CHAPTER VII
WOMEN PHYSICIANS: A PEEP INTO THEIR LIVES AND STRUGGLES

This chapter aims at documenting untold and unheard stories of women who dared to gatecrash into a 'man-only' profession. Moving and inspiring, as these stories are, they have remained untold and unheard for reasons to be noted presently. Their struggle to walk the forbidden path served as a source of inspiration to younger generations in times to come. They were instrumental in changing the attitude of society towards a profession deemed 'dirty' now turned a 'noble' one. However, live change came gradually, almost step by step.

The women who figure in to this chapter had varied experiences in their lives, single as well as married. Yet, they share some common characteristics at the conceptual level since women from all castes and communities had to overcome socio-religious taboos and traditions to study and practice medicine. They had to strike and maintain a very delicate balance between their personal and professional lives.

After the establishment of British Rule, western India underwent the process of a new awakening under the impact of English education. This renaissance created a class of western educated males and social reformers. Improvement in the status of women was central to the agenda of reform. Naturally, they worked for freeing women from the tyranny of what they considered social evils and customs, so as to enable them to cross the threshold and enter the area of 'new light' i.e. education. This phase was full of turbulence and heated of arguments.

In addition to reformers, Christian missionaries also encouraged women to get educated so as to bring out their fine qualities of love and tenderness into family and social life. Being the primary care-takers of children, their role was crucial. However, the missionaries worked for the spread of Christianity among the Indians.
The popular poem entitled the "Songs for the little ones at Home" reflects the views of missionaries' on Indian women and her character, the horror of infanticide among the non-christians:

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“See the heathen mother stand
Where the sacred current flows
With their own maternal hands
Mid the wave her bebe she throws
Send, oh send the Bible there,
Let its percepts reach the heart
She may then her children spare
Act the tender mothers part.”
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In their efforts to liberate women from age-old restrictions, the social reformers sought progressive legislation from the British government. The reformers realized the value of education for girls and led society in sending them to school. As regards medical education, we find that Christian missionaries and wives of European officers along with reformers were the first to initiate women into learning and practicing the science of medicine.

Silence of the Sources

For almost all other substantive chapters of the thesis data was available in conventional sources of history. A frightening blank was drawn for this one. Even after getting the benefit of medical education, hardly any woman has recorded her experience. Among the secondary works also very few works explore the painful struggle and meaningful role of women in medicine.

Women did author a few autobiographies, memoirs and articles on Women's Health Care but these occasional pieces hardly ever touched upon the hurdles and struggles marking their journey to a medical degree and profession. Aside from this, we also have to take into account that available autobiographies of medical women had some in-built limitations. They were written by the authors when they were past seventy five. The works suffered from loss of memory on their part and lacked chronology of narrating the facts. They devoted more space
to their normal work rather than the pathetic condition of women wanting to enter the medical field. In view of this complete silence in conventional sources, the gap is filled by partially by using the incidental references in journals and magazines like 'Stree', 'Manoranjan', 'Navyug' 'Kirloskar' etc.

**Oral History**

However, any piece of historical research has to be based on authentic original sources to be acceptable. In any case, women constitute the silent voices of history having been excluded from the role of authors and actors of historical events. No doubt the methodology of oral history has, by and large, been applied in reading the silence of illiterate women in folklore, superstition and myth. One may also note its application in anthropological studies with focus on the individual. Kluckhohm’s discerning comment is well worth citing,

“One of the most astonishing gaps in anthropological knowledge is the lack of other than the most general of generalization as to regularities in culture change. This one may suspects is largely due to the circumstances that anthropologist have thus far viewed these phenomena in too gross a perspective with too little attention to the concrete individuals in whom changes actually begin.”

This chapter is based on oral interviews conducted and documented to record experiences of 'concrete individuals in whom changes actually begin'. The nature of the work required the strenuous and taxing exercise of holding oral interviews of medical women of our period who happened to be alive and was willing to share their experiences. It demanded utmost patience, tremendous hard work and a series of unending visits. In spite of sincere efforts, few women were frankly willing to share information. A variety of constraints like ill-health, loss of memory, busy schedule and family environment adversely affected the effort to reconstruct a narrative of silent struggle. The process was also marked by a number of internal variations.

To take just one example, Dr. Kamalabai Ashtaputre and Dr. Sunanda Paranjape happened to be ninety plus at the time of the interview. Dr. Ashtaputre
had a sharp memory to recall the past but being bed-ridden. She could hardly talk for the minutes. But she filled up the whole questionnaire with the help of her secretary while Dr. Paranjape happened to be in good health and could talk for almost five hours but owing to confused memory lost the correct chronology of events, but presented a focuse insight on stories of Zenanas.

In some cases, I had to conduct interviews with the help of relatives of the lady concerned, which is also accepted method. Late Dr. Sudha Bidaye, one of the earliest well-known doctors of Poona, was bed ridden when I approached her. She also had suffered loss of memory. I discussed her life with her elder brother and brothers-in-law while the questionnaire was filled in by her daughter-in-law and her doctor son.

I would like to place on record my sense of deep gratitude to some prominent practitioners who spared me four to five hours even when they happened to be on the last leg of the journey of life. They understood the purpose and significance of my work. One was Dr. Banoo Coyaji, a Pioneer and one of the Architect of K. E. M. Hospital, Poona and the other was Dr. Goher Irani, Founder and Chief Medical Officer of Meher Free Dispensary, Meherabad, Ahmednagar. Regrettably both expired after a year of the interview. Cases, such as these enhance the value of this work.

Locating correct names and addresses of medical women of the colonial period was another major challenge as the records were not updated to enter their post-marriage details. Dr. Mrs. Leela Bhagwat went out of the way in helping me to find ‘hidden’ medical women of the period of our study. In this very context I feel grateful to Dr. Anant G. Sathe, a famous and early Gynaecologist and Social worker in Health and Dr. K. B. Grant, one of the founders of Ruby Hall Hospital, Poona and Mr. Kaluram Mangalchand, Pioneer of Ayurvedic Drug House at Ahmednagar. Finally, in many cases valuable documents were lost either due to natural disasters or unawareness on the part of the family of their importance or a generation gap among the doctor and her children. A few doctors have put the condition of not disclosing their names, while agreeing to give the interviews.
Given the formidable obstacles in this exercise, the gains in terms of collection of data are neither sufficient nor satisfying for reconstructing untold and unheard stories spoken of. But a determination to document all the dimensions of this slow and silent struggle from stray, incidental and uncorrected individual pieces to evolve salient features of a lengthy battle emerged. The dictum of Maya Angelou, "There is no agony like bearing an untold story inside of you is evident."  

The Indian scenario was for more complicated since the subcontinent was under colonial rule. However crossing of socio-religious taboos was as much essential for Indian women to rise from the dark domain of ignorance and illiteracy as was the initiative from the government. Indian women shared the fact of secondary status with their European counterparts with marginal differences here and there. A couple of concrete cases follow.

**Gender Bias Experiences**

**Birth of a Girl**

Birth of a Girl was generally unwelcome in the first half of twentieth century. However the girl child fared slightly differently if the family happed to be wealthy and progressive.

The Phatak family of Pune could be called rich, aristocratic and progressive in which women often went to watch plays of *Bal Gandharv* in a theatre and moved in horse-carriages. When Janakibai was born, the parents were expecting a son. She therefore, was dressed like a son till the time to join school. Ms. Sudha Apte, her daughter explained. “Possibly they thought that she would behave like a son being so dressed. But the times and serial customs militated against their wish as she had to be married at the age of eleven.”

On the other hand, another doctor affirmed on condition of anonymity that her parents were so unhappy with her birth that the ritual of *namakaran* or naming ceremony was not performed for her. She was given a name only when admitted to school. Being a child in a joint family, every one called her by only name he/she liked. She even laughed saying, “I was special so I got so many names in
my childhood.” However, her elder sister had been duly and ritually named at a customary ceremony. Being the fifth daughter, she was a burden for her parents. Thus both cases highlight constraints of being born a girl child.

Nature of Education

If mere birth was unwelcome, getting enrolled for schooling was much more so in view of the pernicious custom of child marriage. The role and functions of women differed very little whether they happened to be child, wife, widow or mother. Heavy, indeed, happened to be household duties, all this while wearing nine-yard sari with a covered head.

In spite of all constrains if some girls succeeded in entering a school, they used to be withdrawn in view of the prescribed custom of child marriage. The Bombay Chronicle contains a telling comment on the contemporary reality in this regard: “...very few girls however go to school and the merest handful to a University. Even the high school girls are sometimes condemned on marriage to the traditional seclusion of the Hindu wife.”

Society saw the utility of education only in terms of training the girls to perform household duties. Nurse Indira Waman Kale has thus indicated the view of her husband on women’s education, “It should enable women to read and write letters; set up and run the household efficiently and watchfully. The mark of a good housewife is offering hospitality to a guest with a smiling face.” However, all these qualities could be cultivated even without formal education!

Professional Education

Many social evils and beliefs militated against women’s education. Social reform associations focused on purdah or seclusion, child marriage, polygamy and enforced widowhood in their programmes and campaigns. The Prarthana Samaj, the Arya Samaj and Brahmo Samaj highlighted the importance of education for women: not only primary but professional as well. Even a casual reading of contemporary debates and controversies would bring home their role as well as contribution. The Missionaries’ efforts resulted in mixed responses of Indians due to socio-religious prejudices, fear of conversion.
Ironical, as it may seem, the birth of the socio-religious reform movement was on the ground prepared by imperial rule. A new class consisting of educated Indian males-teachers, doctors, engineers, clerks and writers gradually emerged on the Indian social scenario. Having come under the influence of western ideas and ideals through English education, this class was initiated into ideologies of liberalism, utilitarianism, freedom from restrictions on realizing one's self-identity. Though small to begin with, this group, known at the time a "New Learners", developed a desire to extend the frontiers of knowledge to women in their families. This encouragement from 'New learners' group touched off a transitional phase in the history of women's education, when they journeyed from the stage of primary and secondary to professional education.

The only safe profession for women, acceptable to tradition bound society in the beginning was that of a teacher. For education of women only lady teachers were required. Naturally, the idea of preparing professional teachers was acceptable even to orthodox sections of society. Employment of women also contributed to the income of families.

Though employment oriented, medical education involved socio-cultural risks for women, society has some other reservations as well which are reflected in debates on the issue during the period of our study.

The main objection was the study of anatomy and physiology which was not possible in western medical science without the dissection of a human body. The Scriptural injunctions termed the dead body as 'impure' and only classes standing lowest in the social hierarchy handled them, outside the limits of a village. Handling dead bodies and treating wounds involved dealing with blood and flesh which was deemed 'dirty.' Working in hospitals would require touching or treating male patients as well and any contact with a man other than a husband was prohibited to women. Yet another 'risk' was compulsory enrollment in co-educational institutions as no college was available exclusively for women. In India this, in fact, was a major dissuading factor for women in the presidency to enter medical college. As a consequence the rate of women in medicine was quite insignificant in proportion to the population.
However against these formidable obstacles, one major fact stood out and that was the high rate of maternal mortality. The ‘New Learner’ group recognised the importance of medical education for women in this context and broke the barrier. We may note some concrete examples.

Among early doctors of Poona was Mrs. Chapala Khadilkar, daughter of Shri Ramkrishna Karandikar, who was an engineer. She was among his seven children, and yet, he supported her financially and morally to complete her graduation in Medical Science. He had a liberal and utilitarian bent of mind. Dr. Chapala did her MBBS at Grant Medical College, Bombay in 1934 and she had to stay at Seva Sadan Hostel, Gamdevi, Bombay leaving behind her native town, though she could do her matriculation and Inter-Science there.

Yet another example of a liberal parent is that of Shri Narayan Yashwant Vete. He was much ahead of his times and hardly ever put hurdles in the progress of his daughters. He was of the view that both his daughters should not marry and devote their lives to serving the society in the medical field. After his wife expired, he never remarried, which was very rare is those times. He implanted his ideals in the minds of his daughters and the seed germinated in Miss Krishnabai Vete.

She never went to school, staying with her grandmother. She appeared for the matriculation as a private student. As she came of a vaishya caste, which was a progressive community in western India, dissection of a human body was not objected to. She completed her MBBS from Grant Medical College in 1925.

However, these constitute exceptional examples where a few fortunate girls got support from their parents. Early marriage and early widowhood often wrecked their dreams of getting a degree. As a matter of fact, we can cite a few examples in which some women doctors had to remain content with learning at home to begin with.

Dr. Anandibai Joshi did her primary education at home under the guidance of her husband. Dr. Rakhmabai was fortunate in having a father like Dr. Sakharam
Arjun Raut who was a social reformer. He made arrangements for her education but she was placed in a painful dilemma as regards learning English. Her husband had put a condition that if she learnt it, he would disown her. She attempted self-learning but soon found it tough to learn at home. The rate of progress was low. To quote her own words, “I used to ask a number of pronouncians and meanings of English words at a time when my European lady friends happened to call”.

She also wondered how her husband, qualified only upto VI standard was capable of understanding English. “I was asked to sign it in my usual way. I naturally signed in Marathi...I did not understand English, why was it interpreted to Mr. Dadajee (her husband) who is capable of writing the ‘Exposition’ and it is asserted had studied up to the VI standard.”

A detailed account of a life in the medical profession represents untold narratives of many others with minor variations.

Janakibai Phatak came of a rich and progressive family but was married off at the tender age of eleven. She had just been introduced to alphabets. By sheer good luck, her husband’s family happened to be highly educated and progressive. Her father in-law and brother-in-law both were doctors while the sister-in-law was studying in Hujur Paga School, Poona. Her husband attempted L.L.B. but failed thrice. He used to tutor all children in the family.

Janaki had a heavy load of housework. From early morning she attended various duties getting no time to study. But she had a strong urge to learn so she used to frequent the room in which children were taught. Whatever little she could catch, she would keep repeating the rest of the day. By the age of fifteen she managed to get the books of Tarkhadkar’s English from her brother-in-law and increased her vocabulary. This irregular and hap-hazard but determined learning process so enhanced her capacity that at the time of preparing for examinations, children used to lag behind her in answering her husband’s questions. However, the English language was the major problem to get over.
As noted above, her husband could not clear the L.L.B. examination even after three attempts. Naturally, she needed to obtain a qualification and support the family. It so happened Ramabai Ranade was closely associated with her family and offered her all encouragement. In those days, the classes of Seva Sadan were held in the house of Justice Ranade.

Mornings were devoted to attending household work only in the afternoon when the family was taking some rest, she used to come out concealing a pencil and notebook in her clothes and enter the compound of Ranade. At times, she would place them on the window and pick them up coming out of the house. The residential toilet was her study-room where she used to keep her book. She used to memories the words in the course of washing clothes or cleaning utensils. However, even this schedule was disrupted owing to frequent rituals and festivals like Mangalagaur, Gauri-Ganapati, Diwali etc. Attending school remained a dream for her but she was determined to learn somehow.

She had interest in sports, could compose a poem and sing a song. She composed a bhupati rag and sang it when Poona Municipality felicitated Lokmanya Tilak. However in the absence of formal education and the problem of English, she had to opt for a Nursing Course. However, LCPS required a basic certificate of Matriculation which she could pass only by the time she had two children.

Being goaded by her friends, she appeared for interviews seeking admission to LCPS. The panel consisted of Dr. Shikhare, Dr. V. D. Phatak, Captain Oak and Dr. S. L. Ranade. She had learnt to talk in English by then. So she was selected for the medical course in 1923 and completed LCPS from B. J. Medical School, Poona in 1927. However, her parents did not like her breaking out of mould and stopped talking to her.

Dr. Janaki Phatak engaged on multiple fronts in medicine. By opening her private clinic, she offered voluntary services to the Maternity Home of Seva Sadan and also delivered lectures on women's health care at its Ahmednagar Branch in the Public Health Visitor Course. She worked four months in Bala
Saheb Deshpande Hospital, Ahmednagar. She acquired extensive experience in handling the cases of obstetrics and gynecology. For a year she worked in KEM Hospital, Bombay in 1928. Then she opened her own hospital in Poona. She sent her children to a hostel so that their studies were not affected by hospital work at home.

But her courage and patience were to face yet another challenge. Around 1939 she suspected developing breast cancer. She discussed her case with doctors, hiding the fact from the family. She started the treatment. Even surgery failed to relieve her of the terminal illness. She sold the hospital, made her will and insisted her daughter become a nurse, as the time was running out for her.

So strong was the mother-daughter bond, that Sudha complied with her wish to become a nurse, though she aspired to be a doctor. She cleared nursing exam. in 1938 with first class and joined Sasson Hospital, Poona. However she had her own regrets that “Dr. Janaki Phatak was not a matriculate, did not have a single factor favouring her education, and yet, she did LCPS. In my case, all the circumstances were favourable and I was dreaming of becoming a doctor but had to enter the nursing profession. What was the use?” However, she kept telling me, ‘Throughout your life you won’t need to beg or borrow from others’. She married a doctor, who did private practice. But her in-laws were against a nursing job in Sasson Hospital. So she had to resign. After a long gap she resumed her profession when her husband was no more. The entire account of this mother-daughter struggle to work in the medical profession was narrated by 70 years old Mrs. Sudha Apte, the nurse and daughter of Dr. Phatak.

Interestingly, Janakibai Phatak left Rs. 5 per month in her will for customary ‘Choli-bangles’ to Sudha and sealed all silver items and valuables in a trunk for her. She should not give it to her brother and father. Sudha confessed that she has lacking courage and strength.
Gender: Selection of Stream

The hold of patriarchal norms on society was so strong that treating daughters on par with sons took a long time even in progressive families, some concessions on the educational front were granted while for full freedom to choose, women had to struggle and bear hardships. We may analyze this phenomenon from some other examples.

Dr. Sumati Kanitkar happened to be the daughter of Mr. Khare an advocate. He arranged basic education for all his daughters till their marriage. When Sumati reached a eleventh class, he started searching a groom for her. However, she wanted to do a course in medicine and filled the form. Her mother Shakuntala Khare offered her moral support since she was a famous local *dai* and happened to be a close relative of Yashodabai Agarkar, wife of social reformer Agarkar. Mr. Khare wanted his son to become a doctor and spent extra on his education. He was of firm view that 'medical education was not suitable for girls'. He stopped talking to Sumati. But Sumati got a scholarship of Rs.5/- for the first year of M.B.B.S. which was raised to Rs. 10/- in the second year, she secured a gold medal! After graduation, she did F.C.P.S. in 1948 and completed M.D. in 1949. She had to leave her home Nagpur for her studies and join G. S. Medical College, Bombay. She was appointed at Sion Hospital, Bombay. After her marriage, her father Mr. Khare started talking to her. It is also noteworthy that in spite to his opposition, he financed her stay in the hostel and expenses of P.G. studies, what stands out from her story is the fact of sons, even if mediocre, were favoured more than intelligent daughters in so-called progressive and educated families.

But the case of Dr. Sudha Bidaye is radically different. She lost her father early and was so deeply touched by his suffering chronic asthama that she decided to become a doctor. Being the eldest among children she seized the opportunity and joined B. J. Medical School, Poona for LCPS. She stayed with her mother who was so attached to her as to stop even her son’s education for want of means. Indeed, such was the grinding poverty of the family that Sudha had neither good food nor presentable clothes. She slept in a petticoat washing the Sari at night so as to wear it next day as she had two saries only. With no money to afford
transportation, she walked to college and back home. She completed LCPS in the first class and joined a government hospital in Kathiawad, Gujarat. Among other women passing through identical hardships are the names of Dr. Ambu Patankar, Dr. Shakuntala Mote and Dr. Leela Mokashi noted.  

Turning now to other communities we find factors of finance and patriarchal prejudice stood in the way of women there as well. Dr. Goher Irani, a Parsi doctor belonged to a family with scant financial resources. She developed a desire to become a doctor but the mother wanted to give preference to her brother on the simple logic contained in her response, “No you are a girl and any day you will be getting married. So what’s the use and anyhow we have no money to pay your college fees…. In fact, there has been enough of studying.” This was the situation when the girl happened to be intelligent rather than the boy! However, God came to Goher’s help in the shape of Merwan S. Irani, well known as Meherbaba, a spiritual guru of that time, supported her financially from Inter science to M.B.B.S.

Dr. Diana Levi was a Bene Israel, a Jew. She was greatly influenced by the work of Dr. Jerusha Jhirad, Chief Medical Officer of Cama Hospital, Bombay and also a Jew, a friend of her mother. However, her father was merely a carpenter and her mother, a head-mistress. She was allowed to complete B.Sc. Fortunately she did D.A.S.F. a condensed course of allopathy and ayurveda.

Miss Zahirunissa is the first Muslim doctor of Poona having studied in B. J. Medical College, Poona. She qualified for Dufferin Fund Scholarship to do her P.G. in London but the family did not allow her though the IWW had just ended in 1945. She regretted this fact even at the age of eighty when she gave the interview.

Who would do ‘dirty’ work?

The notions of pollution and purity are characterizing the attitude of society to the profession of midwifery. As it involved working in area culturally forbidden with social restrictions and demanded that this “impure” work be handed over to only widows, unmarried, ugly or destitute women for attending to
women in labour. These women were treated as bad omen for socio-religious and cultural rituals, and hence kept away from them. This downtrodden class of women got an opportunity to come out of the seclusion and gain respect and faith from society. Society permitted widows to enter in this profession to escape her from remarriage.

Here again the considerations of caste played their part. While higher castes accepted the services of a widow in the family or society, the lower castes employed *dai* from their own community. Since these women happened to be ritually inauspicious or useless, society expected them to involve in ‘impure’ work of midwife.

As regards women of this category, the income generated from the job and the need of society for their services worked as factors of motivation. Widows had undergone the stage of delivery. So their experience came handy for them. The destitute and ugly derived a sense of satisfaction of that they could enter the *Zenanas* of respectable families to offer their services for the job considered ‘dirty’.

In course of time, *dais* acquired such prestige that even educated families attached more importance to their advice than that of a qualified doctor. This fellow feeling and personal concern was missing in the treatment offered by the nurses in hospitals or maternity homes. Nurses were often shouted at and neglected the struggling mother. They had contempt towards patients and aimed at showing off their knowledge and Superiority.\(^{23}\) An additional diversion was racial prejudice. European doctors male or female were rather indifferent to the delivery problems of Indian Women. Dr. V. N. Purandare, the well-known Obstetrician and Gynecologist of Mumbai has referred to a misconception in this regard, “The gynaecology cases of Indian women were handed over to male Indian doctors because European doctors had a misconception that Indian women were dirty in this phase.”\(^{24}\)
Factors Motivating Women to enter Medical Field:

Even the Dufferin Fund failed to attract high-caste Brahmin women to medical profession. The early entrants were from certain castes and communities who had a tradition of non-vegetarian food in their homes. Some developed liking for the profession while others aimed at fulfilling financial need of the family. Some happened to be idealists treating the profession a ground for social work while a few wanted to follow in the footsteps of their elders in the family: a father, an uncle etc. Some of the child widows also opted to enter the field as otherwise their life was bleak.

Dr. Ida Scudder felt the acute need of women physicians to attend to the problems of women in India. She was the first medical missionary of Madras Presidency. Dr. Goher Irani was attracted to the profession from early childhood. She was fascinated by the prestige of a doctor. She reminisced, "Till the age of nine I had no idea of being a doctor. Then I came in contact with a small Irani girl, staying nearby in the Khusru Quarters. To me she appeared extremely weak and time. So I set about collecting various powders from the kitchen to administer her with. My medicinal powders consisted of ginger, turmeric, Jeera etc. which I used to store in round shoe-polish tins. The girl would respond obediently to my prescriptions though her condition continued to be the same as she vomited the dose soon. However, this was my first doctoring at the age of nine."

A major factor motivating women to be physician was suffering of a family member for want of medical expertise. In some cases it was too late to come to their rescue as lady doctors were not available. Dr. Jerusha Jhirad was influenced by the efficiency of Dr. Benson who treated her sister. Dr. Ashtaputre felt sad for her mother’s pathetic condition and decided to be a doctor. Dr. Anandibai Joshi lost her first son due to lack of medical service and cultural taboos, this incident motivated her. Dr. Sudha Bidaye’s father had chronic asthma which so affected her as to awaken the desire to be a doctor. Dr. Shaik found that her younger sister died as the medical help could not come in time. However, a section of women was motivated by material considerations. Dr. Bidaye, Dr. Paranjpe, Dr. Madhumalti Gune and many more opened their dispensaries, maternity homes and nursing homes. In rare examples we also have
women under the influence of pioneer women in the field. Dr. Diana Levi, Dr. Segula Aptekar, Dr. Sara Israel all Jews, and inspired by the example of Dr. Jerusha Jhirad.

In the first half of the twentieth century, the active participation of women in the Gandhian movement also contributed to the self-confidence of many women entering and practicing the medical profession to serve humanity.

Widows in Medicine

We have to note a distinct category of women in Indian Society which took up medical profession on account of the helpless situation in which fate had placed them and society cared little for their plight. This was the status of widows. Annapurna Jaeel of Poona become widowed at the age of thirty with the heavy responsibility of rearing four sons and two daughters. Neither her in-laws nor her parents were willing to support her. In fact, the in-laws were supposed to place several restrictions on her in compliance with socio cultural traditions. The children had little chance of a decent education in a big joint family. Annapurna was obliged to undertake B.P.N.A. course and worked as 'trained nurse' to help mothers in delivering children. Thus it was a question of her very survival and that of her children. Lacking time and money, she could not upgrade her qualification to do a diploma. In fact, she was also overage to be admitted to it. Luckily for her, the city of Poona had undergone a metamorphosis and people developed awareness to solicit the services of a 'trained nurse' rather than familiar functionary dai. She became in the process the only bread-winner of the family. Her daughter also followed into her footsteps and did LCPS. Both, then, together opened a clinic and nursing home and maintained the family from their income. Incidentally, Annapurna's daughter, Mathura Jaeel, who completed LCPS in 1931, never married and devoted herself lifelong to the welfare of her family.

Fortunately for us we have the detailed narrative of the struggle another widow-turned-doctor had to face. Dr. Mathutai Athalye a daughter of well-to-do but orthodox Hindus became widow at the tender age of twelve. She was tall and beautiful. The custom required tonsuring of widows but she somehow resisted. However, it was easy for her to obtain education. When Kamalabai Deshpande
opened her school for girls at Satara, she insisted on joining but her father was afraid of social censure. However, now that she was a widow, he consented to send her to school on the persuasion by Maharshi Karve. But a severe condition was imposed: the priority of housework to attending school. Taking of examinations year after year and passing was not as important as doing various duties at home. Even when she fell ill and suffered from typhoid, the visit of a doctor was resented by elder ladies of the family with, “why should a doctor be called for a good-for-nothing ‘person who is ill in words as well as deeds ?” Crossing all such customary but painful hurdles she passed her vernacular final and received a prize of Rs. 10/-. As she wanted to be a doctor, she requested her parents for it. Being a widow, she was not interested in participating in extra curricular and cultural activities of her school but Hujur Paga School Poona, worked a change in her attitude. She authored brilliant pieces of short play, performed challenging roles on stage and proved a good sportswoman winning prizes and scholarships in the process.

She finished her matriculation from Hujur Paga School and Inter-Science from Fergusson College. Interestingly, many people approached her with marriage proposals while some letters were also received from unknown well wishers to the effect, “Take care of a widow’ or ‘Don’t send her alone to School’. ‘Beauty, which is the free gift from the Lord, and youth of your daughter should be properly protected. Anyone would crush the budding flower!’

As ill-luck would have it, her father expired at the time of her completing Inter-Science. She could not go to Bombay for MBBS nor did she get admission to B. J. Medical School, Poona, being average. Relatives advised her not to do LCPS. However, Mathu was determined. She directly approached Dr. Noronha, a high officer at B. J. Medical School and clarified her predicament. Being a child-widow with pressure from her orthodox parents, she could not finish her Inter-Science within the age-limit prescribed for admission. Dr. Noronha was so impressed by her plea that she secured admission as a special case!

This opened another chapter of struggle in her life. Alongwith studying for LCPS, she was to look after her ailing mother and two young nephews in
compliance with the word she had given to her late father. Even before completing the course, she lost her mother. The strain told on her health and she was bed-ridden for a month with typhoid and pneumonia. All these boded so ill for her performance at the examination and she would have surely failed. But she proved her competence to come out not only first in B. J. Medical School, Poona, but winning prizes in surgery and midwifery as well!

She got houseman ship in Sassoon Hospital, Poona with a monthly honorarium of Rs. 70/- in addition to a room for residing in the ward. She also was to visit Urdu Girls' School on a monthly payment of Rs. 20/-. She received training in Obstetrics and Gynaecology under RMO Dr. Ambekar. After finishing the internship, she completed LGO from Madras Government Hospital. Her wish to do MBBS was still unfulfilled and she made one last effort to get admitted to G.S. Medical College, Bombay. She could not succeed owing to financial constraints and opposition from relatives.

She, therefore, went back to her native place Satara and joined as RMO at Dr. Agashe's Hospital. Even after the struggle of epic dimension, described above, she could not cast off her stigma of being a widow. The Society of Satara looked at her with contempt on all auspicious occasions and celebrations where her presence was forbidden. Once it so happened that a couple came to her after trying several courses to conceive a child. With the help of Dr. Athalye they were blessed with a child.

Naturally, they invited her on the 12<sup>th</sup> day Ceremony and at their specific insistence she went to attend. Soon the gathered ladies began talking, "she is a doctor, so what! Why should such inauspicious people be invited on such an auspicious occasion?" Overhearing such remarks, Dr. Athalye left pretending some emergency.

In yet another incident, she was called to attend the delivery problems of a woman in the house of Kelkar Shastri who used to deliver lectures on the Bhagwadgita year after year at the temple dedicated to lord Rama. It was a complicated case of haemorrhage, which was not possible to relieve unless shifted
to hospital. When she advised shifting and offered to take her, Kelkar Shastri categorically stopped her saying that a Suhagan (a married woman) would accompany her. She could go late separately. This was the strange situation of society treating a widow-doctor with contempt and yet, expecting her to save the patient as well as the child which Dr. Athalye, of course, did efficiently. When people showered praise, her laconic reply was, “But all this was accomplished, in your eyes, by a widow, an inauspicious widow only!”  

These few but stray events from the life of Dr. Athalye constitute an unknown and untold chapter in a history in the struggle of Indian women to come into their own. They bring out in high relief the contradictory attitude of contemporary Society.

Very few details are available about another child-widow, Dr. Mathurabai Uchagaonkar LCPS. She was appointed as chief lady-doctor at a Maternity Home in Bangalore in 1916. Her services were totally dedicated to the welfare of society. She did new operations like forceps deliveries and caesarean sections alone and always successfully. She had achieved high skill and competence. Dr. R. Mudaliar was highly impressed by her efficiency remarking that both the mother and child were safe in her hands.

Financial Support

Parallel to patriarchal prejudices was the obstacle of general poverty of rural as well as urban society. It worked so greatly that even incentives like concessions and scholarship offered by the government and public funds were not enough to free prospective women students to join and complete a course in medical science. The father of Dr. Ambu Patankar was a retired employee with a pension of Rs. 300/- per month. He was unable to meet the expenditure of her education is medicine. She had to opt for B.Sc. However, during WWII, she seized the opportunity to enroll for LMP. But her wish to go further for DGO and MBBS was refused by the father. After wasting precious years of life in futile efforts she joined KEM, Hospital. More or less identical are the cases of Dr. Kashibai Navarange who did B.A. & LCPS and of Dr. Leela Bhagwat, Dr. Kumudini Dandekar. They attributed the factor of poverty to the joint family system in which an income was distributed among twenty to thirty members constituting the family while the resources were meager. Added to this was the
fact of family or personal tragedy in many cases. Dr. Madhumalti Gune (Nee Sule) lost both her parents, so her maternal uncle called all the five siblings to Sholapur but left them at the railway station. Next they came under the care of a grandmother. Madhumalti entered Karve’s Hingane Ashram and remained there till matriculation. In the ashram she was required to make hundred and fifty Bhakars (Chapatis/ Roti of course grain) every day for inmates of the ashram.  

Dr. Kamalabai was the daughter of Krishna Ekbote who was the editor of a magazine. This was not liked by her grandfather, so Mr. Ekbote separated from the joint family. However, at the tender age of five, she lost her father and had to live with her grandfather alongwith three siblings and mother. By the age of eleven she lost all her siblings and mother. As is clear, the grandfather was very conservative and strict, not permitting her to matriculate. Somehow she convinced him and went on to do LCPS in B.J. Medical School, Poona.

Dr. Goher Irani had to struggle hard. She narrated the stages of her struggle. “Those were the days of depression… very little money. My premedical subject was science; so it needed a lot of hardwork, every minute I had to study. However, for want of fees, I needed a job on the side. There were very few jobs available to women in those days, but I started tutoring a small girl for Maths, French and English. I got up early and walked to the girl’s house, a far distance of about two to three miles at 6 a.m. This is because I did not have six paisa for the bus, so I preferred to walk. At 8.30 am I went straight to College and return to home in the evening... It was a very tough time in my life. There was no money, even for lunch.”

Even when the struggle was over to become a doctor, some of them could not get over their fear of the world around in their practice. Dr. Tarabai Vasudeo Godbole had grown up as a child under the shadow of the fear of death. So timid and self-conscious, she never made any visit to a patient throughout her career.

In fact financial constraint obliged many others to foot out long distances adding to their woes. Standing in the laboratory for at least six-seven hours while doing practicals, itself was tiring. It was much more so nourishing diet was
lacking as well. Dr. Ambu Patankar walked from home to college, then to the dispensary or hospital and again back home. "It was extremely taxing and we had hardly sufficient food." 38 Inspite of attending to her duties in the hospital, she used to walk six-seven miles in a day. Added to this terrible strain was a night job at a maternity hospital for money.

Incidentally, Dr. Madhumalti Gune was the first woman to use a bicycle in Poona for commuting and home visits.39 A girl in Indian society customarily remained undernourished those who still opted and succeeded in joining the medical profession found their physical health a great handicap. Dr. Motasha refers to the case of Dr. Kripabai Christi who was advised against traveling to Europe for getting medical education she was admitted to Madras Medical College and secured first class in all subjects except Chemistry. However, so fragile was her health by then, that she dropped out.40

Medical Profession and Marriage:

The struggle of woman did not end with securing admission to an institution of medical education or even completing the course. Much more suffering and sacrifice was in store when she attempted to practice the knowledge so acquired. In terms of hurdles and sacrifice, there was not much qualitative difference at the family level since her status continued to be secondary to that of her husband and for all practical purposes, she had to cast herself in a double role: working hard to keep family members in good humour and attending to the problems of her patients. However we have to take note of variations within this generalized scenario on the basis of data we have collected.

To begin with, woman physicians had to remain single as getting eligible life partners was not easy. Practicing of medicine brought economic independence and freedom to choose one’s partner. It was not possible to accept discrimination in family life where traditional value systems prevailed. Naturally many remained unmarried, mostly in Jewish, Parsi and Christian communities as males were not well qualified educationally being engaged in business. A new trend was established by women in medicine against traditional custom, that marriage and child nurturing were the aim of life of women. Few are listed here
who gave more importance to career than married life: Doctors (Miss) Dinbai Jehangir Dubashi, (Miss) Jaya Khandwala, (Miss) Diana Levi, (Miss) Ambutai Patankar, (Miss) Karuna, (Miss) Mehnaz Karkaria, all were graduates.

Sheer idealism inspired their service to fellow beings required full devotion while matrimony was sure to result in maternity with concomitant responsibility to rear children. We could name Dr. (Miss) A.M.Benson, Dr. (Miss) Anne Walke, Dr. (Miss) Jeshua Jhirad, Dr. (Miss) Khareghat, Dr. (Miss) Gulbai, Dr. (Miss) Jerbanoo Mistry. Following into the footsteps of pioneers also motivated many to remain unmarried, - like Dr. (Miss) Ida Scudder, Dr. (Miss) Aptekar, Dr. (Miss) Machado Haigel.

Dr. Sunanda Paranjpe was a Hindu woman, remained unmarried owing to evil practices of polygamy and gender prejudices prevalent in society. Her mother was the second wife of her father who married with the expectation of a son. When she delivered a girl (Sunanda), he went back to his first wife and lived with her only. He neglected and often humiliated his second wife, refusing all financial help. Having been exposed to this sorry scenario from childhood, Sunanda developed an antipathy to her father, never being on talking terms. However, at the ripe old age of ninety-two she did regret her attitude of utter indifference towards her father. No doubt, it was contradictory situation to be placed in because she had been eye witness to the sufferings of her mother who became a mental patient in later life.

The classic case of Rakhmabai’s refusal to go to her husband’s house. Reflects the strong will independence and sharpness of brain. She opted a medical degree thereafter and lived single all her life.

Yet another variation can be located in the case of Dr. Kamala Ashtaputre who married a doctor husband and yet had to shoulder all domestic duties. The day of marriage was marked by an event with a significant sequence. Her teachers had been invited to a meal and they all showered generous praise on her in the presence of her husband. Talking about her talent and all round personality. This generated a natural sense of inferiority in her husband who had
grown up with the widespread and established notion of male superiority. The obvious outcome of this event therefore was mental and physical harassment of Kamalabai from day one to the day of her separation. Interestingly, Ashtaputre couple maintained a cordial façade outwardly often participating in social and political movement and taking part in struggle of the freedom movement. They did have a daughter before formally separating. Again a divorcee woman had little respect in society and that is another dimension to the story of Dr. Ashtaputre.

What was required in the first place was a radical change in the psychology of men in union with medical women. Wanting to marry a medical graduate was not enough adjusting with her willingly to allow her required space in her professional life was equally desirable. This was not easy to come about, given the hold of age-old norms of conduct prescribed for man and woman. The very definition of being a woman was in terms of roles specifically assigned to her and without compromise on this, no woman could effectively function as doctor. Dr. Soman, for example, was in the IMS holding a very high post, unimaginable for women in those days. Nevertheless, she was supposed to be a devoted wife and affectionate mother to function like any other married woman. Her husband insisted on hot and fresh food which she was supposed to serve even if she did not have time. The other side of the situation was the inability of husbands to manage household work so as to relieve wives a bit for their professional work. In fact, Vishram Bedekar used to tell his wife that men should get proper education to behave with their educated wives.

A telling example in this regard was that of Laxmibai Tilak who went to Miraj Medical School for completing a course. She took admission to diploma course in medicine for the cause of social service. Just after four months a friend of the family, Dr. Hume from Ahmednagar wrote to Dr. Wanless for sending her back immediately because her husband and children were miserable in her absence. It was also instructed to keep the letter secret from her. Dr. Wanless arranged the packing of her luggage on the pretext that she was not strong enough to handle heavy patients. Naturally her training as a nurse remained incomplete.
What is much more shocking and also a bit ironical is the total lack of understanding even in families where not only the spouse but also other members happened to be medical professionals. The case of Dr. Sumati Khare is quite glaring in this regard. At a Diwali function there was a family get together and about twenty five members were to attend. Dr. Khare prepared full lunch for all in a grand style and all could partake of the lunch at the same time. However, before the lunch could begin, she had received an emergency call for a delivery case and she left for the hospital. Khare family had several doctors including her own husband and all were well familiar with the nature of the profession. Yet, her husband was upset and asked her not to leave home in such circumstances. The family would not like to suffer on any count and even women with medical degrees were to give priority to domestic duties. He failed to differentiate between emergency and normal cases which were strange and unfair on his part being himself a doctor! It also reflects deep-seated patriarchal values even in educated and so called progressive families. As a consequence, Dr. Sumati Khare had to stop her full-time practice. In spite of high degree and remarkable skills of her profession, she had to be content with a part time job and full-time family duties. As she happened to be a daughter of Inamdar family with orthodox attitude, she could not get support from her parental family as well. Her husband has financially supported his sister for a medical profession. It is often seen in all Indian families that discipline imposed on a daughter-in-law differs from that on daughters and sisters. Too late in life, other members of the family regretted their callous attitude and contemptuous neglect of their sister-in-law in denying her legitimate space to practice her profession. 47

However it's not easy to generalize from the cases noted above. We do have some happy exceptions. Dr. Shanta Saptarshi married an industrialist Gulabchand and got involved in handling a variety of industrial and social matters, hardly getting any time to devote to her profession. 48 However she did open a big hospital and served the people. Dr. Madhumalti Gune married a student of her father who stood by her morally and financially. In cases where women happened to be the sole bread-winner, the attitude of husband was understandably found to be different. In fact such women physicians married on the condition that they would continue to pursue their profession even after
marriage. As the spouse happened to be a non-doctor and took pride in fact of having a doctor-wife, he was willing to undertake the familiar role of mother as well as father so as to free the wife to attend her patients.

The husbands of Dr. Samati Kanitkar and Dr. Leela Bhagwat shared a fair load of administrative work in their maternity homes and looked after children as well. Such was the cases also in the lives of Dr. Kalatai Joshi and Dr. Sheikh of Ahmednagar.

In the late 1940s if a husband was not well-settled in terms of profession the doctor-wives opened their private clinics and maintained the whole family from their income. In fact they functioned as head of the family as well till the spouses settled in their lives.

**Motherhood**

Apart from familial roles as wife and daughter-in-law, all married doctors had also to pass through the phase of motherhood. Helping other women to deliver was so demanding that they had to neglect their own stage of pregnancy and post natal care. Dr. Kamala Ashtaputre worked hard till her ninth month and was rightly reprimanded not only by her grandmother or neighbours but by the maid servant as well, “You will help other women in delivering their children, but in some case you would deliver your own child in the process.” Dr. Madhumalti Gune lost two of her children but she had the burden of her family on her shoulder. Identical were the cases of Dr. Leela Mokashi and Dr. Kharadkar though the former took extra care in during her pregnancy. However, she had no time to devote to her daughter and sons respectively. As regards resuming work after delivery, Dr. Ashtaputre, Dr. Leela Bhagwat, Dr. Leela Mokashi, Dr. Kharadkar and nurse Laxmi Sabnis attended their patients after a week of their own deliveries.

Dr. Leela Bhagwat, Nurse Laxmi, Sabnis, Dr. Ashtaputre, Dr. Leela Mokashi, Dr. Kharadkar started their practices after their own delivery within a week. Because patients insisted that at least they should be present in labour room.
Risks of being a Woman Doctor

Most women doctors were afraid of traveling alone for home visits to patients, so the husbands or relatives especially male as compounding used to accompany at night. Doctors in Pune always took proper care.

Dr. Tarabai Godbole never did home visits because she was practicing in an area full of gangsters, ruffians. Her husband accompanied her to and fro from home to clinic. Later she gained people's faith in her work, but she never visited.

Dr. Diana Levi narrated an event when she had to visit a slum-area. Dr. Diana Levi started her general practice in Bombay. She had newly opened a clinic so she started home visits. One day she got a call from a patient, so she visited him, treated him in a slum area. It was an evening at 7.30 p.m. when she came out from the patient's home she saw, a crowd of men and women inhaling and drinking something. On enquiring she was advised to stay away from that place because it was an opium den. She was frightened and left the place immediately. She narrated this today, "when I heard this, my heart stopped a minute...we are doing work for humanity but we do not know the nature and behavior of surroundings. We should take care."

Dual Roles and Power in Domestic Front

As regards the status of lady doctors one may be guided by widespread perception that the status of an earning woman is necessarily better than that of non-earning one. However it's not that simple. Variations in this regard are also available. Dr. Kharadkar had hardly any power of decision in the family. The kids were resentful as it was not possible to devote time to them.

In fact, Dr. Sumati Khare, Dr. Leela Bhagwat and Dr. Zahirunnisa Shaikh were not even frank in their responses on the point. Dr. Shaikh was so poor that she had no finance to open her own clinic. She worked in a government hospital. She has narrated her routine, "I would prepared breakfast for the family and heat water for their bath. The food for the day was then cooked after which I attended my own work .... The walk to Civil Hospital Ahmednagar was nearly six-seven Kms both ways as I could not afford a vehicle. Being the only lady doctor in the
hospital it was not possible to return at a fixed time. Rich families expected me to visit their homes to attend deliveries arranged by Civil Hospital Surgeons. I had to go with sterilized instruments. The kit being heavy, a nurse had to accompany and it used to be a long wait for the job to be over. After the delivery, when the mother and child were safe, I could head back home. As well-to-do families enjoyed good relations with the civil surgeon, it was not possible to say no. No doubt we got some extra money but the energy and time involved left no time for family life. Family functions I mostly missed and had hardly any time for my only son.” The life of Dr. Haimvati Sen, lady doctor in-charge of the women’s Hospital in Chinsurah in 1895 is similar.

Given the above pattern of life, talking of change in status of earning woman is meaningless. This simply indicates that the status of women was not enhanced on acquiring competence and qualification as doctor in their own families. They were expected to do all the domestic duties that other housewives did traditionally. Thus pursuing the profession became only a source of self-fulfillment in place of empowering or even liberating them.

The callousness of the family sometimes bordered on brutality. Dr. Leela Mokashi was married to a doctor and both together had built a hospital from their income to serve the total holistic approach in health care to society of Baramati. However, as soon as her husband expired, both her doctor sons and daughters-in-law acquired total control on hospital. Even earlier in life, the family did not allow her to complete graduation and Post graduate studies due to domestic responsibility for nurturing children. She came to Poona totally handicapped owing to a surgery on her legs. Sitting now on wheel-chair she maintained hereself by offering treatment to slum-dwellers. More or less identical cases were also those of Dr. Kusum Pathak, Dr. Ketki Virkar and Dr. Malti Narurkar.

In yet another case, the husband happened to be a political leader. His doctor wife used to earn large income to support his activities and even elections. He rose to the position of cabinet minister and, as it happens, forgot the support she had given. When she stopped practice at age sixty. She had nothing to fall back upon. Even her daughters failed to appreciate the sacrifice she had made.
After being thrown out by her own daughter she came to Poona suffering from cancer. Hers is indeed a touching life history in which neither the spouse nor the progeny treated her with love and concern. Another case of Dr. Karandikar earned and supported her husband and family. Mr. Karandikar actively participated in the freedom movements. Dr. Karandikar became popular in surrounding area for correct diagnosis and dedicated service in Dahanu. We can imagine the lives of families of freedom fighter.

This raises the question of relationship between concerned doctors on the one hand and their respective families on the other. Were the women physicians unaware of financial management of their clinics or hospitals? Why did they not involve themselves in checking the account of expenditure? Didn’t their husbands give respect and attention to the work they did? This could have led the families to do likewise. Why didn’t the husbands set aside some money for their maintenance in old age?

The only plausible explanation appears to be the idealism of doctors themselves in concentrating exclusively on relieving the distress of their suffering sisters. Thought of securing their own future, hardly crossed their mind. The joy of learning and the opportunity to use that learning for the benefit of ailing women so overshadowed their lives as to result in their own ruin in worldly terms. Dr. Mathura Jael did home visits during which she used to stay with the patients for two days for complete recovery. Dr. Sudha Bidaye’s husband was admitted to hospital, she assured his condition from doctors. Other family members were accompanying him. So she first attended her patient’s delivery in home. Perhaps that’s the price all idealists have to pay.

Majority of lady doctors started their own maternity homes and attended patients at home as well. Naturally their spouses or relatives had to help in managing hospitals. Among the doctors who were married to non-medical spouses we may note the names of Dr. Leela Bhagwat, Dr. Tarabai V. Limaye, Dr. Tarabai Godbole and many more. In fact, between 1935-45 those who were married with non-medical husbands. Among physicians with doctor husbands the names, a few listed here Dr. Kamalabai Ashtaputre, Dr. Irene Dean, Dr. Leela Mokashi, Dr.
Shantabai Kharadkar, Dr. Sumati Phadake, Dr. Vimalabai G. Ketkar need note here. Help from husbands in attending domestic duties was not usually available but management of hospitals they did voluntarily as in Dr. Kala Joshi’s case. Dr. Ashtaputre looked after their only daughter when Dr. Kamalabai Ashtaputre went abroad to complete her post graduates and specialization studies. Dr. Kharadkar helped his kids in their studies.

**Break up in Education and in Career**

In the light of what we have already seen its hardly surprising that many woman physicians took a break in their education or profession owing mainly to attend to their family. Dr. Ketaki Virkar had her private clinic but working on both fronts she found problematic. Therefore, she gave up private practice and joined fixed hours at the government hospital. She looked after the family and reared children. She worked as a Surgeon in Seth Morarji Urji Hospital at Surat in 1950. She performed general surgery and attended obstetric cases. Dr. Sumati Kanitkar took seven years off for marriage and bringing up children. Dr. Malati Nerurkar did D.G.O.(1966) sixteen years after completing M.B.B.S.(1956) had to set aside two years for marriage and bringing up children. Mrs. Sudha Apte was a nurse working in Sasson Hospital prior to marriage. After her marriage to Dr. Apte, she left her job and never mentioned her nursing profession to the family. It was a large joint family so she devoted hereself entirely to household work attending sisters and brothers-in-law who were all getting educated, but hated the nursing profession.

**Sexual harassment:**

The entry of the women in medical profession was completely disliked by male doctors as well as patriarchal, gender biased society. Indian medical women faced numerous humiliating conditions. By and large, destitute ugly, widow women entered in this field for economic independence. Some have described harassment during examination.

External Male examiner deliberately asked the questions about the process of intercourse, rape and the positions of male genital organs. A few women doctors experienced taunting by their male classmates during anatomy lectures,
medico-legal cases and Veneral Disease Department. Few experienced sexual abasement were assaulted by rich patients, European patients and doctors. Even during service an unmarried or widow lady doctors, were harassed and chased by male doctors and patients for either marriage or else favours.57

Forbes58 has given on account of such cases in Ahmedbad in the early 1930s. Dr. Miss Ahalyabai Samant, the director of the Municipal Dispensary of Nadiad reported that Dr. Balabhai abducted and assaulted Dr. Samant. The district and sessions judge gave punishment of a year in prison to Dr. Bhatt. The Chief justice of the High Court’s decision stated: “If women engaged in professional work come out into the open world they must adopt the standards of the ordinary men and women of the world. They cannot expect to retain the hyper-sensitive notions to modesty which their ancestors in purdah may have possessed.”59

Association of Medical Women of India and pioneer medical women persuaded government to appoint a lady doctor as examiner.60 Dr. Daddbhay was the first external examiner for graduation, but they were very few so that it would not really help women students.

Professional Struggles
Practice in Zenana Hospitals

The Dufferin Fund and local philanthropist started many Zenana Hospitals to accommodate Purdah nashin women especially the higher classes of Muslim community. It received good response from the society. But the lady doctors suffered lot. Dr. Rakhmabai 61 focused their problems in early half of twentieth century at Randher in Gujarat that, “These hospitals were exclusively for women and children. Lady Doctor called from Bombay to attend these Muslim ladies. These lady doctors were young, they had come due to their ambition but they were not stayed more than two months. They had not any freedom. They had to stay within the campus of Zenana Hospital. They have the restrictions same as the patients had. They were not allowed to cross beyond the wall of the garden...they literally lived as prisoners....secondly the male had different perceptions to see these lady doctors.” Hospital committee members always preferred either middle age or widow lady doctor on such post.62
Dr. Sumati Khare-Mote also had the same experiences but she faced the little but different. Mostly the royal classes had hold on these hospitals and dispensaries. These Royal ladies had problem how to waste the time. Dr. Sumati discussed the situation of the work experience in Zenana Hospitals. Among the lady doctors, one doctor was attended them day and night. They did not like to replace her or made any circulation work. They complained smaller illness and lady doctor should attain in their gossiping also. The most important thing that these ladies were refused to received western medical treatment. If any new, beautiful lady doctor appointed on the nearby hospital, they sent orders to her to meet them. She should not regret or refused it. Otherwise she had again transferred because they sent complain to provincial government against her. Dr. Khare-Mote emphasized it was difficult to work under such condition. One had to dare to say no to them. Once she received calls just for meeting, twice she visited, but third time she was firm on her refusal.

Dr. Sunanda Paranjape shared somehow same experiences but she also traced that if Dufferin Fund controlled, it was not make any difference. But Royal ladies were also progressive mind. They were eager to understand western treatment but very few either followed it or allowed to treatment. Dr. Sumati Bidaye had the experiences to work in the hospitals where mixed community were treated in Gujarat and Rajasthan. Other communities had trusted on lady doctor sooner than Muslim one. She was unmarried and joined the service in the civil hospital. Though she was in-charge of hospital she still faced socio-cultural prejudicial attitude from the society, she lived with her brother in quarters in hospital premises.

Dr. Mathu Athalye had experienced the same, who was widow. She was invited for look her beauty that they heard about it. Moreover they were unknown the changes outside the Zenanas. So they were surprised with fear, happy and suspicious about a widow became is a surgeon. They want to check it. Once they realized they would like to increase friendship and conversation with her. Dr. Athalye was only Lady Medical Officer who had burden of work and she regretted to accompany them without any work.
Women Surgeons

Lady Physicians and Surgeons were devoted to relieve pain and problems of Indian patients in their reproductive phases through their private practices in urban as well as in rural areas. Very few ladies would go for study in Obstetrics and Gynaecology in India in nineteenth century. Dr. Dossibai J.R. Dadabhoy, Dr. Jhirad was some notable exceptions with very few others in this profession. Dr. S.S. Thakur explained, “This was primarily because the general impression among the masses was that lady surgeons could not perform surgeries as well as their male counterparts.”

Dr. Nargesh D. Motashaw added, “Those were tough times for women surgeons.” It is very difficult to trace their careers as surgeons. If they started their career as surgeons, then they would not get suitable jobs. This phase did not change in post Independence India also Dr. Nargesh D. Motashaw, Obstetric & Gynaecology Surgeon added, “I still remember a matron in Breach Candy Hospital telling me how much more competent than a male surgeon. I would have to be in order to come anywhere near him. A man could get away with a mistake, not so women”.

British patients always preferred male obstetricians than female practitioners. After achievements of well-known Obstetrician and general practitioner Dr. N.A.Parandare had called to visit rich families. The only difference was that these patients of rich classes had delivered at their residence under strict supervision and treatment of obstetricians and Indian women had no trust in European doctors.

In spite of this cry of gender biased profession, many women selected it and went abroad and did specialization in Obstetrics and Gynaecology. Some were attached to hospitals, others opened their maternity homes. In late 1930s, two special wards were constructed with the help of Governor’s Hospital Fund for the treatment of Veneral Diseases and Skin patients with 16 beds at KEM Hospital Parel, Bombay, It opened on 15th June 1936.
It was a general conception among people in society, veneral diseases were curable. Shakuntala Praranjape mentioned the cruel practices behind curing diseases. Dr. Shakuntala Khare- Mote had come across numbers of cases of girls’ age between 3 to 6 years, who were dead having been raped by men suffering Sexually Transmitted Diseases seeking a cure.

Rural Medical Relief:

Women doctors worked in the interior parts of the presidency, especially in remote and or rural areas. It was quite a difficult task considering the fact that the basic amenities of life were not available. List below indicates places in brackets. Doctors Sudha Bidaye (Junagad, Pune), Mathutai Athalye (Agra, Junagad, Sabarmati, Ghataprabha), Sunanda Paranjape (Indore, Lahore, Agra), Kamalabai Ashtapatre (Dhule), Goher Irani, (Satara, Ahmednagar), Irene Dean, Jyoti Chakrabarty, Ketkar, Shaikh, Kusum Saraf, Pathak, (all at Ahmednagar), Kusum Phatak (Kurla), Karandikar (Dahanu), Sumati Khare-Mote (U.P., Rajasthan), Nirmala R. Kasat (Nashik), Suman V. Kher (Takegoan), Leela Mokashi (Baramati), Sunati Kshetramade (Kolhapur), Sumati Kamitkar (Amaravati, Poona), Sumati Phadke, Madhumalati Gune, Leela Mastakar (Kopargaon), Chapala Khadilkar (Poona), Banoo Coyaji (Pune, Wadhu, Loni) Tarabai Jadhav (Ahmedabad, Rajkot), Diana Levi (Parel, Suburbans of Bombay), Shalini Tilak (Poona), Janakibai Apte (Poona), Tarabai Limaye (Poona), Kharadkar (Ahmednagar), Joshi (Khar, Santacruz), Nalini Sathe (Satara), Meheraz Karkaria, Karuna (both worked as a missionary in rural health surgeons).

There was great difference amongst the residents of urban and rural sectors. All above mentioned lady doctors narrated their experiences, hurdles that they faced during their tenure among the rural who had a firm belief on tantric, spirit and souls. It was deep rooted in to society.

They tackled not only health issues but also family matters. It was part of their unconventional profession. Second if lady doctors were to succeed in treating the pet animals only then would gain patient’s trust on their ability to treat human beings.
Other problems faced patients as well as lady doctors as due to non-availability of transport facility lack of roads, electricity, medicines, instruments, no sources could reach about new discoveries and new inventions.

They had no interaction, discussion about new discoveries, consultation and communication with other doctors.

Generally patients tried dais and or midwives. If complications were out of treatment then they rushed to doctors. Patients condition was literally miserable, terrible and desperate. Dr Sumati Kanitkar narrated one experience, “Bhivvadi, near Bombay was a thermal power station 1800 feet high. It was case of twins. One baby was delivered at home, but second could not come.... It was obstructed one ..... patient was carried from hill to Sion Hospital in a hurry on a wooden cot and / or in bedsheets.” Most women felt victim to these harsh conditions and harrowing travel to the hospital. Dr. Ashtapatre described, “patients would travel to my doors in carts or on horses, seriously ill, or on death, beds with one baby already delivered and the other still inside or an arm or a leg sticking out.”

In such a conditions that doctors and surgeons could not take appropriate decisions due to late entry of patients. They had to try and save either the mother or the child from all possible ways.

Another incident, “it's her twelfth delivery. Earlier all her deliveries were at home. And all of them lived. This time it was an obstructed one. She was a great fighter... when she entered the hospital ... a head, an arm and a leg had already come out. But still she was agitated and prolonged delivery... after permission by her husband for an operation... Her ten children and husband waited outside for twelve hours in bewilderment and anxiety...the decision was taken for an operation...before we operated her she delivered a two headed child...on the spot she died due to heavy haemorraghe and long struggle during the process.”
Thousands of women died during journey from home to hospital. Lady doctors were appointed as In-charge or doctors in hospitals. They had to administer it within lack of infrastructure. Dufferin Fund hospital had also not escaped from these situations in rural areas. Dufferin Fund Hospital Amaravati had only one oxygen cylinder and shortage of syringes and medicines, cotton and instruments. They had taken care to see that all operations delivery cases were done in the daylight because till 1970s, electricity was not available in rural Maharashtra. Mostly women surgeons had put a banner in front of clinic that the relatives of patient should bring torches and petromax lanterns, in case the emergency cases came at late night. Doctors Ashtaputre, Leela Mokashi, Zaihrunnisa Shaikh, Shalinibai Tilak, Nalini Sathe, Athalye, Mehemaz Karakaria did number of surgeries and obstructed operations in the light of lamp, lantern, torches and / or petromax lanterns. Even where electricity was available, it was always short circuit and bulbs and fuses shut off. Bulbs were not available in the markets, because they used high power bulbs.

Patients had beliefs and misconceptions about the heavy bleeding and certain signs and symptoms. In such conditions, they refused to take treatment; even educated families were not different in this regard.

Dr. Mathu Athalye narrated the incident during 1930s, when she received a call from Jamnalal Bajaj family for delivery of his daughter Oam. After childbirth, Oam suffered heavy bleeding. So the doctor wanted to control it by giving injections. But her mother Jankidevi Bajaj refused stating that heavy bleeding was good for health (which was a misconception) so that patient would be free from all toxicity. But heavy bleeding was the prime factor of high rate of maternal death. Athalye told her son Kaml Nayan Bajaj and took permission from him and then gave injections to Oam.

However almost all lady doctors emphasize the patients’ strong will power where by some how they survived through extremely critical conditions.

The home visits added new set of problems. One physician narrated his experience at late night, he visited. The woman was lying on a sheet in a dark
room only a little diya (lamp) was there, where you have to manage all. It was a farmer’s home where at one side there was pile of grain sacks. At a corner of the room, a woman who had obstructed twins one child was born and kept aside and the other was still inside the Doctor sat near a pile of grain sack. Behind it other women accompanied the patient. When the second child was born, family members and women rushed to the place. In the bustle, a touched the heap of sack, it tumbled down on the patient, doctor and the first child. The first child was crushed under it and the doctor injured. Somehow the doctor saved his life. Dr. Kamalbai Ashtaputre spoke of inhuman ways adopted by a family to carry a woman from home to hospital. ‘The patient had visited my maternity home in miserable condition, seriously ill or on death beds in carts or on horse with one baby delivered and the other baby still inside or with an arm or a leg sticking out.’ Similar experiences were noted by well known and renowned Obstetric & Gynaecology surgeon Dr. Banoo Coyaji, Dr. Kanitkar, Dr. Leela Mokshi and others who were engaged in rural section.

The Surgeons avoided Caesarean Sections because post operative phase was critical and no penicillin or antibiotics had been discovered at the time. That was the reason septic cases occurred when handled by ‘untrained’ dais or women. Advanced anaesthesia was not used in hospitals. The then ether was used. After 1970s Surgeons had easily available chloroform and the branch of anaesthetic developed in late 1945s. Stethoscope, keen observation and the skilled hands played an important role for treatment. Blood transfusion services were not proper (developed in late 1950s in urban sectors). People did not understand the blood group and its theory.

Relatives totally rejected the services. Medicines were not in the form of pills. They were in powder and tinctures. Physicians used to prepare and mix in proper quantity. All medicines were brought from cities. These were in short supply during wars, revolts and outbreak of epidemics. They also prepared saline, glucose solution. Medicines had reached villages from government wagons and were distributed under strict watch but insufficient quantity.
There were many places with inadequate water due to draught in India. Water is needed in large quantity by medical women for all purposes, before handling cases, cleaning new born child, washing hands before and after. Soap was not available. Disinfectants were out of reach. Dr. Shankutala Khare-Mote described when drinking water had a great shortage where could doctors get water for our purposes during home visit. Hygiene and sterile condition are the basic weapons to control infection with the help of water. Often she did home visits and either carried water or used mud, soil, or cloth for cleanliness. Thus they could not stick to western science.

The modern ambulance service was yet to come into existence. Late entry patients carried in a bedsheets tied to two sides with bamboo sticks or on a wooden cot or whatever family felt. By and large, children (till 5years) were carried in a basket. (See Appendix Photograph-D) Maternity homes had no facility of any transportation to carry out patients to nearby hospitals. Dr. Ida scudder was first to use a car in Vellore for visiting patients. Even when the vehicle was available hospitals used it sparingly due to shortage of oil, needing supply of level form city petrol pumps.

Durferin Hospitals at Amaravati arranged bullock carts for emergency. Dr. Leela Mokashi, Dr. Banoo Coyaji, Dr. Ashtaputre, Dr. Shalini Tilak, Dr. Madhumalti Gune, Dr. Chapalbai Khadilkar used their cars for transportation of patients after 1950s.

Women surgeons were not trusted though they had acquired MS, MD or FRCS. The medical women faced a shortage and utter lack of medically ‘trained’ subordinate staff. Dr. Rakhmabai said, ‘I am very unfortunate that I could not get any intellectual dedicated, assistant women doctors. She described her staff’s anecdotes of Christi, Parsi lady who was fond of hunting. She kept a horse for riding. In fact, she avoided checking patients and giving medicines to them at the proper time. She was irregular, careless faithless and indisciplined. Within twelve years, five doctors assisted Rakhmabai, all were incapable and worked to look stylish. Dr. Ida Scudder, Dr. Wanless and all medical persons who ran their hospitals faced the same problems. Due to shortage of secondary
staff; almost all medical women started to trained local women under their
guidance. Some were preparing persuaded for the certificate courses.95

Women Physicians and Freedom Struggle:

We hardly need to point out that the initial year of study come just after
the birth of an all-India organization to counter the tyranny of colonial rule and the
last year of our study witnessed the termination of colonial rule itself. The whole
period bristled with sustained and ever-expanding struggle for freedom. The
nature of this struggle in the first half of twentieth century metamorphosed from
class to mass movement in which people from all walks of life and sections of
society participated.

It redounds to the great credit of women physicians that first they fought
for admission to medical college to pursue their profession on getting the degree
and, next, they fought for freedom of our nation fitting themselves in the plans and
movements of Mahatma Gandhi. Of course, we have the data from only a few but
it speaks volumes for the depth of their love for the motherland and high sense of
sacrifice in the cause that ultimately triumphed.

Dr. Vimal Limaye was the first lady Surgeon of Poona. With her husband,
Mr. Vishnu Limaye, a Sanskrit scholar, she participated in the freedom
movement. The couple switched to wearing khadi clothes. She was imprisoned a
number of times. She was bold enough to put up tricolour the uniting flag of
Indian nationalism on the top of her hospital. On 15th of August, 1942 a British
Officer happened to pass by and noticed ‘tiranga’ on Limaye Maternity Home. He
immediately warned her of serious consequences and demanded its removal,
failing which he threatened to shoot. Incidentally, Dr. Limaye was alone at the
hospital but she was firm but polite in her reply, “I respect your national flag. In
the same manner you have to respect my national flat.” The officer was upset at
her adamant attitude and climbed the staircase to remove the flag but returned and
left without a word.96 Dr. Limaye won a quiet victory for her ideal. She also
later participated in the Sarvodaya Movement of Vinoba Bhave. The Limaye
couple were true disciples of Mahatma Gandhi and subscribed to the principle of
‘Simple living and high thinking’!
Dr. Kalatai Joshi, the first dentist of Ahmednagar was born to a revolutionary social worker Janakibai Apte and her school teacher husband Mr. Parshuram. The couple was steeped in nationalist ideology and was actively involved. Janakibai was member of Rashtra Seva Dal. All this made great impact on the girl Chandrakala nee Dr. kala who had deep, resonant voice. With knowledge of music, she sang patriotic songs at big conferences. On one occasion her song so touched Sane Guruji that he cried. She was imprisoned for her support of the nationalist struggle for three months in 1940, when she was in the ninth standard. When the Principal took disciplinary action and rusticated her from school for traitorous action of joining nationalist procession, other students went on strike in her support. The principal had to revoke her rustication and the day was declared as ‘holiday’. Later Chandrakala quipped, “A school normally observes holiday to condole the death of a person but I am alive here, and yet, the school has declared a holiday for me”. Following into the footsteps of her mother, she also joined Rashtra Seva Dal and offered hearty support to its programme.

Equally interesting is the life of Dr. Kamalabai Ashtaputre. She switched to Khadi from student days. She stayed in B.J. Medical School Hostel, Poona, which was poor in maintenance of hygienic conditions. The students initiated a protest demanding it and it was led by Kakasaheb Gadgil, Nanasaheb Gore, S. M. Joshi and R. K. Khadilkar. Likewise, in course of opposing the visit of Simon Commission to India, the students raised the slogan of “Go back Simon”, and left the college. The mother of Kamalabai advised her to withdraw from such activities so as not to lose the government scholarship. After appearing of LCPS examination, she went to see Sawarkar at Ratnagiri. After marriage, she consistently put on khadi sari but because of financial constraints used rough cheap fabric. She alongwith her husband joined Harijan Sevak Sangh and started a clinic. Dr. Ramkrishan Ashtaputre participated in Independent Satyagraha in 1939 and consequently was imprisoned. Dr. Kamalabai contrived a plan to pass on 20-25 bombs for Sabotage to underground leaders. She located many places in rural areas for their shelter. She was jailed when her daughter was barely eight years old. The couple was behind bars in course of Quit India Movement, 1942. She had to soften her attitude later as the daughter remained
totally uncared for in her absence owing to imprisonment. She lived her high ideals in other ways as well. She founded Kasturba Hospital as a mark of homage to Kasturba Gandhi in 1945, a Montessori style Bal Mandir on 15th August, 1948 and a primary school at Dhule in 1952.

Among others to suffer imprisonment during Quit India Movement, we may note the name of Dr. Miss Joglekar and Dr. Mrs. Kulkarni (nee Shanta Vaidya). There were some other doctors who could not offer active support to the freedom movement. However, they articulated it clandestinely by offering financial support. Among these names of Dr. Chapalabai Khadilkar and Dr. Kamalabai Karandikar could be mentioned.

No doubt the data collected and cited above is scanty in content and selective in nature but the very fact of its fresh and untapped character renders it valuable. The stray pieces of facts fit into the high historical them of freedom struggle and reveals that even while struggling to get over family obstacles and patriarchal prejudices to realize their potential for medical service to the society, women were idealistic as well as bold enough to come out at the call of Mahatma Gandhi and contribute in their own way to the struggle for freedom of India.

Medical Women Missionaries

The missionaries made slow, silent but singular contribution to women’s health care. By its very nature their task was tough, given the plural nature of Indian Society. They made no distinction of caste, class or creed. They had to attune themselves to varied weather condition of Indian subcontinent and learn the language of the region they worked in. They had to learn local languages, get over lack of basic amenities such as food, water, medicine, vaccinations and face the frequent outbreak of epidemics. They took long time for obtaining the trust of the people to their services.

Balfour focused the problems of medical women who had come from abroad to work in India. These medical missionaries faced multiple problems in comparison with other missionaries. They worked at unknown places where poor people surrounded them. Many factors scared medical missionaries such as...
languages (at least a way of common communication) that were most important to understand the sign, symptoms and history of diseases of patient. Other factors were strange dresses, hot weather, multiple insects, dusts, varied customs and beliefs, multicultural and multi religious society. Almost all annual reports of missionaries were filled with the strange things. They described their customs and advised number of tips like don’ts and dos.

Dr. Cora Stiger freshened to couple of Dr. William Wanless and his wife Mary for the medical services in India. Miss Stiger was frustrated that Indians’ manners, customs and habits could not bring out good results of her dedicated and hard work. She died from server heart attack in 1865. They were to clear local language examination within a year. Many medical missionaries had a heavy workload; they spent nearly ten hours in hospitals. Besides, they had to go to Church for evangelical work. Mrs. Mary Wanless a trained experienced nurse and wife of Dr. Wanless died from cholera at Miraj in 1904. Many women got married shortly after they arrived in India and they left within a year.

Unfortunately almost all missionary hospitals and dispensaries had to face the problem of trained nurses whose number was low and the reason was inability to adjust to unfamiliar environment as also marriage. Sister Superintendent Gertrude Anna had to leave India because she suffered serious ill health, in the European General hospital Bombay in 1885-1886. Her report stated that she was good and compatible, recording high appreciation of her work.

In spite of utter absence of transport facility, they carried medicines, instruments from cities to villages. However, they were hampered by various factors in their work. They were required to collect funds, finance their efforts. They were lacked training to operate in tropical, totally unfamiliar environment. They had to face socio-religious prejudices of the people for whom they worked. Tackling age-old cultural beliefs was tremendous obstacle.

In one particular case, Dr. Ida Scudder cleaned the wound of the patient and did the dressing, however the next day when she opened it. She found it filled with ash! Though rarely recorded, such examples indicate the nature of the
challenge confronting the missionaries. Though rarely recorded such examples indicate the nature of the challenges confronting the missionaries. But they fulfilled their other aim that of opening doors into the hearts and minds of the natives. 109

In view of intense struggle that women had to undergo for mere admission to medical education and the sustained sacrifices they had to make for practicing the knowledge, whatever little contribution they would make entitles them to the prominence given. We hardly need to point out that they could have made monumental contribution to Women’s Health Care if they had enjoyed total freedom from patriarchal prejudices, familial restrictions and traditional taboos of socio-religious nature.

Next chapter we discuss the contribution of physicians and surgeons to women’s health care and their achievements.

Endnotes and References

1. The term ‘medical women’ includes nurses also apart from practicing or non-practicing doctors.
2. RNP, Bombay Chronicle, 17th January 1886.
4. Tapan Raychoudhari & Geraldine Forbes (eds), The Memories of Dr. Haimbati Sen: from child widow to lady Doctor, Roli Books, New Delhi, 2002; Karlickar, ‘Kadambini and the Bhadralok’, EPW, April 26, 1993, pp. 173-78; Balfour &Young, The Work of Medical Women; See supra notes 54 in chapter I.
5. It always take care to use Autobiography and memoirs because Roy Pascal has rightly pointed out, “The line between autobiography and memoir or reminiscence is much harder to draw”, Roy Pascal, Design and Truth in Autobiography, EP, 1960, P.5
8. Ibid, p. 4.
10. Meherijoti Sangle interviewed 80 year old Nurse Sudha Apte, BPNA, who is a daughter of Dr. Janakibai Phatak, Pune, 2006.
11. Ibid.
14. Some cases found but it was mostly Maharashtra, Gujarat had exceptional cases, Neera Desai, Social change in Gujarat, Bombay, 1978; Meera Kosambi, Crossing threshold: Feminist Essays in Social History, Permanent Black, Ranikhet, 2007, p. 145.
15. See more discussion in Chapter V.
17. Ibid, p. 17.
18. Ibid, Appendix D, p. 239
20. 'choli-bangles' is customary term with cultural meaning. It's virtually a provision for daughter so as to render her independent for basic needs as a woman.
22. Ibid; Dr. Shakuntala Mote, and Dr. Ambu Patnakar was somehow similar of above cases. Due to poor family both were refused education. Dr. Mote helped financially with her brothers and sisters very well known personality of her father in Maharashtra was Mr. Khare Master, who believed girls education is necessary; Dr. Patankar completed her education after joined at K.E.M. hospital and coyaji's dispensary
23. Interviewed Dr. V. N. Purandare, Mumbai, 2007,
24. Ibid.
25. ARDF, 1889, p. 11.
27. Here one could also note the example of another noble widow, the mother of Dr. Shakuntala Ponkse who worked in a hospital and earned to maintain family. However, she was victim of tuberculous owing inadequate and poor quality food meant for a widow. It was also not possible of work at home and hospital front simultaneously in Desai & et. All. (eds) Mage Partoni Pahe, op. cit., p. 30.
29. Ibid, p. 22.
31. Ibid, p. 35.
32. Ibid.
33. Ibid, p. 36.
34. Karloskar, Diwali Volume, 1929, pp. 166-169.
35. Dr. Kumudini Dandekar, Ph. D., Medical Scientist and Statistic who worked on many Government Planning Projects and on Demographic Reviews. I took her interview because she is contemporary of women doctors who were in 1935s. I got relevant information and cross checking events. Her elder and younger sisters were doctors; so she was an eye witness of all these changes in their families. She is a sister of Vibhavan Shirurkar.
36. Interviewed Dr. Ranjana Nargolkar, the only daughter of Dr. Madhumalti Gune in 2006. She is also renowned Gynaecologist at Pune.
38. Interviewed Dr. Patankar, Pune, 2007.
39. Dr. A. G. Sathe and others added information. Dr. Nargolkar (D/O Dr. Gune) agreed.
41. The first woman doctor graduated (LMS) from the University of Bombay.
42. Varde, op. cit.; Chandra, op. cit., She expressed her opinion, feeling and sentiments through articles under title 'A Hindu lady' in Times of India and Samajaswathy during her case was filed in the court.
44. Interviewed Dr. Kumudini Dandekar who reviewed details of their personal experiences with illustrating examples.
45. Ibid
47. Interview with sister-in-law of Dr. Sumati Khare, Dr. Kumudini Dandekar.
50. Almost all feared to do home visits. The then there were riots, freedom struggle movements. All women were not believed on calls, who did private practice.
51. Interviewed with Mr. Godbole, son of Dr. Godbole.
52. Interviewed with Dr Diana Levi.
53. Interview with Dr Shaikh, Ahmednagar, 2005.
54. Raychoudhan & Forbes (eds), op. cit., p. 22
55. Interview with Dr. Mokashi.
56. Interviewed, request to disclose their identity.
57. Ibid.
61. Varde, op.cit., p. 146.
63. Even medical staff of Junagad followed *purdah* custom and worked Dr. Khare-Mote objected this because she could not recognize the staff. Interviewed Dr. Dandekar; Sumati Khare- Mote, op. cit., pp. 124-25.
64. Interviewed Dr. Sunanda Paranjape, Pune.
65. Ibid.
67. Shah & ct. All, *A Geneaology of Obstetritician and Gynaecologist*, FOGSI, Mumbai, n.y., pp. 95; Dr. Naomi Reubel, Jew, MBBS, FRCP, in *Gynaecology* (Edinburg), FRCS (London) suffered heavy bleeding. Dr. Jhirad operated on her but it was failed and she died in early age.
68. Ibid, pp. 127-128.
69. Interview with Dr. N.A.Parandare. He recalled the same cases received to Doctors N.A., B. N. Purandare that quack surgeons operated on them.
70. RNP, *Bombay Gazette*, August 1892.
73. Shakuntala Khare –Mote, op.cit, p-27.
74. 75, 76, 77 All appointed by Women Medical service and Dufferin Fund hospital as In-charge of Lady Doctor and Surgeons. Later Dr. Bidaye opened her Maternity Home at Pune. Sumati Kanitkar joined Sion Hospital, Mumbai.
75. Dr. Jadhav continued with WMS.
76. Meherjyoti Sangle checked the Patient’s Records and Registers. The Column of Name of Patients is cow, goat, buffalo, dog and cats. There are various natures of cases as injury, fractures, stomach pain and even obstructed cases of animals. Dr. Kalatai Joshi who was a dentist of Ahmednagar, treated on bull’s tooth. Dr. Mehemaz Karkaria treated lot of such cases. All others had same experiences.
78. Interviewed Dr. Ashtaputre, Dr. Banoo Coyaji, Dr. Karuna, Dr. Karkaria. Almost all lady doctors had treated all such critical cases.
80. Dr. Kanitkar said, "We have to use it only in emergency."
81. Athalye, op. cit., p. 64.
84. Dr. Kanitkar said, "We have to use it only in emergency."
85. Athalye, op. cit., p. 64.
88. In late 1940s, penicillin discovered, yet on experimental basis started to use it. British government had put restrictions on it during IIWW. Only registered practitioners could buy in a very less quantity from district health officer and submit detail report. The Provincial Health Department had maintained the register of stock and cross checked of the buyers often. This arrangement was not easily managed in rural areas. Penicillin bulbs were used for post-operative care. Antibiotics has first introduced in 1942.
90. Chloroform had developed step by step. Morphia was used in earlier stage in only critical stages. Later ether used.

91. **Favourite Prescriptions**

92. Dr. Mehemaz Karkaria managed the situation when hospital purchased an Ambulance. But the petrol pumps were not available everywhere as well as always shortage of oil. Petrol pumps were available only in cities. So that the hospital used bullock cart more than ambulance, only in an emergency cases. Roads were not built up and the condition was worst in rainy season.


94. Varde, op. cit., pp. 159-61.

95. Missionary Hospitals started training to Christians students, later it opened to all. Private Hospitals trained them after they appointed in hospitals.


97. Interviewed Dr. Joshi, son of Dr. Kala Joshi.


100. Ibid, p. 56.

101. Relatives filled up questionnaire. Dr. Abhyankar, daughter of Dr. Khadilkar; Mrs. Shubhangi Karandikar, Daughter-in-law of Dr. Kamalabai Karandikar.


104. Dr. Cora Stiger was famous, well known medical missionary, skilled doctor engaged her activities in Bombay.


107. GD, 1887, 13, p. XII.
