Clark, H.-L. (2013) Civilization and syphilization: a doctor and his disease in colonial Morocco. *Bulletin of the History of Medicine*, 87(1), pp. 86-114.

(doi: [10.1353/bhm.2013.0003](https://doi.org/10.1353/bhm.2013.0003))

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Deposited on: 18 February 2022

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Civilization and Syphilization: a Doctor and his Disease in Colonial Morocco

Hannah-Louise Clark

Abstract

In colonial North Africa a mutilating disease resembling syphilis was a focal point for French medical debate about the world history of syphilis, the physiological effects of climate and race, and the science of microbiology. From 1916 to 1919, the French venereologist Georges Lacapère established a pilot scheme in Fez, Morocco, for diagnosis and treatment of "native" syphilis. In 1923 he published his research findings and coined the disease concept "Arab syphilis" to describe a form of syphilis found in Morocco, Algeria and Tunisia, which he characterized in behavioral terms. Lacapère's work was not simply derivative of earlier discourses, nor was it a straightforward outcome of his clinical experience in Morocco. The careers of Lacapère and Arab syphilis problematize the analytical use of race to understand colonial medicine in the Maghreb.

Keywords:

Syphilis, Morocco, colonialism, civilization, behavior, race

From the military occupation of Morocco and the imposition of a French Protectorate in 1912, French physicians who traveled and worked in the country marveled at the frequency and

severity of syphilis,¹ describing it as the quintessential Moroccan pathology.² In 1923, Georges Lacapère, a French venereologist who had spent three years directing a syphilis clinic in Fez, published research in which he argued for the existence of a distinct form of syphilis throughout Morocco, Algeria and Tunisia: a disease he called “Arab syphilis.”

This article studies two colonial careers: that of Georges Lacapère, and the disease concept articulated in his monograph *La Syphilis arabe: Maroc, Algérie, Tunisie*.³ It situates Lacapère’s ideas within the professional, intellectual and colonial milieus in which he operated, and shows the ways in which his work acquired traction among contemporaries. In exploring the fortunes of a doctor and his disease concept, and undertaking a close reading of his medical writings, the article provides insight into broader historical questions concerning the production of biomedical knowledge, understandings of race, and approaches to colonialism during the first decades of the twentieth century.

Historians of medicine have tended to emphasize the connections between syphilis and social constructions of sexuality, gender, and class or racial difference. Extant scholarship on syphilis in imperial settings has shown how this disease acted as a lightning rod for anxieties about colonial control – notably of interracial sexual contacts – and for the application and production of stereotypes of colonial subject peoples.⁴ Certainly, such interpretative emphases can be placed on Lacapère’s work, which abounds with references to Moroccan sexuality and family life. Racial issues are proclaimed in the very title of the book. However, this approach would not exhaust the intellectual or discursive content of *La Syphilis arabe*.

Lacapère’s principal text is complex and at times contradictory, but in essence argued that the Arabness of Arab syphilis inhered not in essential biological differences – whether

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between human races, or between microbial strains – but in the transformative effects of civilization on the individual. Lacapère suggested that Arab syphilization was intimately connected with cultural habits. His approach rested on a confluence of clinical research, the bacteriological laboratory, neo-Lamarckian inheritance, a social hygienist perspective, and assumptions about the pathology of modern life, exemplifying what Gaudillière and Löwy term “the incomplete bacteriological revolution.”⁵ This article aims to explicate Lacapère’s intervention, giving particular attention to the meaning of “race” at play in his writings. If scientific racism found blatant expression in some elements of French medicine in twentieth-century North Africa, as described, for example, in Richard Keller’s intellectual history of the Algiers School of Psychiatry,⁶ the case of Arab syphilis evinces that difference could be understood in other, more idiosyncratic, terms.

The first part of this article follows Lacapère’s career from its early stages in Paris, to his professional and scientific experiences in Fez. Evidence for this latter phase is drawn from scientific publications, as well as correspondence between Lacapère, his colleagues, and Resident-General Louis-Hubert Lyautey (colonial administrator of Morocco from 1912 to 1925), to describe the daily running of the syphilis clinic and Lacapère’s methods of research, diagnosis and treatment. The metropolitan, colonial, and wartime contexts of Lacapère’s study go a long way towards explaining the disease model he developed. Once repatriated in 1919, Lacapère continued to collect data and organized his findings into monograph form. The second part of this article explores in depth the intellectual basis of Arab syphilis, examining the reception of the book and its thesis in medical circles at home and abroad. The article concludes by analyzing

the repercussions of Arab syphilis for contemporaries' beliefs about France's civilizing mission, and for our understanding of the colonial project in Morocco.

Early Influences: Paris and Prison

Lacapère began his medical career in Paris, qualifying as *médecin des hôpitaux* in 1898. He specialized in dermatology and its subfield venereology, acquiring experience as *chef de clinique* to Alfred Fournier at the Hôpital Saint-Louis, a Paris institution long associated with the study of skin diseases. Fournier was a giant in the field of French venereology.⁷ Under his direction, the Saint-Louis became the pre-eminent French hospital for research and treatment of venereal diseases, boasting 1,000 beds and 11,000 consultations in 1900, as well as an extensive teaching collection of waxworks and photographs.⁸

Lacapère's training amidst these unparalleled resources led him to understand syphilis principally as a sexually transmitted infection, with three discrete stages. After infection, a painless chancre would incubate and take form, typically in the genital area. In the secondary phase, some five to six weeks later, the "poison" spread throughout the body, causing headaches, rashes, and mucous lesions. The disease could then lie dormant for an indefinite period of time. The appearance of chronic inflammation and tumors after a period of latency indicated the tertiary stage. In its most nefarious complications, tertiary syphilis affected the cardiovascular and central nervous systems.⁹ A clinical concept introduced by Fournier was of particular relevance to Lacapère's understanding of syphilis: "parasyphilis," a condition that covered a range of disorders linked statistically to syphilis, including General Paralysis and Tabes. These

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phenomena received considerable attention in *La Syphilis arabe*, and Fournier's *Traité de la syphilis* was the touchstone for Lacapère's analysis.

In 1903, Lacapère joined the Paris faculty, delivering lectures for a practical course on syphilis and other skin diseases.¹⁰ But the diagnostic and therapeutic basics covered by the course were in flux. In the wake of Pasteur's and Koch's work on germ theory, venereologists had shown enthusiasm for a microbial origin of syphilis infection, but found experimental proof wanting: it had proved impossible to culture the organism, bacteriologists had failed to inoculate animals, and nineteenth-century microscopes and stains were insufficiently powerful to reveal the germ. In 1905, the zoologist Fritz Schaudinn was able to observe the bacterial agent of syphilis under the lens of a dark-field microscope; the organism, a tiny, motile spirochete, was given the binominal label *Treponema pallidum*. In 1909, the bacteriologist Paul Ehrlich and his collaborator Sahachiro Hata derived a compound of arsenic effective against *Treponema pallidum*: Arsphenamine, registered under the trade name "Salvarsan" in 1910. Whereas existing mercury treatments only slowed spirochetes down and were noxious to the patient, Salvarsan appeared to eradicate them.

During this decade of rapid transformation in his field, Lacapère worked as consulting physician at the Prison-Hospital Saint-Lazare in Paris, where women registered or operating clandestinely as sex workers were incarcerated by the city vice squad, and forced to undergo treatment – typically with mercury and potassium iodide – if infected with venereal disease.¹¹ At the Saint-Lazare, Lacapère had the opportunity to use arsenic therapies. He became an early champion of Salvarsan and its later, less toxic iterations, Neosalvarsan and Novarsenobenzol, publishing on techniques and methods of administration and potential side effects, and

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publicizing his support for this “modern treatment” internationally in medical journals and speaking engagements.¹²

Lacapère’s experience with the drug may explain his wartime mobilization to Morocco in 1916 at the personal request of Lyautey, who charged him with running the first “anti-syphilis” clinic for Moroccans and building a network of clinics throughout the protectorate. The Resident-General believed medical aid would pacify Morocco, and handpicked a small cadre of Parisian experts to organize a health service for Moroccans.¹³ In addition to Lacapère, Lyautey recruited specialists in general medicine, radiology, bacteriology, malaria, otorhinolaryngology and psychiatry.¹⁴ However, Lacapère’s appointment was the most critical. France was at war, and statistics gathered on North African troops stationed at the Front showed high levels of tertiary syphilis infection.¹⁵ North Africa was a reservoir for military enlistment, and yet many potential recruits were found to be syphilitics, unfit for service: there was an urgent need to establish protocols for the treatment and control of syphilis. Lacapère’s professional duties included lecturing to troops stationed in the region, as well as inspecting the health of new recruits to the Fez *tabor* (battalion). Evidently, Lacapère’s research into Arab syphilis was inspired and made possible by the circumstances of war, which provided him with a research opportunity and ample clinical material.¹⁶

Lyautey’s specialists were encouraged to “be thirty years ahead of [their] time,” the avant-garde of biomedicine in the colony.¹⁷ Lacapère, like other French medical personnel in Morocco, was free to organize treatments as he saw fit, and his experiences with Salvarsan made him the ideal choice for Lyautey.¹⁸ But while Lacapère brought the scientific solutions of microbiology and pioneering arsenic therapies to Morocco, his understanding of Arab syphilis

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also imported metropolitan attitudes of the day. In Europe, anxieties about the “venereal peril” had reached fever pitch by the early decades of the twentieth century. Originally perceived as an urban and industrial phenomenon, syphilis was feared to be infiltrating all levels of French society, a trend accelerated by the number of soldiers infected during the Great War. The Third Republic’s main solution was to issue stern public health warnings to troops, and to police and medicalize prostitution. Given Lacapère’s background at the Saint-Lazare, it is unsurprising that his writings expressed concern for sexuality and the regulation of prostitution in Morocco, although a separate clinic for *filles soumises* operated in Fez, where Lacapère rarely ventured.

Morality and military hygiene were not the only influences on Lacapère’s approach to syphilis in Morocco. Also pertinent to his disease model were what Rosenberg has termed “pathologies of progress:” the fear that the growth of urban, industrial society was inimical to a healthy body and mind.¹⁹ The menace of modernity to mental life was typified in George Beard’s theory of neurasthenia,²⁰ and in Richard von Krafft-Ebing’s famous description of general paralysis as the product of “civilization and syphilization.”²¹ Historians of French imperial ideology have explored the moral and material aspects of the *mission civilisatrice*, equating to the *mise en valeur* of colonial populations, exploitation of natural resources, and the march of modern infrastructure and commerce.²² Yet it is the pathological, not the productive, powers of civilization and their ability to transform the individual’s susceptibility to disease that are hinted at in *La Syphilis arabe*.²³

Overseas Experience: Fez and its Clinic

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Unlike many doctors, sociologists or ethnographers who participated in creating the technical and conceptual structures of Protectorate rule in Morocco, Lacapère did not have prior experience in Algeria. He knew no local languages and was unfamiliar with North African societies. His expectations were formed by his military superior, Resident-General Lyautey, whose policies in Morocco were forged by pragmatism and defined against a negative understanding of recent Algerian history. In Lyautey's mind, military conquest in Morocco would go hand in hand with humanitarian assistance; development was to be kept out of the hands of rapacious European settlers; and the French would rule by coopting existing elites. Above all, Lyautey's approach was characterized by reverence for "traditional Morocco" – a politically loaded concept that comprised everything from customary law and urban design, to architectural motifs and artisanal practices – and for parallel but distinct paths of modernization for Moroccans and Europeans.²⁴

The site for Lacapère's clinic was the city of Fez, Morocco's capital until the French conquest. When Lacapère arrived in 1916, Fez was inhabited by 95,000 Muslims, 10,000 Jews and a negligible European population.²⁵ Lacapère's patients were 95 per cent Muslim, since the Jewish community had its own dispensary.²⁶ He commented on the social practices of Muslims in the city: "Fez is the religious city *par excellence*, and one might say that all its inhabitants observe rigorously the prescriptions of Qur'anic Law."²⁷ He was led to believe that Moroccans were "much more faithful to the principles of the Muslim religion" than their co-religionists in Algeria and Tunisia,²⁸ and was astonished by the severity of fasting during Ramadan.²⁹ Yet the stability enjoyed by this bastion of religious learning and tradition was deceptive. Colonial expansion into the countryside, land expropriation, ongoing guerilla warfare in hinterland of Fez,

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and urbanization, particularly along the Atlantic seaboard, were disrupting traditional forms of existence and driving rural migrants – and their diseases – to Morocco’s cities.³⁰ The city of Fez alone had a transient population of 15,000 in 1918, many of whom lived in makeshift camps.³¹

A building owned by the influential Moroccan notable and collaborator, T’hami al-Glaoui, was made available for use as a clinic. The facility was equipped with an x-ray machine and a laboratory, where Lacapère could examine syphilitic material and conduct serological testing using the Bordet-Wassermann reaction. The reaction, a complement-fixation test invented by Jules Bordet in 1901 and applied by August Wassermann in 1906 to the diagnosis of syphilis, was essential to Lacapère’s diagnostic armory;³² indeed, this serological test formed part of laboratory routine for dispensaries throughout Morocco and the world for several generations of doctors. The central clinic was supported by a network of infirmaries and mobile clinics in the hinterland of Fez, a model that Lacapère extended to Tanger, Rabat and Marrakech.³³ Lacapère himself conducted a mission to the Atlas and Sous mountains in 1918.³⁴

Fez had a recent history of violence against doctors: the city submitted to the French in 1912 only after riots, in which the French Hôpital Murat was attacked and resident Europeans had to barricade themselves inside.³⁵ Yet according to Lacapère and his assistant Laurent, unfortunate locals were more than willing to seek treatment at clinic Dar el-Glaoui, which was lodged within the city walls in “*plein milieu indigène*.”³⁶ All treatment was offered free of charge on an outpatient basis;³⁷ on occasion, Lacapère also performed out-of-hours home visits to women and children.³⁸ In total, Lacapère documented that between July 1, 1916 and February 15, 1919 he examined and treated 3,000 patients. *La Syphilis arabe* included details of an additional 10,982 consultations given by his successors Decrop and Salle from February 15,

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1919 to December 1, 1923.³⁹ Clearly, the clinic gained in popularity over time, as word spread about the services offered there. So great was enthusiasm for treatment at Dar el-Glaoui that the words for “injection” (*huqn*) and “Novar” (an abbreviation of Novarsenobenzol) became interchangeable in the local dialect.⁴⁰ Instances where Lacapère was granted access to homes, and the relatively high proportion of women patients at the clinic (34 percent of all consultations), further attest to a high degree of interest in the services he provided.⁴¹

Though crowds did attend, Lacapère noted that the majority of patients resorted to the clinic only “after exhausting their own treatments,”⁴² which he claimed were limited to thermal baths and applications of earth, camel dung and cabbage leaves.⁴³ A colleague in Fez, Dr Lapin, attributed locals’ reluctance to seek treatment at his tuberculosis clinic to fatalism and mistrust.⁴⁴ Lacapère offered more concrete reasons for patients’ delay: the fever, headaches, and anemia symptomatic of early syphilis were easily mistaken for more commonplace afflictions, such as malaria, which was endemic to the region.⁴⁵ People were disinclined to put aside their work for such trifles, and it was only when lesions became so severe that they compromised activities of daily living that sufferers presented “without delay” at his clinic.⁴⁶ As the sick would not always come to him of their own accord, Lacapère decided to go to them. He conducted his own statistical research, systematically tracking down syphilitics among patients at other Fez dispensaries and subjecting them to clinical, verbal and serological examination.⁴⁷ He also examined 272 children in the two Franco-Arab schools of Fez.⁴⁸

Since Lacapère spoke no Arabic, he relied on North African assistants to facilitate his work. Despite their translations, he remained linguistically challenged. For instance, *La Syphilis arabe* includes a short lexicon of disease names used by the major religious and ethnic groups in

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Fez. To their users, these names corresponded to separate illnesses, rather than discrete phases of the same infection. Moroccans with previous exposure to French medicine might call primary syphilis “*changher*” (chancre) if they identified it at all; secondary and tertiary syphilis were “*en-nouar*” (flowers), and occasionally “*mrd el-kbir*” (the “great disease”) among Arabic-speakers; “*Tafôuri*” was current among the Chleuh Berbers (meaning pustule, although Lacapère gave no translation); and Jewish inhabitants of Fez spoke of mouth ulcers as “*harr*” (hot) and syphilis as “*mrd al-fssad*, disease of the vaccine [sic]”.⁴⁹ “It seems that a confusion has arisen among them,” he went on to say, “between the pox and smallpox.” On reading this, two scholars from the Institut des Hautes-Études Marocaines declared they “did not know from where M. Lacapère has taken this intelligence,” pointing out that Lacapère had confused the Arabic sibilant *sin* with the emphatic sibilant *sad*, leading him to misread “disease of debauchery” as “disease of vaccination.”⁵⁰ This confusion is hugely significant, as it belies the claim made by Lacapère that Moroccans did not look upon syphilis as a sexually transmitted illness.⁵¹

Lacapère’s communication problems are also suggested by his ignorance of local medical traditions, and his continual references to the imprecision of his patients’ medical histories. Witness, for example, his astonishment that “only after first consultation with the doctor does the native learn the name of his illness,”⁵² or that patients could not date the onset of their affliction precisely: “‘It was the year it rained a lot,’ responds one; ‘It was in the time of Abd-el-Aziz,’ replies another.”⁵³ In fact, rainfall levels were of critical importance to an agrarian society that experienced frequent drought-related famines, and tying an event to weather conditions or an important power broker was a culturally legible technique of marking time.⁵⁴ These patients were able to date their infections with a fair degree of precision, but their accounts were

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incommensurable with Lacapère's calendrical notion of time. This style of dismissing patients' testimonies was not unique to Lacapère, or even to colonial medical encounters. Behind his frustration lurked the unreasonable expectation that local people should appreciate a medical specialization of which most French doctors were largely ignorant.

Foreign Bodies: Patients and Microbes

As a military doctor in the Armée d'Afrique, Lacapère had experience dealing with colonial troops, but the Fassi patriarchs, mothers, black slaves and children who attended his clinic were novel clinical subjects. He discovered that syphilis in Fez infected a distinct demographic, and differed in morphology, from cases in France. His patients were "almost always" prepubescent children.⁵⁵ Lacapère paid particular attention to patients' skin tones – describing individual Moroccans as "fair," "as white as a European," "bronze," "coffee-colored," "dark," "black" – and the distinct appearance this gave their condition.

More significantly, in Fez, patients' symptoms forced Lacapère to rethink the semiology and nosology with which he apprehended syphilis in Europeans. Instances of primary and secondary lesions in Moroccan Muslims and "less-Europeanized Jews" were rare, or passed unnoticed.⁵⁶ The few primary lesions he did examine were frequently non-genital in origin.⁵⁷ The secondary and tertiary stages of syphilis appeared to blend into each other,⁵⁸ as lesions underwent myriad modifications, and even formed on the scar tissue of older lesions.⁵⁹ One striking feature of his patients' syphilis was the absence of psychiatric problems: Fournier had detected parasymphilis among 30 percent of tertiary syphilitics; Lacapère in only 4.5 percent of cases.⁶⁰ Whereas the spirochetes of untreated Europeans with late stage syphilis attacked the

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viscera and nervous system, in Moroccans the infectious agent penetrated even deeper into the skin.

Each chapter of *La Syphilis arabe* related in detail the extraordinary mutilating, monstrous effects of Arab syphilis, which included lesions whose size, form, frequency, and gravity were unlike anything Lacapère had seen in Europe: echthymatous and rupioid syphilis; vegetative and cheloidian lesions; verrucous and papillomatous nodules; and infiltration and atrophy of osseous tissue and bones by gummata. Lesions of the upper respiratory tract were particularly common among North African syphilitics;⁶¹ gummata of the vocal cords and build-up of scar tissue in the larynx could lead to voice loss and even slow suffocation.⁶² But the most visibly distressing deformities involved the extension of mucocutaneous lesions at the borders of the nose and mouth into the nasopharyngeal mucous membranes: following bacterial superinfection, the nose itself collapsed and ulceration consumed the entire face. Dr Decrop, who also worked at the clinic, recorded that,

The procession of the sick, crossing the Medina from the Hospital Cocard to the Dar-el-Glaoui Clinic in order to be treated there, was a scheduled attraction... that the tourists... would never forget: twice a week, some on foot, others on mules or small donkeys, the long caravan would slowly move along, [the sick] poorly hiding under dirty rags the ulcers on their legs and their hideous masks eaten away by syphilis of the face. It was a tableau worthy of Goya.⁶³

Lacapère's clinical gaze had been well trained at elite institutions in France, but in Fez he had to learn to see differently. Initially, he overlooked signs of syphilis that diverged from his European casework.⁶⁴ As he acquired more experience at the clinic, he perceived that the bodies

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of his Moroccan patients were palimpsests of lesions, scars, and traces of disease and physical debility.⁶⁵

Why did the same infection express itself so differently in Europeans and Arabs, or, indeed, Arabs, Berbers and Jews? This problem had motivated a succession of nineteenth- and early twentieth-century researchers throughout the imperial world. Observers of “native” or “exotic” syphilis debated whether it was the virulence of the *graine* (seed, that is, agent of syphilis) or the receptivity of the *terrain* (soil, or individual constitution) that was responsible. The footnotes to *La Syphilis arabe* reference more than forty authors whose special focus was syphilis in North Africa alone.⁶⁶ In particular, Lacapère referred to the work of nineteenth-century physicians at the *Clinique des maladies des pays chauds et des maladies syphilitiques et cutanées* at the Algiers’ medical school.⁶⁷ The name of this clinic gives some clue to the orientation of much of its research: a warm climate was understood to favor the different localization of syphilis in “natives”. Indeed, when Lacapère was a young lecturer, the standard textbook on exotic dermatology in use by Paris faculty, Edouard Jeanselme’s *Cours de dermatologie exotique*, attributed different expressions of disease to the influence of race and climate.⁶⁸ Other specialists broke with climatological explanations and looked to the rising science of microbiology for answers. One author referenced – and refuted – by Lacapère was Alphonse Gemy, Chair of Dermatology at the Algiers’ medical school in the late nineteenth century.⁶⁹ Although Gemy was writing before the identification of the bacterial agent of syphilis, he supported the “parasitic theory” of infection.⁷⁰ Evoking the Pasteurian research program into the virus-vaccin, Gemy argued that the habitual application of mercury in European cases of syphilis had attenuated the virus⁷¹ in the body, weakening the disease agent over

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generations. In contrast, Arabs left their syphilis untreated, and so their *graine* was more potent.⁷²

Advances in laboratory techniques took these debates to a new level. Morel-Lavallée proposed the notion of a “neurotropic” form of syphilis in 1889, a theory given further weight in 1914 by experimental studies on rabbits conducted by Pasteurians Levaditi and Marie. These researchers suggested that the differences between exotic and European syphilis could be explained by the existence of multiple strains or “races” of virus with distinct tissual affinities: the neutrotrope and dermatrope.⁷³ According to this argument, if Arab syphilis did not affect the cerebrospinal axis, it was simply because it was caused by a dermatropic virus. But Lacapère disagreed: according to Maître Fournier there was one syphilis virus; it had to be the individual sufferer that determined the kind of infection. How else could the dualists explain the many cases in which Europeans developed neural complications with syphilis caught from “native” women?⁷⁴ *La Syphilis arabe*, along with Lacapère’s other writings, rejected a biological basis for variation, and was a check to Pasteurians, subordinating laboratory experiment to clinical observation.⁷⁵

Like the majority of French doctors in Morocco, Lacapère suspected that male and female prostitution was at the root of the problem of Arab syphilis – unsurprising, given his professional background – though he did not explain how this claim might sit with rigorous observance of “the prescriptions of Qur’anic law.” In *La Syphilis arabe* and a 1917 article in *Annales des maladies vénériennes* he estimated the number of sex workers in Fez at two to three thousand (for a population of approximately 100,000);⁷⁶ in 1918, he grossly inflated these figures for the polite readership of *France-Maroc*, a monthly magazine for affluent pro-colonial

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businessmen and their wives, claiming that “the number of prostitutes has reached almost ten thousand, and among these one can consider the percentage with syphilis to be 100 percent.”⁷⁷

However, the early age of most victims was a challenge to the diagnosis of venereal syphilis. Lacapère realised that the infections he treated frequently appeared to be non-genital in origin.⁷⁸ How then was the disease transmitted? Lacapère set about solving this riddle with labwork and fieldwork. He and Laurent spent long hours in the clinic laboratory, in an attempt to discover whether mosquitoes could transmit the treponema: perhaps a reflection of the interest in insect-transmitted diseases generated by Manson’s and Ross’ discoveries concerning filariasis and malaria. Lacapère described how they attempted to introduce the *Treponema* into the proboscis of mosquitos:

We gathered chancrous material which microscopic examination had shown [to contain] numerous treponemas. We soaked the parasites [sic] in it for several hours, and then we washed and crushed them, after which we inspected them under the ultra-microscope to see if it was possible to discover a few treponema that these parasites [sic] might have absorbed. We were not able to detect a single one.⁷⁹

This hypothesis overturned, Lacapère took to the alleyways of Fez and scrutinized local behaviours. He concluded that a number of activities could “open the door for the virus:” visits to the barber (historically a vector of disease in Europe), who also carried out minor surgeries and blood-letting;⁸⁰ the male practice of shaving the genital area, typically carried out with a borrowed razor and insufficient lathering;⁸¹ the use of unsanitized instruments for circumcision, tattooing, scarification, and tooth extraction; arm-to-arm vaccination; and shared use of

contaminated drinking vessels, water pipes, chewing gum and cigarettes.⁸² In sum, the potential for contagion was found in the most mundane Moroccan daily practices.

Arab Syphilis: Diagnostic Tool and Disease Concept

Lacapère viewed his time in Fez as a research and career opportunity. This is evident from the way he coordinated the collection of data from colleagues in Fez and throughout North Africa after his departure from Morocco, publishing *La Syphilis arabe* in 1923. Awarded the Académie de Médecine's Prix Ricord, the highest honour for a French venereologist, this treatise of 492 pages and 77 photographic plates was the first pan-Maghribi specialist medical text. It opened with a description of the cultural context for Lacapère's researches and followed with chapters on vectors of transmission and the distinctive appearance of Arab syphilis, whose horrors were catalogued in more than 100 easily referenced clinical diagnoses, illustrated graphically by photographs of patients and pen and ink drawings of skin tissue under magnification.

In publishing *La Syphilis arabe*, Lacapère was also following the orders of his military superior, Resident-General Lyautey. Lacapère had been transferred to Morocco to establish a pilot scheme for diagnosis and treatment of "native" syphilis. Along with a network of clinics and mobile sanitary units, this volume was part of his legacy: a diagnostic aid addressed at inexperienced French physicians who would staff "native" infirmaries throughout Morocco.⁸³ A reviewer for the Protectorate's medical journal, *Maroc Médical*, hailed the work as the "ABC" of African syphilis, the "breviary" that would be consulted daily.⁸⁴

What defined syphilis as an Arab disease? Lacapère's serological research contributed to his certainty that syphilis was an Arab affliction. Though many patients denied having the

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symptoms of syphilis, and in nine out of ten samples of syphilitic material he was unable to see treponemes under his ultra-microscope, the test almost always gave a positive result.⁸⁵ Just as in Europe, the use of serum diagnosis in Morocco appeared to reveal the extent to which asymptomatic syphilis was latent among the population. In retrospect, this certainty was ill-founded: in the years following the development of the Bordet-Wassermann reaction, some observers demonstrated that the test was highly uncertain, and that it was possible for an infected individual to produce no reaction or for a successfully treated individual to continue to produce a reaction.⁸⁶ Furthermore, it was recognized that other diseases, including malaria, leprosy, and tuberculosis, could produce a false positive.⁸⁷ Nonetheless, the test led Lacapère to assert that at least 70 to 75 percent of the population in Fez and its surrounding region – perhaps as many as 90 percent – were infected with syphilis.⁸⁸ It was no wonder that he considered syphilis to be an “Arab” disease.

But why did Lacapère identify syphilis in North Africa as “Arab,” rather than “Berber,” the other major ethnolinguistic group in the region? Historians of the Maghrib refer to the apparatus of knowledge with which the French interpreted North African societies as a “colonial vulgate,” a key component of which were racial and cultural divisions drawn between Arabs and Berbers.⁸⁹ Lacapère was not sufficiently immersed in its rubrics to be making an argument based on these supposed distinctions. In fact, whereas precursors to Lacapère had sought to identify the effects of race and ethnicity on disease, Lacapère dismissed their influence. While skin tone might affect the basic appearance of syphilitic lesions, biological difference between races, he said, could explain nothing “in a people like the Arab people, composed of an infinity of very diverse races:”⁹⁰ “Arabs, Berbers, Moors, Jews, Mozabite, and Negroes from the Sudan.”⁹¹

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Lacapère was not denying the existence of race, but he was disputing its power to determine disease morbidity. Syphilis in Morocco was Arab rather than Berber because it was fostered by risky behaviors that originated in Arab urban culture.⁹² But culture wasn't only a vector for the disease: Lacapère also argued that culture had a mediating effect on the individual organism. Lacapère judged that Arab syphilis was a purer form of the disease; untreated Moroccan lesions allowed the viewer to travel back in time to "French syphilis of the Middle Ages."⁹³ As he elaborated his explanation, the qualifying adjective "Arab" then slipped to that of "Muslim." The mutilating effects of Arab syphilis were due to the physiology of Moroccan Muslims, which differed from Europeans not because of race, but because of their lifestyle. These differences took three major forms: malaria, alcohol, and mental activity.

In common with earlier theorists of "exotic" or "native" syphilis, Lacapère hypothesized that the frequency of malaria among North African populations was a major cause of the malignity of Arab syphilis. Malaria resulted in anemia and arterial hypotension. The decrease in blood pressure prevented the circulatory system from transporting sufficient nutrients to skin tissue, which thus became more susceptible to infection and necrosis.⁹⁴ In Lacapère's catchy phrase, "hypotension brings necrosis, hypertension brings sclerosis."⁹⁵ Ironically, at the same time that Lacapère was attributing disfiguring lesions to malaria, contemporaries were championing its use to treat syphilis, following pioneering research by the Austrian neurosyphilis specialist Julius Wagner-Jauregg.⁹⁶

Although *La Syphilis arabe* focused on the Fez clinic and its Moroccan context, it was a comparative work incorporating data from Tunisia and Algeria. Lacapère argued that the devotion of Moroccan Muslims to their faith and to Islam's prohibition of alcohol also

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contributed to hypotension. Algerian Muslims and Jews were in closer contact with Europeans politically, especially in the cities, and shared a fondness for alcoholic drinks: their syphilis had more in common with the European.⁹⁷ Lacapère was not alone in identifying the transformative influence of alcoholic spirits on North African minds and bodies. The ravages caused by alcohol were a recurring theme in the colonial press as well as a major medical and imperial preoccupation. In Algeria, journalists joked of “assimilation by alcohol” and expressed concern that drinking was the only aspect of French civilization that North Africans had willingly embraced.⁹⁸ Once Morocco was given protectorate status, a low tax threshold on imported spirits from France led to a surge in consumption of hard liquor. A *dahir* (decree) banning the import, manufacture, circulation, sale and possession of absinthe was passed in 1914, and higher taxes placed on spirits, but alcohol consumption was still perceived as a problem, as indicated by Lacapère.⁹⁹

In addition to the influence of disease and spirits, Lacapère invoked general civilizational differences to explain North Africans’ apparent immunity to afflictions of the central nervous system. Childhood acquisition of syphilis protected Moroccans from neural lesions, because childhood was a period during which the brain was at rest. He explained that adult North Africans who acquired the infection were spared nervous system involvement because, in terms of social organization, they were not at an evolutionary stage at which such lesions could exist. Beyond the “most simple commercial transactions and... the study of the Qur’an; the native exercises only his memory which is, of all the intellectual faculties, that which functions the most automatically and with the least cerebral effort.”¹⁰⁰ To support his claims, Lacapère drew upon the opinions of Antoine Porot, Head of the School of Psychiatry at the University of

Algiers: according to Porot, the emotional and affective life of Arabs was minimal, and their capacity for empathy limited, thereby decreasing incidences of cerebral excitement that predisposed an individual to nervous syphilis.¹⁰¹ This hypothesis was confirmed for Lacapère by cases in which Algerians had developed neurological complications: these patients were reported to be inveterate drunkards and literate in French, evidence of their hypertension and mental excitement.¹⁰² Back in France, a discourse of civilization and its discontents attributed neurasthenia, hysteria, and other mental maladies to modern living. In contrast, Morocco's pre-modern condition was evident from both the structure and symptoms of its syphilis.¹⁰³

Postscripts: Lacapère and Arab syphilis

Lacapère was quick to trumpet his success in *La Syphilis arabe*, claiming that gruesome lesions responded dramatically to treatment in eighty percent of consultations.¹⁰⁴ On Lacapère's return to France, his publication of a separate textbook on arsenotherapy, injection regimes and doses, as well as his contributions to medical journals in France and Morocco, make clear that Fez and its treatment-naïve population provided him with a valuable testing ground.¹⁰⁵ But Lacapère's research, as well as the experiences of contemporaries, showed that these drugs were no magic bullet. Although they were effective against the spirochete, they caused adverse effects in the patient, organ damage in particular, and a long course of treatment was required to prevent the patient from relapsing.¹⁰⁶ Lacapère gave limited coverage of these problems in *La Syphilis arabe*. Instead, he excused failure and remission with classic tropes: the "natives" were negligent, ignorant, and failed to persevere with treatment. Their apathy, he argued, was based on the realization that "this disease is almost inevitable."¹⁰⁷

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Not only did Lacapère remain silent about therapeutic failures, his publications also glossed over the administrative challenges he faced. Yet official correspondence makes clear that many of the limitations of the syphilis campaign in Fez were not due to patients, but to the administrative and financial chaos of the Protectorate health service. In June of 1919, Lacapère met with Lyautey and expressed concern that the military leadership's cronyism, inefficiency and dismissive attitude towards specialization would derail his program of research and the treatment program he had established in Morocco. That same year, he and Laurent penned searing critiques of the *Assistance indigène*'s management: "'Be thirty years in advance!'" Laurent scoffed, "[Dr Mauran] has done almost nothing for the native hospitals, and the little he has done is based on examples of the last century."¹⁰⁸ The colleagues emphasized a lack of long-term planning, scant equipment, and poor working conditions. Doctors were singlehandedly responsible for every detail of the running of clinics and hospitals: the wards, surgery, and pharmacy, to say nothing of tasks for which they had no talent or training, such as human resources, laundry and accounts.¹⁰⁹ It emerged that Lacapère, mystified by bookkeeping, had inadvertently overpaid for supplies of arsenic therapies while in Fez, spending at least fifty percent more than the military pharmacy because of lack of oversight.¹¹⁰

Lacapère and his colleague intended to make public their views on the military mismanagement of the health service. However, Laurent was asked to withdraw an unfavorable journal article before it went to the typesetters, and Alphonse Mauté, Lyautey's chief consultant on general medicine, pressured Lacapère into silence.¹¹¹ Their complaints, expressed privately to Lyautey, point not only to familiar tensions between military and civilian actors in empire, but also to the managerial, material, and scientific challenges presented by an ambitious program of

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disease management that brought the most modern treatments and techniques to bear on the problem of syphilis, without the basic infrastructure to serve the needs of the communities it targeted. Historians of medicine in colonial contexts routinely draw attention to sins of omission and commission on the part of colonial health care interventions. The above episode makes clear that the failure of the *Assistance Indigène* to live up to Lyautey's rhetoric was not lost on colonial agents such as Lacapère.

After his departure from Fez in 1919, Lacapère held no further responsibilities in the Moroccan health service. Lyautey had invited him and other wartime specialists to remain connected to the Protectorate through the work of an advisory board, the Comité Technique Médical du Maroc, but it is likely that Lacapère's contempt for the leadership of the health service made attending committee meetings an unattractive prospect.¹¹² However, the publication of *La Syphilis arabe* shows his commitment to the syphilis mission in Morocco, as well as concern for professional recognition. *La Syphilis arabe* was a practical manual that, in tandem with a technical handbook authored by Lacapère on use of the Wassermann reaction and arsenic therapies,¹¹³ would equip doctors with the necessary diagnostic and therapeutic tools to treat the "uncivilized" syphilis of North African populations. His careful classification of the signs of Arab syphilis and exposition of differences between European and Arab forms would permit readers to convert the Eurocentric nosology of their training into locally relevant knowledge.

To Lacapère, Arab syphilis was untreated venereal syphilis under the influence of behavior and other diseases, but his thesis did not end the debate on "native" syphilis. Indeed, one aspect of *La Syphilis arabe* highly valued by specialists – its comparative data, notably

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statistics on neurosyphilis – also drew the most criticism.¹¹⁴ Nonetheless Lacapère’s interpretation, and ghoulish photographs of his patients, continued to attract attention in journal articles and university theses throughout French North Africa and the metropole over the next thirty years. But by the 1940s and 50s, an increasing number of psychiatrists and physicians found fault with the widely held belief that neurosyphilis was absent in Arabs. Writing of Algeria, Drs Marill, Porot, and Bardenat suggested that medical and mental health facilities available to North Africans were so inadequate and medical examinations so cursory that any argument based on them was meaningless: “We lack the data to generate valid statistics and, in particular, the absence of psychiatric services and asylums in Algeria does not allow for the gathering of patients necessary for an effective survey.”¹¹⁵

If the appearance of Algerian research in the *Bulletin de l’Institut d’Hygiène du Maroc* gave Lacapère’s successors pause for thought, the dissemination of findings by Ellis Hudson on “*Bejel*: the endemic syphilis of the Euphrates Arab” sowed a different kind of doubt.¹¹⁶ Hudson’s research was published in the late 1930s, and by the early 1950s had filtered through to dermatologists in the Moroccan health service, who conjectured that the disease in *La Syphilis arabe* bore all the signs of endemic, not venereal, syphilis.¹¹⁷ The World Health Organization and UNICEF agreed, declaring Morocco among the foci of endemic syphilis, and launching a mass treatment campaign with penicillin in 1953-4.¹¹⁸

That Lacapère should be suspected of missing signs of neurosyphilis, or of conflating endemic syphilis with venereal syphilis is unsurprising: the spirochete was first observed in 1905, but the biological relationship between subspecies and strains of *Treponema*, and the distinct syndromes of venereal syphilis, yaws, endemic syphilis and pinta, were not elucidated

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until 1951. The fragile spirochete cannot easily be cultivated *in vitro*, and there is still no laboratory test that can distinguish between sub-species.¹¹⁹ It was fieldwork, rather than labwork, that enabled researchers to distinguish their symptoms and modes of transmission: endemic syphilis is characterized by the almost complete absence of late cardiovascular, neurological and visceral complications; is transmitted by oral and household contacts, such as through shared eating and drinking utensils; and is distinguished from venereal syphilis by childhood acquisition.¹²⁰ There is much rich documentation on the history of confusion between venereal and non-venereal syphilis in colonial Africa, to which this analysis of Lacapère may add a new chapter.¹²¹

Yet my intention here is not to provide retrospective interpretation of Lacapère's clinical material, even where available documentary and photographic evidence may support a different diagnosis. Not only would it be methodologically naïve to re-label Arab syphilis according to present-day knowledge,¹²² it would also distract us from a crucial point of argument. Unlike counterparts in French and British colonial states who assumed that they were dealing with an epidemic of venereal disease, Lacapère created a new category of African syphilis in order to reconcile clinical, epidemiological and laboratory data with his respect for Fournier and his understanding of medical science of his day. Yet Lacapère did not hold Arab syphilis ontologically apart from European syphilis: essentially it was the same disease, but its accidental properties provided a window into France's disease past, just as they signaled the state of Moroccan civilization in the present. An awareness that the treponemes, lesions, and mental states of Lacapère's Moroccan patients may not have been what they seemed only reinforces our awareness of the difficulties he faced in conforming models developed in Europe with his North

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African experience, and gives prominence to the cultural, moral, technological and scientific assumptions and limitations that played into his diagnoses.

Conclusions

This case study raises questions about emphasis on race in the historiography of colonial medicine, particularly in literature on French science overseas. Scholars of medicine in colonial contexts have rightfully given prominence to the relationships between race, science and medicine. However, recent interventions by Tilley, Fogarty and Osborne have urged historians to look carefully at the ways in which race inflected scientific research, rather than taking its significance for granted. In *Africa as a Living Laboratory*, Tilley argues that although colonial states were by definition “racial states,” racial thinking could take many shapes and forms.¹²³ Moreover, Tilley’s analysis of British Colonial Office-sponsored medical research reveals how limited availability of funds and concern for political stability prevented support for projects motivated by race prejudice. In the case of France, Fogarty and Osborne challenge the perception of the late-nineteenth and early-twentieth century as the high watermark of scientific racism in Europe. Their close reading of scientific writings by French naval and army doctors – major producers of medical literature on the colonies – indicates that views on race continued to take into account the importance of culture and environment, and varied considerably from researcher to researcher.¹²⁴

Lacapère’s ideas about Moroccan otherness were certainly embedded in a belief in European superiority. However, the thing that struck Lacapère most during his time in Fez was not his patients’ physical traits or color, but their alien ways of living, praying, working, eating and relaxing. He created a diagnostic category in which not race but civilization defined the

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“Other,” accounting for the expression of disease and its transmission. This difference was there for all to see in Arab syphilis.

The colonial careers of Lacapère and Arab syphilis afford us an opportunity to think about the role of colonial and metropolitan discourses in the framing and production of biomedical knowledge. It is salutary to present this episode of medical history in terms of a dual career, rather than the history of French medical campaigns against syphilis. Such an approach highlights how an individual’s research obsessions; wartime duties; perceptions of Moroccan society and unfamiliar peoples, tongues, and places; and manipulation of available diagnostic technologies and an uncertain medical science were key determinants of how he came to frame the symptoms he saw as “Arab syphilis.” Viewing Lacapère and Arab syphilis as individual careers made possible by historical conjuncture also reminds us that disease categories, like medical vocations, are means to an end, not ends in themselves. While the physical clinic of Dar el-Glaoui continued to receive patients, and many institutions of the Protectorate endured until Moroccan independence, Arab syphilis and Lacapère were retired when they were no longer useful, giving way to other explanations of disease and to younger personnel. The notion of a disease career brings to the fore that medical ideas – much like human beings – have natural life spans and can fall in and out of favor.¹²⁵

Finally, Lacapère’s reworking of the models of his dermatologist counterparts and his contribution to the field of exotic syphilis speaks to the colonial project that was under construction during his years in Fez. Lyautey’s neo-conservative policies aimed to preserve Moroccans (and by extension, their French overlords) from what he perceived as the more undesirable effects of modernity. On a theoretical level, Lacapère’s discourse had significant

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repercussions for this civilizing mission. Since backwardness was culturally mediated, and not biologically immutable, Lacapère allowed the possibility that Moroccans, like their syphilis, could move from the Middle Ages to modernity with French assistance. This suggested that the fight against syphilis was not merely a question of how much arsenic therapy could be administered.

In 1950, surveying the mixed results of colonial anti-syphilis efforts in Morocco, Eugène Lépinay, a government consultant on public health and himself a dermatologist, lamented that complete prophylaxis could only be achieved if every Moroccan were “grounded in a more exact comprehension of the benefits of western civilization.”¹²⁶ The emphasis here is on benefits, as civilization also meant *syphilization*, which Lacapère knew well. The pure, ancestral form of syphilis that Lacapère identified in Fez had once been found in the interior of Algeria and the Tunisian Protectorate, but thanks to more prolonged contact with Europeans in the large towns of the Mediterranean coast, where civilization had introduced itself under its habitual guise – cafés, café-concerts, bars and prostitution – “the habits of intemperance and intoxication,” as well as the intellectual stimulus of industrialization, were seen as transforming Arab infections.¹²⁷ This was not civilization as Resident-General Lyautey intended it, but these cultural influences were blamed for increasing the incidence of nervous syphilis. Although syphilis epidemics were typically seen as a threat to colonial authority, not only in French Morocco, here, ironically, they could be visible proof of the effects of the civilizing mission, as “Arab syphilis” gave way to European-style infections.

¹ On the history of the colonial period in Morocco, see C. Richard Pennell, *Morocco since 1830: a History* (New York: New York University Press, 2000); Daniel Rivet, *Lyautey et l'institution du protectorat français au Maroc, 1912-1925*, 2 vols (Paris: L'Harmattan, 1988) and *Le Maroc de Lyautey à Mohammed V: le double visage du Protectorat* (Paris: Denoël, 1999).

² Dr Paul Remlinger, director of the Pasteur Institute of Tangiers, described venereal disease as “the heart, the essence even, of Moroccan pathology.” Paul Remlinger, “Les Maladies vénériennes et la prostitution au Maroc,” *Annales d'hygiène publique et de médecine légale*, 19.2 (1913), 97-106, quotation on page 7. All translations from the French are my own.

³ Georges Lacapère, *La Syphilis arabe: Maroc, Algérie, Tunisie* (Paris: Doin, 1923).

⁴ The history of syphilis is well-worked terrain for social historians of medicine, particularly of colonial medicine and race. The majority of this literature has examined cases in British imperial history: Karen Jochelson, *The Colour of Disease: Syphilis and Racism in South Africa, 1880-1950* (Basingstoke: Palgrave, 2001); Philippa Levine, *Prostitution, Race, and Politics: Policing Venereal Disease in the British Empire* (Routledge: London, 2003); Megan Vaughan, “Syphilis in colonial East and Central Africa: the Social Construction of an Epidemic,” in *Epidemics and Ideas: Essays on the Historical Perception of Pestilence*, ed. Terence Ranger and Paul Slack (New York: Cambridge University Press, 1992), 269-302. Historians of medicine in the U.S. have identified similar congeries of public health inequalities and racial stereotyping in the infamous Tuskegee syphilis experiment, see for example James H. Jones, *Bad Blood: The Tuskegee Syphilis Experiment* (New York: The Free Press, 1981); Susan Reverby, *Examining Tuskegee: the Infamous Syphilis Study and its Legacy* (Chapel Hill: University of North Carolina Press, 2009); and Paul A. Lombardo and Gregory M. Dorr, “Eugenics, Medical Education, and

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the Public Health Service: Another Perspective on the Tuskegee Syphilis Experiment,” *Bull. Hist. Med*, 80.2 (2006): 291-316.

⁵ Jean-Paul Gaudillière and Ilana Löwy, “Introduction. Horizontal and Vertical Transmission of Diseases: The Impossible Separation?” in *Heredity and Infection: The History of Disease Transmission* (London: Routledge, 2001), ed. Gaudillière and Löwy, 1-18, quotation on page 4. Contributors to this volume assail the notion of a decisive “bacteriological revolution,” illustrating how explanations of disease transmission have varied across time, geographies, institutional settings and individual researchers, but have consistently relied on “hybrid” assemblages of heredity, constitution, environment and infection.

⁶ Richard Keller, *Colonial Madness: Psychiatry in French North Africa* (Chicago: University of Chicago Press, 2007).

⁷ In addition to producing important synthetic works on clinical and social aspects of syphilis, Fournier held the first chair in Cutaneous and Syphilitic Disease at the Paris Faculty of Medicine, trained a generation of venereologists, and founded organizations for prophylaxis on a national and international level. Claude Quétel’s *History of Syphilis* trans. Judith Braddock and Brian Pike (Cambridge: Polity Press, 1990) provides details of Fournier’s work as well as a general overview of the intellectual, cultural and social dimensions of syphilis from its emergence in western Europe in the late fifteenth century to the present day.

⁸ *Ibid.*, ch. 8, 176-210; and Gérard Tilles, “The Hôpital Saint-Louis from 1607 to 1945,” in *Dermatology in France*, ed. Daniel Wallach (Toulouse: Editions Privat, 2001), 381-417.

⁹ Details drawn from Georges Lacapère, *Les Contagions vénériennes au Maroc*, lecture delivered at Meknes, December 1918, 14-17. The lecture was intended for a lay audience of army officers, Please note: This is the author accepted manuscript of an article accepted for publication by the *Bulletin of the History of Medicine* on 27/11/2012. The final version appeared as Hannah-Louise Clark, “Civilization and Syphilization: A Doctor and His Disease in Colonial Morocco,” *Bulletin of the History of Medicine*, vol. 87 no. 1 (2013): pp. 86-114. [doi:10.1353/bhm.2013.0003](https://doi.org/10.1353/bhm.2013.0003). Please read and cite the final, definitive version whenever possible.

and conveys a simplified understanding of the clinical manifestations and epidemiology of syphilis as understood by Lacapère.

¹⁰ Toussaint Barthélemy, *La Syphilis: revue mensuelle de médecine spéciale*, vol. 1 (Paris: Rédaction Administration, 1904), 319-320.

¹¹ For more on the history of the Saint-Lazare, see Paul Blum, “The Hôpital Saint-Lazare in Paris: Its Past and Present History,” *Brit. J. of Ven. Dis.* 24.4 (1948), 151-152. Regulations applied to sex workers in mainland France are described by Jean-Marc Berlière, *La police des mœurs sous la IIIe République* (Paris: Seuil, 1992), and Alain Corbin, *Women for Hire : Prostitution and Sexuality in France after 1850* (Cambridge: Harvard University Press, 1990).

¹² Lacapère collaborated with Emery in testing the new Ehrlich method, see Émile Emery, *La Méthode d'Ehrlich: traitement de la syphilis par le dioxydiamidoarsénobenzol (salvarsan); étude clinique et thérapeutique* (Paris: Octave Doin, 1911). In addition to articles published in Paris- and Morocco-based journals, Lacapère discussed his therapeutic methods in George [sic] Lacapère, “The Modern Treatment of Syphilis,” interview in *Amer. J. of Dermat. and Genito-urinary Diseases* 16.1 (1912), 19, and represented the views of the “French School” on treatment in an address to the Medical Society for the Study of Venereal Diseases in London on April 30, 1926, see Georges Lacapère, “Marriage and Syphilis,” *Brit. J. of Ven. Diseases* 2, 8 (1926), 308–322.

¹³ A Sultanic decree of 21 October 1912 created the *Service de l'Assistance publique*. Resident-General Lyautey passed a law on 20 Mar 1915 creating a separate military wing and civilian wing for the service; the former initially directed by the chief physician of occupying French forces, Dr Jourdan, the latter by Dr Mauran. Abdelmounim Aissa, “La Santé publique au Maroc

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à l'époque coloniale" (Ph.D. thesis, Université Paris I, 1997), 77.

¹⁴ Archives Nationales de France (ANF), Papiers Lyautey (PL) 475AP/172/203-204. The majority of these specialists (Mauté, Noire, Paiseau, Guisez, and Clerambault) were consulting physicians at Paris hospitals, with the exception of the bacteriologist (Pinoy), drafted from the Paris Pasteur Institute.

¹⁵ Lacapère, *La Syphilis arabe*, 149.

¹⁶ In this sense, Lacapère's work was akin to the "*thèses de guerre*" submitted by mobilized medical students who wrote dissertations based on experiences with colonial troops. Michael Osborne and Richard Fogarty, "Views from the Periphery: Discourses of Race and Place in French Military Medicine," *Hist. and Philos. of the Life Sciences* 25 (2003), 363-389, discussed on 378.

¹⁷ ANF PL 475AP/172/196. The instruction was conveyed verbally to Lacapère and Laurent by the Director of the Moroccan Health Service.

¹⁸ "Minutes de la Société Médico-Chirurgicale du Brabant," *Maroc Médical* 1 (1921), 31-32.

¹⁹ Charles Rosenberg, "Pathologies of Progress: The Idea of Civilization as Risk," *Bull. Hist. Med.* 72.4 (1998), 714-730. Rosenberg describes how a tradition equating health with spiritual and corporeal asceticism combined with the new science of psychiatry in the latter part of the nineteenth century to "emphasize the peculiar psychic dangers posed by an ever more urban, technologically based, communications-oriented, and unsettling mobile society," 720-721.

²⁰ See Barbara Sicherman, "The Uses of a Diagnosis: Doctors, Patients, and Neurasthenia," *J. of the Hist. of Med. and Allied Sciences* 32.1 (1997), 33-54.

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²¹ Richard von Krafft-Ebing, *Arbeiten aus dem Gesamtgebiet der Psychiatrie und Neuropathologie* (Leipzig: J.A. Barth, 1899), part 2, 21.

²² See for example Alice L. Conklin, *Mission to Civilize: The Republican Idea of Empire in France and West Africa, 1895-1930* (Stanford: Stanford University Press, 1997).

²³ Lacapère was not advancing a critique of empire in elucidating the connections between civilization and syphilization. However, colonial psychiatrists in East Africa the 1930s would develop the notion of “deculturation” to express the idea that the stimulation of European civilization was sending Africans mad, a concern prefigured in Lacapère’s work. On the theory of deculturation see Megan Vaughan, *Curing their Ills: Colonial Power and African Illness* (Stanford: Stanford University Press, 1991).

²⁴ Lyautey’s methods and style of governance are analysed by William A. Hoisington, Jr. in *Lyautey and the French conquest of Morocco* (New York: St Martin’s Press, 1995) and Rivet, *Lyautey et l’institution du protectorat*, vol. 2, 121-287. Specific examples of Lyautey’s neo-conservative approach can be found in Spencer D. Segalla, *The Moroccan Soul: French Education, Colonial Ethnology, and Muslim Resistance, 1912-1956* (University of Nebraska: Lincoln, 2009); Paul Rabinow, *French Modern: Norms and Forms of the Social Environment* (Chicago: University of Chicago Press, 1995); and Gwendolyn Wright, *The Politics of Design in French Colonial Urbanism* (Chicago: University of Chicago Press, 1991).

²⁵ There were some 40 Europeans living in Fez in 1913, and 300 in 1917, 13 of whom Lacapère would treat for syphilis. Figures from *Annuaire économique et financière du Maroc* (Casablanca: Rapide, G. Mercié & co., 1917); *Annuaire du Maroc: administrative, commercial, industriel, agricole, vinicole* (Casablanca: Fontana frères, 1913).

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²⁶ Lacapère, *La Syphilis arabe*, 16.

²⁷ Lacapère and Charles Laurent, "Influence du traumatisme sur les localisations de la syphilis. La front des Islamistes," *Paris-Médical* 27, (January-June 1918), 95.

²⁸ Lacapère, *La Syphilis arabe*, 191-192.

²⁹ Lacapère and Laurent, "Influence du traumatisme sur les localisations de la syphilis," 95.

³⁰ These social transformations are described by Daniel Rivet, *Le Maroc de Lyautey à Mohammed V*, chapters 6 & 7, 187-267 and Ellen Amster, "Medicine and Sainthood: Islamic science, French colonialism and the politics of healing in Morocco, 1877-1935," (Ph.D. Thesis, University of Pennsylvania, 2003), 169-170. The effects of the political shift wrought by the Protectorate on Morocco's urban and regional order are analysed in Jean Déthier, "Urbanisation of Concepts of Housing, Urbanism, and Country Planning: Morocco," in *From Madina to Metropolis: Heritage and Change in the Near Eastern City*, ed. L. Carl Brown (Princeton, New Jersey: Darwin Press, 1973), 196-243. French land policies are detailed in Pennell, *Morocco since 1830*, 171-172.

³¹ Georges Lacapère and Georges Decrop, "La Syphilis dans les pays arabes. Les modes de contag. Aperçu statistique," *Annales des maladies vénériennes* 12 (December 1917), 658-659.

³² Lacapère, *La Syphilis arabe*, 466.

³³ Georges Lacapère, "La Syphilis nerveuse chez les Arabes," *Maroc Médical* 13 (1934), 9.

³⁴ Lacapère, *La Syphilis arabe*, 7.

³⁵ Ellen Amster, "Medicine and sainthood," 157-158.

³⁶ Lacapère, “La Syphilis nerveuse chez les Arabes,” 8. See also Lacapère, *La Syphilis arabe* and ANF PL 475AP/172/198. The clinic was adjacent to Dar El-Glaoui in Rue Dar El-Glaoui. Today the building contains private residences.

³⁷ Lacapère, *La Syphilis arabe*, 122.

³⁸ Two such cases are referenced in *ibid.*, 122 and 400.

³⁹ Lacapère, “La question de la dualité des virus syphilitiques et les causes d’orientation de la syphilis,” *Revue française de dermatologie et vénéréologie* 2 (1925), 112.

⁴⁰ Rollier, Maury, “Situation actuelle du problème vénérien au Maroc,” *Maroc Médical* 296 (1950), 196. The slippage between the word for an injection and the specific drug name was confirmed for me anecdotally on June 28, 2009, when I talked with a venerable Fassi shopkeeper who had been treated at the clinic by Dr Salle. He remembered floods of patients going to receive a “novar.”

⁴¹ During Lacapère’s directorship of the clinic, women represented 34 per cent of Muslim consultations, men 54 per cent and children 12 per cent; the ratio for Jewish consultations was 34 per cent, 45 per cent and 21 per cent. Lacapère, *La Syphilis arabe*, 16. Lacapère’s forays into homes, and the number of women presenting at Dar el-Glaoui clinic, complicate arguments presented by Ellen Amster and Daniel Rivet that Moroccan women overwhelmingly escaped, or were excluded from, the health care mechanisms of the Protectorate – not only by colonial design, but also at the behest of their male family members. Ellen Amster, “Medicine and sainthood,” and Daniel Rivet, “Hygiénisme colonial et médicalisation de la société marocaine au temps du protectorat français (1912-1956),” in *Santé, médecine et société dans le monde arabe*, ed. Elisabeth Longuenesse (Paris: L’Harmattan, 1995), 105-128.

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⁴² Lacapère, *La Syphilis arabe*, 15.

⁴³ *Ibid.*, 15, 187. Language barriers, a lack of curiosity, or a heavy workload at the clinic, may have contributed to Lacapère's ignorance of local healing practices. A French Algerian public health expert who visited Morocco in 1901 recorded that urban medical practitioners employed therapies comparable to standard French remedies, and an account by Georges Salmon, head of the 1903 French Scientific Mission to Morocco, recorded use of potassium iodide and the quick traffic in sarsaparilla conducted near the sanctuary of Moulay Idris in Fez. Lucien Raynaud, *Étude sur l'hygiène et la médecine au Maroc suivi d'un notice sur la climatologie des principales villes de l'Empire* (Algiers: S. Léon, 1902); and Georges Salmon, "Les 'Achchabin de Fès," in *Archives Marocaines*, vol. 8 (Paris: E. Leroux, 1906), 87-98.

⁴⁴ Dr Lapin described how "Si Mohamed, more so than Jacques Bonhomme, ... rejects the idea that strangers have come to disturb his habits, ... however poor his shack, however shrewish his wife, it is better (*mektoub*) for the sick man to stay on his mat, wrapped in his burnous, than to go to an establishment where nothing reminds him of his ancestral customs" in Lapin, "La lutte contre la tuberculose," *Maroc Médical* 28 (1924), 5-6.

⁴⁵ Lacapère, *La Syphilis arabe*, 119.

⁴⁶ *Ibid.*, 14, 189.

⁴⁷ *Ibid.*, 6.

⁴⁸ *Ibid.*, 269.

⁴⁹ *Ibid.*, 3.

⁵⁰ Henri-Paul-Joseph Renaud and Georges S. Colin, *Documents marocains pour servir a*

l'histoire du "mal franc" (Paris: Librairie Larose, 1935), 10. The Arabic root ف س د connotes

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“he was, or became, bad, evil, corrupt...; devoid of virtue,” whereas ف ص د signifies “He cut, or slit, [or opened,] a vein,” in this instance the practice of inoculation. Edward W. Lane, *Arabic-English Lexicon* vol. 2 (Cambridge: Islamic Texts Society, 1984), 2396 and 2404.

⁵¹ Lacapère, *La Syphilis arabe*, 3.

⁵² *Ibid.*, 17. References to the untrustworthiness of patients’ accounts of their condition are scattered throughout the text.

⁵³ Lacapère and Decrop, “La Syphilis dans les pays arabes,” 655.

⁵⁴ In Lawrence Rosen’s anthropological analysis of the structures and categories of memory, his Moroccan interlocutors are found to situate events in relation to important persons and networks of social obligation, rather than linear processes, *The Culture of Islam: Changing Aspects of contemporary Muslim Life* (Chicago: University of Chicago Press, 2002), 89-94.

⁵⁵ Lacapère, *La Syphilis arabe*, 12-14; Lacapère, “La question de la dualité des virus syphilitiques,” 117.

⁵⁶ Lacapère, *La Syphilis arabe*, 12, 46; Georges Lacapère and Charles Laurent, “Immunisation chez les hérédosyphilitiques. Le tubercule de Carabelli chez les indigènes du Maroc,” *Paris-Médical* 29 (1918), 422.

⁵⁷ Lacapère, *La Syphilis arabe*, 3.

⁵⁸ *Ibid.*, 101, 107, 152.

⁵⁹ *Ibid.*, 182.

⁶⁰ Lacapère, “La question de la dualité des virus syphilitiques,” 114.

⁶¹ Lacapère, *La Syphilis arabe*, 194.

⁶² *Ibid.*, 200.

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⁶³ Georges Decrop, "Où en est la syphilis marocaine," *Maroc Médical* 296 (1950), 138.

⁶⁴ Lacapère, *La Syphilis arabe*, 102.

⁶⁵ *Ibid.*, 98-99, 149.

⁶⁶ Although the great majority of these texts arose from an Algerian context (40); a smaller number of works on Tunisian and Moroccan material (3 and 4 respectively) were also cited.

⁶⁷ The clinic was renamed the *Clinique de dermato-syphiligraphie* on January 4, 1910. See Larbi Abid, "L'école de médecine d'Alger: 150 ans d'histoire: de 1857 à 2007," *Santé Maghreb* <http://www.santetropicale.com/santemag/algerie/hist/index.asp> Consulted February 7, 2012.

⁶⁸ Like Lacapère, Jeanselme (1858-1935) specialized in dermatology and studied in Paris under Fournier, but subsequently had a far more international career, taking part in missions to French Indochina, the British colonies of Burma and Singapore, and Dutch Java. His experience in the field parlayed into a position at the Faculty of Medicine in Paris where he delivered his course in "exotic dermatology" under the auspices of the newly-founded Institut de Médecine Coloniale. Laignel-Lavastine, "Edouard Jeanselme, historien," *Bulletin de la Société française d'histoire de la médecine* 33 (1939), 146-7. Reflecting the prevailing belief that black people enjoyed relative immunity from disease, Jeanselme argued that syphilis among African populations attacked the skin rather than the brain, and its primary and secondary lesions were generally absent. Jeanselme invoked race and climate to explain the difference. However, he speculated that different expressions of disease might follow from differences in lifestyle, and that as European habits of industry and commerce became more widespread, colonial subjects might react differently to the "venereal poison." Edouard Jeanselme, *Cours de dermatologie exotique* (Paris: Masson & Cie, 1904), 148, 179-80.

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⁶⁹ An active lecturer and theoretician, Gemy was the first Chair of the *Clinique des Maladies des Pays Chauds et des Maladies Syphilitiques et Cutanées* at the Algiers' School of Medicine; he communicated with Fournier, and contributed his own observations to scientific publications in the metropole. His views on native syphilis are summarized in Alphonse Gemy, *Cours complémentaire de Clinique des Maladies Syphilitiques et Cutanées. Leçon d'ouverture de l'année scolaire, 1883-84* (Algiers: A. Jourdan, 1884).

⁷⁰ Gemy, *Cours complémentaire*, 23-27.

⁷¹ "Virus" is used by Gemy and Lacapère in the historical sense of a substance produced within the body by a disease, especially when contagious or infectious or used for vaccination, or of any agent causing an infectious disease, rather than in modern sense of "a biological entity which is typically smaller than a bacterium, and able to function only within the living cells of a host animal, plant, or microorganism." *Oxford English Dictionary* online version, consulted February 7, 2012.

⁷² Gemy, *Cours complémentaire*, 23.

⁷³ Charles Levaditi and A. Marie, "Le tréponème de la paralysie générale," *Compte-rendu de l'Académie des Sciences*, CLVIII (1914), 1595, meeting of June 8, 1914; Levaditi and Marie, "Étude sur le tréponème de la paralysie générale," *Annales de l'Institut Pasteur: journal de microbiologie* 33.11 (1919), 751-775.

⁷⁴ Lacapère, *La Syphilis arabe*, 390.

⁷⁵ *Ibid.*, 390.

⁷⁶ *Ibid.*, 25.

⁷⁷ Lacapère, "La Lutte contre la syphilis au Maroc," *France-Maroc* 2 (1918), 57.

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⁷⁸ Lacapère, *La Syphilis arabe*, 3.

⁷⁹ *Ibid.*, 46.

⁸⁰ *Ibid.*, 27-28.

⁸¹ *Ibid.*, 24.

⁸² *Ibid.*, 28-31.

⁸³ *Ibid.*, 149.

⁸⁴ E. Lépinay, "La Syphilis arabe," *Maroc Médical* 18 (1923), 187-188, quotation on 188.

⁸⁵ Lacapère, *La Syphilis arabe*, 15, 36.

⁸⁶ The biochemical, ethical and professional problems inherent in the Bordet-Wassermann test are described in Ludwik Fleck, *The Genesis and Development of a Scientific Fact*, reprinted with an introduction by Thomas S. Kuhn (Chicago: University of Chicago Press, 1979 [1935]), 74-79.

⁸⁷ See for instance William Allen Pusey, *The Principles and Practice of Dermatology*, 3rd ed. (London: D. Appleton and Co., 1917), 660.

⁸⁸ Lacapère, *La Syphilis arabe*, 6.

⁸⁹ For instance, Edmund Burke III and Lahouari Addi, writing about images of Morocco and Algeria respectively in French ethnological literature, have analysed the colonial myth of ethnic diversity. The myth held that there were profound ethnic splits in North Africa, particularly between Arabs and Berbers, and it served to show that there was no homogenous society around which to build a nation or constitute a state. Moreover, a series of romantic stereotypes about Berbers drawn from the Algerian "Kabyle" myth were powerfully influential in shaping the image of Moroccan Berbers in the first decade of the Protectorate. See Edmund Burke III, "The Image of the Moroccan State in French Ethnological Literature: a New Look at the Origin of

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Lyautey's Berber Policy," in *Arabs and Berbers: From Tribe to Nation in North Africa*, ed.

Ernest Gellner and Charles Micaud (London: Duckworth, 1973), 175-199; Lahouri Addi,

"Colonial Mythologies: Algeria in the French Imagination," in *Franco-Arab Encounters*, ed. L.

Carl Brown and Matthew Gordon (Beirut: American University of Beirut, 1996), 93-105.

⁹⁰ Lacapère, *La Syphilis arabe*, 395.

⁹¹ *Ibid.*, 49.

⁹² In the nineteenth century, Algerian physicians referred to a disease called "Kabyle Leprosy," so-called because it was purportedly endemic among the one million Kabyles resident in the Department of Algiers. Alphonse Gemy and Lucien Raynaud later insisted that this leprosy was in fact a "scrofuloid" form of syphilis, evinced by the swift and remarkable therapeutic effects of high doses of mercury and potassium iodide on sufferers. Alphonse Gemy and Lucien Raynaud, *Étude sur la lèpre en Algérie et plus spécialement à Alger: mesures prophylactiques* (Algiers: J. Torrent, 1897), 9.

⁹³ Lacapère, *La Syphilis arabe*, 2.

⁹⁴ *Ibid.*, 98-99, 126-127.

⁹⁵ *Ibid.*, 389.

⁹⁶ Such treatments were in use in Algeria; the use of somatic shock therapies is detailed in Keller, *Colonial Madness*.

⁹⁷ Lacapère, *La Syphilis arabe*, 11.

⁹⁸ For example, see *inter alia*, *Al-Akhbar* articles on "Alcool et l'Islam," May 7, 1911;

"Catastrophes et alcoolisme," February 19, 1911; "L'Assimilation par l'alcool," July 2, 1911;

"La Lutte contre l'alcoolisme en Afrique du Nord," May 10, 1914.

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⁹⁹ “Périls marocains. Alcool et speculation,” *Al-Akhbar* June 7, 1914. A similar law was passed in wartime France, see Dominique Duprez and Michel Kokoreff, *Les Mondes de la drogue* (Éditions Odile Jacob: Paris, 2000), 297.

¹⁰⁰ Lacapère, *La Syphilis arabe*, 390.

¹⁰¹ *Ibid.*, 390. For extended treatment of Porot’s prominent role in North African psychiatry and the Algiers School see Keller, *Colonial Madness*.

¹⁰² Lacapère, *La Syphilis arabe*, 383.

¹⁰³ *Ibid.*, 360-5.

¹⁰⁴ In some instances the lesions disappeared “under [his] very eyes,” *ibid.*, 173.

¹⁰⁵ The case of Lacapère reinforces work by Keller and Pelis on experimental clinical research in North Africa, see Keller, *Colonial Madness*, and Kim Pelis, *Charles Nicolle, Pasteur’s Imperial Missionary: Typhus and Tunisia* (Rochester, N.Y.: University of Rochester Press, 2006).

¹⁰⁶ John Mann, *Life Saving Drugs: the Elusive Magic Bullet* (Cambridge: The Royal Society of Chemistry, 2004), 9. Lacapère cites several cases where treatment failed, or where injections produced side effects, toxic shock, and even death. Lacapère, *La Syphilis arabe*, 200, 400.

¹⁰⁷ *Ibid.*, 362.

¹⁰⁸ Laurent, “Les Hôpitaux indigènes du Maroc,” ANF PL 475AP/172/199

¹⁰⁹ Laurent was particularly forceful on this point: “A doctor is designed to treat the sick and not to be an hotelier.” ANF PL 475AP/172/197. In Rivet, *Lyautey et l’institution du protectorat français*, vol. 2, 234 this remark is misattributed to Lacapère.

¹¹⁰ Lacapère to Lyautey, June 28, 1919, ANF PL 475AP/172/211.

¹¹¹ Alphonse Mauté to Lyautey, July 5, 1919, ANF PL 475AP/172/212

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¹¹² *Ibid*, and Lyautey, “Instruction relative à l’Institution de Conseillers Techniques Médicaux pour le Maroc à Paris,” January 15, 1919, ANF PL 475AP/172/202

¹¹³ Lacapère, *Le Traitement de la Syphilis par les Composés Arsenicaux* (Paris: Masson & Cie, 1918).

¹¹⁴ For example, a paper presented at a 1944 Algiers’ medical congress threw doubt on the validity of available data, including those in *La Syphilis arabe*. The authors went so far as to accuse Lacapère of exaggerating and/or inaccurately citing figures for syphilis infection in the region. Maurice Raynaud, Elie Hadida and François-G. Marill, “Au Sujet de la syphilis exotique. Value des statistiques relatives à la fréquence de la syphilis en Algérie,” in *25^e Anniversaire de l’Institut d’Hygiène et de Médecine d’Outre et de l’Afrique du Nord 1923-1948* (Alger: Imprimerie Nord-Africaine, 1948), 81-91.

¹¹⁵ Antoine Porot and Charles Bardenat, cited in François-G. Marill, “Le problème de la syphilis nerveuse de l’indigène musulman algérien dans ses rapports avec quelques données d’ethnographie et de démographie,” *Bulletin de L’Institut d’Hygiène du Maroc* 1 (1941): 5-33, quotation on 32.

¹¹⁶ Ellis Herndon Hudson was the first to bring the non-venereal form of syphilis known as *Bejel* to the attention of the international medical community following research at the Presbyterian Mission in Deir-ez-Zor, Syria, in “Bejel: The endemic syphilis of the euphrates arab [*sic*],” *Tropical Medicine and Hygiene* 31.1 (1937): 9-46. Hudson referenced Lacapère in his historical article “Treponematoses and African Slavery,” *Brit. J. of Ven. Diseases* 40 (1964): 43-52.

¹¹⁷ Messerlin and Maury, “La Lutte contre le syphilis au Maroc,” *Maroc Médical* 365 (1955): 1239.

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¹¹⁸ Centres des Archives Diplomatiques de Nantes, Maroc/Secretariat Général du Protectorat/141-Santé. “Compte-rendu de la mission à Genève, 6ème Assemblée Mondiale de la Santé,” June 6, 1953.

¹¹⁹ Peter L. Perine *et al.*, *Handbook of Endemic Treponematoses: Yaws, Endemic Syphilis and Pinta* (Geneva: World Health Organization, 1984), 2.

¹²⁰ *Ibid.*, 13-16.

¹²¹ Studies of the confusion between treponemas in British and French colonies include, *inter alia*, Henri Boiron, Alice Basset, Hervé Basset, and Monique Castets, “Contribution à l’étude de la syphilis au Sénégal,” *Bulletin de la Société de pathologie exotique et de ses filiales* 55 (1962), 98-116; Bryan Callahan, ““Veni, VD, vici”?: reassessing the Ila syphilis epidemic,” *J. of Southern African Studies* 23.3 (1997): 421-40; J. N. P. Davies, “The History of Syphilis in Uganda,” *Bull. of the World Health Organization* 15 (1956), 1041-55; Marc H. Dawson, “The 1920s anti-yaws campaigns and colonial medical policy in Kenya,” *Internat. J. of African Historical Studies* 20.3 (1987), 417-35; Karen Jochelson, *The Colour of Disease*; and Megan Vaughan, “Syphilis in Colonial East and Central Africa.”

¹²² Positing a one-to-one correspondence between “Arab syphilis” and endemic syphilis would be not only incautious (given the absence of verifiable case studies and evidence of etiology), but also unsound, privileging present-day biomedical definitions of venereal syphilis and endemic syphilis with ontological status. For a clear statement of the argument against retrospective diagnosis see Andrew Cunningham, “Transforming Plague: The Laboratory and the Identity of Infectious Disease,” in *The Laboratory Revolution in Medicine*, ed. Andrew Cunningham and Perry Williams (Cambridge: Cambridge University Press, 1992), 209-244; for a more dramatic

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example see Bruno Latour, “On the Partial Existence of Existing *and* Non-Existing Objects,” in *Biographies of Scientific Objects*, ed. Lorraine Daston (Chicago: University of Chicago Press, 2000), 247-269.

¹²³ Helen Tilley, *Africa as a Living Laboratory: Empire, Development, and the Problem of Scientific Knowledge, 1870-1950* (Chicago: University of Chicago Press, 2011), 217-259, quotation on 219.

¹²⁴ Osborne and Fogarty, “Views from the Periphery.”

¹²⁵ This framing is inspired by work in the history of science that takes a biographical approach to scientific ideas, phenomena and objects, see Daston ed. *Biographies of Scientific Objects* and Lorraine Daston ed. *Things that Talk: Object Lessons from Art and Science* (Cambridge, MA: Zone Books, 2004).

¹²⁶ Eugène Lépinay, “La lutte contre les maladies vénériennes au Maroc,” *Maroc-Médical* 29, 296 (1950), 124-131, quotation on 129.

¹²⁷ Lacapère, *La Syphilis arabe*, 479.