

Introduction

AN ARCHIVE OF SKIN, AN ARCHIVE OF KIN

I BEGIN WITH THE PHOTOGRAPH of a young boy named Keliiahonui, who was born around 1897 in the Hawaiian Islands (figure 1). His clinical photograph, taken at the Kalihi Hospital and Detention Station in Honolulu on September 11, 1903, marks his official appearance as a leprous person in the Hawai‘i Board of Health archive when he was six years old. Keliiahonui was one of approximately eight thousand people with who were sentenced to lifelong incarceration at a remote settlement on the island of Molokai.¹ Photographs like his were foundational to modern medical knowledge and a criminal system of medical segregation.

When Keliiahonui was captured as a leprous suspect by the colonial state, he was also “captured” by the medical photograph. Although there were diverse photographic conventions of patient imaging, Keliiahonui was photographed against a plain background with most of his clothes removed to reveal his somatic stigmata. This photograph marked his transformation from a person to a prisoner-patient; he entered the realm of civil and legal death. His photograph resides today in a file at the Hawai‘i State Archives in Honolulu, where I was able to handle the yellowing albumen print. Filed by a single case number, the photograph is organized by the year of his medical examination, 1903. This photograph is a material trace of Keliiahonui’s once living presence. Decades after his death in 1914 in the Molokai settlement, his exact grave is unknown.² Each photograph represents a person and a life interrupted by medical surveillance and incarceration.

Outbreaks of leprosy in Hawai‘i began to cause alarm in the early 1860s, following waves of devastating smallpox and measles epidemics that decimated the population.³ According to the law passed in 1865 by the Kingdom of Hawai‘i legislature, people believed to have leprosy were



FIGURE 1. Clinical photograph of Keliiahonui, cropped from original full-length. Kalihi Hospital case 336, September 11, 1903, six years. Hawai‘i State Archives.

removed from their homes and medically inspected. If confirmed as leprous and incurable, they were to be exiled to a “place of isolation” within the Hawaiian archipelago.⁴ The kingdom’s Board of Health selected Mākanalua, the northern peninsula of the island of Molokai, for this purpose. Although Molokai is the island closest to the main island of O‘ahu, they are separated by the rough Kaiwi Channel (map 1). The forbidding cliffs and limited landing shores of Mākanalua created a natural prison and discouraged escape (figure 2).⁵

Among the numerous names given by Hawaiians to this place of exile were “luakupapa‘u kanu ola” (grave where the living are buried), “luahi o ka make mau loa” (fiery pit of endless death), and “lahui i hoehaeha” (nation of great agony).⁶ Incarcerated patients became subject to the full authority of the Board of Health and its agents. If a person was married, a diagnosis of incurable leprosy gave a non-leprous spouse legal grounds for uncontested divorce.⁷ Parents with leprosy had to leave their non-leprous children behind. The settlement was a place where people were left to die of a disease that was then incurable.



FIGURE 2. Shoreline of Makanalua peninsula, Molokai, near original Kalawao leprosy settlement. Photograph by author.

Leprosy afflicted Natives, settlers, and immigrants of all economic and social backgrounds, but the majority of exiled men, women, and children were Kānaka ‘Ōiwi (Native Hawaiians), the Indigenous people of the Hawaiian archipelago.⁸ Hawaiians referred to this new illness as “mai Pake” (Chinese sickness), possibly because the first Chinese contract laborers arriving in the 1850s recognized its symptoms or because a Chinese person had this illness.⁹ The alarming spread of this so-called Chinese leprosy among Native people was first discussed in the kingdom’s Board of Health proceedings in 1863. Less than three years later, the first group of people was exiled, all twelve of them Kānaka ‘Ōiwi.

Although referring to “Chinese leprosy,” the kingdom’s leprosy laws originally focused on Kānaka ‘Ōiwi, not Chinese.¹⁰ Immigrant laborers from Asia and Portugal became ensnared in these sanitizing logics as global migration to Hawai‘i increased in subsequent decades. Thus Chinese, Japanese, Portuguese, Korean, and Filipino settlers and their descendants also were exiled, as well as people of mixed racial backgrounds. European and American settlers constituted the smallest number of incarcerated people. Responses to

leprosy in Hawai‘i shifted over several decades from a disease believed to primarily afflict Natives to one found disproportionately in its “native and oriental” populations.¹¹

The Hawai‘i segregation policy began in 1866 and ended over a century later in 1969, making this the longest and most severe practice of medical incarceration in modern history. The Molokai leprosy settlement incarcerated over six thousand people in its first forty years, from 1866 to 1906, becoming an influential global site for the compulsory removal and lifelong detention of leprosy patients.¹² The outbreak and management of leprosy in Hawai‘i was closely watched, reanimating global concern about this ancient disease.¹³ Other nations turned to Hawai‘i as a medical-carceral model. Legislation establishing compulsory leprosy segregation was passed in Norway in 1885, the British colonies of New South Wales in 1890, Cape Colony in 1891, Ceylon in 1901, the Philippines in 1901, Canada in 1906, and Japan in 1907.¹⁴

A disease known but little understood for millennia, leprosy is understood by scientists today as communicable through slow-growing bacteria in respiratory droplets. Leprosy is now known as Hansen’s disease, named for the Norwegian bacteriologist Gerhard Henrik Armauer Hansen, who discovered the bacilli in 1873. Leprosy is not highly infectious; transmission requires long-term exposure to untreated patients. It may take decades to manifest.¹⁵ It is also difficult to diagnose, with symptoms confused with eczema, vitiligo, psoriasis, and other skin conditions. However, because *Mycobacterium leprae* affects the peripheral nervous system, the disease can cause nerve damage in the coolest parts of the body—the hands, feet, skin, and eyes—sometimes with disfiguring effects. It can cause deformation of nostrils and facial tissue, loss of fingers and extremities, paralysis of eyelids, blindness, and chronic pain.¹⁶

Perhaps because leprosy can dramatically deform the face, as Susan Sontag has suggested, the illness became associated with the loss of personhood and bodily integrity in a Western context. A “dreaded” disease like leprosy instills different responses of shame and revulsion than a “lethal” disease.¹⁷ For Western observers in the nineteenth century, leprosy instilled far more dread than tuberculosis, although the latter killed far more people.¹⁸

The interpretation of leprous bodies as non-human, perverse pollutants became powerfully animated and attached to racial-sexual difference during Western colonial expansion. Represented via disabled raced bodies from the colonies, leprosy provoked stigma and panic in the West in the high age of

empire. Leprosy was resignified as an “imperial danger” and “tropical disease” spread by colonized people to white Europeans in the nineteenth century, although it had been endemic in parts of Western Europe and reappeared in England in the 1840s.¹⁹ This linkage between leprosy and racial contamination prompted compulsory forms of removal and segregation.²⁰

Whereas people with leprosy in medieval Europe were often relocated in leprosaria outside of towns, this exclusion was adapted and codified as a system of permanent and compulsory segregation in colonial regimes.²¹ Leprosy institutions in the age of empire, rather than providing shelter or relief for the sick, shifted to establishing a cordon sanitaire that isolated the infected from the well.²² In Hawai‘i, a legal-medical code institutionalized the radical and racialized exclusion of all those determined to have leprosy. How was this removal of thousands of Native Hawaiians from their natal homes made possible?

For decades prior to annexation by the United States in 1898, settler occupation and colonial pressure subordinated Hawai‘i law, health, trade, and land tenure to the West.²³ The Hawaiian Kingdom, in an attempt to appear respectable and civilized in the “family” of modern Western nations, adopted a legal system modeled on the West that transformed its governance and society.²⁴ This transition to Western law privileged white foreigners, who were familiar with these systems of governance. By the 1840s, these foreigners occupied powerful leadership positions in the Hawaiian government.²⁵ Some of these prominent settlers later participated in the U.S.-backed overthrow of Hawai‘i’s monarchy in 1893 and supported American annexation of the quasi-colony in 1898.

This transfer of authority from Hawaiian chiefs to Euro-American settlers was starkly apparent in Papa Ola, the kingdom bureaucracy known in English as the Board of Health (BOH).²⁶ Missionary descendants and non-missionary settlers dominated the ranks of the Papa Ola leadership. Only physicians trained in Western medicine received licenses to practice medicine in the kingdom, effectively displacing and delegitimizing *kāhuna lapa‘au* (traditional Hawaiian medicine practitioners) and their expertise.²⁷

Established in 1851 by the Hawai‘i legislature as Native Hawaiians were beset by deadly epidemics, the Papa Ola acted as a key biopolitical instrument of the state to protect and ensure life. Biopower, as analyzed by Michel Foucault, is the power of “making live and letting die.” It operates by “optimizing the capacities of a population through interest in health, fecundity, illness and longevity.”²⁸ The exercise of biopower in Hawai‘i prioritized the

economic investments of the white settler oligarchy and preservation of law and order. Fearing damage to the mercantile and sugar plantation economy, white settlers urged the strict containment of leprous people.²⁹

Viewing the hefty budgets, voluminous reports, and files dedicated to eliminating the leprosy problem in the kingdom, one might conclude reasonably that leprosy killed more people than any other disease. No other public health problem received as much sustained attention and infrastructure as leprosy within the kingdom, the quasi-U.S. colony, and (as of 1900) the territory of Hawai‘i. Yet relative to contemporaneous diseases, leprosy was far less lethal. It was not a significant enough public health threat to warrant the systematic carceral response I discuss in this book.

Outbreaks of mumps, smallpox, venereal disease, measles, and influenza since Western contact in 1778 had led to the decimation of the Native Hawaiian population.³⁰ By 1915, pneumonia and tuberculosis were the top two causes of death in Hawai‘i, while leprosy ranked a distant tenth.³¹ In comparison with the long simmer of leprosy infections, bubonic plague and smallpox outbreaks in Hawai‘i were relatively short-lived and episodic. Public health and quarantine efforts directed toward the latter in Hawai‘i do not exhibit the frenetic attention paid to leprosy. In the broader context of fin de siècle United States, influenza and tuberculosis were far greater public health threats than leprosy, each killing nearly two hundred thousand people, while there were only 278 confirmed cases of leprosy.³² So why did health agents and settlers in Hawai‘i mount such a bulwark against leprosy? Anxieties about leprosy encompassed concerns far beyond health, disease, and economics.

COLONIAL EXCHANGES AND OBSESSIONS

Leprosy took on geographic and racialized associations as a tropical disease emanating from the Pacific region in the late nineteenth century.³³ From the vantage point of Europeans and Americans living in metropolitan and colonial zones of contact, leprosy was a highly contagious, incurable, and racially contaminating disease prevalent among a range of non-white peoples: Indigenous Pacific Islanders, Asians, “Negroes,” and inhabitants of the Indian subcontinent.³⁴ The disease’s very ambiguity was perturbing: the more knowledge produced about leprosy, the less seemed to be certain.

Disturbing the boundaries between the visible/invisible, clean/dirty, colonized/colonizer, able/disabled, settler/Native, leprosy became a colonial obsession. Physicians could peer at leprosy bacilli under a microscope as early as 1873, but the transmission of the microbe was frustratingly elusive. Health agents in Hawai'i and contemporaneous sites in the British Empire debated whether the disease was hereditary or spread by sexual contact, food, soil, or blood. Visible under the microscope, but hidden beneath the skin and in the body, leprosy bacteria could emerge as infections years later, confounding scientists. With leprosy's unpredictable incubation period, a person could appear "clean" or uninfected while potentially harboring and spreading these germs.

Leprosy thus became an apt metaphor for the duplicitous colonial subject. The German microbiologist Eduard Arning unwittingly conflated the uncontrollable leprous body and the unruly Hawaiian body in 1884 when he wrote, "[W]e must look upon every single leper as a hot-bed of disease . . . He, at any rate, breeds and multiplies a poisonous germ; and is, on this account, dangerous."³⁵

Nathaniel B. Emerson, a son of American missionaries and the Molokai leprosy settlement's first resident physician, expressed similar bewilderment peering at people's skin, behavior, and moral character. In his clinical notebook, Emerson assessed a thirteen-year-old Hawaiian boy in 1880: "This boy's skin is perfectly clean and free from speck or flaw. And it hardly seems possible that this handsome, healthy and clean boy is a leper." Emerson could not bring himself to trust his own sight: those who appeared "clean" and beautiful could be polluted where the eye could not reach.³⁶ This boy passed Emerson's inspection and never became sick. However, twenty-five years later, the now-grown boy would see his only daughter sentenced to the Molokai settlement and die there.

Leprosy also became intertwined visually and discursively with promiscuity and immoral sexuality in Hawai'i's intimate, porous zones of contact. In this colonial imaginary, leprosy was a dangerous racial-sexual invasion crossing the threshold from soiled to "clean" bodies, a contention that I explore in chapter 3. Hawaiians and immigrants were culpable agents, spreading leprous germs through wanton sexual contact and non-conjugal domestic intimacy. George Fitch, an American-born government physician posted at the Molokai settlement, and his colleagues insisted that leprosy and Native sexual deviance must be related. "The disorder has been allowed to run on unchecked and uncontrolled," Fitch asserted, because of the "uncontrolled licentiousness" of Hawaiians.³⁷

While principally represented as a germ spread by contaminated Native bodies, leprosy also remained a visible reminder and symptom of the fallibility and erotic excesses of nineteenth-century colonial society, a society that would not be fortified easily by a cordon sanitaire. Leprosy was a libidinal haunting, a symptom of white civilization's erotic weaknesses. White (male) settlers willfully transgressed by having sex with, living in intimate proximity to, and marrying Native women. Although emerging from putatively repulsive and immoral Native bodies, leprosy contaminated white bodies because white men could not control their own bodies and desires. Concluded Martin Hagan, an Ohio-born physician who had joined the ranks of Hawai'i's government physicians, "Emigrated Americans and Europeans having intimate intercourse with the lepers, sooner or later take the disease."³⁸

CARCERAL MEDICINE

The U.S. Supreme Court ruled in *Jacobson v. Massachusetts* (1905) that vaccinations could be mandated by the state, citing smallpox epidemics and the greater public welfare. This decision confirmed the legal authority of police power in matters of public health. Yet Hawai'i had already severely curtailed individual liberties and criminalized contagion on a wide scale four decades prior to this case. The 1865 Act to Prevent the Spread of Leprosy granted "full power" to health agents to confine and exile all leprosy people. The euphemistic terms "conveyance," "isolation," and "seclusion" in this legislation fail to convey the forced removal, containment, and natal alienation experienced in Hawai'i. I rely on *incarceration* to designate the widespread, overlapping practices and institutions of colonial carcerality in which leprosy control was enmeshed, including insane asylums and juvenile reform schools.³⁹

Medicine practiced in a colonial society, as Frantz Fanon cogently argued, cannot be separated from the colonialism that enabled it. The colonial condition enabled physicians to gain access to the bodies and culture of colonized subjects.⁴⁰ More specifically, I delineate Western biomedicine's role in these carceral practices. Hawai'i's leprosy regime conjoined medicine and law in a carceral system.⁴¹ This system produced and depended on what I am calling *carceral medicine*—a juridical-medical system that worked to incarcerate particular bodies and produce knowledge about those bodies. Carceral medicine worked within and alongside the service of Hawai'i's settler-colonial state to control, subordinate, and sanitize threatening and non-normative

bodies, the majority of whom were Native Hawaiians and non-white immigrants.

Disparate personnel—physicians, health agents, bacteriologists, nurses, and missionaries from North America, Britain, Germany, France, Japan, and Spain—lent their expertise and labor in this medical regime as formal and informal state actors. Some were chief architects and administrators of leprosy institutions, mapping influential policies for detention, incarceration, and parole. Others labored for many years on the ground.

A methodical surveillance and detention system was made possible by a grid of government physicians and district sheriffs. Government physicians, all Westerners licensed in Western medicine, were posted in twenty-six different island districts.⁴² These physicians had private practices, but also were appointed by the Board of Health. They were responsible for reporting suspicious cases of leprosy to the board and providing monthly reports.⁴³ “On the constant, vigilant outlook,” doctors and district sheriffs dispatched “suspects” to Honolulu, where they were admitted and examined at the city’s receiving station and hospital.⁴⁴

Physicians then consigned people to one of three medical-judicial categories that determined a person’s freedom and un-freedom: “Not a Leper,” “Leper,” and “Suspect,” as I detail in chapter 2. A “leper” was someone who was “incurable or capable of spreading the disease of leprosy.” Those in this category were exiled to the Molokai settlement for the rest of their lives. A “suspect” was someone who was a “doubtful” case or “not in sufficiently advanced stages” to spread the disease. Suspects could be detained or recalled for future inspection. Despite their projected rigidity and authority, these categories could be porous and ambiguous, as I discuss in chapter 2.

In addition to government physicians, still others benefited from the carceral regime as short-term medical tourists who gained unfettered access to leprosy prisoners for experiments, visual curiosity, and private ethnographic research. As historian Regina Kunzel has analyzed, the twentieth-century American prison became a “laboratory of sexual deviance.”⁴⁵ Leprosy institutions were productive carceral laboratories for foreigners to scrutinize disease, race, indigeneity, and sexuality in a captive, colonized population. An exemplar I deliberate in chapter 1, the German dermatologist and bacteriologist Eduard Arning, experimented on prisoners, photographed Hawaiians, and collected material culture in the early 1880s in an ambitious bid to salvage medical and cultural data from disabled Hawaiians. His access to a range of Hawaiian subjects, he admitted, was afforded because he was a

physician. Arning wrote, “This role of physician brought me trust and sympathy, which I could put to good use.”⁴⁶

In total, these diverse practices of carceral medicine were similar to and contemporaneous with other Western state technologies that catalogued, organized, and studied criminal or non-normative raced bodies, such as late nineteenth-century German anthropological photographs of races of men; nascent criminal “mug shot” photographs; and the French criminologist Alphonse Bertillon’s detailed descriptions of criminal bodies placed in a vast filing cabinet at Paris police headquarters.⁴⁷ The Italian physician Cesare Lombroso’s studies of “criminal man” and “criminal woman,” which included galleries of inmate photographs, tied bodily non-normativity to moral depravity.⁴⁸

People with leprosy were treated and imaged as patients, inmates, and deviant criminals in Hawai‘i, as I analyze via overlapping visual and textual representations. The mundane accounting of the Kaka‘ako Branch Hospital in the 1880s lists its “inmates present,” with a Dr. Clifford B. Wood serving as physician and quasi-warden. The succeeding Kalihi Hospital was surrounded by a fence, but detained men and women climbed through it to fraternize with friends, lovers, and family in Honolulu. Instead of erecting a higher fence, the Board of Health resolved to discipline recalcitrant patients by sending them to Molokai.⁴⁹ After the United States incorporated Hawai‘i as a territory in 1900, people residing in the settlement were enumerated as “institutional inmates” in the U.S. census.⁵⁰ Mirroring and intensifying the language and practices of imprisonment, patients released in the twentieth century were not merely discharged; they were released on “parole” and photographed as parolees.⁵¹

AN ARCHIVE OF SKIN

These carceral practices lead us back to the child Keliiahonui’s clinical photograph. While his clinical photograph first entered him into a criminal registry of leprosy suspects in 1903, a year later this same photograph surfaced far beyond Hawai‘i in the influential *Journal of the American Medical Association* (figure 3). Even later, the photograph was repurposed for a public health lecture by the pathologist who led the National Institute of Health.⁵² After Keliiahonui’s exile to Molokai in 1903, he was also photographed in the settlement, probably by a French-born Catholic priest serving as a medical missionary. This latter image later appeared in early to mid-twentieth-cen-



FIGURE 3. Keliihonui, captioned as “Tubercular Leprosy in a Young Native Girl,” in Senn, “Leprosy in the Hawaiian Islands,” *Journal of the American Medical Association*, August 13, 1904. Cropped from original.



FIGURE 4. Keliihonui, Catholic lantern slide, ca. 1910. Slide LS8-48, Congregation of the Sacred Hearts of Jesus and Mary U.S.A. Province.

tury Catholic lantern slides and a French-language biography of the Belgian priest Damien de Veuster (figure 4).⁵³

Photographs of Keliihonui taken during incarceration thus circulated to diverse locales and publics far outside of the Hawai‘i leprosy archive during and after his short life. Clinical photographs remained indefinitely in the archive, taking on a life of their own even after the people they indexed had died. The dispersed photographs provide us a sense of how far and wide images of incarcerated patients moved through time and space. Keliihonui

is but one person, but he represents thousands of other Hawai‘i patients who were photographed and archived by the state and then seen and interpreted by transnational medical, religious, and lay publics through the twentieth century.

What distinguished this modern regime of medical incarceration from previous ones was its intense investment in visual technologies. The camera was adapted and put to effective use for carceral medicine, and a vast, prolific archive of leprosy bodies emerged from the colonial-carceral state, as I detail in chapter 2. This book begins in a visual culture of leprosy that I call an *archive of skin*, an archive that exposed and organized raced-sexed bodies into intelligible and visible entities. What was this archive of skin? More than any other colonial or “tropical” location, Hawai‘i produced spectacular images of leprosy patients that were collected, archived, and displayed. Despite this broad circulation, we know remarkably little about the production and institutional contexts of these visual archives of skin and even less of their meanings.

Every leprosy suspect captured in Hawai‘i from at least 1898 was photographed individually during medical examinations at a Honolulu detention facility and entered into the Board of Health’s leprosy files. This visual cataloging of Indigenous and Asian bodies constitutes one of the most extensive in America’s Pacific empire. Approximately 1,400 of these images survive from a fifteen-year period between 1895 and 1909, but there were likely thousands more shot as the practice continued at least until the 1950s.

These are portraits of criminality and disability—repressive portraits, to borrow Allan Sekula’s phrasing.⁵⁴ Photographs established important medical and legal evidence for lifelong incarceration and exile, confirming a clinical diagnosis of leprosy and documenting a suspect’s somatic condition upon capture. Above all, the photograph dominated the clinical record. The photograph was the central part of the leprosy case file in Hawai‘i, traveling with a patient’s clinical file, sometimes for decades. Unlike contemporaneous identification systems that relied on textual descriptions, the case files were less “commitments to paper” than commitments to *images*.⁵⁵

The Hawai‘i Board of Health archive of skin is distinct as a genre of medical photography because it was instituted and financed by the colonial state. American physicians made and collected photographs of unusual clinical cases as early as the 1840s for diagnosis and documentation.⁵⁶ However, the Hawai‘i archive was far more extensive and deliberate than an assembly of pathological images taken by individual physicians. Analyzed in chapter 2,