Guillaume LACHENAL, *The Lomidine Files: The Untold Story of a Medical Disaster in Colonial Africa*, transl. from French by Noémi Tousignant (Johns Hopkins University Press, 2017)

The Lomidine Files opens with the titular disaster in 1954 when 32 people died in Gribi, Cameroon, soon after receiving an injection of Lomidine—a drug that was believed at the time to not only treat but also prevent sleeping sickness and that had been promoted in an extensive public health campaign in West Africa known as "Lomidinization." According to early reports, this catastrophe came as a complete surprise to those who ran the campaign on the ground, to the colonial administrators who managed it, and to the scientists who developed and convinced themselves of the preventive properties of Lomidine. Guillaume Lachenal carefully traces the steps that preceded that fateful day, starting in the 1930s. But it is only when he returns to Cameroon in 1954, and to the inquiries that followed, that we finally learn what caused the deaths in Gribi, as well as in a few earlier cases. And it is then that we finally understand why Lachenal insists throughout the book that Lomidine had no preventive effects, even though during the years of the Lomidinization campaign, the cases of sleeping sickness in many regions were reduced to less than 1% of the population.

The story begins conventionally enough with European scientists developing a drug, Lomidine, for the treatment of sleeping sickness, and later turning it into powder form or saline solution that they believed could be periodically injected as a preventive measure. Celebrating Lomidine as a potential "magic bullet," colonial administrators in West Africa organized a public health campaign of Lomidinization. Lachenal describes in fascinating details the efforts made by the colonial administration in *repeatedly* providing Lomidine injections in affected regions once or twice a year. Ultimately, "preventive injection in the buttocks of several cubic centimeters of Lomidine solution" was repeated more than a million times across Africa before the end of the colonial period [57]. This was one of several large colonial public health campaigns at the time, and the images of men, women and children lining up at mobile clinics for a vaccine, a dose of drugs, or other treatments are familiar (a typical

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one is reproduced on the cover of the book). What these images fail to capture, and what the book describes, are the procedures that were adopted to rationalize these campaigns, including the use of Taylorist methods to manage the movement of those who administered the injections, so as to allow thousands to be injected on the same day. As mentioned above, the results of Lomidinization were spectacular—so much so that it seemed possible to imagine the complete eradication of sleeping sickness in West Africa.

Yet Lachenal hints at "ambiguities" and other unexpected events even before the disaster in Gribi, Cameroon—for example, cases in which people who received an injection still caught the disease, an occurrence that was difficult to explain at the time. Lachenal describes how instead of casting doubt on the project, such ambiguities led, on the contrary, to greater insistence on an even more comprehensive campaign. All people in the affected areas had to be injected, and when that did not bring the expected outcomes, people in neighboring areas also had to be injected. Evidently, the campaign was driven by a supposed common good without much regard for individual rights. That was partly why none of the prior incidents were sufficient to turn the colonial administration against Lomidinization, until the 32 deaths, which occurred at a time of anti-colonial unrest, making it impossible for the colonial rulers to simply bury the information as they had done earlier. The investigation that followed identified defects in the injection process that led to the deaths. A few years later, new revelations convincingly explained how an intervention that appeared to clearly reduce the number of people suffering from sleeping sickness turned out to be not only dangerous to administer but useless in its effects.

Given the known ambiguities and the later revelations, Lachenal, a science historian, asks, "How did it become possible and acceptable for thirty-two people to die… after they were injected with a medicine that was already (half-)known to not really protect against a disease that, in any case, was no longer present in the area?" [7]. To answer that question, he seeks to understand doctors' "persistent determination" and "unshakable trust" in a context of "profound uncertainty and insecurity" [12]. Lachenal is not satisfied with generic statements on the evil of colonialism or on the ethically-blind machinery of medical inventions and applications. Rather, he suggests a less treacherous but no less damaging logic that led to the catastrophe: *bêtise*. Lachenal borrows this term from philosophers interested in the pathology of reason. It stands for "reason at its most arrogantly

assertive," and for "a confident and calculated form of foolishness" [13]. He implies that *bêtise* is not the stupidity of ignorant people but the stupidity of people who are blind because they *think* they know—hence, it amounts to "active ignorance" [159].

Bêtise is an extremely useful concept for deciphering the "messianic, mediocre, enthusiastic, and obstinate contribution of medicine to European imperialism" [2]. One could think of it as an alternative to a rationalized conception of action in which the colonial administrators and doctors, who put effort into and devoted resources to fighting sleeping sickness, would be seen as cynical co-conspirators willingly experimenting with West Africans' lives. It is also an alternative to the overly forgiving image (still cultivated by the French National Academy of Medicine, which criticized the book) of brave men and women who were led by humanitarian ideals to cure and advance medicine away from home, with negative effects that they could not have been aware of. Instead, *bêtise* is about willful *ignorance*—and it offers, certainly for sociologists, a novel way of thinking about ethical blindness. Perhaps the most useful theory of action that allows for such blindness is that put forward by Bourdieu, including his analysis of "double truth".[1] Following Bourdieu, one could imagine these colonial agents as holding a "colonial/racist" truth, and a "humanitarian" truth that denies the former. Bourdieu's analysis requires repression of a truth which one otherwise knows—a self-deception that is possible due to collective work. *Bêtise* enriches our understanding of the origins of blindness and the means of repressing what should have been easily observed.

In this book, *bêtise* effectively illuminates the logic—and, at times, tragedy—of colonial medicine. The most explicit illustrations are those of the *racialized* logic of Lomidine use, including the conducting of early experiments on "volunteers" from Africa, forced participation in the Lomidinization campaign, the telling fact that Lomidinization was meant for *all* Africans but *not* meant for Europeans, and the blaming of Africans (including their emotional or cognitive states) when something went wrong. Potentially falling under the same racialized logic was the Taylorist approach to medical care, the willingness to use medical intervention without knowing exactly how it worked, and the favoring of collective over individual needs.

As we know, some of these practices could also be found in racialized settings that are not colonial. In turn, some of these

[1] Pierre Bourdieu, 1998, "The Economy of Symbolic Goods," in *Practical Reason: On the Theory of Action* (Stanford, Stanford University Press: 92-123).

practices—including, for example, prioritization of the collective over the individual, or blaming the patients in order to protect the medicine—could be found in public health campaigns and other medical interventions more generally. (In this regard, it would have been useful if Lachenal discussed the ethics of experiments and the administration of drugs during the 1950s in mainland France, as compared to the colonies.) This suggests to me, and I assume this is Lachenal's intention, that the logic of *bêtise* applies beyond the colonial context. After all, we know of many other tragic public health campaigns or medical interventions—think of the prescription of thalidomide, also in the 1950s. We also know of many *successful* public health campaigns. Lachenal himself concedes that, "Colonial medicine was, at times, an extraordinarily effective apparatus and thus an object of desire." Immunization in general—from the public health campaign that led to the eradication of smallpox in the 1970s to flu vaccine campaigns at the beginning of every winter in the United States—is rightly celebrated. The distribution of antiretrovirals is another public health campaign that many consider a success story. This has important implications, since it may mean that while the tragic incompetence of the Lomidinization campaign may be a reflection of *bêtise*, if *bêtise* is a constant presence in the public health field, then *bêtise* hardly necessitates useless or dangerous results.

Bêtise certainly does not necessitate useless *and* dangerous results. Lachenal skillfully links together two issues that may more usefully be analyzed separately. He offers the Lomidine disaster as a case in which Africans under colonial rule died receiving a preventive measure that was useless. But the deaths were caused by a faulty administration of the injections, which had nothing to do with the uselessness of Lomidine in preventing sleeping sickness (other than the obvious fact that the campaign would never have been undertaken if the uselessness of Lomidine had been known). It is therefore useful to analytically differentiate the danger of the drug from its uselessness: Africans died in the course of a "routine" public health campaign *and* the public health campaign was useless. This leads to the question of how the book's analysis—and the utility of *bêtise*—would be altered if it transpired that Lomidinization was in fact what it was supposed to be: a miracle injection that could eradicate a catastrophic disease. From a critical perspective, and this is important, it makes absolutely no difference. The critical analysis, including the use of *bêtise*, still very much holds, especially since the deaths *were* preventable. Deaths resulting from a public health campaign are utterly unacceptable

regardless of whether or not the drug itself was effective. So, while emphasizing the campaign's uselessness certainly makes the case more dramatic, it has the unfortunate effect of limiting the potential scope of Lachenal's brilliant insights. Those insights could also be applied to *successful* public health campaigns, or to reversed situations, when racialized sentiments, for example, do not lead to inefficient medical interventions but, on the contrary, *deprive* patients of efficient treatment—a notorious example, of course, being the case of Africans not considered as suitable patients for antiretroviral drugs.

It is certainly possible that successful public health campaigns—those that did not end up with dead patients *and* offered effective treatment—were designed and conducted differently. That is, that there are medical discoveries and interventions that are able to avoid the curse of *bêtise*. And that it is lack of active ignorance that explains their success. Such a possibility has significant implications—not only for the social sciences but for health policy as well. Lachenal does not elucidate the specific context that made Lomidinization a failure while other campaigns met success—this is not necessary for his analysis. Still, it would be interesting to investigate the kinds of methods, imaginations and rules in other health campaigns that allowed successful public health campaigns to avoid or perhaps just minimize blindness. Lachenal, at times, seems to put at least some faith in the ability of the local population—including through mass absenteeism—to expose what the establishment willingly ignores. As Didier Fassin[2] beautifully documents in *When Bodies Remember* in regard to AIDS denialism in South Africa, and as was also evidenced in the more recent case of Ebola, resistance due to lack of trust "travels" from one public health campaign to another. If scientists cannot distinguish a good medical intervention from a bad one, why should patients be able to do so? Mistrust in the (no-longer colonial) medical establishment therefore has long-lasting effects. The implications, again, are important. We now also have to consider the long-term traumas that *bêtise* inflicts.

By 1970, sleeping sickness again reached epidemic proportions in several regions in West Africa. Since the 1990s, according to the World Health Organization (WHO) website, screening and early treatment have helped reverse the curve. Today, the WHO talks about elimination, but not eradication, of the disease. *Pace* the French National Academy of Medicine, which apparently blacklisted the

[2] Didier Fassin, 2007, *When Bodies Remember: Experiences and Politics of AIDS in South Africa* (Berkeley, University of California Press).

book, I urge medical scientists, health activists, public health experts, executives of multinational pharmaceutical companies, public officials of affected countries, and officials of international organizations, bilateral development agencies and philanthropic organizations—not to mention the sociologists, anthropologists, historians and others who study them—to read this book. And read it carefully. It cannot tell us how to avoid the catastrophic outcomes of *bêtise*, but it should have a humbling effect, as it offers a painful remainder of the costs to others—not of evil, but of simple passivity, stupidity and arrogance.

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