Chapter -VII

MEDICAL SCIENCE AND EDUCATION
IN COLONIAL INDIA

It was the Portuguese who has introduced modern medicine into India first, when Albuquerque founded the Royal Hospital in Goa in 1510. This hospital was later handed over to the Jesuits in 1591 who managed it remarkably well and in 1703 introduced a rudimentary form of medical training with Cipriano Valadarews as its master. By 1842 this was converted into a school of medicine and surgery. Although the Portuguese brought medicine first, it was the French and later the British who established and consolidated it in India widely and firmly.¹

Temporary military or civil hospitals might have existed for long, we do not have information about regular hospitals till the years 1664 in Madras, 1670 in Bombay and 1707 in Calcutta.² More hospitals were gradually established as the pressure on existing ones increased in these as well as at new military stations which came up in the wake of speedy political conquests. As the volume of work and responsibilities of the medical officers increased, they started looking for low-cost Indian helpers. Such indigenous helpers, employed when young, gradually picked up a considerable amount of useful knowledge in the course of their hospital duties. These humble assistants were variously addressed as ‘native dressers’ (Madras), ‘country doctors’, ‘black doctors’ (Bengal), and ‘black assistants’ and ‘apothecaries’ (Bombay).³ Later they were more popularly known as ‘native doctors’ and recognized under this title by the government in 1767 when one of them was attached to each battalion of sepoys. By 1821 two of
them were ordered to be attached to each regiment and one or more to each civil station. Starting their careers as dressers or compounders, they had to, for promotion to higher rank and pay, undergo examinations conducted by their medical officers.

In 1740 the medical department, to supervise and conduct the medical affairs of the East India Company, was created which comprised British military surgeons and their local assistants. To give more logical and legal foundations to medical services, ‘Bengal Medical Service’ was started in October 1763. Individual medical officers serving in the Bengal Presidency were, with effect from 1 January 1764, combined into a regular medical establishment with fixed grades and rules for promotion. Once the medical services were regularized in Bengal, the central government started realizing the need for assimilating the so-called native doctors into the lower rungs of its medical organization. This realization, however, came as late as 1812, by the time native doctors had proved their immense utility by rendering their services in the multifaceted medical works during various military operations of the Company right from the Carnatic Wars (1740 onwards). The practice of appointing Indian assistants to accompany the troops in the field started from 1767 and became an established convention by the beginning of the nineteenth century. Hence in June 1812, recognizing the services of the native doctors to be indispensable, a “Subordinate Military Medical Department” came to be constituted and the native doctors were termed as third class servants. From 1767 to 1812, the British, however, hardly paid any attention to the need for formal and institutional medical education of their Indian helpers and assistants. Imperial wars and territorial
aggrandizement remained the predominant concerns of the British during this period.

**Hesitant Steps: The First Medical School**

It was only after the passage of the Charter Act of 1831, which set aside a sum of Rs. 1,00,000 per annum for the education of the natives, that the British began to show concern over the problems of content and medium of medical education to the Indians. Another catalytic factor was the creation of a sub-medical service for the army in June 1821, which consisted of European and Eurasian boys and for whose medical training arrangements were made by the General Order of 15 June 1821. These developments precipitated the demand for a uniform and proper institutional medical education to those Indians aspiring to become native doctors.

‘Orientalism’, which had provided healthy diversions to the British governors general and administrators right from time of Warren Hastings. Spurred the promotion of medical science and influenced the earliest educational policies of the British. Intensive researches in oriental art, literature, science and philosophy carried out by a host of dedicated researchers at the Asiatic Society of Bengal further stirred the imagination of the policy planners. The Medical Board, impressed with the antiquity of Sanskrit language and the availability of excellent treatises of ayurvedic medicine, placed before the government in 1822 the proposal of establishing a novel medical institution where Western as well as indigenous medical sciences would be taught side. This dual system of medical education initially thought of as one which would meet all the desired ends, faced a variety of problems in the years to come and finally ended in a failure.
First, it was to meet the ever-increasing military demand of native doctors, educated through the vernacular medium, whom it was impossible to educate through the English medium at the given state of educational advancement. And second, it was to provide to the Indians, through Western medical education, an opportunity to witness the ‘superiority of the new race’. With such avowed aims the Native Medical Institution was established at Calcutta in June 1822 with Surgeon James Jamieson as its superintendent.

The Native Medical Institution could only become operational from, October 1824 as the death of Surgeon Jamieson intervened and it took Surgeon Peter Bretton, who assumed charge in June 1823, some time to reorganize the whole scheme afresh. At about the same time Sanskrit medical classes were started at the Calcutta Sanskrit College where the works of Charak, Susruta and other Indian writers were studied along with the translated treatises in Urdu. Likewise Urdu classes, with the treatises on Unani as well as the already mentioned translated works, were started at the Calcutta Madarsa.

This pattern, otherwise unique and remarkable, of imparting medical education of the Indians, however, met with stiff resistance from the Court of Directors. Its dispatch of 18 February 1824, drafted by James Mill, observed with disgust, ‘With respect to sciences it was worse than a waste of time to employ persons to teach and learn them in the state in which they were found in the Oriental book. Our great aim should be not to teach Hindu learning, but sound learning’. When the Court sent order for its abolition, the Government of India (GOI), however, remonstrated and pleaded the practical utility of such an institution. A long debate ensued at the East India
House on 21 June 1826 and finally the Court withdrew and approved its establishment.¹⁶

Surgeon Bretton was succeeded by John Tytler in November 1830. Tytler was a noted Orientalist and during his tenure many vernacular translations appeared. Next, a small 30-bed hospital, for practical training in close proximity, was set up in August 1831, and was attached to the Sanskrit College. Besides the efforts of Tytler, the hospital was largely the product of liberal donations made by Babu Ram Commul Sen.¹⁷ The grandfather of famous social reformer Keshav Chandra Sen. Later he was made a member (and the only Indian) of the Medical Commission of Lord William Bentinck. All along, Tytler espoused the cause of medical education to the Indians through vernacular languages. He regarded them rich enough to incorporate Western medical learning and hence disapproved and opposed any imposition of English language till 1835 when he finally had to succumb.¹⁸ During the brief existence of the Institution (1824-34), the native response remained somewhat lukewarm. The Institution’s report for the year 1829 noted that the candidates were procured with great difficulty, so much so that the superintending surgeon of Cawnpore division, to whom applications were made for recommendations, advised not only an increase in pay to the pupils, but also superior prospective advantages in government services.¹⁹ The prospect of permanent employment in government service appeared to be the only real inducement for drawing students. To a small extent, the Brahmanical taboos on learning anatomy also acted as a deterrent. Again the fear of competing with the native professionals with altogether a new science also made the aspirants security conscious; second, the class character of the early native doctors, too, reflected that the appeal
of medical education was still very limited. Most of the early native doctors were either the sons or relatives of the native army officers or those of the native doctors. Very few among the general masses were attracted towards it.²⁰

Progress of medical education took an abrupt turn in the year 1833. When the ‘language controversy’ was raised through academic and official circles. The medium of instruction for higher education formed the bone of contention and Lord Bentinck appointed a committee to enquire and report upon the state of the Native Medical Institution which had, ‘disappointed the just expectations of the government’ and to suggest improvements to make it an efficient. And error-free institution.²¹

By the time the Calcutta Medical College was established in 1835, English had already become the official language of India after the acceptance of Macaulay’s celebrated Minute on Education.²²

The Medical Commission of Bentinck consisted of a few members of the Committee of Education with the addition of some medical officers and one Indian, Babu Ram Commul Sen. The Committee prepared an extensive report and presented it in October 1834. it enumerated the inseparable defects of the Institution and recommended its abolition. the important defects pointed out were, first, the expenses of the government were regarded to be disproportionate to the utility of the native doctors in government services.²³ Second, securing a class of professors with high professional acquirements and an extensive knowledge of Eastern languages was difficult as well as exceedingly expensive. Third, there was a great expenditure on translation which in turn enabled to impart only a superficial
knowledge of Western medical science. And lastly, the lack of the study of practical anatomy made the entire education incomplete and unproductive.²⁴

The Calcutta Native medical Institution was the first teaching institution of its kind in British India. Though the foremost objective of the government was to train a class of native doctors in Western medical system for military and civil requirements, an attempt at carrying forward the indigenous medical systems along with it added a novel feature to the British medical policy. With the abolition of the Institution, for nearly a period of 85 years, the cause of rejuvenating and promoting the indigenous medical systems was lost, till the constitution of provincial governments under the Act of 1919.²⁵

New Openings and the Warm Response

In accordance with the recommendations of the Medical Commission, Bentinck in January 1835 issued an order abolishing the Native Medical Institution, Along with this the medical classes conducted at Calcutta Sanskrit College and Calcutta Madarsa was also discontinued. The same order sanctioned the foundation of Calcutta Medical College from 1 February 1835.²⁶

Medical College was started to train a group of 50 students on monthly stipends, ranging from Rs. 7 to Rs. 12, according to their seniority and merits. On leaving college, the native graduates were to be employed as sub-assistant surgeons (SASs), in the discharge of the duties of the duties of medical attendant in large dispensaries established in different parts of the country, on salaries ranging from Rs 60 to Rs 100 per month. They were,
however, not compelled to enter government service and were free to establish themselves for private wherever they pleased \(^\text{27}\).

For the changeover to the education of Western medical sciences through the English medium, the intellectual and social climate of the reascent Bengal in the 1820s and 1830s acted both as a catalytic and a receptive agent.

The English class at Calcutta Medical College was constituted with 50 foundation pupils without any distinction of caste or religion with the ability to read and write English and Bengali or English and Hindustani besides this, the candidates should be between the ages of 14 and 20 and should produce certificates of respectable connections and conduct. Europeans, Eurasians, Anglo-Indians, apothecaries of the sub-medical department and later on a fixed number of Ceylonese and Burmese students were allowed to join this class. The course was to last for three years at the end of which they had to pass an examination conducted by the examination committee of the College. After completing the course they were given a diploma in medicine and surgery by the College, till Calcutta university was founded in 1857 which granted the degrees of Doctor of Medicine (MD) and Licentiate in Medicine and Surgery (LMS). The degree of Bachelor of Medicine (MB) was added later on in 1860. Likewise the duration of study was raised to four (1840) and later to five years (1845), and the minimum qualification for admission \(^\text{28}\). was Matriculation (1857) and later to the First Arts (FA) (1860). The first batch of students to secure the Diploma of Medicine and Surgery in 1838 consisted of Uma Charan Set, Dwarka Nath Gupta, Raj Kristo Dey and Nobin Chunder Mitter. These four students were soon
appointed as SASs to the hospitals at Dacca, Murshidabad, Patna and Chittagong respectively at Rs. 100 per month.

The military class of the Medical College did not perform well and was always short of the government’s expectations in quality as well as in numbers. This class always created disciplinary problems for the College administration and it lacked effective control over them as they were on the military payrolls. The number of failures and forced expulsions were, for long, quite substantial. Thus, when the government asked for a greater number of native doctors urgently for the army in June 1838, the College Council refused to lower the standards of education to meet such a demand. Instead the College Council mooted a proposal to create an opening in the army for English class diploma holders and appoint them as SASs. The government turned down this proposal. Apparently, the government did not like to sully the all-white character of the military establishment by the induction of the natives into its intermediate ranks.

**Medical Education in Madras**

Unlike the one in Bengal, the Madras Medical College was founded as a Medical School by the Honourable Sir Frederick Adam, by an order of the government, dated 13 February 1835. It opened its first session with 10 medical apprentices (Eurasians) and 11 Indian pupils (locals) on 1 July 1835 in the rooms adjoining the quarters of the surgeon to the General Native Hospital. The School was removed in 1836 to a new building erected for this purpose. The first curriculum of studies embraced anatomy, materia-medica, medicine and surgery, and the duration of the course was two years. As the School continued its works, additional professorships were
sanctioned for anatomy, physiology, midwifery, ophthalmology and chemistry, and subsequently the duration of the course was extended to three years 30.

In 1838, some changes were introduced in the School. Originally the School was opened for training subordinates for various kinds of medical work in the army: the Eurasians were employed as apothecaries and the locals as dressers in the army. In 1838 the School was opened to the civilians as well. However, the prejudices against Western medicine ran so high that for eight years no civilian came forward to register at the School. When some of the civilians finally joined, it was decided to conduct three different courses, one for the physicians to run for a period of over four years, another for the apothecaries for a course of four year. And the third for training the dressers for over three years. The medical students after qualifying were accorded a graduate diploma known a ‘Graduate in Medicine, Midwifery and Chirurgery’ (GMMC) 31.

In April 1847, stipendiary civil students were admitted for a five-year course to qualify for the civil SAS. The Madras Medical School they came on a level with those of Calcutta and Bombay, though the name was not changed to Medical College until 1 October 1850. The first bate of these civil students qualified in 1852 and were the first to receive diploma from the College. In 1855-56, the diploma of the Madras College was recognized by the Royal College of Surgeons, London 32.

E.G. Balfour, SG. Indian Medical Department (IMD), in a long communication to the acting chief secretary to the Government of Madras in August 1877, accounted extensively for the state of medical practices in
Madras Presidency, the conditions of the people and their health needs and put forward a proposal for a particular type of medical education best suited to the local needs and conditions. He observed that in the territories under the Government of Madras, there were about 8,000 practitioners, of whom only 450 were educated servants of the government attached to the army, or lent to the civil hospitals, and the remaining were the Hindu vaidyas and the Muhammadan hakeems, who practiced as physicians. Further, he noted with concern that in countries little civilized or largely agricultural or pastoral, medical men were few compared with their numbers in kingdoms possessing a large civic population. In Russia, for instance, there was one medical man to every 14,116 inhabitants, in Hungary one to every 5,492, in Austria one to every 4,355, and in the towns of Great Britain the proportion was about one to every 1000, but in Madras Presidency the number had been one to every 60,000. Southern India, thus, needed 8,000 to 10,000 educated men to replace the vaids and hakeems on the one hand and to match with the huge population to be comparatively favorable on the other. Next, he illustrated the fact that the agricultural population had no means to pay for the services of an expensively educated medical man, and what the state had to consider was a kind of professional education for which people could pay. He wanted the government to understand the stark reality that one-third of the three and a quarter million ryot-farmers of Madras Presidency had such small landholdings that they paid less than Rs. 10 as annual rent. This lot of people, in his view, could benefit only through the easily accessible and low-cost native doctors instead of the high profile and expensive city-based medical graduates.
Before him, Lord Napier, the governor of Madras, had envisaged a scheme to train village doctors (Vaids and their sons) through the medium of vernaculars so that medical aid could be placed within the easy reach of the rural population of Madras. Towards its execution, however, no steps appear to have been taken in the following years.

In one respect, however, the Madras Medical College proved very radical and exemplary as it opened its door to female students in 1875, at a time when they were debarred from other medical colleges in India and even in Britain where their admission to the medical colleges was being debated and discouraged. The year 1875 also witnessed the institution of the LMS degree which continued for a period of 50 years and was finally abolished in 1925; the degree of Bachelor of Medicine and Bachelor of Surgery (MBBS) which replaced it was extended to five and a half years with the introduction of a six months pre-registration course. Next, Madras University was the first to recognize the importance of hygiene and in 1888-89 instituted a new degree, ‘Licentiate in Sanitary Science’. The examination was open only to the holders of other medical degrees and registered medical practitioners, and the subjects comprised general pathology, hygiene and analytical chemistry.

**Medical Education in Bombay**

The establishment of a medical college in 1845 named after a conscientious and benevolent governor of Bombay, Robert Grant, a beginning in medical education on the model of the Calcutta Native Medical Institution was made in 1826 by Elephinstone, the then governor of Bombay. Elphinstone founded the Medical School with a loftier objective of ‘general
diffusion of medical science among the natives, by educating native youth to knowledge of the European system and then sending them into the district to practice.'  

Sir Robert Grant, shortly after becoming the governor of Bombay in 1835, directed his attention to the expediency of establishing a native medical school in the Presidency. As deeply interested in this subject, he ordered for an investigation into the state of medical practice in the Presidency and the feasibility of disseminating European sciences. The work of investigation was entrusted to the Managing Committee of the Bombay Medical and Physical Society. The Bengal Medical College (known later as Calcutta Medical College) had been by then two years in operation and its successes had triumphantly regarding the fallacy of the visionary opinions and imagined difficulties regarding the native prejudices. The Committee reported favorably. The investigations revealed the facts that native medical practices throughout the Presidency were in a degraded state and attempt to ameliorate would definitely be welcome without any contemplated prejudice coming in its way. Based on these data, Governor Grant framed a proposal for establishing a medical school and sent it to Calcutta in June 1838. It was approved by Lord Auckland’s government. But before this communication had reached Bombay, Grant had passed away  

Growth of Medical School in India

The decade of 1870s witnessed a proliferation of medical schools in the country. As more and more students joined the vernacular licentiate classes of the medical colleges, the need became pressing to transfer these to
separate locations attached with regular, well-attended and well-functioning hospitals

The non-presidency medical schools situated in other parts of British India, owing their origins earlier than government’s standardization of their curriculum of studies in 1878, and significant for their experiment and evolutionary character, were Agra Medical School in the NWP Lahore Medical School in the Punjab and Nagpur Medical School in the Central Provinces (CP). The oldest among them was the Medical School at Agra which was founded in 1854 for the instruction of apprentices of government dispensaries in vaccination work and was attached to the Thomson Hospital. Dr John Murray, the then civil surgeon and later the first principal of the School subsequently suggested a general scheme which was duly sanctioned for the education of native doctors.

In 1870, the Lt Governor of the NWP presented a proposal to the supreme government for establishing a medical college in the province, either at Agra or Allahabad.

Turning down of this proposal was interesting in view of the fact that the Raja of Vizianagaram was ready to donate Rs. 2,00,000 for such an institution at Allahabad. But the government insisted on the total funding of the outlay and maintenance of the institution by the natives, either through subscription or through provincial revenues. The Government of India (GOI) thus scuttled the proposal mainly due to the fear of financial involvement 37.

Medical Education in the Princely States

Only at two places, Indore and Hyderabad, did medical education find its beginning in the princely India of nineteenth century. The Medical
School at Indore was opened in 1878 to train the natives as medical subordinates for employment in Indore and the neighboring states. It owed its origin to the efforts of Surgeon-Major Thomas Beaumont, the then residency surgeon of Indore. It was supported by the native states of Rajputana and the CP.

The Medical School at Hyderabad was unique as here for long teaching was imparted in Urdu which was the state language in the Nizam’s territory. It is said that Nawab Nazir-ud-Dowalah, the Nizam of Hyderabad, fell ill in 1843 and he did not recover for quite some time under the treatment of the Unani hakeems. Fraser, the then British Resident in Hyderabad, recommended treatment of the ailing Nizam by the Residency Surgeon W.C. Maclean. The Nizam recovered and the Western system of medicine rose high in royal esteem. He ordered the establishment of a school for teaching it in Hyderabad with Maclean as its superintendent. The Residency Hospital in this school was enlarged in 1848 to provide for wider opportunities in clinical instruction.

In 1883, the medium of instruction was changed to English by the Principal Surgeon-Major Thomas Beaumont as by then a substantial number of English-educated students were available with the growth and spread of English schools in Nizam’s territories.

Medical Education of Women in India

Though by 1875 there was a widespread hospital network throughout India run by the government, municipalities and district boards, women and infants were, however, the most neglected segments of the Indian society in matters of medical aid and attendance. Strict purdah system and strong
social prejudices against treatment by male physicians made women’s plight all more pitiable. Since there were no women doctors on the hospital staff, they had none to look forward to except the indigenous dais that with their age-old practices played havoc with their health when in distress. The scale of female casualty in childbirth, and infant mortality, was very high in India. Despite knowledge of this fact, the GOI kept aloof, particularly in the post-Mutiny period, as not to interfere in the socio-religious customs of Hindus and Muslims in relation to the treatment of their female folk. Mrs. Scharlieb, the earliest crusader for women’s equal right with their male counterparts in receiving medical aid and education in India illustrates, in her Reminiscence, the kind of existing Indian conservatism.

The first attention to this sorry state of affairs of Indian women was drawn by the Christian missionaries who, individually as well as well as through setting up of small dispensaries in different parts of the country, tried to alleviate their sufferings in various ways. Besides offering charitable help in the form of medical attendance and drugs, they tried to impart medical education to Indian women as a private arrangement. Dr. Humphrey, a member of the Methodist Episcopal Church, started a class for training women at Nainital in 1869. This venture did not succeed and the class was closed down in 1872. The same mission, however, wrote to America requesting for the services of a medical woman to instruct a class of native Christian Girls, as also to practice in the city as opportunity would present itself. The one who responded to it was Clara Swain, MD, from the USA. She arrived at Bareilly in January 1870 and at once took up the work of teaching medicine, nursing and compounding to a class of 14 girls of the orphanage attached to the mission at Bareilly. In 1873 these girls were
examined by a board of three doctors and pronounced to be competent health workers 39.

Another well-known female medical missionary in India was Miss Rose Greenfield who came to Ludhiana in the Punjab in 1875 under the Society for Female Education in the East. She taught female students and also devoted time to attend on patients. In 1893 and the following years she was largely instrumental in organizing and opening the Women’s Medical School at Ludhiana in association with Dr Edith Brown, the first principal. Miss Greenfield continued to work in Ludhiana and in other cities in the Punjab till 1924 when she retired after 49 years of dedicated service in India. In recognition and honour of her services, she was awarded the Kaisar-i-Hind medal in 1926.

**Spread of Homeopathy in India.**

In India homeopathy initially moved along with Dr Honigberger, as already noted. After winning the trust of Ranjit Singh he was appointed physician to the Sikh Court which provided for him an influential position to carry on his practice and research for more than a decade. Besides this, he was made a superintendent of the gunpowder mill and gun manufactory 40. Recounting the post-Ranjit Singh developments Dr Honigberger mentioned that when the English came, the durbar to erect a public hospital outside the city. The management of that establishment was entrusted to him, and he then obtained the long desired opportunity of continuing his experiments, uncontrolled, in the new method of treatment, and on a large scale, until the annexation of the country, in May 1849. The results of his researches, he noted delightfully, surpassed his most sanguine anticipations. About
response from the people, he recorded that his waiting room was constantly filled with patients, attracted not only by the inviting appearance and sweet taste of the medicines (lozenges), and the pretty wooden boxes in which they were delivered but also by their efficacy which they found those bonbons to possess. The establishment presented a curious aspect. His department. More resembling, in its adjuncts, a confectioner’s shop than a repository of drugs, was on one side of the building, and the other side was occupied by the Hakeem appointed by the durbar to assist him, and who was at liberty to treat patients according to his own system.

**Traditional Medicine and Its Crisis of Confidence**

Whereas Allopathy (mainly), and homeopathy (Partly), the two alien medical systems, kept striking deeper roots in the Indian soil, the indigenous medical systems correspondingly kept losing ground steadily and irretrievably. Ayurveda and Unani-tibb had no answer to the new diagnostics and novel vaccines. Finding themselves badly mauled and let down, the indigenous systems went into a sulky withdrawal. For instance, when Madhusudan Gupta dissected a dead body in 1835, a vaid of high repute, Gangadhar Ray, left Calcutta in disgust. Escape into the old grooves appeared more natural than to confront the new challenge 41.

That the ‘ignorant vaids and hakeems’ were losing their practice and influence was evident from the fact that more and more patients were flocking to the government hospitals and dispensaries. The people were increasingly getting convinced that method of allopathic treatment was superior to their own and that it could cure diseases in a manner never seen before 42. For the decline of their medical systems, the vaids and hakeems
squarely blamed the British government. Lack of governmental recognition and financial support for the revival and rejuvenation of indigenous systems remained their prominent grouses against the government. There was nothing new in this, particularly for the vaids who had nursed similar grievances against the Muslim rulers during the medieval period.

It is amazing to note that despite the continual decline, the vaids and hakeems made no attempt to change their familial mode of medical education throughout the nineteenth century. Their lack of enthusiasm for the institutional promotion of their knowledge appears more glaring when contrasted with the fledgling homeopathy which, despite numerous odds and allopathic rivalries, could boast of a handful of medical schools and colleges by the 1880s. in sharp contrast, however, they were quick and to learn from their allopathic counterparts the practices of fixed consultation fees, priced medicines and publicity and publicity through advertisements. Profiteering aspects of Western medicine were welcome but education and research were not on their agenda.

Though no social and institutional efforts to stem the crisis of confidence that engulfed and hampered the indigenous medical sciences were forthcoming, some notable personal efforts were made to synthesize the best of the two conflicting systems. The new quest underscored that European theory and Indian experience, if amalgamated, would yield fruitful results beneficial and gratifying to both the contenders equally. That would, in particular, ‘enlighten and liberalize the native medical profession in the mofussil. The most prominent protagonist of this syncretism was Raja Serfoji, the last Maratha ruler of Tanjore.
Having surrendered real power to the British Resident, Raja Serfoji spent his time in the pursuit of knowledge. Father Schwartz, a German missionary, was his friend, philosopher and guide. Fascinated by the different medical systems, he opened an institution for research and called it ‘Dhanwantri Mahal’ (abode of Lord Dhanwantri, the God of Medicine). There he assembled leading physicians from ayurveda, Unani, Siddha and Western systems. As a result of their interactions and investigation, the best among the tried and effective remedies were collected in a series of works named Sarabendra Vaidya Muraigal. These were composed by the court post in Tamil verse to facilitate easy memorizing and popularization. Ahead of his times, Serfoji had also organized a hand painted hebarium of medicinal plants in natural colors. In the eye wing of his ‘Dhanwantri Mahal’ were maintained the ophthalmic case sheets in an album, with authentic pictures of the eyes and its defects for research purpose. This is perhaps a very early example of a ‘methodical clinical research’ under native patronage, and must have induced the traditional medical practitioners to take cognizance of the new therapies and methods. A man of considerable affluence and influence as serfoji was, his syncretic attempts must have mellowed the indifference and isolationism of the vaidas and hakeems in and around Tanjore and even for beyond, to some extent.

As Western education progressed in India, a section of the intelligentsia sought the revival and simplification of indigenous knowledge. Two very popular vaidas of Calcutta, Gangaprasad Sen and Neelamber Sen started the process of ayurvedic rejuvenation by publishing the sacred texts in Bengali. Later, Gangaprasad started the first ayurvedic journal in Bengali called Ayurveda Sanjivini. Moreover, he manufactured, commercialized and
even exported ayurvedic medicines to Europe and America. Gupta informs us that the drug business thrived so well that one of the kabirajes, Chandrakishore Sen, was soon counted among the richest men in the country. In 1898, he shifted his dispensary to Kalutola for large-scale production. All along, he published inexpensive books to propagate the scientific essentials of ayurveda. Gangadhara Ray, too, was inspired to undertake large-scale production and set up a manufacturing unit in 1884 called N.N. Sen and Co. Private Limited, Calcutta. By 1900, ayurvedic drugs had created a good demand and a fair share in the drug market of India. Its successes lured others to follow and soon ‘Sakti Ausadhalaya’ of Dacca, ‘Sadhana Ausadhalaya’ and ‘Kalpataru Ayurvedic Works’ were competing with one another in the market by the first decade of the twentieth century.

By 1900, the professionalization of ayurvedic practice and the commercialization of ayurvedic drugs on the lines of the Western model were zealously achieved but it drew a blank on the educational front. The most highly educated and westernized Indians shared the views of S.C.G. Chukerbutty who lambasted the indigenous practitioners for their educational lapses. Every Boydo was a born Koberaj (physician)…. To suppose that a Boydo could not be a physician unless he passed an examination was to question the ruling of Menu (an ancient law-giver)’. He was not in favour of medical education through Sanskrit of Arabic. He called it ‘Oriental mania’. There was, however a moderate point of view, too, among the English-educated class of Indians, championed by Bal Gangadhar Jambhekar. He wanted the native practitioners to improve and study ‘anatomy from the natural subject’. Moreover, he pressed the need for educating the children of vaids and hakeems and wanted the government to
undertake translations or writing synthetical books for this purpose. The monopolistic approach of both the European and Indian practitioners of allopacy, however, proved the biggest stumbling block for such ventures.

In the IMG of 1876, an assistant surgeon of Peshawar, Chetan Shah, wrote on how ‘Hakims are not so ignorant as doctors believe them to be. In this piece, Shah countered the dismiss of Yunani Hikmat by one of his colleagues, Radha Nath Roy (assistant surgeon from Aligarh), point by point, citing extensively from the Tib-i-Akbar and other traditional texts. He concluded:

The Yunani system of medicine as contained in Persian and Arabic literature, though very inferior and in some respects absurd and ridiculous, presents several useful hints of practical suggestions which should not be lost sight of. We should not throw off the roses because they are surrounded with thorns. We can pick out and learn a few good things even from savages.

GROWTH OF HOSPITALS AND PHARMACY IN INDIA

The earliest reference we find of the establishment of any hospital meant for treating the sick native civilians was that of the General Native Hospital founded in 1792 at Calcutta. ‘Prior to this, all references to the existence of hospitals occur only in association with the British army constituted of European as well as native sepoys. Public health policy, in that very sense, emerged as an offshoot of military health policy of the British. It acquired added impetus by the mid-nineteenth century as the rulers increasingly realized that if their surroundings remained diseased and
uncared for, it was difficult to fully protect themselves even at their secluded and spacious hill stations and civil lines \(^{50}\).

Various types of hospitals, thus, came into existence by the middle of the nineteenth century which, may, conveniently, be placed under four broad categories. First and foremost of these were the ‘military hospitals’ meant for the treatment and rehabilitation of the soldiers and sailors of the Company. The military hospitals, again, were of two types, temporary and regular. Temporary or camp hospitals were an immediate and urgent arrangement in some old ruined buildings for medical aid to the soldiers near the battlefields. Once the war was over such hospitals were either abolished or shifted to newer war zones Regular military hospitals were established within the confines of the cantonments or stable military stations and were well-staffed and well-regulated. The second category comprised all such hospitals either at the metropolis or the district headquarters which exclusively attended on the European civilians. The third category comprised the general hospitals meant for all including the natives. In the fourth and last category came the charitable hospitals and dispensaries which were mostly the outcome of native efforts and were maintained by public government aid as well. The first three categories of hospitals were mainly financed and maintained by the government.

The four-tier set-up of the hospitals, for the convenience of administration and finance, was further classified as Class I, Class II, Class III-A and Class III-B as the hospital network expanded substantially in the post-Mutiny period and became a plank of the government’s medical policy to involve, more and more, the local bodies in the promotion of public health in India. Class I hospitals were those which were located in the capital, the
presidency headquarters and at important army cantonments. They were largely financed by the supreme government or the presidency governments. The share of the corporation was marginal and, therefore, the subscriptions solicited from Europeans and natives formed a considerable part of their total outlay. Class II hospital were maintained and managed by municipalities or the local fund of the sub-divisional headquarters. Class III-A hospitals were entirely under private management and though Class III-B hospitals were also under private management they received financial aid from the government or the local bodies. Class I hospitals were placed under the charge of the covenanted medical officers (the members of the Indian Medical Service [IMS]) who were designated as civil surgeons and assistant surgeons. Class II hospitals were mostly placed in charge of Indian medical graduates (who passed the five years’ course, either LMS or MBBS) designated as sub-assistant surgeons (SASs). Class III-A and III-B hospitals were mostly run by native doctors of hospital assistants or apothecaries of various descriptions. Native doctors worked in subordinate positions of the first two classes of hospitals as well. During times of emergency or due to non-availability of qualified doctors, the services of the pensioned subordinates or private practitioners and the missionary doctors were sought in order to keep the regular functioning of the lower categories of hospitals unaffected. The civil surgeon posted at the district headquarters was the chief medical officer in charge of supervision and inspection of all the dispensaries of the district and was supposed to send an annual report of their functioning to the government.

Besides this system of graded hospitals and their administration, another important feature of British medical policy was to set up temporary
lunatic asylums almost everywhere the Europeans resided in sizable numbers. Indian heat was, for many of them, too much to bear and most often they used to lose their mental balance. It offered quite a good business to few of the surgeons, as initially such mental asylums were put to private management by such people who had a place, time and inclination to take upon this risky venture in lieu of fees given either by the government for its servants or by the relatives of the patients.

Some of these asylums were, later on, taken over by the government and by mid-nineteenth century few of them were operating in almost every province of British India. Another set of hospitals to meet the requirements of chronic and contagious diseases like leprosy, tuberculosis and different kinds of fevers came up from time to time in the form of leper asylums, tuberculosis (T.B) sanatoriums and fever hospitals respectively. Also, to check and mitigate the ravages of epidemic or killer diseases like smallpox, cholera, malaria, kala-azar and plague, temporary hospitals were set up for the treatment of the respective diseases. They were abolished once the diseases were put an end to. However, in the endemic areas, they were granted a longer existence, lastly, by the end of the eighteenth century, lock hospitals were set up within the premises of most of the European regiments to protect European soldiers from venereal diseases. In the lock-hospitals Indian women were subjugated to periodical medical examination and if found healthy they were certified to carry on prostitution with the soldiers as usual, and if found infected, they were retained and treated to the hospital; and if found to be incurable, they were expelled from the regimental of cantonment premises.\(^{52}\)
Growth of Hospitals in Madras

We find the earliest mention of an emergency hospital for the sick soldiers in a letter dated 10 November 1664, from William Gyfford and Jeremy Sambrooke at Fort St. George, Madras, to the Agent of East India Company, Sir Edward Winter. The letter reveals the pitiful conditions of the soldiers in the Fort who, during Sir Winter’s absence in Masulipatnam, fell terribly sick. Few of them had died and the condition of around 10 was wretched. Since no necessary medical help was available the Englishmen died on the allies soils like dogs. Hence, for the purpose of their treatment ‘Mr. Cogan’s house was rented for 2 pagodas a month’ and a doctor was appointed who while treating them, would not allow the soldiers to have meat, or alcohol. The petitioners implored the Agent for the approval and takeover of this hospital and sought the sick soldiers to be declared ‘Free Guard’ which meant ‘period off-duty’. The latter, however, does not say anything about the people appointed and their capabilities. This hospital was enlarged in 1679 when it was under the charge of Bezaliel Sharman 53.

The second hospital at Madras was built, between 1679 and 1688, by public subscription, at a cost of 838 pagodas, nearly Rs. 3,000. It was a large two-storey building and was a property of the Church and vestry. It stood in the fort, near the Church and adjoined the Company’s sorting go down, a situation which was found inconvenient in various ways. In 1688, during the governorship of Elihu Yake, the Madras Council decided to acquire this hospital building, paying its full value to the vestry, and directed that a new hospital be built near the river. Besides the new and enlarged second hospital, the third also came up during Yale’s term of office in 1690 in James in the Fort.
Many more such hospitals came up at different military stations in the eighteenth century, some of which were destroyed and some shifted during the course of Anglo-French conflicts for supremacy in the south (1740-63). Once the tension of the protracted war was over, some old hospitals were restored while few new ones were constructed, the biggest among which was completed in 1772 and later came to be known as the Madras General Hospital\textsuperscript{54}.

The idea of a hospital for the natives of Madras was first mooted by Surgeon William Garden in 1787 to the Medical Board and the Nawab of Karnatik. But nothing came out of this proposal. After 10 years of continuous persuasion Assistant Surgeon John Underwood was able to get a sanction from the Court for this hospital, the cost and maintenance of which was to come from the Company. The earliest mofussil hospitals in the Madras Presidency were set up in the thirties of the nineteenth century and by 1842 only six civil hospitals could be set up in the entire presidency outside Madras. It seems probable that when the Madras Medical School and College struck deeper roots and started producing substantial number of graduates and native doctors, in excess to the civil and military demands of the government, the process of hospital extension must have received a fresh impetus. Moreover, with the support of benevolent governors like Lord Napier and a gradual realization in the official circles of the presidency’s deplorable state of medical affairs and the pressing needs of the people, expansion of civil hospitals and dispensaries in the district and subdivisional headquarters was the obvious outcome.
In 1793, the Madras Council sanctioned the proposal of Assistant Surgeon V. Conolly for the establishment of a lunatic asylum at Madras. In 1794, it started functioning, the asylum having been built by Conolly who received Rs. 825 per month for its use. It remained his property till he sold it to one gentleman named Dalton. In 1867 the Madras government sanctioned the construction of a new lunatic asylum. It came up in 1871 costing Rs. 2,00,000. In 1892 the criminal lunatics of the Madras Presidency, who had up to that date been kept in jails, were transferred to this asylum. In the category of specialized hospitals, a hospital for lepers of all races and both the sexes was set up in 1816 (reported by Madras public letter dated 26 September 1816) which later developed into the Madras Government Leper Hospital.

By the end of the year 1880 Madras Presidency could boast of 218 hospitals and dispensaries of various descriptions. The year 1881 saw 38 new dispensaries being added and one abolished at Anjengo, making a total of 255 at the year. Of the larger hospitals at the Presidency and headquarters of revenue districts, 39 were directly under the charge of the commissioned medical officers and 16 were administered by apothecaries of the military establishment temporarily serving in the civil department. Assistant surgeons were in charge of seven dispensaries, while civil apothecaries held charge of 54. Hospital assistants held charge of 103, and the rest of the dispensaries were managed with the help of local hospital assistants, private practitioners and borrowed doctors from the missionaries.

Compared to the presidencies of Bombay and Bengal one glaring omission to be found in the growth of hospitals in Madras Presidency was the fact that very little initiative came forth from the wealthier sections of the
society for the promotion of either public and charitable hospitals or medical education. As their response and contribution towards the advancement of the medical services were lukewarm and almost negligible, the people had to depend largely on the government agencies for such services. The government on the other hand, functioned according to its imperial priorities and financial constraints.

**Growth of Hospitals in Bombay**

From the Surat Diaries we come to know that the first suggestion for establishing a hospital for the soldiers was made in 1670. The project, however, hung in suspension for a few years and according to De Fryer’s travelogue the project materialized towards the end of 1676. Dr Fryer stayed as a practicing surgeon at Bombay from December 1674 to March 1677. Again, the Bombay Diaries enables us to know the use of hospital ships in the offshore of Bombay as it notes ‘Dr. Michill came ashore from hospital ship with list of killed and wounded. The use of hospital ships for the reception and treatment of the wounded in war appears to be a remarkable advance in military medicine of the time.

Another hospital in Bombay seems to have been built in 1737. In 1745-46, a lunatic asylum was added to this building and in 1755 a room for ‘surgical operations’ was planned to be added. Forbes states that when left Bombay in 1784, ‘there then existed three large hospitals, one within the gates for Europeans, another on the Esplanade for sepoys. And a third for convalescents on the adjacent island (called Old Woman’s Island)’. The first to these was the General Hospital of the day within the city and was completed by 1801.
Among them, the most prominent and pioneering contributor to the growth of hospitals and medical education in the presidency was Sir Jamsetjee Jejeebhoy (Sir J.J.), a public-spirited man of very high repute.

Early in the year 1838, Sir Jamsetjee Jejeebhoy offered to pay to the government treasury a sum of Rs. 100,000 provided the government would contribute an equal sum, and grant interest at the rate of 6 per cent on both contributions. The annual income thus generated would be expended on a hospital established for the relief of the sick native poor of all denominations.

It was finally decided to build the proposed hospital in close proximity of the Grant Medical College and designate it as Jamsetjee Jejeebhoy Hospital. The hospital was to accommodate 300 patients.

The Alibless Leper Home on Trombay island was founded on 25 March 1890, and the Leper Hospital at Parel was completed in June 1891. a lunatic asylum at Colaba was established in 1826. in the category of special hospitals, the Dutch had founded a laseretto (or leper hospital) in 1728 at Cochin, on the Malaber coast, which was later annexed by the British. In 1789 a smallpox hospital was sanctioned and established at Tellichery, probably the first specific hospital in India for any infections disease. Both the latter hospitals were officered from and subordinated to Bombay, though most of their correspondence were conducted through Madras $^{57}$.

**Growth of Hospitals in Bengal**

The first Calcutta hospital in 1707 fro the benefit of the Company’s soldiers and sailors. In October 1707 the Council of Fort William resolved to build a hospital, selecting as its site ‘a convenient spot close to the burial
ground’. The Company contributed Rs. 2,000; the rest of the money was raised by public subscription. Captain Alexander Hamilton, a sailor who wrote an account of his travels in the East satirically commented about this hospital. ‘The company has a pretty good hospital at Calcutta, where many go in to undergo the penance of physic, but few come out to give an account of its operation’.

The second hospital was a temporary building erected inside the Old Fort on the recovery of Calcutta by Lord Clive in 1757. The hospital does not seem to be a well-managed one as it had few ill-furnished dingy rooms bereft of free and open air. When the Old Fort was converted into a customs house, it became absolutely necessary to build a new hospital. the Council, accordingly in October 1762, judged it expedient that a commodious one be erected as soon as possible, at Kidderpore 58.

The first General Native Hospital, for natives not in the service of government, appeared in 1792 and it was the precursor of the present Calcutta Medical College Hospital. The returns of the hospital for the Year 1805-06 show that during the year 220 in-patients and 2,874 out-patients were treated and 1,286 vaccinations were performed. There were 53 deaths. 4,265 were relieved and discharged, while 62 patients, 19 in and 43 out, remained under treatment at the close of the year.

The Calcutta Medical College Hospital had its beginning on 1 April 1838, when a small clinical hospital with 30 beds and an out-patient dispensary was opened to provide clinical instruction to the students of the new college. To earnestly tackle the periodical recurrence of malarial fevers, Baboo Muttylal Seal donated a piece of ground in the immediate vicinity of
the Medical College in 1844 for the purpose of erecting a fever hospital. Also it was felt that in none of the hospitals and dispensaries of Calcutta, any special provision was made for the indoor treatment of fevers. For this a Fever Hospital Committee was constituted and was asked to raise funds through subscriptions ⁵⁹.

**Role of the Missionaries**

Besides the government and the public- spirited wealthy Indian elites, another agency at work in the spread of hospital network and Western medical sciences in nineteenth century India, was the Christian missionaries of various denominations. Rev. John Lowe, who, for nine years, superintended the medical missions in Travancore, and afterwards occupied the important position of secretary of the Edinburgh Medical missionary society for 21 years, wrote a book on the works of the various medical missionaries in India. The book entitled Medical Missions. Their place and power, gives us a fairly good account of the benefits of the healing art in abating suspicion and prejudice, disarming hostility, and winning the confidence of the people towards the missionaries.

During his stay in Travancore, Dr Lowe placed the medical missions on such a sound basis that it developed into an agency of great utility. He was instrumental in training a number of native medical evangelists, whom he appointed to take care of the branch dispensaries established throughout the province:

The native medical evangelists have all been trained, either by the late Dr. Thomson or by ourselves, at the Neyoor Mission Hospital, and from personal observation, we can testify to their skill and success in the
treatment of disease, as well as to their faithfulness and zeal as evangelists. The influence that they have among their fellow countrymen is very great, and they have access where the ordinary native agent does not approach \(^{60}\).

Contrary to the warm response of the people towards the missionaries in south India, they faced stiff resistance in the north. Referring to Kashmir, Lord Bishop of Calcutta remarked, ‘We are Knocking one door which may, through God’s help, be opened for the truth to enter in. the church Missionary Society made an effort to in Christianity into Kashmir in 1854, but the violent opposition the missionaries encountered there forced them to withdraw, and it was not until 1862 that the attempt was renewed. Again the few efforts made proved futile. However, in 1865, Dr Elmslie succeeded in making a dent and set up a small dispensary at Srinagar Writing about his work the next year in 1866, Dr Elmslie observed that the religious exercises of the dispensary were conducted in the same manner as last year. On all Occasions without a single exception, the behaviour of the people was quiet and attentive. In their addresses missionary doctors seldom express reference to the absurdities of Hinduism or to the errors of the religion of the ‘false prophet’ as they deemed such references to better suited for solitary interview, rather than for the crowded assembly.

Dr Maxwell, the immediate successor of Dr Elmslie, was sent out in 1874, and a hospital was erected because of his influence over the maharaja. He was later, succeeded by Dr Neve who, struck by the growing popularity of the hospital, wrote that the fame of the hospital had reached far and wide-into the remote valleys, crossed snowy passes to Ladak and Skardo, and even penetrated with merchant caravans into khotan and yarkand. The hospital became so well-known that in 1881, it recorded 30,000 visitors. The
procedure of treatment gradually became similar to that of neyoor: prayer, dispensation at the hospital and propagation of the faith personally 61.

Dr Lowe informs us about the other missionaries at work in different parts of the country. In Rajpootana, four European medical missionaries were working connected with the united Presbyterian church; medical missions of the church missionary society in the Punjab and that of the church of Scotland in Chumba; of the Irish Presbytsian church in Gujarat; of the Baptist missionary in Delhi; of the free church of Scotland in Pachamba and madras; and that of the American board in connection with their Arcot mission.

The hospital and dispensary in connection with the Arcot Mission, located at Ranipet with a branch dispensary at Vallajapet Proved to be very successful and stood out amongst the medical establishments of the different missionaries. Dr H.N. Scudder headed the Arcot mission which having been established in 1866, soon became popular among the hative Christians of this district of south India. Dr Scudder, after time, noted with pleasure that though at first, the people came cautiously and timidly, and usually from the lowest castes, everything changed afterwards. Hindus of the highest castes and Muhammadans alike availed themselves of its benefits without any shadow of a fear, the average annual attendance of out-patients being upwards of 30,000 and of in-patients about 1,300 per year.

To the question whether the practised mode of evangelization had been successful or not, Dr Scudder found it assuredly to have yielded positive results. Though his view was not shared by the regular missionaries, he, however, maintained that many cases of conversion hand occurred
within the walls of the hospital, and members who came over to them had affirmed that the preaching they heard on the dispensary verandah really led them to inquire after the truth. Encouraged by such experiences he considered that every mission ought to have, at least, one medical arm. He felt sorry that even by 1870 many missions were still without this agency and in his view that was a poor policy looking at the subject from a worldly point of view. As a testimony to the evangelistic results, Dr Scudder cited the experiences of a Brahmin convert who, while in dire need, was helped by the mission in every possible way. Before a gathering of 200 Brahmins, farmers and officials organized by the Arcot Mission, the Brahmin convert narrated his tale of early abhorrence and later conversion as:

I have watched the missionaries, and seen what they are, what have they come to this country for? What tempts them to leave their parents, friends and country to come to this unhealthy clime? Is it for gain or profit they come? Some of us, country clerks, receive larger salaries than they … when he first came; he was met with cold looks and suspicious glances, and was shunned and maligned. But he was not discouraged; he opened a dispensary and we said, `Let the pariahs (lowest caste of people) take this medicine, we will not’; but in the time of our sickness and distress and fear we were glad to go to him, and he welcomed us. We complained at first if he walked through our Brahmin streets; but when our wives and our daughters were in sickness and anguish, we went and begged him to come, even into our inner apartments-and he came, and our wives and our daughters now smile upon us in health has he made any by it Even the cost of the medicine he has given has not been returned to him…. Now what is it that makes him do all this for us? It is his bible!... the bible!... there is nothing to compare
with it, in all our sacred books … they do not force it upon us, as did the Mohammedans with their Koran; but they bring it in love and say; look at it, and see if it is not good….

Even after making allowances for the exalted emotions of a recent convert, the account of the Brahmin does reveal a kind of humanitarian concern among the missionaries for the wretched, hapless and ill-treated poor of India, which was largely lacking in the social practices of Hindu and Muslim religious ideologies. Social ostracization was the minimum that the leper and the Insanes in India were subjected to. Excepting some stray references to the prevalence of feeding the lepers twice a day by some temples in south India in the twelfth century, we do not come across much evidence of either the government or the religious establishments evincing any meaningful compassion for these unfortunates of the Indian Society. The medical works of the missionaries were of great significance particularly in the geographical zones of the princely states of Kashmir, Rajpootana, Mysore, etc., where the people almost wholly lacked the medical aid by the state. Though belonging to the white race and generally not opposed to the imperial rule, they did put the government under occasional ecclesiastical censure particularly with reference to the existence of Lal bazaars and the growing lewdness and lasciviousness among the white soldiers. Rev. Thomas Carr, the archdeacon of Bombay, protested indignantly to the commander-in-chief in 1834, `A number of females are kept in buildings in a bazaar called the `Lal Bazzar`` within the lines of the regiment, and the men go there for the gratification of their passions` 63. It is, however, a different story how and why they failed to check this moral depravity and the defilement of Christianity. Thus their contribution to the progress of the
hospital system and western medical sciences, braving the heat and dust of India, was quite commendable. Particularly, the practice of the healing art by well-qualified lady physicians in the harems and zenanas was greatly gratifying and advantageous to the much neglected Indian womenfolk.

The Lock-Hospitals

As the imperial authority of the British rested on the British soldier, and more dependently after the Mutiny of 1857, the government accorded top priority to their needs and desires, even if these be morally repugnant and dehumanizing. The government gradually evolved a policy of providing Indian women to satiate the sexual lust of the soldiers, who were naively described as ‘our young soldiers’ as young ‘our boy soldiers’ For their ‘young boys’, the military authorities regulated prostitution, first, locally and later on a general and systematic basis Regimental brothers or lal bazaars, and lock-hospitals consequently, came to be maintained to serve the twin purposes of facilitating mercenary sex and protecting the soldiers from the infections mercenary sex and protecting the soldiers from the infection of venereal diseases. In government’s view. Special provision seemed necessary for the sexual satisfaction of British soldier because they came from the lover classes and so were thought to lack the intellectual and moral resources required for continence, while as ordinary soldiers they lacked the material resources required for marriage. The official elite, on the other hand, were supposed to shun Indian mistresses and content themselves with their British wives, for it was feared that their soldier-like vulnerability to physical lust would inexorably lower them in public estimation of imperial
authority. The prestige of the ruling race thus became a matter of serious concern. The obvious contradiction between the care with which the military authorities provided facilities for sexual relations between British soldiers and native women, and the care with which upper classes or the ruling elites tried to discourage sexual relations between British officials and native women, had a fundamental concern common to the two distinct social classes of the same race. That concern was how best to preserve the structure of power. In the one case the soldiers’ virile energies had to be maintained. In the other case the social distance between the official elite and the people had to be preserved.

Next, any talk of abolishing prostitution in the regiments was seen to be hazardous and replete with dire consequences. Not only that the reckless soldiers would broil into the bazaars risking their masculinity but the prospect of homosexuality would lead to the most devastating sort of degeneration. Prostitutes were seen as necessary and hence there was no attempt to reform them in the lock-hospitals. This was also justified on the ground that they were hereditary prostitutes. It was said that in cantonments the registered women prided themselves on their social superiority to sweepers who, under the caste system, were universally despised. The military authorities often emphasized how respectable these professionals were unlike the deviants alienated from the society in Europe.

An important feature of the medical policy regarding the lock-hospitals, frequently resorted to from 1805 to 1897, was that when the ratio of prevalence of venereal disease among the soldiers did not decline for a
considerable period, some of the hospitals were abolished considering them a wasteful expenditure. But again, even after the closure, as the ratio of venereal diseases kept on increasing, more and more of lock-hospitals were opened. Venereal diseases were prevalent among the British soldiers on a wide scale and roughly varied between 29 to 43 per cent during the course of the nineteenth century. As a social experiment the lock-hospitals were closed from 1830 onwards. But the growth in venereal diseases continued to rise, and lock-hospitals were reopened, first locally and from 1864 as a matter of an all-India policy. Again in 1888, they were in principle abolished as moral reformers began to apply pressure. But they had to be reestablished in 1897 as the disease continued and unabated affecting the soldiers. Moreover, every closure, almost immediately, aroused protests in military circles.

The term ‘lal bazaar’ came to have a special significance, as denoting the red light or brothel area of the regimental bazaar, superintended by an elderly woman whose duty it was to ensure that the prostitutes were healthy and that those infected were either expelled or sent to hospital. Before the end of the eighteenth century, the GG-in-C has authorized the building of ‘hospitals for the reception of the diseased women’ at Berhampur, Cawnpore, Dinapur and Fatehgarth. The patients (European soldiers or prostitutes) were forbidden to leave until they had certified as cured. At times, an emphasis was made on ‘decent women of caste and proper years’ for better management of these hospitals, and for making the profession safer and healthier. ‘The Board assumed, no doubt with reason, that the more prosperous patients, whom they wanted to attract would be of higher caste’.

Indian women forced into prostitution were generally the helpless creatures of misery, deprivation and exploitation. Socio-economic hardships
forced 10 to 20 per cent of the women to join the military brothels; among
them some were young widows, the result. Of child marriage and some were
destitutes. There was often an influx of rural women into prostitution in
times of famine. In case these compulsions did not meet the demands,
kidnapping crimes in Calcutta and Midnapur were resorted to. The situation
was in a way, as noted by Ballhatchet, similar with that of the European
women who were driven by hardship into urban brothels, many of whom
were refugees from anti-Semitism in Eastern Europe.\textsuperscript{66}

In the government-run lock-hospitals, however, the diseased
prostitutes were subjected to all kinds of crude and obnoxious medical
examinations by the male military surgeons and while indoors, were kept
under filthy and degrading conditions corresponding to the worst maintained
jails of the time. To improve the hospital conditions, a proposal was mooted
in Madras in 1868 to introduce the trained female nurses into the hospitals to
Madras including the ‘Lock Hospital in Black Town’ The GOI came down
heavily on the Madras proposal rejecting it in toto. J.M. Cunningham,
sanitary commissioner, GOI, reacted sharply that trained European head
nurse was hardly required for the ‘Lock Hospital in Black Town’, where the,
prostitutes under treatment would nearly all be natives. If such a proposal
was to be sanctioned, he noted sarcastically, and then there was no reason
why a European nurse should not be allowed not be allowed for every
similar institution throughout India. A convenient excuse quite apparently,
but this was the government’s standard response to stall the proposals which
did not involve the European populace for which it always had funds and
will to spend them in abundance. The second proposal was put forward by
the Army Sanitary Commission in 1898 which suggested the employment of
female hospital assistants under the direction of medical officers for the treatment of the treatment of the prostitutes 67.

Lord Elgin, though opposed to the idea, reluctantly asked the different medical schools and colleges to report on the availability of such female hospital assistants for the proposed job. The response was, however, utterly negative.

The lock-hospitals, more or less, kept functioning along the set pattern, a century old progress of medical science and personnel hardly contributing anything towards their improvement. In imperial perception the sex workers were viewed as vectors rather than victims of disease. Hence the administrative focus was on preventing others (soldiers) from being infected by them and not vice-versa. Indian response to this socio-military and socio-medical problem was one of studied indifference. The spectacle of a few thousand of Indian women surrendering themselves to the lust of the British soldiers was hardly a matter of any concern either to the feudal classes or to the riding Indian middle classes, Despite the whole affair of the regimental brothels, being ethically repulsive and medically mismanaged, it ought to be conceded, however, that the imperialists were at least not hypocrites as they frankly accepted and lawfully operated one of the oldest professions of the mankind.
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