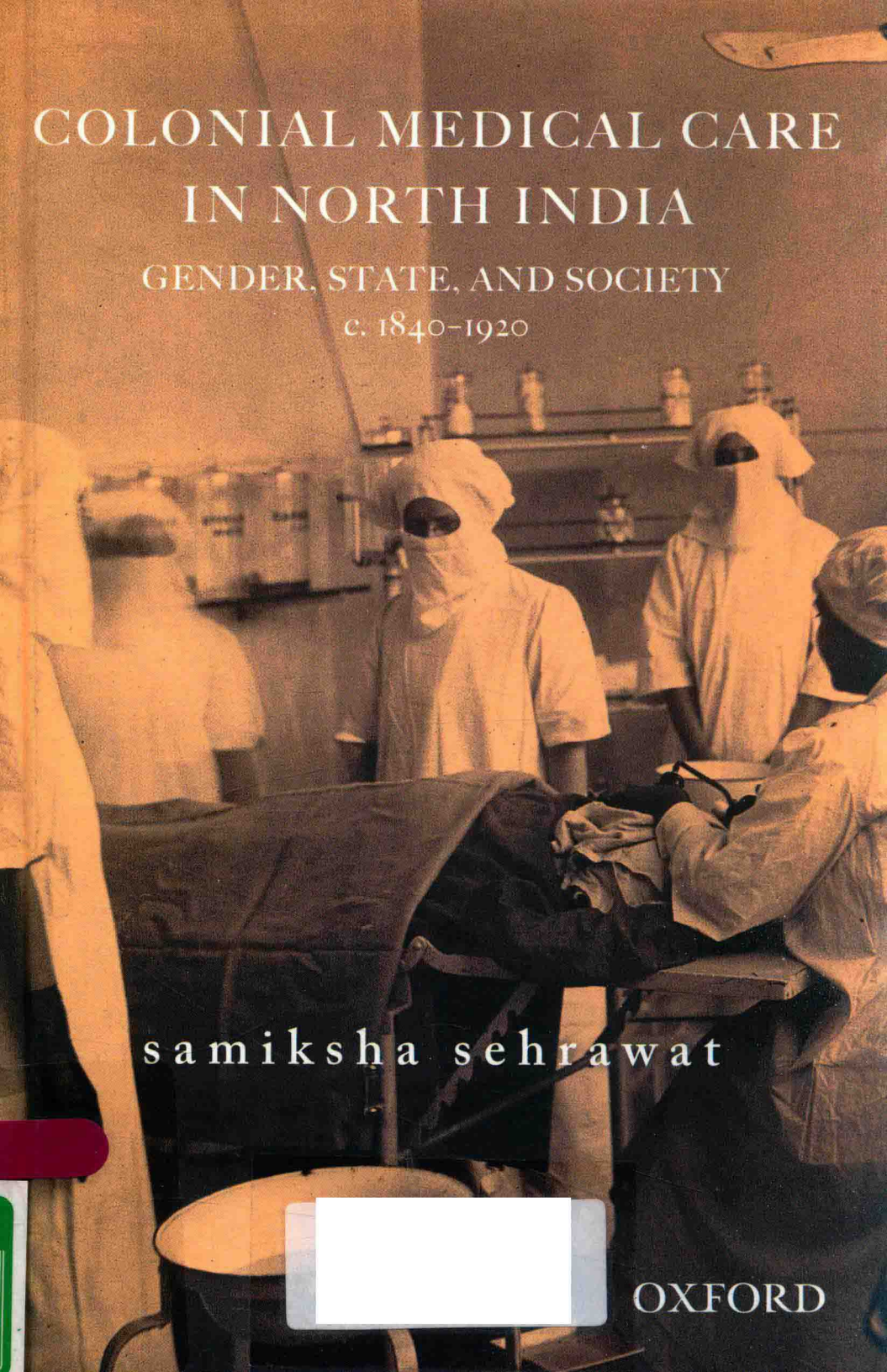
COLONIAL MEDICAL CARE IN NORTH INDIA

GENDER, STATE, AND SOCIETY c. 1840–1920



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Published in India by
Oxford University Press
YMCA Library Building, 1 Jai Singh Road, New Delhi 110 001, India

First Edition published in 2013

ISBN-13: 978-0-19-809660-3
ISBN-10: 0-19-809660-7

Typeset in Minion Pro 10.5/13
by Alphæta Solutions, Puducherry, India 605 009
Printed in India by G.H. Prints Pvt Ltd, New Delhi 110 020

COLONIAL MEDICAL CARE IN NORTH INDIA

For my parents

PREFACE

This book is the result of a long engagement with the place of medical care in the lives of ordinary folk in India. I began with hopes of reconstructing what medical care meant for peasants, women, and other marginalized groups in colonial north India. This proved ambitious given the paucity of primary sources and the paucity of organized medical care for these groups. I came to realize that to recover marginalized perceptions of medical care, a basic history was needed that traced the emergence of colonial medical care, analysed how it related to Indian society, and asked why it left so many people outside its ambit. This book addresses these themes, as part of my engagement with the place of such institutions in the lives of peasants, women, and the poor in north India.

In the course of writing this book I have acquired many debts. Mark Harrison supervised the research from which this book emerged and has inspired with his intellectual fertility and commitment to rigorous research—I am grateful for his encouragement and support over the years. Without the constant guidance that Biswamoy Pati and Indrani Sen have provided since my first forays into academics, I would not have been able to give shape to the ideas that make this book—my debt to them is enormous. My thanks also to Waltraud Ernst, who encouraged me first as my DPhil examiner and since then

with her enthusiasm for my work. The inspired teaching of Anshu Malhotra, Shahid Amin, and Sumit Sarkar has been a profound influence.

Margret Frenz, Mary Heimann, David McKee, and Lata Singh were instrumental in helping me in the very early stages when this book was only a fragile idea. Felix Schulz, Ben Houston, and Xavier Geugan of the Newcastle History Writing Group encouraged me with detailed comments on early drafts of several chapters. Jeremy Boulton provided valuable feedback on the statistics. Thanks to Saurabh Mishra for reading chapters of an early draft and for his hospitality. Several colleagues took out time to help me formulate my ideas, directed me to useful sources, or challenged me to rethink my arguments—Rama Baru, Deepak Kumar, Roger Jeffery, Nandini Bhattacharya, Pratik Chakrabarti, Partho Datta, Rana T.S. Chhina, Sloan Mahone, Neshat Quaisar, and Mridula Ramanna. Labour on this book was possible due to the kindness and companionship of my colleagues at the Wellcome Unit (Belinda Michaelides, Jo Robertson, and Margaret Jones), the University Strathclyde (David Brown and Arthur McIvor), and Newcastle University (Thomas Rutten, Diana Paton, Martin Farr, Matt Perry, Rachel Hammersley, Joan Allen, Tim Kirk, and Susan-Mary Grant). My students at Newcastle University have encouraged me more than they know by their curiosity about the contents of this book and by reading early drafts—thanks especially to Nicola Burrow, Anna Howard, and Florence Rees.

Staff at various repositories and archives facilitated access to both primary and secondary sources, often beyond the call of duty—my thanks to the staff at the Wellcome Library, London; the Bodleian Library, Oxford; St Hilda's College Library, Oxford; the erstwhile Indian Institute Library, Oxford; the National Archives of India, New Delhi (especially Jayaprabha Raveendran, Pradeep Kumar, Santosh Tyagi, and Vandana Devi); the British Library, London (especially 'Ghalib' Mohammed Hossain, Kwame Ababio, Bob MacDonald, and Dorian Leveque); the National Library of Scotland, Edinburgh (especially Jan Usher and Francine Millard); the Robinson Library, Newcastle; the Delhi State Archives, New Delhi; the Punjab State Archives, Chandigarh and Patiala; and the Haryana State Archives, Panchkula. My thanks for the financial support I have received from the Felix Scholarship Trust; the Modern History Faculty, St. Hilda's

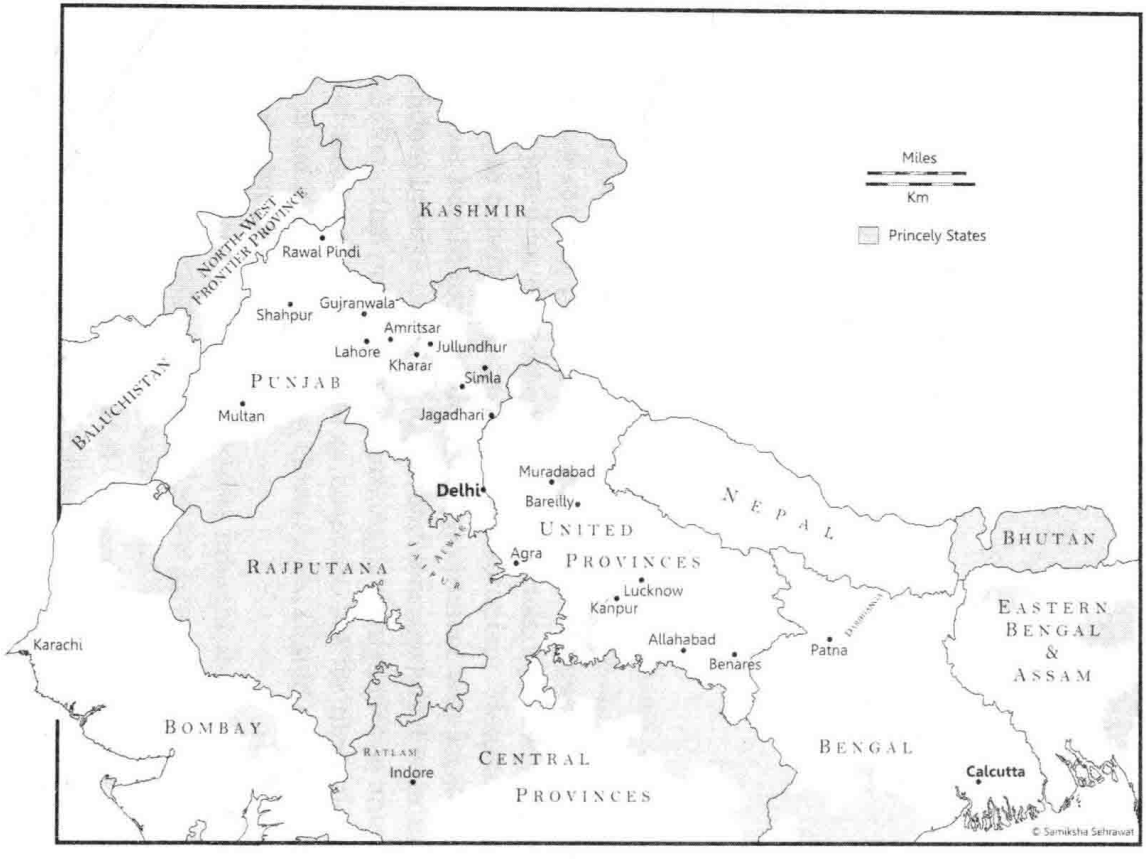
College, the Beit Fund, and the Arnold Fund at University of Oxford; and Newcastle University and the British Academy. Audiences at the South Asia Seminar, University of Leeds; Wellcome Unit for the History of Medicine Seminar, University of Oxford; History Department Seminar, University of Delhi; the 'Gender, Society and "Development" in India, 1860–2000' Conference, Nehru Memorial Museum and Library; the German Historical Institute, London; and the Centre for South Asian Studies Seminar Series, University of Edinburgh, provided opportunities to discuss this work. My thanks to the anonymous reviewers for suggestions to help improve this monograph. Without the support of the editorial team at Oxford University Press at a crucial time, this book would not have become a reality.

I am grateful to friends for sustaining me with cheer and humour through the lonely task of writing this book, especially Chris Andreas, David Green, Alis and Dragos Oancea, Pooja Satyogi, Elena Svirko, Kritika and Salil Chugh, Arpita Bannerjee, Om Ghosh, and Pranav Garg. My family has supported this project through its long gestation with enormous patience and my nieces and nephews have provided the most welcome distractions from its labours—my thanks to my parents, my dear mother-in-law, Akki, Aman, Angad, Dipu, Madhav, Mahi, Mishu, Neeraj, Pawan, Sameer, and Sweta. Lastly, I would like to thank Manu for his unstinting support. Every idea in this book owes to his timely interventions and willingness to engage in discussions at every hour of the day and night. He has made this book and much else possible in more ways than I can count.

ABBREVIATIONS

AMWI	Association of Medical Women in India
APAC	Asia, Pacific and Africa Collection
ASR	*Annual Sanitation Report*
BC	Board's Collections
BL	British Library
BMJ	*British Medical Journal*
C-C	Chief Commissioner
CCO	Chief Commissioner's Office
CMC	Calcutta Medical College
CMGP	Civil and Military Gazette Press
CoD	Court of Directors
CUP	Cambridge University Press
DAR	*Delhi Administration Report*
DCO	Deputy Commissioner's Office
D-C	District-Commissioner
Dept	Department
DF	Dufferin Fund
DFR	*Dufferin Fund Report*
DSA	Delhi State Archives
EIC	East India Company
FS	*Financial Statement*
G-G	Governor-General

G-GiC	Governor-General in Council
Gen.	General
GoI	Government of India
GoP	Government of Punjab
H	Home Department
IMS	Indian Medical Service
IPC	India Public Consultations
IOR	India Office Records
IESHR	*Indian Economic and Social History Review*
JAMWI	*Journal of the Association of Medical Women in India*
KIH	Kitchener Indian Hospital, Brighton
M	Medical Branch
MB	Medical Board
Mil.	Military Department
M&S	Medical and Sanitary Branch
MAS	*Modern Asian Studies*
NAI	National Archives of India
NWPHDR	*North-Western Provinces Hospital and Dispensaries Report*
OUP	Oxford University Press
PHDR	*Punjab Hospitals and Dispensaries Report*
PSA	Punjab State Archives
Secy	Secretary
SGP	Superintendent of Government Printing
SINP	*Selections from the Indian Newspapers Published in the Punjab*
SVN, Punjab & NWP	*Selections from the Vernacular Newspapers published in the Punjab North-Western Provinces, Oudh, Central Provinces, Central India and Rajputana*
UPHDR	*United Provinces Hospitals and Dispensaries Report*
WMS	Women's Medical Service
WMSI	Women's Medical Service in India



Map 1 North India in 1911

INTRODUCTION

The *Zamindar*, a weekly newspaper published from Gujranwala district in Punjab, ran a news article on 8 April 1908 decrying the lack of medical care for peasants. It explained that although 'agriculturists' were taxed for providing hospitals, schools, and roads, they did not stand to benefit from any of these institutions: 'Hospitals would be of great benefit to *zamindars*, but government only locates these institutions in large cities and towns, and consequently it is the urban population...that profits [from them]. Agriculturists give an immense sum of money annually in aid of hospitals, but for them alone no medical aid is available.... [The] Government should give the matter particular attention'.[1]

Writing in reaction to the mortality brought about by the plague epidemic, the newspaper assumed that the government had a duty to provide medical care for those taxed. Such assumptions arose from the acceptance by modern states of the need to maintain their population in a healthy and productive state. The Indian colonial state too became involved in providing medical care for its subjects from the early nineteenth century. The state's involvement in improving access to Western medical care for the indigenous population formally

[1] *Zamindar* (Karmabad), 8 Apr. 1908, *SINP*, vol. 21, no. 17, p. 234.

began with the decision in 1838 to provide government funding for a network of dispensaries. These were initially limited to Bengal and the North-Western Provinces, but the state was committed to expanding the network if the experiment was deemed successful. Tentative in the beginning, this decision sowed the seeds of what was to grow into a large, if inadequate, urban-centric network of hospitals and dispensaries. This network formed the spine of the colonial medical apparatus and represented 'public' medical care for the Indian population. The development of medical care in India also took a peculiar trajectory which was shaped by its colonial context. The hospitals and dispensaries that were part of this network were considered 'charitable' institutions, to be maintained primarily from voluntary subscriptions, for the benefit of those sections of the population unable to pay for medical care—others were to be provided medical care by private practitioners. The state involved itself in the administration of medical institutions only to encourage indigenous philanthropists to contribute to hospital funds, acknowledging no obligation to provide medical care for the Indian population. The issue at stake was whether providing medical care to the Indian population was an '[aspect] of government...within the competence of the state', and imbricated in this were questions of 'what is and what is not political, what is public and what is private, and so forth'.[2] The relationship between health and governance thus involved the larger politics of colonial domination and resistance which were closely linked with the economics of delivering medical care.

The nineteenth-century initiative to establish dispensaries in India was borne of the reconfiguration of the relationship between state and medicine in post-Enlightenment Europe. From the early modern period, the political philosophy of mercantilism had stressed the importance of the population of a state to its prosperity. Absolutist states sought to boost population numbers to ensure a productive labour force and plentiful military conscripts.[3] The emergence of

[2] Nikolas Rose, *Powers of Freedom: Reframing Political Thought* (Cambridge: CUP, 2004), p. 18.

[3] This led to an emphasis on the use of statistics to count a state's population and to measure its strength in terms of the health of its population. In Britain, such concerns gave rise to political arithmetic, which sought to measure births, deaths,

ideas of the 'medical police' and state medicine, and the creation of health administrations over the eighteenth and nineteenth centuries in Europe was linked with such concerns. State medicine regulated medical practice, promoted enforcement of quarantines, and led to the regulation of public nuisances, but sometimes also contributed to curative care (for instance, in Sweden and France).[4] Government regulation of the health of the population from the eighteenth century has been characterized as 'biopolitics' by Foucault. For Foucault, biopolitics involved both the disciplining of individual bodies as a machine but also the regulation of the health of the state's population by focusing on 'the preservation, upkeep, and conservation of the "labour force"'.[5] The latter was achieved through the various functions performed by the state from the eighteenth century through the apparatus that was created by state medicine and the 'medical police'.[6]

Provision of health care for the poor was made across early modern Europe—hospitals in Renaissance Florence providing treatment to

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and levels of ill-health. See Julian Hoppit, 'Political Arithmetic in Eighteenth-century England', *Economic History Review*, New Series, vol. 49, no. 3, 1996, pp. 516–40 and Paul Slack, 'Government and Information in Seventeenth-century England', *Past & Present*, 2004, no. 184, pp. 33–68.

[4] George Rosen characterized this thus: 'The welfare of society was regarded as identical with the welfare of the state', Rosen, 'Cameralism and the Concept of Medical Police', in Rosen, *From Medical Police to Social Medicine: Essays on the History of Health Care* (New York: Science History Publications, 1974), p. 122. For a useful overview, see Dorothy Porter, *Health, Civilization, and the State: A History of Public Health from Ancient to Modern Times* (London: Routledge, 1999), pp. 48–53. In Britain the influence of ideas of state medicine from the second half of the nineteenth century privileged preventive medicine, with a focus on inquiry into the causation and prevention of diseases and collection of accurate vital statistics. Roy MacLeod, 'The Anatomy of State Medicine: Concept and Application', in F. Poynter (ed.), *Medicine and Science in the 1860s* (London: Wellcome Institute of the History of Medicine, 1968), p. 199–227.

[5] Michel Foucault, 'The Politics of Health in the Eighteenth Century', in Michel Foucault, *Power* (New York: The New Press, 1994), ed. James D. Faubion, trans. Robert Hurley et al., *Essential Works of Foucault, 1954–84*, p. 95.

[6] See Michel Foucault, 'Right of Death and Power over Life', in Paul Rabinow (ed.), *The Foucault Reader* (London: Penguin, 1991), pp. 261–7 and Foucault, 'The Politics of Health', pp. 90–105.

the working urban poor and the eighteenth-century French network of *hospitaux-generax* and *hotel-dieu* represent important examples of increasing state interest in maintaining the health of a productive workforce.[7] The ability of the state's population to add to its prosperity by being productive had led to new attitudes to poor relief that distinguished between the 'deserving' and the 'undeserving' poor. According to this criteria, which came to be widely deployed across Europe, the 'deserving' poor were those labourers and artisans whose sickness could jeopardize their ability to support themselves and be productive whereas 'undeserving' poor were those who were to be blamed for their poverty, such as beggars, vagrants, and prostitutes.[8] Although the state played a role in organizing medical care in France and some other European countries, Britain was considered home to the voluntary hospital system, which placed the initiative for medical care primarily in private hands. In nineteenth-century Britain, medical care was to be provided by private practitioners for those who could afford to pay, by voluntary hospitals (funded by voluntary subscriptions and donations) for the 'deserving' poor, and by workhouse infirmaries (funded by Poor Law rates) for the indigent. Medical care provided in voluntary hospitals focused on the treatment of acute but curable diseases to allow patients to return to work, while workhouse infirmaries tended to have chronic cases and were meant, at least initially, to discourage 'healthy but feckless poor' from resorting to charitable relief.[9] This emphasis of the British medical system on

[7] For an overview, see Silvia De Renzi, 'Policies of Health: Diseases, Poverty and Hospitals', in Peter Elmer (ed.), *The Healing Arts: Health, Medicine and Society in Europe, 1500–1800* (Manchester: Manchester University Press, 2004), pp. 136–65; for Renaissance Florentine hospitals, see Katharine Park, 'Healing the Poor: Hospitals and Medical Assistance in Renaissance Florence', in Jonathan Barry and Colin Jones (eds), *Medicine and Charity Before the Welfare State* (London: Routledge, 1991), pp. 31–9; and for French *hotel dieu*, see Lawrence Brockliss and Colin Jones, *The Medical World of Early Modern France* (Oxford: Clarendon Press, 1997), pp. 678–88.

[8] De Renzi, 'Policies of Health', p. 149.

[9] For overviews, see Joan Lane, *A Social History of Medicine: Health, Healing and Disease in England, 1750–1950* (London and New York: Routledge, 2001), pp. 44–95 and Steven Cherry, *Medical Services and the Hospitals in Britain 1860–1939* (Cambridge: CUP, 1996), pp. 41–53, 57–78.

maintaining the labouring power of the poor has been characterized by Michel Foucault as 'labour force medicine'. Foucault dubbed this 'medical control of the destitute' and argued that this system represented the system of 'tax supported welfare', to make the poor 'more fit for labour and less dangerous to the wealthy classes'.[10] This 'welfare' function was an important part of the exercise of biopolitics by the modern state. Though seeming to echo these notions of state medicine, the Indian government's initiative to invest in medical care followed 'the colonial rule of difference'.[11] For Foucault, the exercise of biopower was an important aspect of the emergence of a new 'political rationality' associated with the modern state—'governmentality'. This new form of governance required ruling authorities to 'act upon the details of the conduct of the individuals and populations who were their subjects, individually and collectively, in order to increase their good order, their security, their tranquillity, their prosperity, health and happiness'.[12] In contrast, 'colonial governmentality' in India was marked by an interest in 'increasing the productivity of labour... [by] increasing disciplinary control over labour rather than through the enhancement of human capital, despite its attempts to introduce modern education, sanitation, and modern medicine'.[13] The measure to fund curative care for the indigenous population in 1838 came not so much from the assumption by the colonial state of the responsibility for providing 'labour force medicine' to keep the Indian labouring population healthy and productive but rather emerged from a concatenation of colonial projects and exigencies.

[10] Foucault, 'Birth of Social Medicine', in Foucault, *Power*, pp. 151–5.

[11] Partha Chatterjee has argued that the difference between the colonial state and 'the modern state' is elaborated by the rule of colonial difference, which 'mark[s] the points and the instances where the colony had to become an exception', *The Nation and Its Fragments: Colonial and Postcolonial Histories* (Princeton: Princeton University Press, 1993), p. 22.

[12] Rose, *Powers of Freedom*, p. 6.

[13] U. Kalpagam, 'Colonial Governmentality and the "Economy"', *Economy and Society*, vol. 29, no. 3, 2000, p. 432. For Kalpagam, the colonial state was preoccupied with knowing the characteristics of the population in detail so as to evolve its regulatory mechanisms but not with aspects such as education, health, and nutrition. Although Foucault's conceptions of biopower and governmentality visualized

Fundamental to the justification of colonial rule in India was the idea of British tutelage of Indian subjects to develop the latter's capability for self-rule.[14] The colonial state's self-conscious departure from British precedent in funding the establishment of dispensaries in the nineteenth century was meant to facilitate this colonial project.[15] As medical care in nineteenth-century Britain was to be provided through private initiative, there was considerable opposition to state

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their full constitution only in the West, other scholars have sought to elaborate what constituted colonial governmentality. Gyan Prakash characterizes colonial biopower as being preoccupied with enumerating the economic, demographic, and epidemiological properties of the population, and the state's preventive measures as 'enact[ing] coercive rule as the welfare of the population', *Another Reason: Science and the Imagination of Modern India* (Princeton: Princeton University Press, 1999), pp. 125–7. For other interpretations of biopower in colonial India, see Sarah Hodges, 'Governmentality, Population and the Reproductive Family in Modern India', *Economic and Political Weekly*, vol. 39, no. 11, 2004, pp. 1157–63; Sunil Amrith, 'Food and Welfare in India, c. 1900–50', *Comparative Studies in Society and History*, vol. 50, no. 4, 2008, pp. 1010–35; and Stephen Legg, *Spaces of Colonialism: Delhi's Urban Governmentalities* (Maiden: Blackwell, 2007). For useful discussions of colonial governmentality in India, see Kalpagam, 'Temporalities, History and Routines of Rule in Colonial India', *Time and Society*, vol. 8, no. 1, 1999, pp. 141–59 and Georgio Shani, 'Empire, Liberalism and the Rule of Colonial Difference: Colonial Governmentality in South Asia', *Ritsumeikan Annual Review of International Studies*, vol. 5, 2006, pp. 19–36. For a discussion of colonial governmentality and medical interventions in colonial Cambodia, see Ing-Britt Trankell and Jan Ovesen, 'French Colonial Medicine in Cambodia: Reflections of Governmentality', *Anthropology and Medicine*, vol. 11, no. 1, 2004, pp. 91–105.

[14] Thomas Metcalf, *Ideologies of the Raj*, vol. III.4, *The New Cambridge History of India* (Cambridge: CUP, 2007), pp. 199–203.

[15] The focus on British developments here is important not so much to paint a picture of what was 'lacking' in the Indian context as much as to throw light on how British precedents influenced Indian policymakers. Interrogating why divergences were made from contemporary British practice also throws light on the form colonialism took in India. Despite the dangers of ahistorical generalizations proceeding from historical comparisons, Charles Tilly has emphasized the importance of comparative approaches provided they are rooted 'in genuine historical structures and processes', see his *Big Structures, Large Processes, Huge Comparisons* (New York: Russell Sage Foundation, 1984), p. 85.