Military Medicine and the Ethics of War: British Colonial Warfare during the Seven Years War (1756-63)

ERICA CHARTERS

Abstract. This article examines 18th-century European warfare, tracing the first formal codifications of conventions of war, frequently introduced by military physicians and initially regarding the treatment of the sick and wounded. It outlines to what extent these conventions were followed in practice, particularly in the challenging environment of American irregular warfare, with a focus on the most well-known incident of “biological warfare” in the period: the deliberate spread of smallpox by British officers among Amerindians in 1763. More broadly, it demonstrates that the history of military medicine provides a fruitful method with which to uncover assumptions about the ethics of war.

Keywords. smallpox, military medicine, biological warfare, Seven Years War

Résumé. Cet article retrace les premières codifications formelles des conventions de guerre lors des guerres européennes du dix-huitième siècle, fréquemment introduites par des médecins militaires et, initialement, concernant le traitement des malades et blessés. L’article esquisse dans quelle mesure ces conventions étaient respectées, particulièrement dans l’environnement difficile de la guerre américaine, avec une attention spéciale sur l’incident le plus connu de ‘guerre biologique’ de la période : la transmission délibérée de la variole par des soldats anglais aux Amérindiens en 1763. Plus largement, cet article démontre que l’histoire de la médecine militaire offre une voie fructueuse pour étudier les questions éthiques relatives à la guerre.

Mots-clés. médecine militaire, variole, guerre bactériologique, Guerre de Sept ans

Erica Charters, Wolfson College, University of Oxford.

CBMH/BCHM / Volume 27:2 2010 / p. 273-298
Before the 1758 siege of Louisbourg, the Commander-in-Chief of British forces in North America, General Jeffrey Amherst, urged his troops to be vigorous in battle. He reassured them that they would enjoy plenty of provisions, as well as proper hospital care in case of illness or wounds. He also reminded them that each regiment had specific objectives, which if accomplished, would deliver a British victory over the French. The light troops, for example, were to focus their attack on:

Indians, Canadians and other painted savages of the Island, who will entertain them in their own way and preserve the Women & Children of the Army from their natural Barbarity. Indians spurr’d on by our Inveterate Enemies the French, are the only Bruts [sic] and Cowards in the Creation, who were ever known to exercise their Crueltys on the Sex, and to Scalp and mangle the poor sick soldiers, and Defenceless Women. When the light troops have by Practice and experience, acquir’d as much Caution and Circumspection, as their spirits & activity these Howling Barbarians will fly before them.¹

Amherst’s command during the Seven Years War in a theatre which was characterized by so-called irregular warfare and contact with Amerindians is infamously linked to the allegedly deliberate spreading of smallpox among the Delaware Indians at Fort Pitt in 1763.² As a result, not only has Amherst been widely condemned, but the very nature of British warfare during this period has been held to have involved regular biological warfare against Amerindians. More broadly still, European conventions of war, it has been argued, were challenged and occasionally cast aside in the face of North American wilderness-style warfare.

While neither Amherst’s character nor the actions of British officers at Fort Pitt in 1763 are faultless, it is by no means apparent that the British armed forces regularly used disease as a weapon.³ Rather, a detailed examination of the practice of military medicine, as well as of the threat that smallpox posed to British campaigns, demonstrates that on the whole the British armed forces maintained their conventions of war. The incident at Fort Pitt in 1763 should thus be seen as an exceptional deviation from, and not a typical indication of, the nature of British war in America. Such an interpretation has consequences for our understanding of the nature of warfare in the American colonies more generally, including British fighting during the War of American Independence.⁴ Here, however, my primary concern is to elucidate how a focus on military medicine and responses to disease among the British armed forces provides a fruitful method with which to uncover assumptions about the ethics of war. Such assumptions, implicit in practices, are difficult for historians to trace and prove. Published treatises on the law and ethics of war are of limited utility since they provide no evidence that conventions were followed in reality. Disease among the armed forces, on the other hand, was frequently interpreted in published works as
well as in private correspondence. Moreover, it was a very real physical entity that had to be dealt with in order to ensure victory. Disease and military medicine thus provide an interface between the theory and the reality of war. By the same token, disease also throws into sharp relief the distinction, central to the 18th-century European ethics of war, between combatants and non-combatants.

This article begins with an examination of the threat smallpox posed to British campaigns in the American colonies during the war, focusing on its effect on provincial (British colonial American) support. It ends with a discussion of conventions of war which concerned civilian immunity through an analysis of practices of military medicine and the treatment of prisoners of war. This provides the context for a brief re-examination of the case of Fort Pitt in 1763 in the light of the wider practices and rhetoric of smallpox in British colonial warfare. As Amherst’s speech before Louisbourg reminds us, a courageous and well-disciplined British fighting force required the assurance that they would only die gloriously in battle, and would not be left to be ravaged by disease, starve, or suffer the ignominy of brutal attacks on unarmed invalids — a fate little better than that of helpless civilians.

SMALLPOX AND BRITISH MILITARY STRATEGY IN THE AMERICAN COLONIES

Smallpox in the American colonies has been studied within the context of disease exchange between Europe and America in the early modern period. These examinations focus particularly on the ravages of European disease among American Indigenous Peoples and on debates over mortality rates and how these correlated with destruction wrought by European warfare. European activity in the Americas often spread diseases, resulting in high rates of morbidity and mortality among Amerindian populations; the sheer presence of Europeans had a noticeable short- and long-term demographic impact. This in turn allowed Europeans to conquer territory with relative ease. Both English and Spanish early settlements in the Americas suffered from high mortality rates due to sickness. However, Spanish and English colonists apparently interpreted such high rates differently. The Spanish expressed regret over such mortality, whilst English colonists are described as concluding, “God had providentially cleared the land of its inhabitants to accommodate His chosen people.” As historians have pointed out, this was due to Spanish desire for Amerindian labour, in contrast to English plans to settle and pasture American land, which was therefore preferred depopulated. Contemporaries and historians have thus interpreted high rates of disease among Indigenous Peoples with reference to the nature of colonial rule. For example, the early Spanish colonial
conquest has been characterized as the “Black Legend” of atrocities and cruelty. Such an interpretation is in many ways historically accurate, yet it was also used by other European powers to justify the conquest of Spanish colonies.8

Recent historiography has challenged altogether the assumption of a uniform demographic impact of European diseases upon Amerindians. Such studies grant Amerindians historical agency, as they recognize that social and political organization or responses to disease varied across Amerindian populations. They also demonstrate that historians can be guilty of biological determinism or allow penitence over European wrongs to encourage sweeping generalizations or vague language referring to “virgin soil” populations or the process of “weeding out.”9 The debate over mortality rates and the explanation of differences in mortality may never be entirely resolved. But it is clear that smallpox in the Americas continues to be interpreted in relation to the nature of colonial rule. As a consequence, its incidence in the British colonies is read with reference to the presence and actions of British imperial forces.

Such interpretations are hardly surprising. Disease and health have long been used as indicators of the nature of governance, and responses to disease often incorporate ideas of blame and moral responsibility. Theories of political arithmetic, still influential among European nations throughout the 18th century, claimed that a strong and large population equalled a strong and powerful nation. While there was vigorous debate over how exactly the strength of the nation should be calculated and evaluated, these topics were discussed within the assumption that good government resulted in population growth, while population decline was a sign of despotism.10 Disease was frequently interpreted as a symptom of a degenerating society, especially since this was a period that was anxious about the effects of commercialization, luxury, and urban development.11 At the same time that Europeans recognized Indigenous American vulnerability to diseases, the image of the “noble savage” also provided an interpretation of their previously disease-free life. In his travel diaries of the Americas, Jonathan Carver noted: “The Indians in general are healthy and subject but to few diseases, many of those that afflict civilized nations and are the immediate consequences of luxury or sloth being not known among them.”12

Eighteenth-century medical theory posited that lifestyle and constitution predisposed some individuals to disease more than others, and hence it was not surprising to contemporaries that Amerindians suffered from different diseases and in different ways than did Europeans. At the time of the Seven Years War, these physical differences were noted by both provincials and British observers. British officers and soldiers recognized that provincial soldiers suffered higher rates of sickness than their British-born counterparts. Unusually, the diseases afflicting sol-
diers were not products of the North American climate. According to provincial diaries, the provincials were suffering from flux, fevers, and smallpox. Flux, referring to dysentery or diarrhoeal diseases, and contagious fevers such as typhus, were common complaints in unsanitary and crowded conditions, such as those that prevailed in army camps. The highly contagious smallpox, in particular, would have quickly spread within the confines of an encamped army. British regular soldiers suffered less from such complaints, first, because they were more likely to have been recruited from urban centres where such crowd diseases were prevalent, and, second, because they had already been used to living in army camps before arriving in North America. The circumstances of army camps thus helped spread crowd diseases among newly recruited soldiers. The incidence and fear of smallpox encouraged provincial hostility to military service. This in turn added to British officials’ frustration over what they considered the ill-discipline of provincial soldiers.

Smallpox was one of the most mortal European diseases during the 18th century. Survivors were left with superficial pockmarking, while severe cases resulted in blindness, skin infections, infertility, and a horrifically ravaged appearance. Writing at mid-century, the physician Richard Brocklesby reported, “[t]he Small-Pox is reckoned deservedly amongst the most dangerous diseases that are commonly to be met with throughout all Europe.” Incubation lasts from 10 to 12 days, after which sufferers experience back, muscle, and head pains, high fever, and the characteristic rash. In severe cases, the rash becomes confluent, causing septic skin infections and massive hemorrhages of the skin, lungs, and other organs. Two strains or variants of smallpox are widely recognized: \textit{Variola major}, with a mortality rate of 25%, and \textit{Variola minor}, with a mortality rate of 1%. The severity of smallpox appears to have changed over time: most medical historians agree that smallpox became much more fatal sometime during the 16th century, and 18th-century contemporaries recognized that there could be a “good” kind and a “bad” kind, possibly corresponding to \textit{minor} and \textit{major}.

There is no cure for smallpox, but one survived attack provides lifelong immunity. As a result, inoculation, in which infectious material is purposefully administered in order to cause what is hoped to be a mild attack, was used to confer immunity upon an individual. The practice originated in various forms in Eastern countries, and gained notoriety and finally acceptance in Britain during the 18th century. The operation was risky and dangerous at best, practised only in the immediate threat of a smallpox epidemic. Not only could an inoculated individual end up suffering from a severe or fatal form of the disease, but also once inoculated the patient was a source of infection. Inoculated patients were carefully sequestered for the duration of the disease and
its incubation, and were advised to follow a diet and bleeding regimen before and after the procedure.\textsuperscript{19}

Smallpox is spread by airborne droplets through the respiratory tract, and is thus easily spread within living quarters, as well as being carried in a sufferer’s clothing, possessions, and bedding. The disease was contagious in crowded and unsanitary living situations, such as urban centres. During the time of the Seven Years War, smallpox was endemic in London: the Bills of Mortality show deaths from smallpox every year, with epidemics peaking every two to three years. Demographic historians have demonstrated that in towns with a medium level and density of population smallpox epidemics occurred in regular five-year cycles, predominantly affecting children.\textsuperscript{20} Apart from rural migrants, the majority of adults in medium-sized towns were immune to the disease, having survived a smallpox attack during childhood.

Contemporaries were aware of the association between smallpox and urban centres, and the risk for those who had not previously suffered from the disease when they visited a town. The parson, George Woodward and his family, living near Oxford, exemplify reactions to smallpox and inoculation in Britain during this period. Woodward initially refused to inoculate his family, but later changed his mind: “we are induced to it by the great risk they will run in the natural way, (which there is no likelihood of their avoiding when they go out to schools) and from that uncommon success, that this practice meets with everywhere …”\textsuperscript{21}

He hired an Oxford physician to perform the inoculation, and a surgeon visited the children more than once after the operation to bleed them and oversee their sickness, while the children were nursed and cared for by servants as his non-immune wife was sent away for the duration of the treatment.\textsuperscript{22} Unlike the prosperous Woodward, who enjoyed an annual income of more than £200, lower-class families would not have been able to afford the expense, care, or time necessary for such a procedure.\textsuperscript{23} For these reasons, it was not until the more streamlined and less expensive Suttonian method became popular from the later 1760s, and when parish officials began paying for the procedure in the 1770s, that inoculation of the poor and labouring classes became more widespread in Britain.\textsuperscript{24}

As a result, those men enlisted into British regiments and arriving in North America in the late 1750s and early 1760s would, by and large, not have been inoculated against smallpox. Given the relative popularity of inoculation in Britain during the 18th century, especially compared with the hesitancy of France, historians have assumed that new recruits were inoculated upon joining the army.\textsuperscript{25} Yet no surviving enlistment records from the Seven Years War indicate that smallpox or its inoculation were discussed. Inoculating new recruits, and isolating and caring for them once the smallpox erupted, would have required special medical wards
and attendants. As no records of such an operation exist, we can safely assume widespread inoculation was not instituted by the British Army in the 1750s or 1760s. Even during the War of American Independence, inoculation appears to have been practised by the British Army only once campaigning had begun, and in response to an already raging smallpox epidemic throughout the American colonies.26

Yet even without inoculation, most British Army recruits would have been immune to smallpox. Studies of the British Army suggest that most men came from lower-class, labouring and low-skilled backgrounds, and especially from urban centres such as London, when other work could not be found.27 As the population density of these towns would have been sufficiently high to maintain endemic levels of smallpox, there was every likelihood that most British recruits would join the army immune to smallpox, having already suffered from that disease. In his military medical treatise based on observations recorded during the Seven Years War, Richard Brocklesby explained, “[i]n the army, at the beginning of the late war, I found two out of nine soldiers in the marching regiments, who, by living remote from the metropolis in country quarters, had till then escaped this disease.”28

By contrast, American-born provincial soldiers would likely not have suffered from smallpox before joining regiments in the 1750s and 1760s. Not only was the population density insufficient to maintain smallpox even in the major urban centres (including New York and Boston), but quarantine measures imposed on ships ensured that outbreaks were unusual. Although the American colonies had suffered from epidemics in the 1720s most populous centres avoided outbreaks for up to 20 years at a time.29 As a result, provincials born during those periods would be vulnerable to smallpox, and greatly feared the disease which appeared to target them more than British regulars.30

With the onset of war and the arrival of troops from Europe, smallpox broke out in the American colonies, spreading from an epidemic beginning in French Canada in 1755. Late in 1756, the Commander-in-Chief, the Earl of Loudoun reported to the Duke of Cumberland from New York:

the Small Pox is spread over, I think, the whole of this Country, except New England, from where I have not heard of it yet: It is at Albany, It is here, and it is at Philadelphia, and among the Six Nations; they got it from the French, at Niagara; and the French in Canada, had it all last Year; when it first broke out, it made a very great Alarm in the Country, but now that is over, except among the New England Men.31

French officials recognized that the disease was imported to their American colonies from Europe. M. de Doreil wrote to Paris in October 1757, “[u]pon the troubles of war has supervened an epidemic disease which
has been introduced by the ships that brought the soldiers. It has already committed great ravages ...” Montcalm, the French commander, recorded in November 1757, “La petite vérole qui n’est regardée en Canada comme une maladie populaire qui prend tous les vingt ans, fait du ravage cette année, quoiqu’on l’ait eue il y a deux ans. Elle a été communiqué par les Acadiens et les Anglois pris au fort Guillaume-Henry.” The travel of Amerindians, especially along their northwest trade corridor, was held responsible for the spread of smallpox. An Amerindian was even blamed for having brought smallpox back to Britain on a transport ship. Reporting on an outbreak of smallpox among the soldiers on board a ship at Portsmouth, General Hopson told Lord Barrington:

The Woman is an Indian Squaw, was Wife to an Indian, a Soldier, turned over among others into the Royals, & who, Since He came here, died of ye Small Pox. This Woman brought the Distemper with Her from aboard one of ye Men of War. Mr. Young likewise reports to me that all these Soldiers that were turned over have the Sickness to a Violent degree.

Not only did the movement of the Amerindian allies spread smallpox, but the disease also influenced Amerindian military strategy. Based on the variation in annual rates of Amerindians allied with the French, D. Peter MacLeod argues that smallpox was integral to Amerindian war strategy. These fluctuations do not directly correspond to the success or failure of French military ventures, but rather to the incidence of smallpox. French officials were aware of these consequences, and tried to obviate them in various ways. On occasion, they even told their Amerindian allies that it was the British who were responsible for spreading the disease, a tactic of blame that was hardly new. Montcalm recognized the ill-effects of smallpox, and wrote in his journal early in 1758: “Les sauvages ont perdu plusieurs d’entre eux de la petite vérole; c’est fâcheux; ils seront dégoutés de venir en guerre de nos côtés...” The effects of smallpox were similarly felt among provincials. As immunity to smallpox is not genetic, and as there is no perceptible difference between genetic immunity to disease of Europeans and Amerindians, American-born Europeans in the 18th century would have been just as susceptible to the ravages of the disease as Indigenous Americans. Although one study on measles suggests that the overall genetic homogeneity of Amerindians may have contributed to the virulence of an epidemic striking an early Aboriginal settlement, it is questionable whether this can be applied to 18th-century smallpox outbreaks. With provincial soldiers living and fighting side-by-side with British soldiers, and then returning to their homes when winter brought annual campaigns to an end, smallpox first attacked provincial troops and was then spread throughout the colonies.
British officials who noticed the high rates of smallpox among the provincials (both troops and civilians) were aware of its wider implications. Proposals for medical care given to Cumberland during the 1740s, for example, included the suggestion that soldiers be inoculated so “that the places in which [the soldiers] are quarter’d will be freed from the apprehensions and danger they are constantly in of having the smallpox brought amongst them.”41 Loudoun described the course of the disease to Cumberland in the spring of 1757:

We have the Small Pox raging among the troops that are embarked, and among the Ranging Companys—Mr. Webb has it among the Troops, the Independent Companys, and the New York Provincials; but the kind is good and very few die, but I expect it will go over the whole continent. The Terror People have for it in this country is inexpressable, altho’ that is a good deal diminished from the care we have taken, both of the People that are infected with it and to prevent its spreading.42

During the siege of Louisbourg in 1758, Captain John Knox recorded in his journal, “[t]he troops have suffered considerably by sickness; but, though I am told so, I find, upon inquiry, the loss has been mostly among the Rangers and New England artificers, to whom the small-pox has proved fatal.”43 Robert Rogers, the provincial Ranger leader, likewise reported that many Rangers had died from smallpox during 1757.44 Both Loudoun and Amherst wrote on the topic of smallpox, not only to officials in Britain, but also to the governors of the American colonies, who were understandably concerned with outbreaks of the disease. Amherst made what appears to be a reference to inoculating provincial soldiers, when in 1758 he wrote to Lieutenant-Governor De Lancey of New York pleading for more troops and arms, assuring him, “[s]uch of your men as have not had the small pox and are afraid of it, shall be so disposed of, that they need be under no apprehensions.”45 No other references to inoculation in North America during the war survive. As inoculating thousands of individuals (including caring for the infectious and helpless patients for weeks afterwards) would require large-scale organization and resources, the lack of any accounts or hospital preparations concerning inoculation indicates that no such operation took place. Along with the high rates of smallpox which provincials suffered throughout the war, this suggests that Amherst’s proposition was never implemented.46

One may be tempted to interpret the absence of centralized, large-scale inoculation among the British forces as lack of consideration for the welfare of provincial and British troops. However, not only was inoculation then by no means a widely accepted practice in British society, but widespread inoculation among the 30,000 troops scattered throughout North America during the campaign would have caused
more problems than it offered solutions. As every inoculated soldier would have been infectious and unable to care for himself for a few weeks at least, general inoculation would have crippled British forces, killed hundreds of soldiers, and spread smallpox among camp followers and into nearby settlements. A comprehensive medical practice of inoculating British troops was not implemented until vaccination in the 1790s made smallpox prevention easier, cheaper, and safer. At mid-century, by contrast, inoculation was only infrequently and informally practised among British troops, dependant entirely on the initiative of regimental officers and surgeons who could ensure the consent and care of inoculated soldiers. As many were as scared of inoculation as of smallpox itself, widespread and mandatory inoculation would not even necessarily have assuaged provincial fears of the disease. Even in British urban centres where smallpox was endemic, both outbreaks of the disease and inoculation schemes caused alarm during this period.

As in the case of the Amerindian allies of the French, provincial soldiers were reluctant to serve with the British army because of smallpox. In June 1758, James Abercromby reported to Pitt: “I have left two Additional Companies of Lord John Murray’s with four Companies of Provincials, computed at 100 each, to garrison Fort Edward, and one Company of the Royal Americans, for the Duty in Albany, as no Provincials wou’d venture to serve there, on Account of the Small Pox.”

Smallpox had appeared in Albany as early as October 1756, when Amherst wrote to the Governor of New Hampshire. Amherst pledged that he would “take every step in my power” to prevent the disease spreading through the province, as well as asking Governor Wentworth to help ensure that the provincial troops would not disembark at Albany. Amherst ended his letter insistent, “I do assure you no care shall be wanting on my part to prevent this misfortune from spreading.” Amherst knew well the danger his campaign was in from smallpox. In November 1756 he wrote to Governor Hopkin at Albany expressing hope that the smallpox would abate with the arrival of winter. He also noted that rumours of it breaking out among troops had caused “both the New England Troops and the Indians [to] leave us and go home.”

Provincials even used the disease as an excuse for having deserted. For Amherst, a commander already constantly troubled by troop shortages, provincial reluctance to serve because of smallpox fears must have seemed like just another aggravation so characteristic of those frustrating provincials. And, as illness and temperament were inextricably linked in 18th-century medical theory, medical and military men believed that higher rates of disease were the result of the sufferer’s constitution and character. Brocklesby, for example, theorized that the bad habits of a military life meant that smallpox was more virulent within an army than among a civilian population: “A greater relaxation...
of all sobriety and temperance is supposed to prevail, in all military life, than among other orders of men. It is therefore natural to conclude, that such a disease as the small-pox is more destructive, in every army in England, than any other acute disease.” Smallpox was thus one of the problems the British military associated with the undisciplined provincial troops, and it was yet another cause of provincial recruitment difficulties, troop shortages, and desertion. The fear of smallpox threatened alliances with Amerindians, and fears of the disease among similarly susceptible provincial populations generated civilian disaffection over troop quartering and supply infrastructure. Such fears, as Montcalm had noted, could be exploited, with the French telling Amerindians that the British were responsible for the spread of the fatal disease: disease accusations had become military strategy. It was therefore a necessary element of British strategy to try and assuage provincial fears of smallpox—whether by assuring provincial governors that they would take precautions against the disease spreading into civilian populations or by suggestions of inoculation among soldiers.

It is in the context of the wider rhetorical and strategic significance of smallpox and the fear of the disease in the American theatre, that accusations of smallpox being spread deliberately by the British need to be re-examined. This is particularly pertinent with respect to the 1763 incident at Fort Pitt, where British officials allegedly spread smallpox among opposing Amerindian forces; it also applies to similar accusations concerning the War of American Independence. Mark Wheelis, writing about biological warfare in the early modern period, notes the difficulty in establishing whether or not disease was spread deliberately as part of British battle strategy. Other than Fort Pitt, the one “well-documented” incident, in all the years of colonial contact there are only: “a mere handful of additional mentions of such incidents, most of which lack convincing detail, are second- or third-hand, and are uncorroborated. The great majority of first-hand accounts of frontier life do not even hint at the practice …”

Wheelis nevertheless concludes that—given the context of frontier warfare, characterized as less structured and disciplined than traditional European siege warfare—one can, and should, conclude that biological warfare was used by the British: “From this perspective, the few surviving records could be viewed as evidence for a pervasive practice of biological aggression, most instances of which escaped notice. Certainly this is a widespread view among Native Americans, whose traditions include many undocumented stories of such attacks.”

On the other hand, historians such as Matthew C. Ward claim that “there is little direct evidence that the British army ever consciously used “germ warfare,” noting that such attempts would have caused more harm to British strategy than good. However, Ward maintains
that British military officials were aware of the role the army was playing in spreading disease among Amerindian populations, and more specifically, in “undermining Indian ability to resist the British.”

Elizabeth Fenn finds one firmly documented case of British officials deliberately spreading smallpox among American Revolutionary forces and civilian populations, as well as numerous accusations of deliberate spreading made by American Revolutionaries and their allies. She concludes cautiously: “Confronted by rebellion and frustrated by atrocities committed by a “savage” American enemy who often refused to face off head-to-head on the field of battle, British officers may well have believed the propagation of smallpox was justified and put this belief into practice, especially given the fact that the law of nations apparently permitted it.”

Each historian here is searching for patterns, and from incomplete evidence that includes accusations by hostile forces of disease spreading, draws wider conclusions regarding the common practice of the British armed forces during the 18th century regarding disease as a tool of military strategy or colonization. For each case, the evidence itself does not change, only the context in which it is placed. For the one well-documented case of deliberate spreading of smallpox, all agree that Amherst and the British officer Henry Bouquet exchanged letters complaining about the nature of Amerindian attacks. The two British officers did not simply object to the brutality of the attacks; they each expressed a desire that the Amerindians be gotten rid of, Amherst famously writing, “You will do well to try to Innoculate the Indians, by means of Blankets, as well as to Try Every other Method that can serve to Extirpate this Excruciable Race.”

This note, written in a manner bearing no resemblance to a British official order, was nevertheless clearly followed through. An invoice that included blankets from a smallpox hospital given to the Indians in order to spread the disease was later dutifully approved by Bouquet. As this was not a regular military order, it is necessary to consider why Bouquet and Amherst responded in such a fashion.

ETHICS AND WARFARE

It is clear that Bouquet and Amherst believed the conventions of regular warfare had been contravened by Amerindian attacks on civilians or non-combatants, as well as assaults that they described as unnecessarily severe. This concern with the justness of how war was waged, or *jus in bello*, was central to European war ethics in the early modern period. The idea of a “just war” was based on the principle of restraint and moderation in war (*media res*): one was to act violently only insofar as it was necessary. Hence, wanton destruction and pillage were beyond the bounds of normal warfare. The question for thinkers such as Jean-
Jacques Rousseau was not what made it just for a state to go to war, or indeed whether or not rules of war existed, but rather, what those rules of a just war ought to be. More particularly, restraint in war was dependent upon the distinction between combatants and non-combatants. As Colm McKeogh explains: “The prohibition on killing civilians was the first restriction on war to be founded in international law, predating prohibitions on weaponry. In the 18th century, this law or custom of war was embedded in the military tradition of every European power.”

The distinction between combatants and non-combatants was first drawn on the basis of sick and wounded soldiers. Specifically, military hospitals were declared non-battle areas and sick and wounded soldiers (along with the medical personnel caring for them) were deemed non-combatants, and so not to be taken prisoner. For example, the first officially formulated international laws of war stemmed from concerns regarding the treatment of wounded soldiers (The Geneva Convention on Prisoners of War, 1864). The wounding of a soldier, and a soldier taken prisoner, is thus the moment when a combatant becomes a non-combatant. Theorists of international law agree that these constraints on war regarding the sick and wounded are universal principles, found in most civilizations and across most time periods. Jean S. Pictet, for example, cites the story of Louis XV, before the battle of Fontenoy in 1747, declaring that the wounded be treated “[E]xactly like our own men, because when they are wounded they are no longer our enemies.” As the United Nations war crimes expert M. Cherif Bassiouni points out, the soldiers, by virtue of being invalids, were non-combatants: “They were hors de combat.”

It was not until the 17th and 18th centuries that such principles were regularly codified. The 1743 agreement to mutually protect the military hospitals at the battle of Dettingen made between the Duke de Noailles, the French commander, and the Earl of Stairs, the British commander, is frequently cited as an example of this early codification. The British military physician John Pringle is often credited for the agreement, noting in the preface to his Observations on the Diseases of the Army (1752), it “was strictly observed on both sides all that campaign; and tho’ it has been broke through since, yet we may hope that in a future war, the contending parties will make it a precedent.” This appears to be the case, as the agreement was formally expanded during the proceeding British-French war. There were at least four conventions regarding the treatment of sick, wounded, and prisoners in place during the Seven Years War, three of which were between Prussia and her enemies, and the fourth, the Convention of Écluse, between Britain and France. Given how little space Pringle devotes to discussing the 1743 agreement, and how no military commanders remarked on the novelty of these
conventions, it appears that these were indeed simply codifications of practices already widely in place. Examining terms of surrender, for example, one finds that details regarding care for the sick and wounded is always included, as is special treatment for prisoners of war. The Convention of Écluse stated that prisoners were to be kept for no longer than 15 days, during which time they were to be given daily bread and money rations, and exchanged for an enemy of equal rank after that time.

The historian of Britain during the Seven Years War, Reginald Savory, concludes that such terms were generally followed. Yet perhaps unsurprisingly, when we examine warfare in more detail, such formal terms proved difficult to strictly enforce, even among European powers. However, what is more notable and significant is that the principle of these conventions was upheld throughout the war, and any breaches of the Convention were noted and objected to, whether they happened in Europe or in the colonies.

In Britain during the Seven Years War, for example, officials were responsible for over 20,000 foreign prisoners of war, stationed in various British urban centres. Such large numbers suggest that prisoners were held for longer than the stated 15 days. Moreover, it is apparent that other official regulations were not followed throughout the war: many local populations gave greater freedoms than were officially decreed to prisoners of war stationed in their midst.

Following both custom and the Convention of Écluse, the French government paid what was called the Royal Bounty to French prisoners. This small amount of money allowed the prisoners to buy necessities such as clothes and foodstuffs (especially fruits and vegetables). By 1759, the French government had defaulted on its payment of the bounty. British local agents for the prisoners and British local populations were well aware of the bad conditions which resulted for French prisoners. The Sick and Wounded requested additional funds from the Admiralty for prisoners in these circumstances, reporting in December 1759, “particularly, as their King having withdrawn the Allowance formerly made them which enabled them to purchase Cloaths &c, vast numbers of those poor People are now in all Our prisons becoming almost naked, which may very reasonably be expected to encrease the number of sick....” With no clothes for many of the prisoners in the winter of 1759-60, increasing sickness, and with the British Admiralty unable to pay any additional funds, British civilians raised money to pay for these enemy combatants. The largest organization was the Committee on French Prisoners, who first met in London in December 1759, raising more than £4,000 by June 1760, mostly spent on some 6,000 shirts, and 3,000 coats, caps, and shoes for the prisoners. It was funded by public subscription, similar to other voluntary charitable organizations and
committees established during the war that bought clothes and shoes for British troops.74

There are other forms of evidence that demonstrate civilian populations’ sympathies towards the prisoners. Regiments and militias were chastised for taking the prisoners drinking, rather than guarding them.75 Commissioners were ordered to investigate repeated escapes of prisoners, especially with reports of houses where the inhabitants “made it their practice to harbour Prisoners of War who deserted, and to assist them in making their escape by means of Neutral ships,” with one man prosecuted for helping a prisoner escape justifying “what he had done on a Principle of Charity.”76 Such assistance demonstrates that even if official regulations regarding cartels of war could not be followed, such as the Royal Bounty, their principles were maintained. In this case, British civilians clearly considered enemy soldiers, when taken prisoner, as hors de combat, and provided them with material goods and care when required.77

These sentiments are also found in practice closer to the scene of battles, and beyond the traditional battlefields of Europe. In India, during the siege of Pondicherry, which was to decide which European power would control trade of the sub-continent, the French commander Lally objected when the British contravened what he clearly considered a known custom. Soon after the beginning of the siege, Lally wrote to Coote complaining:

Mr. Pigot and Coote have not only carried away and retained all my surgeons, but also my priest and servants, and all other people who should be at liberty by the terms stipulated in a formal cartel between my master and yours ... and signified to me at the same time that our wounded should not be dressed without I sent linnen and medicines.78

Lally continued in the same letter to request that British officials implement established medical responsibilities for enemy forces by making a distinction between European and Royal troops on the one hand, and Indian and Company troops on the other. He concludes:

So, Sir, as a European and a King’s man I fulfilled my duty towards you and Mr. Cornish, and sent each his surgeons, and assure you your scorbuticks will be taken as much care of here, as if they were with you. As an Indian and a Company’s man, I am bound by the customs of the country who know no right but that of force, therefore cannot send you your seamen till the prisoners of Trichinopoly are returned me.79

Through this polite demand and threat of further repercussions, the medical obligations were fulfilled: the officers were clearly simultaneously European and colonial officers. Correspondence between Lally and Coote continued throughout the duration of the siege, the two
officers developing a friendship in the midst of their fighting. The officers dined together and Coote regularly gave Lally gifts of imported food, all in the midst of a siege aimed at starving the French at which, reportedly, it succeeded, at least as far as the rank and file were concerned. In October 1760, Lally thanked Coote for his gifts of food and requested more Gloucester cheese should Coote have some left over. As Lally eloquently summarized the situation in a letter accompanying French bills of exchange sent to Coote so that they would not be destroyed during the siege, “[i]t is our fate to dissent in publick station and to agree in private acts of civility.”

Lally’s complaints demonstrate not only that there were established customs concerning the sick and wounded in times of war, but that these continued to be expected even in a colonial and foreign environment. Such behaviour between French and British military enemies is not surprising as even in the midst of warfare, gentlemanly and polite behaviour, as well as similar social backgrounds and a conception of military professionalism, united officers. When taken prisoner, for example, officers dined with their captor officers, and were expected to live in relative ease and comfort. Officers simultaneously led battle and transcended its enmity.

Medical practitioners were in many ways hors de combat even more so than gentlemanly officers. As agreed informally and formally, medical men could cross battle lines in order to treat the wounded and sick, and, given the immunity granted to hospitals, also operated in a kind of neutral zone. This meant that medical practitioners were granted unusual liberties during war. On occasion, this was exploited. In India, in January 1758, a surgeon named La Forge was court-martialled and executed, after he was found guilty of planning a surprise French attack on the British garrison of Trichinopoly while serving as a surgeon at that British military base. The French were not alone in using a surgeon as a spy. For example, Doctor William Forth served as physician to Alivardi Khan, Nawab of Bengal. In December 1756, the Select Committee at Fort William engaged Doctor Forth to stay on at Chinsura, and from there “to transmit us from time to time such intelligence as he may judge to be of any consequence to the Company’s affairs,” specifically, on the actions of the Nawab. Forth was enthusiastic in his task, regularly reporting to company officials on his conversations with the Nawab and others at the Nawab’s court, as well as the movements of the Nawab’s troops. During campaigns in Germany, one official even suggested that correspondence regarding surprise attacks be sent in the form of prescriptions: a dose in the morning indicated a morning attack, while one in the evening indicated likewise.

Such examples of medicine being used for political or military ends meant that medicine, and medical men, were trusted by both sides.
After all, one can only act as a spy, or pass coded messages, if one is not suspected of any such designs. This neutrality of medical men is also demonstrated in their responsibilities for prisoners of war. In Britain as already noted, it was the Sick and Wounded commissioners of the Admiralty who were responsible for prisoners of war, with at least one local agent a physician. When complaints were sent to the Sick and Wounded Board regarding either the state of the French prisoners or the local agents, it was medical men who were sent to investigate and provide a report to the Board. Not only were such men already known to the commissioners of the Sick and Hurt Board, but they were also professionally qualified to examine into the welfare of the prisoners, and had the necessary social standing that would garner respect within local communities and with the commissioners.

The head of French military medicine and hospitals at Quebec in 1759, M. de Gernier, demonstrates the breadth of responsibilities given to military medical personnel. Writing to the French authorities after Quebec fell to the British, in October 1759, de Gernier explained that soon after the French defeat, de Gernier met the officer in charge, George Townshend. This meeting ensured the protection of the hospital and its patients and the fulfillment of the cartel regarding sick and wounded soldiers. Townshend stated “un hôpital netoit point une place de guerre, qu’on ne devoit point y attirer le feu.”87 Townshend gave de Gernier an officer and 12 men “pour y servir de sauve garde contre les troupes anglaises …”88 Notably, de Gernier later reported that the British guards also protected the hospital “contre nos sauvages et les Canadiens.”89 It appears such protection was well-needed, as during the settlement of the terms of capitulation, confusion and pillage erupted; de Gernier remarking that this was more due to the French colonists than the British. Yet even in this confusion, de Gernier asserts that the terms of capitulation were fulfilled, as were the terms of cartel regarding the sick and wounded that Townshend was eager to establish, with enemy soldiers sent away as prisoners, and recovered invalids sent back to their respective parties. Even more significant, in the midst of this confusion and after battle that included the traditional tactic of destroying local crops and storehouses, the British officers gave de Gernier provisions enough for his hospitals. The Frenchman exclaimed: “J’ay trouvé dans les Généraux anglais de L’humanité, des facilités es quelques bontés particulières pour moy, etant connû des uns de réputation, les autres ayant eu l’honneur de les voir à la nouvelle Yorck, à Londres, et Edembourg.”90

Many factors came together to provide care for the sick and wounded after the battle on the Plains of Abraham. As de Gernier recognized, underlying the protection and provisioning of the French hospital was a formal agreement between the two warring European states. But as he also clearly noted, this had to be discussed and negotiated between
individuals, who were far away from the seats of French and British power. His professional and social status as a medical practitioner ensured that he was trusted, just as he had requested a British guard headed by an officer of good character. Moreover, as the one French officer who remained in the besieged city, de Gernier was given responsibilities far beyond the usual remit of medical personnel. As well as overseeing the general hospital and its British guards, de Gernier noted that Vaudreuil and Lévis had granted him powers regarding the colony and the armed forces:

Ces affaires sont de tous les genres : article d’equipages, propriété des biens des Citoyens, moyens es [illeg] de mettre la Capitulation de la ville à execution, mecontentement, recrimination reciproque, menaces de represailles, décisions d’affaires des particuliers, [illeg] d’effets pris de personnes arretées, passeports, grace particuliers &c….91

Such a responsible medical officer and such accommodation between two enemy sides were not always on display. After the French surrendered Trois Rivières in 1760, the French officer complained that the British refused to grant proper immunity to all sick and wounded troops, but were instead keeping them as prisoners of war. At Quebec, after the battle of Ste Foy and the final French retreat at the end of April 1760, the British commander James Murray complained to the Chevalier de Lévis that the French were not strictly following the cartel. Murray specified article 27, which ensured that “les malades ne seront point faits prisonniers, qu’ils pourront rester en sureté dans les hôpitaux.”92 While negotiations between Murray and Lévis became bogged down in the problem of supplying provisions to enemy soldiers when each side was clearly short of food for their own troops, the correspondence also included the loan of newspapers from Europe, both officers in agreement over their surprise at not featuring more in such gazettes.93 For historians, the breaches are easier to trace than when conventions were followed.

This is the case especially in the context of colonial or “irregular” (as contemporaries called it) war.94 In the report of Major Gladwin, the details of which partly spurred Amherst and Bouquet to discuss using smallpox against the Amerindians, the language clearly demonstrates these breaches. Bouquet is told of the “base and treacherous behaviour of the Indians” who claimed to be paying a “friendly visit” to the British but then “murdered several of our people.”95 The language of crime, not of war, continues to inform the report: Gladwin describes how after entering the British fort with a peace pipe, the Ottawas “immediately commenced open hostilities by killing the King’s cattle, and murdering the people who had the care of them.”96 Amherst states that he will ensure both that British possessions remain safe, and that the “barbarians” be punished “who have thus perfidiously massacred his Majesty’s
subjects." For British officials, these were unnecessary and disproportionate acts of violence committed against non-combatants, and were thus massacres and murders, illegal and unjust forms of warfare. Such tactics were common among Amerindian warfare, which relied on targeting civilians in guerrilla-style attacks, and leaving evidence of the brutality behind to instill further fear and destroy morale. As Peter Silver remarks, this style of warfare had a “special power to unnerve and stun disordered people’s faith that they understood how things around them worked.”

One may question the profundity and purposes of these conventions of war. Given that historians recognize war as a cultural phenomenon, and particularly in such occasions as here when two cultural practices of war demonstrably clash, is there more to be said than that this demonstrates a conflict of cultures? If not, Bouquet, Amherst, and individual British commanders would be exonerated from their burden of guilt regarding biological warfare. According to the theory of non-combatant immunity, what Amherst and Bouquet objected to when the Ottawas attacked the civilians and off-duty soldiers was the treatment of such individuals as a means, rather than as Kantian ends in themselves. As the philosopher Richard Norman puts it: “The objection to attacking civilians is not so much that what they are doing poses no threat, but that attacking them is not really a response to what they are doing at all.”

British commanders’ use of disease as a weapon in response to perceived Amerindian violations of the conventions of war was itself unconventional, and hence immoderate and unjust, for the same reason. It involved the indiscriminate use of force, as it would cause destruction among the enemy population of both combatants and non-combatants, in clear contrast to contemporary standards of the jus in bello. Moreover, the language that Bouquet and Amherst used when discussing such a possibility, to “try every other method that can serve to extirpate this execrable race,” is offensive to readers today, especially given the general history of European (or European-descended) officials’ actions towards Indigenous Americans. Unsurprisingly, Amherst’s comment and this particular episode have been used as shorthand for the history of European–Amerindian relations. As Adrienne Mayor elucidates in her analysis of the intertwining of history, literature, and legend:

That garments containing deadly, viable smallpox virus were actually given—sometimes intentionally—by Europeans to Native Americans is undeniable and well documented. In the context of unresolved cultural conflict, recrimination, and remorse, the historical reality of the smallpox holocaust among Native Americans—coupled with the plausibility of planned genocide—has converged with suspicion, rumor, and belief in ways that recapitulate themes and motifs associated with the classical Nessus shirt and other poison-garment tales.
It also remains offensive because we continue to uphold the conventions of war first formally implemented during the 18th century: the discriminate use of force aimed only at combatants.

Theorists categorize the use of biological weapons, terrorism (when civilians are targeted), and guerrilla warfare as asymmetrical warfare: warfare that is considered unjust and immoderate, but part of coherent military strategy used against a militarily-superior enemy. The political philosopher David Rodin explains that all tactics of asymmetrical warfare “seek to obtain a strategic advantage from a position of conventional military weakness by subverting the paradigm of war which has become accepted, particularly in the developed Western countries.”103 Significantly, he notes that such tactics work particularly well against Western societies because they make use of “the ‘open’ nature of Western societies—the active media and the democratic accountability of leaders.”104

The significance of asymmetrical warfare is not that one side does not follow conventions of war, but rather, that the opposing side cannot respond in like fashion. Even if acted in retaliation, such reciprocity will be censured. It is breaches in the *jus in bello*, but also *accusations* of such breaches, that demonstrate a particular culture’s conventions of war. In 18th-century warfare, accusations of disease-spreading were slurs, and thus, British commanders were expected to refrain from such practices.

**CONCLUSION**

The deliberate spread of smallpox by British commanders, and immoderate acts of warfare in general, thus need to be understood as potentially damaging discourse, as well as events. Discourse, representations, and accusations were, and remain, part of colonial relations, both influencing the formation of identity and action. We know the role reports regarding the so-called “Black Hole of Calcutta” played in British imperial rule in India, and the reports of Amerindian attacks on Fort William Henry.105 In this context, it is significant that the exchange between Amherst and Bouquet regarding the “extirpation” of the Amerindians was not part of their normal correspondence. Unlike all of their other letters during the war, these ones had no dates or other official notes, and instead of the customary signature, were unsigned or had only initials. This does not absolve them of their crime. If anything, it demonstrates their guilty knowledge that they were clearly contravening customs of war. By the same token, it further affirms that this was a breach of conventions, and therefore not part of customary warfare.

Conventions of war are frequently broken, especially when confronted with the reality of war, and particularly when confronted with an enemy who seems to shock and unsettle with its very mode of battle. Fighting any enemy prompted soldiers to depersonalize their foe, but
especially when this foe used morally shocking martial practices. Such a reaction was found not only in the colonies during this period, but also in Scotland and Ireland. Disease and medicine are fundamental to the conventions of war. These conventions attenuate the hardships of war by designating who and what is hors de combat, regardless of how difficult and controversial it is in reality to remain aloof from the enmity of war.106 For historians, the difficulty is establishing whether the reality and the conception of warfare coincided. In Amherst’s opening address, we see British assumptions and expectations regarding conflict and armed struggle. We also see how the experience of colonial warfare challenged these principles, demanding that the British commander articulate them clearly, and assure his men that they would be upheld.

ACKNOWLEDGMENTS

I am grateful to Dr. Guy Chet, Prof. Mark Harrison, Dr. William J. Ashworth, Dr. Henry Meier, two anonymous reviewers, and Prof. Geoffrey Hudson for comments on earlier drafts of this paper.

NOTES

1 Huntington Library, San Marino, California, Loudoun Papers (hereafter LO) 5847, Amherst, Address, 3 June 1758, HMS Namure.
2 I use “Amerindian” and “Indigenous People,” following standard convention, even though I am aware that this can be imprecise and problematic.
5 See below for more on smallpox, its incidence, and inoculation during this period.


14 Anderson, A People’s Army, part I.

15 Even in World War I, new recruits in the British Army tended to fall sick once housed in barracks where diseases of their fellow soldiers were quickly spread. In Canada, medical authorities established “segregation camps” for new recruits in 1916 as a remedy.

16 See e.g., Charters, “Disease, Wilderness Warfare.”

17 Richard Brocklesby, Oeconomical and Medical Observations, in Two Parts. From the Year 1758 to the Year 1763, inclusive (London, 1764), p. 231.

18 There is still debate over whether a variety of types exist, for a clear and recent discussion, see Henry Meier, “Smallpox in Stuart London: Causes and Effects of an


22 Woodward, Letters, 5 October 1757, p. 103-4.


24 Razzell, Conquest, chap. 4; see Deborah Brunton, “Smallpox Inoculation and Demographic Trends in Eighteenth Century Scotland,” Medical History, 36 (1992): 403-29, by the end of the 18th century its implementation was not standardized.

25 See e.g., Miller, Adoption, p. 170-71.

26 See Orders of 24 June 1776, in James Murray Hadden, Hadden’s Journal and Orderly Books: A Journal Kept in Canada and upon Burgoyne’s Campaign in 1776 and 1777, ed. Horatio Rogers (Albany, 1884), p. 193; also see Fenn, Pox Americana, chap. 3; see below regarding informal inoculation during the Seven Years War.


28 Brocklesby, Oeconomical, p. 231.


30 Duffy, Epidemics, p. 109; 22.


33 John J. Heagerty, Four Centuries of Medical History in Canada and a Sketch of the Medical History of Newfoundland (Toronto: The Macmillan Company of Canada, 1928), p. 41-42; Brumwell, Redcoats, p. 42.


36 The National Archives (TNA), WO 1/973, 535: Hopson to Barrington, 27 March 1757.


38 MacLeod, “Microbes and Muskets,” p. 51.
41 British Library (BL), Cumberland Papers, mfr 695, reel 89, 59/259.
45 TNA, WO 34/30, fo. 15: Amherst to De Lancy, 21 May 1758.
46 Loudoun mentions inoculation in a letter to Cumberland, 22 November to 26 December 1756, in *Military*, ed. Pargellis, p. 280, but only as something he will do.
47 Brocklesby, *Oeconomic*, p. 231; for inoculation upon enlistment in the 1770s see Pell’s narrative, cited by Steppler, “Common Soldier,” p. 278; Fenn claims widespread inoculation among the British troops during the American War, but not on the basis of British documentary evidence, see *Pox Americana*, chap. 3.
48 See the boycott of inoculation by surgeons and apothecaries in Winchester. Hampshire Record Office, Winchester, W/B/26, Winchester City administrative records, f. 1, 15 February 1758 (and see ff. 2-4).
49 TNA, CO 5/50, 332/169, Abercromby to Pitt, 29 June 1758.
50 TNA, WO 34/24, 1, Amherst to Wentworth, 22 October 1756.
52 TNA, WO 34/90, 235, Walker to Amherst, 23 June 1762.
59 Fenn, “Beyond Jeffrey Amherst,” p. 1579.
60 BL, Add MS 21 643, Amherst to Bouquet, n.d., 241.
70 National Maritime Museum (NMM), ADM F/21, Sick and Wounded to Admiralty, 28 May 1761.
71 NMM, ADM F/16, Commissioner Bell to Sick and Wounded, 22-23 August 1757.
72 NMM, ADM F/20, Sick and Wounded to Admiralty, 29 September 1759.
73 Proceedings of the Committee Appointed to Manage the Contributions…for Cloathing French Prisoners of War (London, 1760).
74 NMM, ADM F/21, Sick and Wounded to Admiralty, 27 May 1761.
75 See e.g., NMM, ADM F/20, Sick and Wounded to Admiralty, 11 April 1760; TNA, ADM F/21, Coxside Prison to Sick and Wounded, 28 November 1760.
76 NMM, ADM F/19, Sick and Wounded to Admiralty, 5 July 1759; TNA, ADM F/19, Sick and Wounded to Admiralty, 14 June 1759.
77 Erica Charters, “Civil Soldiers: Prisoners of War in Britain during the Mid Eighteenth Century” (unpublished paper, 2008).
78 Oriental and India Office Collection, BL (OIOC), MSS Eur F190, 378-9: Lally to Coote, iii, 15 May 1760.
79 OIOC, MSS Eur F190, 378-9: Lally to Coote, iii, 15 May 1760.
80 OIOC, MSS Eur F190, 391, Lally to Coote, iii, 13 October 1760.
81 OIOC, MSS Eur F190, 398, Lally to Coote, iii, 16 November 1760.
83 OIOC, MSS Eur Orme India.XIII, 14: Caillaud to Madras, January 1758.
85 OIOC, MSS Eur Orme India.V, 51: Committee at Fulta, 22 December 1756. On Forth’s activities, see e.g., OIOC, MSS Eur Orme India.V, 56: Fort William Committee, 16 January 1757.
86 BL, Cumberland Papers, mfm 692, reel 84.
87 Archives de la guerre (l’armée de terre), Vincennes, (hereafter AG) séries A1, 3540, de Gernier, 15 October 1759, lettre 102.
88 AG, A1, 3540, de Gernier, 15 October 1759, lettre 102.
89 AG, A1, 3540, de Gernier, 15 October 1759, lettre 102.
90 AG, A1, 3540, de Gernier, 15 October 1759, lettre 102.
91 AG, A1, 3540, de Gernier, 15 October 1759, lettre 102.
92 AG, A1 3574, Murray to Lévis, 11 May 1760, lettre 42.
93 AG, A1 3574, lettre 40; see lettres 40-74 regarding the dispute.

BL, Bouquet papers Add Ms 21643, Amherst to Bouquet, 23 June 1763, 296.

BL, Bouquet papers Add Ms 21643, Amherst to Bouquet, 23 June 1763, 296.

BL, Bouquet papers Add Ms 21643, Amherst to Bouquet, 23 June 1763, 296.

Silver, *Savage Neighbours*, p. 96; and note 94.


The term “race” during this period was closer to our modern conception of “nation,” see e.g., Ivan Hannaford, *Race: The History of an Idea in the West* (Baltimore: The Johns Hopkins University Press, 1996), chap. 7. Regarding the details of these relations within the context of disease and medicine during a later period, see e.g., Maureen K. Lux, *Medicine That Walks: Disease, Medicine, and Canadian Plains Native People, 1880-1940* (Toronto: University of Toronto Press, 2001).


For India, see e.g., Kate Teltcher, “‘The Fearful Name of the Black Hole’: Fashioning an Imperial Myth” in Bart Moore-Gilbert, ed., *Writing India, 1757-1990* (Manchester: Manchester University, 1996); for the American colonies, see Steele, *Betrayals*; Silver, *Savage Neighbors*.