States of Emergency:
Colonial Doctors, Violence, and the End of Empire
in Kenya and Algeria, 1952-1962

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Abstract

Medical involvement in acts of violence, especially torture, seem irreconcilable with the ethics of professional conduct as reflected in *The Hippocratic Oath* and enshrined in post-war medical ethics codes and the human rights regime. Through a comparative assessment of doctors involved in the counterinsurgency campaigns in French Algeria and British Kenya during the 1950s, this thesis will demonstrate the varying degrees to which a range of medical experts came to actively or passively support the practice of torture and other forms of repressive violence in these colonial conflicts. Remarkably, the role medical professionals played in counterinsurgency efforts, especially in relation to actual violent practices during states of emergency, has received little cogent historical attention. This is especially true for the final years of the colonial era when both France and Britain encountered violent challenges to their rule. In these contexts, the colonial authorities used wide-ranging emergency powers to establish networks of detention centres, camps, and resettlement villages to interrogate and hold suspected 'terrorists' and troublesome populations. Within these centres, detainees experienced harsh conditions and a pervasive atmosphere of violence which was, to a lesser or greater degree, monitored and sustained by medical experts working for the colonial authorities.

This thesis represents the first detailed comparative history of medical involvement in French and British counterinsurgency violence in Algeria and Kenya. It adopts a diachronic approach that examines the place of medicine and its practitioners within the wider social, economic and political milieu of the respective colonies and reveals them to be complex and deeply embedded social actors within these territories. As such, doctors working and living in the colonies had various personal stakes in the survival of the colonial order. These interests, this thesis argues, coupled with their loyalties to the colonial authorities, sometimes resulted in practitioners taking part in torture and other inhumane acts. To achieve this, the thesis utilises a range of recently declassified archives in both France and Britain, which allows it to unite multiple disparate historiographical trends related to colonial violence, medical participation in human rights violations, and the history of colonial medicine more generally. In particular, the study examines the concept of the 'dual loyalty dilemma' to assess the various pressures that may have led doctors to participate in violence. The findings of this work highlight the importance local factors on the ground played in shaping the conduct and extent to which a given doctor became entangled in the wider atmosphere of violence in these conflicts, which should caution us against simplistic explanations for why individuals participate in atrocities.

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Acronyms and abbreviations

Abbreviations	Meaning
ALN	Armée de libération nationale
AMREF	African Medical Research Foundation
BCMS	Bible Churchmen's Missionary Society
BMA	British Medical Association, London
BMJ	The British Medical Journal
CMS	Colonial Medical Service
CRUA	Comité révolutionnaire d'unité et d'action
CSDIC	Combined Services Detailed Interrogation Centre
CTT	Centres de tri et transit
DPU	Dispositif de Protection Urbaine
ECHR	European Convention on Human Rights
FCO	Foreign and Commonwealth Office, London
FLN	Front de Libération Nationale
FNF	Front National Français
IBEAC	Imperial British East Africa Company
ICRC	International Committee of the Red Cross, Geneva
KAR	King's African Rifles
KCA	Kikuyu Central Association
KCU	Kikuyu African Union
KNA	Kenya National Archives, Nairobi
KPR	Kenya Police Reserves
LNHO	League of Nation's Health Organization
LSD	Lysergic acid
MNE	Mouvement national des étudiants
MNLA	Malayan National Liberation Army

MTLD	Le Mouvement pour le triomphe des libertés démocratiques
OAS	Organisation de l’Armée Secrète
ORAF	L'Organisation de la résistance de l'Algérie française
PCA	Parti Communiste Algerien
PoW	Prisoners of war
PPA	Parti Populaire Algérien
RPO	Reserve Police Officer
SAS	Sections administratives spécialisées
SHD	Le Service historique de la Défense, Paris
SMC	Service médical de colonisation
SOAS	The School of Oriental & African Studies, London
TNA	The National Archives, London
UFNA	Union française nord-africaine
UNCAT	The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
WHO	The World Health Organisation, Geneva
WMA	The World Medical Association, Ferney-Voltaire

Author’s declaration

I declare that this thesis is a presentation of original work and I am the sole author. This work has not previously been presented for an award at this, or any other, university. All sources are acknowledged as references.

Introduction

On the night of the 12 June 1957, Henri Alleg, a French-Algerian citizen and editor of the anticolonial paper, *Alger républicain*, was arrested by French police on the streets of Algiers while *en route* to visit the home of Maurice Audin, a fellow member of the banned *Parti Communiste Algerien* (PCA). Once in custody, Alleg was handed to a paratrooper division that had recently taken control of Algiers, the capital city of France's treasured colony in order to root-out supporters of the Algerian nationalist group known as the *Front de Libération Nationale* (FLN). Since November 1954, these anticolonial insurgents had been engaged in an increasingly bloody guerrilla war against their European colonisers, which saw both sides perpetrating extreme forms of violence. Alleg was subsequently taken and held for a month at the El-Biar detention centre in a suburb of Algiers, despite having no charges brought against him.[1] During his detention, he was subjected to a variety of torture techniques at the hands of his captors: he was burnt, electrocuted, held underwater to simulate drowning and was suspended from the ceiling in painful positions. Despite this treatment, Alleg refused to answer his interrogators questions. Frustrated, one soldier told him explicitly that they had 'scientific ways […] to make [him] talk'.[2] The following morning, Alleg was escorted to 'the infirmary', where he met a military doctor, a captain who identified himself as 'Marcel'. After explaining to Alleg that 'I shall not hurt you and I promise not to do you any harm', Marcel injected him with sodium pentothal, a barbiturate favoured at the time as a 'truth serum' among some psychiatrists and police investigators. While Alleg was under the influence of this drug, Marcel questioned him about the location of a FLN operative. Despite the drug's influence, Alleg was able to stay silent and gave nothing away to this doctor-cum-interrogator.[3]

[1] Henri Alleg, *La Question* (Paris: Les Éditions de Minuit, 1958), p. 7.
[2] Ibid., p. 53.
[3] Ibid., pp. 54-60.

As the fires of revolution were starting to spread across French North Africa in what is now known as the Algerian War of Independence, a similar revolutionary struggle was already underway in the British East African colony of Kenya. In late August 1954, Josiah Mwangi Kariuki, a young member of the African nationalist insurgent group known as Mau Mau, was transferred from the British detention camp at Langata to one at Manyani, in Kenya's coastal province.[4] This particular facility was designed to house the more recalcitrant members of the rebel organisation who had been in armed conflict with the British authorities since October 1952. At the time of their arrival at Manyani, Kariuki and his fellow detainees would have faced cramped and degraded conditions as the camp was in the middle of a typhoid epidemic which the British authorities were desperate to conceal from the public.[5] Yet while typhoid, born from insanitary conditions, was spreading throughout the site, the detainees at Manyani were also being routinely beaten and abused by camp warders. According to Kariuki's memoir, published a year after Kenya gained its independence in 1963, six detainees were killed by 'special Riot Squad' at the end of 1954 in an effort to 'teach [the detainees] a lesson'.[6] Rather than admit to such abuse, the British authorities used the epidemic to conceal their use of violence: the deaths were explained away as additional typhoid victims.[7] Although the six detainees died in the camp hospital run by a Dr. Kirren, there is no indication that the health professionals working at the facility attempted to correct the account. Indeed, when discussing the violence with Kariuki, Kirren allegedly explained that, when it came to abuse, his duty was merely 'to cure detainees who had typhoid, not those who were ill from beatings'.[8] It is not clear whether Kirren was demarcating the limits of his responsibilities or expressing outrage at the conditions in the camp. What is clear, however, is that he did not prevent further

[4] Josiah Mwangi Kariuki, *Mau Mau detainee: the account by a Kenya African of his experience in detention camps 1953-60* (Penguin, 1964), p. 91.
[5] By September 1954, the epidemic was so advanced that it had spread to Langata camp as well as the nearby Mackinnon Road camp. By October, the infection had claimed at least 86 lives, while hundreds of others were to be infected before it ended towards December of that year. TNA CO 822/801. 'Manyani Camp Typhoid Epidemic: Report by Director of Medical Services', 13 October 1954. See also David Anderson, *Histories of the Hanged: The Dirty War in Kenya and the End of Empire* (New York and London: W.W. Norton & Company, 2005), pp. 318-320.
[6] Ibid.
[7] Kariuki, *Mau Mau detainee*, p. 97.
[8] Ibid., p. 98.

abuse from taking place. There are no records of any doctors complaining about the use of violence in the Kenyan detention camps, nor any signs that they challenged the practice more generally. The concern, it seems, was merely for preventing and treating sickness and disease.

The two cases presented here, Alleg's experience of torture in French Algeria and Kariuki's account of violence in British Kenya, draw attention to an underexplored feature of these colonial wars of independence. That is, the role medical professionals and the institutions of medicine played in supporting the perpetration of violence by European security forces. In both examples, doctors employed by the state operated in direct proximity to the exercise of torture and other forms of violence in detention facilities controlled by the imperial powers. In one case, a military doctor allegedly participated in the interrogation of a helpless prisoner, while, in the other, a physician working within the confines of a camp appears to show little concern for evidence of beatings. Whether it is a case of actively taking part in violence or performing duties which enable the victims of torture to continue to experience such trauma, the therapeutic and ethical role of the doctor is drawn into question. For example, despite his claims to 'not hurt' Alleg and to do him 'no harm', few would regard the non-consensual use of drugs on a helpless detainee to be therapeutic or in his best interests. Similarly, historians should question whether Kirren's unwillingness or inability to address the violent conditions in Manyani camp was a personal failing or evidence of widespread apathy or tacit approval for such practices among health professionals in the colony. At a broad level, both cases raise serious ethical questions about the extent and the ways that doctors and other medical experts working in these two colonies assisted with the use of torture and other abuses during these rebellions.

This thesis represents the first comparative historical investigation into this subject. It will demonstrate that doctors in 1950s North and East Africa were involved in a variety of violent interventions that sought to coerce troublesome populations into complying with colonial rule

and its demands.[9] This work will show that, in these two contexts, a range of medical experts undertook activities that supported torture and other forms of repressive violence. Remarkably, the role medical professionals can play in counterinsurgency efforts, especially in relation to the perpetration of actual violence during official states of emergency, has received little cogent historical attention. This is especially true for the final years of the colonial era, when both Britain and France encountered violent challenges to their authority. In these contexts, the colonial authorities used wide-ranging emergency powers to establish networks of detention centres, camps and resettlement villages to interrogate and hold suspected terrorists and troublesome populations. Within these centres, detainees experienced harsh conditions and a pervasive atmosphere of violence which was, to a lesser or greater degree, monitored and sustained by medical experts working for the state. This historical blind-spot is thus regrettable, as research into these practices can offer valuable comparative perspectives for understanding more recent experiences with counterterrorist campaigns, such as the War on Terror, and current debates surrounding medical and scientific participation in state-engineered repression.[10]

The aim of the present study is to unite several historiographic trends related to violence in these two emergencies, medical involvement in torture and other inhumane acts, and the history of colonial medicine more generally. It does so by consulting a range of recently

[9] Today, doctors are often recognised as the enforcers and monitors of the international human rights regime; their participation in acts of organised and systematised violence is therefore seen as inherently wrong or concerning. The roles within this capacity of protecting human rights is enshrined within the four Geneva Conventions of 1949 and the two Additional Protocols of 1977, as well as the World Medical Association's *Tokyo Declaration*, 1975.

[10] In 2004, members of the US army and the CIA used torture and other cruel and inhumane acts such as rape and even murder on detainees being held at the Abu Ghraib prison in Iraq. Although military doctors did not participate directly in the abuse, significant questions were asked as to where they were and why they did not try to stop it. More recently, in 2014, *The New York Times* and, later, Human Rights Watch called for two American psychologists, John Bruce Jenson and James Elmer Mitchell, to be investigated and tried for their development of a set of 'enhanced interrogation techniques' which were used by the CIA to interrogate detainees in Afghanistan. In 2017, the lawsuit against these two scientists was settled outside of court. Since then, in 2018, the American Civil Liberties Union managed to win the release of a 90-page account of the CIA's Medical Services involvement in torture, which demonstrates the extent to which military physicians willingly and actively took part in American torture activities in Iraq and Afghanistan.

declassified archives in London and Paris, which have hitherto been underexplored in relation to the subject of medical participation in the torture campaigns waged by British and French colonial security forces during these conflicts. Through these documents, it is possible to examine whether or not a sustained and careful comparative examination of medicine, both as an institution and through the actions of its various practitioners, can shine new light on the nature of violence during the two colonies' emergencies. The thesis achieves this by adopting a cross-cultural comparative study of medical experts involved in colonial counterinsurgency programmes aimed at the suppression and interrogation of rebels during the 1950s and the early 1960s. Specifically, it compares the British efforts to suppress the Mau Mau uprising in Kenya (1952-1960) with France's contemporaneous struggle against the FLN in Algeria (1954-1962). While this work examines the place of medicine and its practitioners within the colonial environments of North and East Africa, it makes no claim to be either a history of medical policy or procedure in Algeria and Kenya, nor does it attempt to provide an exhaustive account of decolonisation in either context, despite touching on both of these subjects. Instead, it presents a comparative and diachronic approach locating medicine and its various practitioners not only within the wider colonial order in both territories, but also in relation to contemporary international ideas and practices generated in the immediate postwar years. This, it shall be shown, elicits similarities and differences in the types of conditions, pressures and incentives that led some doctors to become complicit in colonial violence. The work has therefore resisted simply reconstructing and assessing the various ways these professionals took part in regimes of violence. To do so would have sundered these historical actors from their context and reduced the complicated relationship between colonists, of whom the doctors discussed here were a part, and colonised to mere caricature. Moreover, this thesis does not wish to suggest that all colonial doctors were unfeeling and immoral agents of the state, or that they all necessarily supported or took part in the respective counterinsurgency efforts.[11]

[11] Indeed, there are explicit instances of doctors who resisted and challenged the nature of the conflicts and actively supported the rebels in their fight, especially in Algeria. However, an assessment of these individual's activities rests beyond the scope of this thesis.

Many medical professionals within both Kenya and Algeria, as well as others across the empires, were motivated by genuine desires to help the indigenous populations and to extend the perceived benefits of western healing practices to those under colonial rule.

However, as will be demonstrated in this work, doctors, both as a profession and as individuals, were deeply embedded within the cultural, economic, political and social milieu of the colonies, and therefore often had a direct stake in the maintenance of these environments. Moreover, once violence eventually broke out, the colonial powers utilised the expertise of a range of medical practitioners, psychiatrists and other scientists of the mind to explain the psychological state of the rebels, the causes of their apparent violent mindsets and the appropriate responses needed to quell nationalist agitation. In both contexts, these experts drew on and reinforced old racial prejudices and pseudo-scientific concepts concerning the innate inferiority and perceived savagery of the nationalists. But rather than being simply agents of empire (as will be discussed below), this analysis will also highlight points of tension and conflict between some colonial doctors and the imperial authorities. When the future of the colonies was in question, members of this profession were among the most outspoken, active and sometimes aggressive defenders of colonial rule. This, however, did not mean that they invariably supported the methods employed by the colonial administration. At times, when it appeared that official approaches were failing, doctors took the law into their own hands and formed militia groups or counterterrorist organisations that were equally hostile to the government. Nevertheless, when the security forces interrogated suspected 'terrorists' in police stations, detention camps and other locations, doctors working for the imperial authorities were rarely far from sight. Sometimes these professionals merely monitored the health of detainees prior to their interrogation or administered treatment after they had been tortured. At other times, though admittedly less frequently, doctors took an active role in the interrogation processes itself and helped the security forces cover-up evidence of abuse.

While this comparison reveals common themes and features regarding the ways in which doctors participated in wider cultures of violence, it also exposes key differences. This thesis demonstrates that although doctors provided vital support in the exercise of colonial violence during the emergencies, the nature and degree of this participation cannot be generalised, as local factors played an important role in determining how and why a given physician took part.

Historical background

Before addressing the anatomy of this thesis in more detail, it is worth exploring the recent historical events and changes in the historiography of colonial violence that enabled it to come together. Following his torture, Henri Alleg became one of the first to use his personal experience of trauma at the hands of the French military to draw public attention to their conduct in Algeria. With the passage of time, other testimonies have come to light, as participants in the Algerian War have, as Mildred Mortimer notes, 'begun to unburden themselves of guarded secrets'.[12] Similarly, Kariuki's account was among the first wave of 'Mau Mau' memoirs to explain life behind the barbed-wire of Britain's detention camps in Kenya. As such, the details of these two accounts have been known to scholars for decades. Even so, the role played by the doctors in both accounts remain underexplored. Indeed, the contribution of medicine to the violence of these two colonial wars more generally has largely fallen outside the scope of existing studies. This may be because, until recently, historians lacked the necessary documentary evidence to make sense of what appeared to be comparatively minor features of two otherwise sensational stories about wider abuses. However, recent high-profile scandals related to the legacy of these two colonial wars, as well as a distinct evolution in the historiography of colonial violence more generally, have brought to light previously unknown archives for historical research. This section focuses on these

[12] Mildred Mortimer, 'Tortured Bodies, Resilient Souls: Algeria's Women Combatants Depicted by Danièle Djamila Amrane-Minne, Louisette Ighilahriz, and Assia Djebar', *Research in African Literatures*, 43 (2012), 101-117 (p. 107).

developments and the impact they have had on our understanding of violence during the Kenya and Algerian emergencies. This provides a crucial background for assessing the place of the current study in relation to this literature and how an investigation into the role of medicine can provide new perspectives on the application of violence in these conflicts.

It has long been known that excessive violence such as torture was used by French and British forces during the Algerian War and the Mau Mau uprising, respectively, as the cases opening this chapter illustrate. Until recently, however, it was not clear to what extent such violence had been exceptional or how aware the respective colonial governments had been of its use. The British approach to counterinsurgency operations in Kenya, as well as other locations, has often been perceived as less heavy-handed and violent than that of other colonial powers. In fact, until the late 1990s, Britain's methods for suppressing African insurgents were hailed as exemplary; they represented a more civilised and peaceful approach to non-conventional warfare in the postwar period which utilised 'minimum force' to appeal to the loyalties and sensibilities of colonial subjects.[13] This success is often contrasted with France's failed counter-revolutionary tactics in Indochina and Algeria, which were known to be more violent. As such, the Algerian War has had a longer and more explicit association with the practice of torture than its East African counterpart.

There are a number of explanations for this. Firstly, ever since the early days of the Algerian War, reports of torture, such as Henri Alleg's allegations, generated international outrage at France's tactics in North Africa.[14] Secondly, as David Anderson has noted, the British have

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[13] For instance, Robert Thompson's 1966 book, *Defeating Communist Insurgency*, is recognised as one of the influential sources that promoted a special British approach to winning insurgency wars. More recently, scholars like Thomas Mockaitis have published a number of studies that praise the successes of British counterinsurgency campaigns in Malaya, Cyprus and Northern Ireland. Although Mockaitis acknowledges that the situation in Kenya was not always as 'clean' as in other conflicts, any use of excessive violence—in his view—was the work of untrained police personnel at the local level and was confined to the start of the emergency. See Thomas R. Mockitis, 'The Origins of British counter-insurgency', *Small Wars & Insurgencies*, 1 (1990), 209-225 (p. 223).

[14] During the Algerian War itself, several high-profile cases were reported to French and international audiences which made detailed allegations of the use of torture by French forces. In particular, the cases of Henri Alleg, Maurice Audin, Djamila Bouhired and Djamila Boupacha were reported in the

always been 'coy' about digging into the unsettling features of their colonial past.[15] Torture has long been identified as a double-edged and destructive weapon in any war—one which can have serious corrosive effects on the prestige and reputation of the states which practise it.[16] As such, allegations of its use by British colonial forces were allowed to disappear for many decades.[17] Thirdly, and more significantly, the reason why torture in Algeria has received wider academic and public attention is because of events that took place at the end of the 1990s. The court trial of Maurice Papon in 1997-1998 for crimes against humanity committed during the Second World War brought wide attention to police violence against Algerian protestors in Paris, in 1961.[18] The trial raised questions about France's past activities during the war and turned attention towards the availability of police and military archives for historical work. In addition, in 2001, Louisette Ighilahriz, a former FLN militant, published her memoir detailing the appalling treatment she had received at the hands of the notorious 10th Parachute Division while being detained over a ten-week period in 1957.[19] Her account implicated prominent military officers who served in the Battle of Algiers as being personally involved, and triggered a large public debate about torture. Ighilahriz's account corroborated details from the earlier memoir of General Jacques Massu, who had personally overseen the use of torture at the time when Ighilahriz and Alleg were being detained.[20] In the same year that Ighilahriz published her memoir, Paul Aussaresses produced his unrepentant account, which not only confessed to using torture and murdering FLN nationalists in Algeria, but also actively praised the results of such activities.[21] Thus, what started with Papon's trial quickly

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French press, bringing the realities of the military's conduct to the metropole. In addition, during and soon after the war, a number of historians began publishing accounts of the struggle which kept the subject of torture within French memory.

[15] David Anderson, *Histories of the Hanged: The Dirty War in Kenya and the End of Empire* (New York and London: W.W. Norton & Company, 2005), pp. 292-293.

[16] Ibid.

[17] Ibid.

[18] Joshua Cole, 'Massacres and their historians: Recent histories of state violence in France and Algeria in the twentieth century', *French Politics, Culture & Society*, 28 (2010), 106-126 (pp. 106-107).

[19] Louisette Ighilahriz, *Algérianne. R*écit recueilli par Anne Nivat (Paris: Fayard/Calmann-Lévy, 2001).

[20] Jacques Massu, *La Vraie bataille d'Alger* (Paris: Plon, 1971).

[21] Neil Macmaster, 'The torture controversy (1998-2002): Towards a 'new history' of the Algerian war?', *Modern & Contemporary France*, 10 (2002), 449-459 (p. 450). See also Paul Aussaresses, *The*

turned into a new social and political-cultural attitude in France, one that sought to understand the role of torture in its colonial past.

In Britain, the situation changed between 2009 and 2012, when the High Court ruled against the Foreign and Commonwealth Office (FCO) after five elderly Kenyan claimants filed suits against their former colonial rulers. These Mau Mau veterans alleged that, while being held by British security forces during the Kenya Emergency, they had been subjected to torture and various other abuses in the British detention and screening camps. This case, as Caroline Elkins has observed, '[stirred] the strategic amnesia of the British colonial government', leading to the disclosure of thousands of new end-of-empire documents that had previously been hidden away in a high security facility in Hanslope Park, near Milton Keynes.[22] The 'Hanslope Disclosure', or 'Migrated Archives' as it is often referred to, contains 8,000 files pertaining to thirty-seven former colonies and revealing detailed evidence of the extent to which excessive violence was used during the British counterinsurgency efforts. For Elkins, who served alongside David Anderson and Huw Bennett as a historical expert witness for the trial, the fact that these files 'had been spirited away [from Kenya] at the time of decolonization' was evidence of a wider British plan to bury the secrets of its torturous past.[23] She argues, compellingly, that the circumstances surrounding the disappearance of these files is itself a story worth telling, especially as, in addition to illuminating the extent of violence taking place in the camps, they reveal the degree to which the colonial state in London—including but not limited to the Colonial Office—was complicit in condoning and covering it up.[24]

Battle of the Casbah: Terrorism and Counter-Terrorism in Algeria, 1955-1957, trans. by Robert L. Miller (New York: Enigma Books, 2004).

[22] Caroline Elkins, 'Looking beyond Mau Mau: Archiving Violence in the Era of Decolonization', *The American Historical Review*, 120 (2015), 852-868 (p. 857).

[23] Ibid.

[24] Ibid., p. 860.

It is these recently disclosed sets of documents released by the French and British governments, along with other official (especially for the Kenya case) and unofficial records and other published materials, which form the core of the present study.[25] Scholars who have already accessed these archives, as will be shown below, have highlighted several important themes for understanding the ways in which torture and related violence were exercised in these wars. Firstly, research has demonstrated that the practice was not just common among the colonial police, military and other members of the colonial security forces during the wars, its practice also took different forms in each context which changed over time. For instance, Raphaëlle Branche has shown that, rather than being an isolated phenomenon practised by a few fanatical French soldiers, torture was in fact an instrumental part of the military's approach to population control in Algeria. As she says, it was a 'weapon of war, a violence used by design' to defeat a revolutionary enemy.[26] For torture's apologists, both during the Algerian War and more recently, this was a key argument to justify its use: torture, they contend, was a vital method for obtaining operational intelligence in a new type of conflict, one taking place within heavily populated urban centres riddled with 'terrorist' networks.[27] Central to this logic, Branche has shown, is the assumption that those undergoing interrogation had something to confess and were therefore guilty. Torture thus became a kind of preliminary punishment that eliminated the recourse to legal proceedings, which, the military complained, were too slow and too lenient.[28] By utilising such justifications, soldiers armed themselves with a utilitarian imperative to act brutally towards an individual in order to save the lives of the many.

[25] Official records include, but are not limited to, publications by the British government such as as F. D. Cornfield, *Historical Survey of the Origins and Growth of Mau Mau* (H. M. Stationary Office, 1960) and the *Report of the Kenya Land Commission* (H.M. Stationary Office, 1933).
[26] Raphaëlle Branche, *La torture et l'armée pendant la guerre d'Algérie: 1954-1962* (Paris: Gallimard, 2001), p. 27.
[27] Raphaëlle Branche, 'Torture of terrorists? Use of torture in a "war against terrorism": justifications, methods and effects: the case of France in Algeria, 1954-1962', *International Review of the Red Cross*, 89 (2007), 543-560 (p. 549).
[28] Ibid.

In addition to being seen as a precision tool for extracting intelligence, torture was also a weapon of domination. As Branche notes, 'much more than a method of obtaining information, torture was a warning to all', and rumour served the military's aims by propagating the terror among the population.[29] If its use occasionally killed a detainee, then the same death communicated the power of France to the Algerians. This made torture an expression of political domination.[30] To appreciate how significant this is, it is necessary to understand its use not only as an act of excess in a chaotic war but as part of the wider system of repression within the colonial context which allowed such practices to emerge in the first place.[31] This is a particularly important point that has since been stressed by other scholars: The military's use of illegal violence in Algeria, not just torture, formed part of a long history of repression that can be traced back to the earliest days of France's occupation of the territory.[32]

In order to create these environments of repressive violence, the colonial governments manipulated and misused various institutions to support their rule. The law, Sylvie Thénault has shown, was a vital tool in France's military strategy, since it produced legally 'exceptional' conditions in which violence could take place.[33] Similar to the 'state of exception' described by the philosopher Giorgio Agamben, Thénault has revealed the extent to which the French legal system was inverted and weaponised against the nationalists to create environments where extreme violence—torture, rape, disappearances and summary executions—became permissible.[34] This was achieved through the use of key emergency laws issued in Paris which transferred the control of the civil courts in the North African colony to

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[29] Branche, *La torture et l'armée pendant la guerre d'Algérie*, p. 590.
[30] Ibid., p. 591.
[31] Ibid., p. 29.
[32] Olivier Le Cour Grandmaison, *Coloniser. Exterminer: Sur la guerre et l'État colonial* (Paris: Fayard, 2005); Sylvie Thénault, *Violence ordinaire dans l'Algérie colonial: Camps, internements, assignations à résidence* (Paris: Odile Jacob, 2012).
[33] Sylvie Thénault, *Une drôle de justice, Les magistrats dans la guerre* (Paris: Découverte, 2001).
[34] Giorgio Agamben, *Homo Sacer: Sovereign Power and Bare Life* (Stanford: Stanford University Press, 1998); Sylvie Thénault, *Une drôle de justice*.

the military tribunals.[35] The introduction of these emergency powers by the political authorities allowed the military to conceive of and wage a war that twisted justice into a form of judicial repression within the Algerian courts and sanctioned semi-legal practice of internment and the illegal practice of torture.[36] Importantly, Thénault has shown how magistrates became accessories to these exceptional circumstances and aided in perpetuating the misappropriation of their professional institutions. Through inaction and a passivity born out of 'fear of resisting the army by acting against torture, disappearances or summary executions', the French magistrates in Algeria showed remarkable solidarity with the military's aims.[37]

Just as the history of colonial violence had deep roots in the early stages of France's conquest of the North African territory, so too were the conditions of the emergency immersed in a colonial legal exception that dated back to the colony's earliest days.[38] French policy towards its colonial subjects was one of deep inequality where the access to legal and political office and representation was always skewed in the Europeans' favour. The colonial character of justice in Algeria was therefore a manifestation of French sovereignty on a conquered territory and people. The Muslims were by default French subjects who were denied the rights associated with French citizenship. They existed outside the 'normal' rule of law of metropolitan France.[39] By the time war broke out after 1 November 1954, the long colonial past, an 'exceptional regime' in an 'exceptional environment', was inherited by the military.[40] The French authorities sought to control the Algerian population and to sift rebels and their supporters from the wider population through the use of an extensive system of concentration camps. This was brought about by Article 6 of the emergency law of 3 April 1955, which allowed the 'Minister of the Interior in all cases and, in Algeria, the Governor General' to

[35] The state of emergency was first voted on the 3 April 1955 and later extended on 22 August 1955.
[36] Sylvie Thénault, *Une drôle de justice,* p. 9.
[37] Ibid., p. 160.
[38] Ibid., pp. 15-28.
[39] Ibid., pp. 18-22.
[40] Ibid., p. 22.

‘pronounce the assignment of residence in a territorial division or a specified locality of any person’ residing within the territory whose activities might be deemed ‘dangerous for public safety and security’ of the territory.[41] However, the same article continued to state that ‘Under no circumstances may the assignment of residence result in the creation of camps, or the persons referred to in the preceding paragraph’. Despite this, the first camps in Algeria were opened in May 1955 as part of the law’s allowance for placing suspects under house arrest.[42] Over the course of the conflict, over two million Algerians were relocated into what were called *camps de regroupement*, which formed a prominent part of the Plan de Constantine reforms launched by President Charles de Gaulle after his return to power in 1958.[43] While these camps were officially intended to protect the rural Algerian population while also helping to disrupt the nationalist underground networks, they were often the locations of extraordinary violence. Alongside these regroupment camps were detention camps designed for purely military purposes. The military established networks of *centres de tri et transit* (CTT), which were legalised in 1957, to screen and categorise detainees. The fates of the detainee varied, depending on how they were categorised.[44] After 1958, there were also the military internment camps where selected detainees were subjected to ‘re-education’ in order to turn them to the French cause.[45]

The situation in Kenya was not dissimilar; the excessive, punitive and retaliatory nature of the violence perpetrated by both sides of the Mau Mau uprising had its roots in the longer history of the British settler colony. The so-called ‘pacification’ of the territory had been achieved

[41] Article 6 of loi 55-385 du 3 avril 1955 instituant un état d’urgence et en déclarant l’application en Algérie.
[42] Sylvie Thénault, ‘L’internement en France pendant la guerre d’indépendance algérienne’, *Recueil Alexandries,* 15 (2008).
[43] Sibylle Scheipers, ‘The Use of Camps in Colonial Warfare’, *The Journal of Imperial and Commonwealth History*, 43 (2015), 678-698 (p. 689).
[44] The categories included ‘to be released’; the ‘unwanted’, who would be detained for longer in either the CTT or in a civilian-run camp called a *centre d’hébergement*; and finally, the ‘criminals’, who were to undergo trial under common law. See Raphaëlle Branche, ‘The French in Algeria: Can There be a Prisoner of War in a ‘Domestic’ Operation?’, in Sibylle Scheipers (eds.), *Prisoners in War* (Oxford: Oxford University Press, 2010), pp. 178-179.
[45] Sylvie Thénault, ‘Personnel et internes dans les camps français de la guerre d’Algérie Entre stéréotypes coloniaux et combat pour l’indépendance’, *Politix*, 1 (2005), 63-81 (p. 67).

through savage campaigns of destruction by British military forces in the late nineteenth century.[46] Corporal punishment was a pervasive feature of inter-racial relations in pre-Emergency Kenya, where the European settlers, police forces and even school teachers beat the Africans in order to enforce a racial hierarchy in the country.[47] Any anti-colonial resistance throughout the years of occupation was similarly met by collective punishment, imprisonment, executions and terror.[48] Although all these forms of force were unleashed upon Mau Mau and suspected Mau Mau supporters during the Emergency, it would be a mistake to conceive of colonial violence as unchanging. Indeed, when it comes to understanding how violence played out in the Emergency itself, David Anderson has usefully shown that there were two relatively distinct phases. The first took place between October 1952 and the end of 1955, when the emphasis was on the gathering of tactical intelligence to identify the enemy.[49] This was of prime importance for waging a successful counterinsurgency campaign, just as it was in Algeria. As Colonel J.M. Forester noted in 1957, the 'identification of terrorists and an early appreciation of their methods and habits is essential for the efficient conduct of operations'.[50] However, as time went on, the practice of screening evolved into a coercive exercise designed to extract confessions from detainees and to punish them for their defiant ways. By the end of the emergency, specific forms of torture had become systematised within the British detention centres and were being used to break the will of hard-core Mau Mau.[51]

In Kenya, the British authorities framed their use of emergency powers in relation to the British Emergency Powers (Defence) Act of 1939, a statute that gave the government

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[46] Fabian Klose, *Human Rights in the Shadow of Colonial Rule: The Wars of Independence in Kenya and Algeria*, trans. by Dona Geyer (Philadelphia: Philadelphia University Press, 2013), p. 61.
[47] Paul Ocobock, 'Spare the Rod, Spoil the Colony: Corporal Punishment, Colonial Violence, and Generational Authority in Kenya, 1897—1952,' *The International Journal of African Historical Studies*, 45 (2012), 29-56.
[48] Caroline Elkins, *Britain's Gulag: The Brutal End of Empire in Kenya* (London: Jonathan Cape, 2005), p. 55.
[49] David Anderson, 'British abuse and torture in Kenya's counter-insurgency, 1952–1960', *Small Wars & Insurgencies*, 23 (2012), 700-719 (pp. 700-701).
[50]TNA WO 291/1670, p. 74. J.M. Forster, Operational Research Unit Far East, *A Comparative Study of the Emergencies in Malaya and Kenya*, Report Np. 1/1957.
[51] Anderson, 'British abuse and torture in Kenya's counter-insurgency' (p. 701).

unrestricted power to detain individuals deemed dangerous to the state during a time of war.[52] Yet they also drew inspiration from the Malayan Emergency Regulations ordinance of 1948, which had been used to suppress a communist insurrection in that colony a few years earlier. In contrast to the Act of 1939, these regulations empowered the state to detain suspected insurgents indefinitely, and allowed for detention to continue even after the colonial state of emergency had expired.[53] Given that Mau Mau was interpreted as a form of 'collective African atavistic insanity', the British authorities devised the 'Rehabilitation programme' to 'treat' this perceived ideological sickness. Once arrested, detainees were meant to make their way through the 'pipeline', a series of detention camps, transit camps, work schemes and relocation settlements that were built by the British colonial authorities to isolate, discipline, punish and ultimately 'rehabilitate' supposed Mau Mau followers. Originally, the Rehabilitation programme was conceived as a humanitarian project by a limited number of the more liberal minded colonial officers who hoped to offer social and economic benefits to the Kikuyu who confessed to having taken Mau Mau oaths.[54] The British campaign for the 'hearts and minds' of their Kenyan subject thus reinforced the idea of Britain's 'civilizing mission', what Caroline Elkins refers to as its 'raison d'être for colonizing the Kikuyu people'.[55] Yet Elkins has shown that the rehabilitation camps became spaces of torture, punishment and death, as liberal ideals gave way to what she regarded as 'eliminationist' racism that ran riot. By her reckoning, the British had detained '1.5 million people, or nearly the entire Kikuyu population' who were subsequently 'physically and psychologically [atomized]'.[56]

Later works by Daniel Branch and A.R. Baggallay show that, far from being an institutionalised plot to wage a racial war, the history of violence and torture in the detention camps is more detailed and complex. Branch, who explores the history of imprisonment in

[52] Stephen Morton, *States of Emergency: Colonialism, Literature and Law* (Liverpool: Liverpool University Press, 2013), p. 125.
[53] Ibid.
[54] Elkins, *Britain's Gulag*, p. 101.
[55] Ibid., p. 100.
[56] Ibid., p. xii-xiii.

colonial Kenya in the years between 1930 and 1952, explains how poor funding had always meant that Kenyan prisons were understaffed and were sites of disease and violence. As such, there was a reliance on untrained officers who exercised a punitive approach to imprisonment. Although finances were set up to help expand these camps during the Emergency years, the underlying logic running them had not changed—they were still cramped, understaffed and prone to disease and violence. As such, I would argue, there is no evidence to suggest the Emergency set up to combat Mau Mau introduced a new desire to eliminate the Kikuyu people—violence here is part of a longer history of colonial abuse and neglect.[57] Both Baggallay and Branch's work demonstrate that the decline in efforts to meet the original rehabilitation programme had a more textured history than Elkins suggests.

Indeed, a closer look at the provisions set aside for the rehabilitation programme indicates that the escalation in violence and increased reliance on torture were also influenced by changes in available finances and demands from the government. Baggallay argues that the British government had originally planned to embrace the liberal rehabilitation programme, but after the success of Operation Anvil in 1954—an effort to eliminate Mau Mau from Nairobi—the detention camps swelled with suspects. In order to operate effectively, the rehabilitation programme would have required additional funds, but the Ministry of Finance actually reduced their budget and, instead, increased that available to 'Internal Security and Defence'—including prison officers.[58] The department responsible for rehabilitation was thus stretched too thin and could not afford to provide the requisite training for its staff. Instead, Thomas G. Askwith, the head of the Community Development Department in Kenya, was forced to employ members of the Prison Department who had a long history of using violence, as Branch has demonstrated.[59] Moreover, after 1955, the introduction of release targets eroded

[57] Daniel Branch, 'Imprisonment and colonialism in Kenya, c. 1930-1952: Escaping the carceral archipelago', *The International journal of African historical studies*, 38 (2005), 239-265 (p. 263).
[58] A. R. Baggallay, 'Myths of Mau Mau expanded: rehabilitation in Kenya's detention camps, 1954-60', *Journal of Eastern African Studies*, 5 (2011), 553-578 (p. 560).
[59] Branch, 'Imprisonment and colonialism in Kenya' (p. 243).

any hope for rehabilitation and resulted in the transformation of camps into sites of torture—any action was deemed acceptable if it led to confession, the prerequisite for release.[60]

Given that a large portion of this study takes place within the confines of detention centres, Elkins and Thénault's works on the British and French camps, respectively, are particularly useful. While Thénault's assessments have been careful and measured, Elkins' work has caused more controversy as a result of her belief that 'there was in late colonial Kenya a murderous campaign to eliminate Kikuyu people, a campaign that left tens of thousands, perhaps hundreds of thousands, dead'.[61] By evoking 'genocide', Elkins simplified the meaning of torture and colonial violence, turning them into rhetorical tools for producing a 'black and white' representation of the Emergency. Less consideration has been paid to the wider historical context or the variables that motivated individual actors or groups to get involved in the repression activities at different stages of the conflict. More recently, however, Elkins has conceded that the situation was more complicated than she originally assumed and has even cautioned us against 'an overtly state-dominated understanding of mass violence'.[62] Instead, we need to ask questions about 'who organized the violence' in order to understand how weak states and their actors responded to violent insurgents.[63] With the release of the Migrated Archives, historians have started to ask important questions about those who participated in abuse, their personal culpability and how the torture and abuse was organised.[64]

Taken together, these studies of violence and torture in Algeria and Kenya have demonstrated the extent to which such practices were embedded within the two countries' colonial situations. They have addressed questions related to the evolution of violence within specific contexts, while also assessing the ways in which institutions, especially the colonial legal

[60] Baggallay, 'Myths of Mau Mau expanded' (p. 568).
[61] Elkins, *Britain's Gulag*, p. xiv.
[62] Elkins, 'Looking beyond Mau Mau' (p. 868).
[63] Ibid.
[64] Anderson, 'British abuse and torture in Kenya's counter-insurgency' (p. 700).

systems, created the local conditions of exception that allowed torture and related atrocities to be carried out by colonial security forces. Yet few of these studies have considered the role of other institutions and professions in supporting the exercise of state repressive force during emergency conditions. Given that doctors were almost ubiquitously present when instances of torture took place, the dearth of scholarship on the role of medicine during the Kenyan and Algerian emergencies is especially surprising and, indeed, unsatisfactory.[65] It is, after all, not coincidental that, in *The Gulag Archipelago*, Alexandr Solzhenistsyn referred to the doctor in the Soviet concentration camps as the torturer's 'right hand man'.[66] This thesis thus represents the first focused analysis of medical practitioners who were involved in the use of torture in these two contexts.

To be sure, the subject of medicine and violence in Algeria and Kenya has not been completely overlooked. Both Anderson and Elkins, as well as others, have touched upon the role of particular doctors involved in the Kenya Emergency when discussing the health of detainees held in the pipeline. But these references are incidental, brief and used primarily as additional illustrations of the atrocious conditions experienced by detainees during their confinement.[67] In contrast, Branche is one of the few to offer a direct consideration of doctors within the wider history of the Algerian War. Although Branche's discussion is limited to a few dozen pages or so of her early work, it represents virtually the only attempt to examine the activities of specific doctors and the ways that medicine in Algeria was subverted to the military's needs.[68] Branche's pioneering efforts have not found a Kenyan counterpart, despite the Migrated Archives providing concrete evidence that situates several doctors within range of torture. As mentioned above, this work seeks to address this scholarly gap, but to do so, it first

[65] Elaine Scarry, *The body in pain: The making and unmaking of the world* (New York and Oxford: Oxford University Press, 1985), p. 42.
[66] Alexandr Solzhenistsyn's *The Gulag Archipelago 1918-1956* (New York: Harper Row, 1974), p. 208.
[67] See Anderson, *Histories of the Hanged*, pp. 311-327; Elkins, *Britain's Gulag*, pp. 143-145; Baggalley, 'Myths of Mau Mau expanded' (pp. 565-566); and Klose, *Human Rights in the Shadow of Colonial Violence*, pp. 158-159.
[68] Branche, *La torture et l'armée pendant la guerre d'Algérie*, pp. 467-478.

needs to examine the state of the existing literature surrounding medical involvement in other torture campaigns, as well as that related to the practise of medicine in Algeria and Kenya more generally. This will be purpose of the next section.

Historiography: current discussions on doctors and torture

If the repressive role of colonial doctors in Kenya and Algeria has been hitherto neglected, other contexts have been better served. Over the last three decades, there have been multiple reports and studies into doctors involved in torture regimes and human rights violations in contexts as varied as Russia, Uruguay, Chile, Kuwait, South Africa, the former Yugoslavia, Turkey and, more recently, Iraq and Afghanistan.[69] The problem is that few of these studies, if any, have been conducted by historians; rather, the authors tend to be medical practitioners or involved in medical-related organisations. While much of this work shows little consideration for the wider historical contexts surrounding these instances of state-sponsored violence, it nevertheless provides a useful framework to guide an investigation into such abuses with this perspective. The overriding emphasis within this work has been to understand *how* doctors have contributed to regimes that torture while also seeking measures, regulations, codes of conduct and other solutions to prevent future participation.

There are a number of useful points identified by these studies when taken as a whole. Importantly, this body of work has shown that while many types of medical practitioners can get involved in human rights violations, those most likely to assist in torture are those

[69] See S. Bloch and P. Reddaway, *Soviet Psychiatric Abuse: The Shadow Over World Psychiatry* (London: Gollancz, 1984); M. G. Bloche, *Uruguay's Military Physicians: Cogs in a System of State Terror* (Washington: JAMA, 1987); Mark Hurst, *British Human Rights Organizations and Soviet Dissent 1965-1985* (London and New York: Bloomsbury, 2016); E. Stover, *The Open Secret: Torture and the Medical Profession in Chile* (Washington: American Association for the Advancement of Science, 1987); T.A. Brennan and R. Kirscher, 'Medical ethics and human rights violations: the Iraqi occupation of Kuwait and its aftermath', *Annals of Internal Medicine*, 117 (1992), 78-82; M. Rayner, *Turning a Blind Eye: Medical Accountability for Torture in South Africa* (Washington: American Association for the Advancement of Science, 1987); Steven H. Miles, *Oath Betrayed: Torture, Medical Complicity and the War on Terror* (New York: Random House, 2006).

responsible for examining and caring for prisoners.[70] Within detention camps, doctors appear to perform several important tasks that are common across these disparate contexts. These activities can be understood as either passive or active forms of collusion and include: evaluating the victim's capacity to withstand torture; providing medical treatment to victims if complications occur; falsifying autopsy reports or providing false diagnoses in order to hide the evidence of torture; violating the professional confidence of the doctor-patient relationship by providing medical information to security staff; actively participating in the interrogation itself, especially through the use of so called 'truth drugs'; and finally, failing to respond to the signs of torture, to take wounds and complaints seriously and generally remaining silent in ways that allow the practice to continue.[71]

While this list of methods of collusion might be useful for comparing and contrasting the ways that doctors took part in violence in the Algerian War or the Kenya Emergency, these studies tend to favour psychological explanations for *why* doctors colluded in the first place, which is less helpful. In particular, the concepts of 'doubling' and 'atrocity-producing situations', which were created by the American psychiatrist, Robert Jay Lifton, have featured heavily within this literature.[72] Lifton himself has used these concepts, whereby otherwise 'moral' and

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[70] British Medical Association, *Medicine Betrayed: The Participation of Doctors in Human Rights Abuses* (London: Zed Books, 1992), p. 40.

[71] This list, which I compiled from a number of summaries of medical involvement in torture, is not exhaustive. See E. Stover, *The Open Secret: Torture and the Medical Profession in Chile* (Washington: American Association for the Advancement of Science, 1987); Laurel Baldwin-Ragaven, Jeanelle de Gruchy and Leslie London (eds.), *An ambulance of the wrong colour: Health professionals, human rights and ethics in South Africa* (Cape Town: University of Cape Town Press, 1999), p. 91-112; and Darius Rejali, *Torture and Democracy* (Princeton and Oxford: Princeton University Press, 2007), p. 398-399.

[72] In part three of *The Nazi Doctors*, Lifton explained the concept of 'doubling' to account for the psychological mechanism that allowed German doctors to undertake appalling breaches of medical ethics, such as assisting in the euthanasia programmes. Doubling, as Lifton sees it, is 'an active psychological process, a means of *adaptation to extremity* […] The adaption requires a dissolving of "psychic glue" as an alternative to a radical breakdown of the self'. Alternatively, and more specifically for doctors involved in torture, Lifton proposed the 'atrocity-producing situation' to account for why individuals become complicit in violence. Lifton describes the atrocity-producing situation as 'one so structured, psychologically and militarily, that ordinary people can readily engage in atrocities'. This mechanism for producing complicit physicians, Lifton argues, takes place through gradual acclimatising to violence and abuse by way of a 'sequence of socialization'. For 'doubling', see Robert Jay Lifton, *The Nazi Doctor: Medical Killing and the Psychology of Genocide* (Basic Books, 2000), p. 422; and for a clear explanation of 'atrocity producing situations' in relation to

'ethical' individuals become supporters or perpetrators of cruel conduct, to explain why American physicians took part in the abusive environments of the recent War on Terror, especially in Abu Ghraib, in Iraq.[73] Although these explanations remain popular among medical practitioners seeking to account for medical involvement in atrocities, they are nevertheless epistemologically limited for historical research. They are too generalised, deterministic and tell us little about the specific factors that may influence a given individual at a given time and place to take part in violence; nor do they provide an explanation for the extent of this violence and how such activities are carried out.

Moreover, the emphasis on 'atrocity producing situations' places the responsibility for atrocities on the corrupting influence of institutions and the state. Indeed, despite stating that 'Physicians are no more or less moral than other people', Lifton identifies the profession as 'the heirs to shamans and witch doctors', who have a 'special magic in connection with life and death' of which '[v]arious regimes have sought to harness […] to their own despotic ends'.[74] Such a statement plays down the agency of those doctors who participate in atrocities while maintaining the image of the profession as otherwise ethical. Alternatively, other scholars have adopted a similar structural-normative approach to produce more nuanced accounts of violence than Lifton, who has been accused of making grandiose claims and overstatements.[75] Through an examination of torture among Brazilian police, Huggins *et al.* have explained the perpetration of violence as a result of a slow and gradual normative process whereby individuals become acclimatised to such acts over time.[76] Similarly, Christopher Browning's famous study of the Polish Reserve Police Battalion 101 under Nazi occupation has shown how mass murder and routine, the exceptional and the normal, became fused during

doctors involved in torture, see Robert Jay Lifton, 'Doctors and Torture', *The New England Journal of Medicine*, 351 (2004), 415-416.
[73] Lifton, 'Doctors and Torture' (p. 416).
[74] Ibid.
[75] Ben Shephard, *A War of Nerves* (London: Jonathan Cape, 2000), p. 361.
[76] Matha K. Huggins, Mika Haritos-Fatouros and Philip G. Zimbardo, *Violence Workers: Police Torturers and Murderers Reconstruct Brazilian Atrocities* (Berkeley, Los Angeles and London: University of California Press, 2002).

the every-day experience of these 'ordinary men'.[77] Browning's approach is particularly useful for the present study as it is multi-layered; it allows for groups or subgroups at the centre of analysis to behave differently while also offering multi-causal explanations for why this may be the case.[78] Although he draws on psycho-sociological perspectives to guide his assessment, Browning is not rigidly bound to them, as he balances these perspectives with historical factors concerning individual beliefs, ideology and opportunity.

Lifton's recent work on torture exposes a set of assumptions that are interesting in their own right. Unlike other sets of professionals involved in modern conflicts, doctors as a group are often associated with ethical standards which are *expected* to play some part in guiding their conduct.[79] Yet these expectations, along with the development of modern medical codes of ethics, are themselves the products of complicated historical variables. Lifton's psychological explanations reveal little about the influence medical ethics exerts on professional conduct in a given time and place. What types of pressures can come into play when a doctor participates in a conflict scenario where torture is rife? How do they understand such dilemmas and how do they negotiate them? It would be a mistake to simply assume that the *Hippocratic Oath* has always meant the same thing to everyone at all times, or that doctors operating in different types of conflict always understand their roles and responsibilities in the same way. Indeed, have doctors always seen themselves as the protectors of human rights as they are commonly believed to be today?[80]

It is only in recent years that historians have begun to turn their attention to these questions. Latterly, scholars have taken a closer look at how contemporary medical ethics regimes have come into existence, especially those related to human experimentation (especially within the

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[77] Christopher R. Browning, *Ordinary Men: Reserve Police Battalion 101 and the Final Solution in Poland* (New York, HarperCollins, 1998).
[78] Ibid., pp. 191-223.
[79] Ibid., (p. 416).
[80] Rejali identifies doctors as the front line in the identification of torture, as they have 'a specialized set of skills to diagnose the use of' some techniques. See Rejali, *Torture and Democracy*, p. 16.

Nazi concentration camps), the development of the *Nuremburg Code* and medical and scientific involvement in the research, development and testing of chemical and biological weapons during the Cold War.[81] Such studies have not only drawn attention to the relative effectiveness of ethical codes in governing medical and scientific research using human participants, they have also offered important perspectives for contemporary research ethics.[82] Nevertheless, the dilemmas surrounding human experimentation, especially in relation to national security considerations and wartime conditions, are only one area where established medical ethics can become strained; medical participation in interrogation is, of course, another. When it comes to the subject of medical ethics and doctors' participation in torture, scholarly interest in bioethics has tended to favour the subject of professional loyalty itself. Given that this theme, professional loyalty, appears throughout this thesis, it is worth examining the state of existing scholarship on this subject.

The use of so-called 'enhanced interrogation techniques' by British and American forces in Iraq and Afghanistan in the 2000s drew attention to the thorny problems posed by medical complicity in violent conflicts.[83] The concept of the 'dual-loyalty dilemma', sometimes referred to as the 'dual-obligation dilemma' or 'mixed agency', has become a common feature

[81] George J. Annas and Michael A. Grodin (eds.), *The Nazi doctors and the Nuremberg code. Human rights in Human Experimentation* (New York and Oxford: Oxford University Press, 1992); J. Katz, 'The Consent Principle of the Nuremberg Code: Its Significance Then and Now', in George J. Annas and Michael A. Grodin (eds.), *The Nazi doctors and the Nuremberg code. Human rights in Human Experimentation*, pp. 227-39; Katz, 'The Nuremburg Code and the Nuremberg Trial. A Reappraisal', *JAMA*, 276 (1996), 1662-1666; Katz, 'Human Sacrifice and Human Experimentation: Reflections at Nuremberg', *Yale Journal of International Law*, 22 (1997), 401-18; U. Tröler and S. Reiter-Theil (eds.), *Ethics Codes in Medicine* (Farnham: Ashgate, 1998); A. Frewer and M. Rothhaar, 'Medicine, Human Rights and Ethics: Paths to Universal Rights', *Medical Health Care Philosophy,* 13 (2010), 247-249; V. Roelcke and G. Maio (eds.), *Twentieth Cenutry Ethics of Human Subject Research: Historical Perspectives on Values, Practices, and Regulations* (Stuttgart: Franz Steiner Verlag, 2004); Ulf Schmidt, *Justice at Nuremburg: Leo Alexander and the Nazi Doctors' Trial* (Basingstoke: Palgrave Macmillan, 2004); W. U. Eckart (eds.), *Man, Medicine, and the State: The Human Body as an Object of Government Sponsored Medical Research in the 20th Century* (Stuttgart: Franz Steiner Verlag, 2006); Ulf Schmidt, 'Medical Ethics and Human Experimentation at Porton Down: Informed Consent in Britain's Biological and Chemical Warfare Experiments', in Ulf Schmidt and A. Frewer (eds), *History and Theory of Human Experimentation: The Declaration of Helsinki and Modern Medical Ethics* (Stuttgart: Steiner, 2007); Ulf Schmidt, *Secret Science: A Century of Poison Warfare and Human Experiments* (Oxford: Oxford University Press, 2015).
[82] Schmidt, *Secret Science*, pp. 9-11.
[83] Fritz Allhoff, 'Physician Involvement in Hostile Interrogations', *Cambridge Quarterly of Healthcare Ethics*, 15 (2006), 392-402.

within bioethical discussion on this topic. This can be understood as a conflict between clinical professional duties to the patient, on the one hand, and, on the other, obligations, expressed or implied, real or perceived, to the interests of a third party, such as an employer, an insurer, the state or the military.[84] For instance, military physicians have medical obligations to those in medical need and are required to exercise beneficence and non-malfeasance, both of which form the foundation of modern medical ethics, to needy combatants on either side of the conflict and not to undertake any activity that might (intentionally) make anyone medically worse off.[85] Yet, at the same time, these professionals may have competing obligations to their regiment and the state, applying contrary pressures to their conduct.[86] These pressures, it is assumed, can lead some military physicians to use medical knowledge and skill for purposes other than healing—for instance, for conducting illegal human experimentation (as in the case of Nazi doctors during the Second World War); for designing and building such lethal weapons as biological or chemical weapons; or, as in the case of the present research, for assisting with torture and abusive interrogation.[87]

The dual-loyalty dilemma, especially within the military context, has continued to pose intractable challenges. While it is beyond the scope of this study to examine the range of potential options raised by these authors for current conflict scenarios, the examination of professional loyalty in relation to medical ethics and conduct is interesting from a historical perspective. This is especially so in the cases of Algeria and Kenya, where the nature of revolutionary warfare in settler colonies presented alternative challenges to the types of 'conventional' struggles these scholars have assessed. The contention is that, during irregular

[84] Leslie London, Leonard S. Rubenstein, Laurel Baldwin-Ragaven and Adriaan Van Es, 'Dual Loyalty among Military Health Professionals: Human Rights and Ethics in Times of Armed Conflict', *Cambridge Quarterly of Healthcare Ethics*, 15 (2006), 381-391 (p. 391).
[85] Fritz Allhoff, 'Introduction', in Fritz Allhoff (eds.), *Physicians at War: The Dual-Loyalties Challenge* (Springer, 2008), p. 5.
[86] It is worth noting that dual loyalty is not just limited to military physicians. As Fritz Allhoff has noted, there are cases where modern physicians outside of the armed forces also have responsibilities beyond those to their patients. These include forensic psychiatry, occupational health and public health. See Allhoff, 'Physician Involvement in Hostile Interrogations'.
[87] Allhoff, 'Introduction', pp. 5-7.

conflicts, such as those experienced during the Kenyan and Algerian emergencies of the 1950s, the situation becomes even more complex: under these conditions, civilian doctors can be drawn into the conflict and put into positions where they are required to behave or operate in ways that challenge the understanding of their professional and ethical obligations. This is not to say that the emergencies introduced an entirely new set of circumstances that radically changed the attitudes, behaviours or loyalties of these professionals *per se*. On the contrary, it seems that the emergencies merely polarised older, more deeply entrenched prejudices and allegiances, prompting some to act on them in ways that varied in degree, not in type, from pre-emergency conditions. Rather than simply witnessing a binary strain between the professional loyalties of the doctors, on the one hand, and the demand of the state and military, on the other, these two complicated contexts reveal a whole range of competing factors that might have influenced how physicians understood their obligations and interpreted their roles.

These considerations foreground another interesting gap in the existing historiography. While a significant body of research has covered the subject of colonial medicine, tropical hygiene policy and scientific practice across the British and French empires,[88] somewhat less attention has been paid to colonial doctors and health-care providers as a distinct social group within these colonial settings.[89] Secondly, and more bafflingly, the little social historical research that is relevant to these two contexts has adopted a comparatively limited chronological span. For

[88] Influential work on the history of colonial medicine includes, but is in no way limited to: Ann Beck, 'Medical Administration and Medical Research in Developing Countries: Remarks on Their History in Colonial East Africa', *Bulletin of the History of Medicine*, 46 (1972), 349-358; Meghan Vaughan, *Curing their ills: Colonial Power and African Illness* (Cambridge and Malden: Polity Press, 1991); David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India* (Berkley and Los Angeles: University of California Press, 1993); Shula Marks, 'What is Colonial about Colonial Medicine? And What has Happened to Imperialism and Health?', *Social History of Medicine*, 10 (1997), 205–219; Mark Harrison, *Medicine in an age of commerce and empire* (Oxford: Oxford University Press, 2010); Pratik Chakrabarti, *Medicine & Empire, 1600-1960* (Basingstoke: Palgrave Macmillan, 2014); Olivier Le Cour Grandmaison, *L'Empire des hygiénistes: Vivre aux colonies* (Paris: Fayard, 2014).

[89] Some notable work on this subject does include, for example, Vaughan, *Curing their ills*; Mary P. Sutphen and Bridie Andrews (ed.), *Medicine and Colonial Identity* (London and New York: Routledge, 2003); Warwick Anderson, *The Cultivation of Whiteness: Science, Health & Racial Destiny in Australia* (Melbourne: Melbourne University Press, 2005); and Charlotte Ann Chopin, 'Embodying 'the new white race': Colonial Doctors and Settler Society in Algeria, 1878-1911', *Journal for the Social History of Medicine*, 29 (2015), 1-20.

instance, Charlotte Ann Chopin has recently shown how the French doctors in Algeria were representatives of the Third Republic in the colony, while also fitting in as local settlers among the other European communities. Rather than being simple agents of empire, Chopin argues, these doctors embodied the ideals and attitudes of a distinct form of 'whiteness' among the settlers.[90] Her analysis highlights specific tensions within the French medical culture in Algeria that arose from this dual identity as government employee and members of the settler societies, but her study stops at 1911.

Similarly, in the British context, Anna Crozier has provided one of the few histories of the British Colonial Medical Services in East Africa.[91] Rather than examining the policies and practices of medicine in East Africa, Crozier's account tracks the evolution of this underexplored branch of the Colonial Services, its recruiting processes and culture and the experience of individual Medical Officers working in Kenya, Uganda and Tanganyika during the twentieth century. While Crozier's work provides excellent contextual detail for understanding the characters and attitudes of those selected by the Colonial Services to work in their overseas territories, her focus tapers off at the start of the Second World War. Although she provides a brief overview of the years leading up to independence, it forms a brief coda to her concluding chapter. More recently, the same author has also produced an edited volume which seeks to shine greater light on the various medical practitioners and health care providers who competed and occasionally collaborated in East Africa in the first half of the twentieth century.[92] This collection of essays does add greater texture and diversity to the previous account, but it still fails to cover the post-war years as well.

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[90] Chopin, 'Embodying 'the new white race' 1-20.
[91] Crozier's study was itself intended to address the shortcomings of the first generation of scholars who wrote about British medicine in East Africa. These books, Crozier maintains, tended to be produced by former practitioners reminiscing about their glory days in the colonies or, in the case of historians like Anne Beck, extolled the benefits of western medical practices with little reflection on their impact on the colonial situation, especially their potentially negative implications for indigenous populations. See Anna Crozier, *Practicing Colonial Medicine: The Colonial Medical Services in British East Africa* (London: I.B. Tauris, 2005).
[92] Anna Greenwood (eds.), *Beyond the State: The Colonial Medical Services in British Africa* (Manchester: Manchester University Press, 2016).

This is a startling omission given that, as members of the colonial order, these professionals would have embodied what Ann Laura Stoler referred to as 'imperial formations' upon which the legal, institutional, and cultural bases of colonial discrimination were built.[93] These were shared presumptions and cultural norms that were commonplace in the late nineteenth and twentieth centuries which justified coercion and discrimination, as Stoler states, through ideas of 'imperial guardianship, trusteeship, delayed autonomy, temporary intervention, conditional tutelage, military takeover in the name of humanitarian works, violent intervention in the name of human rights, and security measures in the name of peace'.[94] Since the 1970s and 1980s, historians interested in the subject of colonial medicine have emphasised the ways colonial interventions impacted on indigenous health and institutions. Rather than continuing to produce triumphalist accounts of medicine as a civilising and enlightening enterprise, these scholars reconfigured the narrative to show it as a means for securing imperial domination and repression.[95] Yet while historians no longer see medicine as simply a 'tool of empire', there has been remarkably little attempt to account for the role of this institution within obviously violent contexts and its functions as a contributing or direct source of suffering, such as the emergencies addressed here. Indeed, in 2008, Richard Keller explicitly noted that the 'complicity of medicine in the structural violence of the colonial situation reveals a range of iatrogenic forms of suffering and a setting in which medicine cannot be construed without also accounting for its operation as a force of oppression'.[96] Within this context, the clinic itself was a space where the colonial conflict could play out. As such, the encounter between doctor

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[93] Ann Laura Stoler, 'Imperial debris: reflections on ruins and ruination', *Cultural Anthropology*, 23 (2008), 191-219 (pp. 193-194).
[94] Ibid., (p. 193).
[95] For example, Gerald W. Hartwig and Karl D. Paterson, *Disease in African History: An Introduction Survey and Case Studies* (Durham: Duke University Press, 1978); Michael Warboys, *Science and British Colonial Imperialism: 1895-1940* (University of Sussex, DPhil. Thesis, 1979); Daniel R. Headrick, *The Tools of Empire: Technology and European Expansion in the Nineteenth Century* (Oxford: Oxford University Press, 1981); R. Macleod and M. Lewis (eds.), *Disease Medicine and Empire: Perspectives on Western Medicine and the Experience of European Expansion* (London: Routledge, 1988); and Alfred W. Crosby, *Ecological Imperialism: The Biological Expansion of Europe 900-1900* (Cambridge: Cambridge University Press, 1993).
[96] Richard C. Keller, *Colonial Madness* (Chicago and London: Chicago University Press, 2008), p. 161.

and patient, where the doctor was a representative of the colonial oppressor and the patient an indigenous subject, could become an opportunity for the latter to exercise resistance and political defiance. Yet I would argue that even Keller has not gone far enough: rather than simply looking at the structural contributions medicine made to the exercise of colonial violence, what about such instances where doctors participated in explicitly violent acts themselves?

This point was made by Frantz Fanon, the Martinique-born psychiatrist and anticolonial writer, when he drew on his experience as a psychiatrist working at the Blida Psychiatric Hospital in Algeria, during the emergency. Fanon's work is well known to postcolonial critics and some historians of colonial medicine.[97] For the former, he is the founding father of the field of postcolonial studies, but for the latter, he has had limited application outside of the history of colonial psychiatry.[98] This is unfortunate, given that his work is rich in material for studying African colonial medicine during the period of decolonisation. What Fanon offers, unlike other theorists such as Agamben, is an account of the lived experience of colonial subjects facing the everyday reality of colonial violence and their methods of resistance. More importantly for this thesis's purposes, Fanon is one of the few contemporary thinkers who attempted to wrestle with the entanglements of medicine and the colonial system and its impact on both the indigenous population and the make-up of the colonists' society. This is a point that is regularly underplayed or altogether forgotten by postcolonial writers, who fail to account for Fanon's role as an historical actor in the Algerian War or, indeed, his position as a psychiatrist schooled in the medical knowledge and skills of the 'oppressor'.[99] His interpretations of the impacts the colonial encounter had on both the coloniser and the colonised was indebted to his educational background and his experience as a black subject

[97] In particular, see Frantz Fanon, *A Dying Colonialism*, trans. by Haakon Chevalier (New York: Grave Press, 1965); and Fanon, *The Wretched of the Earth*, trans. by Constance Farrington (London: Penguin Books, 2001).
[98] Richard C. Keller, 'Clinician and Revolutionary: Frantz Fanon, Biography, and the History of Colonial Medicine', *Bulletin of the History of Medicine*, 81 (2007), 823-841 (p. 825).
[99] Ibid.

of colonialism working as a doctor in the colonial setting of Algeria. This should be stressed: Fanon's medical career, as recent studies by Keller and Filippo Menozzi have argued, was the linchpin that connected his work on racial identity to his later work as an anticolonial thinker and revolutionary.[100] It was his experience as a psychiatrist that exposed him to the injustices of colonialism and its effects on the personalities of the colonised.

However, this too should be problematised. Fanon became a vocal supporter of the Algerian nationalists and eventually threw his lot in with the FLN. As such, his anticolonial writing comes to us as testament to his outrage, disappointment and anger against the colonial authorities, which will have certainly influenced the way he constructed his cases. Both of his most famous publications, *A Dying Colonialism* and *The Wretched of the Earth*, contain specific instances where medical practitioners, his colleagues working in Algeria, abused their power, took advantage of the natives or actively abused their status as doctors in order to assist the police or military during the war.[101] In fact he even directly implicates doctors in torture operations. Yet Fanon does not always provide names or details that can be used to verify his claims. The identities of both the victims of abuse and its perpetrators are missing while the reader is faced with anecdotal evidence of serious breaches in ethical conduct and professionalism. The lack of tangible evidence accompanying Fanon's work may give reason for caution but it does not make it useless. In fact, it provides an opportunity to test Fanon's claims for historical accuracy. By comparing the accounts contained in his publications with other sources related to the Algerian War, it becomes possible not only to gain a greater

[100] Ibid., (p. 826); and Filippo Menozzi, 'Fanon's Letter: Between Psychiatry and Anticolonial Commitment', *Interventions*, 17 (2015), 360-377.

[101] For example, in *A Dying Colonialism*, Fanon includes a description of how a medical practitioner would 'very often [assume] an aspect of systematized piracy', which included injecting patients with 'twice-distilled water' and charging them for penicillin or vitamin B-12. He explained how, in rural settings, doctors would 'boast of taking X-rays with the aid of a vacuum cleaner' and at market days, would offer patients a variety of 'salt serum' injections sold at varying prices. The doctor, Fanon assures us, knew that the native would 'almost always choose the most expensive injections'. See Frantz Fanon, *A Dying Colonialism*, p. 133.

appreciation for Fanon's work, but also to assess its applicability to other African contexts, such as the Kenya Emergency.

Definitions and scope

The chosen case studies, the Algerian War of Independence and the Kenya Emergency, are rich in historical data for analysing the various ways in which doctors, a profession associated with healing, benevolence, confidence and loyalty, could become entangled with wider efforts to understand, respond to and combat militant anti-colonial movements. Before describing the structure of the thesis, it is worth defining a few terms. Firstly, by 'doctors', I am chiefly referring to individuals with formal medical training and qualifications who worked either for the state in a military capacity or as medical officers within the colonial medical services. The doctors directly involved in the counterinsurgency campaigns in both contexts were in nearly every case white European men. However, the discussion is not limited to these men alone. A whole variety of medical experts with loyalties to different associations and social groups also feature within this history. Thus, I will also discuss private and commercial practitioners working and living among the settlers in each colony, as well as medical missionaries, who exerted a powerful political and social presence within the colonial situation, especially in the eyes of the natives. In addition, the analysis will consider broader non-medical scientific expertise, such as those extended by sociologists, psychologists and anthropologist who worked in the colonies. Although these individuals were not medically trained, they often worked closely with their medical colleagues who frequently absorbed, often without question, their ideas and theories.[102]

[102] Shane Doyle, 'Social disease and social science: the intellectual influence of non-medical research on policy and practice in the Colonial Medical Services in Tanganyika and Uganda,' in Anna Greenwood (eds.), *Beyond the State: The Colonial Medical Services in British Africa* (Manchester: Manchester University Press, 2016), pp. 126-152.

Secondly, although this study is mostly concerned with medical involvement with acts of torture, it is not myopically focused on this phenomenon in isolation. Instead, it pays attention to the place of torture in relation to other forms of violence and abuse that took place within the same contexts. In order to make this distinction, 'torture' can be understood as the deliberate and systematic infliction of physical or psychological torment on detained and helpless individuals for the purpose of obtaining confessions, information or for intimidation and punishment. There are a few aspects of this definition that call for further explanation. Firstly, it identifies torture as a directed and purposeful activity, enacted with a view to gaining information or confession, punishing, coercing or intimidating victims. This latter purpose, intimidation, is particularly interesting, as it is not necessarily limited to the direct victims of torture. As discussed above, Branche has shown that the systematic torture of Algerians by French paratroopers was only partially aimed at gaining information and submission; an additional objective was to intimidate the wider Muslim community. In her own words: 'Torture is often thought to be intended to make people talk. In fact, as used for political purposes in Algeria and other comparable situations, torture was designed chiefly to make people listen'.[103] Teresa Marcias has made a similar point about the purpose of torture in Chile between 1974 and 1990. Death and torture in this context not only eliminated the enemy, but also helped to submit the entire population to the new order being introduced through fear.[104] Purpose, perhaps, is the most decisive criteria that distinguishes torture from other forms of abuse.

This definition assumes that victims have some knowledge of what the torturer's intentions are. There must be an answer or a submission to a demand that they can offer to satisfy the torturer, whether or not this leads to an actual cessation of violence. The infliction of pain and suffering must be intentional.[105] Purely negligent conduct, such as forgetting about a detainee

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[103] Branche, 'Torture of terrorists?' (p. 557).
[104] Teresa Macias, ''Tortured bodies': The biopolitics of torture and truth in Chile', *International Journal of Human Rights*, 17 (2013), 113-132 (p. 114).
[105] Amnesty International, *Report on torture* (London: Gerald Duckworth & Co, 1973), p. 17.

who subsequently starves to death, lacks intentionality and purpose and it is not classed as torture, even though the victim may have experienced 'severe pain and suffering' both mentally and physically.[106] However, if this negligence is deployed systematically, to serve one of the purposes discussed above, then it can be understood as an act of torture. For example, if one detainee starves to death, as in the above example, this is negligence, but if a detention camp uses starvation as a way of extracting information, gaining conformity from detainees or perpetuating terror, then it can be classed as torture. In both Algeria and Kenya, the detention centres established to hold suspected rebels were often cramped, unhygienic and isolated locations where disease, as with the case of Manyani camp discussed above, was rife. Starvation was also used routinely to punish unruly prisoners. There is good evidence to show that, in both cases, such conditions were used as a deliberate means to exacerbate the suffering of the detainees. However, the accounts of disease and conditions of privation are too numerous to be given a worthy analysis alongside more direct forms of abuse where the bodies of detainees were the objects of coercive force and aggressive conduct by other individuals in close proximity. As such, a thorough analysis of health within the camps falls beyond the scope of the current study. Instead, it focuses on those instances where interrogators or other individuals subjected detainees' bodies to direct suffering and violence.

I have also avoided trying to define torture with reference to the severity of pain experienced by the victim, as is the case in the UN *Convention against Torture*. There are a number of reasons for this. Pain is a subjective experience and defies easy objectification and quantification. Approaching torture simply as pain inflicted on a body will only provide a partial glimpse into what is actually taking place in the 'theatre of torture'. As historian Marnia

[106] 'Severe pain and suffering' forms part of the UN's definition of torture as expressed in Article 1 of the UN Convention against torture. However, the measurement of pain is far too subjective to lend itself to practical categorisations; it is also nearly impossible to account for in the historical record. As such, I have avoided relying on it within my own definition, despite its use within Article 1 of the United Nation's Convention against torture. See Article 1, The UN *Convention against Torture,* 1984. http://www.ohchr.org/EN/ProfessionalInterest/Pages/CAT.aspx. See also Manfred Nowak, 'What Practices Constitute Torture?: US and UN Standards, *Human Rights Quarterly*, 28 (2006), 809-841 (p. 830).

Lazreg states, it is 'the totality of the torture *situation* that needs to be grasped in order to understand that torture is not definable in terms of bodily harm or psychological torment alone'.[107] For an historian studying torture, an exclusive focus on the victim's body would overlook many other features that mark it as an historical subject. These include the space wherein it is conducted; the relationship between the torturer and his tools and the techniques he employs; the preliminaries—what French torturers in Algeria referred to as 'softening the victims—as well as what happens between torture sessions that could last for one to three days, and at times several weeks on and off'.[108] Torture presents the historian with a complex social situation with multiple meanings that cannot be understood without a wider appreciation of all the elements that fuse to make torture so oppressive.

There are other reasons why pain as a subject can be troublesome for historians. Pain leaves little evidence to prove its existence. Scars and damaged flesh can speak of a person's trauma, but that evidence is often absent when examining historical cases. This is especially true for modern torture, as the twentieth century has witnessed a move towards 'clean torture' or covert torture—torture that leaves few discernible marks. As Rejali put it, 'When torturers turn to covert torture, they deliberately induce a breakdown in one's ability to show one's pain to others, stripping their words of the marks that give the speaker credibility'.[109] The rise in the use of clean torture by (ostensibly) democratic states, so Rejali argues, seems to correlate with the increased number of international bodies and media organisations monitoring human rights abuses in the twentieth century. Democracies that have reason to deploy torture have learned to rely on techniques that are difficult to detect. If the signs of torture on a victim's body are now difficult to detect, even when relatively fresh, then the effort to rely on them as historical evidence must naturally be fraught with difficulty.

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[107] Marnia Lazreg, *Torture and the Twilight of Empire: From Algiers to Baghdad* (Princeton and Oxford: Princeton University Press, 2008), p. 6.
[108] Ibid.
[109] Rejali, *Torture and Democracy*, p. 30.

Even written descriptions of an individual's pain may be difficult to analyse. Elaine Scarry has portrayed pain as 'unshareable', as language is inadequate to the task of clearly describing one's subjective experience in a way that is intelligible to someone else.[110] A historian seeking to define torture through a pain threshold would need to make a judgment on the level of pain and suffering a historical actor has experienced in order to classify it as torture. This may be relatively straightforward in the case of first-person accounts, such as that offered by survivors like Alleg in Algeria, but what about descriptions of someone else's pain? A historian consulting prison medical records, for example, may not find sufficient evidence to help them make such a judgement, as the medical language may obfuscate the patient's emotional state and their individual experience of the pain. The risk here is that incidents of torture may be overlooked because a description of a person's suffering is not convincing enough.

What is a good alternative to a pain threshold? One of the key features of torture that is implied by, but is not part of, the UN definition is the helplessness of torture victims. Lazreg regarded this as the most fundamental distinction between torture and other cruel and inhuman treatments. In her view, 'it is the powerlessness of the victim, the inability to defend herself and her absolute vulnerability to the torturer that captures the specific character of torture'.[111] This aspect of her definition is very useful for thinking about torture. If a police officer, for example, deliberately injures the leg of a fleeing suspect in order to enact a lawful arrest or to prevent the escape of a person lawfully detained, or uses physical force for breaking up an unlawful demonstration or quelling a riot, he or she might intentionally inflict severe pain on the person concerned without it being classified as torture. There is a sense of proportionality within this: the use of force amounting to cruel, inhuman or degrading torture depends on the force applied in relation to the lawful goal achieved.[112] However, if a person is arrested, the further use of physical force for the purpose of intimidation, punishment, discrimination,

[110] Scarry, *The body in pain*, pp. 10-11.
[111] Lazreg, *Torture in the Twilight of Empire*, p. 6.
[112] Nowak, 'What Practices Constitute Torture?' (p. 833).

information or confession might constitute torture. The prisoner's vulnerability and powerlessness in this second case is what helps to define it as torture. Powerlessness is therefore a vital component of the definition of torture. It provides a useful way to move beyond the pain threshold approach for understanding the subject and opens up consideration to the wider context in which torture takes place. It is also easier to identify powerlessness in the historical record. By observing the status of the victim, their level of helplessness and vulnerability, in relation to that of the torturer, it is possible to make judgements on whether or not a given situation may have involved torture before considering the other components that help to characterise it—purpose, intention, and those responsible for its infliction and management.

Thesis: question, structure and methodology

As established above, there have been few concerted, sustained and contextualised historical assessments of the ways in which colonial medicine and its practitioners participated in and supported the use of torture and other abuses in colonial wars of independence. Fewer still have attempted a comparative perspective.[113] With the release of the Migrated Archives in Britain, both Anderson and Elkins have started to ask comparative questions about Britain's use of violence in other overseas territories.[114] Similarly, in 2013, Laleh Khalili called for comparative discussions about violence in various contexts across the world. Aiming to move scholarly analysis of the history of violence away from a narrow focus on isolated regions like the Middle East and North Africa, Khalili has appealed to scholars to produce broader analyses

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[113] One of the few solid comparative examinations of these two emergencies is Fabian Klose whose study explores the emergence of the human rights regime in the twentieth century and shows how the French and British colonial powers actively sought to limit its application to their overseas subjects, especially when it came to their nationalist struggles for independence. In particular, Klose explores how international debates on human rights contributed to the process of decolonisation at a time when Britain and France were undertaking their respective wars against Mau Mau in Kenya and the FLN in Algeria. Moreover, his discussion also includes consideration of the role played by the International Committee of the Red Cross, which, for the first time in its existence, started to explore the extent and limitations of its mandate to intercede in this type of non-conventional conflict.

[114] Elkins, 'Looking beyond Mau Mau'; and Anderson, 'British abuse and torture in Kenya's counter-insurgency'.

which 'bridge [the] archipelagos of scholarship' on the subject of violence.[115] This thesis takes up this call by analysing the counterinsurgency operations conducted in Algeria and Kenya. Moreover, by focusing explicitly on colonial medicine and doctors, it provides fresh perspectives on a hitherto underexplored aspect of counterinsurgency violence. The aim, ultimately, is not only to provide new insights into the ways that some doctors can support acts of extreme violence, but also to offer a nuanced and empirically-strong explanation of the reasons why they might be led to do so.

This analysis is shaped by one overarching question: to what extent and in what ways did colonial doctors contribute to the practice of torture during the Algerian and Kenyan wars of decolonisation? To effectively deal with the subject, it is necessary to address a number of subsidiary questions. Firstly, given that we already have evidence that members of the profession played some sort of role in colonial repression, did the medical community in the colonies contribute to the rise of violent anticolonial nationalism in these settings and did this shape their conduct in any particular way? Once hostilities erupted, how did the colonial authorities respond and did they utilise the expertise and knowledge of any particular practitioners to help them understand the threat and contribute to its potential remedies? Moreover, given that—as Clarke has noted—doctors enjoyed a certain level of social and political power among the settler communities to whom they belonged and whom they served, how did private practitioners respond to the nationalists? Conversely, when working in medical capacities for the military or the colonial medical services, in what ways did doctors contribute to the use of torture by the colonial security forces and how did this relate to contemporary standards of ethical conduct? Finally, how did doctors respond when faced with the realities of torture and the challenges it posed to their professional practice and the security demands of the respective emergencies?

[115] Laleh Khalili, 'Thinking about Violence', *International Journal of Middle East Studies*, 45 (2013), 791-794 (p. 791-792).

In order to address these questions, I make use of a range of sources, both official and published materials, drawn from British, French and Kenyan archives to assess when and how doctors participated in the colonial counterinsurgency efforts, especially within the detention centres.[116] Unfortunately, due to significant logistical difficulties, I was unable to consult Algerian archives. Nevertheless, a large amount of the core material for this thesis has come from The National Archives (TNA), London, and Le Service historique de la Défense (SHD) in Paris, where the majority of the declassified documentation on Britain (the Migrated Archives) and France's colonial torture campaigns is housed. These documents have been vital for filling in the gaps in the existing literature as they allow us to place doctors directly within the institutions and sometimes the spaces where violence took place. In order to contextualise these events and the coeval views of the medical communities in both the colonies and the metropoles, I have consulted archives from a range of other locations, including the Kenya National Archives (KNA), the Wellcome Trust, the London School of Tropical Medicine, the Special Collections at SOAS, Rhodes House Commonwealth and African collection at the Bodleian Library in Oxford, the Sciences Po Archives and the Bibliothèque nationale de France, in Paris. In addition, I have used various digital archives, such as those of the *British Medical Journal*, the World Medical Association and major newspapers such as *The Guardian* and *Le Monde* to gain biographical information about certain practitioners and details on wider events and debates when needed.

In many instances, the events being discussed here featured in the work of other historians who have examined allegations and cases of torture and abuse, but the doctors within these assessments have either only been mentioned in passing or else have been entirely overlooked. As such, care has been taken to situate the findings with reference to the secondary literature in order to show how a re-examination of some well-known cases, such as those opening this

[116] Due to the size of this thesis, I have not been able to provide the original French text in all instances. I have therefore relied on my own translation of these documents which I have had checked by native speakers. I am therefore confident that the translations I offer here are suitable for this work.

work, can yield new perspectives when approached from this angle. However, this dissertation's empirical bases pose a number of challenges that must be understood at this stage.

Given the depth of official denial and cover-up that took place during in the Kenya Emergency, it is likely that we are still missing crucial information about alleged atrocities and the individuals involved, the availability of the Migrated Archives notwithstanding. The situation is not dissimilar in Algeria. The French government went to great lengths to conceal the official records regarding the use of torture. As Thénault and Branche have noted, 'the best way to keep a practice secret is to leave no trace of it'.[117] But while the French government and military tried to stymie the spread of information about their clandestine and illegal practices in Algeria, multiple participants on both sides of the conflict have recently published memoirs which add greater contextual detail to the official record. Of course, memoirs and the act of recalling events from the distant past present their own challenges for historical analysis. But when handled with due caution, these documents, some of which have been produced by former doctors, can still be used to substantiate areas where the official evidence is thin. In contrast, although there have been a number of memoirs published by police and military officers who fought against Mau Mau insurgents, the same cannot be said about their medical counterparts. This constitutes a frustrating absence in the historical record for this struggle. As mentioned above, in the years following decolonisation, a number of British medical officers published nostalgic accounts of their days in the East African colony, but when it comes to the Emergency, their accounts largely fall silent. Although the official records at TNA permit to place many doctors in direct proximity to the types of violence discussed in this study, these practitioners themselves have had little to say on the matter, either to explain the situation, to deny their participation or to denounce others. Where possible, I have therefore tried to draw attention to the gaps in evidence, as an omission can

[117] Sylvie Thénault and Raphaëlle Branche, 'Le secret sur la torture pendant la guerre d'Algérie', *Matériaux pour l'histoire de notre temps*, 58 (2000), 57-63 (p. 57).

sometimes be just as telling as a direct admission.[118] Nevertheless, there are portions of the following analysis that draw on sparse and sometimes patchy material; where appropriate, any potential limitations to the interpretations have been acknowledged in the text while efforts have been made to provide alternatives if possible.

Regardless of these gaps, the material presented in this dissertation makes it possible to argue that, not only were French and British doctors involved in the torture and violence perpetrated by colonial security forces in Algeria and Kenya, they were also often central to their justification, systemisation and maintenance. Although it is not always possible to identify the extent to which a given practitioner was aware of the whole system of repression in which they operated, it is clear that when torture took place within these colonies, medicine and its professionals were frequently present in one form or another. Yet it would be a mistake to assume that the presence of these professionals in and around the torture chamber amounted to any real reliance on sophisticated scientific interrogation techniques within either state. In this sense, the findings of this thesis contribute to recent scholarship which debunks and challenge ideas about effective 'scientific' methods for gaining the truth through the application of pain and suffering.[119] More often than not, when doctors participated in torture, it was to monitor the health of victims or to help cover-up or deny evidence of its application. Even in extreme cases such as the use of truth serums in Algeria, the existing evidence is clear that such methods were ineffective and unreliable tools of persuasion.

The role of the doctors discussed in this work and the reasons why each individual became entangled in counterinsurgency violence are predictably complicated and multifaceted. By

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[118] For example, in the now famous trial of David Irving who, in addition to falsifying and distorting evidence about Hitler's involvement in the Final Solution, also carefully omitted evidence of his awareness and approval of the *Reichskristallnacht*. See Richard J. Evans, *Telling Lies About Hitler: The Holocaust, History and the David Irving Trial* (London and New York: Verso, 2002), pp. 213-215.

[119] See Rejali, *Torture and Democracy;* and Erik Linstrum, *Ruling Minds: Psychology in the British Empire* (Cambridge, Massachusetts and London: Harvard University Press, 2016), pp. 175-188.

contrasting and comparing both contexts within each chapter, this study seeks to untie several such explanations. The benefits of this type of approach is that it avoids drawing what Heather Jones refers to as 'partisan interpretations' of the perpetration of violence in both contexts.[120] This is because a comparative approach assumes there are key variables that influence the ways in which doctors participated in these programmes that are unique or common to these contexts. These include the ways Britain and France governed their respective colonies, the ways medicine was established within each setting and the place of different types of medical professionals who provided care for different groups of people. In order to explore these themes, I start by situating French and British colonial medicine as it was practised in Algeria and Kenya, along with its doctors, within the longer history of the colonies in North and East Africa. This is the primary function of Chapter 1. It argues that, while medicine was useful for the occupation and establishment of the colonial state, the doctors who took part in this process were complicated actors in their own right who enjoyed certain social, economic and political benefits that were otherwise absent in metropole. As such, when nationalism started to manifest in each colony, some members of the medical professions contributed, actively or otherwise, to factors, circumstances and pressures that alienated the native populations. Eventually, these grievances led to the outbreak of hostilities in Algeria and Kenya, which accounts for why doctors were among the first victims of anticolonial violence in both countries.

Once violence broke out in both colonies, the governments found themselves facing what they regarded as a new type of warfare inspired or directly managed by Communist subversion. As such, it is not possible to grasp the logic governing the colonial authorities' responses to these threats to colonial rule without accounting for their place in the broader history of the Cold War. With this in mind, Chapter 2 addresses initial colonial appraisals of the nationalist movements. This is particularly interesting as, in both cases, colonial authorities utilised the

[120] Heather Jones, *Violence Against Prisoners of War in the First World War: Britain, France and Germany, 1914-1920* (Cambridge: Cambridge University Press, 2011), p. 8.

expertise of a range of experts of the mind, including sociologists, anthropologists and psychiatrists, not only to explain the nationalists' mindsets, but also to prescribe appropriate treatment for their perceived psychological conditions. These experts drew on old, established and fundamentally local racial perspectives about the ostensibly irrational and violent tendencies inherent in African populations. These, I shall show, were then married with contemporary anxieties about brainwashing and vulnerable minds. Rather than interpreting the nationalists' recourse to violence as a response to long-held grievances or as the tactical outcome of guerrillas fighting an asymmetrical war, British and French authorities chose to regard them as displays of innate savagery. Crucially, and something which has been overlooked by many scholars, is the fact that these government -employed experts were fixated on the role indigenous religion played in stirring up this perceived atavism. Both the FLN and Mau Mau were, to a lesser or greater degree, regarded as violent religious cults, an interpretation that predates the recent views of terrorism as stemming from religious fundamentalism. It was these 'scientifically' sanctioned views of terrorism in Algeria and Kenya that underpinned the counterinsurgency tactics employed by the security forces, especially the use of the detention centres to process and rehabilitate (in Kenya) and re-educate (in Algeria) the indigenous populations.

Building on some of the themes discussed in the first chapter, Chapter 3 examines the responses of doctors who did not work for the colonial state but were themselves settlers living among the politically dominant and vocal European communities. As already discussed here, the violence that took place within the Algerian War and the Kenya Emergency cannot be simplified to a basic binary relationship between the colonial state and the nationalists. Instead, a range of concerned settlers formed militia organisations to take the protection of the colony into their own hands when they felt their respective governments were unable or unwilling to sufficiently protect their interests. This is another feature of these two wars which has received curiously little historical attention: in both contexts, but especially in Algeria, a notable number of doctors organised and led extremely violent counterterrorism activities which

utilised torture as part of their efforts. In fact, as will be demonstrated later, in Algeria, these doctor-led European militias were so dissatisfied with the French government's approach to the crisis that they organised their own terrorist networks to fight both the FLN and the loyal colonial authorities. The role of these aggressive settlers who just happened to be doctors reveals deep tensions between members of the medical profession and the colonial state in a way that further challenges ideas of doctors as simple agents of empire. The involvement in acts of terrorism and violence also draws into focus pressing questions about the role of the doctor in relation to the codes of ethics surrounding their profession. Rather than viewing their ethical obligations in deontological terms, these doctors clearly believed there to be a point of separation between their roles as healers and their personal interests as socially empowered settlers.

It should be stated here that chapters 4 and 5 contain material that some readers may find challenging or disturbing, as the focus of the analysis moves onto the ways that doctors employed by the state assisted with and responded to the use of torture in the detention centres. In particular, Chapter 4 examines the development of new international codes of medical ethics in the immediate post war period to show how the language enshrined within these instruments was often too imprecise and vague to be of practical use for doctors faced with the challenges associated with interrogation and torture. When it came to justifying the use of state-sponsored and systematised torture techniques, the military and colonial authorities appealed to doctors to provide a humanitarian and scientific veneer to the administration of pain. Whether it involved them directly endorsing specific techniques or simply monitoring the health of detainees before and after its application, the colonial authorities required medical assistance. In other instances, as in the aforementioned case of Henri Alleg, doctors sometimes became directly involved in the interrogation process. The use of truth drugs on terrorist suspects in Algeria remains an important distinction between these two conflicts, as there is little evidence to suggest that British doctors were prepared to use such methods against Mau Mau.

While military doctors in Algeria may have played a more active role in the interrogation and torture of detainees, this does not mean their British counterparts were any less instrumental in similar activities in Kenya. In particular, the Medical Officers working in the detention centres appear to have either turned a blind-eye to the signs of torture within these camps, such as with Dr. Kirren mentioned above, or else conducted their clinical duties in order to maintain the bodies of those undergoing torture. In fact, doctors responded to the realities of torture in various ways; this is the topic of Chapter 5. Although such reactions could be rationalised in several ways, often the result was that doctors remained silent in the face of such abuse. This silence and potential indifference to suffering went a long way to maintaining the efficiency of Kenya's preferred torture technique, the now notorious 'dilution technique'. In this final chapter of the thesis, I also discuss instances where torture went too far and killed its victims and instances in which the victims themselves were able to draw attention to their plight. In a few rare cases, news of excessive abuse reached wider audiences in the metropoles, generating public outcry. In order to quell concerns or to help cover-up evidence of torture, doctors could act in various ways that played into the hands of the colonial authorities. By falsifying autopsy reports or death certificates, doctors concealed the true causes of death. In other cases, a rigid adherence to professional neutrality, which neither confirmed nor denied evidence of torture, allowed other government agents to fill in the explanatory gap with their own narrative. Interestingly, in both countries, there were high-profile scandals related to the victims of torture and other abuses that foreshadowed the end of the conflicts. In Algeria, public interest in the trial of Djamila Boupacha, a young Algerian nationalist who attempted to bring rape and torture charges against the French military, revealed not only the types of barbarous treatment that Algerians experienced while in detention, but also the lengths to which military doctors were prepared to go to hide and downplay signs of abuse. In Kenya, the deaths of 11 detainees at Hola Camp brought the realities of British conduct in the detention camps to the British public, a scandal that had a direct impact on ending British rule in that colony. Here too, it will be shown, the doctors involved with the camp hospital, and

the subsequent inquest into the deaths, played a number of roles in supporting the government's efforts to conceal the true extent of violence.

Chapter 1. The curious case of the dying doctors

That medicine and militant anticolonial nationalism in either Kenya or Algeria should have a direct relationship may, at first sight, appear surprising. However, as will be argued in this chapter, the former had a significant place in the story of the rise of the latter. While the history of nationalist agitation in the two colonies has been assessed and analysed by multiple generations of scholars, this chapter offers a novel perspective that examines the complicated and multifaceted role played by medicine in fostering and informing indigenous political opposition. It argues that the perceived split in doctors' loyalties and the unequal distribution of medical care in the colonies undermined their value in the eyes of local peoples. In particular, the chapter uses the violent deaths of a notable number of doctors during the two conflicts to highlight the ways in which medicine could be seen to exacerbate existing strains between the rebels and the colonial state. While the number of doctors involved in these attacks is too small to claim that the rebels undertook a targeted programme against medical professionals *per se*, the circumstances surrounding this violence still offer valuable insights into the wider colonial situation.[1] So, while this chapter addresses the influence exerted by colonial medicine as an institution in Kenya and Algeria more generally, it also demonstrates how embedded physicians were within the wider social, political and economic fabric of the colonies. This discussion has a number of benefits: it provides a solid background for understanding the historical forces and conditions that led to the outbreak of political violence in both colonies in the 1950s, while also helping to situate medical communities within their specific colonial milieu (in many ways, the material in this chapter foreshadows particular events and themes that will be elaborated on in more detail in Chapter 3). By doing so, it highlights the particular political, economic and social stakes these practitioners had in the survival of the colonial order. This, it will be shown, provides an explanation for how colonial doctors became embroiled in the state's counterinsurgency operations and why some of their

[1] In Kenya, I have found evidence of 3 to 4 doctors among the victims of Mau Mau violence, while in Algeria I found 8 references to doctors targeted by the FLN.

number would go as far as actively participating in torture and other acts of violence once the emergencies were underway.

1.1. First blood: the symbolic place of doctors in colonial society

On the 24 January 1953, the white settler community in Kenya was shocked by the murder of Roger and Adeline Esmee Ruck (referred to as Esmee), their six-year-old son, Michael, and their African servant. These deaths, which took place on their farm in North Kinangop, near Aberdare Forest, were to be a definitive moment for the state of emergency that had been in effect since October 1952. The Ruck family, as David Anderson noted, represented everything that Kenya's European settlers held dear.[2] The family were young, sociable and popular, and both Roger and Esmee were active in the colonial community: Roger was a member of the Kenya Police Reserves (KPR), while Esmee was a qualified doctor who ran a clinic on their farm, where she treated African squatters from all over the neighbourhood.[3] The fact that the Kenyan insurgents had slaughtered such a respectable family proved in the eyes of many that Mau Mau was little more than a savage group of 'terrorists'. While the family's murder generated great concern within the Kenyan and British press, the medical community were particularly shaken by the death of one of their own.

Less than a week after the Ruck murders, the Kenya Branch of the British Medical Association (BMA) held their annual general conference in Nairobi. Those present at the meeting felt that the wider medical community should be acquainted with what Dr. Robert Howitt Wiseman, the Honourable Secretary of the Kenya Branch, described as 'the wanton attacks which have been made and of the continuing threat to life in Kenya'.[4] Wiseman, writing in *The British Medical Journal* (BMJ) in February 1953, asserted that dangerous 'gangs' of Mau Mau

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[2] Anderson, *History of the Hanged,* pp. 93-94.

[3] Esmee Ruck actually practised medicine under her maiden name, Esmee de Smidt. See anonymous, 'Search for Murderers of British Family', *The Manchester Guardian,* 26 January 1953; and anonymous, 'Obituary', *British Medical Journal*, 28 February 1953, p. 513.

[4] Robert Howitt Wiseman, 'Mau Mau', *British Medical Journal*, 7 March 1953, p. 65.

exercised ‘no discrimination in the choice of victims […] unless it [was] to choose those who [were] elderly or who [were] held in especial esteem by Africans whom they [had] befriended’. That doctors seemed to be potential targets is implied by Wiseman here, but it is further supported by the fact that Dr. Ruck was not the only practitioner to be attacked by Mau Mau. Indeed, Wiseman pointed out that Dr. Dorothy Meiklejohn and her husband, Commander I.H. Meiklejohn, had also been attacked on their property in Thomson Falls, Rift Valley, in November 1952. Although Dr. Meiklejohn survived with extensive wounds, her husband was less fortunate.[5] Then, on 15 May 1954, Dr. C. H. R. Pentreath, a retired ophthalmic specialist, was ‘senselessly attacked by Mau Mau terrorists’ while walking to buy cigarettes from a nearby inn. He died from his injuries four days later.[6]

The murder of doctors by Mau Mau may at first appear to be evidence of the desperate tactics employed by the Kenyan nationalists. Both the Ruck family and the Meiklejohn’s lived on isolated farms outside of the relative protection of larger towns or cities. In fact, the Meiklejohn property was so remote that Dr. Meiklejohn had to drive between 7-8 miles to reach the police station following her attack.[7] These settlers may have appeared more vulnerable and thus less likely to pose a threat to Mau Mau gangs, who, in the early stages of the conflict, would raid settler properties to secure food, medication and weaponry.[8] Yet the explanation that these attacks were purely opportunistic fails to account for the special brutality which seems to have characterised them. The fact that the European victims were mutilated suggests that the families were specifically targeted for reasons that were significant to their assailants.

[5] Anonymous, ‘SURVIVOR'S STORY OF MAU MAU RAID: Seven Kikuyu Charged with Murder’, *The Manchester Guardian*, 23 January 1953.
[6] Anonymous, ‘Obituary’, *British Medical Journal*, 29 May 1954, pp. 1270-1271.
[7] Anonymous, SURVIVOR'S STORY OF MAU MAU RAID: Seven Kikuyu Charged with Murder, *The Manchester Guardian*, 23 January 1953.
[8] Anderson, *Histories of the Hanged*, p. 94.

Just as doctors appeared among the early victims of the Kenyan insurgency, European doctors were also targeted by the Algerian FLN. For example, on 14 November 1954, thirteen days after the Algerian War had started, a band of about 40 'outlaws' attacked Pasteur, a small Algerian village in the north of the country named after the famous French microbiologist. The violence broke out near the home of Dr. Vezon, who, after seeing his wife to safety, returned to the scene in the company of a rural guard called Bouakar Ahmed. They then encountered and confronted a 'bandit' hiding in the shadows who shot at Dr. Vezon and the guard. While Ahmed was killed, Dr. Vezon was wounded but still able to fire his own weapon, killing the assailant.[9] Then, on 5 January 1956, Dr. Jacques Vanier, a volunteer with the military's *sections administratives spécialisées* (SAS), designed to provide free healthcare to the rural population during the Algerian War, was ambushed and killed in Bouzina while *en route* to assist an allegedly injured Muslim woman.[10] Dr. Vanier was far from the only doctor associated with the military to be directly targeted during the war.[11] Civilian doctors were also targeted. On 15 November 1956, a Dr. Nackach was murdered by rebels while leaving his home in Vallee to treat a sick Muslim patient. On 8 January 1957, in Alma, a town near Algiers, a Dr. Ettighoffer, who was also the vice-president of the Confederation of Algerian Winegrowers [*Confédération des Vignerons des Trois Départements Algériens*], was attacked by 'outlaws' as he surveyed his property with his manager. Both men were seriously injured

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[9] Anonymous, 'QUARANTE BANDITS EN ARMES ont attaqué le petit village de Pasteur', *Le Monde*, 17 November 1954. <https://www.lemonde.fr/archives/article/1954/11/17/quarante-bandits-en-armes-ont-attaque-le-petit-village-de-pasteur_2026138_1819218.html> [Accessed 17 November 2017].

[10] Anonymous, 'LES MÉDECINS MILITAIRES et l'assistance médicale gratuite en Algérie', *Le Monde*, 28 August 1957. < https://www.lemonde.fr/archives/article/1957/08/28/les-medecins-militaires-et-l-assistance-medicale-gratuite-en-algerie_2326178_1819218.html> [Accessed 17 November 2017].

[11] On 29 March 1956, a medical officer, Lieutenant Guillemont was kidnapped and killed by FLN forces in Djidjelli, on the same day, a medical auxiliary called Maurice Feignon was captured and tortured by rebels. On 11 June 1956, a Lieutenant Petit an administrative officer at the military hospital of Sétif was shot and killed while, a day later, a medical officer called Captain Fauvy was killed in Djidjelli as well. These deaths have since been collected together within the websites of French right-wing organisaitons as evidence of France's apparent betrayal of her European subjects in the colony as well as the loyalists who sought to continue colonial rule in the territory. Even today, the death of doctors at the hands of the FLN is portrayed by these ultras as a sign of the barbarism among the FLN.

but not killed.[12] Finally, on 28 February 1957, *Le Monde* reported the death of Dr. Jouane, the General Councillor of Guelma, in north-eastern Algeria, who was killed by a 'terrorist' as he left the home of a Muslim woman he had been treating. According to the article, Dr. Jouane's death 'provoked strong emotion' among the locals, as he was held in 'general esteem'.[13]

Similarly, the attacks in Kenya and Algeria were presented in a way that emphasised the rebel's sheer brutality. The aforementioned Wiseman, of the *BMJ*, described the Ruck family murder as an expression of Mau Mau's indiscriminate violence. The fact that Esmee Ruck was a doctor is repeatedly stressed in the memoirs of Europeans involved in the Kenya Emergency; the nature of her charitable work was contrasted against the extremely violent circumstances surrounding her death.[14] In the Algerian cases, *Le Monde* presented the attacks as distinct, stand-alone segments of larger reports. The separation of these cases from other victims mentioned in the same articles implies there was something particularly significant or violent about these murdered doctors. Yet, these reports do not consider alternative explanations for why these individuals were killed by the nationalists. Repeatedly, there is a feeling of shock and confusion over how the terrorists could reject the civilization that the colonial powers were offering them. However, for Frantz Fanon, there were plenty of reasons for this phenomenon.

When it came to doctors being murdered or targeted by FLN forces, Fanon believed it was because they had betrayed their ethical positions, the very core of what it was to be a healer. As he stated in *A Dying Colonialism*, colonial doctors had excluded themselves from 'the

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[12] Anonymous, 'DES REBELLES HARCÈLENT SOUK-AHRAS', *Le Monde*, 9 January 1957. <https://www.lemonde.fr/archives/article/1957/01/09/des-rebelles-harcelent-souk-ahras_2329536_1819218.html> [Accessed 17 November 2017].

[13] Anonymous, 'Une patrouille ouvre le feu dans la Casbah d'Alger CINQ MORTS, TRENTE-SEPT BLESSÉS, *Le Monde*, 28 February 1958. <https://www.lemonde.fr/archives/article/1957/02/28/une-patrouille-ouvre-le-feu-dans-la-casbah-d-alger-cinq-morts-trente-sept-blesses_3134093_1819218.html> [Accessed 19 March 2018].

[14] For instance, see Michael Blundell, *So Rough a Wind* (London: Weidenfeld and Nicolson, 1964), p. 123; Peter Hewitt, *Kenya Cowboy: A Police Officer's Account of the Mau Mau Emergency in Kenya* (London: Avon Books, 1999), p. 55.

protective circle that the principles and the values of the medical profession have woven around [them]'.[15] This was something that was 'never […] clearly understood by world opinion'.[16] The violent deaths of doctors in Algeria stood out as being irregular and disturbing for Europeans, even when compared to the 'cruellest wars' where it was traditional for 'the medical corps to be left unscathed'.[17] Fanon continues to assure us that the 'Algerian political men', the FLN and their supporters, were 'quite aware of the existence of the laws of war. They [knew] the complexity of the problem and the dramatic situation of the European population'.[18] Killing a doctor was thus a conscious decision, one made with a full understanding of its significance. Colonial doctors had, for the FLN and Fanon at least, shed their commitment to the patient and given their loyalty to the authorities and to their own sectional interests.

Although it is not clear which 'principles and values' Fanon is referring to here (something that will be discussed in Chapter 4), his critique of colonial medicine is useful for identifying three ways in which colonial doctors could be seen as contributing to the atmosphere of repression and violence in Algeria. Firstly, medicine and its practitioners were often viewed as being closely associated with the French authorities and the exercise of power.[19] Doctors as well as engineers, school teachers, the police and rural constables were all seen as representatives of colonial power, extensions of colonial oppression in the eyes of the colonised. They made even routine activities, like the compulsory visit by the doctor to the *douar*, small rural indigenous villages, seem suspicious.[20] Doctors were simply too closely associated with colonial rule. Secondly, there was also the problem of their social standing within the colonial order itself. According to Fanon, '[b]ehind "the doctor who heals the wounds of humanity" appears the man, a member of a dominant society and enjoying in

[15] Fanon, *A Dying Colonialism*, p. 135.
[16] Ibid.
[17] Ibid.
[18] Ibid.
[19] Ibid., p. 121.
[20] Ibid.

Algeria the benefits of an incomparably higher standard of living than that of [their] metropolitan colleagues'.[21] This was largely because, in centres of colonisation, the doctor was more often than not a landowner as well. 'It is exceptional', Fanon tells us, 'to see in Algeria, a colony which attracts settlers, a doctor who does not take up farming, who does not become attached to the soil'.[22] Finally, there was the social and political standing of these individuals within the colonial administration and settler communities. The flexibility of colonial society meant that the type of divisions between professions that existed in the metropoles were less pronounced or else absent entirely. Professionals such as medical practitioners, lawyers and engineers could also benefit from agricultural pursuits to supplement their incomes and provide a legacy for their children. By owning land in these overseas territories, doctors became politically invested in maintaining the colonial order. They therefore often took up prominent positions within the local administration and settler communities where they became, Fanon claimed, 'leaders of colonialist movements'.[23]

As is made clear by some of the aforementioned examples, a number of the doctors targeted by the rebels in Kenya and Algeria were closely associated with colonial security forces. In fact, the focus on Dr. Ruck's professional status actually obscures that of her husband, who, unlike Esmee, was known to be 'less kindly' towards the Kenyans.[24] As a member of the Kenya Police Reserves, Roger would have been associated with an institution renowned for its heavy-handed and repressive approach to law enforcement, in the eyes of the natives. In addition, Dr. Meiklejohn was married to a retired military Commander. In Algeria, multiple doctors who worked with the military were assassinated during 1956. In addition, several of

[21] Ibid., p. 133.
[22] Ibid.
[23] Ibid., p. 134.
[24] Peter Hewitt, a former member of the Kenya Police Reserves, like Roger Ruck, explained that Roger had a reputation for being less friendly towards Africans, especially after the death of Eric Bowyer, another settler murdered shortly before the Rucks. Roger was also known to be a man of 'strong views', which, as David Anderson has noted, is 'settler shorthand for conservative and outspoken'. Such qualities may well have contributed towards the Mau Mau's decision to target him and his family on that fateful night. See Peter Hewitt, *Kenya Cowboy: A Police Officer's Account of the Mau Mau Emergency in Kenya* (London: Avon Books, 1999), p. 55; and Anderson, *Histories of the Hanged*, p. 93.

the attacks took place on the private farmland of the doctors in question, especially in Kenya. The ownership of this property, as will be discussed in detail below, was a contentious issue for both colonised Kenyans and Algerians. By owning land and hiring local workers for cheap labour, these doctors may have become synonymous with the types of inequalities the rebels sought to address, especially with relation to the apparent wealth that came with land ownership. Finally, it is clear from the obituaries concerning doctors in Kenya that many of them held important ties to the administration and wider settler communities. In Algeria, too, Dr. Jouane was not only a practicing doctor but also a local General Councillor.[25]

Far from being isolated occurrences with little value, the deaths of doctors in Kenya and Algeria highlight points of interests concerning the wider story of how the respective rebellions came to pass. Individually, these accounts may appear insignificant and unrelated; however, it can be argued that, if taken together, they expose deeper connections between the colonial situation and the wider grievances that produced the respective rebellions in each context. The question is, however, how did these situations and conditions take root in the first place? How did doctors come to inhabit such prominent and contentious positions within the colonies and how did this contribute to the growing resentment that surrounded them?

The factors common to these cases—the administration of medicine in the colonies and its association with colonial authority; the financial and economic interests of settler doctors; and the political opportunities that their profession afforded them in the colonies—will be explored in the rest of this chapter. This will help elicit new perspectives on the rise of militant nationalism in both Algeria and Kenya. Although this chapter does not intend to provide an exhaustive history of medicine in the two colonies, it is important to delve deeper into their respective formations to assess the types of organisations and professionals who provided healthcare in each context. What will become clear is that, despite key idiosyncrasies, the

[25] Ibid., p. 134.

overall influence of western medical science in the North and East African colonies fed into a wider atmosphere of alienation and exclusion which served as a backdrop for fostering nationalist sentiment. Although colonial medicine was a multifaceted enterprise which varied in its application and interaction with local communities across the empires, the story of medicine within these two settings shines direct light on the different conditions that led to the respective emergencies. As will be demonstrated in the next sections, while medicine played a fundamental role in justifying colonial settlement in Kenya and Algeria, its association with the interests of the European settler communities found a counterpoint in the exclusion of indigenous inhabitants. This, coupled with the economic, social and political standard of living of individual doctors, contributed to compromise the image of the profession in the eyes of local peoples.

1.2. Conquest, medicine and subjugation

When it came to conquering overseas territories, medicine played a fundamental role in the French military's wider aims. Not only did doctors administer to the army's needs, they also served a broader political purpose. As Hubert Lyautey, the French conquer of Morocco admitted as late as 1933, '[t]he physician, if he understands his role, is the primary and the most effective of our agents of penetration and pacification'.[26] For the French, western medicine and the perceived benefits it offered indigenous populations represented the core impetus for its so-called *mission civilisatrice*, its justification for colonial occupation.[27] The healing of locals was thought to demonstrate the superiority of European civilization and could provide 'backwards' peoples with a means for progress. This is not to say medicine was solely

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[26] As quoted in Richard C. Keller, 'Madness and Colonization: Psychiatry in the British and French Empires, 1800-1962', *Journal for Social History*, 35 (2001), 295-326 (p. 297).
[27] William Gallois, 'Local Responses to French Medical Imperialism in Late Nineteenth-Century Algeria', *Social History of Medicine*, 20 (2007), 315-331 (p. 315). More generally, see Mathew Burrows, '*Mission Civilisatrice*': French Cultural Policy in the Middle East, 1860–1914', *The Historical Journal*, 29 (1986), 109-135.

a vehicle for colonial ideology, as recent studies have shown.[28] But, as this section will demonstrate, its association with the military conquest of Algeria and its support for the European population came at the expense of Algerians and their needs.[29] In fact, the administration of medicine in the colony during the nineteenth and early twentieth century helped to establish and reinforce some of the more significant political divides between the colonial state and the indigenous populations.

The conquest of Algeria was a particularly bloody struggle which started in 1830, when General Thomas Robert Bugeaud, *marquis de la Piconnerie*, undertook a military expedition to help prop-up the Bourbon throne and to satisfy the financial interests of the merchants in Marseille.[30] Bugeaud took a fleet of 635 French ships loaded with 34,184 soldiers to the shores of Sidi-Ferruch, whence they occupied the seaports of Algiers, Oran and Bône. Over the next 40 years, French forces conducted an increasingly cruel and repressive conquest of the Arab population by way of 'scorched earth' tactics which saw whole towns, cities and even the culture fall victim to extraordinary violence.[31] It has been estimated that during the conquest the size of the Algerian population dropped from about three million to two million.[32] Contemporaneously, in order to consolidate control of the territory, the French initiated an

[28] In particular, recent work has sought to reassess the level of agency and resistance exercised by colonised peoples. In the Algerian context, see Hannah-Louise Clark, 'Expressing Entitlement in Colonial Algeria: Villages, Medical Doctors, and the State in the Early 20th Century', *International Journal of Middle East Studies*, *48* (2016), 445-472. For more general account of the changes in historiography around colonial medicine, see Chakrabarti, *Medicine & Empire*; and Keir Waddington, *An Introduction to the Social History of Medicine* (Basingstoke: Palgrave Macmillan, 2011), p. 278.
[29] Clark's recent study shows that in reality, few French doctors were willing to practice medicine in rural zones. Their absence was lamented by small rural villages and towns who requested medical visits from colonial doctors even after the military had been involved in repressive activity in the local area.
[30] Robert Aldrich, *Greater France: A History of French Overseas Expansion* (Basingstoke: Macmillan Press LTD, 1996), 26-27.
[31] For a detailed assessment of France's occupation strategy and the destructive methods used to eliminate Arab opponents (as well as civilians), see Le Cour Grandmaison, *Coloniser Exterminer*, pp. 7-22. See also pp. 138-140 for details on the French massacre of over five hundred Arabs in 1845 in the grotto of Dahra.
[32] Ibid, p. 188.

intensive settlement policy which sought to marginalise the Arab population by increasing the number of Europeans in the country.[33]

It was as a result of this increase in the number of European settlers that a connection between medicine and the colonial conquest first came about, since medical expertise was used to promote the health of the fledgling settler communities. In the 1830s and 1840s, Bugeaud placed medicine and the need for an ambitious health-care system at the centre of debates surrounding the future of the colony. This was not without good reason. Thousands of settlers routinely died from the cholera or malaria epidemics that plagued the cities and wiped out a number of new villages. In 1835, for instance, cholera killed 12,000 people in Algiers and 14,000 in Constantine (these figures included indigenous Algerians).[34] The policies envisaged by Bugeaud and others were thus vigorously debated in the colony and in Paris, highlighting deep tensions between the two.[35] Even at this early stage, the provision of medical care was informed by political differences between, on the one hand, the interest of the military and settler society in Algeria and, on the other, the expectations of decision makers in France. These tensions would continue to exist throughout the colonial period right up to the emergency of the 1950s. Yet the expectations and desires of the military and the settlers in Algeria were themselves frequently at odds. Algeria came to be governed by a so-called *mixte* system, which combined civil and military powers. In terms of the organisation and administration of medicine, a highly incoherent system emerged where military, civil and commercial medical practitioners often competed for clients and expressed conflicting views on how medicine should operate in the colony.[36] From an outside perspective, such as that of a local Algerian, it would have been difficult to differentiate between these various practitioners and thus between military and civilian medicine.

[33] Klose, *Human Rights in the Shadow of Colonial Violence*, p. 79.
[34] Aldrich, *Greater France*, p. 144.
[35] Ibid.
[36] William Gallois, *The Administration of Sickness: Medicine and Ethics in Nineteenth-Century Algeria* (Basingstoke: Palgrave Macmillan, 2008), p. 63.

During the 1850s, the French government established the *Service médical de colonisation* (SMC) following the long period of conquest. The SMC existed to assist the Second Empire in its consolidation of French control in its North African territories. It supplied treatment to the registered needy while relaying disease statistics to the central administration.[37] As the conquered territory expanded, Charlotte Ann Chopin has shown, the SMC passed from military to civil jurisdiction in 1861. Through a series of decrees, a grade system was established for doctors which confirmed their positions as 'agents of special services', essentially civil servants with some professional autonomy. The SMC then remained under the control of the General Government of Algeria, even after administrative responsibility for the colony was transferred to the French Home Office in 1870.[38] However, the military also continued to have a significant medical presence in the colony. On 7 January 1890, a decree issued by the office of the State Secretary of the Colonies established a Colonial Health Advisory Council, a Colonial Health Corps (*Corps de santé colonial*, a company of French colonial doctors) and provided for hospitals services in every French colony and protectorate.[39] The establishment of this corps further blurred the lines between military and civilian medical affairs and meant that doctors across the range of service providers were forced to compete with one another for clients.[40] Over the next six decades, the administration of medicine in Algeria would be beset by two constantly reoccurring themes: firstly, both the military and civilian medical communities (SMC doctors and commercial practitioners) would struggle for dominance of a system that was consistently underfunded and mismanaged by

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[37] Chopin, 'Embodying 'the new white race' (p. 6).
[38] Ibid.
[39] Laurence Monnais, 'Which medications did they trust? The Role of French Colonialism in Vietnamese Attitudes towards pharmaceuticals, 1858-1939', Paper presented at Princeton Workshop in the history of science, 'Science across Cultures—Historical and Philosophical Perspectives,' Princeton University, 24 October 2003, p. 2.
[40] Philippe Bonnichon, Pierre Geny and Jean Nemo, *Présences françaises outre-mer, XVIe-XXIe siècles: Science, religion et culture* (Éditions Karthala, 2012), p. 224.

successive French governments.[41] Secondly, the benefits of such healthcare as was available were enjoyed by a very small proportion of society: namely the European settler communities.

For the most part, SMC doctors resisted the need to practice medicine in rural zones. As Clark has shown, those who did were referred to as *toubib du bled*, a sort of 'backwater doctor'.[42] Each physician attempted to cultivate a private practice but also received a stipend from state coffers for performing a statutory number of free public consultations; a monthly inspection of schoolchildren and sex workers; food and water quality inspections; and various administrative functions. But working in the rural communities, which could be separated by vast expanses of unpaved mule tracks, was a daunting and unattractive prospect for many.[43] While this was not a rewarding job in the eyes of the doctor, this type of clinical encounter was, as mentioned above, a site of suspicion for the natives who saw the collection of nosological data as a form of state surveillance and control. This was because the doctor's presence in the *douar* was often preceded by the police authorities who gathered the population for the visit.[44] Given the strong ties between medicine and the police, as well as the infrequency of doctors' visits, it is easy to see why rural Algerians may not have been convinced by the agents of France's *mission civilisatrice*. A programme to deal with this situation was initiated in 1904, when Muslim youths began to be trained as auxiliaries to provide medical outreach to Muslim villages in the *douar*. These auxiliaries assisted colonial physicians and provided hygiene education to local people. Their efforts were valuable in combining the biomedical ideas of the Europeans with autochthonous notions, forming a hybrid system of medicine and care.[45] Yet the overall impact of this effort was limited. Indeed, those living away from the larger urban centres may never have encountered state medical

[41] Gallois, *The Administration of Sickness*, p. 39.
[42] Clarke, 'Expressing Entitlement in Colonial Algeria' (p. 447).
[43] Ibid. (pp. 448-449).
[44] Fanon, *A Dying Colonialism*, p. 121.
[45] Clarke, 'Expressing Entitlement in Colonial Algeria' (p. 455).

services such as doctor's consultations, vaccination, and drug distribution at all, though they would have certainly been affected by the state's sanitary policy.[46]

Generally speaking, the imperial powers had little interest in improving the health of colonial populations over the long term. Whereas medical research centres, such as the network of Pasteur Institutions established across the French empire, sought to classify and quantify tropical infections, their fixation on microorganism in the first-half of the twentieth century meant they were preoccupied with fighting 'isolated phenomena' rather than intervening to address the general socio-economic conditions that produced them.[47] It was only when key aspects of colonial management came under threat that a concerted effort to intervene occurred. That is to say that, as Sunil S. Amrith explains, 'colonial states only mobilized their medical policy at moments of crisis and emergency, and particularly in response to epidemic disease'.[48] Despite the introduction of basic public health measures, such as small pox vaccinations, water purification and quarantine measures, the infant mortality rate in Algeria remained at 160 per thousand live births at the start of the Second World War.[49] So while medicine was one of the pillars of the French civilising mission in Algeria, the indigenous populations were clearly excluded from its benefits for the most part.

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[46] Ibid. (p. 446).
[47] Anne Marcovich, 'French colonial medicine and colonial rule: Algeria and Indochina', in Roy Macleod and Milton Lewis (eds.), *Disease, Medicine and Empire: Perspectives on Western Medicine and the Experience of European Expansion* (London and New York: Routledge, 1988), pp. 103-115 (p. 114). See also Marie-France Laberge, 'Les instituts Pasteur du Maghreb: la recherche médicale dans le cadre de la politique coloniale', *Revue française d'histoire d'outremer*, 74 (1987), 27-42.
[48] Sunil S. Amrith, *Decolonizing International Health: India and Southeast Asia, 1930-65* (Basingstoke: Palgrave Macmillan, 2006), p. 22.
[49] However, rates of epidemic disease had started to fall in the first half of the century. Outbreaks of plague, cholera and typhus, which had decimated whole villages for much of the nineteenth century, became less frequent. The death rate from such infections fell to lower than 20 thousand during the interwar years and then, after a small peak in the 1940s, to 17.5 per thousand by 1954. See John Ruedy, *Modern Algeria: The Origins and Development of a Nation* (Bloomington and Indianapolis: Indiana University Press, 2005), p. 120.

As with Britain, France had been party to the ten International Sanitary Conferences which first took place in Paris in 1851 and then concluded in 1938.[50] The Conferences attempted to create health codes governing the human body in order to limit the spread of disease throughout the world. Following the end of the First Word War, France also joined the League of Nation's Health Organization (LNHO), which represented a second attempt at formulating global health policy and introducing a common vocabulary about hygiene.[51] The postwar belief in scientific advances and the practical achievements in disease prevention instilled into this community a belief that research and internationally organised preventative measures could eliminate many diseases and socio-economic causes of ill-health. This culminated in a collective effort to improve the health of all humans.[52] Yet these international initiatives had limited impact on daily life in the colonies. Any targeted programmes for specific disease, such as malaria and sleeping sickness, did not tackle the social root-causes and structural inequalities that produced disease and ill-health in the colonies.[53] As Randall Packard asserted, 'despite a great deal of rhetoric around the health of the empire, little change occurred in the direction or definition of health in the tropics between the [world] wars. Health remained defined as the absence of disease and the control of disease continued to be viewed in narrow technical terms'.[54]

Instead of regarding the locals as individuals to be treated and enhanced by western bioscience, many Europeans regarded them as harbingers of infection to be controlled and even eliminated. For example, on April 1921, the mayor of Cherchell, a town along the

[50] Norman Howard-Jones, *The scientific background of the International Sanitary Conferences 1851-1938* (Geneva: World Health Organisation, 1975).
[51] Martin David Dubin, 'The League of Nations Health Organisation', in Charles Webster and Charles Rosenberg (eds.), *International health organisations and movements, 1918-1939* (Cambridge: Cambridge University Press, 1995), 56-80.
[52] Ibid., p. 73.
[53] Jennifer Johnson, *The Battle for Algeria: Sovereignty, Health Care, and Humanitarianism* (Philadelphia: University of Pennsylvania Press, 2016), p. 31.
[54] Randall Packard, 'Visions of Postwar Health and Development and Their Impact on Public Health Interventions in the Developing World', in Frederick Cooper and Randall Packard (eds.) *International Development and the Social Sciences: Essays on the History and Politics of Knowledge* (Berkeley: University of California Press, 1997), pp. 93–115 (p. 96).

Mediterranean coast, wrote to the Prefect to complain about the threat to health posed by migrants traveling from the interior. The migrants, the mayor explained, 'brought with them the threat of typhus […] to a settlement which had until then been spared'. Evoking language that presented the town as being under siege, the mayor added that 'the only means we had of defending ourselves against this invasion was to guard all the gates into the town'.[55] The Prefect responded by coordinating with the mayor of Algiers to impose travel restrictions on migrants by introducing a ticket system so that only the uninfected could travel on to the capital. This, William Gallois has suggested, was a calculated move on the Prefect's part as he knew that the mayor of Algiers objected to charitable assistance that drew on the city's budget for 'beggars who needed to be purged from Algiers'.[56] Rather than feel any obligation towards the sick, colonial officials made a distinction between the lives worth protecting, those of the white settler 'public', and those to be segregated and excluded from the healthy society of the European cities, the Muslim natives.[57]

Here, a deep divide between the settler communities, on the one hand, and the poor indigenous populations, on the other, comes to the surface. Throughout the period of colonial occupation, the Muslim population, especially the rural communities, were regarded as vectors of disease. Such beliefs had deep roots within western medical circles, who regarded the poor and non-European races as inferior and, more often than not, natural sources of infection that posed a threat to security.[58] Although the subject of medicine and the 'scientific' racial stereotypes it produced will be discussed in greater detail in the next chapter, it is worth noting here that French medicine conceived of the Muslims as wholly Other, and produced theoretical foundations for justifying European dominance and a range of racial inequalities in the

[55] Quoted in Gallois, *The Administration of Sickness*, p. 1.
[56] Ibid.
[57] Ibid., p. 6.
[58] Mark Harrison, 'Medicine and the Management of Modern Warfare', *History of Science*, 34 (1996) (379-410), 395. For a wider discussion on the twentieth century history of disease and its links to security issues, see Nicholas B. King, 'Security, Disease, Commerce: Ideologies of Postcolonial Global Health,' *Social Studies of Science*, 32 (2002), 763-789.

colonies.[59] As demonstrated in this section, far from providing a means for always elevating and assisting the lives of the Algerian population, some aspects of French medicine contributed to a general process of marginalisation and exclusion of non-Europeans in the colony. Many of the political and social issues produced by this exclusion fed directly into the list of grievances held by the disaffected Algerians who sought political change in the twentieth century. Although this should not be overstressed as there were instances where medicine was of great benefit to the locals, as will be explored below, the overall list of grievances eventually led to the rise of the FLN and the Algerian War of Independence. Although the next section focuses on the political, economic and social factors that led to the War, medicine and matters concerning health still played a role not only in the continued marginalisation of Algerian Muslims but also in their responses to this process.

1.3. l'Algérie, c'est la France

Since the conquest, the Muslim population had been relegated to an underclass status defined on racial grounds. The white settler population, known as the *colons* or *pieds-noirs*, dominated every facet of life. As the former FLN member and historian, Mohammed Harbi, explained:

> Racial affiliation was the line of demarcation among people. The privileged were, regardless of all class differences, the Europeans, even the workers among them. They all understood themselves as French, as the occupiers of Algeria, and as victorious conquers. The vanquished were to pay tribute to them in one way or another.[60]

When Algeria became an extension of France in October 1871, the Ministry of the Interior took responsibility for the country and its indigenous population. However, for the Arabs, little changed. Although they were *de facto* French subjects, they were without representation and

[59] Keller, *Colonial Madness*, p. 123.
[60] Mohammed Harbi, 'Bauern und Revolution', 127-128. Quoted in Klose, *Human Rights in the Shadow of Colonial Violence*, p. 79.

enjoyed few civil rights.[61] Even natives who became doctors, for example, could be regarded as tacitly joining the oppressor's camp while distancing themselves from the medical and traditional practices of their people.[62] They were at once divorced from their heritage while also not quite 'French' enough to fit in with the colonisers among whom they worked. On a legal level, Muslims were not subject to French law, instead, they were regulated under the *code de l'indigénat*, a penal code whose harsh provisions were only applicable to 'subjects', which was first established in 1874 and subsequently modified in 1876, 1877 and 1881.[63]

Excluded from the provisions of French law and politically disenfranchised, Algerian Muslims were also marginalised in terms of land ownership—something they shared with the East Africans in Kenya. As the first country conquered by the French in the nineteenth century, Algeria was made a colony for settlers. Its constitutional status as an extension of the metropole made it 'France-outside of France', providing a superficial excuse for the French political class to affirm that '*l'Algérie, c'est la France*' [Algeria, it is France].[64] This sentiment was fiercely stressed by a politically active and vocal settler community, whose members hailed not just from France, but also Spain, Italy, Greece and Malta. Their influence was especially prominent along the coastline, in the large Europeanised city ports and the Mitidja—rich, flat farmland which the French had cultivated from swamp. This was fertile terrain that boasted all the benefits of the south of France. As Alistair Horne wrote, 'in country that might be Languedoc, straight eucalyptus-shade roads led through a prosperous and tidy

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[61] Muslims could become French citizens only if they rejected Islam and their cultural habits, served in the military and learnt the French language. Few Muslims accepted these conditions, and those who did were viewed with suspicion by both the communities they rejected and the racially prejudiced Europeans they joined. Aldrich, *Greater France,* p. 212. See also Fanon, *A Dying Colonialism*, pp. 40-41.
[62] Fanon, *A Dying Colonialism*, p. 132.
[63] Sanctionable crimes included, for example, meeting without authorisation; departure from the territory of the municipality without a travel permit; disrespectful acts; and offensive remarks towards an officer of authority even outside of his functions. Punishments included individual fines and imprisonment, as well as collective punishment, corporal punishment, forced labour, and the confiscation of property. See Patrick Weil, 'Le statut des musulmans en Algérie colonial,' *Histoire de la justice*, 16 (2005), 93-109 (p. 96) and Le Cour Grandmaison, *Coloniser Exterminer*, p. 22.
[64] Martin Shipway, 'Algeria and the 'Official Mind'; the Impact of North Africa on French Colonial Policy South of the Sahara, 1944-58', in *The Algerian War and the French Army, 1954-62: Experiences, Images, Testimonies, 2002,* (New York: Palgrave Macmillan, 2002), 61-75, (p. 61).

succession of cereal and citrus farms, drenched with orange-blossom scent in May, and vast vineyards, owned by *pieds-noirs* and operated by Muslim labour'.[65] This land, some of the most fertile in Algeria, had been seized by Europeans following the imposition of the Warnier Law of 1873. This law, introduced by August Warnier, the representative of the settlers in the French parliament, transformed the process of buying and selling land by imposing private, rather than tribal, ownership.[66]

The principles of free trade imposed by the French was meant to lead to progress and civilisation for the Algerian Muslims, which would lead to greater assimilation and *francisation*. In reality, the act legalised a veritable landgrab whereby the best and most fertile land was bought from the locals.[67] This process typified the general history of the Algerian colony, as Jean-Paul Sartre noted:

> [W]hen the French troops arrived, *all the good land was* cultivated. The so-called development thus relied upon a plundering of the inhabitants that continued for a century. The story of Algeria is the progressive concentration of European land ownership at the expense of Algerian ownership.[68]

Few Muslims had a notion of private ownership, and none understood the French concept of legally binding property contracts, in particular the way in which contracts had to be signed by a surnamed individual.[69] Opportunities for fraud, as Martin Evans notes, were plentiful,

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[65] Alistair Horne, *A Savage War of Peace: Algeria 1954-1962* (New York: New York Review Books, 2006), p. 45-46.
[66] Article 1 of Warnier Law says : *l'establishment de la propriété immobilière en Algérie, sa conservation et sa transmission contractuelle des immeubles et droits immobiliers, quels que soient les propriétaires, sont régis par la loi française. En conséquence, sont abolis tous droits réels, servitudes ou causes de résolutions quelconques, fondes sur le doit musulman ou kabyle, qui seraient contraires à la loi française.*] See Eugène Robe, *La Propriété immobilière en Algérie, commentaire de la loi du 26 juillet 1873* (Algiers : Juillet St Lager, 1875), p.5.
[67] Mahfoud Bennoune, *The Making of Contemporary Algeria, 1830-1987* (Cambridge: Cambridge University Press, 2002), p. 46.
[68] Jean-Paul Sartre, *Colonialism and Neocolonialism, trans. by Azzedine Haddour, Steve Brewer and Terry McWilliams* (London and New York: Routledge, 2001), 34-35. Emphasis in original text.
[69] Martin Evans, *Algeria: France's Undeclared War* (Oxford: Oxford University Press, 2012), p. 23.

and the result was that between 1880 and 1908 as many as 451,000 hectares of land were purchased by Europeans at little cost.[70] A process of dispossession that had been in place since the French arrived in Algeria in 1830s was rapidly accelerated. By 1870, settlers had acquired 481,000 hectares supplemented by an additional 687,000 hectares which were annexed in retaliation for the 1871 Muslim uprising. This additional land was granted directly to the settlers by the state.[71] Through this dispossession, Bugeaud's plan to consolidate the subjugation of the populace and to strengthen French rule was realised.

The conversion of the land into a profitable entity was part of a global economic phenomenon and the same process could be seen in French Tunisia and Morocco, or the British territories of Rhodesia, South Africa and, as will be argued below, in Kenya.[72] This transformation became the foundation stone of French Algeria. The settlers had a right to remain in the country because the land had been acquired legally. Moreover, the cash crops they produced, notably cork, alfalfa and wine, were sold competitively in foreign markets, while the Muslim population struggled to even feed their own families. Wine production was potentially one of the more contentious industries in Algeria for the natives. While accounting for half of Algeria's exports to France and, as a result, granting considerable power to the wine lobby, it hardly helped the economic predicaments of the Muslims as it provided little steady work, produced a crop that could not nourish a starving family and was ultimately offensive to the Islamic religion.[73] Within this context, it is easy to see why Dr. Ettighoffer may have become a target for FLN hostility. Dr. Ettighoffer was not only a trained medical practitioner, he was also the Vice-President of the Confederation of Algerian Winegrowers.[74] It seems that the attacks against colonial doctors was not completely random or arbitrary, but linked to wider

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[70] Ibid.
[71] Ibid.
[72] Evans, *Algeria*, p. 25.
[73] Horne, *Savage War of* Peace, p. 62.
[74] I was unable to find much of substance about Dr. Ettighoffer other than his role within the Confederation of Algerian Winegrowers and to confirm that he was a doctor of medicine working in Algiers in the 1920s. It is possible he had retired by the time he was made vice-president in the 1950s. See *L'Echo d'Alger : journal républicain du matin*, 3 July 1922.

colonial policies of repression, humiliation and (religious) disrespect, especially when concerning the growing of wine.

Algeria was, up until the 1960s, one of the world's largest wine exporters and by a wide margin.[75] Although the height of the industry in Algeria was reached during the 1930s, wine production continued to prosper until the period of decolonisation, save for a sharp decline during the Second World War. Following the war, the production of Algerian wine doubled from 9 million hectolitres in 1945 to 18 million by 1953. Algerian wine producers were therefore in a prodigious position, but the crucial point here is that the benefits of this industry rested almost entirely in the hands of the *pied-noir*. This small, but socially dominant, minority owned 97 percent of Algerian vineyards and produced 99 percent of the wine.[76]

The private purchase of the best land by the Europeans created two unequal agricultural systems that led to the collapse of Muslim rural society. Not only was their land less fertile, they also lacked the agricultural technologies and techniques available to the settlers.[77] The result was an unstable system that, as Evans notes, regularly tipped into famine conditions, notably in 1905, 1908, 1912 and 1937, the 'year of great hunger'.[78] Under such circumstances, children, so Albert Camus claimed, were often seen fighting with dogs for scraps of food.[79] Reflecting on this situation, Sartre asked pointedly: 'Will we ask the Algerians to thank our country for allowing their children to be born into poverty, to live as slaves and to die of hunger?'[80] The only possibility for many Muslims was to sell their properties or face destitution. Hundreds of thousands of young rural labourers found themselves in need of work

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[75] Giulia Meloni and Johan Swinnen, 'The Rise and Fall of the World's Largest Wine Exporter-And Its Institutional Legacy', *Journal of Wine Economists*, 9 (2014), pp. 3-33 (p. 3).
[76] Ibid.
[77] This subsistence economy was fragile and collapsed under the demographic explosion that saw the population triple to 6 million in the period between 1871 and 1936. See Evans, *Algeria*, p. 35.
[78] Ibid.
[79] Albert Camus, 'Misère de la Kabylie,' in Camus, *Actuelles III : Chronique algérienne, 1939-1958* (Paris: Gallimard, 1958), p. 29.
[80] Sartre, *Colonialism and Neocolonialism*, pp. 37-38.

and became increasingly antagonistic towards the European population.[81] Large numbers flocked to the cities and towns, or to the Mitidja, where the settlers' prosperous vineyards needed cheap labour. By 1930, 428,000 Muslims were employed by large farming enterprises, but the country was deeply divided between the successful Europeans and the downtrodden Muslim population who felt they had been robbed of their land and forced into subjugation.[82] The cities experienced their own migration boom at the same time.[83]

The land question caused embittered resentment in Algeria and gave birth to a form of 'agrarian patriotism' from the 1920s onwards. Landowners increasingly found themselves to be at odds with their workers.[84] Overall, discontent over landownership, the repressive nature of the colonial regime and its racial discrimination led to various strikes, acts of defiance and ultimately nationalism throughout the first half of the century. Although many of these grievances were shared by other colonial peoples, not least in Kenya, there was one feature of the Algerian context which makes it stand out. That is, a significant number of the prominent nationalist leaders had some form of medical training. Although there were certainly other intellectuals and professional men among the politically active Algerians, such as layers and imams, the number of doctors, especially among the moderates, is interesting. This is a point briefly acknowledged by Horne in a footnote to *A Savage War of Peace* where he said: 'It will be noted that many of the nationalist intellectuals [...] were doctors, pharmacists or lawyers'.[85] For Horne, this was because these professions offered fewer barriers to advancement for educated Muslims. Although Fanon had more complicated views on this,[86] it nevertheless demonstrates that colonial medicine was not simply a tool of oppression and repression. In

[81] W. B. Cohen, 'The Legacy of Empire: The Algerian Connection', *Journal of Contemporary History*, 15 (1980), 97-123 (p. 110).
[82] Evans, *Algeria*, p. 35.
[83] Prior to the First World War, roughly 8.5 percent of the Algerian population lived within these urban centres, but by 1954 this had swelled to 16.6 percent. See Ruedy, *Modern Algeria*, p. 124.
[84] Evans, *Algeria*, p. 36.
[85] Horne, *A Savage War of Peace,* p. 40.
[86] Fanon, as mentioned above, believed Algerians who trained in western professions, especially medicine, found themselves marginalised or trapped in a point of suspicion between both their traditional communities and the settlers.

fact, it was more Janus-faced: in some instances, it contributed to the general atmosphere of alienation in the colony while also providing, in isolated cases at least, a means for social liberation. In some cases, French education provided some Algerian doctors with greater social standing within their communities when it came to championing nationalists causes.

At the start of the twentieth century, after years of silence from resistance movements, a new generation of Algerian youths found their voices. These individuals, known as the Young Algerians, were French-educated and often from privileged backgrounds. They formed associations and mutual aid societies that promoted the idea of greater assimilation of the natives into French society.[87] One of the more prominent members of this group was Dr. Benthami ould Hamida, a French citizen who eventually became a professor of ophthalmology.[88] Benthami, who was elected to the Algiers Municipal Council in 1908, ran the most important Young Algerian delegations in Paris and was recognised as the leader of this early political movement. In 1926, Benthami became the first president of the *Fédération des élus indigènes* [the Federation of Elected Natives], which adopted a programme for greater incorporation with France, until he was unseated in 1930.[89] The *Fédération* was then split into three departmental groups, the most dominant of which was in Constantine. The leaders of this branch of the reorganised *Fédération* were themselves both trained in medical-related subjects. The first, Dr. Mohammed Saleh Bendjelloul, held a medical degree from the University of Algiers and served as a public health service physician in 1924.[90] His political views were slightly more radical than Benthami's, as he championed equal rights as well as assimilation for the Young Algerians.[91] While Bendjelloul was the most visible and powerful leader of the *Fédération*, he is not as well remembered as the second leader, Ferhat Abbas, who remains one of the most significant moderate nationalist politicians of modern Algeria.

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[87] Lizabeth Zack, 'Early origins of Islamic activism in Algeria: The case of Khaled in Post-World War I Algiers', *Journal of North African Studies*, 11 (2006), 205-217 (p. 209).
[88] Ruedy, *Modern Algeria*, p. 108.
[89] Ibid.
[90] Ibid., p. 133.
[91] Weil, 'Le statut des Musulmans en Algérie coloniale' (p. 107).

Abbas was born in Affirs, a small village in the eastern region of Djidjelli, in 1899. His privileged background allowed him to climb the social ladder and to qualify as a pharmacist at Algiers University. In 1931, he established his own pharmacy in Sétif, which served as a personal 'fiefdom', with a population of roughly 30,000, two-thirds of which were Muslim.[92] Then, in 1933, Abbas was elected to the General Council of the Constantinois, and, in 1936, he joined the Municipal Council of Sétif and the *Délégations financières* in 1936.[93]

For Abbas, as for the other moderates, education was a key source for ensuring a fairer, more integrated Algeria. This was in contrast to more radical nationalists such as those from the Ulama d'Algérie, a religious organisation which grew out of the Koran schools and which was avowedly anti-Western.[94] Assimilation of any form was to be rejected by the Ulama, who wanted to unite Arabs and Berbers, without discrimination, in a formal Islamic community built around Koranic laws. The Ulama slogan was 'Islam is our religion, Algeria our country, Arabic our language'.[95] There was also the radical views of individuals like Ahmed Messali Hadj, founder the Paris Étoile Nord-Africaine, which became the first Algerian party in 1926 and clearly advocated Algerian independence. Messali and his followers were frequently in conflict with the French administrative authorities and the judiciary, which forced him to continue his campaigns underground. In 1937, Messali established the political party, the *Parti Populaire Algérien* (PPA) after the Étoile was disbanded. With independence as its primary aim and a well-structured propaganda campaign to circulate its agenda, the PPA gained considerable influence across Algeria. Yet moderates like Abbas continued to push for assimilation rather than independence. In 1938, Abbas founded the *Parti de l'Union Populaire*

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[92] Evans, *Algeria*, p. 56.
[93] Ibid.
[94] Klose, *Human Rights in the Shadow of Colonial Rule*, p. 81. See also Henri Grimal, *Decolonisation: the British, French, Dutch and Belgian Empires* (London and Henley: Routledge & Kegan Paul, 1978), p. 74.
[95] Grimal, *Decolonisation*, p. 74.

Algérienne pour la conquête de droits de l'homme et du citoyen, which refused to accept a future divorced from France.[96]

The situation, however, changed significantly during the Second World War as conditions in Algeria deteriorated. Food shortages due to crop failures and rationing from 1940 to 1942 and an outbreak of typhus radicalised many nationalists. In addition, the educated bourgeoisie took inspiration from the news broadcasted on the radio and, in particular, the principles enshrined in the Atlantic Charter by President Roosevelt and Prime Minister Winston Churchill in 1941.[97] Increasingly, the attitudes of moderate nationalists were hardened as they came to realise that assimilation was meaningless; independence from France was the only reasonable future for the colony.[98] Eventually, Algerian nationalism, which had been diverse and divided prior to the conflict, was unified in 1943 by Abbas when he drew-up the *Manifeste du peuple algérien*. The text, which decried the Algerian condition, called for, among other demands, an end to colonisation and exploitation, equality for all regardless of race and religion, the recognition of the Arabic language, and compulsory education for children of both sexes.[99] Algeria was to be a unified, autonomous and democratic state which would be recognised and protected by a federal relationship with France.[100] Keen to recruit natives for the war effort, General Henri Giraud and the then General Governor of Algeria, Marcel Peyrouton, initially accepted the *Manifeste* as a working hypothesis and encouraged the Muslims to make a list of realisable proposals. However, this was largely interpreted as time saving measure which forced Abbas to produce the *Additif au Manifeste*, a more radical document that espoused national self-determination and independence.[101]

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[96] Klose, *Human Rights in the Shadow of Colonial Rule*, p. 81.
[97] In particular, the nationalists were struck by the principle within the Atlantic charter which extolled self-determination for all peoples. See Klose, *Human Rights in the Shadow of Colonial Violence*, pp. 11-17; Francis Koerner, 'Le mouvement nationaliste algérien (Nov. 1942 – mai 1945)', *Revue d'histoire de la Deuxième Guerre mondiale*, 93 (1974), 45-64 (p. 55).
[98] Ibid.
[99] Ruedy, *Modern Algeria*, p. 146-147.
[100] Grimal, *Decolonisation*, p. 118. See also Bernard Droz and Evelyne Lever, *Histoire de la guerre d'Algérie 1954-1962* (Éditions du Seuil, 1991), p. 31.
[101] Klose, *Human Rights in the Shadow of Colonial Rule*, p. 82.

Eager to out-manoeuvre the nationalists, the government under General Charles de Gaulle and his deputy, General George Catroux, who governed Algeria, promulgated the Ordinance of 7 March 1944 which granted French citizenship without requiring Muslims to renounce their heritage and submitted the natives to the rules of French common law. Article 3 of the Ordinance allowed the new citizens to be 'registered on the same electoral lists as non-Muslim citizens' and allowed them to participate 'in the same polls'.[102] In addition, in the years following the end of the Second World War, France and Britain both attempted to overcome some of the long-standing health and labour conditions for the colonial subjects. This was, as Jennifer Johnson noted, only undertaken because Empire 'presented a potential solution to the crisis in Capitalism'.[103] The war had left both colonial powers in urgent need of resources to fuel their economic recovery. Throughout the war itself, the colonial territories had provided essential raw material and foodstuffs, yet their true potential remained unrealised.[104] As such, rather than move towards decolonisation in the post-war period, the colonial powers recommitted themselves to restoring the colonial *status quo* to their pre-war hegemonic positions. Both Britain and France focused their attention on introducing planned economies for the colonies. Africa, in particular, became a prized asset at a time when the future of the colonies in Asia was more contentious. Money poured into infrastructure such as roads and railways, as well as social welfare, hospitals and education as well. At this point, the idea that the state played a role as agent for the promotion of the welfare of its inhabitants was introduced to the colonies with increased medical services.[105] In particular, attention was paid to improving native health and nutrition, but, as with earlier targeted medical campaigns surrounding infectious disease, the colonial authorities did not address the social roots of inequality.

[102] Bénédicte Fortier, 'L'indigène algérien : du sujet au citoyen (1944-1947)', *Le genre humain*, 32 (1997), 53-61 (p. 56).
[103] Johnson, *The Battle for Algeria: Sovereignty*, p. 32.
[104] Klose, *Human Rights in the Shadow of Colonial Violence,* p. 52.
[105] Michael Crowder, 'The Second World War: Prelude to Decolonisation in Africa', in Michael Crowder (eds.), *The Cambridge History of Africa Volume 8: From c.1940 to c.1975* (Cambridge: Cambridge University Press, 1984), 8-51 (p. 46).

For the nationalists, all these efforts were too little too late. Firstly, Abbas, the Messalists and most of the ulama rejected de Gaulle's 1944 proposals. Abbas responded by creating the association *Amis du manifeste et de la liberté* on 14 March 1944, through which he intended to create a national front extended to the ulamas and the clandestine supporters of Messali Hadj.[106] Algerian nationalism was now more radical, more separatist and increasingly hostile towards colonial rule at the end of the Second World War. Yet as demonstrated by the post-war recolonisation efforts, the French had little intention of abandoning Algeria. If necessary, they would resort to extreme violence to protect it. In May 1945, dissident violence broke out in Sétif during demonstrations and resulted in 21 European deaths. The insurrection movement spread over the following days to the countryside and to cities such as Bone, Guelma and Batna. Several French victims were subsequently mutilated and displayed.[107] Yet while this violent nationalist outburst was shocking for the Europeans in Algeria, France's retaliatory repression was, as Bernard Droz and Evelyne Lever note, 'pitiless and often blind'.[108] It will never be clear just how many natives were killed by France's retribution, but the FLN propaganda suggested over 40,000 people were killed.[109] If these figures are questionable, then the limited 1,500 admitted by the French administration seems just as suspicious. The reality is probably four or five times higher than this, but either way, the Sétif massacre served as the spark that ignited the fires of revolution for the Algerian nationalists. On the night of the 31 October into the morning of the 1 November 1954, a radical group of insurrectionists called the *Comité révolutionnaire d'unité et d'action* (CRUA) led a coordinated guerrilla strikes across six military districts (*wilayas*). Although casualties were low, the psychological impact was huge.[110] The CRUA later reformed itself into the FLN and organised a national

[106] Droz and Evelyne Lever, *Histoire de la guerre d'Algérie 1954-1962,* p. 31.
[107] Anthony Clayton, *The Wars of French Decolonization* (London and New York: Longman, 1994), p. 30.
[108] Droz and Lever, *Histoire de la guerre d'Algérie 1954-1962*, p. 32.
[109] Ibid.
[110] Klose, *Human Rights in the Shadow of Colonial Rule*, p. 84.

liberation army called the *Armée de libération nationale* (ALN).[111] The Algerian War of Independence had started.

Yet while the war of independence would come to engulf all members of colonial society on both sides of the conflict, as will be shown in subsequent chapters, the FLN were keen to also wage an organised and effective propaganda campaign which struck at the heart of the occupying power's failures. This campaign, too, demonstrates the extent to which France's inability or reluctance to address entrenched health and social inequalities was a significant political issue for the Muslims. As the War started, the FLN took note of the language surrounding healthcare, international development and modernity which was being promoted by the colonial powers in the post-war period and used it to create their own alternative healthcare system. The ultimate expression of this effort was the formation of the *Croissant-Rouge Algérien* in 1957, the FLN's vehicle for disseminating medical aid and healthcare to both, so their pamphlets claimed, 'combatants and civilians' during the war.[112] The *Croissant-Rouge* was a valuable propaganda device, as it allowed the FLN to demonstrate their humanitarian aspirations and to appeal for international aid in their struggle. This came in direct contrast to the ways in which the French security forces and some doctors corrupted medicine during the war and used it as a weapon against the rebels, as will be demonstrated later in this work.

Jennifer Johnson has recently argued that by establishing national healthcare institutions, like the *Croissant-Rouge*, the FLN were presenting themselves as a 'proto-state' that could provide better care then the colonial authorities.[113] Although this was a political move performed by other anticolonial groups in the British and French empires during the Cold War, it nevertheless demonstrates the extent to which healthcare provisions and medicine were

[111] Grimal, *Decolonisation*, p. 293.
[112] Jennifer Johnson Onyedum, '"Humanize the Conflict": Algerian Health Care Organizations and Propaganda Campaigns, 1954-62', *Journal of Middle East Studies*, 44 (2012), 713-731 (p. 713).
[113] Johnson, *The Battle for Algeria*, p. 4.

political matters for the rebels.[114] This is an important point that distinguishes the nationalist campaigns of the FLN from those of Mau Mau in Kenya. While the FLN successfully launched a viable programme for delivering healthcare to the Muslim population and drew international support to their efforts, the Kenyan nationalists did not. In fact, it seems the senior members of the political dissidents in East Africa still hoped for a limited number of British doctors to continue to immigrate to the country, even after they won their independence. This desire for medical migrants contrasted with a general call for the cessation of European migrants more generally, which suggests that the nationalists did not have an effective plan for medical provisions.[115] The FLN's ability to produce the *Croissant-Rouge* therefore marks a significant point of contrast between the two contexts and shows how important medicine and its administration were for the rebels. By the time hostilities erupted in the colony, the French had become all too aware of this fact.

In 1955, the Governor General of Algeria, Jacques Soustelle, created the military-run *sections administratives spécialisées* to perform security and welfare work in mostly rural areas—places where colonial doctors had largely failed to minister to the sick throughout the colonial period.[116] The SAS was therefore largely a propaganda organisation: their purpose was simultaneously to provide medical care in rural settings and to convince the rural communities of the benefits of the French presence in Algeria. Johnson has convincingly argued that the SAS was established to woo the hearts and minds of the Algerian inhabitants away from the FLN's attempts to foster humanitarian support and to cast themselves as better providers of health-care and welfare. The French authorities believed that the SAS could promote a more

[114] Ibid., pp. 2-5.
[115] TNA FCO 141/5667/17/1. Letter of complaint from Mau Mau detainees addressed to Governor Baring, 17 November 1954.
[116] Although these communities had contact with auxiliary medical practitioners, as Clarke demonstrates, the general belief among the French at the start of the Emergency was that these inhabitants had never encountered European medicine, the core of the French 'civilising mission'. How then could they reject it? See Hannah-Louise Clark, Doctoring the *Bled*: Medical Auxiliaries and the Administration of Rural Life in Colonial Algeria, 1904-1954 (Unpublished dissertation: Princeton University, 2014), p. 11.

humane version of empire by offering greater healthcare for those previously neglected portions of Muslim society.[117] By doing so, they acknowledged not only the level of inequality that had characterised much of the period of colonial occupation but also the close association between healthcare and military objectives.[118] It is this final point which helps to explain the number of French doctors who were killed by the FLN in 1956, as mentioned in the first section. These individuals, especially Dr. Vanier, were providing healthcare through the SAS as part of a wider military strategy. It is therefore clear that the FLN's attacks on some doctors was not random. While the French press described the provision of this care as an act of humanitarianism, the FLN recognised it as another French tactic in the war. In fact, as early as 1961, a group of young French conscripts denounced the darker side of the SAS when they wrote in *Esprit*:

> […] the soldier turned schoolmaster, the S.A.S. officer, even the doctor of the Free Medical Service are not just teachers, administrators, and doctors; they are military personnel and are never allowed to forget it. In this war, which is overturning all our values, they are not primarily serving the Muslim children, or the sick of the village; they are serving a cause; they are one more weapon in the battle. The army only supports the S.A.S. system because it plays this dual role.[119]

Under the state of emergency, the military would use their control of the civilian medical services as a means for policing the Muslim population. Following their defeat at the hands of the nationalists in the protracted war in Indochina (1946-54), the French army had little time

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[117] Jacques Frémeaux, 'Les SAS (sections administratives spécialisées)', *Guerres mondiales et conflits contemporains*, 208 (2002), 55-68.
[118] Increasingly during the twentieth century the armed forces were required to supply healthcare and medical provisions to their soldiers, as Mark Harrison has shown. Yet the SAS's medical aid formed part of a broader propaganda campaign where offering healthcare to the indigenous populations was a weapon in the war against the rebels. For more on the connection between healthcare provisions and modern warfare, see Harrison, 'Medicine and the Management of Modern Warfare'.
[119] Quoted in Pierre Vidal-Naquet, *Torture: Cancer of Democracy,* trans. by Barry Richard (Middlesex: Penguin Books, 1963), p. 45.

to dissect or make sense of what had happened before they were plunged into the Algerian War. The loss of their influence in the east left them embarrassed and terrified that Algeria, the last colony of significance, would also be lost to nationalist fervour. The French army, especially the paratrooper divisions, therefore carried out extreme levels of violence and waged a terror campaign against the FLN that included the use of torture, extra judicial executions, assassinations and disappearances. A more detailed analysis of these aspects of the war will take place in later chapters, but at this stage it is important to note that the extent of the military's involvement in the conflict is a crucial factor that distinguishes the Algerian War from the Kenyan Emergency. In the context of the former, the civilian administration found itself constantly tussling with the military for control, especially as the army had a propensity for excessive and ill-judged interventions in politics and dissident behaviour that resulted in a failed military coup in April 1961.[120] The result was that medicine, in the eyes of the politically active on both sides of the conflict, was a weapon to be harnessed against the enemy. As in the early years of the colony, medicine was once again being controlled by the military—a development which goes a long way towards explaining why so many medical practitioners undertook activities that supported torture and violent interrogation. Although (as will be seen in Chapter 3), many civilian doctors also took part in forms of terrorism and violence, the military's control of Algeria during the war meant that the medical-assisted violence in this territory followed a distinct course from Kenya.

Given the density of the above narrative, it might be in order to summarise the main conclusions so far. The administration of medicine in Algeria for most of the period of French occupation offered negligible benefits to the majority of the Muslim population. However, this was not always due to deliberate contempt for the indigenous races, though that was certainly a factor. The French SMC was underfunded and consistently entangled in power

[120] Martin S. Alexander, Martin Evans and J. F. V. Keiger, 'The 'War without a Name', the French Army and the Algerians: Recovering Experiences, Images and Testimonies', in Martin S. Alexander, Martin Evans and J. F. V. Keiger (ed.) *The Algerian War and the French Army, 1954-62: Experiences, Images and Testimonies* (Palgrave Macmillan, 2002), pp. 1-39 (p. 9).

struggles with the military. As such, it is easy to see how the motives and activities performed by one could be confused with those of the other, which may account for why doctors became targets of aggression during the Algerian War. Yet the close association between the administration of medicine in the colony and the conditions of privation and deprivation that contributed to the nationalists' cause cannot be discounted. Health care and medical attention were predominantly reserved for the European population and often at the direct expense of Algerian lives. As such, French medicine in Algeria helped to reinforce the political, social and economic marginalisation of non-European communities. Medicine's role as a tool of repression and exclusion would not be forgotten by the Muslim nationalists, who adopted its ideals and aims for their own political purposes once the rebellion was underway. The strength of the connection between medicine and the military is one of the most significant features of the Algerian War and will be important for understanding the ways in which doctors supported the French state's counterinsurgency efforts in subsequent chapters. The next section will explore the rise of nationalism in Kenya. Although the military played a less significant role in the establishment and maintenance of this colony, from the perspective of local Africans, the provision of medicine was no less marginalising or contentious.

1.4. Medical administration: Kenya

In the early stages of colonial settlement in Kenya, medicine was, unlike its French counterpart, closely aligned with trade rather than military occupation. This is arguably because British officials were not really interested in the territory for its own sake; it was a link in the overall British Mediterranean and central African policy.[121] This should not be taken to imply that the British military were less aggressive than their French counterparts, however.[122] In 1888, the Imperial British East Africa Company (IBEAC) was issued a royal charter to trade in, and administer, the region. The Company brought with it administrators,

[121] Ann Beck, *A History of the British Medical Administration of East Africa* (Cambridge: Harvard University Press, 1970), p. 11.
[122] Klose, *Human Rights in the Shadow of Colonial Violence*, 61.

commercial managers and the first government doctors to attend to the medical needs of the British residence. Prior to this, there had been little medical presence in the region, save for a few pioneering doctors attached to expedition parties and missionary physicians.[123] Doctors worked for the IBEAC until it was officially disbanded in 1895, when the territory of Kenya became a British protectorate and settler colony, whereupon they were absorbed into government service. Although the IBEAC quickly realised they were unable to establish trade in the hinterland without British military and financial support, the military only played a role in the administration until the first decade of the twentieth century, after which its influence was greatly diminished.[124] During these early years, the distinction between military and civilian roles was blurred, especially when it came to practicing medicine. Military doctors had often been the first to establish the foundations of a medical infrastructure, but once the protectorate fell under civil management, these individuals usually transferred to civilian posts.[125] This is a marked contrast to the situation in Algeria, where—as we know—military and civilian administrators continued to struggle for dominance throughout the colony's history.

Another distinction of note has to do with how the British administered their overseas territories more generally. It was assumed that British colonies should be largely self-supporting and funded by taxes drawn from the indigenous populations.[126] As such, the Colonial Services in each territory were afforded a certain degree of independence from central authority in London. Even though the Secretary of State for the Colonies and the Colonial Office had ultimate responsibility, individual colonial governors exercised a great deal of power.[127] This autonomy was also reflected in the Colonial Medical Service (CMS), which, employing nearly a third of all Colonial Staff in 1900, was the second-biggest

[123] Crozier, *Practicing Colonial Medicine*, p. 5.
[124] Beck, *A History of the British Medical Administration of East Africa*, p. 19.
[125] Ibid, pp. 8-9.
[126] Ibid, p. 14.
[127] Crozier, *Practicing Colonial Medicine*, pp. 2-3.

personnel branch of the British Empire.[128] Although often referred to as a single body, the CMS was run as a distinct administrative organisation in each country, often with its own terms and conditions of service.[129] The Medical Department was one of the major departments of each colony and like others, such as the Treasury, the Legal Department and the Public Works Department, was headed by a member of the profession concerned—the head of the Medical Department was therefore always a doctor. Unlike in Algeria, where it was mostly military doctors who would be involved in the counterinsurgency tactics employed against the FLN, it would be members of this CMS who had the most prominent role to play in the detention camps where the majority of Mau Mau detainees were held. It is therefore important to understand how these medical-civil servants operated within the country, especially in relation to other healthcare providers, and how they were perceived by Kenyans.

The CMS was, like other departments within the Colonial administration, underfunded and low on personnel. This remained a constant challenge for the administration of medicine in East Africa and would have implications in the Kenyan detention camps during the Emergency.[130] The healthcare that the Medical Services could provide for the nascent settler community was thus limited, especially in the early days of British rule. Similar to the medical services in Algeria, Colonial medicine in Kenya was principally aimed at protecting the lives of settlers, traders and the members of administration from the infectious diseases that threatened their interests.[131] The welfare and provision of healthcare for the African population lay outside their purview until after the First World War, unless disease prevalence among their communities posed a threat to the health of the British.[132] For example, in 1902, an

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[128] Ibid., p. 3.
[129] Crozier, *Practicing Colonial Medicine*, p. 9.
[130] Indeed, even in 1958 the problem was debated in the House of Commons where the systemic shortage of doctors in the colonies was causing considerable concern. See Hansard. House of Commons Debate, 'Doctors', Mr. Blenkinsop MP, 17 June 1958, paragraphs 887-888.
[131] Michael Worboys, 'Colonial Medicine', in in Roger Cooter and John V. Pickstone (eds.), *Companion to medicine in the twentieth century* (London: Routledge, 2003) p. 67; see also Michael A. Osborne, 'Acclimatizing the World: A History of the Paradigmatic Colonial Science', *Osiris*, 15 (2000), 135-151.
[132] The diseases that caused the most trouble for the Colonial Medical Services in Kenya were malaria, plague (bubonic and pneumonic), small pox and sleeping sickness, which all had recurring

epidemic of plague broke out in Nairobi. In order to stop it spreading to the European community, several doctors took it upon themselves to burn down the local Indian bazaar with seemingly little consideration for the consequences.[133] In the end, a Dr. Spurier was brought in from Zanzibar to take over the medical measures and to stop the sporadic burnings, despite those responsible for these extreme measures being thanked by the Secretary of State in England.[134] Consequently, as with Algeria, the benefits of Western medicine were largely reserved for the white settlers living in the colony.[135] If care was extended to the natives, it was only when they presented a threat to the health of the nascent settler communities.

Moreover, due to financial restraints, the Colonial Medical Service in Africa rarely acted entirely autonomously. In fact, resources and expertise from other locally-based health agencies were often pooled together, formally or informally, even if their interests did not always agree with one another.[136] In particular, running alongside the official administration of medicine in East Africa was the work performed by medical missionaries of various denominations.[137] These services, unlike those offered by the CMS in the early days of the

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epidemics in the years between 1900 and the start of First World War. During this period, the colonial government spent a considerable amount of time experimenting with various measures to address the issue, but the impact was limited. See Beck (1970), pp. 24-25; Marc H. Dawson, 'Socioeconomic Change and Disease: Smallpox in Colonial Kenya, 1880-1920', in Steven Feierman (ed.), *The Social basis of Health and Healing in Africa* (Berkeley; Oxford: University of California Press, 1992), pp. 90-103 (pp. 90-91).

[133] John Carman, *A Medical History of the Colony and Protectorate of Kenya: A personal memoir* (London: Rex Collings, 1976), p. 5.

[134] Ibid, pp. 5-6.

[135] There was also a large Indian community in Kenya who played an important role in the early years of the colony, especially in relation to the construction of the railway line. Some of them even served as CMS doctors in the first years of the twentieth century. Interestingly, I have not encountered the names of any Indian doctors in the detention camps used by the British to hold those arrested during the Emergency. This is likely because, by the 1920s, there was a general effort within the colonial medical services to limit the number of Indian doctors. See Anna Greenwood and Harshad Topiwala, 'The maintenance of hegemony: the short history of Indian doctors in the Colonial Medical Services, British East Africa', in Anna Greenwood (ed.), *Beyond the State: The Colonial Medical Services in British Africa* (Manchester: Manchester University Press, 2016), pp. 64-84.

[136] Greenwood, 'Introduction', p. 2.

[137] There was a missionary presence in Algeria during the period of French colonialism, especially during the second half of the nineteenth century. Different orders of missionary societies saw it as their responsibility to not only convert the North African Muslims to Christianity, in order to fend-off the perceived rise of Islam in Africa, but also to fight the rise of secularism in France. Despite the important role Catholic missionaries played in Algeria, there is currently less evidence that medical missionaries had the same type of impact on the political situation in the colony as their East African counterparts in Kenya which is why they have not received as much attention in the present work. For

colonies, were directed at the indigenous population. Although missionaries were not part of the Colonial Medical Services *per se*, the work of the two institutions was, as Markku Hokkanen states, deeply 'intertwined, with each benefitting from the other's cooperative co-existence'.[138] In essence, the colonial government required to contribute very little to the civilising mission being carried out by various Christian denominations in East Africa. This is not to suggest that missionary societies and the Colonial Medical Services had an easy relationship, nor that the former were the handmaids of the latter. Indeed, recent scholarship has shown that although there were many instances of collaboration between the colonial authorities and various missionary societies across Africa, disagreements between the two were common, especially when related to administrative policy.[139] As Michael Jennings states, medical missionaries did function as 'agents of empire' to a certain extent, 'but in ways more complex and nuanced than is often presented […]. Ultimately, missionaries were agents of their mission first and foremost'.[140] For many Africans living outside of the urban and administrative centres, however, the distinction between the two was meaningless: missionary medicine was not an alternative form of western medicine, it *was* western medicine.[141] Where interests were shared, the two supported one another. In some cases, the level of collaboration between missionary doctors and the CMS was so intense that doctors with the Church Missionary Society[142] negotiated dual roles as missionaries and colonial medical officers up to the period before the 1940s.[143]

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details on French missionary presence in the French empire, see Aldrich, *Greater France*, pp. 128-131.

[138] Markku Hokkanen, 'The government medical service and British missions in colonial Malawi, c. 1911-1940: crucial collaboration, hidden conflicts', in Anna Greenwood (eds.) *Beyond the State: The Colonial Medical Services in British East Africa* (Manchester: Manchester University Press, 2016), pp. 39-63 (p. 40).

[139] Ibid., pp. 55-57.

[140] Michael Jennings, 'Healing Bodies, Salvation of Souls': Missionary Medicine in Colonial Tanganyika, 1870s-1939', *Journal of Religion in Africa*, 38 (2008), 27-56 (p. 34)

[141]Ibid. (p. 28).

[142] The Church Missionary Society is often abbreviated as CMS, however in this piece I will continue to refer to it in full so as to avoid confusion with the Colonial Medical Services.

[143] Yolana Pringle, 'Crossing the divide: medical missionaries and government service in Uganda, 1897-1940', in Anna Greenwood (ed.), *Beyond the State: The Colonial Medical Services in British Africa* (Manchester: Manchester University Press, 2016), pp. 19-38 (p. 19).

Yet the missionaries' ultimate aim differed from that of the colonial authorities. Missionaries emphasised the gospel of healing as an essential aspect of their work among the Africans. Their medical care was supplied alongside their greater aim: the Africans' spiritual salvation. As David Hardiman notes, the 'sickness' of the African, for Evangelicals, reflected both 'moral and physical contamination'. As such, 'any Godly person who understood the rudimentary principles of hygiene and sanitation was in a position to bring health to the 'native' by cleansing their bodies with soap and their minds with the Gospel'.[144] Healing was an important tool for conversion, and so missionary medicine had a dual purpose for which the objective of healing bodies was subservient to saving souls.[145] This was a contentious problem for many of these 'hyphenated-hybrids', as Dr. Chesterman called them, who felt torn by the dual-nature of their role.[146] In fact, there was a long running debate among missionary doctors regarding the extent to which they should capitalise on the opportunity to evangelise at the bedside. Some, like the famous missionary doctor, Albert Cook, had the conversion of souls as their priority, and maintained that medical work would water down evangelisation, leading to superficial conversions only.[147] However, in times of epidemics and given the scarcity of available personnel and resources, it was not unusual for missionary doctors working in remote locations to find their time for spiritual commitments compromised by the sheer number of patients. As Dr. Frank Lake of the Church Missionary Society for the Christian Medical College in Vellore, south India, queried in 1949:

> How do we do it? Do we close the dispensary when we have seen the first six hundred patients? Do we say to the next two hundred, who because of greater infirmity took

[144] David Hardiman, 'Introduction', in David Hardiman (ed.), *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa* (Amsterdam and New York: Clio, 2006), p. 5.
[145] Jennings, 'Healing Bodies, Salvation of Souls' (p. 36).
[146] Kenya National Archives (KNA) MSS/3/479/91. Quoted by Dr. Frank Lake, 'An address delivered at the Conference of the Medical Advisory Board of the "Conference of British Missionary Societies"' reproduced in 'The Realignment of Medical Missions To-Day to Meet New Demands' and circulated among the Kenyan Church Missionary Society medical staff in 1949.
[147] Vaughan, *Curing their Ills*, p. 58.

> longer to crawl the weary road to the hospital: Sorry no more to-day; the priorities of the Kingdom of God must be served?[148]

Yet Dr. Lake's answer to this question was ultimately to echo Cook's. Lake suggested missionaries follow the example set by Christ in the 'Synoptic accounts of our Lord's healing miracles', and asked: 'What do our acts of physical healing achieve?' It was foolish, he argued, to believe that a physical cure would result in a patient entering 'within the sphere of spiritual redemption'.[149] Secular medicine emphasised obligations to all patients, but missionaries, Lake stressed, had to limit their clinical duties if they were to effectively deliver on their spiritual ones. It is not clear as to how members of the Kenyan Church Missionary Society responded to Lake's views. Reverend W. Scott Dickson, the General Secretary of the Church Missionary Society, asked readers to 'not assume [that] I agree with the paper', but it seems they were at least indicative of debates that run throughout the colonial period, as Meghan Vaughan notes.[150]

There are a few points of interest here. Firstly, as mentioned above, missionaries were among the first to introduce Western medical practices to Kenya and many other countries that would become part of the British and French empires.[151] Indeed, in many instances, missionary hospitals and dispensaries were set up decades before colonial governments accepted any general responsibility for African health.[152] Medicine in East Africa was thus associated with Christianity from the outset. It was the missionaries who pioneered biomedical science in these colonies, who established rural hospitals and clinics, trained personnel and introduced

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[148] KNA MSS/3/479/91. Dr. Frank Lake, 'An address delivered at the Conference of the Medical Advisory Board of the "Conference of British Missionary Societies"' reproduced in 'The Realignment of Medical Missions To-Day to Meet New Demands' and circulated among the Kenyan CMS medical staff in 1949.
[149] Ibid.
[150] Vaughan, *Curing their ills*, pp. 58-59.
[151] Missionaries also played a role in the colonisation of Algeria, but as noted above, it was military medicine which had the most influence over the colony for most of its formative years.
[152] Charles M. Good, 'Pioneer Medical Missions in Colonial Africa', *Social Science and Medicine*, *32* (1991), 1-10 (p. 1).

'western' midwifery and child care practices to the Africans.[153] It was not until the years following the First World War, as with the French example, that the Colonial Medical Services started to provide some healthcare to the native population in East Africa and therefore limit their unofficial cooperation with missionary doctors. This provided a significant amount of political strength to the missionaries who administered healthcare to the Africans. In fact, it highlights a crucial factor in the rise of nationalism in Kenya: the link between the missionaries' Christian zeal and their medical aid could be extremely contentious in the eyes of the natives, especially when they interfered with their traditional customs.

The emphasis on Christian spirituality was often fundamental and sometimes unyielding. In this world view, if illness was the result of sin, then the roots of that sin, in many cases, were the evils of traditional society.[154] African indigenous religious beliefs were viewed as unacceptable, primitive, uncivilised and as potential sources for infection. The missionaries took particular exception to the practices of witchcraft, ancestor worship, modes of dress, African dances, polygamy and burial practices.[155] In some instances in Kenya, the services provided by missionary schools and hospitals could only be accessed by the Africans such as the Kikuyu—Kenya's largest ethnic group that made up the vast majority of Mau Mau—if they renounced their own traditional beliefs and 'pagan' customs.[156]

One of these traditional customs that caused political controversy for the medical community and the colony more generally was the Kikuyu's practice of female circumcision, or clitoridectomy. As a Dr. John W. Arthur explained in 1942, 'the missionaries, many of whom are medical men, and nurses have spoken of "the sexual mutilation of women" as being a more correct term than "circumcision."'[157] Dr. Arthur explained that, from a medical perspective,

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[153] Vaughan, *Curing their Ills,* p. 56.
[154] Ibid, p. 57.
[155] Anderson, *Histories of the Hanged*, p. 18.
[156] Elkins, *Britain's Gulag*, p. 20.
[157] John W. Arthur, '"Female Circumcision" among the Kikuyu', *The British Medical Journal*, 24 October 1942, p. 498.

the operation had ‘physical and psychological’ effects on ‘girls in puberty’ and could lead to excessive bleeding and even death. Yet, according to Arthur, the ‘most disastrous results of the operation occur[ed] at times of childbirth, especially with primiparae’. This meant that labour was often delayed and the mother or child, or even both, could die ‘from the unfavourable conditions of the operation’.[158] In the early part of the twentieth century, some missionary hospitals working with the Kikuyu had banned the practice for their converts. ‘As the result of a strong stand taken by some of the missions working among the Kikuyu from 1916 on,’ Arthur tells us, ‘many Christian girls are now saved from this operation, and thus in certain areas the custom is becoming a thing of the past’.[159] The reference to ‘Christian girls’ in this passage is interesting as, up to this point, Arthur had made no reference to the Kikuyu’s religious belief. Indeed, the correspondence says nothing else related to religion. One could be forgiven for assuming that Arthur’s views on female circumcision were based purely on medical grounds, but this final line betrays a certain religious objection, one that almost seems to link Kikuyu’s ‘pagan’ practice with dangers to health.

What Arthur fails to mention in his correspondence is that he himself played a direct role in a political clash that came about because of the ban on female circumcision in Kenya. Arthur had started his medical work in Kenya in 1909 and had been opposed to the practice from the start.[160] He and two colleagues, Dr. Stanley Jones and Dr. H. R. Philip, the Church of Scotland Mission doctor of Tumu Tumu province, had also been ‘vigorous’ campaigners against the practice on religious, medical and humanitarian grounds.[161] During the late 1920s, several missions, including the Church of Scotland Mission, the Africa Inland Mission and the Gospel Missionary Society, applied pressure on colonial officials in Nairobi to change their approach of indirect rule. Typically, the British colonial authorities allowed local chiefs or what were

[158] Ibid.
[159] Ibid.
[160] Beck, *A History of the British Medical Administration of East Africa*, p. 93.
[161] Ibid., pp. 93-94.

known as Local Native Councils to exercise authority over the natives and their customs.[162] In this situation, however, the officials in Nairobi urged local African authorities to regulate and restrict female circumcision. In 1929, Dr. Arthur, who was the 'feisty' head of the Church of Scotland Mission, along with his European staff had insisted that all their African employees, primary teachers, as well as church elders and members sign an oath renouncing the custom of female circumcision. He even insisted that the Africans swear that they were not members of the Kikuyu Central Association (KCA)—a radical African political organisation that came to prominence in Kikuyuland in the early 1930s.[163]

According to Anne Beck, Dr. Arthur had always had a pro-African attitude and a history of trying to protect African land rights and access to education from more hard-lined settlers like Lord Delamere.[164] However, the political repercussions of his anti-female circumcision stance were far larger than Arthur had anticipated. As Donald Schilling notes, 'Seventeen of the bush school teachers refused to sign and were dismissed; the church at Kikuyu lost nine-tenths of its members, including eighteen of fifty elders; and the mission's bush schools, assigned teachers who had taken the oath, were boycotted and shut down'.[165] Other missions that took a similar stance also found their flocks depleted in their thousands. The Kikuyu founded their own churches that permitted the practice, in response. On 11 December 1929, the Kikuyu's practice of female circumcision became a hotly debated subject in Parliament back in London.[166] The policy embarrassed more moderate missions while straining relations between government officials and the missionaries opposed to circumcision. This single cultural issue

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[162] Authorised in 1925 by an amendment to the Native Authority Ordinance, local native councils were established in the more progressive districts of Kenya by 1952. They served as a 'safety valve' for acceptable African political expression and action. By bringing together competing political segments of the community in each district, the colonial government sought to reduce potentially dangerous frictions and at the same time undermine the purpose of the African protest organisation. See Donald G. Schilling, 'Local Native Councils and the Politics of Education in Kenya, 1925-1939', *The International Journal of African Historical Studies*, 9 (1976), 218-247 (p. 221).
[163] Beck, *A History of the British Medical Administration of East Africa*, p. 94.
[164] Ibid., p. 96.
[165] Donald G. Schilling, 'Local native councils and the politics of education in Kenya, 1925-1939', The International Journal of African Historical Studies, 9 (1976), 218-247 (p. 236).
[166] Hansard. House of Commons Debate, 'Colonial Policy in Relation to coloured races', 11 December 1929, paragraphs 581-616.

ended up mobilising Kikuyu peasants for the first time and, in doing so, provided the KCA with a mass political basis that would contribute to a growing sense of nationalism among the politically minded Kikuyu.

The controversy caused by missionary doctors like Dr. Arthur and his colleagues demonstrates the delicate situation medical missionaries working in the colonies faced. Although the fundamental principles underlining the ban on clitoridectomies were grounded in humanitarian and medical terms, the missionaries' continual desire to stamp-out all unchristian indigenous practices nevertheless contributed to the Kikuyu's negative response. Arthur's medical responsibilities were tainted by his missionary zeal in the eyes of the natives, causing them to transmute into political issues. Indeed, while on an evangelical tour of central Kenya, where he was preaching on the 'evils' of clitoridectomy prior to the ban in 1929, Arthur reportedly accused the KCA of being agitators and despoilers of 'God's work'. He even reportedly thumped the pulpit in anger, causing concern among the other European missionaries who were present.[167] Arthur's controversy thus highlights an interesting alternative to the type of dual-loyalty dilemma discussed so far. Rather than being torn between his commitments to the healing profession and the military, as is the case in other contexts, Arthur was caught between his professional role and his religious beliefs. This is an area worth wider investigation, but for now it is important to note that the divide created by the circumcision topic served as a point of orientation for the nationalists in Kenya.

The KCA, who aimed for a progressive spread of education and training for Africans, were also determined to preserve tribal customs, which included female circumcision. Jomo Kenyatta, the future president of Kenya, felt strongly about the retention of circumcision itself and the rites that accompanied it.[168] For him and for many other Kikuyu, the practice was part of the essence of Kikuyu life. A Kikuyu girl who refused to undergo the operation could not marry a Kikuyu husband; and this meant, as Anderson argued, that there would be no exchange

[167] Anderson, *Histories of the Hanged*, p. 19-21
[168] Jomo Kenyatta, *Facing Mount Kenya* (London: Secker & Warburg, 1974), pp. 130-154.

of bridewealth—livestock and goods given to the family of the bride by the family of the groom. This exchange served as a social glue that bound families to one another in relations of obligation and reciprocity.[169] A challenge to this tradition was a direct challenge to the survival of the Kikuyu society. The repeated demands that were issued by Kikuyu politicians in defence of circumcision demonstrated, in their eyes, the realities of Britain's 'civilising mission'. The colonial government responded to the KCA with unequivocal hostility, labelling it a dangerous and subversive organisation that was unrepresentative of the Kikuyu majority.[170] Arthur's ban was therefore further evidence in the minds of the KCA that colonial authority, religion and the limited medical aid the native received were all part of a system that would erode traditional values; the price for 'progress' in this instance was too steep.

The clitoridectomy controversy allowed the KCA to gain significant strength.[171] In the 1930s, they turned their attention to one of the most significant grievances of the Kikuyu, the struggle for land that, they believed, had been stolen by white settlers. The politics that played out over the next decade would shape the rise of Mau Mau in the 1950s. The issue of land was central to the politically active Kikuyu's list of grievances and ultimate demands. They were determined to return the White Highlands to African ownership. Of the many factors that combined to foster anger, resentment and a feeling of dispossession among the indigenous populations in both Algeria and Kenya, the subject of land and its ownership features strongly. The next section will show the extent to which this factor was also exacerbated by the presence of doctors. It goes a long way to explaining why many of the first victims of Mau Mau violence were prominent settlers, but also, more specifically, doctors.

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[169] Anderson, *Histories of the Hanged*, p. 19.
[170] Elkins, *Britain's Gulag*, p. 21.
[171] Daniel Branch, *Defeating Mau Mau, Creating Kenya: Counterinsurgency, Civil War, and Decolonisation* (Cambridge: Cambridge University Press, 2009), p. 31.

1.5. Land, nationalism and the rise of Mau Mau

Since the arrival of the first European settlers in 1902, land in Kenya had been divided by race, just as it had been in South Africa. In 1915, the Crown Land Ordinance recognised 'native rights' in lands reserved for their use, and in 1926 the British consolidated this division by creating African Reserves for each of Kenya's 'tribes', leaving the highlands, what would be known as the 'White Highlands', for the Europeans.[172] The White Highlands had absorbed large chunks of land in Kiambu and Murang'a, as well as areas further north, around Nyeri and Nanyki, and great tracts of land in the Rift Valley, and far to the west on the plateaus beyond.[173] Prior to the arrival of the Europeans, most of these lands were grazed by the Masai, while the richest part, little more than one percent of the area, had belonged to the Kikuyu. Once the settlers took possession of them, however, the only Africans allowed on the land were the squatters employed as labourers by the Europeans. Settlers saw this land as rightfully theirs as they had, as John Lonsdale says, claimed it 'by virtue of treaty and achievement; it was their own sure footing in uncertain times'.[174] For two generations, these Europeans had been tending to and taming the land; their young had prosperous futures tied to its soil and their dead had been buried within it.

The same was true for the medical community. Since the early days of European settlement in Kenya, some doctors were attracted to the colony for the financial opportunities it offered. For example, in 1896, Henry Albert Bödeker arrived in Kenya seeking to make his fortune from private practice before eventually joining the Colonial Service in 1899.[175] However, the land offered the greatest opportunities for securing a living, even for medical practitioners. In 1919, following the First World War, the pro-European War Council in Kenya established the Soldiers Settlement Scheme, with support from Governor Sir Edward Northey. The scheme

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[172] Anderson, *Histories of the Hanged*, p. 21.
[173] Ibid.
[174] John Lonsdale, 'Mau Maus of the Mind: Making Mau Mau and Remaking Kenya', *The Journal of African History*, 31 (1990), 392-421 (p. 402).
[175] Ann Crozier, *The Colonial Medical Officer and Colonial Identity: Kenya, Uganda and Tanzania Before World War Two* (Doctoral thesis, University College London, 2005), p. 148.

enabled veterans to claim land as British settlers, even if they lacked capital to develop their holdings.[176] Yet one feature of this scheme solidified the connection between the land issue and the medical community in a way that was more defined than in North Africa: an amendment to the scheme made by Northey himself saw ex-service doctors being offered free farms to encourage them to attend to the newly arriving soldier settlers.[177] The provisions of this medical scheme were designed to keep the doctors on their farms for as long as possible. If the farms were sold to anyone other than a doctor in the first five years after allotment, the full *stand premia* on the land had to be paid. Thereafter, the *stand premia* were reduced to a fifth for each year the doctor remained on the farm and after ten years the land became free.[178] Although the number of doctors who benefited from this scheme was relatively low—25 doctors, four nurses and a dentist—those who did gain land seem to have received a substantial amount.[179] For instance, the family of Lieutenant-Colonel C.A. Cunningham, the only doctor in the district of Laikipia, in central Kenya, gained 10,255 acres through the Soldier Settler Scheme.[180]

Although the scheme offered ex-service doctors a chance at securing a livelihood in Kenya, it still had significant drawbacks. One of the most frustrating seemed to be that these doctors were often tied to land in extremely isolated locations with few resources at their disposal. Competition for clients was tight and settler doctors often had to compete with Government Medical Officers for civil service patients, some of the few in Kenya who could be relied on to pay their bills.[181] Overall, the medical settlers attempted to avoid proceeding to the soldier settlement districts. For example, Dr. Pentreath, one of the victims of Mau Mau mentioned above, engaged in a series of five attempted exchanges of land in order to both secure a farm

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[176] Beck, *A History of the British Medical Administration of East Africa*, p. 74.
[177] C. J. D. Duder, *The Soldier Settlement Scheme of 1919 in Kenya* (Doctoral Thesis, University of Victoria, 1978), p. 200.
[178] Ibid.
[179] C. J.D. Duder, 'Men of the Officer Class': The Participants in the 1919 Soldier Settlement Scheme in Kenya', in *African Affairs*, 92 (1993), 69-87 (p. 77).
[180] Duder, 'The soldier settler scheme of 1919 in Kenya', p. 612.
[181] Ibid., pp. 454-455.

and reside close to Nairobi so he could maintain an eye practice he had established.[182] Flexibility was needed, and the Government exercised it where possible. Dr. M.C. Wetherell, a local medical settler who had been assigned a farm in the Kipkarren area, was also appointed as District Surgeon for Eldoret and allowed to use his practice there to count as occupation of his farm. Cunningham was permitted an extension of his then 1,760-acre farm in response to local demand for a doctor, in order that he might work it as an economic unit.[183]

If a steady flow of patients was insufficient to maintain a 'colonial' lifestyle, then doctors were forced to either subsidise their incomes by cultivating the land, or else to return to Britain.[184] As such, those who remained in Kenya were tied to the land as a necessity for survival. This meant that they would be responsible for maintaining the health of the European community, and to a lesser extent the Africans, in their allotted district as well as tending to their own agricultural enterprises. The hardship of this role was not necessarily without reward. Indeed, the need for qualified doctors meant that those who took up positions in the settler districts became invaluable members of the community and could rise in the ranks of the local hierarchy. This particular benefit will be discussed in more detail in Chapter 3, but it foregrounds an important feature of the colonial situation in Kenya. On these extensive farms, doctors were not only benefiting from the soil at the expense of the Kikuyu, they were also among the settlers who exploited their labour.

This is where the significance of the farming scheme with respect to the Mau Mau uprising starts to take shape. Following the end of the First World War, colonial authorities began to consider vital reforms in their management of African communities. Missionaries, colonial officials in East Africa and reformers in the metropole supported efforts to improve the standard of education available to Africans. The idea was that an expansion of education

[182] Ibid., p. 455.
[183] Ibid.
[184] Ibid.

should be principally directed at increasing the number of Africans with technical qualifications. But, crucially, this limited goal of native advancement met strong resistance. As Beck notes, ‘European settlers felt that their need for African unskilled labor should be given priority over any other consideration’.[185] African advancement was a secondary consideration when it came to protecting the interests of the settler community. The Soldier Settler Scheme added pressure to this problem as the need for more African labour came at a time when African wages were already being depressed by the new settlements.[186]

Rather than offer wage incentives, European employers and colonial authorities relied on coercion to recruit African labour, which was mostly drawn from the Kikuyu population. This was achieved in four ways. Firstly, the Africans were forced into reserves (through the 1915 Crown Lands Ordinance), which were defined rural areas, much like the homelands in South Africa.[187] Each ethnic group had their own separate reserve. This practice of divide and rule was also a cornerstone of the colonial government’s labour policy. With insufficient land in their reserves, many Africans had little choice but to migrate to the Europeans’ farms in search of work. Increased taxation on native huts also pressured Africans to migrate in search of employment, but the government regulated this too. It forced all African men by law, to carry a pass, or *kipande*, that recorded a worker’s finger print, name, employment history, ethnicity and current employer’s signature. Finally, when the Europeans and authorities realised that African farmers were more successful than the largely inexperienced settlers, further regulations were imposed that forbade Africans from growing the major cash crops—coffee, tea and sisal.[188]

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[185] Beck, *A history of the British Medical Administration of East Africa*, p. 74.
[186] Ibid.
[187] Elkins, *Britain’s Gulag*, p. 15.
[188] Sisal is cultivated and naturalised in many countries. The fibres produced from its leaves are used to make rope, cord, twine and various other products. Ibid., pp. 15-17.

By the 1920s, the British presence in Kenya was secure. Whereas colonists in other territories, most obviously Australia, had to live or die by the labour of their own hands, those in Kenya could count on the sweat of African peasants to maintain agricultural development.[189] Doctors brought to Kenya under the Soldier Settlement Scheme would have presumably benefited from this cheap labour as well, along with other settler doctors drawn to Kenya for its opportunities. This, it can be argued, helps explain why doctors featured so prominently among the first causalities of the Mau Mau uprising. It was not necessarily their medical titles that made them targets, though it should be apparent by now that, from the perspective of the Africans, such qualifications were unlikely to be associated with benevolence and non-malfeasance. Instead, because of their links to the land, these doctors contributed directly to one of the most contentious political issues in the colony and would have undoubtedly appeared as representatives of the wider settler communities who had marginalised the Africans.

Many Africans, especially the Kikuyu, still claimed ownership of the land they were forced to cultivate for the European settlers. With the passage of time, and the steady increase in African population, pressure on the African reserves became apparent. By the 1930s, both the moderate nationalists, the KCA, and the conservative chiefs who maintained close loyalty to the British authorities, agreed on the extent of the land problem. Chief Koinange was particularly vocal in drawing attention to the issue and successfully persuaded the British government to inaugurate the Kenya Land Commission in 1932.[190] The hope was that the Commission would be 'above suspicion' and, according to Lord Sanderson speaking in Parliament on 4 May 1932, should have 'secure[d] the complete confidence of the African population'.[191] However, this was never realised. Prior to the Commission's arrival in Kenya,

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[189] Anderson, *Histories of the Hanged*, p. 81.
[190] David Anderson, *Eroding the Commons: Politics of Ecology in Baringo, Kenya, 1895-1963* (Oxford: James Currey, 2002), pp. 126-35.
[191] Hansard. House of Lords Debate, 'Kenya Land Commission', Lord Sanderson, 4 May 1932, paragraphs 307-308.

the KCA and the chiefs set about obtaining evidence of land claims from the African population. A questionnaire was prepared and circulated by the KCA and filled in with help from the chiefs. A Kikuyu Land Board Association was created by the KCA to gather additional evidence, collate land claims and find witnesses to give testament to the Commission. In total, the land claimed by the Kikuyu amounted to about 60,000 acres. But when the Commission reported its recommendations in 1934, the Kikuyu were to be greatly disappointed.[192] Far from taking African grievances seriously, the Commission decided to confirm the status quo, merely offering Africans, by way of consolation, lands of substandard quality in areas in which the Europeans had no interest. This infertile and less accessible land amounted to only a fraction of that lost to the Africans—an increase of about 3 percent to 'the native reserves' and an additional 21,000 acres as 'Native Lands'.[193]

The report felt that a 'great disservice' would be done to the country if the British were to 'compromise future development by locking up rigidly in tribal compartments land not yet required by the tribes, because we apprehend that at some uncertain date in the future it might be required'.[194] That is, the contested land was better off being used by Europeans for productive agriculture than squandered while waiting for Africans to develop it themselves. The outcome of the Commission's recommendations hit the Kikuyu particularly hard and effectively removed all hope of ever recovering their loss, but it also hardened attitudes. As Anderson notes, '[t]he Land Commission report was the stone upon which moderate African politics was broken'.[195] For the Kikuyu, the real struggle for land had just began and more militant nationalism found expression in the everyday effort to resist the colonial authorities from implementing the Commission's recommendations. Over the next twenty years the seeds of rebellion continued to grow as the African population increased in size and pressures on

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[192] Anderson, *Histories of the Hanged*, p. 23.
[193] O. F. Watkins, 'The Report of the Kenya land Commission', *Journal of the Royal African Society*, 33 (1933), 207-216 (p. 209).
[194] *Report of the Kenya Land Commission* (London: H. M. Stationary Office, 1933), pp. 518-519.
[195] Anderson, *Histories of the Hanged*, p. 23.

their limited land holdings prompted further resentment towards the tightening grip of the settler community. Kikuyu militancy and a full uprising eventually erupted in the late 1940s and early 1950s in what would be known as the Mau Mau rebellion or the Kenya Emergency.

On the 20 October 1952, following the assassination of Chief Waruhiu by Mau Mau commandos earlier that month, Governor Baring declared a state of emergency in the colony.[196] Through the use of various emergency regulations, the colonial authorities were vested with far reaching powers which enabled them to arrest and detain Mau Mau suspects without court orders and to suspend civil rights.[197] Unlike in Algeria, however, the emergency regulations did not provide for martial law to be enacted in Kenya. As such, the military played a more limited role in Kenya than they did in Algeria. Their presence was initially enhanced by way of five regiments of the King's African Rifles (KAR) and the Lancashire Fusiliers for what was a relatively short military campaign that was concluded by 1955.[198] The military's initial response was to undertake the mass arrest of 180 leading African political figures, including Kenyatta, who were suspected of being the ring leaders of Mau Mau. Operation Jock Scott, as this initiative was named, sought to sever the heads of the movement from its body through a pre-emptive strike. Unlike the French in Algeria, who were caught unaware by the FLN's coordinated attacks in 1954, the British authorities attempted to out-maneuverer the nationalists before they could act. But rather than weaken the nationalist sentiment, Britain's opening strategy merely radicalised Mau Mau militants under the command of individuals like Dedan Kimathi and Stanley Mathenge, who waged a guerrilla war in the Kenyan jungles. If Mau Mau's violence had been inspired by the conditions created by the state of emergency, as Carl Rosberg and John Nottingham have surmised, then Klose is certainly correct in arguing

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[196] Anonymous, 'Mau Mau Shoot Africa's Churchill', *Daily Mail*, 8 October 1952.
[197] Morton, *States of Emergency*, pp. 125-126.
[198] Branch, *Defeating Mau Mau, Creating Kenya*, p. 49. See also Huw Bennett, 'The Other Side of the COIN: Minimum and Exemplary Force in British Army Counterinsurgency in Kenya', *Small Wars and Insurgencies*, 18 (2007), 638-664 (p. 648).

that 'the planned preventive strike of the emergency thus achieved the exact opposite of its intended purpose'.[199]

The extent of Britain's counterinsurgency strategy will be discussed in the next chapter. At this point, however, it is worth noting that when violence broke out, members of the Kenyan medical community were eager to offer their own explanations for its causes. According to Dr. Wiseman, who wrote to the *BMJ* following the death of Dr. Ruck, it was overpopulation and the shortage of food for the Africans that had led to the rebellion. Wiseman notes that in 1947-8, the Kenya Branch put forward the case for a Royal Commission to investigate the 'population problem'.[200] The Kenya representatives at the Annual Meeting at Cambridge in 1948 pleaded for support for the proposal and subsequently the Council of the BMA recommended it to the Colonial Office. However, as Wiseman pointed out, 'the Government then in office […] declined to recommend the appointment of a Commission'. The consequences of this were dire: 'some African "intelligentsia" have been encouraged to believe that their prosperity lay in expelling the British and seizing political power by force'.[201]

Absent from this explanation of the rise of Mau Mau was any reference to the land grievances raised by the politically active Kikuyu. Wiseman does draw attention to land-based issues, but only with reference to comments made by 'casual visitors to the Colony', that is, the views of European travellers, not the Africans inhabitants themselves. He writes that these visitors 'are impressed by the disparity between the productive farm lands of European settlements and the soil-eroded areas of certain native reserves'. Wiseman, however, is quick to state that 'no competent authority has ever advocated that the solution of the food problems of the Africans lay in interfering with the successful farming of the former'.[202] Wiseman's statement echoes

[199] Carl Rosberg and John Nottingham, *Myth of Mau Mau: Nationalism in Kenya* (London: Pall Mall Press, 1966), p. 277; Klose, *Human Rights in the Shadow of Colonial Violence*, p. 71.
[200] Wiseman, 'Mau Mau', p. 65.
[201] Ibid.
[202] Ibid.

the aforementioned views of the Land Commission: the fertile farmlands of the White Highlands were better off in European hands, since Africans would not be able to use them effectively. This was the most important point of Wiseman's correspondence and, by extension, the views of Kenya Branch of the BMA. Under no circumstances were the metropolitan colleagues of the Kenya medical profession to attempt to interfere with the situation in Kenya:

> The Kenya Branch is anxious that the profession should become acquainted with these facts, lest in a desire to help the Africans of Kenya some of its members might misinterpret events and hinder a return to orderly progress on which alone the health of all communities, but especially that of the African depends.[203]

It is clear from this extract that the 'return to ordinary progress' and 'the health of all communities' meant a return to pre-Emergency conditions where Europeans had held unquestioned supremacy. Wiseman's views betray the type of attitude towards the plight of the native population that Fanon drew attention to. Colonial medicine in Kenya revealed itself to be closely aligned with the economic interests of the settler population. African health was contingent on the Europeans maintaining their land rights.

In light of all of this, it is easy to see how landowners like the Rucks could become targets for hostilities when the Kikuyu's frustrations finally turned violent. The colonial medical services in Kenya, along with the assistance of prominent missionary doctors, had directly contributed to the political, economic and social conditions that eventually festered into outright resentment and aggression.

[203] Ibid.

Conclusion

By contextualising the deaths of a number of physicians murdered during the Algerian and Kenyan uprisings, this chapter has shown that doctors working in the two colonies were not always viewed as simple healers or providers of medical care. Indeed, it seems that the attacks on certain medical professionals by the nationalists were not always random. The contention of this chapter has been that that, in both countries, doctors were so deeply embedded in the colonial order that they could be seen as representatives of the types of offenses and grievances associated with European occupation in the eyes of the natives. This is because, in the colonies at least, these professionals were often involved in activities, or ways of life, that were similar to those of other settlers and that saw them benefiting in ways that excluded the indigenous populations. For some locals, the doctor was a potentially corrupt individual whose loyalties to patients had been subverted by their commitments to other institutions or their own self-interest. Practising medicine in the colonies, it seems, could be a highly political activity which rarely had the locals' best interests at heart. In order to examine this split-loyalty phenomenon and the factors that contributed to it, this chapter also critically engaged with the work of Frantz Fanon and, specifically, the claims he made concerning colonial doctors. Essentially, it is possible to identify a number of factors that appeared to cause the split in doctors' loyalties across both contexts, splits which contributed to the lists of grievances held by the respective nationalist groups.

Firstly, the administration of medicine in Algeria and Kenya helped to establish and maintain an atmosphere of alienation and exclusion whereby African communities were reduced to an underclass status. This was partially achieved through the medical community's close connection with the colonial authorities, especially the military and security forces in both contexts. This connection, however, was particularly strong in Algeria, where medicine had played a fundamental role in supporting the military conquest of the territory in the nineteenth century. In this case, while the colony ceased to be controlled by the army towards the end of

that century, the military nevertheless maintained a strong presence within the colonial order up until the Algerian War when they took control once again. This meant medical aid and healthcare were provided by a competing mix of military, government and private commercial practitioners. It was not always easy for an outsider to distinguish between these competing groups.

Physicians working for the French *Service médical de colonisation* or the British Colonial Medical Services were expected to care principally for the state and specifically for the settlers. The benefits of medicine, which were touted as one of the core elements of the civilizing mission by both France and Britain, were therefore rarely extended to the indigenous populations. Financial and administrative limitations contributed to this failure, but there was also an inherent racial prejudice underlying both systems. Moreover, when medicine was provided for the natives, it usually came with a price and was deployed with coercive aims: in Algeria, the military's attempt to win over the Muslim population with the formation of *sections administratives spécialisées* demonstrated the ease with which medicine could be co-opted as a propaganda tool. This fact contrasted with the creation of the *Croissant-Rouge Algérien* by the FLN, who adopted and adapted the international language of medicine and humanitarian aid for their own political ends. While the institution of medicine contributed to the marginalisation of the Muslims in Algeria, it also arguably provided prominent nationalists with a status within the native communities for building a political base. Interestingly, a large number of early anticolonial Muslim leaders, such as Dr. Hamida and Abbas, had some sort of medical training.

Although the military had less of a role to play in the management of Kenya, the medical system was no more coherent, especially for the natives. The financial limitations on the Colonial Medical Services in East Africa resulted in medical missionaries of various denominations providing the majority of health services for the Africans. The work of medical missionaries provided healthcare to the Kikuyu and other Africans under the condition that

they renounce their traditional beliefs and practices. Ultimately, the disquiet this caused in Kikuyu society led to their first mass political revolt, something that fed directly into the formation of Mau Mau in the 1940s and 1950s. This is an important distinction between the Algerian and Kenyan situations. The controversy surrounding clitoridectomy, which was framed on medical ground though it was equally a moral question for the Christian missionaries, represented a rare moment where the acts of a doctor had real, tangible impacts on the political situation in the colony.

The question of land rights and ownership forms an important issue for both countries, though it arguably became a more central political grievance for the Kikuyu in Kenya. For the Algerians, the conquest of their country by the French in the 1830s started a process of land dispossession that would have severe consequences for the rural population by the 1920s. Mass unemployment and famine conditions created a disenfranchised and resentful proletariat with little recourse but to migrate to the European cities or to accept work on the farms and vineyards of settlers. European doctors, Fanon tells us, owned—and drew considerable benefit from—some of these wealthy and fertile properties. Dr. Ettighoffer was one such doctor who, in addition to his role as a medical practitioner, was also in a senior position in the Confederation of Algerian Winegrowers at a time when Algeria's wine production was among the largest in the world. This may have been a strong reason why he was attacked by the FLN in 1957.

There is, at present, more evidence for the intimate connection between the Kikuyu's land claims and the land holdings of colonial doctors in Kenya. Similar to Algeria, British colonial authorities in Kenya enabled European settlers to claim ownership of the more fertile farming lands in the colony, the White Highlands. By creating the tribal reserves, the colonial government forced the Africans onto less profitable soil. The loss of this land became a central issue for the KCA in the 1930s and 1940s and would be the main political rallying point for Mau Mau. A key turning point in this issue came after the First World War with the Soldier

Settler Scheme of 1919, which bolstered the number of British farmers in Kenya as well as introducing more doctors to help maintain their health. These doctors took up farming as a secondary income and, in many respects, had substantial portions of land. The Africans they employed had few labour rights and were forbidden to grow the major cash crops that brought in the wealth for the settlers. Once resentment gave way to violence in the 1950s, some of these landowning doctors, such as Esmee Ruck, would be among the first victims of Mau Mau. Members of the British Medical Association in Kenya would use these attacks to draw attention to the perceived evils of Mau Mau and, in doing so, demonstrate their misreading of the causes for the rebellion. Instead of recognising the Kikuyu's grievances, individuals like Dr. Wiseman reinforced ideas about the settlers' entitlement and thus side with the economic interests of the British settlers.

By the time the emergencies were issued in both colonies, the rebels had adopted a range of guerrilla and terrorist tactics which they used to undermine the European hold on their countries. Initially, the British and French administrations along with international observers were caught off guard by the brutality of the rebels' tactics and their apparent indiscriminate violence, as seen with the confusion inspired by the deaths of doctors mentioned in this chapter. As such, both colonial powers became convinced that they were dealing with an altogether new form of threat, one inspired by the wider Cold War spectre of Communist subversion. In order to combat such tactics, the security forces called on a range of medical, psychiatric and social scientific experts to help inform their methods and to shine light on the causes of dissatisfaction among the native populations. The next chapter will examine the ways in which Britain and France drew on these experts and used them to justify the creation of the extensive networks of detention centres that were used to hold any suspected dissidents. These centres became the sites where the majority of torture and violence took place within the respective emergencies. It is therefore crucial to understand the extent to which such violence was justified by expert opinion.

Chapter 2. States of Madness: framing the wars for the vulnerable hearts and fragile minds of colonial subjects

On 7 July 2005, a series of coordinated suicide bombers attacked the London transport system killing 52 people. Explanations for what caused the four terrorists to undertake this extreme violence varied, but three months later, on 2 October 2005, the British Home Secretary Charles Clarke believed he had the answer. These educated young men may have been 'brainwashed'. Islamic extremists, Clarke suggested, were unlike 'classic' revolutionaries who fought for a political cause. Instead, the men involved in the London bombings resembled fanatical members of 'religious cults', indoctrinated into renouncing western society. 'What we know about other religious cults', he went on to say, 'may offer some insight into how these men ended up behaving in this appalling way'. Drawing on psychological-sounding language, Clarke asserted that perhaps 'anti-brainwashing techniques' could be used to 'deprogramme' the 'sort of fanaticism behind' the London bombings.[1] By evoking the notion of brainwashing, Clarke's explanation tethered the rise of modern terrorism to the Cold War fear that covert organisations sought to exploit, manipulate and indoctrinate the vulnerable minds of otherwise innocent citizens. It also suggests that some form of psychological intervention could be used to 'treat' those victims of this manipulation. This raises a number of interesting questions: firstly, were earlier historical terrorist groups seen as being inspired by legitimate political grievances, as Clarke claimed, or were they also deemed to be the product of religious indoctrination? Moreover, to what extent did ideas about 'brainwashing', a product of the Cold War, interact, challenge or confirm contemporary interpretations of terrorist groups and what role did psychology play in this understanding?

What is striking about Clarke's claim is that it is far from correct. While Clarke believed the overt religious extremism of modern Islamic terrorism marked it as being distinct from

[1] Anonymous, 'Clarke wants terrorists treated like victims of cult brainwashing', *Daily Telegraph*, 2 October 2005.

previous revolutionary groups, this chapter will show that the reverse is true. It will argue that, rather than being recognised as legitimate political movements with valid claims and grievances, Mau Mau and the FLN were identified in contemporary interpretations as atavistic recurrences of past savagery inspired by their non-Christian heritages. Be it the 'pagan' and 'savage' oath-making practices of Mau Mau or the mentally damaging influences of the FLN's Islamic enthusiasm, it will be shown that the religious overtones of these political rebellions became *foci* of understanding for the colonial authorities and much of the western world. While this, for many in the colonies and Europe more generally, was the only way to explain the level of violence committed against Europeans by these groups, it was also an opportunity for scientists of the mind, especially ethnopsychiatrists, to show how their knowledge of native psychology could help counterinsurgency efforts. As such, this analysis will demonstrate how the outbreak of hostilities in Kenya and Algeria was a chance for some ambitious scientists to reassert their commitment to the colonial order and to move their expertise from the laboratory to the political arena.

Explaining this process highlights the two main claims of this chapter: firstly, the history of the counterinsurgency campaigns in Kenya and Algeria needs to consider the global context of the Cold War brainwashing scare, especially in the case of Algeria; secondly, while some British and French security and counterinsurgency thinkers were preoccupied with fighting the communist subversion which they believed inspired these conflicts, it was the psychiatric and psychological communities that provided the specific explanations for the manifestations of violence in both colonies. It was, this chapter asserts, the expertise of these scientists that shaped the representation of the two rebel groups as religiously insane 'terrorist' cults. The analysis builds on the work of Richard Keller and Sloan Mahone, who have produced valuable studies into the power of ethnopsychiatry and psychological thinking in Algeria and East

Africa, respectively.[2] These scholars have demonstrated how scientific expertise or psychological ideas about native mindsets promised not only to account for the nature of rebellious consciousness, but also offered ways to combat it. However, although these works provide an excellent foundation for investigating the links between colonial psychiatry and the interpretation and suppression of indigenous nationalist groups, they are limited to their respective case studies and do not explore their broader implications. This omission calls for an exploration of how the Cold War fear of 'brainwashing', what was a very undefined idea at the time as it is now, with its notions of mental vulnerabilities to subversive methods of manipulation, influenced or coexisted with local explanations for deviant native psychology. The meeting of these two independent spheres, the military and the colonial psychiatric communities, this chapter argues, helps to understand how the Cold War's world-wide contest for 'the very soul of mankind'[3] became embroiled in colonial efforts to control manifestations of indigenous political violence. It was a point where international ideas about vulnerable minds met with and were adapted to older explanations about mass psychology in the colonies. Together, they generated the image of terrorists as dangerous religious zealots—an image that is strikingly similar to those held today.

2.1. The Cold War, revolutionary warfare and the fear of communist brainwashing

For the British and French security forces, the conflicts in Kenya and Algeria represented struggles that were familiar while also being peculiar to the postwar world. On the one hand, 'guerrilla' wars, literally 'small wars', had long been waged between imperial authorities and various indigenous groups in their colonies.[4] Yet on the other, the paranoia produced by the

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[2] See Chapter 5 of Keller, *Colonial Madness;* and Sloan Mahone, 'The psychology of rebellion: Colonial medical responses to dissent in British East Africa', *The Journal of African History*, 47 (2006), 241-258.

[3] The phrase used by former president George H.W. Bush quoted in Robert J. McMahon, 'Introduction' in Robert J. McMahon, *The Cold War in the Third World* (Oxford: Oxford University Press, 2002), p. 2.

[4] Diek Walter, *Colonial Violence: European Empires and the Use of Force* (London: Hurst, 2017).

start of the Cold War coloured the perception of these rebellions, making them appear distinctly *modern* in their eyes. As the guerrilla wars unfolded against the backdrop of this bipolar, geopolitical conflict, many officials in London and Paris detected communist interference, if not directly involved in the conflicts, then at least inspiring their manifestation. International Communism, they believed, would not be achieved through overt expansion, but by spreading dissent between nations, exploiting national and racial movements and backing them if necessary by the clandestine supply of arms and money.[5] For example, even as late as 1960, the British Colonial Office believed Jomo Kenyatta, whom they regarded as 'the architect' of Mau Mau, had learnt communist methods for promoting political agitation while visiting Russia in 1929-30 and, again, in 1933.[6] The French, on the other hand, believed Moscow was trying to build a 'solid communist core' by inspiring revolutions in North Africa and the Middle East with the hope of establishing pro-communist post-colonial states.[7] Yet it was the Chinese Revolution, led by Mao Tse-Tung, that had signalled the arrival of a new form of warfare that would, in the minds of British and French military theorists, come to define future wars.[8]

Mao's teachings highlighted the key objectives for waging a successful war of national liberation and could be used as a recipe for others. Chief among these objectives was the mobilisation of the masses. The very life of a successful guerrilla campaign rested on this support: '[the guerrilla] can neither exist nor flourish if it separates itself from [the masses']

[5] This perception was influenced by Khrushchev's new assertiveness towards the 'Third World', whereby Russia would provide financial support to newly independent states as they made the transition to Communism. See Karl Moore and David Charles Lewis, 'Globalization and the Cold War: The Communist dimension', *Management & Organizational History*, 5 (2013), 5-17 (pp. 10-11).
[6] F. D. Corfield, *Historical Survey of the Origins and Growth of Mau Mau* (H.M. Stationery Office, 1960), p. 219.
[7] SHD 1 H 2411/d.1. 'Les Missions de l'armée française dans la guerre révolutionnaire d'Algérie', presented as part of the Conference Donne A S.H.A.P.E. par le General de corps d'armée Allard, Commandant le corps d'armée d'Alger avec l'assistance des Colonels Godard et Goussault on 15 November 1957.
[8] Roger Trinquier, *Modern Warfare,* trans. by Daniel Lee (London: Praeger Security International, 2006), p. 5.

sympathies and cooperation'.[9] Not only could this support provide food, shelter and other resources, it was also a source of new recruits, intelligence and shelter. Through popular support, so Mao's often quoted phrase goes, the guerrilla becomes 'a fish' that can swim in the water provided by the people. Where the conditions are right, these fish can thrive where their enemies drown.[10] This was the only means by which a revolutionary war could hope to engage in a prolonged guerrilla campaign against a technically advanced and seemingly overpowering enemy. Yet the question that vexed many counterinsurgency theorists was a simple one: how did Mao gain popular support from the masses? The answer they arrived at would become a defining feature of the Cold War as well as of counterinsurgency responses in the colonial wars: Mao, it was believed, had achieved mass indoctrination during the Chinese Revolution through mind-control programmes that 'brainwashed' the population into subservience.

Brainwashing is arguably the essence of cold warfare, even if it is a vague and, until recently, underexplored concept.[11] As Timothy Melley notes, the Cold War was 'a conflict of ideas and persuasion fought not on the battlefield but through propaganda, psychological warfare, and other ideological weapons'.[12] The fear of brainwashing had its origins in American anxieties over communist mind-control during the 1940s. The term was brought to public attention by the American journalist Edward Hunter, who published a *Miami News* article on the subject in September 1950, roughly three months after the start of the Korean War.[13] A year later,

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[9] Mao Tse-tung, *On Guerrilla Warfare* (University of Illinois Press, 1961), p. 8.

[10] Michael Fitzsimmons, 'Hard Hearts and Open Minds? Governance, Identity and the Intellectual Foundations of Counterinsurgency Strategy', *Journal of Strategic Studies*, 31 (2008), 337-365 (p. 339).

[11] Within the last few years, a range of studies have turned their attention to 'brainwashing' and ideas around the science of persuasion in the Cold War context. In particular, Daniel Picks 'Hidden Persuaders' project has mapped out how psychologists and other scientists of the mind helped ideas about brainwashing become so pervasive in Cold War culture.

[12] Fitzsimmons, 'Hard Hearts and Open Minds?' (p. 21).

[13] There is currently a debate over whether or not Hunter was in fact employed by the CIA to popularise the idea of brainwashing as an imminent threat, as the term has been found in government documents that appear to predate Hunter's own publications. However, this could just mean that both Hunter and the CIA picked up the idea from Chinese sources, independently. See Timothy Melley, 'Brain Warfare: The Covert Sphere, Terrorism, and the Legacy of the Cold War', *Grey Room*, *45* (2011), 18-4; Charles S. Young, *Name, Rank, and Serial Number: Exploiting Korean War POWs at*

Hunter, who was a propagandist with a fascination for the Far East, published, *Brain-Washing in Red China: The Calculated Destruction of Men's Minds*, which warned of a vast Maoist system of ideological indoctrination. The Chinese people had, Hunter claimed, been subjected to a coercive 'thought-reform', a process that used mind-numbing repetition to convert the entire population into conforming puppets. As he said, 'Unrevealed tens of thousands of men, women, and children had their brains washed'.[14] The notions raised by Hunter disturbed a broad audience, but panic became palpable in 1952, when a group of American Air Force POWs publicly confessed to releasing various biological agents including anthrax, cholera, typhus and plague on North Korea. These confessions were then accompanied by a further thirty-five captured pilots, while 5,000 of 7,200 American POWs signed confessions or petitioned the United States government to end the war. In addition, a further 21 POWs refused repatriation.[15] The nature of these confessions seemed too fantastical; the communists had to be using some secret method to control the minds of these soldiers. President Eisenhower articulated the response to this threat when he stated, privately, that it was a 'basic truth' that 'the minds of all men are susceptible to outside influence'.[16] The United States, he told a San Francisco crowd in October 1952, was locked in a 'struggle for men's minds', and what was needed in order to combat this was a 'psychological effort put forth on a national scale'.[17]

Yet there is a distinction to be made here. In the early 1950s, when Hunter first published *Brain-Washing in Red China*, he drew a distinction between two terms that would become entwined later in the decade—something that is still the case today. He wrote that 'Brain-washing is indoctrination, a comparatively simple procedure, but brain-changing is

Home and Abroad (Oxford: Oxford University Press 2012). See also a Marcia Holmes, 'Edward Hunter and the origins of 'brainwashing'', produced as part of the 'Hidden Persuaders' project: http://www.bbk.ac.uk/hiddenpersuaders/blog/hunter-origins-of-brainwashing/ [Accessed 28 August 2019].

[14] Edward Hunter, *Brain-Washing in Red China* (New York: The Vanguard Press, 1953), p. 4.

[15] Timothy Melley, 'Brain Warfare' (p. 24).

[16] From Kenneth Osgood, *Total Cold War: Eisenhower's Secret Propaganda Battle at Home and Abroad* (Lawrence: University of Kansas Press, 2006), pp. 53-54, quoted in Melley, Brain Warfare' (p. 24).

[17] Melley, Brain Warfare' (p. 24).

immeasurably more sinister and complicated'.[18] 'Brain-changing', for Hunter, represented the wholesale transformation of an individual's beliefs and memories. In effect, it amounted to the creation of a completely new personality and became the type of Cold War fantasy that haunted America in the 1950s and 1960s, becoming a stock feature of popular culture across Western society. While the extent to which Britain and France shared in America's hysteria over the fear of communist 'brain-changing' is debatable, the two countries were nevertheless influenced by the ideas of mass indoctrination and psychological vulnerabilities associated with brainwashing. Mass indoctrination could be achieved, as Hunter showed, through a mix of processes that took advantage of physical suffering and psychological pressure, a blend of political torture through self-criticism meetings and propagandist theatre.[19] This was a process against which there was thought to be no defence; citizens from all walks of life and all levels of society could fall victim to this form of brainwashing. As such, Western military and security forces would have to pay greater attention to mass indoctrination and devise ways to combat and replicate these methods for their own purposes. However, they were not alone in their increased concern for the mind's perceived vulnerability and the manipulation of the masses' psychological states.

2.2. Vulnerable Minds

The immediate postwar period experienced a significant increase in the ambitions of psychiatrists and social scientists on an international level for promoting global harmony. The European experience of fascism had left a scar on the minds of many. Never before had the ideals of democracy seemed more vulnerable and so tightly bound to ideas about collective mental health. Nazi Germany, it was believed, had shown that not only individuals but entire nations could become mentally ill. As such, future liberty, peace and international cooperation increasingly required the intervention of medical professionals and human scientists to help

[18] Hunter, *Brain-Washing in Red China*, p. 10.
[19] David Seed, 'Brainwashing and Cold War Demonology', *Prospects,* 22 (1997), 535-573 (p. 538).

protect democracy from what Daniel Pick referred to as 'the renewed bouts of popular authoritarian "sickness"'.[20] As the 'Statement by the International Preparatory Commission of the International Congress on Mental Health', held in London in August 1948, made clear:

> [t]here can be no world community until individuals and groups have learned to live at peace with themselves and one another, and until they have ceased to struggle for their own sense of group solidarity at the expense of hostility and violence against others.[21]

The assumption underlying the discussions at the Congress, as well as informing many contemporary international and interdisciplinary research efforts, was that the mind and its associated beliefs, attitudes and ideals were not innate or fixed. The mindsets that led to the formation of violent nationalism could be influenced. In this respect, the views of the international psychiatric community and counterinsurgency theorists were in agreement: minds could be changed. In order to effect change, one needed to appreciate the ways in which attitudes and ideals were formed, the cultural values that informed them and an appropriate way to (re)educate individuals and groups.[22] Who better to engineer and direct this type of activity than those with expertise in the ways in which minds work? As John Rawlings Rees, the chairman and President of the World Federation for Mental Health, suggested, it was time for psychiatry and the scientists of the mind to apply 'our various skills in the mental health field to "sick groups", to communities and to national tensions, rather than limiting ourselves to the day-to-day developments of psychiatric and mental health work'.[23]

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[20] Daniel Pick, *The Pursuit of the Nazi Mind: Hitler, Hess and the Analysts* (Oxford: Oxford University Press, 2012), pp. 182-183.
[21] Anonymous, 'Statement by the International Preparatory Commission of the International Congress on Mental Health', (1948), 65-99 (p. 80).
[22] Ibid. (pp. 79-84).
[23] J. R. Rees, 'The International Congress on Mental Health', *British Medical Bulletin*, 6 (1949), 5–7 (p. 5).

Against this backdrop, the rise of anticolonial nationalist sentiments in the colonies was regarded with suspicion and concern. Britain and France were keen to portray empire as a model of transnational solidarity and even a world government, which made anticolonial movements appear more than a little reminiscent of the violent European nationalism that had traumatised the world.[24] This anxiety was most clearly expressed by the political theorist Martin Wight, who warned of the dangers of letting 'the tyranny of some little African Hitler' take advantage of the African's desire for independence.[25] The minds of the Africans, as well as other non-white races, were thought to be inherently vulnerable to manipulation. Unlike the European mind, which was rational and intelligent, had a keen sense of justice, decency and civilisation, the black African was irrational, unintelligent, indecent and primitive.[26] Similarly, the Muslim population of North Africa was seen as being temperamental, apathetic and lazy, fatalistic, superstitious and ultimately possessing criminal impulsivity—an image captured clearly by the knife wilding Arab in Albert Camus's *The Stranger*.[27]

For much of the first half of the twentieth century, the differences between races were thought to be biological. These assumptions were supported through the views and findings of prominent eugenicists and anthropologists who saw the Africans' 'innate' limitations as crucial factors to be understood when supplying welfare, development, education and related medico-legal resources to colonial subjects. For example, in the British context, during a speech given at the Annual Dinner of the Kenya Branch of the British Medical Association in 1931, the then President of the organisation and one of Kenya's foremost mental experts and eugenicists, Dr. H. L. Gordon, stated that:

[24] Linstrum, *Ruling Minds*, p. 157.
[25] W. Arthur Lewis, Michael Scott, Martin Wight and Colin Legum, *Attitude to Africa*: *A survey of the main problems of British Africa, suggesting the lines of policy that any British government should follow in the years ahead* (Penguin Books: Middlesex, 1951), p. 36.
[26] Vaughan, *Curing their Ills*, p. 101.
[27] Albert Camus, *The Outsider* (London: Penguin Books, 2013), pp. 53-54.

> Native backwardness could never be made to disappear under the mere trappings of civilization. No prevention of disease, bonification, education or religion could enable them to gather grapes off thorns or figs off thistles.[28]

A few years later, Gordon's colleague, Dr. F.W. Vint, found 'empirical evidence' demonstrating the physical difference between African and European brain sizes. This notorious study was carried out on Kikuyu bodies coming from the King George VI Hospital in Nairobi. According to his findings, Vint concluded that 'the average weight of the brain of the Kenya native is 10.6 per cent. or 152 gm. less than the average weight given for the brain of the European'.[29] Meanwhile, French psychiatrists and anthropologists also represented the Algerian as inherently Other, though the Muslim was deemed to be more 'evolved' than the sub-Saharan African, a 'half way between the primitive and the developed Westerner'.[30]

Yet by the 1930s, a mix of psychiatrists, anthropologists and social scientists working in the colonies started to explain the differences between races largely in cultural terms. The affinity between these professions extended into the fabric of the colonial order and shows how medical and social scientists collaborated and shared knowledge and expertise in order to understand the indigenous populations.[31] Together, these scientists of the mind offered an analysis of social evolution and a scientific language for explaining a range of vexing behavioural traits amongst colonised people, from excessive docility to outright criminality and rebellion.[32] The chief concern here was for a scientific understanding of the collective psychology of indigenous populations, not individuals. This is the important point: the

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[28] Quoted in Chloe Campbell, *Race and Empire: Eugenics in Colonial Kenya* (Manchester: Manchester University Press, 2007), p. 39.
[29] F. W. Vint, 'The Brain of the Kenya Native', *Journal of Anatomy*, 68 (1934), 216-223.
[30] The explanations blended together ideas about the native's psychical being, Arab and Muslim social culture more generally, and their ethnic identity, all of which was presented rather confusingly. See Jean-Michel Bégué, 'French Psychiatry in Algeria (1830-1962): from colonial to transcultural', *History of Psychiatry*, 7 (1996), 533-548 (pp. 544-545).
[31] Shane Doyle, 'Social disease and social science', p. 126-127.
[32] Megan Vaughan, 'Introduction', in Vaughan and Mahone (ed.), *Psychiatry and Empire* (Basingstoke: Palgrave Macmillan, 2007), p. 1.

indigenous populations were always understood in collective terms, long before the psychiatrists present at the International Conference of Mental Health had met to discuss the psychology of European communities. And like their metropolitan counterparts, these scientists believed their knowledge and expertise should not be limited to the clinic. As will be discussed in subsequent sections, these professionals sought direct involvement in the administration of the colonies, especially when it came to dealing with rebellious groups.

An issue of considerable concern for colonial administrators, medical psychiatrists and social scientists alike was the effects that western culture had on indigenous minds. The dominant view was that modernity and 'civilization' exerted profound pressure on the vulnerable minds of the indigenous populations. The native who went mad in a 'native' fashion was relatively harmless, it was just another example of their innate irrationality. A native who underwent education and had been influenced by western civilisation, however, was seen as posing a greater threat to the colonial administrators.[33] 'Madness' in these individuals, some believed, could manifest in violent ways that challenged the colonial order itself. This condition was referred to as 'acculturation' or 'detribalisation' and became the subject of numerous psychiatric, psychological and social scientific studies.[34] The question was, what was 'normal' for indigenous populations? Indigenous minds were thought to be dysfunctional even when healthy; as such, the 'normal' colonised mind was somehow pathological. This was brought about by the administrators' inability to differentiate the pathological behaviour of the genuinely sick from the unusual or 'un-European' nature of indigenous habits. As Megan Vaughan asks, 'Was it "normal" for Africans to have visions, for Malays to suffer group hysteria, for colonized subjects more generally to be "paranoid"?'[35]

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[33]Vaughan, *Curing their ills*, p. 108; Mahone, 'Psychology of Rebellion' (pp. 242-244).
[34] For example, see Leonard H. Ainsworth and Mary D. Ainsworth, 'Acculturation in East Africa. I. Political awareness and attitudes toward authority', *The Journal of Social Psychology*, 57 (1962), 391-399 and Mary D. Ainsworth and Leonard H. Ainsworth, 'Acculturation in East Africa. IV. Summary and Discussion', *The Journal of Social Psychology*, 57 (1962), 417-432. Alternatively, see Homer G. Barnett, 'Acculturation: an exploratory formulation the social science research council summer seminar on acculturation, 1953: comment', *American Anthropologist* 56 (1954), 1000-1002.
[35] Vaughan, 'Introduction', p. 1.

The case of extreme religious or superstitious expression confounded the boundaries between normality and pathology more than most indigenous behaviours in both Kenya and Algeria; this seems to be particularly true when religious exuberance was coupled with political activism. In both Kenya and Algeria, the colonial authorities could not accept nationalist groups who placed their ethnic and religious identities above the benefits of empire's civilizing mission.[36] For British and French security forces, nationalists in all their colonies were criminalised as 'thugs', 'gangs', 'bandits' and 'terrorists'.[37] But in Kenya and Algeria, these terms coexisted with psychological explanations about the indigenous population's peculiar mindsets. Such groups were regarded as inherently unstable and suffering from a psychological condition that forced them to take refuge in their primitive cultures and religious heritages. Here the Cold War fear of mass indoctrination and brainwashing, an *esprit du temps,* met with the colonial psychiatrists' beliefs in native mental vulnerabilities and religious enthusiasm. What it generated was a hybrid interpretation of Mau Mau and the FLN as psychologically criminal terrorists who had been manipulated and indoctrinated by sinister agents in similar ways to those inspired or supported by the communists. It also, as Marouf Hasian Jr. notes, transformed them into the kind of political outcasts that Giorgio Agamben called *Homo Sacer*, a pariah who can be dehumanised or killed with impunity.[38] The next two sections of this chapter will show how the image of Mau Mau and the FLN as religious terrorist groups was created and sustained in Kenya and Algeria, respectively.

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[36] David French, *The British Way in Counter-Insurgency, 1945-67* (Oxford: Oxford University Press, 2011), p. 59-60.
[37] In Algeria, they were also called the *fellagha,* an Arabic word for 'head-splitters' which was borrowed from the Tunisian nationalist struggle. See Lazreg, *Torture and the Twilight of Empire*, p. 112.
[38] Marouf Hasian Jr., 'The Development of Ethnographic Science and Psychological Warfare During the Suppression of the Mau Mau Rebellion', *Journal of Medical Humanities*, 34 (2013), 329-345 (p. 338). See also Agamben, *Homo Sacer*.

2.3. The myth of Mau Mau

In November 1953, a secret report on Mau Mau activities was sent by the District Commissioner for Nakuru to the District Officer in the Londiani Forest Division in Kenya. The report was written with the aim of presenting a counter argument to individuals 'of both races African and Europeans who continually criticise the effort of government agents to supress the evils of Mau Mau'.[39] In it, the District Commissioner provided a metaphor for understanding the perceived situation facing Kenya's security forces:

> A doctor will not discharge a patient and send him to the convalescent ward, until he is convinced that he is cured. The Kikuyu Tribe is suffering from a terrible disease—it is undergoing a gradual treatment by expert doctors.[40]

The 'terrible disease' mentioned in the above quote refers to Mau Mau itself and perfectly sums up a view of the nationalist movement that has become known as the 'myth of Mau Mau'. In this fabricated version of events, the image of the rebels as a pathological Other formed the cornerstone for the colonial authority's response to the emergency. This section will explain how the 'myth' came about. In particular, it will focus on the role of such 'expert doctors' as the paleoanthropologist and self-appointed Kikuyu expert, Dr. Lewis S. B. Leakey, and the ethnopsychiatrist, Dr. John Colin Carothers. Together, their expertise produced the explanation of Mau Mau as a mentally debilitating cult, while also offering a 'cure' for their collective sickness that the British government could present as a humanitarian front to their traditional counterinsurgency operations: the rehabilitation programme that coupled isolation in detention camps with re-education and a need for the 'infected' Kikuyu to be 'cleansed' through 'confession' and forced labour.

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[39] TNA FCO 141/6750/64, p. 5. Author redacted, 'Resistance Movement Centre, Bahati, Nakuru, Report on Mau Mau Activities: Maji Mazuri—Eldama Ravine Area', C. November 1953.
[40] Ibid., p. 4.

When it comes to the formation of the myth of Mau Mau, the traditional story circulated by the government goes like this: prior to the rise of nationalism in Kenya, the Kikuyu were viewed favourably. Europeans in Africa were fond of racial stereotypes, and those applied to the Kikuyu were almost completely positive. The tribe was noted for 'its devotion to education, its ability to work hard, and its intelligence'.[41] Although it is unclear whether this image was damaged by the Kikuyu's political mobilisation around the clitoridectomy controversy mentioned in the previous chapter, they were still celebrated for having taken to Christianity, accepted wages for their labour and for being entrepreneurial. In all cases, it seemed like the Kikuyu were racing towards civilization and embracing its benefits.[42] Their transformation into the savage killers of the Mau Mau movement was thus seen as having something to do with this enthusiasm for progress. This was the quintessential example of 'acculturation' described above. The pressures of civilization had profoundly influenced the collective psychology of the Kikuyu people and trapped them somewhere between their tribal past and a civilized future. Mau Mau, with its 'pagan' oaths and brutal violence, was the expression of the Kikuyu's flight from modernity. The infamous oath-taking ceremonies used to convert previously 'loyal' Kikuyu into barbarous killers were described as perversions of traditional Kikuyu oath-taking practices, an unholy blend of ancient and modern elements.[43] Once administered, the oath would exploit this mental weakness and effectively brainwash the tribesman into following the instructions of devious troublemakers, such as Jomo Kenyatta, who had always rejected civilization. This image of Mau Mau quickly came to dominate the official government analysis of Kenya's troubles. There were no grievances or justifiable claims to be aired; the Kikuyu had been infected with what the prominent white settler, Michael Blundell, summed up as 'a mind destroying disease'.[44]

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[41] Ian Henderson, *The Hunt for Kimathi* (Hamish Hamilton: London, 1958), p. 16.
[42] Anderson, *Histories of the Hanged*, p. 279.
[43] Ibid.
[44] Blundell, *So Rough a Wind*, p. 171.

This interpretation of African politico-religious groups as mentally unstable had a longer history predating the rise of Mau Mau. As Sloan Mahone has convincingly demonstrated, the colonial administration in Kenya had encountered several prophetic movements during the first half of the twentieth century that were seen as inspiring 'epidemic hysteria' among the African populations and were frequently documented by Kenyan officials and anthropologists.[45] African psychological disturbances were seen as contagious and capable of assuming epidemic proportions. The most notorious Kenyan prophet was Dini ya Msambwa, a popular religious movement of the 1940s, which sought primarily to protect or reclaim lands that were being encroached upon by white settlers. Inspired by 'the mad prophet' Elijah Masinde, they became one of the largest movements of this kind in East Africa, causing much concern for the Kenyan government.[46] Doctors and administrators classed the prophesies and desires of movements like Dini ya Msambwa as being fantastic, an echo of African 'magical' modes of thinking. Such millenarian groups demonstrated, to colonial medical and administrative staff alike, that African populations were subject to periodic spats of mass madness or psychic epidemics just as they were vulnerable to tropical diseases that afflicted the body.[47] When it came to initial reports of Mau Mau's manifestation in Kenya, the colonial government naturally resorted to the time-tested interpretation that it was just another example of African religio-political thinking.[48] As Carl Gustav Rosberg and John Cato Nottingham put it, it was unrest by an old patter.[49]

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[45] Mahone, 'The Psychology of Rebellion' (p. 251).
[46] Ibid.
[47] Ibid. (p. 243).
[48] In fact, evidence that the British suspected a connection between Mau Mau and Dini ya Msambwa in the early days of the uprising emerged in 2011, when previously hidden documents on the Kenya Emergency were released as part of the Hanslope Park disclosure. In June 1953 the Director of Intelligence and Security reported to Kenyan Commissioner of Police and the Chief Secretary that Mau Mau members had met with Dini ya Msambwa adherents who advised them to conduct oath-taking ceremonies in the Trans Nzoia area of Kenya. According to this report, Dini ya Msambwa had also allegedly 'advocated stronger oaths' for adherents in order to 'expel the European from Kenya'. Although this document does not contain any references to pathology or mental disturbances, it nevertheless demonstrates that earlier prophetic movements had indeed impacted on interpretation of Mau Mau and that the oath-taking ceremonies needed to be monitored in order to limit the spread of their doctrine. See TNA FCO 141/5877. 'Dini ya Msambwa/Mau Mau Link-up', 1952.
[49] Carl Gustav Rosberg and John Cato Nottingham 1966. *The Myth of "Mau Mau": Nationalism in Kenya* (New York: Praeger), p. 330.

Yet the chief exponent of Mau Mau's cultic roots was the Dr. Leakey, mentioned above. Raised by missionary parents, he had grown-up among the Kikuyu and boasted that he was even fluent in their language. Colonial officials were so convinced by his self-proclaimed knowledge of the Kikuyu that they permitted him to attend a private meeting at the Colonial Office in London to discuss the troubles brewing in Kenya on 15 September 1952.[50] In the course of the Emergency, Leakey published two influential books, several magazines and news articles and delivered numerous public speeches in Britain and Kenya. His interpretation dominated the terms of serious intellectual discourse about Mau Mau until the late 1960s and, according to Bruce J. Berman and John M. Lonsdale, is still accepted by some anthropologists.[51] It is through his work that the idea of Mau Mau as an evil cult would receive wide circulation; Leakey's trajectory also demonstrates how selected anthropological knowledge could be useful for the colonial authorities who cherry-picked ideas and theories that backed-up their existing prejudices.

In his 1952 book, *Mau Mau and the Kikuyu*, speedily written and published a month after the state of emergency had been declared in Kenya, Leakey explains to an all-white readership how Kikuyu's customs '[broke]-down under the impact of European civilization'.[52] Although he evoked the idea of acculturation as causing 'mental unrest and instability' among the Kikuyu, which made them vulnerable to manipulation by 'an unscrupulous few',[53] he did not initially subscribe to the belief that Mau Mau was an atavistic return to a savage psychological state.[54] However, if Leakey's earlier work was milder in its appraisal of the Kikuyu, these

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[50] Bruce J. Berman and John M. Lonsdale, 'Lewis Leakey's Mau Mau: A study in the politics of knowledge', *History and Anthropology*, 5 (1991), 143-204 (p. 144).
[51] Ibid.
[52] L. S. B. Leakey, *Mau Mau and the Kikuyu* (London: Methuen, 1952), p. vii.
[53] Ibid., p. 17, 85.
[54] Instead he recognised the Kikuyu's genuine grievances over their loss of land to the white settlers, the insecurity of jobs on white farms, overcrowding in the remaining Kikuyu lands, the terrible wages of urban workers and the social insult of the colonial colour bar. The government's inability to take these issues seriously made the Kikuyu vulnerable to political agitators, such as the Kikuyu Central Association and the Kikuyu African Union (KCU) from whom Mau Mau was understood to have developed. The oath-taking ceremonies, which Leakey regarded as corrupted and illegitimate versions of traditional Kikuyu practices, were designed to subvert Kikuyu values and were the means by which the rebels 'forced Mau Mau on the masses'. See Leakey, 1952, pp. 105-115, 85-93 and x.

views would prove short lived. In November 1954, Leakey published *Defeating Mau Mau*, which described the rebellion as nothing short of an anti-Christian and perverse religion. Admitting that the movement was '*to some extent synonymous with* [earlier Kikuyu] *political organisations*,' Leaky now saw the truth: Mau Mau '*was in fact a religion and that it owed its successes to this fact more than to anything else at all*' (emphasis in the original text).[55] The arrival of European culture, and thus Christianity, had persuaded many Kikuyu to turn away from their traditional beliefs. This was only a superficial conversion, though; a spiritual void remained to be exploited by the leaders of Mau Mau. By making the movement a religion, its manipulative creators could gain the support of thousands of adherents: it was Mau Mau as a religion and not a political group that 'turned thousands of peace-loving Kikuyu into murderous fanatics'.[56]

Leakey's work was taken seriously by the colonial authorities, who not only circulated copies of his work to police and security personnel, but also relied on his expertise for devising a policy to deal with the crisis in Kenya. In 1953, the newly appointed Governor, Evelyn Baring, set up a working group to report on the sociological causes underlying the Mau Mau movement. On this committee was Leakey himself, Thomas Askwith, a liberal officer who had been Municipal African Affairs Officer in Niarobi, and Sidney Fazen, secretary of the Kenya Land Commission. This special committee would create the 'Rehabilitation' programme. This programme targeted the Kikuyu population at large, while the military, security and police forces supressed the guerrillas fighting in the forests. For all intents and purposes, this was the government's social counter-revolution.[57] The aim was to combat Mau Mau indoctrination and return the Kikuyu to being progressive citizens of the modern world.

[55] L. S. B. Leakey, *Defeating Mau Mau* (Methuen & Co. LTD: London, 1954), p. 41.
[56] Ibid., p. 43.
[57] Caroline Elkins, 'The Struggle for Mau Mau Rehabilitation in Late Colonial Kenya', *The International Journal of African Historical Studies*, 33 (2000), 25-57 (p. 25).

The basis of discussion for this committee was a report submitted by Askwith on 27 August 1953 upon returning from Malaya, where he investigated the 'methods adopted in connection with the detention and rehabilitation under the Emergency Regulations' in that economically important colony.[58] Since 1948, the British had been engaged in a guerrilla war against the Malayan National Liberation Army (MNLA). Here the British were quicker than the French at adapting to their opponent's Maoist guerrilla tactics, as will be explored in more detail in the next section.[59] The key to success was the strategy of isolating the rebels from the civilian population. This, according to Lieutenant-General Sir Harold Briggs, who was responsible for devising this plan, cut the rebels off from their vital support networks among the people by resettling substantial portions of the population in what were referred to as Resettlement Areas, while rebels and suspected rebels were detained without trial in smaller detention centres. Consequently, five hundred thousand Chinese were resettled into five hundred heavily controlled camps called 'new villages'.[60] The method of resettlement, known as 'the Briggs Plan', was deemed so successful that it became the method of choice in Kenya during the Mau Mau emergency. In fact, the British used forced resettlement in Malaya and Kenya to a far greater extent than did the French in Algeria or the Portuguese in Angola and Mozambique. According to David French, the British moved about half of the Chinese population in Malaya and roughly 70 percent of the Kikuyu, Embu and Meru in Kenya.[61]

In Malaya, the Briggs Plan was continued and expanded under General Templer, who became the High Commissioner of the colony in February 1952, after his predecessor, Sir Henry Gurney, was assassinated. It was he who provided Askwith with briefings on attempts to secure a lasting peace through re-education and the resettlement of the insurgents and their

[58] FCO 141/5666/303/p. 1. Thomas Askwith, 'Detention and Rehabilitation', 27 August 1953.
[59] Klose, *Human Rights in the Shadow of Colonial Violence*, p. 110.
[60] Ibid., 2013, p. 110. See also Simon Smith, 'General Templer and counter-insurgency in Malaya: hearts and minds, intelligence, and propaganda', *Intelligence and National Security,* 16 (2001), 60-78 (p. 62).
[61] David French, 'Nasty not nice: British counter-insurgency doctrine and practice, 1945-1967', *Small Wars & Insurgencies*, 23 (2012), 744-761 (p. 752).

supporters. Askwith was particularly taken by Templer's insistence that 'the hearts and minds of the people must be won'.[62] The phrase 'winning the hearts and minds' of the people, which has often been falsely attributed to Templer and his use of a well-aimed propaganda campaign in Malaya,[63] has come to mean a campaign that balances military force with larger policies aimed at economic and political development. Its focus is on addressing the causes of unrest.[64] By securing the trust of the people, according to this logic, the 'sea' in which Mao's 'fish' swam would be reduced to little more than a puddle, allowing the military to take care of the remaining armed rebels. Askwith, upon returning to Kenya, was keen to stress that the failure to address wider political, economic or social problems in the colony might lead to the work of rehabilitation being 'undone and a wave of communist sympathy [would recur]'.[65]

As such, Askwith did not regard the Malayan detention camps as locations for punishment. Instead, they were sites where the Chinese and Malays could be 'befriended' by the Government officers and shown the benefits of Western civilization. The hope was that 'the Communist-infected detainees and other detainees of varying degrees of discontent' would see the errors of their ways and 'take their place […] in the life of the community'.[66] Rehabilitation was seen to be so important that the Malayan government created a temporary Detention Camps Department under the Ministry of Defence and separate from the Prisons Department. This, Askwith explained, was because detainees were not prisoners and to treat them as such would 'detract from the value of the rehabilitation process itself'.[67] But not all detainees could be rehabilitated. Police Interrogation Units were used to screen and classify detainees as 'black' or 'grey', depending on their level of communist indoctrination. 'Blacks' represented the hard-core communists. Deportation was the only option for these irredeemable

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[62] FCO 141/5666/303/p. 3. Thomas Askwith, 'Detention and Rehabilitation', 27 August 1953.
[63] The phrase was first used by Lieutenant-Colonel C.E. Bruce of the Indian Political Department in 1938 in his book about the North-West Frontier of India. See Paul Dixon, 'Hearts and Minds'? British Counter-Insurgency from Malaya to Iraq', *Journal of Strategic Studies*, 32 (2009), 353-381 (p. 361).
[64] Ibid.
[65] FCO 141/5666/303/p. 3, Askwith, 'Detention and Rehabilitation'.
[66] Ibid., p. 4.
[67] Ibid., pp. 2-3.

individuals. ‘Greys’ could be ‘saved’ despite having some communist sympathies, but they would require the correct treatment by advancing through a series of rehabilitation stages aimed at providing greater re-education and voluntary or paid employment.

Templer’s approach to the Malayan Emergency is commonly regarded as setting the standard for a less coercive form of counterinsurgency that could be replicated elsewhere, as it was in Kenya. However, recent scholarship has shown this to by a myth with as much substance as that of Mau Mau as a disease. The British approach in Malaya and eventually Kenya involved high levels of force and both physical and psychological coercion. In fact, it seems the ‘success’ in Malaya depended on an effective propaganda campaign that took place in an environment where a range of illegal transgressions and human rights abuses were permissible. As Paul Dixon has powerfully argued, in addition to Templer’s ‘hearts and minds’ campaign, the British security forces in Malaya also relied on mass arrests; the death penalty for carrying arms; detention without trial for up to two years (which between 1948 and 1957 led to a total of 34,000 people being held without trial for more than 28 days); deportations; movement restrictions; control of foods and shops; censorship; collective punishment in the form of fines and curfews; arson against the homes of communist sympathisers; treating prisoners as criminals and hanging hundreds of them; and the forced resettlements mentioned above.[68] When Templer took control in 1952, these methods of control and intimidation had already defeated much of the rebel forces.

By the time Askwith made his journey to study Templer’s ‘hearts and minds’ campaign, Kenya had already witnessed mass arrests. Some 1,400 persons had been detained under the Emergency Regulations, along with 9,000 convicts imprisoned for Mau Mau offenses and ‘the many ex-squatters, and person returned to the reserves as a result of screening, together with the waverers normally domiciled in the reserves’.[69] Settler opinion had been hardened by the

[68] Dixon, ‘Hearts and Minds’? (p. 368).
[69] TNA CO 822/489/83. Telegram from Baring to Lyttleton, 13 July 1953.

brutal killings of several families in the White Highlands and the horror of the Lari Massacre could only be answered with greater violence. In fact, many conservative observers believed total war with the Kikuyu was the only solution. Under pressure, the governor, mirroring the Malaya example, issued Emergency regulations that transformed Nairobi into a totalitarian space with full control of the Kikuyu's existence.[70] Emergency Assizes were established to enforce the new penal code. The tally of executions reached 1,200 by June 1953, with hundreds more awaiting the gallows. Many thousands more were found guilty of lesser Mau Mau offences and consigned to imprisonment for terms that ranged from several months to a lifetime. Yet the sheer number of suspects meant that the Emergency justice system was unable to deal adequately with the crisis. Baring was forced to issue mass detention orders under the Emergency Powers Regulations 1953. Fearing international criticism for detaining so many Africans without trial, the Conservative government in London stressed the word 'rehabilitation' in the hope that it would convey a greater sense of humanitarian concern. Askwith's report and the subsequent work of his colleagues on the special committee was thus the government's liberal veneer providing a reformist face to otherwise extremely coercive measures taking place in Kenya.

Askwith was in a position to learn from many of the precedents set by the Malayan Emergency as well as British experience in 'readapting' communists on the Greek island of Makronnissos.[71] Yet there were two features of the Kenya Emergency that made it distinct from other colonial emergencies: Mau Mau were not communist and their oath-taking practices were uniquely African in nature. For the rehabilitation process to succeed in Kenya, something had to be done about the oaths.[72] It was at this point that Dr. Leakey came to the front line. His recommendations, discussed explicitly in *Defeating Mau Mau*, bring to mind Charles Clarke's statement about 'treating' Muslim terrorist that opened this chapter. While

[70] Elkins, 'The Struggle for Mau Mau Rehabilitation in Late Colonial Kenya' (p. 36).
[71] Ibid.
[72] TNA FCO 141/5666/303/p. 10. Thomas Askwith, 'Detention and Rehabilitation', 27 August 1953.

Clarke advocated ‘deprogramming’ techniques devised by anti-cult psychologists, Leakey devised a programme to ‘de-oath’ Mau Mau initiates for the same reasons. Those who had taken the lower level oaths—there were thought to be six or seven in total—could be ‘rehabilitated’ by a ‘Full and free confession followed either by a traditional cleansing ceremony, or by a genuine return to Christianity’.[73] For the hard-core Mau Mau, however, those who had taken the ‘more advanced and bestial and foul oaths’, he was more doubtful. These individuals may be beyond salvation and would need to be segregated ‘for the rest of their lives, so that the evil they have done and the knowledge of it eventually dies with them’.[74] Leakey’s recommendations were first put into action in the Bahati and Sabukia Resistance Movement Centres which were run by local farmers. Here government ‘witchdoctors’ or Kikuyu traditional cleansers would aid in the confession and cleansing ceremonies. Upon touring Bahati, Askwith was to say that the process was ‘psychologically sound, and moreover, successful’.[75]

Confession and cleansing would quickly become the precondition for detainees to move through ‘the pipeline’, a series of detention, transit and work camps created for the purposes of cleansing Mau Mau from the minds of the Kikuyu. In order to be effective, so official policy stated, confession had to be voluntarily given and publicly if necessary where ‘the population is more obdurate’.[76] The standard view was that confession was ‘a great relief to those concerned, and renders them receptive to an attractive allegiance’ to the government. Despite Askwith’s liberal aims, detention officers and warders would use the need to obtain confessions from Mau Mau suspects as an excuse to commit extensive violence. What was initially meant to be a therapeutic act quickly became an opportunity for torture and other abuses designed to coercing detainees into subordination. The British authorities in Kenya had

[73] Leakey, *Defeating Mau Mau,* p. 85.
[74] Ibid., p. 86.
[75] TNA CO 822/794/1. ‘Rehabilitation’, 6 January 1954.
[76] TNA CO 822/794/52. Savingram from Governor Baring to the Secretary of State for the Colonies, 3 January 1956.

used the scientific insights of an anthropologist to legitimise what was becoming a standard treatment for insurgent forces in various colonial settings: coercive force used to aid in political (re)indoctrination. As such, the conditions in the Pipeline quickly came to resemble those experienced by the US POWs in the detention and re-education camps of Korea or, as will be discussed in the next section, French POWs in Indochina.

While the Governor's Reconstruction Committee, established in November 1953 to ensure the proper direction and co-ordination of all matters affecting the reconstruction of Kenyan society, officially endorsed the rehabilitation plan at the end of January 1954, Askwith wanted more.[77] He sought the approval of an acknowledged expert on Kikuyu psychology, Dr. John Colin Carothers, an ethnopsychiatrist and former head of the Mathari Mental hospital, Nairobi. Carothers was recognised as the founder of the East African 'School' of psychiatry and the most important authority on the 'African mind'. In 1953, he produced *The African Mind in Health and Disease* for The World Health Organisation (WHO), which drew similarities between African patients at the Mathari hospital and leucotomised Europeans.[78] He concluded that African inferiority was the result of their having underdeveloped frontal lobes.[79] The hope was that he could extend his special knowledge of the African mind to help the government win and maintain the support of loyal Kikuyu, Embu and Meru.[80] If Leakey offered the scientific legitimacy for the Kikuyu's need to confess their crimes and Mau Mau allegiances, it was Carothers who established the myth of Mau Mau as justification for the liberal ideal of rehabilitation and the continued need for British stewardship of Kenya.

[77] Elkins, 'The Struggle for Mau Mau Rehabilitation in Late Colonial Kenya' (p. 40).
[78] Fanon was particularly critical of Carothers's leucotomy argument in *The Wretched of Earth*, where he denounced it as being an example of the same form of overt racism espoused by members of the Algerian psychiatry community. See Frantz Fanon, *The Wretched of the Earth*, p. 244.
[79] J. C. Carothers, *The African Mind in Health and Disease: A study in* Ethnopsychiatry (World Health Organisation, 1953), p. 157. See also J. C. Carothers, 'Frontal Lobe Function and the African', *Journal of Mental Science*, 97 (1951), 12-48 (p. 12).
[80] Jock McCollock, *Colonial psychiatry and 'the African mind'* (Cambridge: Cambridge University Press, 1995), p. 67.

The Psychology of Mau Mau, as McColloch points out, was the only study of its kind commissioned by a colonial government to be written by a psychiatrist. It therefore represented a landmark in the history of ethnopsychiatry.[81] The short 28-page document sought to explain the psychology of the native African, the effects of acculturation that 'shocked' the Africans out of their habitual gradual approach to cultural transition and the rise of Mau Mau. It also offered recommendations for treating the problem over a long-term period. With this document, psychiatry had certainly escaped the confines of the clinic. Conceding that no biological difference between Africans and Europeans existed, Carothers stressed that important distinctions were still evident. Culture was the determining factor and, despite European presence in Africa, the belief in magic and the supernatural persisted. Christianity, the cultural underpinnings that influenced the development of European thinking, allowed what he described as an individual's ability to:

> build a balanced understanding of oneself and the world; an understanding which is not afraid to see the weakness in oneself, for one can also see the strength; an understanding which enables one to view events as governed by forces which are indifferent to oneself and not by "wills" that love or hate one; an understanding which need not be grossly undermined by living among alien people.[82]

In contrast, the Africans' animism meant that 'misfortunes are seldom seen as one's own fault. They are seen as the work of evil 'wills' and since the power of these wills is now largely replaced by the power of the European, the latter is apt to be regarded nowadays as the sole author of all evil'.[83] The Kikuyu's political grievances were therefore not legitimate but part of the African's inability to practise the type of self-reflection produced by a mind raised in a Christian culture.

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[81] Ibid.
[82] J. C. Carothers, *The Psychology of the Mau Mau* (Government printer, 1954), p. 4.
[83] Ibid., p. 12.

Carothers compounded this view of the irrational African psyche by likening Mau Mau oaths to Early Modern European witchcraft. What the Kikuyu and past practitioners of witchcraft had in common was a 'desire to achieve some personal aim which they could not achieve within the "righteous" social framework of their time'. Instead, these people made bargains with the Devil in order to gain their wishes. Carothers was not shy in identifying Jomo Kenyatta as the Mephistophelean figure in this context: 'if one substitutes pagan culture and Christianity for the Catholic faith, and Jomo Kenyatta for the Devil, the two are often virtually identical'.[84] Continuing to tap into contemporary anxieties over mind control as well as subjects of scientific research, Carothers speculated that the Fourth Mau Mau oath contained 'the essential ingredients for hypnosis'. Through monotonous repetition of the ceremonies delivered by a prestigious administrator who commands absolute attention, multiple attendees could fall victim to this altered state of consciousness. This was because 'groups are hypnotized more easily than individuals'. It was therefore 'most likely that hypnosis plays a part in these assembles, and that the suggestions and commands imparted there may govern the subject's thinking and behaviour afterwards in varying degrees, as happens in hypnosis'.[85]

Education, or a lack of it, was a principal concern for Carothers. Western education had largely been delivered through religious institutions provided by missionary societies, but as Carothers continued to state, 'only about half of all Kikuyu boys complete 4 years of schooling and only a tenth complete 8 years even in recent years'. The figure for girls was even smaller.[86] Consequently, the majority of African children were educated at home, where they were taught the magical and animistic principles and supernatural-based morality by their mothers. It was within the home context that the psychological conflicts caused by the clash between Western civilization and traditional African culture came to a head. A man who had received some education and Christian teaching would find himself in 'a world in which the beliefs he learned

[84] Ibid., p. 16.
[85] Ibid., p. 18.
[86] Ibid., p. 7.

in childhood had become inapplicable and ineffective'. Yet 'internal conflict' was 'perpetually aggravated by the presence of the women' who, due to not receiving proper education, tempted him back to the 'old ways', like some latter-day Eve.[87]

The fact that Carothers paid considerable attention to the role of women is significant. Prior to the rebellion's outbreak, African women were thought to be passive, peaceful and uninterested in politics. But as Katherine Bruce-Lockhart has shown, Kikuyu women played a fundamental role in administering Mau Mau oaths. Mau Mau women also took part in combat, while women in the civilian 'passive wing' served as 'couriers, scouts and spies who provided food, ammunition and information to the guerrilla forest fighters'.[88] By 1953, Askwith had to conclude that women played a pivotal role in 'keeping Mau Mau alive'.[89] The British administration's surprise at these militant women may explain why Carothers emphasised their role in his report. In fact, he believed their lack of education combined with the patriarchal nature of Kikuyu society provided a psychological explanation for their enthusiasm. Accepting Mau Mau would not only bring them closer to 'their men', it would also give them 'unprecedented power', power that would only grow in the promised land free of Europeans.[90]

When it came to recommending possible solutions for these problems, Carothers suggested the establishment of a series of educational programmes aimed at teaching home hygiene as well as moral instruction to install notions of truthfulness and accountability among the young. Above all, the Kikuyu had to learn that the right to political power could only be obtained by being responsible. Carothers also endorsed the development of a Malayan-style resettlement

[87] Ibid., p.10.
[88] Katherine Bruce-Lockhart, '"Unsound" minds and broken bodies: the detention of "hardcore" Mau Mau women at Kamiti and Gitamayu Detention Camps in Kenya, 1954-1960', *Journal of Eastern African Studies*, 8 (2014), 590-608 (p. 593).
[89] Thomas Askwith, *From Mau Mau to Harambee* (University of Cambridge, African Studies Centre), p. 106.
[90] Carothers, *The Psychology of the Mau Mau*, p. 17.

scheme to create new villages where the Kikuyu families could come together. The stability of the family was key. Crime and mental instability in Europe and America, he asserted, were most rife in areas with 'floating populations and where parental influence is weakened and unsettled'. To be civilised, the African would need to have the opportunity to develop a family lifestyle conducive to those aims. Yet most importantly for our purposes, Carothers poured explicit praise on Askwith's rehabilitation programme. After visiting a number of Resistance Movement Centres, Transit and Detention camps, Carothers felt Askwith had shown 'masterly psychological insight', and continued to 'endorse unhesitatingly all the observations and recommendations it contains'.[91]

Together, Leakey and Carothers provided settlers and colonial administrators with the scientific arguments they needed to justify their treatment of the Kikuyu and the purging of the enemy's mindset. Although it is tempting to see the use of the expertise provided by Leakey and Carothers as evidence of the partnership between state ideals and ambitious scientists, the case is not that simple. British psychiatrists and human scientists such as anthropologists did develop deeper relationships with government officials during this period, but that is not to say that tensions did not exist and that everyone agreed with their interpretations.[92]

In 1954, *The East African Medical Journal* published an article by Dr. John Wilkinson of the Church of Scotland Mission Hospital in Tumutumu, Kenya. According to this physician, far from being an insane cult, Mau Mau was 'primarily a political movement', and a 'virtually […] totalitarian system' with a 'well-organised and disciplined army' that used terror to force conformity from other Kikuyu.[93] In the same year, the anthropologist Max Gluckman argued in the *Manchester Guardian* that Mau Mau was caused by labour exploitation, land alienation

[91] Ibid., p. 23.
[92] Linstrum, *Ruling Minds*, p. 157.
[93] John Wilkinson, 'The Mau Mau Movement: Some General and Medical Aspects', *The East African Medical Journal,* 31 (1954), 295-314 (p. 299).

and the proscription of African unions and political parties by the British.[94] But one of more cutting critics was Peter Worsley, a contemporary anthropologist, who challenged both Leakey and Carothers's pathological arguments. Worsley argued that they not only perpetuated a myth of white settlers as misunderstood paternalistic liberal conservatives, but also the image of Mau Mau as a vicious cult.[95] Instead, Worsley stressed that Mau Mau was a political response to the atrocious treatment Africans received in the colony. Worsley even went as far as questioning Leakey's qualifications: 'he can by no stretch of the imagination be called a trained anthropologist'. The fact that Leakey had served as an intelligence officer during the Emergency and had been an interpreter at Kenyatta's trial put his objectivity in question. For Worsley, '[Leakey's] general involvement and sociological ignorance oblige the reader to examine his conclusions very critically'.[96] On the subject of Carothers, Worsley was even more scathing, referring to his work as 'racist nonsense disguised as scientific "psychology"' which 'has already been exposed for what it is by both anthropologists and psychologists'.[97]

These discordant views suggest that British scientists were far more resistant than their French counterparts when it came to the ethical and professional limits of their expertise, especially on the subject of Kenyan detainees. This will be explored in more detail in subsequent chapters, but for now it is worth noting that, when it came to implementing the rehabilitation programme, the psychological recommendations put forward by Leakey and Carothers were applied by police, detention staff and colonial administrators. One reason for this could be that psychiatry, and any other form of psychological medicine as a discipline, was poorly represented in the colonial context of East Africa. As Mahone has shown, an *ad hoc* professionalism grew out of a small network of asylums in Kenya, Uganda, Tanganyika and Zanzibar which gave rise to an 'East African School' of psychiatry. But although it had a

[94] Linsturm, *Ruling Minds*, p. 183.
[95] Peter Worsley, 'The Anatomy of Mau Mau', *The New Reasoner*, 1 (1957), 13-25 (p. 15).
[96] Ibid.
[97] Ibid. (p. 22).

degree of intellectual autonomy and authority within the colonies, it was still a largely underrepresented discipline with few qualified staff.[98] As such, the Pipeline detention centres were staffed by non-experts who replaced the scientific ideas in circulation with their own interpretations of the detainees' psychology. This would be used to justify their recourse to violence. With this in mind, the findings of this chapter support Eric Linstrum's suggestion that the postwar history of psychological expertise in Kenya, as in other British colonies, is 'less a morality play about the corruption of intellectuals than a cautionary tale about the state's selective use of expert knowledge'.[99]

2.4. From Indochina to the 'Algerian mind' and its violence

The French psychological community in Algeria was more involved in operations against the FLN than their British counterparts in Kenya. Generally speaking, French colonial psychiatry enjoyed a more active role for its expertise among the colonial administrations and the military, especially in North Africa. This could be explained by the relationship between the psychiatric profession in the metropole and their colonial colleagues. The story of what became known as the 'Algiers School' of French psychiatry, founded by Professor Antoine Porot, stands in stark contrast to the general pattern of colonial psychiatry. While psychiatric institutions in British colonies largely languished due to lack of funds, with their staff feeling more like frustrated prison warders, psychiatry in North Africa was at the cutting edge of French medicine.[100] Between 1911 and 1954, psychiatrists in Algeria embarked on a programme of radical institutional reform. They codified ideas about the relationship between ethnicity and psychopathology while pushing the limits of experimental treatment. As Richard Keller has shown, their ambitions shifted the intellectual and institutional gravity of

[98] Sloan Mahone, 'East African Psychiatry and the Practical Problems of Empire', in Megan Vaughan and Slone Mahone (ed.), *Psychiatry and Empire* (Basingstoke: Palgrave Macmillan, 2007), p. 41.
[99] Linstrum, *Ruling Minds*, p. 16.
[100] Vaughan, 'Introduction', p. 6.

professional psychiatry from France to North Africa.[101] They were the brave new face of French medicine and provided the intellectual and professional milieu in which Frantz Fanon would practise his psychotherapy and develop his damning criticism in *The Wretched of the Earth*. Yet the most important point of distinction here between the role of psychology in Kenya and Algeria is that, in the latter context, psychiatry was always closely bound-up with the military. From the First World War, its practitioners articulated their mission in the language of battle and struggle against the North African indigenous population. As Keller explains in *Colonial Madness*, 'the historical development of the Algiers School presents a crucial example of colonialism's discordant logic in practice, where a nuanced, detailed, responsive, and even progressive scientific circle with utopian ambitions was simultaneously an uncomprehending, violent entity driven by militant racism'.[102]

By the 1950s, psychiatry and, especially, ethnopsychiatry were, as the military doctors Gallais and Plangues put it, undergoing a 'revolution'. No longer bound to simple 'armchair ethnographies', such as those of the French anthropologist Lucien Lévy-Bruhl's theory of primitive mentality, the brave new psychiatry could rely on modern techniques: psychological testing, psychoanalysis, narcoanalysis (the use of barbiturates to produce altered states of consciousness in psychotherapy), electroencephalograms and hormonal studies.[103] Ethnopsychiatry, according Gallais and Plangues, as well as Porot and his student Dr. Jean Stutter, should not be limited to the hospital but used for the political administration of the native population.[104] The ultimate manifestation of this commitment to the military operations

[101] Richard C. Keller, 'Taking Science to the Colonies: Psychiatric Innovation in France and North Africa', in Sloan Mahone and Megan Vaughan (ed.), *Psychiatry and Empire* (Basingstoke: Palgrave Macmillan, 2007), p. 18.
[102] Keller, *Colonial Madness,* p. 123.
[103] P. Gallais and L. Planques, 'Étude sur les déficiences mentales dans les territoires d'outremer: Perspectives ethnopsychiatriques dans l'Union Française', *Médecine Tropicale*, 11 (1951), 5-30 (pp. 9-25). See also Alice Bullard, 'The Critical Impact of Frantz Fanon and Henri Collomb: Race, Gender, and Personality Testing of North and West Africans', *Journal of the History of the Behavioural Sciences*, 41 (2005), 225-248 (p. 231).
[104] Gallais and Planques, 'Étude sur les déficiences mentales dans les territoires d'outremer' (p. 6). See also Antoine Porot and Jean Stutter, *Le "Primitivisme" des indigènes nord-africains, ses incidences en pathologie mentale, par le professeur* (Marseillaise : *Impr.,* 1939).

in Algeria would be in France’s psychological warfare programme aimed at the Algerian rebels during the war of independence. However, in order to appreciate how this programme was created, it is first necessary to explore the formative experience the war in Indochina had on the French military prior to the Algerian crisis.

The French were the first to appreciate the effectiveness of the communist guerrillas’ new tactics when they faced a bitter defeat in Indochina. Here the Vietnamese Liberation organisation, under the leadership of Ho Chi Minh and General Vo Nguyen Giap, succeeded in mobilising mass support from the population and managed to end France’s colonial rule in Southeast Asia with its victory at Dien Bien Phu in 1954. This victory, according to the French military theorists, was due to the communists’ ability to control the population. For example, Colonel Charles Lacheroy, a French official engaged in the conflict and eventually the pioneer of revolutionary-war theory, believed that the Viet Minh’s success lay in the creation of a totalistic environment. Here all aspects of the Viet Minh’s social relations were rationally and systematically controlled by what he called ‘parallel hierarchies’—overlapping networks of communist groups in various committees and associations.[105] These parallel hierarchies, Lacheroy explained, formed the physical means by which ‘the Vietminh system [...] bends the masses to obedience, to work and to the war effort’. But this was only part of the first step in waging a ‘total revolutionary war’. By controlling and monitoring the physical activities, the population would be open to ‘psychological warfare’ which controlled what they thought. As he said, ‘when you hold a glass firmly, you put what you want in it’.[106]

Within this context, Lacheroy regarded the indigenous masses as docile and passive. This was a view shared by other French theorists: although they may have some desire for independence, this seemed to be less likely. As the French army official Roger Trinquier stated

[105] SHD 1 H 2411/d.1/p.7. Colonel Lacheroy, ‘La Guerre Révolutionnaire: Conférence no.1 Leçons de l’Action Viet-Minh et Communiste en Indochine’.
[106] Ibid., p.10.

in his 1964 book on counterinsurgency, *Modern Warfare*, 'Such support may be spontaneous, although that is quite rare and probably a temporary condition'.[107] Instead, the indigenous population were seen to be generally amenable to manipulation, regardless of the ideological content, which made them the ideal targets of subversive propaganda and terrorism.[108] This passivity is similar to the image of the brainwashed Chinese subjected to Mao's thought-reform as described by Hunter; it may have also influenced Jean Lartéguy's portrayal of the Viet Minh in his novel *The Centurions*, where he described them as 'a hive of sexless insects [that] seemed to operate by remote control, as though somewhere in the depths of this enclosed world there was a monstrous queen, a kind of central brain which acted as the collective consciousness of the termites'.[109]

Although a work of fiction, Lartéguy's description, first published in French in 1960, taps into the view that the conversion to communism necessarily destroyed an individual's autonomy and stripped away liberty. It also helped to popularise the idea that was widespread in western society and felt keenly by the French military: international communism was a threat not only to French values but western civilisation itself. Faced with the prospect of this 'insect hive' spreading across the Third World, colonial rule came to be seen, in Maria Lazreg's words, as 'a bulwark against an immoral and shadowy adversary'.[110] A war against this 'subversion' was thus a legitimate and worthy cause, but also a mission to save France and Western Europe from destruction. Once the signs of revolution appeared in North Africa, the French authorities were quick to interpret it as part of the same phenomenon, the tide of communist subversion. As stated by the French military: 'This Algerian revolution, led by the pan-Arab movement, risks setting fire to Europe and America'.[111] Thus, to fend off such an existential threat, the

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[107] Trinquier, *Modern Warfare*, p. 6.
[108] Lazreg, *Torture and the Twilight of Empire*, p. 24.
[109] Jean Lartéguy, *The Centurions* (Penguin Books, 2015), p. 20.
[110] Lazreg, *Torture and the Twilight of Empire,* p. 21.
[111] SHAT 1 H 2411/d.1. 'Les Missions de L'armée francais dans la guerre révolutionnaire d'Algerie', (Conference Donne a S.H.A.P.E. par le General de Corps d'Armee Allard Commandant le Corps d'Armee D'Alger avec l'assistance des colonels Godard et Goussault), 15 November 1957.

military would need to use any means necessary. In order to fight an enemy who used psychological manipulation to force conformity from the vulnerable minds of the population, the French would need to use their own form of psychological action to overturn the revolutionaries' influence on the Algerian masses.

Yet Lartéguy's novel also captured another feature of the French experience in Indochina that was to have a lasting impression on the military's mindset and the methods they would ultimately use in Algeria—the experience of French POWs in Indochina. As Marie-Catherine Villatoux notes, 'Any serious study of the psychological treatment of rebel prisoners in Algeria can hardly ignore the influence exerted by the Indochinese experience on a large section of the French officer corps of the 1950s and 1960s'.[112] Lartéguy's account of his fictional soldier's imprisonment in the Viet Minh's re-education camps illustrated the idea that enemy combatants or particularly recalcitrant groups, such as military officers, would need to undergo specific indoctrination methods that blended physical discomfort with psychological coercion. In Lartéguy's version of the Viet Minh's notorious Camp No. 1, 'the Voice', the communist functionary responsible for overseeing the conversion of the French soldiers to Communism, is described as 'behaving like a scientific chemist'. He 'regulated [the soldiers'] hunger, their fatigue and their despair so as to reduce them to the exact point to which, broken and deranged he could at last work on them and drill them against their past by concentrating on what still remained: the elementary reflexes of fear, fatigue and hunger'.[113] Lartéguy's description of these officers' experiences fits eerily well with the accounts of French officers incarcerated in Viet Minh prisons.

For example, in 1956 Captain Prestat of the *Service historique de l'armée* complied some of these accounts and narratives into a report titled *L'endoctrinement des prisonniers de guerre*.

[112] Maria-Catherine Villatoux, 'Traitement psychologique, endoctrinement, contre-endoctrinement en guerre d'Algérie : le cas des camps de détention, *Guerres mondiales et conflits contemporains*, 208 (2002), 45-54 (p. 48).
[113] Lartéguy, *The Centurions*, p. 96.

In this document, Prestat described the indoctrination methods used on French officers as attaining 'a sort of perfection in "moral techniques."' These techniques could be broken down into 5 phases which, according to an unnamed officer,[114] consisted of: 'brainwashing, obsession, compromise, creation of collective consciousness, and denouncement and hope'.[115] Under the section for 'Brainwashing', the report described how prisoners had to be put into a receptive condition in order to 'listen sympathetically to the doctrines and the teachings of the [Communist] party'. This involved, for instance, maintaining a high mortality rate in the camps to frighten the remaining prisoners; separate them from news sources and reading material in order to give them a 'thirst for reading, to stir up [their] appetite' to read even communist propaganda; to strip all officers of their ranks and isolate them to 'from having the slightest bit of influence'; and the 'writing and signing signature of a manifestos' by the prisoners (which many refused to sign). Although the report notes that '[t]here was no brutal punishment' in the camp, it continues to explain how the prisoners' conditions deteriorated 'almost scientifically'—a line that is extremely reminiscent of Lartéguy's above quote. And similar to that quote, the prisoners found their food rations increasingly restricted while their guards became more aggressive and abusive: 'They beat us with cudgels, they slapped us'. Any particularly recalcitrant prisoners were then subjected to isolation for a number of days, depending on the perceived infraction or the will of 'the higher authorities of the camp'. These techniques amounted to what Lacheroy called the 'flattening', a process that broke down an individual's resistance: 'when the prisoner has nothing to hang on to, he is ready' for indoctrination.[116]

This unique experience, generating deep trauma, led many officers returning from the camps to question the meaning of their commitment and the very nature of the conflict they had been

[114] This officer may be Captain Alain de Braquilanges, who was imprisoned in the actual Camp No. 1 until 1954. The extract contained in the report seems to have come from his *Methode psychologique utilise pour forcer l'adhésion des esprits,* see Villatoux, 'Traitement psychologique' (p. 49).
[115] SHD 1 H 2411/d.1/p. 1. '*L'endoctrinement des prisonniers de guerre*', conference of Captain Prestat, 10 March 1956, Centre d'Instruction de guerre psychologique.
[116] SHD 1 H 2411/d.1/p. 5-6. *L'endoctrinement des prisonniers de guerre*', 1956.

confronted with.[117] But for some officers, the lesson learned in Indochina would be valuable for combating the FLN in Algeria. The French military had to concede that the 'disintegration of personality by psychological aggression is today as dangerous a threat as the disintegration of matter by thermonuclear aggression'.[118] The indoctrination of prisoners in the colonial wars in Indochina and Algeria were thus part of the Cold War writ large. For example, on 7 February 1956, General Lorillot, Commander of the Tenth Military Region, sent a document to the Resident Minister in Algeria that explained how lesson taken from China, Indochina and Korea had shown that psychological warfare was particularly useful for dealing with prisoners of war. These techniques had been honed by the Office of Psychological Action of the Tenth Military Region and were used to formulate a plan for the 'detoxification of prisoners' who could be turned to aid the French in their propaganda efforts.[119]

Detention played a fundamental role in the military's counterinsurgency strategy. The avowed aim, as in Kenya, was to isolate the rebellious elements from the passive members of the population. Although the creation of detention camps was prohibited under the Emergency Law issued in Paris for Algeria on 3 April 1955, the first camps in Algeria were opened in May 1955 as part of the law's provisions for placing suspects under house arrest.[120] The military soon established a network of detention and internment centres that would become the sites of extreme violence and torture that seemed, in part at least, to be coterminous with efforts to brainwash or 'detoxify' the prisoners. Several camps were created: *Centres of Triage* and *Transit*; concentration camps named *Centres d'Hébergement* (accommodation centres); Military Internment Camps and the shadowy Re-education centres.[121] It was especially within confines of the latter centres that the military focused attention on turning specific enemy combatants to the French cause. Nevertheless, the indoctrination of detainees was not limited

[117] Villatoux, 'Traitement psychologique' (p. 49).
[118] SHD 1 H 2411/d.1/p. 1. '*L'endoctrinement des prisonniers de guerre*', 1956.
[119] SHD 1 H 2573/d.1. 'Centre-Endoctrinement des fellagha: Project general', c. July 1956.
[120] Thénault, 'L'internement en France pendant la guerre d'indépendance algérienne'.
[121] Lazreg, *Torture in the Twilight of Empire*, pp. 46-47.

to the Re-education camps. In the end, the entire Muslim population were the target of France's psychological warfare programme. Faced with the seeming insidious threat of the communist indoctrination tactics, the French responded by institutionalising their own psychological warfare programmes for offensive and defensive purposes.[122]

Responding to the communist psychological tactics in Indochina, the French established the *Bureau de la guerre psychologique* in 1953, but its actions remained relatively modest; it focused on the distribution of propaganda in the form of leaflets, newspaper broadcasts and loudspeaker messages.[123] It was in 1957 that the *Cinquièmes Bureaux* (Fifth Bureau) came into being with the specific mission of combating the FLN's propaganda. For the Bureau, the struggle against the enemy was understood in psychological terms. As a previously classified report notes: 'Why do we say psychological warfare? Because war consists in imposing one's will on the adversary. Formerly it was imposed by material violence. Today it is possible by psychological violence'.[124]

This approach to warfare demanded 'scientific and technical intelligence' to inform the Bureau of 'the evolution of psycho-sociological knowledge' of their opponents.[125] As such, its tactics were separated into two forms. On the one hand, there was *Action psychologique* (psychological action) aimed to 'train, develop, support morale and immunise personnel against psychological attacks'.[126] On the other hand, *Guerre psychologique* (psychological warfare) targeted enemy combatants and the native population, seeking to disrupt, modify and control their attitudes and behaviours.[127] Although propaganda was used in *guerre*

[122] Paul Villatoux, 'L'institutionnalisation de l'arme psychologique pendant la guerre d'Algérie au miroir de la guerre froide', *Guerres mondiales et conflits contemporains*, 208 (2002), 35-44 (p. 36, 39). See also Lazreg, *Torture and the Twilight of Empire*, p. 61.
[123] Villatoux, 'L'institutionnalisation de l'arme psychologique pendant la guerre d'Algérie au miroir de la guerre froide', (p. 36).
[124] SHD 1 H 2524/d.1. 'La guerre psychologique: conference no.1', c. July 1956, p. 5.
[125] SHD 1 H 2411/d.1. 'Conference on: le renseignement psychologique', c. June 1957, p. 3.
[126] SHD 1 H 2524/d.1. 'l'Action Psychologique dans les Force Armée', date unknown, p. 5.
[127] Lazreg, *Torture in the Twilight of Empire*, p. 61.

psychologique, it was deployed to convert detainees and natives to France's cause. They utilised censorship, loudspeaker announcements, graffiti, images and radio to convince the Algerians of the benefits of French civilisation and to take advantage of their mass psychology. Ultimately, the aim was, as the Bureau put it, 'to remotely control the spirits, from the outside'.[128]

In order to deliver a viable psychological warfare programme, the *Cinquièmes Bureaux* explored various academic traditions and compiled a bibliography of influential research into the human mind.[129] Yet the dominant theme running through this research was the psychology of groups or masses. The military's experience in Indochina and their encounter with the logic of brainwashing formed the context in which they sought to understand group and mass behaviours. In a general sense, military thinkers turned to the work of Gustave le Bon and Serge Chakotin to guide their thinking.[130] Le Bon was among a group of French thinkers who believed democracy ushered in the rule of the mob. His work influenced Freud's conception of group psychology but was also being taught in the École Supérieure de Guerre before World War II.[131]

For counterrevolutionary thinkers, le Bon's concepts reduced revolutions to a dynamic where psychologically vulnerable people in crisis situations were exploited by manipulative leaders.[132] The crowd alone, Le Bon claimed, is a-rational. In order to create action within the

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[128] SHD 1 H 2524/d.1. 'La guerre psychologique: conférence no.1', c. July 1956, p. 6.

[129] Their exploration of this psychological literature can be separated into two categories: what they referred to as 'the Soviet school', defined by the work of Ivan Pavlov and 'the American school', based on Carl Jung's collective psychoanalysis (which they conflated with behaviourism). According the Bureau, the Soviets had used Pavlov's classical conditioning techniques to wage a war of words in their propaganda campaigns, but while they considered it instructive, the French military ultimately deemed it to be passé. The American school, however, caught the *Cinquièmes Bureaux's* attention. They were particularly interested in Jung's ideas of collective psychoanalysis, determining the extent to which Muslim culture contained the type of archetypes in his theories, and whether they pertained to his concepts of the 'the sacred'. See SHD 1 H 2524/d.1. 'La guerre psychologique: conférence no.2', c. 1957, pp. 1-8.

[130] Lazreg, *Torture and the Twilight of Empire*, p. 62.

[131] Ibid.

[132] SHD 1 H 2411/d.1. 'Note sur le rapport du Capitaine Prestat', 1955, p. 1.

crowd, revolutionary leaders tap into perceived inequities and political grievances. This is what he referred to as the rational logic for a revolution, but it accounts for only one part of the process. The leaders have to overrule the mass's reason by awakening 'different forms of logic', which included 'affective logic, collective logic and mystic logic'.[133] Although all these logics played a role in creating and moving the masses, le Bon saw mystic logic as being particularly troubling. The 'mystic temperament' attributed mysterious power to superior beings or forces and was thought to be 'at the bottom of all religious and most political beliefs'. 'Buddhism, Islamism, the Reformation, Jacobinism, Socialism […] seem very different forms of thought', he argued, 'yet they have identical affective and mystic bases, and obey a logic that has no affinity with rational logic'.[134] Properly manipulated, mystic logic constituted the might of the great popular movement. It was the means by which a non-violent person could be brought to arms or even motivated to die for the cause.[135]

Reading le Bon's work makes it clear why members of the *Cinquièmes Bureaux* became convinced that Islam sat at the heart of the Algerian problem. In their minds, communists had taken advantage of the efforts of some Islamic religious men who were exploiting the religious consciousness of the population in order to 'fight against the integration of Algeria with France'.[136] The masses were being mobilised through, if Le Bon was correct, their mystic logic. As such, an effective counterrevolutionary campaign would need to account for the psychology of the Muslim group. It was on this point that the Bureau turned to the Algiers School for their expertise.

Fortunately for the French military, the Algiers School had been producing published research on the subject of the Muslim masse for decades. As Keller has noted, while the *Cinquièmes*

[133] Gustave le Bon, *The Psychology of Revolution*, Project Gutenberg http://www.gutenberg.org/cache/epub/448/pg448-images.html [24.05.2018].
[134] Ibid.
[135] Ibid.
[136] SHD 1 H 2411/d.1. Capitaine Jacques Mercier, 'La Guerre Révolutionnaire en Algérie', May 1958, p. 15.

Bureaux wanted to create 'mass man' for *guerre psychologique*, Porot had already produced a psychological account of the Muslims as, like Kenya's Africans, extremely suggestable multitudes.[137] In 1918, while describing conscripts, Porot avowed that the indigenous population, due to their religiously-inspired docility, formed 'ignorant masses'.[138] As such, the military set about trying to gather as much data on the psychology, sociology, ethnography, politics, customs and culture of the Muslim population; essentially it sought to codify their souls in order to pinpoint the best means for understanding, controlling and modifying their temperaments. The extent to which the military relied on this information is evidenced in a conference paper circulated by the *Centre d'Instruction Pacification et de Contre Guerilla* during the war, which provided a detailed overview of these features.[139] It shows how much the military relied on the work of Porot and his colleagues. The document is saturated in the psychological stereotypes of Muslims that had been common to the Algiers School since the early part of the twentieth century. Although it tries to distance itself from ideas that portray the indigenous population—referred to as French-Muslims—as inferior to Europeans, the document nevertheless describes them as instinctive, impulsive, lacking a developed faculty for reasoning, imagination and a critical mind, credulous and superstitious.[140]

The French military were particularly keen to identify a psychological explanation for the FLNs use of violence, which they described as corresponding 'to a specific character of the Arab temperament'.[141] This was an old stereotype that saw North Africans as inherently violent and homicidal. In 1932, Antoine Porot and his student Don Côme Arrii attempted to explain what they believed to be a behaviour peculiar to the 'North African race', what they called the frequency of criminal impulsivity'.[142] The article, which was a revised version of

[137] Keller, *Colonial* Madness, p. 155.
[138] Antoine Porot, 'Notes de psychiatrie musulmane', *Annales médico-psychologiques*, 74 (1918), 377-384 (p. 380).
[139] SHD 1 H 2524/d.1. Sociologie Musulmane : Causerie no. 9', c. 1957-1958.
[140] Ibid., p. 1-2.
[141] SHD 1 H 2409/d.1. 'Action Psychologique du Conflit', c. 1957, p. 14.
[142] Antoine Porot and Don Côme Arrii, 'L'impulsivité criminelle chez l'indigène algérien. Ses facteurs', *Annales médico-psychologiques*, 14 (1932), 588-611 (p. 589).

Arrii's thesis, examined forty criminal cases heard in French-Algerian courts and concluded that the '*indigene*'—a category that made no distinction between Kabyles, Arabs and Moors—possessed a flawed mindset that predisposed them to violent impulses. Porot and Arrii believed the aetiology for this 'impulsivity' lay in two categories. The first, 'morbid pathology', included 'alcoholism and other intoxicants', 'delirious or demented states', '*crisis excito-motrices* (crisis of motor excitation)' and 'epilepsy' which accounted for half of the sample population. Yet the most significant group, in the authors' view, were the members of the second group. These individuals suffered from 'constitutional impulsivity' derived from 'the elements of personality related to race, morals, beliefs [and] instincts'.[143] Violent criminality in this group was generated through mental debility caused by the tropical environment, coupled with natural credulity and suggestibility, the tendencies to stubbornness and mental perseverance leading to poor judgement or logic. These Muslims experienced a 'weakness of social feeling in its altruistic forms', had a 'contempt for human life' and were jealously possessive.[144] This view of the criminally impulsive Muslim became so influential that Fanon even recalled speaking with his psychiatrist colleagues who stated 'It's a hard pill to swallow, but it's been scientifically established'.[145]

Despite its popularity among French psychiatrists, the study presented a rational flaw that was consistent in Porot's reasoning: his research focused on individuals facing criminal charges, mainly for murder, and his task as a forensic psychiatrist was to determine degrees of criminal responsibility. As David Macey points out, Porot and his colleagues often extrapolated more general statements about the Muslim population from their limited data. There was also no attempt at using a control group for his studies.[146] Yet this research also demonstrates the ambitious aims of the Algiers School. For Porot and Arrii, psychiatry offered a means for shaping policy towards Algerians generally, but also those immigrating to mainland France.

[143] Ibid., pp. 588-611.
[144] Ibid., pp. 610-611.
[145] Fanon, *The Wretched of the Earth*, p. 241.
[146] David Macey, 'The Algerian with a knife', *Parallex*, 4 (1998), 159-167 (p. 165).

While conceding that the pathological cases in their study were not legally culpable for their actions, the cases under 'constitutional impulsivity' should be treated harshly. In the interest of the 'educational value of punishment', the authors argued, 'justice in such cases must take its course'. It was only 'through examples and sanctions that those unkind and instinctive beings will be taught that human life must be respected'. In their view, French North Africa required intense policing.[147]

The FLN's terrorism, like Mau Mau's, was regarded as indicative of a mental pathology brought about by a reversion to past savagery. In 1956, Dr. F. Lagrot and Dr. J. Greco, published an article in *La Presse Medicale* containing thirty photos of people who had been mutilated by FLN members. These individuals had had their noses, ears and lips cut off.[148] For many, this article showed the 'true face' of the terrorists and was eventually distributed worldwide to health organisations and medical associations.[149] Yet for the psychiatrists, these mutilations demonstrated something more general. According to doctors A. Fourrier, P. Michaux and J. Thiodet, of the laboratory of Forensic Medicine at the University of Algiers, the mutilations committed by the terrorists were 'the serial and stereotyped reproduction of […] criminal acts that have always been practiced in this country'. These atrocious disfigurements were 'suggestive of the tenacity of a collective atavism', or '*paléophrénie réactionnelle*',[150] 'that could be thought to have vanished'.[151] Islam, they argued, was the source of this atavism. As they explained, to stand before Allah, Muslims had 'to appear intact

[147] Porot and Arrii, L'impulsivité criminelle chez l'indigène algérien', p. 611. See also Keller, *Colonial Madness,* p. 140.
[148] F. Lagrot and J. Greco, 'Les mutilations facials au cours du terrorisme en Algérie et leur réparation', *La Presse Médicale,* 51 (1956), 1193-1198.
[149] Klose, *Human Rights in the Shadow of Colonial Violence*, p. 218.
[150] The term p*aléophrénie réactionnelle* was coined by C. A. Pierson in 1955 to serve as a new label for the long-held assumptions about North African primitivism and their 'ancestral' tendencies towards impulsive criminality and violence. As he stated, p*aléophrénie réactionnelle* referred 'to a less evolved ontology and a sensitivity that has changed little since the [North Africans'] distant ancestor'. See C. A. Pierson, 'Paléophrénie réactionnelle: Physiopathologie de l'impulsion morbide en milieu nord-africain', *Maroc medical,* 360 (1955), 642–47.
[151] A. Fourrier, P. Michaux et J. Thiodet, 'Aspects particuliers de la criminalité algérienne', *Algérie Médicale*, 61 (1957) quoted in Antoine Porot and Charles Bardenat, *Psychiatrie médico-légale* (Paris: Maloine, 1959), p. 305.

in the Celestial Court', therefore victims of mutilation would be forbidden to take part in posthumous experience.[152] The FLN's mutilations were thus seen as evidence of a reversion to this ancestral violence, an explanation that was not dissimilar to those used to account for Mau Mau's return to primal aggression. Yet when it came to the subject of mass insanity in the Algerian population, members of the Algiers School had a different explanation to their Kenyan counterparts.

As late as 1960, Porot and Dr. Charles Bardenat believed that the Algerian nationalism stemmed from a pathological form of North African 'xenophobia'. This was because the FLN's violence was directed against 'subjects belonging to an occupying race and generally of a different religion'.[153] There were no political motivations for these attacks; they were just the acts of 'solitary [lunatics], deeply committed to the mystique of their religion which dictates to them a hostile behaviour towards the foreigner'.[154] But Porot and Bardenat were careful to state in a footnote that 'xenophobia' in this case 'is only a strictly individual behaviour or reaction to subjects of another race or religion and not as a collective movement or uprising against occupants'. This seems difficult to reconcile with the situation taking place in Algeria in 1960, when the number of FLN supporters was reaching new heights. If terrorism was only the pathological xenophobia of the few, how did these scientists understand the sheer number of supporters who had taken part in the uprising? Keller does not continue to analyse this particular source, but arguably, the answer lies in the pages that follow.

Although Porot and Bardenat only briefly discuss the 'Algerian terrorists', they nevertheless provide a subtle explanation of the psychological mechanisms at play in leading the masses to support the FLN; an explanation that not only accounts for why so many Algerians joined together but may also provide a theoretical justification for the military's use of detention and

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[152] Ibid.
[153] Antoine Porot and Charles Bardenat, *Anormaux et Malades Mentaux devant la justice pénale* (Paris: Librairie Maloine, 1960), p. 155. See also Keller, *Colonial Maddness*, p. 152.
[154] Ibid., p. 155.

segregation. The section on xenophobia is followed by a discussion of 'family and collective psychosis'. According to the authors, families or collections of people can suffer from 'deliriums' where by the delusions of 'an isolated individual', usually delusions of persecution, are shared by one or more individuals.[155] Building on earlier ideas about contagious delusions, such as Professor J. Delay's use of the term 'personality in several persons', a condition where each participant contributes to a common delirium 'according to the extent of his means', these delirious groups acted like a cohesive cell. But Porot and Bardenat are careful to state that 'this applies mainly to family psychoses where the number of deliriants is quite limited'. In these cases, the 'cure' for the family's delusions is to break-up the group and to separate the 'passive subjects' from the solitary lunatics responsible. Although they do not mention the political situation unfolding in Algeria at the time, the discussion acknowledges that 'collective psychoses' concerning the reaction of crowds or social masses 'are not without analogies with certain family psychoses'. The influence of individual xenophobic zealots among crowds, if this logic is extended, could thus operate in a similar way to those with persecution delusions within a family unit. Although the authors do not continue with this line of thought, if the relationship between family members is the microcosm of the masses, then it is conceivable that the 'cure' for mass psychosis would also rest in separating the agitators from the passive population. This would represent a very close affinity between the ideas of the Algiers School and the counterrevolutionary theorists.

Although it is not possible to assess the extent to which the military used this particular part of Porot's works for their own aims, there are nevertheless clear indications that they read his work. Moreover, there is evidence to suggest that Porot supported, at least to some extent, the military's use of mass detention in Algeria. A top-secret memorandum titled '*Sur le problème de la mentalité des Musulmans*' produced on 1 June 1959, shows that the *Cinquièmes Bureaux* sought the expertise of 'Drs. Porot and Sutter'[156] with the explicit aim of developing a

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[155] Ibid., p. 159.
[156] Presumably a misspelling of Dr. Stutter.

psychological programme to speed up the 'recuperation of fullagha detainees'.[157] Their expertise, along with those of other experts on Islamic culture,[158] was sought for an 'objective study of the mentality of Muslims' to 'produce evidence for stereotypes' about 'the most profound element of Muslim culture'. Experiments were devised to gather information on Muslim self-perception, the effects of education and personal experience on cognitive development, the role of religion in shaping Muslim psychology, the archetypal content of their culture (in keeping with the military's interest in Jung's psychoanalysis) and whether it influenced their perception of the government's work in Algeria. The experiments even envisaged using a 'projective tests' of the type designed by Dr. Ombredane for Congolese natives.

It is currently unclear whether this research project delivered usable data for the military, but it at least shows that a range of civilian experts, especially psychiatrists, were actively involved in devising potential 'treatments' for 'rehabilitating' Algerian prisoners of war. However, it should be stated plainly that these research programmes do not implicate these scientists in any of the violent activities known to have taken place in the Algerian detention camps at this point. Their connection to the French military's activities does not mean these were the individual psychiatrists whom Fanon described as being in the 'habit' of 'flying to the aid of the police' and subsequently aiding in the torture and interrogation of FLN suspects.[159] Nevertheless, the evidence explored in this section has shown there were close affinities between the military's aims and the beliefs and ambitions of the psychiatric communities in Algeria. As with the situation in Kenya, eminent enthopsychiatrist like Porot and his colleagues provided scientific explanations for the rebels' behaviour that reinforced older stereotypes about the natives' criminal propensities and their roots in religious thinking, in

[157] SHD 1 H 2460/d.1. '*Sur le problème de la mentalité des Musulman',* 1 June 1959.
[158] These experts included Professor Philippe Marçais, the French Arabist and politician, and Professor Louis Massignon, an influential Catholic scholar of Islam and pioneer of Catholic-Muslim mutual understanding.
[159] Fanon, *A Dying Colonialism*, p. 138.

this case Islam. Unlike their Kenyan counterparts, however, the Algerian psychiatrists did not advertise their associations with the government to the same extent as Leakey and Carothers. Nevertheless, the link between their views of North African psychology reveals something of the extent to which the Algiers School participated in the military's psychological warfare campaigns. Although the military had learnt the value of mass detention through their experience in Indochina, their use of it on the Algerian population took on a specific local flavour through their collaboration with these psychiatrists.

Conclusion

This chapter has argued that the postwar confidence in the power of psychiatrists, psychologists, sociologists and anthropologists to explain and 'treat' a plethora of social issues, combined with the paranoia induced by the Cold War, placed greater emphasis on the vulnerability of minds to subversive 'brainwashing' and ideological manipulation. These complicated forces came together in an untidy way during the wars for liberation in Kenya and Algeria, where the counterinsurgency strategies of the respective colonial security forces were given a scientific veneer by ethnopsychiatrists and anthropologists to help legitimise them. As such, the British and French governments were able to explain away the political grievances of the Kikuyu and the Algerians by identifying them as religiously insane and mentally unstable. While Mau Mau initiates were understood to be suffering from collective epidemic hysteria brought on by the stresses of the modern world, the Algerians who joined the ranks of the FLN were expressing an innate criminal impulsiveness rooted in Islam. Typically regarded as inherently violent and criminal, these older stereotypes about Muslim behaviour were updated to represent the terrorist as religiously radical murderers, something that is reminiscent of the stock image of the terrorist in the modern War on Terror.

While both the British and French colonial forces relied upon the expertise of psychiatrists to inform their responses to their respective insurgencies, the extent to which these practitioners

collaborated with the government varied. In Kenya, Leakey and Carothers were far more open in their support and cooperation than their French colleagues were, as they both published accounts of their explanations and advice for public consumption. Although the Algiers School of ethnopsychiatry did not publicise their role in the counterinsurgency efforts against the FLN, the long existing links between the School and the French military meant that their research and views found a close affinity with the latter's aims. Evidence even demonstrates how Porot and his colleagues worked with the military in the detention camps in an effort to research techniques for rehabilitating FLN supporters.

As such, these scientists not only promised to diagnose the rebellious condition, but they also offered new weapons against the enemy mindset. In Kenya, this would take the form of the government's 'rehabilitation' programme designed specifically to remove the 'disease' of Mau Mau from the misled and corrupted Kikuyu population, while in Algeria, the French military would wage their *guerre psychologique* (psychological warfare) against the terrorists and the population in order to break down and recreate new French-Muslim citizens. In both cases, extensive systems of detention centres and resettlement villages were used to separate the indigenous population from the guerrillas, who were then subjected to 're-education', a blend of psychological and physical coercion techniques used to 'shock' them into subservience. Every aspect of life within these totalistic environments, from the availability of food, the supply of medical care, access to reading material, news or correspondences with family loved ones, was carefully monitored and administered to help break down the detainees' psychological resistance and political allegiance. As such, this chapter provides a foundation for understanding the coercive activities, including the systematic use of torture, to be discussed in subsequent chapters. The ultimate aim of these counterinsurgency programmes was to create new model subjects who respected colonial rule; but in conflicts regarded as wars for the survival of empire as well as western ideals, those responsible for creating these new citizens would use any methods they could.

Chapter 3. 'The torturer who happened to be a doctor': settler doctors, counterterrorism and colonial violence

This chapter is about violence. Specifically, it is about violence perpetrated by European doctors living and operating in Kenya and Algeria during their respective emergencies. At the time when the rebellions first erupted, none of the doctors mentioned in this analysis were involved with the military or colonial security forces. Many, if not all of them, were operating as private practitioners within their local settler communities—though admittedly some in the Algerian context had gained military experience during the Second World War. Yet once the colonial conflicts were under way, some physicians within the settler communities in both colonies either joined official counterinsurgency efforts, meted out their own forms of vigilante violence or actively organised militia groups to undertake counterterror activities to further their own political goals. The fact that they were members of the medical community thus appears, at first glance, to be incidental.[1] Indeed, a shallow assessment of these cases might conclude that the perpetrators were simply bad apples. Yet, as contended here, the number of doctors implicated in, or responsible for, organising and sometimes actively participating in acts of brutality and terrorism is sufficient to warrant a deeper reading of the situation. Why was it that so many European doctors feature in incidents of violence during these wars, especially in Algeria? Were their actions spontaneous and novel or were they characteristic of a type of violence that had a deeper history in the colonies? Moreover, were doctors swept up in the frenzy, becoming reluctant collaborators or did they play a more active role in leading settler opinion?

A thorough answer must take into consideration the position and status of doctors within colonial settler communities, as well as the conditions and pressures created by the emergencies in both contexts. These men of science (for they were all men in this instance)

[1] The title of this chapter comes from *A Dying Colonialism*, where Fanon tried to explain how European doctors in Algeria would become torturers. See Fanon, *A Dying Colonialism,* p. 135.

were often prominent figures among the settlers. They also personified a particular set of masculine and 'heroic' characteristics that made them ready for action. Once the settler communities felt sufficiently threatened by the insurrectionists, these doctors, with their personal stakes in the colonial *status quo*, were never likely to challenge the culture of permissible violence unleashed by the emergency conditions. However, while there is evidence that civilian physicians perpetrated violence in both contexts, the case is stronger for Algeria where there is a greater variety of documents revealing the extent to which these individuals took-up arms during the conflict. This violence took on a specific form which highlights a set of political and social factors absent from the Kenyan case. An examination of the doctors involved in civilian counterterrorism in the French colony reveals the existence of a network of extreme right-wing doctors that extended from Algeria to Paris. These individuals expressed a type of deep-rooted ultra-right-wing and separatist political belief that had been present in the colony since its early days. But, as argued here, it was the conditions created by the emergency that crystallised their existing attitudes and provided an opportunity for action.

The material presented in this chapter is subdivided into two parts. The first part introduces a series of case studies from Kenya and Algeria, where doctors were embroiled in violent situations where acts such as torture, beatings or terror took place. Here the discussion focuses on the types of activities performed and how these reflect wider settler attitudes towards the respective colonial authorities and their counterinsurgency methods. The second part of this chapter places these case studies within wider scholarly discussions regarding doctors as settlers in the colonies as well as the factors that might have led them to take part in such violence. The aim is to show that through the interactions and responses of the doctors involved in violence, the historian can identify and measure tensions between individual groups and the state in times of crisis. In either contexts, the impetus for vigilantism or the recourse to brutality appear to have been inspired by a sense of vulnerability and a deep-set fear that had been present among the settlers since the earliest days of the colonies. A fear that

the numerically greater indigenous masses would rise up to displace them while the colonial authorities would fail to defend their interests. Ultimately, this fear led prominent members of the settler communities to take the law into their own hands.

3.1. Kenya: intelligence, screening and abuse

Before examining the cases where British doctors were involved in abuses in Kenya, it is worth returning to a point raised in the introduction to this thesis; that the nature of violence in Kenya was not static but evolved over time in relation to the changing nature of the Emergency more generally. During the early years of the Emergency, most accusations of torture and abuse tended to focus on the actions of the screening teams established to gain operational intelligence from Mau Mau suspects working on European farms. Later, this would develop into a type of coercive and often violent effort to extract the types of confessions mentioned in the previous chapter. Officially, screening was 'a process to obtain or extract a confession by intensive interrogation from a multiple of facts and based on a promise of clemency if the confession be judged full and a veiled threat of reprisal if it be not so considered'.[2] In reality, this 'veiled threat' often gave way to outright brutality and torture. Caroline Elkins claims that the Kikuyu who experienced Kenya's detention camps continue to use the English word 'screening', as no Kikuyu or Kiswahili word captures the terror it invokes for them.[3] It was only after 1956, in the second phase identified by Anderson (as discussed in the above), that torture became institutionalised within certain detention camps. At this point, as Anderson notes, a 'codified regime of violence' was introduced to break the hard-core Mau Mau, a method known as the dilution technique.[4] The subject of torture will be addressed in the next chapter; for now, it suffices to note that, prior to 1956, there is no evidence that the government sanctioned systematic violence, though they were certainly

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[2] TNA FCO 141/6521/12, p. 2. Sir Vincent Glenday, *Inquiry into Screening Camps and Interrogation Centres Under the Control of the Provincial Administration*, 1955.
[3] Elkins, *Britain's Gulag*, p. 62.
[4] Anderson, 'British abuse and torture in Kenya's counter-insurgency' (p. 701).

aware of its existence.[5] Instead, during this early phase, the situation in Kenya was marked by a persistent atmosphere of panic among the white community and a feeling of improvisation.[6]

Once the Emergency was underway, the colonial authorities started a process of mass deportation of Kikuyu to the reserves in early 1953. A series of screening centres were established throughout the Rift Valley and Central provinces to process this population.[7] Local settlers and colonial officers channelled thousands of Kikuyu through these centres, where the repatriates were subjected to intense interrogation that could last for days. Responding to the insurgency threat in a way that mirrored the principal aims of counterinsurgency theory, Governor Baring and the new commander in chief, General George Erskine, ordered their men to screen Mau Mau suspects for any useful counterterrorism information. Such information included the locations, strength and armament of gangs; names of gang leaders; gang tactics; methods of obtaining food and the sources of contact on farms; routes used by the gangs; locations of hideouts; their morale and future intentions; and any information as to the type of propaganda circulated by Mau Mau leaders for the benefit of their followers.[8] In addition to obtaining intelligence, screening aimed to separate anyone with any degree of Mau Mau affiliation from otherwise 'loyal' Kikuyu, thus reducing the population pool in which the insurgents could hide. Interrogation was thus a valuable means for obtaining this information, but it was not to be conducted indiscriminately. In July 1953, a secret memorandum was circulated among the security forces, which 'lay down the procedure for handling and interrogating Mau Mau prisoners and surrendered personnel taken by the military units'.[9] According to this document, interrogation was to take place as soon as possible after capture in order to capitalise on the detainee's low morale. The goal of interrogation was to be limited

[5] Ibid. (pp. 700-701).
[6] Rosenburg and Nottingham, *The Myth of "Mau Mau"*, p. 292.
[7] Elkins, *British Gulag*, p. 63.
[8] TNA FCO 141/6750/55/1. Special Branch, 'Notes for Screening Teams', 23 October 1953.
[9] TNA WO 32/21721. Secret Report, 'Operational Intelligence Instructions: Prisoner Interrogation', July 1953.

to obtaining 'information which will assist current local operations'. Importantly, the use of 'violent methods', it stressed, 'seldom produce accurate information'.[10]

Official instructions notwithstanding, the reality of screening was often violent and brutal. This likely had much to do with the types of people employed as screening officers. Given that the British had a policy of avoiding martial law in their states of emergencies, as mentioned above, the situation in Kenya remained a civil affair for its duration.[11] Although military personnel were conscripted to fight the insurgents, a critical role was assigned to the local police and the Kenya Police Reserves, whose ranks were bolstered by willing European settlers and overseas recruits at the start of the Emergency. These officers would work with members of the Kenya Home Guard, who consisted of teams of Tribal Police and loyalist Kikuyu who formed anti-Mau Mau militias. The so-called 'screening teams' responsible for carrying out the interrogations were formed out of a mix of these groups. While the Home Guard and loyal Kikuyu often used screening as an opportunity to settle old scores or fulfil personal vendettas against other Africans, the settlers involved in the security efforts brought with them their own attitudes, paranoia and views on how to handle Mau Mau suspects. In a short time, the overseas officers came to share these sentiments.[12]

The settlers involved in the screening process often turned to extreme forms of violence that drew on older practices of punitive violence. This type of violence, described by Matthew Hughes as the 'banality of brutality', consisted of collective punishments, corporal and capital sentences, coercive interrogation techniques and the denial of basic standards of human rights by the colonial security forces.[13] This was coupled with an ingrained racial prejudice about African savagery, a belief that Africans had a limited capacity to feel pain, and a new sense of

[10] Ibid.
[11] French, *The British Way in Counter-Insurgency*, p. 74.
[12] James B. Wolf, 'Asian and African Recruitment in the Kenya Police, 1920-1950', *The International Journal of African Historical Studies*, 6 (1973), 401-412 (p. 403).
[13] Matthew Hughes, 'The Banality of Brutality: British Armed Forces and the Repression of the Arab Revolt in Palestine, 1939-39', *English Historical Review*, 124 (2009), 313-354.

vengeance inspired by Mau Mau's attacks on Europeans. For these 'interrogation specialists', violence was the quickest and most effective means for achieving their ends.[14] The 'third-degree', a euphemistic term for abusive interrogation that was commonplace in Kenya, became more frequent. The settler, D. H. Rawcliffe, expressed this best when he noted that, in 'the first months of the emergency the beating of prisoners and suspects became almost a routine measure if it was thought that information was being withheld'.[15] Not only did every member of the security forces know of it, they also spoke about it and often ordered or participated in it themselves.[16] The pervasive opinion, Rawcliffe suggested, was that 'the only way to counter the terror of Mau Mau was by even greater terror'.[17] While the need for pertinent information was meant to be the ultimate aim of interrogation, many members of the security forces engaged in extreme acts of cruelty for their own purposes. Prisoners were often left to die in their cells, were shot for no reason and abused more generally. Even the Christian missionary societies were aware of the brutality taking place in screening centres, such as the one at Thomson's Falls, which they called a 'cruelty camp'.[18]

But one reason why abuses frequently took place was the widespread fear that the colonial authorities were not handling the situation efficiently. One settler, Christopher Todd, explained in his memoir how he and other farmers in the Naivasha area had become so 'exasperated by the lack of action taken by Government to suppress the menace' that they formed a Vigilance Committee 'to take the law into their own hands for the purpose of protecting the lives of their families should the occasion arise'.[19] Rather than disband this group of vigilantes, Governor Baring absorbed them into official structures in order to offer them the same kind of legal protection afforded to the police.[20] For the government, as Geraint

[14] Klose, *Human Rights in the Shadow of Colonial Violence*, p. 174.
[15] D. H. Rawcliffe, *The struggle for Kenya* (London: Victor Gollancz ltd, 1954), p. 68.
[16] Ibid.
[17] Ibid.
[18] Quoted in Elkins, *Britain's Gulag*, p. 63.
[19] Christopher Todd quoted in Elkins, *Britain's Gulag*, p. 64.
[20] Ibid.

Hughes notes, such militias provided a cheap and ultimately deniable means for combating the insurgents.[21]

In addition to the official screening camps, there were dozens of illegal or unregistered screening centres throughout the Rift Valley and Central provinces being operated by settlers. According to Elkins, one particularly notorious camp was run by a 'Dr. Bunny'.[22] Using oral testimonies from a settler whose brother, a member of the Kenya Regiment and a 'pseudogangster',[23] had boasted of Bunny's techniques, and another from a member of the local Moral Rearmament Movement, Elkins explains how Dr. Bunny earnt the nickname 'the Josef Mengele of Kenya'.[24] According to these reports, Dr. Bunny had 'experimented' with interrogation techniques that included burning the skin off Mau Mau suspects and feeding them their own testicles.[25] Yet these are the only fragments of evidence provided by Elkins in support of these claims. Since the publication of *Britain's Gulag*, Dr. Bunny's misdeeds have been cited by several subsequent scholars, but few have added additional information to the case. This is largely because of the paucity of the available documentation, but a question remains as to whether this is just hearsay.

There was indeed a Dr. Reginald S. Bunny in the Naivasha area of Kenya at this time. He was a missionary for the Bible Churchmen's Missionary Society (BCMS), who owned his own farm, ran a local practice and appears to have served as a Colonial Medical Officer in Naivasha, or had at least partaken in official medical business for the government prior to and throughout the Emergency.[26] In 1951, the BCMS arranged for Bunny and his wife to move to

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[21] Geraint Hughes, 'Militias in internal warfare: From the colonial era to the contemporary Middle East', *Small Wars and Insurgencies*, 24 (2016), 196-225 (p. 202).
[22] Elkins, *Britain's Gulag*, p. 67.
[23] Pseudogangsters were teams of Mau Mau defectors who had been 'turned' to support the colonial forces. They would usually be led by European officers who disguised themselves as Africans in order to infiltrate Mau Mau forest fighters.
[24] Ibid.
[25] Ibid.
[26] Jonathan M. Hansen, *Development at the Margins: Missionaries, the State, and the Transformation of Marsabit, Kenya in the Twentieth Century* (Unpublished thesis: Vanderbilt University, 2015), p. 141.

Marsabit in north Kenya, but the elderly doctor suffered a series of health issues that prevented him from completing the journey. Subsequently, these health issues caused him to retire from the BCMS and to return to England, but this was not until the 1960s.[27] While living in Naivasha, Bunny was appointed to the Naivasha Township Council and had developed a good reputation among government officials. Among his duties was the examination of recruits called-up as a result of the 1951 Compulsory Military Training Ordnance, as well as serving as an Official Visitor to the Naivasha Prison for the purpose of the Prisons Ordnance.[28] In addition to this, he also provided medical assistance to the Kenya Police Reserves in the district at the beginning of the Emergency, alongside a Dr. Campbell and a Dr. Lockwood.[29]

It is currently unclear whether there is any additional information surrounding Dr. Bunny and his time in Kenya. How then are historians to respond to this dearth of information regarding an individual charged with such extreme violence? The written evidence does not offer any new insight to support or detract from the oral evidence Elkins offers in her book, but leaves us with accusations by two contemporaries, one of which is recorded as anonymous. It is not necessarily surprising, however, that such evidence is missing given that, as Rawcliffe noted at the time, '[t]here was a tacit conspiracy involving the Kenya Government, the police and the Press not to reveal or even hint at anything which the outside world would term acts of brutality or callous behaviour towards the Kikuyu'. Efforts to hush-up incidents of indiscriminate shootings and flogging of suspects were, he says, 'surprisingly successful'.[30]

Given the depth of official denial and cover-up that took place in the Kenya Emergency, as discussed in the introduction of this thesis, it is possible that details of Bunny's alleged atrocities may not appear in any surviving official records. Moreover, as it seems Bunny's

[27] Ibid., pp. 141-142.
[28] See 'The Compulsory Military Training Ordinance, 1951', *The Kenya Gazette*, 18 August 1959, p. 910; and 'The Prisons Ordinance (Cap.78)', *The Kenya Gazette,* 23 September 1958, p. 1091.
[29] KNA MSS/128/23/315. Anonymous, 'K.P.R. Doctors', c. 1954.
[30] Rawcliffe, *The struggle for Kenya*, p. 68.

supposed activities took place in the Naivasha countryside, there may have been fewer witnesses to make substantial reports. Despite this, these oral testimonies still have some value, even though Elkin's own work in *Britain's Gulag* fails to provide much in the way of a discussion of the methodological limitations associated with such evidence. In the cases of extreme political violence, oral statements like these may provide additional clues to incidents that do not appear in the public domain. In this case, it is interesting that the testimonies provided by Elkins came from two Europeans and not from Kikuyu involved in the uprising. Nevertheless, their trustworthiness remains unclear. Regardless of the complex debates surrounding alleged cases like that of Dr. Bunny, there are other doctors whose involvement in Kenyan counterinsurgency are accompanied by documentary evidence but are nevertheless still ambiguous.

One such case relates to Dr. Michael Wood (later Sir Michael Wood).[31] In his memoir, *Going An Extra Mile*, Dr. Wood provides a personal account of his family's experience as amateur farmers as well as of his personal efforts to establish the flying doctors service in Kenya in the late colonial and early post-independence years. As useful as his memoir is for contextual information regarding the life of a European doctor in Kenya, the subject of the Emergency receives little mention.[32] While Dr. Wood's account is laconic, Susan Wood, his wife, provides greater insight into the family's experience of (and involvement in) the troubles. In her own memoir, *A Fly in Amber*, Susan Wood presents the Emergency as a time of pervasive unease and threat: 'During the years that followed [the start of the Emergency] we were often to feel the effect of suspicion and mistrust in our community and the compulsions of widespread fear'.[33] 'The tension waxed and waned', she explained, 'we learnt to live with elaborate

[31] Dr. Wood was the founder of the Kenya Flying Doctors, later to become the African Medical Research Foundation (AMREF).

[32] Dr. Wood makes one quick reference to the Emergency when he states that 'Kenya managed to come through the sound barrier remarkably unscathed despite a rebellion and other hazards along its path'. Michael Wood, *Going An Extra Mile: The adventures and reflections of a flying doctor* (London: Collins, 1978), p. 32

[33] Susan Wood, *A Fly in Amber* (Nairobi: Kenway Publications, 1997), p. 55.

precautions of lock and key, and ultimately we put away our guns fearing that they might be a reason for attack'. One interesting, if unelaborated, comment that Susan includes in her account is that, in the early stages of the Emergency, the Wood's farm 'was chosen as the base for a police post which patrolled the area'.[34]

This is the only mention of the police base in Susan's memoir. It tantalises the reader by raising a host of questions about the everyday activities taking place at the post, as well as the daily interactions between the Wood family and their temporary guests. Thanks to the official records contained in the Hanslope Disclosure, it is possible to get around Susan's obvious reticence. We thus learn not only that the Wood's farm was indeed the site of a police base, called Section 9A Police Post, but also that Dr. Wood himself was a member of the KPR at this time.[35] This is a detail that is absent from both Michael and Susan's memoirs and subsequent biographies of their lives in Kenya. It is (to say the least) curious that such unusual events as the presence of Section 9A Police Post and Dr. Wood's role as temporary police officer during one of the most politically turbulent periods in the colony's history should be so omitted from their memoirs. Put differently, given their efforts to portray themselves as progressive settlers, why did they not explain this otherwise extremely interesting situation if there was nothing to hide? Perhaps a reason for this omission is because both the police base and Dr. Wood were implicated in reports of violence that were becoming common elsewhere in Kenya at this stage in the Emergency.

At the start of June 1953, Mwangi Kiruthi, a suspected Mau Mau supporter, was taken to the post on the Wood's farm by 'an enthusiastic [KPR] Officer' called Mr. Bryson. Mwangi spent two nights in custody. On the second day, Mwangi claims to have been screened by Headman Jusu Mureme, Sub-Headmen Shadrack Njuguna and others. Later, he received four strokes to

[34] Ibid., pp. 54-55.
[35] TNA FCO 141/6167/36/1. 'Statement made by Mwangi s/o Kiruthi' recorded by P.D. McEntee, 8 June 1953.

his back and was extorted thirty shillings.[36] Although Mwangi admitted that the strokes were not hard and that he was wearing a 'greatcoat' at the time, a medical report compiled four days later by Dr. R. MacFiggins indicated that there was 'evidence of marking on the right side of the back, consisting of a vertical mark about [three inches] long and [one inch] broad' and 'on the left side of the back there is a short indistinct marking, also vertical'. MacFiggins concluded that 'These marks are in accordance with the markings caused by a whip'.[37] Conceding responsibility, the District Officer paid Mwangi fifty shillings as compensation for his ill treatment, not as recompense for this stolen money.[38] Mwangi's case situates abusive interrogation directly on the Wood's farm. At the same time, in the Uplands area, on the 26 June 1953, sixty railway employees were screened and allegedly assaulted by a screening team made up of members of the Kikuyu Home Guard under the direction of Reserve Police Officer (RPO) Wood. Mr A. H. Twohey, Permanent Way Inspector in Uplands, reported that the railway workers returned with complaints of beatings, some even needing first aid before being sent to the hospital for further treatment.[39] The 'two European Police Officers', of which Wood would have been one, with the Home Guard and Chief Makimei, lined up all the railway workers and 'beat them to try and obtain information' about a murder that had recently taken place at Uplands. An identifying parade was carried out but the identifying witness failed to initially pick anyone out. He was subsequently beaten until he 'picked out three Railway employees' who were then arrested and detained.[40]

According to a report by H. R. Walker, the Senior Superintendent of Police, Wood gave a statement that he had 'noticed the screening team employ certain methods to extract

[36] Ibid.
[37] TNA FCO 141/6167/9/2. R. McFiggins, Medical Officer, General Dispensary, 'Ref: Mwangi Kiruthi', 8 June 1953.
[38] TNA FCO 141/6167/36/p. 1. District Officer, Kiambu to the Officer of the District Officer, Chura Division, 'Reply to the statement of Mwangi s/o Kiruthi', 28 August 1953.
[39] TNA FCO 141/6167/18/1. H. R. Walker, 'Assaults on railway employees—Kitjab, 26.6.53', 2 July 1953.
[40] TNA FCO 141/6167/18/2. H. R. Walker, 'Assaults on railway employees—Uplands'.

information from people who refused to talk'.[41] The methods in question consisted of making a man place his fingers on the ground and then walk around in circles, presumably to disorient them, and the use of stress positions where a suspect would be forced to squat 'with his hands through his legs holding his ears'. Woods, the report claims, had insisted that these techniques were only used for minutes at a time and that he had personally intervened to stop the screeners from forcing suspects to carry heavy boulders above their heads. Ultimately, RPO Wood stressed, 'at no time did he see any of the people being screened, being assaulted or beaten by the screening teams'.[42]

That RPO Wood and Dr Michael Wood were the same person is confirmed beyond doubt by a hand-written complaint available in the Kenya National Archives. The document in question also accuses Dr. Wood of being present when screening violence was taking place on his own farm. According to the complaint:

> [F]or two weeks passed, an [*sic*] European K.P.R. officer known as Dr. Wood [...] with assistance of Headmen and members of home guard [...] have been arresting people and took them to Dr. Wood's home, where a detention camp have been allocated and there people are beaten, some even to death, and made to confess that they are Mau Mauists and that they have taken the oath.[43]

The complainant continues to explain that in 'the so allocated camp there is a court of which Dr. Wood is the President; those who admit that they have taken the oath are asked to pay fines amounting from thirty shillings to sixty shillings'.[44] Interestingly, this was the same

[41] TNA FCO 141/6167/21. H. R. Walker, 'Assault on railway employees by members of the home guard—Uplands area', 14 August 1953.
[42] Ibid.
[43] KNA MAC/KEN/33/6. Anonymous, the document is heavily damaged but it has a heading line that reads 'In the Chura Division of Kiambu District Detainees Homes Destroyed with fire. People Are Made To Confess That They Have Taken Oath in a Point of A Gun'.
[44] Ibid. Though it is admitted that receipts were given after these fines were paid.

amount of money Mwangi Kiruthi was charged during his interrogation, though this subsequent allegation admitted that receipts were given after these fines were paid. Although these allegations are insufficient to accuse Dr. Wood of being violent himself, they certainly demonstrate that Dr. Wood was, at a minimum, a direct witness of the violence being used to force confessions from suspects, and that he knowingly permitted such acts—which he himself may have personally organised—to take place on his property.

The extent of the abuse discussed in this section relates specifically to doctors taking on roles that were completely separate to their professional ones. They were not acting in a medical capacity but as private citizens who undertook violence within a normative framework shaped by the abusive acts that were taking place across the colony in response to Mau Mau. This was a form of violent interrogation designed to extract information and confessions from Mau Mau suspects. Like other settlers-turned-inquisitors, Wood, and possibly Bunny, may have believed their own methods were more effective than those prescribed by the government. Indeed, the accusation that Wood presided over an unofficial court on his property suggests that he was not only willingly committed to the counterterrorism efforts, but happy to embellish these punitive practices with creative flare. The example of Bunny and Wood, in other words, show that these doctors were parties to a climate of violence performed by other settlers—settlers who feared that the Government's stance was too soft, slow and unequal to the task of defeating the enemy. Although the official response of the colonial administration was not to support such activities, they nevertheless were aware of their existence. The cases to be examined in the next subsection provide a counter-example: in Algeria, the doctors involved in violence undertook a campaign of terror and aggression against *both* the FLN and the French authorities themselves.

3.2. Algeria: bazookas and barricades

While evidence relating to the doings of Kenyan doctors during the Emergency has only recently come to light, the Algerian scenario is quite different. The cases discussed in this

section were not only reported in the French metropolitan media at the time, they were also picked-up by the international press. In fact, the situation was so noteworthy that it led the historian Alistair Horne to state, in his famous *A Savage War of Peace*, that 'One of the more curious and less easily explained sidelights of the Algerian war was the presence in its more violent aspects, on both sides, of so many from a profession dedicated to the saving of human life'.[45] Consequently, the cases in this section have a higher profile than their East African equivalents, even though this does not mean their details are necessarily clearer. A veil of secrecy still surrounds certain aspects of the events and the people involved. Nevertheless, they highlight deep tensions within the Algerian colony between the settlers, the medical community and the French government in Paris.

The media attention these cases attracted reveals another important distinction between the Kenyan and Algerian contexts: the cases discussed here all took place in an urban environment. Unlike in Kenya, where the majority of the reports concerning doctors and abuse came from rural areas and settler farms, the Algerian War itself was initially an urban guerrilla war. From the beginning, French military success forced the revolutionaries on the defensive in 1954-1956. In response, the FLN took to the network of convoluted alleyways and narrow streets of Algiers, where they waged an urban terror campaign. The French military responded with swift and brutal action. The notorious 10th Colonial Parachute Division, commanded by General Jacques Massu, took over the city *manu militari*. The Muslim population in the Casbah area, in particular, were subject to constant patrols, house-to-house searches and armed checkpoints. It was within this environment that Algiers became a battle zone in 1956-1957 and witnessed the systematic use of torture by 10th parachutists.[46] By September 1957, the FLN had been defeated in Algiers, which turned the conflict towards the rural areas.[47] The subject of the military's use of torture will be discussed in greater detail in the next chapter,

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[45] Alistair Horne, *A Savage War of Peace*, p. 350.
[46] Branche, *La torture et l'armée pendant la guerre d'Algérie*, pp. 165-205.
[47] Ian F. W. Beckett, *Modern Insurgencies and Counterinsurgencies: Guerrillas and their Opponents since 1750* (London and New York: Routledge, 2001), pp. 162-163.

but for now it is worth noting that their presence in the capital was supported by willing members of the *pieds-noirs* community. These Europeans, like their Kenyan counterparts, were ready to fight against the nationalists themselves. Some proved even willing to challenge the French authorities when they saw fit.

On 16 January 1957, the office belonging to General Salan, the then Commander-in-Chief of the French forces in Algeria, was hit by a rocket fired from a 'homemade' bazooka. Although Salan was absent at the time, his Chief of Staff, Major Rodier, was killed in the blast.[48] Remarkably, this act of terrorism was not perpetrated by members of the FLN, but rather by European settlers living in Algeria. The bazooka had been fired by Philippe Castille, a member of *L'Organisation de la résistance de l'Algérie française* (ORAF), a clandestine 'counterterrorism' group led by a Dr. René Kovacs. Kovacs was of Hungarian heritage but was born in Algeria and had served as a medical officer in an infantry battalion during the Italian campaign in the Second World War.[49] According to Paul Aussaresses, a French army general involved in the Battle of Algiers, Dr. Kovacs was of the opinion that General Salan would, sooner or later, favour independence for the Algerians. The fear of losing the standard of living they enjoyed in Algeria had led Kovacs, who Horne describes as being 'passionately attached to Algeria', and his group to turn to terrorism in order to protect it.[50] Kovacs himself played a direct role in the plot to kill Salan. As Aussaresses tells us, Kovacs wanted Salan shot with a '24-29 automatic rifle', but Castille was able to persuade him that this was 'absurd and that the best weapon would be an offshoot of the Panzerfaust',[51] a single shot anti-tank missile developed by the Germans in the Second World War. It was a crude home-made version of this weapon that was ultimately used against Salan.

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[48] Anonymous, 'Un chef de groupe contre-terroriste Rene Kovacs, est arrete à Alger', *Le Monde*, 31 January 1957. < https://www.lemonde.fr/archives/article/1957/01/31/un-chef-de-groupe-contre-terroriste-rene-kovacs-est-arrete-a-alger_2331380_1819218.html> [Accessed 25 March 2018].
[49] Aussaresses, *The Battle of the Casbah*, p. 109.
[50] Horne, *Savage War of Peace*, p. 182.
[51] Aussaresses, *The Battle of the Casbah*, p. 11.

The ‘bazooka affair’, as it became known in the international press, attracted significant attention. As mentioned above, this was in contrast to the situation in Kenya, where news about the atrocities and violence carried out by colonial doctors appears to have been successfully censored. Although some reports of abuse more generally did reach the British public, by and large, these had limited impact for most of the conflict. The situation only changed towards the end of the Emergency, when reports of the Hola Camp massacre reached public attention and led to an impassioned response.[52] French civil and military authorities also sought to put the lid on the violence that accompanied ‘counter-terrorist operations’ for ‘security reasons’, though their efforts were frequently frustrated by their anticolonial opponents who exposed the extent of violent practices in Algeria and Paris to international opinion. As noted in Chapter 1, the FLN managed to gain far greater attention to their plight than the internationally isolated Mau Mau could.[53] Thus it was that details of the bazooka affair were reported across the western world, despite efforts from the French authorities to conduct the subsequent military trial behind closed doors.

Initially, Kovacs insisted that his aim was only to intimidate Salan with the bazooka attack and that he had no intention of assassinating him. However, in a statement made after his arrest, Kovacs explained that he had sought to replace General Salan, who was deemed ‘too soft’, with General Cogny, a former commander of French troops in Morocco, who—Kovacs surmised—would impose a military dictatorship in Algeria upon arrival.[54] The plot, according to Kovacs, was so imbedded in intrigue that even high-profile politicians such as Senator Michel Debré, Minister of Justice in 1958 and later prime minister, were implicated.[55] The

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[52] Eric Linstrum, ‘Facts about Atrocity: Reporting colonial violence in postwar Britain’, *History Workshop Journal*, 84 (2017), 108-127 (p. 108).

[53] Matthew Connelly, *A Diplomatic Revolution: Algeria’s Fight for Independence and the Origins of the Post-Cold War Era* (Oxford: Oxford University Press, 2002), part 3. Raphaëlle Branche and Jim House, ‘Silences on State Violence during the Algerian War of Independence: France and Algeria, 1962-2007’, in Efrat ben-Zeer, Ruth Ginio and Jay Winter (eds.), *Shadow of War: A Social History of Silence in the Twentieth Century*, (Cambridge: Cambridge University Press, 2010), 115-137 (p. 116).

[54] Anomalous, ‘Former Commander as Witness: “Plot” Allegations Denied’, *The Times*, 14 October 1958, p. 9.

[55] A transcript of Kovacs’s confession was published in Raoul Salan, *Mémoires: Fin d'un Empire*, vol 3, Algérie Française (Paris: Presses de la Cité, 1972), p. 113. Kovacs also allegedly produced a

military trial, which started in July 1958, continued to attract significant international attention and provoked protests from the French press due to repeated delays. For them, there was much at stake. According to an article published by *Le Monde* on 24 July 1958, 'the trial of the assassins of Commander [sic] Rodier' was 'more than a legal action'. It was 'a test of moral significance', a 'matter of knowing whether or not the life of a French superior officer [had] the same value depending on whether the murderer and his accomplices [were] of Muslim faith or not'.[56] Their chagrin was aimed at the complacency with which counterterrorism violence had routinely been ignored by the French authorities. Kovacs attended the trial briefly before being excused from proceedings on medical grounds. Allegedly, he was suffering from an unspecified skin disease that required surgery and a period of convalescence.[57] Kovacs then fled to Spain after being granted bail. In his absence, his five accomplices accused him of having masterminded the plot and that he had spoken of a mysterious and powerful 'committee of six' who would bring General Cogny to Algeria once Salan had been 'removed from office'.[58] Although these allegations did not result in any members of this supposed committee being prosecuted, Kovacs's five accomplices were sentenced to terms of imprisonment and hard labour. Kovacs himself was sentenced to death *in absentia* and remained abroad for the rest of the war.[59]

Dr. Kovacs and the bazooka affair have only received glancing attention from historians discussing the Algerian War; they remain curious footnotes demonstrating the chaotic nature

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second confession while in prison which was published by André Figueras in his *L'Affaire du Bazooka*. The extent to which either of these documents can be trusted is unclear, though. As Stuart Van Dyke notes, 'These documents are undoubtedly genuine, though what they contain is not necessarily' so. See Stuart Van Dyke, 'The Bazooka Affair: Preview of May 13th, 1958?, *Proceedings of the Meeting of the French Colonial Historical Society*, 6 (1982), 129-135 (p. 130).

[56] Anonymous, 'La principal accusé s'est fait opérer', *Le Monde*, 19 August 1958. <https://www.lemonde.fr/archives/article/1958/08/19/le-principal-accuse-s-est-fait-operer_3144896_1819218.html> [Accessed 19 March 2018].

[57] Ibid.

[58] Anonymous, 'Military Court "Cheated" by Dr Kovacs's counsel', *The Manchester Guardian*, 9 October 1958, p. 11.

[59] Kovacs had first mentioned the Committee of Six during his confession to the police. The most prominent members of the Committee were the aforementioned Debré, as well as Pascal Arrighi, a Gaullist deputy from Corsica; General René Cogny, commander-in-chief of French forces in Morocco; and Alain Griotteray, a reserve captain.

of the struggle taking place at the time. This is especially true outside of France. Horne described the affair as ‘one of the most mysterious and shadowy episodes of the whole war’.[60] He concluded that the violence revealed ‘the profound malady and disaffection’ at ‘the heart of the French army, extending to the higher reaches of the Fourth Republic itself’.[61] Yet this focus on the military fails to tackle the obvious question of why a European doctor was the ring leader for the events that took place. Indeed, this point was never addressed by the press or subsequent investigations into the affair. In *L'affaire du bazooka*, the journalist André Figueras suggested there were suspicions at the time that Kovacs was actually in league with Soviet intelligence operating in East Germany.[62] However, there is little evidence to suggest this was the case. Nevertheless, this claim demonstrates the level of confusion surrounding this individual and his role in the assassination attempt. Regardless of whether or not Kovacs had conspired with members of the French political elite, he still felt sufficiently attached to *Algérie Française* to disregard the ethical standards of the healing profession. Like his counterparts in Kenya, he had acted in a private capacity as a colonial citizen willing to commit murder. Although, in this instance, Kovacs's violence was strategic, part of a broader right-wing revolutionary plot, the same doctor also appears to have indulged in more mundane acts of brutality aimed at rebel suspects.

In 1963, Pierre Vidal-Naquet, the French historian famous for exposing incidents of torture during the Algerian War, accused Kovacs of operating a private torture chamber in the Villa des Sources, a suburb of Algiers. Before being arrested in the bazooka affair, Vidal-Naquet claims, Kovacs had been part of a supplementary police force that would later become part of the *Dispositif de Protection Urbaine* (DPU), a European militia that practiced abuse with impunity.[63] This group was formally set up in February 1957 by Robert Lacoste, the then Governor General of Algeria, to coordinate the activities of European and Muslim vigilantes

[60] Horne, *A Savage War of Peace*, p. 182
[61] Ibid.
[62] André Figueras, *L'Affaire du Bazooka* (Paris: Déterna Éditions, 1999), p. 15.
[63] Vidal-Naquet, *Torture: Cancer of Democracy*, p. 55.

with the operations of the 10th Paratrooper Division in Algiers. Kovacs was apparently the leader of one of these earlier vigilante groups whose activities played out with no supervision from the military authorities. After all, as Vidal-Naquet stated, '[t]here was no need to supervise the inhabitants of the European areas: it was the Muslims who worked [there] who were subject to constant surveillance'.[64]

It is tempting to regard Kovacs as a lone figure, an anomaly with deeply fanatical beliefs. Indeed, Horne tells us that, when he interviewed Senator Debré at the end of the War, the Senator dismissed Kovacs as having 'hypnotised himself into the false belief that the committee of six had really wanted him to assassinate Salan'.[65] Yet this 'bad apple' type of explanation is not satisfying. It tells us little about Kovacs's motives or his role as a doctor within the settler community. Moreover, it fails to account for why so many European doctors were involved in counterterrorism activities alongside Kovacs.

Dr. Jean-Claude Pérez was arrested and held with Kovacs's five associates on suspicion of being involved in the attack. Although he was not directly involved in Kovacs's mission (Pérez claims that he tried to distance himself from the ORAF, despite his sympathies with Kovacs's cause), he was incarcerated for other counterterrorism activities at the same time.[66] Pérez described himself as a self-styled maverick, a heroic figure who, when faced by the FLN's terror, felt that 'staying passive was not in [his] nature'.[67] According to Pérez's memoir, *Le Sang d'Algérie*, Kovacs and he had known one another for years prior to the bazooka affair. They had trained in the same medical school and even taken the same martial arts classes

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[64] Ibid., pp. 54-55.
[65] Horne, p. 182.
[66] Anonymous, 'L'attentat au bazooka contre l'hôtel de la 10e région militaire', *Le Monde*, 9 February 1957. < https://www.lemonde.fr/archives/article/1957/02/09/l-attentat-au-bazooka-contre-l-hotel-de-la-10e-region-militaire_2327816_1819218.html> [Accessed 12 April 2018]. See See also Jean-Claude Pérez, *Le Sang d'Algérie* (Paris: Édition du Camelot et Édition de la Joyeuse Garde, 1992), p. 123.
[67] Pérez, *Le Sang d'Algérie*, p. 93.

together.[68] Like Kovacs, Pérez was deeply invested in settler society and ascendancy in Algeria and organised one of the first urban counterterrorist units after finishing his national service as a medical officer in 1955.[69] Unlike Kovacs, however, his counterterrorism activities did not end with the bazooka affair.

Following his release from prison, Pérez became recruiting master for the para-military militia attached to the *Front National Français* (FNF), set up by Jo Ortiz, a *pied-noir* restaurant owner. The FNF functioned as an umbrella organisation for other 'ultra' right-wing groups, including 'The Group of Seven'.[70] This group with its barely concealed far-right, pro-authoritarian overtones consisted of characters like Robert Martel, who had already been arrested and released for involvement in counterterrorism activities; Ortiz, the organiser of this belligerent band; and Pierre Lagaillarde, a lawyer in Blida and a hot-headed student leader at the Algiers University. There was also another individual with connections to the medical community in the ranks of the Group of Seven: Dr. Bernard Lefèvre, who was mobilised as a doctor in 1943 but who had turned to homeopathy after the Second World War. He was referred to as the group's 'intellectual' and would play a central role in counterterrorist action to come.[71] Finally, once Ortiz had established the FNF, he was joined by Jean Jacques Susini, a twenty-five-year-old medical student who had studied in Paris before returning to Algeria. Susini was the leader of *Mouvement national des étudiants* (MNE) and became a powerful orator for these bands of European fanatics.[72]

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[68] Ibid., p. 123.
[69] Horne, p. 350
[70] Ibid., p. 349.
[71] J. -M. Theolleyre, 'Le docteur Lefèvre a beaucoup plus parlé de ses théories que des événements du 24 janvier', *Le Monde,* 14 November 1960. <https://www.lemonde.fr/archives/article/1960/11/14/le-docteur-lefevre-a-beaucoup-plus-parle-de-ses-theories-que-des-evenements-du-24-janvier_2095659_1819218.html> [Accessed 6 January 2019].
[72] See Jacques Frémeaux, 'Les barricades d'Alger (24 janvier-1er février 1960)', in Alain Corbin and Jean-Marie Mayeur (ed.), *La Barricade* (*Éditions de la Sorbonne* 1997). Digital version available at: https://books.openedition.org/psorbonne/1226#authors. [Accessed 18 October 2018]

On 13 May 1958, right-wing activists in Algeria, led by Ortiz and Lagaillarde, along such military leaders as Colonel Trinquier, General Salan, Kovacs's earlier target, and General Jacques Massu, the popular 'hero' of the Battle of Algiers, took control of the country in a *coup d'état*. 100,000 European protesters took to the streets and converged on the American Cultural Centre where they rioted. Meanwhile the police and military stood aside. That evening, General Massu was asked to form a *Commité de salut public* [Committee of Public Safety], which he accepted; in an announcement to the press the following morning, he explained that he was holding the position until General Charles de Gaulle returned to power.[73] The outcome of this take-over had devastating effects in Paris and, faced with the threat of a paramilitary force taking over the capital, the Fourth Republic collapsed. In its place, on 30 May 1958, de Gaulle formed the Fifth Republic and, on 4 June, famously announced to the people of Algeria: 'I have understood you'.[74] For the settlers and, more specifically, their right-wing factions, this was not only a sign of change in what they had regarded as the defeatist methods of previous governments towards the Algeria situation, it also demonstrated that their conspiratorial activities could mobilise *pieds-noirs* opinion and action in Algeria. Their optimism was short-lived.

By 1959, the new French government's stance on the future of colonial Algeria had become less secure: de Gaulle had announced a referendum on Algerian autonomy, the FLN had fuelled renewed anxiety by carrying out fresh attacks on civilians, and General Massu had been dismissed, much to the chagrin of the *pieds-noirs*.[75] The tension these events caused culminated in an insurrection led by the FNF in which Pérez, Lefèvre and Susini all played key roles. In January 1960, passive resistance quickly evolved into direct confrontation in what is now known as '*La semaine des barricades*' [the week of barricades], when Europeans once again took to the streets in another wave of violent protest. Their hope was a repeat of

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[73] Droz and Lever, *Histoire de la guerre d'Algérie*, pp. 168-180.
[74] Jacques Massu, *Le Torrent et la digue* (Paris: Plon, 1972), p. 107.
[75] Evans, *Algeria: France's Undeclared War*, pp. 270-271.

the success of 13 May 1958. On the evening of 23 January 1960, Lagaillarde and hundreds of paramilitaries occupied Algiers University.[76] The university became a fortress which Lagaillarde intended to hold, so he told onlookers, until de Gaulle stepped down or gave in to the *pieds-noirs*' demands. He was soon joined by an additional 20,000 demonstrators who gathered to support the protest. While the French paratrooper forces hesitated to get involved, the local police attempted to break-up the mob, which led to an open gun fight with the *pieds-noirs*.[77] The barricades and the insurrectionists continued to hold their ground in defiance until the 1 February 1960, when the leaders finally faced defeat after de Gaulle refused to accede to their demands and metropolitan opinion swung decidedly against their efforts. Very quickly, the FNF leadership disappeared from the scene: Ortiz went into hiding, Lagaillarde surrendered, while Pérez, Lefèvre and Susini were all held in custody awaiting trial.[78] This was not the end of the violent activities some of these doctors were involved with. Dr. Pérez and Susini went on to play crucial roles in the *Organisation de l'Armée Secrète* (OAS), a short-lived right-wing paramilitary organisation led by General Salan that carried out their own FLN-inspired terrorist attacks against both the nationalists and the French authorities.[79]

Among those present during the Week of Barricades was a counter-terrorism group to which historians have devoted no attention. The members of this group referred to themselves as Assistance and Protection [*Assistance et Protection*] and consisted of some 600 doctors and nurses with licenses to carry arms.[80] In an interview given to *Le Monde* on 14 January 1960, nine days before the start of the Week of Barricades, their president, Dr. Fernand Féral, voiced

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[76] See Droz and Lever, *Histoire de la guerre d'Algérie*, pp. 235-236; and Evans, p. 271.

[77] In the ensuing gun fight, fourteen police officers and eight civilians were killed while another 59 gendarmes and 33 civilians were injured. See Frémeaux, 'Les barricades d'Alger'.

[78] Horne, *A Savage War of Peace*, p. 373.

[79] It is beyond the scope of this chapter to go into a wider account of the OAS activities, but it is worth noting that Pérez in particular became the OAS's Chief of Operations and presumably supported the use of extreme violence to achieve their political aims. After the war, Pérez went on to run a thriving medical practice in Paris.

[80] Anonymous, 'L'Association "Assistance et Protection" invite les Algérois à défendre l'Algérie française" par les armes s'il le faut', *Le Monde*, 15 January 1960. <https://www.lemonde.fr/archives/article/1960/01/15/l-association-assistance-et-protection-invite-les-algerois-a-defendre-l-algerie-francaise-par-les-armes-s-il-le-faut_2098026_1819218.html> [Accessed 19 March 2018].

the type of thinking that seems to have been current among the other doctors discussed here: 'the subversive war [waged by the FLN] teaches us that every individual is a fighter'. He went on to declare that the 'fate of Algeria depends on us, when we are two hundred and fifty thousand fighters, I challenge the outlaws to put us out'.[81] Here Féral was addressing everyone, regardless of whether they were European or Algerian, doctor or not, to join the fight for *Algérie Française*, and to take 'weapons in hand if […] needed'. It seems Féral and his colleagues were terrified of the threat posed by the insurgents, so much so that he felt 'our right to life takes precedence over the penal code'. This fear was so palpable that Féral was willing to call on the mass execution of all FLN members and their supporters:

> In the countryside, every man must be a fighter, every farm become a bunker and every village a fort. Volunteer police officers need to be created to multiply searches. Above all, the death of terrorists is immediately enforceable, and death for those who assist them […] we have to stay alive if we want to defend ourselves later on the political plane, which does not interest us for the moment.[82]

Following the gun fight of 24 January, the Assistance and Protection movement was one of the first extremist groups to be disbanded by the police; Dr. Féral was placed under house arrest.[83] His call to arms clearly spoke of a level of aggression and anxiety common among many members of the European community in Algeria, but one that found particular expression among practicing medical personnel. Féral saw the FLN's continued existence as posing an actual threat to the lives of all Algerian citizens, not just the disgruntled Europeans. The answer, in his mind, was a full-scale campaign to exterminate anyone associated with the

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[81] Ibid.
[82] Ibid.
[83] It would appear that the court in Paris had questions over the extent of Féral's involvement in the violence committed during the Week of Barricades. However, in 1961, Féral escaped custody and went on the run with four other suspects. He was eventually found hiding in Notre-Dame de Tournay abbey and rearrested. See Anonymous, 'M. Féral est ramené à Paris par la police', *Le Monde,* 12 December 1960. <https://www.lemonde.fr/archives/article/1960/12/09/m-feral-est-ramene-a-paris-par-la-police_2105876_1819218.html> [Accessed 20 March 2018].

enemy. By evoking mass murder, Féral and, by association the other medical practitioners involved in Assistance and Protection, were setting themselves up as defenders of the colonial *status quo* willing to fight for European privileges in Algeria.

Under the conditions of the Algerian War, many civilian agents of medical care demonstrated a propensity for violence. In choosing this path, they were motivated by hostility to metropolitan policies—policies which posed a direct threat to the future of *Algérie Française*—and, like in Kenya, by existential fear over the actions of the insurgents. However, in contrast to Kenya, the sheer number of doctors actively leading these insurrectionary groups is significant. While there is evidence of a few individuals becoming embroiled in the atmosphere of permissive violence in the East African colony, their activities were isolated and limited in terms of political agitation. In contrast, the Algerian insurrectionists sought to affect far deeper political change and utilised terror tactics in the process. Yet the question as to why these doctors, in either colony, were motivated and able to adopt such violent methods remains unaddressed. This following section will examine this subject. It will consider the various social, cultural and political factors that may have combined to lead some civilian doctors to join the counterterrorist efforts or to become militia leaders themselves.

3.3. Cowboys and pioneers

On one level, the case studies discussed above provide interesting insights into the reaction to the emergencies on the part of some colonial doctors. Yet, on another, they reveal something of the dynamic between colonial individuals and the state. If the details are correct, these doctors felt compelled, for one reason or another, to resist official approaches to crisis situations. In Kenya, this took the form of doctors deliberately undermining official restrictions against violent interrogations, while in Algeria, Kovacs and the members of the FNF resorted to open subversion and terrorism to directly challenge the French military and the government. That is not to say that Algeria did not also witness incidents of private torture

carried out by medical practitioners. The fact that Kovacs was implicated in just such activities suggests there may be more instances where doctors were involved in torture that have not yet come to light. Nevertheless, the points of divergence between the two patterns of violence is useful for identifying specific features of the social, cultural and political milieux in Kenya and Algeria.

In *A Dying Colonialism*, Frantz Fanon explained how, due to their economic interests in the survival of the colonial order, 'very often [the European doctor] assumes the role of militia chief or organiser of "counter-terrorist" raids'.[84] Although Fanon was specifically addressing doctors in Algeria, it is possible to see his remarks as relevant to the Kenyan context too, though to a more limited extent. If Elkins's claims are correct, they would suggest Dr. Bunny took it upon himself to play local inquisitor, as his actions do not appear to have been sanctioned by the government. Although it is not possible to know how enthusiastic Dr. Wood was about having a police post on his farm, his actions, as well as his role as a police officer and the accusation that he was 'President' of the unofficial court, all suggest a level of personal investment in the counterterrorist activities unfolding on his property. For Fanon, European doctors in Algeria formed militias because they were often landowners and were thus 'economically interested in the maintenance of colonial oppression'.[85] Both Bunny and Wood would have had a personal material stake in the maintenance of the colonial order, given that they owned their own farms. In the case of the latter, Wood was emphatic that farming had always been a personal ambition of his.[86] Nevertheless, the limited documentary evidence relating to these two cases restricts efforts to reconstruct the two doctors' individual rationales for taking part in the Emergency.

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[84] Fanon, *A Dying Colonialism*, p. 134.
[85] Ibid.
[86] Wood, *Going An Extra Mile*, p.32.

As noted in Chapter 1, there is also strong evidence that some *pied-noir* doctors enjoyed the agricultural benefits that Algeria had to offer. For instance, as we have seen, Dr. Ettighoffer was a physician who had practiced medicine in the country as well as becoming an influential landowner and vice-president of the *Confédération des Vignerons des Trois Départements Algériens*. Although the Algerian doctors involved in the counterterrorist activities discussed above were not farmers, they still had substantial ties to the colonial economic order. Prior to the bazooka affair, Kovacs ran a clinic in El-Biar and also owned a hotel in Palma de Mallorca.[87] He was married to a wealthy Spanish wife who supported his lavish lifestyle at a time when he was not actually practicing medicine.[88] Dr. Pérez practiced medicine in Bab-el-Qued in Algiers and enjoyed a wide network of contacts within the European community. He was extremely sympathetic to their cause. Pérez even tells us that, upon returning to work after his release from prison in April 1956, he was praised by his patients for his counterterrorism activities.[89] Although they were not farmers, these individuals were clearly rooted within the colonial lifestyle as well as socially sensitive to settler opinion. These scattered data foreground the relationship between colonial doctors and the settler communities they served; they also raise a pertinent question: did doctors absorb their settler clients' beliefs and attitudes or did they help shape them too?

In both sets of cases, the doctors associated with violence were deeply embedded in local settler communities. It is worth noting again that Bunny was appointed to the Naivasha Township Council. For their part, Susan and Michael Wood's respective memoirs are replete with tales of them rubbing shoulders with members of the Kenya administrative and social elite. They too were influential and respected among the settlers. In fact, they felt so established within the country that, in the mid-1950s, they became actively involved in campaigns for the colony's future. Interestingly, it was against the tide of settler opinion: in

[87] Figueras, *L'Affaire du Bazooka*, p.16.
[88] Van Dyke, 'The Bazooka Affair' (p. 130).
[89] Horne, *A Savage War of Peace*, p. 350.

1956, Michael and Susan started helping David Stirling set up the Capricorn Africa Society; a political body which, in Susan's own words, espoused the beliefs 'that all men are equal in dignity before God' and that 'all racial discriminations' should be outlawed.[90] Their aim was to help campaign for a multiracial Africa where all people lived equally. Yet despite these liberal aspirations, Susan (as well as the Capricorn Africa Society) was categorically opposed to the idea of 'Africa for the Africans', something she and Michael felt was regressive and ultimately 'an escapist solution'.[91] Mau Mau thus posed a direct challenge to the Woods' avowed hopes for a multiracial Kenya. In fact, Susan's memoir implies that she regarded the rebellion as an act of 'insanity' and that the rehabilitation programme was both necessary and effective: 'The process of rehabilitation', she writes, 'had begun and the slow return to sanity was beginning to be felt; men and women were returning from the camps to their homes'.[92]

In another revealing case, the prominent settler and politician, Michael Blundell, provides additional evidence of a close connection between Kenyan doctors and the attitudes and sentiments of the wider settler population. In his memoir, *So Rough a Wind*, Blundell described the anger and agitation among the settler community that followed the murder of the Ruck family in January 1953. The morning after the murder, Blundell was travelling to Nairobi for a meeting of the elected members of the Legislative Council with Governor Baring to discuss the creation of a Defence Council. However, he had heard of plans for a mass march of some 1,500 settlers on Government House by the 'more extreme elements among the settlers in the city'.[93] Blundell then goes on to say that the first person he contacted was a Dr. Thornton and a Mr Vigar, who he thought 'might be implicated in the scheme and urged them to use their influence against any such ideas'.[94] Dr. Thornton and Mr Vigar made no commitments; the march went ahead as planned. It is interesting that Blundell's first recourse

[90] Wood, *A Fly in Amber*, p. 90.
[91] Ibid., p. 55.
[92] Ibid., p. 89.
[93] Blundell, *So Rough a Wind*, p. 258.
[94] Ibid., pp. 123-4.

was to contact a doctor who he felt would have 'influence' over the rest of the settler mob. This apparent influence and the fact that Dr. Thornton ignored Blundell's request suggest the latter shared in the anger and hostility of the hard-line settlers and may have been a leading figure in organising them.

While few scholars have addressed the question of the role of doctors in Kenya specifically, a number of historians have demonstrated how doctors, and medicine more generally, were integral to shaping racial identities in the colonies.[95] For instance, the previous chapter examined how a range of psychiatrists and anthropologists used their expertise to construct ideas about the indigenous populations' physical and mental states. Similarly, medical knowledge was deployed to construct a set of contrasting characteristics, behaviours and physical traits that were peculiar and distinctive among Europeans. In particular, Warwick Anderson has demonstrated how, in late nineteenth- and early twentieth-century Australia, concepts of 'whiteness', 'white race' and 'white organism' became figures of speech identifying a range of 'differences' distinguishing Europeans from the colonial natives. These 'differences' were not limited to skin colour, which Anderson argued was low on the 'racial calculous', but included a range of physical and cultural signs as well.[96] 'Whiteness', Anderson contends, was not fixed or immutable, it changed over time and was filled with 'physical, cultural and political significance'.[97] Given their privileged position within the colonial communities, doctors were chiefly responsible for defining and imparting these ideas. In the early days of the colonies, before and during the early twentieth century, they advised politicians and the public on how to survive in tropical climates, and how to behave hygienically and in a civilised fashion befitting their race. In Kenya, they were even consulted

[95] For example, see Anderson, *The Cultivation of Whiteness*; Vaughan, *Curing their ills*; Sutphen and Andrews (ed.), *Medicine and Colonial Identity*; and Chopin, 'Embodying 'the new white race'.
[96] Anderson, *The Cultivation of Whiteness*, pp. 1-2.
[97] Ibid., p. 3.

on questions related to the Soldier Settler Scheme to advise on the 'type' of British individual who could best settle in Kenya's climate, as mentioned in Chapter 1 of this thesis.[98]

It was not enough for doctors to prescribe ideals associated with whiteness, they were expected to embody them too. Charlotte Ann Chopin has shown how colonial doctors in early twentieth-century Algeria were 'servants of many masters', that is, they had multiple loyalties to different interest groups.[99] Not only were they answerable to the French authorities in Algeria, as representatives of the state, but they were also accountable to the European settler community, of which they were part, and to other members of the medical profession to which they belonged.[100] By 1911, when Chopin's study ends, the 'interests of [these] three so-called "masters" did not always neatly converge'.[101] Whereas the French authorities hoped the medical community would use their influence to facilitate the assimilation of the European population to the cultural values of the French Third Republic, the latter were also under pressure to defend the local settler communities. Often, the loyalty to the settlers was strongest. In fact, Chopin argues that 'doctors strategically mobilised different imperial, local and gendered identities' to strengthen their professional claims. In particular, they came to embody a set of values that were celebrated among European settlers: a form of vibrant masculinity that championed strength, dynamism and direct speech and behaviour. Such behaviours from doctors could and often did express themselves in acts of aggression and violence. 'When directed at representatives of the state administration', Chopin says, 'these acts expressed a rivalry for social authority based on competing ideals of masculinity'.[102] Doctors were also aggressive towards local Muslims and Jews, whom they viewed as being racially inferior. For example, Chopin discusses the case of a Dr. Castelbou, who in 1883 physically assaulted a Muslim soldier in a French garrison at Aumale after the soldier had told him to be less reckless

[98] Dane Kennedy, *Islands of Wight; Settler Society and Culture in Kenya and Southern Rhodesia, 1890-1939* (Durham, US: Duke University Press, 1987), pp. 109-120.
[99] Chopin, 'Embodying 'the new white race' (p. 1).
[100] Ibid.
[101] Ibid.
[102] Ibid. (pp. 15-16)

with his horse. Castelbou went on to throw a volley of insults at the soldier that included 'dirty pig' and 'dirty Arab' before turning his aggression towards the assembled crowd of natives. There was also the case of Dr. Rauzières, who forced his way into the tents of nomads of Beni-Ouazzine whilst the men were absent in order to invasively provide vaccinations to the women and children.[103] The outcome of these incidents of aggression undermined the image of the doctor as the representative of the French civilizing mission and their role as agents of benevolence.

The doctors in this context reinforced the kind of racial prejudice and violence towards non-western populations which was typical of colonial settings. However, the trajectories of Kovacs, Pérez, Lefèvre, Susini and Féral also illuminate a feature of the experience of colonial doctors that has received less attention. That is, the adhesion of many such medical practitioners to far-right beliefs expressing deeply held xenophobic and racist sentiments and a desire for more authoritarian politics. According to Samuel Kalman, since the early part of the twentieth century, Algeria was home to quasi-fascist sentiments that, as he put it, 'craved independence from the *metropole*, and frequently mobilized violence in order to dominate Muslims and Jews'.[104] This Algerian form of 'fascism', as Kalman contends, was exceptional in that it sought to foster a greater imperial order instead of merely trying to imitate metropolitan French, Italian or German movements. It also drew on more explicitly hateful language and the use of political violence as a means for actions and the self-image of its supporters.[105] What is also interesting here is that, according to Kalman, these ultranationalists 'firmly [believed] that Algerian Europeans constituted a unique racial fusion, heralding a new man at once youthful, virile, and brutal in stark opposition to the degenerate, effeminate and weak French'.[106] Such a juxtaposition between the masculinity of Algerian settlers and the

[103] Ibid. (p. 17)
[104] Samuel Kalman, *French Colonial Fascism: The Extreme Right in Algeria, 1919-1939* (Basingstoke: Palgrave Macmillan, 2013), p. 2. Emphasis in original text.
[105] Samuel Kalman, '*Le Combat par tous les moyens*: Colonial Violence and the Extreme Right in 1930s Oran', *French Historical Studies*, 34 (2011), 125-153.
[106] Ibid.

feeble metropolitan man drew heavily on *fin-de-siècle* notions of the 'feminisation' of the world and the subsequent belief that manhood was in a state of 'crisis'.[107] This was an image of the French metropolitan man more generally. This description of the 'new man' is very close to the ideals of dynamic masculinity discussed by Chopin and captures something of characters of those involved in the FNF and associated right-wing movements during the Algerian War.

An examination of the networks revolving around Algerian extremist-doctors also strengthens the claim that acts of aggression towards the government were not merely reactive expressions of settler unrest. They were also part of older ultra-traditionalist and violent movements. For instance, Robert Martel, mentioned above as a member of the Committee of Seven alongside Pérez, Lefèvre, and Susini, had originally been the head of the 'Christian Fascist' group called *Union française nord-africaine* (UFNA). He was in contact with a counterrevolutionary secret society in Paris called 'the Grand O', which was inspired by Dr. Félix Martin, an earlier extremist-doctor who was the only survivor of the Cagoulard conspiracy that had tried to topple the Third Republic in the late 1930s.[108] The Cagoulards, officially known as the *Comité secret d'action révolutionnaire* or *La Cagoule*, like the fascist groups involved in the Algerian War, had themselves used terror, intimidation, bombings and assassinations to try to cause political instability in France.[109]

Similarly, Dr. Lefèvre had deeper roots in older authoritarian movements, while also being one of the most vocal agitators in Algeria. He had been a supporter of the Vichy government after 1940 and was an avowed disciple of Charles Maurras, the leader of the fascist *Action*

[107] Christopher E. Forth, *The Dreyfus Affair and the Crisis of French Manhood* (Baltimore: Johns Hopkins University Press, 2006), p. 7.
[108] Philip Williams, 'How the Fourth Republic Died: Sources for the Revolution of May 1958', *French Historical Studies*, 3 (1963), 1-40 (p. 5).
[109] Annette Finley-Croswhite and Gayle K. Brunelle, 'Lighting the Fuse: Terrorism as Violent Political Discourse in Interwar France', in Chris Millington and Kevin Passmore (eds.), *Political Violence and Democracy in Western Europe, 1918-1940* (Basingstoke: Palgrave Macmillan, 2015), pp. 144-159.

Française movement of the 1930s. Maurras's philosophy was antisemitic, monarchist and antiparliamentary, all of which were sentiments expressed by Lefèvre throughout the Algerian War.[110] Lefèvre, a fundamentalist Catholic, was also a keen admirer of António de Oliveira Salazar, the authoritarian statesman who served as Portuguese Prime Minster between 1932 and 1968. Some of Lefèvre's ideas were expressed in a correspondence with *Le Monde* in late August 1958. In his letter to the newspaper, Lefèvre criticised General de Gaulle's Algiers speech of 4 June. For Lefèvre, de Gaulle's African policy was the worst since the end of the Second World War, despite having been the 'brain' responsible for organising the 13 May coup that had brought him back into power. Lefèvre criticised the new Republic's Constitution for being too conciliatory towards the Muslim population;[111] for maintaining political parties, which he saw as the root of all France's ills; and for being criminally secularist. In addition, he appears to have praised the Soviet Union for being a 'true application of a fascist state'.[112]

Chopin argued that the European doctors in early twentieth-century Algeria were not interested in overthrowing French colonial rule. Instead, they wanted to revitalise empire with their formation of a new whiteness that was masculine and virile.[113] Yet as we have seen, by the time of the Algerian War, some doctors felt confident enough to form counterterrorism groups and to actively fight against the French government when their interests were threatened and the opportunity presented itself. Given the number of Europeans who

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[110] Jean Lacoutre, 'Le docteur Lefèvre critique le général et le projet de Constitution', *Le Monde,* 1 September 1958. <https://www.lemonde.fr/archives/article/1958/09/01/le-docteur-lefevre-critique-le-general-et-le-projet-de-constitution_2313265_1819218.html> [Accessed 15 June 2019].

[111] Lefèvre was particularly displeased by the lack of reference to 'integration', a policy devised by Jacques Soustelle, the Governor General of Algeria, whereby administrative power was to be decentralised in Algeria through the creation of new departments. The Muslim population would, in theory, be given parity of representation in the towns among other reforms. However, by 1958 these policies were viewed with suspicion by both the Muslim population and many French citizens. For the *pieds-noirs*, 'integration' was envisaged in reverse terms: it was not as a means to bring equality to the colony. Instead, it would ward off the evolution of Algerian autonomy and independence by forcing the Muslim culture to be submerged and subsumed within French ideals. See Horne, *A Savage War of Peace*, p. 107, 306.

[112] Ibid., and J. L., 'Une lettre du docteur Lefèvre au "Monde"', *Le Monde* 4 August 1958. <https://www.lemonde.fr/archives/article/1958/09/04/une-lettre-du-docteur-lefevre-au-monde_2312113_1819218.html> [Accessed 15 June 2019].

[113] Chopin, 'Embodying "the new white race"' (p. 3).

supported their efforts, it would seem these extremist-doctors in Algeria were doing more than embodying settler culture, they were leading it.[114]

This idea that colonial doctors reflected and embodied a particular form of masculinity, one that was maverick in some way, is also relevant to the Kenya case, although it was perhaps constituted differently. Whereas the extremist doctors in Algeria championed a form of masculinity that is reminiscent of the popular interwar ideal of the 'heroic soldier',[115] their Kenyan counterparts appear more as pioneers and adventurers. This heroic image of the doctor, as Meghan Vaughan noted, is an enduring one in western culture.[116] Self-sacrificing, adventurous and pioneering, the view of lone scientific missionary figures battling against Africa's wild nature with few resources has held cultural currency to this day, especially among medical practitioners.[117] Although this image dates back to the age of African exploration and such pioneer physicians as David Livingstone, Dr. Wood's memoir, published in the 1979, is still clearly informed by it. In the Forward to *Going An Extra Mile*, the Afrikaner novelist Laurens van der Post described the Woods as adventurers. He waxed lyrically about Dr. Wood's bravery and daring as a self-taught pilot who undertook numerous solo flights into the Kenyan wilderness, exercising ample self-sacrifice when treating patients to near exhaustion before charting a risky return flight home.[118] Wood's flying adventures form the central theme of his text where frequent reference to precarious conditions, long distances and the urgency of the situation adds drama to his surgical anecdotes. That life in the colonies would appeal to a particular type of doctor with an adventurous personality provides perhaps

[114] Though it must be admitted that just because many groups joined in with the various protests organised by the FNF, they were not all far-right extremists. The 13 May uprising and the Week of Barricades were supported by numerous settler groups who were reacting to the fear inspired by the FLN's attacks. See Marie Dumont, 'Les européens dans la rue pendant la guerre d'Algérie', *Guerres mondiales et conflits contemporains,* 2 (2002), 59-85 (p. 59).
[115] See Juliette Pattinson, 'Fantasies of the 'Soldier Hero', Frustrations of the Jedburghs', in Linsey Robb and Juliette Pattinson (eds.), *Men, Masculinities and Male Culture in the Second World War* (London: Palgrave Macmillan, 2018), p. 25.
[116] Vaughan, *Curing their ills*, p. 155.
[117] Bertrand Taithe and Katherine Davis, 'Heroes of Charity?' Between Memory and Hagiography: Colonial Medical heroes in the Era of Decolonisation', *The Journal of Imperial and Commonwealth History*, 42 (2014), 912-935 (pp. 912-913).
[118]Laurens Van Der Post. 'Forward', in Wood, *Going An Extra Mile*, pp. 9-15.

further context for understanding why some doctors in both colonies became embroiled in counterterror violence: they shared a sense of themselves as self-styled men of action.[119]

The qualities expressed by this 'type' of adventurer doctor were similarly present in doctors hired to be Medical Officers by the Colonial Office in London. Anna Crozier has noted that the British colonial medical services attracted doctors who sought to enter into a particular lifestyle. Firstly, there was the appeal associated with the practice of tropical medicine which offered scope for clinical practice and epidemiological research that was unattainable in Britain. Secondly, and more importantly, choosing the colonial medical career 'allowed for the formation not only of a professional, but also a social, political and cultural identity, based on race, Britishness and the new tropical medicine'.[120] Crozier demonstrated that British colonial doctors in Kenya held onto the same ideas and ideals as the settlers they cared for. Settlers and their doctors were all bound together by certain emblematic behaviours: 'As well as physically converging, as often as they could, at clubs, dinner parties and sporting events, they were also bound, despite geographical distances, by uniformity of approach and attitude'.[121] The outcome was an attitude of entitlement, of largely racial superiority and a sense of pioneering spirit that has been present in Kenyan cases discussed in this chapter.

The British colonial services, unlike the French, were largely centralised and standardised. This meant the government could carefully screen applicants to make sure they adhered to specific criteria, assessed on both objective and subjective grounds. The Colonial Office

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[119] This idea has been explored in other contexts, such as Ulf Schmidt's research into German doctors under the Third Reich who were 'men of action' [t*atmenschen*], tasked with redefining and replacing traditional values surrounding the individual human subject. In the Third Reich, the needs of individuals were subordinate to those of German population, the whole. By enacting this change in values, German doctors believed they were paving the way to a new social and racial utopia. Although the Algerian extremists wanted to redefine the values of the colonial order, the term 'men of action' relates more to their martial ideals and readiness to undertake political violence. For more information on *tatmenschen* and Nazi medical ethics, see Ulf Schmidt, 'Medical Ethics and Nazism', in Robert B. Baker and Laurence B. McCullough (eds.), *The Cambridge World History of Medical Ethics* (Cambridge and New York: Cambridge University Press, 2008), pp. 595-608 (p. 596).
[120] Crozier, *Practicing Colonial Medicine*, p. 1.
[121]Ibid., p. 131

recruited a 'type' that had certain common expectations, which in turn helped to inform the identities of the colonial communities of which they were part. Up until the interwar period, the process of selection for the Colonial Services, whether for a medical role or any other position, was based on patronage—the introduction of candidates by existing officers.[122] The objective criteria for selecting a medical candidate included: the need to be naturalised British citizens (providing proof of their status); to have passed their examinations in both medicine and surgery and had several years experiences as physicians or house surgeons; to have served in the war effort; and, ideally, they should be unmarried men. Women were not discouraged from applying, but most of the Colonial Office's recruits were men.[123] There was also an understanding within the Colonial Services more generally that non-European candidates should be refused roles. Though this was not to be communicated in writing if a failed candidate asked for a reason.[124] In terms of subjective criteria, candidates were expected to meet certain social, ideological and physical expectations. They were expected to be athletic and mentally stable in order to survive the tropical conditions, but they were also expected to hold the values of the traditional British gentleman—the characteristic of leadership, militarism, conservatism (and pro-empire), sportsmanship and fairness, manners and consciousness of the British tradition. This 'gentlemanly' tradition also tapped into the broader upper-middle class prejudices of racism, religion and gender.[125] An ideal candidate would therefore be passionate about protecting the empire, and be capable of commanding respect from the indigenous populations.

Although Dr. Wood did not serve as a government employee, understanding the type of candidates who became Medical Officers in Kenya has two uses. Firstly, it illustrates how medical experts shared in similar values, beliefs and attitudes which underpinned the medical culture in the colony. Secondly, although there is currently no evidence that Medical Officers

[122] Ibid., p. 12.
[123] Ibid., p. 20-21.
[124] Ibid., p. 24.
[125] Ibid., p. 34-35.

undertook the type of violence discussed here, these government doctors were *the* individuals responsible for the health and wellbeing of detainees in the Kenyan pipeline where systematic torture took place after 1957. As such, examining how these individuals functioned and were selected goes a long way to understanding their responses to torture in the camps (which will be the subject of the next chapter). This British 'type' of colonial doctor is different to the one identified by Chopin in Algeria, however. Although both groups of doctors and, by extension, settler communities, seem to share in a sense of entitlement, racial superiority and a desire for healthy athletic physical vibrancy, the Algerian extremists stand in contrast with the semi-aristocratic, almost feudal, nature of the Kenyan settlers. Indeed, although the settlers in Kenya were prepared to take matters into their own hands in order to deal with Mau Mau insurrectionists, as demonstrated above, they did not express the same kind of overt hostility towards the colonial authorities or the security forces, even when they felt that more could be done to protect them. Nevertheless, the doctors in all these cases embodied forms of masculinity that were informed by the racial identities current in the colonies; they valued particular qualities that were heroic and action orientated. This was something Fanon also commented on, though only in passing. He noted that, in the colonies, 'in normal times—that is, in the absence of the war of liberation—there is something of the cowboy and the pioneer even in the intellectual. In the period of crisis', however, 'the cowboy pulls out his revolver and his instruments of torture'.[126] Both sets of doctors, those in Kenya and those in Algeria, appear to be representative of such doctors-cum-cowboys.

Conclusion

This chapter has examined a series of cases where settler doctors perpetrated acts of violence in order to highlight key social, cultural and political differences between the colonial situations in Kenya and Algeria. While there is evidence of doctors being involved in counterterrorist violence in both colonies, important differences still exist. The analysis

[126] Fanon, *A Dying Colonialism*, p. 69.

reveals significant local idiosyncrasies that influenced the extent and nature of these activities. When doctors became involved in this violence, they did so in specific ways that resonated with their surrounding settler communities. These differences highlight specific historical points of tension between settler communities and the colonial authorities. As such, the extent to which doctors partook in brutality varied both in terms of degree and type. In Kenya, as this chapter has shown, doctors perpetrated acts of violence against Mau Mau suspects when they felt that the colonial government was being too weak or slow in its handling of the emergency. Their resistance to the colonial authority's methods manifested themselves in a willingness to use extreme forms of abuse and torture in order to force Mau Mau suspects to provide information or to confess. As such, these doctors, like other settlers serving in the security forces, demonstrated the viability of alternative, more aggressive, ways of dealing with the terrorists. Espousing the views of people like Todd, some colonial British doctors appear to have been critical of the ineffectual methods employed by the colonial government in response to Mau Mau. The situation in Algeria, however, was considerably different. In Algeria, the doctors involved in violence and acts of terrorism demonstrated a level of political dissatisfaction and dissent that challenged the political elite in France and indeed contributed to the collapse of the Forth Republic. These doctors managed to mobilise the *pieds-noirs* opinion and anger in a way that encouraged further violence and political demonstration on the streets of Algiers.

Yet these acts of violence were not random, nor was it a coincidence that so many colonial doctors should have been responsible for organising or committing them. This chapter has argued that the reason why so many doctors were involved in brutality and abuse during the emergencies was that they held a specific place within the colonial social milieu. These individuals were members of the dominant social and political group in Kenya and Algeria. They enjoyed, as Fanon noted, a lifestyle and set of economic benefits that set them apart from their colleagues in the metropole. As such, when the emergencies were declared in both colonies, doctors, with their multiple loyalties, were among the first to defend the settler

interests. However, these doctors, especially in the Algerian case, were also representatives of deeper political attitudes and affiliations. These professionals, Kovacs and the members of the FNF, all shared fascist beliefs and attitudes that were current in the colony since the early twentieth century. Yet they also demonstrated a type of vibrant masculinity that championed action and a propensity for acts of aggression and violence. This set of characteristics, too, had a deep history among medical professionals in Algeria; it certainly contributed to these individuals joining in the abuses when the emergency was underway. Although there is no evidence that the doctors in Kenya shared such separatist fascist political beliefs, it seems they too embodied and celebrated heroic masculine qualities. Dr. Wood in particular was recognised as an adventurer and a pioneering pilot who frequently risked his own life for the benefits of his patients.

An important caveat needs to be introduced at this stage. The settler doctors who took part in violent activities in the context of counterinsurgency campaigns did so for the most part in an individual capacity rather than a medical one. The doctors in both colonies were not acting as doctors; they were not offering medical or scientific knowledge and skills to the counterinsurgency efforts. As such, their involvement does not constitute a dual-loyalty issue as defined within modern literature where their professional ethics are being divided between competing pressures. Their roles as unofficial screeners, auxiliary police officers or militiamen were independent of their primary roles as doctors. As such, it seems their professional ethics remained just that: a set of principles to be applied to their patients. Despite the deontological nature of the Hippocratic ideal, these doctors appear to have viewed their ethical obligations in practical and disposable terms. For these doctors, rather than being a set of ethical principles informing a doctor's identity and everyday interactions, they remained guides to professional conduct which stopped where the clinical encounter ended. While they may have exercised the Hippocratic qualities of beneficence and non-maleficence to their patients, they were equally happy to resort to and organise acts of violence against their enemies when operating as colonial citizens. The next chapter, on the other hand, will examine

the other side of this situation: instances where doctors were acting as medical experts in violent circumstances. The discussion will shift from counterterrorist violence performed by citizens to one where torture and other human rights abuses took place either under medical supervision or drew on their expertise to help perfect the security responses to the rebellions.

Chapter 4. The torturer's 'right hand man'? medicine, medical ethics and torture

This chapter examines the various ways in which medical expertise was used by the French and British colonial governments and security forces for their counterinsurgency campaigns. It focuses specifically on instances where medical practitioners were directly involved in officially sanctioned forms of violence in Kenya and Algeria. In particular, it asks questions about the relationship between systematised and institutionalised violence and the role of medicine. To what extent did medical knowledge inform or support official methods of torture? Was this expert knowledge used in the same way in both contexts or were there specific differences in the types or aims of the activities being sanctioned? Moreover, to what extent was any medical collusion passive or active? For instance, did doctors operate in capacities that supported the implementation of torture, becoming what Martha K. Huggins *et al.* called 'atrocity facilitators', or did they sometimes undertake abuse themselves and thus become 'direct perpetrators'?[1]

The following discussion extends the existing historiography in a number of ways. In the first section, it examines efforts to revivify old and standardise new international codes of medical ethics following the end of the Second World War. As mentioned in the introduction to this thesis, historical interest in this subject has mostly focused on the *Nuremburg Code* and the role of doctors involved in human experimentation. This attention to human experiments has come at the expense of broader efforts to assess the ways in which postwar international ethics codes were devised and promulgated to guide the conduct of doctors in times of war. It will be argued that these new international codes, although admirable in their aims, applied primarily to conventional warfare scenarios, and so failed to consider the novel challenges

[1] According to Huggins *et al.*, 'atrocity facilitators' can be understood as individuals who operate around torture while not taking a direct part in its application. Facilitators can deliver victims to torture, watch the abuse take place, guard detainees and remain silent as atrocities continue. See Huggins *et al.*, *Violence Workers*, p. 138.

raised by the new revolutionary wars that took place in the 1950s. Because of this, these international instruments had little to offer doctors encountering torture in such conflicts. This provides the background for assessing the various ways in which doctors in Algeria and government medical officers in Kenya responded to the institutionalisation of torture in both emergencies. As mentioned in previous chapters, since Fanon first drew attention to the situation, scholars have been aware of the presence of doctors in the torture chambers of Algeria. Yet little scholarly work has attempted to draw this material together and to assess its broader significance, especially in relation to the role of doctors in the Kenya detention centres who, to a far greater extent, have remained invisible to historical analysis.

The contention here is that histories of violence in these wars have said more on the methods of torture than on the mundane ways in which they were legitimised and institutionalised. Medicine, it will be argued, played a fundamental structural role in state-sponsored torture, especially in Kenya, where medical officers were required to examine detainees before and after they underwent abuse. In both contexts, physicians (military and civilian alike) in Algeria and government medical officers in Kenya provided knowledge and oversight to calibrate and maintain the officially sanctioned systems of violence in each colony. While there were many similarities between the functions of doctors in both colonies, important differences nevertheless existed. While members of the Colonial Medical Services in Kenya helped to maintain the system of violence initiated in the detention camps after 1957, they were excluded from the violence itself. In contrast, in Algeria the pressures of urban guerrilla warfare seemed to encourage some military and civilian doctors to apply more interventionist technique to the interrogation process: the use of narcotics to extract information from uncooperative prisoners.

4.1. 'The suffering man is sacred': torture and postwar medical ethics

As has been discussed already, Fanon believed that it was their willingness to abandon their medical ethics that made some doctors the direct target of insurgent violence. Ultimately, as

Richard Keller has noted, in Fanon's eyes, colonial medicine occupied an impossible position: 'One could serve colonial interests or medical interests, but not both: the adoption of the colonial mantle necessarily meant the abandonment of Hippocratic commitments to patient care'.[2] At best, this 'colonial situation' led doctors to be dismissive and apathetic toward the plight of the indigenous population, but at worse, Fanon stressed, it led them to aid the violent excesses of the Emergency: 'Professional morality, medical ethics, self-respect and respect for others, have given way to the most uncivilized, the most degrading, the most perverse kinds of behaviour'.[3] Although it is clear that, for Fanon anyway, medical practice in both the colonies and the European metropoles shared particular ethical standards, it is not exactly clear which standards he is referring to and who expected doctors to abide by them. When it came to acts of violence such as torture, what were the ethical codes governing this conduct?

As a consequence of the extensive list of human rights violations during the Second World War, the international community sought to establish an absolute ban on torture in a series of new international human rights conventions, treaties and international laws. While documents like the United Nations' *Universal Declaration of Human Rights*, passed on 10 December 1948, and the codification of the *European Convention on Human Rights* (ECHR) in 1950 sought to enact a general ban on torture, it was not until the early 1970s that The World Medical Association (WMA) created a code specifically addressing the conduct of doctors involved in interrogation and torture.[4] It is thus worth examining the evolution of international medical codes of conduct in the immediate postwar period, as they provide a foundation for understanding how medical involvement in violent interrogation and torture detracted from international norms. This is all the more important since there appears to be some confusion among scholars as to what these ethics were. For example, the French historian, Raphaëlle

[2] Keller, 'Clinician and Revolutionary' (p. 825).
[3] Fanon, *A Dying Colonialism*, p. 138.
[4] At the twenty-ninth World Medical Assembly in 1975, the WMA adopted the *Tokyo Declaration* in October 1975, which provided a set of guidelines for medical professionals faced by circumstances that included the use of torture and other cruel, inhuman or degrading forms of treatment or punishment.

Branche, has noted that, when it came to a doctor's conduct in Algeria, 'the oath of Hippocrates is clear: "even under threat, I will not admit to using my medical knowledge against the laws of humanity"'.[5] Yet this quote is incorrectly attributed to the *Hippocratic Oath*; it is actually taken from the *Declaration of Geneva*, which was adopted by the WMA at its second General Assembly in September 1948, with the distinct aim of reaffirming and updating its Hippocratic predecessor.[6]

The problem with the *Hippocratic Oath* was that its loose and vague language could be used to justify inhumane activities, such as when Karl Brandt, the Nazi physician, defended the Nazi euthanasia programme as an extension of Hippocratic ethics.[7] As such, the WMA devised the *Declaration* of *Geneva* to modernise it and to be taken by new doctors 'at the time of being admitted as a member of the medical profession', so that they could pledge their '[lives] to the service of humanity'.[8] With the *Declaration*, the doctor vows that 'the health of my patient will be my first consideration', to 'respect the secrets which are confided in me', not to 'permit considerations of religion, nationality, race, party, politics or social standing to intervene between my duties and my patient' and to 'maintain the utmost respect for human life from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity'.[9] The rest of the *Declaration* pledges doctors to respect their teachers, to practice their profession with dignity, to maintain the profession's honour and traditions and to ensure fraternity among its members.

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[5] Branche, *La torture et l'armée pendant la guerre d'Algérie*, p. 470.

[6] A version of the 1948 *Declaration of Geneva* can be found at: https://www.wma.net/policies-post/wma-declaration-of-geneva/. [Accessed 4 September 2018.]

[7] Karl-Heinz Leven, 'The Invention of Hippocrates: oath, letters and Hippocratic corpus', in U. Trohler and S. Reiter-Theil (ed.), *Ethics Codes in Medicine: Foundations and Achievements of Codification Since 1947* (Ashgate Publishing, 1998), p. 14.

[8] *Declaration of Geneva*.

[9] Here I am using the original language from the code as first published in the September 1948 Declaration of Geneva, adopted by the General Assembly of the World Medical Association.

A year later, in October 1949, at the Third General Assembly in London, the WMA adopted the *International Code of Medical Ethics* into which the *Declaration of Geneva* was to be incorporated. The *International Code* is subdivided into three parts. Under the first section, labelled 'Duties of Doctors in General', the *International Code* sought to protect the standard of professional conduct. In particular, it addressed the anxieties expressed by the Medical Chamber of Western Germany at the first General Assembly by codifying as unethical any collaboration 'in any form of medical service in which the doctor does not have professional independence'.[10] Physicians were to be free from institutional control, such as the state. When it came to patient care, the *International Code* stated that 'Any act, or advice which could weaken physical or mental resistance of a human being may be used only in his interests'. The relationship between doctors and their patients was further outlined in the second section, 'Duties of the Doctor to the Sick'. The doctor 'must always bear in mind the obligation of preserving human life'; 'A doctor owes to his patient complete loyalty and all the resources of his science […]'; 'A doctor shall preserve absolute secrecy on all he knows about his patient because of the confidence entrusted in him'; and 'A doctor must give emergency care as a humanitarian duty unless he is assured that others are willing and able to give such care'.[11]

Together, the *Declaration of Geneva* and the *International Code of Medical Ethics* represented an updated version of the Hippocratic ideal of *primum non nocere* [first, do no harm]. They reaffirmed the responsibility to protect life and to refrain from causing harm as fundamental principles of medical conduct, as had been the case with the *Hippocratic Oath*. Not only were doctors forbidden from undertaking any act that might weaken the physical and mental resistance of a human being, not necessarily just their patients, they were also to preserve life when it was in their power to do so and to guard the secrets entrusted to them by their patients. However, there were a number of limitations to these codes. Firstly, they held little standing

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[10] Anonymous, 'Minutes of the General Assembly in London', *World Medical Association Bulletin*, 2 (1950), 5-35 (p. 10).
[11] *International Code of Medical Ethics*, adopted by the Third General Assembly of the World Medical Association, London, England, October 1949.

within the legal community. Secondly, as George J. Annas and Michael A. Grodin point out, these two updated codes were consistent with the wider 'physicians-protection' goals of the WMA.[12] In these codes, the physician's rights held greater weight than patients' rights. An older sense of medical paternalism, expressed as '*the doctor knows best*', was allowed to persist. For example, while a doctor may have been expected to forgo any act or advice that might weaken their patients' physical and mental resistance, this was only when it was contrary to the patient's *interest*. Yet it was ultimately the doctor who decided what these interests were, or were not, in this context. Thus, patients and their bodily autonomy were not necessarily protected by this stipulation.

But one of the more significant limitations of the *Declaration of Geneva* and the *International Code of Medical Ethics* was that they were too general in purpose. Although produced in the wake of the Second World War, the text of these two codes sought to guide medical professionals' attitudes and practices in everyday environments. Generally speaking, few doctors are likely to encounter situations where their assistance could be considered cruel or tantamount of torture. The language enshrined within these international medical codes did not necessarily factor in the ambiguities and novelties presented by a conflict environment where the meaning of certain clauses could be harder to interpret. For instance, the *International Code* obliged physicians to provide emergency care as a humanitarian imperative, but could this be used to justify treating a patient-prisoner who had been tortured in the knowledge that they would only undergo further mistreatment?[13] How should a physician respond when they know their treatment will lead to their patient's undergoing further abuse? As will be shown in the next chapter, these dilemmas regularly played out when

[12] The WMA was formed in 1946 to promote ties between national medical organisations and among doctors across the world. One of the primary aims of its First General Assembly was to discuss 'the principles of social security' to protect the welfare of physicians themselves. These principles were designed to support the personal and financial welfare of physicians rather than the security of patients. See George J. Annas and Michael A. Grodin, 'Medicine and Human Rights: Reflections on the Fiftieth Anniversary of the Doctors' Trial', *Health and Human Rights,* 2 (1996), 6-21 (pp. 10-11).
[13] Though it must be stated that the final pledge of the *Declaration of Geneva* is unambiguous when it binds the physician to maintaining the utmost respect for the laws of humanity.

doctors were faced with torture victims. The guiding principles of the WMA's codes were not necessarily helpful in the rare, but morally demanding, circumstances created by the emergencies in Kenya and Algeria.

Yet while other post-war humanitarian documents, such as the *Universal Declaration of Human Rights* and the *ECHR* which banned torture outright, were still coming into existence, international efforts were directed towards strengthening existing conventions that protected the rights of individuals involved in wars. In February 1945, Max Huber, the president of the International Committee of the Red Cross (ICRC), addressed a letter to the governments of 'the Big Five' (United States, Great Britain, the Soviet Union, France and China) as well as to the national Red Cross committees, to raise support for addressing, reaffirming or even expanding 'Hague Law'.[14] The next four years saw various experts drafting revisions to existing international humanitarian law. These were accepted at the Seventeenth International Red Cross Conferences in Stockholm in 1948 and finally ratified as the Geneva Conventions by fifty-nine states on 12 August 1949.[15] In addition to updating the terms of the two existing conventions agreed in 1928, two new conventions were added, along with the first codified definition of 'war crimes'.[16] The outcome was a set of conventions that protected the individual rights of soldiers, shipwrecked members of the armed forces, prisoners of war and civilians in warzones.

Although the *Geneva Conventions* were not specifically directed at the medical community, it was understood that physicians had a particular responsibility for ensuring their application in the field of battle. This was because, according to Jean-Pierre Schernholzer of ICRC,

[14] Geoffrey Best, *War and Law Since 1945* (Oxford: Oxford University Press, 1994), p. 80-81.
[15] Jean S. Pictet, 'The New Geneva Conventions for the Protection of War Victims', *American Journal of International Law*, 45 (1951), 462-475 (pp. 464-467).
[16] The four conventions are: (1) Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field; (2) Geneva Convention for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea; (3) Geneva Convention relative to the Treatment of Prisoners of War; and (4) Geneva Convention relative to the Protection of Civilian Persons in Time of War.

physicians and the *Geneva Conventions* shared a common principle: 'the suffering man is sacred'.[17] This meant that the rights of patients, be they soldiers, prisoners or unarmed civilians, were to be protected by the physician before consideration of politics or other external pressures. This was because, so Schernholzer contended, the medical profession, especially doctors, and the ICRC were both bound by the same ideals: 'to alleviate human suffering [*alléger la souffrance humaine*]'. Without doctors, he argued, the ICRC would be powerless, while the doctors owed the ICRC for having 'imposed on the world' the principles they had long been defending, 'namely the equality of men in the face of suffering'.[18] As such, doctors were meant to be particularly bound by the rules established by the *Geneva Convention* generally, and were to specifically safeguard the health and wellbeing of soldiers, prisoners and civilians who were to be free from harm such as torture, as codified in all four conventions.[19]

Article 3, which is common to all four conventions and is often referred to as the 'convention in miniature', guaranteed the extension of basic humanitarian standards to non-international conflicts, such as civil wars or revolutions, and could be ignored neither by governments nor resistance movements without stepping outside the bounds of civilization.[20] As such, in internal conflicts, such as the Kenya Emergency and the Algerian War, civilians and combatants no longer actively fighting due to illness, wounds, detention, or any other cause were protected under the *Geneva Convention*.[21] Article 3 ensured that: [V]iolence of life and person, in particular murder of all kinds, mutilations, cruel treatment and torture, taking hostage, outrage upon personal dignity, in particular humiliating and degrading treatment, the

[17] Jean-Pierre Schoenholzer, 'Le médecin dans les Conventions de Genève de 1949', *Revue Internationale De La Croix-Rouge Et Bulletin International Des Societes De La Croix-Rouge*, 35 (1953), 94-126 (p. 102).
[18] Ibid. (p. 94).
[19] Ibid. (p. 103).
[20] See also Fabian Klose, 'The colonial testing ground: The International Committee of the Red Cross and the violent end of empire', *Humanity: An International Journal of Human Rights, Humanitarianism, and Development*, 2 (2011), 107-126 (p. 108).
[21] Ibid. (p. 109).

passing of sentences and carrying out of executions without previous judgement pronounced by a regularly constituted court, affording all the judicial guarantees which are recognized as indispensable by civilized people,' was prohibited under any circumstances.[22] In addition to this general ban on torture, a separate article in each of the four conventions also prohibited torture under any circumstance.

Although the establishment of such fundamental basic standards as those enshrined in the *Universal Declaration of Human Rights* and the Geneva Conventions marked a breakthrough for international humanitarian law in the postwar period, especially in regard to conduct in internal conflicts, the idea, as Fabian Klose has shown, was not popular among the colonial powers.[23] Britain in particular was keen to oppose adoption of the provision to extend international humanitarian law to internal armed conflicts of any kind, because it feared international intervention in colonial uprisings.[24] Passages in the draft Geneva Convention that banned, for instance, the use of collective punishment caused significant irritation to the Colonial Office, as this was a standard punitive measure used to quash rebellious activities overseas.[25] The deadlock caused by this disagreement over the terms of the Conventions was only broken when the French delegation at the 1949 conference sought to limit the extension of all aspects of Article 3 to a bare minimum in cases of 'internal conflicts'.[26] Klose argues that the French proposal was not an expression of 'heartfelt commitment to the humanitarian protection of the colonial population during internal unrest'.[27] This, he shows, is because the French had opposed the passage related to 'colonial conflicts' in the conventions. Instead, they were motivated by their experience with German occupation and denial of combatant status

[22] Article 3 of the Geneva Convention, in ICRC, ed., Geneva Convention, 24.
[23] Klose, 'The Colonial Testing Ground' (p. 109). See also Klose, *Human Rights in the Shadow of Colonial Violence*, p. 38-46.
[24] Klose, *Human Rights in the Shadow of Colonial Violence,* pp. 38-46.
[25] Ibid.
[26] Ibid.
[27] Klose, 'The Colonial Testing Ground' (p. 109).

to resistance fighters. They ultimately wanted to protect their own population in potential future conflicts.[28]

The human rights established by the various postwar conventions were not to be extended to the colonial conflicts breaking out in East and North Africa. Colonial authorities did not want their own security forces to be impeded by humanitarian norms, nor for the rebels to enjoy protections in their struggles against the colonial order. So, while colonial officials were expressing the need to ensure their colonial subjects were treated in accordance with the Geneva Convention, the unofficial standard was one of brutality and repression. For example, in June 1955, Léon Boutbien, a French MP, asked the President of the Council: 'if, indeed, the Government cannot admit that it is conventionally bound by the [Geneva Convention] with regard to the events of Algeria, which cannot be assimilated to an armed conflict within the meaning of the Convention, France must however apply to the outlaws […] the humanitarian provisions mentioned in Article 3'.[29] Yet even as late as 1958, the French military in Algeria were being told to do the opposite. While discussing treatment of detainees in Military Camps in Algeria in March 1958, General Raoul Salan, the head of the French army in Algeria who was targeted by Dr. Kovacs in the previous chapter, explicitly stated that 'It is understood that interns should not be considered as prisoners of war'.[30] For Salan, the ability to gain information from suspects was a crucial part of French counterinsurgency tactics; nothing could be allowed to prevent security forces from obtaining it: '[Therefore the] Geneva Conventions are not applicable to [detainees] […] and the search for intelligence by their interrogation always allowed'.[31]

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[28] Ibid.
[29] SHD 1 H 2460/d.1. Written question produced by Monsieur Boutbien reproduced in 'Annex a la Note de Service No. 2319 en date du 3 September 1956'.
[30] SHD 1 H 1492/d.2 General R. Salan, 'Camps d'Internées Militaires', 19 March 1958.
[31] Ibid.

Torture was thus permitted to play a crucial role in the colonial response to insurgents in both Kenya and Algeria. By refusing to regard the uprisings as legitimate wars and by dehumanising the rebels, as discussed in the Chapter 2, colonial authorities allowed their security forces to step outside of the agreed standards for civilised combat. To what extent the members of the medical communities in Kenya and Algeria were conscious of this or how they understood their ethical responsibilities is difficult to know, given the extreme paucity of sources reflecting on the subject.[32] However, captured in the recalibrated postwar medical ethics codes were several overlapping standards of conduct that were applicable at the time. Chief among these was the rule that medical practice, knowledge and intervention should not be directed towards any act that detracted from the therapeutic interests of the patient. This even extended to any act or advice capable of weakening the physical or psychological resistance of the patient, if it was not in their interests. Moreover, doctors were to remain independent agents free from institutional pressures, such as those imposed by the state, and were to provide care and attention free of prejudice while protecting the covenant of professional secrecy at all costs. The following sections will assess the various ways in which members of the colonial medical services and military doctors contravened, ignored or stretched the meaning of these principles. It is clear that the failure to extend the minimal protections afforded by the Geneva Conventions and the nascent human rights regime meant that detainees were left with few protections. Moreover, colonial and military doctors were further ill equipped to understand the highly ambiguous circumstances generated by revolutionary wars, an ambiguity that allowed many to act with impunity.

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[32] To date, I have not found evidence of any real discussions or debates concerning ethical practices in relation to the colonies and colonial subjects. This absence, I would suggest, might account for why historians discussing medical conduct in these territories, such as the aforementioned Keller and Branche, have fallen into questionable assumptions about the universal meaning surrounding the *Hippocratic Oath*.

However, this is not to suggest that the situation would be any different if a sufficient code of ethics had existed at the time. As the WMA acknowledged while discussing the creation of the *Geneva Declaration* in 1948:

> As a stream cannot rise above its source, so a code cannot change a low-grade man into a highgrade doctor, but it can help a good man to be a better man and a more enlightened doctor. It can quicken and inform a conscience, but not create one.[33]

The following sections will examine how the medical practitioners in both Algeria and Kenya supported, challenged or tried to ignore the systematic use of torture in the two conflicts. The responses to these ambiguities were various and covered every instance between tacit approval and active engagement with torture.

4.2. 'Certain medical opinion': legitimising torture in Algeria

On 15 January 1955, early into the Algerian War, *L'Express*, a weekly review, published an article by the journalist and writer, François Mauriac, entitled 'La Question', a French term for torture. Mauriac's article reported the testimony of a friend, referred to as R., a priest with *le Mission de France* living in the northeast Algerian province of Constantine. R.'s account explained the extent to which he had, for unexplained reasons, witnessed the local police using extreme violence in their interrogations.[34] When the Algerian war started, operations were separated between the army, on the one hand, and the police and *gendarmerie*, on the other. The former had recently returned from their defeat in Indochina, where, as discussed earlier, they had learnt to appreciate the power of torture in a revolutionary war, while the latter were

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[33] Quote taken from Anonymous, 'Declaration of Geneva', *World Medical Association Bulletin,* 1 (October 1949), pp. 108-109 (p. 109).

[34] François Mauriac, 'La Question' reproduced in 'Algérie: dès 1955, François Mauriac dénonçait la torture dans L'Express', *L'Express*, 20 December 2012. https://www.lexpress.fr/actualite/monde/afrique/algerie-des-1955-francois-mauriac-denoncait-la-torture-dans-l-express_1201581.html [Accessed 16 July 2018].

essentially responsible for supressing the uprising in the towns and countryside. The police and *gendarmerie*, as will be shown below, also had a long history of using excessive violence as part of their practice. The police's initial response was to systematically arrest known political agitators, such as members of the nationalist organisation known as *Le Mouvement pour le triomphe des libertés démocratiques* (MTLD). Although the MTLD had nothing to do with the FLN's rebellion, members were arrested and subjected to torture at the hands of the police.[35]

The methods used, R. claimed, were a mix of beatings and stealth techniques designed to leave few or no marks on the victim's body. These included techniques that would become common throughout the war: the use of electrocution, simulated drowning, prolonged and exhausting interrogation sessions, and isolation and hunger.[36] In the end, suspects would sign confessions and implicate others as terrorists just to make the interrogation stop. One of the cases mentioned by R. was that of Moulaï Merbah, the Secretary General of a faction of the MTLD, who had been arrested and severely beaten over a five-day period, despite Article 114 of the Penal Code effectively repressing arbitrary detention. By the time his lawyer was allowed to see him, Merbah's back showed the signs of his treatment: it 'was covered with open or barely covered wounds'.[37] Mauriac continued to explain that, according to R., a 'forensic doctor' had been invited to examine Merbah and, instead of enquiring into the source of these injuries, had certified that he was '*le mieux du monde*' ['the best in the world' or 'in perfectly good health']. The doctor's certificate, R. suggested, subsequently convinced the French Minister of the Interior, François Mitterrand, that Merbah had not been mistreated at all. After their abusive interrogation, suspects were dragged to a magistrate at unusual hours so as to limit the number of witnesses to their trial. In a few cases where suspects wounds were seen, such as when R.'s

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[35] According to Pierre Vidal-Naquet, the MTLD were in a state of internal chaos themselves at the time of the outbreak of war and so had nothing to do with the FLN's rebellion. See Vidal-Naquet, *Torture: Cancer of Democracy*, p. 32.
[36] François Mauriac, 'La Question'.
[37] Ibid.

wife saw the 'injured chest' of a man named Abd el-Haziz, the judge called for a medical examination but insisted that it not take place in 'the presence of a professor from the Faculty of Algiers'.[38] Presumably, this was to ensure the doctor selected could be trusted to reach the right verdict that would not contradict the police's views.

Mauriac's article brought the realities of France's campaign of suppression to the French public in Paris. It not only highlighted the extent to which torture was already a tool being deployed against suspected rebels, but for our purposes, it also revealed the close connection between torture and the institutions of medicine and law. As noted by Elaine Scarry, although other institutions such as the sports stadiums in Chile, the police station in Paraguay, the traffic control office in Greece and even the sweets factory in Algeria might be implicated in torture campaigns, this is usually due to a coincidence of proximity: the torture rooms just happened to be close to a headquarters facility. Yet when it comes to systematic torture, the 'two ubiquitously present' institutions are medicine and law, for, as Scarry notes, 'they are the institutional elaborations of body and state'.[39] As such, when torture is widespread, the doctor and the lawyer are rarely far from sight. This relationship will be discussed further in the next chapter, but for now Scarry raises an illuminating point for our purposes. In order to give institutionalised torture legal protection, Mauriac tried to use medical opinion to justify and strengthen his recommendations.

Following the public outcry generated by Mauriac's article, the Mendès-France government responded in two ways. Firstly, they transferred a number of suspected Algerian police officers to Paris and 'integrated' French police officers with their Algerian counterparts. The hope was that the former group would serve as a positive influence on the latter.[40] Secondly, in direct response to Mauriac's article, Mendès-France commissioned an official investigation to

[38] Ibid.
[39] Scarry, *The Body in Pain*, p. 42.
[40] Vidal-Naquet, *Torture: Cancer of Democracy*, p. 32.

ascertain the truth about police and military tactics in the colony. The civil Inspector-General, Roger Wuillaume, was seconded to the Governor General in Algeria, Jacques Soustelle, in order to investigate the nature of Mauriac's accusations. Despite Mendès-France government collapsing soon after the commission was established, Wuillaume carried out his inquiry and submitted his report to Soustelle on 2 March 1955. Although his investigation was limited to the Kabylie and the department of Constantine, he nevertheless felt he had 'sufficient information to form a judgment'.[41] In the process of his investigation he interviewed sixty-one prisoners at Lambèse, Batna, Guelma and Constantine who, he believed, had been carefully selected 'from among those most unlikely to have been urged by their lawyers to make complaints'.[42] Wuillaume concluded that prolonged imprisonment without trial and the use of torture—beatings, electrocution, various water techniques and others—were not just common, but were also 'old-established practices' within the police culture of Algeria, dating back to decades before the Algerian War.[43] Yet despite the evidence indicating the extent to which violence was a routine part of police practice in Algeria, Wuillaume did not recommend punishing suspected police officers. To do so, he feared, would result in a loss of morale among the police at a time when, by his own admission, these regrettable techniques had led to unspecified 'first-class results'.[44]

Instead, Wuillaume recommend that torture be allowed to continue: 'Ought we nevertheless to continue to accept the procedures described above?'[45] Some forms of physical violence, such as the 'well-known beat-up procedure', were to be banned, along with 'mental violence' that publicly humiliated Muslims who were forced to appear naked in front of their families and to 'engage in unnatural acts' (forced sodomy). However, other forms of violence, which Wuillaume referred to as 'essential if the police [were] to do [their] job satisfactorily', were

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[41] Roger Wuillaume, 'Text of the Wuillaume Report' translated and presented in the Appendix of Vidal-Naquet, *Torture: Cancer of Democracy*, p. 169.
[42] Vidal-Naquet, *Torture: Cancer of Democracy*, p. 35.
[43] Ibid., pp. 170-173.
[44] Ibid., p. 175.
[45] Ibid.

to be permitted.[46] These techniques included prolonged interrogation sessions that caused physical exhaustion and enforcing hunger. They also included ‘water and electricity methods’, which, according to ‘experts’, produced a ‘shock which is more psychological than physical and therefore do not constitute cruelty’.[47]

Although he did not specify who these experts were, Wuillaume continued to state how ‘certain medical opinion’ had convinced him that techniques like the water-pipe methods—where a pipe was forced down the throat of a suspect and water was then poured in to simulate drowning—were harmless if applied correctly. He, however, did acknowledge that electricity was a danger to ‘anyone whose heart is in any way affected’.[48] Ultimately, Wuillaume regarded these techniques as effective alternatives for the police until ‘the introduction into our legal system of the lie detector and the use of pentothal’.[49] By appealing to expert medical opinion in this instance, Wuillaume was trying to add a level of legitimacy and control to these violent acts, perhaps to demonstrate they were not merely the tactics of a brutish police but a seemingly more sophisticated method for obtaining *truthful* statements and intelligence. Interestingly, the claim that these methods were harmless if applied carefully suggested there was a correct way to administer pain which fell under the purview of medical expertise to regulate. There was also a tacit idea that these techniques were acceptable, if crude, substitutes for such ‘scientific’ alternatives as the lie detector and drug interrogation. This latter technique will be discussed in detail below. What the above remarks suggests, however, is the existence of a seeming correlation between medical supervision and the potential respectability of a given torture technique, especially for its assumed ability to produce truthful statements.

Although Soustelle rejected Wuillaume’s recommendations regarding institutionalising electric and water tortures, these techniques would nevertheless become established practice

46 Ibid., p. 176
47 Ibid.
48 Ibid., pp. 176-177.
49 Ibid., p. 177.

among the police and the military during the war. With the military's belief that they were confronted by an entirely new form of conflict in Algeria, the type of subversive warfare discussed in Chapter 2, the French security forces felt that traditional tactics would not prevail against the Algerian rebels. Unconventional tactics were needed and, from 1956 onwards, torture was not only common practice, but was also professionalised and systematised under the leadership of generals like Jacques Massu, Maurice Challe, and Raoul Salan.[50] Torture was a standard method during the screening of arrested individuals for identity checks or during operations. It served the purpose of coercing confession from suspects as well as extracting operational intelligence. However, torture soon took on its own logic and became an instrument of terror and suppression used indiscriminately by the French security forces.[51]

The idea that medical knowledge adds a dimension of legitimacy to otherwise inhumane acts inverts the conventional role of the doctor, and transforms them from agents of healing into 'agents of pain'.[52] In fact, the use of their expert knowledge to advise on an activity that was not in a patient's therapeutic interest itself contravened the principles informing the *Declaration of Geneva* and the *International Code of Medical Ethics*, as discussed above. Similar measures to medicalise aspects of violence were adopted by the authorities in Kenya, as will be shown below, but in this instance medical personnel were required to check the health of suspects before and after they were tortured. This was not a requirement on which Wuillaume insisted. Instead, medical expertise in Algeria was simply called upon to advise on the nature of the techniques, while their implementation was left to trusted police officers in the presence of their superiors.[53] Ultimately, the controlled use of torture in special circumstances was deemed to be a lesser evil than forbidding its use outright. To do so, Wuillaume insisted, would 'plunge the police into a state of disorder and paralysis'.[54]

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[50] Lazreg, *Torture and the Twilight of Empire*, p. 112.
[51] Horne, *A Savage War of Peace*, pp. 197-207.
[52] Scarry, *The Body in Pain*, p. 42.
[53] Vidal-Naquet, *Torture: Cancer of Democracy*, p. 178.
[54] Ibid., p. 177.

4.3. ‘Psychological shock’: the dilution technique and medical oversight in Kenya

As mentioned in the last chapter, there is no evidence of institutionalised or systematic violence in the early phases of the Kenya Emergency. However, this changed with the introduction of a particular form of ‘compelling force’ into the Mwea camps from 1957 onwards.[55] This method, known as the ‘dilution technique’, was originally masterminded by the prison staff officer John Cowan at the Gathigiriri Camp (one of the detention centres in Mwea), but was later adapted and extended to the other camps by Terrence Gavaghan, the colonial district officer for the Mwea camps.[56] In practice, the technique used a mix of warders, African home guards and ‘turned’ rebels to cajole resistant detainees to confess their Mau Mau associations. Its application was brutally simple. Firstly, camp officials would separate the ‘hard core’ and other detainees into smaller, more manageable groups. Unrestrained force was then unleashed on the captives who were subjected to beatings with fists, whips, truncheons, clubs and any other weapons close to hand. The abuse would continue until detainees fell into line, responded to orders and ultimately confessed.[57] A clear description of the technique in action was given by Eric Griffith-Jones, Kenya’s attorney general, when he witnessed its use in the Mwea camps in June 1957. In a secret memorandum, Griffith-Jones explained that ‘In some cases, […] defiance was more obstinate, and some officers immediately converged on the man and “rough-housed” him, stripping his clothes off him, hitting him, on occasion kicking him, and, if necessary, putting him on the ground. Blows struck were solid, hard ones, mostly with closed fists and about the head, stomach, sides and back’.[58] Despite the brutality, Griffith-Jones continued to stress that some restraint was observed: ‘There was no attempt to strike at the testicles or any other manifestations of sadistic brutality’.[59]

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[55] Anderson, ‘British abuse and torture in Kenya's counter-insurgency’ (p. 707).
[56] Ibid.
[57] Elkins, *Britain’s Gulag*, pp. 319-320.
[58] TNA CO 822/1251, p. 3. Secret memorandum from Griffith-Jones’s ‘Dilution Detention Camps – Use of Force in Enforcing Discipline’, June 1957.
[59] Ibid.

Although originally developed for the detention centres in Mwea, the dilution technique was institutionalised by the colonial government and later exported to other camps in early July 1957.[60] After this, the dilution technique was sometimes referred to as the 'intake procedure', as it was generally used to quickly crush any spark of defiance in new prisoners entering the camps. Such intentions were reminiscent of what Primo Levi noted when describing the concentration camps under the Nazis:

> Remember that the concentration camp system even from its origins [...] had as its primary purpose shattering the adversaries' capacity to resist: for the camp management the new arrival was by definition an adversary, whatever the label attached to him might be, and he must immediately be demolished to make sure that he did not become an example or a germ of organized resistance.[61]

In comparison to other forms of abuse and torture taking place in many of the Kenyan detention camps, the dilution technique was organised and systematised. Its ability to coerce conformity and confession from even the most recalcitrant Mau Mau adherents promised to be the solution the British government needed at a time when they were under increased pressure to empty the Pipeline.[62] Governor Baring's enthusiasm for the technique was expressed in a secret and private correspondence to the Secretary of State for the Colonies, Alan Lennox-Boyd, in June 1957, when he wrote:

> In this covering letter to the enclosed papers, I wish to put before you two ideas. The first is that the so-called 'dilution' technique in the camps for detainees is giving very hopeful results indeed and is in fact the only way of dealing with the more dyed-in-the-wool Mau Mau men who will be our problem in the future. The second is its

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[60] TNA FCO 141/6303/57. 'Secretary of African Affairs, 'Mwea Procedure', 24 July 1957.
[61] Primo Levi, *The Drowned and the Saved* (London: Abacus, 1989), p. 38.
[62] Ibid.

> successful implementation depends on our ability to deal with a small number of very difficult men; and if we are able to do this successfully, risks are unavoidable.[63]

The 'risks' in this context was the dilution technique's potential for killing detainees or causing severe injury. For instance, between the 6 and 15 September 1958, three detainees died in three separate incidents at Aguthi Works Camp and at Gathigiriri Camp.[64] Yet despite its potentially fatal outcomes, Baring believed the technique's ability to effect a 'psychological shock', which often led to confessions and cooperation from detainees upon intake, was too valuable to be suspended: 'We have felt that either we must forbid Gavaghan and his staff to proceed in this way, in which case the dilution technique will be ineffective and we will find that we cannot deal with many of the worst detainees, or, alternatively, we must give him and his staff cover provided they do as they say they are doing'.[65] Keen to muster any support for the technique, Baring explained how he had privately corresponded with Dr. Henri-Philippe Junod, an ethnographer and anthropologist who was also a delegate for the International Committee of the Red Cross. Junod, who had been a missionary and knew Baring from their days together in South Africa, had, Baring explained, 'spent his whole life working with Africans and most of it with African prisoners'.[66] According to Baring, Junod had 'no doubt in his own mind that if the violent shock was the price to be paid for pushing detainees out to the detention camps near their districts, away from the big camps, and then onwards to release, we should pay it'.[67] He agreed with Junod and went as far as to say he was prepared to ask him 'at the invitation of the Kenya Government, to visit us again and examine the methods used'.

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[63] TNA FCO 141/6303/7, p. 1. 'Secret and Personal' letter from Baring to Lennox-Boyd, 25 June 1957.
[64] Anderson, 'British Abuse and Torture in Kenya's Counter-Insurgency' (pp. 707-708).
[65] Ibid, p. 2.
[66] TNA FCO 141/6303/7, p. 2. 'Secret and Personal' letter from Baring to Lennox-Boyd.
[67] Ibid.

Junod's role in legitimising the dilution technique has been well known for some time.[68] Yet, it is unclear just how much Junod was aware of and supported this technique. In 1957, after trying for several years to gain entry to Kenya, the ICRC was finally allowed to visit the detention camps. During this first visit, Dr. Junod and another ICRC delegate, Dr. Gailland, visited prison and rehabilitation camps over a two-month period. According to Josiah Mwangi Kariuki, famous for *'Mau Mau' Detainee*, an account of his experience in the Kenya detention camps, Dr. Junod was 'a very intelligent and quiet man, and listened to all our troubles with close attention'.[69] This earnt Junod the nickname *Muthuri wa Itathi*, a title of respect among the Kikuyu for someone who judges actions calmly and dispassionately. Kariuki concluded that Junod was thus 'a truly good man'.[70] According to Gavaghan, however, Junod had given his support to the dilution technique when he saw it in action during his visit to the Mwea camps. Apparently, Junod told him: 'Do not distress yourself' ['*Ne vous inquiétez pas*'], he said; 'compared to the French in Algeria, you are angels of mercy'.[71] Historians have also noted that Junod failed to mention the use of torture in Kenya in his final report to the ICRC, which they regard as tacit support for its use.[72]

Various scholars, Eric Morier-Genoud demonstrates, have questioned the motives for this omission.[73] Some have concluded that the British tricked Junod and the ICRC in their inspection mission by not showing the delegates all the prisons and the extent of the violence taking place behind the barbed wire. Others suspect that the ICRC omitted a complaint against torture because of prejudice held by the Committee and Junod himself.[74] Fabian Klose has

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[68] Elkins, *Britain's Gulag*, p. 331.
[69] Kariuki, *'Mau Mau' Detainee*, p. 148.
[70] Ibid.
[71] Terence Gavaghan, *Of Lions and Dung Beetles* (Devon: Arthur H. Stockwell, 1999), p. 235.
[72] Ekins, *Britain's Gulag*, p. 331 and Helena Coban, 'The Role of Mass Incarceration in Counterinsurgency: A Reflection on Caroline Elkins's Imperial Reckoning in Light of Recent Events, *Radical History Review*, 96 (2006), 112-136 (pp. 125-126).
[73] Eric Morier-Genoud, 'Missions and Institutions: Henri-Philippe Junod, Anthropology, Human Rights and Academia between Africa and Switzerland, 1921-1966', *Schweizerische Zeitschrift für Religions-und Kulturgeschichte*, 105 (2011), 193-219 (p. 210).
[74] Nicolas Lanza, 'Le Comité international de la Croix-Rouge et le soulèvement des Mau-Mau au Kenya, 1952-1959', *Relations internationales*, 1 (2008), 91-110 (p. 102).

gone so far as to explain the omission as sheer negligence on part of the ICRC and Junod more generally.[75] However, Morier-Genoud has recently shown that Junod did in fact denounce the torture taking place in the camps in his report to the ICRC, but that a decision was made at the ICRC headquarters to remove it from the final report.[76] He also cautions against accepting Gavaghan's statement concerning Junod's support, given that the latter raised it in passing in a 'self-serving auto-biography which he published just as veteran Mau Mau fighters prepared a court case against the British in London in 1999, forty two years after the event'.[77] This is plausible, as Gavaghan may well have been trying to deflect responsibility from himself and his role in systematically applying the dilution technique, but Junod's advice to Governor Baring is harder to dismiss. In fact, Morier-Genoud fails to provide a suitable explanation for this. Thus, the fact remains that Junod may well have accepted that torture was a necessary evil if it brought about a faster resolution to the Emergency. While Junod was not a medical doctor, and so he was not bound by the same ethical principles associated with that profession, his relationship to the ICRC was nevertheless significant as, if Dr. Schernholzer's views are correct, the ICRC and the medical community shared a common ideal about suffering victims. As such, Junod's personal views on this torture technique indicate another example where an individual's professional ideals were at odds with their personal ones. Regardless, despite his role within the ICRC, his personal advice to Baring seemed to be one of reassurance and not necessarily expert guidance for the method itself. However, this is not to say physicians had no role to play in the implementation of the technique.

The dilution technique was not to be carried out indiscriminately and without safeguards. According to Griffith-Jones, the method was only to be conducted by conscientious European officers who would assess whether such force was even necessary and appropriate.[78] After

[75] Klose, 'The colonial testing ground' (pp. 108-111).
[76] Morier-Genoud, 'Missions and Institutions' (p. 210).
[77] Ibid.
[78] TNA CO 822/1251. Griffith-Jones, '"Dilution" Detention Camps. Use of Force in Enforcing Discipline', June 1957.

this, they would only proceed in a measured manner that was not excessive or would not lead to serious injury. Before these steps were taken, however, detainees were to undergo a medical examination: 'every detainee included in a 'dilution' intake should be medically examined before leaving his previous camp and any to whom force is applied should be medically examined again immediately after completion of the intake'.[79] For Griffith-Jones and Baring, the presence of a medical expert was an important safeguard that made the dilution technique's implementation more palatable. The motivation for this is unclear, but perhaps the hope was that the presence of medical oversight would add a humane veneer to torture. Indeed, this is one of the reasons why many efforts to legitimise torturous interrogation, such as with the Wuillaume report (mentioned above) and examples in more recent contexts, have stressed the need for doctors to be present during the interrogation procedures.[80]

This is an interesting point which an exclusive focus on the bloody outcomes of torture tends to obfuscate: it is easy to miss the mundane ways in which it was normalised. Medicine played a key part in this process in Kenya. While Wuillaume had merely consulted expert opinion for his recommendations in Algeria, Griffith-Jones had bound physicians to the locations where torture took place. In addition, this prescription for a medical examination prior to and after its implementation made the dilution technique almost indistinguishable from already

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[79] Ibid.

[80] For example, in 1972, in what is known as the Parker Report, the British tried to legitimise its torture techniques by insisting on the presence of a doctor to monitor the acts during its Northern Ireland campaign. See point 41 of the Report of the Committee of Privy Counsellors appointed to consider authorised procedures for the interrogation of persons suspected of terrorism (1972). Point 41 states that:

> We think that a doctor with some psychiatric training should be present at all times at the interrogation centre, and should be in a position to observe the course of oral interrogation. It is not suggested that he should be himself responsible for stopping interrogation—rather that he should warn the controller if he felt that the interrogation was being pressed too far having regard to the demeanour of the detainee, leaving the decision to the controller.

More recently, in Iraq and Afghanistan, the American military insisted on the presence of various clinicians when suspects underwent harsh interrogation. See Hubert Lister Parker Baron Parker of Waddington, *Report of the committee of Privy Counsellors appointed to consider authorised procedures for the interrogation of persons suspected of terrorism* (HM Stationery Office, 1972). See also Steven H. Miles, *Oath Betrayed: Torture, Medical Complicity, and the War on Terror* (New York: Random House, 2006), p. 59-61.

sanctioned forms of corporal punishment which were still standard practice in the Kenyan penal system of the 1950s. Here the procedure for administering corporal punishment also required detainees to undergo medical examination prior to being flogged. For example, in January 1959, the District Officer in Nyeri, Mr. Brookes, requested permission to flog 8 detainees at the Aguthi Works Camp for refusing to follow orders. Permission was granted and, on the following day, the detainees were 'examined and certified fit by the Government Doctor, Dr. Twigg' before undergoing punishment.[81] It is arguable that by referring to the dilution technique as 'corporal punishment' and institutionalising it with the same requirements for medical examination, the procedure could be hidden behind a more acceptable mantel of established punitive violence.

A good example of the power of this ambiguous phrasing can be seen in a set of new instructions for the 'Intake of Z Detainees'[82] that were circulated by the Commissioner for Prisons to the staff at the Embu camps (Thiba, Kandongu, Gathigirir and Mewa Camps) on 27 July 1957. The instructions were distributed a few weeks after the dilution technique had received official sanction through the approval of Regulation 17 of the Emergency (Detained Persons) Regulation.[83] The instruction for the 'intake procedure' stipulated that, firstly, 'the only force which may be used is "overpowering" force; "beating" force may not be employed'.[84] It is not clear what 'overpowering force' is in the context, but once the new prisoners arrived, had their heads shaved, clothes changed for camp clothes and received a

[81] TNA FCO 141/6568/52/2. 'The Chief Secretary's Complaints Co-Ordinating Committee. Meeting Held in the Office of the Deputy Public Prosecutor, Attorney General's Chambers at 2.15, p.m.', 8 July 1959.
[82] Z detainees were those hardcore Mau Mau adherents who had previously been classified as 'black' under the original categorisation systems established at the start of the Emergency. As the Emergency wore on, the colonial authorities devised a different system for classifying Mau Mau inmates based on the level of their perceived allegiances. Z1 was reserved for senior or more determined supporters, while Z2 and Y were used to designate lesser members. Detainees would progress through these categories, ideally from higher to lower, on their way through the rehabilitation process where they would be designated as X before release. See Anderson, *History of the Hanged*, p. 314.
[83] The Regulation legalised definitions of 'compelling force' and 'punitive force', and allowed officers in the detention camps to use violence as a normative practice. See Anderson, 'British abuse and torture in Kenya's counter-insurgency' (p. 707).
[84] TNA FCO 141/6303/39/1, p. 1. Commissioner of Prisons, 'Intake of Z Detainees', 25 July 1957.

‘pep-talk’ from a rehabilitation assistant, they were to be asked, one-by-one, whether they intended to cooperate. If any said no or remained ‘mute of malice’, then the ‘Officer in Charge of the camp should arrange to make a charge against him under Regulation 17 of, and Item 9 of the Third Schedule to, the Emergency (Detained Persons) Regulation, 1954’.[85] After this, if found guilty of the offence and ‘corporal punishment’ is needed, ‘the detainee should be medically examined to ascertain whether he is fit to undergo corporal punishment’, which should ‘only be administered in the presence of a medical officer or the Officer in Charge’. The instructions continue to specify the number of strokes permitted under the regulations, which could have related to the type of ‘overpowering’ force mentioned above (although it is unclear) which regularly relied on the use of batons.[86]

According to Gavaghan, however, this process was too slow, as meting out punishment for each individual could take up to an hour at a time. As such, Griffith-Jones approved Gavaghan’s ‘streamlined’ process, which punished recalcitrant detainees collectively, ‘rather than one after the other’.[87] Also, given that the Officer in Charge would be present from the start of each intake, there was no need to gain his approval for subsequent punishment. Nevertheless, the need for a medical officer to be present continued to be stressed.[88]

To what extent, however, did prisoners actually receive a medical examination as part of this intake procedure? The evidence is patchy, but there is enough to show that this safeguard was taken seriously, at least in certain camps. For instance, on 3 October 1957, the then Permanent Secretary of Defence, A. C. Small, wrote to the Commissioner of Prisons to explain that, owing ‘to the quietness of the recent intakes at the Mwea Camps the doctor there is no longer fully employed and the Director of Medical Services has asked and it has been agreed that he

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[85] Ibid.
[86] Ibid., p. 2. See also TNA FCO 141/6303/168/2, p. 1. I.P. Kelloway, Officer in Charge of Detainee Section, Special Branch to the Senior Assistant Commissioner of Police, ‘Rehabilitation Methods: Mwea Camp’, 28 November 1957.
[87] TNA FCO 141/6303/26, p. 1. Griffith-Jones, ‘Mwea Procedure’, 2 July 1957.
[88] Ibid., p. 2.

can be transferred elsewhere'.[89] He continued to stress, however, that should intake increase at any time, then 'a doctor will be made available to accompany and to attend with the Deputy or Assistant Commissioner of Prisons at the intakes and that it will be the responsibility of the Commissioner of Prisons to ensure that his Deputy or Assistant Commissioner going to the Mewa to attend an intake is accompanied by a doctor'.[90] Later, in another confidential correspondence, W. M. Campbell, Small's replacement as Permanent Secretary for Defence, explained to the Director of Medical Services in Kenya, that the 'intake procedure', the dilution technique as modified by Gavaghan, was not to be applied to the Athi River detention centre. Because of this, there was no need for a Medical Officer to be present during prisoner intake at this facility.[91]

Yet it also seems the role of the medical officer was not always clear. Around the time when the new instructions for implementing the dilution technique were being circulated, Dr. Twigg, expressed confusion over his duties under the new Regulations. According to R. G. Turnbull, the then Acting Governor, Dr. Twigg was 'under the impression that it was his duty to stand by to ensure that an excessive degree of force was not employed'. This, Turnbull noted, was not the case, as the only force permitted was the force necessary to overcome resistance. Instead, Twigg's role was to 'carry out a medical examination of the detainees after they had been through the intake procedure; and […] to carry out the responsibilities laid down under section 88 of the Prisons Ordinance in connexion with the administration of corporal punishment'.[92] However, it was crucial that the doctor played no part in the handling of detainees during the 'intake procedure'. In fact, 'He should not be present at that time but should come on the scene after the detainees had been shaved and reclothed'.[93] This seems to be contradictory. According to the instructions discussed above, doctors were expected to

[89] TNA FCO 141/6303/117. A. C. Small, 'Mwea Camps—Intakes', 3 October 1957.
[90] Ibid.
[91] TNA FCO 141/6303/132. Correspondence from W. M. Campbell to the Director of Medical Services, 'Intakes—Athi River', 14 November 1957.
[92] TNA FCO 141/6303/24, p. 1. 'R.G. Turnball, 'Mwea Procedure', 17 July 1957.
[93] Ibid., p. 2.

examine the prisoners before ‘corporal punishment’ and to witness it in action, but Turnbull seems to be suggesting that the rough-handling of detainees should take place prior to the head shaving. Despite this uncertainty, it is apparent that medical officers were not called upon to actively engage with the actual process of beating detainees. Perhaps this was an attempt to protect the medical profession’s ethical standing, since a direct involvement in the carrying out of violence would have certainly undermined the image of the physician as healer; yet the reasons for this distancing are not made clear in the existing documents.

Although physicians were not required to take part in acts of violence themselves, it is clear that in both Algeria and Kenya, medical expertise was sought to help legitimise efforts to systematise and institutionalise torture in the respective counterinsurgency campaigns. In this regard, these doctors were still on the periphery of the violence, even in Kenya, where their presence was required to monitor detainee’s conditions before or after they were abused. There is therefore a distinction between monitoring or advising on a set of violent techniques and practically carrying them out. By requiring doctors in Kenya to merely examine detainees after they had been beaten, doctors were not necessarily contravening the ethical principles enshrined in the international codes of medical conduct. Ultimately, they could argue that they were merely doing their jobs by treating these victims. However, there were other instances where physicians took a more direct role in the interrogation process, especially in Algeria. This will be the subject of the next section.

4.4. ‘The injection that makes you talk’: truth drugs and interrogation in Algeria

The use of what was referred to as the ‘*sérum de vérité’* [truth serums], or sometimes ‘truth drugs’, to extort confessions or gather information from detained subjects is arguably one of the most interesting points of distinction between the Algerian and Kenyan emergencies. In the former context, the administration of these drugs by European medical experts assisting the military’s interrogation process either made them explicitly complicit in the violence or

turned them into *de facto* interrogators themselves. The situation was straightforward, if not in terms of legal or ethical implications, then at least in terms of their application: a reticent suspect thought to have vital information is injected with a substance designed to overcome their conscious resistance. Or, as Fanon described it, the ‘principle of [the truth drug] is well known: a chemical substance having hypnotic properties is injected into a vein, which, when the operation is carried out slowly, produces a certain loss of control, blunting of consciousness’.[94]

Since the nineteenth century, psychiatrists had been interested in the potential of various substances (hashish, opium, cocaine and mescaline) to overcome unconscious resistance and bring to light repressed psychological states.[95] Throughout the first half of the twentieth century, doctors and psychiatrists experimented with other types of drugs, such as scopolamine, a sedative derived from the same family as nightshade and mandrake, and barbiturates like sodium pentothal (sometimes sodium thiopentone) and sodium amatol.[96] Originally developed for anaesthesia, barbiturates were found to make patients more suggestable in the precomatose stage or during recovery from unconsciousness. Once relaxed, the subject would be open to ‘narcoanalysis’, that is, psychotherapy conducted on a patient in a dream-like state. For the therapist, narcoanalysis could help diagnose psychosis and treat amnesia and neurosis.[97] However, it was also believed that, in this suggestible state, patients would feel more inclined to offer truthful statements about their past experiences.[98] The apparent ability of these drugs to render an individual incapable of lying was therefore of obvious appeal to criminal investigators or intelligence officers.

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[94] Fanon, *A Dying Colonialism*, p. 137.
[95] Rejali, *Torture and Democracy,* p. 387. See also Carl N. Edwards, Samuel I. Miles, and August Piper, ‘Deception: Truth Serum,’ *Wiley Encyclopedia of Forensic Science* (2009), 1-13 (p. 1-3).
[96] Rejali, *Torture and Democracy*, p. 387.
[97] This form of psychotherapy was used extensively during the Second World War by British and American psychiatrists seeking to help traumatised patients return to battle.
[98] Alison Winter, ‘The Making of “Truth Serum”’, *Bulletin of the History of Medicine*, 79 (2005), 500-533 (p. 501).

The use of truth drugs by medical professionals involved in interrogation marks the transition from passive contribution to torture, the subject of previous sections, to torture itself. It also highlights an area of historical research that has gained remarkably little attention, especially in the case of the Algerian War of Independence. In this context, two case studies—that of Henri Alleg and Louisette Ighilahriz—are known to have included doctors administering truth drugs as part of wider efforts to extract information from them. However, although some historians have commented on or acknowledged the presence of these drugs in these two accounts, little attempt has been made to systematically analyse or place them within a wider context.[99] The present section will address this before providing a more thorough consideration of the historical significance of the drugs involved and their legal and ethical implications. As noted in the introduction to this study, that truth drugs were used in Algeria was well known at the time of the conflict. As Fanon stated in 1959: 'The European doctors in Algeria use the "truth serum" with staggering frequency'.[100] Alleg's account of his interrogation under its influence, which was quickly published in France as *La Question* in 1958, remains one of the best known examples, but the publication of Louisette Ighilahriz's memoir in 2001, brought to light new details about this practice. Ighilahriz became the first Algerian woman to bring to the attention of the French and Algerian public the extent of France's suppression tactics in all their violence, including her testimony about being raped and tortured. Her account is valuable, not only because it provides additional insights into the French security forces' general use of torture, but also because it demonstrates their reliance on truth drugs for this purpose.

While Alleg's account offers a glimpse into how the French military used these drugs in interrogation, Ighilahriz's story elaborates on the experience of being drugged, as well as

[99] For example, see footnote in Vidal-Naquet, *Torture: Cancer of Democracy*, p. 177; Franz Kaltenbeck, 'On Torture and State Crime', *Cardozo Law Review* 24 (2002), 2381-2391 (p. 2386); Rejali, *Torture and Democracy,* p. 388; Dan Wood, 'Revisiting *La Question*: A Political-Phenomenological Critque of Merleau-Ponty's Assessment of Algerian Decolonization', *Studies in Social and Political Thought*, 22 (2013), 11-29 (p. 20).
[100] Fanon, *A Dying Colonialism*, p. 137.

showing how FLN trained their operatives to resist their influence. In her memoir, Ighilahriz recalled talking to an 'ex-medical student' who taught her and other mujahideen 'how to act in case of arrest'.[101] The student explained how they 'had to concentrate to try to avoid the effects of the pentothal 'truth serum' that the French administered to their prisoners'.[102] Referring to the procedure as the 'injection that makes [you] talk' [*La piqûre qui fait parler*], Ighilahriz was instructed not to think about the FLN organisation or any compromising information when being interrogated with drugs. Instead, she was trained to focus on one or two people 'outside the Organisation'.[103] Ighilahriz chose to think about her father who had already been imprisoned by the French, and Hjrissa ben Amar, another FLN *maquisard* (guerrilla), who had died a few months earlier.[104] This 'psychological training', as she called it, became invaluable when Ighilahriz was eventually captured by French security forces. While recovering in hospital from the extensive injuries she had sustained during her arrest, Ighilahriz was injected and questioned by an unknown person. Not only does she not recall who administered the injection, she also, unlike Alleg, has no memory of the questions put to her at the time. The effects of the drug were so strong that she only remembered coming-to in her hospital bed, where she was assured by an unknown *maquisard* that she had not given anything away to her captors.[105] Instead, and in keeping with her training, she only talked about her father and Ben Amar.[106]

What are we to make of Alleg's and Ighilariz's respective accounts? On the one hand, they were both produced by individuals who were critical of France's conduct in the war; Ighilahriz was also an enemy combatant. As such, their testimonies require caution: their contents are difficult to prove, while the possibility cannot be ruled out that they are distorted by individual

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[101] Louisette Ighilahriz, *Algérianne. R*écit recueilli par Anne Nivat (Paris: Fayard/Calmann-Lévy, 2001), p. 92.
[102] Ibid.
[103] Ibid.
[104] Ibid., p. 101.
[105] This apparent loss of memory has been recorded in similar situations where so called 'truth serums' have been used. See Schmidt, *Secret Science*, pp. 326-347.
[106] Ibid., pp. 105-107.

prejudice.[107] Moreover, Ighilahriz's produced her story decades after the events took place and in collaboration with two others: Anne Nivat, the journalist who collected and recorded her testimony, and Ouardia, her sister who supported her as she retold her memoires and helped exorcise her trauma for the public.[108] The product is therefore a collective endeavour, which could raise questions about the veracity of the facts being presented.[109] Nevertheless, these types of memoirs are still important tools for social historians, as they give voice to testimonies that are often missing from official accounts. In fact, this is particularly important for the subject of torture generally and the use of truth drugs specifically, as there are few solid sources to prove such techniques were used by the French.

French officials did not refer to torture by name, even when its practice became a normal part of their counterinsurgency strategy. General Massu, who used torture systematically during the Battle of Algiers in 1957, recommended 'coercive methods', while others used euphemisms such as 'professional errors', and 'certain methods peculiar to Intelligence services'.[110] Marnia Lazreg even notes that the Church developed its own 'torture vocabulary', referring to 'methods that do not respect the other' or 'intrinsically bad methods'.[111] To date, it was not possible to find any open recommendation by the French military or colonial authorities for the use of truth drugs as a technique.[112] Though it should be recalled that Wuillaume suggested electrocution and water torture were the best options for police interrogators pending the introduction of lie detectors and sodium pentothal in the French legal

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[107] In an appendix to his *Torture: Cancer of Democracy*, Pierre Vidal-Naquet names Alleg's doctor-interrogator as Captain Chevrel of the Army Medical Service who had denied Alleg's claims to having been drugged. However, Vidal-Naquet continue to state that Chevrel did not bring any evidence 'for defamation of character' against Alleg. See Vidal-Naquet, *Torture: Cancer of Democracy*, p. 177.

[108] Mortimer, 'Tortured Bodies, Resilient Souls' (p. 108).

[109] Ibid.

[110] Lazreg, *Torture and the Twilight of Empire*, p. 114.

[111] Quotes taken from Lazreg, *Torture and the Twilight of Empire*, p. 114.

[112] I found one reference to drugs used for 'torture' in the appendix of a report comparing the psychological warfare approaches and methods of western, totalitarian and communist States. Appendix II, '*Doctrine Politique Communiste*' explains how '*procédés physiques'* [physical processes] such as sleep deprivation and '*emploi de drogues Tortures*' [use of torture drugs] were thought to be used in the Soviet Union. SHD 1 H 2411/d.1/370. 'Annex 11: Doctrine politique communiste', p. 24.

system.[113] However, while being interviewed by Raphaëlle Branche in 2000, Dr. Jean Suaud, a former military doctor, explained how his chief medical officer had permitted the use of truth drugs against Algerian detainees. According to Suaud, the chief medical officer would have some prisoners believe they were receiving a 'soothing injection' when in reality they were being injected with sodium pentothal.[114] His aim was 'to try […] through the truth serum […] to obtain information that others could have after physical torture'.[115] If Suaud's statement shows that some physicians did use sodium pentothal during the Algerian War, it raises questions about whether or not this was viewed as an acceptable and reliable technique at time.

Two European psychiatrists in Algeria who expressed mixed feelings about the benefits of this drug for criminal investigations were Professor Antoine Porot and Dr. Charles Bardenat, who already featured in Chapter 2. Ever eager to promote the power of psychiatry for areas outside of the clinic, these two psychiatrists published *Psychiatrie Médico-Légale* in 1959, which explored, among other things, the 'detection of lies [and] provocation of confession'.[116] Their assessment considered the probative value of hypnosis, mental tests, lie detectors, psychoanalysis and what they referred to as chemical narcosis techniques, that is, truth drugs. In effect, Porot and Bardenat were discussing the science of 'sincerity'.[117] While acknowledging the value of narcoanalysis for therapeutic purposes, Porot and Bardenat, like their metropolitan colleagues, were of the opinion that this technique did not necessarily produce the uncomplicated window into a suspect's soul that popular opinion believed. As they explained, individuals of a strong mindset could be troublesome: '[an] extremely resistant subject which, once adopted a system of denial', reminiscent of Ighilahriz's training, 'will remain there for a very long time and nothing will be shaken; they will support under narcosis their false claims'.[118] Conversely, 'minds of low complexion' could easily be influenced by

[113] Wuillaume, 'Text of the Wuillaume Report', p. 177.
[114] Branche, *La torture et l'armée pendant la guerre d'Algérie*, pp. 469-470.
[115] SHD GR 4K 38. Interview of Jean Suaud with Raphaëlle Branche, 15 February 2000.
[116] Porot and Bardenat, *Psychiatrie Médico-Légale*, p. 87.
[117] Ibid., pp. 87-96.
[118] Ibid., p. 91

interrogations themselves. The psychiatrists admitted that 'the malleability of some minds indeed is considerable'.[119] Like many scientists in the late 1950s, Porot and Bardenat were of the opinion that the use of truth drugs in criminal investigations were untrustworthy. As they said, information obtained from narcoanalysis was not to be given 'too much credit'.[120]

The issue here was that some subjects could mistakenly blur facts with fantasy while under the influence of these drugs. A good example of this in the Algerian context was a case recorded by the former soldier, Jean-Pierre Vittori, in *On a torturé en Algérie*. In his account, Vittori explained how he had witnessed an arrested fellagha being interrogated on suspicion of 'urban terrorism'. According to Vittori, a doctor was summoned to 'supervise the use of the truth serum' after other unspecified interrogation techniques had failed. Once injected, the pentothal caused the man to sink 'into a semi-comatose state', and after an initial short pause, the 'valves opened and the "patient" [started to tell] the details of an extraordinary attack perpetrated in Algiers a few weeks' before. This attack, the drugged *fellagha* claimed, had killed twenty soldiers and destroyed an entire military post. The problem, Vittori continued, was that this was complete fantasy—no such attack had ever taken place at any military post.[121] Meanwhile the prisoner continued a confused tirade against the French, explaining how he was fighting against them. 'In a way', Vittori went on, 'he takes his desires for realities and his dream is fulfilled under the influence of drugs'. The revelations of the fellagha's testimony apparently left the doctor 'trembl[ing]' at the thought of what would be revealed if pentothal was 'administered to the entire [Algerian] population'.[122]

Another problem facing truth drugs at this time was the claim that their use could also be a form of abuse or torture. For example, in both Alleg and Ighilahriz cases, as well as those mentioned by Suaud, the doctors or those administering sodium pentothal—it is not clear

[119] Ibid., p. 90.
[120] Ibid.
[121] Jean-Pierre Vittori, *On a torturé en Algerie* (Paris: Éditions Ramsay, 2000), p. 79.
[122] Ibid.

whether or not it was actually a doctor, nurse or even a soldier who injected Ighilahriz—did so without seeking the subject's consent. If Suaud is to be believed, his chief medical officer even deceived his patients. It is quite clear that the use of sodium pentothal for interrogation could not be interpreted as a therapeutic procedure, and so its use would have been a violation of the *Geneva Declaration* and the *International Code of Medical Ethics*. However, the use of truth drugs in this way was also hotly debated in French courts and European military research laboratories, such as Porton Down in Britain, following the end of Second World War, as will be discussed below.

The case of significance in this context was the trial of Henri Cens, in 1948. Cens was a police officer suspected of collaborating with Nazi forces during the occupation years. However, in 1943, during a prison riot in Montpellier, Cens was accidentally shot in the head. Although he survived the incident, he was supposedly left with a form of aphasia rendering him incapable of remembering or speaking.[123] In order to establish whether or not he was fit to stand trial, the court appointed a board of expert psychiatrists to assess his case. During their examination, one of the psychiatrists administered sodium pentothal to Cens, telling him it was for 'therapeutic purposes'.[124] While under the drug's influence, Cens reportedly uttered one positive '*oui*' in response to the psychiatrist's questions which, they subsequently argued in court, was evidence that he was malingering and feigning his aphasia.[125] Cens was convicted. Soon after he brought a legal case against the psychiatrists, charging them with assault and battery, illegal search and the violation of professional secrets.

[123] Jean Rolin, *Police Drugs*, trans. by Laurence J. Bendit (London: Hollis & Carter, 1955), p. 70.
[124] Ibid., 72.
[125] George H. Dession, Lawrence Z. Freedman, Richard C. Donnelly and Frederick C. Redlich, 'Drug-Induced Revelation and Criminal Investigation', *The Yale Law Journal*, 62 (1953), 315-347, (p. 316).

Although the court decided in the favour of the psychiatrists,[126] the Cens case generated significant discussion throughout Europe. Responding to the controversy generated by the psychiatrists' conduct, the Council of the Paris Bar Association adopted a resolution opposing the use of drugs during interrogation.[127] The psychiatrists involved in the case were criticised for violations on four grounds: they had violated the article of the French Penal Code binding doctors to professional secrets; they had violated the provision on forbidding the questioning of an accused outside the presence of his advisers; they had violated the article forbidding assault and battery; and they had deprived the patient of his free will by using the truth drug.[128] Yet not all medical and legal associations were as decided on the question of this interrogation technique and the law. In March 1949, the *Académie de Médecine*, consulted by public authorities, issued an unfavourable opinion on the legitimacy of narcoanalysis for criminal investigations as well, despite contrary opinion expressed by Professors Baudouin and Laignel-Lavastine.[129] Conversely, the *Société de Médecine Légale de France* declared narcoanalysis to be lawful for forensic evaluation, as long as it was performed on a strictly medical basis.[130] With a few exceptions in both Britain and America, the feeling was largely the same: evidence obtained by way of narcoanalysis could not be trusted for criminal investigation. In Holland and Spain, the law prohibited all procedures of physical and moral coercion to provoke a confession, while in Western Germany, special precautions were put in place to protect any defendant from infringing their right to defence by techniques affecting their conscience and moral freedom.[131]

[126] It seems the psychiatrists involved were able to persude the court that they were only acting in accordance with routine psychiatric procedures necessary to get Cen's to answer the limited questions put the them. See Dession *et al*, 'Drug-Induced Revelation and Criminal Investigation', (p.316).
[127] This is presumably what Fanon was referring to when he wrote that 'All the Academies of Medicine of all the countries in the world have formally condemned the use of this practice for legal ends and the doctor who violates these solemn proscriptions is obviously contemptuous of the fundamental principles of medicine'. See Fanon, *A Dying Colonialism,* p. 137.
[128] George H. Dession *et al*, 'Drug-Induced Revelation and Criminal Investigation' (p. 316).
[129] Porot and Bardenat, *Psychiatrie Médico-Légale*, p. 94.
[130] Ibid.
[131] Ibid.; see also D. Colwyn William and Ilse Boon, 'The Prohibition in Western Germany of the Admission of Evidence Obtained Through Narco-Analysis', *The British Journal of Delinquency*, 2 (1951), 55-57.

The argument that the use of these drugs was a form of torture that constituted a direct attack on human dignity was also expressed outside of the courtrooms. For instance, in October 1953, Pope Pius XII grouped narcoanalysis with torture in a text he produced for the Fourth International Congress on Criminal Law.[132] In his paper, Pius denounced the whole practice of detention without trial as a mockery to the Law. He, in particular, stressed that:

> Preliminary investigation must exclude physical and mental torture and narco-analysis, firstly because they are against the natural law even if the accused is guilty. And also because very often they give the wrong results. It not infrequently happens that they produce exactly the confessions required by the court […] not because the accused is in fact guilty but because his physical and mental energy is exhausted and he is ready to make any sort of declaration that is required. Better prison or death than such physical and mental torture![133]

In their work, Porot and Bardenat draw close attention to a whole spectrum of opinions on the moral implications of these drugs as expressed by various medical professionals, jurists and social scientists across Europe. By the late 1950s, it is clear that opinions were divided. For themselves, Porot and Bardenat concluded that 'in the judicial investigation, [the use of truth drugs] by police or magistrates is reprehensible because it constitutes a systematic and deliberate splitting of human rights by a kind of breach of conscience'.[134] However, this condemnation was limited to the use of truth drugs by non-medical individuals; Porot and Bardenat were far more ambivalent when it came to their use by medical experts. They admitted that the recourse to narcoanalysis could be useful in exceptional cases. One such case might be when narcoanalysis is called for by the defence to ascertain the mental responsibility

[132] Pius is currently a controversial historical figure as he had been well informed about the types of medical atrocities performed by German scientists during the Second World War and remained silent about them while also having close ties to the regime. See Schmidt, *Secret Science*, p. 371.
[133] Quoted by Louis Allen, 'YES I SAID YES I WILL YES', *Blackfriars*, 39 (1958), 474-487 (p. 482).
[134] Porot and Bardenat, *Psychiatrie Médico-Légale*, p. 95.

of a defendant and their ability to stand trial. Presumably, by willingly consenting to narcoanalysis in order to strengthen the defence, the accused would not be subjected to the type of legal violations involved in the Cen's trial—their minds would not be invaded by the prosecution but willingly probed to strengthen their case. As an example, Porot and Bardenat cite the work of their colleague at the Algiers School of Psychiatry, Dr. J. M. Sutter, who reported on just such a case in 1951, where his use of narcoanalysis proved the inability of a suspect to stand trial due to 'obvious signs of a true psychosis'.[135] Ultimately, according to Porot and Bardenat, it seems they agreed with Sutter when he wrote that 'the truth […] is that the doctor, and the psychiatrist more than any other, is at every moment in the presence of ethical problems of which no scale, no immutable code can bring him the solution; an uninterrupted series of cases of conscience where he must engage with all the resources of his moral dynamism'.[136]

Despite providing a thorough consideration of the strengths and the various scientific, legal and ethical limitations surrounding narcoanalysis for criminal investigations, Porot and Bardenat did not address its use by doctors involved in France's counterinsurgency campaign. By the time of their publication in 1959, Alleg's account had already generated significant international attention and outrage. It is curious that these two psychiatrists did not denounce such tactics, especially given that individuals like Fanon had accused the European psychiatrists of being complicit in such practices.[137] The use of sodium pentothal by the French security forces in Algeria was, as with the Cens case and the views of many contemporary intellectuals, a violation of the medico-legal and ethical standards at the time. The administration of truth drugs to Alleg and Ighilahriz in particular was a form of assault and battery; it stripped them of their free will, contravened the privileges of the doctor-patient relationship regarding professional secrets and was administered without legal representation

[135] Ibid. See also J. M. Sutter, 'La subnarcose chimique', *Revue de droit canonique* (1951), 679-82.
[136] Porot and Bardenat, *Psychiatrie Médico-Légale*, p. 96.
[137] Fanon, *The Wretched of the Earth,* p. 228.

for the suspects. As such, these drugs represented a way in which European doctors in Algeria directly contributed their expertise to the atmosphere of violence playing out in the country. It also points to a marked difference between France's war in Algeria and the Kenya Emergency.

4.5. 'Clever and unscrupulous combination of methods […] well known': British resistance to drug interrogation

Although the British security forces in Kenya did not use truth drugs in their interrogation sessions, this does not mean that such drugs were not considered at all. On 12 January 1955, W. F.B. Pollock-Morris, the Secretary of Defence in Kenya, sent a correspondence to the Director of Intelligence and Security in Nairobi, inquiring about a matter raised by a Dr. Alfred H. Becker.[138] Becker, a controversial figure who was a Rehabilitation Officer at the detention centre on Manda Island, had written a letter on 6 January 1955 to the 'Commissioner for Community Development and Rehabilitation on the subject of applying the narco-analysis treatment in the screening of detainees'.[139] The details of Becker's original letter are currently unknown, as are the views expressed on it by Pollock-Morris and the Ministry of Defence.

If the British security forces were resistant to the idea of using truth drugs in Kenya, it was not due to any ethical or moral objections on their part. Instead, their attitudes were reflective of broader scepticism among the military and intelligence officials regarding the science of interrogation more generally. During and after the Second World War, Britain had experimented with the use of various drugs to enhance their interrogation processes. These techniques differed from the type of narcoanalysis performed in Algeria in that they were not

[138] It is not currently clear what Dr. Becker's profession was before he became a Rehabilitation Officer, but he was known to be a particularly zealous character who was implicated in multiple grievances by Mau Mau detainees, including psychological and physical abusive coercion. In 1955, he was transferred from Manda Island to another unidentified camp after he stirred up controversy when he wrote letters to friends of detainees impressing on them the need to pressure the detainees into confessing.
[139] TNA FCO 141/6178/66. W.F.B. Pollock Morris, 'Narco Analysis', 12 January 1955.

necessarily seeking pertinent information from suspects. Instead, British experiments with these substances sought to control the minds of their subjects, as will be shown below. Nevertheless, the arguments for their usefulness and reliability were dismissed on similar grounds to their French counterparts: the results gained from these substances were deemed unreliable and ultimately unconvincing by both British scientists and the security experts. For example, in 1940, the British military set up an interrogation centre, known as a Combined Services Detailed Interrogation Centre (CSDIC), in Cairo, where captured enemy agents were injected with amphetamines and the hormone thyroxine during interrogation sessions.[140] One interrogation office, Alexander Kennedy, a physician who would go on to become a professor of psychological medicine at Edinburgh University, combined these drugs with hypnosis and other stress-inducing factors, such as ambiguous sounds and visual stimuli, to produce hallucinations in his subjects.[141] Despite attracting the curiosity of high-ranking intelligence personnel, such as Dick White, a commander of MI5's B Division, Kennedy's techniques did not catch on. According to White, drug-assisted interrogation of this kind took too long to extract information that more direct methods could produce in hours.[142]

In the 1950s, British scientists once again explored the potential power of truth drugs as part of a joint research programme with the United States. The 'brainwashing scare', discussed in Chapter 2, inspired a series of joint investigations between US and British scientists into possible mind-control methods being employed by the Soviets. According to the American Psychiatrists Irving Janis, who was corresponding with his British counterpart, William Sargent, between 1949-1950, Soviet interrogators were using a mix of 'conditioning techniques' and 'drug treatments' to extort confessions.[143] Yet as Erik Linstrum has shown, scientists consulted by the War Office (and later the Ministry of Defence) on this matter were

[140] Ian Cobain, *Cruel Britannia: A Secret History of Torture* (London: Portobello Books, 2013), p. 24.
[141] Ibid.
[142] Ibid., pp. 24-25.
[143] Linstrum, *Ruling Minds*, p. 184.

unconvinced.[144] This was especially the case for the medical researcher, Harold Himsworth, who argued that the communists were unlikely to deploy elaborate mind-control techniques when easier and more effective methods were already available.[145] For Himsworth, it was 'very doubtful whether we are here dealing with any strange drug such as would delight the hearts of the cheaper writers of thrillers'.[146] Far from developing a new technique that 'robs the subject of his will and allows new beliefs to be implanted in him without his being aware', it was more likely that 'the observed results can be accounted for by a clever and unscrupulous combination of methods which are well known'. These included, Himsworth suggested, 'undermining the subjects [sic] physical strength by under-feeding, inducing extreme fatigue by lack of sleep, the relentless maintenance of the "sword of Nemesis" atmosphere, the adroit alternation of hope and fear, and blackmail with regard to relatives and institutions to which the prisoners are devoted'.[147]

Despite Himsworth's reservations, however, further research into the novel effects of certain substances was conducted as part of a larger CIA-funded initiative. In 1951, the Harvard anaesthetist, Dr. Henry K. Beecher, travelled to Europe in search of 'ego-depressant' drugs for enhancing interrogation as part of a top-secret US 'special interrogation programme' known as Operation Artichoke. Beecher was originally interested in the effects of what Alfred W. McCoy called 'the Gestapo's drug of choice', mescaline, but later turned his attention to hallucinatory effects of lysergic acid (LSD).[148] During his travels across Europe, Beecher tipped off the British Joint Intelligence Bureau about the powers of LSD. Although British scientists had already taken an interest in the substance's potential as an incapacitating weapon before Beecher's arrival, a more concerted research programme took place between 1953 and

[144] Ibid., p. 184.
[145] Ibid.
[146] TNA DEFE 9/37. Top Secret letter from Dr. Himseworth to H. T. Tizard, 4 December 1950.
[147] Ibid.
[148] Alfred W. McCoy, 'Science in Dachau's Shadow: Hebb, Beecher, and the Development of CIA Psychological Torture and Modern Medical Ethics', *Journal of the History of Behavioural Science*, 43 (2007), 401-417 (p. 411).

1954, which saw the drug administered to unsuspecting soldiers at the British chemical and biological warfare facility at Porton Down.[149]

Despite this research, British methods of interrogation, especially in overseas territories like Kenya, did not change much over the course of the 1950s and 1960s. As noted in Chapter 2, despite the British government's use of psychological expertise to frame the official interpretation of, and approach to, the threat of Mau Mau, there is little evidence that scientists of any sort tried to develop new interrogation techniques. More often than not, the feeling was that scientific approaches, especially drug-assisted interrogation, were too slow and ineffective. In the end, it was easier to rely on the more 'traditional' types of coercive methods listed by Himsworth: controlled and restricted feeding, sleep deprivation, a persistent sense of impending judgment and an oscillating atmosphere of peril and the promise of salvation. These techniques did not require the assistance of scientific experts to implement them; any police officer, soldier or Special Branch operative could apply them in a detention centre. However, if the Kenya Emergency was a kind of laboratory for experimenting with novel counterinsurgency techniques, then the experimenters in this case were individuals like Cowan and Gavaghan—ordinary individuals with little-to-no scientific knowledge. Yet they regarded themselves as *the* experts, often drawing on personal experience and instincts to inform their brutal methods. As Linstrum explained, 'When military and police interrogators laid claim to the language of expertise—as they habitually did—they were touting powers of intuition rather than technical knowledge'.[150] Rather than help to devise elaborate torture techniques, medical officers in Kenya merely monitored them.

[149] Ulf Schmidt has shown that further experiments took place between the late 1950s to the 1970s. See Schmidt, *Secret Science*, pp. 326-336; Dominic Streatfield, *The Secret History of Mind Control* (London: Hodder & Stoughton, 2007), pp. 71-73.
[150] Linstrum, *Ruling Minds*, p. 185.

Conclusion

This chapter has demonstrated that, through various means, a range of medical expertise was utilised by the colonial authorities and security forces to help legitimise, humanise, monitor and even participate in sanctioned forms of torture. In most cases, these exerts provided either scientific opinion to strengthen the official efforts to legalise torture, examined and checked the health of detainees prior to and after undergoing torture or else actively intervened in the interrogation process in order to gain operative information themselves. Despite the extraordinary circumstances and conditions these doctors were working in, they were nevertheless participating within their professional capacity as healers. Such unusual encounters between the doctor and detainee-patients raised substantial questions about the contemporary standard of international codes of medical ethics which may have influenced or at least informed their conduct. Examining the relative effectiveness or limitations of such international codes adds greater understanding to what has been an underexplored and underappreciated aspect of this subject. As has been argued here, the few historians who have examined medical participation in violence during the Algerian war have demonstrated a less than nuanced understanding of the different codes of ethics that came into existence in the immediate postwar period. Yet as demonstrated above, the World Medical Association promulgated two important codes that were designed to update the perceived weakness of the *Hippocratic Oath* at the same time as the nascent human rights regime was coming into existence.

As with the *Hippocratic Oath* before them, the WMA's *Geneva Declaration* and the *International Code of Medical Ethics* carried little legal weight and were still too vague to be of practical use for doctors involved in the novelties of an unconventional war where torture was rife. Yet where these medical codes were still largely paternalistic in terms of the rights they afforded the doctors over the autonomy of the patient, the Fourth Geneva Convention, which arguably shared the same ideals as the medical profession, should have provided greater

protection to detained individuals. However, both Britain and France refused to extend the protections it enshrined to their overseas subjects, especially in Kenya and Algeria where anticolonial sentiments were turning into outright hostilities. As such, torture became a permissible practice within the detention centres in both contexts and the doctors involved in treating its victims did so without any clear guidance on how to act. As this chapter has argued, it is not clear that the existence of such guidelines would have necessarily made a difference.

When it came to trying to legitimise and legalise torture, both the British and French authorities relied upon medical opinion to add strength to their efforts. In Algeria, this was part of Roger Wuillaume's official recommendations following his investigation into alleged abuses in the North African colony. Wuillaume's report not only proved that the French police were using torture as part of an established approach to interrogation in Algeria, it also demonstrated the extent to which certain techniques were deemed to be acceptable. In order to convince others of this, Wuillaume's relied on testimonials from unidentified doctors who trivialised or underplayed any potential dangers associated with electrocution and the water-pipe method. Although Muillaume's recommendations were not officially sanctioned, the techniques he suggested became part of the military's arsenal of pain during the Battle of Algiers. By providing such medical advice, the doctors involved managed to invert their role from agents of healing to *de facto* agents of harm. The situation in Kenya was somewhat different. In this context, Kenya's attorney general helped to systematise the dilution technique by making it a formal requirement that detainees be examined by a medical officer before and possibly after they experienced its use. As this chapter has argued, Griffith-Jones achieved this by making the technique almost indistinguishable from other forms of corporal punishment that were legally sanctioned by the British government. Despite this, the technique was recognised as potentially lethal at the time of its creation, but the British authorities, including Governor Baring, believed any risk was outweighed by its ability to extract confessions from even the most resistant of detainees. He even received personal assurance

from Dr. Junod, of the International Committee of the Red Cross, who offered advice on how to make the technique more effective if needed.

Through their presence and medical examination of diluted detainees, medical officers in the Kenyan detention camps helped to normalise this torture technique, but there is currently no evidence to suggest they actively participated in any abuse. This is in direct contrast to French physicians, certainly those working for the military but possibly also civilian doctors, who used truth drugs to extract information from detained suspects. The case of Louisette Ighilahriz is a key source of evidence: her memoir not only provides additional information on the military's use of torture more generally, but also shows how the hospital ward could become an interrogation chamber. In fact, it seems that the military's use of these drugs was so widespread that the Algerian *maquisards* were trained to resist their influence even though there is little official information to prove it. Nevertheless, through testaments by physicians such as Dr. Suaud, it seems this particular technique was used far more frequently than has previously been suggested. The use of such drugs by the military came at a time when their legality and effectiveness were under scrutiny from lawyers and scientists alike. The case of Henri Cens, which predated the Algerian War by nearly a decade, had drawn international attention to the legal and ethical issues surrounding their use and even prominent doctors in the Algiers School of Psychiatry attempted to temper assumptions about their abilities to gain truthful and accurate statements. The British security forces, however, were less willing to use these techniques in their campaigns against Mau Mau, despite their adoption being at one point suggested by Dr. Becker. As argued here, this had less to do with any moral objections on the part of the Ministry of Defence, and more to do with Britain's overall view of such technique, which they had experimented with in other forums. Ultimately, the British security forces preferred to use less 'sophisticated' methods of coercion, such as the dilution technique, which were merely monitored by medical experts.

Chapter 5. Bodies of evidence: medical reactions to evidence of torture

How did physicians react when presented with the realities of tortured bodies in the detention centres of Algeria and Kenya? What did they do when called on to perform tasks that were not always 'compatible with the one that the tortured people may [have been] hoping for'?[1] This final chapter will explore these questions by examining torture's aftermath. The analysis is split into two halves. The first half examines how physicians responded to the use of torture generally and how they may have rationalised their roles or tried to carry out their duties under conflicting pressures. The second half turns attention to the thorny question of what happened when torture (or other human rights violations) resulted, intentionally or not, in detainees being killed. Or to be more precise, what role did the medical profession play in helping to conceal evidence of abuse? In both Algeria and Kenya, as will be demonstrated, the bodies of torture victims were made to disappear in order to conceal the criminal act.[2] Alternatively, elaborate scenarios could be contrived where the victims were somehow presented as being responsible for their own deaths. For instance, victims might be shot by the security forces after they had reportedly 'tried to escape' custody.[3] However, within both contexts during the 1950s and early 1960s, situations occurred which raised too many questions to be simply ignored. In these rare occasions, the victims of violence were able to draw attention to themselves and their plight; in other cases, the sheer number of the dead was too high to be ignored. In such instances, the bodies of the victims of torture, the wounds and markings they exhibited, were left as ghastly testaments to the realities of their ordeals and the methods used

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[1] Branche, *La torture et l'armée pendant la guerre d'algérie*, p. 467.

[2] For Kenya, see David M. Anderson and Paul J. Lane, 'The unburied victims of Kenya's Mau Mau Rebellion: where and when does the violence end?', in Jean-Marc Dreyfus and Élisabeth Anstett (ed.), *Human remains in society: Curation and exhibition in the aftermath of genocide and mass-violence* (Manchester: Manchester University Press, 2016), pp. 14-37; for Algeria, see Fabian Klose, *Human Rights at the End of Empire,* pp. 185-186.

[3] Richard Evans, *Law and Disorder: or scenes of Life in Kenya* (Bath: The Pitman Press, 1956), pp. 188-189.

by their assailants.[4] This is especially important in two conflicts where the voices of Algerians and Kenyans carried little weight.[5] In this context, the lesions, scars, abrasions, burns and other marks could be powerful indicators of their claims and wider regimes of violence, but they were not enough to prove this on their own. An expert eye was needed, and who better to interpret the meaning of such things than medical doctors? But, as this chapter will demonstrate, this expertise was far from uncontested and could easily support, rather than refute, state efforts to deny abuses.

This chapter explores this theme and supplements the scant studies that have examined medical collusion in state cover-ups and denials of torture. It focuses less on the existence of cover-ups, since the evidence pertaining to them is overwhelming,[6] but on the light that these cases throw on the complicated relationships between experts, the security forces and the use—and abuse—of medical evidence. As will be shown below, when faced with evidence of torture, physicians responded in complex ways and had a range of reasons for why they may have continued to support those who performed torture. Yet when it came to investigating allegations of torture within the colonies, medical experts could play a fundamental role in either supporting or undermining institutionalised and professional violence. A doctor's interpretation of the evidence and their expert opinion could draw attention to irregularities or it could perpetuate the silence surrounding institutions that tortured.

5.1. 'Medical masquerade': reacting to torture in Algeria

On the night of 17 December 1959, Dr. Jacques Faure, a young French military doctor, had his first encounter with a torture victim. Just before midnight, he received a call from an officer

[4] Branche, *La torture et l'armée pendant la guerre d'Algérie*, p. 473.
[5] Thénault and Branche, 'Le secret sur la torture pendant la guerre d'Algérie', *Matériauc pour l'histoire de notre temps*, 58 (2000), 57-63 (p. 59).
[6] See discussion in the introduction of this thesis regarding the revelations of British and French efforts to conceal the evidence of violence in these wars, especially in relation to the Migrated Archives in the former context.

seeking his help. The officer reportedly stated: ‘Come quickly, doctor, a prisoner is wounded, his condition is serious’.[7] The prisoner, a man of thirty-five, was already in a critical state when Faure arrived: he was covered in bruises, both his legs were broken and he was in a semi-comatose state. The officer explained with some ‘embarrassment’ that the prisoner had ‘fallen’ or perhaps had been involved in a ‘brawl’. Despite his injuries, it was impressed on Faure that under no circumstances should the prisoner be allowed to die: ‘*Mais, il ne faut surtout pas qu'il meure, il détient des informations importantes sur la rébellion*’ [But he must not die, he has important information about the rebellion].[8] Yet due to the possibility of escape and the isolated nature of the military post, the prisoner could not be hospitalised. Faure's only option was to administer morphine and lessen the prisoner's pain before he died. This is a theme common to both the situations in Algeria and Kenya—torture routinely took place in remote and isolated locations with little access to sufficient medical facilities or equipment.

For Faure, the lack of provisions contributed to the inverting effect torture had on the doctor-patient relationship. The encounter with the ‘tortured human body’ and the actions of his colleagues who inflicted these wounds, he argued, ‘upset all [his] conceptions’ of the relationship between a doctor and ‘the other’. ‘*The victims*’, he asked, ‘what image could they have of this doctor who belonged to the group that was torturing? Was [he] there to relieve them or on the contrary to ‘rekindle’ them to allow the continuation of the abuse?’[9] This was a sound concern, as other reports showed that soldiers would often tell prisoners they had ‘doctors who can make you last’, a claim that, in a victim's eyes, might transform medicine into a hostile weapon.[10] To make the matter worse, the doctor and victim had few opportunities to communicate outside of a cursory encounter. The ‘wound, the hematoma, the burn were

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[7] J. Faure, ‘Problèmes d'Éthique posés au médecin par la torture: A propos d'une expérience personnelle’, in *Droits de l'homme et contrainte de la personne, XI congrès de l'Académie internationale de médecine légale et de médecine sociale, Acta medicinae legalis et socialis*, 30 (1980), 71-74 (p. 71).
[8] Ibid.
[9] [*Etais-je bien là pour les soulager ou au contraire pour les ‘requinquer’ afin de permettre la poursuite des exactions?*]
[10] *The Gangrene*, trans. by Robert Silvers (New York: Lyle Stuart, 1960), p. 61.

our only grounds of contact behind which there was only misunderstanding', he claimed.[11] According to Faure, this lack of quality care and mediocre facilities in remote areas, combined with the fact that medical examinations were rarely repeated, meant that the victim could easily come to believe in a 'medical masquerade'.

Reflecting on his experience in the 1980s, Faure appeared to be trying to salvage the reputation of military doctors associated with torture. He admitted that testimonies on torture were well known at the time and that military physicians 'could not ignore its existence'; yet torture remained for him a 'horror that could not involve the doctor'.[12] When he tried to confide in other military doctors of various ages and ranks, he was faced with three types of response: 'firstly, denial—"I was wrong"; secondly, commiserations: "we do not make war with choir children"; thirdly, threats: "as a French soldier, I was silent, obeyed or sanctioned."'[13] If his testament is to be believed, doctors were largely passive in their interactions with torture. At worst, they were subordinate to the military hierarchy. The French military doctors are portrayed as professionals caught in the chaotic maelstrom of armed conflict and torture. Soldiers perpetrated torture while the doctor played a regrettable role in concealing it from wider scrutiny. However, what about the more ethically ambiguous cases where doctors were clearly involved in torture, such as when they administered truth drugs? Or, less ambiguously, when they encouraged abuse? For instance, Ayad Ahmed ben Abdelkader, a 25-year-old resident of Boghari, in the province of Médéa, complained that, between 9 September and 1 October 1959, he was subjected to a series of cruel tortures at the hands of various prison and

[11] Faure, 'Problèmes d'Éthique posés au médecin par la torture' (p. 72).
[12] [*et pourtant la torture était restée pour moi une horreur qui ne pouvait concerner le médecin*], Ibid. (p. 72).
[13] Ibid.

military staff.[14] In addition to these torments, he also claims he was hit by prison guards on the order of a Dr. Dalbie.[15]

Even if Faure's account omits doctors as perpetrators, it still provides an insight into the social pressures and dynamic surrounding institutionalised torture. As he asserted, torture could only become a collective activity if it received consent from the group concerned. Faure argued that the social pressures within regiments made it difficult for him and his colleagues to challenge the use of torture, to revolt against the group, or resign.[16] Ultimately, the only remaining option, he claimed, was to compromise by treating the victims. Yet archival evidence does suggest that other doctors may have been willing to resign in the face of torture and abuse in the French detention centres. For instance, in November 1961, the police prefecture for Oran requested assistance from a military doctor for the *Centre d'Hebergement* at Arcole, as there was a staff shortage among civilian doctors due to 'absences' or 'the refusal of some to continue the services that were entrusted to them'.[17]

While Faure continued to collaborate with the torturers in his regiment, his account reveals how embedded doctors were in these military units. This was a relationship that could become uneasy due to the nature of the acts. For instance, he explained how a sick officer who was 'very much engaged in the practice of interrogation' had hesitated to seek medical attention for several days because he feared Faure would refuse to treat him.[18] However it was the less seasoned soldiers, the 'young apples', who had been 'thrown into the [Algerian] turmoil', who concerned Faure the most. One 22-year old sub-lieutenant told Faure that he had started to

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[14] From the 9 September to the 1 October 1959, Ayad Ahmed ben Abdelkader, a 25-year-old resident of Boghari, in the province of Médéa, was arrested and detained. Throughout this period, he was frequently moved between the Boghari Commissariat and the Moudjebeur military camp, where he was electrocuted, underwent the water method several times, was forced to eat salt for 4 consecutive days and was slashed across the back with a knife and had salt rubbed into the wounds. SHD 1 H 1240/8. Audition de Temoin, 'Ayad Ahmed ben Abdelkader', 27 January 1961.
[15] Ibid.
[16] Faure, 'Problèmes d'Éthique posés au médecin par la torture' (p. 72).
[17] SHD 1 H 1492. Paleologue, 'Mise à la disposition de M. le Préfet de Police, d'un Médecine militaire', 24 November 1961.
[18] Faure, 'Problèmes d'Éthique poses au medecin par la torture' (p. 73).

take pleasure in dominating suspects through torture and even in killing them. The soldier questioned his ability to 'rehabilitate himself' back to civilian life after this military service.[19] These interactions with the soldiers and their physical and mental health provided Faure with what he called his 'second revelation about the doctor's role' in torture: 'those executioners [...] also needed the doctor'.[20]

Faure's concern for the impact torture had on the health and mental wellbeing of the torturers is itself not a unique observation, though one that is rarely acknowledged in historical analysis. In the final chapter of *The Wretched of the Earth*, Fanon included a series of case studies drawn from victims of torture and their torturers that he recorded while working as a psychiatrist during the Algerian War. Case number 4 of series A involved a 28-year-old police officer who, while working at an 'anti-FLN brigade', became involved in interrogation which 'never occurred without some "knocking about"'.[21] The problem was that the young police officer was being haunted by his experience. 'Now I've come so as I hear their screams even when I'm at home. Especially the screams of the ones who died at the police headquarters', Fanon claims he reported. The situation became more acute when the police officer accidentally saw one of his torture victims, described as a 'patriot', in the hospital, an encounter that caused both the officer and the patriot great psychological unease. According to Fanon, the police officer had to be given sedatives due to his anxieties while the patriot was later found in the hospital toilet trying to commit suicide.[22] Eventually, the police officer's condition improved enough for him to return to France while the hospital staff had to convince the patriot that 'the whole thing was an illusion' brought on by fatigue.

In another case recorded by Fanon, Case 5 of series A, a police inspector who was tormented by nightmares found himself, especially when at home, 'wanting to hit everybody all of the

[19] Ibid.
[20] Ibid.
[21] Fanon, *The Wretched of the Earth*, p. 213.
[22] Ibid., pp. 213-214.

time'. Apparently one day he 'threw himself' at his wife after she criticised him for beating the children too severely. The inspector tied her to a chair and beat her while saying to himself 'I'll teach her once and for all that I'm the master in this house'.[23] He only stopped his assault after the children started screaming. Realising that he was losing control, the inspector sought Fanon's help and confessed that his role within the war was playing on his mind: 'The thing that kills me most is the torture. You don't know what that is, do you? Sometimes I torture people for ten hours at a stretch […]'.[24] But far from seeking a release from his role, Fanon claims, the police inspector wanted to be helped to 'go on torturing Algerian patriots without any pricking of conscience, without any behavioural problems and with complete equanimity'.[25]

These cases—Faure's and the two discussed by Fanon—illuminate another point at which torture splinters the doctor's loyalties between multiple parties. In this case, the category of 'patient' is expanded to include not only the bodies of the victims of torture but also the psychological states of the torturers.[26] Given the social pressures introduced by group consensus surrounding the practice of torture, it is possible to see why Faure continued to struggle with the problem of torture thirty years later. From his perspective in the 1980s, writing in response to the United Nations Commission on Human Rights preparations for the International Convention against Torture,[27] Faure felt his experience in Algeria highlighted 'the absolute necessity of rules of ethics' to which the doctor must be accountable. He

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[23] Ibid., p. 215
[24] Ibid., p. 216.
[25] Ibid., p. 217.
[26] Interestingly, there was concern for the psychological health of those meting out violence in the Kenyan camps too, though this concern was not expressed by a doctor. In his instructions on how to conduct the dilution technique, Griffith-Jones mentioned that 'the psychological effects on those who administer violence are potentially dangerous; it is essential that [those administering violence] should remain collected, balanced and dispassionate, and should consciously and resolutely resist the natural upsurge of temper and hot blood'. See TNA CO 822/1251. Griffith-Jones, '"Dilution" Detention Camps. Use of Force in Enforcing Discipline', June 1957.
[27] The full title is The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT). UNCAT was open for signature, ratification and accession in December 1984 and came into force on 26 June 1987.

acknowledged that, prior to the war, he felt such ethics were obsolete and yet when faced with the realities of revolutionary war, he was less certain.[28]

In light of the above, monochromatic views of doctors faced with torture in Algeria are untenable. Some resisted, some collaborated for various reasons, while others took a more active role in assisting the violence. Although there were substantial institutional pressures dictating these responses, individual conscience seems to have played a key role in guiding conduct. A final case illustrating this point can be gleaned from the aforementioned story of Louisette Ighilahriz. In her memoir, Ighilahriz explained how her life was saved by a military doctor called Commandant Richaud, who intervened on her behalf. Having been injured in battle, captured and injected with a truth serum, Ighilahriz was subsequently imprisoned and repeatedly raped and tortured by French soldiers, especially a Captain Jean Graziani, over two months.[29] For most of this time, she was left naked in her cell and was, by the time Richaud encountered her, covered in excrement and her own menstrual blood.[30] During their first encounter, Ighilahriz did not trust Richaud, as her experience with doctors had taught her to mistrust them. She had originally interpreted Richaud assurances that he would 'heal' her [*soigner*] as a threat; ''heal': it was a term commonly used by the military to imply execution'.[31] Despite her concerns, Richaud kept his word and had her transferred to Maillot Military Hospital at Bab el-Qued, where the staff, much to their chagrin, were instructed to heal her before she was transferred to a prison where she would be safe.[32]

Richaud takes on a particularly paternalist role, which, as Mildred Mortimer has noted, betrays a gendered perception of the place of women in combat. This is especially evident when, as Ighilahriz claims, he pleads with Ighilahriz to abandon her cause: 'My child', he told her, 'you

[28] Faure, 'Problèmes d'Éthique poses au médecin par la torture' (pp. 73-74).
[29] Ighilahriz, *Algérianne*, p. 117.
[30] Ibid.
[31] Ibid., p. 119.
[32] Ibid., p. 120.

are too young for the resistance. I beg you, leave that to others, to men, for example'.[33] This focus on her gender also highlights a reason for Richaud's actions. From her recollection, Commandant Richaud had saved her life because she resembled his daughter. He stresses this point in her account: 'you know, you remind me of my daughter; she is the same age as you. It's been six months since I have seen her'.[34] Richaud's motivation for saving Ighilahriz's life appears more personal, as Mortimer has argued.[35] Yet it also begs the question of whether his ethical obligations as a doctor, a healer, aided him in this decision at all. Did Richaud object to the way a detainee was being tortured or were his objections merely limited to this particular individual who resembled his daughter? To put it differently, would he have intervened to save anyone else? It is difficult to say, given that his voice has been transmitted to us only through Ighilahriz's memoir, but it is telling that the subject of torture is absent from their discussions. At no point does Richaud appear to have complained about Ighilahriz's general treatment or to have expressed outrage for the conditions he found his patient in. This is an important point, as it would suggest Richaud was more tolerant of torture than has typically been acknowledged by other historians. Perhaps Richaud had become so accustomed to routine exposure to torture that he could no longer recognise it as exceptional. As Faure warned, despite his initial outrage, routine had a numbing influence: 'The daily parade of 8-10 people was quickly part of the routine and I was frightened the day I realised that my revolt had fallen'.

However, the reactions of other medical staff to Ighilahriz's liberation may say more about the novelty of her situation. For instance, when first arriving at the Maillot Military Hospital, the attending staff were instructed to heal her wounds on Commandant Richaud's orders, and not to amputate any of her limbs.[36] While crying out in pain as a nurse removed a bandage, Ighilahriz claims she was told: 'Shut up, fellagha! Tell yourself when you drop bombs, it is at

[33] Mortimer, 'Tortured Bodies, Resilient Souls' (p 109).
[34] Ighilahriz, *Algérianne*, p. 123.
[35] Mortimer, 'Tortured Bodies, Resilient Souls' (p. 109).
[36] Ighilahriz*, Algérianne*, p. 121.

least as bad!' The reaction to Ighilahriz's pain demonstrates hostility among the military medical personnel towards terrorists receiving treatment. Although the nurses did provide it in this case, it was evidently begrudgingly. Clearly, this was a deeply charged environment, within which medical obligations were strained by the political situation in Algeria. Ultimately, whether a French military doctor opted to collaborate, ignore or challenge torture came down to a mixture of institutional and social pressures combined with their own personal reasons. Although this is likely true of torture conducted in any context, the number of memoirs and personal reflections on the situation in Algeria allows for a more nuanced image of those moments when medical experts encounter extreme violence. This type of contextual data, however, is missing from the Kenya context, where there has been substantial silence surrounding the role of medical officers in the Emergency, especially those who visited the detention centres. Nevertheless, the documents released as part of the Hanslope Disclosure allow for a partial image of the attitudes towards torture and its victims to emerge. This forms the subject of the next section.

5.2. 'It was impossible for the doctor to say […]': silence and indifference in Kenyan camps

The dilution technique, discussed in Chapter 4, continued to be systematically employed in the detention camps until it eventually killed eleven prisoners in the Hola Detention Camp in March 1959. It was only after the Fairn Committee, established to investigate into these deaths, recommended its cessation that this form of torture was finally prohibited.[37] The Hola Camp incident will be discussed in more detail later on in the chapter, but from the evidence presented above, it is possible to assume doctors were routinely present when the technique was used in the detention centres after 1957. Yet it is curious that the available records make no mention of resistance or condemnation from these medical practitioners, even after the

[37] Klose, *Human Rights in the Shadow of Colonial Violence*, p. 182.

technique killed multiple detainees and seriously harmed many others. Moreover, it appears that the numerous letters of complaints produced by detainees regarding abuse that were smuggled out of the detention centres also failed to implicate doctors monitoring the violence, despite their presence being indisputable.[38] To the historian, these medical officers appear like spectres in the historical record: their presence lacks both substance and sound.

Assessing this type of silence is difficult. As Steven H. Miles noted, silence in cases of torture is 'like dark matter, difficult to detect and harder to measure'.[39] While it is possible to suggest the silence of doctors witnessing torture in Kenya equates to some level of tacit approval for the dilution technique, it leaves us to speculate as to why this deep silence continued for so long over a three-year period. Why did no one come forward even after the technique killed multiple people and injured countless others? There are a few potential explanations. Firstly, this silence may indicate a type of ingrained indifference to suffering, reminiscent of that noted by Dr. Faure above, on the part of colonial medical officers and detention staff more generally. This is similar to the numbing process of normative violence discussed by Browning in the introduction to this thesis. For instance, before the dilution technique was institutionalised in the camp system, there were frequent signs of abuse being recorded in camp medical reports. In 1956, a list of 'chronically sick detainees' at Manyani Special Camp was replete with questionable injuries: 'broken legs', 'paralysed legs', 'broken hands', 'feeble legs', 'lame legs', 'broken arm', 'broken knee', 'fractured waist', 'one hand cut off', 'bad arm' and so on.[40] At no point in the document is there any concern for why so many detainees had broken or missing limbs. It is of course possible that some of these unexplained injuries were the result of unrelated events or accidents. But these data, coupled with evidence from the recent British

[38] There are multiple such letters contained in the Migrated Archives at The National Archive, London, however, medical matters are rarely mentioned in them, save for complaints about insufficient care and unsanitary conditions. To date, this research was unable to identify any complaints that singled out any doctors in relation to beatings and similar treatment.
[39] Miles, *Oath Betrayed*, p. 120.
[40] KNA AH/9/8/70. Commissioner of Prisons, 'Chronically Sick Detainees', 20 June 1956.

High Court case raised by Mau Mau veterans, reveal a distinct correlation between abuse and lameness, as Katherine Bruce-Lockhart has noted.[41]

Indifference to suffering could also lead doctors to interpret complaints of violence as signs of obstinacy and malingering. On 13 February 1959, a letter was smuggled to London from the Gitamayu detention camp, which, from June 1958 to April 1959, had been home to a group of recalcitrant hardcore female Mau Mau detainees who had resisted rehabilitation.[42] The letter, which appealed to the 'Second Queen Elizabeth' and 'all members of the House of Commons', listed the types of complaints that had become standard within the detention camps. Female detainees complained of being 'screening by force and [of being] beat much [more] when [they were] screening'. This treatment, they claimed, had left them lame and injured: 'we cannot walk because we are hurt'.[43] The women even complained that African and European staff would not allow them to visit the hospital when injured.[44] Responding to these claims, Dr. O.H. Killen, the Medical Officer of Health for Kiambu, visited the camp on 19 February 1959, where he examined seven female detainees who were reportedly unable to speak or walk. However, rather than investigating the reasons behind these women's symptoms, Killen was dismissive of their characters and unsympathetic. He complained that the women were 'sourly and uncooperative and they appeared to be resentful of [his] presence'.[45] Instead of finding legitimate signs of abuse, Killen claimed to see no 'physical abnormalities'; he even claimed to have persuaded a few of the women to walk with sticks. Each patient exhibited some sign of psychological trauma, but instead of investigating this further, Killen interpreted it as evidence of their obstinacy. For example, Gachina Nyambia Kahun, a patient who could not walk, was described as being 'completely disinterested in her surroundings'; her inability to walk was attributed to her having forgotten how to use her legs

[41] Katherine Bruce-Lockhart, '"Unsound" minds and broken bodies' (pp. 599-600).
[42] TNA FCO 141/6324/58. District Commissioner for Kiambu, 'Rehabilitation – Female Detainees', 5 June 1958.
[43] TNA FCO 141/6324/93/. 'All Women Detainees'
[44] Ibid.
[45] TNA FCO 141/6324/96/4. O.H. Killen, 'Gitamaiyu Detention Camp', 20 February 1959.

'through long disuse' and to her having 'little desire to recall' how. Four other women who were unable to walk or talk, who Killen could not make an 'impression on', were admitted to hospital for 'further examination and rehabilitation (medical)'.[46] There is currently no evidence to suggest why these women were in this state, but Killen ultimately concluded that 'from my examination of the detainees and questioning of the warder staff, I am satisfied that discipline in the Camp is good; there is no ill-treatment of the detainees and the detainees are adequately cared for'.[47]

There are two other potential explanations for this silence. One is shame, whereby practitioners encountering such situations may have felt powerless or regretted their involvement to such an extent that they could not speak up about it without revealing their roles. However, this is not easy to demonstrate through the existing evidence. Alternatively, practitioners may not have been aware of the real extent of the abuses which were taking place. As Huggins *et al.* point out, a form of 'organizational fragmentation' is often relied upon to enable violence to take place as a normative condition.[48] In both Kenya and Algeria, the detention camps and interrogation processes occurred in scattered and often isolated locations across the colonies. Few staff had a holistic view of the system in its entirety, and each camp, especially in Kenya, was overseen by largely autonomous commandants.[49] Although it is clear medical personnel visited the camps, both the testaments of detainees and detention staff indicate that these visitations were often infrequent and cursory. As mentioned above, when it came to monitoring the dilution technique, Turnbull insisted medical officers should not be present for the procedure itself but should evaluate the health of detainees after their treatment. The extent to which doctors were therefore aware of the nature of the procedure is questionable. Even if they understood that injuries did result from the dilution technique, it is unclear whether these wounds were the products of excessive force or were part of the

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[46] Ibid.
[47] Ibid.
[48] Huggins *et al.*, *Violence Workers*, p. 2.
[49] Anderson, 'British abuse and torture in Kenya's counter-insurgency, 1952–1960' (p. 713).

'compelling force' sanctioned by the Emergency regulations. This is a key point: as far as the staff carrying out abuse were concerned, violence was an authorised part of the detention process.[50]

So far, this chapter has explored the reactions of doctors who worked with the victims of torture in the detention camps. In the cases discussed here, the extent to which doctors were socially embedded within military units in Algeria could explain how practitioners effectively became 'numb' to the presence of torture. Alternatively, as both Faure and Fanon suggested, the torturers themselves may have required medical support, which in turn could have pressured doctors to participate. In such circumstances, how easy is it for a doctor to choose whom to be loyal to? Although we do not have similar reflections for the Kenya context, it does seem that there too some sort of 'numbing' was taking place, which may have made medical officers indifferent to the suffering of Mau Mau suspects. Yet there were other, more calculated ways that doctors could react when faced by these situations, especially when torture led to the deaths of its victims or when news of its performance caused scandals back in Europe. This forms the subject of the second half of this chapter, which will examine instances in which doctors were, willingly or not, involved in wider efforts to cover-up and deny allegations of abuse and maltreatment. This broader discussion will be followed by a close assessment of two high-profile cases which saw British and French doctors participating in events that contributed, to a lesser or greater degree, to bringing both emergencies to an end.

[50] Ibid.

5.3. 'Why did you come to get me if he's dead?': falsifying death certificates in Algeria

Sometime during the Battle of Algiers (1957-1958), Paul Aussaresses, the French military general who caused controversy in 2000 with his defence of torture, arrested an Algerian man who had been denounced as a bomb manufacturer for the FLN.[51] This man, described as 'very thin' and 'about 40', had admitted to Aussaresses that 'on occasion he had manufactured bombs but that he was no longer doing it'.[52] The man denied knowing what happened to the bombs after he made them, nor was he responsible for arming them or choosing where they were to be detonated. This information, Aussaresses recalled in his memoir, was 'enough to have him executed', but at the time Aussaresses wanted to know more. The detainee was thus subjected to further questioning. At this point, the detainee became defiant and 'wouldn't talk', so Aussaresses and his men used water torture—what was referred to as the 'water pipe' method in the last chapter—to loosen his tongue. 'I signalled my men, who tied his hands behind his back and stuck the hose into his mouth. The man chocked and struggled'. However, the man remained defiant. A handkerchief was then put across his face and water was sprayed 'over it to prevent air from getting through'.[53] After a few seconds, the cloth was removed and the man was found to be dead.

Despite his assurances that 'prisoners would rarely die during an interrogation', Aussaresses conceded that 'it did happen'.[54] Yet while the details of his actions in the war are well known among historians, less attention has been paid to how Aussaresses dealt with the body of his victim and how that fits into the wider context of the Algerian War. Unfortunately, we only have Aussaresses's memoir to fill in these gaps, which thus needs to be carefully and critically considered. Nevertheless, it does provide some insight into how concealment was achieved.

[51] Aussaresses, *The Battle of the Casbah*, p. 129.
[52] Ibid., pp. 129-130.
[53] Ibid., p. 131.
[54] It is not clear just how many times this 'did happen' during Aussareses's time. Aussaresses, *The Battle of the Casbah*, p. 129.

Following the prisoner's death, Aussaresses tells us that he called an unnamed doctor, who, as he explained, 'was an old friend of mine from my school days in Bordeaux'. Rather than tell the doctor what had happened, Aussaresses explained that 'I was talking to the prisoner and he fell ill'. He added that the 'prisoner' had tuberculosis—a condition of which Aussaresses had become aware during the interrogation—and he wondered if the doctor could 'see what's wrong with him?'[55] After the doctor expressed surprise and outrage at the fact that the prisoner was dead, he apparently asked: 'why did you come to get me if he's dead?' It was at this point that the doctor reportedly realised the reason for Aussaresses's call: 'I had called him so he would send the body to the hospital and get it out of my sight once and for all'.[56]

The fact that a prisoner had died during this type of interrogation is not necessarily unusual, despite earlier assurances from French doctors that the water-pipe method was relatively safe.[57] What is notable, however, is that Aussaresses sought help from a doctor to take care of the body. Yet his account leaves us with more questions than answers. What happened to the body? Who was the doctor in question and who was the prisoner? To what extent can we trust Aussaresses's account? At present there are few answers to these questions and what we do have is incredibly thin. Despite this, it does seem, from this memoir, that the doctor who received the body was complicit in covering up the cause of death. Presumably, Aussaresses contacted this individual for this reason. He must have been confident the doctor would not ask unwanted questions or report the cause of death as suspicious. Although doctors and the medical community were called upon to help conceal the deaths of detainees in both Kenya and Algeria, the evidence is particularly compelling for the latter country. This is yet another aspect of the Algerian War which has received little attention from historians. One partial exception is Raphaëlle Branche, who briefly considered the evidence of doctors in Algeria

[55] Ibid., 131.
[56] Ibid.
[57] In 1955, Roger Wuillaume recommended permitting the water pipe method as a trustworthy police technique after apparently receiving assurances from unnamed medical experts that it was safe, if practiced properly. See Chapter 4 for more details.

being summoned by the army to 'establish reports of death' after torture had gone too far. As discussed above, the French paratroopers and the police often relied upon military physicians to monitor and treat detainees undergoing interrogation. Often though, as Branche notes, this care could not prevent fatalities.[58] Death from gangrene and cardiac arrest was not unusual, and the methods of interrogation themselves, as with the case above, could prove lethal, even if death was not the ultimate intention.[59] Regardless of whether or not a detainee was deliberately or accidentally killed, Branche explained, doctors were often called upon to help conceal the true cause of death.

One physician who has admitted to carrying out this type of activity during the conflict was Dr. Jean Suaud, mentioned in the previous chapter in relation to the use of truth drugs in Algeria. For Suaud, death certificates or other medical records were falsified by keeping the information they provided to a minimum. This drastically reduced the room for alternative (and unwelcomed) interpretations. As he stated, 'The certificate then signed by the doctor simply mentioned the death without further explanation […]'.[60] Without any additional information, it became almost impossible to determine whether or not a given individual had indeed died from the recorded causes.[61] This was a useful linguistic device that protected both the military from unwanted attention and, as will be shown below, the very doctors who abetted them in their activities. The usefulness of this method of obfuscation is openly singled out by Aussaresses, whose frank—if retrospective—account lends itself to historical analysis. Firstly, in addition to confirming Branche's claims, Aussaresses's anecdotal evidence offers further insights into the relationship between the military and the doctors they worked with. Secondly, some of these cases can be verified through independent archival material. It seems there existed a tacit relationship between military hierarchies and doctors, who may have understood what was expected of them even in the absence of explicit instruction.

[58] Branche, *La torture et l'armée pendant la guerre d'Algérie*, p. 473.
[59] Ibid.
[60] Quoted in Branche, *La torture et l'armée pendant la guerre d'Algérie*, p. 474.
[61] Ibid.

Indeed, Aussaresses was involved in another case which lends further weight to Suaud's claim. In his memoir, Aussaresses describes how he had hanged a FLN leader called Larbi Ben M'Hidi on the night of 3 March 1957 in order to make his assassination look like suicide. The body was then abandoned at the doors of an unnamed hospital.[62] This hospital turns out to be Maillot Military Hospital, the same one where Louisette Ighilahriz was transferred by Dr. Richaud after her experience of being tortured.[63] As noted in that case, the staff receiving her at the hospital were unimpressed with having to treat an 'enemy terrorist' and would have neglected her had they not been under direct orders. It is probable that the hospital and its staff would have been well acquainted with the paratroopers' practices and the role the hospital could play in aiding them when an Algerian body arrived at their doors without explanation. In this instance, there would not necessarily need to be any direct instructions, their place being taken by a shared culture of collusion and common understanding. This interpretation is certainly supported by the documentary evidence surrounding the case.

On 4 March 1957, the day after Ben M'Hidi's execution, Lieutenant-Colonel Marey, of the *Commandement Militaire du Département d'Alger*, contacted the Colonel and the Chief Medical Officer of Maillot Military Hospital. Marey explained that Ben M'Hidi had taken 'advantage of a transfer' for interrogation and tried 'to commit suicide by hanging on the night of March 3 to 4'. Marey alleged that Ben M'Hidi's 'attempt' was detected, and so 'he was rushed to the Hospital Maillot'. He, nevertheless, had 'died on the way'.[64] This explanation matched the official one circulated to the press at the time.[65] Later, on the 16 May 1957, Médecin-Lieutenant Pierre Bloch and Médecin-Aspirant Jean Hudelo confirmed that they had

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[62] Aussaresses, *The Battle of the Casbah,* p. 140.
[63] SHD 1 H 2584/d.5. Lieutenant-Colonel Marey, communication sent to Monsieur le Médecin Colonel, Médecin Chef du Hopital Militaire Maillot, 4 Mars 1957.
[64] Ibid.
[65] On 6 March 1957, it was announced that Ben M'Hidi had hanged himself in his cell using 'shreds from his shirt' which he had made into a rope and tied around the bar of his window. Anonymous, 'LE SUICIDE DANS SA CELLULE DE LARBI BEN M'HIDI EST ATTRIBUÉ À L'ÉTAT DE DÉPRESSION OÙ LE CHEF F.L.N, SE SERAIT TROUVÉ', *Le Monde*, 7 March 1957. <https://www.lemonde.fr/archives/article/1957/03/07/le-suicide-dans-sa-cellule-de-larbi-ben-m-hidi-est-attribue-a-l-etat-de-depression-ou-le-chef-f-l-n-se-serait-trouve_2332479_1819218.html> [Accessed 26 June 2019].

received Ben M'Hidi's body on the night of his death. Their explanation, however, demonstrated the power of limiting the information recorded on death certificates. These two doctors avoided providing any insights or additional information other than the most basic facts concerning the body. The doctors merely confirmed that Ben M'Hidi's 'death had occurred before his arrival at Maillot Military Hospital on March 4, 1957'.[66] Not only did this statement match the official explanation that Ben M'Hidi had died *en route* to the hospital, it also confirmed the real events themselves. The doctors then added that 'Our attention was not drawn to any apparent marks of injury', which confirmed that Ben M'Hidi had not undergone any torture or ill treatment prior to his death.[67] Given the paucity of information, who would be able to discern the truth from the cover-up when examining these statements?

What is missing from this document is any form of assessment or evaluation of the evidence the doctors were examining. By merely providing a basic description of the body upon arrival at the hospital, these two military doctors avoided proffering any incriminating information that could threaten the security forces or their own professional standing. Yet this method also provided them with a plausible excuse, if searching questions had been asked. After all, their brief description was not technically a lie. It matched both the real circumstances surrounding Ben M'Hidi's death and the suicide story spread by the colonial authorities. It thus becomes difficult to analyse their level of complicity as the available information is insufficient for us to determine between these two narratives.

The falsification of records was thus another way in which medical professionals in Algeria could grease the wheels of the torture campaigns enacted against the rebels. As with doctors directly participating in violent interrogations, the falsification of medical records was also a violation of the principles enshrined in the Hippocratic ideal. The doctors subordinated their

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[66] SHD 1 H 2584/d.5. Médecin-Lieutenant Pierre Bloch and Médecin-Aspirant Jean Hudelo, certificate confirming the state of Ben M'Hidi's body upon reception at Maillot Military Hospital, 16 Mai 1957.
[67] Ibid.

ethical duty to the patient to a higher authority, in this case the military and their need to cover-up murder. Although the tactic of falsifying death certificates has been used by doctors involved in torture campaigns in various other contexts in the decades since the Algerian War,[68] it still highlights an important point of distinction between the ways in which doctors aided in concealing the truth of torture in Algeria and Kenya. To date, this research has found fewer clear cases where doctors falsified death certificates *per se* in the East African colony. Quite possibly, this is a result of evidentiary limitations. It is only through the confessions and memoirs of former doctors operating in Algeria that we are able to substantiate the disparate slithers of documentary evidence in the archive. As mentioned elsewhere in this thesis, doctors who worked in Kenya during the Emergency have not published such revealing accounts about their practices, nor has the Kenyan Emergency produced its own Aussaresses. Yet absence of evidence is not evidence of absence, and while it should not simply be assumed that there were similar cases of medical cover-up, the possibility of similar efforts having taken place in Kenya should not be ruled out *a priori*, as will be seen below.

5.4. 'I could not say definitely that these injuries were the cause of death': medical neutrality and pathology reports in Kenya

On 5 September 1958, a detainee called Kabugi Njuma was killed by the 'intake system', the alternative name for the dilution technique, when he and 29 other prisoners entered the Aguthi Works Camp. The District Officer, Samuel Githu, and several screening elders approached the 'new comers' in the standard way. The latter were invited to confess and were beaten when they showed resistance. Githu even went among the prisoners, who were squatting, and started to kick and strike them before they were 'hustled' to the Screening officer outside the camp. There, they were once again beaten and ordered to confess, resulting in 'a good deal of screaming and shouting'.[69] Finally, the prisoners were separated into two groups: those willing

[68] Rejali, *Torture and* Democracy, p. 398.
[69] Anderson, 'British Abuse and torture in Kenya's Counter-insurgency' (p. 708).

to cooperate and those who refused. The six who refused were taken to an eight-foot-deep pit, where Githu threatened to bury them alive while kicking dirt onto them. The new arrivals were then taken to the football field where they were issued buckets filled with soil, roughly 50lbs each, and their shirts 'tied with string at the waist and then filled with soil'. They were then made to carry the filled buckets on their heads at pace, 'shifting the soil from one part of the field to another'.[70] Kabugi soon collapsed and 'made no attempt to get up and, whilst prostrate', he was kicked and beaten by Githu, who still ordered him to confess. His unresponsive body was left where he had fallen for two hours. Eventually, District Officer Duffy ordered that he be taken back to his cell. Instead, he was taken to the dispensary, where a dresser pronounced him dead on arrival.[71] His body was wrapped in a blanket and taken to Nyeri Provincial Hospital without any identification or explanation.

Here, a Dr. Hadman carried out a post-mortem but did not fill in the death report until the 16 September, over ten days after Kabugi's death.[72] The doctor found that death was 'due to shock brought about by an infarction of the lower lobe of the right lung'. He also found bruising and abrasions on the body and noticed that Kabugi's hands were swollen.[73] During the postmortem, Kabugi's death was incorrectly recorded as a 'pulmonary infection' on the certificate, not an 'infarction' caused by abuse.[74] Furthermore, certain organs were removed from Kabugi's body for further laboratory tests but were destroyed before these could be carried out.[75] At the inquest, the European officers lied under oath in an effort to cover up the reasons for Kabugi's death. This, as well as the poor display of medical evidence, led the examining magistrate to return the verdict of death from natural causes.[76] Later, after a series

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[70] TNA FCO 141/5668/50, p. 4. 'The Chief Secretary's Complaints Co-Ordinating Committee. Meeting Held in the Office of the Deputy Public Prosecutor', 1 January 1959.
[71] Ibid, p. 5.
[72] Anderson, 'British Abuse and torture in Kenya's Counter-insurgency' (p. 708).
[73] TNA FCO 141/5668/50, p. 4. 'The Chief Secretary's Complaints Co-Ordinating Committee. Meeting Held in the Office of the Deputy Public Prosecutor', 1 January 1959.
[74] Hansard. Parliamentary Debate, 'Prisons and Detention Camps, Kenya', Barbara Castle MP, 24 February 1959, paragraphs 1037-1038.
[75] Anderson, 'British Abuse and torture in Kenya's Counter-insurgency' (p. 708).
[76] Ibid.

of detainees sent letters detailing the events of 5 September to Colonial Secretary Lennox-Boyd and Labour MP Barbara Castle, a new inquiry was opened into Kabugi's death. On reviewing the evidence, Kenya's Attorney General concluded that 'the medical evidence would clearly not sustain a prosecution for murder or manslaughter', but proposed that Githu be charged with three accounts of assault occasioning actual bodily harm.[77]

This verdict was far from exceptional. When Europeans were prosecuted for assault during the Emergency, they rarely received full sentences. Frequently, medical evidence demonstrating explicit signs of abuse and torture was equivocated by doctors and lawyers alike. The issue was even touched upon in the House of Commons on 24 February 1959, following the Attorney-General's decision to prosecute Githu for mere assault, even though the case had clearly involved a death. The MP for Northampton, Reginald Paget, stated that:

> […] this is the sixth case of which I am aware where no murder charge has been brought each time one is told that it is very unfortunate and that a man did fire a revolver but, unfortunately, the damage done to the heart of the deceased was such that it was impossible for the doctor to say that the heart might not previously have had some natural defect from which the chap might have died, and that therefore a charge of murder cannot be brought and the Government are very reluctantly obliged to accept the plea of common assault.[78]

Despite his appeal for answers, the discussion did not linger on the flimsiness of medical evidence in these cases. Though Barbara Castle noted that there had been some indication that Kabugi's infarction had started before the incident, which had confused the verdict, there was no further attempt to question the role of the doctor in investigating abuse.[79] This, as shall be

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[77] Ibid. (p. 709).
[78]Hansard. Parliamentary Debate, 'Prisons and Detention Camps, Kenya,' Reginald Paget MP, 24 February 1959, paragraphs 1025-1026.
[79] Ibid., paragraphs 1038-1039.

demonstrated below, was a common feature of these investigations. A generous interpretation of this resistance to draw firm conclusions about the nature of injuries or the causes of death is that it represented an attempt to remain neutral. A less charitable reading, however, is that this ostensible neutrality betrayed loyalty to a higher authority—the colonial order and the security forces—at the expense of the doctor's responsibilities to the victims.[80] The ability to remain neutral seems particularly suspicious, given the sheer number of rumours and reports of abuses emanating from the detention camps at this time. Yet, as will be presently seen, in those rare cases where members of the security forces were placed under investigation for their role in an abuse inquiry, the neutrality of the medical profession allowed them to get off with minor charges.

The effects of such neutrality could be compounded by misinformation on the part of the officers involved in a given case. One such instance was highlighted by Eileen Fletcher in her 1956 report.[81] In addition to drawing attention to the appalling conditions within the Kenya detention camps, her account also touched on cases of torture. In particular, in a section entitled 'Tortured to death', Fletcher dwelt on the case of Kamau Gichina, who had been taken into custody as he was suspected of having stolen £350 from a Home Guard post. During the inquest, a European District Officer, who doubled up as 'Third-class Magistrate', admitted to witnessing the suspect being beaten by the Home Guard. Apparently, 'sticks were tied to the back and front of his legs and squeezed tightly'. A European Police Inspector admitted to having helped the African Home Guard by placing sticks behind the prisoner as he kept falling over. Another African witness claimed that two of the sticks had been sharpened at both

[80] Amnesty International Medical Commission and Valérie Marange, *Doctors and Torture: Collaboration or Resistance?* (London: Bellew Publishing, 1991), pp. 26-27.
[81] In 1956, the Quaker social worker turned whistle-blower, Eileen Fletcher, published *The Truth About Kenya: An Eye Witness Account*, which explained the state of the camps that she had witnessed during her service as a Rehabilitation Officer at Athi River and Kisumu camps, among others, from December 1954. Fletcher described an atmosphere of horror where unhygienic and overcrowded facilities, some exceedingly crude in design, were filled with men, women and children who were detained without trial, some for years at a time. Prisoners were abused indiscriminately and torture was rife. Moreover, prisoners were often forced to carry out heavy labour while ill and severely malnourished.

ends.[82] Gichina was then pushed into a stream where he was shot at by European policemen, before spending the night in a garage where he was handcuffed to an upright pole. The garage was exposed from multiple sides, and the prisoner only had a thin blanket to keep off the cold and rain of that night. On top of this, the European officers refused to let him eat. Gichina finally died on the 10 May 1955; when his body was removed, Fletcher reported, 'a piece of skin came off one arm' and then a larger piece stuck to the floor of the vehicle that transported him to the hospital.[83]

Yet while the circumstances surrounding Gichina's death were clearly irregular and abusive, the individual examining his body, a Dr. W. M. Brown from Tumu-Tumu Mission Hospital, initially stated that 'I could not say definitely that these injuries were the cause of death'. He was only able to conclude that, though the body was not free of injuries, 'there was no evidence of any disease in the body'. [84] The problem was that the District Officer accompanying the corpse, a H. W. Richmond, persuaded the doctor that the victim 'had looked quite normal' the day before his death. Richmond later added that 'Prior to Dr. Brown's conversation with me I had no cause to suspect that Kammu Gichina had been subjected to maltreatment while in custody'.[85] In addition to this misinformation, Chief Inspector Coppen, who was involved with Gichina's interrogation, had also suggested to Dr. Brown that the death may have been the result of poisoning.[86] This led Dr. Brown to remove and send samples of the victim's organs to a pathologist for investigation. In the subsequent inquest, Richmond was found to have misled the doctor, as well as having tried to deny that the conversation had happened at all. Furthermore, the pathologist's report on the poisoning claim had returned negative findings,

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[82] Fletcher, *The Truth About Kenya*.
[83] Ibid.
[84] Fletcher, *The Truth About Kenya*. Fletcher's report, which lacks page numbers, quotes Brown as saying that the victim had 'extensive multiple weals all over the body. Superficial skin on outer side of left arm had been removed from the knuckles to two inches above elbow, and 12 square inches removed from inner side. Blisters on fingers and legs. A wound [1 and quarter] inches long and [quarter] inch deep over left shin bone. On the back 30 square inches of superficial skin had been removed'.
[85] TNA FCO 141/6540/13. Statement by H.W. Richmond concerning the death of Kamau Gichina, 7 November 1955.
[86] Ibid., p. 3.

thereby implicating Coppen in the attempted cover-up. It was this misinformation that led Brown to his inconclusive verdict. Even though Brown later admitted that 'in view of the negative poisoning finding, I should think it is possible that [Gichina's injuries] were the cause of death', it was too late. In October 1955, Lennox-Boyd was able to use Brown's initial findings to placate the House of Commons and to state that the initial murder charge levelled against the officers involved in Gichina's death had been reduced to 'grievous bodily harm because the medical evidence […] was that death might have resulted from causes other than this maltreatment'.[87] Rather than being evidence that the rule of law in Kenya was faltering, Lennox-Boyed argued that the medical evidence showed precisely the opposite: the fact that the Supreme Court was able to exercise 'its power of revision in this case appears to me to show that the rule of law and order does prevail in Kenya'.[88]

Similar to the aforementioned Kabugi case, the use of medical evidence in Gichina's case served as a means for sheltering those involved in torture and violence from criminal proceedings. In both instances, the doctors involved in the post-mortems were unable or unwilling to provide a conclusive verdict over the evidence of abuse. Moreover, there is a hint of 'bungling' or poor judgement in both instances, which aided in these outcomes. For example, in Kabugi's case, Dr. Hadman did not record the findings of his post-mortem in a timely manner, nor did he do it correctly. This was a mistake, if that is what it was, which had severe implications for the case. As for Dr. Brown, the existing documentation seems to suggest he was swayed by Richmond and Coppen's deception, despite having the evidence of the mutilated body before him. For whatever reasons, Brown did not consider this evidence to be suspicious enough to warrant further questioning at the time. However, it must be remembered that Brown was not an official pathologist, but a missionary doctor. It is not easy to know how he *should* have acted under these circumstances when he was presented with

[87] Hansard. House of Commons Debate, 'Kamau Case (Police Organisation)', Lennox-Boyd, Secretary of State for the Colonies, paragraphs 180-181.
[88] Ibid.

evidence of abuse. This is an important point, because his role as missionary doctor and the related fact that he was not acting in an official capacity actually provided further protection for Richmond. This being the case, Kenya's Attorney-General, Eric Griffith-Jones, explained in a secret telegram on 31 October 1955 that Richmond could not be prosecuted for a criminal offence, because he had not misled a 'person employed in the public service' within the meaning of Section 124 of the Penal Code.[89] Instead, Richmond was merely dismissed as a District Officer, only to be later employed as an African Affairs Officer by the Aberdare County Council.[90]

While the findings of these doctors were used to reduce the charges made against those involved in the violence, there were those who saw such activities as signs of potentially widespread corruption. On 5 October 1955, Sargent Duncan G. Macpherson, the Assistant Commissioner of Police, produced a report into incidents where officials—District Officers, Magistrates, loyalist Chiefs and Headmen—had undertaken action which led to the loss of 'vital evidence which ruined the possibility of a murder charge being laid' against guilty parties. His report began with Richmond's activities, which had resulted in Dr. Brown not being able to perform a 'complete Post Mortem', but continued to examine other incidents where medical evidence was either missing or insufficient for the prosecution. Macpherson believed he had 'uncovered a conspiracy' where various chiefs and headmen in the Nyeri Area sought to control information about torture and abuse so that it could be suitably covered up after passing '[t]hrough the proper channels'.[91] In fact, he had evidence that those who did not comply with these efforts were threatened with 'Delegated Detention Orders', which would have had them imprisoned along with Mau Mau suspects.

[89] TNA FCO 141/6510/6. Secret telegram from the Attorney-General, 31 October 1955.
[90] TNA FCO 141/6510/100. Deciphered telegram to the Secretary of State, 15 February 1957.
[91] TNA FCO 141/6519. D.G. Macpherson, 'Special Report' sent to E.N. Griffith-Jones, 5 October 1955, p. 3.

Within this ‘conspiracy’, the control of medical information played an important role. For instance, at Fort Hall, the District Officer, a Kikuyu Guard known as Kopf, had received a report of rape by two police constables. Kopf apparently started investigating the report on the same day that he received it, the 25 June 1955. However, he did not report to the police until the following day, ‘with the result that valuable medical evidence was lost’.[92] In another instance, Macpherson explained that on 1 August 1955, ‘a woman engaged on communal labour under Home Guard was so severely beaten by one of the Home Guard that she died in hospital’ three days later.[93] A relative reported the incident to the police on the 8 August, which led to the victim’s body being exhumed and subject to a postmortem examination. The evidence confirmed the witness’ allegations of beating but ‘due to putrefaction, cause of death could not be established beyond reasonable doubt’.[94] Yet while this inconclusive verdict was not unusual, as we have seen, this case revealed additional concerns which are important for understanding the role of medicine in these investigations. According to Macpherson, the main difficulty was that the hospital attendant and the dresser who examined the victim’s body, as ‘no doctor attended this woman’, certified death as due to ‘Malaria and Diarrhoea and no bruising’. This, Macpherson stressed, ‘was pure rubbish’.[95] Here was clear evidence that the medical record had been deliberately altered to conceal the truth about abuse. However, rather than condemn the hospital assistant and the dresser for their actions, Macpherson was ‘quite satisfied that’ they were ‘got at’ and ‘deliberately gave false information to cover up’. Rather than merely aiding in the concealment effort, it seems these medical assistants may have been coerced and threatened by the Home Guard involved in this case. As such, it is not possible to conclude that evidence of complicity in cover-ups like this were free of threats of violence from the officers involved in their investigation. Having said that, however, there is a significant difference in the status of an African assistant or dresser compared to a European doctor. So, this should not be overstated.

[92] Ibid.
[93] Ibid.
[94] Ibid.
[95] Ibid.

As with the other cases mention above, the efforts to manipulate the medical information prevented Macpherson and his men from laying a charge of murder on those involved. In the end, the Home Guard could only be charged with 'Causing Grievous Bodily Harm' on the strength of the pathologist's findings.[96] Macpherson's exasperation with the situation in Kenya eventually led him to resign from his post in July 1956. Initially, he told the colonial administration that he was leaving on 'medical advice' as he was suffering from high blood pressure and headaches.[97] However, in 1959, Macpherson sent a letter to Barbara Castle after the extent of abuse in Kenya entered the public domain following the murder of detainees in Hola Camp that year (see below). In his letter, extracts of which were read out in the House of Commons, Macpherson explained that he had left the police force due to the widespread violence in the colony and the lack of willpower from the administration to address it.[98] He added that 'I would say that the conditions I found existing in some camps in Kenya were worse, far worse, than anything I experienced in my four and a half years as a prisoner of the Japanese. I was horrified'.[99] Despite the significant role the loss of vital medical evidence played in his earlier report to Griffith-Jones, Macpherson appears to have made no mention of this particular problem in his letter to Castle.

In light of all these cases, it is clear that medical information and death certificates were meddled with by practitioners in both Algeria and Kenya. It is, however, unclear whether this amounted to conscious collusion on the part of the doctors involved. There is certainly evidence that some sort of tacit, if not outright, relationship of understanding existed between doctors and the military in Algeria. This is particularly obvious in the cases of Ben M'Hidi's

[96] Ibid.
[97] TNA FCO 141/6519/24, p. 5. R. C. Catling, Commissioner of Police, 'Personal and Confidential', 25 June 1959.
[98] Hansard. House of Commons Debate, 'Hola Detention Camp', Barbara Castle MP. Paragraphs 310-311.
[99] Ibid. It, however, should be noted that Macpherson had also sought re-employment with the Kenya police after his initial retirement on several occasions. For R.C. Catling, the Commissioner of Police in 1959, this evidence made Macpherson's testimony dubious. See TNA FCO 141/6519/29/p. 6. R.C. Catling, 'Personal and Confidential' report to The Minister of Defence and Internal Security, Nairobi, 25 June 1959.

death. In Kenya, however, the existence and nature of this relationship are more difficult to establish. Nevertheless, the number of pathology reports that ended with an inconclusive verdict provided the Kenyan authorities with an effective means for dismissing investigations into allegations of abuse. For now, it is worth noting that death certificates were not the only reports that doctors associated with the military could falsify to conceal evidence of torture, nor were their efforts always successful. The next section will examine the first of two case studies which will bring this story to an end. Here the evidence of medical collusion in the military's cover-up efforts gave rise to a scandal which drew significant public attention. The analysis shines light on the workings of the military tribunals that were set up to prosecute supposed Algerian 'terrorists' during the emergency years. In doing so, it reveals the extent to which certain professionals attempted to use their medical expertise to disavow and undermine the testimonies of the victims of torture. It also provides a rare instance where these practices were challenged and contested by other experts rallied together by the Defence. As such, the case study reveals the extent to which medicine and the law featured as chess-pieces in wider political attempts of state denial.

5.5. 'A most scandalous piece of professional dishonesty': contested expertise in Algerian military courts

When it came to fighting subversion in the Algerian War, the military succeeded in obtaining an unprecedented transfer of power from civil justice to military justice. Article 12 of the law of 3 April 1955, which established a state of emergency in Algeria, provided for this transfer.[100] The granting of authority to hear cases which normally fell under the jurisdiction of the criminal courts was a significant step in consolidating military control over Algeria. As

[100] It stated that 'When the state of emergency is established in part or the entirety of a department, a decree issued at the behest of the Minister of Justice and the Minister of Defence may authorise military courts to hear crimes and related felony cases that [normally] fall under the department's appellate court'. These powers were later extended by the law of 23 April 1955, which provided an extensive list of crimes that could now be prosecuted by military courts. These included a variety of petty crimes, as well as those more directly related to terrorism. See Sylvie Thénault, 'Armée et justice en guerre d'Algérie', *Vingtième Siècle. Revue d'histoire*, 57 (1998), pp. 104-114 (p. 106).

Sylvie Thénault put it, 'the political authorities and the army made the law into a weapon of war which they used against the Algerian freedom fighters'.[101] Rather than provide any sense of actual fairness, though, the military courts in Algeria operated as a parody of justice. In fact, in many instances, the courts already had the verdict decided before proceedings even started. This situation was described by French lawyer Jacques Vergès and the writer, Georges Arnaud, as 'far worse than a denial of justice, a fake justice' made up of 'sham [trials]' and 'plywood' judges where 'only the guillotine would be true'.[102] Medicine, as will be seen, played a pivotal role in supporting these performances.

On 2 June 1960, Simone de Beauvoir, the feminist intellectual and existentialist philosopher, published an article in *Le Monde* called 'Pour Djamila Boupacha'. Her article drew attention to a case which would have been disturbingly familiar to readers in Paris: a young 22-year-old Muslim girl had been detained by French paratroopers in Algeria and confessed to having planted a bomb which had failed to explode in September 1959. The young woman, Djamila Boupacha, was subsequently charged with criminal conspiracy and attempted homicide, but she later filed a civil indictment against her interrogators, retracting her confession and alleging that her original statement had been extracted through torture.[103] According to de Beauvoir, Boupacha's ordeal had started on the night of 10 and 11 February 1960, when a large group of *Harkis*, *gardes mobiles* and police inspectors burst into the Boupacha household, where they beat up Djamila, her father and brother-in-law, before escorting the three suspects to El-Biar detention centre.[104] Here Djamila was, as de Beauvoir said, 'given a kicking by a group of soldiers' who broke one of her ribs. Five days later, she was transferred to Hussein Dey, where her ordeal continued. Three *harkis*, two soldiers and three police

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[101] Thénault, *Une drôle de justice*, p. 9.
[102] George Arnaud and Jacques Vergès, *Pour Djamila Bouhired* (Paris : Les Éditions de Minuit, 1957), p. 8.
[103] Simone de Beauvoir, 'Pour Djamila Boupacha', *Le Monde*, 2 June 1960. <https://www.lemonde.fr/archives/article/1960/06/02/pour-djamila-boupacha_2092987_1819218.html> [Accessed 12 January 2018].
[104] Ibid.

inspectors tortured her using electricity on her legs, face, anus and vagina and, between shocks, continued to kick her and put cigarettes out on her skin. Next, she was hanged over a bath by a pole and immersed several times.[105]

Given the content of the piece, as well as the title itself, it is clear that de Beauvoir was recalling the work of Vergès and Arnaud in the case of Djamila Bouhired, which had stirred significant outrage in France in 1957 for similar reasons.[106] There was, however, one feature of Boupacha's case that made it distinct. Several days after her abuse, her interrogators performed what they called the 'bottle treatment', in which the neck of a bottle was forced violently into the victim's vagina in order to rape her and remove her virginity.[107] This final abuse became a common form of assault during the Algerian War. Like the use of electricity, which was often targeted at the genitalia, the rape of both men and women served the purpose of not only torturing the victim, but also terrorising them and their communities. Although sometimes performed for sexual gratification by men, this was not always the aim, as Djamila Boupacha's case demonstrated. Rather, as Branche has powerfully stated, it was 'the woman herself who is the target'.[108] The assault left few physical marks, but it carried a symbolic meaning which was particularly potent within the Muslim communities in Algeria.[109] Rape

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[105] Ibid.

[106] On 11 July 1957, Djamila Bouhired and Djamila Bouazza were the first two women to appear before the Permanent Armed Forces Tribunal [*le tribunal permanent des forces armées*] in Algeria. Both young women were accused of helping to organise or executing bomb attacks against Europeans earlier that year. Bouazza was accused of planting a bomb on a coffee table in Coq Hardi in Algiers, which killed multiple people and injured dozens more. Bouhired was a 26-year-old Algerian militant supporter of the FLN. She was arrested on 26 April 1957, after being found carrying important correspondences intended for two leaders of the rebellion, Yacef Saadi and Ali Ammar (otherwise known as Ali la Pointe). Bouazza had also told the court that Bouhired had also actively planted bombs. While the case seemed damning, it was not straightforward. Firstly, Bouazza was thought to be mentally unstable and so her allegations were suspect, while Bouhired had also alleged that she had been tortured while in custody. Despite many complaints from their legal representatives, the military court would not allow the defence to provide any counter-evidence to support their case and ultimately sentenced to two women to death on 15 July 1957, four days after the trial started. In response, Vergès and Arnaud published *Pour Djamila Bouhired*, which contained the first public denunciation of military's use of torture in North Africa and the irregularities in court procedure taking place in its defence.

[107] Ibid.

[108] Raphaëlle Branche, 'Des viols pendant la guerre d'Algérie', *Revue d'histoire*, 75 (2003), 123-132 (p. 128).

[109] Lazreg, *Torture and the Twilight of Empire*, pp. 154-160.

was thus used as a tool of terror and domination across the colony, since, through the victim, the soldiers could reach her family, her village and all the circles to which she belonged.[110]

While this pernicious practice was widespread, Boupacha's indictment against the French military has generated an unusual amount of material. Her case has thus been examined by historians interested in a range of questions related to gender, women's bodies and violence within the war more generally; few, however, have paid specific attention to the ways in which medicine featured in the trial.[111] This may be because the official dossier concerning her case is currently unavailable for historical research.[112] Despite this, in 1962, at the war's end, Halimi and de Beauvoir published *Djamila Boupacha*, which provides a detailed account of her case as it progressed through Algerian and French courts.[113] The book contains a summary of Boupacha's experiences in court provided by de Beauvoir, as well as a narrative account of the Boupacha's case, official correspondences, the text for Boupacha's civil indictment, extracts of court transcripts and, most importantly, the various medical reports concerning her person. It thus remains an extensive and valuable source for assessing medical involvement in the attempted cover-up of torture and rape in the Algerian War. Her allegations show significant similarities with the case of Djamila Bouhired, mentioned above, and others who challenged the French authorities; but they go further still by showing instances where the experts themselves contradicted and invalidated one another. As such, the case of Djamila Boupacha raises questions about contested expertise in high-profile cases concerning state denial.

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[110] Branche, 'Des viols pendant la guerre d'Algérie', 128.
[111] One exception to this is a short analysis of the two doctors involved in the Boupacha case by Branche. See Branche, *La torture et l'armée pendant la guerre d'Algérie*, pp. 474-476. Others who have discussed her case more generally include Marnia Lazreg, 'Chapter 6: Women: Between Torture and Military Feminism', in *Torture and the Twilight of Empire*, pp. 145-169; Ryan Kunkle, '"We Must Shout the Truth to the Rooftops:" Gisele Halimi, Djamila Boupacha, and Sexual Politics in the Algerian War of Independence', *Iowa Historical Review*, 4 (2013), 5-24; and Judith Surkis, 'Ethics and Violence: Simone de Beauvoir, Djamila Boupacha, and the Algerian War', *French Politics, Culture & Society*, 28 (2010), 38-55.
[112] It was not possible to consult the documents related to this case as part of this study. This is because they are currently covered by the 75-year restriction period without special derogation.
[113] Simone de Beauvoir and Gisele Halimi, *Djamila Boupacha: The story of the torture of a young Algerian girl which shocked liberal French opinion*, trans. by Peter Green (Paris: Gaillimard, 1962).

On 15 March 1960, thirty-five days after her arrest, Boupacha was brought before the investigating judge. It was here that she retracted her confession and indicted the soldiers who had abused her.[114] Without losing any time, the magistrate, a M. Bérard, sent her to be examined by a medical expert on the same day. Although this move might be read as a demonstration of concern for the young woman and her health, it is much more likely it was just part of a wider, well-rehearsed performance. Her examiner, Dr. Jean-Claude Lévy-Leroy, appears regularly within the historical record in relation to claims of torture. It seems he was a useful candidate for this examination, as his approach to such sensitive cases was characteristically brief, descriptive and neutral in tone.[115] Lévy-Leroy was thus an ideal expert for an examination and trial which already had a forgone conclusion. Lévy-Leroy examined Boupacha's body and provided a scant report which was, as Halimi says, 'a dozen lines long, and that was all'.[116] Within this short report, Lévy-Leroy mentioned that '[Djamila Boupacha] told me she had undergone various "tortures" about a month previously. When examined completely naked, she presented no special marks or scars'.[117] This was his only acknowledgement of the girl's claims about torture which neither directly refutes or supports them. He went on to state that:

> All that I found was a slightly painful reaction to pressure upon the left-hand side of the rib-cage. Apart from this I found, at the upper end of the fifth (r.h.) metatarsal, a reddish patch about 1 cm in diameter, which she declares to have been caused by contact with an electrode.[118]

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[114] Anonymous, 'Le cas de Djamila Boupacha signalé à la Commission de sauvegarde', *Le Monde*, 27 May 1960. <https://www.lemonde.fr/archives/article/1960/05/27/le-cas-de-djamila-boupacha-signale-a-la-commission-de-sauvegarde_2089098_1819218.html> [Accessed 15 July 2019].
[115] Branche, *La torture et l'armée pendant la guerre d'Algérie*, pp. 474-475.
[116] De Beauvoir and Halimi, *Djamila Boupacha*, p. 52.
[117] Dr. Lévy-Leroy's medical examination of Djamilia Boupacha, 15 March 1960, reproduced in de Beauvoir and Halimi, *Djamila Boupacha,* pp. 105-106.
[118] Ibid.

His examination did not suggest any alternative causes for the detainee's complaints, nor did it question their origins, though it certainly seems to play down their severity. In addition, Lévy-Leroy does not factor in the length of time that had elapsed between his patient's alleged abuse and his examination. Delaying examinations was a useful tactic for the military when it came to reports of torture, as the longer they could be delayed, the more the traces of torture would fade.[119] This was a particularly useful method for dealing with traces of electrocution, as the relatively small marks it left disappeared more quickly than lacerations or deep bruising. In fact, in an article published as early as May 1957 in the journal *Esprit*, Paul Thibaud drew attention to this feature of electric torture. In the article, Thibaud noted that 'the application of electrodes on wet skin (by sweat for example) may only cause sparks and therefore small burns, the lesions have often been noted by doctors, but they are officially attributed to "skin diseases"' such as eczema. He went on to quote a sarcastic comment by a Dr. Hovnanian, according to whom this form of eczema 'would be peculiar to Algerian prisons'.[120] The military would have thus known that, by the time Boupacha made her accusations regarding torture, most signs of this trauma would have faded from her body. But what about her rape claims? On this subject, Lévy-Leroy stated that 'It should be noted that she shows signs of acro-cyanosis of the extremities, together with certain menstrual troubles of a constitutional nature'. He went on to stress that 'On the day I examined her, there remained no trace of permanent partial disablement'.[121]

This was Lévy-Leroy's apparent clinical description of the 'bottle treatment' Boupacha claimed to have endured.[122] His descriptive account did not attempt to link the forensic evidence on her body with the narrative provided by the girl herself. Instead, he described the

[119] A similar tactic was used in the case of Djamila Bouhired, who was not examined by the military doctor until a month had passed following her complains. In this time, her wounds had more or less healed, presenting the doctor with an opportunity to produce a negative report. See Arnaud and Vergès, *Pour Djamila Bouhired*, pp. 77-78.
[120] Paul Thibaud, 'Comment fonctionne la justice en Algérie', *Esprit*, 250 (1957), 859-873 (p. 863).
[121] Dr. Lévy-Leroy's medical examination of Djamilia Boupacha, 15 March 1960, reproduced in de Beauvoir and Halimi, *Djamila Boupacha,* pp. 105-106.
[122] Ibid.

wounds as being of a 'constitutional nature', an unexplained expression which served no useful purpose other than to deny the possibility that Boupacha's 'troubles' had been caused by abuse. The doctor's refusal to elaborate on his findings proved useful for the French government. The day after *Le Monde* published de Beauvoir's article, the newspaper was forced to issue a communiqué 'on order of the general delegation'.[123] President Michal Debré had ordered the seizure of all copies of 'Pour Djamila Boupacha' in Algiers and issued a statement regarding the case. The statement impressed upon the public that 'even before the publication of this article information was opened to the prosecution of Algiers, on complaint of the interested [party], to determine the accuracy of the facts alleged'. To this end, the communiqué stressed, 'the results of the medical report' had not 'concluded to the reality of abuse'.[124] It is curious that the government treated Lévy-Leroy's report as a negative testimony despite it containing some references to certain anomalies in Boupacha's condition.[125] This was only possible because the doctor had failed to connect the evidence with the girl's claims, thus providing an opportunity for his findings to be used against her. It is noteworthy that Lévy-Leroy did not attempt to set the record straight. In fact, it is likely he had no interest in doing so, as there is sufficient evidence of his complicity in the government's cover-up efforts.

In his report of 15 March, Lévy-Leroy explicitly stated that he had conducted some sort of gynaecological examination on Djamila Boupacha. However, he later contradicted himself in court on 14 June 1960. While being questioned by M. Courmontagne, the *Juge d'Instruction* who replaced Bérard on the Boupacha case, Lévy-Leroy reportedly declared that he had not in fact examined 'the girl's genital organs, since she made no complaint of having been assaulted sexually'.[126] Moreover, while his report had indicated that Boupacha was naked

[123] Anonymous, 'Un article sur le cas de Djamila Boupacha provoque la saisie du "Monde" à Alger et un communiqué du gouvernement', *Le Monde*, 3 June 1960. <https://www.lemonde.fr/archives/article/1960/06/03/un-article-sur-le-cas-de-djamila-boupacha-provoque-la-saisie-du-monde-a-alger-et-un-communique-du-gouvernement_2093607_1819218.html> [Accessed 15 July 2019].
[124] Ibid.
[125] de Beauvoir and Halimi, *Djamila Boupacha*, p. 67.
[126] Dr. Lévy-Leroy's statement in court, quoted in de Beauvoir and Halimi, *Djamila Boupacha*, p. 52.

during this examination, the court transcript shows that the doctor suggested she had retained her shift the whole time.[127] This statement not only denied that Boupacha had raised the rape issue at the time, it also went against the doctor's own official report. According to Halimi, Lévy-Leroy added that 'These examinations are always slightly embarrassing', in a way that trivialised the situation and demonstrated a false sense of decency regarding a sensitive matter.[128]

Lévy-Leroy's involvement in the court proceedings is a powerful example of a doctor subordinating his responsibility to the patient in order to serve a higher authority. Yet the contradiction between his report and his subsequent court statement also raises questions about his relationship to the cover-up effort. It is peculiar that the doctor should so blatantly contradict himself when the defence had access to his original report. The impression is difficult to escape that collusions between medical experts and French authorities were not necessarily straightforward but potentially messy. Nevertheless, as with the case of Djamila Bouhired before it, the military courts had no intention of offering a fair trial, and the discrepancies in Lévy-Leroy's account were not addressed by M. Courmontagne. This is not surprising. By this time, the Boupacha case had gained too much public attention and needed to be, as Halimi put it, '[wound] up as soon and as quickly as possible'.[129] For de Beauvoir, this was a serious outrage. As she stated:

> Faced with so flagrant a discrepancy in his evidence one might well be tempted to proclaim this a most scandalous piece of professional dishonesty; but for old medical hands in Algeria such a concept simply does not exist. They are there, invariably, to

[127] Ibid.
[128] Ibid., p. 106.
[129] Gisele Halimi's narrative of the Boupacha case, in Simone de Beauvoir and Gisele Halimi, *Djamila Boupacha* (Paris: Editions Gallimard, 1962), p. 106.

> *deny* that maltreatment has taken place, not to confirm it: they are simply performing their allotted role.[130]

Further evidence implicating Lévy-Leroy in the cover-up emerged later in July 1960, after Boupacha officially filed her complaint against the military. In an effort to quash the claimant's allegations, Bérard, before being replaced by Courmontagne, nominated three new doctors to examine Boupacha without seeking the consent of her council. These doctors—Dr. Sirot, Dr. Bonafos and Dr. Godard—provided another concise report. Its findings, however, corrected Lévy-Leroy on several important points.[131] According to these three doctors, '*Djamila Boupacha's body* [was] *marked in various places with numerous scars. These scars could have been caused either by contact with some red-hot point, or else deliberately inflicted with some sharp red-hot instrument*'.[132] With regard to her claim about a broken rib, they found that '*She has a deformation at the base of the anterior extremity of the left-hand hemithorax*'. Finally, on the subject of rape, they observed that '*she is no longer virgo intacta, since her hymen has been ruptured by the insertion of some hard, blunt body, e.g. an erect penis*'.[133]

While this second report is just as brief as the first, the little information it does offer is in direct contrast with the findings of Lévy-Leroy's examination on 15 March. According to this later report, Boupacha's body did indeed exhibit signs of injury which clearly had a bearing on her claims. However, the gynaecological assessment was the most damning. Rather than Boupacha suffering from some vague 'menstrual troubles of a constitutional nature', the three

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[130] Simone de Beauvoir, 'Introduction', in de Beauvoir and Halimi, *Djamila Boupacha,* p. 12. (Emphasis in original).
[131] It should be noted that there is a high chance Dr. Gardad is the same medical expert who examined Djamila Bouhired in 1957 when she made her allegations of torture. According to Vergès, Bouhired was examined by a Dr. Goddard who provided a similarly scant and inconclusive account of her wounds. In fact, he recorded a festering bullet wound which had been kept open by subsequent beatings as being 'fistula of tuberculous origin' while another wound that had already closed was described as an 'old tuberculous fistula'. See Arnaud and Vergès, *Pour Djamila Bouhired*, p. 77-78.
[132] The medical report produced by Dr. Sirot, Godard and Bonafos as reproduced in Simone de Beauvoir and Gisele Halimi, *Djamila Boupacha*, p. 104. (Emphasis in original text).
[133] Ibid.

doctors found clear evidence that she had been penetrated. Given this information and the discrepancies between his report and his statement at the hearing, the only possible conclusion is that Dr. Lévy-Leroy was either an incompetent practitioner or someone determined to invalidate the plaintiff's testimony. Yet while this second report does provide some support for Boupacha's case, it remains notably shallow in its assessment. While making no recommendations for follow-up procedures to examine the nature of the scars and marks on her flesh, the report does not attempt to assess the seriousness or the possible causes of the injury to her rib.[134] In addition, the doctor's reference to an 'erect penis' would certainly suggest they were considering alternatives to the 'bottle treatment'.

Regardless of whether these experts were deliberately avoiding linking her wounds to her story, the discrepancies between their findings and Levy-Leroy's proved useful for the Defence. They allowed Halimi to arrange for a third medical examination to take place, but this time in Paris, with a set of doctors selected by the Defence.[135] This was a vital development. It not only provided Boupacha with a chance to gain medical evidence to boost her claims, it also contrasted greatly with the above-mentioned case of Djamila Bouhired, where the Defence lawyers were prevented from submitting counter-evidence.[136] Moreover, by transferring her to Paris for the assessment, Boupacha and her legal counsel would have been away from Algeria and the immediate point of control for the military. The final medical examination, in theory, should have been straightforward and unambiguous. However, this was not to be the case. By 1960, the Algerian War was not only a thorny political issue in Algeria; the ferocity it evoked in the more right-wing members of society had spread to the capital. Djamila Boupacha's case had essentially become a microcosm for the broader political divide surrounding the Algerian conflict. Far from being a simple and objective medical

[134] de Beauvoir and Halimi, *Djamila Boupacha*, p. 116.
[135] Anonymous, 'CINQ MÉDECINS SONT DÉSIGNÉS POUR EXAMINER EN MÉTROPOLE DJAMILA BOUPACHA', *Le Monde*, 19 July 1960. <https://www.lemonde.fr/archives/article/1960/07/19/cinq-medecins-sont-designes-pour-examiner-en-metropole-djamila-boupacha_2102119_1819218.html> [Accessed 15 July 2019].
[136] Arnaud and Vergès, *Pour Djamila Bouhired*, pp. 40-41, 90-91.

examination, then, Boupacha's body and the explanation for the marks it exhibited were now woven into this wider political fabric of unrest.

The examination took place at the infirmary in the Parisian prison of Fresnes, on 28 July 1960.[137] The doctors selected for the job included Professor Lantuejoul and Funck-Brentano, two gynaecologists from the Academy of Medicine; Professor Duperrat, a dermatologist; Professor Christiaens, an obstetrician, and Dr Hélène Michel-Wolfrom, who was commissioned for both her psychiatric and gynaecological experience at the direct request of Halimi.[138] Even at the point of examination, it is possible to detect the level of tension produced by the meeting between the doctors and their patient. According to Boupacha, all the doctors performed their tasks as quickly as they could and refused to interact with her at all. Only Dr. Michel-Wolfrom engaged with the patient to any notable extent. In fact, she was the only member of the five experts to volunteer a full and unambiguous statement concerning the patient's condition and the story she professed. This was not because the other doctors were necessarily unable to confirm Boupacha's account, but because they could not agree on how best to present their findings.

Given the wider political context, it is easy to appreciate the problem. On the one hand, if the five doctors produced a report that affirmed the young woman's story, they would essentially be supporting a suspected terrorist at a time when the 'Algeria question' was becoming an increasingly heated topic in the metropole. In fact, according to Halimi, when one doctor suggested they give an unambiguous result in favour of the girl's claims, one of his/her colleagues retorted: 'Want to get yourself knocked off in the street by a bunch of hotheads?'.[139] The deeply political nature of the case was clearly affecting the experts' observations and

[137] Ibid.
[138] Confusingly, *Le Monde* referred to Professor Chistianens as 'expert in forensic medicine' and not an obstetrician. See Anonymous, 'CINQ MÉDECINS SONT DÉSIGNÉS POUR EXAMINER EN MÉTROPOLE DJAMILA BOUPACHA', *Le Monde*, 19 July 1960.
[139] One of the five doctors quoted in de Beauvoir and Halimi, *Djamila Boupacha*, p. 124.

straining their professional allegiances. In this instance, rather than having their loyalty divided between the state and the patient, it was the doctors' personal safety which was the major factor. The decision to assist a suspected terrorist could make the doctors a direct target of political violence by the fanatic believers in *Algérie française*. However, to provide Boupacha with anything other than an objective medical assessment would violate the doctors' ethical responsibilities to protect their patient's best interests.

The situation provides a vital insight into the types of pressures expert witnesses can face when agreeing to take on high-profile and controversial cases. The unstable political atmosphere reveals the limits of professional objectivity. In the context of the Algerian War, the clinical encounter had become part of the theatre of conflict and was now wrapped up in the state's attempts to disavow allegations of torture. Faced with such a dilemma, the five doctors opted for a compromise. The twenty-two-page medical report submitted to M. Brossette at the Paris High Court of Justice was still neutral despite being significantly longer and more detailed than the previous two provided by the military. Dr. Duperrat's dermatological findings were negative: he found no evidence that the marks on Boupacha's skin had been caused by cigarettes or electrodes, though he did not offer an alternative cause. Similarly, Dr. Christiaens regarded the evidence of a 'hemithoracic deviation', her rib injury, as not significant enough to 'form the basis of any definite verdict … since it could just as easily be rachitic in origin as due to external violence'.[140] Yet while these statements neither confirmed nor refuted Boupacha's story, a relatively conclusive diagnosis was offered regarding the gynaecological examination. Here the doctors affirmed that:

> Granted that after five months of rapid healing of vulvovaginal tissue normally makes it impossible to identify the method employed in any particular instance of defloration; and, further, bearing in mind the fact that we could consult no other

[140] Extract of the medical report of the five doctors examining Djamila Boupacha, quoted in de Beauvoir and Gisele Halimi, *Djamila Boupacha*, p. 125.

> examination of the subject's genital organs made *prior to her arrest*, our answer [is] nevertheless: *Yes, Djamila Boupacha may well have had the neck of a bottle inserted into her vaginal passage*.[141]

However, they added that, as of the date of the examination, it was 'impossible to specify either the date or the exact method of her defloration with any precision'. Despite this caveat, the doctors went on to explain that 'the tightness of the vaginal passage, the thickness of the hymen, and the narrow localization of the actual perforations […] all might well argue *in favour of traumatic defloration*'.[142] This conclusion was significant, but it was still couched in hesitant and neutral language. The five doctors' neutrality, however, differed from previous instances. While Lévy-Leroy and even Sirot, Bonafos and Godard had issued bland descriptive statements in order to serve the interests of the military, either willingly or through pressure, neutrality in this examination was primarily a self-defence tactic, intended to protect the doctors involved from potential threats and actual violence. Yet while four of the five Parisian doctors thought it prudent to sit on the political fence and were unwilling to take a definitive stance on Boupacha's claims, Dr. Michel-Wolfrom's psychiatric evaluation did answer in the affirmative.[143]

When Dr. Michel-Wolfrom first examined Boupacha on 28 July 1960, she questioned the patient on her personal life, Muslim marriage customs, and Algeria in general.[144] She also encouraged Boupacha to keep a diary and promised to return for a second visit in September. According to Halimi, Michel-Wolfrom became convinced that 'Djamila was quite incapable of telling a lie or pretending in any way'. This, Halimi believed, was a 'vital diagnosis' for their case.[145] Although this may be hyperbole, it was indeed Michel-Wolfrom's willingness to

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[141] Ibid. (Emphasis in the original text).
[142] Ibid., p. 125-126. (Emphasis in the original text).
[143] Although it cannot be ruled out that the doctors involved in her previous examinations were not subjected to threats from the military either.
[144] de Beauvoir and Gisele Halimi, *Djamila Boupacha*, p. 120.
[145] Ibid., p.123.

offer a testament to Boupacha's claims that made the difference in the end. Michel-Wolfrom's contribution to the final medical report focused on her psychological profile, presenting Boupacha as a religiously devout and obedient daughter, who was essentially sexually immature and almost naïve.[146] According to this testimony, she was thus the perfect devotee for the FLN who provided her with a cause to pursue. This was clearly an important part of the defence for Boupacha's case. Michel-Wolfrom's findings needed to provide strong evidence that Boupacha was indeed a victim of rape if she was going to add weight to the more hesitant verdicts provided by her colleagues in this third report. If this could be achieved, Boupacha's wider torture claims would also gain notable strength. Because of this, the plaintiff's character and image were just as important for her claims as the marks on her body. And as with the latter, an expert eye was needed to *prove* this. So while the army tried to portray Boupacha as a fanatical terrorist who had questionable sexual relations with her accomplices—thus invalidating her rape story—Michel-Wolfrom's psychological testimony attempted to present her as politically minded and spiritually devoted to her nationalism.[147] She was not a violent or duplicitous terrorist but a sane Muslim girl who was ultimately a virgin.

The most important point to note about Michel-Wolfrom's observations is that they invert the traditionally pejorative view of the Muslim in Algeria. As mentioned elsewhere in this work, ethnopsychiatry in Algeria played a vital role in constructing an image of the Algerian population as innately violent and religiously irrational. In fact, as argued above, according to experts at the Algiers School of Psychiatry, it was the Algerians' apparent religious zeal that turned the nationalists into violent terrorists in the first place. In contrast, Boupacha's religious devotion was here presented as a sign of her innocence, something that bolstered her

[146] See the extract of Dr. Michel-Wolfrom's contribution to the five doctor's medical report, reproduced de Beauvoir and Gisele Halimi, *Djamila Boupacha*, p. 123.
[147] In July 1960, the military circulated a photo of Boupacha in the company of several FLN soldiers in an attempt to discredit her image. The images were given to multiple right-wing magazines, which used them to portray the girl as having questionable sexual relationships with the soldiers. See de Beauvoir and Gisele Halimi, *Djamila Boupacha*, p. 87.

allegations. 'Her mind', Michel-Wolfrom reported, 'seems wholly concerned with political issues, and with accomplishing such tasks as her superiors in the FLN laid down for her'.[148] This was because, Michel-Wolfrom went on, Boupacha 'had identified her personal aspirations with her sense of patriotic and religious mysticism. She is ambitious by nature; but she swears she is devoted, body and soul, to the service of her country'.[149] The girl was thus selfless when it came to the subject of romance, apparently regarding, as Halimi added, the 'harbouring of her fighting comrades as a duty, and made a sharp distinction between the *camaraderie* engendered by war and the inclination of one's own heart'.[150] Virginity was therefore sacred to Boupacha: 'virginity for her was a totemic symbol, with positively magical significance'.[151] Her status as a virgin was thus a defining psychological feature for Boupacha, according to this account. Her repeated emphasis on the Muslim nuptial ritual requirement that the bride should shed 'virgin blood during the consummation' was a strong indicator that her claims were true, at least in the eyes of her legal counsel and Michel-Wolfrom. For the latter, they were a clear psychological sign that Boupacha's 'mentality [corresponded] with that of a virgin'.[152] While it has been suggested that de Beauvoir and Halimi stressed Boupacha's femininity to gain public sympathy for the young woman's plight, this psychiatric diagnosis also utilised her religious convictions in a similar way.[153] Through this affirmative report, Boupacha gained 'scientific' support for her allegations, which, combined with the gynaecological findings, greatly enhanced her plea. Although it is unclear how the French authorities felt about this development, it appears the cumulative evidence within Boupacha's case had rattled them.

Following the submission of the report to the *Juge d'Instruction*, Boupacha and her legal counsel were prevented from viewing the whole dossier concerning her case. It seems M.

[148] Ibid., p. 126.
[149] Ibid., 126.
[150] Ibid., p. 126.
[151] de Beauvoir and Gisele Halimi, *Djamila Boupacha*, p. 126.
[152] Ibid.
[153] Surkis, 'Ethics and Violence' (p. 44).

Courmontagne in Algeria had stepped up his efforts to obfuscate the legal process. By refusing them access to this information, the magistrate directly violated their legal right to view these documents as part of the *Code de Procédure Pénale*.[154] By this stage, the dossier was replete with incriminating evidence through which the crimes committed against her could be reconstructed. Despite this, the strength of the medical report from the five Parisian doctors, along with the earlier medical discrepancies, was sufficient to get the trial adjourned and transferred to the Appeals Court in Caen, France, on 15 December 1960. Boupacha's case was thus finally removed from the jurisdiction of the Algiers Bar.[155] It was, however, not until 17 April 1961 that Boupacha finally became acquainted with the findings of the five medical examiners.[156] Although the medical report substantiated her claims and contributed to removing the case from the military's jurisdiction, the legal proceedings surrounding her case continued to drag on over the next year. The military in Algeria and their courts continued to hinder the requests for additional evidence and interviews with personnel involved in her interrogation. As the case progressed, witness testimonies from military staff and Boupacha's fellow detainees produced an increasingly damning image of the military's practices in Algeria.[157] Despite this, her torturers were never put on trial. On 29 June 1961, Boupacha was sentenced to death. In the event, however, she was amnestied on 20 March 1962, as part of the Evian agreement which brought the Algerian War to an end.

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[154] de Beauvoir and Gisele Halimi, *Djamila Boupacha*, p. 128.
[155] Anonymous, 'A LA COUR DE CASSATION: LA PLAINTE POUR SERVICES DE MILLe BOUPACHA SERA INSTUITE A CAEN ET NON PLUS A ALGER', *Le Monde*, 17 December 1960. <https://www.lemonde.fr/archives/article/1960/12/17/la-plainte-pour-sevices-de-mlle-boupacha-sera-instruite-a-caen-et-non-plus-a-alger_2105512_1819218.html> [Accessed 15 July 2019].
[156] de Beauvoir and Gisele Halimi, *Djamila Boupacha*, p. 135.
[157] In a letter addressed to 'Monsieur le Général Cdt. La R.T. et le C.A. d'Oran', the Général de Corps d'Armée and Commandant Supérieur des Forces en Algérie, Ailleret, showed considerable concern for the revelations made regarding named soldiers involved in Boupacha's case. Although I have not been able locate a response to this letter, his concerns reveal the extent to which the military were becoming increasingly rattled by her case. See SHD 1 H 1246/d.2. See also Anonymous, 'L'INSTRUCTION DE L'AFFAIRE BOUPACHA', *Le Monde*, 1 July 1961. <https://www.lemonde.fr/archives/article/1961/07/01/l-instruction-de-l-affaire-boupacha_2265228_1819218.html> [Accessed 15 July 2019].

Although the scandals caused by individuals like Djamila Bouhired, Djamila Boupacha and other high-profile Algerian nationalists contributed to the unpopularity of the conflict in France, their stories were not enough to conclude it. In fact, by the end on 1961, the French view of Algeria was less one of outrage and more one of apathy. There had been too many scandals, too many reports of torture, massacres, political intrigue and military plots.[158] As de Beauvoir had powerfully warned in her original article in *Le Monde,* 'The most scandalous part of scandal is the getting used to it'.[159] Unlike the situation in Kenya, where it is possible to identify one decisive event which signalled the end of the conflict (see below), the situation in North Africa was different. President de Gaulle had gestured for peace negotiations with the FLN as early as January 1961, but these efforts were fraught with challenges,[160] not least because violence committed by the *Organisation de l'Armée Secrète* was causing significant disruptions. The OAS took the war against the FLN into their own hands and carried out multiple bombings, torture campaigns, assassinations and disappearances against Muslims and moderate Europeans alike, in order to forestall any negotiations between de Gaulle and the rebels.[161] They even attempted a full military putsch against the President in April 1961.[162] Eventually, the violence of this civil war spilt onto the streets of Paris on 17 October 1961, when a FLN non-violent protest was met by an indiscriminately violent police crack-down under the Paris police chief, Maurice Papon.[163] On top of this, the OAS exported their terrorism to the metropole as well and brought about anarchy in the capital.

Following the Evian agreement and the continued bloody struggle between the OAS and the FLN in Algeria, the majority of the *pieds-noirs* population felt unsafe in the newly independent

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[158] The scandals of the Algerian War were greeted with the same type of detachment by the French as more modern versions have in recent years, such as Guantanamo Bay, Abu Ghraib and Baghram. See Surkis, 'Ethics and Violence' (p. 38).
[159] de Beauvoir, 'Pour Djamila Boupacha', *Le Monde*, 3 June 1960.
[160] On 8 January 1961, de Gaulle organised a referendum where voters were asked to respond to questions about self-determination for the Algerian people. See Droz and Lever, *Histoire de la guerre d'Algérie, 1954-1962*, p. 297.
[161] Evans, *Algeria*, pp. 291-292.
[162] Benjamin Stora, *La gangrène et l'oubli* (Paris: La Découverte, 1998), pp. 204-205.
[163] Josh Cole, 'Remembering the Battle of Paris: 17 October 1961 in French and Algerian Memory', *French Politics, Culture & Society*, 21 (2003), 21-50 (p. 24).

country. Independence was thus accompanied by a veritable exodus which saw both Europeans and *harkis* loyalists leave North Africa for the metropole. Many of the colonial doctors mentioned in this work went with them. Djamila Boupacha and her family were released from prison on 21 April 1962. The amnesty had saved her life, but it had also stripped her of the chance to prosecute her torturers or the doctors who aided them. Her case, however, remains important, for it illustrates the ways in which the state mobilised medical evidence and expert testimony to aid in its denial efforts. It, moreover, speaks to the limits of this evidence and shows how the Defence could use counter-expertise to outmanoeuvre the Prosecution in an adversarial court. Finally, of course, it is worth bearing in mind the distinctiveness of Boupacha's case and the presumably much more common instances in which counter-evidence could not be deployed, because the investigations into alleged violence were being conducted within a closed environment. Did Kenyan doctors play a similarly significant role in state efforts at cover-up during the Emergency? This is the question to which we now turn.

5.6. 'A great administrative disaster': Hola Camp and medical testimony

In the final years of the Emergency, the Special Detainee Camp at Hola, a closed camp not far from Mombasa, near Kenya's south-eastern coast, operated as a dumping-ground for 'hardcore' Mau Mau, the more politically-minded and recalcitrant rebels. According to colonial officials, these individuals were 'the worst types of detainee', beyond hope of rehabilitation.[164] As stipulated under section 22 of the Detained Persons Regulation, detainees at Hola, and other special detention camps, who were deemed to be 'fit for work' were 'employed in work which the officer-in-charge is satisfied will assist in bringing the Emergency to an end and to that end shall do such work of the nature aforesaid as he may be required to do by the officer-in-charge'.[165] Although this work was seen as a fundamental step

[164] TNA FCO 141/5651, p. 2. J. Hayden Lewis, Commissioner of Prisons, 'Directive for use of force in detention camps', 10 September 1957.
[165] TNA CO 542/52. Section 22 of the Emergency (detained persons) Regulation, 1954.

in the rehabilitation process, in many instances, it amounted to arduous forced labour. This was the warders' preferred punitive measure to tame the prisoners. As the settler Sir Richard Woodley saw it, forced labour was 'slavery from dawn to dusk, on a ration sufficient to keep [the detainee] alive and working but no more'.[166] As a result, it was not uncommon for detainees to organise work strikes in protest against their conditions, something that the British saw as the greatest example of defiance to their authority.[167]

Since early February 1959, harsher measures had been introduced to combat the high levels of perceived malingering and resistance present at Hola.[168] In particular, John Cowan, the Senior Superintendent of Prisons and the original master-mind behind the dilution technique (see Chapter 4), recommended that the problem could 'best be solved by firmness and by intelligent co-operation between the authorities concerned'. His proposal, what became known as the Cowen Plan, was a recalibrated version of the dilution technique which recommended splitting the detainees into small, manageable groups when subjecting them to hard labour and then using 'compelling force' to coerce them to work. Although he was keen to officially state that 'This does not imply a brutal and harsh regime', the reality was very much the opposite.[169] In fact, on the 17 February 1959, the Commissioner of Prisons, John Lewis, admitted in a

[166] Woodley quoted in Klose, *Human Rights in the Shadow of Colonial Rule*, p. 157. This was not new, since the reliance on forced labour reflected an older colonial tradition of exploiting convicts as a source of cheap labour. See Florence Bernault, 'The Shadow of Rule: Colonial Power and Modern Punishment in Africa', Frank Dikötter and Ian Brown (eds.), *Cultures of confinement: a history of the prison in Africa, Asia, and Latin America* (Cornell University Press, 2018), pp. 55-95 (pp. 71-72).
[167] Anderson, *Histories of the Hanged*, p. 317.
[168] TNA FCO 141/5651. J.B.T. Cowan, Senior Superintendent of Prisons, 'Discipline – Hola Camp', 11 February 1959.
[169] As discussed in the previous chapter, from July 1957, torture in the form of the dilution technique was officially sanctioned within the Kenya detention camps. This provided prison staff with the legal justification for extreme acts of violence, especially if it led to a prisoner's confession. In addition to this, the prison staff were issued a series of directives which permitted the use of force in certain conditions, such as in self-defence, during prison riots, attempted escapes or to overcome 'violence or resistance'. The loose language surrounding the 'use of force' meant Hola Camp could operate with the type of impunity that characterised the detention process. See TNA FCO 141/5651. J. Hayden Lewis, Commissioner of Prisons, 'Directive for use of force in detention camps', 10 September 1957.

report to the Minister of Defence that the Cowan Plan involved 'the use of a certain degree of force in which operation someone might get hurt or even killed'.[170]

On the morning of the 3 March 1959, 85 Mau Mau detainees were taken to perform hard labour as part of the daily routine at Hola. The detainees were escorted to the surrounding fields and given tools for their job as part of an ongoing government irrigation scheme. They were ordered to begin work under the supervision of a group of African warders who greatly outnumbered them, accompanied by Michael Sullivan, the Camp Commandant, who followed in a land rover.[171] Despite pressure from the guards and threats from Sullivan, the detainees repeatedly refused to work. The exact details of what followed on that morning remain unclear, but it is known that the African warders, dressed in riot gear and armed with batons, beat the prisoners on Sullivan's command.[172] Despite trying to defend themselves with their labour tools, the detainees were overcome by the assault. By the end of the day, 10 were dead, while many others were badly injured; another individual, Ngugi Kariti, lay dying in the hospital. He succumbed to his wounds a few days later.[173]

Prior to the incident at Hola, the British public had rarely been stirred by reports of abuse coming out of the colony. However, by the time news of the deaths reach Britain on the 4 March 1959, sentiments had changed. Despite the outrage generated by what is now called the Hola Camp massacre, Governor Baring and Lennox-Boyed, back in London, were determined to protect their people in Kenya. Almost immediately after the deaths were reported to authorities in Britain, efforts to cover-up the true reasons for the detainee's demise and the

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[170] TNA CO 822/1267. Records of the Proceedings of an Enquiry Under Colonial Regulation 60 into charges against Superintendent M.G. Sullivan, M.B.E., and Assistant Superintendent A.C. Coutts, both of the Kenya Prisons Service', p. 23.
[171] David M. Anderson, 'Mau Mau in the High Court and the 'Lost' British Empire Archives: Colonial Conspiracy or Bureaucratic Bungle?', *The Journal of Imperial and Commonwealth History*, 39 (2011), 699-716 (p. 705).
[172] Elkins, *Britain's Gulag*, pp. 346-347; Anderson, 'Mau Mau in the High Court and the 'Lost' British Empire Archives' (p. 705).
[173] Anonymous, 'Inquest on 11 Mau Mau: HAD BEEN "PREVAILED ON" TO WORK', *The Manchester Guardian*, 19 March 1959.

extent of the violence in the camp were set in motion. Baring and Lennox-Boyed, along with the then Prime Minister, Harold Macmillan, were determined to avoid a scandal during an election year.[174] Due to fervent opposition from the Labour MPs, however, the government was forced to conduct a series of inquests into the Hola incident.[175]

Public inquest investigated deaths considered to be 'unnatural', 'violent', 'sudden' or 'accidental' and involved, in normal circumstances, the findings being subjected to public inquiry by a coroner and a lay jury.[176] Within these investigations, the coroners had no formal medical training to guide their thinking but it was through them and the jury's verdict that the cause of death would be decided. This was a process that was based on a form of civic participation,[177] but at Hola, the government managed to resist the demand for an independent, and thus public, inquiry. The subsequent investigations remained internal affairs and were not as rigorous as the opposition would have liked.[178] Moreover, the evidence gathered by colonial officers investigating the events was poorly assessed and rarely questioned by the acting government. As with the military tribunals in Algeria, what followed was a parody of justice, where the careful control of post-mortem evidence and any medical-related information was crucial for sustaining the cover-up effort.

As will be shown below, although the official inquests were anaemic in their search for *truth*, their use of medical evidence reveals the same issues as had come to the fore in earlier investigations into violence: the doctors involved in the investigations adopted an anodyne neutrality vis-à-vis the allegations of abuse; the experts were apparently misled by suggestions from officers involved in the incident; while a certain level of bungling further limited the impact of the findings. In addition, a comparison of the inquest reports and transcripts with

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[174] Elkins, *Britain's Gulag*, p. 349.
[175] Ibid.
[176] Ian Adnan Burney, 'Viewing Bodies: Public Order, and English Inquest Practice', *Configurations*, 2 (1994), 33-46 (p. 33).
[177] Ibid.
[178] Elkins, *Britain's Gulag*, p. 349.

the debates held in the House of Commons over the Hola Camp incident reveals just how significant the medical interpretation was for both the Conservative Government and the Opposition which challenged them. This is a point of contrast with the Boupacha case, in that the findings of the inquests were discussed in Parliament, and not just in the press. Also, unlike in France, where the plaintiff's legal counsel and supporters drew explicit attention to medical complicity in the court's games, little was made in Britain of the medical professionals' involvement in the Hola inquest's cover-up efforts. This, it is argued here, was because the doctors involved were regarded as minor figures in a wider government conspiracy. The Opposition's focus on bringing down high-profile leaders in an election year afforded the same doctors a measure of protection.

Medical provisions at many camps in Kenya were often extremely limited. Hola Camp, on the other hand, housed both a sick-bay and a hospital, which was about half- to three-quarters of a mile from the camp. It even had a resident physician who lived on site.[179] Dr. Ronald William Moyes, a young Medical Officer in his mid-twenties, had qualified as a doctor in Britain in 1956, before transferring to Kenya in July 1958. Prior to his posting at Hola, Moyes had only eleven weeks of experience with treating African patients while in Kwale, not far from Hola itself.[180] It is curious that the government would appoint someone with so little experience for monitoring the health of detainees in a camp that was regarded as the last bastion of Mau Mau resistance, though it should be admitted that, by 1959, the Colonial Officer was experiencing a serious shortage of medical staff for the colonies.[181] Moyes carried out his functions at the camp with the aid of six African dressers and one assistant.[182] In terms of medical provision,

[179] TNA CO 822/1267. 'Records of the Proceedings of an Enquiry Under Colonial Regulation 60 into charges against Superintendent M.G. Sullivan, M.B.E., and Assistant Superintendent A.C. Coutts, both of the Kenya Prisons Service', p. 43. See also the oral evidence given by Dr. Ronald William Moyes in the same source on 8 June 1959. Ibid., p. 71.
[180] Anonymous, 'The "Unco-operative" beaten: Inquest on Mau Mau detainees', *Manchester Guardian*, 25 March 1959.
[181] Hansard. House of Commons Debate, 'Doctors', Mr. Blenkinsop MP, 17 June 1958, paragraphs 887-888.
[182] TNA CO 822/1267. 'Records of the Proceedings of an Enquiry Under Colonial Regulation 60 into charges against Superintendent M.G. Sullivan, M.B.E., and Assistant Superintendent A.C. Coutts,

Hola was better than many camps but still extremely lacking in terms of the effective care it needed to offer detainees in a compound of that size. As such, on the morning of the 3 March, Moyes was unprepared for the number of injured detainees who would flow through the hospital. Nevertheless, his account of his involvement, available in the transcripts of the subsequent inquests into the incident, is worth a detailed examination.

The first point to note in the inquests is that, when the detainee-patients started to enter the hospital on the day of the massacre, Moyes appeared unwilling to acknowledge evidence of potential abuse. According to his testimony at the first inquest on 18 March 1959, it was at 1pm that Sullivan came to report that 'he had brought in some detainees some of whom were dead and he wanted me to examine them'.[183] The injured detainees, along with the six dead, were transported to the hospital in a lorry. The surviving patients were then placed in wards but soon an additional 'three batches' of injured detainees turned up at the hospital. Moyes admitted that his first concern was for the living, so he turned his attention to the injured rather that examining the bodies of the six dead detainees. At this point, another detainee died. His body was taken out to join the others.[184] The patients showed signs of 'bruising, abrasions, fractures and suspected fractures'. Some of the bruising was, as Moyes explained during the inquest, of a 'linear nature and possibly caused by sticks'. Despite this, Moyes admitted that 'I did not get the impression at that time of serious injury'.[185] Other patients were unconscious on arrival, and another died a quarter of an hour later. This detainee had black eyes and broken teeth; his death, Moyes noted, was probably due to 'internal head injury'.[186]

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both of the Kenya Prisons Service', p. 55. See also Anonymous, 'The "Unco-operative" beaten: Inquest on Mau Mau detainees', *Manchester Guardian*, 25 March 1959.
[183] TNA FCO 141/5651. Dr. Ronald William Moyes witness statement in 'Inquest on Eleven Persons who Died in the Hola District, Coast Province, on or about 3rd March, 1959. Vol. 1', p. 39.
[184] Ibid., p. 40.
[185] Ibid.
[186] Ibid.

Soon afterwards, another two unconscious detainees were admitted to the hospital. They, Moyes thought, exhibited signs of 'aspiration of pneumonia', with water coming out of their mouths and noses. While this may have seemed a perplexing set of symptoms to be faced with in this context, Moyes suggested that he had been initially 'persuaded' by a prison officer that the detainees had been drinking heavily from a water bowser at the time when they started to collapse. Not unlike in the aforementioned case of Dr. Brown, Moyes appears to have been deliberately misinformed by officers involved in the event. The scenario they suggested was that the water was somehow contaminated or that the detainees' keenness to quench their thirst had caused them to drown themselves. Although the Press Office Handout, which was circulated on the 4 March 1959 to report on the Hola deaths, did not explicitly connect the fatalities with the water, the implied causal relationship allowed it to become *the* initial explanation for the deaths at Hola.[187] It is possible that this was the preferred explanation of a government caught on the back-foot by the incident. Typhoid epidemics had killed detainees in camps at earlier stage of the Emergency.[188] By implying a connection with a 'contaminated water source', the authorities were probably trying to present the deaths as the result of negligence, rather than the more serious charge of outright abuse. It certainly seems that the colonial authorities took this explanation seriously enough to have the water, along with stomach content and liver samples from the dead detainees, examined by Mr. Norman Kirby, the Government Chemist, on the 6 March 1959. However, as with the Gichina case in 1955, the examination found no traces of 'poisonous substances' and thus returned a negative finding.[189]

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[187] The Press Office Handout, 'Death of Ten Detainees at Hola', states that 'The deaths occurred after they had drunk water from a water cart which was used by all members of the working party and by their guards'. TNA FCO 141/5651. 'Hola Inquest Case No. 1 of 1959. Exhibit No. X: Kenya News: press Office Handout No. 142: Deaths of Ten Detainees at Hola', 4 March 1959.

[188] In particular, there was a serious typhoid epidemic in the Manyani and Mackinnon Road camps after the conclusion of Operation Anvil in 1954. The epidemic claimed over 86 lives and infected hundreds more before it ended in late December that year. See TNA CO 822/801. 'Manyani Camp Typhoid Epidemic: Report by Director of Medical Services', 13 October 1954. For a general discussion of this epidemic, see Anderson, *Histories of the Hanged*, pp. 316-320.

[189] TNA FCO 141/5651. Norman Kirby witness statement in 'Inquest on Eleven Persons who Died in the Hola District, Coast Province, on or about 3rd March, 1959. Vol. 1', p. 10.

Despite the water explanation having been rejected by the time of the first inquest in March 1959, Moyes stuck to his initial impressions with little elaboration. He, however, added more detail in a subsequent inquest held in June of that same year. This later inquest was initiated by the Macmillan government as an internal disciplinary proceeding against Sullivan and his assistant, Superintendent A. C. Coutts, who were charged with providing misleading information to the government investigators and playing down the use of force during the massacre. In particular, they were accused of trying to cover-up the violence when a committee consisting of W. M. Campbell, the Acting Deputy Commissioner of Prisons, Mr. A. C. Small, the Under Secretary of Defence, and Mr. Garland, an Assistant Secretary in African Affairs (referred to collectively in the transcripts as 'the trio'), conducted an initial investigation into the events of 4 March 1959, the day after the massacre. In June, Moyes described the two patients as having 'bubbly chests' and that he had seen 'the water in the lorry near the mouths of the corpses'.[190] Moyes claimed he had come to this initial diagnosis through his fleeting examination of the corpses at the time, along with the oral explanations offered by prison officers. Although the drowning story had been abandoned by the government a week after it was first circulated, Moyes was still repeating it nearly four months later with little discernible effort to add clarity or to set the record straight.[191] Interestingly, in the final public report on the Hola camp incident published in July 1959, Baring even acknowledged that Moyes had been responsible for 'exaggerating the part played by excessive consumption of water' through 'his preliminary diagnosis of the cause of death in some of the cases as aspiration pneumonia'.[192]

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[190] TNA CO 822/1267. Oral evidence from Dr. Ronald William Moyes, 8 June 1959 as part of 'Records of the Proceedings of an Enquiry Under Colonial Regulation 60 into charges against Superintendent M.G. Sullivan, M.B.E., and Assistant Superintendent A.C. Coutts, both of the Kenya Prisons Service', p. 71.

[191] Although Kirby's report contributed to the water story being dropped, there were other reasons. Barbra Castle had also received evidence from D.N. Prit, the left-wing QC who was representing the detainees in Kenya. According to an interview Castle later gave, Prit had managed to obtain the autopsy reports of the 11 dead detainees which showed the extent of violence used to kill them. Elkins, *Britain's Gulag*, p. 345.

[192] Evelyn Baring, 'Despatch's from Governor, Kenya to Secretary of State for the Colonies', in *Further documents relating to the deaths of eleven Mau Mau detainees at Hola Camp in Kenya* (London: Her Majesty's Stationary Office, 1959), p. 7.

Yet if his account is to be believed, Moyes had been influenced and possibly misled by the prison staff who were directly involved in violence. What we are presented with is thus the image of a doctor who was either incompetent or gullible. This, however, can only be part of the explanation, since Moyes was not operating in a vacuum. His acquaintance with the other detainees-patients who were brought into the hospital on the 3 March should have aroused some suspicion. In fact, this highlights a feature that is missing from his wider account: what were the testimonies and claims of the detainees-patients whom he was treating? At no point in any of the inquests does Moyes mention or show consideration for their explanations of what happened that morning or for the marks on their bodies. When the detainee's responses were discussed at all, it was generally to explain how unhelpful they were. Dr. Maurice Rogoff, the Government Pathologist who had been called in to examine the bodies of the detainees on the 4 March, described their living companions as 'bloody unhelpful' and as refusing to answer his questions about the incident.[193] It appears there was great distrust between the detainees and the doctors employed by the state to treat them. This is not surprising given the close relationship between the security forces and the medical officers in these camps. If the detainees-patients did not trust Moyes and his colleagues to protect them, why would they confide in them? This adds greater suspicion to Moyes's account of that day. In fact, it was only when he was directly questioned on the subject that he admitted that there had been some sort of conflict between the prison officers and the detainees. He did not volunteer the information. Apparently, he was told at some unspecified point in the afternoon of 3 March that 'non-cooperative' detainees had been 'hit', but he could not recall who had told him this. However, he said nothing more on this point and then added that, prior to that day, he had not 'seen any injuries probably the result of physical violence on any of the detainees'.[194]

[193] CO 822/1267 Dr. Rogoff had also worked on the Gichina case as the Government Pathologist, p. 50.
[194] Ibid., pp. 43, 53.

Moyes's testimony, therefore, rested solely on the physical characteristics of the bodies he had examined and not the victim's own explanations. Nor did he see fit to draw attention to the reports of abuse that were circulating in the camp that day, despite clearly being aware of them. During the June Inquest, by which time the cover-up was gaining greater public scrutiny, the young doctor admitted that, when he had been questioned by 'the trio', he had failed to convey the stories about the 'fracas and melee' which he had heard on the day.[195] Instead, he stressed, 'I was not taking it on myself to mention a fracas, I was only mentioning what I saw in the hospital'.[196] This was in response to questions regarding the origins of the drowning story which was subsequently circulated by 'the trio' after their initial investigations in March. But even these medical observations were far from unambiguous. What is curious, though, is that Moyes was permitted to restrict his testimony to these purely clinical matters. Although it may not have been unusual for an ostensibly independent expert witness to be called upon to offer an interpretation of medical evidence on its own, what is suspicious is that Moyes was both offering medical evidence and an interpretation while also being involved in the events themselves.

The expert witnesses in Algeria, such as Dr. Levy-Leroy and Dr. Gardard, were not involved in the violent circumstances that had caused Boupacha's injuries. As such, their medical observations of her complaints were independent of the events that had caused them, even if the conclusions they drew were still shaped by the military. Yet in Kenya, a doctor who was working and living in the camp, and who had also been present on the day of the massacre, was allowed to simply state his medical observations in the inquest without being challenged. The problems presented by his dual-role do not seem to have featured in any of the discussions surrounding the Hola Camp murders. The fact that Moyes's role as a witness may have interfered with his professional observations was not, it seems, even considered. Within the

[195] CO 822/1267. Dr. Moyes's testimony when re-examined on the subject of violence in the camp, p. 73.

[196] Ibid.

official inquests, Moyes is constantly above suspicion. This is to be expected, given the extent to which Macmillan's government was trying to mitigate the situation by controlling the inquest itself. The only time when suspicions were raised about his professional knowledge and role during the incident was when the findings of the June inquest were questioned in the House of Commons by the opposition on 27 July 1959.

The subject was first broached by Sir Dingle Foot, the MP for Ipswich, who raised the question of the Hola Camp deaths along with the 'the wider question of the detention without trial in British Dependencies of British subjects and British-protected persons'.[197] Dingle Foot was particularly unimpressed with the findings of the June inquest, which amounted to very little, save for a slight reprimand to the Commissioner of Prisons, and to Sullivan, who was 'required to retire from the service without loss of gratuity'. These were the only two individuals who were penalised in any way. As Dingle Foot noted, 'Everybody else who was concerned in this matter gets away scot-free'.[198] Of particular interest to Dingle Foot was 'the summary of the information which was given to Mr. Campbell and his colleagues by Dr. Moyes'. Here, Dingle Foot pointed to a 'conflict of evidence between Dr. Moyes and Mr. Campbell'. According to this summary, the former had reported that, on the 3 March, he had admitted a number of detainees to hospital with bruises, and that there were 'two possible fractures and all had high temperatures'. The latter, on the other hand, had stated that Moyes had not told them anything 'about any other injuries' other than minor cuts and bruises. This description of the injuries was further softened in Campbell's final report, which stated that 'The Medical Officer informed us that quite a number of those in hospital were suffering from slight bruises; one man was given immediate attention on being injured in the scuffle on the way to the work site […]'.[199] In this instance, suspicion was directed at Campbell; later in the debate, however, Barbara Castle pointed the finger directly at Moyes:

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[197] Hansard. House of Commons Debate, 'Hola Camp, Kenya (Report)', Mr. Dingle Foot MP, 27 July 1959, paragraphs 181-182.
[198] Ibid.
[199] Ibid., paragraph 183-185.

> Let me come to the Medical Officer at Hola, Dr. Moyes. Here is a man who when ten men have died gives his opinion as to the cause of death as aspiration pneumonia. I am no medical person, but I have consulted my hon. Friend the Member for Stoke-on-Trent, Central (Dr. B. Stross) and, as I understand it, aspiration pneumonia is caused when men inhale water into the lungs as happens in drowning; and nobody at Hola had had a bath. What was really happening was that dying men were vomiting water that they had drunk, and any person fit to hold the office of medical officer in charge of detainees ought to have enough medical knowledge to be aware of that fact.

She then went on to add: 'Of course, perhaps he did, but perhaps like everybody else he was "covering up"'.[200] Moyes, she suggested, was playing his part in the concealment effort. In her view, 'The most significant words of all in this business were spoken by Mr. Marsden, the District Officer, at the inquest. He said: There was a general attitude amongst all Europeans not to say anything'.[201]

Yet while Moyes's testimony may have done little to illuminate the reality of violence at the camps, the government pathologist, the aforementioned Dr. Rogoff, was more forthright. The postmortem evidence he presented to the first inquest in March 1959 determined that the detainees had indeed been killed by violence. Through his examination, he concluded that multiple victims died from acute pulmonary oedema.[202] He added that the symptoms of this 'may be similar' to those of 'aspirative pneumonia', as suggested by Moyes. The key point here was that the pneumonia 'resulted from material going into the lungs which should not do'.[203] Ngugi Kariti, the last victims of the Hola attack, had also died from this as well as

[200] Hansard. House of Commons Debate, 'Hola Camp, Kenya (Report)', Barbara Castle MP, 27 July 1959, paragraphs 231-232.
[201] Ibid.
[202] FCO 141/5651. Statement by Dr. Rogoff, pp. 25-39.
[203] Ibid. 38.

'Acute congestive heart failure', which, Rogoff argued, was 'caused by shock and haemorrhage due to severe loss of blood caused by multiple bruising', that is, 'the result of violence'.[204] Yet while this may have appeared to be a damning indictment against those running the camp, it was itself not free from ambiguity.

Dr. William Eric Laws, one of the three doctors brought in to assist Moyes following the deaths, had come up with the idea that some of the victims may have been suffering from severe scurvy. Scurvy is a Vitamin C deficiency disease that, as Rogoff explained, could result in a tendency to bleed 'onto skin, bone, muscles and other parts of body'. This, he said, 'May lead to weakening of bone resulting in earlier fracture than in normal individuals'.[205] The implication was that, had the detainees been suffering from scurvy at the time of the attack on the 3 March, then some of them may have had a lower 'Resistance of body to shock', which would have resulted in their deaths. For Laws, the scurvy diagnosis might have helped explain the 'rather abnormal amount of bleeding particularly in the case of' Ngugi Kariti, whom Laws viewed as an exceptional case. On the 9 March, Laws and his colleagues found two patients in hospital who were suffering from 'classical scurvy'. Both these individuals had been in hospital before the incident took place on 3 March. Instead of trying to carry out further investigations, however, they decided to just treat 'all the seriously ill as possible scurvies'.[206] He found that, of those in hospital after the incident, 'All the cases of haemoptysis—some 13—which had occurred at different times had recovered from their blood spitting by the evening of 12th March 1959'.[207] However, despite this, it was still far from certain that the deceased had been suffering from the deficiency disease. In fact, Rogoff repeatedly asserted that the detainee's injuries in themselves would have been 'sufficient […] to have caused death without involving the level of vitamin C or ascorbic acid deficiency'.[208] Even Laws had to

[204] FCO 141/5651. Statement by Dr. Rogoff, p. 34.
[205] Ibid., pp. 36-37.
[206] Ibid., p. 45.
[207] Ibid., p. 45.
[208] Ibid.

concede that 'there is no evidence' that the eleven dead had suffered from scurvy.[209] Rogoff's conclusions were further supported by the forensic evidence supplied by Dr. Geoffrey Lowe Timms, the Assistant Director of Laboratory Services in Medical Research Laboratory in Nairobi. Timms had examined the lungs of Ngugi Kariti and found evidence of severe haemorrhaging. After stating that he 'had never seen anything like it before', he admitted that such condition could be 'a result of blows on the chest wall'. Nevertheless, although he agreed with Rogoff's findings concerning the probable cause of death, he could not discount the possibility that some sort of deficiency disorder had contributed to the excessive bleeding among the various victims.[210]

The final inquest report of July 1959 accepted that 'there was almost certainly a sub-clinical state of vitamin C deficiency in Hola on 3rd March'.[211] Rogoff's reported explanation that 'the onset of scurvy is insidious and that early symptoms may be overlooked by an experienced doctor', suggested there was an error of oversight here.[212] Many of the detainees involved in the attack had an underlying deficiency disorder, which made them more likely to die from violence, but the symptoms of this disorder, at this stage, were too slight to be easily detected. Despite this, the level of violence was in itself sufficient to kill most of the victims. Moyes, therefore, was presented as not necessarily being remiss for his confusing diagnosis. The implication was that Sullivan had failed in his responsibilities and that he had tried to deliberately mislead 'the trio' when they arrived the day after the deaths to investigate the situation. However, as Barbara Castle noted in the House of Commons during the debate in June 1959, Moyes, Sullivan and the Commissioner for Prisons had all been aware of the scurvy epidemic at Hola as early as February that year. A secret report sent to the Commissioner by Sullivan on 13 February 1959, just under a month before the massacre, shows that Moyes was

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[209] Ibid., p. 46.
[210] FCO 141/5651. Testimony of Dr. Geoffrey Lowe Timms, p. 47.
[211] *Further documents relating to the deaths of eleven Mau Mau detainees at Hola Camp in Kenya*, (London: Her Majesty's Stationary Office, 1959), p. 46.
[212] Ibid.

actively investigating the 'large numbers [of detainees who were] reporting sick, some with swollen limbs' and who were unable to work on the irrigation scheme.[213] 'Those swollen limbs', Castle explained, 'were the sign of the scurvy which was later found by the coroner to have been widespread in the camp'.[214] Rather than use this information to further condemn Sullivan or even Moyes, Castle turned her attention to 'the Commissioner of Prisons', who 'did not consider this sign of widespread sickness among co-operative detainees worthy even of comment from him, let along investigation'.[215] In addition, Castle presented evidence that the Commissioner had ignored warnings from Sullivan that the use of the Cowan Plan in Hola was ill advised. By taking this line, Castle continued to implicate the whole colonial government and the Colonial Office in negligence and efforts to cover up the extent of violence in the camp and the colony more generally.[216]

By concentrating on the colonial powers-that-be, Castle took the focus away from the doctor in this instance. Moyes thus escaped any further scrutiny into his role in the cover-up efforts. He continued to serve as the resident doctor at the camp and, after the Emergency came to an end and Kenya received its independence, he was a registered medical practitioner in Kenya up to as late as 1964.[217] In the end, it seems, the Opposition were not willing to expend energies to pursue one doctor who may have colluded with the security forces to disguise the violence at Hola. What they were really after were the officials who had conspired to bury the evidence more generally. Why would they be worried about individual cogs when they were trying to bring down the vast engine of indiscriminate violence in the detention camps?

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[213] FCO 141/5656. Copy of M.G. Sullivan's telegram to The Commissioner of Prisons, 13 February 1959 in 'Decypher telegram to Secretary of State', 12 June 1953.
[214] Hansard. House of Commons Debate, 'Hola Detention Camp', Barbara Castle MP, paragraphs 301-302.
[215] Ibid.
[216] Ibid., paragraphs 300-306.
[217] Though it must be stated that the 'List of Registered Medical Practitioners and Dentists' described him as being 'out of the Country' in Sept. 1964. *The Kenya Gazette,* 16 September 1964, p. 1015.

The Hola Camp massacre was to be the decisive event in Kenya's road to independence.[218] It expedited the emptying and closing of the detention camps and finally brought the Emergency to an end in 1960.[219] After this, as Anderson says, 'there was no way back'. Even members of the Tory party presented the events at Hola and the subsequent whitewashing efforts as a disgrace. Famously, the young Enoch Powell stated in the July debate at the House of Commons that the whole thing was 'a great administrative disaster'.[220] Regarding the standard of treatment in Kenya, he added: 'We cannot say, "We will have African standards in Africa, Asian standards in Asia and perhaps British standards here at home." We have not that choice to make. We must be consistent with ourselves everywhere'.[221] If this was not possible, he argued, then Britain should divest itself of its empire. On 12 January 1960, the Kenya Emergency was officially lifted. Ian Macleod, Lennox-Boyd's replacement as Secretary of State for the Colonies, then started the transition process to give Kenya a constitution and a majority black rule.[222] Independence was eventually granted on 12 December 1963. The end of the Mau Mau rebellion was thus largely brought about by the excessive use of violence that had characterised the British counterinsurgency campaign throughout the 1950s. Unlike in Algeria, and despite their involvement in the Emergency, many colonial doctors continued to live and serve in the newly independent nation along with other wealthy settlers. Medical collusion or complicity with violence and torture were tacitly forgotten as part of President Jomo Kenyatta's more general 'forgive and forget' policy.[223] There would be no investigations

[218] Anderson, *Histories of the Hanged*, p. 326.
[219] Following the final inquest, a small Committee, headed by R.D. Fairn, one of Her Majesty's Prison Commissioners, carried out an investigation into the remaining camps. The advice of the Fairn Committee was responsible for putting an end to the use of 'lawless violence' in the camps, especially that related to the dilution technique. See Rosberg and Nottingham, *The Myth of the "Mau Mau"*, p. 346.
[220] Hansard. House of Commons Debate, 'Hola Camp, Kenya (Report)', Enoch Powell MP, paragraphs 237-238.
[221] Ibid.
[222] Elkins, *Britain's Gulag*, p. 353.
[223] A year after coming into office, on the 20 October 1964, Kenyatta broadcast across the following message: 'Let this be the day on which all of us commit ourselves to erase from our minds all the hatreds and the difficulties of those years which now belong to the history. Let us agree that we shall never refer to the past. Let us instead unite, in all our utterances and activities, in concern for the reconstruction of our country and the vitality of Kenya's future'. Quoted in Elkins, *Britain's Gulag*, p. 360.

or prosecutions into any act of violence during the rebellion, nor would any European doctor attempt to break the deep culture of silence that continued to surround these events.

Conclusion

This chapter has examined the various ways that physicians reacted to torture and the damaged or deceased bodies it produced. The analysis was split into two halves, the first of which contrasted the ways that doctors in Algeria and Kenya normalised, rationalised or justified their actions or how they came to develop a sense of apathy or indifference to abuse. The second half examined more extreme situations where medical expertise and opinion was sought by the colonial governments or the security forces to help conceal evidence of abuse, especially in cases which drew unwanted public attention. In particular, it has shown that in both contexts, it is not easy to identify whether doctors willingly colluded with torture or whether they were caught up in what were otherwise extremely complicated and politically charged situations with few obvious answers. In particular, Dr. Faure's reflections on his first encounter with torture in Algeria paints a picture of an ill-equipped professional working in isolated locations far from adequate medical facilities. Under such conditions, the doctor-patient relationship was already strained as there was very little a doctor could do for an injured detainee. Although Faure's account should caution us against drawing all-encompassing conclusions about complicit doctors, it does not address other instances where doctors took a direct role in interrogations or actively encouraged abuse. The brief image he offers nevertheless highlights less obvious features of the doctor-torturer relationship which are rarely acknowledged by other scholars. That is, torturers themselves could be seen as victims for whom military doctors were responsible. Even the case evidence provided by Fanon shows that those carrying out extreme interrogations could become psychological damaged by these activities. Under such circumstances, it is not apparent to whom doctors owes their loyalty or how they should respond. Nor did doctors always act consistently, as Dr.

Richaud's intervention to save Ighilahriz may have simply been a one-off act to save a young woman who resembled his daughter.

Unfortunately, due to the lack of personal testimonies for the situation in Kenya, it is not possible for us to say whether or not medical officers in the camps experienced similar dilemmas, nor can we guess how they might have responded if they had. Yet the absence of medical objection to the institutionalisation of the dilution technique and the injuries and deaths it caused could speak for itself in this case. At no point during this research was it possible to find any letters of complaint or concern from the doctors who monitored the health of detainees undergoing dilution. In fact, there may have been a widespread attitude of apathy or indifference among the medical officers working with abused detainees in these camps as signs of abuse regularly appear within the medical records for these facilities but do not seem to generate any concern. Alternatively, this silence could be interpreted as a failure on the doctors' part to recognise the signs of abuse for what they were. There is good evidence to suppose that the medical officers who visited these camps were not always aware of just how extensive the violence was. It is possible then, that a process of compartmentalisation took place whereby doctors, along with other staff, were prevented from knowing what type of role they were playing or from knowing what marks came from legitimate, legal force and which scars were made by torture.

Yet while the extent to which doctors were aware of their participation in torture regimes is unclear, there are other cases where medical collusion seems more suspicious. This involved incidents where medical expertise and knowledge were used to obfuscate or directly conceal evidence of abuse. The second half of this chapter explored various cases where doctors were embroiled in wider efforts by the colonial authorities or the security forces to either dispose of bodies or cover their tracks. As has been a recurrent theme in this thesis, we have more candid evidence for this phenomenon in Algeria, where the memoir of General Aussaresses implicated a number of doctors in assisting him with his interrogation and assassination

activities. Although his inflammatory account should be approached cautiously, it still provides insights into the relationship between the paratroopers and certain doctors who seem to operate on an unspoken mutual understanding. In fact, Aussaresses's explanation of the circumstances surrounding Ben M'Hindi's death supports the testimonies of other physicians, such as Dr. Suaud, who have acknowledged the role doctors played in falsifying death certificates. This type of explicit intervention marks a distinction between the function doctors played in these two colonial conflicts. At present there does not appear to be any concrete evidence of British doctors falsifying death certificates, but there are signs that they meddled with the pathology reports. Throughout the Emergency, the Kenya Police Reserves and the Home Guard were accused of killing detainees under interrogation, but it seems the pathological investigations rarely produced definitive answers to prosecute the offenders. The case of Kabugi Njuma, in particular, reveals a possible instance where the examining pathologist even deliberately mis-recorded the cause of death as being due to pulmonary infection. Alternatively, Dr. Brown, the missionary doctor examining the body of Kammu Gichina, was misled by the District Officer involved in the case. In fact, Brown's status as a missionary doctor allowed the attorney general to clear Richmond of further charges as he was not operating in an official capacity. It therefore seems there was a wider effort among Home Guard to hide medical evidence more generally in order to prevent investigations into torture.

Both these strands, the direct falsification of records or the inability for doctors to perform their duties during investigations into abuse serve as valuable backgrounds for understanding the last two cases examined at length in this chapter. The court trial of Djamila Boupacha in Algeria and the Hola Camp massacre in Kenya not only provide further details on the atmosphere of collusion and confusion present in both contexts, but they also help to bring the narratives concerning these two emergencies to an end. While it is well known that the military manipulated the law in Algeria in order to hold show trials that legitimised the execution of captured FLN rebels, the case of Djamila Boupacha represents a rare instance where a range of medical expertise was used to undermine the plaintiff's accusations. In this case, Dr. Lévy-

Leroy appears as an unambiguous offender who purposefully underplayed Boupacha's injuries, especially those related to her rape claims, as well as openly lying during court. As has been suggested here, this is either a sign of an incompetent doctor or one who was deliberately trying to dismiss her case. Yet the extent to which his report conflicts with that of Drs. Sirot, Bonafos and Godard highlight an almost careless effort to participate in this cover-up effort, which may itself tell us something about the messy nature of such collaborations between the medical community and the military. Nevertheless, these contradictions allowed Boupacha's counsel to secure a transfer to the metropole where she could be examined by five practitioners who were beyond the military's reach. But even in Paris, the examination of Boupacha's body was not free from political pressures. In fact, this chapter has argued that, by this stage in the War, Boupacha's case had become a microcosm of the wider political instabilities surrounding this conflict and so an affirmative or negative report was itself a contentious and politically charged act which could put the safety of the examining physicians into question. Ultimately, it was Dr. Michel-Wolfrom's affirmative psychological and carefully worded gynaecological report which made the difference. Using language that presented the young woman as a naïve virgin and a religiously devout nationalist, Michel-Wolfrom was able to vindicate Boupacha's claims. Despite this, Boupacha did not receive justice for her case, nor was she ever put on trial as the amnesty introduced at the end of the Algerian War removed her chance of pursuing her torturers.

Finally, the death of eleven detainees during the Hola Camp massacre represents the last significant scandal in the Kenya Emergency which directly led to the end of the detention process and Kenya's subsequent independence. This case, it has been shown, brings together many elements of the types of ineffective medical reporting that characterised other investigations into abuses in Kenya. Despite the Opposition's efforts back in Parliament to have the incident subject to an independent investigation, the actual inquests were organised by a Government determined to protect the staff involved in the violence. During these inquests, the resident Medical Officer for Hola Camp, Dr. Moyes, functioned simultaneously

as a material witness and expert, which raised few objections from either examining magistrates or the Opposition in the House of Commons. The testament Moyes offered was confused and unclear, especially as he seemed to initially suggest the detainees had died from drowning or contaminated water. He was also reticent for the most part when it came to the rumours about the violence that had taken place on the morning of the 3 March, pointing out, much like Dr. Brown before him, that he had relied on information gathered from other staff to shape his verdict. Unlike Brown however, Moyes had direct access to the detainees who witnessed the attacks, but he paid them little attention. As such, the detainees-patients were not permitted to provide their own account of what happened to their bodies. As with the case of Djamila Boupacha in Algeria, the medical findings were crucial for dictating the trajectory of the investigation, but in the end the pathologist's findings were not definitive enough for any serious criminal charges to be brought against those involved. The Opposition scrutinised the details of inquest reports but, so this chapter has argued, any potential evidence of collusion between the medical staff at Hola and the wider cover-up effort were of secondary importance when the overall aim was to topple the Government itself.

Conclusion

This thesis has told the story of European doctors who, through direct or indirect means, supported, participated in and generally contributed to counterinsurgency violence. Through an empirical comparative assessment of the Algerian War of Independence and the Kenya Emergency, it has demonstrated the extent to which these practitioners participated in the official counterinsurgency operations conducted by the British and French security forces. It has also revealed a multiplicity of ways in which this support was provided.

Having focused specifically on the role of medicine in relation to torture, this dissertation has not attempted to provide a comprehensive discussion of medical policy or practice in the colonies, or a detailed account of decolonisation. Instead, it affords a particular glimpse into the actions of a complicated set of historical actors at a time when the established order of things was under threat and environments of permissive violence came into existence. By doing so, it has brought into dialogue with each other a number of discrete historiographies on colonial violence, medicine and the role of doctors in historical torture campaigns. In particular, the study built upon recent revisionist scholarship that has reassessed important questions related to the exercise of excessive and repressive violence in the final years of empire in North and East Africa.[1] This literature has demonstrated the extent to which violence, especially torture, became a systematic form of domination in these conflicts. Yet while historians have explored the ways that institutions, such as the law, provided structural support for these practices, the role of medicine within these emergencies has not received sufficient attention. This study has addressed this gap. While adding more nuance and detail

[1] For the Kenya Emergency, see: David Anderson, *Histories of the Hanged;* Anderson, 'Mau Mau in the High Court and the 'Lost' British Empire Archives; Anderson, 'British abuse and torture in Kenya's counter-insurgency, 1952-1960'; A.R. Baggallay, 'Myths of Mau Mau expanded: rehabilitation in Kenya's detention camps, 1954-60'; Caroline Elkins, *Britain's Gulag*, 'Looking Beyond Mau Mau'. For the Algerian War, see: Raphaëlle Branche, *La torture et l'armée pendant la guerre d'Algérie*; Branche, 'Torture of terrorists? Use of torture in a "war against terrorism"'; Sylvie Thénault, *Une drôle de justic*. Finally, for a comparison of both contexts, see Fabian Klose, *Human Rights in the Shadow of Colonial Violence*.

to our historical understanding of medical participation in torture, its findings also have wider implications for our understanding of the relationships between individuals and the colonial authorities, medical practices under states of emergency and the exercise of violence by modern democratic regimes involved in overseas counterinsurgency activities.

In addressing the questions posed at the start of this research, the comparative discussion has highlighted several important themes common to both the Algerian and the Kenyan colonial contexts. These include the role medical professionals played in the French and British conquest and occupation of the two territories during the nineteenth and early twentieth century. Medical professionals, moreover, were deeply rooted into the colonies' economic, political and social order, which, unwittingly or otherwise, contributed to the rise of violent nationalism. European psychiatrists, as well as other scientists of the mind, offered expertise to both 'diagnose' and 'treat' the collective psychological causes that produced the FLN, Mau Mau and their violent ways. These experts represented the 'terrorists' organisations as consisting of 'brainwashed' religious fanatics. Some prominent medical practitioners among the European settler communities became personally involved in violence when the state's management of the perceived anticolonial threat seemed ineffective; doctors helped to justify or add a humane appearance to certain torture techniques. They also aided with their administration by treating and dealing with the consequences of these methods. Sometimes this led them wilfully to conceal or falsify records and reports in order to deny or play-down evidence of torture.

Although these shared themes and features have been useful for framing this analysis, local and national peculiarities were no less important. They played a fundamental role in shaping and influencing, not only the reasons for how and why torture was practiced, but also the specific ways that doctors participated in it. Ultimately, the histories of medical participation in violence in Algeria and Kenya, the ways that it evolved and the types of individuals who participated in it varied, due to a range of important temporal and contextual factors peculiar

to the wider histories of the two colonies. For instance, during the early stages of both conflicts, colonial doctors featured prominently among the settlers who were attacked and often killed by the insurgents. Yet while this was common to both Algeria and Kenya, a closer examination of these murdered or targeted doctors revealed a wealth of information about not only the place of medicine within the colonial order, but the factors that contributed to the rise of violent anticolonial movements in both colonies. Chapter 1 of this thesis explored this point. It showed that, in colonial Algeria, the administration of medicine meant that civilian and military medical practices were perceived to be more intimately entangled than in Kenya, where a distinction existed between the Colonial Medical Services and medical missionaries. Despite being a central symbol of the European civilizing mission in both colonies, medicine and its benefits were rarely extended to local people in the same way as settlers. In fact, France's failure to provide adequate healthcare for the Algerians allowed the FLN to create their own competing health system in the form of the *Croissant-Rouge Algérien*, once the Algerian War started. This was in contrast to the situation in Kenya, where Mau Mau were not able to present themselves as a proto-authority in the same way as their North African counterparts.

The behaviour and activities of some doctors in Kenya had a more directly fostered anti-colonial sentiments among the Kikuyu. The controversy surrounding the clitoridectomy scandal served as a distinct rallying point for Kenyan nationalist, but it also highlighted an important instance where medical ideals merged with or became confused with religious ones. Doctors were also among some of the wealthier landowners in both colonies, but in Kenya, there is currently more evidence that shows the extent to which these settlers benefited from this situation, something which helps account for why doctors were among the first to be attacked by Mau Mau. Once hostilities erupted in both countries, the psychiatric and psychological expertise mobilised by colonial authorities drew on established perceptions of the indigenous populations that represented them as mentally unstable, inferior and ultimately prone to hysterical violence. In North Africa, the Algiers School of Psychiatry, which had

historical connections with the French military, used its expertise to present the FLN as Islamic extremists whose innate criminality led them to commit heinous mutilations and acts of terrorism. For their part, their Mau Mau counterparts were understood by ethnopsychiatrists and anthropologists as expressing a form of collective madness provoked by acculturation.[2] Ultimately, Chapter 2 argues that these ideas about 'collective insanity' provided local explanations that fed off a wider international faith in the powers of the science of the mind in the post-war period, as well as contemporary fears about the Cold War and the threat of communist subversion and brainwashing techniques.[3]

These scientists' expertise helped inform and structure the colonial authorities' programmes to 're-educate' (Algeria) or 'rehabilitate' (Kenya) the indigenous populations and treat their perceived 'sickness'. In practice, these policies relied on detention centres, concentration camps and resettlement villages to divide the population and cut the insurgents off from their supply chains. These camps, as has been known for some time, became the sites of extreme violence. Yet, as this work has demonstrated, torture and abuse were not the exclusive preserve of the police or the military. In both Algeria and Kenya, the settlers undertook counterterrorist activities and formed militia organisations to fight the rebels. In Kenya, there is some evidence to suggest that doctors participated in the screening processes in the early days of the Emergency, when individuals like Dr. Bunny or Dr. Wood participated in violent interrogative activities to coerce confessions from Mau Mau suspects. While the evidence pertaining to this type of activity in Kenya is rather sketchy and does not support the conclusion that there was a wide-scale programme among civilian doctors to fight the insurgents, the Algerian picture is less ambiguous. Here a surprising number of civilian doctors undertook torture and terrorist activities against both the FLN and the French authorities when the future of France's role in the country came into question. This network of extremist doctors and their ultra-right-wing

[2] Anderson, *Histories of the Hanged*, pp. 279-284.
[3] As mentioned in Chapter 2, the subject of 'brainwashing' has recently received focused attention from scholars working on the Wellcome Trust funded project, 'Hidden Persuaders'.

sentiments still awaits detailed historical exploration, yet they played a crucial role both in the mobilisation of political dissent among the European settlers and the use of violence within this context. What is interesting—as was argued in Chapter 3—is that these doctors appeared to have made a decisive break between their roles as healers and protectors of the sanctity of life, on the one hand, and their personal interests in the maintenance of the colonial order, on the other.

Besides demonstrating the important role of settler doctors in the violence perpetrated by European non-state actors during the conflicts, this investigation has also shone light on the functions physicians performed when torture became a systematised practice among the security forces, especially in the detention centres. The findings of Chapter 4 show the extent to which medical professionals became actively and passively embroiled in torture. In particular, it showed how both the French and British colonial authorities sought medical participation in (or validation of) specific techniques, such as water torture in Algeria or the dilution technique in Kenya, to add a humane and scientific sheen to their justifications. While British medical officers were officially required to monitor the health of detainees before and after a dilution intake, it does not seem that the French made such a stipulation in Algeria. Regardless, French military doctors were just as likely to be in close proximity to abuse. In fact, while there is at present no evidence suggesting that British medical officers took any active role in torture, the use of truth drugs by French military physicians represented just that. This is one of the most significant distinctions in this study. Although scholars have been aware that these drugs were used by the French in Algeria for some time, this study has expanded our understanding of this underexplored feature of the Algerian War. Not only did French military physicians use these tools to actively participate in coercive interrogation, they also used them to compete with their soldier colleagues. This highlights an interesting social dynamic between military medical staff and the regiments they served. Moreover, knowledge of their use was so widespread that the FLN combatants undertook special training in order to resist their influence. This contrasted greatly with the situation in Kenya. As this

thesis has shown, the reasons why the British security forces did not use truth drugs against Mau Mau had to do with the demands of the rehabilitation process and with perceptions of narcoanalysis more generally. Whereas the French military sought to extract operative information from FLN suspects through narcoanalysis, the British resorted mainly to coercive techniques to extract confessions. Moreover, there appears to have been a general distrust among British military and defence scientists of the drug's effectiveness. In the end, the British preferred more tried and tested techniques, such as sleep deprivation, starvation and extreme isolation in conjunction with the dilution technique.

Chapter 4 also examined the development of a new and updated set of medical ethics codes that emerged in the immediate post- Second World War period. Along with the rise of the human rights regime, these international guides to medical ethical conduct were produced in the hope they would prevent a repeat of the Nazi regime's murderous excesses, especially in relation to medical atrocities and human experimentation.[4] However, the WMA's *Declaration of Geneva* and the *International Code of Medical Ethics*, created for this purpose, lacked relevant language for doctors faced with the realities of torture. Moreover, they were not enforceable. In the end, it seems that British and French doctors operating in and around the detention centres in Kenya and Algeria had to rely on their own judgment. Demands posed by the need for information and the counterinsurgency strategy of mass detention, coupled with understaffed and ill-equipped facilities, often meant that military and medical officers alike were faced with dilemmas that could not easily be resolved through recourse to such codes of practice. In fact, there is currently little evidence informing us as to what types of ethical or moral ideas these doctors evoked in their work or whether they regarded their practices as unethical in any way. Nor is there any indication that had there been a more concrete set of principles, such as those that would eventually form the WMA's *Tokyo Declaration* on torture,

[4] Annas and Michael, 'Medicine and Human Rights'.

that this would have made any material difference to these conflicts. After all, the existence of this code from 1975 has not stopped doctors from participating in torture.[5]

Chapter 5 examined the ways that doctors responded to torture. It seems that doctors encountering torture may have been 'numbed' by exposure to it over a period of time, which made it less likely for them to challenge it or even to recognise evidence of abuse when they saw it. Interestingly, doctors also expressed responsibility and empathy towards the torturers themselves, who may have exhibited psychological symptoms as a result of their acts. This analysis also raised questions about the extent to which practitioners were aware of such violence, especially in the Kenya detention camps, where a fractured administrative system existed which prevented individuals from seeing the whole picture. Nevertheless, within these latter facilities, there seems to be good evidence that British medical officers were either unprepared to acknowledge other signs of abuse or were generally indifferent to them.

The second half of this final chapter also addressed the ways that doctors helped, intentionally or not, with wider efforts to conceal evidence of mistreatment. Be it through falsifying death certificates, providing misleading pathology or medical reports, or intentionally playing down the severity of direct evidence of torture, doctors in both Algeria and Kenya aided wider efforts to deny or conceal abuse. In particular, it was argued that neutral and purely descriptive language could be used by doctors dealing with the bodies of torture victims in a way that played into the hands of the colonial authorities. These authorities were then able to superimpose their own explanations onto these limited reports to explain away troublesome cases. This was achieved through a comparison of two important cases in France and Britain, which focused public attention on the use of torture in these conflicts. While these two cases highlight how medical evidence and testimony could be used to deny allegations of abuse in

[5] For the full text of the Declaration of Tokyo, see: <https://www.wma.net/policies-post/wma-declaration-of-tokyo-guidelines-for-physicians-concerning-torture-and-other-cruel-inhuman-or-degrading-treatment-or-punishment-in-relation-to-detention-and-imprisonment/> [13 December 2019].

the detention camps, the types of allegations and the general situations surrounding them vary greatly. The case of Djamila Boupacha illustrated the ways in which medicine and the law could be instrumentalised by the French authorities in order to deny justice to the rebels as well as legitimising their execution. What made this case significant was that the claimant was alive and able to draw public attention to her situation. This was in direct contrast to the situation in Kenya, where the Hola Camp incident drew public attention because of the sheer number of detainees killed by the dilution technique. While Boupacha's trial highlights the strategic value medical evidence could play for either the defence or the prosecution in an adversarial military court, the Hola Camp incident exemplified deep issues surround criminal investigations into allegations of abuse during the Emergency, as well as the government's tactics for covering them up.

Boupacha's trial brought into focus a range of medical activities that helped deny the torture and rape allegations she made against the military. Doctors working for the army appear to have deliberately provided ineffective and incomplete medical assessments of the complainant's body to undermine her case. Yet these slim medical reports raised more questions than they answered, allowing the Defence to have her case adjourned and moved to France, away from the military's immediate spheres of influence. This chapter, however, tried to caution against overstating the power of medical evidence in this case. Although a significant amount of the narrative presented by de Beauvoir and Giselle Halimi revolved around the findings of the various medical examinations Boupacha was subjected to, it is arguable they would not have amounted to much had her counsel not succeeded in drawing public attention to her plight. It was their ability to keep the case in the public domain which ultimately prevented her allegations from being quashed by the military courts as others had been many times before. Nevertheless, the role of the doctors hired by Boupacha's counsel reveals the extent to which the application of medicine to a terrorist suspect could be seen as a controversial and politically dangerous move. Rather than being a purely objective practice,

the five medical experts who examined her wounds in Paris appear to have couched their report in neutral terms to avoid committing themselves to a politically contentious verdict.

The story of concealment in Kenya, on the other hand, did not take place within the courts but through inquests and parliamentary debates to impede efforts to investigate allegations of abuse or to quell questions from the opposition. The disappearance or invalidation of medical evidence appeared to be part of a wider effort within the Kenya Home Guard, the screening teams, and the government more generally, to conceal signs of torture. While there were some efforts to prosecute individuals for clear cases of excessive force, it seems the pathology reports were often too inconclusive to convict the accused of murder. It was argued that the Hola Camp massacre represents a clear instance in which the inquests commissioned by the government were designed to avoid exposing the pervasive atmosphere of violence that took place behind the barbed-wire in many detention camps in Kenya. Rather than admit that the eleven detainees had been killed through violent means, the initial explanation suggested that they had either drowned themselves or else been poisoned by a contaminated water source. Once this was dismissed, the doctor in residence at the camp was actually consulted as both an expert witness and a material witness for the case, despite having been involved in the incident on the day. Yet while the inquest was unprepared to question the doctor's participation in this investigation, the Opposition raised questions about it in the House of Commons. Eventually, the evidence provided by Dr. Rogoff was sufficient to prove that the eleven detainees at Hola Camp had been killed through the use of force. This, however, proved insufficient to pin charges on any individuals, while the Opposition failed to pursue Dr. Moyes for his role in the whole affair. In the end, the Opposition's real aim, it was argued, was not the subordinates but the whole government.

The conclusion that doctors' participation in abuse was contingent upon a complicated interaction between local and historically specific factors may not appear especially ground-breaking. However, the findings of this research challenge the standard psychological

explanations employed by the medical experts and organisations who have studied other contexts where doctors participated in torture.[6] It is not possible to simply regard the doctors within this study as immoral or cruel in all instances, nor can we regard them as passive agents of corrupt or shoddy colonial regimes. Although chapters 3 to 5 have certainly revealed cases where physicians showed little regard for the victims of torture or actively participated in violence, there are plenty of other situations where doctors behaved more ambiguously or even attempted to help victims of torture. This should not be surprising given that, as demonstrated throughout this thesis, medicine in the colonial context was not a homogenous practice constituted by a unified set of professionals serving the same ends or indeed the same clients.

Instead, the doctors discussed here were themselves complicated agents with varied professional backgrounds, loyalties and social roles within the colonial setting. The subject of professional loyalty has thus formed a theme that weaves together multiple strands of this thesis. In particular, it has been used to examine the types of social, cultural, political and economic factors that may have influenced a given doctor's activities or behaviours. It has also helped to elicit tensions between the role of the medical profession within its clinical and therapeutic capacities, as well as helping to identify the beliefs and ideals of the same professionals as individuals situated in the colonial order. By conceiving of these professionals as dynamic and complicated historical agents in their own right, with varying levels of commitment to the survival of the colonies and competing personal interests, it is possible to question the effectiveness of some modern perspectives on doctors and their professional loyalties. For instance, the British Medical Association recently argued that an answer to the modern dual-loyalty dilemma rests in affording the medical profession greater freedom from government agencies.[7] Yet the results of this study have shown that both government-employed and private doctors were capable of actively participating and perpetrating abuse if

[6] British Medical Association, *Medicine Betrayed*; Lifton, *The Nazi Doctor*; Lifton, 'Doctors and Torture'; Miles, *Oath Betrayed*.
[7] Julian Sheather, Rhian Beynon, Tom Davis and Kamran Abbasi, 'Torture and doctors' dual obligation', *British Medical Journal,* 350 (2015), 1-2 (p. 1).

they deemed it necessary to defend their personal interests or fulfil their political aims. We should therefore be careful about relying on overly generalised or simplistic explanations for doctors' participation in human rights violations.

What can be concluded, however, is that scholars have much to gain by looking beyond the simple interface where doctors became entangled with military or security-run interrogation operations. By comparing and understanding the contexts within which the doctors discussed here lived and worked, as well as the types of personal commitments they had to the colonies, historians can access greater information about the beliefs, ideas and attitudes that they espoused. Moreover, as this study has paid consideration to wider international forces generated in the immediate postwar period, it has broadened the historical study of decolonisation in the Cold War. In particular, it has shone greater light on the role of medical and human sciences in relation to counterinsurgency and torture. The application of this approach to other wars of decolonisation or counterinsurgency operations could yield greater information about the ways in which medical practitioners and scientists participated in violence. As mentioned in the introduction, scholars such as Eric Linstrum and Darius Rejali have developed thoughtful accounts of the ways that human scientists and others experts were employed in counterinsurgency and torture activities, respectively. These studies have debunked the idea that scientists provided sophisticated and scientifically calibrated techniques to produce the 'truth' in interrogations. However, there is still a lot more to be learned from examining groups of experts involved in such practices to understand what they thought they were doing and why. As Marnia Lazreg has argued when discussing the French approach to torture, while it is important to examine what people *did* in terms of supporting torture, it is also necessary to understand what they thought about what they were doing.[8] There are still questions to be answered about the ways the medical community more generally thought about their responsibilities, ethical obligations and abilities when working within

[8] Lazreg, *Torture and the Twilight of Empire*, p. 3.

highly violent contexts. Such studies could contribute to a greater understanding of the ways that different expertise became entangled with counterinsurgency activities, how local and international ideas about medical conduct impacted on their motivations or resistance, and how they reconciled any dilemmas.

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'Comparative history', Deborah Cohen tells us, 'is a tremendously uncertain business'.[9] One of the potential obstacles to such analyses is what she calls 'archival snafus' related to the asymmetric availability of sources in cross-country comparisons. While common in comparative studies, this challenge can become especially intractable when dealing with highly contentious material and classified documents. The present study has encountered such problems. Chief of all is the comparative dearth of material relating to British doctors working in Kenya. French military doctors in Algeria appear to have been far more actively involved in the practice of torture than their colleagues in East Africa. However, this may simply be an effect of the availability of additional sources, such as the memoirs and interviews provided by different actors involved in the Algerian War. In contrast, as noted earlier in this work, there is a conspicuous lack of memoirs and reflections on the part of doctors attached to the colonial medical services during the Mau Mau uprising. Moreover, recent research has shown that a succession of British governments undertook extensive efforts to 'cleanse' the historical record of sensitive, incriminating and potentially embarrassing evidence of crimes committed in Kenya during the colonial period.[10] Because of this, one cannot conclude that the available sources, even including the so-called Migrated Archive, provide a full picture of the situation

[9] Deborah Cohen, 'Comparative History: Buyer Beware', *Bulletin of the GHI Washington*, 29 (2001), 23-33 (p. 25).
[10] Anthony Badger, 'Historians, a legacy of suspicion and the 'migrated archives'', *Small Wars & Insurgencies*, 23 (2012), 799-807. For more on Operation Legacy and the destruction of colonial records, see Shohei Sato, ''Operation Legacy': Britain's Destruction and Concealment of Colonial Records Worldwide', *The Journal of Imperial and Commonwealth History*, 45 (2017), 697-719; and Ian Cobain, *The History Thieves: Secrets, Lies and the Shaping of a Modern Nation* (London: Portobello Books, 2016).

in Kenya. The conclusions of this study should therefore be understood as tentative and as built on occasionally uncertain ground.

This thesis has, not unlike other investigations into colonial violence, followed groups of individuals associated with specific institutions. As a consequence, it has tended to privilege the activities and views of white European male doctors. Other voices, such as those of nurses, indigenous medical professionals and the detainee-patient are largely absent from this work. This was, to a large extent, due to available sources. Although oral histories may have provided a valuable insight into the lived memories of individuals involved in the events discussed here, or else they may have filled in the gaps within the existing document evidence, unfortunately, I was not able to secure the participation of any volunteers. Unfortunately, few of the doctors mentioned in this work are alive today. Although I made efforts to contact the families of certain individuals in this work, I was not successful in securing any useful responses.[11]

There are also notable limits with the key documents consulted for this work. These sources, drawn from the British National Archives and the Service historique de la Défense in Paris, were extremely valuable for answering the questions posed by this investigation. But while they have formed the core of this thesis, it must be remembered that they were compiled and produced by administrative personnel working for the British or French authorities. They therefore tend to exclude any written material produced by the victims of detention or torture. Although I have been able to capture brief individual remark by detainees who smuggled letters out of the detention camps, I have not been able to unearth more substantial sources

[11] I tried to contact the family of Dr. Wood, Dr. Rogoff and a few other doctors who worked in Kenya more generally, but they declined to reply to me. I am, however, grateful to Dr. Michael Javis, whose father, Dr. John Javis, was in charge of the King George VI hospital in Nairobi during the Emergency. Michael Javis declined to be interviewed by me but did provide useful information that allowed me to track down the memoires of the Wood family. For the Algerian context, I tried to contact the family of Dr. Richaud as well as the lawyer, Gisele Halimi for details about the doctors involved in the Djamila Boupacha case, but they too did not reply to my enquiries.

from those affected by the practices of torture in Kenya. The memoirs I have used do provide a perspective from some of these detainees, especially in Chapter 4, but it would have been useful to contrast these details with accounts by those recorded at the time. The findings of this study should therefore not be regarded as the final word on this complicated history. Rather it is only one part of a multifaceted story of colonial medicine in the context of violent decolonisation and the factors and pressures that led some individuals to take part in, support, or otherwise enable torture to take place. Further research could pay greater consideration to the missing voices just mentioned. It would also be interesting to provide a more direct analysis on the recruitment process which brought doctors into the detention camps or the role of nurses and African and Muslim doctors within these emergencies.

This raises another limitation of the present work. Although the focus on physical torture and abuse has allowed me to address important questions about medical participation in explicit forms of violence, it has come at the expense of less obvious ways in which medicine contributed to repression. That is, how were disease and privation used to enhance the suffering of inmates in conjunction with violence? The subject of the administration of medicine within the detention centres has likewise not been a central concern of the present study. Yet there are considerable questions to be answered about the ways in which disease, privation and starvation were used by detention staff as a form of torture in their own right, and how doctors responded to this. A broader consideration of this aspect of life in the detention camps might also tell us a great deal about how doctors understood their clinical responsibilities within these centres of repression. The everyday experience of detainees living in these facilities, as well as the implications such conditions of abject deprivation and disease had on their wellbeing has received less concentrated analysis. Nor do we fully understand the full extent to which doctors were present within these facilities and what type of care was offered to detainee-patients as a standard. A future study into these important questions could be contrasted with the situation taking place outside of these camps during the same years, as

our knowledge of how medicine and its communities functioned within the wider emergencies is currently underdeveloped.

The interplay between psychiatry and the apparent religious causes of anticolonial violence discussed in Chapter 2 also highlights a potentially fertile area for further research. It would be interesting to consider the 'scientific' explanations offered for the rise of Mau Mau and the FLN with other contexts, such as the Malayan Emergency or French Indochina, where communist-inspired insurgents were more typical. Were there instances where British and French doctors provided psychological views of the rebels and, if so, did they factor in native religious practices? Moreover, what would this tell us about the role of psychiatrists who support counterinsurgency efforts and does it have any relevance for current debates about radicalised Islamic terrorists? It is also unclear how religion, more specifically the religious beliefs of the European doctors involved in Kenya and Algeria, factored into their attitudes and behaviours. As mentioned in Chapter 1, many of the doctors in Kenya in particular were connected to missionary groups, while many of the offenders mentioned in Chapter 3 were themselves devout Christians. This raises important questions about the role of medical missionaries during the emergencies. If religion played an underlying role in informing not only the image of the nationalist but also the conduct of these doctors, how did this manifest in these struggles? More specifically, the subject of missionary medical ethics (which was touched upon in Chapter 1) could also be an area worthy of more focused discussion, as this has received little historical attention, despite the findings of this work demonstrating that the needs of religious ministration sometimes blurred or distorted medical ones.

Finally, the focus of this study has been on doctors who participated in or supported torture and related practices. Another avenue for future research is the role played by medical 'resisters', that is, those individuals who either refused to participate in violence or else attempted to denounce it or even switched sides to support the nationalists. Chapter 4 and Chapter 5 considered the responses of doctors who faced torture in the detention camps or else

examined the bodies of its victims. However, only a few individuals, specifically Dr. Richaud in Algeria, were shown to have tried to challenge or improve the condition of detainees, but this was admittedly due to the victim resembling his daughter. Yet in Algeria, there were others who undertook a more concerted effort to undermine or resist the French military's activities. Fanon is of course the most famous, but there is also Dr. Pierre Chaulet, a colleague of Fanon, who actively turned to supporting the FLN in their efforts.[12] It is also known that French authorities were led to introduce regulations that forced medical personnel to denounce such injured combatants if they encountered them.[13] This was because many of the latter were receiving treatment and care from European practitioners working in a civilian capacity. A careful consideration of the ways that certain elements within medicine could serve as a vehicle for resistance would provide a valuable counterpoint to this study, which has focused on extreme cases where individuals have misused, misappropriated and applied their medical expertise, knowledge or social status to the destruction of lives.

[12] Horne, *A Savage War of Peace*, p. 139.
[13] Fanon, *A Dying Colonialism*, ft.5 on p. 135.

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