INTRODUCTION

Medicine and Empire in London

> So widespread is our empire, so intimately connected are we with countries of different, and for the most part warmer, climates than our own, that there is scarcely a family in these islands that has not some relative who occasionally returns to his native place from abroad.
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> —James Cantlie, "Clinical Observations on Tropical Ailments," *British Medical Journal*

In 1907 the colonial surgeon James Cantlie (1851–1926) reflected on the abundance of former imperial servants receiving medical treatment at home in Britain. Writing in a medical journal aimed at domestic practitioners, Cantlie captured an urgent need for metropolitan physicians and surgeons to be able to diagnose and treat the "tropical ailments" more typically associated with colonial spaces. From at least the eighteenth century, European administrators, officers, military men, soldiers, missionaries, doctors, wives, and servants had been moving between Britain and its growing colonial territories.[1] However, this movement was not one way. Since the earliest days of the East India Company, European colonists had been returning to their "native" soil at the end of their careers to recuperate their health and reconnect with friends and family. While the Anglo-Indians of the eighteenth and early nineteenth centuries had braved a months-long journey around the Cape of Good Hope, in the second half of the nineteenth century travel time was reduced to a matter of weeks as quicker, steam-powered ships sailed via the Suez Canal.[2] In London the construction of deep docks for the larger steamships in the 1880s ensured that the city became a transportation hub for travelers to and from the British Empire.[3] No longer were imperial servants returning only when their time abroad had come to an end; they also traveled home to see their families, enjoy a period of study leave, or recuperate from the "debilitating atmosphere" of the tropics

before going out again to their postings.[4] Minds enervated by the sun, livers disrupted by the tropical heat, blood teeming with parasites—these patients brought the Empire home and, in so doing, transformed medicine in Britain.

This book explores how these imperial bodies challenged and changed medical knowledge in late nineteenth- and early twentieth-century London. It is about the incredibly mobile people of the British Empire in the high imperial period, approximately 1880 to 1914, and their entanglements with domestic British medical practice and research. From the hospital to the consulting room, from the pages of medical journals to patent medicine advertisements, and even behind the doors of the city's homes, the bodies of imperial peoples transformed medicine and concepts of health and disease at the very heart of the Empire. The nature of these engagements, the spaces in which they occurred, and how they were physically experienced by the people involved are the central subject matter of this book. Medical knowledge moved and was made along the networks of empire: forged by the coming together of patients, doctors, and surgeons, as well as nonhuman agents like diseases, parasites, and environmental factors. These encounters took place at different scales and in diverse places of knowledge making: in medical journals, in specialist hospitals, on the dissection table, and in the bloodstream. The ways in which exchanges between London and the Empire took place are complex and nuanced: certain bodies moved freely while others were constrained and immobile; some ideas caught on while others were rejected. Where and how such exchanges took place are informative of the structures of imperial hierarchies of power. Racialized beliefs about white and non-European bodies, knowledge of temperate and tropical environments, the influence of power, prestige, and authority mediated the trans-imperial creation of medical knowledge in this period. These factors also influenced which bodies and which forms of knowledge had the "mobility capital", in Mimi Sheller's formulation, to move along the networks of empire and establish themselves within British medical practice.[5]

Imperial Bodies in London is a postcolonial history of British medicine. It engages the tools and perspectives of geographical theories and postcolonial approaches to contribute to an already rich field of historical work at the intersection of medicine and empire, while shifting the focus from colonial to metropolitan spaces. Since the 1980s historians have explored the ways in which medicine was an active tool of imperial power.[6] Drawing on the insights of postcolonial scholarship, this new wave of critical colonial medical history interrogated the role of Western medicine and medical practitioners in creating and reinforcing categorizations of race, sexuality, gender, and disease which served to perpetuate

and justify imperial power and control over colonized peoples.[7] At the same time, historians of "new" imperial history turned the mirror on Britain itself, demonstrating how the metropole was transformed by the imperial project.[8] Scholars working in literary studies and cultural history have interrogated imperial encounters, continuing a vibrant postcolonial tradition which explores the constructed and contingent nature of British culture and "new colonial selves."[9]

Despite the flourishing interest in a postcolonial approach toward Western medicine in the colonies, Warwick Anderson has observed that British medicine has remained almost untouched by the same level of critical analysis: "I do not think it is enough to decolonize 'colonial medicine' and produce fresh national narratives when we can argue that a colonial mentality 'contaminated' much of Western medicine."[10] While some scholars have taken up Anderson's challenge in the twenty years since he wrote these lines, the historiographical focus has undoubtedly remained on colonial spaces. In recent years Roberta Bivins has argued that historians of medicine still have yet to fully engage with the influence of the British Empire on medical discourse at home.[11] Bivins suggests that the intersection of medicine and empire in British medicine represents an important and under-explored field, where the "interdependency of local and global networks of knowledge," as well as "quotidian interactions between physical bodies and environments," can be more closely examined.[12] A refusal to engage with these ideas risks the history of medicine in Britain becoming provincialized—divorced from key developments in the history of empire and indeed the discipline of history more broadly.

This book builds on the work of the small number of scholars who have taken up the challenges set by Anderson and Bivins and have turned their attention to the ways in which British medicine can be understood in its imperial contexts.[13] These works are often characterized by an attention to the rich intersections of health, race, power, and spatiality—unpacking the complicated and uneven ways that imperial medical cultures met and converged. Mark Harrison has revealed the mechanisms through which medical knowledge was generated from returning "invalids and entrepreneurs" of empire in the late eighteenth and early nineteenth centuries.[14] Harrison suggests that it is more useful to think of imperial medicine as a reciprocal engagement between Britain and its Empire, rather than a directional flow of knowledge. Similarly, Bivins has explored the encounter of "alternative" medical practices from around the globe in nineteenth-century Britain.[15] Her work demonstrates how such flows of knowledge were "cross-cultural" rather than "unidirectional" and the central role played by

patients in bringing new ideas into British medical culture. Of particular note is Douglas M. Haynes's prolific work on tropical medicine, imperial medical politics, and the life and work of Sir Patrick Manson (1844–1922).[16] Haynes's careful and critical analysis of "imperial medicine" as a medical culture spanning British and colonial spaces is a key source of inspiration for this book. In recent years new scholarship has brought a critical transnational perspective to the study of medicine and empire.[17] For example, Deborah Neill's exploration of the transnational knowledge exchange which created tropical medicine as a specialty demonstrates the importance of intellectual spaces like professional societies, conferences, and journals in creating and communicating medical knowledge across imperial spaces.[18] Ryan Johnson's analyses of the material culture of imperial medicine in the late Victorian period demonstrates how anxieties around race and tropical climate were made physical in the form of new protective clothing displayed and sold in the domestic market.[19]

This book should be read alongside these volumes and adds to them in several ways. First, it brings to the high imperial period a focus on imperial medical encounters more typically applied to the late eighteenth and early nineteenth centuries. Scholars working in the early modern period have highlighted the intensity and openness of exchange between Britain and its colonies, in terms of materia medica as well as medical knowledge and practice.[20] By the middle of the nineteenth century, some historians argue, the boundaries between British and Indian medical practices had solidified.[21] By focusing on the later period, I emphasize that the encounter between imperial and domestic medical knowledge did not cease with legislation like the 1858 Medical Act and the late nineteenth-century shift toward specialization. While British medical practitioners undoubtedly became less willing to adopt indigenous medical practices in this period, I will argue that imperial knowledge exchanges simply took new forms—facilitated and stymied by different forces. Of course, a thriving scholarship on tropical medicine has shown how this discipline was made in and between metropolitan and colonial spaces.[22] Yet works which confined their focus purely to this specialty have missed the opportunity to view the effects of imperial encounters in other medical and surgical domains. *Imperial Bodies in London* demonstrates the utility of considering developments across the different fields of digestive health, psychiatry, and ophthalmic surgery, as well as addressing tropical medicine in London. Such purposeful eclecticism serves to highlight similarities and differences across the medical specialties as they emerged in the period which was simultaneously the height of empire and the professionalization of British medicine.

Not only does this book focus on Britain itself; it interrogates in particular the imperial city of London. In so doing it lends a specificity to the understanding of knowledge construction at a smaller scale than more sweeping national, transnational, or trans-imperial studies.[23] Informed by the work of scholars of the imperial encounter in Britain, the focus on the imperial metropolis of London serves to reveal how this imagined and real "heart of empire" was enmeshed in the networks of empire—its busy and diverse populace making and remaking Britishness through continual conversation and negotiation.[24] As Antoinette Burton has observed, "Colonialism . . . was made, contested and remade in the . . . local spaces of the everyday."[25] These everyday spaces of medicine in London at different scales are at the center of this analysis. The metropolitan focus also differentiates this book from recent contributions that have focused on empire, medicine, and networks of knowledge in colonial spaces.[26] In its commitment to everydayness, I also purposefully do not center contagious and epidemic diseases. While of course many of the greatest disease threats of this period were understood to be "imperial" in origin—like "Asiatic" cholera or yellow fever—their appearance in London was either exceptional or the subject of intense regulation at the border. By focusing on climatic and parasitic diseases, this book joins a growing literature that moves beyond an unbalanced focus on the contagious diseases which have arguably dominated studies of medicine and empire to this point.[27] Instead, I am more interested in the quotidian health challenges experienced by mobile imperial peoples—the tummy upsets, frazzled minds, weary eyes, and hidden parasitic cargo which passed easily through quarantines and port surveillance.

As this introduction will explore in greater detail, these "imperial bodies" were most often (but not exclusively) returning empire builders, settling in London after a period (or even a lifetime) abroad in tropical climates. While Cantlie felt that there were few turn-of-the-century Britons who were not intimately connected with a "tropical returner," the experiences of ex-colonials, and in particular their health concerns, have been almost entirely overlooked by historians.[28] As Waltraud Ernst has observed, "The human cost of colonial service in socio-economic terms for the families of recruits; the impact on local social networks, Poor Law, relief and hospital services in Britain of colonial servants on their return; and, not least, the socio-demographic effects of a steady flow of diseased and invalided army, navy and civilian personnel back to Britain have yet to be investigated."[29] My intention in focusing largely on white European ex-colonials is not to reinforce a triumphalist narrative of the sacrifice it took

to build some imagined benevolent empire. Rather, this book aims to reveal the ways in which white imperial bodies were constructed through their health concerns and trans-imperial mobilities and in so doing to critically interrogate and challenge, in Elleke Boehmer's words, the "binaries of colonial self and colonized other."[30]

Networks, Spaces, and Mobility

The British Empire was built on mobility. The ability of European peoples to travel to and colonize far-flung tropical lands in order to reap economic benefit was quite literally the foundation of the imperial project. The idea that movement, migration, and exchange were central to imperialism has not been overlooked by "new imperial history"—a historical turn which has been intentionally spatial.[31] The circulation of books, things, and people; migration between colonial spaces; and the development of transportation infrastructures and technologies have all been the subject of excellent studies.[32] However, while scholars have *implicitly* drawn on space in their histories of empire, the geographer Alan Lester has argued that few have *explicitly* engaged with geographical theory to inform their analyses.[33] It has been only in the last decade that historians of empire have begun to work critically with geographical theories like networks, mobility, and multi-scalar analyses to enliven the sense of an empire on the move.[34] As Antoinette Burton and Tony Ballantyne have suggested, a "kinetic" model of imperial space that is attuned to the meetings and collisions of "mobile subjects" may hold the key to capturing the contingent, mobile, and constantly shifting nature of the Empire and its peoples.[35] This book aims to demonstrate the usefulness of spatial theory and ways of thinking to explore the creation of medical knowledge through mobility and networks. It will demonstrate the centrality of considering not only mobility but also immobility, as who could or could not move of their own volition was deeply embedded in the power structures of empire.[36]

Capturing a lively sense of movement in an uneven, contingent, and ever-changing imperial network presents significant methodological challenges for the historian. To hone in on such a network is to inherently freeze it in time and space for the purpose of analysis. As David Lambert and Peter Merriman have observed, unlike the work of contemporary mobility scholars, it is not possible for historians to literally "follow" their subjects while they are on the move.[37] In the 1980s the historian David Fieldhouse suggested that it would require nothing less than a two-headed "Janus-like" researcher to be able to consider both

metropole and colony in the same sphere.[38] Yet to continue to view colonial and metropolitan spaces as separate is to continue to reinforce a divide purposefully created by colonizers to decenter colonial people and places—treating the Empire "as if it occurred on another planet."[39] Despite the enormity of the challenge, over the following decades numerous historians and geographers have gone on to suggest theoretical and methodological tools which can assist scholars to do precisely that. While the language varies, almost all deploy spatial imaginaries which permit for the location and isolation of particular moments or spaces of "encounter" or "contact" as a way to speak to the connections between colonial and metropolitan spaces.[40] For example, Mary Louise Pratt conceived of the contact zone as a "space of imperial encounters, the space in which peoples geographically and historically separate come into contact with each other."[41] Pratt's contact zone is a spatial metaphor—the "transculturation" she describes typically occurring in paintings or novels. Yet contact or encounter metaphors do not go quite far enough in considering how imperial peoples and ideas not only met but engaged with one another, nor the mechanisms which facilitated this. John Darwin argued that the interactions between Britain and its colonies can be understood as multiple "bridgeheads."[42] Alternatively, Tony Ballantyne has suggested we can view the imperial project in terms of a "web"—a metaphor which suggests its fragile and dynamic nature.[43] Arguably the most influential spatial approach to help bridge the gap across imperial spaces has been Alan Lester's concept of networks, nodes, and circuits.[44]

With his concept of a network, Lester moves away from a perspective of empire that upholds the metropolitan versus colonial dichotomy in which knowledge, goods, and people flow from the core to peripheral imperial spaces.[45] Instead, the network concept imagines empire in terms of reciprocal trajectories of influence, of "multiple meanings, projects, material practices, performances and experiences of colonial relations" without "privileging metropolitan or colonial spaces."[46] The vast spaces of empire are best understood as a sphere of multiple trajectories, some stronger and some less prominent, coming together in different "nodes" and contributing to a unique sense of place.[47] The networks and nodes can be literal—for example, the telegraph network, the railways, or the docks—but also imaginative, for example, networks of professional contacts or dispersed family groups. But as Ballatyne and Burton note, "the kinetics involved in imperial space making" are for the most part metaphorical—most subjects of analysis did not "literally feel the ground moving beneath their feet."[48] Networks can bring together not only people, but also ideas and even nonhuman actors like

parasites, diseases, and microscope slides. In an imperial network analysis, the metropolis is often the spatial focus; however it "recasts the relationship between metropolitan centre and colonial periphery into a more contested, unstable and mutually constitutive framework."[49]

A network approach has its weaknesses; as Mark Harrison has argued, the term *network* seems to imply a structural rigidity which cannot capture the very different and uneven ways that colonial actors engaged with one another within the hierarchy of imperial power.[50] However, the benefit of a network, rather than the metaphor of circulation, is that it allows for an analysis of specific nodes—typically spaces—in which the actors moving along and through a network can be temporarily suspended in their journey for the purpose of analysis. It is an approach that has been used by many historians and geographers of empire who focus on particular sites across scales as a way of using the local and specific to speak to the broader machinations of empire.[51] For example, Samuel Hyson and Alan Lester have explored the "micro-spaces" of British military hospitals in the First World War, conceived of as "networked imperial sites," allowing this analysis to speak to not only the experience of individual patients and doctors but the "politics of maintaining the Raj itself."[52]

In this book I use a nodal "snapshot" approach which analyzes particular spaces as a way of speaking to these mobile imperial networks. Through a close look at specific spaces and moments of interconnection where trajectories meet, it is possible to speak to much larger networks. As Valeska Huber argues in her analysis of the Suez Canal, "At a time of global connections, localities matter."[53] In imperial medicine these sites of encounter might be a hospital, the pages of a medical journal, or the body itself. What unites these diverse and uneven spaces is that all have been profoundly shaped by mobilities, the bodies, diseases, ideas, techniques, and equipment which populate them have arrived in these spaces, in these moments, by circulating along the networks of empire. The heterogeneity of the sites and snapshots which form the focus of the chapters that follow is reflective of the vastly different terrains in which imperial peoples and ideas encountered each other and, indeed, of the many different forms of mobility and immobility at play within imperial networks. They highlight what Huber calls the "multiple mobilities" of empire across scales.[54] Combining the broader scale of the city of London with the "micro-sites" within it allows us to encounter a variety of different actors who have been "on the move" and the spaces which shape and have been shaped by the wider imperial project.

The term *mobility* in the title of this book serves to highlight that my

approach combines a network-based analysis with the insights of mobility studies.[55] Emerging in the early 2000s, an interdisciplinary turn toward mobility developed out of a cross-pollination of sociology and geography to better understand a contemporary world which seemed constantly on the move.[56] Scholars were interested in the structures, practices, and experiences which facilitate or disrupt movement—particularly political, economic, and social structures.[57] Unsurprisingly, embodiment and the experience of the body in motion have been a central subject of concern.[58] Which bodies can move, who has "mobility capital" is revealing of broader power relations.[59] While mobility scholars have tended to focus on the contemporary hypermobile world and its transportation technologies,[60] in recent years a mobility framework has been fruitfully applied to the study of empire by historians and geographers.[61] In *Empire and Mobility in the Long Nineteenth Century*, Lambert and Merriman have gathered together a wide range of interdisciplinary authors to interrogate subjects like migration, trekking, vagrancy, and sailing.[62] In the realm of medical history, Markku Hokkanen's book on medical practice in Nyasaland (Malawi) uses networks and mobility to understand how interconnected networks informed medical knowledge in the area in the nineteenth and twentieth centuries.[63] However, this approach has yet to be applied to imperial medicine in Britain.

While it is informative to follow people, ideas, and things literally in motion, here I treat mobility as inherent and embedded in the sites of encounter examined. The mobility theorist John Urry suggested that mobility is more aptly described as a "post-disciplinary" lens, rather than a codified theory, which seeks to bring mobility back into the picture where many branches of academia have been "a-mobile" and "a-spatial."[64] In this sense, the term *mobility* signifies a way of thinking—an attunement to movement and circulation (and indeed to immobility) and their effects on particular places, bodies, and ideas. The intention of this book is to use spatiality and mobility as twin lenses which can reveal the unequal, uneven, and often unexpected ways that the movement of bodies challenged and created knowledge. Closely intertwined, movement and space are mutually constituted, imperial spaces becoming what Ballantyne and Burton call "the ground of consistently territorialized mobility."[65] Networks and the "nodes" within them serve as "socio-spatial configurations of mobility systems," which either support or limit mobility.[66] Yet these spaces are far from neutral backdrops: the specific spatial contexts in which the trajectories of empire meet inform the nature of the engagement, effect the experiences of the bodies involved, and influence the knowledge produced.

Body, Disease, and Power

This book follows a long line of historians who have foregrounded the imperial body as a site of power, control, and experience. David Arnold's watershed work *Colonizing the Body* considered the assimilation of Western medical practices in the British Raj through the lens of the Indian body—how obtaining corpses for dissection or experimenting with treatment regimens on captive prison populations formed the basis of the Anglo-Indian medical enterprise. His application of a Foucauldian approach to the body as "a site of colonizing power" has been influential for scholars seeking to understand the materiality and experience of empire.[67] Numerous historians have worked on issues including sexuality and marriage; daily rituals of dress, diet and hygiene; the control of bodies through quarantine, asylums, and vaccination programs; the role of intermediaries and subordinates; and even the management of dead bodies as a method for interrogating the embodied imperial experience.[68] This rich scholarship has demonstrated how empire was inherently physical, based on the manipulation, control, and exploitation of colonized bodies and disease, discomfort, and anxiety on the part of empire builders. In the words of Elizabeth Collingham, "The body was central to the colonial experience . . . as the site where social structures are experienced, transmuted and projected back on to society."[69] This book will enhance and extend this argument by exploring imperial bodily experience not from the perspective of colonial spaces but within the metropole itself. It will demonstrate how the body remained at the center of concepts of disease, environment, and embodiment as it traversed tropical and temperate environments.

The movement of such bodies between metropolitan and colonial spaces was one of the ways in which the Empire was "domesticated" in Britain through the creation of an imperial medical culture. A proliferation of literature from within new imperial history has looked at imperial influences at home from popular culture to advertising, food, music, museums, and even clothing.[70] Often referred to as an approach which "domesticates empire," authors within this branch of new imperial history argue that the idea of *Britain* was derived from its colonial project, dependent on the existence of an Empire against which British culture defined its values of domesticity, order, discipline, cleanliness, comfort, and safety.[71] For Catherine Hall and Sonya Rose, the metaphors of home and the imperial family also helped the Empire to feel "ordinary" and "a part of everyday life."[72] Through mass-produced goods, advertising, and photography, Victorians

bought and brought the Empire into their homes, literally and figuratively consuming it. However, the ways in which medicine and medical knowledge were "domesticated" in Britain have been almost completely overlooked—with the notable exception of the circulation of materia medica and their influence on the British medical marketplace.[73] Yet studies which focus on material goods ignore the fact that "things" are far from the only items to circulate in and through imperial spaces. As Ballantine and Burton have argued, the body was the "flesh and bone of empire," the "connective sinews" of colonial power, yet its mobility has been largely overlooked.[74] The imperial body was a vehicle for medical knowledge and practice, bringing the Empire home to London and ultimately making imperial medicine an everyday in the metropolis.

To be a body in motion between metropolitan and colonial spaces was to traverse not only distance but also changes in climate. The question of whether Europeans could survive and thrive in their tropical colonies was arguably one of the largest issues facing colonial administrators and imperial servants. This conundrum has been the subject of an equally large amount of attention in the historiography of empire and health in the nineteenth century.[75] The term *acclimatization* originally referred to the ability of plants and animals to adapt to new environments, but by the late eighteenth century it was increasingly applied to the ability of Europeans to stay alive in climates different from their native land.[76] However, understandings of acclimatization were far from static and responded to major epistemological shifts in the nineteenth century, including the advent of germ theory.[77] Numerous authors have explored nineteenth-century concerns around disease and the supposedly pathological nature of the tropics in order to explore the creation of scientific knowledge and public health practices.[78] Drawing on post-structuralist theory, these scholars have considered the ways in which the body, and indeed the environment itself, was constructed through discourses of temperate and tropical, salubrious and infective, black and white, feminine and masculine.

The movement of the analytic lens from the colonies to the imperial metropolis destabilizes many preconceptions about the role of climate and illness, and therefore provides a unique opportunity to reexamine these concepts. The dichotomy between the diseased tropics and the salubrious temperate climate of England was profoundly disrupted by increased mobility of bodies between imperial spaces. London in this context becomes a liminal space—both a danger and healer, a health resort for "tropical invalids," despite a prevalent domestic discourse about its insalubriousness.[79] Following imperial bodies in London

provides a rich seam of inquiry for exploring the perceived influence of the tropical climate on the body, even many years after the return home. Similarly, by asking questions about climate and its influence on health in London rather than the colonies, the issue of race and racial immunity, for both European and non-European bodies, comes to the fore.

Setting

In the late nineteenth century London was Britain's national and imperial capital—an administrative, financial, commercial, and transportation hub, as well as a center of medical expertise. It was a teeming and rapidly expanding metropolis, outstripping its rival capitals of Paris, Vienna, and Berlin with a population that was multiplying at a rate of over one million per decade.[80] By 1900 London was home to more than five million people—extending to nine million if including its fast-developing greater metropolitan area. It was also a city divided both literally and metaphorically along socioeconomic lines: the wealthy classes clustered in the city's West End and well-to-do suburbs, and the working classes pushed into unsanitary and crowded housing in the notorious East End. The conflation of disease, empire, and race contributed to an imaginary geography of the city where the east and its "fever dens" were dark, dangerous, and backward, while the west, the seat of power, represented cleanliness and civilization.[81] Throughout the city, empire was woven into its very being—from august institutions like the Foreign, Colonial, and India Offices, which administered its territories from Whitehall, to its specialist societies which studied the Empire and its peoples; to the museums which displayed the wealth of colonial lands; to the docklands where the wealth of empire was unloaded for consumption.

The historian Jonathan Schneer has described the London docklands in the late nineteenth century as a "nexus of empire": a site where goods from all over the world were imported to the city to be sold and traded.[82] Tea, precious metals, medicines, and spices were the currency with which the "gentlemanly capitalists" of the City, London's business district, built the financial wealth of the Empire.[83] Homes were filled with imperial commodities from textiles to tea and curry powder, imperial themes were used to sell health products, and the rights of colonial peoples were debated in town halls.[84] As Hall and Rose have argued, the Empire was "taken-for-granted as a natural aspect of Britain's place in the world and its history."[85] Yet the steamships carried far more than just goods; they also carried people. The "relocation costs" of empire were incredibly high: the physical toll

that the imperial project took on its soldiers and servants affected health in colonial spaces as well as at home.[86] People sick with dysentery, typhoid, malaria, and other illnesses made their way back to London; officers on furlough and their wives and children came home after a period of service abroad. Indian students traveling to take up their studies in medicine and law, tourists from around the globe, and medical officers on study leave took advantage of new, shorter, and more affordable trips, bringing an ever-increasing diversity of imperial bodies to the capital.[87] Costs of such trans-imperial journeys were kept low by the poorly paid lascar (South Asian) and African sailors who crewed the steamships and lived, temporarily, in the areas surrounding the deep docks, including Shadwell, Limehouse, and Poplar.[88]

By the mid-nineteenth century Britain's Empire in India had become consolidated. The opening of the Suez Canal in 1869 and advances in transportation technology meant that new steam-powered ships were able to more effectively shuttle imperial servants between metropolis and colony.[89] Where their predecessors would have died abroad or on the journey home, empire builders now had the opportunity to return to recuperate their health.[90] Physicians at home and in the Empire concurred that a return to the "bracing air" of England was the best remedy for tropical invalids.[91] Larger deep docks in the eastern Thames served to accommodate the heavier steamships, solidifying these new rapid connections between tropical spaces and the imperial metropolis, which served as a transportation, commercial, political, and cultural hub for the Empire. While the port city of Southampton in the south of England may have been the port of call for military ships and the mighty mercantile city of Liverpool in the north a hub for commerce, London was the center of civilian transportation, hosting the embarkation point for Peninsular and Orient (P&O) steamships.

Accompanying this revolution in transportation technology was a surge in population flows across the Empire. Between 1815 and 1914 over twenty-two million Brits emigrated abroad.[92] While many relocated to settler colonies in America, Australia, and New Zealand, such migration patterns should not be seen as one way. Empire builders "careered" across imperial spaces, pursuing new opportunities, changing postings, creating new families and social connections—to say nothing of the growing tourism industry or movement of imperial students from the Empire to the metropolis.[93] As a result of this increased mobility between imperial lands and London, by 1901 over thirty-three thousand of the city's residents reported their birthplace within the British Empire.[94] The vast majority of these were white Europeans who had been born abroad but returned

home to the capital. Capturing the essence of this circulation between Britain's Empire and London, Rudyard Kipling (1865–1936) imagined the P&O route between the imperial metropolis and India as the "Exiles' Line" (1890):

> Bound in the wheel of Empire, one by one
> the chain-gangs of the East from sire to son,
> The Exile's line takes out the exile's line
> And ships them homeward when their work is done
> How runs the old indictment? "Dear and slow,"
> So much and twice so much. We gird, but go.
> For all the soul of our sad East is there,
> Beneath the house-flag of the P. and O.[95]

This book begins in roughly 1880 because it represents a period of increased mobility between London and the British Empire. In 1880 the Royal Albert Dock opened, bringing with it a large number of empire builders who used the new deeper docks as a point of return and departure between Britain and its eastern colonies. By this period new statistics gathered by the British Army in India began to show decreased mortality among its soldiers stationed there, yet at the same time optimism about the ability of Europeans to acclimatize to tropical life sharply declined.[96] In the years around 1880 several important discoveries were made about the nature of tropical disease: in 1879 the Scottish physician Sir Patrick Manson discovered that mosquitoes were the vector for filarial disease in humans, and in 1880 the French army surgeon Charles Laveran (1845–1922) identified the malaria parasite.[97] A focus on specific causes of disease opened up the possibility of more direct interventions to improve European health in the colonies. Yet at the start of this period the "medicine of warm climates" was in many ways the same as it had been mid-century—still strongly environmentalist in its views of disease. Since 1873 Sir Joseph Fayrer (1824–1907) had served as the president of the India Office Medical Board and continued to espouse traditional climate-based causes of illness in India.[98] From the 1890s there was a shift toward the new "tropical medicine," which, influenced by germ theory, was interested in identifying more specific vector-based causes of disease.[99] Inspired particularly by Manson, a new generation of practitioners hunted the insect and animal hosts for the biggest disease threats to white colonists in the tropics.

London was also unique in the context of British medical teaching, research, and practice in this era. For many aspiring doctors and surgeons, a period of

training in a London hospital was the best option to obtain the qualifications and connections they needed to succeed in their careers. While medical registration changed significantly over the course of the nineteenth century, the licensing examinations offered at metropolitan institutions like the College of Surgeons, College of Physicians, and the Society of Apothecaries attracted students from across the country, and indeed the Empire.[100] Practical experience in London's voluntary hospitals was also essential to completing their training.[101] Physicians and surgeons operated semiautonomously from the hospitals, "walking the wards" with their fee-paying apprentices and holding the much-coveted positions of "honoraries" or "consultants." In addition to hospital practice, medical practitioners had their own private practices for fee-paying clients, typically located in their homes, with the city's top practitioners clustered around prestigious Harley Street. Charitable dispensaries, Poor Law asylums and workhouses, working men's clubs, and even insurance agencies all contributed to the busy marketplace for medical expertise.

For those who could afford it (or who could obtain the right permissions), Londoners had access to the best and brightest physicians and surgeons in the country.[102] For most of the English population, however, London may as well have been India. Yet the hospital is far from the only site of medical knowledge making we are interested in here. London's asylums and specialist societies, medical museums, and private consulting rooms are also important spatial terrains for considering the engagement of domestic medicine with colonial peoples and ideas. More conceptually, the spaces of imperial medicine in London expanded to the docks, the streets, the city's homes, and the pages of medical publications and popular newspapers.

It is typical to finish studies of the Victorian and Edwardian eras, and indeed of the "high" or "new imperial" period, in the year 1914.[103] As Thomas Richards has observed, there is a tendency to view "the First World War like a band of scorched earth dividing Victorian from modern Britain."[104] Like Richards, I have not found it possible to draw such an easy line. Many of the conversations and movements that began pre-1914 were only temporarily suspended during the war years. The students and professors of the London School of Tropical Medicine were called up to the front, causing the numbers working in the Albert Dock Hospital to dwindle until teaching was suspended. Tropical medicine researchers continued their disease research but were guided by the needs of the military. Similarly, the heated discussions within ophthalmology on improvements in cataract surgery declined sharply during the war years. Yet when Robert Henry

Elliot (1864–1936) returned to London from his tour of duty, he combined his prewar experiences of ophthalmic surgery in India to establish the specialty of tropical ophthalmology in 1917.[105] The mass movement of European troops to tropical lands during the conflict, as well as their subsequent demobilization, only served to make debates around tropical disease more pressing than ever.[106] Therefore the high imperial period is here understood to include the years immediately following the war—although the conflict is not itself a subject of interest in *Imperial Bodies in London*.

Terminology

With the aim of interrogating concepts as broad and contentious as empire, tropical disease, and imperial bodies, it is necessary to begin with some framing of how this book approaches these terms. When speaking of empire, I refer specifically to the British Empire and its formal colonies on the Indian subcontinent, Africa, Australia, New Zealand, Canada, and the West Indies (fig I.1). This is not to overlook the importance of Britain's informal empire in South America and China or scholarly discussions which have questioned what the term *empire* means. British colonialism was far from a coherent political project. As Ballantyne and Burton have suggested, "Empires, like webs, were fragile and prone to crises where important threads were broken or structural nodes destroyed, yet also dynamic, being constantly remade and reconfigured through concerted thought and effort."[107]

Scholars of the new imperial history, influenced by the work of postcolonial and feminist historians, have sought to criticize a purely politico-economic view of empire, arguing that the Empire was more than simply territorial. Empires were also affective, held together by "tense and tender ties" and characterized by embodied experience, including intimacy, alienation, and pain.[108] It is necessary to think of the British Empire not as one defined political and administrative entity but as multiple competing imperial projects. Colonial regimes were made up of players at different levels with competing "agendas and strategies for rule," to say nothing of the agency and resistance of colonized communities.[109] The effects of these regimes were far-reaching and are still with us today. By acknowledging the multiplicity of imperialisms, it is possible to view its contingency, its contestations, and its "tensions."[110] Like these scholars, I view the Empire as enmeshed and connected but also contingent and unequal. For the sake of clarity, I will use the term *British Empire* to refer to the British imperial territories and *empire* to refer to the concept.

The majority of this book focuses on Britain's Indian Empire, with its African colonial interests, particularly in the Congo region, addressed in Chapter 4. These colonial spaces represent the ideal terrain in which to carry out a study on mobility because their colonization was predicated on the idea of movement. Unlike the settlement colonies of Canada, Australia, and New Zealand, the transient colonists working or living in India and Africa expected to come home. Following the Indian Mutiny of 1857, a series of four *Reports on the Colonization and Settlement of India* were commissioned by the British Parliament. These reports found that white colonists would not be able to live permanently in the Indian climate, and mechanisms were put in place to ensure colonizers would periodically return to their native climate.[111] This deep-seated notion that settlement was not possible in tropical climates informed approaches to the later colonization of Africa.[112] Therefore health concerns around the suitability of white bodies in tropical climates and anxieties over medicine's ability to combat or alleviate this state of affairs were deeply imbued in the administration of and medical care within these colonial spaces. Furthermore, the formal nature of British political, economic, and cultural interventions in these spaces facilitated the movement of medical professionals to official government postings. This resulted in the creation of well-documented circuits of knowledge, such as specialized medical journals, and dedicated spaces, such as hospitals and asylums, which serve as rich sources for analysis.

The title of this book refers to the "imperial body," which begs the question: Who exactly is considered imperial? Elizabeth Collingham's classic work, *Imperial Bodies*, explores the British body in India, demonstrating "the impact of colonialism on the bodies of the [empire's] protagonists."[113] It is a goal which this book shares, although I examine the imperial British body in its domestic contexts. However, the term *imperial* has also a much broader meaning, referring generally to people, places, ideas, and things relating to an empire. For example, Douglas Haynes argues that using the term *imperial medicine* to refer to medical practice across Britain and its colonies can bridge the "metropolitan" and "colonial divide."[114] It is in this more expansive sense that the term is employed here. *Imperial bodies* can usefully refer not only to the British in India but also the many other diverse bodies connected with the Empire who dwelled in, visited, or transited the metropolis in the high imperial era. In this book I will be focusing on three categories of imperial bodies: transient white "tropical returners" living and working between Britain and imperial spaces, "country-born" Europeans born and raised in the Empire, and non-European visitors and migrants to the imperial capital.

Individuals who had passed any substantial time in the tropics were viewed as inherently changed by their exposure to *lux orientale* (the light of the East). As Ernst has observed, Europeans returning from India were viewed as a class apart, distinguished by their strange accent, interests, and ways of eating, dressing, and behaving.[115] Referred to by contemporaries as tropical returners or "tropical valetudinarians," homeward-bound Europeans were faced with unique challenges—socially, economically, and, as we will explore, medically.[116] Tropical life not only affected these cultural attributes but was perceived to transform the body itself; Europeans were believed to have undergone a "subtle constitutional transformation" which remained embodied within them even after return.[117] People who were born in India or Africa to European parents may not have been *returners* in the literal sense of the word but were still perceived as imperial to those they encountered in London. To delineate returners as only those who had temporarily been in the Empire is to ignore the experience of domiciled Anglo-Indians and other Europeans born abroad but who felt Britain was a place to come home to.[118] However, the boundaries between these country-born people and Eurasian, or mixed-heritage, individuals was complex and fluid, dependent on factors not limited to skin color but also linguistic ability, education, and the ability to travel between colonial and metropolitan spaces.[119]

Crucially, non-European imperial travelers, visitors, or migrants are also considered a part of the category of imperial bodies. More accurately described as "arrivals" or "arrivants," according to Boehmer, these people nonetheless formed an important part of the imperial bodily corpus which figured and refigured British medicine.[120] At the turn of the twentieth century there were an estimated ten thousand Indian citizens living in Britain, as well as approximately one hundred thousand people of African origin and a very small community of about four hundred people from China.[121] Compared to Britain's population generally, and even to London's specifically, the number of colonial peoples residing domestically was relatively small. However, these imperial communities exerted an influence far greater than their real numbers, and contemporary Londoners were acutely aware of their presence. As Antoinette Burton has observed of Indians in Victorian and Edwardian London, "They were everywhere—on street corners, in West End theaters and lodging houses, in traveling road shows and exhibitions, in slums and working-class neighborhoods, in university lecture courses and medical school laboratories."[122] Most famously, colonial denizens were to be found in London's East End docklands, where sailors from around the world made possible Britain's busy commercial and transportation links with its

Empire. The presence of racially diverse sailors was a frequent refrain of social explorer literature of the period, which cast the docklands as a microcosm of empire.[123]

Colonial visitors to London tended to be divided along stark lines of elite and underprivileged, with working people like lascars and ayahs living very different lives from the educated upper classes who made the trip from India for pleasure or intellectual pursuits.[124] While by the late nineteenth century it was possible for Indians to qualify as lawyers, physicians, and civil servants, licensing exams were held only in London, necessitating aspiring students to travel to the city to study and obtain their qualifications. Gravitating toward the West End of the city, imperial travelers and migrants came for work, for study, to visit family, or simply as tourists who felt a strong connection to the imperial "homeland."[125] It is important to remember that in the case of migrants or immigrants from India, they too were imperial citizens, making London their capital as much as anyone else's. Indian subjects of the Crown could (at least theoretically) travel freely across the British Empire—and in the high imperial period, many did. As scholars of the British–Indian encounter have demonstrated, students, doctors, lawyers, and social reformers contributed to a cultural and political cosmopolitanism which centered around London as the "heart of the empire."[126] Of course, these people too could become returners if their travels brought them from India to England several times—as was undoubtedly often the case for lascar sailors. For the purposes of this book, it is essential that these peoples be included in the categorization of the imperial body. Despite their very different experiences from British and country-born Europeans, these individuals too were "othered" by their contact with imperial spaces, and their quotidian health anxieties helped to inform and transform British medicine.

Anglo-Indian is one of the most important and most challenging contemporary terms used to describe imperial bodies. This phrase was widely used in the late eighteenth and nineteenth centuries to refer to the British in India, as well as to returned colonists at home in Britain. With the 1911 Government of India Act, the meaning of the term was officially changed from Europeans residing in India to individuals of mixed European and Indian parentage.[127] Reading publications by imperial physicians and surgeons, it is not unusual to hear British-born members of elite services like the Indian Medical Service refer to themselves as "Indian," "old Indian," or "Anglo-Indian" practitioners. Patients too, whether in India or in Britain, were given these appellations if they had lived for a period in the Raj. Yet by the outbreak of the First World War, *Anglo-Indian* as a term

overlapped increasingly with *Eurasian* and *half-caste*, derogatory terms referring to people of mixed descent. The difficulty of establishing accurate terminology highlights the fluidity of race and the role of disciplinary practices in creating these social categories.[128] Acknowledging the complexity of the racial categories these terms imply, many researchers continue to use *Anglo-Indian* in its nineteenth-century sense, as a reflection of the sources they draw on, and this book does the same.

Any study that deals with the subject of race as a category must do so critically. Many recent postcolonial historians and geographers have noted the complex interplay between metropolitan and colonial spaces that produced and reified concepts of race, class, and gender.[129] As Mark Harrison has argued, the idea of race as a fixed concept originated in the late eighteenth century, with earlier writers not regarding "physical or mental characteristics as fixed or innate."[130] Throughout the eighteenth and even into the nineteenth century, race was a relatively fluid concept, although racist ideas of European superiority informed early colonialism and systems of slavery. By the middle of the nineteenth century, more essentialist views of writers, like the controversial anatomist Robert Knox (1791–1862), which lent medical and scientific credence to racial hierarchies, had become dominant. Douglas Lorimer has argued that scientific racism can be seen as an invention of the nineteenth century, both a combination of domestic ideologies relating to evolution and slavery, but also in terms of environmental anxieties in the colonies.[131] The mechanisms of the creation of race and bodily difference have generated a fascinating breadth of scholarly production.[132]

Today scholars across a number of fields, but in particular critical race studies, acknowledge and explore the socially constructed nature of race.[133] Lorimer has observed that "race is at root a question of power," and it is therefore unsurprising that race has played an important role in postcolonial reassessments of empire and medicine.[134] Historians like Elizabeth Buettner have called for an attentiveness to the highly "subjective criteria" which defined whiteness in multiracial imperial societies, and the "elaborate mechanisms designed to maintain and police" boundaries between groups.[135] By shifting focus from colonial to domestic spaces, this book will consider the construction of "whiteness" through the lens of mobile imperial bodies arriving in London, adding to the literature that has sought to identify the ways empire defined and molded European bodies and identities. Race, and its relationship to imperial medicine, as this book tracks, represents a point of tension, disagreement, and temporal as well as spatial specificity.

The term *tropical disease* also requires further reflection. What makes a disease tropical? As Michael Worboys has observed, the illnesses traditionally associated with tropical climates are really the diseases of poverty and malnutrition.[136] While the phrase *tropical medicine* is traditionally associated with the research of Patrick Manson and other practitioners who investigated vector-borne diseases like malaria, there is a very long history of a distinct medical practice in European colonial spaces. This "medicine of warm climates" emerged as early as the eighteenth century, with practitioners focusing on the supposed pathogenic influence of the tropical environment as the core cause of the diseases which seemed to plague Europeans.[137] Heat, humidity, and the sun were all seen as environmental factors to which the white body was not accustomed and which were likely to result in inflammation, fevers, and other diseases, notably cholera, dysentery, and typhoid. It is notable that throughout the eighteenth and for most of the nineteenth century, this paradigm of disease causation was also racialized—indigenous peoples were believed to not suffer from the same diseases that seemed to afflict white bodies. This notion of "racial immunity" informed militaristic imperial practices that saw the recruitment of indigenous peoples to fight campaigns in conditions believed to be too dangerous for Europeans.[138]

It is worth noting that the climatic conception of disease was not limited to imperial spaces. In Britain the environment had long been associated with the causation and spread of diseases.[139] Rooted in the traditions of Hippocratic medicine, water, wind, temperature, rotting waste, and in particular foul-smelling "miasmas" were widely believed to be the root cause of disease well into the nineteenth century.[140] While the British did not have the tropical sun to worry about, the cold, damp, and raw climate was believed to predispose residents of Albion to respiratory diseases, including the "white plague": tuberculosis.[141] Dysentery, typhoid, and other diseases that challenged Europeans in the tropics were of course also commonplace at home—although they were believed to take a more deadly form in the climate of the tropics. As the Scottish physician Charles Morehead famously observed in 1882, "Disease in India is not disease in England."[142] While environmental beliefs proved to be especially tenacious in colonial spaces, physicians both in Britain and its Empire were keenly concerned with the intersection of climate, disease, and the (European) body, even as the germ theory of disease began to take root in the late nineteenth century.[143]

In this sense a mid-nineteenth-century tropical disease might be, as the following chapters will explore, "tropical liver" or "sunstroke insanity," conditions

perceived as having arisen from exposure to heat. In the late nineteenth century new advances in microscopy and bacteriology led physicians like Robert Koch, Patrick Manson, and others to search for the causes of tropical scourges in new places. After discovering the mosquito as a vector for filariasis (a disease caused by parasitic round worms), Manson developed a paradigm of tropical medicine in which the parasitic diseases of the tropics were hosted and transmitted by insect vectors.[144] However, as Manson himself wrote in the introduction to his ground-breaking 1898 textbook, the term *tropical disease* is essentially one of convenience.[145] Here too, *tropical* becomes a useful if broad nomenclature to delineate illnesses associated with tropical environments—from those earlier pathologies believed to be derived from exposure to hot climates, to later formulations which blamed the presence of germs and parasites. As Helen Tilley has argued, the new language of vector-based diseases represented another permutation of older environmental ideas which centered climate and racially-different bodies as the sources of disease.[146] These tropical conditions were often latent and asymptomatic, with the physical effects of contact with colonial lands lying dormant in the blood and liver and reoccurring over intervals of months or even years. Whether caused by exposure to hot climates or the action of an insect or animal vector, these tropical diseases were seen to irrevocably alter the body, even once removed from tropical spaces. It is important that tropical disease be viewed in this broader sense of bodily engagement with the tropical environment so that we may speak of medicine beyond simply the specialty of tropical medicine. Instead, this book considers British medicine more widely in its imperial contexts, arguing that many specialties of medicine (as the case studies that follow will demonstrate) are better understood in a trans-imperial light.

Sources

To reimagine medicine in London as imperial medicine, it is necessary to carefully consider what sources might make up its archive. While all archives are inherently mediated constructions, the very nature of the doctor–patient relationship in the nineteenth and early twentieth centuries obscures the voices of individuals in the medical records on which this book is based. The history of medicine has been largely physician-centric as a result of the nature of medical archives, written by and for the eyes of the medical profession—a state of affairs the historian Roy Porter argued leads to "major historical distortion."[147] The patient records kept by hospitals and other medical institutions, such as admissions registers,

case notes, and death registers, are subject to the vicissitudes of organizational priorities. However, it is also important to acknowledge that the information which has been retained is equally indicative of medical epistemology as institutional context. Clinical paradigms shifted over the eighteenth, nineteenth, and twentieth centuries as changes in societal attitudes and developments in medical technology altered the way clinicians viewed, or "gazed" at, their patients. The nineteenth century represents a move away from patient-based, bedside medicine to a view that erased the "sick man," in Nick Jewson's famous formulation, to be replaced with impersonal disease classification.[148] Accordingly, the patient records from the late nineteenth century usually record only a name, address, description of condition, and date of death or discharge. The humanity of the individual has been erased in favor of pathological description.[149]

While the archival traces remain mediated voices, the breadth of sources employed in this book aims to show a spectrum of imperial knowledges and their contribution to the production of medical knowledge. The official voice of the British and Anglo-Indian medical profession can be interrogated in the pages of widely read medical publications of the period like the *British Medical Journal*, the *Lancet*, the *Indian Medical Gazette*, and the *Journal of Tropical Medicine*. Advice books and medical publications by imperial doctors, as well as autobiographical accounts of return by physicians and patients, represent a more personal perspective by individual commentators. Hospital and asylum records form an important part of this work and are, in many cases, a site where the patient voice can be recuperated. However, the insights into patient experience which can be gleaned through clinical records are often brief and superficial, limited to the information an attending physician felt was relevant to diagnosis or treatment. As a result, when using clinical records I draw on a wide variety of snapshots of patient experience which considered together can be used to develop my arguments. In contrast, a deeper level of investigation can be carried out into the work of more prominent practitioners like Joseph Fayrer and Patrick Manson, whose extensive publications and surviving archival materials provide more nuance into their lives and research. The wealth of Victorian print media in terms of newspaper reports, advertisements, and pamphlets also figures as important sources in the imperial medical archive.

Objects, while not the sole focus of this analysis, feature among my sources. These take the form of the tools of the trade of medicine and medical research of the late nineteenth century: surgical tools, illustrations, photographs, and "specimens," namely, preserved human tissue. Material culture and consumption have

been a central focus for historians interested in empires everyday practices.[150] Thomas Richards has argued that the commodity was a defining feature of Victorian culture and that consumption was a central method for creating a vision of Britain and its place in the world.[151] In a similar vein, human remains and other medical material culture served as an important method for practitioners to share and communicate new discoveries or ideas. In this book, items of medical material culture, from blood slides to patient records, are addressed within this wider scholarship which focuses on objects as a methodology for exploring the "textures" of everyday imperialism in Britain.[152] The mobility of these medical objects, and their shifting meanings in new contexts, links into the wider theoretical framework of circulation and mobility. The role of medical material culture within this empire of things has been largely overlooked, an omission which this study will hopefully go some way to address.[153]

Structure

This is a book of two parts. Each part contains two chapters and is accompanied by a brief introduction. Each of the chapters contains themes around a particular organ, reflecting the anatomical categorization of the medical museums which inspired the research and informed contemporary approaches to the body. These chapters are also roughly chronological, reflecting the shifting scales from gross anatomy (the liver) toward the microscopical (the blood) which occurred over the course of this period. Part I explores the mobility of bodies and their role in medical knowledge making in London. It consists of two chapters focusing on returning European empire builders and the intersection of environment and health in the British medical marketplace. Together they interrogate how circulating imperial bodies in the form of patients influenced the development of knowledge in London's medical institutions. Beginning roughly in 1880, they demonstrate the continued importance of climatic discourses to domestic conceptions of health and illustrate how colonial concerns over the environment caused a reassessment of the supposed healthfulness of the British climate. They illuminate the challenge presented to imperial power structures by returning tropical invalids, whose health challenges revealed the inherent frailty of the colonial project. From the streets of Anglo-Indian Bayswater to the wards of the Royal India Asylum at Ealing, mobile peoples from the Empire guide these case studies, which reveal the profound effect the presence of these bodies had on popular and professional medical discourses in London.

Chapter 1 centers on traditional understandings of the liver as the "seat" of tropical disease—the organ most profoundly affected by the heat and, consequently, the rapid return to colder climates.[154] It subverts the traditional discourse that the return home was the natural cure for Europeans suffering from the effects of tropical climates, and instead demonstrates a widespread discourse on the dangers of what might be termed *reacclimatization*. I argue that digestive complaints represented the most frequently experienced form of tropical disease in European returners. Focusing on chronic diseases emanating from the liver, like recurrent dysentery and diarrhea, it reveals the complexities of chronic health problems that were both caused and cured by the rapid transportation home that accompanied advances in steam power. I demonstrate that the survival of trust in the salubrious power of the "native air" of England was closely linked the political stakes of the return home. If chronic tropical disease could not be cured by a sojourn at home, how was the imperial project to continue?

Chapter 2 focuses on the brain. It delves into the world of early psychiatry and asylum care, revealing the prevalence of imperial bodies in London psychiatric institutions. In particular, it unpacks the construction and use of sunstroke insanity as a diagnostic category, considering the extent to which exposure to the tropical sun was believed to cause madness in European brains, months or even years after return. Focusing on the work of the prominent Anglo-Indian physician Sir Joseph Fayrer, this chapter reveals the contested nature of climatic medical beliefs in the domestic context. While most literature has treated anxiety about the physical effects of pathogenic tropical climates on European bodies as being distinctive of colonial contexts, this chapter argues that much of this knowledge was actually produced within Britain. Working with a unique patient population at the Royal India Asylum at Ealing in West London, Fayrer and his collaborator Thomas Beath Christie (1828–1892) identified organic changes wrought by the tropical sun. Yet the sunstroke insanity diagnosis did little to persuade many domestic "alienists," who preferred to attribute the madness of ex-colonial patients to drink or heredity factors. Nevertheless, widely reported trials and inquests demonstrate the resilience among the general British public of the belief that the tropical sun could drive Europeans mad. Sunstroke insanity served as a useful apology for the violent and often criminal actions of ex-colonial soldiers. However, this environmental construction of insanity applied only to white bodies, with non-Europeans or mixed-race individuals in London asylums entering into a very different psychiatric framework, which emphasized social environment as the cause of mental imbalance.

Part II shifts the focus from the movement of bodies to the mobility of medical knowledge and practices. Focusing on case studies from ophthalmology and tropical medicine, Chapters 3 and 4 illustrate the mechanisms which either facilitated or prevented the circulation of medical ideas between domestic and colonial spaces. It hones in on the centrality of metropolitan prestige as an arbiter of knowledge mobility and the relative merits of communication media like text, illustrations, and microscope slides to transmit information across colonial spaces.

In Chapter 3 the eye is interrogated as a node around which imperial surgery converged. While Victorians were captivated by photography and other technological advances that altered the way they saw the world, the medical care of the eye was itself an equally popular concern—and hotly debated.[155] This chapter reflects the changing terrain of British medicine and looks specifically at the specialty of ophthalmology to consider mobile and immobile surgical techniques for treating cataracts. A discussion of the notorious Old Bailey trial of the Indian "oculists" in 1893 demonstrates the challenge that imperial forms of knowledge could present to a supposedly professionalized domestic practice. The problematic hypermobility of indigenous oculists operating in London reveals a dissatisfaction among the working classes, which made space for the success of imperial practitioners. The case of the Smith-Indian operation, however, illuminates how certain forms of knowledge, even ones developed by British practitioners, were unable to transfer to the imperial metropolis. By refusing to pay homage to the domestic profession and emphasizing the superiority of Anglo-Indian surgeons, the firebrand Henry Smith (1859–1948) became the master of his own demise and the center of a professional scandal which dominated professional journals across the early twentieth century. The difficulty of communicating the complex nature of the technique and beliefs around the suitability of certain procedures on different races effectively blocked the movement of a new practice believed by many to be a ground-breaking improvement in ophthalmic surgery.

Chapter 4 reflects the conceptual shift of scale that characterized early twentieth-century science. Moving away from gross anatomy and looking at the microscopic scale of blood, I focus on the parasitic infections which typified Mansonian tropical medicine. The ability of blood to contain a hidden parasitic cargo was a boon for researchers like Manson, who pursued his research in London after his return from China. By interrogating the spaces of Manson's research, in particular his home and the Albert Dock Hospital, it is possible to understand how tropical medicine constructed, and was constructed by, its

research subjects. A close examination of Manson's home at 21 Queen Anne Street reveals the centrality of his domestic environment to the development of his research work in London. This chapter further reveals how the London School of Tropical Medicine in Greenwich was a purposeful construction by Manson and his colleagues, using deliberate tactics to attract and monopolize racially "other" patients from the busy docklands. Following the "pathological pilgrimage" of blood slides through the networks of empire, the chapter interrogates how Manson was able to draw bio-information by capitalizing on his prestige as the founder of a new specialty. The parasites suspended in blood films, patients, and infected insects were essential collaborators in Manson's research practice, often to the detriment of his non-European patients. Diseased bodies from the Empire, both European and non-European, were not feared but subjects of desire for medical practitioners in the competitive world of British medicine.

The conclusion draws together these case studies, reflecting on the ways in which they illuminate the role of mobile bodies in the construction of imperial medical knowledge in London. The empirical chapters provide an insight into a unique period in the history of British medicine—one in which potential "contagion" from the Empire was seen as a boon rather than a threat. Mobile imperial bodies and their embodied diseases were perceived as a desirable commodity which contributed to a "lively cosmopolitics" of medical practice in this period.[156] I argue that more-than-human theories of entanglement have much to lend to histories of imperial medicine by bringing to the fore the centrality of nonhuman actors, from laboratory animals to parasites.

Ultimately *Imperial Bodies in London* captures something of the quotidian experience of health and disease in late Victorian and Edwardian London. As Cantlie's observation indicates, to not acknowledge the far-reaching impact of imperial experiences is to misunderstand something central to the way medicine was practiced and experienced in this period.[157] The abundance of clinical records about imperial bodies—whether soldiers, officers, merchants, missionaries, or sailors—helps to create a better picture of the phenomenology of the imperial project. There can be no doubt that the British imperial project was profoundly destructive to the indigenous peoples whose resources and lands were forcefully appropriated for the economic and political advantage of British elites. However, this process also took a physical and mental toll on working- and middle-class empire builders. The patients we will encounter in London's hospitals, asylums, and consulting rooms formed the essential machinery that allowed empire to continue. The Empire itself seemed embedded in their very

organs, its destructive capacity settling in their livers, their brains, their eyes, and even the blood coursing through their veins. Their aches, pains, and diseases challenged British practitioners and became the foundation on which a new imperial medical culture was built.