'Whenever the history of the social life of India comes to be written, the influences and developments of the movement for supplying medical aid to the women will constitute a weighty consideration.'

-Mary Frances Billington, 1895.

European medical science was able to establish its difference from and superiority to indigenous healing traditions of India over the nineteenth century. In order to do this, it was important to standardise medical education and bolster professional status vis-a-vis less qualified attendants. The process continued into the twentieth century with the passing of Acts of Registration. Medical women played a crucial role in making hospitals and medicalised childbirth acceptable to women of the 'respectable' classes of Bengal. The emergence of women doctors as 'upholders of purdah' led to acrimony between them and the Medical Department of the Government. This was, in effect, a strategy to ensure their own niche within the medical establishment. There was a concomitant requirement for the entrenchment of medical women as a separate but equal branch within the colonial medical services. This was the distancing of medical women from all lesser
practitioners of healing and midwifery. Not only were they to be plainly seen as having nothing in common with dhais, a distance had to be maintained between women who belonged to the more elite branches of medical service and the holders of lesser degrees and qualifications. The latter had the potential to spread medical ideas into remote areas, but the professional interest of medical women did not countenance the parallel development of a subordinate category of women practitioners, at a time when their status was insecure. This worked to ensure the elite character of medical aid to women. The issue of purdah and midwifery related also to the professional status of the graduates of Indian medical colleges, when the paucity of labour cases for the practical instruction of male students was the reason given for the de-recognition of Indian medical degrees.

Distinguishing the 'lady doctor'

At a special meeting held to discuss the status of medical women vis-a-vis their male counterparts, Dr Kathleen Vaughan of the National Association for Supplying Female Medical Aid to the Women of India said the problem of ambiguity arose from 'calling everyone a lady doctor, whether she [was] a dai or otherwise.' Some of this confusion was certainly rampant among the general public, especially where the distinguishing factor of race did not exist, as the pioneer Bengali medical woman, Kadambini Ganguli, discovered

'Dufferin Fund, Report on a Special Meeting presided over by Lady Hardinge, at Government Place, Calcutta, on 11 a.m., 6 March 1912, p.6.'
on a visit to a wealthy but conservative Bengali home. Having intervened in a complicated case, she was served a meal on the verandah encircling the inner courtyard of the house, where the maidservants generally ate. The lady of the house sent a message through a servant that the 'dhais' (Kadambini Ganguli had been accompanied by an assistant) should clear up after themselves, throwing away the banana leaves they had eaten off and wiping the floor.

(The lack of public awareness regarding the distinction between midwives and women doctors was probably more acute if the latter were Bengali women and especially if they were licentiates of the vernacular medical classes, which required very rudimentary education for admission.)

In a story published in 1921, a character says many 'lady doctors' from the Campbell Medical School are the educated daughters of maidservants. His wife adds that the only 'bhadralok' who allow their daughters to study medicine are Christians or 'Bemmos' (Brahmos). The doctor (who is a tragic heroine in this story) turns out to be the first wife of the very man who has engaged her

'Lila Majumdar, Pakdandi, Calcutta, 1986, p.102. However, the knowledge that she was a doctor may not have helped Dr Ganguli. Ethel Bleakley, who worked for several years as a medical missionary in Nadia district with the Church of England Zenana Mission Society, describes how she would enter a home by the front door, passing through crowds of men, but after the delivery she would have to leave through the back door, taking care not to touch any one. (Meet the Indian Nurse, London, 1949, p.10.)
services (for his second wife). Lost on the riverbank many years ago, she was abducted and taken to a brothel from which she managed to escape because a providential attack of smallpox made the 'madam' abandon her at the Campbell Hospital. There, a dhai adopted her and paid for her medical education at the same hospital.3

Despite this apparent confusion about the exact 'status' of medical women, it is important to consider the role played by them in the spread of medicalisation in midwifery in Bengal. It was their contribution that made medical attendance and hospital births 'respectable' by drawing to their side the sympathies of upper-caste Hindu and Muslim women of Bengal, to whom the idea of male attendance and delivery in hospital were both anathema.)

Male attendance on women

Jadunath Mukherjee, in his textbook of 1867, said:

We must admit that the women of our country have not benefited at all from men learning midwifery. Women, after intolerable labour pains, have ultimately laid down their lives at the hands of midwives but would not hear the mention of a 'doctor' delivering them and, that too, within the house.4

3Kaliprasanna Dasgupta, Lady Daktar, Calcutta, 1921, pp.1-42.

4Jadunath Mukhopadhyaya, L.M.S., Dhatri-shiksha ebang prasuti-shiksha arthat kathapakathachhale dhai ebang prasutidiger prati upadesh, Chinsura, 1875, 3rd edition, pp.3-4. The author is said to have written the book after his first child died at birth because of mismanagement. His book is reported to have been 'found in use in almost every educated Hindu family in Bengal'. See Loke Nath Ghose, The Modern History of the Indian Chiefs, Rajas, Zamindars,
A Muslim bhadramahila of East Bengal, born in 1909, describes how purdahnashins were examined by male doctors, with a mosquito net draping the patient, while Begum Rokeya's long essay, Avarodhbasini, is replete with such instances.5

Although it was widely maintained that women in India would not see medical men, but there is evidence that women did in fact attend the hospitals and dispensaries staffed entirely by men, long before the advent of medical women.4 In 1840, a large lying-in hospital was constructed in the grounds of the Calcutta Medical College by public subscription. This contained a hundred beds and was intended to provide clinical material for the students.7 In 1849, Dr H.H. Goodeve, requested the Government to increase the allowance of Rs 250 per month for the lying-in hospital by Rs 50 as the


The complaint is that no 'respectable' women attend the hospitals and dispensaries. See IOL/GOB:Medical Proceedings, April 1874, file 32 [11], from C.T. Buckland, Commissioner Burdwan to Secretary, Government of Bengal:Judicial, para.4. The C.M.O. of Bankura complained that the women who came to the dispensaries were 'from the poorest classes, generally prostitutes, vagrants, and mendicants'. The Civil Surgeon of Hooghly said that the Sub-Assistant Surgeon in charge of the Uttarpara Dispensary said 'clinical material' for the instruction of dhais was not a problem because there was not much difficulty in inducing 'women of the lowest classes' to be confined in the wards of the Dispensary.IOL/GOB File 32 [12] March 1874, para 3. (p/175)

Calcutta Medical College, Centenary Volume, 1934, p.23.
number of patients had increased owing to the popularity of the Hospitals, in spite of the fact that they had to be encouraged to come to the hospital by little gifts in the shape of clothes for themselves and their children when they left, and received an allowance for indulgences such as tobacco while in the hospital.8 In 1852-53, when the Medical College Hospital was opened, of a total of 350 beds, 116 were reserved for women and children, and 50 beds devoted to pregnancy and diseases associated with it. A Professor of Midwifery was placed in charge.9

By the time the Eden Hospital for women was opened in the Medical College complex, the movement for the medicalisation of childbirth had gained a number of influential patrons.10 The number of Indian patients who had been coming to the old obstetric wards of the Medical College Hospital was said to have grown over the last several years.11 The Eden Hospital was occupied on 17 July 1882. It offered accommodation to 41 Europeans and 42 Indians.12 The Principal of the Medical College reported that among the 139 newborn infants at the Eden Hospital in 1883, there was not a single case of neonatal tetanus prevailed. This was attributed to

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8Ibid., p.29.
9Ibid., p.31.
10"Calcutta Medical college, Eden Hospital Centenary Volume, 1982.
11Bengal Medical Proceedings 1880, File no.11, Collection 2, Proceedings no.58. (ioL/ f /14-75).
the superior design of the hospital, while the prevalence of the disease in 'the native town' was attributed to the 'privation of air, which forms a part of native midwifery.'

What was medicalisation?
To assess the impact of the introduction of Western medicine on childbirth in Bengal, we may consider what the 'medicalisation of childbirth' meant at different points of time, and whether it is correct to see the process as being steered solely by doctors. As Adrian Wilson points out, 'the history of childbirth transcends the limitations of the professions and techniques and can include them.'

In colonial Bengal, a number of influential groups and individuals, European and Indian, advocated the application of the new principles in childbirth. The implication of a passive acceptance (suggesting that women were either mere 'recipients' or 'victims') or a blanket rejection by patients must also be questioned. Evidence shows that, at times and in certain places, more indigent and lower-caste women attempted to avail of the facilities provided in hospitals than the hospitals themselves cared to admit. It is likely, therefore, that the responses of patients would influence the nature of treatment and the delivery systems involved.

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If we differentiate the process of medicalisation, it can be seen to include advances in technology, which become the province of professionals, intra-professional issues, the nature of the patient-doctor relationship and the greater authority exerted by the doctor, and the place of treatment. Roger Jeffery states that Indian medical traditions took little interest in matters dealing with women's health. There is some evidence of women healers within the ayurvedic tradition: the 1871 Census mentions 290 women kaviraj and 215 women hakims. Two nineteenth-century women healers of Calcutta, whose prowess was celebrated in two pieces of doggerel by Ishwarchandra Gupta in Samvad Prabhakar, were 'Rajur Ma' and 'Jadur Ma'. None of these women, however, practiced midwifery.

The first large-scale intervention of medical professionals in midwifery took place in Europe and it was against this background that claims were made for the undisputed sway of Western medical practices in parturition and post-natal care. Until the latter half of the nineteenth century, the primary concern of the Indian Medical Service was the protection of the health of the army and of the European population, and the emphasis was decidedly on curative rather than preventive medicine. Public health concerns centred around the control of epidemic diseases, such as cholera, malaria,

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smallpox and plague. These, in fact, continued to receive top priority in the twentieth century, as a medical women ruefully noted:

The difficulties and complete neglect [of women's and children's health] do not arise so much from lack of money as from lack of sympathetic understanding by state and public alike.

While male doctors 'obsessed with the White Man's Burden' had next to no time for 'such insistently less claimant ills as anaemic mothers and starved infants', she regretted, the public was unaware of the issues. By implication, therefore, educating both the medical establishment and the Indian public was the task of medical women.

Speaking of eighteenth-century France, Jean-Pierre Goubert stresses the mythical character of the opposition between the learned and popular medicine. 'The break', he asserts, '... was more at the level of collective notions than the area of medical learning and social practice.' For instance, Dr Jadunath Mukherjee's popular


18Mary Scharlieb, 'Foreword' to Margaret I. Balfour and Ruth Young, The Work of Medical Women in India, Bombay, 1929, p.xi.

19Ibid.

20Jean-Pierre Goubert, 'The Art of Healing: Learned medicine and Popular Medicine in the France of 1790' in Robert Forster and Orest Ranum eds., Medicine and Society in France, Baltimore and
Bengali text on midwifery recommended putting a woman's hair into her mouth to speed her labours, a common practice among dhais.  

By the middle of the nineteenth century the great advance that Western medicine had made over the traditional Indian system was probably the principle of 'Listerism'. We cannot, however, regard its practice as universal or thorough, even in the major hospitals in the largest urban centre. Previous theories of miasmatic disease still held sway over the minds of hospital administrators and medical men. This emerges in several comments on the insanitary conditions in anturghars. Sir Patrick Hehir of the Indian Medical Service, wrote of the smoking baskets of coal that were hung up in the Medical College Hospital at Calcutta when he was a student, presumably in the last years of the nineteenth century, to purify the atmosphere. It is interesting that fumigation was one of the special faults, in medical perception, of the anturghar.

It is a moot point, however, what the radical step of hospitalisation entailed in terms of what we now regard as the advantages of medical procedures. In 1878, it was strongly insisted that the general atmosphere of a hospital was polluted by

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having the out-patient department under the same roof and by the presence of obstetric wards, which were believed to be an important source of 'hospitalism'.'

An enquiry into the causes of 'hospitalism' was made at the Calcutta institutions in 1881. 'Hospitalism', it was later explained, 'seems to have included sloughing, gangrene, erysipelas, pleuresy, pericarditis, empyema, peritonitis and all cases of septicaemia' and was responsible for 31.06 per cent of mortality in the Medical College Hospitals between the years 1864-69. It was to the introduction of 'Listerism' that the gradual conquest of 'hospitalism' was later attributed, although the Listerian method remained controversial in Indian hospitals as late as the 1880s. Up to that time, there was a strong school of thought, subscribing to the miasmatic theory of disease causation, which maintained that the prevalence of septic disease in the Medical College Hospital was due to radical defects in the construction of the hospital.

Since it was believed that having obstetric wards under the same roof as the rest of the wards was dangerous, a separate obstetric

"IOLR: Report on the Calcutta hospitals by the Committee appointed to inquire into Medical Expenditure in Bengal, 1878 (O'Kinealy Report), p.9.

"Medical College Centenary Volume, p.52.

"Ibid., pp.52-54."
block (the Eden Hospital) was constructed. In 1885, four cases of septicaemia were reported from the Eden Hospital and Dr Harvey, the superintendent, attributed this either to 'the insanitary conditions of the bustis close to the hospital' or to the 'badness of the hospital washing'.

The principle of asepsis was seen by a number of people who were influential in the medical establishment as unnecessary, impractical and expensive. The First Surgeon of the Medical College Hospital, Dr Kenneth McLeod, had to explain his alleged adherence to the principles of the Listerian method. He clarified:

*I have not in one single case, since I became first Surgeon, carried out the Listerian method in all its details.* (itals original)

This, he said, was in response to the comment in the Lieutenant-Governor's Resolution of the previous year, which he interpreted as a reprimand:

The advantage of strict Listerism seem doubtful in hospital practice, while, as a system to be taught exclusively to pupils, it is not desirable.

One of the principal objections against 'Listerism', apart from the suspicion of faddism that is hinted at, was the expense involved. In connection with the costs of the procedures, it was reported that they were not attempted at the Campbell Hospital (formerly the

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27Report on the Calcutta Medical Institutions 1881, p.3.
An examination of the practices described in case histories from the Medical College hospital is revealing. They show us the extent of the belief in humoral principles. Dr Goodeve's Midwifery Hospital Register reported a case of 'sloughing uterus, dysentery, death'. Taramony, a Hindoo female, 24 years old, was admitted to the hospital five months pregnant in August 1842 and was delivered of a dead male child by forceps in January 1843. Having developed puerperal fever and diarrhoea, she was treated with leeches on the abdomen, a bran poultice, senna and emetic tartar, injections of warm water in the vagina. She died shortly after.\(^3\)

More detailed is the report on the case of Beebee Jaun, who died of impeded labour, followed by puerperal fever, phlebitis etc. She was bled repeatedly with the application of leeches and given purges of castor oil and turpentine. Reportedly of 'strong and robust habit of body', she was in hospital for over a month and was bled from either arm (losing 36 ounces of blood) and given laudanum. The delivery took 28 hours. During the following day, she was reported to have slept poorly and talked incessantly and wildly, had a hurried small pulse, and general pains all over her

\(^3\)Report on the Calcutta Medical Institutions, 1881, p.11.

\(^3\)Allan Webb, *Pathologica Indica*, Calcutta, 1848 (first published 1844), p.321. The senna and tartar emetic were intended to purge the body but would have led to total dehydration after diarrhoea. The leeches and the poultice related to the treatment of fever.
body. Her head was shaved at noon and thirty leeches applied behind her ears; a 'brisk purgative of Jalap and scammony' was administered, and after its operation a mixture of antimony, liquour and ether and camphor was prescribed to be used all night. She was delirious all night and strayed through the ward in quest of her child...24 leeches were applied to the iliac tumour, a warm poultice over the abdomen and vulva; cold lotions to the head and one 'fever powder' every hour - a lavement of warm conjee, water and soap was applied every four hours, and the bladder to be regularly emptied. She was a little more tranquil in the day but by the next day, 'her delirium had subsided into mania', the countenance was extremely pale and anxious. Thirty leeches were, consequently, applied to her temples, and three days later when she complained of pain in her left shoulder and arm, it was observed that wounds had formed on both arms where venesection had been performed. Twelve leeches were applied to the vein. She died on 3 August 1845. In his remarks, Dr Stewart, Professor of Midwifery, condemned himself for not having applied the forceps, adding that a difficult labour endangered the state of the brain.

Apart from the method of treatment, it is relevant that women could stay for periods varying from one to four months in hospital, and the idea of the mother being separated from the infant after

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Webb, Pathologica India, pp.326-329. The case suggests how strongly influenced by humoural theories the doctors were. Bleeding and purging were intended to reduce the 'heat' that was causing the fever.
Medical work among Indian women who refused to see male doctors was first undertaken by women missionaries, many of whom lacked formal training or qualifications. Early zenana mission work had centred around education and the teaching of such skills as embroidery and crochet, but it was soon found that this was of limited efficacy as a means of proselytisation. It was hoped that medical aid and the provision of succour to the ill would prove of greater benefit, and many missionary women undertook to visiting hospitals and to practising some form of healing themselves, mainly among the inmates of zenanas who were notoriously unwilling to avail of male medical aid.33 ‘...while education is one key, a medical mission is another, to unlock closed entrances both in city and village life. Female medical missions are indeed a key to it every lock, and she who practices the healing art may hope not only to cure, but to Christianise her patients...to deposit the leaven of the Gospel in numberless hearts and homes.’34 Dr Ethel Bleakley asked rhetorically where else in Nadia but in a Mission Dispensary would

33 In Work While It Is Day: A Memoir of Lydia Miriam Rouse by Her Husband, G.H. Rouse describes his wife's weekly visits to the Medical College Hospital, Calcutta, 1885, p.141.

The battle for the extension of medical education among women in Britain had been helped by the powerful images of Indian women dying in childbirth rather than calling in male medical attendance. Such stories, emanating mainly from missionary sources, were often published in the British press and helped garner public support for the cause of women doctors. There was little opposition to educating women to work for this noble cause and, by the end of the century, as many as a third of the graduates of the Royal Free Hospital in London said they wanted to work in India.

Important among the early medical missionaries were American women. The American women were the first fully qualified doctors, as medical colleges opened their doors to women in America before they did in Britain. The Indian Normal School and Instruction Society of Britain followed in their wake but the women they sent out were, in 1875, women who had gained sufficient knowledge to be very useful. This was referred to as 'kutcha' work, and it was work of this nature that made Hannah Catherine Mullens familiar with the travails of Bengali women in childbirth.

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36 I am indebted to Dr Rosemary Fitzgerald, who has done extensive research in the Royal Free Hospital Archives, for this information.

37 See her detailed description in her novel Karuna o Phulmanir Bibaran.
Medical education had been made available to a few Englishwomen in 1867, but it was not until the end of the century that large numbers were permitted to join medical institutions. As Dame Mary Scharlieb, one of the first four women to join the Madras Medical College in 1875, pointed out in 1929 that it was only a generation ago that 'even in England and America, would-be medical women were still fighting hard to obtain education, especially in the form of clinical training both as undergraduates and as junior practitioners.'

The American missionary, Dr Clara Swain, who came out to India in 1869 and practised in Bareilly for some twenty-five years, was the first qualified medical woman to work in India. Her account suggests that from the time of her arrival, many women welcomed her professional presence, though they wished she would pay home visits. It was only after women were permitted to join medical courses in Britain that many more qualified doctors came to work in India. Indeed, one of the reasons given for permitting women to study medicine at all was the need to send medical women to India. Dr Ruth Young recorded that a large proportion of the women who first studied medicine in the West did so with the express object

38 Mary Scharlieb, op.cit., p.ix.

39 Clara A. Swain, A Glimpse of India: Being a Collection of Extracts from the Letters of Dr Clara A. Swain, First Medical Missionary to India of the Women's Foreign Missionary Society of the Methodist Episcopal Church in America, New York, 1909, p.46.
of becoming medical missionaries.\textsuperscript{40}

In the 1860s and 1870s many zenana missionaries started taking up medical practice, usually after furlough or a period of leave in Britain. Short courses in midwifery and medicine began to spring up. (In 1877, the London School of Medicine and the Royal Free Hospital began to train women formally. Unqualified medical missionaries began to work in association with or to be succeeded by medical women.\textsuperscript{41} Many pioneer missionaries, who had been doing kutcha work for years, returned to Britain to acquire formal training and degrees.) One such individual was Dr Margaret Bielby, who wrote of her experience:

Friends of this mission have quoted me as an example of what an unqualified medical missionary can do, but they either forget, or do not know, the circumstances of my case. People see only the outside; they know nothing of the hours of anxious reading when I ought to have been at rest, and of, at one time, broken health because the burden was too much for me; and also, when I first went out to Indian there was not a college or university that gave diplomas or licenses to ladies. Whatever I may have done, I should have done better had I been qualified, and should have been free to go on with my work now instead of returning to my studies for two or three years ...\textsuperscript{42}

By 1395, the number of lady missionaries with some surgical

\textsuperscript{40}Dr Ruth Young, 'Medical Education for Women' in E.W.C. Bradfield ed., An Indian Medical Review, Delhi, 1938, p.154.

\textsuperscript{41}Balfour and Young, p.14.

training was said to be considerable." Surgery was a specialisation not generally open to women, yet the circumstances of work in India were such that medical women were called upon to perform operations upon purdahnashins or women who refused to be attended by male doctors. An American journalist observed in 1895:

English missionary doctors have been known to attempt cases and even operations of the highest complexity merely upon their own slender knowledge, and the results have not always been wholly satisfactory.

On the other hand, missionary doctors were said to have succeeded in carrying the frontiers of medicine further than the state medical establishment would ever do. Their patients included, especially in rural areas, who had no access to professional care. The number of poor Christian converts who attended their hospitals and dispensaries was also remarked upon. In fact, medicine was an important component of the evangelising mission, as is borne out by the account of the reform of midwifery practices by the European narrator in Hannah Catherine Mullens's novel, Phulmani o Karunar Bibaran. She is not a medical woman herself, but the wife of a Civilian. In Mullens's mind, Christianity and science are so clearly identified that the observance of irrational superstitions and 'un-medical practices' like pushing a woman's hair into her mouth to speed her contractions or making her kneel

45 Report of the Third Decennial Missionary Conference, Bombay, 1892–93, p. 327. Miss A.S. Kugler said this was the justification for medical missions even after the establishment of the Dufferin Fund.
in labour are given as examples of traces of heathenism lingering in Christian families."

The advantages of seclusion
Medical work in India was not without its rewards, especially for medical women who were afforded professional benefits they would rarely enjoy in Britain, such as independent charge of dispensaries and hospitals, and the opportunity to perform surgical operations. Surgery, as the most prestigious specialisation in medicine, was rarely open to women." Thus seclusion meant the creation of a separate women's space was created even for women who did not themselves observe purdah. As Hanna Papanek observes:

Another consequence of the sharp division of labor between the sexes and the limitations on contact between unrelated men and women implied in the purdah system is the development of separate female clienteles for some services which must be provided by other women. Paradoxically enough, the restrictions of the purdah system create new opportunities in the 'contact services', such as medicine and education, for educated women serving a female clientele. ... Since these professions are not directly competitive with men's occupations, they are less affected by the strong prejudices against women working outside the home which can be seen in other occupations."

This was similar to the observation by Balfour and Young:


"Balfour and Young, pp.8-10.

Strangely enough in India there is little sex prejudice as regards work. Women's entry into medicine was accepted as a natural and suitable event.⁴⁹

In fact, many doctors spoke of the 'rewarding' nature of the work, and the appreciation expressed by grateful patients and their families. The heady feeling of indispensability was strongest in 'the great cities of Punjab, U.P. and Central India' in whose mohullas 'women's medical work is perhaps at its most ideal'. The Kiplingesque fascination with the rugged and uncivilised aspects of Indian life made Bengal less than a favourite with aspiring medical workers. The Bengal bureaucracy and medical establishment was too well-entrenched to allow the 'freedom and challenge' of the woman doctor in far-flung areas like Baluchistan, 'where many of these wild and more or less hostile tribes-people get their first lesson in empire co-operation in the wards of the zenana hospital'.⁵⁰ In addition, the southern, eastern and western parts of India had plenty of private specialists, and the women's hospitals were most important as institutions where the custom of purdah was most widespread.⁵¹

The Dufferin Fund

It was purdah that had justified the establishment of a separate chain of women's hospitals. When the Countess of Dufferin went out to India as Vicereine, she carried the Queen's instructions to

⁴⁹ Balfour and Young, p.101.

⁵⁰ Ibid., p.8.

⁵¹ Balfour and Young, pp.11-12.
interest herself in the matter of medical help to the women of India. The National Association for Supplying Female Medical Aid to the Women of India or the Countess of Dufferin's Fund established in 1885 was the outcome. The majority of Dufferin hospitals were concentrated in North India, the major hospitals in the south being in Caste and Gosha Hospital in Madras and the Dufferin Hospital in Hyderabad, where Muslims and some of the Hindu elite practised the seclusion of women. (The Dufferin Fund was frequently accused of encouraging the institution of purdah, and it was also alleged that it served to further the cause of medical women as an interest group, whereas in fact there was no real need for such separate hospitals.) There were reportedly many public misconceptions about the true purpose of the Fund, but the main objectives of the Fund, repeatedly mentioned in its Annual Reports were:

1. **Medical tuition**, including the teaching and training in India of women as doctors, hospital assistants, nurses, and midwives.

2. **Medical relief**, including -

   (a) the establishment under female superintendence of dispensaries and cottage hospitals for the treatment of women and children;

   (b) the opening of female wards under female superintendence in existing hospitals and dispensaries;

   (c) the provision of female medical officers and

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"Harriot Dufferin, 'The National Association for Supplying Female Medical Aid to the Women of India' in The Asiatic Quarterly Review, April 1886, pp.257-58.

53 Ibid., p.34.
attendants for existing female wards;
(d) the founding of hospitals for women where special funds or endowments are forthcoming.

3. The supply of trained female nurses and midwives for women and children in hospitals and private houses."

The class to which the Fund addressed itself was made plain: it was the purdahnashin women of India. By the end of the century, the Government of India maintained an elaborate state-supported medical establishment which kept up over eighteen hundred institutions, in the form of civil hospitals, under the chief medical authority (usually the Civil Surgeon) of the district in the mofussil and under the professors, physicians and surgeons of the medical colleges of the Presidency towns." In addition, small dispensaries, generally affording accommodation for a few in-patients and under the control of an Assistant Surgeon or a Hospital Assistant, had grown under both state and private patronage." It was reported that the only women who went to such general institutions were 'the poorer and working class women'. Although the hospitals had special female wards, the doctors were all men. The Dufferin Hospitals were a response to the perceived need for special hospitals for women of the 'respectable' classes,

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54 See the articles of association of the National Association for Supplying Female Medical Aid to the Women of India, included in all the Annual Reports of the Association.


56 Ibid.
reported to willingly avail of the medical aid proffered by zenana missionaries.

Secular services for the purdahnashin

In a short story called 'Nurse Nellie', which Rokeya Sakhawat Hossain claimed was based on an incident from real life, the author revealed some of her characteristic ambivalence about aspects of 'Westernisation'. It is about a Bengali Muslim woman from a sharif family who was lured away from her husband and children by the machinations of nursing sisters at a zenana hospital where she had spent a brief period, mainly due to the good offices of her husband, who also had 'progressive' ideas about women's education. Converted to Christianity when her illness and vulnerability made her most susceptible, 'Nellie' ends up a hospital drudge, the defiling nature of whose tasks, such as carrying slops and dirty buckets, is repeatedly emphasised. The narrator thinks she must be a Methar by caste, and when she speaks to her learns that Nellie regrets her conversion and reads the Qoran in private. and the narrator feels it an insult to the Qoran to be handled by hands that do such unclean work.57

This story is significant because of the attitude it reveals towards hospitals in general and towards mission hospitals in particular. The work of nursing is clearly regarded as menial and

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'low-caste', so that the hospital itself is not a neutral space but a place of potential danger and defilement. In addition, there is the threat of conversion or loss of faith because of the evangelising zeal of missionaries.

The story was published in 1921, though it may have been written considerably earlier, but as early as the 1880s, the Dufferin Fund felt the need to dissociate it from any proselytising project. The first important point to be repeatedly emphasised by the founders of the Fund was the non-sectarian nature of the services offered. The deliberate distancing from missionary endeavour that was given prominence in the literature of the Fund was to lay at rest popular fears about the motive that lay behind medical assistance. Medical women coming out to work in India under the auspices of the Fund had a clause in the contracts they were obliged to sign, stating they would desist from any evangelising activity. This led to some controversy as many zenana missionaries availed of the opportunities offered by the Fund to pursue a professional course of medical training and some wished to continue the work they had been doing under the umbrella of the Dufferin organisation. The founder of the Fund, Lady Dufferin was obliged to state:

The National Association is founded upon the principle that it is to be strictly unsectarian, ... though nothing seems more easy theoretically, in practice we find ourselves constantly stumbling against it;...5a

5aHarriot Dufferin, op.cit., p.268.
The reason for this, she said was that, 'having strongly at heart the organisation of a system of medical relief for the women of the country', they were 'as yet obliged to sternly keep aloof from almost the only organisation for the purpose which exists and is already in working order.' Although they would have been of the greatest possible help to the Fund, it could not employ them for they were 'bound in honour to use the money subscribed on the faith of our unsectarian principles, in such a way as to satisfy the most exacting critic.' The money for the Fund had been subscribed by such luminaries as the Maharajas of Jaipur and Alwar and the Nizam of Hyderabad and a host of lesser donors from the ranks of the landed classes.

Lady Dufferin took particular care to explain the exact position of the Fund with regard to medical missions, in answer to some of the controversy that had arisen in this regard. A 'missionary lady in charge of two dispensaries in Bengal had put some questions to the Committee, to which she replied:

I. The National Association cannot employ missionaries, nor can it provide hospital accommodation in which it is intended to combine medical treatment with religious teaching.

It may, in certain case, be glad to avail itself of medical missions as training agencies, and may occasionally attach an assistant to missionary dispensary in order to give that assistant the benefit of further training on leaving college under a lady doctor's supervision; but in such cases it would have to be clearly understood that the assistant's duty would be strictly confined to medical work.

II. No officers in the employ of the National Association can be allowed to exercise a missionary calling.

III. The National Association cannot undertake to provide
funds for the travelling expenses, or establishment of medical missionaries. 59

Speaking at the ninth annual meeting of the Association, the eminent Bengali barrister, Monomohon Ghosh, lauded the decision of the Central Committee that the doctors employed by the Fund, should in addition to their regular work at the hospital, pay visits to the homes of such patients as were precluded by social custom from coming to the hospitals and were, moreover, unable to pay the requisite fees for medical attendance. 60 This desire that the Fund take up domiciliary work was at least partly fuelled by the initial lack of enthusiasm for hospital treatment by the very class that the Fund sought to draw to its wards. It was admitted that the higher caste and zenana women had not availed themselves as freely of the facilities offered to them as it had been hoped they would.

This was despite the provision of what were anticipated to be their smallest need, including separate cooking arrangements and accommodation for a personal servant in the private wards at the Lady Dufferin Victoria Hospital in Calcutta. 61 There were separate wards for Hindu and Muhammadan patients. 62 Indian advisers had been consulted regarding design and architecture, and the purdah wards

59 Ibid., pp. 268-269.
60 Ibid., Appendix XXI, p. 116.
61 Billington, p. 96.
were carefully planned to exclude male intruders.63

In 1894, the Superintendent of the Dufferin Hospital in Calcutta complained that the new buildings coming up all around the hospital (at the crossing of Amherst Street and Bowbazaar) overlooked it on all sides. Purdahs and chicks were being used to protect its character as 'a select purdah hospital', but she put forward a case for a 'more private situation and a larger compound.'64 The next year, it was reported triumphantly that that all the patients admitted in 1895 were of a 'high or good caste':

we have on record the highest caste women amongst our Hindu patients, and most of our Muhammadan in-patients are high-caste purdah-nashin women.65

It is interesting that more Muslim women were reported to attend the hospital than Hindu, on account of the more stringent taboos

63The ordering of space became even more crucial for the Dufferin hospitals than for the general because seclusion was the primary rationale of the purdah hospitals. They attempted to incorporate some of the features of the andarmahal within Indian homes with concessions to the medical desiderata of fresh air and sunlight. In 1918, Dr.Catherine Wickham reported on the unsatisfactory design of the Ripon Hospital in Simla in the Annual Report of the Dufferin Fund:

It is not possible to observe any "Purdah" arrangements in this hospital. There are three separate entrances and men walk in and out of the wards of the out-patient department as they like; there is no one is to prevent them or to enquire their business. I would like to see all entrances closed except the main one, where a chaprassi should be stationed and males only allowed to enter by permission.


that Hindu women of the higher castes observed in matters of food and drink, apart from the pollution associated with the site of the hospital itself. If a major consideration of the Muslim women was privacy and seclusion from the male gaze, the hospital was an acceptable place for treatment.

It was to protect the caste feelings of the zenana women that it was decided to exclude converts to Christianity from its wards. This gave rise to some bitterness but it was argued that the Fund had been established to benefit caste Hindu and Muslim women and the presence of a class they regarded as 'something like pariahs' would subvert its true purpose. On the other hand, it was argued, Christian women had no scruples about attending either missionary hospitals or civil hospitals and had, therefore, no special reason to come to the purdah hospitals. The Dufferin Hospital took care to exclude even from its out-patient department women who were felt to be capable of going elsewhere for advice and who were felt not to be entitled to go to the Dufferin Hospital, as they would become a cause of offence to high-caste and purdahnashin women. The Superintendent was particularly careful about this, she said, when she discovered that 'good-caste women' did not return willingly to the hospital, on the ground that they met women they did not care to meet. In 1896, it was decided to exclude European and Christian women.

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66Ibid., 153-54.
67Billington p.107.
68Dufferin Fund 1895, p.154.
Eurasian women from the Dufferin Hospital in Calcutta, leading to a fall in the number of in-patients. In 1880, the midwifery department of the General hospital had been virtually abolished. This was reported to have affected the poorer Christians of Calcutta and nearby districts most of all. However, it was reported that very large numbers of European and Eurasian patients availed of the facilities for delivery at the Medical College Hospital, more so since the spread of the railway network.

In 1894, the superintendent of the Dufferin Victoria Hospital, Calcutta, reported that they had been very strict about the class of women they admitted but she was glad to say a fair number of purdahnashin patients had been treated. She said the prejudices of high-caste patients about admittance as indoor patients was greater in Bengal than in the 'up-country districts'. Many of these women and their relatives considered it a disgrace to live in a hospital. She observed that 'very frequently the husband or brother of a patient, who would be glad to come as an in-patient, prevent her from remaining or take her away as soon as admitted.' A very large family, especially young children, were another common problem.

There were only nine confinements in the hospital that year and

66 Dufferin Fund, 1896, p.3.

77 Bengal Medical Proceedings, April 1880, annexure, IOL Collection 15 - 1/4, from J.Ewart to Secretary GOB, Judicial and Political, p.7. (OLO: P/14-78)

78 Bengal Medical Proceedings, 1880, File no.11, IOL Collection 2, Proceedings 58 and 59, from Surgeon-Major T.E.Charles MD to Secretary, GOB, Medical-Municipal Department, dt.4th October 1880. (OLO: P/14-78)
seven abortion cases. She had also observed that women were more 'shy and reserved and less ready to accept the full medical and surgical treatment' offered. They ran away from hospital at the prospect of 'only a very small operation'. She had seen women of the best class who will not even allow a stethoscope to be applied to their chest, nor a small eye-dropper to come near their eyes. They simply hand you their pulse,...'"

Examining the pulse was an important part of the ayurvedic and yunani diagnostic procedures in general, and was the usually the method used for women."

The general paucity of confinement cases was explained simply as a result of 'high-caste and purdah-nashin' women's preference to be confined at home. In 1897, the hospital had no maternity cases at all. In 1900, it was deemed that the experiment of having none but purdahnashin women in the hospital was a failure and it was decided to exclude only women of 'certain classes and professions, and to admit persons of the cup-bearing classes of Hindus and those who correspond to them among Muhammadans.' By


"In Tara Shankar Bandyopadhyaya's novel, Arogya Niketan (Calcutta, 1954) there is a description of the 'clash of cultures' when a kaviraj trained in the art of pulse-reading finds himself edged out of business by a doctor trained in Western medicine.

"Dufferin Fund, 1895, p.154.

"Dufferin Fund, p.43.

1903, however, Calcutta reported an increase in purdah patients, chiefly for surgical operations."

**Spreading into the mofussil**

In his speech at the first annual meeting of the Dufferin Fund, Lord Dufferin had said the object was to found an Association which would ultimately supply the women of India with proper medical advice and attendance under conditions 'consonant with their own most cherished ideas, feelings and wishes.'

Our ambition is eventually to furnish every district, no matter how remote, if not with a supply of highly-trained female doctors, at all event, with nurses, midwives and female medical assistants who shall have such an acquaintance with their business as to be a great improvement upon those who are now employed."

Although the Dufferin Hospitals remained confined to the larger towns and cities, smaller branches of the Fund began to operate in the mofussil because of the growing number of Indian women with the rank of Sub-Assistant Surgeon or Hospital Assistant. They were licentiates of the 'medical schools', such as the Campbell Medical School in Sealdah, which gave instruction in Bengali. They appear to have met with varying responses. In Bankura, for example, a woman called Hemangini Devi, a Hospital Assistant, was in sole

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77Dufferin Fund, Bengal Branch, Annual Report, 1903, p.7.

78Speech of the Marquess of Dufferin and Ava, Viceroy of India, at the first annual meeting of the National Association for Supplying Female Medical Aid to the Women of India, quoted in the Annual Report for 1895 of the Dufferin Fund, p.123.
charge of the local hospital." She reported that women of all castes came to the hospital for treatment and that she also attended many cases in the town gratis. On the other hand, although a well-ventilated 'cottage ward' with a separate cook-room and latrine attached was constructed in Chinsurah in 1895, with a seven-foot wall to ensure privacy, the only occupants reported were said to be poor, respectable Eurasian women. In Barisal, jhaps (mat screens) were erected for privacy in the Dufferin ward of the Civil Hospital, though the hospital was not strictly a purdah one. Purdah women were brought now and then in covered and closed carriages, but the majority of the patients were said to be mainly 'poor and lower class'. In Chittagong, it was reported that even poorer Muslims observed purdah, so the patients at the Dufferin ward were mainly Hindus. In 1897, after the old building of the hospital was converted into a separate purdah hospital, the number of patients was reported to have increased. Although Dinajpur had a separate women's hospital with cottage wards, only nine purdah nashins were reported to attended in 1896, while the poorer

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79 Report of the Bengal Branch, Dufferin Fund, 1894, p.161. Hemangini Devi was the wife of Professor Kulabhi, a Christian and teacher at the Bankura College. I am indebted to Abhijit Sen for this information.

80 Dufferin Fund, 1896, p.33.

81 Ibid., p.39.

82 Ibid., p.52.

83 Dufferin Fund, 1897.
classes had attended in large numbers. Similarly, in the Anarkali Hospital in Berhampore, District Murshidabad, attempts to preserve the hospital for purdahnashins had led to the hospital being virtually unused, leading to the sanction of its use by all classes.

While it seems the assumption was that purdahnashins were mainly from the more prosperous classes, a correspondent in The Statesman of 8 July 1891 spoke of the failure of the Fund to reach the 'respectable poor', who 'would rather die in their own homes without medical aid than visit a hospital or dispensary, though entirely conducted by ladies'. Such women, said the letter, could not visit public hospitals for fear of social disapproval, nor could they afford the fees generally charged by lady doctors for home visits. If the statistics of the women who visited hospitals were taken, declared Z.M. (whose initials suggest a Muslim name), hardly one in a hundred would be of a really respectable or good caste.

In 1899, Colonel Hendley, Inspector-General of Civil Hospitals, inspected all the women's hospitals in Bengal. In his report, he laid much stress on what he conceived to be the principal object of the Fund, that was, to provide medical aid for those who could not

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8*Ibid., p. 69.
85Ibid., p. 99.
86Letter to the Editor, reprinted in The Statesman Hundred Years Ago, 8 July 1991.
or would not obtain it through male agency. He recommended the attendance of medical women as General Practitioners in the homes of the 'better classes' and the training of dhais, rather than in trying to attract women to hospitals. He pointed out the impossibility of having purdah hospitals in the true sense if there were male compounders working in them. He held also that the admission of non-purdah women deterred the 'real zenana ladies' from attending, and that out-patient practice took up far too much of the time that could be utilised in home visits to purdah ladies. He suggested that these difficulties could be avoided by directing to the general hospitals all those women who could be properly attended to in them."

Reporting on the twenty-six hospitals and dispensaries funded by the Dufferin Fund in Bengal Presidency outside Calcutta, Dr Catherine Wickham said only half were headed by qualified medical women. 'The majority of the hospitals were cheerless and comfortless, very public and unlikely to attract the class of women for whom they were designed...The women and children looked as if they would not hesitate to consult a male doctor and go as willingly to a civil general hospital.' Dr Wickham reported that those hospitals which had 'cottage wards' attracted women as in-patients despite their gloominess and the general idea that the way to keep them 'purdah' was to close all the doors and windows. The

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87Bengal Branch of the Dufferin Fund, 1899, p.3.
88Dufferin Fund, 1918, pp.36-37.
only hospital that seemed to have been found satisfactory was the Dufferin Hospital, Calcutta. It is not that the others were not drawing patients, but here the emphasis was so clearly on the class sought, that the very purpose of the Fund was seen to be subverted by the attendance of women other than of the purdah-observing classes. Even at the Dufferin Victoria Hospital, the Superintendent, Dr M.V. Webb, reported the same year that although the number of paying patients who hired the expensive private cabins at the hospital (these cost more than similar ones at the Eden Hospital) grew every year, more than half the patients at the hospital were not strictly 'purdah' women but 'respectable women who prefer to be treated by their own sex.'

Meanwhile, the cause of medicalisation found allies from outside the medical profession. Medicine and hospitalisation represented for individuals like Cornelia Sorabji, all that was beneficent and progressive in imperial rule and Western civilisation. Herself a barrister and a second-generation Christian, she was, in her own words, 'brought up English' and was uncompromising in her desire to reform the Indian way of life, regarding the cause of Indian women her special calling. As the Lady Superintendent to the Court of Wards, Bengal, Bihar and Orissa, and Assam, she played an active role in encouraging the purdahnashin wards to come to Calcutta for

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"See her autobiography. Cornelia Sorabji, India Calling, London, 1934."
medical treatment at the cottage wards of the Dufferin Hospital, and arranging for medical women to visit the estates. On at least one occasion, she turned her own home in Calcutta into an 'aseptic ward' for the benefit of a particularly recalcitrant woman.\(^1\)

**Medical education for Indian women**

In 1894, the Annual Report of the Dufferin Fund reported that it had been decided that the scholarships offered by the UK Branch should be open to women who passed in India and were 'desirous of going home to take the higher degrees in medicine and to qualify as lady doctors of the first grade.'\(^2\) The experience of the past ten years had led the Central Committee to believe that 'for some reasons the system of engaging ladies who have received a preliminary education in India, and who have completed their studies at home would prove advantageous and perhaps preferable to that of obtaining the services of English lady doctors direct from the schools of medicine in London, Edinburgh, and other universities.' The former possessed the advantages of having some knowledge of the country and its customs, and of the ways, habits, and diseases of its women, and were as a rule, fairly acquainted with the language.

Medical education for Indian women had not come without opposition.

\(^1\)Report of the Lady Assistant to the Court of Wards for 1914-15, MSS Eur 165/131, p.5, and for 1915-16, MSS Eur 165/132, p.4. Sorabji was also eager to introduce mothercraft classes for zenana women.

\(^2\)Dufferin Fund, 1894, p.9.
Balfour and Young commented sardonically about the particular delay in admitting women to the Medical College in Calcutta, though Bengal Presidency was generally regarded as 'progressive'. They point out that in 1876, 1879 and again in 1882, all proposals towards this end were turned down. The Surgeon-General of the Indian Medical Department had declared in November 1873 that he was not an advocate of the opening of 'female medical school for the general teaching of the medical art.' In his opinion, teaching should be confined to midwifery, and the common diseases of women and children.

In May 1882, A.W.Croft, the Director of Public Instruction solicited the opinion of the Principal and the Council of the Medical College, Calcutta, as to the admission of females to classes at the college and urged that they should be admitted on the ground of the great alleviation of suffering which would probably result if there were a body of qualified practitioners to whose admission to zenanas there would be no objection, as well as on the ground that if the Medical College classes were thrown open to females, a career of usefulness would be provided for those ladies, native and others, who are now passing the University examination.

It was proposed that women be admitted to the LMS course if they passed the entrance examination, but when the proposal was put to

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'Balfour and Young, p.101.
'GOB, General: Education, July 1883, Proceedings nos.1-11, File 10.88.'
the vote at a Council meeting, four members out of five voted against it. It was recommended that if medical education for women was found to be necessary, a separate college for women should be established, while the opinion was also expressed that such education was not, in any case, extensively demanded and that an extension of existing training in midwifery would be sufficient to meet the requirements of the case. On one point, that is, the matter of lower qualifications for entrance, the whole Council was unanimously adverse. Some of the members of the Council objected to medical instruction to women altogether; others to instruction given in mixed classes. The need for women doctors was denied by some, while others asserted the general unfitness of the sex for the practice of the profession. The single supporter of the suggestion was the Acting Principal of the College, Dr Harvey.

The Director of Public Instruction, Croft, emphasised that

the conditions of social life in this country are such that the existence of a body of thoroughly trained and qualified female practitioners may have the effect of rescuing large numbers of the women of India, either from a life of suffering or from premature death."

Croft was of the opinion that it was sufficient if women candidates had passed the Entrance examination of the University, as a temporary exception in favour of women candidates only, but the Principal demurred, saying the F.A. examination was a necessary qualification to ensure knowledge of English and 'general intelligence'. The Council, however, voted against lowering the

"Ibid."
standard for admission and, with Harvey dissenting, against the admission of women at all.

They declared mixed classes were objectionable, and were likely to exercise a 'demoralising' effect on both sexes, especially in such subjects as Anatomy and Surgery. Second, if women were to be educated in medical science at all, it was necessary to provide a separate school and hospital for them. Third, they said there was not, in their opinion, any general demand for female physicians and surgeons among Indians, and, fourth, more extended training in midwifery and diseases of children would suffice to meet the requirements of the case.

Among the individual members of the Council, J.F.P. McConnell felt 'personally strongly opposed to this proposition', saying the most eminent and leading members of the profession in Britain and the medical press were unanimous, on both physiological and social grounds, in their condemnation of the pursuance of higher medical education by women. He said women were already being trained as midwives and had 'the privilege of attending lectures on the diseases of women and children, and the practice of the maternity department'. Increased facilities in this direction would be afforded by the opening of the new Eden Hospital. He added that the conditions of social life among the natives in this country continued unfortunately to demand women skilful in the treatment of diseases 'peculiar to their own sex', but he said there was as yet
no evidence that there was any real demand for women general practitioners. He felt women doctors would not only not command the confidence of the community but were absolutely unfitted for the exercise of such a profession, from 'physical and other causes'.

Dr McLeod, the First Surgeon of the Hospital, said women were unfitted for the medical profession, which demanded 'physical power and endurance, cool judgement, and strong nerve, - qualities in which women are specially deficient'. He agreed with McConnell in all his opinions, and said women doctors were not likely to command respect, confidence, and acceptance in India. Greater liberality of sentiment would, he argued, lead to the development of the existing confidence in male doctors. He had himself found women perfectly willing to be attended by himself. At the same time, he was approving of the education of women as midwives and nurses, 'the more thoroughly, scientifically, and systematically the better,' though he did not feel young, unmarried girls were the best candidates for this training. Nicholson argued that with the education of women, the prejudice against men would die out and the demand for women doctors would contract.

Among the first few names of women graduates of the Indian medical schools, there were more European names than Indian, though the latter was said to be a growing category. It was generally felt that respectable Indian women were unwilling to pursue medicine as a career, even if they were qualified to do so, because of co-
education. It was reflection on the lack of candidates that scholarships offered by the district boards of Pabna and Mymensingh went a-begging. The educational prospectus for the Calcutta Medical College for 1885-86 had separate requirements for women." At the same time, it was necessary to have a lower standard of qualifications for admission to the Campbell Medical School, which began admitting women in 1887. The Vernacular Licence in Medicine and Surgery was awarded between 1853 and 1906.

The first woman to be admitted to the Medical College was Kadambini Ganguli in 1884. This was the year that the Swarnamoyee Hostel was constructed thanks to the munificence of the Rani of Cossimbazar. The first women to graduate were Bidhumukhi Bose and Virginia Mary Mitter, in 1889. An appendix of the 1894 Annual Report gave the names of women doctors who had graduated from Calcutta and their present positions. Kadambini Ganguli who had practised in Calcutta and Florence Dissent, originally from Allahabad, but then working at the Eden Hospital in Calcutta, were singled out for

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99Rani Swarnamoyee represented the very class whose cooperation the Dufferin fund sought to enlist. Herself an illiterate woman, the Rani had been delivered of one of her four children by a European medical man in 1842. See Somendra Chandra Nandy, History of the Cossimbazar Raj in the Nineteenth Century (1804-1897), Volume I, Calcutta, 1991, p.267.

100Calcutta Medical College, Centenary Volume, op.cit., p.46.
special mention.\textsuperscript{101}

Maintaining purdah: the dispute over supervision

Since purdah provided the raison-d'etre of the Fund, it is scarcely surprising that the medical women who worked for the Dufferin hospitals should be zealous in protecting the rights to seclusion of their purdah patients. This was to prove a repeated point of dispute with the Indian Medical Department and to become one of the grievances aired by medical women against the more firmly entrenched professional interests represented by the former. The Dufferin Fund was raised by public subscription but it received a state subsidy and its central committee was controlled completely by the medical establishment. Among the grounds on which the Fund was frequently criticised were that the Fund was in fact inactive and it claimed credit for the results that had really arisen out of the efforts of others (such as the missionaries) and that it was inefficient compared to the missions.

A major point of contention was the right of the Civil Surgeon to inspect any of the hospitals and the work of the women doctors at any time. This was justified on the ground that he could do so in any hospital that received an element of state support, but it was argued that this seriously hindered purdah treatment. The Civil Surgeon reserved for himself the right to perform any operations on the Dufferin patients if he chose to do so, as women were

\textsuperscript{101} Ibid., Appendix V, p.76.
considered unsuited to surgery. It was also a matter of the prestige of women doctors, who were not represented on any of the local committees of the Fund, and who were not represented on the Central Committee until 1909. It was this that made the women doctors say the Central Committee was out of touch with the 'real needs' and to have led to the Fund taking the 'fatal step' of ceasing to seek further subscriptions.\(^{102}\) In England, the Medical Women's Association was actively campaigning for equal remuneration for women and men doctors by the turn of the century and it is not surprising that the unfavourable conditions of service compared to the Indian Medical Service of the Dufferin Fund employees caused dissatisfaction among the latter.\(^{103}\)

Clashes with Civil Surgeons is reported to have led to some capable and skilful medical women being driven to leave India and caused great indignation, even among medical women who were not themselves affected. The Central Committee took no strong line on this matter and the Fund was reported to have become unpopular among medical women both in India and in England.\(^{104}\)

**The rift widens**

In Calcutta, on the 6th of March 1912 a special meeting was held at the Government House, under the presidency of Lady Hardinge. That it was a meeting to discuss vital matters is indicated by the

\(^{102}\text{Balfour and Young, p.39.}\)

\(^{103}\text{Ibid., pp.39-45.}\)

\(^{104}\text{Balfour and Young, p.45.}\)
names of those present: Sir Harcourt Butler, Reginald Craddock, C.P. Lukis, Lt. Colonel O'Kinealy, and several other senior members of the Indian Medical Department, as well as Dr Kathleen Vaughan, Dr Katherine Platt and several other women doctors. The meeting turned out to be an acrimonious one, judging by the official minutes, and the collision was between a newly emergent professional sub-group which saw its own interests as distinct from those of the larger professional interest. The key arguments related to the welfare of the women of India, whose true interests both sides claimed to have most at heart.

Sir Harcourt Butler proposed an amendment of Article 20 of the Rules and Regulations of the Association be amended from 'All persons employed by the Association will be required, as a condition of their employment, to act in harmony with and, where necessary, in subordination to the Medical Officers of the Government' to 'all persons employed by the Association will ordinarily be expected to act in co-operation with, and where necessary, in subordination to the Medical Officers of Government.'

The 1911 Report of the Dufferin Fund had said:

With regard to the question of granting Lady Doctors entire control and independence of their hospitals, the opinion appears to be that capable ladies holding higher

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105 Report on a Special Meeting held on 6 March 1912, at 11 A.M., at Government House, Calcutta, presided over by Lady Hardinge.
qualifications in medicine may generally be safely trusted with the internal control of their hospitals and the professional work therein. But for many weighty reasons it is thought advisable that the Civil Surgeon should as a rule be responsible for correspondence with the Government, the financial control of institutions, plans for new buildings etc.. Many ladies in some of the biggest hospitals, however, have stated that they cannot without the Civil Surgeon's help and advice.

The Vicereine and the Central Committee of the Fund were somewhat equivocal: they said the time was ripe to introduce greater elasticity but quite impossible to define how a larger measure of independence of Medical Officers of Government should be given to medical women generally. Sir Pardey Lukis felt that the objectionable nature of the clause was done away with the removal of the phrase 'as a condition of their employment'. He said that 'in subordination to' referred not to the Civil Surgeon alone, but was a more general stricture. This could be applicable to medical women of the 'first class' in two circumstances:

(a) if certain medical women of the first class were to have members of the staff of a medical college or school, the principal being male.

(b) if medical women were to have full control of their hospitals and if the Civil Surgeon were to 'disappear altogether', it was necessary to have some control. They would then have to be subordinate to the Inspector General of Civil Hospitals, who would, with all due respect to purdah, have to inspect their hospitals from the financial and Government points of view.
The rule being applicable also to women assistant surgeons and sub-assistant surgeons, many of whom were in charge of the female wards of ordinary (not Dufferin) civil and district hospitals, he continued, they would have to be under the jurisdiction of the Civil Surgeon.

Dr Kathleen Vaughan said there was great difficulty in getting suitable women because of this very clause. Women never asked for a member of their sex who was 'less qualified than a Civil Surgeon' to be put in charge, but where a Civil Surgeon had sole charge of a women's hospital, it was 'absolutely fatal to the work and discipline'. The only question ever raised had been that of allowing those as qualified as the IMS to be allowed to control their own hospitals and this had not been allowed, so that after some years, the woman in charge of a hospital was either 'turned out or superceded by an Assistant Surgeon. (Here she cited the example of Miss Trewby of Amraoti who had been superceded by an Assistant Surgeon because she did not admit the Civil Surgeon on the grounds of the the objections of the Indian women patients.) The doctor, added she thought the women were perfectly right to object, and the tendency was where the woman had sole control, to replace her by somebody more pliant. In Nagpur, the Civil Surgeon was said to object to women performing operations, whereas, as a rule, the husbands of Indian women insisted they wanted women surgeons and women anaesthetists.

104Report on Special Meeting, p.4.
The problem was portrayed as one of the future of women in medicine in India. This was an additional reason, represented the women doctors, that large numbers of European medical women no longer wanted to come to India, while 'Indian women who take up medicine are few and far between, because they do object, and their parents very rightly object to their being employed in hospitals where men have the free entry...' (emphasis added). The Bishop of Lucknow was said to have told his Indian Christian congregation that he wished particularly that girls should not enter the Dufferin service nor into medical work at all, where they were to be employed in the same places 'with Indian men without any proper protection'; and it was said to be the feeling that as a rule it was a most difficult thing for any Indian woman to take up the work. The 'Indian sub-assistant surgeon class' was 'wanting in respect to women assistants'. There was said to be an idea prevalent that any girl who took up this lower work was not of 'good character' and there was a consequent need for the controlling authority of some responsible person.

It was not suggested by the amendment, said the representative of the medical women, that some one with a better degree should control those who are badly qualified but that 'because a man is a man he should have control over a woman, however much better qualified she is than he is'. 'A good class will not join the
Dufferin Service or will leave it because of this clause...the lady doctor has to do the work of the nurse, and is simply a bottle-washer to the Civil Surgeon'. In Calcutta, where the clause was not applicable, she said, there was no trouble getting good doctors. Wherever it was applicable, 'the lady doctor has to do the work of the nurse, and is simply a bottle-washer to the Civil Surgeon.' 109

The President and committee stood firm on the matter, though Miss Vaughan said the approval she and other women doctors (including Mary Scharlieb in London) had expressed at the previous meeting in Simla had been of the phrase.'in harmony with'. They had not expected the phrase 'in subordination to' in Article 20 to be retained. As the rule stood, it was very ambiguous as did not specify the Civil Surgeons' right to exercise control and could be interpreted to mean 'any male sub-assistant surgeon'.110

The early years of the twentieth century saw a spate of resignations from the Dufferin Fund, and the First World War meant there was a greater demand for qualified medical officers in Britain. Meanwhile, though the number of Indian women doctors continued to grow, the Fund must have been considerably alarmed

109Ibid., p.5.

110What is made more explicit by example quoted is the fear of the subordination of white women to Indian men. In the princely state of Rampore, the English lady doctor left her post because an Indian state surgeon with an LRCPS of Edinburgh objected to having the lady doctor independent of him.
over the resignations for they issued warnings in successive years, warning women that there was now no shortage of doctors and to therefore to consider the prospects of unemployment after sudden resignation."

What are we to make of this dispute ostensibly over a feminist question of control and equity? We see the coming of age of the medical women’s lobby and, to the extent that women of Indian and Eurasian origin also occupied some posts in the Dufferin Fund, it could be simplistically interpreted as a simple gender issue. However, there is an overt racism built into the assumptions as well. It was true that in the past medical missionaries with less than adequate qualifications had undertaken the treatment of purdah women, including instances of surgery, but it was felt necessary to avoid all official association with kutcha work. There had been some criticism of the training of a class of women hospital assistants, but it was pointed out that the cases were hardly analogous. The latter knew they were responsible to the Civil Surgeon of their district, and worked under his control and supervision. This was to prove a sore point with the better

\[11^{11}\text{See Dufferin Fund, 1907, p.6: 'it has happened on several occasions during the past few years that ladies who have not been altogether satisfied with their posts have resigned them somewhat suddenly, sometimes before they have taken the precaution of securing the promise of a new appointment. As the supply of medical women continues to be considerably greater than the demand, especially where fairly well-paid posts are in question, the Committee takes the opportunity of warning all ladies connected with the Fund that they run considerable risk in hastily throwing up appointments, however uncongenial they may appear to be.' This warning was repeated in subsequent annual reports.}\]
qualified women whom the Dufferin Fund employed.

The Association of Medical Women in India

In 1907, an independent Association of Medical Women in India was established, though it was not formally inaugurated until two years later.¹¹² Forty-two members representing medical aid given to women and children in government, mission and Dufferin and hospitals in the independent princely states were present at the first general meeting held in Bombay in 1909. Addressing the meeting, Dr Annette Benson of the Cama Hospital said:

Looking at the medical profession in India, we see men organised in a service offering worthy careers to its members, with fair rules of pay, promotion, leave and pension. We see women a nondescript, scattered number of isolated units, at the mercy of chance employment and still chance-conditions of service and almost always in subordinate positions. Yet the majority of the better class women of India have no one to look for help in sickness and childbirth but these same isolated units. For the good of this large factor of the population, and therefore in the name of the public weal, we aim so to improve the conditions under which medical women work as to make their work more efficient and their reward fair.¹¹³

Dr Benson was President of the Association, Dr Catherine Wickham the Secretary, and the other founders were Dr Alice Sorabji and Dr Kathleen Vaughan. A deputation to Simla in 1909 put forward the following demands:

1. The Secretary of the Dufferin Fund should be a qualified medical man.
2. At least one qualified medical woman should have a seat on the Central Committee.

¹¹²See A. Neelameghan, Development of Medical Societies and Medical Periodicals in India, 1780 to 1920, Calcutta, 1963, p.68.
¹¹³ibid.
3. An efficient service of medical women for India should be organised and carried out by the Government of India.

Dr Kathleen Vaughan asked to join the committee of inspection for Dufferin Hospitals, while Dr Emma Slater formed a U.K. branch of the Association of Medical Women of India in order to rouse public opinion in that country.\[114\]

The Women's Medical Service

A compromise was eventually worked out with the establishment of the Women's Medical Service of India, which was roughly on par with the IMS - although it had less favourable conditions of service, it was an independent cadre and the running sore of subordination was healed for the time being. Yet, the problem of dependency on government subsidy remained as acute as ever.

The WMS was established in 1914, with the Government of India awarding a subsidy of Rs 1.5 lakh annually to the Dufferin Fund to form the service. There was disappointment that the WMS was in effect in the hands of the fund, the salaries were lower than for the IMS, and the qualifications demanded of appointees were not the highest possible. The qualifications were lowered to employ women already working in India, including Indian women, and the Government of India expressed its unwillingness to fund a rival body to the Dufferin fund. The important changes made were the introduction of permanence of service, increments of salary and

\[114\] Balfour and Young, pp.45-48.
provident funds, furlough after three or four years, and study leave. The most significant politically were the right to attend hospital committee meetings and full professional control over the hospitals. Appointment was vested fully in the Central Committee.¹¹⁵

In 1922, the WMS narrowly escaped the austerity drive known as the Inchcape Axe thanks to the personal intervention of Lady Reading. Balfour and Young comment ruefully: 'when economy is needed a beginning is made with the women's work'.¹¹⁶ There was reported to be 'a great deal of actual leakage through marriage and other reasons'.¹¹⁷ There was also the fact that women doctors tended to be found in hospitals or in private practice in towns only, leaving the rural areas untouched.

The exceptions were the mission hospitals and dispensaries which often functioned in the remotest areas. Mrs Rosalie Roberts worked as a nurse in the Mission Hospital at Sarenga, West Bengal, between 1926 and 1936. She describes people travelling forty or fifty miles, taking two days on the road, to come to the hospital, as they were not within reach of a Government hospital.¹¹⁸

¹¹⁵Balfour and Young, pp.49-50.
¹¹⁶Ibid., p.58.
¹¹⁸IOL: Oral Archives,Eur R56/2.
It was argued that one of the major duties of the Women's Medical Service was the training of dhais, a responsibility that some of the doctors apparently found irksome. Training had been carried out, sometimes with notable success, by medical women since the middle of the nineteenth century, and it was a recognition of this success, as well as an admission of the impossibility of providing trained midwives, leave alone medical women, all over the country that had led to the establishment of the Victoria Memorial Scholarships Fund for the training of indigenous dhais. It was partly to meet this specialised need that a new category of health official was created in the Lady Health Visitor in 1918. The Lady Chelmsford All-India League for Maternity and Child Welfare set up that year ran four Health Schools in the cities of Calcutta, Bombay, Delhi and Madras.

A memorandum on the need to extend medical aid by women was placed by the AMWI to Lady Irwin, the vicereine, in which it was stated that there were 96 hospitals and 43 dispensaries staffed by women medical missionaries, 26 hospitals in charge of members of the WMS, and women's wards in most of the civil hospitals or dispensaries. However, local governments had not availed themselves of fully

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120 See Brief Resume of the Victoria Memorial Scholarships Fund, 1902.

121 See Annual Reports of the Lady Chelmsford League published with the Dufferin Fund Reports.
The politicisation of the professional interests of women doctors enabled them to claim to be the only custodians of women's health in India. They spoke on the issue in important bodies at the national level. In 1930, the National Association for Supplying Medical Aid by Women to the Women of India (as the Fund was now called) made a Statement before the Indian Statutory Commission, in which they said that the female population of British India was estimated to be about 120 million, but the number of women with registrable qualifications was about 400. Of these, 42 were with the WMS under the Countess of Dufferin's Fund, and 15 in the Junior branch of the Fund and in the training reserve. About 90 were working under provincial Governments in Local Fund hospitals. Possibly 150 were working under Missionary Societies and over 100 were in private practice. Therefore, it was estimated, that there was roughly one qualified woman doctor for every 30,000 of the female population in British India. The memorandum went on to say that the purdah system in India made the need for women doctors far greater than in other countries, and that it was a 'matter of common knowledge' that the proportion of deaths at childbirth was

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122 Memorandum on the need for the extension of Medical Aid by women in India presented by the Association of Medical Women in India to H.E. the Lady Irwin, 1930.
notoriously high and the ratio of infant mortality deplorable. It was pointed out that apart from its annual subsidy towards the WMS and the grant towards the maintenance of the Lady Hardinge Medical College, Delhi, the Government of India did nothing to supply women doctors to the people, but left this to local bodies and charitable institutions who were not able to achieve very much in the face of the magnitude of the problems. Significantly, the statement also put forward a demand for support for research and teaching specifically for and by women. The first all-India Conference of Medical Women was organised in 1938. Eighty-three medical women attended and resolved:

'It is the right of every woman to be able to claim adequate attention before, during and after childbirth.'

It seems to have been clear to its members that the medical women's lobby would have to work independently. It had little connection with, for example, the nationalist lobby. In an editorial, the *Journal of the Indian Medical Association* criticised the various organisations that engaged women doctors for being 'top-heavy' and for emphasising curative rather than preventive medicine.

'Defective midwifery' and medical politics

In the early 1920s, a new and contentious issue arose within the

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125 See JIMA, III:9, pp.397-398.
ranks of the medical profession and encouraged the incipient nationalism among Indian medical graduates that was later to crystallise into such bodies as the Indian Medical Association.¹³⁶ This also arose over the question of inspection - in this case the inspection of Indian medical institutions by the General Medical Council of Britain. The University of Calcutta had applied in 1890 for the recognition of its medical degree, which the GMC had granted in 1892 but the latter did not inspect the medical colleges until 1907. The dispute arose over the lack of practical experience of midwifery that was afforded to most medical students.

In 1868, midwifery and the diseases of women had been added to the subjects taught in the vernacular classes at the Medical College (later transferred to the Campbell Medical School).¹³⁷ In 1922, there were not enough obstetric cases for every student to handle the requisite twenty labour cases prescribed by the GMC. An anonymous article in the Calcutta Medical Journal said the decision of the GMC was influenced by political considerations. It pointed out that the first suggestions about defective midwifery training had been made by IMS officers from the United Provinces in 1913 to the Public Service Commission but this had not been made much of before as IMS Professors of Midwifery were themselves responsible


for medical education. The 'defective midwifery' argument, he further suggested, had been advanced in order to insist upon a period of obligatory training in England before an Indian could appear for the IMS. Sir Pardey Lukis suggested before the Commission that owing to conditions in India, it was almost impossible to secure proper training in midwifery for male students. Senior European members of the IMS stated that there was a lack of clinical material for teaching midwifery in the Calcutta Medical College, but Dr Kedarnath Das, an eminent surgeon and the inventor of the Bengal Forceps, as well as Dr Nilratan Sarkar, who was emerging as the spokesman of the nationalist medical lobby, challenged the statistics and statements, the latter saying that if the available cases were utilised for the purpose of training Indian students, there should be no difficulty at all. The Royal Commission did not endorse the IMS view but emphasised the need for a practical course in midwifery. The British Medical Association was seen to be espousing the cause of the elite Indian Medical Service, especially by criticising the Public Service Commission.128

Sir Patrick Hehir of the IMS, a member of the Medical Services Committee established in 1919, declared the training in obstetrics and gynaecology could not be compared to British hospitals because of the exceptional social conditions that made Indian women object

to men attending to them in their confinements. He said that it was reported that even in the hospitals, the Indian midwives sympathised with the sentiments of patients and the students allotted particular cases were often not sent for by the midwife. However, Hehir felt the difficulties had been exaggerated as he and his contemporaries had had no such difficulties when they were students of the Medical College.  

In his Presidential Address to the All India Medical Conference in Lahore in December 1929, Dr B.C. Roy, then Professor of Medicine at the Carmichael Medical College, Calcutta, said the bulk of licensing bodies in England did not have sufficient clinical material either:

The General Medical Council shamelessly rejects recognition of the Indian degrees, not particularly that of Calcutta University, while they dared not do the same with regard to the London and Cambridge Universities when they failed, even so late as 1925, to give the requisite number of twenty labour cases to each student before appearing at the examination.  

There was a school of thought that attributed the paucity of obstetric cases to the emergence of zenana hospitals and the fact that many of the women who would otherwise have come to the teaching hospitals went to the former instead. Women students, in fact, did very well in this regard, compared to their male counterparts.

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131 Patrick Hehir, p.46.
counterparts, so much so that a normal five-year course of training was said to render them experts in midwifery.\textsuperscript{132}

The issue did not, however, become one of gender but, rather, one of the standing and prestige of Indian graduates and degrees, with the interests of men and women assumed to be subsumed by a larger professional interest. The question of why women preferred to attend the maternity homes run by the Corporation to the Eden and Carmichael hospitals was raised at the Congress of the Far Eastern Association for Tropical Medicine held in Calcutta in December 1927. The answer, provided by Dr Alice Headwards was that the latter suffered from the disadvantage of being teaching institutions where medical students attended or witnessed many of the cases, which many of the women objected to.\textsuperscript{133}

Medical research and publications

There had emerged a tradition of medical research among the European doctors in India, which focussed on the particularities of health and disease in the tropics and how these were affected by the context of local customs and habits (see Chapter Four).\textsuperscript{134}

Medical women were regarded as particularly privileged in having

\textsuperscript{132}\textsuperscript{Ibid., p.121.}

\textsuperscript{133}\textsuperscript{See comments by Rai Bahadur Dr. Chuni Lal Bose and response by Dr Alice Headwards, in Discussion on Organisation of Child Welfare Work, Proceedings of the Seventh Congress of the Far Eastern Association for Tropical Medicine, pp.847, 857.}

\textsuperscript{134}\textsuperscript{See, for example, the series of Indian Medical Research Memoirs and the Bulletins of the Indian Research Fund Association.}
access to the inner world of the zenanas or andarmahals, and the late nineteenth century saw a number of books by doctors, describing the conditions they were privy to. Other writers, such as missionaries, drew extensively upon medical accounts.\(^\text{133}\) 

If the earlier works tended to be descriptive and dwelt on exotic aspects, the twentieth century saw the growth in the number of scientific accounts based on detailed observation.\(^\text{136}\) The classic studies by Dagmar Curjel of the conditions of maternity among women workers in Bengal industries and by Florence Barnes of Bombay were commissioned as part of the League of Nations's campaign for maternity benefits, and they threw light on aspects of the conditions under which women workers had to live and work. The role of women doctors had been crucial in the passing of the Age of Consent Bill in 1891 and the report of subsequent Age of Consent Committee under Sir Moropant Joshi in 1929 drew extensively upon the evidence of medical women.\(^\text{137}\) Several social issues relating to issues of gender with political resonances were raised by medical women. The health aspects of the practice of seclusion was one, as was the question of age at marriage. (Ante-natal work in


\(^{\text{136}}\) For example, M.I. Balfour, 'Maternal Mortality in Childbirth in India', in the Indian Medical Gazette, 62:646, 1927.

\(^{\text{137}}\) See the Report of the Age of Consent Committee - the evidence of 400 medical women is cited.
India was introduced entirely through the efforts of medical women. At a time when birth control was still controversial and had received no official sanction, medical women were enthusiastic proponents of the cause. Margaret Sanger and subsequently Edith How-Martyn and Eileen Palmer received warm welcomes in Calcutta. Members of the AMWI ran a birth control clinic in Calcutta in the 1930s. An outstanding piece of research was the study of maternal mortality in Calcutta conducted by Dr Margaret Neale-Edwards of the Dufferin Fund in 1936-37.

Conclusion

The medicalisation of childbirth would not have extended to the middle classes with the relative ease with which it did if it were not for the role of medical women. Early midwifery practice by the medical profession was restricted to the wards of the major hospitals and was more in the nature of seeking 'teaching material' for clinical observation and practice. Consequently, it was by its very nature self-limiting. The obstetric revolution that had taken place in England in the eighteenth and nineteenth centuries was brought to India by mainly medical women.

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140Margaret Neale-Edwards, Maternal Mortality in Calcutta, IRFA Health Bulletin no.15, Delhi, 1938.
In the nineteenth century, it had been assumed that medical women would be little more than glorified midwives. The growth in their numbers and prestige enabled them to operate as an independent professional sub-group. This led to the appearance a seeming schism within the medical profession. Ultimately, the difference of interest was shown to be more ostensible than fundamental. Its reconciliation within a broader pursuit of professional consolidation was reflected in the efforts to pass medical registration acts that would at one sweep deny recognition to indigenous medical traditions. The Bengal Medical Act of 1914 established a Medical Council and a Medical Register for Bengal, which led to deep resentment among Kavirajes and other indigenous practitioners.141 At one time establishing the sole right of graduates of recognised medical schools and colleges to give medico-legal evidence and dismissing all practitioners of alternative healing as charlatans, the medical profession appeared to have made little distinction between, on one hand, the high traditions of Ayurveda and Yunani medicine and the relatively low-skilled and low-prestige tasks such as those performed by traditional birth attendants. (By the end of our period, the issues of racial discrimination and nationalism within the medical profession had superceded the differences based on gender)142


142 Dr Margaret Catchatoor, formerly of the Dufferin Fund, had no recollection of any dispute involving the question of supervision or the general subordination of medical women to their male colleagues. She practiced in Calcutta in the late 1930s and