A Black Scourge?: Race and the Rockefeller's Tuberculosis Commission in Interwar Jamaica.

From 1927 till 1942, the Rockefeller Foundation's International Health Division (IHD) ran a tuberculosis (TB) commission in Jamaica that carried out research into the epidemiology of the disease, examined the efficacy of a vaccine, and offered basic treatment. The commission was led by Dr Eugene Opie, a leading American TB expert, and employed various other North American doctors and researchers. As was common with other IHD projects, the commission also relied heavily on local staff. Based amongst others on the diaries of the commission's staff and correspondence between the commission and the IHD's headquarters in New York, this paper explores the role that race played in the Jamaican TB commission. It first explains how and why the commission was set up and sets out the nature of its work. It then moves on to explore the role that race played in the research carried out by the commission. And finally, it looks at the role of race in staff interactions and staff-patient relations.

By centralising race in the IHD's Jamaican TB commission, this paper adds to three interlinked sets of scholarship. First, existing work on TB. Since the publication in 1989 of Randall Packard's *White Plague, Black Labour: Tuberculosis and the Political Economy of Health and Disease in South Africa*, various studies have been published on TB outside of Europe and North America, including several on the (former) British Empire. Most of the latter are more concerned with epidemiological and pathological understandings of TB and institutions to cure the disease in the colonies than with attempts to control and prevent it, and focus mainly on India and Africa.[1] Second, this study augments the scholarship on Caribbean health and medicine. While colonial medical history has been an established sub-discipline within the history of medicine since the 1980s, Caribbean medical history is a relatively new field.[2] Existing studies have hitherto largely ignored TB.[3] And third, this paper adds to

existing literature on international health organisations, including the forerunners of the WHO, such as the Pan American Sanitary Bureau (PASB) and the IHD. Existing studies on the IHD have also largely ignored TB. And although they have admitted that IHD staff was not free from racial prejudices, they have not explored in any detail the various ways in which race informed the organisation's work and how this in turn helped to uphold existing racial hierarchies.[4]

The TB Commission

In 1912, when TB was made a notifiable disease, there were 68 cases of TB in Jamaica, nearly all of the pulmonary kind. Numbers soon increased and in 1927 there were 797 cases and a death rate of 13.4 per 10,000 of the population, which was nearly three times that in the UK and the US.[5] Yet Jamaica ran far behind some other Caribbean colonies in tackling the disease. The only institution that until 1927 provided care for TB patients was the poor house and this only catered for those in a far advanced stage of the disease.[6] In 1927, the IHD noted from a report by Dr Benjamin Washburn, the head of the IHD in Jamaica, that TB was a main cause of death in the island. It then informed Dr Wilson, the chief medical officer, that if the Jamaican government deemed it useful and a 'competent man be secured for the purpose', the Rockefeller Foundation could assist in undertaking a TB survey. It stressed that although the survey would be made through the government medical department and be placed under the direction of the chief medical officer, there was no need for a 'vote of funds by the government'. As all government expenditure had to be paid for from local revenue and which was limited, this did much to persuade Wilson and he became even more supportive when he was told that the IHD had secured the services of Dr Eugene Opie. Opie was the Director of the Henry Phipps institute for the study, prevention and treatment of TB at the University of Pennsylvania in Philadelphia, an institute with a state of the art laboratory, a

50-bed hospital and large outdoor clinics.[7] Opie became the consultant for the commission which mean that he trained staff sent out from North America; visited the island once or twice a year; and oversaw the results of tests submitted by local staff.

By 1927, the IHD was already carrying out work in Jamaica, ranging from hookworm and yaws control and school dental clinics to parochial health departments. That the IHD had hitherto avoided TB work in the island was largely because of the Rockefeller Foundation's experience with TB control work in France during and in the immediate aftermath of the First World War (WWI). In May 1917, it set up a French TB commission that ran over 200 dispensaries and 4 mobile educational units. After the War ended, problems over the French government's financial contribution to the commission and other issues soon mounted and by the end of 1922, the work of the IHD's TB commission in France had virtually ended.[8]

Wycliffe Rose, the IHD's director, and also his successor Fredrick Russell regretted the IHD's involvement in TB control and vowed in fact never to get involved in TB control work again. This was largely because at that time TB was unlike most of the other diseases that the IHD worked on, such as hookworm or yellow fever. There was not some insect that could be singled out as the main vector and be attacked by a 'magic bullet'. In fact, when the IHD undertook its work in France, TB was a social disease for which there was no quick fix. The only cure at the time was a good diet, sunlight and rest.

Yet by the late 1920s, the idea that TB was curable became more prevalent as patients with mild cases of TB were sent to sanatoria and with artificial pneumothorax (collapsed lung) some of them recovered. Also by the late 1920s, experiments with a vaccine were undertaken.[9] These developments made the IHD less averse to getting involved with TB in Jamaica. Yet its experience in France meant that it did not want to offer treatment to TB sufferers but merely provide the Jamaican government with a set of recommendations on how best to prevent, control and treat TB.[10] To do so, Opie needed more accurate information

about its prevalence and nature than the statistics provided by the registrar-general, as many cases and especially deaths from TB went unrecorded because patients did not alert medical authorities or the latter failed to recognise TB. To that end, Dr Washburn, who was appointed as the local director of the TB commission, carried out tuberculin tests in a few schools; lung tissue was gathered from the general hospital, the mental hospital and the poor house in Kingston; and a clinic was set up in Kingston in July 1928 with the specific aim of gathering data.[11] The latter was the focal point of the TB commission in the first few years of its work. To encourage people to visit it in order to be tested by means of a tuberculin test and followed up if the test proved positive, the clinic offered basic treatment and relief for TB patients. As its main aim was to gather data for a TB survey on the basis of which recommendations could be made to government, the medical officer in charge of the clinic, one of its two nurses, and a clerk were all paid for by the IHD. As the government would take over the clinic after the survey was completed and convert it into a testing and treatment facility, it provided the building for the clinic.

The IHD often employed local staff as this lowered the access barrier for patients. Because the clinic was to be taken over by the government, Washburn worked together with Wilson to select its medical officer and nurse from amongst the Jamaica Medical Service. They initially looked for a doctor with experience in TB but as none was immediately available they appointed the white, locally-born Dr Joyce Isaacs. She had a medical degree from University College London and been a resident obstetric assistant and casualty officer at Westminster hospital. In addition, Helen Walker, a white, English-born woman and former matron of the Kingston hospital, was appointed as the clinic's head nurse. The local Anti-Tuberculosis League (ATL) provided and paid for a second nurse. And one of the health visitors employed by the Kingston and St Andrew Corporation (KSAC) was ordered to work

under the direction of the clinic. These two black nurses had to visit patients at home. And finally, Margaret Manning, another white, locally-born woman, was appointed as clerk.[12]

The Kingston clinic followed the procedure established by the Henry Phipps Institute in collecting data. Each patient received a serial number. As soon as the patient tested positive, his family was placed on a visiting list of the nurses and received a family number. In a folder under the family number, records were then collected of all members of the household. A nurse visited the family at regular intervals and observed and recorded their housing and habits and gave advice on how it could protect itself.[13] The procedure was adapted to some extent to the conditions in Kingston.[14] Finances, for instance, did not allow like in Philadelphia for large numbers of X-rays. Isaacs completed regular reports which she forwarded to Opie, who in turn informed Dr H. H. Howard at the IHD headquarters. In 1930, the clinic moved to a new and larger building that included an X-ray laboratory. This along with publicity work by the ATL led to an increase in patients. By 1931, some 3,208 patients had been registered.[15]

It was decided in 1930 to enlarge the scope of the survey beyond the clinic and the Canadian Edward Flahiff and the American Hugh Smith were appointed for this work. After a brief training at the Phipps Institute, the men were sent out do field work first in Smith village on the outskirts of Kingston and then in other parts of the island. [16] This field work, closely modelled on the method employed by the IHD's hookworm commission, consisted of the medical officer in charge of the survey and one nurse, moving from house to house, giving tuberculin tests. If found positive, they gave people a note to report for an X-ray and in some small towns and rural areas they even provided positive reactors with transport to the nearest X-ray laboratory. Those who failed to turn up to the X-ray examination were visited at home, while anyone who showed a lesion of any description had to give a sputum sample, was given a thorough physical examination, and his of her detailed history was taken. By

1932, the commission acquired a mobile X-ray unit manned by Dr Flahiff that considerably sped up this process.[17] In most areas, about 65 to 90 per cent of the population agreed to take a tuberculin test, which was a very high take-up rate. It needs to stressed that until then, nowhere in the world had there ever been such a wide-scale TB survey. This field survey along with the opening up of five other clinics led to the appointment of more local black nurses and also necessitated more clerical staff to enter data as well as the appointment of a driver, an assistant medical officer, and more specialist staff. Dr Clifford Wells, for instance, was appointed as the head of the X-laboratory and was assisted by a locally-born doctor, who already had some experience in X-ray work.

But the TB commission not only gathered data to provide the government with a plan on how best to control TB; it also carried out trials with a vaccine. Washburn regarded this trial as 'probably the most important feature of our tuberculosis programme'.[18] Research into a vaccine for TB started in the early twentieth century. By 1921, the French scientists Albert Calmette and Camille Guerin of the Pasteur Institute began to trial their live vaccine BCG on human beings. Between 1924 and 1928 some 114.000 infants susceptible of getting TB were vaccinated with BCG. Statistics suggested that it was an effective vaccine as there was a drop in mortality rate amongst the vaccinated children. Yet many still questioned the efficacy of BCG and looked towards an alternative vaccine, which received impetus from the so-called Lübeck disaster of 1930 in which 73 of 250 vaccinated babies died and 135 became infected and never recovered.[19] An alternative proposed to BCG was vaccination with heat-killed tubercle bacilli. One of the scientists involved in this was Opie. In 1932, Opie had taken up a position at Cornell University. He and his team at Cornell first trialled the vaccine on rabbits. In their next stage, they used it on patients at the Jamaican mental hospital.

Most patients at the mental hospital came from rural districts with little exposure to TB. There were about 2,500 patients , with about 540 new admissions each year. Except for

the ill and most violent, patients were allowed access to large compounds, one for each sex, with no restrictions on their movement. This arrangement along with overcrowded sleeping quarters facilitated the spread of TB. As such, the hospital offered an excellent opportunity to study the spread of contagion and the commission therefore included it in its TB survey. Initially, it was just interested in following patients who tested negative for TB upon entering and determine how quickly developed the disease.[20] From 1932 onwards, half of all newly admitted patients that were found negative upon entering were given the vaccine with heat-killed tubercle bacilli and the other half were designated as controls. Initially, the vaccinated group was injected every week for up to ten weeks but gradually a single injection was used and they were tested seven weeks later. If tested negative, they were then given another injection. Both the vaccinated and control groups were given a tuberculin test and X-ray every three to four months for the duration of their stay.[21]

Between 1932 and 1938 about 210 patients were given the vaccine and 206 were used as controls. Some 23 of the vaccinated group developed TB and 39 of the control group, while 16 of the vaccinated and 27 of the controls died from TB. The conclusion reached on the basis of this study was that heat-killed tubercle bacilli vaccine offered some protection in the first eighteen months after vaccination and that it could be used especially on certain groups at a high risk of infection, such as medical students, trainee nurses, hospital attendants etc. It was, however, admitted that the conclusion was problematic as the vaccinated group had been exposed to severe infection at the time when they were acquiring immunity, while the controls that did not get manifest TB seemed to have acquired infection and were protected by it.[22]

The vaccine trial, which ran until 1942, was gradually extended to other groups. It was first extended to an industrial school for boys and two orphanages because the population in the mental hospital was of a relatively high age and its impact on a younger age cohort

needed to be ascertained. And from 1939 onwards, the commission rolled the trial out to the general population and by then it involved at least some degree of consent. They began with the vaccination of primary and secondary school children in- and outside of Kingston, partly because teachers were 'willing and eager to aid in securing the vaccination' of school children. The children were given a 'permit slip' to be signed by parents or guardians several days prior to the tuberculin test, authorising the child to be tested and vaccinated if necessary. By the end of 1940, some 7,739 tuberculin negative children had been vaccinated.[23] The commission hoped that the schools taking part in the trial would be 'the channel for broadcasting our work to the homes in the district'.[24] This indeed seemed to have worked because by 1940 when the trial was extended to the population at large in some designated areas, about 11,000 people – half of whom were vaccinated and half were designated as controls – or nearly one per cent of the total population had taken part. The vaccine trial came to an end two years later when results showed little difference between the vaccinated and non-vaccinated groups.[25]

Existing data does not indicate whether the adults that took part in the trial or gave permission for their children to be vaccinated were fully aware of what they were participating in. That many were eager to take part should firstly be seen largely in light of the publicity given to the general population trial. While the trial in the mental hospital, industrial school and orphanages was never mentioned in public, the general trial was regularly and very positively referred to in the main newspaper *The Gleaner*. In fact, the IHD even put adverts in the paper calling upon people, who had recently moved to Kingston to get vaccinated. And the trial was also mentioned in a radio broadcast by the TB officer for the colony, Dr Corry, in 1939.[26] And that so many people came forward can also be explained by the poor standard of medical care. As mentioned, TB was a leading cause of death before the arrival of the TB commission. In 1934, Opie gave the government his set of

recommendations. A lack of funds meant that the government could not implement all of them so that by the late 1930s there was still relatively little treatment available for TB sufferers. There was a TB hospital in Kingston run by the KSAC. And most, but not all, parochial boards had by then a TB ward in their poor houses but this was the last resort for TB patients. Hence many people welcomed a 'magic bullet' to prevent infection with TB. Yet this does not mean that resistance was absent as the third section will demonstrate.

Race and Research

The main focus of the Jamaican TB commission was research. It first of all tried to assess the prevalence, nature and spread of TB. When the survey was extended beyond the Kingston clinic, it soon became apparent that the incidence was lower in rural than urban parishes. And the survey also revealed that TB was mostly confined to adults and took a very rapid course. But the survey also tried to assess whether black people were more susceptible to TB than whites and/or if the disease took a different course in them.[27] Opie had already examined differences between white and black patients at the Phipps Institute. The data collected in Jamaica had to enable him to explore in more detail whether the 'characters, clinic course and mode of spread' in blacks varied from that of whites.[28]

To facilitate this part of the research, forms used included data on skin colour.[29] Like on other IHD projects in the Americas, the TB commission struggled to come up with a racial classification and mapping people onto it.[30] It came up with a range of skin colour designations that were a mix of locally-used and imported terms: black, dark brown, light brown, pale brown, white, East Indian and Chinese. An additional locally-used designation 'Sambo brown' was added in 1932.[31] Staff were particularly uncertain as in what category to place 'racial mixtures', such as African-Chinese people. Should these be entered under 'light brown with no reference to the racial mixture?' or should additional categories be added for

‘half Chinese, half Syrian, or half something else?’.[32] It is likely that locally-born staff put people in different categories than ex-pat staff. Education, income, speech, propriety, ownership of property and so on all affected how locals perceived skin tone. Thus if they considered a person to be of the more common type, they would place him in any of the categories on the darker side of the colour spectrum. But if they saw him more as a member of the better class, then they would place him in any of the categories on the lighter side. Thus a dark-skinned head teacher was most likely to be returned to them as ‘sambo brown’ rather than ‘black’ because of his occupational status.[33]

Because there were so few whites, Chinese and East Indians affected with TB, the studies published by the TB commission concentrated on ‘the Negro race’. The term ‘Negro race’ was not commonly used in Jamaica at the time not even by the colonial government, which used the following terms to designate race in the census: White, Black, Coloured, Chinese, East Indian, and Other. The use of the term ‘Negro race’, then, clearly indicates that the studies were geared first and foremost towards American doctors and researchers. The commission concluded that TB in ‘the Negro race in Jamaica’ was of a different kind than TB in whites in Europe and America, pursuing a more rapid and fatal course and also spread more quickly.[34] But by adding that more African Jamaicans than ‘American Negroes’ showed tubercle bacilli in their sputum and also showed more ‘infiltrating pulmonary lesions of the childhood or first infection type’, the TB commission suggested that race was not the main explanatory variable. In fact, they attributed the ‘more rapid course’ and type of TB that affected the ‘Jamaican Negroes’ to their socio-economic circumstances and culture: ‘uncleanly habits, unhygienic housing conditions, and lack of facilities for segregation of those who suffer with the disease’.[35]

Already in their first published report from 1930, based on data gathered by the clinic, Isaacs and Opie had attributed some of the marked differences in the incidence and nature of

the disease between Jamaican 'negroes' and Philadelphia whites to their culture. They concluded, for instance, that it was not just poverty but also particular habits that facilitated the quick spread of the disease, such as 'promiscuous relations' and their ignorance of 'habits of cleanliness.'[36] Thus while the officers of the TB commission did not state that black people were naturally predisposed to TB or a particular type of TB, they still saw race as a factor in the epidemiology of TB but which was now packaged as 'culture'. It could be argued, then, that their reports reflect the onset of the shift from scientific to cultural racism, which gained momentum after the Second World War.

But although the evidence gathered showed almost from the start that TB was a social disease and that certain racial groups were not predisposed to it, many IHD staff could not shake off their belief that blacks were naturally more susceptible. For instance, Dr Rufus Cole, the scientific director of the IHD, remarked that the findings of the TB survey 'would be applicable not only to other tropical countries' but also to 'our Southern States'.[37] And the commission's pre-occupation with the role of skin colour equally demonstrates a reluctance to let get go of the idea that race in and of itself played a role in the transmission and nature of the disease. The TB commission was not just concerned to see if TB was different in white and in black people but also tried to asses whether there were any marked differences between 'black' and lighter-skinned African Jamaicans with regards to the incidence and nature of TB. This focus arose probably because of the concern expressed by various groups in America at the time about racial intermixing. In fact, it was not the first time that Jamaica was used as a laboratory to assess the impact of racial mixing. Elsewhere I have explored a study undertaken in 1927-28 by the American Eugenics Record Office to assess the impact of human miscegenation. In this study, some 100 'blacks', 100 'browns' and 100 'whites' were subjected to various physical and mental tests and it was argued by the authors that there

were physical and mental disharmonies amongst the hybrid race of the 'browns' that should warn against racial mixing.[38]

A preliminary report about the role of colour in TB transmission was completed in 1934 based on surveys conducted in four parts of Kingston that had a similar class status. Although the population was given one of the afore-mentioned colour designations, they were for this particular study divided into two broad categories: 'black and dark brown' and 'light brown and others'. On the basis of X-rays taken, it was concluded that 'childhood lesions did not vary with color but that adult lesions increased definitely as color shades became lighter'.[39] The relation between colour and incidence and nature of the disease was also addressed in the survey of rural parts of the island. But here where more than 90 per cent of the population was returned as 'black', it was found that 'tuberculin reaction among persons of racial mixture does not differ in frequency from that of those wholly Negro'.[40]

Race was not just a variable in the epidemiological research of the TB commission but also underpinned its decision to trial the vaccine in Jamaica. The Jamaican trial was one of several experiments in the years surrounding the Second World War in which black bodies were misused in order to advance American medical science. The most notable is the Tuskegee syphilis experiment that ran from 1932 till 1972 and in which 439 men with late stage syphilis and 185 controls without the disease were watched but not supposed to be treated. And another that has become known more recently is the STD study in Guatemala undertaken by the US Public Health Service from 1946 till 1948 in which 1300 men and women were infected with syphilis and other STDs and only half of them were treated.[41] That Opie decided to trial the vaccine not in Philadelphia or any other part of the US but in Jamaica was, as in the case of the Eugenics Record Office experiment, because conditions in the island made it easy to do this research. There was a chief medical officer interested in preventive TB work and helped the commission secure human subjects without a consenting

process. It would have been far more difficult, albeit it not impossible as the Tuskegee experiment shows, to undertake such a wide-spread trial in the US. Here it would have been harder to find officials to agree to undertake trials in orphanages and mental hospitals, and race relations were such that it would also have been more difficult to get adult black men and women to consent to take part in a vaccination trial, once experiments with selected groups were completed.[42]

The vaccine trial started in the mental hospital, followed by the orphanages and industrial school, and was finally rolled out to the general population. That it started with groups that were not in a position to consent is unsurprising because, as Washburn told Howard, in Jamaica 'as elsewhere people don't like to feel that they are being "experimented" upon.'[43] The patients in the mental hospital and the children in the orphanages and industrial school that were vaccinated were because of the close link between class and colour at the time mostly 'black' and 'dark brown'. We do not know what they were told about the tests that they were subjected to and the inoculations they received but it is unlikely that many would have questioned this process. They were then, as John Farley has argued more generally of people who took part in IHD research, 'convenient guinea pigs'.[44]

Even though the general population trial was reported in the paper, it seems not to have been clearly conveyed to the people that not everyone would be vaccinated. In fact, the commission expressed the fear that many of the controls would demand to be vaccinated. And it also fully realised that it would be difficult to follow up the vaccinated and control groups in the poorer sections of Kingston, where the population was very unstable, a problem that also plagued the Tuskegee experiment.[45] Flahiff made a suggestion to counteract this problem; namely, an additional trial in a rural part of Quebec (Canada), where TB was also highly prevalent but the population fairly stable. Yet he soon questioned this because it might be 'much more difficult' to explain to the Quebecois than to the Jamaicans why some

individuals were vaccinated and others were not.[46] So again we see that stereotypical ideas of race informed the work of the commission. Flahiff assumed that African Jamaicans were less intelligent than the whites Quebecois and could thus more easily be fooled into accepting why they were not vaccinated.

Race and Staff Interaction and Staff-Patient Relations

As in the case of other IHD projects in the Americas, the Jamaican TB commission was marked by a hierarchy that was based on and helped to reinforce dominant ideas about race and colour: the most senior posts were held by white (local or ex-pat) staff and the most junior by dark-skinned Jamaicans. At the time, there were African-Jamaican doctors, who were as well trained as Isaacs and like her also lacked experience in TB work. Yet none was ever considered for the post nor even to become her assistant. The latter post was allocated to the white, locally-born Dr Richard Cory. The IHD was convinced that it was best to appoint 'black nurses' for the home visiting work and for the field surveys 'as it would be easier for them to adjust themselves to local conditions'.[47] The most prestigious nursing positions, on the other hand, were reserved for white women, such as head nurse of the clinic. When Helen Walker resigned from this post in August 1930, the aim was to get another white woman to replace her. Yet in an island where whites made up less than 2 per cent of the total population, it was quickly realised that this would not be easy unless the overseas nursing association was asked to supply a nurse from England. As this would take too much time, it was suggested to offer the position to a 'brown girl', who had only been working at the clinic for two months but was seen to be 'by far the best nurse with any colored blood'.[48] Clearly, then, she was regarded as second-best.

And a further illustration that white women were preferred for the more senior nursing posts, when Dr Wells was appointed in 1932, Dr Howard asked if it 'would be

possible to get a suitable white nurse in Jamaica' to work with him. Considering the concerns about racial mixing in the US at the time, this is perhaps unsurprising as the two would have to work closely together. Attempts were made to meet this request. Mrs Dun, the white wife of a local government official who had been trained and worked as an X-ray technician in the US, was seen as the ideal candidate. And she also came highly recommended by the chief medical officer.[49]

The racial hierarchy operated by the TB commission mapped closely onto that used by the government medical service. The most senior positions in government medical service, such as head of a hospital or matron, were always held by white ex-pats. Local whites were the second-highest ranking officers. As I have shown elsewhere, they were often appointed to posts for which there could easily have been found more experienced or better qualified African Jamaicans. Many African-Jamaicans doctors and some nurses occupied fairly high roles in the service but they tended to be appointed to the more senior posts only in an acting capacity. These tended to be mostly light-skinned men and women because their positions required a secondary school education; even to get into nursing school required a Cambridge junior certificate. As class and colour were closely entwined at the that time, it was mostly light-skinned boys and girls who went to secondary school. And the bottom of the government medical service were the mostly un- or poorly-trained nursing staff, such as the mental hospital attendants or rural midwives.[50]

The sources on which this paper is based reveal little overt discrimination of white ex-pat staff towards black staff like that expressed by Cornelius Rhoads, who undertook research for the IHD into anaemia in Puerto Rico and complained to Frederick Russell that Puerto Rican people were the 'laziest, most degenerate and thievish race of men'.[51] Yet they do reveal that North American doctors were informed by the racial prejudices and ideas of their own society. For instance, the IHD bio-statistician Dr Hugo Muench visited Jamaica in 1932

and included in the diary of this visit are several lists of made-up first names that he had read while analysing data from the Kingston clinic, such as Viris and Synsent, which, he argued, showed 'imagination and some originality!'. The exclamation mark conveys that he did not mean this as a compliment. Wells, on the other, was highly critical of the non-white members of the commission. He wrote, for instance, that 'one familiar with local personnel in Jamaica fully realizes their short-comings and the necessity for prolonged instruction and training'.[52] And Dr John Weil, who worked on the vaccination trials with the general population in the late 1930s, was also less than appreciative of local staff, claiming for instance that local nurses had developed a 'Rockefeller Foundation complex', asking for taxis to take them to and back from work. In other words, these black women had, according to him, risen above their status.[53]

But not all ex-pat members of the commission held such opinions about local staff. Washburn, for example, disputed Wells' observation claiming that local staff were 'as efficient as any I have had in any place in which I have worked.'[54] And because Flahiff seemed to relate well to local staff, Opie decided to put him and not Wells in charge of the vaccination trial because 'he is less likely to make up his mind before hand and works in closer sympathy with his associates'.[55] Flahiff even went the extra mile for some local staff. In 1939, for instance, he asked if there was a possibility for Dr Parkin, who assisted in the taking of X-rays in the field, to take a course in radiology in the US. He was asked to provide not just information about Parkin's 'training and experience' but also whether he was 'white or colored'.[56] This question points to the racism in American hospitals as the time because even in the non-segregated North there was a strong dislike of dark-skinned doctors. As Flahiff was keen for Parkin to get onto a course, he described him not as 'colored' but as '"swarthy"; that is, nearer a light brown'.[57]

As already mentioned, not everyone welcome the commission and its work. When the commission extended its work beyond the clinic to a survey of selected areas in Kingston, they encountered considerable opposition from locals. In fact, even the locally-born sanitary inspectors, who undertook a census of each person living in the area and handed out letters to householders explaining the survey were ill-treated. Rumours circulated that the tuberculin test was an instrument used by the 'white race to destroy the colored race'. And more particularly, it was claimed that it would lead to infertility in women, which particularly caused concern as lower-class men and women placed a high value on fertility.[58] A successful way used to overcome this opposition was to offer everyone who submitted to a tuberculin test also an X-ray: being able to see their own lungs on a screen led many men and women to submit to a test.[59]

Like the sanitary inspectors, local nurses were also not immune from abuse. The nurses attached to the Kingston clinic, for instance, often had to deal with patients, who did not want to be visited because their neighbours would realise they had TB and shun them.[60] Especially when the vaccination trial was rolled out across the general population, the nurses encountered a lot of opposition. This should largely be seen in light of a birth control campaign that was started around the same time and was widely reported in the press.[61] It was assumed by many men and women that the nurses wanted to trick people into adopting birth control. And others refused to cooperate with the trial because they saw it as 'a campaign initiated by the white people to poison all the black people in the island'.[62] These two objections often merged together. One nurse, for example, encountered a soap box orator in Trench Penn, who told a crowd that 'at present the black population was in ratio of 14 to 1 white man, that white people were, therefore trying to decrease the black population. That was why they were going around injecting people, particularly women, to dry up their wombs.'[63] The island-wide labour riots that had occurred only a year earlier and which had

done much to raise race consciousness also does much to explain this opposition to the vaccination trial.[64]

Conclusions

The studies on race and medicine that have been published in recent years have tended to fall into two categories: narratives of abuse and suffering and narratives in which non-white people triumph over adversity. The story presented here is largely one of abuse: black bodies, especially those of the most vulnerable were used to test medicine that was to help first and foremost white bodies. It is less a story of non-white people triumphing over adversity. Although African Jamaicans did not uncritically accept the work of the TB commission, many welcomed the Kingston clinic and others that were set up in its wake as well as the vaccine trial. The sheer fact that TB was one of the main causes of death and that medical care in the island was very basic, especially with regards to TB, largely explains why so many African Jamaicans did not resist but appreciated the work of the commission.

But this does not minimise the role that race played in the work of the commission. The commission's research into the epidemiology of TB came out of a particular understanding of race; namely, that the black and white were inherently different and that this difference mattered when it came to diseases. Although the commission concluded that it was not biology but socio-economic circumstances that explained why TB in African Jamaicans took such a rapid and fatal course, it struggled to shake off this belief in the natural difference between white and black and hence a scientific racism with a cultural racism. But while the commission started on the assumption that racial difference mattered when it came to disease, it did not assume the same when it came to drugs. It never attempted to assess whether white and black people responded differently to the vaccine: it just wanted to test whether the vaccine was as effective in human beings as it was in the rabbits used by Opie at Cornell. It

used black bodies to test the vaccine because they were easily available. Like the Tuskegee experiment, the vaccine trial was based on and helped to reinforce the idea that black bodies were of a lesser value than white bodies.

And race also informed staff interaction and staff-patient relationships. Ex-pat members of the commission brought with them their particular understanding of race. They assumed that for certain positions only whites were suitable and looked down upon the norms, values and practices of African Jamaicans. As such, this study lends further support to existing work that exposes the structural racism integral to American medicine. But not only the commission also the government medical service was not free from institutionalised racism. Many members of the commission were appointed by the chief medical officer in liaison with Washburn and Opie. This meant that the staff hierarchy of the commission was effectively a race/colour/class hierarchy.

So in various ways, then, race played a role in the Jamaican TB commission, ranging from informing the research questions asked and the intra-staff relations to the selection of research subjects and the appointment of staff. And the staff hierarchy that emerged along with the wide-scale use of black bodies to inform American medicine in turn worked to reinforce the idea of white superiority and black inferiority.

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[1] See, for instance, Niels Brimnes, 'Vikings against Tuberculosis: The international Tuberculosis Campaign in India, 1948-1951', *Bulletin of the History of Medicine*, 81, 2 (2007), 407-30; Mark Harrison and Michael Worboys 'A Disease of Civilisation: Tuberculosis in Britain, Africa and India, 1900-39', in Lara Marks and Michael Worboys (eds), *Migrants, Minorities and Health: Historical and Contemporary Studies* (London: Routledge, 1997), 93-124; Michael Worboys, 'Tuberculosis and Race in Britain and Its Empire, 1900-50', in Waltraud Ernst and

Bernard Harris (eds), *Race Science and Medicine, 1700-1960* (London and New York: Routledge, 1999), 144-66.

[2] The first edited collection on the history of Caribbean health and medicine was only published in 2009. Juanita de Barros, Steven Palmer and David Wright (eds), *Health and Medicine in the Circum Caribbean, 1800-1968* (London: Routledge, 2009).

[3] See Debbie McCollin, 'World War II to Independence : Health Services and Women in Trinidad and Tobago, 1939-1962', in de Barros, Palmer and Wright (eds), *Health and Medicine in the Circum Caribbean*, 227-48; Darcy Hughes Heuring, *Health and the Politics of Improvement in British Colonial Jamaica, 1914-1945* (Proquest UMI Dissertation publishing, 2012); Margaret Jones, *Public Health in Jamaica, 1850-1940: Neglect, Philanthropy and Development* (Kingston: University of the West Indies Press, 2013).

[4] There is a substantial body of work on the IHD. The first studies were mostly institutional histories. A second wave offered a sharp critique of the IHD questioning its humanitarian claims and presented it as little more than an instrument of US imperialism. But the most recent work on the IHD, which tends to focus on a single location or a single disease, has presented a more nuanced picture by paying as much attention to the Rockefeller staff as to local players, strategies, health traditions and institutions and their interplay. See, for instance, Marcos Cueto (ed.), *Missionaries of Science: The Rockefeller Foundation and Latin Americ*a (Bloomington: Indiana University Press, 1994) and Steven Palmer, *Launching Global Health: The Caribbean Odyssey of the Rockefeller Foundation* (Michigan: University of Michigan Press, 2010). John Farley has devoted four pages to the Jamaican TB commission in his *To Cast out Disease: A history of the International Health Division of the Rockefeller foundation, 1913-1951* (Oxford: OUP, 2003). While he has ignored race in this discussion, he has briefly touched upon it in his examination of other IHD projects in the Americas, such as the hookworm campaign in Guyana.

[5] Eugene L. Opie and E. Joyce Isaacs, 'Tuberculosis in Jamaica', *The American Journal of Hygiene*, 12, (1930), 3-4.

[6] Opie and Isaacs, 'Tuberculosis in Jamaica', 6.

[7] Washburn to Wilson, 6 July 1927; Wilson to Washburn, 14 July 1927; Washburn to Howard, 5 December 1927l; Wilson to Washburn 11 November 1927. Rockefeller Foundation (RF), RG 5, 1.2 box 302, folder 3831. Although Opie took up a position at Cornell University in 1932, the IHD continued to finance his work as he had then moved on to develop a 'magic bullet' for TB: a vaccine with heat-killed tubercle bacilli. Farley, *To Cast out Disease*, 189.

[8] Farley, *To Cast out Disease*, chap. 3.

[9] Farley, *To Cast out Disease*, 185.

[10] Howard to Opie, 17 March 1928, RF, RG 1.1. 437K, box 2, folder 27.

[11] He said: "we emphasize, and be consistent in, supporting the study and investigational activities of the clinic". As cited in, Farley, *To Cast out Disease*, 188.

[12] Opie to Howard, 6 July 1928, RF RG 1.1. 437, box 1, folder 2.

[13] Opie and Isaacs, 'Tuberculosis in Jamaica', 8-9.

[14] Opie and Isaacs, 'Tuberculosis in Jamaica', 9.

[15] Program for 1932, RF RG 1.1. 437 K, box 3, folder 33.

[16] They selected areas that allowed them to compare factors, e.g. some areas were isolated, others were nearer to a town, some had a higher proportion of people with a higher socio-economic standing, etc.

[17] E. W. Flahiff, 'A tuberculosis survey in Jamaica', *American Review of Tuberculosis*, 37, 5 (1938), 563-64.

[18] Washburn to Russell, 12 August 1931, RF RG 1.1. 437, box 6, folder 72.

[19] Simona Luca and Traian Mihaescue, 'History of BCG vaccine', *Maedica*, 8, 1 (2013), 53-8.

[20] Opie to Howard, 15 March 1929, RF RG 1.1. 437 K, box 2, folder 28.

[21] Programme for 1932 RF RG 1.1. 437 K, box 3, folder 33. It seems that Opie already envisioned using the mental hospital for the trial at the start of the TB survey. See Opie to Howard, 9 December 1929, RF RG 1.1. 437 K, box 3, folder 34; Washburn to Howard, 24 March 1929, RF RG 1.1. 437, box 6, folder 70.

[22] C. W. Wells, E. W. Flahiff and H. H. Smith, 'Protective inoculation against human tuberculosis with heat-killed tubercle bacilli', *American Journal of Hygiene*, 29 (1939), 155-64; C. W. Wells, E. W. Flahiff and H. H. Smith, 'Results obtained in men with the use of a vaccine with heat-killed tubercle bacilli', *American Journal of Hygiene*, 2 (1944), 116-26.

[23] Washburn to Sawyer, 4 July 1938, RF RG 1.1. 437, box 8, folder 101.

[24] Dr Flahiff's diary, January 1939, RF RG 12, box 154, folder Flahiff.

[25] Linda Bryder, `"We shall not find salvation in inoculation": BCG vaccination in Scandinavia, Britain and the USA, 1921-1960', *Social Science & Medicine*, 49 (1999), 1163.

[26] See, for instance, *Gleaner* (4 March 1939, 23 March 1939, and 22 January 1940).

[27] Also in other places and for other diseases did the IHD collect information on race and ethnicity but not always with the overt aim to see if race was a major factor in the nature and spread of disease.

[28] Report on Tuberculosis work in Jamaica: Visit May 5 to 13 1932, RF RG 5.2, box 43, folder 263.

[29] Report on Tuberculosis work in Jamaica: Visit May 5 to 13 1932, RF RG 1.1. 437, box 4, folder 54.

[30] Seem for instance, the case of Costa Rica and Nicaragua as discussed by Steven Palmer in his *Launching Global Health*, 132-33.

[31] On the variety of local terms used to designate skin colour, see Council Taylor, *Color and Class: A Comparative Study of Jamaican status groups* (Yale PHD 1955).

[32] Smith to Putnam, 29 October 1932, RF RG 1.1. 437, box 6, folder 79.

[33] Taylor, *Color and Class*, 48.

[34] Persis Putnam, Joyce Saward and Eugene L. Opie, 'The spread of tuberculosis in negro families of Jamaica', *American Journal of Hygiene*, 16 (1941), 22.

[35] Putnam, Saward and Opie, 'The spread of tuberculosis', 31. An earlier study based just on the clinic results had already suggested similar differences. See Opie and Isaacs, 'Tuberculosis in Jamaica', 14.

[36] Opie and Isaacs, 'Tuberculosis in Jamaica', 19-20.

[37] Rufus Cole: RF RG 1.1. 437, box 1, folder 2.

[38] See my, 'An American race laboratory: Jamaica, c. 1865-1940'. *Wadabagei*, winter (2007).

[39] Putnam to Muench, 24 September 1934, RF RG 1.1. 437, box 7, folder 88.

[40] Wells, Flahiff and Smith, 'Protective inoculation', 155

[41] See, for instance, Susan M. Reverby, 'Ethical failures and history lessons: The U.S. Public Health Service Research Studies in Tuskegee and Guatemala', *Public Health Reviews*, 34, 1 (2012), 1-18 and Harriet A. Washington, *Medical Apartheid: The dark history of medical experimentation on black Americans from colonial times to the present* (New York: Anchor Books, 2006).

[42] That the Tuskegee experiment happened was largely because of the lack of medical care available to black people, similar to Jamaica. It is unlikely, for instance, that the director of the black-run hospital in Tuskegee would have agreed to take part in the trial if rural black people had been able to get access to basic health care. Reverby, 'Ethical failures', 5.

[43] Wasburn to Howard, 24 March 1931, RF RG 1.1. 437, box 6, folder 70.

[44] Farley, *To Cast out Disease*, 189.

[45] Memorandum for Jamaica: Tuberculosis vaccination studies 1942, RF RG 1.1. 437, box 9, folder 115.

[46] Flahiff to Washburn, RF RG 1.1. 437, box 8, folder 102.

[47] Diary Washburn, October 1936, RF RG 12, box 493, folder Washburn.

[48] Carley to Howard, 15 July 1930, RF RG 1.1. 437, box 5, folder 65.

[49] Howard to Carley, 2 July 1930, RF RG 1.1. 437, box 5, folder 65.

[50] See my, 'Modernity, Race and Mental Health Care in Jamaica, c. 1918-1944', *Journal of the Department of Behavioural Studies* and 'A True Maverick: The Political Career of Dr Oswald E. Anderson, 1919-1944', *New West Indian Guide*, 87, 3-4. (2013).

[51] As cited in Farley, *To Cast out Disease*, 81.

[52] Wells to Washburn, 2 February 1932, RF RG 1.1. 437, box 6, folder 69.

[53] Diary Weil, RF RG 12, box 506, folder Weil.

[54] Washburn to Howard, 5 February 1931, RF RG 1.1. 437, box 6, folder 69.

[55] Opie to Sawyer, 1 September 1937, RF RG 1.1. 437, box 8, folder 99.

[56] Lambert to Flahiff, 15 August 1939, RF RG 2 437, box 181, folder 1305.

[57] Flahiff to Sawyer, 8 September 1939, RF RG 2 437, box 181, folder 1305.

[58] See my *Destined for a life of Service: Defining African-Jamaican Womanhood, 1865-1938* (Manchester: Manchester University Press, 2011), chap. 2.

[59] Wells to Washburn, RF RG 5.3, box 183, folder 2271.

[60] Report of the Kingston Tuberculosis Dispensary, quarter ending March 31/32, RF RG 5.3, box 183, folder 2275.

[61] On this campaign, see Nicole Bourbonnais, 'Class colour and contraception: the politics of birth control in Jamaica, 1938-1968', *Social and Economic Studies*, 61, 3 (2012).

[62] Flahiff diary February 1939, RF RG 12, box 154, folder Flahiff.

[63] Flahiff diary March 1939, RF RG 12, box 154, folder Flahiff.

[64] On the riots see, Thomas C. Holt, *The Problem of Freedom: Race, Labor, and Politics in Jamaica and Britain, 1832-1938* (Baltimore: Johns Hopkins University Press, 1992).