CHAPTER V

PROFESSIONALISM AND POLITICS OF GENDER IN THE MEDICAL FIELD IN THE 19TH CENTURY
The professional British women dominated the scene in the 19th century and the professional Indian women came into picture only in the last decade of the century. There were two types of British women doctors. Those who were born and trained in Britain and who came to India for the sole purpose of training and professional work, and those who were born in India (as their parents were in British services). They got training either in India or in England but practised in India. Histories of these women doctors reveal the dilemmas, pressures and dreams of women who dared to step out of the prevailing social norms and tried to do something that challenged the established norms of the male dominated society, both in India and in Britain.

This chapter attempts to explore some of the professional and personal experiences of these women available in historical records, and locate these in the social, economic and genders politics of the 19th century. It is divided in three parts: the first deals with the life histories of these women, the second deals with the conflicts between professional aspirations and gender roles, and the third part focuses on the personal dilemmas of the British women doctors.

LIFE HISTORIES OF WOMEN DOCTORS

The 19th century witnessed gradual acquisition of freedom and education by women. There were two sets of women: those who were not actively involved in the women's movement, but their general awareness and opportunities for elementary education had raised the expectations to look for avenues outside home, and those who were active members of the women's movement and sought education, especially medical education on the same terms and conditions as available to men. We in this section focus on those women who acquired medical education and came to India for employment and experience. We have seen in Chapter III that women who got into the medical field were those who could afford to pay their fees and had some support from the family. The famous among them were Sophia Jex-Blake, Edith Pechey, Mary Scharlieb, Miss Benson, Frances Elizabeth Hoggan (Morgan), Ivy Kees, and Miss Annie Walke. There were others who were associated with missionary work. The famous among them were Clara Swain, Miss Sophia Ida Scudder and Edith Brown. Miss Beilby came as a medical missionary without formal medical degree. She worked for few years
in India before she went back to England to complete her medical education. The Indian women who took medical education were Anandi Bai Joshi, Rukma Bai, A.W. Jaganardhan, Kashi Bai Nowrange, Cecilia D' Monte, and Dr. Jhirad. There were many more, but we have taken only those about whom some information is available in the historical records. The first woman doctor from America was Elizabeth Blackwell, whose name appeared first on the British Medical Register, followed by Elizabeth Garrett Anderson. Elizabeth Blackwell never came to India, but it would be interesting to know about her to understand the circumstances that made medical education inaccessible to women in America and Europe.

Elizabeth Blackwell was born in Bristol in 1821. She was the third daughter of Blackwell and she had three younger brothers. She was known as a very stubborn child. She was not interested in the work that was considered to be woman's work. Housekeeping, sewing and knitting was wastage of time for her and she always wished to do something different but did not know what to do.

Her father was sugar refiner in Britain. but he along with his family moved to USA due to labour riots. He took great interest in the anti slavery movement in USA. Failure in business forced the family to move to the city of Cincinnati from New York.¹ Due to financial difficulties in the family she and her sisters decided to start a day school for girls in their home. She helped her sisters in organising the classes but was not interested in actual teaching.

One incidence that made her decide to get into the medical school was the sickness of her mother's friend. Her mother's friend was suffering from malignant disease, and she told her that a women physician would have better understood her disease. She also suggested that why doesn't she become a physician. The proposal surprised her but it made her think of the possibilities of taking up medical education.

Elizabeth Blackwell's family was equally surprised when she declared that she would apply to medical colleges for admission. She met professors of medical colleges, but they discouraged her and told her that there had never been a woman student in any of the medical colleges in USA. She tried almost in all colleges of New York but was unsuccessful. In fact many of the professors did not know how to react to the demand
made by a woman for admission. The committees of the medical colleges unanimously declined to give her admission. Finally she got admission in Geneva College almost by mistake. Though the college had sent her acceptance letter, she was made to feel that she was not accepted, and that her presence in the college was an embarrassment for the faculty. In spite of all these difficulties she continued her studies. She was also advised by the professors to miss dissection classes as her presence would embarrass male students. The professors advised her that if she wanted to help the sick, she should chose to be become a nurse and not a physician. She was hard working and determined to continue her medical studies despite discouragement from the faculty, and as a result on many occasions she did better than her male counterparts. She managed to complete her medical education and got her diploma in 1849.

She was very ambitious and wanted to have degree in surgery as well, and no college in America would offer her this. She moved to Paris where her sister lived and had a job as a writer. No college in Paris was ready to take her as it was inconceivable to the French directors that a woman could be a physician and she could want the privilege of being a post graduate student of surgery. She decided to get into the La Maternite as a student apprentice (nursing student). This was a three months course for the poor peasant girls to be trained as nurse/midwives. She decided to get into this course, as there was no other way to get access to hospital. She along with other girls lived in a very protected environment and had very long working hours and equally strict rules of conduct. No woman was allowed to go out without permission. Her determination to become a surgeon was the driving force behind her ability to bear it all! Her work at the infirmary had impressed the doctor in charge and he suggested that she should enrol herself for two years course instead of three months to get diploma in medicine. She told him that she already had diploma from America and she was interested in getting degree in surgery. He said the only way he could help was to allow her to attend some of the rare operations, but diploma in surgery was difficult for a woman. She had an accident while handling a case of eye infection. Her one eye was impaired and it took her more than a year to recover. The impaired eyesight put an end to her desire to become a surgeon.

She also visited London where she met Florence Nightingale and came back to America in 1851. She tried to establish herself as a practising doctor but had difficulty in
getting patients. Like her male colleagues, the patients also did not trust a woman doctor. She had to depend on the private charity to establish and run a dispensary for women. She applied for a job in the hospital, but was refused and was advised to run a dispensary.

Meanwhile, one of her sisters, Emily, also chose to take up medical education. Emily was refused admission in Geneva College, so she attended Rush Medical College in Chicago, but she had to leave half way as the Illinois Society of Medicine had objected to admission of women in the college. Finally, her sister secured admission at the medical school of Western Reserve University at Cleveland. Emily was also interested in training as a surgeon. Sir James Simpson, the Scottish surgeon, taught at New York Hospital, and he agreed to take her sister as a medical student assistant provided she came to Edinburgh. She had two years training under him.

Elizabeth Blackwell continued her efforts for opening a medical college for women. In fact, she had an ambitious plan for having a college for women physicians, nurses, and hospital for women and children. With great difficulty and persistent efforts, she was able to open New York Hospital for Women and Children. The hospital and the school for women came up with the contribution from the ladies. She also got a fund of $750 from the State Legislation after the hospital got going. Otherwise, she collected funds with the help of ladies' groups with whom she had regular meetings. Most of her patients were migrants and poor peasants.

Her friends invited her to Britain in 1858 where she gave a series of lectures. Her name was enrolled on the British Medical Register. She wanted to stay back in London and work as she felt that there was immense scope for work in London. She wrote to her sister, "There is an immense charm in this fresh field, I like working and living in England, and there is no limit to what we might accomplish here!" In was here that Elizabeth Garrett listened to her and decided to take up medicine as a career.

Elizabeth Garrett got inspired with the work of Blackwell when she came on a lecture tour to England in 1858. She also decided to get into the medical field. She along with her parents came to London to look for avenues for medical education. She met many doctors to get training under them. Like Blackwell, she was also advised by male doctors that she should concentrate on being a nurse rather than a physician as it was
men's work (Chapter III, pp.148-49). We have also focused on her struggle to get into the medical field in Chapter III.

After obtaining medical education, like Blackwell, she was also living alone in London for the sake of clinical experience. Blackwell lived in an overprotected rather strict environment in Paris, whereas Garrett lived alone in Philpot Street in London. In 1864 she went to the London Hospital for the first time and she was able to learn a lot by observing patients being treated by male doctors. The other way she learned her lesson was by going with the doctors on rounds carrying their instrument box, which they used for examining patients during rounds.

She had a dispensary for women and children in London and gradually her reputation consolidated. In 1869, Elizabeth Blackwell also visited London "for a temporary though prolonged residence", partly in the hope of being able "to assist in the pioneer work so bravely commencing in London" 7 Within a year she opened St. Mary Dispensary for Women that was later known as the New Hospital for Women. She was not satisfied with her L.S..A., and that time Paris had opened its university to women. She obtained M.D. in 1870 and on her return from Paris she married J. G. Anderson in 1871.

Elizabeth Garrett Anderson was more fortunate than the others who had borne the brunt of the struggle to get into medical field. She was not over zealous even though in her own time she had been ambitious and had the support and goodwill of some of the medical men who were ready to teach her. In contrast, medical professors refused to teach women students linked to women's movement privately, due the pressure from the medical faculty. Moreover, private tuition did not make them eligible to take examination of the medical board, and this was the main cause of concern for women at Edinburgh. Garrett's entry into the medical profession set the pace for women doctors, but her entry had made thing difficult for other women as it was soon realised by the medical 'club' that women's entry into the profession would soon increase competition within the profession. 8

The women at Edinburgh were struggling to get into the medical field at that time. They were Sophia Jex-Blake, Edith Pechey, Isabel Throne, Miss Evans, and Miss
Chaplin. Elizabeth Garrett was not in favour of active campaign for medical education and she wanted to avoid any kind of confrontation with male medical professionals. She had suggested to women that "the quickest way to getting the law of registration altered is to systematically ignore it. If 100 women were practising medicine in England in a creditable manner, and were able to say that they were unregistered, through no fault or wish of their own, the injustice of the case would be felt universally". But women at Edinburgh had no other option but to continue their struggle to get into the medical field.

Sophia Jex-Blake was the leader amongst the women who were seeking admission in the medical school at Edinburgh. We have seen in Chapter III that she was most aggressive and many times did not agree with suggestions made by Elizabeth Garrett. Her struggle was weakened by her failure in medical examination. She was subjected to humiliation and insult by the medical professionals and by the media. Her close relatives also advised her that she should not waste her time in legal battle and should obtain medical degree from abroad. She got her medical degree from Bern along with Edith Pechey. Finally, she settled down in Edinburgh and opened a hospital and dispensary for women and children in 1878.

Edith Pechey's life history is of great interest to us as she was the first woman doctor to come to India and also that she was one of the five women who had led the struggle for medical education in Edinburgh. She was born on 7th October 1845 in the village of Langham, Essex in England. There were very few opportunities for women to get education, but Edith Pechey was fortunate. Her father was a scholar at the University of Edinburgh and had received MA degree. Besides he was author of religious work and was associated with the administration of the school maintained by the nonconformists in the parish.

She along with other women had tried very hard to get permission to sit for qualifying examination in Arts. This was a basic requirement for university enrolment. She had also done very well in her studies. In spite of that she along with others had to go through all the struggle and humiliation for choosing a profession that was never thought to be for women. She and the others paid more fees as compared to the male students and also bore the cost of legal battle that they lost in the court.
London School of Medicine for Women was opened in 1877 on the initiative of women, where Edith Pechey delivered the inaugural address. She had been in medical practice and was lecturing in Leeds. She also went to Vienna for additional practice in surgery. This was the time when Mr. Kittredge of Bombay offered her the post of first physician at Cama Hospital. He had started the 'Medical Women for India Fund' with the support of others in Bombay. The fund intended to build a hospital for women to be staffed by women doctors from England, and also to encourage women's education by providing scholarship to women students.

Edith Pechey’s work started from a small dispensary, pending the completion of the hospital. She was the first physician of the Cama hospital. She also had a large private practice. She charged very high fee from the patients to which the management had objected once. She also won herself and her staff the same salary as was paid to the men doctors, in the belief that lesser compensation to women physicians would undermine their professional status. She was a member of Asiatic Society of India and later on became its Vice president. 11

She married Herbert Phipson in March 1889, whom she met sometime after her arrival in India. He was a wine merchant and a naturalist and was also associated with Medical women for India Fund. He had been active in the establishment of the Natural History Society of Bombay and was the Honorary Secretary for almost twenty years. In 1891, she along with her husband founded Pechey-Phipson Sanatorium in Nasik, near Bombay. She retired from Cama Hospital in 1894 and took to private practice. 12 Due to her ill health she returned to England in 1905 where she took part in active campaign for female suffrage. She had also helped an Indian aspirant, Rukma Bai to get admission in the London School of Medicine for Women. 13

In her personal life she was known as pretty, soft-spoken and most attractive of the Edinburgh contingent. 14 She had a good sense of humour which others lacked. In her professional life she was very conscious of her status and was staunch supporter of women’s cause. Professionally she gains a lot in India. She not only earned a private practice, her experience and practice earned her active membership of the Registered Medical Women in U.K.
Mary Scharlieb came to India in 1866 with her husband who was a barrister in Madras. She became interested in medical care of Indian women after hearing about ill health amongst them from her husband’s clients. She decided to take up midwifery training in order to help them. She took up midwifery training in Madras Maternity Hospital with the help of the then Surgeon General, Dr. Balfour. Soon she realised that midwifery training was not enough to meet all the needs of Indian women. She then proposed a scheme for the provision of medical women for the care of Indian women. She had the support and sympathy of the Surgeon General, Dr. Balfour and of the Governor, Lord Hobart. They were personal friends of Scharliebs.

No medical college admitted women in India at that time. There were initial difficulties and delays but with the help of higher officials in the British administration she was able to obtain permission to join medical college as a student. Mrs. Scharlieb with three others entered the medical college in the winter session in 1875. In India, they shared lectures with the male students and attended women’s hospital for clinical work. The women’s hospital was under the charge of Surgeon Branfoot, who advised them against medical education. He was of the opinion that medical profession was not suitable for women and was determined not to teach them, but he could not prevent them from clinical work as they were sent by the government (see Chapter III, p. 167). Mary Scharlieb along with others qualified and passed the final examination in three years time.

She was aware of the difficulties the women were facing to get into the medical field in England. After getting medical degree from India she proceeded to England to join London School of Medicine for Women. From 1878 to 1882, she was at London School of Medicine for Women and obtained M.B.B.S., with honours and gained the gold medal and scholarship in obstetric medicine. For her post graduation she went to Vienna, after which she returned to India in 1883.

In Madras, she set up her private practice and soon she had a lucrative practice that was sometimes difficult to manage. She wanted to have a separate hospital for women, about which she had been talking a lot. Lady Grant Duff, wife of the Governor and Surgeon General supported her appeal for the hospital, and Caste and Goshe Hospital came into being with the financial contribution from the local rich gentry. Mary
Scharlieb was given charge of the hospital that began in a hired house for the time being. She was also appointed as lecturer in midwifery and diseases of women and children to the women students and examiner in obstetrics and gynaecology in the University of Madras.

Though Mary Scharlieb enjoyed her private practice and the recognition that she got in India but, at the same time, she felt guilty of neglecting her children. Yet her professional aspirations and ambitions made her come back to India after her post graduation in medicine. Apart from professional satisfaction, the hope for economic gains was equally important. The access to private rich patients was much easier in India than in England at that time. Attending to poor patients with low fee was one way to prove their competence and was a step towards getting paying patients. “I am living in the hope of work. I have fair number of patients from the beginning, but they are not paying patients...”, wrote Mary Scharlieb. 16

Mary Scharlieb was more fortunate than the women who had to struggle to get into the medical field and also pay fee for their education. Mary Scharlieb got medical education in the government medical college where the cost was born by the government. She had a good private practice and special assignments in the hospital and Medical College.

Frances Elizabeth Hoggan (Morgan) was born in 1843 and was one of the early women doctors. She wanted to be a doctor so she mastered German for a year and then, matriculated at Zurich in 1867. She graduated MD in 1870. She was attached as a medical apprentice to Dr. Elizabeth Garrett. She made a formal appeal to Apothecaries Hall to be admitted for Licentiate Examination. Her memoirs do not say whether she was allowed to sit, but she took the Irish Licentiate in 1877 and was on medical register in that year. 17 She had private practice near Oxford Street in London. She married Dr. Hoggan in April 1874. After marriage they both practised together, and this was noted to be the first instance where a man and woman practised together in England. 18 Her husband died on 17th May 1891 after which she did not resume regular medical practice.
She did not work in India but appreciated the opportunity India offered for trained medical women. She wrote in the *Contemporary Review* in 1882 that Indian women were in need of trained medical help and this had attracted the attention Mr. Kittredge who got actively engaged in the formation of Fund that had resulted in the establishment of Cama Hospital. She was the first woman doctor who pointed out in her writing that IMS had failed in providing relief to the Indian women.

**Miss Annette Benson** was born in London in 1864. She had her basic education at home and took the Cambridge local examination in 1877. She won a scholarship for Newnham College, Cambridge, where she spent five years - from 1880 to 1885 - then joined the London School of Medicine for Women. She qualified in 1890, but with great difficulty she managed to obtain hospital appointment as clinical assistant in a London Infirmary and House Surgeonship in the Victoria Children's Hospital. In 1892 she took the MD examination in London. 19

In 1894 she took up her duties as first physician at Cama Hospital in India. She was the founder and the first president of the Association of Medical Women in India. She was actively engaged in the campaign for the formation of Women Medical Service in India.

She retired from Cama Hospital in 1918 and soon after she was appointed as the Commanding Officer of the unit to help Serbian wounded. In recognition of this she was awarded the Kesar-I-Hind Gold Medal. 20

There were some other women who had either obtained medical education in India or had medical practise in India in late 19th and early 20th century.

**Ivy Keess** was a medical missionary. She obtained her medical degree from Grant Medical College in Bombay in 1909, and then went to London School of Medicine for Women. After completing her education in 1916, she returned to India and served in Quetta, and at Dufferin Hospital at Kanpur and Allahabad. She spent almost all her life in North India. 21
Sophia Ida Scuddar is known as the first missionary girl to have been trained in medicine and worked in India. She was born in Tamil Nadu in 1870, where her father, John Scuddar, an American Missionary was engaged in medical work. She went to the USA for her schooling at the age of eight years after which she returned to India to stay with her parents. Her interest in medicine grew after seeing that the women in difficult labour were reluctant to seek help of his father. She decided to return to America for medical education and joined Philadelphia Medical College for women. After completing her studies from Cornell University in New York, she returned to India in 1900 and started to work with her father. A hospital named the Mary Taber Schell Hospital was started in 1902. A mobile dispensary service was started in 1906 that catered to the needs of people in the surrounding areas. In 1918, she established a hospital and medical school for women at Vellore. This became one of the most famous hospitals in India for medical education and training for women. The missionaries' societies of America and Great Britain extended all help for nursing school which came up in 1909. In 1944, a postgraduate course in nursing education was introduced and in 1946 B.Sc. degree courses of Madras University was introduced. Miss Scuddar's contribution to the establishment of medical education was remarkable. The missionary societies and the alumni of the institution appreciated and recognised her work and dedication.

By the last decade of the 19th century some of the Indian women had also taken up medical education.

Anandi Bai Joshi was the first Indian woman to take up medical studies. She was born on March 30, 1865 in an orthodox Brahmin family of Kalyan near Bombay. She was one of the four children who survived out of the nine born to Ganpatrao. She suffered an attacked of small pox in her childhood and that left pox mark on her face. She stayed with her grand parents who pampered her. She was sent to the school in her early childhood, but she did not really enjoy it much. Her father was proud of her reading ability. Her mother did not love her much, she even physically punished her in an attempt to discipline her. Kosambi has quoted Anandibai Joshi's experiences where she said, "My mother never spoke to me affectionately...She never understood the duties of a mother, nor did I experience the love which a child naturally feels for its mother. This memory hurts me a great deal."
She looked older than her age and this was a cause of anxiety for her parents. Her desperate parents married her to a 27-year-old widower, Gopalrao who was a postmaster in one of the towns near Bombay. Anandibai’s experience of motherhood at the age of 12 and loss of her infant son left her in poor health and unable to bear more children.  

Till this time she had never thought of becoming a doctor nor was she ambitious to aspire for it. “Her husband’s avowed reformist aim of educating his wife seemed sure of fulfilment through his bright and receptive child- wife’s rapid progress”  25 He almost forced her to study without any consideration for the rules of sex segregation in the domestic activities during the working hours and observance of social norms in the orthodox Brahmin families. His ambition to educate his wife and social isolation at his work place led to frequent transfers from his place of work. “Gopalrao’s vicarious personal ambition, coupled with his acquaintance with the American missionaries, ignited the radical plan of taking Anandibai to America for higher studies. He appealed for help to the Rev. Wilder of Princeton, New Jersey in Sept 1878, projecting himself as a progressive brahmin struggling against caste persecution to educate his wife, and enlightened enough to value the message of Christ”  26 The reply from Wilder disappointed him as he suggested that they should stay in India and follow Christianity. This disappointment led to his seeking another transfer to Gujarat. Gopalrao’s personal ambition to educate his wife took him further to Calcutta where he sought paid employment for his wife in postal department. This had made them a laughing stock for Indians and Europeans.  

The correspondence between the missionary and Gopalrao, published in Missionary Review, attracted the attention of B. F. Carpenter of New Jersey who offered to support Anandibai in her higher studies. Meanwhile Gopalrao had lost an important dispatch from the Viceroy to the Governor of Bengal for which he was arrested and suspended from his job. This again led to social isolation for both of them. 28 Anandibai’s plan to join American medical college materialised with the help of Carpenter and she finally sailed to America. 

She reached America on April 7, 1883 with an American missionary who escorted her. She was 18 years at that time. She stayed with the Carpenter family and
enrolled her in Women's Medical College of Pennsylvania in Oct 1883. She received her medical degree on March 11, 1886 and Pandita Ramabai, who was distant cousin, was a guest of honour at this function.

Gopalrao joined Anandibai in 1884, where he created embarrassment for her by making anti American speeches. Anandibai had planned to stay in America for a year to gain experience, but her ill health forced her to abandon her plan and she returned to India on Oct 8, 1886. She was offered a job of doctor in newly created Albert Edward Hospital in Kolhapur, near Bombay, but her health deteriorated due to tuberculosis and she died on Feb. 27, 1887 before she could take up job as a first Indian medical women.

She was the first Indian woman to acquire medical education and become a doctor, but she could not serve as a doctor. Her life is a reflection of a women living under the shadow of her husband, rather than of a lady doctor who took up medical education to fulfil her own ambitions or to serve the needs of Indian women.

Rukma Bai was another woman who took up medical education in the last decade of the 19th century. She was born in 1864 in a well-connected and well-established family. Her father, Dr. Sakaram Arjun held a high position as surgeon to the Viceroy of India. She was married at the age of 12 years but she refused to stay with her husband, as he was idle and vicious. He brought a suit against Rukma Bai in the Bombay High court for the restoration of conjugal rights. The court ordered her to stay with her husband. She still refused to stay with him and appealed to Privy Council of England. She managed to obtain divorce at the age of 17 years as a result of out of court settlement with the help of common friends. At this stage she decided to study further, and with the help of Edith Pechey she obtained admission in the London School of Medicine for Women in 1889. Edith Pechey also requested her friend to take personal care of her while in England. She completed her studies from London School and went to Brussels for post graduation in medicine. She returned to India in 1893, and worked in Cama Hospital under her mentor, Edith Pechey. After working for few months with Edith Pechey she was given the charge of a dispensary in Surat, which later developed into a full-fledged hospital for women and children. Rukma Bai was also a founder member of the 'Association of Medical women of India' which was established in 1907. She was
also admitted to the Women Medical Service in 1916 and retired from her service in 1930. She died in 1936.  

Annie Jaganadhan was another Indian woman pioneer to study medicine in Madras in 1883. She was also the first Indian woman to study medicine in Scotland in 1888. She obtained the triple qualification of passing Medicine, Surgery and midwifery of Scottish College in 1892. She was offered the job of house surgeon in Cama Hospital after completion of studies. She died in 1894, and like Anandibai she also could not do much for Indian women.  

Cecilia D' Monte was born in 1875. She joined Grant Medical College in Bombay in 1892. She got Bai Hirabai Pastonji Gold medal in Midwifery in 1897. She worked in Cama Hospital as the second surgeon in 1901 and continued in that capacity for 27 years, until she was appointed Medical officer in charge.  

Kashi bai Nowrange was from a family that was interested in the promotion of social reforms in Hindu society. She qualified from the Grant Medical College in 1906 and took a short post graduation course in Bombay itself and set up a private practice. She encouraged women to take up midwifery both in the capacity of midwives as well as medical women. She was also the treasurer and secretary of the Arya Mahila Samaj, a Hindu organisation for the welfare of women. She remained associated with Arya Mahila Samaj for almost 40 years.  

Dr. J. Jhirad was also from Bombay and she graduated from the Grant Medical College in 1912, after which she proceeded to England for further studies. In 1916, she took up the post of the Resident Obstetric Assistant at the Elizabeth Garrett Anderson Hospital. In 1917, she was appointed house surgeon in the same hospital. She returned to India in 1919 after obtaining MD in Obstetric and Gynaecology of the University of London. She worked in the Lady Irwin Hospital in Delhi for four months after which she took charge of the Maternity Hospital at Banglore. From 1925 she remained associated with the Cama and Alibless Hospital, first as a house surgeon and then as a medical officer from 1929 to 1947. She was also associated with the special committee on maternal mortality that was set up in 1938.
The lives of these few women whose histories could be gathered from the various libraries, are indicative of the kind of support and spaces that were provided to Indian women who opted for the medical profession. They were not only confined to the hospitals but also practised obstetrics and gynaecology like their British counterparts. They came from the middle and upper class background. Though they were relatively more familiar with the conditions of the masses, the views held by them towards Indian women were not very different from their British colleagues.

**PROFESSIONAL AND GENDER POLITICS/CONFLICTS**

Historical material related to the British women doctors' professional lives, relationships and interactions, highlights certain aspects of their professional and gender politics within the medical profession which is critical for our understanding of the evolution of maternal health services. We have already seen that the British women doctors in India dominated the professional field in the 19th century. There were very few Indian women doctors and their contribution in the establishment of these services become evident only in the early 20th century. The study of the British women doctors' lives bring to light many crucial issues in the process of establishing themselves in India, the circumstances under which they worked, and the conflicts they faced while balancing professional and personal roles. The professional pressures were immense on these women doctors and they had to really work hard to prove their worth within the profession. Their roles were complimentary to the colonial rule, yet in the process of establishing themselves in India they continued to be the victims of gender politics.

**Professional Pressures and Gender Politics**

The British women doctors faced professional isolation and were not offered employment in the British hospitals where they could practise medicine. Medical education without practical experience was useless for them. Male medical professionals opposed their entry into the medical profession and their demand for employment opportunities. British women professionals were forced by the social circumstances to grab any opportunity that came their way, even if it meant moving away from their homeland. Opportunities in India to set up services for Indian women came up primarily with the establishment of Dufferin Fund, though missionaries also had many women
doctors working in mission hospitals and dispensaries. These opportunities in India were important and necessary for professional training and experience. This gave the newly trained women doctors of the 19th century a sense of achievement. Thus women doctors 'redundant' in their own country, found a sense of worth and achievement in India. 35

Though women doctors had better opportunities in India, they were not free from the pressures of male bureaucracy. The women doctors, who were appointed in female wards of the general hospitals, had to work under the supervision of civil surgeon. In some cases, the civil surgeons, junior in age and experience, were to supervise the work of senior women doctors. The women doctors opposed this on the grounds that the presence of male doctors in female wards defeated the very purpose of having special services for women.

In Britain, the practice of women medical professionals was confined to the small private dispensaries run by the charitable bodies. Historical evidence shows that only those women were successful in Britain, who had the support of the male members in the profession. It is not to say that men were responsible for their success, but to point out that the opportunities became available to these women easily compared to those who had no such support. For example, Dr. Frances Hoggan married a medical doctor, and both had a lucrative private practice. Edith Pechey's husband, Herbert Phipson was an officer of the Medical Women for India Fund for many years – a Fund that established Cama Hospital. He was also a merchant, a reformer and a naturalist. In her case, she came to know of Herbert Phipson after coming to India and married him much later. Mary Scharlieb's husband held a high government post, and he used his influence for getting her admission in the medical college at Madras. Elizabeth Garrett was appointed medical officer in the General Postal Department in Britain, with the help of her brother-in-law who was a senior officer in that department.

Except for a few, the women doctors generally faced criticism from their male colleagues. The men in the profession considered them incompetent, even to take care of women patients. They quoted examples even from India to prove their point. Lancet reported that, "In the hospital at Lucknow, ...it is usually found that native female patients decidedly prefer to be treated by gentlemen in the civil and military medical
service, and this notwithstanding that women's ward is under the care of a female practitioner... Without prejudices to the zeal, skill, and good work done by the lady practitioners, we have always maintained that their sex does not as a rule quite reach the levels of efficiency attained by their masculine fellow workers. Their position in the profession has not therefore the commendation of necessity, except this be founded, as hitherto, in India, on the preference of individuals (emphasis added). 36 Such arguments suggest that both the colonial government and the medical professionals used Indian situation for their own benefit without fully understanding the health seeking behaviour of women.

Mary Scharlieb also faced opposition from the superintendent of the Lying in Hospital in Madras when she was undergoing training. Surgeon Major Cocktail, Superintendent of the Lying-in Hospital at Madras was most disappointed when Mary Scharlieb came for practical training. "He told me that I did not know what I was asking for, that it involved much unpleasantness and dirt, and that it was such as he would not permit his wife to undertake...", wrote Mary Scharlieb. 37 He assigned her the most difficult cases. The women were to work long hours. Mary Scharlieb was also made to work long hours. She wrote, "The arrangement ...was that I should be on duty at the hospital from 6 a.m. to 6 p.m., which would suit Dr. cocktail's requirements and satisfy my husband's stipulation that I should return home for dinner and remain the night." 38

Not only medical men, but society at large was also opposed to women's entry into the medical field. One of the popular beliefs was that "knowledge of human body and its functions destroyed the fine gloss of innocence that added to women's charm...". 39

Medical men declared professional boycott of British women doctors. The medical journal remarked "...the confraternity (fraternity) of Physicians and surgeons will not, ... either consult or hold any professional intercourse with those who have assumed a position, and now desire to exercise functions, opposed to the instinct of their sex..." 40 The professional interaction was lacking, as we have seen in chapter III, and the medical journals refused to publish their work on the grounds that reputed journals could not publish the work of the fair sex. 41 Lancet was most vocal in opposing women's entry into the medical field. In 1894, it wrote, " we are surprised at the growth of a spirit of
emancipation, and a struggle - and sometimes struggle for equality of sexes, but what does surprise us is that women should select such unlikely and unsuitable outlet for the exercise of energies. Could there be a more unpromising and absurdly impractical scheme, for example, than this one of a medical corps for women? In 1896, Lancet wrote, 'Entering a profession already overcrowded with the members of opposite sex it is not strange that women should seek 'fresh woods and pastures now' in which to use their newly acquired knowledge.... In India the National Association for Supplying Female Medical Aid to the Women of that country...employs women doctors holding British qualification..." Such remarks indicate that male professionals did not want women into the profession, and did not want any competition from them.

In India also women medical professionals were subjected to criticism by their male colleagues as well as print media. Madras Times, once commented that, "...although the Anglo Indian lady evidently considers it to be the Englishwomen's mission to spend her time in visiting and gossiping with the native ladies.... it is possible enough that the husbands of ladies, both fair and dark complexioned, might naturally suppose that their wives' mission lay in another direction all together, and so oppose it". Though this was said, not in reference to women doctors, but it did point to the social pressures and expectations women had to confirm to in the society.

These pressures and expectations made life difficult for women medical professionals. Mary Scharlieb had mentioned in her private letters that she worked very hard and had long and tiring daily schedule. "I am always tired and sleepy and yet I am most unwilling to remain quietly at home...I still want the excitement of these long hours a day..." Missionary Doctor, Clara Swain had also mentioned in her letters to her friend the long tiring daily routine that she had to follow. Missionary women doctors had also mentioned about their initial experiences that had been very difficult, as they did not know the local language and felt isolated and alien in the foreign land. Some of the women doctors from Britain were posted in the smaller towns and they had not many people to communicate with. These personal experiences suggest that professional aspirations and personal ambitions made them come to India, even though life was tough and hard for them.
The women doctors had to do much more work than their male colleagues to be successful. They also believed that extra efforts were necessary to prove their worth and competence. "Any woman intending to practice in India, especially among the Hindu or Mohammedan women, must be not only as well as prepared for her work as are men doctors but she should at any rate aim at being as near perfection as is possible to mortals. No amount of time and trouble can be misspent in preparing oneself for work among very sensitive and delicate women who will be to some extent unwilling patients and keen critics, and on whose behalf in the hour of emergency and the time of doubt and anxiety it is impossible to invoke the kindly aid of a big brother-consultant".

The opportunities in India opened a vast field for practice and experience. Elizabeth Blackwell had expressed that for the middle class women, India offered good opportunities to prove professional skills and knowledge. They got a place to reassure themselves of their talents and at the same time prove it to others that they were as good as men in the medical profession. Dufferin Fund was established when quite a number of women had qualified from medical schools in Britain and were looking for job opportunities.

The British women doctors had the state patronised organisational structures in India to bank upon. The opportunities in India fulfilled their professional aspirations and got them gainful employment, but it did not always proved helpful for Indian women patients. Their professional aspirations sometimes made them insensitive and unapproachable to poor patients for whom services were started. For example, Edith Pechey refused to reduce her fee for poor patients. She was of the opinion that taking less fee than the male colleagues would lower her reputation. But, she was considerate enough to attend to poor patients free of cost, if recommendation came from the committee of the Women of Indian Fund that had appointed her in India. In an enthusiasm to be equal to men in the profession, they sometimes were insensitive to the real needs of the Indian women.

Though the chances of good medical experience, opportunities for gainful employment and private practice attracted British women doctors to India yet, women doctors were uncertain about their jobs. Not all women doctors were lucky and well connected to get jobs in big cities on a good salary. In some cases, after years of long
service their services were terminated without any prior indication. A letter written by one of the British women doctors, to the Secretary of medical women’s Federation points to this. This doctor wrote on 19-4-1912, "I came out to India in Jan 1893...(and) was sent to open Dufferin hospital at Shikarpur Sind... When my agreement with the central committee was terminated in 1897, I entered into an agreement with the Berar branch for three years...I received my agreement for another 3 years at the end of that time...You can well imagine what I felt when in Jan. this year I received a court notice from ...committee saying that at the end of six months my services would be terminated, for reasons - financial and others." 47 She wrote this letter to caution the MWF and to advise all medical women at home to wait until there was some more stable scheme, and some legal provisions were made to ensure employment of women in India. The professional aspirations and the uncertainty about the future kept these women under constant stress and strain. Living outside their own country, with frequent posting and working under junior male doctors was a cause for worry to women doctors.

There were various things that worried the practising women doctors. While they enjoyed their professional success in India, the uncertainty about the regular income was another point that worried them. The ambitious women who were in private practice were worried about the regular lucrative income, while women under Dufferin Fund were pre-occupied with the working conditions and regular clientele. Women doctors working under Dufferin Fund also kept a close watch at the vacancies arising in Cama Hospital as it offered better salary than the Dufferin Fund. The salaries at the Cama Hospital came from the government whereas the Dufferin Hospitals had a central fund out of which salaries were paid to the doctors. Mary Scharlieb’s private letter, though point to her professional success, she also makes a mention about uncertainty of income from private practice. She wrote in one of her letters that, "...We are settling down nicely. I think we shall have a house ...I am living in the hope of work. I have fair number of patients from the beginning, but they are not paying patients and unluckily large proportions are men.... They are ear and eye cases" 48 She also wrote, "I have so many patients and no fees. However I hope things will improve some day. I am constantly being deluded with false hopes of paying patients" 49

Despite their problem, women doctors gained a lot of experience and respect in India that was not possible and difficult of obtain in their homeland in the 19th century.
British women doctors had acknowledged in their writing the richness of medical experience India had offered to them. "Would you like to do research work in cholera, plague, malaria, tuberculosis, or venereal disease? There is no end to chances to do it in India. Would you like to teach and train young women to become physician to save millions of women and children from the disease and death in their native land / there is so much need for this", wrote one of the women doctors. The British women doctors in India focused on maternity services in the 19th century, leaving many important aspects of health care unattended.

**Women Doctors and Their Relationship with Other Health Professionals**

The women doctors influenced the development of maternal health service in India by training the midwives and nurses and also by motivating Indian women to take up medical profession. Their attitudes towards midwives, nurses and Indian women doctors were crucial in giving direction to the education and training of these categories of medical personnel, and in determining the role of midwives and nurses in these services. The professional contribution of British women doctors in the field of midwifery, nursing and obstetrics and gynaecology over the 19th century has been very crucial and significant.

Though nursing profession got encouragement from women doctors, their contribution was not as significant as it was for the two other professions. They actively campaigned for medical education for women, for the training of midwives and for doing away with traditional dais, as they considered them undesirable. All these had significant influence on the development of maternity care services in India.

The professional interests of women doctors in the 19th century led to three types of educational efforts. One, to provide practical training to its own women who had obtained education in Britain but were unable to get experience; second, to create opportunities for women in India to join medical schools and colleges; and, third, to train local women as midwives for maternity care. All three determined the course of development of services for women. In the following section we explore the interaction of British women doctors with other health care professionals and their attitudes towards each of them.
Women Doctors and Indian Dais

We have seen in the previous chapter that the Indian dais were subjected to lot of criticism by the medical professionals. Their skills and experience were undermined and the efforts were directed to train them in modern methods, based on the newly developed western medical education. In order toestablish themselves in India, women professionals ignored the role and place of traditional dais in the Indian society and in health care of women and children. In this section we focus on their attitudes toward traditional dais and the efforts they made to train and change them.

The process of professionalisation within the medical field was one of the reasons for initiating training for dais. Indian dais were branded hopeless, as they continued their old practice in spite of the training by medical doctors. We have seen in the previous chapter that the lower class of dais, was the main reason for these attitudes. The training of dais was not seriously intended to impart new knowledge as it was for acquisition of cases for teaching and medical practise. Midwives or dais as a professional group met with same kind of criticism in America as well. A survey in 1906 in New York branded them “hopelessly dirty, ignorant and incompetent”.

India provided a field for experimentation for women doctors with new technologies. But the confidence of the masses in dais restricted their access to patients. The best way to get access was to work through dais. The training programmes ensured regular supply of cases in the hospitals for teaching and experimentation. Dais were offered monetary incentives to bring women to hospitals for confinement. There was also suggestion that the official machinery should be used to press upon dais the necessity to do so.

Though some of the medical professionals had appreciated the skills of the Indian dais, their medical education and overriding professional interests lost sight of this important aspect. The education and training of women doctors forced them to thrust new scientific knowledge on the midwives without checking the usefulness of those methods to women and children. In any case there is little evidence to establish that medical professionals were highly trained in dealing with the emergency cases (see Table 2.4, Chapter IV).
The attitudes of medical professionals and British administration are also revealed in their writings and in official reports:

1. A Resident Surgeon of the Medical School at Hyderabad wrote, "Their (midwives/dais) ignorance is extreme, hence the proportion of deaths to recoveries from parturition in the city is something fearful to reflect upon...When (ever) there is a case requiring surgical interference, these midwives send for the wives of the barbers, who operates in the most ignorant and cruel manner with sickle and hook" 53

2. Dr. Marvyn Smith, who was in India for quite some time wrote, "To get at the masses of the people one must try to confirm to their manner and customs, hence it is that I would strongly advocate that we should in the first instance make use, as much as possible of the women who at present practise medicine among the natives..." 54 This indicates that women doctors were aware that Indian women trusted dais, and for this reason British women doctors felt it necessary to work with close co-operation of Indian dais.

3. Mary Frances Billington, a member of the Daily Graphic and the author of the book entitled 'Women in India' remarked about infant mortality in India. She wrote, "The Infant mortality is very high, it is not (on) account of the evil intent but due to the appalling ignorance of the dhais, the professional class of midwives or monthly nurses, whose methods of treatment are simply barbarous, and, indeed, viewed in the light of western scientific knowledge, seems as if they would be enough to kill every unfortunate victim upon whom they were practise" 55 Not only medical professionals but other British people who visited India also expressed the same views about the Indian dais. The social class of dais seems to be the main reason for such attitudes.

4. The British women doctors had admitted in their writings that the Indian dais were quite capable in conducting difficult deliveries with great success. But the government attributed the success of dais to racial inferiority of Indian women, to whom they attended. The government expressed that, "...Owing to their relative higher immunity -the rapidity with which cases of puerperal sepsis clear up in the lower classes in India - such as sweeper caste - who are naturally exposed to much infection, once given a favourable surrounding, opens an interesting but appalling prospect of what the
race must have gone through, before the protective defences on the part of body could have reached such a fine point...” 56

High maternal mortality in India was the main argument against Indian dais. None of the British women doctors tried to reason out the causes for this. Our data shows that even well equipped hospitals did not save the life of women (Table 2.4, Chapter IV). It is evident while the ignorance, lack of knowledge and ‘cultural backwardness’ of both the pregnant women and the midwives was criticised, their poverty and deprivation was never linked to the nutritional ailments which were recognised as common. Thus nutritional deficiencies and anaemia was seen only within the biomedical tradition of the 19th century medical training. Yet, unlike the 19th century Britain no efforts were initiated to set up nutritional services. 57

Traditional midwives were equally popular among the rural masses in England as in India. These midwives, who had no formal training like the Indian dais, attended about 75% of the deliveries in the rural areas in England. The medical professionals wanted training for midwives whom they considered ignorant and untrained. But they did not want any registration for them on the ground that, “In England the principles of liberty are carried so far that, men and women too, insist on their right to employ quacks if they choose...The only possible limitation...is to insist that the public shall be able to distinguish between those who have been educated and registered and those who are not, and to impose penalties on those who pretend to be registered when they are not...” 58 We see striking similarity between India and Britain, as far attending to deliveries in rural areas was concerned. Yet, while in Britain due consideration was given to the fact that the midwives were valued by the communities and therefore their education and training was insisted upon, in India, the numbers of those who defended them were very few while rejection of their work was most visible.

In England women doctors were against giving recognition to the profession of midwifery. A bill Called ‘Midwives Registration Bill’ was discussed in 1896. The British women doctors opposed the bill. The most vocal among the doctors were Dr. Elizabeth Anderson and Mary Scharlieb. Dr. Anderson said, “...midwives were necessary and that they ought to be obliged to show certain amount of knowledge of the processes of normal labour, and of the methods to be adopted for preventing septic infection, but it
was undesirable to give midwives a diploma...they should be put under the direct supervision of the medical practitioners of the locality in which they worked..." 59 The professional interests of women doctors did not want that midwives should share the medical field with them. They wanted midwives only as their helper and not as their competitors.

Women doctors were so desperate for professional recognition and for establishing themselves that they did not wish to share with other practitioners, the only field of medicine that they were assigned. Unfortunately, this was the field that had been the domain of the dais in India. Moreover, the women doctors from the middle class families perhaps felt threatened about their own status in society if they were to accept the caste status of dais. So, they tried to keep distance from lower caste dais and made efforts to replace them with women from the upper caste. The question of professional status was closely linked to training midwives. No women doctor wanted to be mistaken for a midwife. So they popularised their scientific knowledge and skills in surgery and their technical superiority --even if it resulted in the death of woman or child. Even in developed counties, it was observed that technology alone could not save the life of the patients. A survey conducted in New York in 1906 mentioned that the general practitioners were as negligent as midwives, and equally responsible for preventable deformities. 60

Before British women doctors took up the task of training dais in India, the efforts had already been made by the colonial government to train them. The medical doctors were not very happy with the decision of the government to initiate such training programmes for local dais. The medical professionals did not consider it important to train midwives, but the government felt it necessary to have access to the Indian women. In response to the apprehension of the medical community, the Lt. Governor of Calcutta remarked that, "no attempt at elaborate instruction in obstetrics is contemplated by the GOI, or is likely to succeed ...all that is wanted to be done in the existing state of thing is to sent out into Native society as large a body of dhis (dais) as can be procured, at slight cost to the state, better trained than these who now act in that capacity without any instruction beyond that of personal experience and Native tradition". 61 Within a year this experiment failed, the hospitals reported their inability to attract dais for the training. In order to attract dais for the training the government raised the monthly stipend from
Rs.6/- per month to Rs.9/-, but in vein. 62 The government of Bengal even suggested that some monetary incentives could be provided to women patients who came to hospital for confinement. The government had resolved that in order to extend the scheme for instructing local women, each lying-in patient could be given 2 annas per diem as subsistence allowance. 63

Training programmes by the women doctors were started around 1870s. It was in the year 1866 that a midwifery school came in existence in Amritsar. It was maintained through a Municipal Fund and Miss Hewlett was in charge of the school. In 1868, Calcutta government decided to introduce training of dais in the different districts. Lahore Medical School established a class for the instruction of practising dais in 1876. In the year 1883, this class was expanded into one similar to the class for civil Hospital Assistants. A Lady Doctor, Miss Beilby, was engaged for the establishment of a lying-in hospital. The Fund for this came from the local government. Private subscription helped in the construction of the building. The institution was known as 'Lady Aitchison Hospital'. We see that the English women who had midwifery training from Britain established these training schools for midwives. Miss Hewlett was a very experienced person and had been very successful in looking after the school. Dr. Bielby joined the Lahore Medical school after it was established. With the coming of doctors to India these training programmes became common and frequent. The Dufferin Fund organisation had provision for training of dais and supported training activities for them.

The training of midwives was initiated in England also. The training was an outcome of the newly developed scientific knowledge of the 19th century, so some steps were taken in this direction in Britain also. In India, the prejudices were quite strong against the midwives. One of the women doctors remarked that, "... their (midwives) ignorance makes them believe that they have nothing to learn. Then, their prejudices against European methods, the apathy of their patients, who desire nothing better than they are getting; the fact that most dais are old and can not take in new ideas even if they would". 64 Missionaries were the first ones to try giving monetary incentives to midwives. Dr. Berths M. Thomas wrote that, "...this may seem strange to pay them to get them to come, but so great is their prejudice that the method was the only one that offered success at first" 65
In India an elaborate scheme for the training of midwives was drawn in the 1870s, with the involvement of local authorities to ensure regular attendance of midwives in the training programme. One of the women doctors remarked that, "if...we exterminate the whole race of these women the problem would have been a comparatively easy solution, but we can not, ... (as) their hold on people of the land is too strong; over and over again attempts have been made to replace these dais by women of another class, trained more or less in modern methods but almost in every case they have sooner or later retired from the field, vanquished by the indigenous Dai, who prompted by acute jealousy, makes use of methods of warfare of the most insidious kind to dislodge her rival...". 66 This suggests that the British women doctors had tried their best to replace traditional dais but were unable to do so. The professional interests of the women doctors and their purely clinical approach could not appreciate the importance of the dais and their skills. They chose to blame dais and Indian women for not being appreciative of their efforts.

One of the reports of the medical School in Bengal for the year 1904-05 points out that the midwifery cases were very difficult to get for medical students. It said, "Practical teaching of midwifery is always a difficult matter to arrange in schools... the cases available for the teaching purposes being so small indeed..." 67

The women doctors were more successful then their male counter parts as far as training of dais was concerned. But the success was short lived, as it could not sustain the interest of dais in the training programs. Their lack of interest did not result in discontinuation of training programs. So desperate were women to get dais to the hospitals that they sought help from the official machinery. "If the Deputy Commissioner, Tehsildars and other influential officials give an order that dais are to be trained and supervised, in most cases the order will be obeyed, and if a sympathetic women is put in charge of the work it will succeed ", suggested one of the women doctors. 68

The training initiatives failed on two accounts, firstly the dais were not willing to come, secondly, even if they came to the hospital for training few women came to hospitals for confinements. As emergencies could be handled by seniors alone, no practical training became possible. Moreover the training was an attempt to thrust western scientific knowledge on an already existing arrangement which had worked well
for years for Indian dais and Indian women, and they could not understand the value of the new regime.

The women doctors of the 19th century wanted to control dais as well as needed their help in their medical practice. Indian dais had been decision-makers and taken the whole responsibility of the women whom they assisted in delivery. There was a basic difference between the women doctors' perception of dais and the dais' own perception of their work. This was the basic difference and the cause of failure of the training initiatives.

The women doctors failed to grasp the social value of dais in society, and failed to provide supportive and complementary role. They also missed the opportunity to evolve two way learning process. Women doctors' single-minded pursuit of personal and professional gains overshadowed the need for an in-depth analysis of the level of skill and knowledge of traditional practitioners. Thus the traditional dais were labelled as the 'black sheep' and training became a virtue irrespective of its effect.

**Women Doctors and the Nursing profession**

The absence of conflict between women doctors and nurses was primarily rooted in the fact both professions evolved in the west within the overarching frame of medical education. Also, the function of nurses was supportive and not overlapping. We briefly look into the historical background of the relationship between doctors and nurses and the evolution of training programmes for nurses.

Nursing was a relatively new profession as compared to midwifery, and it was an outcome of the development of institutionalised health care in Europe. "Economic and social changes in the eighteenth and nineteenth century created demand for institutional care, and caused hospitals to be established in many towns of Britain and Europe." 69

With the growth of Medical education and with emphasis on extensive clinical teaching, these institutions became significant and the sick gained importance as they became 'clinical material', for teaching. As the significance of these institutions increased, the money from the rich started flowing in to improve the living conditions of
in-patients so that the medical students and doctors could spend time for the purpose of clinical teaching. The patients in these institutions were left under the care of 'caretakers' who provided food and took care of them. The caretakers were mostly middle-aged women without any family support. As the importance of in-patients as 'clinical material' grew, the need to take care of them was also felt necessary. Nurses were employed in these institutions that not only took care of patients, but also carried on the instructions of the doctors. These nurses spent much more time in these institutions than the doctors and medical students. The role of nurses was also redefined, from merely looking after the sick; they became medical auxiliary, working under the doctors, taking orders from them and reporting the progress in the patients. 70

The hospital nurses were usually respectable married, or widowed working class women. 71 These nurses had learned nursing either from their own family members or from the instructions from doctors. They were superior domestic servants and were close in social class to the patients they nursed. 72

Another category of nurses was engaged by the rich to take care of the sick in their homes. These nurses very often belonged to reasonably good families and took care of the sick, like a governess. These resident nurses lived like a family member and received respect from the family members. They did not contribute much to the development nursing of profession. The development of nursing profession is closely associated with the development of institutional care in Europe. Nurses got their training while working with the doctors and their appointment was closely linked to the need of the doctors in patients' care. Nursing was seen as an extension of women's caring role outside family. Nurses were to provide supportive service to the medical practitioners and the sick hence, there were no conflicts initially.

The development of nursing as a profession was also associated with the post war period, when number of surplus single women increased in Britain. 73 The working class women found place in the mills and factories, whereas the middle class women found governess' work suitable for them. Caring role in nursing was a good outlet for the women from this class. 74
Florence Nightingale's participation in the Crimean War marked the beginning of major changes in nursing profession. Nightingale's achievement in the Crimean war led to the recognition that reform by way of training was necessary for the development of a cadre for caring roles. The aim was to provide better-trained nurses with greater discipline and more skill in observation of treatment of patients in the hospitals, but the doctors displayed ambivalence. Some of the nurses were well connected and threatened the hierarchy within the hospital, like Miss Nightingale's influential relationship with the Cabinet Ministers did! Though the number of such nurses was very small, they had great influence on the authorities as far decision making was concerned. These nurses at the top were not interested in money, but cared for status. One of the top nurses, Mrs. Bedford Fenwick, led the British Nurses Association from 1887, with an objective that entry to nursing training should be restricted to the daughters of the higher social classes, and suggested establishment of register that would help the rich to select nurses for home care. Nightingale did not approve of such a scheme as it had very narrow scope for expansion of the nursing profession. She proposed that suitability for entry into the register should be decided by examination. Counter argument was that the nurses needed more of personal qualities that could not be judged by examination. "As vested interests of various sorts declared themselves, the 'thirty years war' began and was fought against a background of rampant snobbery, militant feminism, and personal rivalries".

It was not until 1914 that the nursing registration bill got attention in parliament in Britain. After the 1914-18 World War, there was increase in the demand for nurses in military hospitals. To meet the demand women came up for training and vast numbers of VADs (Voluntary Aid Detachments) were recruited by Red Cross and were given training for a varied period. The number of nurses in the post war period increased and the question of registration came up again in the Parliament. The health Minister envisaged that existing practical nurses would be registered only if they had 'adequate training and experience of nursing the sick'; henceforth three years of training and success in the state examination would be the only way to become registered nurse.

In the 19th century India, the nursing training was restricted to hospitals, and the hospitals trained nurses according to the requirement of the hospitals. Initially, nurses were employed in the army hospitals or the hospitals that took care of the Europeans.
and their families. Usually, each government hospital had the provision for a matron who was in charge of the hospital and three to four nurses took care of the patients in the hospital. Government reports and proceedings point to the appointment of matron and nurses in the hospitals in the Presidencies.  

The matron in the hospital also took care of the female patients in the hospitals and supervised the work of midwives in the hospitals. In 1868, the government of Madras proposed that trained nurses should be attached to those institutes, which were meant for women. The government proposed to procure the services of superintendent and four nurses from England. These nurses were needed for those hospitals that had European female patients. The Sanitary Commissioner wrote in 1868, “It must be borne in mind that all twenty patients, whom it was prepared to assign to one nurse in a military hospital, would be Europeans; and although equal care and attention are most desirable for the native patients, it can not be questioned that European sick, as a rule,... demand more constant watchfulness and labour”  

Nursing care was a privilege that was extended to the European patients in the hospitals. Nursing care of the ‘native’ was not considered that important. The sanitary Commissioner of Madras also wrote that, “If... a large proportion of the sick prove to be native...(then) for this class, attendants taken from among their own country women, properly trained and supervised would prove efficient...and much more suitable...” In fact, the sanitary commissioner suggested that there was no need for nurses for those institutions that had Indian patients especially in the lock hospitals. It said, “European head nurse seems hardly required for Lock hospital ...it is presumed, the prostitutes under the treatment will ...be native” Moreover, most of the nurses came from England and their cost was high for appointment in India.

All lucrative and high-ranking Indian jobs were kept almost reserved for the English ladies. Miss Scott was Matron of the General Hospital in Madras, till 1892. On her marriage, she vacated the post. To get her replacement, Surgeon General wrote to the government of Madras, “For the post of Matron at General hospital a European educated in England and with previous experience is ...(needed). She must be able to keep up the discipline and must be a woman whom the large staff of nurses at the hospital will respect and obey. Experience shows that nurses do not respect nor will they willingly obey orders from a locally trained Matron”
In Madras, nurses were recruited from General Hospital Training School from where they held certificate of qualification. There were four categories of nurses. One, lady nurse probationers; two, special nurse probationers; three, government nurse probationers; and four, private nurse probationers. The training programme for each category was different. The first category nurses were given six months training in sick nursing, second category students were given one year of training, the third category was prepared for employment in hospitals with one year of training, and the fourth category of students were associated with 'Lady Wenlock Nursing Institute. They were required to undergo three years of training. The most important were the private nurses who were thoroughly trained to attend on private patients.

The nursing profession also got impetus from the interest shown by the wives of the British officials. The establishment of Dufferin Fund, Victoria Memorial Scholarship, Lady Curzon's Nursing School in 1904 and the Indian Nursing Association in 1907 by Lady Minto provided much needed support and expansion for training of nurses. By the early 20th century the work of these philanthropic organisations had increased manifold. The training of nurses in India was an early 20th century development. In the 19th century the nurse were appointed in few selected hospitals on a good salary. The organisational support to train nurses in India came with the establishment of Funds by the Vecereines in the early 20th century.

In India, Lady Curzon started Nursing School in 1904, which was superseded by the Lady Minto's Indian Nursing Association in 1907. Lady Minto proposed the scheme, called 'Indian Nursing Association' in 1906 to attend on the Europeans in India. The aim of the newly formed association was to create a reserve of nursing service for the attendance on the European families. "Nurses trained in England who hold maternity certificate will be employed, but English ladies trained in recognized Indian hospitals will also be eligible for admission to the service" The main reason for promoting Nursing scheme was that, "many distressing cases have come to notice, in outlying districts, where skilled nursing would, in all probability, have saved life" The scheme provided a dignified, state patronised governance to the European families, and also ensured gainful employment to English nurses in India.
The organisational structure of the proposed association was somewhat similar to Dufferin Fund. It also had a central committee, with the wife of the Viceroy as President and Viceroy’s Surgeon as Honorary Secretary. Provincial Committees had the Lt. Governor and the Chief Commissioner as nodal co-ordinators. Lady Minto’s Association was for general resources of the Nursing Fund rather than for direct payment of salaries to nurses. The services were neither to benefit Indian people, nor were Indian nurses a part of the newly created service reserve. It is interesting that the funds for the association came from the Imperial or Provincial revenue and the ‘native’ rich contributed to the fund.  

Lady Curzon had also formed the Victoria Memorial Scholarship Fund, in 1903, for improving the conditions of childbirth in India. The Fund was for the training of the hereditary dais as opposed to dais and midwives taken from other classes whose training was left to other agencies and municipalities. It is interesting to note that the training for nurses and course content was decided according to the needs of the Europeans.

The Indian nurses were appointed for those jobs that were considered lower grade, such as inspection of the plague patients on the railway stations, etc. Even within such appointments the European nurses were paid more than the Indian nurses. In 1897, the Director General, IMS wrote to the Surgeon General, inquiring whether nurses were available for plague duty in Karachi. The Director General replied that, “Three European and one native trained nurses have expressed their willingness to go to Karachi. The former requires Rs.10 a day and later Rs.5 exclusive of board, lodging and travelling expenses...If these nurses are really required they should be secured without delay, otherwise they may take up other engagements”  

The Commissioner of Karachi replied, “send to Hyderabad, Sind, the two European nurses for Rs.5/- a day plus board, lodging and travelling. Native nurses would spoil our price”  

The relationship between nurses and women doctors did not have problem. Nurses did not pose any threat to the doctors, rather they provided supportive services for them. Unlike midwives, they did not threaten the professional identity of women doctors. For the men in the medical profession, nurses were seen as doing all that a
women in the family is supposed to do, i.e., taking care of the sick and helping the men and carrying out their orders.

The attitudes of women doctors were positive towards the nurses. Nurses were somewhere in between dais and doctors, but much closer to doctors in relationship. The nurses had to undergo training in midwifery and sick nursing before they could be appointed in the hospital. The qualified nurses were appointed as matron of the hospitals. One of the nurses wrote, “I hold two diplomas; one for sick nursing dated 27th July 1905. One for Midwifery, dated 6th July 1906” 91 She further said, “On completion of my training, I worked for six years as Matron In Charge of the Akyab General Hospital (Burma)...” 92

The nurses were also entrusted the work of training of dais in India. The attitude of nurses towards the dais was somewhat similar to that of the women doctors. They considered them ignorant and blamed them for deaths amongst women and children. “Considering the crude ways in which mothers are treated by the dais, the mortality amongst them is not high during the lying- in period. Those unfortunate cases where death occurs, are usually puerperal cases that can be traced to the neglect of the dais who feel no responsibility, and are quite unconcerned as to what happens to their patients” 93

Nursing as a profession is a 20th century development. In Britain the Parliament approved registration for nurses in 1919, only for those who had ‘adequate knowledge and experience of nursing the sick’ and that henceforth three years training and success in the state examination was necessary to become a registered nurse. 94 Whereas in America, the doctors believed that, “nurses are born, not made, and need intuition and character, meaning obedience, rather than professional expertise” 95 Most of the patients had to pay for the services in America, and hospitals grew not out of facilities for the destitute, as in the case of Britain.96 There was basic difference in the evolution of nursing profession in America and Britain. It was only in 1947 that the standards of nursing were laid down by the legal regulation and New York was the first state to implement it. 97
In the development of nursing profession, gender stereotype played a crucial role. Nursing was considered an extension of female roles in the family where she cared for the family and carried out the orders of the male head. Doctor-nurse relationship was thought to be the replica of such a relationship. In the Indian context also, the leading medical journals commented that the nursing profession was suitable for women rather than pinning their hopes to become doctors, where they were bound to fail miserably. Thus there was no conflict with women doctors either given the nature of their work.

_Professional Relationship within the Groups of Women Doctors_

Women doctors formed a heterogeneous group, though not conflicting, their mutual relationships were certainly uneven. The individual professional aspirations had brought them to India in the second half of the 19th century. As a group they barely contemplated attracting Indian women to the medical profession. Their foremost desire was to establish themselves in the medical profession, though the official rational stressed the desire to motivate Indian women to take up medical profession.

The Indian women's movement in the 19th century, was an outcome of the freedom movement and the social reform movement. It was only in the later part of the 19th century that women took up the issues of women's welfare. The women's movement in the west influenced some of the middle women to take up higher education. It was in the last decades of the 19th century that women like Pandita Ramabai, Anandibai Joshi, Rukma Bai crossed the bounds of familial and cultural restrictions and went abroad to study.

The relationship between the British women and the Indian women was complementary to each other. Though, the women's movement in the west greatly influenced some women who were concerned about women's situation in India, these women confined themselves to education of women. Independent organisations were started to provide education and employment to women. Pandita Ramabai started Sharda Sadan in Pune in 1892. The women's organisations in the 19th century India were reformist in nature and looked for women's emancipation within the patriarchal structure. They did not question the unequal relations within the family. The main thrust was on training them in traditional vocations, such as embroidery, stitching etc.
The women from the west and the women's movement in the west reinforced the desire for women's emancipation among the enlightened Indian women. The focus of the Indian women was to fight against social evils and provide education to women. Equality and equal opportunities for women occupied central stage at much later period.

As a consequence, the middle class women in the Indian society, who had the opportunities, family support and good relations with the women doctors from Britain, took up medical education. The women doctors from Britain used their contacts in finding out suitable schools for them to study and comfortable places to stay. We have seen that Dr. Edith Pechey helped Rukma Bai, to get admission in London School of Medicine for Women. Rukma Bai was among the first women to study medicine in England. She got the personal favour from Dr. Edith Pechey, who requested her friends in England to help her. Anandibai Joshi, the first woman to go and study medicine in America was helped by a missionary from America.

There were not many Indian women doctors in the 19th century. By early 20th century, they joined medical practice but were confined to the lower ranking jobs or worked under the charge of British women doctors. Rukma Bai worked in Cama hospital under Dr. Edith Pechey after completion of her study in 1893. After working for few months at Cama Hospital, she took charge of a dispensary at Surat. Dr. A.W. Jagannadhan was the first woman to study medicine from Scotland in 1888. She was also offered at job of the second surgeon at Cama hospital.

Given the common training of British and Indian doctors the later did not have any special or different agenda to meet the needs of Indian women. They also perceived the need of these women within the same perspective as the British women doctors did. As far as employment of Indian doctors was concerned, the evidence shows that the government preferred British doctors to the Indian doctors. In 1900, the Surgeon General of Bombay expressed that for the post of second physician in Cama hospital, the European doctors were more suitable and desirable. He remarked, "I consider the requirements necessary for an efficient second Physician of this hospital are of a personal character - ability to exercise sufficient authority and control over patients and staff, coolness and nerves in emergencies when dealing with serious cases in the surgical, obstetrics, or medical wards... From my experience of Lady Physician
possessing the above qualification should be a European, trained at home and thoroughly acquainted with the working of a large European hospital" 101 Though, Dufferin Fund at its inception claimed that it aimed to provide relief to Indian women till such time when the Indian women doctors were ready to take charge of the services, nothing of this kind happened even in the early 20th century.

By and large, to begin with the relationship between British women doctors and Indian women doctors was cordial. There is no evidence to show that there existed any rivalry among them in the 19th century. First of all, there were very few Indian women doctors, secondly, the British women doctors helped them, and thirdly, Indian women doctors were not very ambitious. It was only later in the early 20th century that the British women doctors became more ambitious and did not wish to leave the opportunities for Indian women. The formation of Women Medical Service in 1914 had 25 doctors, and most of them were British doctors with only a few exceptions. Of the 24 who were selected initially, 18 were Europeans or Anglo-Indian and six were Indians. 102 In fact some of the Indian doctors had protested for not being included in the newly formed 'Women Medical Service'. The relationship between British women doctors and Indian doctors became sour with the formation of Women Medical Service. The Indian women doctors began to feel threatened by the British women doctors' professional aspirations. There were open protests by some of the Indian women doctors. Miss Joshi, one of the Indian Doctors, along with other 1Indian doctors, sent a letter to the Government on this issue. She also sent a letter to the "Morning Post", that was as follows:

"I am sure many of my country men and women must have learnt with great pleasure of the intentions of the Government to make arrangement for rendering medical aid to the women of India. To this end it is proposed to spend a sum of £ 10,000 annually out of Indian revenue. No taxpayer would grudge the amount if it were to be justly spent; but it is quite clear why it is proposed to spend this amount on Women's corps, to be imported from England, when there are so many Indian lady graduates ready at hand and with far better claims to these posts. The importation of medical women from England or elsewhere would have been justifiable some years ago, but now that we have a good supply of lady graduates of indigenous universities, equally, if not more, competent than the lady graduates of to be imported from foreign universities, it is hard for us to appreciate the justice or the wisdom of the course the government intends
to adopt... (emphasis added)". 103 In the official records this letter has been referred as 'Miss Joshi's' letter, whereas twelve other doctors had signed it. This could mean that government conveniently tried to undermine protest from Indian doctors.

Miss Joshi and her colleagues also gave example from the different hospitals in Britain to point out that British women doctors in India enjoyed privileged status. She wrote, "How many important posts are held there by ladies? So far as I know, most of the house surgeonships are given to men doctors from other medical schools. Again take Samaritan Hospital or the Soho Square hospital for women, the honorary posts there are held by men. Take the Rotunda Hospital in Dublin, which is considered as one of the principal hospitals of the world for maternity work. Even there, all the honorary post are held by men...in the face of these facts, how can these raw graduates, who are not trusted by the women of their own country, inspire confidence among women of a foreign country, and how can they be entrusted with the health and welfare of hundreds of women of India? (emphasis added)" 104 It is interesting to note that Miss Joshi had obtained British qualification, yet she was not included in Women Medical Service.

The relationship between the women doctors working under the missionary organisation and the other women doctors was that of mutual appreciation and antagonism. The professional achievements of missionary women doctors were very proudly quoted in the medical journals to prove the competence of women doctors, as a group. There was no direct interaction among the two groups. For women doctors the professional interests were foremost, whereas for missionaries, medical work was a mean to some other end. Dufferin Fund, from its inception wanted to distance itself from medical missionaries. Replying to a request from a missionary for opening up a dispensary with the help of Dufferin Fund, Harriot Dufferin said, "...We can not aid missionary work, but while we are compelled to stand aloof from medical missions, yet we have a philanthropic work in common, and we certainly have no wish to considered antagonistic to them" 105

Mary Scharlieb had mentioned that she does not want to be mistaken for medical missionary for professional reasons 106 Missionary women doctors, with partial training, were frequently blamed for sabotaging the women's struggle for professional recognition. 107
Women doctors did not make a cohesive group. Despite tensions between the British women doctors and these other professional women, the former did not necessarily function as a unified group. Class perception and individual interest often divided them. Women doctors who were engaged in private practice, like Edith Pechey and Mary Scharlieb, were guided by their own ambitions. They did talk about the common interests of the women doctors. Mary Scharlieb had mentioned in one of her writings that medical profession was not meant for every woman, only women with certain qualities should be encouraged to take up the profession. In addition to the conflicts with the missionaries and Indians doctors, the personal and professional interests failed to make them a unified group and therefore could be easily manipulated by the potentially powerful.

PERSONAL DILEMNAS OF BRITISH WOMEN DOCTORS

The women doctors' professional aspirations often over rode their personal lives often but the dilemma of balancing their personal and professional lives is evident in their private correspondence. They sometimes lived away from their family, which made them feel guilty. In some corner of their heart, they believed that they owed their success to their families and sacrifices made by the family members. The private letters of Mary Scharlieb point to this. She lived with her husband in India, leaving her children under the care of a family friend. Mary Scharlieb’s letters to her family friends raise many issues, along with the question of priorities of medical women. Her case does not speak for all other women doctors, yet it is important to focus on her as she was one of the first women doctors and was very active in women’s movement in Britain and had held important post in India as well as in England. She was also very active in Registered Medical Women’s Association (RMW). She had written many books for medical women. Her family circumstances reflect the dilemmas that were perhaps faced by many women as a mother and a professional doctor while practising in India.

Elizabeth Blackwell felt lonely in her personal and professional life. She wrote once to her friend “I had no medical companionship, the profession stood aloof and society was distrustful of the innovation. Insolent letters came by post, and my pecuniary position was a source of constant anxiety.” She did not marry, and at the age of 33 she confided in her sister
that it was difficult for her to stay alone but she did not wish to marry. She wanted to feel the enjoyment of family life. She adopted a girl from an orphanage who later on helped her in her work. \(^{112}\) She was a pioneer in the field of medicine yet her life was harsh, lonely and hard. It was her determination and strong personality that made her withstand all opposition and humiliation by the medical men and society. In spite of family support, at personal level she took the decision to take up medical profession.

Missionaries also mentioned that they had lived a lonely life in India. One of the women missionaries wrote that she did not have a single intimate friend during her stay in India. \(^{113}\) The professional and personal ambitions sometimes created confusion and restlessness in them.

Mary Scharlieb's private letters throw light on the dilemmas over personal obligations and professional aspirations. She felt guilty of neglecting their children and family. Mary Scharlieb's letters to her friend also bring to light the feeling of guilt and confusion. Most of her letters inquired about her children, but at the same time she avoided sounding desperate. She had always made it a point to mention her success and her income to rationalise her stay away from her children. Her letters show that within few years of private practice she earned substantial amount of money and that gave her lot of satisfaction. It made her rationalise her absence and living away from her children. The money she got was much more than she could get in Britain at that time, yet she was very concerned about her son who she thought might assume that he did not need to work hard!

She sometimes tried to be extra generous and extravagant to compensate her guilt feeling. She spent more money on gifts and later on contemplated that these might send wrong signals to her children. "I am enclosing a letter to the O. B. C. (Oriental Bank Company) asking them to pay you £5.0.0 on my account. I want you to be as good as to get Karl a clock or an album cost not to exceed £1.0.0" \(^{114}\) She also worried about problems that her adolescent son might pose. "I am very much worried ...(and)... disappointed about Karl...I hope he has no mistaken ideas about our position?" \(^{115}\) She also wrote in one of her letters, "Nothing would induce us to have Karl out in India without a covenant or commission. He would be simply a 'European loafer'. This is no country for a European unless he is in the covenant civil service, the army, or
in large mercantile house... Karl cannot come out here on the speculation of ‘finding something to do’ – he would be ruined...” ¹¹⁶ These letters indicate that she was worried about problems her son was facing staying away from the parents. They reflect her efforts to acquire a balance between her personal and professional life.

Mary Scharlieb made good money from her private practice, but she could not openly share the joy of earning good money. She was hesitant to share the joy of her economic contribution to the family with pride. She wrote to Mrs. and Mr. Albert Sharpey Schafer, “...My husband has invested in a new house and had to borrow Rs.2000/ from me to enable him to pay for it.(Don’t allude this when writing) However I hope to receive my Hospital pay tomorrow and have already ordered the draft to be ready for next mail”.¹¹⁷ This suggests that the women doctors still felt that as ‘ladies’ they were to be looked after by the husband and only ‘women’ should contribute to the family income. The dilemma over professional success or social status is evident in historical records. Frances Hoggan and her husband were successful doctors in London. After the death of her husband she discontinued her private practice, even though there was no obvious reason for taking such a step, as she remained associated with the women’s movement and supported the call that Indian women were in great need of British women doctors. Perhaps, the status and prestige of the family was important for the middle class women doctors and earning for the family was not socially accepted even by women.

Thus, the professional aspiration of women doctors amidst gender conflicts that brought them to India in 19th century laid the foundation of maternity services for women. Even in India they were not free from the exclusion and oppression of male professionals and bureaucracy. Their professional aspirations and individual interests undermined the role and importance of traditional birth attendants. Their education, professional training, and their sense of racial and cultural superiority marginalised traditional dais. Yet, there is a need to recognise that women doctors and missionaries contributed to the training of professionals in India, they shaped the services and some of them recognised the value of traditional dais. Even though, Indian women took up medical training and were qualified to take up responsible jobs, the British women doctors dominated the medical field in the 19th and early century. While as professionals they achieved recognition, at personal level they felt stressed and guilty of neglecting their personal obligations.
The British rule created conditions for their employment in India by way of creating an organisational support for them, such as the Dufferin Fund. In the establishment of services for women in India, the professional interests and the administrative interests were combined. The women doctors became a part of the justification for the need of the to British rule in India. The British philanthropic image was reinforced by these initiatives and it got political mileage out of them. This however was not free of problems. We focus on the Colonial politics in the establishment of maternity services in India, in the following chapter.

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