Introduction

The plague in urban areas in the 1890s and 1900s fostered a market for medical advice in urban centres. With the Provincial Government’s policy for urban areas being distinctively different from that for rural areas, the plague also provided the occasion for a spurt in private initiative and enterprise amongst all manner of practitioners and healers to extend their practice. The government, after an initial attempt to regulate medical intervention, had withdrawn from urban medical relief, leaving it increasingly to the initiative of local, urban agencies such as municipalities and private enterprise.

In the following years however, it became increasingly urgent for the colonial government to engage itself in legislative initiatives and rhetoric in an attempt to consolidate the sphere and sanction of Western medical practice and education to which it had committed itself even in the latter half of the nineteenth century.

This chapter shall examine the realm of state policy and medical administration and the response and reception that these elicited; it will look at legislative and intellectual projects the state undertook to define and monopolize its sphere of professional, scientific medical education and practice.
The definition of the claims of government sponsored medical education and practice were voiced centrally through legislations such as the Medical Registration Act and the Bogus Degrees Bill, as well as through debates and enquiries that followed. The government’s medical administrators outlined the claims and assumptions that supported the logic of the government’s sanction and support for western medical education and practice.

In the process of the consolidation of these claims however, Western medical administrators were constantly challenged by pressure during debates about the Bill, from representations that were pressed forward by indigenous practitioners. The assumptions inherent in the claims to monopolize professional standards based upon scientific claims made by western medicine, also affected indigenous practitioners who responded to these claims and interpreted these implications for themselves.

From the logic of the assumptions and the rhetoric inherent in the government’s initiatives however, there emerged through government Enquiries, and Resolutions pressed upon the government, the outline of government attitudes towards indigenous medical education and practice. The colonial authorities, having clarified the norms governing their evaluations of professional legitimacy in medical practice, and having consolidated their priorities in protecting western medical education, now turned to articulate the place of and patronage that was envisaged for indigenous medicine and its practice. The contents of their perception, though debated and resisted in the councils and public forums, were to have an important influence in shaping subsequent mobilization and ideological rhetoric amongst indigenous practitioners, as well as the trajectory of their politics.
The second section of this chapter locates the growing debates and self-assessment amongst medical missionaries as they evaluated the place of their medical work in the changed circumstances of urban practice. State intervention and regulation of the trajectory of private medical work and its education initiatives, also affected missionary medical work in urban areas. The standards of Western medicine, and the organization of its education and practice by the State, also concerned the missionaries who attempted to locate their work and its place amidst these changes.

Medical education and more broadly all Western education, defined in secular and professional terms by the colonial state was questioned in medical missionary writing. Their own perception of medical work was distinct in its religious/Christian based nature. While some missionaries argued that medical practice needed to subscribe to the priorities of Christian evangelical objectives, others argued for Western medicine to gain professional standards as well as to be service-oriented and self-sustaining in its medical consultations and practice. This chapter examines missionary medicine and its debates in its last phase of growth in urban areas, as it sought to combine the needs of evangelicalism and Christian medical service in the rationale of its existence, and defined a sphere for its activities in rural centres.
SECTION I

By the turn of century, urban centres in British colonial India were beginning to witness a diverse and segmented range of commercialised private enterprise in medical education and practice. In the older provinces such as Bombay and Bengal, private medical colleges had gained a considerable clientele of students who subsequently set up Western medical practice in large towns and cities. Even in more educationally backward provinces in North India such as Punjab, private medical colleges in Delhi and Lahore offered separate and combined curricula of western medicine, Ayurved-Tibb and even Homeopathy.¹

Medical practice too had found a growing market for medical advice in an urban clientele. Epidemics such as the plague had over many years offered wider scope for medical relief in an urban milieu, where government had withdrawn from active medical regulation. The years after the plague had seen a more prominent public profile being assumed by enterprising medical practitioners who publicised their medical skills and offered drugs and consultations through pharmacies.²

Reports in newspapers as well as by indigenous practitioners and government observers also noted the growing numbers of new medical men who were incompletely trained or qualified and dabbling in various methods of healing and drug use. One source noted for instance, that Western medicine was being practiced by medicine men ranging from failed Sub-Assistant Surgeons, discharged Compounders, retired Government Duftaries, and attars or druggists.³

¹ Introduction by Captain Henley (I.M.S.) to Enquiry on Indigenous Medical systems in Punjab. GOL, Home Medical, 65-67A, April 1917, pp. 10-12. (Henceforth GOL, HM.)
² See Chapter 3.
³ GOL, HM, 65-67A, April, 1917, 65, p. 3.
The attar or druggist, a traditional ‘quack’ who had threatened the practice of the hereditary Vaid or Hakim had now metamorphosed and multiplied into a diverse number of medicine men who now also dealt in Western drugs and prescriptions. Their popularity and growing clientele was also ensured by the accessibility of their fees and their spread to their presence in smaller towns in Punjab. Western medical practice as offered by the extensive five rupee consultations of Sub-Assistant Surgeons was patronised only by a small elite in large cities.

It was in these years that the colonial government undertook certain legislative initiatives such as the passing of the Medical Registration Act and the Medical Degrees Act in an effort to regulate Western medical practice and education. The Medical Registration Act was first initiated at the level of the Provincial Government in Bombay and in its broad form and content derived from the General Medical Act of 1886 in Britain. It identified and sanctioned certain ‘scheduled’ qualifications that defined the ‘qualified’ medical practitioner, and these qualifications were in turn secured by admission to a Medical Register and through a regulatory body such as the Medical Council. The Bogus Degree Bill was complementary in purpose, and aimed to check, through penalties, the authority to issue degrees and diplomas. Medical degrees could henceforth originate only from state-constituted authorities.

In the preamble to the Medical Registration Bill passed by the Bombay Government, the object of the legislation was stated to be the protection of the public and the medical profession from irregularly qualified

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4 Ibid.
6 GOI, M, 2-6A, August 1911, 2, p. 12.
practitioners. The logic of these initiatives lay however more centrally in the objective of protecting the government medical education establishment.

The colonial government had begun to outline its project to foster Western medical education in the English medium in Punjab the late nineteenth century. The 1880s and 1890s had been marked in the Punjab University by efforts to rid the institution of vernacular based indigenous learning, in particular the Vaid and Hakim classes in the Government Medical College. In subsequent years, the Colonial Government had continued to pursue these interests by trying to secure higher and more uniform standards in its medical colleges.

The colonial government’s priorities were also reflected in efforts on its part to secure status and employment for the medical graduates that were passing out in larger numbers from its medical colleges. In 1908, Morley’s statement committing the Government to an interest in fostering the growth of an independent private medical profession addressed principally these priorities, as it sought to initiate the introduction of a more indigenous element in the I.M.S., as well as to open up faculty positions and the like for them in Government colleges.

In Punjab, a move to ban recruitment for posts of Civil Assistant Surgeons was resisted upon the same grounds. It faced unanimous opposition from provincial medical administrators who argued that it could have an adverse impact upon the preference for a medical career in Government colleges since in the absence of any substantial presence of independent private practice, these government posts remained an important attraction. To remedy the absence of a class of independent private practitioners, the

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8 GOI, M, 2-6A, Aug. 1911, 2, p. 10.
9 PG, M&S, 73-75A, 73.
Provincial Government was also prompted to lay down a ban on affluent, elite patrons seeking medical relief from the charitable Government dispensaries, hoping to deflect them instead to private medical advice from doctors.\textsuperscript{11}

In the process of putting forward the Medical Registration Act Bill in the Punjab Council, members pointed out the lack of urgency in enacting a legislation that aimed at distinguishing legitimate and qualified practitioners.\textsuperscript{12} They stressed that while private practitioners were a small minority in the province, the majority, consisting of government servants scarcely needed legislation to give them legitimate status. However, the priorities of introducing standard, regulatory norms of medical practice as undertaken by the Government of India required legislation to make it broad based, and to be passed in all provinces.

The Medical Registration Act secured significant privileges for ‘qualified’ practitioners such as giving them state recognition, the power to claim fees in court, and the power to sign death certificates and other such declarations.\textsuperscript{13} These benefits, and in particular the sanction of being ‘legitimate’ practitioners was particularly crucial in these years, in view of the possibilities it offered in the newly opened and competitive spheres of local employment.

Local avenues of employment through the networks of local government such as the municipalities were growing to be important sources of income. Amongst medical practitioners, these were important new means of employment. Indigenous practitioners, as voiced in their resistance to this legislation, noted this alignment of state patronage and its implications. In

\begin{footnotes}
\item[12] GOI, Home Legislative, No. 119-121, May 1916, p. 2.
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Punjab, indigenous practitioners had begun to mobilise in the 1890s and subsequently pressed forward demands in 1907,\textsuperscript{14} for revised rates of pay in municipal employment; they also forwarded a representation to the Government of India for it to instruct the Provincial Government to show greater interest in employing indigenous practitioners.\textsuperscript{15}

The Medical Degrees Act was concerned more directly with the interests of government medical education. It aimed at checking the unregulated proliferation of private medical colleges and the practitioners that they produced.\textsuperscript{16} The Act had penal clauses that were pursued by the Provincial Government to monitor the illegitimate use of degree titles by private colleges and ‘unqualified’ practitioners.

When these regulations proved insufficient to their task, the Medical Degrees Act was further amended in 1926.\textsuperscript{17} This time, even the tendency to adopt titles sounding similar to ‘M.D.’ for instance, was banned and the use of this title and its definition of ‘medical practitioners’ was restricted only to qualified practitioners.

These legislative initiatives marked the state’s effort and role in assuming powers to regulate and intervene in setting standards of medical practice. In the Medical Registration Act for instance, colonial administrators papered over differences amongst practitioners to establish a consensus regarding the scope of the scheduled qualifications.

The Bombay Medical Union and other groups of independent, private practitioners pressed for excluding the ranks of the Subordinate Medical

\textsuperscript{14} PG, M&S, 32-35A, July 1907; 1-3A, Nov. 1907.
\textsuperscript{15} PG, M&S, 1-3A, Nov. 1907.
\textsuperscript{17} Government of India, Home Education. Health Lands, 1-5A, May 1926, 5, p. 7. (Hereafter GOI, EHL).
Services from the registration qualifications.\(^{18}\) The Subordinate Medical Services however represented an important and representative constituency in the Government's project to diffuse Western medical education. Colonial administrators refused to narrow the scope of the norms that they identified, and reiterated that the regulatory powers of identifying 'legitimate' from 'illegitimate' practice in establishing professional standards lay with the state, and not other private forums of opinion and judgment. In its response to the Bombay Medical Union representation, it was noted that:

In all countries the sole authority which lays down the conditions constituting qualification for the legal practice of medicine and surgery is the Government of the country.\(^{19}\) [These] medical practitioners... appear to consider that in Bombay this authority rests with local opinion as represented by themselves.\(^{19}\)

The 'qualified' norm of the recognized, medical practitioner that was sanctioned by the Medical Registration Act however, now also served as a more generalised standard, that held up the possibilities of evaluating all 'true' or 'false' practice. During the debate on the Medical Registration Bill in the Punjab Council, various members had expressed strong reservations regarding the principle implicit in the proposed legislation.\(^{20}\) They pointed out that the Bill, needed to be amended to clarify in its use of the term 'registered practitioner' and that of the broader term, 'medical practitioner' in an interchangeable fashion. The Bill, they argued needed to specify that it referred only to the limited class of Western medical practitioners.\(^{21}\) This move was however resisted by the I.M.S. officer introducing the Bill and its wider implications remained.

In response to the identification of these professional norms being applied to evaluate qualified status amongst medical practitioners, many Vaid and

\(^{19}\) Ibid.
\(^{20}\) GOI, M, 2-6A, August 1911, 2, p. 2.
Hakim leaders responded by putting forward other grounds to assert their legitimacy. They asserted instead other factors such as their traditional importance, and their popularity. In the light of the recent plague they argued, Western medicine and its claim to legitimacy had no foundation since it had shown itself no superior to any other system in terms of its medical effectiveness. Indigenous medical practitioners, they claimed had enjoyed far greater success in their drug use and its therapeuic success.22

The Medical Registration Act however asserted the legitimacy of Western medical practice on the basis of its professional status and in turn distinguished it from all lay and unqualified forms of medical practice. Professional medicine and its practice by demarcating its distinct status also excluded all lay intervention and pressure in ordering the former's standards.

At the heart of the Medical Registration Act, the clause that elicited maximum resistance and criticism, in its safeguarding of these professional norms was that concerning ‘infamous conduct’.23 ‘Infamous conduct’ consisted of registered practitioners employing ‘unqualified assistants’, as well as for ‘covering’ or in lending their professional name or service in assistance of or association with an unqualified person. For this they could now be penalized.

This clause aimed to secure the status of ‘qualified’ practitioners by regulating the sphere of their professional activities. Its wider implication for indigenous practitioners, however, was that it clubbed them with unqualified or quack practitioners. Professional interaction was regulated for

22 Sudhanidhi, Year 3, No. 9, p. 356.
the qualified practitioners and the earlier practice of mixing medical practices was now made illegitimate.

The ‘infamous conduct’ clause received wide public attention due to its immediate and effective implementation by Provincial Medical Councils. The Krishnaswamy Iyer case in Madras and the Popat Prabhu Ram case named by the Bombay Medical Council,²⁴ concerned the involvement of these practitioners in the running of a charitable Ayurvedic dispensary and an Ayurvedic College respectively. Association with ‘unqualified’ practice, through dispensaries or private colleges was common and the Medical Council immediately attempted to make an example of such practitioners.

In Legislative Councils, it was pressed for by supporters of indigenous medicine that ‘infamous conduct’ needed to be defined more precisely and that the status of indigenous practitioners was being affected by this clause and ought to be protected. In 1916, indigenous practitioners also mobilised a Council Bill to amend this clause in the Bombay Council.²⁵ This move too, was successfully resisted by the I.M.S. officers. They argued that the power to identify ‘infamous conduct’ represented the very basis of the object of the Medical Registration Act and that it lent ‘status’ to the specific code of practices for qualified practitioners and its deletion was therefore not negotiable.

In the course of wider protest against the legislation that was conducted through Vaid and Hakim bodies such as the All India Vaid-Yunani Tibb Conference led by Hakim Ajmal Khan,²⁶ and in various vernacular press reports and debates, indigenous practitioners questioned the grounds on

²⁴ Sudhanidhi, 1916, No. 6, p. 200.
²⁶ According to the Annual All India Vaid Yunani Tibb Conference Reports between 1914-1918, motions against this clause were passed during Conference sessions every year.
which they had been declared as 'unqualified'. The professional norm put forward by the Government, it was argued, did not really prove the inherent value or the advance of western medical practice over other forms. The difference really lay in the institutionalised state patronage that had supported and directed these standards, that could as easily be extended to indigenous medicine. In a speech to the Mathura Vaid Sammelan for instance, a Vaid leader questioned:

The way the Sarkar wants to save the public from false doctors, it would do no harm if in the same manner the Government attempted to offer protection from fake Vaidas. But without distinguishing between real and false, to call Vaidas and Hakims unqualified...is a matter of grave concern. [After all] how is it that the Sarkar is today able to call doctors qualified? When it has opened dozens of schools and colleges for its education and when for its sustenance lakhs of hospitals have been opened. It must then offer the same facilities to the Vaidas....and for their education offer funds and facilities so that it can be decided who can be termed as qualified or not.\(^{27}\)

The ‘infamous conduct’ clause, after the well-publicised cases considered by the Bombay and Madras Medical Councils was not very closely implemented. In fact, regulations regarding professional conduct amongst qualified practitioners only attempted to introduce a collective interest based upon a professional status and often schisms persisted amongst groups of qualified western medical practitioners.

Local social ties and networks of private patronage brought Indian qualified practitioners to address and debate at forums like Vaid Sammelans.\(^{28}\) Divisions and resentment based upon the spoils of Government employment, tended to set apart ‘foreign’ I.M.S. officers from Indian medical practitioners. Often, Indian officers of the Subordinate Medical Services of the ranks of sub-Assistant Surgeons or Majors attended and addressed Ayurved Sammelans, including sharing their advice on the value

\(^{27}\) Sudhanidhi, 1912, No. 9, p. 355-6 (Emphasis added).
and preservation for instance of the Ayurved *materia medica*. In an unusual but not entirely inconceivable move, the Patel amendment put forward in the Bombay Council jointly carried forth the interests both of indigenous practitioners as well as Subordinate Medical Service officers.\(^2^9\) It sought to introduce a Bill to have the 'infamous conduct' clause deleted as well as to ask for the representation of Subordinate Medical Service officers on the Provincial Medical Council.

However, the Medical Registration Act's real impact lay in the realm of ideas, with implications in terms of norms and standards that would guide state patronage and sanction in affairs concerning medical education and employment. The Medical Registration Act and the Medical Degrees Act, more centrally than other ongoing professionalising initiatives such as the establishment of medical research institutes, professional sites such as hospitals, also had a direct impact upon the ideas and forms of private medical activity in other urban centres.

The process of consolidating state sponsored Western medical education however, was not merely a function of legislative enterprise. The claims to professional status were also buttressed by intellectual rhetoric that elaborated upon the 'scientific' character of Western medical learning and the nature of its education.

This rhetoric was itself not original, for even in the course of the movement to introduce professional organisation and norms to medical practice in the West, the claims of representing 'scientific' medicine lay at the heart of this legitimizing rhetoric. Circumstances in the British colonial context varied somewhat, in the presence of well entrenched systems of indigenous

\(^{2^8}\) Sudhanidhi, Ibid., p. 353.  
\(^{2^9}\) Sudhanidhi, 1916, No. 6, 274-8.
medical learning that found widespread support from the private, non-official public. The definition and projection of the claims to scientific authority in the colonial context had to be stated vis a vis indigenous medical knowledge, and more broadly to affirm the claims to superiority and responsibility of colonial authority.

The device of claiming ‘professional’ status and privileges by the British colonial administration was a defensive move that identified and secured the boundaries of representing scientific medicine. Rather than acting in more comprehensive terms as in Britain under the General Medical Act of 1886 and to penalise and prohibit all lay practice based upon empirical learning; the protection of government sponsored medical education and state sanctioned medical practice in India hinged entirely upon monopolizing claims to represent scientific medicine. It was state initiative and its intervention that guided the pace of this process; private medical societies and medical journals were not a notable feature in the process. In turn the state also faced growing pressure from corporate groups of indigenous practitioners, their council representatives and the native press, that demanded the articulation of government attitudes regarding indigenous medicine.

Vaid journals frequently asked the government to clarify its stand, since the limited and elite clientele affected by the Medical Registration Act, implied the neglect of the condition and quality of medical relief afforded to the masses. Others pointed out that the provision on the one hand, of grants in aid to institutions such as the D.A.V. and the Tibbia colleges, and the declaration on the other of indigenous practitioners as ‘unqualified’,

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30 Sudhanidhi, 1912, No. 9, p. 355 also mentioned in the discussion of this Bill in the Punjab Legislative Council.
demanded a clarification of the government’s attitude towards indigenous medical learning and its practitioners.\(^{31}\)

Between 1916 and 1917 therefore, the colonial government began to outline initiatives, in the form of Legislative Council-based resolutions that declared government commitment, as well as initiated provincial level enquiries that considered the future place of indigenous medical systems. The parameters of these early initiatives were revealing. Both the Council Resolution (1916) and the Punjab Government Enquiry (1917) regarding the condition of the indigenous systems based themselves upon investigating the possibilities of establishing indigenous medical systems upon a ‘scientific’ basis.

The precondition to evaluating any possibility of advancing state patronage or sanction to indigenous medical practice was based upon how far it measured up to representing scientific features that were essential to make claims to professional status. Western medicine, it was claimed, embodied scientific rationale and method and therefore possessed a universal status as a single complete system.\(^{32}\) On the other hand, these Enquiries as well as subsequent discussions on this question characterised Indian medicine as empirical, and having cultural rather than scientific value. They also conceded that indigenous medicines and drug use often displayed efficient application.

Indigenous medicine also represented a tradition divorced from rational-critical content. It needed to be considered on the grounds of it being ancient and of cultural value, because it was organised on the basis of a religious and authority-based tradition. Its roots in religious, scriptural authority,

\(^{31}\) *GOI, Home Legve.*, 119-121A, May 1916, p. 15.

\(^{32}\) *GOI, M*, Council Proceedings, April 1916, Resolution discussing the placing of Indigenous medicine systems on a scientific basis, page 49.
more broadly characteristic of the nature of all indigenous knowledge, defined its unscientific nature and the absence of modernity in indigenous civilization and learning.

In a statement during a later debate, the President of the Bombay Medical Union summed up some of these comparative assumptions saying:

The Western system so-called is a universal system. It is world wide because it is founded on a purely scientific basis. In surgery and Bacteriology,...and in research carried out in all civilised countries, it is a system of constant progress and discovery. The Hindu science, after a brief brilliant period in which anatomy and surgery flourished,...[came] to a standstill. The intensification of the sacred character of the Shastras became invested as the final authority applied to morals and rituals and later to medical science [and acted as the] most effective brake to progress.33

The implications of identifying indigenous learning as lacking universal, scientific principles was to locate it as an ‘empirical’ tradition that was characterized by useful medical method but not qualifying as a complete scientific system. Indigenous medicine therefore was distinguished from the ‘universal’ and ‘scientific’ nature of western medicine which was now identified as a separate preserve to be evaluated upon a distinct standard of judgement. In its religion based, ‘sacred’ tradition, lay an absence of scientific progress as well as scientific method, characterized instead by empirical cures and drug remedies. The reference to a period of an ancient Hindu science as widely researched in Orientalist writing, only made for contrasting an evolved Hindu past, with a static present, marked by an absence of the ability to apply reason or scientific, rational-critical enlightenment.

Supporters of indigenous medicine even during the Council debate on the Resolution on indigenous systems, noted the attempt to fence off the sphere

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of scientific medicine and the location of indigenous medicine as empirical, and culture specific in its values. 34 They argued that indigenous medicine ought to be evaluated and supported for its status as a rational, medical system containing universally applicable medical theories and rational methods of practice. It contained scientific truths, and therefore appropriate methods of ‘investigation’ needed to be applied, not individual bias and judgement, to establish their nature and relevance.

One such speaker argued:

I am against treating the Ayurvedic and Yunani systems of medicine as ancient monuments. I protest against it....if the Ayurvedic and Yunani systems are worth investigation they are worth investigation in the name of mankind,.. what we want is that the science should be investigated for its own sake apart from the uses to which it could be put in India. 35

In the sphere of Government policy in these years there was widespread consensus amongst medical administrators regarding the privileges and separate status that was to be accorded to western scientific medical education and its practice. The debate among officers of the I.M.S who were more sympathetic to indigenous medicine, and others who had less interest in the issue, was now limited to addressing the precise nature of the ‘uses’ of indigenous medical practice implicitly due to its empirical nature, rather than to consider it as a scientific system. Training and education based support was to be guided by the scope of the specific and limited projects with which indigenous medicine would be associated.

In the debate on the Resolution regarding indigenous medical systems, an earlier motion of concern regarding the need to provide rural medical

relief was seen as having relevance to the issue of determining the use and application of indigenous medicine. The proposal to have a vernacular trained Western medical practitioner had already been turned down, on the grounds that this would revive a system similar to the earlier training of hospital assistants and undermine the status of western medical practice. Pardey Lukis, senior I.M.S representative, turned instead to propose that the indigenous practitioner would be suitable for providing cheap and large-scale rural medical relief.

A later opinion based upon this idea would further argue that this principle was sufficient to suggest that no higher training of indigenous practitioners along ‘professional’ lines therefore needed to be undertaken at all. Answering a motion by indigenous practitioners to press forward their registration and seek representation in the All India Medical Council proposed to be formed in 1926, it was suggested that not only would such a move threaten Western medical practitioners, it would also, ‘if adopted….simply limit the number of indigenous practitioners and deprive the masses living in places far away from the towns and cities, [and also make] medical advice more expensive.'

The implications of the loss of ‘status’ implied by these views and inherent in the ‘infamous conduct’ clause was widely noted by indigenous practitioners. The leaders amongst indigenous practitioners realized that by alleging that Vaids and Hakims treated the orthodox and the uneducated, or the rural poor, the urban middle class, elite clientele that employed their services was being appropriated by western medical qualified

36 Ibid, p. 53.
37 GOI, M, Resltn, p. 54.
38 Ibid.
practitioners. The western educated, middle class leadership was now presumed to be naturally aligned to western medicine, a claim that Vaid Sammelans in later years would repeatedly address in urban public debate.

The Resolution on putting indigenous medical systems upon a scientific basis did not commit very much towards indigenous medicine and its patronage. It reinforced however the enclave of scientific medicine claimed in the rhetoric of Western medical practice and began to articulate the basis for treating indigenous medical systems upon different terms.

These assumptions were resisted even during the debate on this Resolution, as much as during other discussions when Council members put forward an amendment or a Bill that put forward the demands of indigenous medical practitioners. During the discussion on the debate on the position of indigenous medical systems, Council members questioned the basis of the claims of Western medicine as monopolising the representation scientific method and application.

They argued that western medicine was itself not completely scientific, and that it had only successfully used scientific method in the area of surgery and shown scientific advance in technology. In areas of medicine such as in drug use for instance, indigenous medicines employed scientific method as well. Medicine, in its origins and aims was universal, and scientific method characterised both western medicine as well as indigenous medicine differing only in a more advanced or less developed degree.

40 Vaid speakers at the Mathura Sammelan repeatedly outlined the range of elite clients—Judges, Doctors—all western educated classes whom they treated. Sudhanidhi, 1912, No. 9, page 355.
41 GOI. M. Resltn, April 1916, p. 55.
42 Ibid.
Within Government-led, official debate, the securing of professional status for Western medical practice and indirectly that of Western medical education, allowed these arguments little headway. In the following years however, indigenous practitioners were to resist these assumptions and the boundaries of scientific medicine and empirical medical method, outside the Councils, in urban public debate.

Provincial level enquiries that stemmed from this resolution however followed, and in 1917 the Punjab Government conducted an enquiry and published a report along the lines suggested by the earlier Resolution on Indigenous medicine produced by the Government of India.

The Punjab Government had been further pressed into considering the question of legitimising indigenous medical practice after its refusal in the face of public resentment, to include Ayurved and Tibbi classes in the King Edward medical college at Lahore. Public funds and support had been collected under the latter assumption, and the Punjab Government’s resistance had been criticized, followed by renewed demands to take into account the emerging changes in the organisation of indigenous medical practice.

The Punjab Government’s Enquiry in 1917 took forward and attempted to apply the professional medical standards laid down in the Medical Registration Act as a wider principle and norm. It employed the categories of professional/scientific and lay/empirical medical practice and elaborated upon their difference, despite attempts by the indigenous practitioners to initiate certain changes towards professionalised education.

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43 Ibid.
44 GOI, M, 65-7A, April 1917.
The Provincial government’s Report argued that reports from civil surgeons in various districts revealed that indigenous medical education and its emerging private institutions lacked consensus or uniformity in their curriculum and organization. Smaller colleges were no bigger than schools that produced fees-oriented students who lacked any professional standard or code. The large colleges such as the D.A.V. and Islamia colleges in Lahore and the Tibbia college in Delhi too had little in common in the degrees and curriculum that they offered.45

These institutions had assumed the form and imitated the structure of Western medical education, but were characterised by the empirical and unscientific nature of indigenous medicine. The use and consultation of English-based texts or English as a medium of teaching was reported as being scarcely developed in these institutions.46 The use of the vernacular, and its association with indigenous medical learning only affirmed the latters empirical, imprecise nature since vernacular languages were regarded as being unable to mediate scientific, concept based knowledge.

Related to the issues of professional standards or uniformity, English medium learning as opposed to vernacular based learning was held forth as a scientific and secular basis necessary for all professional learning. There were reports of a limited number of translations of Ayurvedic texts that were available in English in provinces like Bengal. In Punjab however, private, indigenous medical education was entirely in the vernacular, making it impossible for it to be upgraded and included in the teaching in Government medical colleges.

45 GOI, M, 65-7A, April 1917, p. 20.
46 Ibid, p. 19. For a discussion the redeployment of vernacular languages and their ‘scienticity’ see chapter VI.
The report of the Punjab Enquiry therefore declined to allow the revival of indigenous medical education within the premises of Government medical colleges such as in the earlier experience of 1887-98 at Lahore University. Even the teaching of Western scientific medicine to reform indigenous medical education in private colleges, was to be done by private scientific societies rather than through direct government or university based sanction.

Direct state support once discouraged through the policy of withholding assistance to indigenous medical systems, implied that the steps to be climbed towards seeking state patronage had to be increasingly taken by indigenous practitioners through the channels of the non-official institutions and agencies. The trajectory of their mobilisation in the coming years, through their association with politicised reform bodies and Sammelans in urban arenas, with these bodies and their forums serving as important mediators for mobilisation amongst indigenous practitioners, had its origins in the terms and implications of the professionalised and scientific medical education that the colonial government had begun to consolidate in these years.
SECTION II

Medical mission work and its institutional expansion based upon mission hospitals and dispensaries, including the founding of the earliest mission medical colleges had seen expansion in these years, particularly in the period between 1880s to 1900s.47 This call for medical work in urban areas had been widely accepted by missionaries after the Bombay Conference of 1891-92, when the priorities of a less direct, evangelistic agency, based upon the medium of Christian medical service, had been identified.

However, medical missionaries were also beginning to note the changes in the nature and availability of western medical relief in urban areas. The diverse range of practitioners providing western medical advice in large cities in Punjab was observed in reports from American Presbyterian missions, who themselves had zenana mission hospitals in most of the large cities as well as smaller towns in the province.

Missionaries also cautioned against the growing presence of state medical relief in large government hospitals in the cities, as well as the growing number of private practitioners that were being produced by the government’s medical colleges.48 In Delhi, the Cambridge Mission’s staff noted the founding of the new municipal hospital and questioned the need for widening missionary medical relief in the city in the face of such projects.49 Private philanthropy too in Delhi, was emulating mission

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47 Report, Survey of Medical Missions in India, 1925, Appendix Statement showing Punjab to have the second largest scale of medical mission related hospitals & dispensaries in British India.
48 Report, Laymen's Inquiry, Medical Department Medical Section, 1933, No. 35.
women's hospitals and had begun small, charitable dispensaries and hospitals in the city. 50

The awareness of western medicines, and the acceptance of western medical aid were growing amongst the urban public, which indicated the increasing availability of western medical relief. 51 Medical missionaries noted the call for the expansion of their medical work in and around large cities such as Amritsar and Delhi. Private philanthropy in smaller centres such as at Ambala, and at Karnal, had contributed to the building of hospitals by the American Presbyterians and the S.P.G. Cambridge Missions. 52 Even in smaller towns, medical missionaries noted the familiarity with western medical methods leading to the establishment of a number of Branch dispensaries for instance in the towns surrounding Delhi, and centered around the medical facilities provided by the large mission hospital at Delhi. 53

Despite this expansion in and demand for medical mission services, both missionaries as well as their boards and conferences abroad noted and expressed their concern over the position of government medical facilities and the place for any alternative agencies in providing further services in extending western medical aid. At the World Missionary Conference in Edinburgh, a specially convened session on medical missions noted the growth in government facilities and suggested a much reduced medical missionary enterprise, that would be oriented towards pushing their work 'into fresh districts and to avoid competition with the elaborate facilities under Government auspices.' 54

50 Ibid.
51 S.P.G. and C.M., p. 37.
53 Ibid.
54 Medical Missionary, Volume XVI, No. 6, 1910, pp. 90-6.
The views expressed at the World Missionary Conference were widely reported and discussed in India. Prominent medical missionaries such as William Wanless of the American Presbyterian mission at Miraj gave their views on the implications of the Edinburgh Conference recommendations. These reports also cited the case of medical missions in Burma that had closed down mission hospitals in all centres where government medical facilities had been established.

The Edinburgh Conference recommendations had an important implication, that suggested that medical missionary work was nearly an adjunct to government medical facilities. Medical work by the missions, in extending facilities in western medical relief was an alternative, private medical agency. It therefore raised the question of the relationship of medical mission work in urban centres vis-à-vis the presence of the regulatory functions assumed by state medical administration.

Addressing this question, William Wanless wrote to campaign the views of the newly founded medical missionary association in India.55 He clarified, as many other contemporary mission reports also did, that the extension of the state's medical aid was itself being over estimated. Even in urban areas, it only addressed a partial and incomplete need for scientific medical aid, and therefore medical work itself still continued to have scope in India. His response was of particular significance, since medical missions and their work had been perceived to be sidelined in the discussions and agenda of the World Missionary Conference. Medical work, both in the urban areas and in India's rural areas continue to offer scope for mission work for which mission bodies needed to continue to support medical missionaries.

55 William Wanless was a prominent American Presbyterian Missionary who enjoyed a legendary reputation for his medical work in South India. He also founded the Indian Medical Missionary Association in 1907 and expressed their concerns in forums such as the Medical Missionary journal. Debate covered in Medical Missionary, Vol. XVI, No. 6.
Since the medical Missions had their largest and most elaborate institutional base in provinces like Punjab in the urban centres, medical missionaries in Punjab too addressed the debate regarding the sphere of medical missionary activity. Western medicine or its beneficiaries, it was pointed out, consisted of a specific class of the public. While western scientific medicine still remained challenged by the existence of a large number of indigenous practitioners and quacks in urban centres such as Amritsar, missionary medical work such as amongst the poor in towns and countryside as well as amongst women remained a crucial contribution of the missionaries. Outlining the sphere of work in urban areas in Punjab, the report argued, that:

The great government institutions by no means meet all the needs of the teeming population. Even at a town where, as at Amritsar, the Civil Surgeon has a wide surgical reputation. It is notorious that scores of hakims and quacks make their living, and that a very small percentage of acute medical cases are treated by European methods....In all these towns there are now large numbers of licensed practitioners, but it is to be feared that these benefit only the middle and upper classes of the Indian community, while some purely prey upon the ignorance and sometimes the vices of their constituents.56

Central to these evaluations of missionary medical work and their views about government medical relief, lay the preoccupation regarding the growth in state control over the norms governing the diffusion of western education and its aims. The increase in state control over western education consisted of the consolidation of education standards, that took the form of a closer control over the sites of advanced learning, such as the universities and the elaboration upon professional, secular norms in education.

University administration had been the object of reform in 1904 when government increased its control over university administration by reducing

56 Medical Missionary, Volume XIII, No. 4, 1907, p. 46.
the independent status of Universities. Higher standards, the introduction of diplomas and regular inspections had been proposed in these reforms. A decade later, university related policy was again revised in the light of the Sadler Commission Report (1917). Though addressed to the administration of Calcutta University, it had wider implications that were pursued by the government in the following years. There was also greater representation of the lay public in university based representative bodies, with the suggestion of a Board to control pre-university work, as well as the introduction of the idea of university affiliation.

The consolidation of these standard norms in education, a process initiated in the late nineteenth century, spelt out a single, homogenous ideology and organization for western learning and education. Missionary education and medical work had faced an important challenge from these sites of professional and secular control such as the universities and government colleges.

Missionary medical work too was affected by the norms and ideology that straitjacketed professional medical practice, as determined by government medical colleges, and subsequent legislation such as the Medical Registration Act and the Medical Degree’s Act. Medical graduates who were trained by this system brought a distinct emphasis on the commercial, secular priorities of their work, as frequently noticed by missionaries. These independent private practitioners due to the limitations of their professional education, centred their medical work only in urban areas where they looked to the medical market. Noting this trend, a medical missionary observed:

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58 Ibid.
59 Ibid.
But what becomes of the qualified doctors who have been trained or are being trained by government? Few if any of them settle in the village districts outside of the larger towns and cities. A living for them would scarcely be possible were they to do so. ...  

Government hospitals were also sites that represented the application of the professional norms and ‘secular’ ideology that was a part of the government’s education policy. Medical missionaries were not merely observing the expansion of medical facilities in these years, but in their evaluation of Government hospitals, they were responding to the implications of the government’s education concerns.

Missionary reports of their medical work therefore frequently mentioned cases such as during the plague epidemic of 1905, when Delhi’s public preferred the preventive inoculations of the mission hospital rather than that of the government hospital. Missionary reports in these years therefore frequently emphasised the public preference for mission hospitals because of their ethos of Christian work, as compared to the professional tone of the government hospitals and their services. Reports from smaller towns like Karnal indicated the nature of this choice even amongst small town women, and the Delhi Mission Report on missionary work in the plague years reported:

There were first many questions on medical subjects to be answered, especially about plague and the measures taken by government for disinfection “A god given remedy!” they say to one another, “so she believes in a God of healing, we like her words, we do not hear such things in the State hospitals; there is no word of God.”

The Government’s policy on education rested upon a professional, secular norm that was being laid down in a manner that was far more intrusive than

60 Medical Missionary, Volume XIX, 1913, No. 7, p. 86.
62 S.P.G. & C.M. Reports, 1898-1903, Delhi, 1903 p. 22.
63 Story of the Delhi Mission, p. 131.
earlier in the late nineteenth century. Previously, the outlines of the grant-in-aid conditions had only begun to be formulated. These standards increasingly brought into question the place of Christian missionary work in the context of the state’s education policy.

Due to growing pressure from Indian missionaries, the International Missionary Council in July 1929, initiated an Enquiry to explore the sphere of mission education following the growth in Government regulations. The urgency in the organization of this enquiry committee stemmed most immediately from the introduction of a ‘conscience clause’ regulation in educational institutions in United Provinces and Burma. The clause laid down conditions regarding government’s grant-in-aid allowing exemption from attendance of scripture or other evangelical teaching related classes in mission institutions.

Missionaries feared the extension of this clause and the Report collected opinions from leading missionary colleges regarding the place of evangelical teaching in a context where state policy emphasized professional secular education. The Report noted its assessment of the government’s attitude, emphasizing its priorities of political governance in a colonial setting, which coloured its education policy. In British India, it noted that the course of private, independent education systems were threatened, ‘by the fact that the existing government is only in part representative of the people who are governed, and is therefore more than ordinarily sensitive to the effects of the teaching in State Aided Institutions upon the political and religious convictions of their constituency.’

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65 Ibid, pp. 224-5.
66 Ibid., p. 224.
The Enquiry on the place of Christian higher education also framed a more definite response to the debate regarding the specific place of mission medical work, following the statement of the Edinburgh Conference. It supported certain reforms in Christian education, but insisted that Christian colleges, as distinct from government colleges, continued to have a place because of the Christian spirit they rendered to their students.67

Medical education, which was emerging in these years, was also by the same logic stated to have a place that was not fulfilled by government education in western medicine. Separate medical colleges set up by the missions were recommended so as to be able to train medical missionaries as well as students in the line of Christian medical work.

The debate between missionaries and the state regarding the form and contents of western education, and 'professional western medicine', was important for the missionaries because it addressed the rationale of their work and its ends in urban centers. Missionary medical work in urban areas had an ideological basis, being centred upon the work of establishing amongst the urban middle class public, the spirit of medical work in the Christian spirit.

The Bombay conference in the 1890's had emphasized this, only for it to be reiterated in 1907, during a conference of Protestant missionaries at Calcutta.68 The Calcutta conference had confirmed the end of carrying on Christian work amongst educated Hindus. It had recommended the adoption of an attitude of Christian sympathy in approaching the middle classes rather than that of preaching and confrontation. Hindu religion, it was stressed, needed to be understood and used as a preparation for Christianity, and the Hindus as 'co-seekers' of religious truth rather than heathens.

67 Ibid., p. 272.
These recommendations were echoed by subsequent international conferences in 1910, and later the Jerusalem Conference (1928) concerning missionary work. Direct evangelization through missionary work was condemned and in medical work, the need to offer professional excellence, but in the spirit of Christian service was emphasized.\textsuperscript{69}

Medical missionary work in urban centres was now legitimized by it seeking to provide Christian service. The emphasis upon its service or benevolence based relationship with the middle classes, however, raised important dilemmas amongst medical missionaries, concerning the threat of mission work being confused with philanthropy.\textsuperscript{70} The dilution of the evangelistic zeal of mission work implied the problem of its being confused with social work that was ‘secular’ in its implications.

In meetings following the Calcutta conference (1907), the threat to the religious and inherently the evangelical nature of missionary work was constantly raised. The need to acquire ‘professional’ features such as having qualified practitioners and assistance was accepted, along the lines laid down by the government.\textsuperscript{71} Simultaneously however, the need to maintain a religious/Christian basis was seen as being crucial to guide both the spirit of mission work as well as its ends.

The distinct spirit of Christian medical work seemed to be increasingly difficult to preserve in urban areas. The religious/Christian basis of missionary medicine was seen as being challenged by the professional, secular norms laid down by government education. Medical missionary work, bound by the secular, scientific medicine outlined by the colonial

\textsuperscript{68} Pathak, \textit{American Missionaries and Hinduism}, pp. 118-25.
\textsuperscript{69} Report. Board of Foreign Missions, Medical Department Bulletin, No. 35, March 1933, p. 2
\textsuperscript{70} \textit{Medical Missionary}, Vol. XIX, No. 4, 1913, p. 27.
government and by the perceptions of missionary policy towards the urban educated classes, was to preserve a limited profile in urban areas.

Expansion in medical work was increasingly focused upon rural areas where scientific, professional medicine had made few inroads. Here, medical mission work with its orientation towards western medicine as Christian service had a feel of work that did not compete with their interest of a monopolizing professional medical education and practice as elaborated by the Government.

**CONCLUSION**

State intervention in attempting to consolidate the norms of medical practice and the interests and content of medical education began to take a more concrete shape in the early decades of this century. Through legislation such as the Medical Registration Act and the Medical Degrees Legislation, the colonial medical administration consolidated the boundaries of its interest and put forward claims to establish professional medical practice sustained by the state's sanction and institutional patronage.

The introduction of and crystallization of these standards were a part of a far wider process of establishing the sites and the locations of professional institutional organisation such as medical colleges, research institutes, hospitals etc that were defined and demarcated so as to sustain professional norms of Western medicine, and it diffusion through education and medical practice. These legislative initiatives and the intervention and regulation that it represented introduced a distinct set of norms based upon professional legitimacy and scientific basis that sustained and sanctioned Western medical education and practice. These norms and standards were introduced to consolidate state interests and ideological commitment to Western

\[71\text{Ibid.}\]
education and summoned the scientific authority of western medical knowledge to lay down its monopolistic claims. They also fenced off exchanges with indigenous medicine while reiterating colonial generalizations regarding the nature of indigenous medical knowledge, prompting a reformulation of these representations by indigenous practitioners in the following decades.

The state's intervention in and regulation of medical education and practice however, was a process that also posed an important dilemma for medical missionaries. It created the conditions for them to evaluate the place of their medical work, and to debate the place of benevolent Christian service. The place of their medical work and their interpretation of scientific, western medicine along the lines of Christian ideals was to shift away in these years from urban areas.