

**“From master
bleeder to European
physician”:
medicine, science,
and colonial
difference in the
Spanish Protectorate
of Morocco
(1912-1956) ***

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The article explores the role played by science and Western medicine in the colonization process undertaken by the Spanish State between 1912 and 1956 in northern Morocco. It takes into account the colonizers’ strategy of using medicine to impose the ‘superiority’ of the scientific method. They believed the ‘rhetoric of scientific truth’ would hold greater sway as an effective tool of colonization than reliance on and imposition of dogma from other, more contentious fields, like law or, particularly, religion. Sources for this study encompass different handwritten documents released by the Spanish and Moroccan administrations (Majzen), which can be found at the Archivo General de la Administración (Alcalá de Henares, Spain) and at the Biblioteca General y Archivos de Tetuán (Morocco), as well as writings by Spanish physicians in the form of monographs and journal and press articles, from both the metropolis and the colony.

KEYWORDS: hegemonic thinking; science and subordination; Spanish Protectorate of Morocco; post-colonial studies; colonial medicine.

“Why on earth must one expect a large-scale operational explanation to automatically explain the small as well? What is the reason for these explanations, which seem applicable at a general level, to be universally assumed as pre-eminent?”
(Gwyn Prim, 1991, p.383)

“For the colonized, objectivity is always directed against him”
(Frantz Fanon, 1969, p.69)

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Western medicine in the colonial space

We have elsewhere pointed out some characteristics justifying the implementation of certain health care measures in the Moroccan area of the Spanish Protectorate, such as the defence of the mother country against “exotic” epidemics and diseases, their role as an instrument for the “pacific attraction” of the colonized towards the colonizer and, finally, the protection of the colonizer’s health through the construction of health oases to isolate them from local contagion hubs (Molero, Jiménez y Martínez 2002; Medina, Molero 2002, Martínez, 2004). However, the defence and application of scientific knowledge in the colony was one of the most significant elements of the so-called, by Walter Mignolo (2003), “colonial difference”. Colonial difference is the space where it is attempted to enforce a hegemonic thinking in order to justify the inferiority of human groups; it is, in short, the product of the power relationship between the colonizers and the colonized, where “global designs” merge with “local histories” to which they must adapt and integrate or be adopted, rejected or ignored. The monopolization and control of the form of knowledge and interpretation of reality would be one of the four ways of authority described by Mignolo, together with the control exerted on the economy, politics and on gender and sexuality.

As regards the case under discussion, knowledge control becomes especially relevant due to the protectorate regime within which the colonization of Morocco took place. The State occupying the territory commits itself (at least formally), after the signing of the capitulation, to respect customs and wealth of the occupied territory. Thus, the hegemonic colonial discourse used by the colonizers to outline the basis of a supposed superiority (of all kinds) over the colonized people and of an utter justification of the occupation would not have its utmost expression in the texts pertaining to religion, justice or economy, but precisely in those not admitting any discussion on its universal value: scientific and medical texts.

Thus we are able to establish how the official propaganda of the colonizer State emphasized its respect for the indigenous

population, which was to be helped without suppressing neither their religious beliefs nor their customs, as well as to respect and acknowledge the independence of the native courts of justice. At the economic level, the protectorate system guaranteed the indigenous ownership of community assets and lands (*Habices*, linked to religious cult; those of the *Majzen* or those of the *yemaas*). Colonial propaganda also highlighted that this strategy, being respectful of the native way of life within a supposedly provisional occupation, did not prompt rejection to the presence of a foreign nation among the colonized, and would end up turning, according to physician Ruiz Albéniz's words in 1930, the "imposed protectorate" into the "desired protectorate" (Ruiz Albéniz, 1930). Concepts such as "civilist colonizing strategy", "pacific penetration" or "attraction policy", used by colonial powers, emerge from such idea, thus articulating a desire rather than an actual reality, given the high degree of violence all colonial processes entail (Morales Lezcano, 1984 and 2002).

Nevertheless, this colonial rhetoric did not conceal the "superiority" of Western civilization as it conveyed that it had reached, by means of scientific and technological knowledge, a level of wealth, prosperity and welfare unimaginable in the colonies. Only this consideration was already justifying the territorial intervention for, according to the Western discourse on "the progress", the people of Morocco, as precisely unknowledgeable of the modern scientific methodology, was situated in a lesser "degree of civilization" and, therefore, needed the help of Western countries in order to get out of its "age-old backwardness". Intentionally, medicine was the primary showcase to illustrate the advantages of adopting Western "protection" to the natives, as colonizers were convinced that, according to the words of the *Inspector General de Sanidad Exterior* (General Inspector of Foreign Health) in 1913, "the natural instinct to preserve health and life [is] very much developed even in the most backward and savage races" (Martín Salazar, 1927).

At this point, we must point out that all the assumed tolerance towards the colonized would fade away when talking about science and medicine, and, as opposed to what happened in other areas, the colonizers were unyielding and inflexible. Strategies used to overcome the "resistances" and show the "advantages of science", such as the creation of a Moroccan health workforce, the hiring of European female physicians to look after women and children, or the cost-free status of medicine (Molero, Jiménez and Martínez, 2002), were, in fact, aimed to impose scientific analysis as an hegemonic system of values. The first consequence within the health field would be the native's abandonment of traditional healing means, and the last and definitive one, the acknowledgement of science as it was understood in the West: a tool for neutral

knowledge for all humankind to benefit from, regardless of race, gender or social class.

In spite of the fact that one of the elements shaping the cultural identity of a people is its common way to know and interpret reality, Spanish physicians did not underscore religious thinking as an obstacle to their diffusion of the advantages of European science, and even less among Berbers, who, according to witnesses, were not completely Islamized. Víctor Ruiz Albéniz (Tebib el Arrumi), the physician at the Rif Mines who arrived in Morocco at the beginning of the XX century, stated in 1930 that “the Rif native is an *attenuated, very attenuated Islamic*... Few are the countryside natives making their ritual five prayers; those who precede them with Koranic ablutions are even less, and a much more reduced amount scrupulously observe the fast of Ramadan and the duty of charity” (Ruiz Albéniz, 1930, p. 59). Captain physician Julián Bravo shared this point of view, maintaining in 1932 that “few Moors make the five daily prayers. Many start Ramadan, yet give it up halfway. In all, the *kabileño* [member of the *cabila* - sociopolitical unit in Morocco] is a believer, but for sure poorly welcome by the Prophet, should he be alive in our time” (Bravo, 1932, p.112).

However, the body of native healing knowledge and practices was related, according to European physicians, to “superstition”, a pejorative term implying “deviation” from the “true beliefs” and the expression of the irrationality pervading such practices (Amster, 2003). According to Julián Bravo’s testimony, “the Maghrebis attribute their diseases to the cold, the air and above all to the *Yenun* (plural for *yin*: spirits) or demons; presided by *Iblis* or Satan” (Bravo, 1932, p.113). These beliefs gave a good number of Moroccans cause to devote themselves to healing practices and for these skills to be considered as “true professionals” by their fellow country people (Ibn Azzuz Hakim, 1953, p. 34).

This phenomenon disconcerted European physicians who did not understand the healer’s power over the natives or how health-related habits developed by these healers through the centuries were above the ones intended to be enforced. One of the most frequent complaints of the physicians working in Spanish dispensaries was about natives using European pharmaceutical products according to their particular way to understand diseases. When treating scabies, indigenous people prepared a mixture of oil, sulphur and salt to apply to their bodies while swallowing a piece of bread dipped in it. Consequently, when the European physician prescribed an ointment for this ailment, natives, despite the physicians’ opposition, ended up ingesting it (Bravo, 1932, p.92-3). The power of some talismans did not depend on the healer but on the object itself, and thus the patient or a family member could use it at their own home. This common practice among

Moroccans, as some Spanish physicians protested, prevented sick people from going themselves to the clinic but through a relative in order to ask for medicines and apply them at home, on their own and according to their tradition. Western medicine answer to these problems was also inflexible, for modern medicine implied a medical examination by "organs and systems" that could not be performed in the distance. Julián Bravo admitted that it was difficult to convince them, in such circumstances, "that it is necessary to see the patient in order to cure him" (Bravo, 1932, p.120).

Nevertheless, European physicians blamed healers as accountable for "keeping the population deceived", and did not hesitate over trying to eradicate not only non-scientific practices they considered as "aberrant" or "deviant", but also, and this is what is significant, people creating them and thus the epistemological mechanism generating and transmitting such knowledge. The underlying problem, however, was not the mere substitution of a method by another, but the fact that what was given in return was an elaborated product, already prepared for consumption, while some native healing means, those with an empirical element, were "positivized" and annexed to the Western heritage under the new scientific point of view (Arnold, 1993, p.9).

The superstition to which different healing practices were attributed to brought the European physician back to a period widely acknowledged in the West as "already overcome" and belonging to the history of medicine, studied and used in schools and faculties of medicine until recent, precisely in order to glorify the modern scientific method. Knowledge brought by European physicians was not "revealed wisdom", "empirical while relating to belief", nor even a "classical scientific" knowledge, all these categories very well studied by history of medicine and that, to a greater or lesser extent, were all present in Morocco. Here we would have two kinds of local histories that, developed in distinct spaces and times, come together in the colonial difference. The problem is that one of them, the Western one, was not portrayed as a local history but as a global design with the unequivocal aim of being hegemonic.

Once indigenous medicine were destroyed and Western medicine were imposed, the colonized were denied the "secret" sustaining scientific practices and, while they were asked to have faith in its methods, they were demoted to an auxiliary role in the task of scientific campaigning. In this way, the dependence of the colonized increases for, once the ideas of the hegemonic thinking are assumed, the colonized will need all the scaffolding surrounding scientific practices, including, of course, people and institutions holding, in the West, the monopoly of different fields of knowledge. Significantly, this irreversible dependence has been used to claim

the soundness of the scientific method when, after decolonization processes, it was verified that no people rejected scientific knowledge.

Hierarchy is established in the colonial space according to the racial and patriarchal system instituted by the West since the XVI century. All inhabitants of the planet were classified in accordance with the standard, that is: the European white and heterosexual Christian male and, after the secular ideologies which came forward after the French Revolution, conservative, liberal or socialist (Mignolo, 2003, p.35). In our case, considering the type of knowledge, we could add another two features which are also integral to the Western pattern: rational and positivist.

Science and medicine worked to definitely establish the hierarchy of domination based upon these parameters, including the monopolization of ways of knowing. In our paper, we will follow the three elements that, according to Albert Memmi, define the racist practice based upon difference. First, *differences* between the colonizer and the colonized are searched for and outlined; second, those differences are always considered for the colonizer's benefit; and, last, the differences are exalted to an "*absolute* level, asserting that they are definitive and working for them to become as such" (Memmi, 1971, p. 129). Differences so established will describe the dissimilar "*nature*" of the colonized, making resemblance with the colonizer impossible, for equality, according to this author, would destroy the power relation grating all privileges to the colonizers.

Medicine and race. In search of the difference.

The search for difference is present in the discourse of most medical authors who visited the Moroccan area to work in civilian or military health institutions. References to the native's age-old "*backwardness*" before the European's arrival were common. A quote by Juan Solsona, physician commander and ex-Inspector of the Health Care of the Protectorate (Martínez, 2003), characteristically summarizes them all:

"Moroccans remained out of civilization through the centuries, and medical knowledge had not reached them nor had they cared for searching or knowing it, or divulge and apply it. In this sense, they lived in quiet isolation, with a fatalist interpretation of life's accidents and diseases, and were immersed in the routine practice of rudimentary empirical and naturalistic healing means grouped in several ceremonies based upon superstitions" (Solsona Conillera, 1962, p.8).

The absence of a scientific medicine among the colonized became apparent, according to witnesses, due to the presence in the colony of diseases unknown or eradicated in Western countries, as well as

a more heightened development of common ailments. Some authors justified in this way the high occurrence of malaria in the north of Africa, due to "an absolute lack of knowledge of the nature of the disease" on the part of the natives, leaving them unarmed against the bite of the *Anopheles* (Solsona Conillera, 1945, p.21). It was frequent, among Spanish physicians, to think that the natives did not care about diseases, above all about those with slow development: "the Moor sick of leprosy does not feel his disease as somehow educated lepers: his intellectual knowledge is scarce and his expectations reduced... he is ignorant of his disease, and its name does not cause on him the fright and horror it does on a civilized person" (Toro Cano, 1935, p.87-8). Concerning the diseases common to all countries, Solsona pointed out that tumour wounds "reached startling looks, in the absence of people or services able to make them disappear or to attenuate their tragic seriousness and the apparent ugliness of their visible, external symptoms". As an example, he pointed at "a sick female with a vegetant lip cancer, wandering souk after souk, uselessly searching for the cure" (Solsona Conillera, 1945, p.13-4). Images underscoring exaggerated deformities were very frequent in Spanish works on Moroccan pathology, reinforcing the idea of the natives' state of "backwardness" and "abandonment" (see image n.1). In the same way, it was emphasized that, even though they were the same pathologies, they showed different developments between the colonizers and the colonized.

This "high risk" situation for the health of north-African dwellers was as well attributed to the practices numerous indigenous healers carried out in the area. These people were considered in the same way as the healers, who were outside the official medicine in the mother country, thus being branded as "quack doctors", "swindlers" and "tricksters", who, by means of rituals based upon superstitions, exploited the popular lack of "scientific" culture. These healers, always according to Spanish physicians, not only did not solve any health problem, but, in addition, caused some diseases or facilitated the transmission of others. In this context, not even those native practices with a strong empirical content were respected.

Indeed, one of the most recurrent diseases among the colonized, syphilis,



Image 1 – Upper lip angioma
Source: Solsona Conillera, Juan. Del maestro sangrador al médico. El trabajo y la generosidad de España en la evolución sanitaria de Marruecos. *Archivos del Instituto de Estudios Africanos*, v. 26, p. 7-35. 1962

was portrayed as the product of both indigenous habits and “mistaken” healing practices. The first mechanism of contagion described by European physicians was “the impure intercourse”, for, according to José Martín, “sexual habits among the Moors, notwithstanding religious obstacles, are extremely decadent”. Legal polygamy, adultery and prostitution were included in this section. The second mechanism involved common habits: “Moroccans do not know fussiness; they eat from the same dish, drink from the same glass and smoke from the same pipe”. Finally, the third mechanism of contagion was homosexuality, “here commonplace and scarcely censured”, though, as opposed to what happened in the West, it was a “routine homosexuality, easy to amend, whose only imperative is that of decadent inherited habits” (Martin Gregorio, 1932, p.295-6).

The subordination of indigenous medicine.

In relation to healing practices as syphilis contagion paths, the direct intervention of the barber-surgeon (see images n. 2 and 3), who transmitted the disease through his tools, was emphasized:

“as it is known, Moors shave their heads and pubis; he usually shaves the latter himself, yet the barber provides the tool, after having shaved many... [Other contagion vectors were:] the barber-surgeon: due to the scarifications he does and the cupping glasses and tools he never cleans up. Circumcision: performed in characteristically dirty conditions. Tattoos and teeth extraction” (Bravo, 1932, p.150-1).

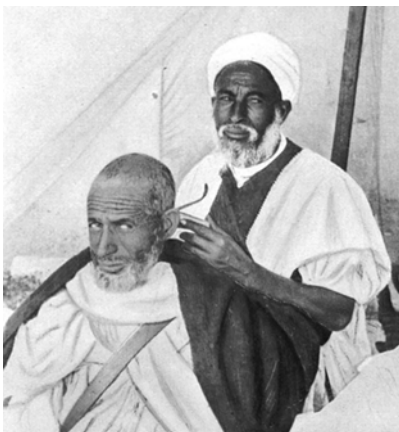


Image 2 – Barber-surgeon from the Rif at the souk. Source: Lazo García, S. *La medicina militar española en el Rif. Los Progresos de la Clínica*, v. 1, p. 193-248. 1913,

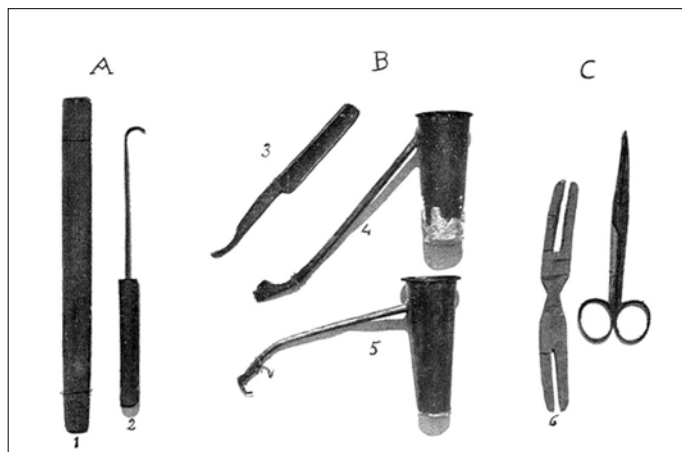


Image 3 – Equipment used for a) uvula extirpation b) bloodletting c) circumcision. Source: Bravo, Julián. *La medicina Española y la medicina indígena en Marruecos. Las Kábilas de Quebdana y Ulad Setut*. Orense, La Industrial. 1932

Attacks on native healers' practices were fiercer when they directly interfered with Western medicine, modifying pathologic symptoms or confusing the European physician's diagnosis. A paradigmatic case was the Moroccans' habit of removing the children's palatal uvula. Western physicians, unaware of this tradition, used to diagnose syphilis for any mutilation or deformity for such an appendix. Therefore, as opposed to what happened with circumcision, uvelectomy was not acknowledged as a beneficial procedure. Physician Lope García did not understand that

"as soon as the child has a persistent cough or vomits for some time, many *kabileños* call up the *ajacham*, who, making the patient's uvula lean on a rough wooden spatula, sections it by its base with some kind of sharp spoon, which many times does not cut what it is supposed to and brings about a serious haemorrhage or wounds of some importance in the soft palate, which, when healed up, may be easily mistaken for mutilations of syphilitic origin"(García de Obeso, 1930, p.210-1).

In order to show even further the danger and futility of this practice, Julián Bravo recounts the content of an interview he maintained with a native performing such operation. According to the latter, the uvula was cut off because "sometimes parents want it, so that their children may talk in a clearer way; other times for breast-fed babies to suck more easily, and because of other throat diseases", such as pains and "hoarseness". However, Bravo added that the "*surgeon*... admitted to us that sometimes children do not get better and die"(Bravo, 1932, p.91-2).

Empirical knowledge on the part of the colonized, above all those related to the plentiful botanic arsenal, was also rejected due to the magic or religious quality of allusions included in their prescriptions. This way, the *oxba*, a herbal tea made of sarsaparilla and rosemary with a healing power attributed to a spirit named *Mebruka* (blessed), who inhabited the sarsaparilla, was used for the treatment of syphilis. At the same time, when the extent of elaboration of a diet or a prescription was considerable and had a certain rational logic, no originality or merit was acknowledged to it, by looking for similarities and comparing such preparation with European medieval prescriptions. In this case, a diet that had to be observed while taking *oxba*, consisting of eating frugally and exclusively "salt-free barley bread, tender chickens, baby he-goats, four-month old lamb meat, yolks, tea and well water" and not spicy, was acknowledged by our Spanish physician as the "hunger therapy" carried out against syphilis in XVIII and XIX-century Europe (Bravo, 1932, p.93-5). Indeed, the official handbook edited by the Spanish government to aid the task of the Protectorate high-ranking officers in charge reminded them "that if, some time before,

[medicine in Morocco] could have been splendid, it has completely lost the superb teachings of other times, and nowadays the physician does not practically exist, but the quack doctor, without any scientific foundation" (*Manual...*, 1928, p.234).

In this sense, it is worth pointing out the Spanish physicians' reactions to the presence in Morocco of the "last Moorish scientific physician" remaining in Tetouan, Sidi Mohamed ben Hosmi el Bakali, reader of Avicenna's Canon, which was set in the Middle Ages and belonging to a historical time already overcome by Europeans (see image n.4). In 1929, the journal *Marruecos Sanitario* began its course with an interview with this traditional physician in which, in spite of the proximity of Morocco, all the topics of the time about the splendour of the Arab past were present:

"the contemplation of this elderly man, of gentle bearing and serene majesty, affect us to such degree of abstraction that our imagination evokes in us the feeling of living for a short while in a remote time, by means of a gigantic leap backward" (Amiguetei y Cajal, 1929, p.12).

Thus, one of the objectives proposed by the Spanish physicians who created the journal in Tetouan was achieved: "... to investigate what scientific level is currently held by Moorish medicine, diving into the underworld of the souk quack doctor's trickster empiricism,



Image 4 – The traditional physician from Tetouan Sidi Mohamed ben Hosmi el Bakali
Source: Bravo, Julián. *La medicina Española y la medicina indígena en Marruecos. Las Kábilas de Quebdana y Ulad Setut*. Orense, La Industrial. 1932

prying among the professionals of the art of healing, going deeply into its roots, in order to find the remains or vestiges left from that thriving time of Cordoba’s Caliphate...” (ibidem, p.10). However, testimonies we have been able to gather suggest us that the Spanish physicians approached the native healers in order to discredit them.

José Sievert, director of the Spanish Laboratory in Tanger, recounted the case of a fictitious treatment applied to a female patient that “thought to have worms in her ear”:

“[the patient] went for help to one of those female healers and I was allowed to attend the cure due to my fake wish to admire and learn so many wonders. After a long conversation and aided by a hollow straw, she hauled out worms from her ear in such amount that they filled an ordinary glass of water. The game was extremely simple: the female quack doctor had the worms ready, being these larvae from the fly *Cophaga carnaria*, grown in a slice of carrion, and with great skill she faked sucking from inside the ear and then she soundly blew them out of the straw into the glass. This she repeated with a great number of small straws, one of which I could provide myself with and which I found filled with worms before being used” (Sievert, 1929, p.48).

In other occasions, the physician waited his turn in the souks only to take action after the quack doctor’s failure in order to show the uselessness of the other’s remedies and, at the same time, the effectiveness of his own. One of these cases is recounted by Bravo in relation to the healing amulets (*hayab* or *jaraz en chelja*), more often used in the area, according to this author, than the preventive ones:

“During our performance as the physician in these *kabilas* [Quebdana y Ulad Setut], we had to allow the *collaboration of friars* in the treatment of patients; yet taking advantage of the right chances, when the patient had already used up all the magic resources, the precise application of a drug or the surgical intervention would demonstrate the uselessness of the amulets” (Bravo, 1932, p.120).

The magic-religious component that went with all healing practices, including those with a high empirical constituent, was also mocked by the Spanish physicians who published their experiences with these healers as “anecdotes” of their stay in Morocco. One recounted by military physician Bertoloty starts from a complaint he himself made to the *Bajá* (the city’s governor) against a dentist-barber who had extracted, together with the back tooth, a piece of jaw from a native soldier of his regiment. The Moroccan authority, according to this physician, “agreed to administer a good few blows to the *doctor* for him to sharpen his technique”. Shortly

afterwards, Bertoloty was sent for by the *Bajá* in order to attend to the explanation the dentist-barber wished to offer him and which we transcribe below:

“That he could not take the blows away as he had already received them, but he did wish his reputation to be saved, and thus he had gathered together all the colleagues from his trade who, acquainted with the case, had subscribed to the following conclusions which he wanted me to know, precisely in front of the authority who had ruled against him. First, that the extraction had been correctly carried out, because the tool was good, the position adequate, and through the known technique, and above all that, the will, which had been left to God. Second, that neither I nor the tool, nor the position, nor the technique, nor the will were accountable for the jawbone to have gone behind the tooth” (Bertoloty, 1930).

The “infallibility” of European medicine.

Together with the discredit and undermining of the indigenous medicine and its practitioners, the strategy of the Spanish administration in order to definitely enforce the scientific discourse and practices consisted of showing, exaggerating, and sometimes manipulating the advantages and excellence of Western medicine. Propaganda messages combined these two premises as it can be seen in image n.5, in which “swindler” healers are set against the “scientific medicine” offered at the Western dispensaries. Health care and medical technology displayed in health care campaigns, free assistance, and all other strategies mentioned above, would aim to show Western science and medicine as the only valid means for the healing and prevention of diseases.

The aim of discrediting indigenous medicine and the need to show the infallibility of Western medicine prompted the Spanish authorities to train physicians deployed in indigenous dispensaries in the “self-interested” use of their treatments. The *Manual para el Servicio del Oficial de Intervención en Marruecos* (*Service Handbook for the Intervention Official in Morocco*) included the following instructions pertaining to the behaviour physicians had to observe in the souks when competing with native healers:

“To all those [patients] whose consequence is worth will [the physician] have to assist, and in all of them he will have numerous and excellent occasions to carry out his necessary and charitable mission. He must, therefore, be provided with the suitable equipment for the implementation of this travelling Medicine and not forget that, above all in the first stages, his beneficial action must «captivate» the natives, as it is ordinarily said. This means that, if in doubt of a convincing success, he must avoid

the treatment of a case, excusing himself as much as possible. He will not waste, in turn, any occasion to achieve a brilliant and showy triumph. This, above all, is exploitable in surgical interventions, where the physician must never run the risk of a



Image 5 – Propaganda poster about indigenous dispensaries. Source: Solsona Conillera, Juan. *Del maestro sangrador al médico. El trabajo y la generosidad de España en la evolución sanitaria de Marruecos. Archivos del Instituto de Estudios Africanos*, v. 26, p. 7-35. 1962

failure. Then again, the clear cases must be prepared and carried out with the utmost publicity and theatricality. Natives are extremely impressionable, and this quality on their part must be taken advantage of with skill by the physicians" (*Manual...*, 1928, p.206).

Ignacio Iribarren confirmed, in 1942, the existence of these practices that he himself carried out when he was a military physician in Morocco. The selection of patients to be treated with the resources of Western medicine, according to Iribarren, was essential for the success of the colonization, for the prestige of the occupying country and the trustworthiness of its most visible tool, science, were at stake:

"the physician's failure is not only the individual failure, but brings with it the failure of the protecting Nation. There must not be forgotten that the physician's mission also bears a political aim that should not be impaired with interventions of a more-or-less random success. This was very much taken into account by the Chief Officers of the military Interventions and it has not been the first time that the physician is asked by the Chief Officer of the Intervention about the possible curability of a native that should be brought in, before advising the patient to go to Surgery. In this way, we got rid at the beginning of quite a few hard times" (Iribarren Cuartero, 1942, p.18-9).

The strategy the physician had to apply in order to collaborate in the ultimate implementation of Western medicine and the eradication of indigenous practices was summarized by Bravo in 1932, who thought that the physician's role should go further than "treating a wound, give ointment for scabies, or smudge the chest with iodine". Indeed, the Spanish physician, watchful of what official orders recommended and according to this author, should take advantage of the occasions in which interventions were easy and surely successful, yet, if he were afraid the treatment would fail and could not avoid applying it, the natives' religious and fatalist interpretation of disease should be resorted to, "leaving Allah (the *Mektub* [it is written] or the *Ynch Allah* [God willing]) to be held well accountable for the medical results" (Bravo, 1932, p.70).

The Moroccan in the eyes of scientific medicine

Finally, in the process of epistemological subordination, the scientific-medical discourse worked for the differences between the colonized and the colonizers, always to the latter's advantage, to be "essential" and thus definitive. According to Memmi, the idea intended to be transmitted from the hegemonic system of values is that Europeans had conquered the world thanks to their nature

predisposing them to it, whereas non-Europeans were colonized because their nature so condemned them (Memmi, 1971, p. 177). Certainly, and even if Memmi thinks that a racist prejudice hides behind this assertion, Western science will be the one certifying the distinct "nature" of one and the other, beginning with the forging in the minds of the natives the idea that they were immersed in "barbarism" before the Westerners' arrival (Said, 1990).

In 1930, Víctor Ruiz Albéniz prefers to give his own opinion on the psychology of the Rif natives as he acquired his experience "in a period and circumstances in which these natives did not have to conceal their character and habits", something they seemed to be doing later, confirming one of the most frequently cited features of the colonized: the art of deceit. Indeed, according to this physician, their "essential defects" and thus belonging to their nature were: "covetousness; distrust and concealing of the truth; boundless penchant for money; lack of social discipline; cruelty in war and vengeful spirit" (Ruiz Albeníz, 1930, p.58 and 62-3).

This index of the Moroccan's traits is repeated in other texts written by Spanish physicians who also prided themselves on having lived for years together with the colonized. Julián Bravo, military physician in charge of the dispensary of the Quebdana and Ulad Setut *Cábilas*, was opposed to the opinions defending the racial degeneration in which Rif people was allegedly immersed. According to this physician, this assertion would not be possible simply because "they never had any wealth to lose. They are like centuries ago; that's all... As a people, they are still living their infancy, they have their own features" (Bravo, 1932, p.106).

Among these features, he underlined the following: "he is lazy... Fond of keeping what is other's, liar and dirty... He does not have in general any notion of cleanliness or hygiene. Even if he washes himself and changes his clothes, he is not bothered by ectoparasites walking on his garments... Proud, above all the Arabs, who zealously keep their genealogy, thus preventing the mix up with others. As a civil servant, he is usually venal. He ignores order, method, and organization. [However], we do not count as a defect the predominance of his sexual passion... The well-known fanaticism, from his religion or from its most distant origins, weighs on him: the *Suerte Munana* (the *Mektub Allah*) constitutes the basis of his philosophy" (ibidem, p.106 and 108).

These ideas on the natives' character were not only addressed to other European scientists (in our case, readers of medical journals) but also, through other divulging publications, to all social layers both in the mother country and the colony. Indeed, colonialism, as Madan Sarup sustains, is a co-operative endeavour albeit not even-handed, and needs the colonized to take up the "truths" coming from Western science, even if it leaves the colonized

in a situation of inferiority (Sarup, 1999, p. 24). Scientific discourse had enough strength to impose the hegemonic way of thinking to the colonized as an absolute and undisputable truth. Frantz Fanon recounts how some French psychiatrists in the occupied Algeria worked up a theory defending that the Algerian was a natural-born criminal. Aggressive behaviour would then be coherent with their biology for, just like among inferior vertebrate animals, the diencephalus was predominant over the cerebral cortex. This theory held that “there is, therefore, no mystery or paradox. The colonizer’s reluctance to entrust the native with a task is not racism nor paternalism, but simply a scientific appreciation of the biologically limited potential of the colonized” (Fanon, 1969, p. 279). Algerian students of medicine at the Faculty of Algiers had to study and learn it. One of them, upon orally rendering these theories, added: “It is hard to swallow, but it is scientifically proven” (Fanon 1969, p. 276).

The case Fanon shows us should not be misleading about the role science assigned to the colonized in their development. The fact that some Algerians belonging to the indigenous elites could study medicine does not mean it was commonplace. Much on the contrary, the epistemological subordination entailed longest possible lengthening of the scientific and technological dependence of the colonized countries. Science and medicine were offered in the colonies as an elaborated product, demoting the natives to an auxiliary role in its development. In 1953, according to Ibn Azzuz Hakim (1953, p. 44), there were 105 general practitioners working in the official Health Care service of the Protectorate, of which only two were Moroccans, while among the auxiliary personnel their number raised to 30 nurses and 30 midwives. When Morocco became independent in 1956, there were, including both areas (French and Spanish), not more than 28 Moroccan physicians (Martín 1973, p. 8).

The long-term adoption and subordination on the part of the colonized peoples of the assumptions and methods of Western science would fulfil the process of domination and dependence of those peoples under the sign of globalization. Once the dissimilar ways of knowing had been destroyed or assimilated, the scientific method would be the only suitable key for the interpretation of the world to the advantage of the hegemonic system of values.

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