

## The “Other” Disease. Tuberculosis in the (Post-)Colonial Context

Janina KEHR

Reviewed: Christian W. McMillen, *Discovering Tuberculosis. A Global History, 1900 to the Present*, Yale University Press, 2015, \$28.00.

**Why can't we control tuberculosis? With this fundamental question, Christian McMillen's latest book shows how the flawed scientific response to the disease is tied to the Western world's colonial past and its narratives of 'sameness' v. 'otherness'.**

“Tuberculosis as an agent traverses history and human bodies, taking hold in some and leaving others in a contingent historical progression.”<sup>1</sup> With these words, Geoffrey Bowker and Susan Leigh Starr described the uneven distribution of tuberculosis among peoples across time, 15 years ago. In his brand-new book on this “ancient disease” (p.10) - *Discovering Tuberculosis. A Global History, 1900 to the Present* - Christian McMillen investigates how the uneven distribution of tuberculosis has been scientifically problematised and addressed during the last 100 years in Africa, the Americas, and India, with questionable success. McMillen's guiding question throughout the book is the following: “why can't we control TB” (p.2)? He answers it through a detailed history of failure and historical amnesia, by showing that the history of tuberculosis is in fact not marching “progressively onwards”, but that it is “an example of regression” (p.226). Throughout his book, McMillen thus demonstrates that TB has never been under control in the long 20<sup>th</sup> century, at least not in the developing world, despite on-going epidemiological, medical, pharmaceutical and policy attempts to do only this: get it under control, find its causes, treat those sickened by it, impede its transmission.

### Researching an *Other* Disease

The first part of the book, “Discovery, 1900-1945”, is written as a history of scientific controversy in regard to the epidemiology and etiology of tuberculosis among racially, ethnically or geographically *Other* populations – that is non-Western, non-White and indigenous populations – be it in North America, New Zealand or Africa. McMillen scrutinizes contrasting theories of disease causation and differential susceptibility to disease of the 1920's and 1930s, where the category of race was crucial. He notably shows that despite very little scientific evidence, and even in the total absence of any serious surveys at all, theories of differential racial susceptibility prevailed in TB research until the 1930's. This is why McMillen argues that “one of the most potent ideas regarding TB and “primitive” populations came into wide circulation when virtually nothing was known of the disease among those populations” (p. 25). The then dominant explanatory paradigm of TB research held that native or indigenous populations are more susceptible to disease due to their different biological, racial and cultural constitution from Whites, or civilized populations. As

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<sup>1</sup> G.C. Bowker et S.L. Starr, *Sorting Things Out. Classification and its Consequences* (Cambridge/Massachusetts, London/England: The MIT Press, 2000), 169.

such, it is part of much wider colonial processes of *othering*, very much present in the medical domain during these days, where native and indigenous populations were casted as substantially different and inferior to the White colonizers. As a matter of fact, TB control continues up to date to be a story of such *othering relations*, or what Nicholas King termed “geographies of difference”<sup>2</sup> : shifting and powerful relations between here and there, us and them, inferiority and superiority, susceptibility, immunity and resistance. That tuberculosis in France today is mainly framed as an immigrant’s disease is but one continuation of this geography of difference, whose start McMillen locates in the early 20<sup>th</sup> century.

In the realm of TB research, the assumption of racial susceptibility slowly declined from the 1930s onwards, even if traces persist until the present day in genetic studies. Also, ideas of social medicine, namely that TB is caused by environmental factors and living conditions, were on the rise, and finally led to a major push to act against TB in the developing countries – a push that coincided with the creation of the World Health Organization after the Second World War. It was in the 1950s thus that “the largest mass action the world has ever known against one single disease” (p. 59) began, with mass vaccination, trial and treatment campaigns on a global scale. It was the high time of “control”.

### **A Global History of Failed Control**

In the second part of the book, “Control, 1935-1975”, McMillen retraces the era of increasing global investment in the fight against TB, an era “marked both by extraordinary energy, commitment hubris, and discovery as well as disappointment, frustration, humiliation, and resignation” (p.59). Taking trials with the BCG vaccine in North America and India, as well as clinical trials with antibiotics in Kenya and India as historical examples, McMillen shows that the world of global public health became more and more fixated on technological solutions to the TB problem, and that narrow, biomedical approaches to disease control became dominant. McMillan argues that, increasingly, “techno-fixes were being offered instead of structural change” (p. 67). This critique of biomedicalised TB-control in the past resonates with critical anthropological studies in the field of global health in the present, which mourn the disinvestment in public health infrastructures in face of an increasing “pharmaceuticalisation”<sup>3</sup> of disease control since the late 1970’s, just after a worldwide Primary Health Care Movement that culminated in the [Alma Ata Declaration of 1978](#).

Throughout the second part of the book, to sum up, McMillen demonstrates through case studies of TB research and control in diverse settings and locations the contradictions and paradoxes of TB prevention and treatment, arguing that the disease became - paradoxically - more and more difficult to control during this “period of greatest scientific progress and most robust institutional engagement” (p.70), between the 1930s and the 1970s.

In the third and last part of the book, “Failure, 1975 – Present”, McMillen shows how historical amnesia regarding prevention and treatment approaches, TB/HIV co-infection and multi-resistant disease aggravated the difficulties of control, right up to the present day. Questions of cost-effectiveness came to dominate the picture of public health since the late 1970s’, and, in the case of TB, the goal was no longer to treat and prevent the diseases by any means, but to treat it as cost-effectively as possible. Tuberculosis control in the form of

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<sup>2</sup> Nicholas B. King, « Immigration, Race and Geographies of Difference in the Tuberculosis Pandemic », in *Return of the White Plague. Global Poverty and the New Tuberculosis*, edited by Matthew Gandy and Alimuddin Zumla (London: Verso Press, 2003), 39-54.

<sup>3</sup> João Biehl, « Pharmaceuticalization: AIDS Treatment and Global Health Politics », *Anthropological Quarterly* 80, n° 4 (October 2007): 1083-1126; João Guilherme Biehl and Adriana Petryna, *When People Come First: Critical Studies in Global Health*, 2013.

Directly-Observed-Treatment-Short-Course, or [DOTS](#), that is a six-month antibiotic regimen, was found to be one of the most cost-effective health programs ever, and the WHO advocated for its global use. TB became a neglected disease, and medical research was largely stopped. By the mid-1990's then, DOTS was in place. The dawning problem of TB bacteria, resistant to the antibiotic treatments, was dismissed in favor of calculations of cost-effectiveness, and so was the growing problem of TB/HIV co-infection, after some initial preoccupation with what was later termed “deadly duo”, “deadly liaison” or “perfect storm”<sup>4</sup>.

McMillen shows throughout this last part of the book, that “historical consciousness” (p. 219) regarding prior problems and approaches in TB control was almost totally absent, even more so, that TB control is a story of “remarkable historical amnesia” (p. 174). McMillen's thus concludes his dense and at times chronologies-jumping history by stating that “we've been exploring the same terrain ever since” (p. 224), that “history is repeating itself” and that “tragic repetition” (p.225) is happening over and over again. His story is one of historical loops and layers of time, of the Old and the New, distinguishable only with temporal hindsight. So when is something New, and when is it Old, and why does it matter for disease control?

### **Shock of the Old or Surprise of the New?**

„So the Old strode in disguised as the New, but it brought the New with it in its triumphal procession and presented it as the Old.“ With these words, Bertolt Brecht expressed a fundamental dilemma of modern times: only camouflaged as the New the Old receives attention, whereas the New is present where no one suspects it, where only the Old, the accustomed, and the no-longer noteworthy is perceived. In our technoscientific world, where innovation is a must in the domain of medicine, McMillen's book “Discovering Tuberculosis” shows how an “ancient disease” (p.10) – tuberculosis - recurs in new guises, yet also sinks in oblivion again and again. In light of new archival material, McMillan recounts a TB history beyond progress, a history rendered possible through the diversity of locations and archives he examines, and by the overlapping temporal chronologies he uses. Such a global, and one must add, recent history of TB control has long been overdue in a field of research, in which historians of medicine largely concluded their histories of TB with the advent of antibiotic therapy in the 1950s and 1960s, not least lead by a stubborn, or might one say, utopian belief in ultimate disease control through scientific progress. With the help of historians of medicine and especially medicine itself, TB was thus turned into what I have called a “disease without a future”<sup>5</sup> (Kehr 2012), a disease that was not supposed to persist in an ever modernizing, technoscientific, pharmaceuticalised environment, and that became uninteresting for future-driven public health. Since the 1970s, TB is thus only rarely associated with scientific novelty, with cutting edge research, with “lively capital”<sup>6</sup>, with all those aspects that make a disease interesting, attractive, profitable for medicine itself, in the past and in the present. Antibiotics, as McMillen clearly shows, provoked indeed a halt in innovation and research for new treatments. It was thus precisely new possibilities of cure through antibiotic therapy that rendered TB control even more difficult, that made TB persist and resist. It was innovation that produced regress. It was the New that conjured the Old. It was the future that revived the Past.

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<sup>4</sup> For a conceptual critique of TB/HIV co-infection, see Lukas Engelmann and Janina Kehr, « Double Trouble? Towards an Epistemology of Co-infection », *Medicine Anthropology Theory* 2, n° 1 (2015): 1-31.

<sup>5</sup> Janina Kehr, « Une maladie sans avenir. Anthropologie de la tuberculose en France et en Allemagne » (Ecole des Hautes Etudes en Sciences Sociales, 2012).

<sup>6</sup> Kaushik Sunder Rajan, ed., *Lively Capital: Biotechnologies, Ethics, and Governance in Global Markets* (Duke University Press, 2012).

But what, then, is the future of global TB control? Diseases without a future, like tuberculosis, can only exist as revenants. They haunt modern medicine, public health and their histories, camouflaged in new guises and old costumes. Yet ultra-resistant TB bacteria, albeit an old problem, are about to propel new scientific – and potentially profitable – research and investment, with new global health initiatives and actors like the TB Alliance or the Bill and Melinda Gates Foundation. Old problems like antibiotic resistance might thus well be the future for a disease without a future. But are today's ultra- and multi-resistant diseases really only camouflaged versions of the Old TB – disguised as the New? One way or the other, epidemic revenants, like TB, are not only to be seen as testimonies of failure and looping effects. They are also epistemic lenses that allow to grasp the absurdities, incongruities and inequalities of modern disease control, their productivities and blind-spots, that are and can be understood, to be sure, but that are also actively forgotten again and again.

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