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What is "colonial" about *medieval* colonial medicine? Iberian health in global context

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Colonial medicine is a thriving field of study in the history of nineteenth- and twentieth-century medicine. Medicine can be used as a lens to view colonialism in action and as a way to critique colonialism. This article argues that key debates and ideas from that modern field can fruitfully be applied to the Middle Ages, especially for the early empires of Spain and Portugal (mid-fourteenth to mid-sixteenth centuries). The article identifies key modern debates, explores approaches to colonization and colonialism in the Middle Ages and discusses how medieval and modern medicine and healthcare could be compared using colonial and postcolonial discourses. The article ends with three case studies of healthcare encounters in Madeira, Granada and Hispaniola at the end of the fifteenth century.

Keywords: medicine; health; colonialism; Spanish and Portuguese empires; global history

In 1997 in a much-cited essay, Shula Marks asked: "what is colonial about colonial medicine?"[1] Ten years later, Waltraud Ernst critiqued this question in another important essay, arguing that it had become a "somewhat hoary catchphrase". For Ernst, asking the question expressed a lack of identity within the field of the history of colonial medicine.[2] For a historian consciously to choose this question to frame a study of colonial medicine in the Middle Ages, that is the period before 1500, it may seem a little like jumping on a bandwagon that has gone off the rails. Yet the history of colonial medicine shows no signs of decline, and its sibling the history of postcolonial medicine is flourishing.[3] In the case of both colonial and postcolonial medicine the focus of research in the English language is on the modern British Empire with occasional glances at other empires and some recent ventures into the seventeenth and eighteenth centuries.[4] For earlier periods, historians of science (botany, pharmacy, cosmography, navigation) have been much more prominent, developing important approaches to the construction and circulation of knowledge. Their approach takes the Spanish and Portuguese empires more seriously but says little about

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[1]Marks, "What is Colonial about Colonial Medicine?"
[2]Ernst, "Beyond East and West".
[3]Anderson, "Where is the Postcolonial History of Medicine?" Anderson, "Postcolonial Histories of Medicine"; Bivins, "Coming 'Home' to Post-Colonial Medicine". "Post-colonial" is a temporal term, referring to the period after decolonization; "postcolonial" is conceptual or methodological.
[4]Cook, *Matters of Exchange*; Chakrabarti, *Materials and Medicine*; "Mobilising Medicine", ed. Cook and Walker.

healthcare.[5] Despite the valiant efforts of a small group of researchers, medicine in the Portuguese empire could still be described as "chronically understudied" in 2013.[6] The early Spanish empire is more heavily researched, but Mexico receives by far the most attention.[7] With both empires, research rarely goes earlier than 1550. By denying that the term "colonial medicine" can apply to earlier centuries, it suggests that there is something intrinsically modern about the term. Yet as we will see below there is scholarship on medieval colonialism, a growing interest in a postcolonial and global Middle Ages, and for twenty years now the field of medieval medicine has burgeoned.[8] Even if the colonial medicine bandwagon is going in a different direction, it is worth jumping on for a bit to find out what medievalists can gain from it. This essay will start by surveying modernist answers to Shula Marks's question, go on to explore debates about medieval colonialism, and end by considering the role of health and medicine in the medieval expansion of Europe with particular focus on Iberian conquests. Considering what was "colonial" about medicine in the Middle Ages will turn out to be a useful way to problematize chronologies and approaches in both Iberian and medical history.

Modern answers to the question of what colonial medicine is

A survey of modern studies of colonial medicine suggests that there is a lack of precision about what "colonial medicine" is or was, and a lot of overlap exists with two other terms: "tropical medicine" and "imperial medicine".[9] These terms are not interchangeable, even if often used indiscriminately. Very few scholars consider whether the word "medicine" itself requires defining. "Tropical" medicine is seen as a discipline of medical science that developed in the late-nineteenth century to tackle the diseases of hot climates. It grew out of older discourses and experiences of illness in the colonies, flourished in research laboratories in Europe and was exported back to the colonies to tackle malaria, sleeping sickness, cholera and nutritional deficiencies.[10] Arguably once exported, it became a form of "colonial" medicine. "Colonial medicine" has been seen as a tool of empire enabling settlement in the colonies, and "tropical medicine" as a method of carrying out the imperial project, however that is perceived, but the relationship between them is not clear-cut. The main difference between "colonial" and "imperial" medicine seems to be that the former refers to medicine practised *in* the colonies. As Mark Harrison notes, "colonial medicine was pre-eminently a medicine of place".[11] "Imperial medicine", on the other hand, refers to health policies imposed by the imperial power and linked to metropolitan policies

[5]Cañizares Esguerra, "Iberian Colonial Science"; *Colonial Botany*, ed. Schiebinger and Swan; Schiebinger, *Plants and Empire*; *Merchants and Marvels*, ed. Smith and Findlen; *Science and Empire*, ed. Delbourgo and Dew; *Science*, ed. Bleichmar et al; de Vos, "Science of Spices"; Raj, *Relocating Modern Science*; Secord, "Knowledge in Transit"; Roberts, "Situating Science".

[6]Cook and Walker, "Circulation of Medicine", 347. But see now the other articles in this issue by Cagle, Farelo, and Rodrigues and Sá, as well as Xavier and Županov, *Catholic Orientalism*, chapter 3; *Medicine, Trade and Empire*, ed. Costa.

[7]Earle, *Body of the Conquistador*; Norton, *Sacred Gifts*; Fields, *Pestilence*; Miéville, "Medical Pluralism".

[8]For research on medieval colonialism and postcolonialism, see references provided below, especially Bartlett, *Making of Europe*; *Postcolonial Middle Ages*, ed. Cohen. For current approaches to medieval medicine, see *Between Text and Patient*, ed. Glaze and Nance.

[9]Haynes, *Imperial Medicine*, 1–11; Chakrabarti, *Medicine and Empire*, ix–xxix. For a wider discussion, see Loomba, *Colonialism/Postcolonialism*, 1–7; Osterhammel, *Colonialism*, 1–22.

[10]Haynes, *Imperial Medicine*; *Warm Climates*, ed. Arnold; Chakrabarti, *Medicine and Empire*, 141–59. For older applications of the "tropics", see Cagle, "Beyond the Senegal", in this issue. On the need to define medicine, see Ernst, "Beyond East and West", 510; Chakrabarti, *Medicine and Empire*, xiii–xiv; Roy, "Science", 448.

[11]Harrison, *Medicine*, 4.

and institutions. The policies affected the colonies but usually did not originate there, although overseas experience could influence implementation of policy in Europe. A good example of this is smallpox vaccination imposed, resisted and negotiated in European countries and European colonies alike from the nineteenth century.[12] To a very great extent, modern European medicine *was* imperial medicine.[13]

It is possible to identify common themes and debates that have emerged over time in studies of colonial or imperial medicine. The first historians of empire in the nineteenth century primarily saw European medicine as a means to keep European troops, sailors and settlers alive in a hostile environment and only later did it become the gift of civilization to the benighted peoples of a disease-ridden world. From the 1920s, however, medicine in the colonies slowly began to be seen in a more critical light as a method of subjugating indigenous peoples with disruptive and often unhealthy consequences; imperial expansion began to be seen as the *cause* of disease. The picture shifted again from the 1960s as decolonized nations considered their approaches to disease and malnutrition. As a result, historians of the new fields of colonial and postcolonial medicine focused from the 1980s on themes of oppression and racial tension leading to or resulting from inequalities in healthcare, especially in the context of epidemic or nutritional disease and madness. Studies of colonial medicine are often full of dichotomies: centre/periphery, colony/metropole, east/west, Western/indigenous. Postcolonial studies usually try to deconstruct these dichotomies or at least to show that the relationships were two-way even if still unequal. However, race, power, disease and inequality continue to dominate as themes.[14]

The most recent scholarship tries to explore the agency of numerous groups: indigenous healers, indigenous medical practitioners trained in Europe or in colonial institutions based on European models, local government officials and both expatriate and native sick people. The historical approaches of Subaltern Studies and "history from below" have interacted very well in the field of the history of medicine to recover the stories of previously neglected or marginalized actors. This process mirrors the enlarging scope of medical history in recent years beyond institutions, physicians and technologies to include patients, low-status health-workers, and more diverse practices that affect mind and body such as bathing, waste disposal, drug use and eating.[15] Ernst also argued in 2007 for area studies: why not a social history of South Asian medicine(s) rather than a history of colonial medicine in India?[16] It seems that the former is the approach of the *Oxford Handbook of the History of Medicine* (2013), which includes chapters on medicine in Latin America, sub-Saharan Africa and Australasia, rather than general chapters on colonial medicine and tropical disease, which was the approach taken by the *Companion Encyclopedia of the History of Medicine* (1993). The only chapter to mention the word "colonial" in its title in the new *Handbook* is interestingly Mark Harrison's study of South Asian medicine.[17] This

[12] *Bulletin of the History of Medicine* 83 (2009) is a special issue on global smallpox vaccination.
[13] Haynes, *Imperial Medicine*, 6, makes this correlation with British medicine.
[14] Marks, "What is Colonial about Colonial Medicine?"; Ernst, "Beyond East and West"; Chakrabarti, *Medicine and Empire*; Arnold, *Colonizing the Body*; Haynes, *Imperial Medicine*; Anderson, "Postcolonial histories of medicine"; *Western Medicine as Contested Knowledge*, ed. Cunningham and Andrews; Vaughan, *Curing Their Ills*.
[15] Ernst, "Beyond East and West"; *Medicine and Colonialism*, ed. Bala; *Crossing Colonial Historiographies*, ed. Digby, Ernst and Mukharji; Chakrabarti, *Medicine and Empire*; Chakrabarti, *Materials and Medicine*; *Imperial Medicine and Indigenous Societies*, ed. Arnold; Attewell, "Interweaving"; Winterbottom, "Of the China Root"; "Mobilising Medicine", ed. Cook and Walker; Roy, "Science"; Porter, "The Patient's View"; *Subaltern Studies*, ed. Guha.
[16] Ernst, "Beyond East and West", 517–19.
[17] Harrison, "Medicine and Colonialism". See also Anderson, "Making Global Health History".

title suggests that there will continue to be debate about how to study medicine in former colonies. Ernst has already warned that national histories of medicine run the risk of repeating the old grand narratives, and that decentring colonialism diminishes the immensity of the abuses that were carried out in its name. Ever since Michel Foucault put pen to paper it has been a truism that medicine is *always* about power. Yet Ernst feels that to compare power relations in Indian medicine too closely to those in British medicine might excuse atrocities specific to colonialism. She prefers to see connections rather than parallels.[18]

Other historians will disagree with Ernst, especially those working on parts of Europe where healthcare relationships are not yet well-studied, such as Portugal. It does not seem surprising that Timothy Walker is one of the most prominent historians working on medicine in the Portuguese empire in the English language. He began his career by researching the role of physicians in the Portuguese Inquisition who sought to eradicate magical healing practices in Portugal. He now explores the role of Jesuit physicians, indigenous healers and pharmaceutical commodities across the Portuguese empire, similarly drawing out tensions between different kinds of healing and different attitudes towards illness. Moving from one hegemonic yet contested system in Portugal to others in Asia shows both parallels and connections.[19] "European" medicine was not monolithic so what was exported to the colonies was equally complicated. Enforced colonization of spaces, minds and bodies occurred in European indigenous medicine as well as abroad and it would be a mistake to see these as separate phenomena.

The most recent research on colonial medicine focuses on these complex connections, not just those between colonizing powers and the colonized, but also those between colonies and different empires.[20] Too great an emphasis on the British Empire is now recognized as a hindrance to understanding other colonial contexts. Comparative work on healthcare in many different places seems to be the way forward, with the long-term goal of "provincializing Europe" within its global context, however impossible this might seem and however fraught the term "global" might be.[21] Medievalists have become interested in a "global" Middle Ages just as the term becomes problematic for some modernists.[22] What is sometimes called the "centre" or the metropole in colonial or imperial history is only another locality, often one that is peripheral to many people. The sociologist of science Bruno Latour argues that "no place dominates enough to be global and no place is self-contained enough to be local"; for him some places are just more "connected" than others.[23] Global knowledge can therefore be defined as knowledge that passes through multiple localities always changing in nature as it travels. Focusing too much on the "global" in medical history can obscure the specificity of healthcare in particular localities.[24] Colonial medicine should therefore continue to mean medicine practised *in* the colonies, connected to the colonizing power through imperial/global processes and policies, but unique to each locale due to climate, indigenous beliefs and practices, regional geo-politics and other complex factors. This essay will therefore consider "colonial medicine" in the Middle Ages as

[18]Ernst, "Between East and West", 511.
[19]Walker, *Doctors, Folk Medicine and the Inquisition*; Walker, "Acquisition and Circulation"; Walker, "Medicines Trade". For health and hegemony, see Arnold, *Colonizing the Body*, 240–89.
[20]For example, Chakrabarti, *Materials and Medicine*, compares India and the Caribbean.
[21]Chakrabarty, *Provincializing Europe*; Loomba, *Colonialism/Postcolonialism*, 255–6.
[22]A new journal *The Medieval Globe* launched in 2014 with a fine special issue on the Black Death. See also Abu-Lughod, *Before European Hegemony*; Ruíz, "Medieval Historians and the World". For an overview of modern debates, see Potter and Saha, "Global History".
[23]Latour, *Reassembling the Social*, 204. See also, *Global History*, ed. Hopkins; *Globalization*, ed. Gills and Thompson; Roberts, "Situating Science".
[24]Anderson, "Making Global Health History", analyses some of the problems.

the medicine of places into which certain "European" groups expanded and settled. Modern colonial medicine is seen as a tool enabling colonization; a method of creating "others" in the colonies and of "othering" the colony itself; a method of drawing boundaries between "them" and "us" by pathologizing racial difference or by controlling access to or regulating healthcare. Medicine is seen as a prism through which to view colonialism in action and as a method of critiquing it since healthcare practices usually accompanied and were influenced by colonial settlement. Some of these aspects can be identified in the Middle Ages. This essay presents some preliminary research that will help to bring medieval colonial medicine into view.

Medieval colonialism

Before considering whether there was a colonial medicine in the Middle Ages, it is important to discuss the concept of medieval colonialism. The idea that there was medieval colonization became attractive to scholars after the publication of Robert Bartlett's highly influential *The Making of Europe* in 1993, although the matter had already been debated for decades. By "colonization", most medievalists mean the migration of peoples of one ethnicity and/or region to another to become the culturally and politically dominant people in that new region through the imposition of their own laws, and the marginalization of the existing population.[25] It has been argued by Bartlett and his followers that there was colonization of this kind during the period of the crusades to the Holy Land, especially after the establishment of four Latin Christian states in Syria and Palestine (1099–1291), during the Norman invasions of England and Sicily in the late eleventh century and the Anglo-Norman/English conquest of Ireland and Wales during the twelfth and thirteenth centuries, and during the settlement of large areas of central Europe and the Iberian Peninsula over many centuries.[26] In more recent years, critics have argued that the concept of "medieval colonization" relates to the nineteenth-century contexts of the first professional historians rather than to medieval "reality".[27] Nevertheless, there is still a general acceptance that there were aggressive migrations during the Middle Ages.

There has been less acceptance of the idea that there was a medieval "colonialism"; that is, colonization as a deliberate centralized policy with specific aims. This is perhaps ironic considering the growing interest in expanding medieval empires,[28] and the important influence of postcolonialism on medieval literature.[29] Critics of medieval postcolonialism argue that medievalists

[25]Bartlett, *Making of Europe*. See also *Medieval Frontier Societies*, ed. Bartlett and MacKay; *Medieval Frontiers*, ed. Abulafia and Berend; Muldoon and Fernández Armesto, 'Introduction"; Jensen and Reynolds, "European Colonial Experience"; Verlinden, *Beginnings of Modern Colonization*; Laiou, "Many Faces of Medieval Colonization".

[26]All of these forms of expansion fit into at least one of the colony types identified in Osterhammel, *Colonialism*, 4–10. It is interesting that earlier Visigothic, Suevi, Arab and Berber settlements of the Iberian Peninsula are rarely seen in the same light as the later Christian expansion, whereas ancient Roman, Greek and Phoenician settlements often are seen as forms of colonialization. I would like to thank both my anonymous reviewers for raising this point in different ways. It is clear that there is a great deal of myopia involved in the history of expansion and much more comparative cross-cultural and cross-chronological work needs to be done.

[27]Piskorski, "Medieval Colonization"; *Historiographical Approaches*, ed. Piskorski.

[28]The special thematic strand of the International Medieval Congress in Leeds in 2014 was 'empire'. See also Reynolds, "Empire"; Burbank and Cooper, *Empires in World History*; Muldoon, *Empire and Order*; Hart, *Comparing Empires.* For debates about what constituted an empire, see McCleery, "From the Edge of Europe"; Morier-Genoud and Cahen, "Introduction".

[29]Altschul, "Future of Postcolonial Approaches"; Altschul, "Postcolonialism"; *Postcolonial Middle Ages*, ed. Cohen; *Postcolonial Approaches*, ed. Kabir and Williams; Holsinger, "Medieval Studies"; "Decolonizing the Middle Ages", ed. Dagenais and Greer.

lack the engagement with temporal and spatial colonialism that their modernist colleagues had to have in order to develop the concept of postcolonialism in the first place.[30] Although in the 1970s Joshua Prawer and Robert I. Burns argued strongly for the colonialism of the crusader kingdom of Jerusalem and the post-conquest kingdom of Valencia respectively, their approaches seem to have been abandoned.[31] Iberianists have preferred to focus on *convivencia* and *reconquista* as methods of debating population movements, exploitation of minorities and cultural exchange, although these terms are also hotly debated, especially *convivencia*.[32] Thomas Madden, historian of Venice and the crusades, categorically denied that the crusades were the first form of European colonialism in an interview he gave in 2006. He argued that Europe was not a dominant cultural force in the Middle East, the numbers of Europeans in the crusader states were tiny, the motivation of crusaders was religious not economic, and maintaining the Latin East was a drain on European resources while at the same time the crusader states were independent of any European state.[33] Most medievalists believe that "colonialism" has to mean a mercantilist policy to conquer, settle and exploit overseas territories on a large scale. Colonies must remain dependent on the colonizing power and from them the colonizer has to draw great wealth in the form of natural resources and markets for exported goods. This fairly narrow interpretation of colonialism may apply to *some* European colonies in *some* periods but it continues to be contested.[34] Although it is not possible here to investigate thoroughly the varying natures of colonialism, it seems that there is scope to open up the medieval debate much more.

Prawer thought nearly forty years ago that the crusader states were indeed anomalous colonial societies because of their political independence. Yet the extent to which they were culturally, religiously and economically independent of Europe is much debated. It is important to distinguish, on the one hand, between the military and religious expeditions sent out from Western Europe from the late eleventh century, which are strictly what should be known as the "crusades", and on the other hand, the Latin Christian polities established in the Holy Land, which had settlement needs that could be described as colonialist but were easily subjected to royal authority when rulers of England, France and the German empire came to the Holy Land.[35] As far as the Iberian Peninsula is concerned, it is difficult *not* to see the deliberately conquered and systematically dominated and exploited former Muslim territories of the Iberian Peninsula in a colonialist light, especially from the 1230s–1240s after the conquests of Seville, Córdoba, Valencia and Faro.[36] The problem is: how long can they be seen in this light? Although it might be useful to describe Seville as a colonized city in the thirteenth century, it does not seem appropriate to do so in the fifteenth century, any more than London was still a colonized city in the thirteenth century.

We also need to consider Catalan and Genoese settlements found across the Mediterranean, and the key role played by Pisa, Genoa and Venice in the crusades, the crusader states *and*, in the case of the last two cities, in Atlantic expansion. It is not an accident that Columbus was

[30]Gaunt, "Can the Middle Ages be Postcolonial?"; Spiegel, "Épater les médiévistes"; Cohen, "Postcolonial Medieval Studies".
[31]These approaches were explored in many works but see especially, Prawer, *Latin Kingdom*; Burns, *Medieval Colonialism*. See also Lourie, *Crusade and Colonization*.
[32] Wacks, "Reconquest Colonialism"; Soifer, "Beyond *Convivencia*"; Wolf, "*Convivencia* in Medieval Spain"; Ray, "Beyond Tolerance"; Glick and Pi-Sunyer, "Acculturation".
[33]"Interview". See also Madden, *Concise History*; Bird, "Crusades".
[34]Loomba, *Colonialism/Postcolonialism*, 5, 22–43; Osterhammel, *Colonialism*, 16–17.
[35]Prawer, *Latin Kingdom*, 478–9.
[36]Fletcher, "Reconquest and Crusade"; O'Callaghan, *Reconquest and Crusade*; Lay, *Reconquest Kings of Portugal*. For an alternative view, see Linehan, "At the Spanish Frontier".

Genoese or that a Venetian wrote the best source for the Portuguese exploration of West Africa in the fifteenth century.[37] Catalan, Genoese and Venetian policy towards the indigenous populations of Menorca, Sardinia and Crete respectively can certainly look like colonialism. The people of Menorca were enslaved en masse after conquest in 1229. Late medieval Genoese settlement at Caffa in the Black Sea is similar to the colonial enclaves or island settlements of later centuries.[38] In fact, islands and enclaves were amongst the first European, i.e. Latin Christian, colonies in the Mediterranean, the Black Sea and the Atlantic, *and* amongst the last European colonies around the world (in order of acquisition: Ceuta, Goa, Macão, the Falklands, Gibraltar, Hong Kong).[39] European settlement in much of Africa, East Asia and South Asia was always limited in contrast to the "white settler colonies" of North America, South Africa and Australasia. Not all colonies were financially lucrative all of the time and most were not initially; some failed altogether. Relationships between colonies and the colonizer were often fraught and could be quite weak across the vast distances involved.

The narrow approach to colonialism relates to a tendency to see colonialism as a British phenomenon – in the interview in 2006 Madden compared the crusader states to British North America – thereby obscuring other forms of colonialism. Some modern colonialist forms were developed over centuries, often through conscious copying of older imperial models, and many had medieval precursors.[40] As Bartlett says in the concluding lines to *The Making of Europe*:

> The European Christians who sailed to the coasts of the Americas, Asia and Africa in the fifteenth and sixteenth centuries came from a society that was already a colonizing society. Europe, the initiator of one of the world's major processes of conquest, colonization and cultural transformation, was also the product of one.[41]

This argument is of course similar to that of Felipe Fernández Armesto, who asserts that patterns of island colonialism as practised by Genoa and the Crown of Aragon were replicated in the Canary Islands and the Caribbean. However, Fernández Armesto downplays the Portuguese role in this process, describing Portugal's expansionist royal family as "an impecunious and parvenu dynasty", a portrayal that researchers are still trying to combat.[42]

The negative portrayal may stem from the problem of fitting Portuguese expansion into the patterns found in British or Spanish colonialism. The Portuguese experience started before the traditional date of 1492 on the uninhabited island archipelagoes of Madeira, Cabo Verde, the Azores and São Tomé e Príncipe, and in West Africa using a negotiated model of settlements and factories similar to that of the Genoese. Only in Morocco, starting with the capture of

[37]Fernández Armesto, *Before Columbus.* For the writings of the Venetian Alvise da Cadamosto, see *Voyages of Cadamosto*, and Cagle, "Beyond the Senegal". Abu-Lughod, *Before European Hegemony*, argues that Italians entered the Atlantic because plague caused the collapse of their previous economy, but this explanation ignores Iberian merchants and the effects of plague on the Iberian Peninsula.

[38]Fernández Armesto, *Before Columbus*; Laiou, "Many Faces of Medieval Colonization", 17–18; Lourie, *Crusade and Colonization*; Balard, "*Genuensis civitas in extremo Europae*".

[39]Fernández Armesto, *Before Columbus*; Gillis, *Islands of the Mind.*

[40]See Loomba, *Colonialism/Postcolonialism*, 1–103; Hart, *Comparing Empires*, 53–76, for debates about modern colonialism, continuities with medieval colonialisms, and the copying of models.

[41]Bartlett, *Making of Europe*, 314. For a similar argument in relation to the colonialist making of medieval France, see Symes, "Middle Ages between Nationalism and Colonialism".

[42]Fernández Armesto, *Before Columbus*, 186, and chapter seven in general. See in contrast, Hair, "Before Vasco da Gama"; Miranda, "Before the Empire"; Subrahmanyam, *Portuguese Empire*, 30–54. Stevens-Arroyo, "The Inter-Atlantic Paradigm", argues instead for different processes of colonization on either side of the Atlantic.

Ceuta in 1415, and for a brief period a hundred years later, was there an aggressive policy of conquest. The early-sixteenth-century aggression was in fact the viceroy Afonso de Albuquerque's (d. 1515) grand strategy for controlling maritime commerce not an attempt at a land empire. He focused on commercial chokepoints such as the Straits of Malacca and Hormuz, and identified Goa, which he captured in 1510, as key to transoceanic routes.[43] Isabel dos Guimarães Sá refers to the Azores, settled from the 1430s, as "a premature colonial experiment", and her comment could equally well apply to Madeira, officially discovered in *c*.1420.[44] The word "premature", however, does not mean that the islands were not colonies, but that their early settlement causes them to fly under the historiographical radar. The uninhabited nature of most of Portuguese islands excluded them from discussions about indigenous rights, in sharp contrast to the Canaries and the Caribbean Islands where contact with native peoples triggered intense debate. In the case of the Canaries this happened as early as the mid-fourteenth century in the writings of Petrarch (d. 1374) and Boccaccio (d. 1375).[45] Outside Portugal, few historians show interest in its pre-1498 expansionism. The Portuguese sphere of economic interests is not mapped in Janet Abu-Lughod's influential study of medieval world systems.[46]

In fact, much of the Iberian Peninsula (Catalonia sometimes excepted) is left out of surveys of European religious and political culture, something that Nadia Altschul calls the "coloniality of knowledge".[47] The Portuguese could share the view expressed by Dagenais and Greer that the Spanish Middle Ages is a product of a double colonization of both territory and of historiography: "The story of the Middle Ages has largely been told from a northern European perspective, a perspective that pushes the Iberian Middle Ages to an exotic, orientalised fringe."[48] Yet it is a mistake to see the Portuguese princes' conquest of Ceuta in North Africa in 1415 as a fringe activity: that same year their first cousin Henry V of England, also the son of a usurper, pursued his own expansionist ambitions at Agincourt. The decision to retain Ceuta, flying in the face of military logic and at huge cost, surely does not differ so much from English attempts to hang on to Calais (the last vestige of Henry V's ambitions) until 1558 against all the odds. Although the German physician Jerome Münzer thought at the end of the fifteenth century that the Portuguese king got "more honour than profit" out of Ceuta, this does not mean it was not a colony.[49]

Similarly the Portuguese Atlantic islands were subjected to deliberate colonialist policies from the 1420s, involving the mass implantation of European institutions, tax systems, commercial activities, agriculture and slavery (a mode of production common in Mediterranean sugar production). None of this means that settlement was straightforward or non-negotiable: the islands had a diverse population of Portuguese peasants and artisans, merchants of Jewish, Flemish, Italian and Iberian backgrounds, and enslaved peoples from the Canary Islands and North and West Africa.[50] The Atlantic islands deserve much closer study by both colonial historians *and* medieval historians interested in empire and expansion. Recognizing a colonial context to Atlantic and intra-Peninsular expansion does not run counter to the widely accepted crusading, reconquest or chivalric motives for it; it simply suggests that colonialism was both an economic and an

[43]Disney, *History of Portugal*, II: 1–77, 119–27; Newitt, *Portuguese Overseas Expansion*, 36–97.
[44]Sá, *Quando o rico se faz pobre,* 118. Some of these islands must have been visited much earlier as they are depicted on fourteenth-century maps: Disney, *History of Portugal*, II: 84.
[45]Abulafia, *Discovery of Mankind*, 33–48.
[46]Abu-Lughod, *Before European Hegemony.* Spain is neglected in much the same way.
[47]Altschul, "Future of Postcolonial Approaches", 12.
[48]Dagenais and Greer, "Decolonizing the Middle Ages", 440.
[49]Műnzer, *Viaje*, 76; Miranda, "Before the Empire", 78.
[50] Greenfield, "Ilhas"; Vieira, "Emigração"; Rodrigues, *Organização*; Catz, *Christopher Columbus*.

ideological phenomenon that flourished in the name of different ideologies and within a variety of economic systems.[51]

Medieval colonial medicine

The foregoing discussion of medieval colonialism explains why there are few studies of medieval colonial medicine. After the present author gave a conference paper on this topic in 2011, a member of the audience queried whether it was tautological to ask "how colonial was medieval colonial medicine". The question implies that medieval medicine *was* colonial; perhaps, it would make more sense to ask *whether* medieval medicine was colonial. Yet the title of Marks's essay on which this essay's title is based has no quotation marks around either of the words "colonial". Her title is not tautological since it is widely accepted that the modern world is "colonial"; the problem was determining what is "colonial" about modern *medicine*. The rest of this essay will argue that there was indeed a medieval colonial medicine in territories where there was colonization.

Taking the zones in which colonization is widely believed to have occurred before 1492, the Crusader States, Norman England and Sicily, Anglo-Norman Wales and Ireland, central Europe, the Iberian Peninsula, Italian and Catalan enclaves, the Atlantic islands and North/West Africa, the fact is that until the 1980s there was little interest in healthcare for most of these regions. The grand narrative of medieval medical history focused on institutional and intellectual matters, often interpreted in a positivist way from a nationalist perspective. The daily practice of healthcare tended to be neglected in favour of intellectual developments. Even since the 1980s, health encounters between Normans and English or Syrians and Franks are rarely seen in the same way as similar encounters in early-modern India or Mexico.[52] There has been much written about the dissemination of Greek, Muslim and Jewish medicine via the twelfth-century Latin translation "movement", but this rarely embeds intellectual concerns in social and cultural contexts. Most text books refer simply to disembodied centres of translation in southern Italy and Spain. There is much less focus on the multi-cultural interface in the Eastern Mediterranean.

The implication in this neglect of the Eastern Mediterranean is that crusaders were more intent on killing than healing, but this approach seems simplistic.[53] It is worth comparing the interests of crusaders to those of Spanish settlers in the New World, where Rebecca Earle has been able to study in detail the attitudes of often illiterate *conquistadores* towards food and health.[54] Piers Mitchell has done a tremendous amount of work to establish crusader medicine as a viable field, but there is still need for further research on healthcare issues in the Eastern Mediterranean. For example, the reflections of the Syrian nobleman Usamāh ibn Munqidh (d. 1188), the sole manuscript of which survives in the library of El Escorial near Madrid, seem ripe for postcolonial analysis; his much-quoted but little understood writings about food and medical practices are rich in hybridity, mimicry, acculturation and ambiguities about "the other".[55]

[51]For chivalric and crusading arguments, see Russell, *Prince Henry*; Goodman, *Chivalry and Exploration*. For reconquest arguments, see Paviot, "Les Portugais et Ceuta". For economic arguments, see Barata, "Portugal and the Mediterranean Trade"; Miranda, "Before the Empire".
[52]Although see Bartlett, *Hanged Man*, for a resuscitation set in thirteenth-century colonial Wales.
[53]Touwaide, "Latin Crusaders"; Mitchell, *Medicine*, 205–19.
[54]Earle, *Body of the Conquistador*.
[55]ibn Munqidh, *Book of Contemplation*, trans. Cobb; Mitchell, *Medicine*. See also Lev and Amar, *Practical Materia Medica.* My student Joanna Phillips is completing a doctoral thesis at the University of Leeds on representations of health and disease in Christian chronicles of the crusades.

As far as the Western Mediterranean is concerned there are many detailed studies of medical practice, especially for well-documented Catalonia and Valencia. Yet when these discuss health encounters between Muslims, Christians and Jews they tend to draw on the conventions of *Convivencia*.[56] It is shared learning or peaceful collaborations that feature most in the scholarship rather than the unequal relationships based on shifting needs and pragmatism that one tends to find in colonial studies; the work that has been done on medicine and religion in the Atlantic world and South Asia has a much sharper edge to it.[57] David Nirenberg's work on religious violence in Castile and Aragon suggests this difference might be how medieval research is framed rather any major contextual difference. If *convivencia* remains a useful term, it no longer refers solely to peaceful interactions.[58] It is time that medical historians also begin to take a more critical view of patient-practitioner relationships, not because they involved people from different faiths but because they may represent the conquered and the conquerors. Moving away from formal medicine to a wider range of "technicians of the body" is more revealing: studies of wet nurses, prostitutes and food providers in the Western Mediterranean highlight the vulnerabilities of Muslims and converts, especially women.[59]

Even within formal medicine, historians working on licensing systems in the Iberian Peninsula have interpreted new legislation in Valencia in 1329 as a method of limiting the practice of medicine by non-Christians, just over ninety years after the conquest of the city in 1238.[60] This is comparable to the ban on the practice of indigenous practitioners without a licence in Goa in 1618, one hundred and eight years after its conquest by the Portuguese.[61] In both the newly conquered parts of the Iberian Peninsula and in post-conquest Mexico and Goa, healers of all kinds were originally tolerated due to the needs of the community. It is well-known that the medical licensing systems of the New World were based on those of fifteenth-century Spain. Similarly, King Manuel of Portugal (r. 1495–1521) reformed a licensing system that had been in place since at least 1338. Yet comparisons are rarely made between other aspects of colonial and Iberian medicine.[62] There could, for example, be more postcolonial scrutiny of how knowledge, manuscripts, medicinal drugs and foodstuffs were circulated, appropriated, (mis)attributed and consumed north and south of the Pyrenees. Such research could draw on debates and approaches developed by early-modern historians of science who have looked at the Spanish and Portuguese Atlantic or who follow the trajectories of particular commodities and practices.

To provide one example of how fruitful medieval-modern comparisons could be, it is worth exploring the similarities between the scholars who came down from north of the Pyrenees from the twelfth century to find manuscripts in the libraries of Castile, exploiting the learning of Muslim and Jewish physicians and translators, and the later "bio-prospecting" for plants and therapeutic knowledge that went on in the Spanish Atlantic.[63] Historians interested in what happened to the manuscripts of medieval Spain after the Christian conquest of Toledo in 1085 could

[56]See most of the excellent research by Luis García Ballester and Michael McVaugh.
[57]For a recent post-medieval approach, see Hayden and Walker, "Intersecting Religioscapes".
[58]Nirenberg, *Communities of Violence*; Soifer, "Beyond Convivencia".
[59]Winer, "Conscripting the Breast"; Mummey and Reyerson, "Whose City is this?" Constable, "Food and Meaning". For "technicians of the body", see Fissell, "Introduction".
[60]García Ballester, McVaugh and Rubio Vela, "Medical Licensing"; López Terrada, "Medical Pluralism"; Lepicard, "Medical Licensing"; Ferragud, "Expert Examination".
[61]Županov, "Conversion, Illness and Possession", 268, gives the date of the ban as 1563, but Pearson, "Portuguese State", 416–18, explains that this earlier ban does not seem to have had much effect. See also figueiredo, "Ayurvedic Medicine", 230; Boxer, "Some Remarks", 296.
[62]López Terrada, "Control"; McCleery, "Medical Licensing"; Mendonça, "Reforma"; Lanning, *Royal Protomedicato*; Miéville, "Medical Pluralism"; Dutra, "Practice of Medicine"; Boxer, "Some Remarks".
[63]Schiebinger, *Plants and Empire*; *Colonial Botany*, ed. Schiebinger and Swan.

pay more attention to research on the construction and circulation of knowledge. There is a debate within the history of science about the extent to which indigenous knowledge travelled with traded commodities: some doubt that imperial bio-prospectors were interested in the cultural "baggage" that came with a drug or foodstuff. It is possible to argue that the Flemish botanist Charles de l'Écluse (Carolus Clusius) in his 1567 Latin translation of Garcia de Orta's *Colloquies on the Simples, Drugs and Materia Medica of India*, first published in Portuguese in Goa in 1563, stripped out the Indian geo-political material that Orta had used to contextualize the drugs, diseases and treatments because they did not matter to him.[64] Harold Cook and Londa Shiebinger contend that not only were early-modern European botanists primarily interested in the utility and profit to be got from drugs, but they struggled to understand "alternative ways of ordering and understanding the world" and therefore had to fit their new knowledge into existing European frameworks such as humoural theory.[65]

In contrast, Marcy Norton argues in the case of chocolate that both the equipment and the rituals associated with the drink in elite Aztec culture travelled with it to Spain; not via European learned texts but through the undocumented daily pragmatism of travellers.[66] Similarly, Kapil Raj, Teresa Huguet Termes, Timothy Walker and Júnia Ferreira Furtado have argued for much more complex and less flowing methods of dissemination. They also focus more on the continued use of remedies and foods in their "original" location.[67] It is probable that these diverse approaches represent some of the differences between "colonial" and "imperial" medicine discussed at the start of this essay; some historians focus on writings produced *as* knowledge for immediate use in the colonies, others explore how these writings were produced *for* knowledge creation elsewhere.[68] So to return to medieval Iberian medical manuscripts: these should equally be seen as traded commodities that were produced in an indigenous cultural context but commodified for the cathedral schools, monasteries, universities and royal courts of northern Europe and Italy. The original identities of the non-Christian authors were of limited interest; even the ancient Greek medical authority Galen became quasi-Christian in the late Middle Ages.[69] Muslim authors and translators were rarely correctly or fully named. The knowledge within these texts was itself a commodity that travelled from one cultural context to another, adapted for new purposes. Alongside the texts also travelled the materials they mention (sugar, figs, raisins, lemons, saffron), many of which became desirable foodstuffs among the same northern elites that collected manuscripts.[70] Nevertheless, these texts were also used in Iberian towns by Muslims, Christians and Jews, and later became the mainstay of Iberian universities as elsewhere; the foodstuffs were closely linked to Muslims within the Peninsula but widely consumed nonetheless.[71]

[64]Orta, *Colóquios*; Županov, "Drugs, Health, Bodies and Souls"; Xavier and Županov, *Catholic Orientalism*, 85–96; Costa and Carvalho, "Between East and West"; Costa, "Geographical Expansion"; *Medicine, Trade and Empire*, ed. Costa; Farelo, "Garcia de Orta", in this issue.
[65]Cook, *Matters of Exchange*; Cook, "Global Economies and Local Knowledge"; Schiebinger, "Prospecting" (quotation at 128).
[66]Norton, "Tasting Empire".
[67]Raj, *Relocating Modern Science*; Huguet Termes, "New World Materia Medica"; Walker, "Acquisition and Circulation"; Furtado, "Tropical Empiricism". See also Miéville, "Medical Pluralism", chapter five.
[68]Raj, "Early-modern European botanising"; McCleery, "From the Edge of Europe".
[69]Nutton, "God, Galen and Depaganization".
[70]Miranda, "Before the Empire"; Childs, *Trade and Shipping*; *Regional Cuisines,* ed. Adamson.
[71]García Ballester, "Marginal Learned Medical World"; Constable, "Food and Meaning". For the consumption of some of these foodstuffs in Portugal, see Rodrigues and Sá, "Sugar and Spice", in this issue. For the curricula of the University of Lisbon and the approach of its professors to both new and old learning, see Farelo, "Garcia de Orta".

There are of course differences between Iberian and later intellectual contexts. There was considerable respect already in the twelfth century amongst Latin scholars for medical and natural philosophical learning written in Arabic or Hebrew but based on shared Graeco-Roman theories. Muslim and Jewish practical knowledge about foods, magic, drugs and treatments circulated as a by-product of a search for Aristotle, Galen and Ptolemy. Yet there was a similar respect for Ayurvedic medicine in sixteenth-century India, perhaps because it recognized concepts akin to the humours.[72] Furthermore, the transferability of pagan authors to Latin Christendom was partly due to their prior adaption to monotheism within Islamic cultures. Galenic medicine was largely taught at European universities through authors like the Persians Abū ʿAlī al-Ḥusayn ibn ʿAbd Allāh ibn Sīnā (Avicenna, d.1037) and Abu Bakr Muhammad ibn Zakariyā al-Rāzī, (Rasis, d. 925).[73] Yet what was transmitted was not "pure" Avicenna, but reinventions made to fit the needs of Christian societies. This process is not dissimilar to the way in which a codex of herbal medicine was produced in mid-sixteenth-century Mexico; this text was not "pure" Nahua medical knowledge but a reinvention of it combined with Spanish medicine for new purposes.[74]

A very good recent study of the northern Europe's appropriation of Iberian medical knowledge is Monica Green's fascinating analysis of the transmission of the writings of the late-tenth-century Cordoban surgeon Abū al-Qāsim al-Zahrāwī (Albucasis, d. 1013), normally seen as the high point of medieval surgical expertise. The transmission of Albucasis was not a smooth circulation of ideas. First translated into Latin by Gerard of Cremona (d. 1187) in Toledo, no Latin manuscripts survive until the mid-thirteenth century, as is the case with most of Gerard's work, and most manuscripts thereafter are Italian. The accompanying images were often distorted by copyists who did not understand their function. Most owners were practising physicians and surgeons who may have understood the precise clinical detail. Amongst these individuals were a surgeon of the Aragonese kings, a Jewish physician of the Catalan town of Perelada and a physician of Valencia, but their possession of this book was not a neat circular path back "home".[75]

The present essay's premise is that differences between medical encounters in often fraught contexts such as post-conquest Andalusia and Mexico may be quantitative rather than qualitative. All these encounters are grounded in daily life and practical needs. A useful term is that of the "contact zone" developed by Mary Louise Pratt for eighteenth- and nineteenth-century travel writing and further developed by Londa Schiebinger as the "biocontact zone" where scientific encounters occurred. Pratt uses the term

> to refer to the space of colonial encounters, the space in which peoples geographically and historically separated come into contact with each other and establish ongoing relations, usually involving conditions of coercion, radical inequality, and intractable conflict.[76]

This kind of "contact zone" is familiar to medievalists, who might associate it with the idea of "frontier", as indeed Pratt does also, but they need to start seeing cultural frontiers as much more fraught spaces for colonial healthcare encounters. This essay will end with three examples of medicine in Iberian "biocontact zones" in the 1490s: Granada, Hispaniola and Madeira.

[72]Figueiredo, "Ayurvedic Medicine".
[73]Pormann and Savage-Smith, *Medieval Islamic Medicine*, 165–6.
[74]*Aztec Herbal*, ed. Gates; Viesca Triviño, "Códice de la Cruz-Badiano".
[75]Green, "Moving from Philology to Social History"; Savage-Smith, "Practice of Surgery".
[76]Pratt, *Imperial Eyes,* 6–10; Schiebinger, "Prospecting", 125; Roberts, "Situating Science".

Three biocontact zones

The first example of a medieval biocontact zone is Granada. Not long after the conquest of 1492, an unidentified Christian "minister", whom L.P. Harvey argues was likely to have been the new Archbishop of Granada, Hernando de Talavera (d. 1507), received medical care from an eminent imam, Ibn al-Mawwaq, when his hand began to swell up. In 1501, the Archbishop of Toledo, Francisco Jiménez de Cisneros (d. 1517), was treated by an elderly *curandera*, possibly a highly respected midwife and religious leader known from other sources as the *Mora de Úbeda*. She was ironically the kind of Muslim healer that Cisneros tried prematurely to ban in 1498; not only did her community still need her but so did he! As noted earlier, it was decades before anyone seriously attempted to limit indigenous practice in post-conquest Valencia and Goa. Although these Granadan examples of medical practice seem to have been conducted according to the ideals of peaceful *convivencia*, Harvey sets them in the context of growing tensions within the Muslim community, partly due to Cisneros's harsh approach to conversion, which led to the revolt of the Alpujarras in 1499–1500, and the burning of all books in Arabic in 1501, except notably for medical texts.

In these two cases, the clinical encounter with the "other" could be interpreted as something done out of necessity by sick foreigners or as a means to communicate with local power brokers. The methods of healing are significant; the imam behaved like some saints in both Muslim and Christian traditions; that is to say, his touch may have caused the illness in the first place as he had previously kissed the Christian's hand. Perhaps it was a form of punishment of the "unbeliever" followed by a carefully timed healing that increased the healer's authority. The *curandera* used non-invasive herbal ointments "without giving purges, letting blood or other [internal] medicines", providing an alternative to the failed treatments of the court doctors.[77] Perhaps the point being made here was that gentler methods might enable a stronger body politic without the need for bloodshed. Both these cases can usefully be compared to accounts of cross-cultural clinical encounters in sixteenth- to eighteenth-century India, Brazil, Mexico and West Africa, several of which saw conflicts of opinion, divergent practices and considerable therapeutic success, but also worked symbolically to reflect community tensions.[78] It is not just a case of daily healthcare continuing amidst tensions; the unequal encounters between new political authorities and conquered practitioners signified much deeper "dis-ease" and pointed towards the need for political healing that *with hindsight* was lacking in Granada.[79]

The second example of a Spanish biocontact zone that should be seen as *medieval* is the Caribbean in the 1490s. Diego Álvarez Chanca (d. *c*.1515) was a prominent royal physician from Seville who accompanied Columbus on his second voyage in 1493, returning as soon as he could the following year. In a letter to the municipal council of Seville, Chanca used his medical skills of observation to describe the food and environment of the new world in which he found himself, including accounts of illness, poisonous fruit and cannibalism. He played a crucial role in examining the wound of an indigenous ruler said to have been injured in a conflict related to the deaths of the Europeans whom Columbus had left behind on Hispaniola. Chanca did

[77]Harvey, "Granada under the Catholic Monarchs", 72–3.
[78]See for example, Walker, "Roles and Practices"; Cagle, "Botany of Colonial Medicine"; Cagle, "Dead Reckonings"; Salazar Simarro and Owens, "Cloistered Women"; Pearson, "Hindu Medical Practice"; Fields, *Pestilence*; Sweet, *Domingos Álvares*; Miéville, "Medical Pluralism".
[79]Harvey could have made more of his point that Ibn al-Mawwaq's intervention is only known from a seventeenth-century biographical dictionary. The story of the *curandera* is told by Juan de Vallejo (d. after 1547), who wrote after Cisneros died in 1517 but whose words were only published in an "official" biography by Álvaro Gómez de Castro in 1569.

not believe that the ruler was injured, thereby suggesting that the local people had lied about what happened.[80]

Strangely, Chanca's account has not been much studied from a medical point of view, except in relation to the history of disease, or discussed much in the light of colonial discourse, except in relation to cannibalism.[81] It might be thought that since Chanca's journey occurred after 1492 and took place in the Caribbean, his narrative could be accepted as a modern colonialist account without question. Yet it seems artificial to separate Chanca from earlier medical writers. Although Chanca wrote to the councillors of Seville, he was also a royal physician. His role on the expedition was therefore similar to that of the Catalan physician Arnau de Vilanova (d. 1311), who explained to the king of Aragon how to provision his army and avoid health problems on a proposed military expedition against Muslim Almería in 1309. Chanca is also not dissimilar to the aforementioned German physician Műnzer, whose account of a journey around the (for him) exotic Iberian Peninsula in the 1490s may have been a form of espionage authorized by the Emperor Maximilian (d. 1519) in order to investigate Iberian exploration. Both Chanca and Műnzer used food and illness as gauges of "otherness".[82] In Chanca's case, his narrative ensured that the councillors of Seville saw the indigenous peoples of the Caribbean as untrustworthy man-eaters and the New World as an unhealthy place to live, based on standard medieval environmental theories and his clinical skills. It is surely the case that the main difference between earlier and later accounts of medicine used as a tool of empire to describe and thereby disempower the "other" is the vastly greater number of accounts that survive from later centuries rather than anything intrinsically different in their method and approach.

The final biocontact zone to be studied here is the island of Madeira. On 27 April 1496, the town councillors of Funchal, the main settlement on the island, discussed the case of a man called Andre Janoes, newly arrived on Madeira and probably from Genoa, who claimed to be able to cure a disease called *boulhas*. He said he could cure it within nine or ten days, eighteen to twenty at the most, as long as the sick person kept to the regimen that he recommended. He was supported in his claims by Simão Gonçalves, the hereditary captain of Funchal, who said that Andre had already cured his female slave. The council ended by granting the newcomer a licence to practise.[83] This brief episode might be the first reference to syphilis in Portuguese archives. *Boulhas* is similar to the word *bubas* widely used from the late 1490s to refer to the apparently new disease much later known as syphilis.[84] Neither *boulhas* nor *bubas* were previously used in the minutes of the Funchal town council meetings to refer to disease, despite there often being a lot of detail provided. For example, in 1495 the symptoms of a woman who died of pestilence (*pestenencia*) were described as an *ingoa* (swelling) on the leg and a *vergam* (pustule?) on the stomach.[85] The town authorities were experienced in tackling disease but they took a different approach to *boulhas* in 1496.

Whether the disease was new or not, it is highly significant that the first person on the island to be treated for it was an unidentified enslaved woman. The relative attractiveness of the climate and the gradually less intensive agriculture (moving for a variety of reasons from a sugar to a

[80] *Select Letters*, trans. Major, 19–71.
[81] Cook, *Born to Die*, 28–39; McCleery, "From the Edge of Europe"; Gallinari, *Diego Alvarez Chanca*; Paniagua, *Doctor Chanca*.
[82] McVaugh, "Arnau de Vilanova's *Regimen Almarie*"; Műnzer, *Viaje*, is rich in medical references.
[83] *Vereações*, ed. Costa, I: 464–5.
[84] For the terminology of plague in Portugal, see Roque, *Pestes medievais*, 162–8. By 1504 there was an isolation ward called the "casa das bubas" attached to the new Hospital of All Saints in Lisbon: *Regimento*, ed. Salgado and Salgado.
[85] *Vereações*, ed. Costa, I: 404.

wine economy) meant that Madeira saw considerable European immigration and needed far fewer slaves, compared to the other Portuguese archipelagos further south where conditions seemed much harsher. It has been suggested that most of the enslaved people to be found on Madeira by the mid-sixteenth century (*c.*3000 people or roughly 15% of the population) were probably domestic servants or skilled artisans, many of whom were manumitted at the death of their owner. Despite this relative ease of absorption into the population, life was not easy for slaves. They were likely to have been most vulnerable to the frequent periods of dearth, bad weather and pestilence experienced by the isolated islanders.[86] Slaves were also at the mercy of their master's cruelty. A woman called Cumba, described as a *moura* so probably originally a North African Muslim, was treated so harshly by her master, Fernão Nunes of Funchal, that she died of her injuries. He buried her in his house to conceal the death but the body was found and he had to flee, later in 1489 and 1490 seeking royal pardons which document the crime.[87] The fact that a hue and cry was raised when the body was found implies that this was not deemed acceptable behaviour in Funchal. The 1491 pardon of João Vaz Ousel, a knight of Madeira, describes how he was exiled to Tangiers for killing his male slave; therefore the prosecution that followed Cumba's death was not an isolated example.[88]

Documents like these suggest that the otherwise unknown slave of Simão Gonçalves who was cured by Andre Janoes in 1496 was fortunate in that she was likely to have been a domestic servant of the most powerful man on the island and therefore probably on her way towards fuller integration into the community and deserving of a reasonable level of protection. However, it is also the case that the dead slaves referred to above had become the objects of an increasingly bureaucratic state; their deaths reflect the expansion of legal process, not care for individuals. This situation intensified when Duke Manuel of Beja, the feudal lord of the islands, became king of Portugal in 1495, shifting their administration towards Lisbon.[89] The slaves were elite skilled workers whose deaths represented an economic loss to the local community (whereas the king overrode these local interests by pardoning the culprits). Similarly, the anonymous female slave's medical treatment represented an investment in her person which no doubt was intended to have a positive economic outcome. One should not sentimentalize her care; her treatment by a previously unknown and untested itinerant healer could be seen as a form of medical experimentation on an expendable patient. The possible venereal nature of the woman's illness suggests that she may have been sexually vulnerable, a condition that she shared with earlier Mediterranean slaves.[90] There are many other examples. In 1482, the royal chief-surgeon Master Fernando sought a pardon in Santarém for his Muslim slave Mariam because she had been forced to sleep with a Christian squire.[91] In Goa in 1512, two Portuguese settlers, one of them a physician Master Afonso, fought bitterly over who would be able to marry a probably Hindu woman who had been enslaved and converted for this purpose.[92]

Yet that woman of Goa was considered a suitable wife, at least in India; Mariam's honour could be upheld by the king; and Andre Janoes was permitted to practise medicine on other islanders, not necessarily slaves. His licence implies that the authorities believed that an enslaved person's symptoms and cure could be repeated on non-enslaved bodies; there was no fundamental

[86]Carita, *História da Madeira*; Matos, "Origem"; Greenfield, "Ilhas"; Nepomuceno, *História de Madeira*; Vieira, *Escravos*.
[87]*Documentos inéditos de Marrocos*, 303–4, 311–12.
[88]*Documentos inéditos de Marrocos*, 369.
[89]This can be seen in the increasingly brief council minutes: *Vereações*, ed. Costa, II: i–v;
[90]Winer, "Conscripting the Breast".
[91]Queirós, "Theudas e manteudas", II: 27–8.
[92]*Cartas*, ed. Pato, I: 31–2.

humoural or physical difference between peoples. Medicine here can be seen as a tool of empire in that cases involving sex, health and injury allowed royal authorities to intervene in local politics in order to expand imperial power. These incidents also enabled increased European colonial settlement. There was a complaint about the number of "foreigners" in Funchal later in 1496, but a foreign healer was welcome as was the Portuguese physician Master Afonso in Goa. He failed to get a local wife on that occasion but was not punished because his medical skills were desirable in the precarious new colony.[93] Medicine can also be seen in these cases as a prism through which to view empire in action. Race, power, inequality and disease were as significant in Granada, Funchal, Hispaniola and Goa in the fifteenth and early sixteenth century as they were already in West Africa, as Hugh Cagle demonstrates elsewhere in this issue, and would be later in Asia and the Americas.[94] As in later time periods these cases show too that colonial settlement required pragmatism, flexibility and endurance in order to succeed against the odds. "Biocontact zones" were not just places of colonial encounter; they were spaces were people lived and died.

Conclusion

This essay has argued that healthcare encounters between conquerors and the conquered across Europe and the Middle East as well as in the Iberian Peninsula and its early colonies should be studied as forms of colonial medicine. The essay endeavoured to break down standard periodizations. It also presented a very much broader picture of "medicine" than readers might have been used to previously, using it as an umbrella term to cover a wide range of interventions affecting the human body. Yet a number of issues remain. Throughout the essay there were references to researchers known as "medievalists" and others known as "modernists". These labels appear more deeply entrenched than at first was expected. It is probable that they are not just professional identities and that chronological differences need to be discussed further.[95]

First of all, there is the matter of using medical history to critique colonialism, a major feature of modern colonial and postcolonial scholarship. Although the abuse of enslaved people has featured as a topic, it is difficult to critique fifteenth-century expansionism from the perspective of modern civil rights. David Abulafia takes a rare apologist stance throughout his major book on cultural encounters in the medieval Atlantic.[96] Historians of nineteenth- and twentieth-century colonial medicine can see direct relationships between past and present healthcare in the countries they study and can use their research to critique relatively recent policies. Historians of the Middle Ages are able to demonstrate the relevancy of their fields to the modern world and can certainly draw attention to modern abuses of power through their writing. Yet relevancy and reflection are not the same as direct influence.[97] Modern Europeans cannot be held responsible for acts carried out by fifteenth-century people. On the other hand, taking a colonial approach to medicine might be less problematic for medievalists than doing "global history". Global history is fast becoming a new grand narrative, one that Warwick Anderson argues is really postcolonial history in disguise.[98] It does seem to be the case in any time period that documenting disease or daily life or following the bumpy connections between people and commodities on the move is very closely tied to expanding networks of power and trade as is the survival of much of the evidence. This leads to a second issue. The fact

[93] *Vereações*, I: 569–70; McCleery, "From the Edge of Europe".
[94] Cagle, "Beyond the Senegal".
[95] See also the debates in *Medieval or Early Modern*, ed. Hutton.
[96] Abulafia, *Discovery of Mankind*.
[97] For socially engaged medieval writing, see *Why the Middle Ages Matter*, ed. Chazelle *et al*.
[98] Anderson, "Making Global Health History", 377.

that there is so much more evidence for healthcare in later centuries should not be seen as mere chance; the sheer volume of paperwork that was later produced (not just survived) is representative of major differences in the exploiting and archiving of power relations. The archive is itself a fraught yet dynamic "contact zone" to be analysed, not a passive repository of evidence.[99] The explosion of information that occurred during the reign of King Manuel of Portugal from 1495, although there were precursors, indicates that the 1490s were a very real watershed for Portuguese medical history. Although there has been considerable research on the network of Portuguese charitable confraternities, the *misericórdias*, as a tool of imperial control, much more work could be done on the bureaucratization of healthcare.[100]

Having said all this, medievalists can learn a great deal from modern colonial and postcolonial scholarship. Waltraud Ernst argues that medical historians should be able to produce good-quality regional histories of medicine(s) without resorting to colonial discourses. It might be possible to write a new history of medicine in Madeira of this kind. Yet studies of post-conquest communities must be wary of "official" documentation that tends to emphasize continuities. Reading the town council minutes of Funchal from the late fifteenth century might make one think that the town had always been there. Its records are closely comparable to those of Oporto in northern Portugal and both are crucial sources for Portuguese urban history.[101] It is worth remembering, however, that the minutes of Oporto's council meetings date back to the fourteenth century; Funchal's only survive from 1470. Fifty years prior to that there was no town and the island was deserted of inhabitants. Understanding the story of how a diverse population came to the island, built a town, resisted disease, regulated markets, brothels and privies and within thirty years became a major sugar producer benefits from a colonial framework. Unlike with Cabo Verde and São Tomé further south, this approach rarely happens with Madeira or the Azores, despite similarities in their initial settlement: an example of how political choices that were made in the 1970s during decolonization have affected medieval studies. Similarly, understanding how healthcare worked both practically and symbolically in Granada, Valencia, Jerusalem or Wales is worth studying comparatively through a colonial lens even if it is just for a short period after the conquest in order to observe similar processes of inequality, resistance, acculturation and hybridization. As Nadia Altschul pointed out in the first issue of this journal, medieval postcolonial scholars have long been doing this, with particularly fruitful insights to be gained from study of Latin America.[102] It is time that medical historians joined in to gain a better appreciation of the colonial past of *medieval* and *modern* Europe. Serious discussion of the health impact of the early empires of Spain and Portugal may become a very fruitful way of writing the "global" history of medieval medicine.

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[99] *Archive Stories*, ed. Burton; Stoler, *Along the Archival Grain*.
[100] Just the tip of the iceberg is touched in Mendonça, "Reforma". See also Sá, "Shaping Social Space"; Sá, *Quando o rico se faz pobre*; Abreu, "Training Health Professionals".
[101] Costa, "Actas camarárias portuguesas".
[102] Altschul, "Future of Postcolonial Approaches".

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