u>	<u>6,506</u>
- Average annual net immigration/ (emigration), exclusive of India-Trinidad migration.	5,720 572 emigrants	2,318 232 immigrants	(8,037) 804 emigrants

Between 1911 and 1921, the net total leakage of East Indians was 8,037 people, while the total West Indian net migration was 2,318 people.

⁴ The 24 April 1921 census has been adjusted by subtracting the population increases between January a 31 March: a natural increase of 378 West Indians, a natural decrease of 117 East Indians, and the repatriation of as 1081 East Indians to India.

– Appendix 2.2 –

Vital Statistics for Trinidad (1891-1900) and the United Colony of Trinidad and Tobago (1901-1920), based on Census data and Registrar-General Annual reports, with the total population adjusted for Population Leakage (from Appendix 2.1).
Statistics for the Total Population, including the West Indian and East Indian sectors.

Year	Net Migration: Net Immigrants and (Emigrants)				Population at the end of the year	Total Mean Population
	Net West Indian migration (from appendix 2.1)	Net East Indian migration to and from India	Net East Indian leakage (from appendix 2.1)	Total Net Migration		
1891 Trinidad	2,502	1,980	(543)	3,939	205,147	202,587
1892	2,502	2,566	(543)	4,525	211,558	208,352
1893	2,502	1,203	(543)	3,162	216,300	213,929
1894	2,502	1,812	(543)	3,771	222,086	219,193
1895	2,502	1,837	(543)	3,796	228,065	225,076
1896	2,502	2,374	(543)	4,333	234,140	231,103
1897	2,502	1,113	(543)	3,072	238,048	236,094
1898	2,502	546	(543)	2,505	241,760	239,904
1899	2,502	470	(543)	2,429	246,982	244,371
1900	2,502	(84)	(543)	1,875	252,037	249,509
Total for the decade 1891-1900	25,015	13,817	(5,426)	33,406		
The united colony of Trinidad and Tobago began reporting combined statistics in 1901						
1901 Trinidad & Tobago	1,202	3,378	(276)	4,305	277,639	274,176
1902	1,202	1,598	(276)	2,525	283,480	280,559
1903	1,202	1,808	(276)	2,735	289,108	286,294
1904	1,202	540	(276)	1,467	295,391	292,250
1905	1,202	2,894	(276)	3,821	302,520	298,956
1906	1,202	1,719	(276)	2,646	308,106	305,313
1907	1,202	1,108	(276)	2,035	312,646	310,376
1908	1,202	1,719	(276)	2,646	318,988	315,817
1909	1,202	1,923	(276)	2,850	325,838	322,413
1910	1,202	2,665	(276)	3,592	333,552	329,695
Total for the decade 1901-1900	12,024	19,352	(2,756)	28,620		

Year	Net Migration: Net Immigrants and (Emigrants)				Population at the end of the year	Total Mean Population
	Net West Indian migration (from appendix 2.1)	Net East Indian migration to and from India	Net East Indian leakage (from appendix 2.1)	Total Net Migration		
1911 Trinidad & Tobago	232	2,655	(804)	2,083		
1912	232	1,779	(804)	1,207	342,062	340,751
1913 ⁵	232	370	(804)	(202)	345,565	343,814
1914	232	443	(804)	(129)	348,964	347,264
1915	232	44	(804)	(528)	351,232	263,424
1916	232	1,170	(804)	598	356,221	353,727
1917	232	705	(804)	133	360,938	358,580
1918	232	0	(804)	(572)	363,899	362,419
1919	232	233	(804)	(339)	365,729	364,814
1920	232	(893)	(804)	(1,465)	366,733	366,231
Total for the decade 1911-1920	2,319	6,506	(8,037)	788		

⁵ Detailed statistics on births and deaths are not available for 1913-14. These numbers have been estimated, by averaging the number of births and deaths for the other nine years in the decade.

Natural Increase for the Total Population (including West Indian and East Indian sectors).

Year	Births (from <i>Registrar-General AR</i>).	Deaths (from <i>Registrar-General Annual Reports</i>)	Net Natural Increase for the Total Population
1891 Trinidad	5,396	(4,217)	1,179
1892	7,251	(5,365)	1,886
1893	7,568	(5,987)	1,581
1894	7,608	(5,593)	2,015
1895	8,059	(5,876)	2,183
1896	8,175	(6,433)	1,742
1897	7,927	(7,091)	836
1898	7,962	(6,755)	1,207
1899	8,922	(6,129)	2,793
1900	10,021	(6,841)	3,180
Total natural increase 1891-1900	78,889	(60,287)	18,602
1901 Trinidad & Tobago	9,513	(6,892)	2,621
1902	10,068	(6,752)	3,316
1903	10,194	(7,300)	2,894
1904	11,304	(6,488)	4,816
1905	11,601	(8,293)	3,308
1906	10,877	(7,937)	2,940
1907	11,126	(8,621)	2,505
1908	11,638	(7,941)	3,697
1909	11,662	(7,662)	4,000
1910	11,570	(7,448)	4,122
Total natural increase 1901-1900	109,553	(75,334)	34,219
1911 Trinidad & Tobago	11,674	(7,870)	3,804
1912	11,711	(10,295)	1,416
1913 ⁶	11,828	(8,121)	3,707
1914	11,855	(8,327)	3,528
1915	8,591	(5,795)	2,796
1916	11,917	(7,526)	4,391
1917	12,566	(7,982)	4,584
1918	11,760	(8,228)	3,532
1919	11,567	(9,398)	2,169
1920	11,707	(9,238)	2,469
Total natural increase 1911-1920	111,176	(82,780)	32,396

⁶ Detailed births and deaths are not available for 1913-14. These numbers have been estimated, by averaging the number of births and deaths for the other nine years in the decade.

– Appendix 2.3 –

Statistics for the West Indian Population.
 Vital Statistics for Trinidad (1891-1900) and the
 United Colony of Trinidad and Tobago (1901-1920), based on Census data
 and Registrar-General Annual reports, with the total population
 adjusted for Population Leakage (from Appendix 2.1).

Year	Births (from Registrar -General AR)	Crude Birth Rate ⁷	Deaths (from Registrar- General AR)	Crude Death Rate ⁸	Year End Population	Mean Population ⁹
1891 Trinidad	3,812	29.00	2,957	22.49	133,143	131,464
1892	4,779	35.39	3,497	25.90	136,926	135,034
1893	5,218	37.60	4,032	29.06	140,614	138,770
1894	5,143	36.05	3,564	24.98	144,694	142,654
1895	5,361	36.56	4,002	27.29	148,555	146,624
1896	5,508	36.64	4,456	29.64	152,108	150,331
1897	5,418	35.23	4,528	29.44	155,500	153,804
1898	5,592	35.53	4,312	27.40	159,281	157,390
1899	6,069	37.57	4,087	25.30	163,765	161,523
1900	6,712	40.43	4,683	28.21	168,295	166,030
Total 1891-1900	53,612		40,118			
Total 1891-1900 – average for the decade		36.00		26.97		
1901 Trinidad & Tobago	6,678	35.42	4,745	25.17	190,106	188,539
1902	6,953	36.24	4,621	24.08	193,641	191,874
1903	7,056	36.13	4,975	25.48	196,924	195,283
1904	7,906	39.68	4,437	22.27	201,596	199,260
1905	7,878	38.75	5,621	27.65	205,055	203,325
1906	7,406	35.84	5,470	26.47	208,193	206,624
1907-08	7,284	34.75	5,600	26.71	211,080	209,637
1908-09	7,781	36.53	5,116	24.02	214,947	213,014
1909	7,458	34.40	4,938	22.78	218,670	216,808
1910	7,519	34.08	4,750	21.53	222,641	220,655
Total 1901-1900	73,919		50,273			
Total 1891-1900 – average for the decade		36.18		24.61		

⁷ The crude birth rate is the number of births divided by the mean population.

⁸ The crude death rate is the number of deaths divided by the mean population.

⁹ The mean population is the population at the start of the year, plus 50% of the births and net immigration (from Appendix 2.2), less 50% of the deaths and emigration (from Appendix 2.2).

Year	Births (from <i>Registrar- General AR</i>)	Crude Birth Rate	Deaths (from <i>Registrar- General AR</i>)	Crude Death Rate	Year End Population	Mean Population
1911 Trinidad & Tobago	7,592	33.88	4,933	22.01	225,532	224,086
1912	7,419	32.84	6,826	30.21	226,357	225,944
1913	7,563	33.21	5,023	22.06	229,129	227,743
1914	7,421	32.22	5,332	23.15	231,095	229,934
1915	5,308	30.34	3,731	21.33	232,904	174,678
1916	7,290	31.07	4,739	20.20	235,686	234,295
1917	7,581	31.93	5,038	21.22	238,461	237,074
1918	7,156	29.82	5,152	21.47	240,697	239,579
1919	7,172	29.64	5,508	22.76	242,593	241,645
1920	7,275	29.85	5,972	24.50	244,128	243,361
Total 1911-1920	71,778		52,254			
Total 1911-1920 – average for the decade		31.48		22.89		

– Appendix 2.4 –
 Statistics for the East Indian Population.
 Vital Statistics for Trinidad (1891-1900) and the
 United Colony of Trinidad and Tobago (1901-1920), based on Census data
 and Registrar-General Annual reports, with the total population
 adjusted for Population Leakage (from Appendix 2.1).

Year	Births (from <i>Registrar- General AR</i>)	Crude Birth Rate ¹⁰	Deaths (from <i>Registrar- General AR</i>)	Crude Death Rate ¹¹	Population at Year End	Mean Population ¹²
1891 Trinidad	1,584	22.27	1,259	17.71	72,004	71,123
1892	2,473	33.72	1,868	25.48	74,632	73,318
1893	2,350	31.27	1,955	26.01	75,687	75,159
1894	2,465	32.21	2,029	26.51	77,392	76,540
1895	2,698	34.39	1,874	23.89	79,511	78,452
1896	2,667	33.02	1,977	24.48	82,032	80,771
1897	2,509	30.49	2,563	31.15	82,549	82,290
1898	2,370	28.72	2,443	29.61	82,479	82,514
1899	2,853	34.44	2,042	24.65	83,217	82,848
1900	3,309	39.64	2,158	25.85	83,742	83,480
Total for 1891- 1900	25,278		20,168			
Total 1891 to 1900: average for decade		32.02		25.53		
1901 Trinidad & Tobago	2,835	33.10	2,147	25.07	87,532	85,637
1902	3,115	35.12	2,131	24.03	89,839	88,686
1903	3,138	34.48	2,325	25.55	92,184	91,012
1904	3,398	36.54	2,051	22.06	93,796	92,990
1905	3,723	38.93	2,672	27.94	97,465	95,630
1906	3,471	35.17	2,467	25.00	99,912	98,689
1907	3,842	38.14	3,021	29.99	101,566	100,739
1908	3,857	37.52	2,825	27.48	104,041	102,804
1909	4,204	39.81	2,724	25.79	107,169	105,605
1910-11	4,051	37.15	2,698	24.74	110,911	109,040
Total for 1901- 1910	35,634		25,061			
Total 1901- 1910: average for the decade		36.60		25.76		

¹⁰ The crude birth rate is the number of births divided by the mean population.

¹¹ The crude death rate is the number of deaths divided by the mean population.

¹² The mean population is the population at the start of the year, plus 50% of the births and net immigration (from Appendix 2.2), less 50% of the deaths and emigration (from Appendix 2.2).

Year	Births (from <i>Registrar- General AR</i>)	Crude Birth Rate	Deaths (from <i>Registrar- General AR</i>)	Crude Death Rate	Population at Year End	Mean Population
1911 Trinidad & Tobago	4,082	36.31	2,937	26.13	113,907	112,409
1912	4,292	37.38	3,469	30.22	115,706	114,806
1913	4,265	36.74	3,098	26.69	116,791	116,248
1914	4,434	37.90	2,995	25.60	117,517	116,978
1915	3,283	37.10	2,064	23.33	118,329	88,746
1916	4,627	38.86	2,787	23.40	120,535	119,432
1917	4,985	41.15	2,944	24.30	122,477	121,506
1918	4,604	37.59	3,076	25.11	123,201	122,839
1919	4,395	35.79	3,890	31.67	123,136	123,169
1920	4,432	36.17	3,266	26.66	122,605	122,870
Total 1911-1920	43,399		30,526			
Total 1911-1920: average for the decade		37.50		26.31		

Bibliography

Newspapers

The British Medical Journal
The Lancet
The Medical Times and Gazette
The Mirror
The Port-of-Spain Gazette
The Times

Manuscript Sources. British National Archives. Great Britain Colonial Office (CO) Records.

CO 28-260 (1903) #3831. *Chicken-pox in Trinidad.*

CO 295-254 (1870) #8800. [Crane appointed Surgeon General.]

CO 295-259 (1871) #2696. [Bakewell and the Justice System].

CO 295-259 (1871) #6817. *Medical Dept. of Privy Council to Secretary of State.*

CO 295-259 (1871) #8260. *Letter from Royal College of Physicians to Secretary of State.*

CO 295-274 (1875) #8580. *Scheme for Reorganizing the Medical Services.*

CO 295-276 (1876) #1195. *Return of medical appointments under the new Scheme.*

CO 295-279 (1877) #13574. *Statements against Dr. Crane and the mortality at the Colonial Hospital.*

CO 295-281 (1878) #13202. *Disreputable and inefficient state of Colonial Civil Service.*

CO 295-311 (1886) #19497. *Votes passed by Legislative Council.*

CO 295-311 (1886) #20601. *Surgeon General's Dept.*

CO 295-311 (1886) #22453. *Surgeon General's Dept.*

CO 295-313 (1887) #9405. *Treatment of Medical Witnesses by Chief Justice.*

CO 295-316 (1887) #4669. *Report of Commission on Surgeon General Dept.*

CO 295-316 (1887) #11453. *Observations as to creation of new medical districts.*

CO 295-335 (1891) #21907. *Minutes of Committee to report thereon Medical*

Expenditures.

- CO 295-342 (1892) #6356. *Application for Directorship of Sanitary Dept. Egypt.*
- CO 295-375 (1896) #23257. *Coolies enlisted for labour in Columbia.*
- CO 295-375 (1896) #25430. *Coolies enlisted for labour in Columbia.*
- CO 295-391 (1899) #4024. *Tobago Medical Service.*
- CO 295-391 (1899) #8041. *Observations on Medical and Education Expenditures.*
- CO 295-391 (1899) #11877. *Medical Retrenchment. Confidential Jerningham to Chamberlain.*
- CO 295-393 (1897) #8533. *Return of Coolies from Columbia.*
- CO 295-395 (1899) #6998. *Industries of the Colony.*
- CO 295-407 (1901) #42210. *Class of Emigrants dispatched from Agency.*
- CO 295-417 (1903) #17127. *Epidemic of Eruptive Fever.*
- CO 295-417 (1903) #18788. *Epidemic of Eruptive Fever.*
- CO 295-417 (1903) #20491. *Eruptive Fever Experiments.*
- CO 295-425 (1903) #14062. *Epidemic in Trinidad.*
- CO 295-425 (1903) #14712. *Disease in Trinidad.*
- CO 295-425 (1903) #19555. *Epidemic in Colony.*
- CO 295-425 (1903) #30223. *Epidemic in Trinidad.*
- CO 295-431 (1904) #25694. *Medical Service.*
- CO 295-432 (1905) #14856. *Government Medical Dept.*
- CO 295-435 (1905) #17402. *Colour Question in Trinidad. Memorandum on the Existing Condition of Race-Feeling in the Island of Trinidad.*
- CO 295-436 (1906) #20098. *Indentured Coolie Labourers.*
- CO 295-452 (1909) #32738. *Distressed British Subjects.*
- CO 295-455 (1909) #10150. *Indentured Labourers.*

CO 295-458 (1910) #21244. *USA Quarantine on Trinidad.*

CO 295-465 (1911) #16008. *Jamaica Quarantine on Trinidad.*

CO 295-472 (1911) #5152. *Medical Enquiry Commission.*

CO 318-258 (1870) #4789. *West India Immigration.*

CO 318-258 (1870) #8428. *West India Immigration.*

CO 384-152 (1884) #3694. *Immigration from Madeira.*

CO 384-186 (1893) #20843. *Emigration Despatches.*

CO 885-5 (1889) #75. *Hand Book for Surgeons Superintendent of the Coolie Emigration Service by James M. Laing, M.A. and L.R.C.S.E.*

British National Archives. Colonial Office (CO) Photograph Collection CO 1069.

CO 1069/392/15 [n.d.] *Coolies on Arrival from India mustered at the Depot.*

CO 1069/392/20 [n.d.] *View of San Fernando.*

CO 1069/355/41 [n.d.] *Medical Examination of New Arrivals.*

CO 1069/355/42 [n.d.] *The Emigrants at their Meals.*

CO 1069/355/46 [n.d.] *The Depot Hospital. Accommodation for 94 patients.*

CO 1069/392/128. *Crowd at Western Side of Red House. 23rd March 1903 between 12 & 1 pm (Looking down Abercrombie Street).*

CO 1069/392/130. *Mass Meeting at Queen's Park. 21 March 1903.*

CO 1069/392/138. *The Burning of the Red House. 23 March 1903.*

Great Britain. Parliament. House of Commons. British Parliamentary Papers (BPP).

BPP. Annual Series. *General Report of the Colonial Land and Emigration Commissioners (CLEC).* Published from 1842 to 1854-55.

BPP. Annual Series. *General Report of the Colonial Emigration Commissioners (CLEC).* Published from 1855 to 1873.

BPP. Annual Series. *Papers Relating to Her Majesty's Colonial Possessions (Blue Books).*

- BPP 1839 #3, *Report on the Affairs of British North America from the Earl of Durham, Her Majesty's High Commission, &c. &c. &c.*, 11 February 1839.
- BPP 1839 #3-II#, *Appendix (A) to Report on the Affairs of British North America from the Earl of Durham, Her Majesty's High Commission, &c. &c. &c.*
- BPP 1839 #3-III, *Appendix (B) to Report on the Affairs of British North America from The Earl of Durham, Her Majesty's High Commissioner, &c &c &c.*
- BPP 1840 #35, *Colonial Land Board. Copies of Commissions appointing T.F. Elliot and Robert Torrens, Esquires, and the Hon. Edward E. Villiers, Land and Emigration Commissioners.*
- BPP 1842 #006, *Report to Her Majesty's Principal Secretary of State for the Home Department, from the Poor Law Commissioners, on an inquiry into the Sanitary Condition of the Labouring Population of Great Britain.*
- BPP 1842 #116, *A Bill (as amended by the Committee) for regulating the Carriage of Passengers in Merchant Vessels, 18 March 1842, 5 Victoria.*
- BPP 1842 [355], *Report of the Land and Emigration Commissioners on the necessity of amending the Passengers' Act; with the amendments in detail, and their reasons, and references to the corresponding clauses of the existing Act.*
- BPP 1850 [1163], *Emigration. Papers Relative to the Emigration to the Australian Colonies. Instructions for Surgeons of Emigrant Ships sailing under the Superintendence of Her Majesty's Colonial Land and Emigration Commissioners.*
- BPP 1851 #198, *Emigrant Ship "Washington."*
- BPP 1851 #632, *Report from the Select Committee on Passengers' Act.*
- BPP 1852 #348, *Passengers Act Amendment Bill. 15 Victoria.*
- BPP 1854 #163, *First Report from the Select Committee on Emigrant Ships.*
- BPP 1854 #235, *Cholera (Jamaica). A "Copy of the Report made by Dr. Milroy to the Colonial Office, on the Cholera Epidemic in Jamaica, 1850-51; Copies of Extracts of Despatches addressed to and received from the Governor of Jamaica in relation to the said report."*
- BPP 1854 #255, *A Return of the Names, Stations, Dates of Appointment, and Salaries of the Emigration Officers in the United Kingdom; with a copy of the General Instructions issued for their guidance.*
- BPP 1854 #349, *Second Report from the Select Committee on Emigrant Ships.*

- BPP 1854-55 #293, *Return of the Number of Her Majesty's Ships and Vessels now in Commission on Home and Foreign Service; together with the number and names of the Surgeons, Assistant Surgeons, and Dressers without Medical or Surgical Diplomas, in every Ship or Vessel, and the Number and Names of those Dressers acting as Assistant Surgeons.*
- BPP 1871 [c.393], *Report of the Commissioners Appointed to Enquire into the Treatment of Immigrants in British Guiana.*
- BPP 1873 [c.729], *Report on Leprosy and Yaws in the West Indies.* Gavin Milroy.
- BPP 1874 #293, *Return of the Number and Names of the Ships Employed in Conveying Coolies from India and China to the West Indies since the First day of January 1872 to the Present Date, 9 July 1874.*
- BPP 1874 #314, *East India (Coolie Emigration). Copy of Mr. Geoghegan's Report on Coolie Emigration from India, 21 July 1874.*
- BPP 1875 #240, *Return of Names, Ages, and Nationalities of Persons who have service in the British Merchant Service during the last Two Years as Surgeons and whose Names do not Appear in the Medical Register.*
- BPP 1876 #316, *Ship Surgeons. Return of Names, Ages, and Nationalities of Persons who have Served in the British Merchant Service as Surgeons whose Names do not appear in the Medical Register; distinguishing those who have been permitted so to service since the Date of the Board of Trade's Circular Letter of September 1875 addressed to Marine Superintendents and Shipping Masters.*
- BPP 1881 [c.2995], *Emigrant Accommodation on Board Atlantic Steam Ships. Reports with Regard to the Accommodation and Treatment of Emigrants on Board Atlantic Steam Ships.*
- BPP 1898 [c.8655], *Report of the West India Royal Commission.*
- BPP 1898 [c.8657], *Report of the West India Royal Commission. Appendix C.*
- BPP 1903 [cd.1598], *Papers Relating to the Investigation of Malaria and Other Tropical Diseases and the Establishment of Schools of Tropical Medicine.*
- BPP 1903 [cd.1661], *Papers Relating to the Recent Disturbances at Port of Spain Trinidad.*
- BPP 1903 [cd.1662], *Report of the Commission of Enquiry into the Recent Disturbances at Port of Spain Trinidad.*
- BPP 1904 [cd 1989], *Coolie Immigration, Immigration Ordinances of Trinidad and British Guiana.*

BPP 1906 #357, *Coolie Labour*.

BPP 1910 [cd 5192], *Emigration from India to the Crown Colonies and Protectorates. Report of the Committee on Emigration from India to the Crown Colonies and Protectorates*.

BPP 1910 [cd.5193], *Report of the Committee on Emigration from India to the Crown Colonies and Protectorates. Part II. Minutes of Evidence*.

BPP 1910 [cd 5194], *Report of the Committee on Emigration from India to the Crown Colonies and Protectorates. Part III. Papers Laid before the Committee*.

BPP 1922 [cmd.1679], *Report by the Honourable E.F.L. Wood, MP (Parliamentary Under Secretary of State for the Colonies) on his Visit to the West Indies and British Guiana*.

British Guiana. Government Sessional Papers.

British Guiana. Government Sessional Papers 1880, *Registrar-General Annual Report*.

British Guiana. Government Sessional Papers 1888, *Surgeon-General Annual Report*.

Jamaica. Government Sessional Papers.

Jamaica Sessional Papers 1886-87. *Island Medical Department Annual Report*.

Jamaica Sessional Papers 1890-91. *Report of the Board of Supervision for the Relief of the Poor in Jamaica, for the period of Eighteen Months ended 1st March*.

Jamaica Sessional Papers 1898-99. *Report on the Public Hospital for the year ended 31st March 1899*.

Jamaica Sessional Papers 1898-99. *Report of the Immigration Department for the year ended 31st December 1899*.

Trinidad and Tobago. Government Publications.

Annual Series. The Trinidad Official and Commercial Register and Almanack, Port-of-Spain: Government Printer. Published annually: 1879 to 1893.

Annual Series. The Trinidad and Tobago Yearbook, Port-of-Spain: Government Printer. Published annually: 1898 to 1921.

Census of the Colony of Trinidad, 1891, Port-of-Spain: Government Printer, 1892.

Census of the Colony of Trinidad and Tobago, 1901, Port-of-Spain: Gov. Printer, 1903.

Census of the Colony of Trinidad and Tobago, 1911, Port-of-Spain: Gov. Printer, 1913.

Census of the Colony of Trinidad and Tobago, 1921, Port-of-Spain: Gov. Printer, 1923.

Law Commission of Trinidad, Laws of Trinidad and Tobago. Chronological and Alphabetical Lists of Ordinances and Acts 1832-1983, Trinidad: Law Commission, 1985.

Trade and Taxes Commission, Trinidad, 1886, Port-of-Spain: Gov. Printer, 1886.

Trinidad. Government Sessional Papers of the Legislative Council (LC).

Annual Series. LC Annual Report of the Protector of Immigrants, 1891 to 1922.

Annual Series. LC Annual Report of the Registrar-General (Vital Statistics), 1891 to 1922.

Annual Series. LC Annual Report of the Surgeon-General, 1882 to 1922.

1877 LC #1. *Lunatic Asylum. Annual Report of the Medical Superintendent for 1876.*

1877 LC #22. *Immigration. Abstract of the Quarterly Returns for the year.*

1885 LC #71. *Emigration. Papers Relating to Emigration from Barbados.*

1886 LC #7. *Report by the Surgeon General suggesting a scheme of out-door Poor Relief.*

1886 LC #36. *Report of Select Committee on Emigration from Barbados.*

1886 LC #79. *Rules and Regulations made under Section 5 of Ordinance No. 5 of 1870, for defining the duties of the Colonial Storekeeper with Regard to Hospital Stores, and to Stores Kept in Other Departments.*

1886 LC #86. *Minutes of the Finance Committee with reference to Estimates for 1887. Minute by the Governor Suggesting that Provision be made for the Establishment of a System of Poor Relief.*

1886 LC #92. *Poor Relief. Letter from the Surgeon General Relative to the Provision for the Maintenance of the Indigent Sick in POS.*

1886 LC #97. *Return showing the number of Coolies in the undermentioned Government Medical Institutions on the 20th Day of November, 1886.*

1887 LC #8. *Report of Commission on Trade and Taxes.*

- 1890 LC #83. *Immigration. Correspondence relative to Immigration from the Azores and to the encouragement of Voluntary Immigration from the Mainland and neighbouring Colonies.*
- 1891 LC #20. *Immigration. Minutes of a Meeting of the Standing Committee on Immigration.*
- 1891 LC #32. *Despatch from the Secretary of State with reference to Immigration from the Azores.*
- 1892 LC #12. *Despatch from Secretary of State respecting Expenditure on Medical Establishment and Institutions, with a Minute from the S-G forwarding Return of Emoluments, &c., of Medical Officers.*
- 1897 LC #188. *Papers relating to the question of Poor Relief.*
- 1898 LC #185. *Agricultural Labourers from St. Vincent and Barbados.*
- 1902 LC #23. *Widows' and Orphans' Fund.*
- 1904 LC #59. *Quarantine System in the West Indies. Report of Delegates at Conference in Barbados.*
- 1916 LC #46. *Abolition of Indentured Emigration.*
- 1921 LC #93. *Poor Relief. Report of the Committee appointed to inquire into the system of poor relief in the Colony.*

Rockefeller Archive Center, New York. Rockefeller Foundation (RF) Photograph Collection.

RF Photographs, 451, box 117, 2289, P3377, East Indian who walked 60 miles to be treated.

RF Photographs, 451, box 117, 2294, P266H, Government Hospital in Cedros District. P266I, Estate Hospital at St. Marie, Cedros.

RF Photographs, 451, box 116, 2286, Port-of-Spain Hospital. P6934 Male Ward, 1st Floor, Main Building. P6936 Front/Private Ward. Maternity Hospital on Right. P6937 Front. Main Building. Male Surgical Ward on left.

Primary Sources (Published)

Annual Series. The Colonial Office List. Comprising Historical and Statistical Information Respecting the Colonial Dependencies of Great Britain, an Account

of the Services of the Officers in the Colonial Service, Great Britain: Colonial Office, 1879 to 1921.

Burdett, Henry C., *Burdett's Hospital and Charities Annual 1895*, London: Scientific Press, 1896.

Comins, Surgeon-Major D.W.D., *Note on Emigration from India to Trinidad*, Calcutta: Bengal Secretariat Press, 1893.

de Verteuil, Louis A.A., *Trinidad: Its Geography, Natural Resources, Administration, Present Condition, and Prospects*, 2nd ed., London: Cassell, 1884.

Des Voeux, G. William, *My Colonial Service in British Guiana, St. Lucia, Trinidad, Fiji, Australia, Newfoundland, and Hong Kong with Interludes*, London: John Murray, 1903.

Fraser, L.M., *History of Trinidad from 1814 to 1839*, Trinidad: Government Printing Office, 1896.

Grant, Kenneth James, *My Missionary Memories*, Halifax: Imperial Publishing, 1923.

Hart, Daniel, *Trinidad and the Other West India Islands and Colonies*, 2nd ed., Trinidad: Chronicle Publishing Office, 1866.

Inniss, L.O., *Trinidad and Trinidadians. A Collection of Papers, Historical, Social and Descriptive, about Trinidad and its People*, Port-of-Spain: The Mirror Printing, 1910.

Kipling, Rudyard, *The Writings in Prose and Verse of Rudyard Kipling*, Charles Scribner, 1903.

Malthus, Thomas R., *An essay on the principle of population, as it affects the future improvement of society. With remarks on the speculations of Mr. Godwin, M. Condorcet, and other writers*, London, 1798.

----- *An Essay on the Principle of Population; Or, A view of Its Past and Present Effects on Human Happiness with an Inquiry into our Prospects Respecting Future Removal or Mitigation of Evils which it Occasions*, Vol. II, first American ed., Washington: Roger Chew Weightman, 1809.

Morton, Sarah E., *John Morton of Trinidad. Pioneer Missionary of the Presbyterian Church in Canada to the East Indians in the British West Indies*, Toronto: Westminster, 1916.

Sadlier's Catholic Directory, Almanac and Ordo, 1883, Part II, The Catholic Church in the British Provinces of North America, the West Indies, Central and South America, New York: D.J. Sadlier, 1883.

Seamen's Hospital Society, *London School of Tropical Medicine, Report for the Year 1899-1900* (1900).

Seheult, R., On an Epidemic of Small-pox of Irregular Type in Trinidad during 1902-4, *Proceedings of the Royal Society of Medicine*, 1908 (1), 229-302.

Sewell, W.G., *The Ordeal of Free Labour in the British West Indies*, London: 1861.

Secondary Sources

Allen, Carolyn, "Creole: The Problem of Definition," in Verene A. Shepherd and Glen L. Richards, eds., *Questioning Creole. Creolisation Discourses in Caribbean Culture*, Kingston: Ian Randle, 2002: 47-63.

Anderson, Warwick, "Postcolonial Histories of Medicine," in John Harley Warner and Frank Huisman, eds., *Locating Medical History. The Stories and Their Meanings*, Baltimore: Johns Hopkins University Press, 2006: 285-306.

Arnold, David, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India*, Berkley: University of California Press, 1993.

----- "Disease, Medicine and Empire," in David Arnold, ed., *Imperial Medicine and Indigenous Societies*, New York: St. Martin's Press, 1988: 1-26.

----- "Tropical Medicine before Manson," in David Arnold, ed., *Warm Climates and Western Medicine: The Emergence of Tropical Medicine, 1500-1900*, Amsterdam: Rodopi, 1996: 1-19.

Beckles, Hilary McD., *Natural Rebels: A Social History of Enslaved Black Women in Barbados*, New Jersey: Rutgers University Press, 1989.

Bogues, Anthony, *Caliban's Freedom. The Early Political Thought of C.L.R. James*, London: Pluto Press, 1997.

Bolland, O. Nigel, "Creolisation and Creole Societies: A Cultural Nationalist View of Caribbean Social History," *Caribbean Quarterly*, 44, 1-2 (1998): 1-32.

----- "Systems of Domination after Slavery: The Control of Land and Labor in the British West Indies after 1838," *Comparative Studies in Society & History* 23, 4 (1981): 591-619.

----- "Reconsidering Creolisation and Creole Societies," in Gad Heuman and David Trotman, eds., *Contesting Freedom: Control and Resistance in the Post-Emancipation Caribbean* (Oxford: Macmillan Caribbean, 2005), 179-96.

Brathwaite, Edward Kamau, *Contradictory Omens: Cultural Diversity and Integration in the Caribbean*, Jamaica: Savacou, 1974.

- *The Development of Creole Society in Jamaica, 1770-1820*, Oxford: Clarendon, 1971.
- Brereton, Bridget, "The Experience of Indentureship, 1845-1917," in John LaGuerre (ed.), *Calcutta to Caroni. The East Indians of Trinidad*, Trinidad: Longman Group, 1974: 25-38.
- *Law Justice and Empire. The Colonial Career of John Gorrie 1829-1892*, Jamaica: University of West Indies Press, 1997.
- *Race Relations in Colonial Trinidad 1870-1900*, Cambridge: Cambridge University Press, 2002.
- "The White Elite of Trinidad, 1838-1950," in Howard Johnson and Karl Watson (eds.), *The White Minority in the Caribbean*, New Jersey: Markus Wiener, 1998: 32-70.
- Brown, Laurence, "Inter-colonial migration and the refashioning of indentured labour: Arthur Gordon in Trinidad, Mauritius and Fiji (1866-1880)," in David Lambert and Alan Lester, eds., *Colonial Lives across the British Empire: Imperial Careerings in the Long Nineteenth Century*, Cambridge: Cambridge University Press, 2006: 204-27.
- Bryan, Patrick, *The Jamaican People 1880-1902. Race, Class and Social Control*, Jamaica: University of West Indies Press, 2000.
- "The White Minority in Jamaica at the end of the Nineteenth Century," in Howard Johnson and Karl Watson (eds.), *The White Minority in the Caribbean*, New Jersey: Markus Wiener, 1998: 116-32.
- Bush, Barbara, *Slave Women in Caribbean Society 1650-1838*, Kingston: Heinemann Caribbean, 1990.
- Bynum, W.F., "Ideology and Health Care in Britain: Chadwick to Beveridge," *History Phil. Life Sci.*, 10 supplement (1988): 75-87
- Cateau, Heather, "'A Question of Labor': British West Indian Plantations, 1750-1810," *Plantation Society in the Americas*, 6, 1 (1999): 65-94.
- Challenger, Denise, "A Benign Place of Healing? The Contagious Diseases Hospital and Medical Discipline in Post-Slavery Barbados," in Juanita De Barros, Steven Palmer, and David Wright, eds., *Health and Medicine in the circum-Caribbean, 1800-1968*, New York: Routledge, 2009: 98-120.
- Chapman, J.K., *The Career of Arthur Hamilton Gordon. First Lord Stanmore 1829-1912*, Toronto: University of Toronto Press, 1964.

- Cherry, Steven, *Medical Services and the Hospitals in Britain, 1860-1939*, Cambridge: Cambridge University Press, 1996.
- Chilton, Lisa, *Agents of Empire. British Female Migration to Canada and Australia, 1860s-1930*, Toronto: University of Toronto Press, 2007.
- Churchill, Wendy D., "Bodily Differences? Gender, Race, and Class in Hans Sloane's Jamaican Medical Practice, 1687-1688," *Journal of the History of Medicine & Allied Sciences*, 60, 4 (2005): 391-444.
- Clyde, David F., *Two Centuries of Health Care in Dominica*, Lucknow: Prom Printing, 1980.
- Cohen, Robin, ed., *The Cambridge Survey of World Migration*, Cambridge: Cambridge University Press, 1995.
- Craig, Hewan, *The Legislative Council of Trinidad and Tobago*, London: Faber & Faber, 1951.
- Crowther, M.A., *The Workhouse System 1834-1929. The History of an English Social Institution*, London: Batsford, 1981.
- Crozier, Anna, *Practicing Colonial Medicine: The Colonial Medical Service in British East Africa*, New York: Tauris, 2008.
- Cumpston, I.M., *Indians Overseas in British Territories 1834-1854*, 2nd edition, London: Dawson of Pall Mall, 1969.
- Cunningham, Andrew, and B. Andrews, "Introduction: Western Medicine as Contested Knowledge," in Andrew Cunningham and B. Andrews, eds., *Western Medicine as Contested Knowledge*, Manchester: Manchester University Press, 1997: 1-23.
- Curtin, Philip D., *The Atlantic Slave Trade: A Census*, Madison: University of Wisconsin Press, 1969.
- "The British Sugar Duties and West Indian Prosperity," *The Journal of Economic History*, 14, 2 (1954): 157-64.
- "Epidemiology and the Slave Trade," *Political Science Quarterly*, June 1968: 190-216.
- "The Epidemiology of Migration," in David Eltis, ed., *Free and Coerced Migrations from the Old World to the New. Global Perspectives*, California: Stanford University Press, 2002: 94-116.
- Deacon, Harriet, "Racial Segregation and Medical Discourse in Nineteenth-Century Cape Town," *Journal of Southern African Studies*, 22 (1996): 287-308.

- De Barros, Juanita, "'Improving the Standards of Motherhood.' Infant Welfare in Post-Slavery British Guiana," in Juanita De Barros, Steven Palmer, and David Wright, eds., *Health and Medicine in the circum-Caribbean, 1800-1968*, New York: Routledge, 2009: 165-94.
- "Sanitation and Civilization in Georgetown, British Guiana," Special Issue of *Caribbean Quarterly* 49, 4 (2003): 65-86.
- "'Setting Things Right': Medicine and Magic in British Guiana, 1803-1834," *Slavery and Abolition* (2004): 28-50.
- "'Spreading Sanitary Enlightenment': Race, Identity, and the Emergence of a Creole Medical Profession in British Guiana," *Journal of British Studies*, 42 (2003): 483-504.
- "'To Milk or Not to Milk?' Regulation of the Milk Industry in Colonial Georgetown," *Journal of Caribbean History*, 31, 1-2 (1997): 185-208.
- De Barros, Juanita, and Sean Stilwell, "Public Health and the Imperial Project," *Colonialism and Health in the Tropics*. Special Issue of *Caribbean Quarterly* 49, 4 (2003): 1-11.
- De Barros, Juanita, Steven Palmer, and David Wright, eds., *Health and Medicine in the circum-Caribbean, 1800-1968*, New York: Routledge, 2009.
- de Verteuil, Anthony, *Surgery in Trinidad*, Port-of-Spain: Litho Press, 1996.
- Digby, Anne, *British Welfare Policy: Workhouse to Workfare*, London: Faber and Faber, 1989.
- "The Rural Poor Law," in Derek Fraser, ed., *The New Poor Law in the Nineteenth Century*, London: Macmillan, 1976: 149-70.
- Dunn, Richard S., "'Dreadful Idlers' in the Cane Fields: The Slave Labor Patterns on a Jamaican Sugar Estate, 1762-1831," *Journal of Interdisciplinary History*, 17, 4, 1987: 795-822.
- du Toit, Brian M., "Ethnomedical (Folk) Healing in the Caribbean," in M. Fernandez Olmos and L. Paravisini-Gebert, eds., *Healing Cultures. Art and Religion as Curative Practices in the Caribbean and its Diaspora*, New York: Palgrave, 2001: 19-28.
- Eltis, David, "Free and Coerced Migrations from the Old World to the New," in David Eltis, ed., *Coerced and Free Migrations. Global Perspectives*, California: Stanford University Press, 2002: 33-74.

- “Introduction. Migration and Agency in Global History,” in David Eltis, ed., *Coerced and Free Migration. Global Perspectives*, Stanford: Stanford University Press, 2002: 1-32.
- “Mortality and Voyage Length in the Middle Passage: New Evidence from the Nineteenth Century,” *Journal of Economic History*, XLIV (June 1984): 301-8.
- Emmer, P.C., “The Great Escape: The Migration of Female Indentured Servants from British India to Surinam, 1873-1916,” in David Richardson (ed.), *Abolition and its Aftermath: The Historical Context, 1790-1915*, London: Cass, 1985: 245-66.
- Engerman, Stanley L., “Changing Laws and Regulations and Their Impact on Migration,” in David Eltis, ed., *Free and Coerced Migrations from the Old World to the New. Global Perspectives*, California: Stanford University Press, 2002: 75-93.
- Ernst, Waltraud, “Beyond East and West. From the History of Colonial Medicine to a Social History of Medicine(s) in South Asia,” *Social History of Medicine*, 20, 3 (2007): 505-24.
- Farley, John, *Bilharzia. A History of Imperial Tropical Medicine*, Cambridge: Cambridge University Press, 1991.
- Flinn, M.W., “Medical Services under the New Poor Law,” in Derek Fraser, ed., *The New Poor Law in the Nineteenth Century*, London: Macmillan, 1976: 45-66.
- Fraser, Derek, *The Evolution of the British Welfare State*, 3rd ed., Britain: Palgrave, 2003.
- *The New Poor Law in the Nineteenth Century*, London: Macmillan, 1976.
- Gailey, Harry A., *Clifford: Imperial Proconsul*, London: Collins, 1982.
- Gosse, David, “Health Conditions on Selected Plantations in Jamaica,” *The Journal of Caribbean History* 40, 2 (2006): 215-34.
- Hall, Catherine, *Civilising Subjects: Metropole and Colony in the English Imagination, 1830-1867*, Chicago: University of Chicago Press, 2002.
- Handler, Jerome S., “Diseases and Medical Disabilities of Enslaved Barbadians, From the Seventeenth Century to around 1838 (Part I),” *Journal of Caribbean History*, 40, 1 (2006): 1-38.
- “Diseases and Medical Disabilities of Enslaved Barbadians, From the Seventeenth Century to around 1838 (Part II),” *Journal of Caribbean History*, 40, 2 (2006): 177-214.
- “Slave Medicine and Obeah in Barbados, Circa 1650 to 1834,” *NWIG*, 74, 1-2 (2000): 57-90.

- Handler, Jerome S., and J. Jacoby, "Slave Medicine and Plant Use in Barbados," *Journal of the Barbados Museum and Historical Society*, 41 (1993): 74-98.
- Hardy, Anne, "Smallpox in London: Factors in the Decline of the Disease in the Nineteenth Century," *Medical History*, 27 (1983): 111-38.
- Harper, Marjory, "British Migration and the Peopling of the Empire," in Andrew Porter, ed., *The Oxford History of the British Empire. Vol. III. The Nineteenth Century*, New York: Oxford University Press, 1999: 75-87.
- Harris, Bernard, "Charity and Poor Relief in England and Wales, Circa 1750-1914," in Bernard Harris and Paul Bridgen, eds., *Charity and Mutual Aid in Europe and North America since 1800*, New York: Routledge, 2007: 19-42.
- "Introduction: The 'Mixed Economy of Welfare' and the Historiography of Welfare Provision," in Bernard Harris and Paul Bridgen, eds., *Charity and Mutual Aid in Europe and North America since 1800*, New York: Routledge, 2007: 1-18.
- *The Origins of the British Welfare State. Social Welfare in England and Wales, 1800-1945*, New York: Palgrave, 2004.
- Harrison, Mark, *Public Health in British India. Anglo-Indian Preventive Medicine 1859-1914*, Cambridge: Cambridge University Press, 1994.
- Higman, B.W., "African and Creole Slave Family Patterns in Trinidad," *Journal of Family History*, 3, 2 (1978): 163-180.
- "The British West Indies," in Robin W. Winks, ed., *The Oxford History of the British Empire. Vol. V. Historiography*, Oxford: Oxford University Press, 1999: 134-45.
- *Slave Population and Economy in Jamaica, 1807-1814*, New York: Cambridge University Press, 1976.
- *Slave Populations of the British Caribbean, 1807-1834*, Jamaica: University of West Indies Press, 1995.
- *Writing West Indian Histories*, London: Macmillan, 1999).
- Hitchins, Fred H., *The Colonial Land and Emigration Commission*, London: Oxford University Press, 1931.
- Ho, C., "'Hold the Chow Mein, Gimme Soca': Creolization of the Chinese in Guyana, Trinidad and Jamaica," *Amerasia*, 15, 2 (1989): 3-25.
- Hoefte, Rosemarijn, *In Place of Slavery. A Social History of British Indian and Javanese Laborers in Suriname*, Gainesville: University Press of Florida, 1998.

- Holt, Thomas C., *The Problem of Freedom. Race, Labor, and Politics in Jamaica and Britain, 1832-1938*, Maryland: Johns Hopkins University Press, 1992.
- Hurren, Elizabeth T., "Poor Law versus Public Health: Diphtheria, Sanitary Reform, and the 'Crusade' against Outdoor Relief, 1870-1900," *Social History of Medicine*, 18, 3 (2005), 399-418.
- Inniss, Tara A., "'Any elderly, sensible, prudent woman.' The Practice and Practitioners of Midwifery during Slavery in the British Caribbean," in Juanita De Barros, Steven Palmer, and David Wright, eds., *Health and Medicine in the circum-Caribbean, 1800-1968*, New York: Routledge, 2009: 40-52.
- "From Slavery to Freedom: Children's Health in Barbados, 1823-1838," *Slavery & Abolition*, 27, 2 (2006): 251-60.
- Jabour, Anya, "Slave Health and Health Care in the British Caribbean: Profits, Racism and the Failure of Amelioration in Trinidad and British Guiana, 1824-1834," *Journal of Caribbean History*, 28, 1 (1994): 1-26.
- Jensen, Niklas Thode, "Safeguarding Slaves: Smallpox, Vaccination, and Governmental Health Policies among the Enslaved Population in the Danish West Indies, 1803-1848," *Bulletin of the History of Medicine*, 83 (2009): 95-124.
- John, A. Meredith, "Plantation Slave Mortality in Trinidad," *Population Studies*, 42, 2 (1988): 161-82.
- *The Plantation Slaves of Trinidad, 1783-1816: A Mathematical and Demographic Inquiry*, New York: Cambridge University Press, 1988.
- Johnson, Howard, "Introduction," in Howard Johnson and Karl Watson (eds.), *The White Minority in the Caribbean*, New Jersey: Markus Wiener, 1998: ix-xvii.
- *The Bahamas from Slavery to Servitude, 1783-1933*, Florida: University of Florida Press, 1996.
- Johnson, Stanley C., *A History of Emigration from the United Kingdom to North America 1763-1912*, London: Frank Cass & Company, 1966, reprint of 1913 edition.
- Jones, Margaret, "Infant and Maternal Health Services in Ceylon, 1900-1948: Imperialism or Welfare?" *Social History of Medicine*, 15 (2002): 263-89.
- Kale, Madhavi, "'Capital Spectacles in British Frames': Capital, Empire and Indian Indentured Migration to the British Caribbean," *International Review of Social History*, 41 (1996): 109-33.
- Killingray, David, "The Influenza Pandemic of 1918-1919 in the British Caribbean," *Social History of Medicine* 7, 1 (1994): 59-87.

- Kiple, Kenneth, "Cholera and Race in the Caribbean," *Journal of Latin American Studies*, 17 (1985): 157-77.
- *The Caribbean Slave: A Biological History*, Cambridge: Cambridge University Press, 1984.
- Kiple, Kenneth, and Brian T. Higgins. "Cholera in Mid-nineteenth Century Jamaica," *Jamaican Historical Review*, 17 (1991): 31-47.
- Kiple, Kenneth, and Virginia Kiple, "Deficiency Diseases in the Caribbean," *Journal of Interdisciplinary History*, 11, 2 (1980): 197-215.
- Klein, Herbert S., Stanley L. Engerman, Robin Haines, and Ralph Shlomowitz, "Transoceanic Mortality: The Slave Trade in Comparative Perspective," *William and Mary Quarterly*, LVIII, 1 (January 2001): 93-117.
- Laguerre, Michel, *Afro-Caribbean Folk Medicine*, Massachusetts: Bergin and Garvey, 1987.
- Lal, Brij, "Understanding the Indian Indenture Experience," *Journal of South Asian Studies*, 21, 1 (1998): 215-37.
- Lambert, David, *White Creole Culture, Politics and Identity during the Age of Abolition*, New York: Cambridge University Press, 2005.
- Lambert, David, and Alan Lester, "Imperial Spaces, Imperial Subjects," in David Lambert and Alan Lester, eds., *Colonial Lives across the British Empire: Imperial Career in the Long Nineteenth Century*, Cambridge: Cambridge University Press, 2006: 1-31.
- Laurence, K.O., "A Question of Labour. Indentured Immigration into Trinidad and British Guiana. 1875-1917," Jamaica: Ian Randle Publishers, 1994.
- "The Development of Medical Services in British Guiana and Trinidad 1841-1873," *Jamaican Historical Review* 4 (1964): 59-67.
- "The Trinidad Water Riot of 1903: Reflections of an Eyewitness," *Caribbean Quarterly*, 15, 4, (1969): 5-22.
- Lees, Lynn Hollen, *The Solidarities of Strangers. The English Poor Laws and the People, 1700-1948*, New York: Cambridge University Press, 1998.
- Li, Xiaoping, and Jo-Anne Lee, "Chinese in Canada," in C.R. Ember, M. Ember, and I.A. Skoggard, eds., *Encyclopedia of diasporas: immigrant and refugee cultures around the World*, Springer, 2004: 645-56.

- Look Lai, Walton, *Indentured Labour, Caribbean Sugar. Chinese and Indian Migrants to the British West Indies, 1838-1918*, Baltimore: Johns Hopkins University Press 1993.
- Luke, Learie B., *Identity and Secession in the Caribbean. Tobago versus Trinidad, 1889-1980*, Jamaica: University of West Indies Press, 2007.
- MacDonagh, Oliver, *A Pattern of Government Growth 1800-1860. The Passengers' Acts and their Enforcement*, London: MacGibbon and Kee, 1961.
- MacLeod, Roy, "Introduction," in Roy MacLeod and Milton Lewis, eds., *Disease, Medicine, and Empire. Perspectives on Western Medicine and the Experience of European Expansion*, London: Routledge, 1988: 1-20.
- Mahabir, Noor K., *Medicinal and Edible Plants used by East Indians of Trinidad and Tobago*, Trinidad: Chakra, 1991.
- Mangru, Basdeo, *Benevolent Neutrality. Indian Government Policy and Labour Migration to British Guiana 1854-1884*, London: Hansib, 1987.
- Marks, Shula, "Presidential Address. What is Colonial about Colonial Medicine? And what has Happened to Imperialism and Health?," *Social History of Medicine*, 10, 2 (1997): 205-19.
- Marshall, Woodville K., "Peasant Development in the West Indies since 1838," in H. Beckles and V. Shepherd (eds.) *Caribbean Freedom: Economy and Society from Emancipation to the Present*, Princeton: Markus Wiener, 1993: 99-106.
- Matthews, Gelien, "Trinidad: A Model Colony for British Slave Trade Abolition," *Parliamentary History* 26 (2007): 84-96
- McCollin, Debbie, "World War II to Independence: Health, Services, and Women in Trinidad and Tobago, 1939-1962," in Juanita De Barros, Steven Palmer, and David Wright, eds., *Health and Medicine in the circum-Caribbean, 1800-1968*, New York: Routledge, 2009: 227-48.
- Mohammed, Patricia, "The 'Creolisation' of Indian Women in Trinidad," in Verene Shepherd and G. Richards, eds., *Questioning Creole. Creolisation Discourses in Caribbean Culture* (Kingston: Ian Randle, 2002): 130-47.
- "Writing Gender into History: The Negotiation of Gender Relations among Indian Men and Women in Post-indenture Trinidad Society, 1917-47," in Verne Shepherd, Verene, Bridget Brereton, and Barbara Bailey (eds.), *Engendering History. Caribbean Women in Historical Perspective*, New York: St. Martin's Press, 1995: 20-47.

- Mohapatra, Prabhu P., "'Restoring the Family': Wife Murders and the Making of a Sexual Contract for Indian Immigrant Labour in the British Caribbean Colonies, 1860-1920," *Studies in History*, 11 (1995): 227-60.
- Mooney, Graham, "'A Tissue of the most Flagrant Anomalies': Smallpox Vaccination and the Centralization of Sanitary Administration in Nineteenth-Century London," *Medical History*, 1997, 41 (3), 261-90.
- Moore, Brian. *Cultural Power, Resistance and Pluralism. Colonial Guyana, 1838-1900*. Montreal: McGill-Queen's University Press, 1995.
- "The Culture of the Colonial Elites of Nineteenth-Century Guyana," in Howard Johnson and Karl Watson (eds.), *The White Minority in the Caribbean*, New Jersey: Markus Wiener, 1998: 95-115.
- *Race, Power and Social Segmentation in Colonial Society. Guyana after Slavery, 1838-1891*, New York: Gordon and Breach Science Publishers, 1987.
- Moore, Brian, and Michele Johnson, *Neither Led nor Driven. Contesting British Cultural Imperialism in Jamaica, 1865-1920*, Jamaica: University of West Indies Press, 2004.
- *'Squalid Kingston' 1890-1920. How The Poor Lived, Moved And Had Their Being*, Jamaica: University of the West Indies Press, 2000.
- Moore, Dennison, *Origins and Development of Racial Ideology in Trinidad. The Black View of the East Indian*, Canada: NYCAN, 1995.
- Morgan, Jennifer L., *Laboring Women: Reproduction and Gender in New World Slavery*, Philadelphia: University of Pennsylvania Press, 2004.
- Northrup, David, *Indentured Labor in the Age of Imperialism*, New York: Cambridge University Press, 1995.
- Oxford Dictionary of National Biography* (Oxford: Oxford University Press, 2004).
- Paton, Diana, *No Bond but the Law: Punishment, Race, and Gender in Jamaican State Formation, 1780-1870*, Durham: Duke University Press, 2004.
- Payne-Jackson, Arvilla, and Mervyn C. Alleyne, *Jamaican Folk Medicine. A Source of Healing*, Jamaica: University of West Indies Press, 2004.
- Pelling, Margaret, *Cholera, Fever and English Medicine 1825-1865*, Oxford: Oxford University Press, 1978.
- Pemberton, Rita, "A Different Intervention: The International Health Commission/Board, Health, Sanitation in the British Caribbean, 1914-1930," Special Issue of *Caribbean Quarterly*, 49, 4 (2003): 87-103.

- "Water and Related Issues in Nineteenth-Century Trinidad," *Journal of Caribbean History*, 40, 2 (2006): 235-52.
- Porter, Andrew, ed., *The Oxford History of the British Empire, Volume 3, The Nineteenth Century*, Oxford: Oxford University Press, 1999.
- Porter, Dorothy, and Roy Porter, "The Politics of Prevention: Anti-Vaccinationism and Public Health in Nineteenth-Century England," *Medical History*, 32 (1988): 231-52.
- Porter, Roy, "The Patient's View. Doing Medical History from Below," *Theory and Society*, 14 (1985): 175-98.
- Reddock, Rhoda, "Contestations over Culture, Class, Gender and Identity in Trinidad and Tobago. 'The Little Tradition.'" in Verene Shepherd and Glen Richards, eds., *Questioning Creole. Creolisation Discourses in Caribbean Culture* (Kingston: Ian Randle, 2002), 111-29.
- "Indian Women and Indentureship in Trinidad and Tobago 1845-1917: Freedom Denied," *Caribbean Quarterly* 32, 3/4 (1986): 27-49.
- Richardson: Bonham C., *Caribbean Migrants. Environment and Human Survival on St. Kitts and Nevis*, Knoxville: University of Tennessee Press, 1983.
- *Igniting the Caribbean's Past. Fire in British West Indian History*, Chapel Hill: University of North Carolina Press, 2004.
- Riley, James C., *Poverty and Life Expectancy. The Jamaica Paradox*, New York: Cambridge University Press, 2005.
- Roberts, G.W., and J. Byrne, "Summary Statistics on Indentured and Associated Migration Affecting the West Indies, 1843-1918," *Population Studies* 20.1 (1966): 125-34.
- Ryan, Selwyn D., *Race and Nationalism in Trinidad and Tobago: A Study of Decolonization in a Multiracial Society*, Toronto: University of Toronto Press, 1972.
- Samaroo, Brinsley, "Cyrus Prudhomme David – A Case Study of the Emergence of the Black Man in Trinidad Politics," *Journal of Caribbean History*, 3 (1971): 73-89.
- Seecharan, Clem, *'Tiger in the Stars.' The Anatomy of Indian Achievement in British Guiana 1919-29*, London: Macmillan, 1997.
- Shepherd, Verene, "Emancipation through Servitude: Aspects of the Condition of Indian Women in Jamaica, 1845-1945," in H. Beckles and V. Shepherd (eds.) *Caribbean Freedom: Economy and Society from Emancipation to the Present*, Princeton: Markus Wiener, 1993: 245-50.

- "Gender, Migration and Settlement: The Indentureship and Post-indentureship Experience of Indian Females in Jamaica, 1845-1943," in Verne Shepherd, Bridget Brereton, and Barbara Bailey (eds.), *Engendering History. Caribbean Women in Historical Perspective*, New York: St. Martin's, 1995: 233-57.
- *Maharani's Misery. Narratives of a Passage from India to the Caribbean*, Jamaica: University of West Indies Press, 2002.
- "The 'Other Middle Passage?' Nineteenth-century bonded labour migration and the legacy of the slavery debate in the British-colonised Caribbean," in Verne A. Shepherd, ed. *Working Slavery, Pricing Freedom. Perspectives from the Caribbean, Africa and the African Diaspora*, New York: Palgrave, 2001: 343-76.
- Shepherd, Verene A., and Glen L. Richards, eds., *Questioning Creole. Creolisation Discourses in Caribbean Culture*, Kingston: Ian Randle, 2002.
- Sheridan, Richard B., *Doctors and Slaves: A Medical and Demographic History of Slavery in the British West Indies*, Cambridge: Cambridge University Press, 1985.
- "From Chattel to Wage Slavery in Jamaica, 1740-1860," *Slavery & Abolition*, 14, 1 (1993): 13-40
- Shlomowitz, Ralph, and John McDonald, "Mortality of Indian Labour on Ocean Voyages, 1843-1917," *Studies in History*, 6, 1 (1990): 35-65.
- Singh, Kelvin, *Race and Class Struggles in a Colonial State. Trinidad 1917-1945*, Jamaica: University of West Indies Press, 1994.
- Smith, James Patterson, "Empire and Social Reform: British Liberals and the 'Civilizing Mission' in the Sugar Colonies, 1868-1874," *Albion*, 27, 2 (1995): 253-77.
- Michael Garfield Smith, *The Plural Society in the British West Indies*, Berkeley: Univ. of California Press, 1965.
- Steckel, Richard H., and Richard A. Jensen, "New Evidence of Slave and Crew Mortality in the Atlantic Slave Trade," *Journal of Economic History*, XLIV (March 1986): 57-77.
- Stoler, Ann Laura, and Frederick Cooper, "Between Metropole and Colony: Rethinking a Research Agenda," in Ann Laura Stoler and Frederick Cooper, eds., *Tensions of Empire. Colonial Cultures in a Bourgeois World*, Berkeley: University of California Press, 1997: 1-58.
- Tinker, Hugh, *A New System of Slavery. The Export of Indian Labour Overseas 1830-1920*, London: Oxford University Press, 1974.

- Trotman, David Vincent, *Crime in Trinidad. Conflict and Control in a Plantation Society 1838-1900*, Knoxville: University of Tennessee Press, 1986.
- Walker, James W. St. G., *"Race," Rights and the Law in the Supreme Court of Canada. Historical Cases Studies*, Waterloo: Wilfred Laurier University Press, 1997.
- Watts, Susan, "Dracunculiasis in the Caribbean and South America: A Contribution to the History of Dracunculiasis Eradication," *Medical History* 44, 2 (2000): 227-50.
- Ward, J.R., *British West Indian Slavery, 1750-1834: The Process of Amelioration*, New York: Oxford University Press, 1988.
- Welch, Pedro, "Gendered Health Care: Legacies of Slavery in Health Care Provision in Barbados over the period 1870-1920," *Caribbean Quarterly*, 49, 4 (2003): 104-20.
- Wilcox, Walter F., ed., *International Migrations. Statistics*. Vol. I and II, New York: Gordon and Breach, 1969.
- Wilkins, Nadine Joy, "Doctors and Ex-slaves in Jamaica 1834-1850," *Jamaican Historical Review* 17 (1991): 19-30.
- Will, H.A., "Problems of Constitutional Reform in Jamaica, Mauritius and Trinidad, 1880-1895," *The English Historical Review*, 81, 321 (1966): 693-716.
- Williams, Naomi, "The implementation of compulsory health legislation: infant smallpox vaccination in England and Wales, 1840-1890," *Journal of Historical Geography*, 20 (1994): 396-412.
- Wohl, Anthony S., *Endangered Lives. Public Health in Victorian Britain*, Massachusetts: Harvard University Press, 1983.
- Wood, Donald, *Trinidad in Transition. The Years after Slavery*, London: Oxford University Press, 1968.
- Worboys, Michael, "The Colonial World as Mission and Mandate: Leprosy and Empire, 1900-1940," *Osiris*, 15 (2001): 207-18.
- Thesis (Unpublished)
- Ramesar, M.D., *Indian Immigration into Trinidad 1897-1917*, Unpublished Master's Thesis: University of West Indies, Trinidad, 1973.
- Roopnarine, Lomarsh, *Indo-Caribbean Indenture: Creating Opportunities out of Adversity*, unpublished Ph.d. dissertation, State University of New York at Albany, 2002.