

United States, it has resonances here in Australia too. As I read this book, I found myself thinking: ‘So that’s why we studied that!’ ‘So that explains why we did it that way!’ For the first time, I imagined myself, a medical student at Melbourne in the 1970s, as a minute figure in the history of medical education. More importantly, I came to understand that the formal curriculum has always had less impact in medical education than the ability to motivate students and provide them with opportunities and time to learn for themselves. The lesson of this history is that if we are to save medical education, we must try to change the institutional structures and financial arrangements of health care and the universities, not just reform the curriculum.

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May the People Live: A History of Maori Health Development 1900–1920. By Raeburn Lange (Auckland University Press, Auckland, 1999) xiii, 359 pp.

Maori Health and Government Policy 1840–1940. By Derek A. Dow (Victoria University Press, Wellington, 1999) 280pp.

FOR MANY HUNDREDS OF YEARS, EUROPEANS ATTRIBUTED INDIGENOUS ill-health and population decline to the inexorable workings of providence or biological law; some blamed the victims, arguing that suffering and death were consequences of ‘native degeneration’ or immorality. Most, though not all, white settlers did whatever they could to exculpate themselves. As one group appeared to supplant another, as ‘civilization’ displaced ‘savagery,’ the more humane colonisers attempted to smooth the pillow of the dying race, offering spiritual solace and, more rarely, medical care. Others were developing the country regardless, convinced that Indigenous depopulation was a natural and inevitable process, and there was nothing to be done about it and nothing that needed to be done about it. Of course, Indigenous peoples did survive, though their numbers were reduced and their communities often disrupted and scattered. In the late twentieth century, the deficit in health status, compared to European communities, of the ‘first nations’ of North America and New Zealand at last began to lessen even as the poor health of Aboriginal Australians scarcely changed during this period. Indeed, the decline in Maori population had been reversed in the late nineteenth century;

well before the Australian Aboriginal population began to rise again. In 1896, Maori numbers had fallen to 40,000, but this was their nadir and each subsequent census showed a growth in population. Why have these demographic and epidemiological improvements come earlier to New Zealand? It would seem that Australians might learn something of contemporary value from the history of Indigenous health across the Tasman.

The two books reviewed here add enormously to our knowledge of responses to Maori ill health. Raeburn Lange's study, based on a 1972 MA thesis, is the broader of the two, providing us with a richly contextualised social history of Maori and government initiatives in public health during the early twentieth century. Derek Dow has a deliberately more narrow focus on policy formulation, adding nuance and detail to many of the technical issues that are less important in Lange's history. Both authors have immersed themselves in government archives and other primary sources, without obvious duplication. Lange's book is perhaps the more accessible to an international readership as it assumes less local knowledge. Dow's work, on the other hand, requires some familiarity with the general landmarks of New Zealand history, and with terms like *tohunga*, *runanga*, *kainga*, *hapu*, and *whakapapa*, a glossary would have helped. Interestingly, the authors have significantly different views of Maori health development during this period. Dow argues that there was more Pakeha concern for Maori health, and more Pakeha efforts to improve it, before 1900 than is generally assumed. In contrast, Lange seeks a usable history of Maori-led community development and health work, a story of Maori initiative and innovation. Readers of both books might conclude that these arguments are not, in fact, contradictory and that each is made convincingly.

To an outsider, the most striking feature of the history of Indigenous health efforts in New Zealand is the involvement, and indeed dominance, of Maori doctors and community activists. It is, as Lange points out, an early example—perhaps the first—of Indigenous health work designed and directed by Indigenous people. Maui Pomare, who graduated from a missionary medical college in Chicago in 1896, led the public health work, and in 1923 became minister of health. A brilliant scholar, Peter Buck (Te Rangi Hiroa) received his medical degree from Otago in 1900 and later became the head of the division of Maori hygiene in the health department, before he turned to the study of Pacific anthropology. Also in Buck's medical cohort was Tutere Wi Repa, a somewhat erratic promoter of community health work during this period. The contrast with Australia is stunning. For example, it was not until the late 1980s that an

Aboriginal Australian graduated from the medical school at the University of Melbourne. Unfortunately, neither Lange nor Dow suggests why New Zealand was so much more advanced. Lange perhaps comes closest to an explanation when he discusses the influence of the denominational boarding schools, especially Te Aute College, which in the 1890s provided a secondary education for the first generation of Maori doctors and lawyers, and gave rise to the Young Maori Party. I suspect, too, that this institutional accessibility has something to do with the small scale of the New Zealand social world, the persisting strength of many Maori communities, and an unusually liberal polity which had allowed Maori and women to vote. Whatever the reason, the past of Indigenous health work in New Zealand sometimes reads like an account of developments in contemporary Australia. (Mind you, Australia still has a long way to go: when will an Aboriginal medical doctor become federal minister of health?)

If Pakeha had attended to Maori ill-health for humanitarian or religious reasons, or later because they feared infectious disease might spill over into white communities, Maori doctors appreciated the sickness and suffering of their own people as problems in their own right and worth fixing for their own sake. It was not just a matter of attaining some spiritual grace or protecting vulnerable whites. Lange claims that Pomare, Buck and others set about improving Maori hygiene and living conditions with a special sensitivity and insight that derived from their own Maori background. In a somewhat 'presentist' fashion, he argues that these Maori doctors were engaging in 'community development', treating communities as 'partners', and using their 'communication skills' to urge health reform^a that they were precursors of 'self-determination' in Indigenous health work. A more cynical reading would be that Pomare and Buck were uttering the same old gospel of hygiene and the same doctrines of behavioural reform, but did so in a more plausible manner and with more evangelical fervour. There is little evidence that they actually adapted the message to take account of Maori health beliefs; indeed they took a leading role in the suppression of *tohungas* or traditional healers. Pomare and Buck set up health councils, but these bodies were not so much to represent communities as to ensure that communities did the bidding of the Maori hygiene reformers. Maori doctors were not, of course, mere ciphers of Western medicine, but nor do they seem as innovative as Lange would like us to believe.

Lange's effort to provide a usable history for contemporary Maori health workers thus puts him in an awkward position. In praising the health work 'designed and directed' by Maori doctors, he attributes

improvements in Maori health status and increase in population to the rather conventional interest in personal and domestic hygiene that these doctors demonstrated. In other words, he implies that a failure to adjust to European ways was the problem, and better personal hygiene was the answer. Others might want to point to improved resistance to introduced disease, better socio-economic conditions including housing, and greater use of health care facilities – not just to the reform of ‘personal and communal practices’ (p. 259) that Maori doctors advocated. Lange does admit that death rates began to fall in the 1890s, before any Maori doctors were organising hygiene reform. So what were the causes? Perhaps we should be looking less at what these Maori doctors did, and more at how they came to be there at all. Rather than the originators of Maori ‘community development’, they were perhaps themselves the signs of social and political changes that were already occurring in Maori communities in the late nineteenth century. But if there were earlier underlying community developments, what were they?

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Crack Mothers: Pregnancy, Drugs and the Media. By Drew Humphries (Ohio State University Press, Columbus, 1999, hard back, ISBN 0-8142-0816-9) 206pp., \$US30.

IN *CRACK MOTHERS: PREGNANCY, DRUGS AND THE MEDIA* DREW Humphries interrogates one of white America’s more recent racialised socio-health panics: the consequences on the unborn of maternal addiction to crack cocaine. Her interest is not, however, primarily in the plight of addicted mothers and their babies, but in the media-driven crusade that erupted as part of the war on drugs initiated by the Reagan presidency. It is, therefore, a story about social blaming, discrimination and the misuse of science and biomedicine for political ends.

Cocaine has historically been a recreational drug of the affluent and the avant garde. It only becomes an option for the poor when it is adulterated and boiled down to a rock so that it can be smoked. Whereas in the nineteenth century, watered-down laudanum increased shop-owners’ profits and protected the poor who consumed it from even more severe poisoning, crack is cheaper but produces quick highs followed by savage lows. The result is an intensified craving for relief