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Like its counterparts and models in the United States, the American colonial hospital reflected its social and political circumstances and yet constituted a place apart. This article examines events at the Philippine General Hospital in Manila, from its opening in 1911 until its effective "Filipinization" after 1916. A locus of patient care and treatment, it was also a site of indoctrination, conflict, and contestation. In 1912 hospital irregularities were investigated, and in 1916 the American director was poisoned. The conflicts that emerged between the colonial state and the hospital's American doctors, and between white and Filipino physicians and between doctors and nurses, tended to reproduce the fissures already evident within American colonial culture and drew upon conventionally racialized images of colonizer and colonized. Concomitantly the colonial hospital's distinctive institutional culture shaped the character and outcome of these conflicts.

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The concern among "officials and residents of provincial towns for the improvement of health and sanitary conditions," observed the American director of health in the Philippines, John D. Long, in 1917, "first manifested itself in a practical form in attempts to secure hospitals and hospital relief." Long believed the "first and principal duty" of the public health service was to prevent the appearance and spread of disease, but he nonetheless supported the proliferation of hospitals and dispensaries across the colonial archipelago. He promoted hospital expansion because the modern hospital was potentially the "center from which sanitary education and instruction will radiate in all directions" (Long 1917, 3).[1] While the Philippine public and elements of the medical profession focused on the internal workings of the hospital—especially on opportunities for scientific diagnosis, specific therapies, and safe surgery—the director of health hoped the institution would provide an instructive model of hygienic order and efficient management. It might become an instrument of conversion: a beacon whose light would shine even on the darkest barrio.

Charles E. Rosenberg (1979a) has described the dominant "inward vision" of North American hospitals during this period, contrasting this introspection with their mere "outward glance" toward surrounding communities and environment. No doubt this remains an apt assessment of the interests of the medical and nursing staffs of major Philippine hospitals, but for the colonial health service these institutions also became appealing symbols of progress and benevolence, lighthouses throwing into sharp relief otherwise obscure features of their settings. They made all sorts of novel views and interventions possible.

Perhaps this explains a colonial conundrum. For American health authorities in the Philippines, disease *prevention* was the priority, so they emphasized reform of personal and domestic hygiene and developed sanitary engineering projects (Anderson 2006; 2007). Yet the Bureau of Health also established the Philippine General Hospital in 1910, a modern institution of some 350 beds, along with infectious disease hospitals and smaller provincial hospitals in Baguio (1901), Culion (1906), Bontoc (1910), Cebu (1912), and elsewhere. In contrast, although *clinical* activities preoccupied the medical profession in the United States, there was no federal investment in civilian hospitals. To be sure, a number of city and county hospitals struggled along during this period providing relief to the poor, immigrants, and minorities—but voluntary and charitable institutions dominated the hospital scene in North America.[2] Of course, many private hospitals, generally supported by the Catholic Church or Protestant missionary societies, also operated in the Philippines. A few, such as San Juan de Dios Hospital, established in 1596, predated the American conquest, but most were set up in the first decade of the twentieth century. Many of these voluntary institutions were quite specialized, or dealt with conditions not amenable to modern therapy, or with marginal groups. San José Hospital took in the infirm, insane, aged, and deaf; San Lazaro became a general infectious disease hospital; the Mary J. Johnson Memorial was a maternity hospital; Sampaloc Hospital concentrated on treating refractory venereal conditions; and the Chinese Hospital admitted patients only from this community (McDill 1910; Bantug 1953; Elicaño and Salud 1953; Dayrit et al. 2002).[3] All the same, the major investment in hospitals from a state mostly concerned with preventive measures is surely a vivid illustration of the key role of government activity in colonial settings. Even in the United States' empire, the colonial state made most things (like hospitals) happen.

In this essay, I examine the Philippine General Hospital in an effort to determine what sort of institution it was in its first ten years, to assess what took place within its walls, and to work out what influence it had on the wider community.[4] Like its counterparts and models in the United States, the American colonial hospital was both a reflection of its social and political circumstances and a place apart. A locus of patient care and treatment, it was also a site of indoctrination and contestation. Conflicts soon emerged between the colonial state and the American doctors at the hospital, and between white and Filipino physicians, and doctors and nurses. These disputes tended to reproduce the fissures already evident within American colonial culture, as well as to draw upon conventionally racialized images of colonizer and colonized. Yet the distinctive institutional culture of the colonial hospital additionally shaped the character and outcome of such conflict. In prurient fashion, I will focus on the 1912 investigation into irregularities at the hospital, and the 1916 poisoning of the hospital's American director—both moments of crisis and clarity, revealing the cultural contours of the institution.

A Hospital for a Modern Colony

Writing in 1917, Vicente de Jesús (1917, 11), Long's deputy and the future director of health in the Philippines, declared the "hospital is intended for

the treatment of curable diseases and care should be taken that it is not made use of as an almshouse nor as a home for incurables." This stipulation accorded with progressive medical doctrine in the United States. Charles Rosenberg (1987) and others have traced a shift in the character of the American hospital during the early twentieth century. Once the last resort for poor or marginal members of society, a haven for the chronically ill and incurable, the hospital was becoming a medical workshop, an impersonal institution for the exercise of scientific diagnosis, specific therapeutics, and aseptic and antiseptic surgery. "Between 1870 and 1917," Rosemary Stevens (1989, 17) observes, "the American hospital was transformed from an asylum for the indigent into a modern scientific institution." It was acquiring the properties of a "'hygienic machine' in which the patient's body could be restored, recalibrated, and repaired" (ibid.).[5] Hospitals now occupied huge new buildings: the interiors coated with antiseptics; the wards places of hygiene, bland food, and routine; the beds secured with sterilized linens. Previously objects of charity and care, patients were turning into cases, to be worked-over efficiently before early discharge. Many complained in the United States that the modern, progressive hospital, obsessed with treating acute diseases and enhancing its technical capability, was increasingly impersonal, alienating, and bureaucratic. At the same time, few doubted the advantages of new diagnostic methods, including bacteriology and x-ray machines, and no one challenged the benefits of safer and more skilled surgery, effective anesthesia, and new therapeutics specific to particular diseases. Dominated by the medical profession, these new temples of science began to lure even the middle class with promises of better diagnosis and treatment.

Of course, the transformation of the hospital was far from complete, and we should recognize the durability of many older arrangements. In particular, the city and county hospitals in the United States still attracted mostly those burdened with age, dependence, and chronic illness. Hospitals like Bellevue in New York, Cook County in Chicago, Boston City, Pennsylvania, and San Francisco General were overcrowded, segregated, corrupt, and poorly funded. The delivery of welfare or social service was often as pressing a need as rehabilitation or cure, and occasionally one more readily satisfied. Even if a newer institution such as Johns Hopkins "embodied and symbolized a new scientific medicine," according to Rosenberg (1987, 309), it "still replicated in microcosm the social realities that shaped the larger society outside its reassuring brick walls." The modern hospital could never stand completely outside the society that created it.

As central as the hospital may have become for advanced medical treatment, research, and training, most basic health care continued to take place in the community. Even among those who took recourse to the hospital, few occupied beds as inpatients, most being seen as outpatients and receiving treatment from the dispensary. Still more of the sick never ventured into hospitals at all, seeking care from family members, traditional healers, public health nurses, sanitary inspectors, pharmacists, and local medical doctors.[6] Usually the modern hospital remained liminal in the social world of the sick. In colonial settings, where control over the body could be hotly contested, many communities regarded the new hospitals with heightened suspicion, and hesitated especially to send women and children to them.[7] The value of the hospital as a symbol of modernity probably thus surpassed its prominence in colonial experience.

With the gradual pacification of the archipelago, a few American officials were soon demanding the establishment of a large modern hospital in the capital to provide the latest in scientific diagnosis and treatment. As early as 1900, John R. McDill, a major in the U.S. Army's medical department, reported on the feasibility of implanting an American-style civilian hospital in Manila. It should become, he told Gov. William H. Taft, the "center for the scientific investigation of disease" (McDill 1900, quoted in Snodgrass 1912, 7). More expansively still, Victor G. Heiser, the energetic and authoritarian director of health, urged Dean C. Worcester and other members of the Philippine executive government in 1905 to build a model institution that might disseminate the principles of hygiene and the ideals of science through Filipino communities. Such benevolence would contribute to the policy of attraction, Heiser (1905, quoted in Snodgrass 1912, 21) noted:

> With a new modern building and increased facilities for taking care of native patients, the work of the hospital could be made a mighty factor in demonstrating the sincerity and helpful purposes of the American government. . . One satisfied, grateful patient is worth more than a thousand nominal adherents, as he remains a friend for all time to come.

Regardless of these politically astute remarks, American leaders of the civil government struggled initially to find adequate funding for this

appealing institution. But the influential and stubborn Worcester eventually became engaged in the campaign; allied with Taft, by then the U.S. president, he secured a perfect site near the medical school and government laboratories, along with sufficient funding for construction of an impressive reinforced concrete building (Snodgrass 1912). Heiser (1912, 5) predicted the rising edifice, along with the new adjacent College of Medicine and Surgery, "will ultimately bring about the hygienic regeneration of the Philippine Islands."[8]

In such circumstances, the Philippine General Hospital opened its doors in September 1910 (fig. 1). Although indubitably modern, the hospital's design followed the older pavilion style, perhaps to allow the best possible ventilation in the tropics and to protect against earthquake damage.[9] It consisted of a central administrative building; operating pavilion; medical, surgical, obstetric, and children's wards; nurses' training school; free dispensary; and kitchens. It was not long before Filipinos flocked to the new institution. Although only forty-three beds were occupied in the first month of operation, within a year it was full, even overflowing. The dispensary was more popular still. In the first year it treated more than 24,000 patients and filled almost 40,000 prescriptions; the following year over 60,000 patients attended and nearly 80,000 prescriptions were filled (Forbes 1928, 351).[10] As John McDill (1910, 11), who became the hospital's chief surgeon, exclaimed with pleasure, the "clinical material in the Philippines is unlimited."

Fig. 1. The façade of the Philippine General Hospital, ca. 1910s; photo courtesy of the Rockefeller Archive Center

Fig. 2. The University of the Philippines' College of Medicine and Surgery Building; photo courtesy of U.S. NARA

The Hospital Machine

Even though the hospital was a state instrumentality, the medical school at the University of the Philippines (fig. 2) managed medical and surgical activities within its walls—not nurses, missionary orders, or trustees. In keeping with the most advanced arrangements in the United States, the new hospital was organized from the beginning around the requirements of surgery and medical training and research, with a male medical superintendent directing it and English-speaking medical doctors at the top of the hierarchy. Their watchwords were science, efficiency, and discipline.[11] The hospital functioned ideally as both laboratory and machine, though in practice older habits often asserted themselves. A sick person rarely stayed a simple case; even the most reductionist treatments still necessarily included some holistic or constitutional elements; and scientific management sometimes degenerated into makeshift and negligence.

On arrival, the patient was placed in a "receiving bed," and made comfortable by a nurse before being admitted by a doctor. Any possibly contagious cases were isolated in a room separate from the main ward, or went instead to one of the infectious disease hospitals. Once admitted to the hospital, patients turned over their clothing, to be disinfected and put away in a

locker. On the wards it was forbidden to smoke, gamble, talk loudly, swear, or spit (except in the appropriate receptacles). If patients wanted to leave the hospital for a brief period, they had to obtain written permission from their doctor during ward rounds. They were expected to rest and meekly accept decisions on diagnosis and therapy. In the morning and evening, a junior doctor or intern would visit the patients, taking the opportunity to examine them, chart their course in the individual case records, obtain specimens, and perhaps adjust their treatment. Nurses looked after the general welfare of patients and "the cleanliness and proper sanitary condition of the interior of the hospital." But their principal duty was to carry out promptly and accurately the doctor's orders, as written in the ward book. A chief nurse managed mundane activities on the wards, supervised student nurses, and worked out "daily menus for patients in accordance with approved dietetic rules" (De Jesús 1917, 22, 23). Although permitted some control over supportive care, nurses exerted no influence on therapeutic and surgical decisions.

Contemporary American descriptions of the new hospital emphasized the gleaming, aseptic operating theaters, the abundance of clocks, and the initially pristine toilets. John E. Snodgrass, the deputy director of the Bureau of Health, observed clocks on entering the hospital, on the wards, and throughout the operating pavilion: it was impossible to ignore the passage of time. These regnant timepieces seemed to rebuke any dilatory Filipinos. Snodgrass (1912, 33) also admired the many "capoco-plate vitreous china closets with 'sanitaire pyralis' seats." The toilets were, apparently, the "last word in this line of equipment from a sanitary standpoint." For a short while they stood as glistening sentinels, reminding Filipinos to defecate responsibly.

Central to the modern hospital, adjacent to the administrative offices, was the operating pavilion (fig. 3). The operation appeared the brisk epitome of efficiency, cleanliness, and order. Arcane rituals of asepsis and antisepsis, along with advances in anesthetics, were making all sorts of new surgical procedures possible. McDill (1918) liked to extol the prospects of modern surgery in the tropics. In his pioneering textbook, the chief surgeon reviewed the special problems of operating on natives in hot climates. These procedures took place far from the bases of surgical supply and often with poorly trained assistants. In the hotter months in Manila, the surgeon found his mask, gloves, and gown sorely discomforting. His preferred method of anesthesia required far greater quantities of ether to make up for rapid evaporation—though supposed Filipino "placidity" meant low doses rendered them insensible. The tropical surgeon needed to be familiar with conditions rare or unknown in cooler lands, such as amoebiasis, filariasis, leprosy, and tropical granulomas. To complicate matters, native patients seemed especially disinclined to follow postoperative instructions and usually removed their dressings too early. "Diagnosis and treatment, at their best," ruminated the displaced surgeon, "require not only far greater application and correlation of laboratory findings and bedside observations than in our [cooler] climes, but all of the general and physical conditions of these peoples must be taken into account as well" (ibid., 23).[12]

Surgeons in other tropical possessions echoed McDill's cautions and concerns. At the Medical College of Bengal in Calcutta, Frank Powell Connor (1929, 6) noticed "bacterial life is present in much greater profusion" than back home in England. "The conditions of life in the tropics, associated as they are with heat, dust, dirt and uncleanly habits, provide ample opportunity for septic infection." Therefore, asepsis and antisepsis must always be more rigorous than in cooler locales with more hygienic inhabitants. Microbial incubation was by no means the only problem. "In every sphere of surgical activity," warned

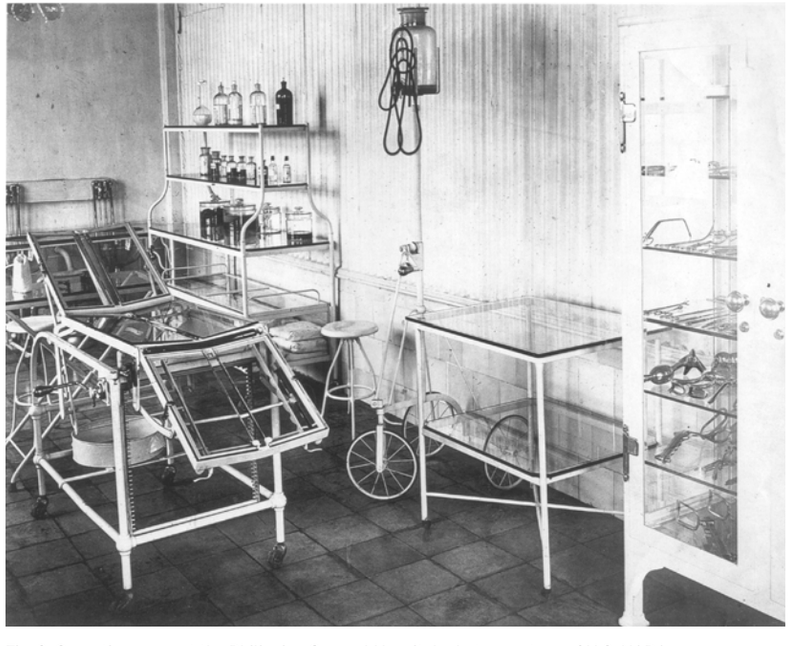

Fig. 3. Operating room at the Philippine General Hospital; photo courtesy of U.S. NARA

Connor (ibid., 4), "the depressant action of tropical heat has to be remembered." In particular, he lamented, "no operating garments are comfortable in hot countries," yet decorum and fastidiousness seemed to forbid nakedness.

McDill (1918) remained confident that medical and surgical intervention would bring tropical rewards. As for so many U.S. colonial bureaucrats and functionaries, it seemed to him that the tropics represented "the future treasure house of the world," and much therefore was at stake. Moreover, it was "the Western medical man who will make possible the evolution of these undeveloped but no longer far-off or mysterious lands by converting their waste places into suitable habitations, not only for their own populations but also for the exotic human transplant who will be necessary for the initiation of the change" (ibid., 17). Surgical intervention, specific therapeutics, and, above all, preventive medicine were "everywhere writing new geography of habitable territory and commercial opportunity" (ibid., 20). The control of disease depended upon "personal hygiene and general sanitary measures whose principles are as universally applicable as those of surgery" (ibid., 21). With hygiene in the lead, therapeutics and surgery marched arm in arm through the wards of the Philippine General Hospital, uplifting its inmates, and thereby eventually converting the "waste places" beyond its walls.

The Therapeutic Institution

An emaciated, pale young woman from Japan soon came under the observation of McDill and the bacteriologist William B. Wherry. Complaining of severe abdominal pain, she was admitted to the wards of the hospital. The girl was "passing a considerable amount of milky, peach-colored urine," her doctors noted, "sometimes quite bloody, which upon cooling contained large and small clots of reddish and yellowish jelly-like material." On microscopic examination, they found some "filarial-like" organisms. The doctors left instruction that the foot of the patient's bed should be elevated, and she may receive "just enough food to sustain life." Everyday McDill injected a weak solution of adrenaline into the patient's bladder. Nurses gave her more adrenaline by mouth and tried to get her to swallow some methylene blue, but had to stop "on account of violent vomiting." At the suggestion of William E. Musgrave, the colony's leading physician, McDill attempted to "sensitize" the adult parasites with daily x-rays to the girl's lower abdomen following doses of quinine. After a week, the patient developed pleurisy and a pulmonary effusion required draining. Gradually, however, her urine became normal. She gained strength so rapidly that McDill felt he could expose her to fifteen minutes of the x-ray before discharge. Later he heard that "the patient is now in Nagasaki and is said to be in good health" (McDill and Wherry 1910, n.p.).[13]

McDill's case notes illustrate the medical commitment to identifying, often through perilous experiment, specific therapy for tropical ailments. Although some interest in diet and personal disposition remains, the physician's therapeutic authority derived increasingly from his scientific expertise, not from any special empathy with the unfortunate patient or insight into her idiosyncrasies. McDill's therapeutic trials could scarcely have been emotionally and intellectually resonant for her in the way they presumably were for him. Indeed, the sick person has become a marginal figure in this account, with merely a perfunctory history and few personal attributes. Laboratory tests directed attention to the causative organism, its life cycle and proclivities. Frequently the laboratory, not clinical rapport, shaped therapeutic decisions. "Filarial embryos," McDill tells us, "in a thin layer of blood collected after cinchonizing, exposed to the rays for five minutes with the bulb sixteen inches away, are not killed, but they squirm about in a very excited manner" (ibid.). The squirming filaria came to enthrall the scientific medico.

During this period, the contribution of laboratory investigation to diagnosis and therapeutics expanded tremendously. The recent identification of quinine as the specific treatment of malaria provides perhaps the most vivid and compelling example. In the 1890s, quinine was still employed empirically for a vast number of undifferentiated tropical fevers, usually in conjunction with other regimens designed to fortify and comfort sufferers. Accordingly, the influential British medical expert Andrew Davidson in 1893 had advised symptomatic treatment above quinine in the relief of malaria. He recommended sponging victims with tepid water, giving them antipyrin for headache and effervescing draughts to soothe the stomach, diminish fever, and hasten sweating (Davidson 1893, 113–216). Emetics such as ipecac or mustard and water also seemed to help the patient, while a purgative—calomel in severe cases, otherwise castor oil or Epsom salts—he claimed was "of undoubted value" (ibid., 207). Only toward the end of the discussion did Davidson (ibid., 213) mention quinine as a specific treatment, based on fresh studies that showed it destroying protozoa and stimulating white blood cells.[14]

Just five years later, Patrick Manson (1898, 110), the founder of the specialty of tropical medicine, stated bluntly that "so soon as a diagnosis

of malaria has been arrived at, unless there be some very manifest contra-indication, the first duty of the practitioner is to set about giving quinine." Then he qualified this remark, observing that as quinine did not cut short the "fever fit," it was wise to wait until the hot stages ended and the patient began to perspire. Although quinine's mode of action was not yet definitely established, he suspected the drug proved directly toxic to the causative plasmodium. Peculiarities of the individual patient and the environment exerted little influence over its specific activity. All the same, Manson continued to believe that symptomatic therapy was indicated. He urged rest in bed and the administration of an aperient, since both were "invaluable adjuvants" (ibid., 111). Bilious forms of the disease warranted doses of calomel, ipecac to clear the stomach, and (to ease gastric distress) mustard poultices to the abdomen, hypodermic injections of morphia, sips of hot water, champagne, or a few drops of tincture of iodine (ibid., 117).

In 1918 Victor Heiser (1918, 229) declared that quinine was certainly "one of the few instances of a true specific that occurs in medicine." No longer could one condone its general use in fevers: laboratory studies confirmed it acted only on plasmodia. Responsible practitioners in Manila were administering the drug as soon as they discovered the organisms in the patient's blood, regardless of the stage of the disease. Yet Heiser, so confident of quinine's special efficacy, reserved a role for treatments attuned to each patient's particular presentation of the disease. To relieve the chill, he recommended morphine or chloroform injections; headaches might benefit from sponging; and vomiting responded to soda water or champagne, or else to the application of a small mustard or capsicum plaster to the stomach. Heiser (ibid., 234) recalled that in the Philippines he invariably started quinine with doses of calomel to produce "free purgation."[15]

Physicians often struggled to identify specific treatments for diseases more refractory than malaria, but they never gave up. Heiser believed chaulmoogra oil was the cure for leprosy; others resorted to serum treatment for diseases like typhoid and plague.[16] An extract of rice polishings (*tiqui-tiqui*) proved a stunningly effective nutritional specific against beriberi, though lamentably unpalatable (Chamberlain et al. 1911; Vedder 1914; Heiser 1918). Briefly, Manson (1898, 313) wondered if ipecac might be specific to dysentery—but medicos at the Philippine General Hospital remained skeptical. When Musgrave (1906) treated a case of amoebic dysentery, he used "cleansing enemas, mild saline laxatives," and Dover's powders for the pain. During his patient's convalescence, she received quinine enemas twice daily, but no ipecac. Other physicians in the Islands could be more sanguine about its use.[17]

Evidently, tropical practitioners in their quest for more "scientific" therapeutics did not simply abandon established regimens and older explanatory frameworks. Despite their professed allegiance to germ theories and ideals of therapeutic specificity, physicians in modern Philippine hospitals usually found it hard in practice to relinquish conventional supportive measures, hygiene stipulations, and symptomatic treatment—activities so long part of routine medical care that they were intimately associated with professional identity. The constitutional equilibrium of the sick, their pattern of intake and excretion, still needed attention. Patients had to temper or modify their behavior in order to get well. Their family life and social circumstances were residual factors in the medical equation. Accordingly, the vision of medical doctors of the Philippine General Hospital was not directed solely inward: they also were taking part in a broader pedagogical project. In particular, physicians' advice reinforced and elaborated the hygienic guidance of the Bureau of Health. As McDill (1910, 11–12) observed, the "general hospital and the medical school will help . . . to realize the greatest hope for the future of these islands, namely, the education of the people in sanitary matters which can only be accomplished by educated native medical men trained in preventive medicine and sanitation." In the colonial tropics, then, even surgery and specific therapeutics were subordinated in the modern hospital to training in bourgeois rules of propriety and the discipline of hygiene. Becoming a patient and becoming a colonial subject were hard to differentiate in this allegory of the personal and the political.

As more generally in the colonial state, medical hegemony in the hospital was far from absolute, and frequently circumvented or contested. Many patients simply put up with efforts to reform their conduct so that they might receive a diagnosis and specific treatment. Their failure to acquiesce in the total regimen frequently provoked consternation and dismay among American and Filipino doctors. Ramon Santos, the resident physician at a hospital in Mindanao, expressed his irritation with unusual candor. When his patients came into hospital they had the "troublesome desire" to bring family with them, a persistent "source of worry to the nurse trained to obey orders and to maintain tidiness and cleanliness." To prevent "the bedside table and the floor from being filled with filthy clothing, bettlenut, buyu, and sputum,"

the overworked nurse was in a state of constant vigilance. Moreover, Santos estimated that fewer than 5 percent of his patients returned for follow up, and the families always frustrated postmortem examination.[18] "As you know," Heiser wrote to an American colleague, "the great mass of the people are poor and have not reached the scientific medicine stage."[19]

Disaffection in the Ranks

It soon became clear that the medical staff at the Philippine General Hospital had more than science on their minds.

The eagle-eyed Worcester took to visiting the hospital at odd hours to inspect its procedures and assess its performance. Generally, it seemed remarkably efficient, although the irascible secretary of the interior deplored the dirtiness of some wards and the accumulated filth of the hospital grounds. Observing the carelessness of some physicians in filling out records and prescriptions, he gave them "preemptory instructions" which they followed "to the letter."[20] Worcester also criticized the long lines for the dispensary, which led to delays in treatment and fights breaking out. But then he fixed his most disapproving gaze on the department of surgery and its leader, McDill. The secretary of the interior had long resented the chief surgeon's claim to have originated the idea of a modern, general hospital in Manila. When McDill was president of the Philippine Islands Medical Association they frequently came into conflict. Worcester also deplored McDill's open encouragement of Filipino physicians and sympathy for the U.S. presidential campaign of Woodrow Wilson. He asserted the stolid Midwesterner was behaving in so bizarre a fashion that he might be suffering from "brain fag," or nervous exhaustion.[21] According to Worcester, the surgeon was a "trouble maker," whose desire for private gain led him to carry on a secret and lucrative private practice, profiting from access to the hospital's beds. Moreover, he blamed McDill when some Filipino physicians provided evidence they did not receive the proper allocation of patients, thereby sowing discord among promoters of Filipinization. It is ironic that Worcester himself would later be condemned, perhaps more justly, for the relentless pursuit of financial advantage and disparagement of elite Filipinos (Stanley 1984; Sullivan 1991).

Worcester obtained the chief surgeon's suspension, noting he "did not always protect the interests of the Government in regard to collections from pay patients, and he was culpable for not more carefully overseeing and directing the work of his subordinates and for failure to prevent their committing certain irregularities."[22] In response, McDill argued the claims of the secretary of the interior were malicious and unsubstantiated. He believed Worcester and Heiser had already approved limited private practice at the hospital. Furthermore, the surgeon heard Worcester confide to a friend: "'I'm going to get McDill, and if they attempt to use the big stick on me and interfere in my department' words to further effect that he 'would stand them all on their heads both in the Islands and in Washington,' and that he had the goods with which to do it."[23]

Forced to resign, McDill quickly decamped to Milwaukee, Wisconsin. He later wrote to President Wilson, pointing out that Worcester was "an offense to society generally, and his long retention in office by those who have had the power of removal is a veritable mystery of the Far East."[24] In his opinion, the self-promoting secretary of the interior was nothing more than a brute and bully. McDill (1918, 174) spent the following years assuring Americans that Filipinos "are nearest akin to Europeans in thought and aspirations of any alien race." He reported that they were "eager to learn all that can be imparted, and have evinced such intelligent capacity that their rapid progress in the art of self-government and their universal desire for education should appeal strongly to American sympathy." He found the medical students "earnest, studious, intelligent, and hard working," but the hospital system had "broken down through lack of direction." Sadly, inveterate American retentionists like Worcester were failing "to cultivate a real sympathy, understanding, and aptitude for the native problems" (ibid., 176).

Addressing the Milwaukee Press Club, McDill (quoted in Storey 1913, 5) claimed that a "theoretically benevolent but essentially despotic oligarchy of five royally salaried American officials" dominated the Philippines. Elite Filipinos had endured these oppressive Republicans with "self-possession, dignity, and courtesy." Despite Worcester's aspersions, which warranted the description "popular trash" and "cruel calumny," these people were not mere "ethnological curiosities" (ibid., 24). Later in 1913, McDill joined others at the Lake Mohonk Conference of the Indian and Other Dependent Peoples in vehemently condemning the injustice of continuing American opposition to Philippine independence. After all, it had been a "shoddy imperialism," based on American prejudice and self-righteousness (McDill 1913, 6). If left to themselves, the Filipino "aptitude for teaching, nursing, and the medical profession, will do more for the physical regeneration of their race than all other influences together" (ibid., 7).[25]

After settling various scores and expelling irritants like McDill, Worcester expressed his high opinion of "the people's hospital." It pleased him that the "fear of hospitals, long so widespread in this country, and so seemingly impossible to overcome, is rapidly vanishing as those who are relieved of their sufferings go forth and tell their relatives and friends their experiences." The modern hospital, he believed, was a stirring example of colonial benevolence.[26]

All the same, internecine disputes continued at the hospital. American nurses became incensed when the chief nurse, Elsie P. McCloskey, appeared to favor some of her supposedly more obsequious Filipina colleagues. They complained bitterly that she had allowed a Filipina to inspect their work, thus breaching professional ethics and colonial custom. Since McCloskey looked to be entangled in a steamy romance with W. Cameron Forbes, the governor-general, it was futile asking Heiser to reprimand her. Beginning a "series of petty persecutions," the chief nurse eventually drove most of her fellow Americans from the service. "Affairs in that institution," a disaffected American nurse asserted, "are in such a chaotic and unsatisfactory condition that many government officials and their families when ill will not step over the threshold."[27]

Irked by the interference of Worcester and Heiser, Musgrave and other senior American doctors sought unsuccessfully to transfer the institution to the University of the Philippines, out of the control of the Bureau of Health. Not surprisingly, Heiser and Worcester vigorously resisted this move, which would have lessened their authority. Worcester described the "plot" as "rather contemptible."[28] Heiser wrote to his mentor, Maj. Edward L. Munson, warning him that Musgrave was a "very slippery individual and will bear watching every minute." The director of health wanted the deceptively courtly Tennessean, appointed as the hospital's superintendent, held to account.[29] Thus the fractious, uncompromising, and petty character of the colonial bureaucracy permeated the wards of the hospital.

It was not long, though, before the institution succumbed to external forces of Filipinization. Within a few years of the hospital opening, Filipinos occupied most of the medical and nursing positions. Musgrave hung on as superintendent until 1916, a year or two after Heiser's departure from the Islands. The Filipina nurses drove the superintendent away. Distressed by the discipline and drill that Musgrave and McCloskey demanded, the nurses became caught up in a contagion of suicide at the hospital from August to October 1916. Twenty of them attempted to kill themselves, many using carbolic acid. Late in August, more than 140 nurses went on strike, complaining of "rigid punishments," "despotic authority," and lack of respect (Colson 1916, 7). They almost closed the hospital. Shortly thereafter, Musgrave forced 130 of them to resign, causing uproar in the community and provoking newspaper condemnation (ibid., 8).[30] The director of the civil service, Everett A. Colson (1916), investigated the imbroglio and exonerated Musgrave and McCloskey. He pointed out that in the modern hospital "efficiency, cooperation, and obedience are not only requested but demanded" (ibid., 54). Evidently, "if the institution was to be brought up to the desired plane of efficiency and kept there it can be done only by strict discipline" (ibid., 55).[31]

Then one night, as he ate a dinner prepared in the hospital kitchen, Musgrave was "taken acutely ill with symptoms of dizziness, cold sweat, nausea, and epigastric [stomach] pain, followed by vomiting. A short time after this, further symptoms of retching, cramps, and repeated dizziness appeared and diarrhea followed." When analyzed at the Bureau of Science, the bloody, frothy vomited material revealed corrosive sublimate. Nurses were the prime suspects.[32]

As soon as he recovered, Musgrave left for San Francisco where he became superintendent of the new hospital of the University of California on Parnassus Heights.[33] In his letter of resignation, the fleeing director recalled that before he introduced discipline and system to the institution:

> The lives of patients had been uselessly sacrificed, even those of private patients in the pay wards. . . . The dead were neglected until the ants would destroy the mucous membranes of the eyes and the bodies were beginning to smell. . . . Helpless babies were allowed to wallow and play in their own filth without attractive special attention. Delirious patients were allowed to escape from the wards to be returned by the police hours later without their absence having been discovered. Misappropriation of government property to private use was exceedingly extensive. Important employees had little regard for punctuality or for other rules necessary to handle the large and varied services of the institution. And so on, though as weird a list of inefficiency, dishonesty and worse, as one cares to go.[34]

Evidently the hospital served as an allegory for the colonial polity, both of them crying out for white American order and efficiency. "I put into force

organization, system and discipline," Musgrave continued. "I had to punish, and severely in many instances, doctors, nurses, and other employees." This made the colonial bureaucrat unpopular and resented. "I have not been able to give adequate punishment even for the most flagrant offenses, whether by doctor, nurse, student, or other employee, without incurring a more or less extensive campaign of criticism from the press and general public. . . . I have had to contend with every form of intrigue, threat and attack that it is possible for minds fertile in this sort of thing to devise."[35] Sick and fearful, this paranoid physician was abandoning the modern white man's burden.

Fernando Calderón, a suave Filipino obstetrician, succeeded Musgrave as superintendent of the hospital and dean of the medical school, calmly occupying both posts for the following twenty years. A progressive, Calderón had trained during the Spanish colonial period at San Juan de Dios Hospital, receiving his licentiate from the University of Santo Tomás. After further study of obstetrics in Paris, he was caught up in political agitation in the Philippines, becoming the president of the revolutionary municipal junta in Ormoc, Leyte, during the Philippine-American War (Fuentes 1986). Although frequently the target of their racial disparagement, Calderón shared his American colleagues' modernizing ambitions. Like them, he regarded himself as a practical man, criticizing "those traditional reactionaries of the first class who find nothing good except conversation and routine" (Calderón 1908, quoted in Snodgrass 1912, 25). He was devoted to hygiene and the improvement of the masses, declaring "what constitutes the nerve of civilization in the present epoch is precisely public hygiene in the towns in general and the health of each citizen in particular" (ibid.).

Retentionists like Heiser had no time for Calderón. Observing the Filipino physician on a trip to the United States, the acerbic director of health decided he was unable "to conform to American notions of propriety" (Heiser 1936, 195). "Things moved too fast for him," and when Calderón addressed medical gatherings Heiser was convinced he "scarcely knew the meanings of words" (ibid., 198). Worcester repeatedly schemed to set up investigations of maternal and infant death rates in Calderón's clinic. Musgrave, too, remained bitter about Filipino usurpers like Calderón. "Few natives," the San Francisco hospital director reflected in 1921, "are mentally constituted to withstand the normal stress of civilization which so many of them adopt" (Musgrave 1921, 399). His composure restored after his flight from the Philippines, Musgrave recalled how twenty years of inculcating "Occidental methods" of conduct and management had merely led to spreading neurasthenia among the "younger generation of more progressive Filipinos" (ibid., 400). Imitation of "Western methods of energy, application, and efficiency" damaged their racially inferior constitutions. To prevent nervous debility, it was necessary for the Filipino to hold "his ambitions and energies within his natural bounds" (ibid., 401). Presumably, this meant refraining from trying to manage a complex modern institution such as the Philippine General Hospital. With the support and protection of his close friend, Manuel Quezon, the nationalist leader, Calderón could afford, however, to ignore feeble and increasingly anachronistic colonial outbursts.

Conclusion

The condition of the Philippine General Hospital provides a distorted and partial reflection of the American colonial regime in the Islands. We find on its wards tensions between benevolence and discipline, improvement and drill, liberality and efficiency, desire and paranoia. We see similar gradations of sovereignty and health, with the full achievement of both usually deferred or temporized. In the daily routines of the hospital the civilizing project was yoked to treatment and cure, yet these attainments must often have seemed elusive and second rate. Among the scientific managers of the colony and the hospital, we can observe the same petty disputes, romantic affairs, breakdowns, incompetence, and corruption. As "cases" and "nationals," ordinary Filipinos must have experienced hope, mystification, frustration, and apprehension. The hospital machine and the colonial machine, if not identical, had come from the same workshop. The difficulty in distinguishing where the colony ends and where the hospital begins makes it harder to accommodate without eyestrain the difference between inward vision and outward glance. Indeed, sometimes outward vision and inward glance may better describe the views of these doctors. No doubt the Philippine General Hospital possessed its own special institutional texture, but its cultural forms and pedagogical aspirations demonstrated in this period distinct colonial features.

Even the modern hospital is a conservative place. Its rituals and routines tend to outlast their rationalization as science or care. Managerial practices; the relations of doctors, nurses, and patients; and patterns of disposal of cases all have proved remarkably durable. Now about a hundred years old, the Philippine General Hospital continues to serve the sick of Manila—but what elements of this colonial legacy might an ethnographer reveal today?

Abbreviations used

U.S. NARA United States National Archives and Records Administration, College Park, MD
RG Record Group at the U.S. NARA

Notes

I am grateful for Jun Aguilar's invitation to write this essay and for the comments I received at the conference on the history of public health and medicine, held at the Ateneo de Manila University in July 2008. Mark Harrison kindly allowed me to read the introduction to his forthcoming edited collection of essays on the colonial hospital. I would like to thank Charles Rosenberg, Rosemary Stevens, and Guenter Risse for earlier discussions on the modern hospital.

1 Long, a veteran of plague campaigns in California, later became the "traveling representative" of the Pan-American Health Organization.

2 On the history of the American hospital see Vogel 1980; Rosenberg 1987; Stevens 1989; Risse 1999, esp. ch. 9. Historians are prone to forget the U.S. government's investment in military hospitals during this period.

3 On the status of hospitals in 1917, see Civil Government Hospitals, RG 350, File 5972–15A, U.S. NARA.

4 This may be a useful supplement to my analysis in *Colonial Pathologies* of those other exemplary yet different sites of confinement, the Culion leper colony and the Baguio sanatorium. For an earlier account of colonial therapeutics, see Anderson 1992, ch. 4.

5 Risse (1999, 467) echoes this when he notes, "the American hospital, so recently a partially medicalized, mostly charitable shelter, had been rapidly transformed into an institution organized on scientific and business principles." For other aspects of this transformation, see Howell 1989; Reverby 1989.

6 For example, in the Philippines see *Instructions for Simple Remedy Packages* (1910) and *Instructions for Simple Remedy Chests* (1923).

7 For India, see Arnold 1993.

8 Heiser (1912, 5) believed the nurses "will go out into the provinces as veritable missionaries of modern medicine, surgery, and hygiene."

9 The San Francisco General Hospital, rebuilt in 1910, also boasted an old-fashioned pavilion design. See Risse 1999; Blaisdell 1999.

10 By 1926 more than 1,000 government dispensaries operated across the archipelago.

11 See Flexner 1911; Rosen 1976; Reverby 1981; Morman 1989. After the commencement of classes at the medical school in 1907, and until 1910, students joined their counterparts from the University of Santo Tomás on the wards of the San Juan de Dios Hospital or gained clinical experience at the Episcopalian University Hospital, a thirty-bed institution that Bishop Charles H. Brent established in 1907. See Santiago 1994.

12 See also McDill and Schiffbauer 1910. Presumably unaware of McDill's work, R. Havelock Charles (1927) in his preface to a 1927 Indian book on tropical surgery claimed with typical British imperial self-regard that it was the first book on the subject.

13 On the generally unrewarding treatment of filarial chyluria, see Manson 1898, 478. Wherry, who discovered the cause of tularemia and the presence of plague in California ground squirrels, later moved to the University of Cincinnati; see Fischer 1938.

14 More generally on the meaning of nineteenth-century therapeutics, see Rosenberg 1979b; Warner 1986.

15 See also Irons 1914.

16 On leprosy treatment, see Anderson 2006, ch. 5. On typhoid, see Lantin 1921. On plague, see Strong 1914.

17 H. R. Hoff, chief surgeon's office, Manila, to surgeon-general, Washington, D.C. 7 Mar. 1908, RG 112, File 24508–120, U.S. NARA.

18 Ramon Santos, Superstitions on modern treatment in Moroland, c. 1912, RG 350, File 5972–34, U.S. NARA.

19 Victor G. Heiser to F. L. Harrison, 29 Nov. 1911, RG 350, File 57–47, U.S. NARA.

20 Dean C. Worcester to governor-general, 31 Jan. 1912, p. 5, RG 350, File 21274–15, U.S. NARA.

21 Dean C. Worcester to governor-general, 31 Jan. 1912, p. 9, RG 350, File 21274–15, U.S. NARA; see also Dean C. Worcester, Investigation into the Affairs of the Philippine General Hospital, c. 1913, p. 8, RG 350, File 21274–16, U.S. NARA.

22 Dean C. Worcester to governor-general, 31 Jan. 1912, p. 9, RG 350, File 21274–15, U.S. NARA.

23 John R. McDill to chief, Bureau of Insular Affairs, 27 May 1912, RG 350, File 15711–16, U.S. NARA.

24 John R. McDill to president, 3 June 1913, RG 350, File 15711–23, U.S. NARA.

25 McDill worked as a surgeon at the Medical College of Wisconsin before moving to Washington, D.C., where he became the medical advisor of the Federal Board for Vocational Education.

26 Dean C. Worcester to governor-general, 31 Jan. 1912, p. 11, RG 350, File 21274–15, U.S. NARA.

27 Mary J. Dugan to chief, Bureau of Insular Affairs, 30 Sept. 1913, RG 350, File 3267–35, U.S. NARA.

28 Dean C. Worcester to Newton W. Gilbert, acting governor-general, 24 Sept. 1913, Box 1, Worcester papers, Aa/2/Ac, Bentley Historical Library, University of Michigan, Ann Arbor, MI. See also Dean C. Worcester's private annotated copy of the Record of the Attempt to Transfer Jurisdiction over the Philippine General Hospital . . . Box 1, Worcester papers. In 1947 Pres. Manuel Roxas transferred the hospital to the University of the Philippines, and seven years later Pres. Ramon Magsaysay gave it administrative independence.

29 Victor G. Heiser to E. L. Munson, 11 July 1914, Heiser papers, American Philosophical Society, Philadelphia, PA.

30 See also Willie T. Ong and Anna Liza R. Ong, "A Triad of Benefits of American Colonialism in the Philippines: Medical Research, Medical Education, and Hospital Care, 1898-1930," typescript, c. 2002, in the author's possession.

31 McCloskey resigned anyhow, and Anastacia Giron succeeded her. McCloskey married Samuel Gaches and became a social worker. After her death, Samuel Gaches established the Elsie Gaches Village in Manila, to provide care and rehabilitation to neglected and abandoned children.

32 W. E. Musgrave to governor-general, 23 Oct. 1916, RG 350, File E21, U.S. NARA.

33 Interestingly, Musgrave introduced student government and relaxed discipline at the University of California's training school for nurses. See Flood 2007. He later became the editor of the *California State Journal of Medicine* and vice-president of the American Medical Association.

34 W. E. Musgrave to governor-general, 23 Oct. 1916, RG 350, File E21, U.S. NARA.

35 Ibid.

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