FUTURES FORETOLD

The Pandemic and Resonance from History

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As the world struggles to come to terms with the impact of the pandemic, and we live through these truly extraordinary times, an astonishing amount of writing has appeared, and continues to do so, on the impact of the SARS CoV–2 virus on life and living as we know it. In professional journals, in mainstream journalism, both print and online, on television, on social media and in almost all forms of public discourse, the sheer amount of content created on Covid–19 is indeed spectacular.

As mental health professionals interested in the history of medicine, the two factors that we find fascinating are the undergirding of these multiple discourses with these particular concerns—the mental health impact of the pandemic, and the various attempts to put it in context of earlier pandemics and disasters.

If we are to start with the historical, as is perhaps appropriate, one of the main sources of learning would have to be the 'influenza outbreak' of 1918. What is—perhaps, inappropriately—called the Spanish Flu in fact claimed its greatest number of victims in India. It could, perhaps more accurately, be called the Bombay Influenza, since it killed between 10–20 million people in India (almost half the worldwide casualties) (Chandra and Kassens-Noor, 2014), and had a far-reaching impact on the politics, history, economy, health and governance of the subcontinent.

An interesting resource here is an article by E. S. Phipson of the Indian Medical Service (IMS) (1923). It is a wonderful review of the epidemiology, natural history, social factors, clinical features and possible preventive strategies, which forms Phipson's MD thesis at London University. Phipson, who was the Assistant Health

Officer in the city of Bombay in 1918, draws on his experience and diverse scholarship to make some interesting observations. It is also instructive how many of these observations remain relevant today.

By all accounts, the contagion arrived in the city of Bombay by the sea route, and from Bombay appeared to spread across the subcontinent. It is interesting that questions unanswered a century ago remain so even now, as Phipson writes:

> These are facts that it is much easier to gloss over than to explain, and in the present state of our knowledge it must be admitted that the genesis of the epidemic in India, is still an open question, unless, indeed, we postulate the existence of some known epidemiological factor 'X' which, introduced from without, turns a smouldering endemic focus into a blazing conflagration (ibid.: 511).

Using data from municipal dispensaries, private medical practitioners across the city, death records, the information collected from various firms, schools, banks, mills and 'other large employers of labour', he creates a fairly compelling argument for the likelihood that the infection arrived at the sea port of Bombay and spread inland. An interesting note is the prevalence rate of 60 per cent among the staff of Greens Restaurant, with its Goan cooks and waiters, drawing parallels to 'superspreaders' of today. Phipson also draws attention to the two phases of the spread of the outbreak, with the first phase being that of June and July, and the second that of September and October.

An interesting metric that emerges on exploring the archives shows that, as in all disasters, either natural or man-made, there seems to be an obvious inequality in the impact of the pandemic. As always, the poor and the disadvantaged are those who experience the greatest impact of the disaster. So the death rates per thousand population in 'Europeans, Parsees and Eurasians' are around 10, while the 'Low Caste Hindus' experience an astonishingly high rate of 61.6. The fact that social inequity leads to a variable effect on different populations should actually come as no surprise. It is a lesson that we should have learnt with every disaster and social upheaval. What is surprising is the rapidity with which this message is forgotten. An interesting fact is that while the poor do not seem to suffer as much in the first phase, they bear the brunt of the second

phase. In Phipson's words: '...those communities whose collective hold on life is known to be slight suffered most during the epidemic, and the converse holds also' (ibid.: 517).

1.	Europeans	..	..	8.3
2.	Parsees	..	..	9.0
3.	Eurasians	..	..	11.9
4.	Jews	..	..	14.8
5.	Indian Christians	..	..	18.4
6.	Caste Hindus	..	..	18.9
7.	Mohammedans	..	..	19.2
8.	Low Caste Hindus	..	..	61.6

In a description of the clinical presentation of an outbreak of illness, it is observed that the manifestation of symptoms can be varied, diverse and protean. While most people will have very mild symptoms when the illness does appear—the picture can be respiratory, febrile, neurological or haemorrhagic—it has many resonances to the observer of today. In the same way, the analysis of mortality figures is hampered by what is called 'co-morbidity', or the presence of other illnesses (and later detected to be severe bacterial infections, which proved fatal, as antibiotics had not yet been invented). Phipson, in his search for the right phrase, quotes Sir Thomas Clifford Allbutt, a prominent physician of the time: '...for the disease fights in part under its own flag and in part treacherously under other flags' (ibid.: 514).

Note is made in the article of the appreciation of public response to the epidemic. Student organisations, religious trusts, mills and firms in the city apparently came together to provide relief. In Phipson's words:

> The appeal for public co-operation met with such a wonderful response, and so whole hearted was the devotion of all workers in carrying out the relief measures adopted, that it is probably safe to say that there was hardly a house in the city, or a unit of the population that did not have a chance of relief… (ibid.: 515).

However, political history tells us that these years also saw the massacre at Jallianwala Bagh, the Moplah rebellion, the beginnings of the civil disobedience movement, and the very public boycott of

the Prince of Wales' visit to Bombay. It is intriguing as to whether Phipson's rosy vision is meant to suggest that, despite all these events, the civic and public response to illness did bring both—rulers and ruled—together. The preservation and promotion of this civic concern and trust, in times of distress, was perhaps essential for governance. Whether this was merely a facade, or of actual unconcern to the political processes, is something that ought to be interrogated. In any case, this huge loss of life is seldom remembered, unlike the famine of 1943 or the Jallianwala massacre.

At that point, infections were often considered divine malevolence, manifesting as a mysterious infection, and not necessarily a political or social problem.

In resonance here, what we have witnessed in present times is a large civil society response, very often with young people as its standard bearers, reaching out to people in distress. The precise forms taken by this engagement, and whether this heralds a greater involvement with civil and political issues, is a question for possible futures to answer.

In closing, Phipson has this to say:

> It has been said that there is a soul of good in things evil, and if the experience of 1918 has brought home to those voluntary workers, especially educated Indians of all classes who rendered such splendid service in times of unprecedented stress, the distressing conditions under which the poor of Bombay continue to exist, it may be that Bombay may have in store for her a brighter history in the future than she has known in the past. In whatever hands her future destinies may lie, let us hope that the lessons of 1918, so hardly learnt, will not be easily forgotten (ibid.: 521).

As an interesting aside, these 'hardly learnt' lessons remain hardly learnt, as the enduring and defining image of the pandemic in India remains that of the migrant worker, rendered unemployed by the lockdown, trudging the dusty roads home.

Conservative estimates place the number of people who have been part of this process of 'reverse migration' as at least 30 million (Chisti, 2020). A large proportion of the urban 'work-force', propelled both by fears of unemployment, homelessness and fear of contagion, have walked thousands of kilometres across the

length and breadth of the country in the agonisingly searing Indian summer, often harassed and sometimes aided by state machinery, and fitfully helped by an uneasily ashamed civil society. The multiple stories of these journeys, these tales of courage, hope, exploitation, neglect and cupidity will need the filters of both time and distance to be told dispassionately. However, the learning that the state response forgets in time—what will happen to millions left stranded without either succour or dignity—needs to be critically evaluated. The painful parallels to the transmigration of populations that attended the independence of India, the partition of the subcontinent, and the striking similarity of the images can escape no eye. It remains ironic that a public health response that is focused on the health and safety of the privileged, that renders invisible the vulnerable, can scarcely be the hallmark of a civilised society.

It is also obvious that if the response to an anticipated health crisis focuses only on health concerns, overlooking real life issues of livelihood and economic sustainability, the likelihood that the humanitarian and economic costs will be unaffordable remains a real possibility. This is also the reason that public health has been the domain of preventive and social medicine. There remain disquieting lessons to be relearnt.

As a consequence of the appalling death rates of the 1918 influenza epidemic, and the several cholera outbreaks that followed, considerable pressure was placed on the government to reform health care. It proved difficult—a not-so-subtle racism within the IMS, the bureaucratic approach to health care that did not allow any planning for either medical services or primary prevention (as that was a local, rather than an Imperial issue; a convenient fig-leaf for inaction), and the almost complete absence of any notion of universal health care, as it could not be articulated or demanded by colonial subjects. Faced with pressure from legislatures, both in London and New Delhi, reforms were promised by the setting up of the Bhore Committee, which were broadly in line with Beveridge-style universal health care. Indeed, in a talk broadcast on BBC in the middle of the Second World War, a senior health official hoped that the provision of universal health care would 'leaven the bread' ('help India rise'), so essential to promote unity and a sense of belonging in post-Independence India. This, however, was not to be, as the economic czars behind the Bombay Plan resolutely opposed any

social and health spending, as did the Bretton Woods institutions. Plans for health care were whittled down, blamed variously on the competing demands caused by Partition, the devaluation of the rupee, crop failures, wars in the 1960s, among others. As a result, health expenditure, as a percentage of GDP, has remained resolutely the same as it was under colonial rule. India now produces almost 20 per cent of the world's doctors, but without a public health care system to absorb them, as health care (along with medical education) has been privatised. The bewildering array of organisations, the lack of any central service that oversees health care (since the IMS, alone among the colonial services, was specifically disbanded), makes coordination and systemic responses at times of crises a near impossibility.

At the other end, the advances in medical science and technology urge and necessitate joint efforts. Advances in genetics, immunology and vaccinations, technology-assisted diagnosis and interventions have had a dramatic impact on how we approach disease. The genome of Covid–19 could be sequenced in weeks, its interface with human and animal genomes also explored, and despite the chaos, there is underlying optimism that the illness is not beyond the gaze of science. However, in societies where access to science and education, and to technology, is skewed—and these are seen as elite pursuits and not a part of the 'public commons', and nor is a right to health care seen as a public good, but rather as a private privilege—things may be quite different. There is thus an understandable suspicion and wariness, as is seen in the reluctance to quarantine or be interred (not treated) in government hospitals, and a proliferation of 'faith'-based approaches, very much like the 'popular' antipathy against vaccinators and plague workers that manifested itself a century earlier.

This should be a matter of concern, as Koch, Haffkine and Ross made immense contributions to the understanding of infectious diseases such as cholera, plague and malaria, based on their work here in India, in the 19th century, and this transformed the nature of social medicine and the social contract of governance. A primeval, or at best a medieval, response to an epidemic perhaps reflects how shallow the notion of modernity and scientific temper are, despite satellites and cell phones. And this is the critical gap between technology-driven bio-medicine and social medicine. In a sense that

is how science develops—incrementally, and in small steps. This is perhaps best exemplified by the fact that today, a few short months after its advent, we know a lot about the SARS CoV–2 virus, but still do not know how to prevent its propagation or cure its manifestation. The trouble is that we look to science for magic, and when that is not forthcoming, we turn to magic, both benign and malign.

Many commentators, commemorating the 1918 epidemic a century later (Kant and Guleria, 2018: 221–224; Taubenberger, et al., 2019) had suggested, and warned, that we were ill-prepared for a resurgent pandemic, which would recur as it had for millenia (Morens, et al., 2020). An interesting facet of these times is also the recognition from the beginning that while it remains a public health crisis, it will also manifest as a mental health crisis, indeed a mental health pandemic. While this has been recognised in earlier disasters, mainly retrospectively, that realisation has happened early this time.

Here we may want to remember that mental health needs and requirements, like medical needs, will be both varied and diverse. This is also something that psychiatry has struggled with historically. Therefore, the impact of the pandemic on the majority of the population is to increase levels of stress, apprehension and dread, making, in a sense, anxiety the new 'normal'. The interesting thing about psychiatry is that unlike medicine, which localises itself in the body, it often manifests itself in the relationships that individuals have with other human beings and the world itself. In situations like the present pandemic, it is these very interpersonal spaces that become fraught with an anticipation of dread. This interpersonal space is now inhabited by an unknown, invisible, viscerally frightening foe. This only engenders anxiety and suspicion, as people begin to believe that nasty surprises lurk on every surface and around every corner, and a life that can be preserved only by a brutish struggle for paracetamol, vaccines or a bed in a hospital.

What this does is to increase the numbers of what is often termed as the 'worried well'. The measures that mental health services will have to consider to deal with this group is something that has actually been discussed in public discourse. Therefore, tutorials and 'webinars' on self-care, exercise routines, advice on hobbies and the development of routine have pretty much flooded the Internet, and certainly helped a very large number of people. What comes to be normalised in this discourse is that these 'worried

well' are the privileged who have access to these suggestions and exhortations. What often does not get the importance that it deserves is the multiple requirements of people with mental illness, those with psycho-social challenges, and those for whom the structural barriers of caste, class and economic vulnerability make these otherwise very useful suggestions a mockery.

The high rates of deaths in the 'care home' and of the homeless, who could not negotiate access to biomedical facilities, have shocked many (Rosen, 2020). Individuals with special needs, whether these be the elderly or those with severe mental illness, who rely on structured, secure and safe social contact, are now suddenly left to flounder, deprived of the tenuous straws that connect them to the 'real world'. Some commentators have even hinted that this 'culling' may be a useful way to reduce the 'burden' of disease. And around us, when care is so difficult to access, and so expensive, would those with mental illness be considered in the sweepstakes? Should we be expecting these choices to be made, by a family or by society—or will we let the market decide?

It is also in the nature of cataclysmic upheaval that it makes these ironies that much more apparent. Margaret Mead, the anthropologist, marked the beginnings of civilisation to the discovery of a healed femur in an archaeological site. This suggested that human society first developed a mechanism and a notion of care—in looking after an injured person till recovery—about 20,000 years ago. Human cultural history has been a long battle against injury, disease and pestilence, although we often remember it as one of wars and conquests and political intrigue. How human society and civilisation will cope, and whether this will bring with it the seeds of change, remains to be seen.

A century ago, Phipson ended on a note of hope:

> It has been the writer's endeavour to present the features of the 1918 epidemic in Bombay, and to indicate the lines on which action ought to be taken in the immediate future. The Bombay of a century hence presents such vistas of possibility, political and sociological, that the mind can scarcely envisage them (1923: 521).

Standing today as we do, a hundred years since these words were written, it is for us to judge how many of those possible vistas we

have realised. It has, however, also been said that, in the past, even the future was better.

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REFERENCES

Chandra, S. and E. Kassens-Noor. 2014. 'The Evolution of Pandemic Influenza: Evidence from India, 1918–19', *BMC Infect. Dis.*, 19 September, 14: 510. doi: 10.1186/1471-2334-14-510. PMID: 25234688; PMCID: PMC4262128.

Chisti, Seema. 2020. 'Explained: How Many Migrant Workers Displaced? A Range of Estimates', *Indian Express*, New Delhi, 8 June. Last accessed on 2 July 2020.

Kant, L. and R. Guleria. 2018. 'Pandemic Flu, 1918: After Hundred Years, India is as Vulnerable', *Indian J. Med. Res.*, March, 147 (3): 221–24. doi: 10.4103/ijmr.IJMR_407_18. PMID: 29923508.

Morens, D. M., P. Daszak, H. Markel and J. K. Taubenberger. 2020. 'Pandemic COVID–19 Joins History's Pandemic Legion', *mBio,* 29 May, 11 (3): e00812-20. doi: 10.1128/mBio.00812-20.

Phipson, E. S. 1923. 'The Pandemic of Influenza in India in the Year 1918. (With Special Reference to the City of Bombay)', *Ind. Med. Gaz.*, 3 November, 58 (11): 509–24. PMID: 29008009.

Rosen, J. 2020. 'How Covid–19 has Forced Us to Look at the Unthinkable', *The New York Times Magazine*, 29 April. Last accessed on 2 July 2020.

Taubenberger, J. K., J. C. Kash and D. M. Morens. 2019. 'The 1918 Influenza Pandemic: 100 Years of Questions Answered and Unanswered', *Sci. Transl. Med.*, 24 July, 11 (502): eaau5485. doi: 10.1126/scitranslmed.aau5485.

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