Medicine and Imperialism in Morocco

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Source: MERIP Reports, No. 60 (Sep., 1977), pp. 3-12
Published by: Middle East Research and Information Project, Inc. (MERIP)
Stable URL: http://www.jstor.org/stable/3011547
Accessed: 08-03-2016 18:31 UTC

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Medicine under capitalism is organized to promote the accumulation of capital. In spite of liberal mythology, such medicine is completely instrumental; it never supports health as an end in itself. Sometimes, capitalist medicine fosters ill-health or death, as in germ warfare, mind control, torture and military medicine. Sometimes it contributes almost nothing to health, as in medical services for most rural areas of the Third World. And sometimes it promotes health, but only in a narrow sense—enough to maintain the strength of workers so that maximum profits can be extracted from them.

The dictates of capitalist accumulation require medicine to adapt to a wide variety of social and political conditions. From one region to another, from one class to another, from one historical period to another, medical services take on different and even polar opposite forms. The most striking contrasts and the most clear evidence of medicine as a capitalist enterprise are found in the Third World. Here medicine is absolutely inseparable from imperialism. Often doctors work as agents of espionage, propaganda and socialization to capitalist rule, while medical systems provide social control and reproduce a labor force to suit the needs of capital.

Morocco is an excellent case in point. During the colonial scramble in the late nineteenth and early twentieth centuries, rival imperial powers used doctors extensively—as diplomats, spies and all-purpose agents—to "penetrate" Moroccan society. Later, during the colonial period, the French employed doctors in their pacification programs. They also set up colonial medicine to provide espionage and propaganda. When their medical system improved the health of the Moroccan people, it did so only to supply an exploitable labor force to colonial capital. The structure and development of this medical system did not change fundamentally when Morocco achieved independence in 1955. Still governed by the laws of capitalist accumulation, Moroccan medicine reflects the social and political continuity of neo-colonialism in Morocco.

THE PRE-COLONIAL PERIOD: DOCTORS AS AGENTS OF COLONIAL PENETRATION

Medical doctors proved especially effective as agents of imperial penetration of Morocco. Frequently working for war ministries, foreign ministries or intelligence services, the doctors subordinated their professional skills to political tasks, enthusiastically preparing the way for colonialism.

These pre-colonial doctors made a few spectacular cures, but they did not raise the general level of health in Morocco. European capital could not yet appropriate the labor power of Moroccans, so it had no stake in maintaining their health. Capital's agenda was dominated by "primary accumulation"—imposing private property and wage labor as a basis for future profits. To accomplish this, it had to seize control of the Moroccan state. Doctors were employed in political work to promote colonial seizure and they did only such health care as was needed to cover up their real activities as spies, diplomats, missionaries, agents and propagandists of colonial rule.
Doctors as Diplomats. As European medicine advanced past Arab medicine, the Moroccan sultans began to invite European doctors to give treatment at their court. Frequently the sultans addressed their requests directly to European diplomats. The chancelleries, quick to grasp the possibilities, soon enlisted doctors in diplomatic tasks. France and Britain, the major colonial powers, sent medical envoys about every five years during the eighteenth and nineteenth centuries. This pace accelerated when colonial seizure appeared on the diplomatic agenda.

The major figure in this stage of medical diplomacy was a Frenchman, Fernand Linares. Unlike his predecessors, whose missions were brief, Linares stayed in Morocco from 1877 to 1902. His great accomplishment was to establish himself as friend and confidant of Sultan Mawlay Hassan. He also gained the ear of the royal chamberlain Sadar al-Adham (“Ba Ahmad”) who virtually ruled after Hassan’s death in 1892.

Linares entered Morocco uninvited, accompanying a French military mission. After little more than a year, he insinuated himself into the sultan’s favor by curing one of the royal wives. Linares was soon offered a residence in Fez, where few Europeans were allowed to live. He then began the active phase of his work. Healing only as much as diplomacy required, he ingratiated himself with the sultan and court circle, played subtly at court intrigues and generally advanced the French diplomatic cause.

Linares outmaneuvered the principal British agent at the court, the soldier-adventurer Harry Maclean. Healing arts proved more compelling than military sciences! The French Minister in Tangier, Saint-Rene Taillandier, described the accomplishments of Linares:

the French ministers had with Mawlay Hassan and his vizirs . . . the semi-official intermediary they had dreamed of: eyes that saw clearly, a pen that kept the record, a word that spoke with finesse, serving faithfully all instructions.1

Another French minister in Tangier, the Count of Saint-Aulaire, admitted in his own recollection

that my conception of this role [of doctor] was much less humanitarian than political . . . I saw Dr. Linares . . . as precious agent of liaison with the makhzan,* capable of neutralizing the rival influences . . . and of preparing the way for what is called ‘the peaceful penetration’ of Morocco.2

Linares’ voluminous diplomatic correspondence, preserved in the French War Archives, leaves little doubt that medicine was subordinate and instrumental to his prime charge as diplomat in the French colonial vanguard.

The British paid tribute to Linares by introducing their own medical diplomat, Dr. Egbert Verdun, to represent British diplomacy at the court in Fez. Though Verdun was never as successful as Linares in gaining the favor of the sultan or the powerful chamberlain, he gained access where many had previously been denied and became a key British liaison between the court and the British Minister in Tangier.

Doctors as Religious Missionaries. When deepening European penetration required action beyond the confines of court diplomacy, and espionage and propaganda among the mass of the population became necessary, the British assumed the lead. Their Presbyterian missionary societies were the first to carry out systematic mass work.

Because of the known Muslim hostility to Christian missionizing, the societies had to disguise the missionaries’ activities. They usually chose medicine as a source of social attraction. Most missionaries recruited for work in Morocco were either trained physicians or were given medical training before being sent into the field.

This medical mission work grew rapidly from modest beginnings around 1885. Ten years later there were six missionary societies active in the country with a total of some 75 missionaries in the field. One of the first missionaries to arrive, Dr. T. G. Churcher, began his work in Tangier, where he set up the headquarters of the North Africa Mission and helped to orient new missionary recruits. In 1892, after seven years in Tangier, he went on to establish a missionary outpost in the capital city of Fez. Dr. Robert Kerr, another early arrival, combined his mission work with active propaganda among audiences at home. An advocate of imperial expansion, Dr. Kerr informed his metropolitan readers that medicine was useful since it “opens many doors which would otherwise be closed.”3

Most of the missionary work centered on the small mission-infirmary set up in a major city. The local population would gather for medical treatment, but first would have to submit to moral and religious indoctrination. As one society arranged it, when the people entered the infirmary they would be confined to one side of the main room. After listening to a gospel reading, they could move to the other side of the room where the medical examinations took place. The Reaper, a British missionary journal, described medicine as a “means of attracting the adult population and getting them to hear the Gospel.”4 Medical work had yet another advantage, according to The Reaper. It served as a lure to financial supporters in the metropole, who preferred medical humanitarianism to religious proselytizing.

The medical missionaries also visited neighboring rural communities. Some even attempted to establish themselves in rural areas on a more permanent basis. This rural thrust followed a long-standing imperial strategy in North Africa: Berber-speaking peoples were considered racially and culturally

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*makhzan = royal government
more prone to European influence. The enthusiastic missionaries translated Biblical texts into several Berber dialects and looked forward to many converts. But penetration of the countryside proved to be both difficult and dangerous and the “Berbers” did not rally to the Gospel. Consequently, the bulk of the missionary activities remained in urban areas. Conversion was just as slight among the urban population as among the Moroccan interior. The number of medical envoys then grew substantially. 

By the end of 1904, the same year that France gained control over the Moroccan state treasury. There were some twenty French “missionaries” by the end of 1905 and about thirty from the other three countries. By 1906, the Act of Algeciras permitted European government agents into the Moroccan interior. The number of medical envoys then grew substantially.

Doctor as Foreign Service Agents. The effectiveness of the British medical missionaries inspired European chancelleries to send state-sponsored doctors to Morocco. France, Germany and Spain—soon joined by England—around the turn of the century began to send military doctors on loan to the foreign ministries. These doctors were charged with gathering information, conspiring with local notables and preparing the mass of the population for colonial takeover. France established the most extensive program of “foreign affairs missionaries,” as they were called. The first French medical envoys arrived in Morocco at the end of 1904, the same year that France gained control over the Moroccan state treasury. There were some twenty French “missionaries” by the end of 1905 and about thirty from the other three countries. By 1906, the Act of Algeciras permitted European government agents into the Moroccan interior. The number of medical envoys then grew substantially. 

The best-known foreign affairs missionary, Dr. Emile Mauchamp, arrived at his post in Marrakesh in October of 1905. Marrakesh was a royal capital along with Fez; it was also the seat of the sultan’s rival brother Mawlay Hafiz as well as the headquarters of the powerful Glaoui family. Mauchamp took up residence in a former home of Dr. Linares. Before long he ingratiated himself with Mawlay Hafiz and also won the confidence of members of the Glaoui family and other local notables. His medical entree enabled him to keep a close watch over the political maneuvers leading to Hafiz’ bid for the throne. He was able to maintain French links to the pretender and his supporters in spite of the preponderance of German financial and diplomatic influence in the Hafizist camp.

Mauchamp’s court intrigues did not prevent him from establishing a clinic which soon drew over a hundred persons each day. When a typhus epidemic broke out in the summer of 1906, Mauchamp’s clinic was swamped with work. Unfortunately for Mauchamp, the intensified intrigue at the Southern court placed great demands on his diplomatic work at precisely the same time. In a letter to his superiors, he commented testily that the epidemic was forcing him to do “lots of medicine and little politics.”

Doctors as Settler-Adventurers. Not least among the medical operatives of European colonialism were the private physicians who came to practice among the settler communities of the coastal cities which grew swiftly in the last half of the nineteenth century. Committed advocates of colonial takeover, who frequently sought to supplement their incomes by extramedical activities, these doctors were swiftly drawn into politics, from yellow journalism to espionage. They complemented the efforts of their colleagues in the missionary societies and the European foreign services. 

Most of the doctors attracted to Morocco in this period were from petty bourgeois families. Lacking social connections and financial support, they had found it difficult to establish practices in the European cities. Colonial practice escaped the invidious social distinctions of the metropolitan cities and could be set up from scratch, not purchased at a high price as was usually the case at home. The colonies provided the opportunity to participate in the European civilizing mission, the adventure of colonial pioneering and, not least, the rumoured ease with which sizeable fortunes could be rapidly accumulated. Morocco was one of the last colonial areas opened to European penetration, but was close to Europe and temperate in climate.

The account of Dr. Felix Weisgerber, a Frenchman who set up medical practice in Casablanca in 1896, captures much of the flavor and social character of the doctor as settler-adventurer:

I was then doctor on board the Bellerophon . . . en route for Batavia. A collision with another ship . . . had immobilized us for a dozen days in Algiers. Coming back from the Far East, after having dreamed for a moment of trying my fortune in the Klondike . . . the recollection of Algiers won out and I opted for a sunny country. But Algeria and Tunisia seemed too civilized. Feeling confusedly that France would soon extend its influence to Morocco and that it would be possible to play the role of pioneer, I came to Tangier. But that town of embassies appeared too Europeanized. So I resolved to establish myself in Casablanca, the only other town in Morocco whose European colony seemed to me sufficient to assure the material existence of a practitioner without outside resources . . .

Weisgerber discovered that the financial situation for medical practice in Casablanca was “hardly brilliant,” but he stayed on. Enterprising, literate and with a keen sense of the necessity and imminence of the French colonial takeover, he wedded his medical pioneering to a variety of endeavors including journalism, diplomacy, cartography, and espionage. Before long he had accumulated a fine city residence, rural properties and a chestful of gold coins.

Many other doctors discovered like Weisgerber that the
prospects for private medical practice were rather dim and sought to supplement their medical incomes in one way or another. Some attached themselves to the European consulates. Other doctors sold their services to less overtly political enterprises. The Austrian doctor Schmiedl was paid by Salomon de Rothschild to minister to the Moroccan Jewish communities in Tetouan, Tangier and finally Marrakesh. This project helped to establish a group of Jewish intermediaries open to European alliances. Still other doctors improved their income by becoming paid espionage agents. Dr. Manuel Tomas Rodriguez, who practiced in Rabat from 1861 until 1876, was simultaneously a Spanish spy.

Whether in search of commercial profit, in the employ of the state, or in the pursuit of personal satisfaction, these early settler doctors rarely neglected the goal of colonial conquest. Dr. Weisgerber, for instance, ministered to the sultan during a royal military campaign, returning with detailed reports on the makhzan and the extent of tribal dissidence. He made maps of the Moroccan interior which he turned over to the French army for use in later invasions. And he wrote numerous articles in newspapers and magazines and often went to Paris to lobby for French colonial intervention.

The settler doctors generally acted as individuals, outside the organizational framework that bound their colleagues in the missionary societies and the foreign services. The thrust of their work, however, was largely the same. They were drawn inexorably into the process of colonial penetration and propaganda. Along with their other medical colleagues, they saw themselves as agents of a new enlightened era of European modernity, which was in fact the era of harsh rule of European colonialism.

Moroccan and European Reactions to the Colonial Medical Enterprise. The doctors all used the cloak of political neutrality and moral authority to live in communities where few Europeans had gone before and to relate to all layers of Moroccan society. Nevertheless, they were rightly regarded with suspicion and even hostility. With the growing resistance to European imperialism, several doctors were singled out for attack and at least two were murdered.

The doctors' Christian missionizing, their contacts with proteges and collaborators, and their mysterious movements around the country all contributed to their public disfavor. Even their medical work may have focused popular indignation, for their cures often failed and they frequently abandoned their more humble patients for the healing of notables or for travels on diplomatic business. The spirit of popular resistance was particularly strong in the old cities of Fez and Marrakesh. In late 1902, British missionary doctor D. J. Cooper was murdered in the city of Fez. Mauchamp, the French foreign affairs missionary, was murdered outside his home in Marrakesh in March of 1907. The circumstances of this case were very clearly political. Though specific accounts of the murder vary, there is general agreement that the cause was Mauchamp's known espionage activities.

Medicine was less effective in forming Moroccan public opinion when its support for European colonialism became clearly visible, but its value for opinion-formation in the metropole met no such obstacle. The doctors had become a justification of colonial expansion and a symbol of enlightened European humanitarianism. The myth of peaceful medical penetration continued to develop, masking the harsher side of colonial penetration. The doctors themselves were principal creators of their own mythology, writing endless articles, pamphlets and books in celebration of their work.

Even as objects of Moroccan fury and assault, the doctors functioned as agents of propaganda and penetration, stirring European opinion favorable to colonialism. The murder of Dr. Cooper was presented in the popular press as a cruel act of religious fanaticism, showing the barbarity of Morocco and its need for a civilizing European rule. The murder of Mauchamp likewise played into larger colonial designs, including the mobilization of mass sentiment in the metropole. By this time, the French were simply waiting for an excuse to begin their military invasion. As one contemporary author tells it:

In 1907, serious events developed which obliged France to act with vigor and undertake its military operations. The assassination of Dr. Mauchamp in Marrakesh caused a tremendous outcry in our country and was the primary cause of our intervention. A coercive act was required to obtain the necessary redress from the Moroccan government.7

 Barely ten days after the death of Mauchamp, units of the French army crossed the Algerian border and seized the Moroccan city of Oujda. After securing the surrounding region, the commander rushed a column south to Marrakesh to "protect the security of the other French and foreign citizens inhabiting the city." The period of "peaceful penetration" was over and the era of armed colonial intervention had begun.

THE COLONIAL PERIOD: PACIFICATION AND CEMENTING COLONIALISM

When the French imposed a Protectorate on Morocco in 1912, they hoped to bring the country quickly under their control. But in the face of fierce resistance, the colonial conquest took nearly twenty more years to complete. Medical doctors were closely associated with this vast program of "pacification," working alongside the advancing French army. As in the pre-colonial period, colonial medicine was entirely subject to the imperative of primary accumulation—focusing on espionage and propaganda, not health care at all.
Those parts of Morocco that had been brought under military control required a different approach to medicine—one which mixed health care with political control in various doses. The expanded reproduction of capital and its labor force became more important as farms, mines, railroads and factories appeared on the colonial landscape. Capitalism did not lay hold of Morocco all at once. It continuously expanded, displacing older social forms. Moroccan society remained a bewildering social composite, including primitive communism, nomadism, slavery, peasant agriculture, crafts, and mercantile trade, in addition to colonial capital proper. The medical system had to be adapted to these different forms. It also was developed to deepen ethnic and political antagonism among Moroccans.

To those outside the sphere of capital* the colonial medical system offered scarcely any health care, concentrating instead on social control. To those inside the sphere of capital, it offered such health care as was necessary to reproduce the class system and the requisite forms of labor. French and European settlers received good care from this system, permitting them to function as managers, bureaucrats, professionals and skilled workers. Most Moroccans were cared for at a far lower level: so that they could survive as unskilled labor, from which the maximum surplus value could be extracted.

Doctors as Agents of Colonial Pacification. Hubert Lyautey, commanding officer of the first invasion forces and first Resident General of the French Protectorate, is credited with developing medical pacification. Lyautey previously served with the French colonial armies in the campaigns of the 1890s in Indochina and Madagascar. He claimed to have realized in Indochina the limits of armed force and the advantages of cultural “understanding” and non-military forms of pacification. When he was transferred to Madagascar and placed in command of a front-line division, he used mobile medical teams for pacification. In 1901, at the height of the campaign, he is said to have wired his commanding general: “If you can send me four doctors, I will send you back four companies.” The doctors arrived and Lyautey was pleased with the results. Not long after, he was transferred to a new command in western Algeria, where he set up regular medical teams to help control the hostile local population. In 1907, as he launched the invasion of Morocco, Lyautey decided to expand medical pacification still further.

The new program centered on mobile health units. Lyautey planned to detach military doctors from their ordinary responsibilities (caring for the sick and wounded soldiers) and form them into units which could move independently of the army. In this way they could thrust into unconquered territory and prepare the population to surrender using “medical propaganda.” Lyautey later described these units as:

Little peaceful troops, continually on the march, who penetrate into the most distant regions, into areas of the most suspicious groups, and to whom we owe so many contacts, sympathy, and even submissions.

During the first phase of the campaign, Lyautey had neither the time nor the medical manpower to set up his full program. Nevertheless, he immediately moved doctors into the vanguard of the invading army. Ambulance groups joined reconnaissance columns, and set up operations in hostile territory to demonstrate French goodwill and attract local leaders for negotiations. Lyautey also assigned doctors to military intelligence expeditions into the hinterlands to divert attention from the intelligence mission and to gather intelligence themselves from patients. Occasionally whole medical units moved out alone into unconquered territory. Doctors Oberle and Cristiani, among others, carried out these missions with initiative and daring, winning praise from Lyautey and rapid military promotions.

When the Treaty of Fez was signed in 1912, the French controlled about twenty percent of the country, including all the major cities in their zone. It was clear that the pacification of the remaining territory would be very difficult: the unsubdued regions had harsh terrain, few supply routes and their populations were fiercely independent. Lyautey planned to expand his medical pacification scheme and to use it to the fullest in the coming campaign. After presiding at the signing of the Treaty, he went to Paris to make arrangements for the transport of army reinforcements for the new campaign. One of his major requests was sixty extra doctors, in addition to those regularly assigned to the army units. He also asked that fifteen other doctors, already on special military duty in Morocco, be placed under his command. The Minister of War was surprised at this novel request. But Lyautey explained that he was going to use these doctors “principally for mobile medical formations, which will penetrate the country little by little so as to improve the health conditions and create for me a solid political propaganda.”

The unsubdued areas were principally mountains and deserts, terrain well-suited and admirably used for guerrilla resistance. The medical pacification teams were brought into play first in the campaign for the Middle Atlas (1918-1920), then in the Rif (1920-26) and finally in the High Atlas, Sahara and Anti-Atlas (1931-34). According to Lyautey and his circle, the doctors had a valuable if not essential role in each of the military victories. The leading medical figures in these campaigns, such as Drs. Colombani and Chatinieres, gained a high standing in French colonial history.

Lyautey left Morocco in 1925, but his view of medical pacification continued to mark official policy and propaganda. A speech he gave at a medical conference in Brussels in 1926 circulated in colonial circles for many years. “There is no fact more firmly established,” Lyautey told his audience, “than the role of the doctor as agent of penetration, attraction and pacification.” Describing the subtle process, he continued:

From the day when a notable, a quaid, or just some suffering devil decides to see a French doctor and leaves his office cured, the ice is broken, the first step is taken, and the relationship begins to be established.

Lyautey elevated this crass manipulation into nothing less than a holy stewardship, justifying in its own right the entire colonial enterprise. As Lyautey concluded his Brussels speech:

Certainly the colonial expansion has its harsh aspects. It is not either beyond reproach or without blemish. But if there is something that ennobles it and justifies it, it is the action of the doctor, understood as a mission and an apostleship.

French ideologues in Morocco continued to draw heavily on the Lyauteist vision of colonial medicine. Medical intimacy held a fascination for them as they theorized about how to win the hearts and minds of the subject people. George Hardy, eminent colonial sociologist, was one of many who held this

*That part of the economy operating under free capitalist mode of production based on the exploitation of wage labor.
view:

What is interesting about the doctor, quite apart from his capacities as a healer, is his potential for moral action. The privilege of the status which he occupies permits him to enter everywhere, to carry succor to everyone, rich or poor, without any strings attached, and to approach them in the moments of least resistance which sickness creates in the patient and his family. He is the person to whom one is obliged to open oneself and who becomes without your noticing it the confidant and the friend.13

The medical programs certainly had an impact during the great campaigns of colonial pacification, persuading some Moroccans to accept French subjugation. But the duration and intensity of the Moroccan resistance testify to the failure of medical manipulation when people are determined to fight for their independence. The statements of Lyautey and his followers contain a large dose of colonial mythology. The settlers and the public in the metropole generally accepted this myth, with its implication of benign French expansion. Settler medical personnel were its staunch advocates, because of the inflated importance attributed to them. But the franker statements of some military commanders show the limits of “peaceful” medical pacification and betray the brutal force within which it operated. General Gouraud’s biography documents the massive destruction and killing, the burning of towns and fields, and the annihilation of local populations.12 General Guillaume, another field commander, expressed his doubts about the statements of Lyautey and his medical collaborators on the process of “peaceful pacification”:

Before the more or less complete failure of the political action, military action was required to break by force the obstinate resistance of the tribes. No tribe came over to us spontaneously. None submitted without combat and some even held out until they had exhausted their last means of resistance . . . Lyautey’s formulas ‘show force in order to avoid using it’ and ‘a construction site is worth a battalion’ cannot properly apply to populations determined to defend their independence down to the last extremity.14

More than 100,000 Moroccans and 20,000 French soldiers died in this colonial carnage.

Medicine and the Colonial System. The regular medical system differed little from the medical pacification programs, especially in the early years. The colonial administration was a military administration, always ready to crush fresh uprisings; the colonial medical system was a military creation. Lyautey placed it in the hands of Col. Marcel Oberle, chief medical officer of the Eastern invasion forces, who set up the system within the army command structure and designed it as an extension of the medical programs already under way.

In the vanguard ran the mobile health teams and behind them came the army. When the army’s work of conquest was done, the authorities set up more permanent health arrangements—at least in those areas where European settlers were expected. They built dispensaries, infirmaries and eventually small hospitals “according to the importance of the centers of colonization and the regions.” Meanwhile, the doctors concentrated on propaganda work with the local Moroccan population, trying to reconcile them to French colonial rule. As Cruchet frankly describes it, medicine

prepared the way for military action, consolidated it, or replaced it according to the nature of the formations considered. In fact it was intimately linked to the military actions and could only be associated with their fortunes. Political events guided its development, which were not without setbacks.15

From 1912 to 2021, the public health system was entirely under military control. Dr. Oberle continued in charge, rising to the rank of Surgeon-General, commanding all aspects of medicine—for the invading troops, the colonial settlers, and the Moroccan population. Eventually, as large areas of the country came under colonial control, Lyautey decided to create an autonomous civilian health service. Although this new service was detached from the army, Oberle remained its head for five more years. He was succeeded by Dr. Jules Colombani, who had won acclaim in the pacification campaigns.

The health service gave good care to settlers and poor care to Moroccans. Military doctors continued to care for Moroccans, while “civilian” service doctors attended the settlers. This Janus-like system reflected the different priorities established for each population: political control in one case, health in another.

Except for major cities, with large concentrations of settlers, most of the country was thinly covered by the medical system. There were scattered dispensaries, to which doctors would come on rounds, and there were mobile units that would move from one village or market to another. The doctors assigned to these posts were expected to gather intelligence and serve as an advance guard of the Bureau of Native Affairs. They mapped out the countryside, made estimates of the population and natural resources, and drew up inventories of wells, villages, fortresses and transport routes. Most important of all was the gathering of information on political structures which would serve as a basis for colonial political control:

the collation of this diverse information was made more complex by the multiplicity of the tribes and above all by their fractions . . . [These] internecine quarrels help, with time and patience, to establish the genealogical tree of the chiefs, to know the marabouts, to weigh the political and religious power of one and the other, and thus, in straightening out these innumerable intrigues, being able to arrive more quickly at the pacification so much desired.16

In the more politically stabilized areas, the Native Affairs Officers took over these intelligence activities. The doctors then concentrated on medical propaganda and on providing health care to the nascent Moroccan working class. Dr. Colombani described this focus in an interview in 1932, speaking of a “dual end—humanitarian and utilitarian”:

The humanitarian end is to affirm, from the very beginning, our role of apostles of civilization . . . the utilitarian end is . . . to preserve by all the means at our disposal, the local human capital so as to get as high an output as possible from labor, the needs for which impose themselves from the beginning for the construction of the newly-occupied country. (emphasis added)17

Colombani and his colleagues worked to preserve Moroccan labor power, but only as it was needed by colonial capital. Since the needs of capital and the supply of labor were both erratic, the health system was always in flux. Usually, so many Moroccans were displaced from the land that they formed a large labor surplus; the colonists could afford to waste this labor rather than “preserve” it. However, labor shortages

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ocasionally developed. In 1923, a severe epidemic killed off several hundred thousand Moroccans, eliminating the labor reserve and driving up wages. The colonial capitalists, alarmed at this threat to their profits, persuaded the authorities to give extra funds to the health services. Labor shortages later lay behind the great expansion of the health system after 1945.

The labor shortages did not last long. Programs to eradicate communicable diseases, developed to protect the settlers, affected the Moroccan population as well, boosting the birth rate. The number of Moroccans tripled during the colonial period, rising from about three million in 1912 to about nine million in 1955. Since land expropriation continued, hundreds of thousands of displaced peasants streamed into the cities, available as wage labor. Some, desperate for work, joined the French army, while others emigrated to Algeria or France. Under these conditions, there was little incentive for the colonial authorities to improve direct health care services. By 1928, for example, the effects of the 1923 epidemic had been completely overcome and there was so much excess labor that another epidemic was permitted to take its course. Said one colonial chronicler:

There wasn’t much that could be done. Death didn’t strike the Europeans, nor the rich natives, but the poor devils. Following the rise in prices of all commodities, disproportionate with their salaries, they have been living for several years in a state of under-nourishment which had not allowed any resistance against sickness.\(^{16}\)

The hospitals, where most health service resources were concentrated, were built in the major cities and were virtually inaccessible to the great majority of Moroccans who lived in the countryside. Little concerned about subsistence peasants or pastoral nomads, the doctors’ main method of treatment was a hurried disinfectant spray for people who came to the local markets. In the countryside, doctors charged fees for worthless injections and sold health service medicines that should have been distributed free. The health service winked at this, even permitting doctors to set up private practices on the side.

The urban hospitals were not open equally to all. Under the guise of honoring different customs, the health authorities established a three-tier hospital system. There were separate facilities for Europeans, Jews and Muslims, following a policy of “divide and rule” as well as reinforcing the colonial caste system of labor. The European hospitals were of course large and excellently equipped. The Jewish hospitals were somewhat inferior. The Muslim hospitals were thoroughly inadequate. An indication of this difference can be found in the 1932 Protectorate Loan: for the cities of Marrakesh, Fez and Meknes, where Muslims outnumbered Europeans by more than fivefold, the allocation for the Muslim hospitals was only a tenth of that for the European hospitals. Europeans, with fifty times the resources, obviously enjoyed vastly superior health care. A few rich and powerful Muslims and Jews had access to the European system.

In the major cities, private medical practices flourished, mainly among the settler population. Some private doctors expanded their business by setting up clinics and sanitariums where wealthy patients came for minor treatment to avoid the large impersonal hospitals. Other doctors fattened their income with retainers from business firms, serving as consultants on safety and work accidents; the less they said about safety, the more the employers were satisfied. Some private practitioners cultivated a clientele among the biggest Moroccan merchants or those in the circle of the sultan’s court. Other doctors parlayed dubious medical credentials into handsome colonial practices. And many plowed back their medical profits into small businesses, farms, or other extra-medical enterprises.

The health of Moroccans remained a world apart. The colonial health service had made a few definite advances: reduction of typhus and trachoma, decrease in infant mortality, fewer plague epidemics. More Moroccans were certainly alive, but paradoxically their daily health condition was probably worse than it had been in the pre-colonial period. Ecological transformations resulting from modern agriculture upset health balances in the countryside. In the mines, lung disease took its toll. Colonial military operations claimed tens of thousands of casualties. In the cities, the old health arrangements broke down: public baths, sunny courtyards and herbal cures no longer contained disease in the crowded old medinas and the spreading shantytowns. Tuberculosis and venereal disease (to mention only the most widespread and deadly) struck down thousands of the new migrants. Colonialism had smashed traditional health practices, the wage system exacted more intense labor, and with rising prices workers could not purchase as much food as they had eaten in the subsistence economy. In 1880, Moroccans ate an average of three meat meals per week; in 1940 they ate only one. Grain consumption also declined. Malnourished Moroccans suffered mental retardation and were prone to every kind of sickness.\(^{19}\)

The colonial health system did not create these conditions, but it was inextricably connected with them. The doctors were usually ready to apologize for the system and its obvious inequalities. They often explained away the social cause of disease in racist terms, like “Arab syphilis” to which Arabs were supposedly racially prone. Most Moroccans were justly suspicious of the colonial doctors and entered the doctors’ care with reluctance and defiance. In spite of myths of the medical community, there was little love of the “good tabib.” When the first nationalist journal, Maghreb, appeared in the 1930s, it scandalized the settler community by attacking Dr. Cristiani of Fez, one of the sacred cows of colonial medicine. And during the first great anti-colonial riot in Sale in 1944, the crowd turned with anger towards the nearest hospital and wrecked it beyond repair.

As the anti-colonial movement gained strength, Moroccans refused medical treatment and boycotted the disinfectant sprayings. When armed struggle began, they turned their fire directly on the doctors. On June 30, 1954, Dr. Emile Eyraud was assassinated; on July 23, 1954, Dr. Claude Thivend was killed in Marrakesh; on March 3, 1955, Dr. Guy Remy was assassinated in the medina of Casablanca; on August 20, 1955, Dr. Andre Fishbacker along with all his European patients was killed in Oued Zem and the hospital burnt to the ground. At the height of the struggle and in spite of the most terrible retribution by the colonial police, the Moroccans gave their harsh diagnosis of the colonial medical system.
MEDICINE AFTER INDEPENDENCE: THE NEO-COLONIAL SYSTEM

Morocco won independence in 1955, culminating years of intense popular struggle. However great the victory over the settler-colonial regime, it only resulted in limited bourgeois-nationalist change. Behind the trappings of formal sovereignty, a neo-colonial society was consolidated. Settlers stayed on, colonial social and political institutions continued to function, and, above all, the enormous investments of metropolitan capital remained firmly in place.

Post-colonial medicine reflected the changes but especially the continuities of the social order. Though Moroccans slowly replaced settlers in the health professions, this did not result in popular health care. The Moroccan nationalists took over the system at a time of economic difficulties and immense labor surpluses. At the urging of international bankers, the regime cut back on “unproductive” expenses, reducing already minimal public health programs. The health authorities ignored the rural population outside the nexus of capitalist exploitation and provided the urban working class with just enough life and breath to carry out their jobs. Doctors were still expected to act as spies and propagandists. Health resources were concentrated even more than before in the big urban hospitals and private practices, insuring good health for the remaining settlers and for the new privileged order of Moroccans: capitalists, bureaucrats, army officers, managers and professionals.

Colonial medical standards were everywhere evident at independence. In Casablanca the enormous new Jules Colombani Hospital served Europeans while the vast Moroccan population pressed at the doors of the small and antiquated Maurice Gaud Hospital. Such was the physical inheritance of French medicine, pride of colonialism.

The scientific and moral inheritance, the professional culture of colonial medicine, was part of colonial ideology. At independence, eminent physicians still spoke of the biological origins of Moroccan Arab diseases, the innate laziness and docility of Moroccans, and the likelihood that desert life had long ago selected those indifferent to pain and suffering. Racism, missionary zeal and scientific/cultural superiority were deeply engrained in the colonial medical tradition inherited by independent Morocco.

The settler doctors, both private and public, wanted to insure their prerogatives in the setting of independence. Fearful of mass violence and deeply distrustful of the Moroccan regime, they threatened to leave en masse if their future was not solidly guaranteed. In response, King Mohammed V summoned their representatives in late 1955, offering assurances and a glimpse of official policy. Doctors were indispensable, the king told his audience, not only because of their technical skills, but also as agents of propaganda. Dr. Dubois-Roquebert, semi-official liaison with the French government and surgeon of the king, recounts the scene:

During his audience, His Majesty announced to us his esteem for the Medical Corps and spoke of what, in the future he expected of it: not only medically but, if I dare to say so, politically. For, by their function, doctors can exercise an undeniable influence on public opinion. They have too much knowledge of people not to be struck by the significance of the suggestions proposed by the sovereign.

When the first royal government was formed, continuity of medical policy was further assured. The king appointed Dr. Abdelmalik Faraj as Minister of Health. Faraj, Morocco’s first French-trained doctor, lacked any active political connections, even among more conservative nationalists. Completely surrounded by a ministerial apparatus of French technicians, Faraj aimed to “preserve the great heritage of French medicine.”

The atmosphere of the ministry remained frozen in the colonial past. The Moroccan minister himself was a caricature of colonialism, amusing even his French staff by his anachronistic pronouncements “in the name of the French Republic.”

Faraj and other Moroccan officials reassured private practitioners that the public health service would not cut into their clientele. Faraj even agreed to cut back the hospital construction program, which clinic-owning private doctors opposed, affirming to one delegation that “we must develop private medicine and permit it to cooperate with public medicine.” Such policies, recommended by French advisors and fully consonant with the needs of metropolitan capital, received the warm support of the French government. As a sign of its approval, in 1957 France agreed to provide extensive technical assistance, including several hundred doctors and health support personnel to maintain public sector services.

While guaranteeing the situation of the European doctors, the Moroccan regime had to increase the number of Moroccan doctors. Out of a medical corps of over a thousand, only two dozen were Moroccans at the time of independence. The regime created a new medical school as part of the new Mohammed V University in Rabat to serve as a teaching center. A vital question concerned curriculum: should the school train generalists in public health medicine or specialists in hospital-centered practice? The first option could foster a medicine for the masses, while the second could foster urban private practice to serve a privileged few. The choice was never in doubt. Specialization was chosen, coinciding with the class structure of Moroccan neo-colonialism.

The new medical school clearly favored private practice. It set such high standards that few doctors were trained, and its standards of admission guaranteed entrance to only students from the best schools and the most wealthy families. Because the school fostered hospital-centered medicine, it promoted a concentration of health resources in a single elaborate teaching hospital, draining funds from social and preventive programs. By the late 1960s, the teaching hospital was swallowing up more than a tenth of the total national health budget. The health service, whose budget was already strained by several large new urban hospitals, had to redeploy its forces. The authorities left posts empty in rural areas and urban slums; allowed most outlying programs to deteriorate; and abandoned the Institute of Hygiene by raiding its budget to cover the escalating expenses of the university hospital center. Although the Institute was the center for training and research in social medicine, as well as the repository of key medical archives, the health authorities allowed its archives to fall into disorder, its journal to cease publication and its display cases to gather dust, their exhibits unchanged since colonial times.

The public health service was nominally controlled by a Moroccan minister, but a French staff ran it for more than fifteen years after independence. This staff, both in the ministry and in the field, shared a perspective rooted in the medical pacification programs. Most were trained in French military medical schools and many were active French military officers, loaned to the Moroccan government as part of technical assistance programs. The interweaving of civilian and military
medicine was reinforced by another continuing practice: as in colonial times, in the countryside doctors in the Moroccan army formed a single nexus with the medical staff of the public health service.

This military-medical culture continued to practice information-gathering as a standard part of medical routine. One French doctor explained after independence the history of espionage work in the medical corps:

[Doctors'] search for this information was motivated essentially by political necessities. But this does not at all decrease its value, nor the merit of the researchers. Authority which is founded on a knowledge of the beings it seeks to rule, which concerns itself with local customs and beliefs in an effort to give them maximum respect, testifies to a scrupulousness and humanism rare in the history of colonialism. The greatness of Lyautey and his students is founded on this constant wish: to know before giving an order, to avoid the wounds of power by controlling and differentiating its line of action, to convince rather than to constrain. 21

Medical intelligence flowed into the ministry of health in the form of field reports. More informally, intelligence travelled along the settler network, providing the French embassy with news of all kinds: a local uprising, the power system in a small town, who was jailed in the prison hospital, even the health and disposition of the king and his ministers.

The French maintained a near monopoly over the medical intelligence system, but they did share some data with their American allies. They regularly dispatched disease cultures to medical authorities at the US naval base at Kenitra; such cultures were then forwarded for analysis to the US Armed Forces Disease Center in Naples, Italy. In the late 1960s, the Health Ministry also agreed to a country-wide study of disease-carrying rodents and their parasites under the auspices of the Pentagon.

A French military official in the health ministry noted admiringly: “The French army, even with its long colonial experience, does not think ahead in this way. The Americans are prepared to go anywhere; they are ready for any contingency.” 22

The royal regime, not content to rely on the French, set up a separate intelligence network in the medical system. The growing number of Moroccan medical social workers, trained for health education and prevention, were placed under the authority of the Ministry of the Interior. These new professionals, though lacking the authority and “attraction” of the doctor, had more mobility and familiarity with the local scene. Able to enter the huts of the poorest peasants and the shanties of the dispossessed in the worst urban slums, they drew maps, took censuses, and gathered many intimate details of social life. Their reports entered the directories of the watchful local police authorities as well as the intelligence files of the Interior Ministry in Rabat.

The continuing espionage and propaganda show the low priority of health care itself, especially as provided to peasants and marginal urban workers. After independence, mass medicine regressed. In the final years of colonialism, when the economic boom caused a huge growth in the Moroccan proletariat, the health services for this new working class had grown rapidly. But after independence the economy stagnated and the proletariat grew only as it emigrated to work in France. Consequently, the laws of capital prevented any improvement in the Moroccan health services.

The health system maintained the Europeans and the most privileged Moroccans at a high level and gave moderately good health to the new Moroccan bureaucracy, the army and employees of large enterprises through insurance schemes tied in to private practices and the best state hospitals. But the health condition of the rest of the population remained poor. There was an increase of malnutrition in the countryside and tuber-
culosis in the cities. Mental disorders stayed at a high level.
Many other scourges evaded the efforts of the health authori-
ties: trachoma, malaria, leprosy, syphilis, bilharziosis and
gastro-enteritis. A sign of the fragile health situation was the
outbreak of cholera in 1970. This deadly disease, which often
accompanied starvation and social collapse, had not been seen
in Morocco since the crop failures and wartime dislocations
of 1943.

In addition to the epidemics were the ravages of flood and
drought, harsh labor conditions in field and factory, and a
decreasing supply of pure drinking water in the coastal cities.
To be ready for crises, the health authorities held back on
ordinary expenses, hoarding credits for emergency demands.
Emergencies only deepened with the worsening condition of
peasant agriculture and spreading unemployment and slums in
the cities. The health authorities of independent Morocco were
no more conscious of this material context than their colonial
forebears. Those few Moroccans in the ministry blamed condi-
tions on their arrogant and conservative French colleagues,
while the French blamed the cupidity and incompetence of
the Moroccans. Both idealized a technocratic model based on
social planning, education and similar palliatives within the
existing social order.

Although the Moroccan population increased and its
material conditions worsened, the public health service got few
budget increases. The regime maintained an openly Malthusian
approach to its “population problem,” hoping to reduce the
mass of surplus labor which was both an economic impediment
and a political threat. Spurred on by strong pressures from the
World Bank, the International Monetary Fund and USAID, the
regime decided in the mid-sixties to further restrict public
health programs so as not to interfere in the “natural” sources
of mortality.

The small number of newly-trained Moroccan doctors
were not attracted by a career in the public health service. They
objected to the low pay and the inevitable assignment to the
countryside. After a brief period of mandatory state service,
they quickly set up lucrative private practices in the major
cities. A 1961 reform drew a few Moroccans into the public
health service by permitting them to open private practices on
the side. Soon many drew public patients into their private
offices and appeared only irregularly at their hospital posts. By
1967 such abuses had become a public scandal, but when a
new minister abolished the system, more than half the regular
Moroccan staff quit in favor of full-time practice. The public
health service remained a foreign institution.

The world of private practice changed even less than the
public sector. These doctors, concentrated especially in Casablanca and dedicated to the pursuit of high incomes, united in
their medical association to preserve a favorable status quo.
They fought even the most modest health insurance projects
and battled even more fiercely any proposed new income tax.
The French medical community was so obsessed with high
earnings that the largest wave of departures after independence
was touched off in 1965 when a small new tax was announced.

The new Moroccan private practitioners were no different
from their settler colleagues. The leadership of the medical
association was Moroccanized by a 1960 law, but the temper
of the organization and its basic claims remained the same.
The first Moroccan president, Dr. Omar Boucetta, argued not
long after assuming office:

What is dangerous for a country in the process of
development are fragmentary measures, superficial
decisions, short term solutions, breaches that are
imprudently opened in a system that should on the
contrary be consolidated. (emphasis added)\textsuperscript{23}

As the 1960s progressed, the ranks of the settler doctors
were depleted through death, retirement or departure in both
the public and the private sectors. In the public health service,
replacements came from the French technical assistance pro-
grams and from East European countries. A few Moroccans
took over the more desirable posts in the regional health
administration and—in big city hospitals. Although the French,
presence continued to decline and Moroccan staffing of the
top posts continued to increase, the new personnel did not
affect the political economy or the moral premises of the
health service.

\textbf{CONCLUSION}

For most of human history, medicine was a branch of religion
and its practice a deep and sacred mystery. Medicine has now
ceded to be a priestly monopoly; nor does it lend its support
to the rule of tribal chiefs, Asiatic despot or feudal nobles.
Though medicine is not secular and far more scientific, it
remains a product of class society and an instrument of ideol-
yogy and oppression. As over a century of Moroccan history has
shown, contemporary capitalist medicine is bent to suit the
needs of accumulation and class rule.

Although the details of Moroccan medical history are
unique, the general principles and even many of the institutional
forms can be found in nearly every country of the world. Re-
formers argue that this can be improved by gradual, piecemeal
change. But only the complete abolition of capitalism can clear
the way for a society insuring good life and health for all.

\textbf{FOOTNOTES}

\begin{enumerate}
\item Georges Saint-Rene Taillandier, \textit{Les origines du Maroc francais; recit
\item Quoted in \textit{Maroc Medical}, Lyautey et le medecin (Casablanca, 1954),
p. 13.
\item As quoted in \textit{Jean-Louis Miege, “Les missions protestantes au Maroc,
\item Quoted in \textit{ibid.}, p. 174.
\item Rene Crochet, \textit{La conquete pacifique du Maroc et du Tafilalet} (Paris,
1954), p. 56.
\item Felix Weigheben, \textit{Au seuil du maroc moderne} (Rabat, 1947), p. 11-12.
\item Quoted in \textit{ibid.}, p. 26.
\item Quoted in \textit{ibid.}, p. 18.
\item Interview with the author, July, 1970.
\item Augustin Guillaume, \textit{Les Berberes marocaines et la pacification
\item Crochet, \textit{p. 79-80.}
\item \textit{ibid.}, p. 277.
\item \textit{ibid.}, p. 110.
\item Andre Colliez, \textit{Notre protectorat marocain: la premiere etape, 1912-
\item See \textit{M. M. Knight, Morocco as a French Economic Venture} (Berkeley,
\item \textit{Bulletin de l’Ordre des Medecins, No. 14 (April, 1957), p. 22.}
\item \textit{Interview with the author, July, 1970.}
\item Omar Boucetta, \textit{“Medecine libre et medecine privee,” Bulletin de
l’Ordre des Medecins, No. 27 (November, 1961), p. 11.}
\end{enumerate}