Medical Transformation in Madras Presidency:

Military and Civilian Perspectives (1880-1935)

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Abstract

The thesis is a critical examination of the factors that contributed to the transformation and evolution of western healthcare in the Madras Presidency between c.1880-1935. The work profiles medical officers and subordinates – both British and Indian, male and female – serving in the Madras Presidency during the period under review. With a focus on the impact of the martial-race theory in the process of Madras army recruitment, this study also explains how deeply connected the healthcare, military, and political administration were in the region.

This study is divided into two broad parts: the first part involves the two initial chapters dealing with political and healthcare administrative structures in the presidency, while the second part comprising of final four chapters explores the shift of western medicine through the decline of the Madras army and follows it up by analysing the roles of elite, subordinate, and female medical services in the context of Madras Presidency. Civilian healthcare and its development were achieved with a systematic and systemic change in the army recruitment system in this presidency. An in-depth examination of Madras and its local population shows the role played by the subordinates and intermediaries in aiding and shaping medical practices. This thesis recasts the idea of the usual coloniser-colonised narrative and elevates the Indian subordinates in a more commanding position, particularly in the rural areas. Formation of local pockets of power going down to the village administrative level made sure the British had far less control and dominance over the medical marketplace than what the present historiography suggests.

This thesis studies the military, healthcare, socio-political, gender issues together, which have rarely been attempted while studying colonial India. It endeavours to do so through a critical re-examination of some previously used materials and the utilisation of some hitherto unused sources from different archives.

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I am indebted to the archives, and particularly the archivists for providing me access in various archives and libraries that I have used for my PhD research. I thank Dr Antonia Moon and other library staff members at the British Library who made me feel welcome and kept providing me new files. I thank the archivists and librarians at the University of York Library, Cambridge University Libraries, Wellcome Collection, LSHTM, LSE (Women's Library), Imperial War Museum, National Army Museum, British National Archives (Kew), Tamil Nadu State Archives, National Archives (India), National Medical Library (India), and Rojah Muthiah Research Library. Special thanks go to Margaret Hoggan and all the staff at the Rockefeller Archive Center for the advice they generously offered, and their help.

I have been extremely fortunate to find friends and colleague in Chennai, New Delhi, London, Cambridge, New York, and the good old city of York. During my long and arduous fieldwork period, I have been privileged to meet some wonderful people who have inspired and encouraged me in my intellectual pursuits, yet kept me sane with their kindness and warmth. These friends and

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Declaration

I declare that this thesis is a presentation of original work, and I am the sole author. This work has not previously been presented for an award at this, or any other, University. All sources are acknowledged as References.

Parts of this thesis have been delivered at conferences across the country and internationally. An early version of Chapter 4 was presented at the International Congress for the History of Technology, 2017. An early version of Chapter 6 was presented at the Social History of Medicine Conference, 2018. I presented an almost full version of Chapter 5 in an invited lecture at the London School of Hygiene and Tropical Medicine, 2019. Parts of each chapter were delivered in a few other conferences like BASAS and EAHMH held in 2019 across the country.

York, 27 September 2019

Introduction

'Local interests too often assume exaggerated proportions from a local point of view. The welfare of Great Britain must be studied as well as the welfare of India, and the fact that she is a part, undoubtedly important, but still only a part of the British Empire, must not be overlooked.'[1]

Such attitude towards studying or understanding colonial India has become increasingly rare ever since the late twentieth century when historians of health and medicine started researching on the socio-economic, political and gender issues to bring out further nuances in studying colonial India. This is one of the many examples of early writings on 'western' medicine that regarded the colonial health services as a monolithic structure without paying attention tot he regional and provincial complexities.[2] They viewed the colonial structures as one-dimensional forces of authority that acted as a 'handmaiden' to subjugate people across the empire. Such depiction of colonial institutions is not only incomplete but also problematic in certain aspects, and there have been critiques of such writings within the existing literature.[3] This thesis, however, will confine its focus on colonial India and more specifically on one of the three officially designated presidencies - the Madras Presidency. The dissertation will emphasise the unique and distinct nature of this particular presidency in colonial India, and in this process point out the necessity of studying colonial contexts individually rather than making generalised assumptions across the empire or even across colonial India. The aim of this thesis is to focus on colonial healthcare services and those responsible for

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[1] Captain G. F. Browne, "Should the European Army in India continue as at present constituted, or should it be converted in whole or in part into a local force?" *The Journal of Royal United Service Institution* XXIX, no. 129 (1885): 295-335.

[2] Andrew Cunningham and Bridie Andrews, "Introduction: Western medicine as contested knowledge" in *Western medicine as contested knowledge,* ed. Andrew Cunningham and Bridie Andrews (Manchester; New York: Manchester University Press, 1997); This thesis uses the word 'western' with caution, and thus the first reference has been used within quotes, but for ease of reading, and flow of arguments, western (without quotes, or capitalisation) will be used in the rest of this study.

[3] Kieran Fitzpatrick, "Tense Networks: Exploring medical professionalization, career making and practice in an age of global empire, through the lives and careers of Irish surgeons in the Indian Medical Service, c.1850-1920," (PhD dissertation: University of Oxford, 2016), Introduction: Defining Professions in an age of Global Empire.

their administration, namely the healthcare workers at various levels. This particular presidency had remained one of the most peaceful provinces during the colonial period, both under the English East India Company (EIC hereafter) and the British Crown.[4] This provided opportunities for colonial Madras to implement and practise a medical policy different from the rest of British India.

Historians have studied this presidency in terms of disease, famine, army, and the police but have largely ignored the medical services barring a few exceptions.[5] This thesis attempts to establish the heterogeneous nature of the presidency and the roles played by the Indian medical practitioners at district and sub-divisional level. However, this work explicitly focuses on how the state policies in the presidency were altered, either willingly or under pressure, over a period of fifty-five years (1880-1935) – the period under review here. The thesis will explore hitherto unexplored areas and research methods to recast the existing notion of medical care in the presidency and more broadly in the whole of colonial South Asia. This thesis sits at the interface between the military, race, and class theories and uses these to explore the transformative phases of the medical services in the colonial presidency. While doing so, it reflects on how the colonial state was a heterogeneous, layered collective of individuals and institutions with a multifaceted understanding of healthcare.

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[4] The East India Company (EIC), also known as the Honourable East India Company or the British East India Company and informally as John Company, was an English and later British joint-stock company. It was formed to trade in the Indian Ocean region, initially with Mughal India and the East Indies and later with Qing China. The company ended up seizing control over large parts of the Indian subcontinent, and colonized parts of South and Southeast Asia. For more details on the EIC's formation and history see, Philip Lawson, *The East India Company: A History* (London, Routledge, 1993).

[5] Leela Sami, "Famine, Disease, medicine and the State in Madras Presidency (1876-78)," (PhD dissertation: University College London, 2006); David Arnold, *Colonizing the body: state medicine and epidemic disease in nineteenth-century India* (Berkeley: University of California Press, 1993); *Imperial medicine and indigenous societies* (Manchester: U.P. 1988); Manas Dutta, "A study of the social composition and organization of the Madras Army 1807-1885," (PhD dissertation, University of Calcutta, 2014), Introduction; Jane Buckingham, *Leprosy in colonial South India: medicine and confinement* (Basingstoke: Palgrave, 2002); Radhika Ramasubban, "Imperial Health in British India, 1857-1900," in *Medicine and Empire: Perspectives on Western medicine and Experience of European Expansion*, ed. Roy Macleod (London; New York: Routledge, 1988); Niels Brimnes, *Languished hopes: tuberculosis, the state, and international assistance in twentieth-century India* (New Delhi: Orient BlackSwan, 2016).

Why Madras?

It is important to discuss why Madras is the focal point of my research. I have stated earlier that the historiography of colonial healthcare has been investigated from different perspectives. But while through the archives, various local documents convinced me that the picture of Madras that has been painted in the existing literature may not have been entirely true or complete. A prolonged archival research enabled me to explore hitherto unused source materials and utilise them to establish my argument and approach the colonial medical services from different perspectives.

This thesis confines its analysis to the Madras Presidency for several reasons – the primary reason is that India-wide studies very often tend to overlook the differences among the three presidencies and tend to generalise the complex and diverse regional characteristics into a uniform pattern.[6] Critically examining a single presidency will afford more freedom and space to this thesis to make systematic use of the archival sources, and to understand and reflect upon the regional context better. Discussions on any aspect of colonial India makes people wonder even today if the scenario was different in the south. Colonial south India, of which the Madras Presidency was a part, appeared so complex that academicians have largely refrained from focusing on that part of the country. Another major reason for not going beyond the Madras Presidency is to emphasise the understanding that the individual presidencies had their unique characteristics, and even within one presidency the dialogues, and policies were rarely homogenous and most often were replete with contradictory tendencies and opinions.[7] The presidency of Madras also had one of the most

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[6] To understand more on the importance of the regional to all-India based study, see Sanjoy Bhattacharya, Mark Harrison, and Michael Worboys, *Fractured States: Smallpox, Public Health and Vaccination Policy in British India, 1800-1947* (New Delhi: Orient Longman, 2005).

[7] Leela Sami's PhD thesis, "Famine, Disease, medicine and state in Madras" explains the heterogeneity of the presidency.

complex structures with five distinct languages coexisting in the region – Tamil, Telugu, Malayalam, Canarese and Oriya – with a substantial speaker base for each of them. Such complexities have ensured that the Madras Presidency presents a very nuanced and compelling case study for this thesis.

Literature Review

The presidency of Madras has been one of the least explored areas in terms of colonial healthcare. However, a careful perusal of the existing literature brings forth a few scholarly works that helped in understanding and explaining the current historiography. There are a few published sources by the colonial administrators or British army officers who were mostly writing to claim the greatness of the colonial office or talking about internal politics.[8] Their works reflect a controversial albeit an important story. However, for understanding the current academic standpoint, it is imperative to focus on the published academic works on and around the themes this thesis aims to explore. After going through a general idea of studying western healthcare in colonial India, I will expand and explain the historiography following the chronology of my chapters. There will be some overlaps, but I have come to realise that this is the way I can do justice to the historiography according to the scope of my thesis as such diverse ideas are rarely explored in a single piece of work.

One of the sources directly relevant to this dissertation, and for setting up the structure was by David Washbrook; he explained how the provincial politics played a significant role in the Madras Presidency and this till date remains one of the most significant works to understand the

[8] E. G. Phythians Adams, *The Madras Soldiers, 1746-1946* (Superintendent, Government Press, Madras, 1948); W. J. Wilson, *History of the Madras Army* (Madras: The Government Press, 1882); Frederick Roberts, *Forty One years in India, from Subaltern to Commander-in-Chief* (London, 1897; reprint, 1898); H. H. Dodwell, *Sepoy Recruitment in the Old Madras Army* (Calcutta, 1922).

presidency down to the district level.[9] A relatively common theme in the literature dealing with colonial medicine has been to understand the extent to which western medicine acted as the 'tool of empire'.[10] David Arnold sees medicine's colonising power as a mix of their military and political prowess and eventually concludes by saying that power was consolidated by medicine and that led to cultural domination. There has been overemphasis of a symbiotic relationship between colonialism, state power and European medical profession, and this resonates with Mridula Ramanna's monograph in the context of colonial Bombay.[11] Mark Harrison, on the other hand, argues that colonial medicine was more limited than Arnold and Radhika Ramasubban had claimed, and was moulded by its social and political contexts.[12] Recent works have pointed out the importance of identifying gaps and understanding modernity in the colonial Indian context, as Harrison and Pati explained in their edited volume.[13] Similar nuanced studies by Sarah Hodges, Maneesha Lal, and Shirish Kavadi in the last two decades aided scholars to raise more pertinent questions about colonial India and its healthcare.[14]

When it comes to the colonies and particularly India, we come across a wide range of scholarship dealing with the public health of the colonial state in general. There has been a general consensus among scholars that western medicine in India was introduced because of the rising

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[9] D. A. Washbrook, *The Emergence of Provincial politics: The Madras Presidency, 1870-1920* (Cambridge; New York: Cambridge University Press, 1976), 35-37; C. J. Baker and D. A. Washbrook, *South India: Political Institutions and Political Change 1880-1940* (Meerut: S. G. Wasani, 1975).

[10] The term 'tool of empire' was derived from D. Headrick, *The tools of empire: technology and European imperialism in the nineteenth century* (New York: Oxford University Press, 1981). Also, see Arnold, *Colonizing the body*; ed., *Imperial Medicine and Indigenous Societies* (Manchester, 1988) and Mark. Harrison, *Public Health in British India: Anglo- Indian Preventive Medicine 1859-1914* (Cambridge; Cambridge University Press, 1994); B. Pati and M. Harrison ed., *Health, Medicine and Empire: Perspectives on Colonial India* (New Delhi: Orient Longman, 2001).

[11] Arnold, *Ibid*.; Mridula Ramanna, *Western Medicine and Public Health in Colonial Bombay 1845-1895* (London: Sangam, 2002).

[12] Harrison, *Public Health in British India*; Radhika Ramasubban, "Imperial Health in British India".

[13] Mark Harrison and Biswamoy Pati (ed.) *Society, Medicine and Politics in Colonial India* (London: Routledge, 2018).

[14] Sarah Hodges, *Reproductive health in India: Histories, politics, controversies* (New Delhi; Orient Longman, 2005); Maneesha Lal, "The ignorance of Women in the House of illness": Gender, Nationalism and Health reform in colonial North India', in B. Andrews and Molly Sutphen (ed.) *Medicine and colonial identity* (London; New York: Routledge, 2003); Shirish N. Kavadi, 'Rochefeller Public Health in Colonial India', in A. Winterbottom & amp; F. Tesfaye (eds.), *Histories of Medicine and Healing in the Indian Ocean World*, Vol. 2 (216), 61-88.

health problems of the European soldiers and primarily to cater to their colonising mission.[15] This thesis recasts the notion of the emergence of medical care or the interest among the locals to join health services through the army recruitment policies exercised in colonial Madras. There has been some scholarly attention on exploring the emergence and implementation of the 'martial-race theory' in the colonial context.[16] But, the inter-connection between the military and civilian healthcare has not been drawn. This thesis argues that the lack of opportunities in the military forced and encouraged the educated local people in the Madras Presidency to look for alternative careers.[17] Stephen Cohen has written about recruitment politics, but this thesis uses such works to take them even further in the case of this particular presidency.[18]

Erica Wald, in her book on army health, argues that the colonial empire faced a contradiction in terms of their military strategy. She further adds, 'As such a valuable, but a potentially unstable asset, considerations regarding his (army recruit) health were central to Company (and later Crown) decision-making.'[19] Her book deals with the problems created and faced by the army inside the barracks until the 1870s in India providing an excellent idea about the condition of the cantonments and the relationship between the *sepoys* and their officers. She states, 'The regulatory framework was not simply imported from Europe and enacted in India. Instead, it grew out of a complex set of circumstances and conditions'.[20] This work covered colonial India focussing on

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[15] Harrison, *Ibid*, Erica Wald, *Vice in the Barracks: Medicine, the military and the making of colonial India 1780-1868* (London: Palgrave Macmillan, 2014).
[16] Heather Streets, *Martial races: the military, race, and masculinity in British imperial culture, 1857-1914* (Manchester: Manchester University Press, 2004); Mark Harrison, *Climates and Constitutions: Health, Race, Environment and British Imperialism in India 1600-1850* (Oxford University Press; Unstated Edition, 2003); Kausik Roy and Sabyasachi Dasgupta, "Discipline and Disobedience in the Bengal and Madras Armies, 1807-1856" in *War and Society in Colonial India, 1807-1945*, ed. Kaushik Roy (New Delhi: Oxford University Press, 2010); Manas Dutta, "A study of the social composition and organization of the Madras Army 1807-1885".
[17] To know more about the social changes in the Madras military see, D. P. Ramachandran, *Empire's First Soldiers* (New Delhi: Lancer, 2008).
[18] Stephen P Cohen, *The Indian Army: Its contribution to the development of the nation* (Berkeley, London: University of California Press, 1971).
[19] Erica Wald, *Vice in the Barracks: Medicine, the military and the making of colonial India 1780-1868* (London: Palgrave Macmillan, 2014), 1-15.
[20] *Ibid.*

mostly the European soldiers, their relationship with the state and the ways of maintaining them. The underlying tone present in the book is the economic factor that always determined the measures taken by the Government of India (GoI hereafter) to control and keep their soldiers safe. As the author concludes by saying, 'The machinations of military and medical officers, aimed at safeguarding the health of the soldiery, quickly travelled beyond military space to profoundly alter colonial state and society.'[21]

David Omissi paints a very detailed picture of the ways Indians were recruited for various army positions. He mentioned, 'The Madras Army, without access to the fertile military labour markets of the north, obtained most of its men from within its own presidency, drawing on a broad social base as it did so'.[22] In such a case, there was attention given to have a good proportion of people from various castes without discrimination.[23] This clearly states the caste issues prevalent in the presidency, which was forcing the British to consider the recruitment of the Indian troops (*sepoys*) from the region. This strategy of recruiting 'martial races', Omissi observes, 'dramatically changed the composition of the Indian Army from the 1880s'.[24] When the army of Madras was not deemed valuable by the GoI, they were mostly left in the barracks and used only for garrison duty without any incentives or job prospects. This increased the chances of them, their families, and other educated youths being encouraged and at times, forced to look for other regular government jobs apart from the military. This thesis, although takes note of these works, takes the argument much further in comparing the military and civilian medical care in the presidency. Although, the above mentioned accounts and a few others give compelling evidence and provides a thorough account of the British Indian military, they are not focussed on one presidency and have failed to

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[21] *Ibid.*
[22] David Omissi, *The Sepoy and the Raj: The Indian Army 1860-1940* (Houndmills; Basingstoke; Hampshire: Macmillan in association with King's College London, 1994)
[23] To read more about the concepts and details of caste see, Niels Brimnes, *Constructing the Colonial Encounter: Right and Left Hand Castes in Early Colonial South India* (Richmond, Surrey: Curzon, 1999); Susan Bayly, *Caste, Society and Politics in India from the Eighteenth Century to the Modern Age* (Cambridge: Cambridge University Press, 1999).
[24] *Ibid.*

connect the, as has been argued in the Chapter 3, direct relation between the army recruitment policy and the medical policies in Madras Presidency.[25]

Radhika Ramasubban has argued, 'With the assumption of control by the crown from the East India Company in 1857, the army in India came to constitute the largest single concentration of British troops outside the United Kingdom – one third of all British troops.'[26] One of the first books drawing my attention to healthcare for the military and also the general idea of colonial healthcare was 'Colonizing the Body' where David Arnold argues about the 'enclavist' nature of the colonial medicine and Nandini Bhattacharya's work on plantations.[27] This thesis, however, tries to explore the idea of enclaves in a broader perspective going beyond the Madras city by examining the districts and sub-divisional spaces in the presidency and how these localised areas grew up as enclaves for health advancement. My objective is to explain how small regional towns projected them as a viable 'medical marketplace' attracting medical innovations and practitioners to different parts of the presidency.[28] Thus, it will be argued that in the latter half of the period under review, these smaller, local spaces had control over major decisions concerning the presidency.

Roger Jeffery identifies three main periods in the history of the imperial state, when he argues that 'Prior to 1860, the state was a curious amalgam of commercial, administrative, and military machines; from 1860-1920 we can see the "High Noon" of the British state in India; from 1920 onward the process of Indianisation began in earnest'.[29] He supports his statement in the latter part of his book where he mentions, 'The IMS was designed to service the Indian Civil

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[25] Wald, *Vice in the Barracks;* Cohen*, The Indian Army*; Dutta, "A study of the social composition and organization of the Madras Army 1807-1885".
[26] Radhika Ramasubban, "Imperial Health in British India".
[27] David Arnold, *Colonizing the Body;* Nandini Bhattacharya, *Contagion and Enclaves: Tropical medicine in colonial India* (Liverpool: Liverpool University Press, 2012).
[28] In 1985, Roy Porter wrote of the premodern 'medical marketplace' 'where physicians, surgeons, and apothecaries . . . melted into each other along a spectrum that included thousands who dispensed medicine full or part time'; For more details see. Mark Jenner and P. Wallis, "The Medical Marketplace," in *Medicine and the Market in England and its Colonies, c.1450-c.1850*, ed. Mark Jenner and P. Wallis (London: Palgrave Macmillan, 2007).
[29] Roger Jeffery, *The Politics of Health in India* (Berkeley: University of California Press, 1988), 78.

Service and the army; only incidentally were services provided for the mass of the population. Any improvement in the health of Indians was no more than accidental and the unintended consequences of quite other policies.'[30] He argued that the general hospitals also had separate wards for Europeans and Eurasians which were separated from the rest of the population. This point on ethnicity encouraged me to examine this in more detail, whether the ward was separated for the high class/caste Indians to that of the lower castes. O. P. Jaggi argues, 'The East India Company began to set aside special houses for sick employees in the seventeenth century, but not until the end of the eighteenth century were separate provisions made for the native indigent sick in Calcutta, Madras and Bombay.'[31] Roger Jeffery taking a cue from Jaggi's work argued specifically about Madras, 'Apart from two dispensaries in Madras town, there was little growth before the mid-1840s. However, subsequent developments were much faster in Madras and Bombay than in Bengal'.[32] This slow progress changed with the turn of the century, and this thesis will explain how Madras started the process of developing their health services to establish the region as one of the most important places for the diffusion of western medicine.

Sanjoy Bhattacharya in his article argues, 'The amount of time, effort, and resources spent by the colonial authorities in targeting the civilian 'priority groups' meant, necessarily, that very little time could be spared to deal with the 'general' population'.[33] Thus, essentially the military received the first attention, then the 'priority groups', and then the general population who came in terms of importance to be provided medical benefits. This thesis will explain how Indians were competing among themselves not only to get a share of the medical marketplace; they were also going head to head with other locals to be prioritised by the Madras government. An article 'Science, Scientific management and the Transformation of Medicine in Britain (1870-1950)' by Steve

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[30] *Ibid.*
[31] O. P. Jaggi, *Western Medicine in India: Social Impact* (Delhi: Atma Ram, 1980).
[32] Roger Jeffery, *The Politics of Health in India*, 14.
[33] Sanjoy Bhattacharya, "Tackling hunger, disease and 'internal security': official medical administration in colonial eastern India during the Second WW (Part II)," *National Medical Journal of India* 15, no. 2 (2002): 101-104.

Sturdy and Roger Cooter helped me understand the transformation in Britain and I have tried to understand that in the context of colonial Madras. The article points out, '. . . to understand how [a display of scientificity] elevated the authority of the medical profession. We also need to understand why the public bought it'.[34] This is a vital question for this thesis as well, and to understand why the local people became passionate about western medical care. The state was pushing for the implementation of the technologies and techniques for civilians, but as will be argued, it started gaining momentum only after the rise in interest among the locals. The western educated/trained 'elites', both British and Indians, who had access to the western medical market were eager to 'sell' their skills in the presidency, and that was a turning point in the diffusion of medicine in this region. Cooter and Sturdy argue, 'The growth of corporatism in medicine as in other spheres of activity was driven, not by the impact of new medical knowledge or techniques, but rather by social, economic and political pressures'.[35] This opens up a completely new area of research, which transcends the boundaries making us think beyond the visible medical innovations into the role of the state, public and in this particular case the military and ethnicity as well. Shinjini Das's work on the 'scientific' form of medicine in the context of Bengal and how this helped in creating a market for western medical techniques in India has also influenced this thesis.[36]

Bhattacharya also argues about the importance of regional studies and criticises how all-India based studies often overlook the regional and presidency specific differences and usually over-generalize.[37] Amna Khalid and Ryan Johnson emphasised that it is imperative to look beyond the popular narrative and explore the subordinate perspectives in the context of health.[38] Rather

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[34] Steve Sturdy and Roger Cooter, "Science, Scientific Management, and the Transformation of Medicine in Britain 1870-1950," *History of Science* 36, no. 4 (1998): 421-466.
[35] Ibid.
[36] Shinjini Das, "Debating Scientific Medicine: Homeopathy and Allopathy in Late Nineteenth Century Medical Print in Bengal," *Medical History* 56, no. 4 (2012): 463-480.
[37] Bhattacharya, *Fractured States*. See also, S. Bhattacharya, "Re-devising Jennerian Vaccines? European Technologies, Indian Innovation and the Control of Smallpox in South Asia, 1850-1950," in *Health, Medicine and Empire,* ed. Pati and Harrison.
[38] Amna Khalid and Ryan Johnson, *Public Health in the British Empire: Intermediaries, Subordinates and the Practice of Public Health, 1850-1960* (New York; London: Routledge, 2012), 1-31; Amna Khalid, "'Subordinate'

than having the one-way knowledge and skill transfer, Madras Presidency experienced a two-way transfer of medical skills. The locals from the presidency, after getting trained, became gradually more efficient with their work and at places, were heading the medical institutes effectively making the British students in India learn from them. Apart from this, the Subordinate Medical Service (SMS hereafter) was run mostly by the Indians, working as intermediaries between the 'natives' and the more prominent Indian Medical Service (IMS hereafter) officers. The idea of collaboration was gaining ground in this respect. In Chapter 5, this thesis has engaged critically with Khalid's work and methodology in bringing forward the role played by medical subordinates in the Madras Presidency. Additionally, this has extended the analysis to the districts and sub-divisional levels of the province. While so doing, it explores the rural and urban complexities as well; more often, the rural complexities have been brought forward in this thesis. V. R. Muraleedharan, although has explored the rural medical care in Madras, his work covers a very short timeframe and thus fails to analyse the changing patterns over the years. Moreover, his work is based primarily sources available in Madras and thus presents largely a one-sided narrative without giving attention to broader nuances.[39] Niels Brimnes has written an excellent piece on subordinate medics in the context of colonial South India, but his focus was only on the early nineteenth century.[40]

There are not too many works examining women's healthcare in Madras either, and Maneesha Lal's work remains one of the most significant works on the theme until now.[41] Her work presents

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negotiations: Indigenous staff, the colonial state and public health," in *The Social History of Health and Medicine in Colonial India*, ed. Biswamoy Pati and Mark Harrison (London; New York: Routledge, 2009), 45-73.

[39] V. R. Muraleedharan, "Rural health care in Madras Presidency: 1919-1939," *Indian Economic and Social History Review* 24, no. 3 (1987): 323-334.

[40] Niels Brimnes, *Languished hopes: tuberculosis, the state and international assistance in twentieth-century India* (New Delhi: Orient BlackSwan, 2016); "Coming to terms with the native practitioner: Indigenous doctors in colonial service in South India, 1900-25," *The Indian Economic and Social History Review* 50, no. 1 (2013): 77-109.

[41] Maneesha Lal, "The Politics of Gender and Medicine in Colonial India: The Countess of Dufferin's Fund, 1885-1888," *Bulletin of the history of Medicine* 68, no. 1 (Spring 1994): 29-64; Maneesha Lal, "Women, Medicine and Colonialism in British India, 1869-1925," (PhD Dissertation, University of Pennsylvania 1996).

a compelling case for understanding women's healthcare, but it remains inadequate for a comparative study with other medical services as she only emphasises on female healthcare. Focussing on Madras Presidency, this thesis presents a comparative study between male and female medical practitioners and receivers of western medicine in this particular colonial context. Most other works on women's healthcare in colonial India presents a rather lopsided view examining only one gender specifically, even though their contributions remain unique and important in the historiography.[42] Sean Lang for example, focuses on the maternal mortality rate in colonial Madras in the nineteenth century, and Sarah Hodges' edited volume explains the state of reproductive health in the region. Their focus although important, fails to emphasise on how far reaching an impact the women's medical service had not only in cases of reproductive or maternal care but also as registered medical practitioners conducting surgeries and other treatments. There are a few other works focusing on gender issues, but they focus on other parts of colonial India or on other aspects and leaves a big gap in the historiography which I aim to address in this thesis.[43] Maina Singh's work also deals with professionalism and women's initiatives in institution building in late colonial India. It touches upon a few aspects of gender role in medicine, although does not cover the southern part of British India.[44]

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[42] Antoinette Burton, "Contesting the zenana: The mission to make 'lady doctors for India, 1874-1885,'" *Journal of British Studies* 35, no. 3 (1996): 368-397; Ambalika Guha, "The 'Masculine' Female: The Rise of Women Doctors in Colonial India, c.1870-1940," *Social Scientist* 44, no. 5/6 (2016): 49-64; *Dai* or *dhais* were the traditional midwives who were instrumental in childbirth and maternity care. The Government of India, however, wanted to replace them with Western-trained midwives in the mid-eighteenth century. To know more on this check, Sean Lang, "Drop the Demon Dai: Maternal Mortality and the State in Colonial Madras, 1840-1875," *Social History of Medicine* 18, no. 3 (2005): 357-378; Divya N. Roy, "Reforming Mothers, Creating Citizens: The politics of Women's Health and Family Planning in Colonial and Postcolonial South India," (PhD Dissertation, University of Pennsylvania, 2014).

[43] Samiksha Sehrawat, *Colonial medical care in North India: gender, state and society, c.1830-1920* (New Delhi: Oxford University Press, 2013); Samiksha Sehrawat, "Feminising Empire: The association of medical women in India and the campaign to found a women's medical service," *Social Scientist* 41, no. 5/6 (2013): 65-81; Madelaine Healey, *Indian Sisters: A History of Nursing and the State, 1907-2007* (London: Taylor and Francis, 2014).

[44] Maina Chawla Singh, "Gender, Medicine and Empire: Early Initiatives in institution building and professionalisation (1890s-1940s) in Shakti Kak and Biswamoy Pati (ed.) *In Exploring Gender Equations: Colonial and Post-colonial India* (New Delhi: NMML, 2005), 93-113.

James C Scott in 1990 claimed that, 'A thick interpretation of hegemony involves a subordinated group's active consent to the values that subordinate them because these values are completely mystified by a dominant group'.[45] This argument has much in common with the core argument of this thesis, however, in the case of Madras, the subordinates did not remain in a subordinate position for long. This thesis, in particular, the role of the medical subordinates, resonates with James C Scott's argument of thick and thin hegemony, particularly the way subordinates and intermediaries were engaging in establishing their control in the rural parts of the province.[46] There were occurrences of collaboration and competition across genders, classes, races, religions, and linguistic groups in the presidency from the top layer to the lowest administrative structure. I have tried to analyse and emphasise on that distinctness of the presidency and explore how hegemony worked differently in different cases across the period. This has also focused on the way hegemony was deconstructed and utilised by different sections of the population, in this case, health workers and administrators.

Sources and Methodology

This study identifies with and further expands on the argument that the British colonial state and the public health and healthcare establishments were not monolithic in structure.[47] As Bhattacharya argues, 'the colonial state is best seen as an aggregate of administrative levels, in which local officials were given - or took - a marked degree of autonomy during the implementation of policies prescribed by departmental superiors based within the central government or at the provincial headquarters'.[48] This study aims to focus on the contradictions and factors that contributed to the presidency undergoing distinct experiences and considers why and how the

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[45] James C Scott, *Domination and the Arts of Resistance: Hidden* Transcripts (New Haven; London: Yale University Press, 1990), 72.
[46] *Ibid.*
[47] Bhattacharya, *Fractured states*, 11.
[48] *Ibid.*

story of medical transformation was unique in the case of Madras. It explores the links between military recruitment or the lack of it in Madras, the political and healthcare structure of the presidency, and the contribution of healthcare services in the region. While doing so, it recognises the heterogeneous identity of the region that allowed people from different castes, classes, and linguistic groups to assimilate even as each group strongly held on to their distinctiveness. The thesis aims to recast the nature of medical care in the colonial context and has studied the elite and subordinate medical services, including the role of both male and female practitioners in disseminating healthcare in the region. There have been very few works on such a theme as rarely have scholars attempted to study such diverse angles together. This thesis has drawn heavily from unreferenced data in English and Tamil and has utilised the available scholarship to further substantiate the argument.[49]

The primary intention while writing the thesis was to explore new avenues of research and strengthen the narrative with previously unused sources and this required prolonged data collection. I will explain my methodological work chapter wise, although there will be some overlap in the process. In the first argument-based section, Chapter 3, I have relied mostly on military files collected from the UK and National Archives, India. The military files have rarely been utilised to study civilian issues and have provided a strong base for this thesis to understand the transformation of western healthcare in the presidency. Materials collected from health and public department files available at the British Library have also assisted the chapter, along with other documents collected from the National Army Museum, the Imperial War Museum in London, and also the Wellcome Library. The contrast and constant shift in the nature of the interaction between the military and civilians in case of medical care prove the significance of this chapter. The next chapter on IMS relies mostly on medical journals, files from the British Library and also a few documents

[49] The secondary literature relevant for individual topics will be dealt in more detail in the appropriate chapters.

from the Rockefeller Archive Center (RAC hereafter) detailing and exploring certain complex issues within the presidency, including class, rural-urban differences and the difference in the narratives of the colonial state, the locals and that of the Rockefeller Foundation officers. While the British narrative was woven around the idea of an apparent colonial benevolence, the files collected locally and from the USA contradict them and reveal how control over the medical marketplace was essential for commanding the health structure.

The final two chapters dealing mostly with two of the most neglected sections of the healthcare services – the subordinates and the women health practitioners – rely heavily on local sources including reports of local, municipal boards, local journal articles, along with the medical and military files. If unchallenged, the colonial narrative provides a lopsided insight into the distinct nature of the health workers, and so delving into other sources is critical in providing a comprehensive picture of the period. The reports and surveys from the International Health Department (IHD hereafter) provide an excellent counter narrative to the colonial record. The letters, diaries and private documents collected from the RAC add another dimension to understanding the health structure and contribution of the presidency.

Limitations - archives and archivists

This research has re-examined some previously used materials and referred to new sources in order to explain the evolution of medical services, and this research has been shaped entirely by the accessibility to materials (or their lack thereof) in different archives and libraries in the UK, the USA, and India. Although most of the materials used in the thesis are in English, a lot of those were collected from different regional and national, libraries and archives in India. My research in the UK has largely been seamless, but the Indian leg has faced certain limitations in terms of availability of materials, or the ease of their access. Of the enormous number of requisitions slips I had submitted in order to get the files at the National Archives, India, less than 10% came back with a positive result, and the others were returned usually with NT (Not Transferred) written over

them. I failed to solicit any explanation or reasons for these rejections and was compelled to continue my research without many essential military documents as these files are only stored in the National Archives these days. In my initial proposal, I had offered to look more closely into the army records, and that did not ultimately materialise because of these adversities. However, I did manage to collect substantial data and could get my hands on about 500 pages of scanned files four months after I requested them. The regional archives were also difficult to work in, given the existence of significant red-tape. The archives of *The Hindu* newspaper whose materials are deployed at length in the thesis was also rather slow in giving access to their data. Even though the librarians were mostly kind and helpful, it was a long bureaucratic process that I had to manoeuvre to convince them to send me the requested files. It took me about six months from the date of my first request to get hold of the scanned copies. I started working in the Tamil Nadu State Archives (TNSA hereafter) first in 2012, and I could locate about 90% of the indices available between 1880 to 1935 in public, medical and public health departments. Chennai experienced a massive flood in December 2015, and when I arrived there at the end of 2016 to conduct my doctoral research, many of those indices have been lost or misplaced. Therefore, on most occasions, I had to work with the available files, and without the indices, it became almost impossible to request the documents, and I had to at times request materials without any inkling about their content. These shortcomings delayed the process of material collection and denied me the chance of visiting a few of the district archives that I had originally planned on visiting. Thankfully, the materials I could lay my hands on, have provided me with enough data to not only convincingly write this thesis but also develop and branch out beyond the initial proposed idea and find newer ways to structure my final chapters.

Chronology and structure

The thesis concerns itself with medical care and services and weaves the narrative along with political events that contributed to the changing nature of western medical care in the presidency. The first significant political change in our period was the 1882 resolution for local self-government for India; this provided the first sense of rights locally with added importance on the municipal, and district bodies. This thesis starts at 1880 to mark the beginning of the viceroyalty of Lord Ripon, who passed the resolution. The next changes were the amalgamation of the British Indian army that put an end to the presidency army system, and it will be argued later that this changed how Madras Presidency became such a significant force in healthcare. This was followed by the amalgamation of the IMS and explains the hierarchical levels from the Governor of the presidency, the government in Calcutta, and in Delhi from 1912.[50] The beginning of the Great War in 1914 contributed massively in the medical structure of the Madras Presidency and has been explored in greater detail in the last three chapters. But, the year 1919 remained significant for this thesis, because of the Government of India Act 1919. Finally, the thesis closes its arguments in 1935, marking the date for Government of India Act 1935, and explains how these contributed to the changing scenario in terms of western healthcare in the presidency. Thus, the political shifts dictate the chronology and justify the choice of choosing this period to study.

This thesis acknowledges that deciphering the transformation of medical care across such a huge province involved a number of different spaces and places. The shift in the attitude of provincial and local governments, the central governments in Calcutta (later in Delhi), and the British Crown in London needs to be understood from different levels and hierarchies. The chapterisation has been made keeping such factors in mind, and the chapters can broadly be divided into three sections. The first section includes the initial two chapters and provides an explanation of the political and medical structure of the Madras Presidency during the period under review.

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[50] On 12 December 1911, King George V, then Emperor of India, along with Queen Mary, his consort, announced the capital of the Raj was to be shifted from Calcutta to Delhi. To know more about this see, Nityapriya Ghosh, Krityapriya Ghosh, *Tranfer of capital, Calcutta to Delhi: documents and report* (Kolkata: Dey's, 2011)

These two chapters look at the interconnected nature of politics (particularly local level politics) and health administration in the districts and sub-divisional levels in the region, providing a background to the following chapters in the process. The first chapter demonstrates the importance of understanding the political nature of this presidency and emphasises on the role it played in segregating and making a section among Indians powerful to control and consolidate power locally. Chapter 2 explores how closely the health policies and administration were linked with the political set-up and how far local politics contributed to shaping medical care in the presidency. This also situates the contribution of the International Health Division as part of the Rockefeller Foundation and how their activities in Madras moulded medical care and how far local politics had an impact on them.

Chapter 3 begins into the next section as it explores the region from 1880 until the beginning of the Great War in 1914 and it signifies how important a role the military played or its consistent disbandment in the province played in shaping the medical scenario of the Madras Presidency. In this chapter, the argument revolves around the medical transformation or the shift from military to civil centric healthcare, and this paves the ground for the introduction of the following three chapters. The subsequent chapters – 4, 5, and 6 – should be understood after going through the initial chapters on medical transformation for a complete grasp of the complexities of the presidency and its healthcare setup. These explore in detail how the medical services worked and changed during this period, focusing more on civilian medical care. Chapter 4 explains the IMS and how it was affected and modified with the changing political situation, but one thing that remained constant was private practice. This chapter expands on the importance of private practice to the colonial administrators as the powerful British doctors were controlling the narrative and eventually, the policies. Chapter 5 concentrates on the subordinates and intermediaries in medical services and how the local politics and control allowed a certain section of people in Madras Presidency to seize control of medical care in districts and sub-divisional levels of administration. This shows how important these subordinates were and how they were controlling and accumulating

power locally. Finally, Chapter 6 recasts the contribution of women medical service in understanding the role played by indigenous women as doctors and patients in embracing and defying western medical care. This section examines how the involvement of people from different levels of society facilitated likely, and on most occasions, unlikely partnerships between health workers and the bureaucracy.

Chapter 1 – The Madras Presidency, 1880-1935: administrative divisions and structures

The geographical area covered in this study was a large and heterogenous province, and in British colonial administrative parlance was termed a presidency. Madras was among three presidencies in colonial India, the other two being Bengal and Bombay. The three presidencies remained the most important administrative divisions of colonial governance in India, and over the years, the EIC kept annexing individual kingdoms and adding new regions to each of these presidencies.[1] One of the primary works exploring the evolving administrative structure of the Madras Presidency is by David Washbrook, who argues that the Madras government had immense power on paper, which, in his opinion, was far greater than the other two presidencies. The pyramidal structure of the administrative setup, he argues, made it susceptible to discretionary and at times autocratic rule by the subordinates.[2] He adds, 'village officers, clerks, revenue and police inspectors and tahsildars were of far greater consequence in deciding the vital questions…'[3] Thus, the administrative bodies at the very base of this pyramidal structure had the ultimate authority in many cases, which essentially points to the presence of an inverted pyramidal structure in case of the governance of Madras Presidency. This chapter provides a background of the Madras Presidency and introduces the political and administrative divisions in the region. This also acts as a background to explaining the health administrative structures in latter chapters.

This chapter is divided into three sections and begins with the three stages of governments trying to control the Madras Presidency and how the changes, mostly political made an impact on the region. The second section has provided a brief summary of the presidency while explaining the political shifts that affected them. The third section has explained the administrative structures

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[1] The Madras Presidency was established in 1640, Bombay Presidency in 1687 and Bengal Presidency in 1690 by the English EIC who started as traders and eventually began to rule India. The territorial limits of these presidencies, however, kept changing with new acquisitions by the EIC. For a British centric report on the presidencies see, John Capper, *The Three Presidencies of India: A History of the Rise and Progress of the British Indian Possessions* (London: Ingram, Cooke, and Co., 1853).
[2] D. A. Washbrook, *The emergence of Provincial politics: The Madras Presidency, 1870-1920* (Cambridge; New York: Cambridge University Press, 1976), 35-37.
[3] *Ibid.*

of the presidency, from the Madras city to the districts, and the village level. It has also explained the ways in which the local residents were controlling the administrative machinery through the years under review. Overall, this chapter looks at the acquisition and expansion of the presidency whilst also examining the changes in its political administration. The impact of major shifts in provincial politics and administrative arrangements will also be taken into account. This allows the thesis to locate the evolving provision of medical and health services in this complex political and social terrain in detail, which then acts as important background information for all the chapters that follow.

1.1 Acquisition of the Madras Presidency: demographic and territorial Changes

David Arnold argues that the main phase of expansion of British authority in South India was between 1792 and 1801. This rapidly added to the size of the presidency, which grew from a set of coastal enclaves to a defined administrative unit of 140,000 square miles in extent and an estimated population of 22 million by the 1850s.[4] The expansion started in 1792 following the Third Mysore War, and in 1801 the Nawab of Carnatic was deprived of his territories stretching from Nellore in the north, through North and South Arcot, Trichinopoly and part of Madura, to Tinnevelly in the extreme south. British Madras, with aggressive territorial expansion, soon became a huge presidency that offered revenues and other benefits to the Government of India (GoI hereafter) for years.[5]

Madras city had opportunities to become an economic powerhouse and occupy an important position in British India. However, the Madras Presidency had a very long coastline, and the presence of several ports diminished the capital city's chances of exclusive control over trade by spreading out economic growth.[6] Madras handled only forty percent of the entire presidency's

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[4] David Arnold, *Police Power and Colonial Rule, Madras, 1859-1947* (Delhi; New York: Oxford University Press, 1986), 15.
[5] Washbrook, *Politics,* 12.
[6] Arnold, *Police Power,* 1-6.

external trade till 1920 which bears testimony that its port was not as important as the ones in Bengal or Bombay.[7] Thus, a tendency to spread out economic development and include the semi-urban and rural spaces in its growth was quite evident. It also faced difficulty on the language front, with five major linguistic divisions in the presidency vying to establish dominance under the British. According to the *Census* of 1921, Tamil was the single largest language, spoken by about 17.5 million people, followed by Telugu with about 16 million speakers. There were also about 3.5 million speakers of Malayalam and close to 1.5 million speakers each of Canarese (present day Kannada) and Oriya.[8] In addition to these, there were nearly a million Hindustani and a quarter million Marathi speakers living within the province. The so-called hill tribes also constituted a significant portion of the population in the presidency, and they spoke a variety of languages.[9] These groups of people came together to form the presidency of Madras; this diversity in terms of caste, class, religion, language, and ethnicity rendered any attempts of studying the province difficult.

Two significant works on provincial politics of Madras Presidency have been by David Washbrook and Christopher Baker.[10] However, the absence of local and regional sources in these accounts render them less significant in gauging the role played by the local residents in a nuanced way. These works also failed to explore how educated Indians were contributing to and actually controlling the administrative machinery in the districts and more significantly in the sub-divisional levels. Anand Yang, while writing on colonial Bihar, has shown appreciation of local involvement and contribution to the provincial politics. He, however, chose to give little or no importance to the colonial rule to the extent of denying that colonialism was real or that it changed the local

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7 Washbrook, *Politics,* 12.
8 *Census of India, Madras*.1921.vol XIII. Part 2 (Madras, 1922), 79-83.
9 *Ibid.*
10 Washbrook, *Politics*; Christopher Baker, *The Politics of South India, 1920-1937* (Cambridge; New York: Cambridge University Press, 1976).

politics of India.[11] The provincial government had always been pro-active in the Madras Presidency, reflecting its power, dimensions and hierarchy among the masses. In reference to those trends, Washbrook wrote,

> The Government in Madras was both a great deal more and a great deal less than the hundred or so Europeans who composed its senior civil service. Involved in it, in one way or another, were the British Parliament, sitting six thousand miles away and concerned with the affairs of an international empire; barely literate peasants, on salaries of four shillings a month and concerned with the taxation of a few barren acres; and the broad spectrum of people and interests which lay between them. Men whose outlooks were bounded by the village, the town, the district, the province, the nation and the empire all were locked together in the chain of government in Madras.[12]

This description provides robust insights into the structure and workings of the government of Madras but does not give us a full assessment of administrative complexities present within the governance of the Madras Presidency.

1.1.a) Three stages of government - London, Calcutta, Madras

Madras Presidency was controlled by three separate policy-making bodies: the Secretary-of-State-in-Council with an office in London associated to a department in the British government, the GoI in Calcutta till 1911 (and in Delhi from 1912 onwards), and the government of Fort St George in Madras.[13] The three sets of governmental structures were at loggerheads, primarily because each of them wanted to be in an advantageous position compared to the rest. Washbrook

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[11] Anand A Yang, *The Limited Raj: agrarian relations in Colonial India, Saran District, 1793-1920* (Delhi: University of Oxford Press, 1989).
[12] Washbrook, *Politics*, 23.
[13] On 12 December 1911, during the Delhi Durbar, George V, then Emperor of India, along with Queen Mary, his consort, announced the capital of the British Raj was to be shifted from Calcutta to Delhi. Lord Hardinge was the Viceroy during the time. Delhi was later renamed New Delhi in 1927. See more in, Nityapriya Ghosh, Krityapriya Ghosh, *Tranfer of capital, Calcutta to Delhi: documents and report* (Kolkata: Dey's, 2011).

notes that initiatives taken by London and Calcutta were systematically opposed by Fort St. George as they insisted the superiors had no idea about the problems facing the presidency of Madras. The evidence of his claims can be found in Lord Ripon's[14] local self-government reforms[15] in 1892, in the 1909 council acts, and also in the constitutional proposals that were pushed through in the presidency despite facing severe criticism from the Madras government.[16] Under Lord Mayo's (fourth viceroy of British India from 1869) viceroyalty, the GoI in 1870, first recognised the principle of developing local bodies for establishing self-governance but it was not until 1882 that local self-government was recognised by the GoI.[17] Ripon wrote, 'What I want is a gradual training of the best, most intelligent and influential men in the community, to take interest and active part in the management of their local affairs.'[18] He made it clear that decentralizing administration would be beneficial to Indians while also improving administrative functions. However, the idea of local self-government was not a new one as municipalities had existed for a long time and were entrusted with the management of local affairs such as sanitation, maintenance of roads, and ferries.[19]

'To the Government of India', Washbrook added, 'Madras appeared a bottomless purse which could be looted whenever the need arose…'.[20] Now, although the GoI forced some reforms, Fort St. George was largely allowed to conduct its administration autonomously including enforcement of law and collection of taxes. The British government and the colonial state's HQ in India

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[14] Lord Ripon was appointed the Viceroy of India in 1880 and he was in office till 1884.
[15] Local self-Government was introduced in India by the Resolution of 1882 during the Viceroyalty of Lord Ripon. This led to higher participation of Indians in local administrative matters and led to establishment of District and Local boards. The members of the boards were also to be partly nominated and partly elected. This led to the rise of local influence in local, regional politics of India which changed the political dynamics of India. See, H. Wheeler, "Local Self-Government in India," *Journal of the Society of Comparative Legislation* 17, no. 1/2 (1917): 153-164.
[16] Washbrook, *Politics*, 24-25.
[17] T. B. Russell, *The principles of Local Government in England and their application in India* (P. Varadachary & Co.: Madras, [n.d]), 66-67.
[18] K.K. Pillay, *History of Local Self-Government in the Madras Presidency, 1850-1919* (Bombay: C. D. Barfivala, Director, The Local Self- Government Institute 1953), 1-5.
[19] *Ibid*; For more details on cross fertilization of colonial and local law and structures of governance see Brimnes, *Constructing the Colonial Encounter: Right and Left Hand Castes in Early Colonial South India* (Richmond, Surrey: Curzon, 1999).
[20] *Ibid.*

only had a veto on legislation and of demand on the revenue. Private papers of Lord Ampthill suggest that during most of the period examined in this thesis, about 60-70 percent of the total income of Madras was used up by the GoI treasury, which crippled the provincial and local governments and prevented them from implementing any social or economic policies to benefit the local masses.[21] This precluded the Madras government from providing any fund for administrative works inside the presidency and triggered the local people against the GoI.

A complex structure of governing British colonies had grown with the expansion of the empire, and its proponents argued that it was simple and efficient.[22] This complex nature, however, was designed to serve a dual purpose; first, to provide free and independent growth to each colony towards self-government and administrative self-sufficiency. There was no apparent rigid control imposed from London, and gradually more local people were allowed to enter the service of their own country. Secondly, it was argued that the organisation of various branches of the colonial service segregating into individual functional services was designed to establish proper coordination throughout the empire.[23] Examining the presidency of Madras explains the reality behind having these small administrative bodies that became powerful on their own and started running their own system of governance locally. The Madras government had to constantly analyse the role of local Indian leaders and collaborate with them to run the administration effectively.

1.1.b) Changes in British India: impact on the Madras Presidency

A broader look at national politics will perhaps make it easier to understand the regional politics in Madras during the period dealt with in this thesis. Sumit Sarkar has pointed out, ever since the British crown assumed control over India, ending English EIC's rule, the viceroy became

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[21] Mss Eur E233/16, Correspondence with Lord Curzon, 1902, Ampthill Papers, Asia, Pacific and Africa Collection (APAC), British Library (BL).
[22] Kenneth Bradley, *The Colonial Service as a Career* (London: His Majesty's Stationery Office, 1950), 10-12.
[23] *Ibid.*

the all-powerful person in the country, along with the Secretary of State for India.[24] From the 1880s, the approach of the GoI began to change as it started collaborating with the English-educated Indian middle-class in addition to the erstwhile Indian nobility such as the zamindars and the princes. This educated intellectual section became the new allies for the GoI to reinforce their administrative structure. However, the situation in Madras, even within the capital city, was significantly different from the rest of British India. With their rigid caste and class divisions, and subsequent Brahminical dominance, Madras failed to witness the rise of an educated middle class like in Bengal. The Brahmins, the dominant caste, began to flex their muscles in the arenas of job opportunities and access to education. The upper caste people with access to English education were enticed by government jobs, mostly in the administrative and health sectors. However, after 1885, with the emergence of Congress as a new front, a much higher level of collaboration had to be organised through legislative council reforms to benefit the masses.[25] Sarkar suggested that these changes rendered the situation in Madras even more complex, with new groups constantly emerging as either collaborators or competitors to the British authority.

The Madras government was distant from their local political bodies, which made them ignorant about the system. Washbrook argues that it allowed the incumbent local administrative groups to have free rein and use the state power in any way they wanted.[26] G. T. Boag, after arriving in India in 1908, became the municipal commissioner and later the chief secretary of the Madras Presidency, and this period saw his ideas of welfare shaping policies across the province.[27] But, the approach of the British officials was severely criticised by the Indians, mostly elites, who were controlling power in the districts and sub-divisional levels in the presidency.

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[24] Sumit Sarkar, *Modern India 1885-1947* (Delhi: Macmillan, 1985), 14-20.
[25] *Ibid.*
[26] Washbrook, *Politics*, 149.
[27] G.T. Boag, *The Madras Presidency* (Madras: Government Press Madras, 1933).

1.2 Establishment and evolution of the local self-government: Impact on Madras Presidency

1.2.a) Background and changes after 1885

After 1857, the administration of the Madras Presidency began to be controlled by a governor, assisted by four executive council members, appointed by the British Crown for a period of five years. Of the members at the council, two were from the Indian Civil Service, third was an Indian with distinction, and fourth was commander-in-chief of the Madras army.[28] This remained the norm until the local self-government resolution was adopted. A major change in the Madras government was implemented after 1895 with the removal of the position of the commander-in-chief as the presidency army system was altered. From this period, three members (two from ICS and one elected Indian), apart from the governor, controlled the executive council.[29] To ease the complications of administering a massive region like Madras, it was further divided into smaller districts. The principal district officers were the revenue collector and district magistrate along with the district and sessions judge. The collector was assisted in discharging his duties by divisional officers and assistants, executive engineer, district forest officer, district medical officer and superintendent of police.[30]

The next important change in the evolution of local self-government in India was the publication of the report on decentralisation in 1909 by the Royal Commission that was set up in 1906. This report sought to return the village community to its former glory by recommending more administrative powers to the *taluks* (sub-district boards) and suggesting the creation of village

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[28] *Ibid.*
[29] E. Thurston, *The Madras Presidency: With Mysore, Coorg and the associated states* (Cambridge: University Press, 1914), 180-185.
[30] *Ibid.*

panchayats for the administration of local affairs with the village headman in control.[31] The First World War brought forth epoch-making changes in the political scenario over the general political scenario of India. These changes prompted a response from Great Britain about giving Indians more responsibility to run local administration culminating with the introduction of the Government of India act 1919.

1.2.b) The Government of India Act 1919: Further changes

The reforms of 1882 were not completely effective in implementing the practice of local self-government, but it initiated a transformation that was only accomplished much later with the Montague-Chelmsford reforms in 1919.[32] The Madras government faced various changes in the administrative structure following the introduction of diarchy or dual government rule.[33] This act divided the law-making subjects into two lists: reserved and transferred. Education, health, local government, industry, agriculture, and excise came under the transferred list and became the responsibility of the provincial governments aided by the local bodies. This made the position of the local boards very important, as they were the ones looking after the local administrative set up in the presidencies. The Secretary of State and the governor-general had very restricted interfering capacity in the transferred list, which was controlled entirely at the whims of the provincial legislative councils where 70% of the members had to be elected in accordance with the 1919 act. These changes enabled the appointment of non-officials as chairmen for urban councils and district boards, as well as designate separate executive officers in large towns and district boards. It restricted central control over matters of taxation to local bodies and increased the control of the

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[31] Report of the Royal Commission on Decentralization, 1908, Chapter XVIII, Para 699, File 2136, IOR/L/PJ/6/873, BL; Panchayats are the only grassroots-level of formalised local self-governance system which was adopted in cilonial India at the village of small-town levels, and had a sarpanch as its elected head.

[32] It was also called the Government of India Act 1919. This Act established the dual government system in the provinces and led to the formation of local councils in rural areas. See Washbrook, *Provincial politics*.

[33] Diarchy or Dyarchy was introduced by the Act of 1919, which established dual rule. The Governor became the executive head of the Presidency while there were ministers who were to be elected to run the regional administration.

village panchayats.[34] T. B. Russell, while comparing the two reforms, described differences from the British system thus:

> It is to be observed, however, that, even after Lord Ripon's resolution, Local Government continued to be regarded in practice as a branch of the central administration. Executive control remained at the hands of officials, who carried on this branch of their duties as officials of the central Government; in rural areas, the elected bodies were generally not much more than advisory committees. This system is in marked contrast to that which has been in force for so long in England, where the institutions of local Self-Government have grown up along with those of the Central Government and, although they recognise the ultimate authority of the latter, are to a very large extent independent of it. It is worth remembering that this latter system is peculiar to England. On the continent of Europe, Local Government is to-day regarded simply as a branch of the central authority, and continental nations do not consider that there is anything undemocratic or reactionary in this arrangement. After the reforms introduced by the Government of India Act of 1919 (The Montague-Chelmsford Reforms), the change from the continental to the English system was accomplished.[35]

The reforms of 1919 could not satisfy the political demands in India. These measures were forced upon the presidencies without consulting Indian members, and their voices were muffled in most of the cases. But it did bring about significant changes in the way India was being governed by the British. Between 1880 and 1920, the administrative structure increasingly became centralised and that, as Baker had argued, 'focussed more political attention on provincial affairs, but there had been few avenues by which men from the districts could gain access to the politics of the province'.[36] Such avenues allowed regions like Mylapore to gain prominence with their strong voices

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[34] Government of India Resolution on Local self-government, No.41, 16 May 1918, IOR/V/27/250/2, APAC, BL.
[35] Russell, *Local Government*, 67.
[36] Baker, *Politics of South India*, 39.

from the upper caste and class residing in the area.[37] The local administrative process continued to be under the purview of the GoI with changes and revisions effected at regular intervals. The Indian statutory commission (also known as the Simon Commission) was appointed by the British Crown in 1927 to examine the working of the governments introduced under the act of 1919 and to improve the existing system. The commission observed that 'in every province, while a few local bodies have discharged their responsibilities with undoubted success and others have been equally conspicuous failures, the bulk lies between these extremes'.[38] The commission decided to mould the Indian system of local government in the model of Great Britain, and they claimed that the appointments to various positions in the municipalities were based on personal connections rather than merit.[39] Finally, with these considerations and new reforms, the Act of 1935 was introduced, which gave India a restricted form of provincial autonomy under the British Crown.[40]

1.3 Local self-government in the Madras Presidency: districts, *taluks* and villages

This section examines the local level administrative structure in the presidency of Madras with a thorough examination divided into two parts. The first part will explain the recognition of local self-government in 1882 and the changes that resulted from it, leading up to 1919. The next part takes up events from 1919 onwards, which acted as a watershed year in the administrative structure of colonial India. This part continues up to 1935 analysing how diverse groups of people exerted their power at the districts and sub-divisional levels such as the *taluks* and villages.

The administrative divisions of the presidency went through an array of changes during the period under review. The Madras Presidency was divided into twenty-six districts with the

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[37] Mylapore is one of the oldest residential parts of the Madras city. In the late nineteenth and early twentieth centuries Mylapore became the intellectual and commercial hub of Madras city and was home to many English educated lawyers and stateman and mostly included the upper caste Brahmins. For a detailed study of caste and class in Madras see, Rupa Viswanath, "Rethinking Caste and Class: "Labour", the Depressed Classes", and the Politics of Distinctions, Madras 1918-1924," *International Review of Social History* 59, no. 1 (2014): 1-37.

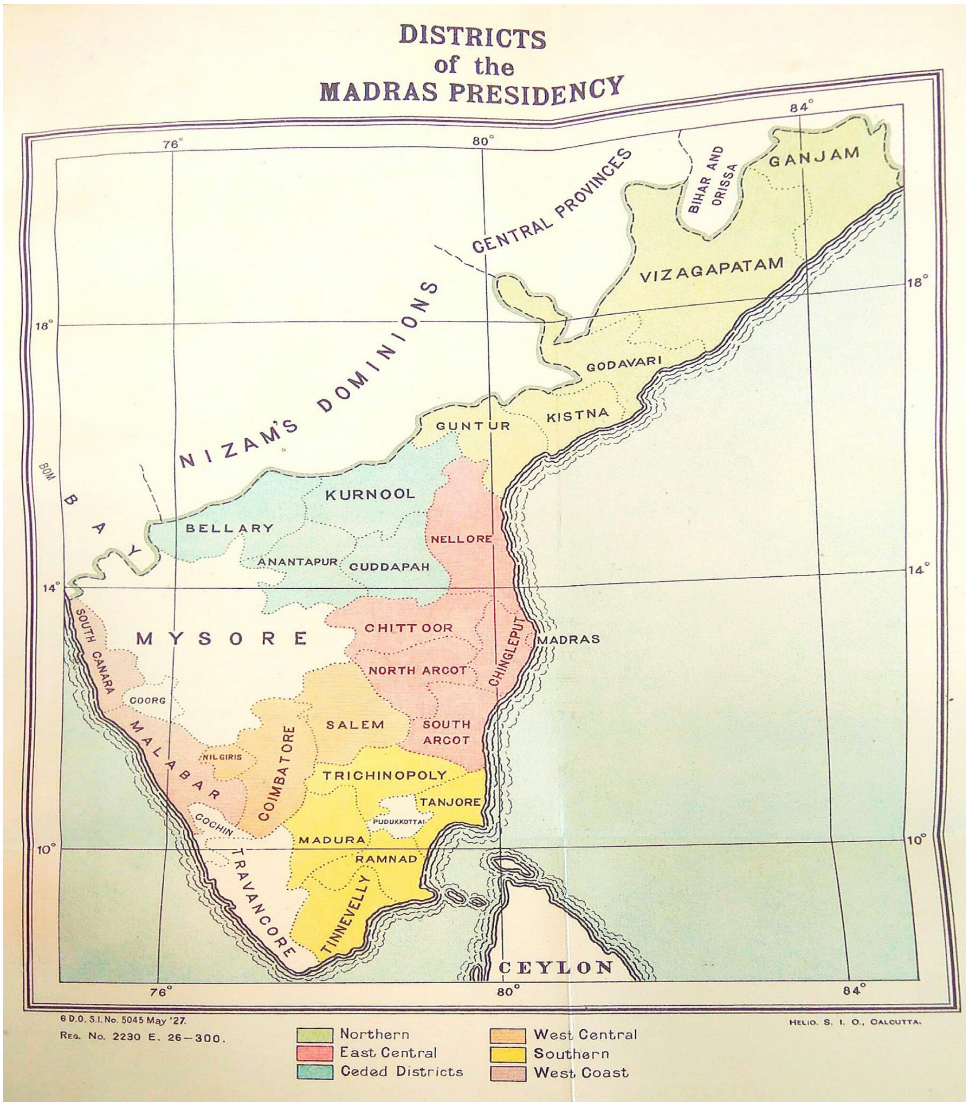
[38] *The Report of the Committee on the Indigenous systems of Medicine* (Madras, 1925).

[39] *Ibid.*

[40] *The Government of India Act, 1935* (Mylapore: Madras Law Journal Office, 1937), 10-25.

Governor in Council sitting at the helm of the administration of the presidency. Over the years, this administrative structure lost its homogenous constitution. The map below shows the Madras Presidency in its entirety along with the districts and different zones.[41]

Image 1.3.1 – Map showing the districts of the Madras Presidency (1927)



[41] The *panchayat* including the Union boards corresponded to the English Parish Council, the *taluk* Board to the Rural District Council, and the District Board to the County Council. This comparison is by no means perfect and the Madras system of administration could by no means be similar or equivalent to that of England. This is just a comparison to give an idea of the hierarchy in the local administration.

[Source- Lieutenant-Colonel G.E.D. Mouat of 2nd Madras Regiment, *Madras Classes, Compiled for the Government of India* (Calcutta: GoI Central Publication Branch, 1927]

1.3.a) Madras reacting to the provision of local self-government

Following the Act of 1882, there was a series of meetings, discussions, and statements by the educated segment of Indians looking to strengthen or maintain their position under the changed system in the Madras Presidency. A few of them wrote to the government seeking positions to control the boards, while others like G. L. Narsing Row tried to reason with the British to be more considerate in implementing a policy that affects most people. He wrote,

> I now speak of Mofussil, and not of Presidency Towns. Election of the Commissioners is quite requisite to produce independent action and responsibility. The question is, who are the electors? How are they to be determined? In England, or rather Europe, the education is more in favour of the wealthy landlords and people of property; but in India, it is sought more by classes as a means of livelihood, and not for the sake of intelligence.[42]

Row recommended that the Indians should be given executive powers in the local and regional boards to discharge their duties without the direct supervision of a European with magisterial powers.[43] Since education was largely a privilege granted traditionally to the upper castes; his recommendation indirectly sought more opportunities for Brahmins and other higher castes. Britain's colonial empire, to put it simply, was too vast for the British Crown to control, and this prompted a change in the Imperial policy.

Washbrook provided a very interesting interpretation of the authority and power of the administrative bodies. According to him, Fort St George in Madras, when examined in the context

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[42] *Proceedings of the Madras Native Association on the Resolution of the Government of India on Local Self-Government* (Scottish Press: Madras, 1883).
[43] *Ibid.*

of the British empire, was a minor outpost, answerable to at least three, and sometimes four layers of superior authority; but in the context of governing the Presidency, it looked like an autocratic ruler.[44] This structure encouraged more people to take advantage of the situation, and the so-called elite section of Indians began to prosper even further with the benefits and money received at the behest of the governor.[45] The concentration of power was also the result of the emergence and spread of western education and, in later years, specifically medical education. This provided the conditions in which the upper section of the society gained more prominence in the administration.[46] Washbrook and Baker have written extensively on how important the provincial government was in the context of Madras. They explained how it had gone much further than the other provincial governments in transferring administrative functions to committees of non-officials; forests, income tax, irrigation, police and excise administration were carried out by, or in consultation with, boards of local notables.[47]

1.3.b) Madras City - impact on the municipal structure and district boards

The statutory municipal boards were introduced in 1850 following the Act 26, which allowed the establishment of municipal institutions in any town of British India. The administration of the municipal affairs of the city of Madras was managed in 1880 under Act V of 1878 by a president, 2 vice-presidents, and 32 councillors. Apart from the president, the rest were Indians, either selected by the government or elected for the posts.[48] The president and vice-presidents were salaried officers appointed by the government. Sixteen out of thirty-two councillors were nominated by the governor in the council while the other sixteen were elected by the voters.[49] In

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[44] Washbrook, *Politics*, 215.
[45] *Ibid.*
[46] W.S. Meyer, *Report on the constitution of additional districts, divisions and taluks in the Madras Presidency, and on other connected matters* (Madras, 1904).
[47] C. J. Baker and D. A. Washbrook, *South India: Political Institutions and Political Change 1880-1940* (Meerut: S. G. Wasani, 1975), "Introduction".
[48] *Administration report, Corporation of Madras* (Madras: S. Murthy & Co. 1881)
[49] *Ibid.*

1883 a committee was appointed to report on local and municipal administration, and one of the results of this committee's report was the enactment of the Madras Municipalities Act, IV of 1884. Under this act, the collector ceased to be the president, who was either appointed by the government or when the government directed, elected by the councillors. The number of councillors was not to be less than twelve, and two-thirds of the number were to be elected by the ratepayers.[50] In Madras, the Municipal Act of 1919 and District Municipalities' Act of 1920 gave powers to the councils to elect their own chairperson and plan their own budgets. The control and supervision of the corporation dispensaries used to be the responsibility of the district surgeons, but from 1919, the city health officers had the authority to command these as new dispensaries were opening up in different parts of the city of Madras.[51] Another law passed in 1925 made city municipalities, whose population exceeded one *lakh* (one hundred thousand), wholly elective while the smaller municipalities received a majority of their representatives through election (4/5th of the total membership).[52] Women got the right to vote and contest in elections.[53] This chapter, however, focuses more on the regions outside the boundaries of the city of Madras, and the following section will explain the boards that controlled administration from the district level onwards.

Following Ripon's Resolution of 18 May 1882, the provincial governments were asked to adopt the system according to local requirements and traditions; to provide an incentive to the local inhabitants to take part in the government, courtesy titles were also introduced.[54] For the sake of revenue administration, the Madras Presidency was divided into districts. In 1850 there were 19 districts, but by 1919 the number of districts went up to 25. Each district came to be split into two to six divisions, the divisions into *taluks,* and each *taluk* consisted of a number of villages.[55] To

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[50] *Ibid.*
[51] *Corporation of Madras*, 1919, 1-3.
[52] Resolution of the Government of India, no.41, 16 May 1918, IOR/V/27/250/2, AP.
[53] Ibid.
[54] Local self-government, Resolution of the Government of India, IOR/L/PJ/6/76, 23 May 1882, APAC, BL; Such titles were Rao Bahadur and Khan Bahadur, see K. K. Pillay, *Self-government,* 35.
[55] K. K. Pillay, *Self-government*, 11; *Taluk* used to be a sub-division of a district, in charge of a number of villages.

control the administration from the district level, local fund boards had been set up to look after rural sanitation, communication and education. There had also been the rise of elected bodies in various provinces.[56]

The local fund board was governed by the Act of 1871, which divided the districts into different 'circles' for the ease of administration. Each of these 'circles' was controlled by a local board with the collector acting as an ex-officio president. The presidency of Madras was divided into thirty six such 'circles', and some districts were classified into more than one 'circle' to maintain the proportion of their population.[57] The local self-government committee appointed in Madras following Ripon's resolution recommended the introduction of the local boards.[58] This resulted in the presidency being classified into smaller administrative bodies for helping the local boards in discharging their duties. A three-tier system of rural administration was adopted – they were the local fund boards (precursor of the district boards), the *taluk* boards and the union boards. These three boards functioned in addition to the corporation of Madras city and district municipalities. Documents consulted for the period under review have revealed that the local body remained similar over the years as they were hardly the ones to be influenced or impacted by the changes in the national or global politics.

The Madras government, following the resolution of 1915, which insisted on the formation of village panchayats, asked the district authorities to replicate the decision.[59] As Boag suggested, the district board was responsible for the administration of local affairs of each revenue district, with a president in charge along with at least 24 members, who were either appointed by the governor or partly appointed and partially elected by the members of the *taluk* boards of the district

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[56] *Annual report of Vaccination in the Madras Presidency* (Madras: Government Press, 1920).
[57] The Madras Local Boards Act 1884, Government of Madras 1885, 26-27, File 846, IOR/L/PJ/6/131, BL; *Proceedings of Madras Native Association on the resolution of the Government of India on Local Self-Government* (Madras: Scottish Press, 1883).
[58] Ibid.
[59] The Madras Village Panchayat Act 1920, File 212, IOR/L/PJ/6/1728, APAC, BL.

from among themselves.[60] These factors indicate that the *taluk* boards had their own autonomy over regional matters allowing them to dictate those while insulating themselves from government control. There were further sub-divisions of the district as they were divided into *taluks* that were under the charge of native *Tahsildars* (revenue officers). The lowest administrative unit for all administrative and fiscal purposes was the village. Every village had a headman responsible for revenue collection with minor judicial powers, an accountant (locally called *shanbog*), and a few subordinates to work with these two officers. The succession of these officer posts was usually hereditary, and this probably continued from the pre-colonial times and remained the same throughout the British period.[61]

Taluk boards were formed for each *taluk* or group of *taluks* consisting of a president with twelve members who might either all be appointed by the government or partly appointed, while the rest were elected from among the members of the union boards or directly by the taxpayers and inhabitants of the *taluk*.[62] The taluk board's jurisdiction coincided with the revenue divisional officers' jurisdiction. The *taluk* board had two distinct sources of revenue – one half of their fund came from taxes that were levied by the district board on their areas and later transferred to them, while the other half consisted of fees such as licence fees from markets that they collected in the district board areas. A district board might, with the approval of the governor or on his direction, transfer any other sums from its fund to the taluk board.

Finally, the union boards were constituted for single villages or groups of villages called unions, each consisting of not less than five members. The headmen of the villages constituting the union were ex officio members, and one of them was appointed the chairman. Members other than village headmen were either all appointed by the governor or partly elected by the taxpayers. The resources of the union board consisted of the proceeds of the house-tax levied in the union and

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[60] G. T. Boag, *The Madras Presidency* (Madras: Government Press Madras, 1933): 6-34.
[61] *Ibid.*
[62] *Ibid.*

any other sums placed at the disposal of the union by the taluk board. In 1915-16, the local government decided to create minor union panchayats for several villages, and this was implemented by the Madras Village Panchayat Act of 1920. The village panchayats played a significant role in formulating health policies locally and looking for compounders to run dispensaries in their villages.[63] This was carried out to help rouse the communal spirit and encourage the villagers to work together for common purposes, and to gather experience in managing affairs affecting their health. By the end of 1924-25, the Madras Presidency had 579 panchayats, and this number continued to soar in the following years.[64]

1.3.c) Seizing control: section of Indians coming to the fore

During the British rule, the GoI often ended up spending an enormous amount of revenue on its army and had little or no surplus to spend on the welfare of its provinces. Thus, the gnawing need for finances over the years contributed to the regional government depending heavily on the district and villages as important political areas in the presidency. A growing sense of political consciousness among the Indians and a rising national awareness made them attuned to new opportunities and openings under the government.[65] A company of sub, deputy and assistant collectors worked under the head of the district administration and used to supervise their subordinates, the *tahsildars* who oversaw single taluks. Below these ranks was a legion of *gumustahs* (Clerk or Steward) and revenue inspectors who were responsible for the administration of about thirty villages.[66] The districts were linked to Fort St George through the board of revenue and the secretariat, and thus a pyramid structure was set up, which controlled the complex administration of the presidency of Madras. The presidency and its administrative officers were bogged down in so

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[63] C. V. Naidu, *The Madras Local Boards Manual* (Thompson and Co. Broadway: Madras, 1922), 276-278.
[63] The Madras Village Panchayat Act 1920, File 212, IOR/L/PJ/6/1728, APAC, BL.
[64] Ibid.
[65] Bipan Chandra, Amales Tripathi and Barun De, *Freedom Struggle* (New Delhi: National Book, Trust 1983), 67.
[66] *Administration report, Corporation of Madras* (Madras: S. Murthy & Co., 1882)

much workload that it became very difficult for the superior officers to keep track of their subordinates. The secretariat was completely aware of its inability to put in the effort required to efficiently control the administration but failed to perform any better for the lack of manpower:

> Under the present system of large divisional charges, however, Divisional Officers, and for that matter tahsildars, are often so tied to their desks as to be not much more than post officers, and their subordinates are left with so little supervision as to constitute a serious danger to public administration.[67]

All orders of government were issued in the name of the Governor in Council, but as has been shown earlier in the chapter, he was acting more as a titular head without having intricate knowledge of the functioning of the smaller administrative bodies. The local fund districts were corresponding with the *mufassil* collectorates as the administration of the local affairs of each place were vested in a district board consisting of a president, who also acted as the collector of the district. In 1891-92, there were in total 86 *taluk* boards, each with a president working as the revenue officer in charge of the division along with twelve other members who were appointed by the government of Madras.[68] The number of panchayats working in the presidency kept changing during the years, as is evident from 1891-92 when it began with 270 panchayats and by the end of the year stood at 320.[69] The work of the council was distributed among the members assisted by secretaries. It will be important to bear in mind the heterogeneous nature of the presidency in terms of its people, languages, religion, caste, and class structure, which greatly influenced the approach of the western medical practitioners in local areas.

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[67] G.O.173 (Revenue), 20 February 1902, Tamil Nadu State Archives (TNSA).
[68] *Report on the Administration of the Madras Presidency (1891-92).*
[69] *Ibid.*

Anil Seal has examined the political importance of the Indian communities and the number of government jobs held by them.[70] Thus, conflict was not only among the rulers and the ruled but also between different sections of Indians. Madras has always faced caste conflict, and this came to the forefront with more Brahmin families holding official posts over a long period of time. The *tahsildars* and *sheristadars*[71], with their very considerable power, began to have enormous control throughout the revenue bureaucracy and could 'make or break the careers of a great many officers beneath his rank'.[72] The control enjoyed by the lower level officers can be explained by what *The Hindu* reported in 1884:

> The office is filled with men who are all members of one and the same family. These men fill the places of important officers such as Huzur Sheristidars, Head Writers, tahsildars, Sub-Magistrates, Taluk Sheristidars and Munshis of Collectors, while men are shut up from promotion for years and years owing to the influence of the family to which the present officials belong with the Collectors. The members of one family may be seen in all the Taluks and the Head-quarters of the district filling from the post of Karnam to the place of Head Writer and Tahsildar.[73]

There were protests emerging among Indians in terms of rights provided in the local self-government regulation. Minutes of dissent was recorded demanding full control over the election of the president of the district boards, which was not clearly stated in the Madras Local Boards Act 1920.[74] This was, as Russell had mentioned, a way of shaping it in the mould of the English system of local self-government.[75] All the officials had to be elected to the union, taluk, or district boards

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[70] Anil Seal, *The emergence of Indian Nationalism* (Cambridge: Cambridge University Press, 1968).
[71] The Sheristadar was the chief officer in Indian court entrusted with the tasking of receiving and checking court pleas. The word has been derived from the Persian word Sarishta-dar meaning 'administrative officer of the court' who supervised all the activities including record keeping.
[72] Washbrook, *Politics*, 36.
[73] Editorial, *The Hindu* February 22, 1884.
[74] Naidu, *Madras*, 353-354.
[75] *Ibid.*

in order to hold any power. Village headmen (munsifs locally), were not exempted and they had to be elected as well. More interestingly, women were entitled to vote and participate as candidates under this Act. The union was divided into wards; each ward contributed one or more members to the union board.

'The sense of dependence of the people on the official classes is so great', regretfully the president of the Madras Native Association[76] states, 'that unless the superior European officers sternly repress in their subordinates any tendency to assume an attitude of indifference or obstruction to the measures in progress, the difficulties in working the scheme will be greatly increased and its success rendered uncertain.'[77] The situation in Madras for the period under review was full of changes and uncertainties, and that renders the administrative structure too complicated to analyse simplistically; there were a few people trying to work under the British while others were openly against the colonial government. All the issues combined in making the structure of administration in the Madras Presidency variegated and complex. During the 1930s, a few residents of the presidency were able to ask difficult and uncomfortable questions to the government as is evidenced in the budget speech by Sir Purshotamdas Thakurdas,

> What is, Sir, the worst feature of the Budget? The proposed taxation holds out no promise to us of the money being spent in any direction which can be said to be of a nation-building utility. One cannot help asking the question, have the Government of India had any consistent economic policy to follow, which would build up the masses and the people of this country?[78]

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[76] Madras Native Association was formed in 1849 by Gazulu Lakshminarasu Chetty. This was the first organisation in Madras to ask for the rights of the Indians in the colonial government. For details, V. Ramakrishna and K. H. S. S. Sundar, "Reassessing the Madras Native Association (1852-67): Some Formulations," *Proceedings of the Indian History Congress* 51 (1990): 412-419.
[77] *Proceedings of the Madras Native Association*, 25-26.
[78] *The Development of Representative Institutions in the Madras Presidency since 1920* (Madras: Printed by the Superintendent, Government Press, 1928), BL.

This region remained largely a peaceful province, even with a few unsettling incidents of strike and non-cooperation in the Madras cotton mills, the South Indian Railways, and demonstration against Simon Commission's visit. Baker argues that 'there had been no sustained attempts to refuse taxes, no serious communal rioting and no terrorist horrors'.[79] Even though Fort St George was satisfied with such developments, they failed to understand the political implications and their complacency enabled Indians who came forward to take the mantle of responsibility in rural areas.[80] The 1930s depression forced the GoI and the Madras government to leave commitments in the presidency they regarded as 'unnecessary', and this allowed the people of influence in the district and sub-divisional levels to fill in the vacuum. This constant push coming from the Indians forced the higher officials in 'Fort Sr George to extricate themselves from the tiresome details of local and provincial administration'.[81] This scenario resonated with the changes in the healthcare structure as the locals began to gradually control the medical marketplace and made significant changes in the presidency health setup. Thus, it is imperative to understand the political and administrative structure and the hierarchy of the Madras Presidency before attempting to scrutinise its healthcare administration as these two were attached in multiple layers.

1.4 Concluding comments

This chapter has explained the structure of administration in the erstwhile Madras Presidency. Setting up this context is important for this thesis, as a complex geographical and administrative entity like the Madras Presidency needs to be laid out in details for the readers to be able to grasp the different administrative and medical structures employed by the provincial government. A thorough examination of the region until 1935 shows clearly that the educated people of

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[79] Baker, *Politics*, 167.
[80] Fort St George was the administrative centre of the Madras government and the entire presidency was supposed to be controlled from here. See, D.M. Reid, *The Story of Fort St. George* (Madras: Diocesan Press, 1945).
[81] Baker, *Politics*, 320-325.

India were questioning and contradicting measures of the Madras government. At places, they were powerful enough to hold their own position for years. The persistent antagonism, questioning of colonial policy, and Indian control over the local and regional administrations ensured that the colonial regime in Madras was never a saga of unrestrained British dominance. Such antagonism was present in Bengal and other provinces, but this thesis will focus on Madras and its complexities.

With the beginning of the twentieth century, the responsibilities of local and regional officers increased manifold, and this chapter provides a background to understanding the complexities of their duties. The chapter has attempted to familiarise readers with the various administrative bodies, divisions and structures that were essential to the effective functioning of the presidency. The chapter has depended largely on secondary sources, and some administrative reports and primary data have been used to elucidate the functions of various bodies and provide a critical understanding of the presidency. The primary documents explain mainly the regional and local administrative structures and throw light on how a few Indians had risen above their fellow countrymen through their contacts and network and had managed to influence the local administration and make their voices count in otherwise British-dominated institutions.

The following chapter, taking the provincial politics into account, will provide further detail about the medical administrative structure of colonial Madras and elucidate the roles played by the Indians, especially in the lower rungs in the district and sub-divisional levels. The chapter will also delve into the competition and contention among the elite and subordinate medical services and in the process, attempt to explain how this contradiction intersected with the caste and class hierarchies among Indians. These two chapters serve as the base of the thesis upon which further primary sources will be examined in subsequent sections to shed light on the complexities of the Madras medical services and the indispensability of at least a handful of Indians in order to sustain this very British institution.

Chapter 2 – The Madras Presidency, 1880-1935: Medical Administrative Structures

This chapter continues the exploration of the local and provincial administrative structures of the Madras Presidency and furthers the discussion by examining the medical administration focussing on the political changes. It studies the complexity of western medical traditions co-existing at that time and how the medical administration allowed healthcare services to thrive and expand within the colonial space. Unfortunately, the scholarship on the medical services in the presidency has been rather thin, although there are a few important works by Sarah Hodges and V. R . Muraleedharan.[1] This chapter calls for the employment of new methodologies in order to analyse the period. It is based on a thorough examination of the reports - a few published and others unpublished - of the GoI and the provincial government of Madras during the period under review. These will further be fortified by a brief overview of the Rockefeller Foundation (RF hereafter) papers and letters covering their survey in Madras.

The objective of this chapter is to explain the relationship between political and medical administrative structures in the Madras Presidency. It does so by deciphering and linking the political trends explained in the previous chapter that had an impact on the medical transformation in this presidency. It begins with providing a background to the medical structures and clarifying the elite and subordinate medical divisions in the presidency. After that, it follows a similar trajectory as the previous chapter in explaining the health administration, first through political shifts, and then in the districts, taluks, and villages.[2] It also explains briefly the competing tendencies prevalent between the colonisers and the colonised to accumulate more prestige

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[1] V. R. Muraleedharan, "Rural health care in Madras Presidency: 1919-39," *Indian Economic and Social History Review* 24, no. 3 (1987): 323-334; Sarah Hodges, *Reproductive health in India: Histories, politics, controversies* (New Delhi; Orient Longman, 2005).

[2] The word 'local' has been used in the literal sense here. There were Local Boards set up to look after the administration of the Taluk and village administrative structures. There have been contentions about the usage of the term 'Local' in the British official documents and the other imperialist sources. Understanding the area that can be termed as 'local' requires a knowledge of the whole presidency and how the district and taluk dispensaries or hospitals were equipped. For more emphasis on this, see Bhattacharya,

and control. Finally, it focuses on the RF, and how the intervention of the International Health Division (IHD hereafter) provides us with an alternative way of understanding healthcare in this period.[3] This chapter explains how the medical administration in the Madras Presidency was intrinsically linked with the local politics, as improvement of healthcare was dependent solely on the political intervention of different levels of governments based on their hierarchy. Colonial India had the highest concentration of British soldiers outside of Great Britain after the 1857 Uprising.[4] When the troops encountered a higher rate of illness or death from epidemic diseases, the GoI was forced to come up with health measures and sanitary reforms to ensure that their security was not compromised. The healthcare for European civilians in colonial India had been entrusted mainly to the IMS. The IMS officers headed military and civilian hospitals, the latter were established more often in the three presidency towns of Calcutta, Bombay and Madras. With the increase in the demand for medical personnel, medical colleges were started in the presidency towns to also train the subordinate staff. The following subsections will aim at analysing and explaining the events and changes that made an impact on how the healthcare set up of the Madras Presidency evolved during this late colonial period.

2.1 Healthcare services in colonial India: a brief overview

Harrison and Worboys, *Fractured States: Smallpox, Public Health and Vaccination Policy in British India, 1800-1947* (New Delhi: Orient Longman, 2005), 11.

[3] There is contention regarding the areas that could be considered rural in the Madras Presidency, particularly the deciding factor that apparently involved introduction and spread of western education/healthcare or the lack of it. The supposed rural areas might also be actually having good treatment, education even if they did not follow the western norm. The clarification of how the terms 'locality' and 'local' are defined in any study dealing with India is important, as they have been used to varying extents in the historiography. This dissertation has used the term local to describe the administrative contexts under the district level throughout the study.

[4] The 1857 Uprising was a major uprising in colonial India against the rule of the British EIC, which functioned as a sovereign power on behalf of the British Crown. Even though it was unsuccessful in overthrowing the British rule, the colonial power was forced to reorganise the army, the financial system, and the administration in India through the Government of India Act 1858. See, Kim Wagner, *The great fear of 1857: rumours, conspiracies and the making of the Indian uprising* (Oxford: Peter Lang Ltd., 2010).

Before examining the province of Madras and its medical administration, this section provides a brief description of the healthcare services in colonial India and how they evolved during the British period. While the historiography of healthcare in British India is rich, the work on Madras remains relatively sparse. The transfer of power from the EIC to the Crown, in 1858, ushered in a new era in the medical care and sanitary reforms. However, the primary focus was still on the health of Europeans and those sections of the Indian population, referred to as the 'priority groups', for whom the government assumed direct responsibility.[5] Within a decade following 1857, as Mark Harrison has pointed out, the government had extended its sanitary purview to include the whole of the Indian population.[6] Unfortunately, the enormity of the 'whole of Indian population' was not something the British government could even perceive at that time, as Harrison has pointed out.[7] Harrison's works did not focus on any particular presidency, although his latter studies addressed specific health issues.[8] In the aftermath of the 1857 uprising, sanitary regulations, and regulating the vital statistics that initially was provided only for the military cantonments were extended to the neighbouring civilian areas as well.

In the late 1860s, at both central and provincial levels, sanitary commissioners were appointed to oversee the health of the 'general population' whose mortality from different diseases began to be recorded in annual reports.[9] The percentage of revenue attributed to colonial medical intervention, including that of vaccination began to increase substantially over the years.[10] Radhika Ramasubban argues that; the British established a 'distinctly colonial mode of

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[5] Sanjoy Bhattacharya, "Tackling hunger, disease and 'internal security': official medical administration in colonial eastern India during the Second WW (Part II)," *National Medical Journal of India* 15, no. 2 (2002):101-104.
[6] Mark Harrison, Public health and Medicine in British India: An Assessment of the British contribution, a lecture delivered to the Liverpool Medical History Society on 5 March 1998.
[7] Mark Harrison, *Public Health in British India: Anglo-Indian preventive medicine, 1859-1914* (Cambridge; New York: Cambridge University Press, 1994).
[8] For example, "A Disease of Civilization: Tuberculosis in Britain, Africa and India 1900-39"; *Fractured States*.
[9] Harrison, *Public Health*, 11.
[10] Bhattacharya, *Fractured States,* 4-6.

healthcare', characterised by residential segregation and neglect of the indigenous population.[11] The importance bestowed upon the colonial 'enclaves' has been highlighted by David Arnold, and he has criticised the GoI for giving the responsibility for health to the poorly-funded and inexperienced local authorities.[12] Although Arnold did some extensive research, his over-reliance on English sources and his extrapolation of evidence from colonial Bengal to other British provinces has come under some criticism in the later period.[13] Arnold claims that western medicine was not only a 'tool of empire' in the sense that it had economic or military utility, but it also performed an important function in legitimising British rule. Medicine was valuable in imperial propaganda, for it manifested the benevolent intentions of India's rulers and attracted increasing criticism of colonial rule in Britain itself. However, in addition to these overtly propagandist functions, medicine played a subtler role in the subordination of British Indian culture. The notion of consent became paramount during the late nineteenth century, and that changed the way western medicine began to be perceived by a specific group of Indians. Some Indians also began to criticise the local residents for neglecting public health and to spread the Eurocentric notion of hygiene in the wake of the twentieth century.[14]

Mark Harrison argues that the imperialist ambitions of the medical profession and those of the GoI did not always coincide. For instance, he stated, the GoI was reluctant to back professional demands for the restriction of unlicensed medical practice until after the First World War, under the belief that this move would threaten the indigenous medical practitioners.[15] The growing number of Indians educated in the western form of medicine and the increase in the

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[11] Radhika Ramasubban, "Imperial Health in British India, 1857-1900," in *Disease, Medicine and Empire: Perspectives on western Medicine and the Experience of European Expansion,* ed. Roy Macleod and Milton Lewis (London: Routledge, 1988)

[12] David Arnold, *Colonizing the body: state medicine and epidemic disease in nineteenth-century India* (Berkeley: University of California Press, 1993); *Imperial medicine and indigenous societies* (Manchester: Manchester University Press, 1988).

[13] Bhattacharya, Harrison and Worboys, *Fractured States*, 4-6.

[14] *Ibid.*

[15] Harrison, *Public Health*, 6-35.

number of locals attending hospitals and dispensaries by the late nineteenth century indicate that a significant number of Indians were becoming interested in colonial healthcare.[16] From the late nineteenth century, Indians had already begun to be employed as municipal health officers, and a number of them were actively involved in the sanitary reform campaigns.[17] However, these sort of employment opportunities were mostly restricted within the upper echelons of the society in the nineteenth century, and it was more pronounced in this presidency because of its caste-based social segregation. Madras witnessed a very different scenario from the other presidencies in colonial India, both in the political and military spheres, which in turn shaped its medical department, and in the process, it showed remarkably distinct developments from the late nineteenth century onwards.

2.1.a) Madras Presidency post-1857: a case study

The Madras Presidency, being the most peaceful among the three presidencies after the mid-eighteenth century, received favourable treatment from the GoI in certain aspects.[18] The peaceful nature of the presidency allowed the government to experiment with its medical administration and establish their control over the people from the southern parts of British India. This apparent peace that has been discussed in the previous chapter allowed the Madras government to rely on the Indians to handle the local administration.[19]

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[16] Roger Jeffrey, *The politics of Health in India* (Berkeley: University of California Press, 1988).
[17] Harrison, *Public Health*, 166-201; Mark Harrison and M. Worboys, "A Disease of Civilization: Tuberculosis in Britain, Africa and India 1900-39," in *Migrants, Minorities and Health: Historical and Contemporary Studies*, ed. M. Worboys and L. Marks (London: Routledge, 1997).
[18] For further details on the early nineteenth century health issues pertaining to colonial South India, please see, Niels Brimnes, "From Civil Servant to Little King: An Indigenous Construction of Colonial Authority in Early Nineteenth-Century South India," in *Engaging Colonial Knowledge: Reading European Archives in World History,* ed. Ricardo Roque and Kim A. Wagner (Basingstoke: Palgrave Macmillan 2012), 163-183; Brimnes, "Coming to terms with the native practitioner: Indigenous doctors in colonial service in South India, 1800-1825," *The Indian Economic and Social history Review* 50, no.1 (2013):77-109.
[19] For more details on provincial politics, see Baker, *South India*; Washbrook, *Provincial politics*.

E. G. Balfour, Surgeon-General of the IMS, in August 1877, wrote about the condition of medical practices in the Madras Presidency, of the people and their health needs and he put forward a proposal for a particular type of medical education best suited to the local needs and circumstances.[20] He observed that in the territories under the government of Madras, there were about 8,000 practitioners, of whom only 450 were educated servants of the government attached to the army or lent to the civil hospitals, and the remaining were either Hindu *vaidyas* and Muslim *hakeems*, practising as physicians.[21] Balfour argued that in the late nineteenth century, Russia had one medical man to every 14,116 inhabitants, Hungary one to every 5,492, Austria one to every 4,355 and in the towns of Great Britain, the proportion was about one to every 1,000. Whereas, Madras Presidency had one medical person for every 60,000 inhabitants. Madras needed 8,000 to 10,000 educated men to replace the *vaidyas* and *hakeems* on the one hand and to have an even distribution of medical workers across the presidency on the other.[22] Such statistics point towards the dearth of trained personnel in the medical institutions across the presidency. There have been instances of the indigenous medical practitioners fighting for their position in the other parts of colonial India and displayed individual categorisations while Madras displayed far more reliance on western practitioners.[23]

Along with the requirement of increasing the number of medical practitioners, there was also the need to have more medics to treat the Europeans, as they considered it beneath them to be treated by non-Europeans. Kenneth Ballhatchet has argued, in a big, bustling city such as Madras, it was often challenging to maintain this 'prestige' of the ruling race. There was no room

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[20] Home Department (Medical), August 1877, no. 41-87, National Archives of India (NAI).
[21] *Vaidya* or *vaid* is a Sanskrit word-meaning physician; the same word is also used in Hindi. It was and is still used in India to refer to a person who practices Ayurveda, an indigenous form of medicine. Hakeem or Hakim is an Arabic word, which refers to a physician, or more specifically a practitioner of Unani or Islamic medicine. For details see, Sanjay Sharma, *Baid, Hakim and Doctors: The Medicine Heritage of India* (Mumbai: Body &Soul books, 2013).
[22] Home Department (Medical), August 1877, no. 41-87, NAI.
[23] Kavita Sivaramakrishnana, *Old Potions, New Bottles: Recasting Indigenous Medicine in Colonial Punjab (1850-1945)* (New Delhi: Orient Longman, 2006).

for spacious civil stations or cantonments. These big cities were also seen to contain many Europeans of the lower classes, and such circumstances sometimes led to problems that perplexed the authorities. Anglo-Indians were looked at unfavourably as they were considered a threat to the social detachment that the ruling race sought to maintain with the subjects.[24]

Public health administration in the presidency underwent many changes in the late nineteenth-early twentieth centuries, aided by different laws enacted by the Madras government. The laws included the Local Boards Act, the District Municipalities Act, the Madras City Municipal Act, the Town Nuisances Act, the Epidemic Diseases Act, the Registration of Births and Deaths Act, the Places of Public Resort Act, the Prevention of Adulteration Act and the Town Planning Act. These collectively helped the construction and maintenance of major sanitary works, such as water supply and drainage, for all minor works such as, in slaughterhouses, for conservancy and lighting arrangements, the training and employment of medical and sanitary officers and vaccinators for the control of epidemics and the accurate registration of vital statistics.[25] Before 1880, there was a sanitary commissioner and a deputy sanitary commissioner for Madras; the latter was in charge of the vaccination work and was also required to take part in the sanitary inspection of the districts. In 1883, the district surgeons were required to advise the collectors in matters affecting the medical and sanitary administration of the district and also supervise the vaccination campaigns. The next section will evaluate the division of medical administration structure in the presidency.

2.2 Medical administration in Madras: elite and subordinate divisions[26]

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[24] Kenneth Ballhatchet. *Race, Sex and Class under the Raj: Imperial attitudes and policies and their critics, 1793-1905* (London: Weidenfeld and Nicolson, 1980), 4.
[25] Home Department (Medical), August 1877, no. 41-87, NAI.
[26] The term 'elite' although is not a very politically correct terminology, but this chapter has used them to explain the hierarchy of the medical services in the presidency. Instead of 'elite', the word covenanted could have been used but it would not give the correct identification. So, for lack of correct word, 'elite' will be used here.

The medical services in colonial India were primarily established to cater to the British soldiers in the army. Madras followed the same strategy and the military medical officers were in charge of most of the critical positions and were controlling the medical scenario in the presidency. But the situation began to change by the1880s as the GoI, and more importantly, the higher officials began to think of the military and civilian medical services as two separate institutions capable of operating on their own. This was a step towards introducing one medical body for the entire army corps and another body to look after the civilian population. Such a move changed the dynamics of healthcare administration for the elite service bodies – the Royal Army Medical Corps (RAMC hereafter) and the IMS. But, importantly, the 1880s began to experience a new shift in the situation of the medical subordinates as they were beginning to be allowed and at times encouraged to take control of different medical institutions in the presidency.

2.2.a) Elite medical services: Royal Army Medical Corps and Indian Medical Service

When talking about the medical services provided for the British Indian army, the extent of medical services concerned and reserved for the colonial army must be thoroughly examined. The medical services in India were classified into several branches, each with their separate objectives. Along with the IMS, there was also the RAMC, which was headed and directed by major-generals and colonels of the Army Medical Service (AMS hereafter). The RAMC was exclusively for the military and solely concerned with the treatment of the British troops and was formed only in 1898 from the erstwhile AMS. This particular branch was entrusted with maintaining the British army in healthy condition and taking care of the medical and sanitary requirements of the British armies around the world. The War Office (WO hereafter) controlled the corps and determined its strength following the political scenario of the country. To the GoI, there was no doubt about the actual purpose of the RAMC, but the function of the IMS had time and again been questioned or brought up for consideration by them. The important

part was that these civil officers were liable to be recalled for military duty at any given time.[27] This thesis is concerned particularly with the IMS and would only give a cursory importance tot he RAMC in Chapter 3. All officers of the IMS were required to serve with the troops at the initial stage of their careers; after successfully completing two years of military service they were eligible to apply for civil employment in particular provinces, but in reality, usually one could get transferred to civilian employment only after six to eight years of military service.[28]

D. G. Crawford writing on the context of IMS quipped, even the Director-General could not promote officers in civil employment without the concurrence of the highest military authorities, and even after being promoted, those officers could be recalled for active service with the army. Even during peace, some were reverted to military duty after years of civil employment and given military administrative appointments after short periods of preliminary training.[29] Any officer of the IMS had usually been subordinate to military chiefs and was liable to be recalled for military duty. But, by 1897, it became quite clear that the military medical appointments were losing its popularity and were unable to attract enough recruits.[30] The GoI had adopted a two-pronged policy; first, they segregated the military side of the IMS from the civil side and combined the latter with the RAMC, which then continued the supply of medical officers for the entire army in colonial India; secondly, the IMS was placed in charge of all civilian medical services.[31] The Surgeon-General for the British Indian army was designated to be in charge of the administration for medical duties connected with the army – both European and Indian.[32] Thus, the GoI tried to keep both these segments functional and reduce tensions between their recruits, but it will be explained in the following chapter how in Madras these two

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[27] Crawford, *History of the Indian Medical Service*, vol. 1, 249.
[28] *Ibid.*
[29] *Ibid*, vol. 1, 90-100.
[30] *Ibid.*
[31] *Report of the Committee appointed by the Government of India to examine the question of the reorganization of the Medical Services in India* (Shimla: Government Central Press, 1919), 12.
[32] W. J. Wilson, *History of the Madras Army* (Madras: The Government Press, 1882), 505-506.

factions created havoc, and the governments had to devise new strategies to make sure they remain functional and non-confrontational.

2.2.b) Subordinate Medical Services: military and civilian

The Subordinate Medical Department of the Army had two branches; their senior branch constituted of apothecaries and assistant apothecaries, most of these people were Anglo-Indians, and were generally employed on civil duty or attached to large station hospitals. The junior branch consisted of three grades of hospital assistants, who were mostly indigenous population. This branch usually furnished people attached mostly from the Indian regiments and ranked 'below native commissioned and above non-commissioned Officers'.[33] However, during the late nineteenth century, relative peacetime encouraged the medics of the IMS to look for private practice and be engaged with civilian hospitals. Initially, the opportunity was seized mostly by the war reserves in the army, but gradually the lure of extra income from private practice enticed other medical practitioners to join the civilian services. The Indian Medical Department was known as the Indian Subordinate Medical Department until 1918, but the outbreak of the First World War induced the improvement of their pay and prospects.[34] The military assistant surgeons were put in charge of civil healthcare that was steadily becoming more valuable with the gradual disbandment of the Madras army. The military sub-assistant surgeons were recruited initially for the Indian troops. They were attached to Indian station hospitals and served under Indian IMS officers.[35] However, the surgeon-general as the head of the civil medical department of Madras continued working for the civilians. The civil medical department began to gain its strength in Madras from the 1890s onwards and following the First World War

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[33] "Native army of Madras: It's constitution, organisation, equipment and interior economy," *The Royal United Services Institute* 32 (1888): 329-63.
[34] *Committee Report*, 22-23
[35] *Ibid.*

and the 1919 Act it was strengthened substantially.[36] Local governments were able to promote sub-assistant surgeons to the rank of civil assistant surgeons. The civilian assistant surgeons were placed in sub-charge of police, jails, lunatic asylums, and state railway hospitals. Apart from these, they were also in independent charge of the local funds, canal and itinerating dispensaries and were employed as travelling medical subordinates on state railways and with the survey and forest parties. These assistant surgeons also had to deal with outbreaks of epidemic diseases occurring in their vicinity.[37]

The official government documents are not silent about the command and ascendency displayed by these subordinates. With political help from the local and village administrative bodies, Indians were becoming very influential. The compounders, who were locally employed and constituted the lowest level of medical administration, were equally important as they were acting as intermediaries between the patients and the medical officers.[38] As chapter 1 has detailed different levels of politics locally, with the emergence and presence of hierarchical structures, the medical subordinates amassed power and in essence, became very powerful in controlling the districts and village healthcare institutes and dispensaries. The hierarchy among Indian medical subordinates and how they amassed power will be examined further in the latter chapters.

2.3 Introduction of local self-government: changes in Madras medical administration

A new era in provincial politics was ushered in following the 1882 resolution in British India, and it altered the structure of the medical administration in Madras as well. One needs to understand local cultures by delving deeper into the administrative structure, particularly with the formation of local self-government in 1880. Harrison's work explained in great detail the

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[36] *Ibid.*
[37] *Committee Report*, 25.
[38] Most of these people were men, the last chapter on women medical service will explain how gender differences worked in medical services in the presidency.

emergence of local self-government and how it changed the medical administration in colonial India. His work provides significant insights, but, being an India-wide study, it lacks a comprehensive analysis focussing solely on this southernmost presidency.[39] There have been writings both criticising and applauding the nature of the British rule in India, more precisely the role played by colonial government with the introduction of the local self-government. Hugh Tinker reached a similar conclusion to that of the British officials in his book where he pointed out 'only in Bengal was there a real demand for sanitary services and some willingness to pay for them'.[40] 'Elsewhere' he added, 'public health was improved only because officials fostered them'.[41] Radhika Ramasubban, on the other hand, claimed that the GoI 'lost the historic moment for initiating sanitary reform' and, at every opportunity, belittled Indian initiatives on matters of public health.[42] Ramanna argues that 'the attitudes of British officials were characterised by contradictions and contemporary bias.'[43] While, on the other hand, the indigenous system was given almost no support from the government, they could not displace it, but it remained to resemble more of an uneasy co-existence as noted by Poonam Bala.[44] Notably, in the Madras Presidency, provincial politics played an essential role in moulding and restructuring the medical administration. The provincial and local boards were the ones responsible for funding and overseeing the district level hospitals and also local dispensaries. The following section will explain how political changes impacted healthcare in Madras, particularly in the rural parts of the Madras Presidency.

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[39] Harrison, *Public Health*.
[40] Hugh Tinker, *The Foundations of Local Self-Government in India, Pakistan and Burma* (London: The Athlone Press, 1954), 73.
[41] *Ibid.*
[42] Radhika Ramasubban, "Imperial Health in British India. 1857-1900," in *Disease, Medicine and Empire*, ed. Roy Macleod and Milton Lewis (London: Routledge, 1988); Harrison, *Public Health*, 166-170.
[43] Mridula Ramanna, *Western Medicine and Public Health in colonial Bombay, 1845-1895* (London: Orient Longman, 2002), 234-243.
[44] Poonam Bala, *Imperialism and Medicine in Bengal: a socio-historical perspective* (New Delhi; Newbury Park, CA: Sage Publications, 1991).

2.3.a) Alterations following the 1882 resolution

District boards were set up for the rural and semi-urban areas from 1881 onwards. Often headed by the district collectors, they were required to raise their resources by levying local cesses. In addition to developmental responsibilities of the areas under their jurisdiction, these bodies were expected to provide for drainage, water supply, general sanitation and maintenance of hospitals and dispensaries, on the advice of the district civil surgeon and the deputy sanitary commissioner.[45] There was no compulsion for the municipalities to employ medical officers, with the result that they largely employed no public health staff at all, apart from vaccinators who were poorly paid and ill-educated. The ineffectiveness of the local authorities led to the formation of a sanitary board between 1888 and 1893 for each district, composed of administrative and public works officers in addition to the sanitary commissioner and the inspector general for civil hospitals[46]

The district level position on which the sanitary boards directly depended was the civil surgeon (an IMS officer). In addition to his primary responsibilities – which included his regular medical duties, the medico-legal work of the district, and the medical charge of the jails and, more perfunctorily, an inspection of outlying dispensaries – he was expected to be the adviser on sanitation in the municipalities of the district.[47] Deputy sanitary commissioners of each province had the responsibility of overseeing several districts, and upon them rested the entire burden of investigating the province. Nevertheless, they (and even the sanitary commissioners) had no executive or disciplinary authority over the civil surgeons or local governments. The deputy sanitary commissioners were hopelessly small in number, for instance in Madras Presidency there were only three for the vast population.[48] After 1898, professional journals began

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[45] Ramasubban, "*Imperial Health,*" 51.
[46] G. T. Boag, *The Madras Presidency* (Madras: Government Press, 1933), 116-127.
[47] *Ibid.*
[48] *Ibid*, 120-134.

to publish writings on medical practices of Indians, which, could be argued to have fostered a sense of identity among the practitioners of tropical medicine.

In 1896, the sanitary board was reconstituted, to include the chief engineer, public works department, the surgeon-general and a member of the civil service. The commissioner and engineer for sanitary purposes were the only advisers of the board. The board continued to work until the end of 1920 when it was replaced by the board of public health consisting of the minister in charge of public health (president), the secretary, local self-government department, deputy secretary, and local self-government department, surgeon general, director of public health, chief engineer, public works department and the sanitary engineer.[49] In 1905, a session was held for the first time to provide training to the men before their appointment as deputy inspectors of vaccination. In the same year, sanitary assistants to the district medical and sanitary officers were appointed for the first time in a few districts. These sanitary assistants were expected to exercise wholesale check over the work of vaccination and deputy inspectors of vaccination, and this scheme continued until 1920. In 1909, two additional deputy sanitary commissioners were sanctioned, but they were only entertained at the end of 1913 when the presidency was divided into three territorial ranges – northern, central and southern – each under a separate deputy sanitary commissioner.[50] In 1913, another scheme was sanctioned, under which it was proposed to employ health officers in 31 municipal towns. Thus, it can be understood that by 1913, the move was already in place to render the provincial governments more important.

2.3.b) The Government of India Act 1919: Indians taking control of local health services

Medical administration became a so-called provincial subject in 1919 following the adoption of the GoI Act.[51] From this point on, as Boag argued, the local governments acquired

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[49] Boag, *The Madras Presidency,* 116-127.
[50] *Ibid*, 110-125.
[51]The GoI Act of 1919 was an enacted by the Parliament of the United Kingdom. It was passed to expand participation of Indians in the GoI. The Act embodied the reforms recommended in the report of

the power to administer their public health departments keeping just a few financial constraints in their mind.[52] A minister for public health was made responsible for these departments, which were made answerable to the legislative council and the governor for their proper administration.[53] A civilian secretary and an under-secretary assisted the minister. Local bodies started assuming responsibility for health and sanitation development and had to report to the Madras government. The public health organisation of the province was commanded by three sub-departments. They were the provincial health department, the public health organisation of urban areas, and the public health organisation of rural areas.[54]

V. R. Muraleedharan has pointed out that the year 1924 marked an essential change in the history of healthcare in the Madras Presidency.[55] A scheme was explicitly devised to deliver healthcare to rural people. It does not mean that there were no dispensaries or hospitals in the rural areas before 1924, but they were established in a haphazard or ad-hoc manner. On average, there were about twenty medical institutions in each district in 1921; that is, one institution for about 75,000 people.[56] About a third of these institutions were without any wards to accommodate patients, the total strength of beds in the presidency was 7630; a ratio of one bed to 5,500

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the Secretary of State for India, Edwin Montagu, and the Viceroy, Lord Chelmsford. This Act represented the end of benevolent despotism and began genesis of responsible government in India. This also provided a dual form of government (diarchy) for the major provinces. In each such province, control of some areas of government, the 'transferred list' were given under the command of a council of ministers answerable to the Provincial Council. The list included agriculture, supervision of local government, health and education. The Provincial Councils were enlarged. For details, see Anil Chandra Banerjee, *Constitutional History of India* (Delhi: Macmillan, 1977), vol. 1, 247-273.

[52] Boag, *The Madras Presidency*, 116-127.

[53] The Act of 1919 in India brought about representative government. Although, the Governor General had the power to override any decisions. Education, Sanitation, Local Self-government, Agriculture and Industries were listed as the transferred subjects. Law, Finance, Revenue and Home affairs were the reserved subjects. The provincial councils could decide the budget for the transferred subjects. The Madras Legislative Council had a total of 127 members in addition to the ex-officio members of the Governor's Executive Council. Out of the 127, 98 were elected from 61 constituencies of the presidency. 28 of the constituencies were reserved for non-Brahmins. 29 were nominated, out of whom a maximum of 19 would be government officials, 5 would represent the Paraiyar, Pallar, Valluvar, Mala, Madiga, Sakkiliar, Thorriyar, Cheruman and Holeya communities and 1 would represent the 'backward tracts'.

[54] A. P. Pillay, *Welfare Problems in Rural India* (Bombay: D. B. Taraporevala sons & co., 1931?), 25-30.

[55] V. R. Muraleedharan, "Rural health care in Madras Presidency: 1919-39," *Indian Economic and Social History Review* 24, no. 3 (1987): 323-334.

[56] G.O. 1606, Public Health, 28 November 1921, Tamil Nadu State Archives (TNSA).

people.[57] The rural population, at least a significant majority of them, had practically no experience of the western systems of medicine since there was no opportunity of coming into daily or even occasional contact with European 'qualified' doctors. The government felt that the facilities in the rural areas were 'extremely inadequate'.[58] Muraleedharan points out that the question of the extension of medical relief was mired in certain basic issues, like the modes of extension of medical care, and finding ways to do so, and this affected the overall developmental course of the whole healthcare system.[59] Even by the government's standard, 'the existing number of institutions must be multiplied at least fivefold (to about 3000) if the rural population is to have medical relief within fairly easy reach'.[60] But these arrangements would definitely require an amount, substantially more than the imposed upper limit of Rs 100 lakhs, even if not a five-fold increase.[61] There were three alternatives available to the government – first was to open a large number of Ayurvedic, Unani and Siddha dispensaries; secondly, to start a large number of travelling and itinerating dispensaries; and finally, to encourage private practitioners (allopath) to settle down and practise in rural areas by giving them incentives.[62] Only the third option was considered viable and feasible for the government as it was the 'cheapest and at the same time the best from many points of view'.[63] A scheme called the Subsidised Rural Medical Relief Scheme (SRMRS) was adopted in 1924 after the GoI realised that encouraging practitioners to move to the rural areas was the best chance to spread western medicine.[64] This started a general drive towards improving rural healthcare at this time, as was evident in other presidencies such as Bengal and Bombay. For Madras, particularly rural Madras, this worked extremely well as this

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[57] Ibid.
[58] G.O. 1522, Public Health, 22 October 1924, TNSA.
[59] Muraleedharan, *Rural Health*, 323-334.
[60] G.O. 1522, Public Health, 22 October 1924, TNSA
[61] Ibid.
[62] Ibid.
[63] Ibid.
[64] Muraleedharan, *Rural Health*, 323-334.

scheme provided subsidies to private practitioners once they agreed to settle down in the villages. The Madras government expected that a large number of private practitioners, who were 'crowding' the urban areas, would be attracted to the rural areas with this scheme.[65] One major condition for the subsidy, though, was that the physicians should treat the 'necessitous poor' free of charge.[66] The change of attitude marked a significant change in the subsequent health policies of the Madras government. However, this step to make more medics interested in rural healthcare signified that more Indians were joining the medical services, and it enhanced the position of already established medics and people associated in the medical administration to have their influence in the villages and adjacent areas.[67]

The local boards had a big hand to play as they were the ones with the power to specify the villages for the rural health practitioners. The local boards concerned were to supply medicines worth Rs 360 per annum to each of these subsidised dispensaries, to be given to patients free of charge. The total cost of a dispensary – about Rs 1,000 per annum – was shared between the provincial government and local bodies in a ratio of 3:2.[68] The task of appointing the medical men and fixing their tenure was left to the discretion of the local board presidents.[69] Although, the government reserved the right to continue granting subsidy in any case or cases after six months' notice or for breach of conditions that gratuitous treatment should be given to the 'necessitous poor'.[70] This was the basic framework of the SRMRS, the actual working of which was left to the respective local bodies. Around the same time, there were attempts to create district health boards on an experimental basis in five districts of Visakhapatnam, Krishna,

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65 G.O. 1522, Public Health, 22 October 1924, TNSA.
66 There was no definition 'necessitous poor' in the original order of this scheme. It can be presumed that an earlier definition was implied here as well, which allowed free treatment (including consultation and medicines) for those with an income less than Rs 30 per month. Those with a higher income were to pay 2 annas for medicines on each occasion, G.O. 399, Medical, 17.09.1917, TNSA.
67 Local Self-Govenment Department (Public Health), no. 678, 11 March 1929, APAC, BL.
68 Ibid.
69 Ibid.
70 G.O. 1522, Public Health, 22 October 1924, TNSA.

Kurnool, Thanjavur and Tiruchirapalli.[71] Medical relief was understood and treated as a local affair, and thus 'all measures for expansion had to be met by the local bodies'.[72] The local boards following political changes in 1919 started wielding more power regarding appointment and execution of duties. In 1929, deputy secretary to the government of Madras, S. Ranganathan, issued an order that gave the local boards' complete power to appoint licentiates in Indian medicine for the Government School of Indian Medicine, Madras to be in charge of the rural dispensaries.[73]

2.4 Rural Healthcare in the presidency: districts, *taluks* and villages

'Modern Madras' had never lost its association with the rural southern part of British India, as Susan Neild argues, 'and even though after coming in contact with the colonial spaces, they ceased to be villages in social composition or function, these urban villages still reflected the predominant settlement type of the indigenous society.'[74] This was reflected in the way locals reacted to the complex western medicine, but the First World War altered the way healthcare, in particular rural health was regarded in colonial Madras. The connection between urban and rural Madras became more significant in establishing their health structure across this presidency. The period immediately following the Great War saw the central and provincial governments take new steps to improve the healthcare set up in India. Propaganda became a new tool for the colonial rulers with the intention of undermining the indigenous medical practices and also exerting a hegemonic control over the local populace. Following the GoI Act 1919, the provincial government of Madras became significant, and the subsequent sections will examine how

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[71] Ibid.
[72] G.O. 80, Public Health, 10 February 1919, TNSA.
[73] Local Self-Govenment Department (Public Health), no. 678, 11 March 1929, APAC, BL.
[74] Susan M. Neild, "Colonial Urbanism: The Development of Madras city in the Eighteenth and Nineteenth Centuries," *Modern Asian Studies* 13, no. 2 (1979): 217-246.

the health policies were being expanded through the districts and villages to the rural sections of the presidency. Focussing on the health administration, this chapter will also provide the space to understand how female medical care and its administration was different from the male perspective.

2.4.a) From districts to the villages: health policies and local responses

Lord Ripon's resolution on local self-government established a gradation of local authorities, which varied across presidencies and provinces. The smallest unit was the local board that covered the *tahsil*, or sub-division of a district, with responsibilities that included sanitation, education, public works, medical services, and sometimes veterinary work. The largest, the district board, was envisaged as a supervising body for the local boards.[75] The district boards of Nellore and Tanjore maintained medical schools of their own; they had forty-three and twenty one paying students respectively in 1894.[76] The Bellary, South Canara, Ganjam and Madura district boards sent seven, two, one and five students respectively at the boards' expense for training at the Madras Medical College, and the Godavari board sent five others at its own cost to the Nellore Medical School.[77] The work conducted by the medical subordinates were listed, but it is almost impossible to get hold of the individual names who were involved. Along with the effort put in by medical subordinates attached to local fund hospitals and dispensaries, the total number of successful operations performed in local fund areas in 1894 was also mentioned; it was 29.6 per *mille* (thousand) of the population against 29.4 per *mille* in the previous year.[78] Chingleput and Tinnevelly exhibited the best results with 40.8 and 45.4 successful operations

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[75] Harrison*, Public health*, 191
[76] Local and Municipal Department, Annexure, Report on the working of the Local Boards and Union Panchayats in the Presidency of Madras, V/24/308, APAC, BL.
[77] Ibid.
[78] Local and Municipal Department, Nos. 2541, 2542, 6 December 1894, V/24/308, APAC, BL.

per thousand of the population. In 1900, there were 21 district boards and 80 *taluk* boards in operation. There were 112 Europeans or Anglo-Indians while 529 were Indian local residents working in the district boards in the year 1901-02.[79] Only half of the members sanctioned for each district boards were elected by *taluk* boards in all districts, except the Godavari area where the elective strength was a little less and in the Nilgiris as there were no available *taluk* boards.[80] In 80 *taluk* boards, there were 68 Europeans or Anglo-Indians and 1045 locals in 1901-02 against 75 and 1025 respectively in 1900-1901. The *taluk* Boards of Madura, Tinnevelly, Sermadevi, Srivilliputtur, Cocanada and Ellore continued to enjoy the privilege of electing their vice-presidents, and the presidents of district boards continued to exercise the power of reappointing the members of *taluk* Boards who had been originally appointed by the Madras government. In 1901-02, there were 381 union panchayats, and they were administered by 3,524 members. Out of these, 48 were Europeans or Anglo-Indians and the remaining 3,476 Indians from the presidency.[81] This system contributed to a large group of people collaborating without any direct European supervision, and this encouraged Indians to seek control over the areas they had been handling. The knowledge of local language and politics were necessary to control the district, local, and union boards, which the Europeans lacked, and this allowed the Indians to gain greater control over the areas than the colonial government would have liked. The *taluk* boards of Rajahmundry, Peddapuram, Cocanada and Calicut opened one or more rural dispensaries with Rajahmundry topping the chart with six in 1928-29.[82] The provincial government, however, continued to pay subsidies for all these dispensaries set up by the *taluks*.[83]

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[79] Ibid (No pp)
[80] Report on the working of the Local Boards and Union Panchayats in the Presidency of Madras, V/24/308, APAC, BL.
[81] Ibid, Anglo-Indians were those with mixed Indian and British ancestry. For a detailed understanding of them, particularly in Madras see, S. Muthiah and Harry Maclure, *The Anglo-Indians: A 500- year History* (New Delhi: Niyogi Books, 2013); Clive Dewey, *Anglo-Indian Attitudes: The Mind of the Indian Civil Service* (London: Hambledon, 1994).
[82] Local Self-Government Department (Public Health), No. 783, 31 March 1928, APAC, BL.
[83] Ibid.

2.4.b) Europeans and Indians: conflicting responsibilities and competition for power

The medical department in Madras dealt with relief, research, and education for the locals. Regarding medical relief, the department was responsible for the maintenance of important hospitals in the city of Madras and at the headquarters of the districts and taluks. In the 1920s, the Madras government began to provide six free scholarships, two of which were reserved for Muslim candidates to encourage Indians to study medicine.[84] However, several private agencies started providing scholarships as well, overall twenty-three, for medical students under various circumstances and conditions imposed. Some were reserved for women, and some were restricted to particular regions, others were exclusively for Europeans, Anglo-Indians or 'native' Christians. This allocation of scholarships allowed many, including a substantial number of Indians, to be trained in European medicine.[85] Madras introduced the 'district health scheme' under which a self-contained public health staff was enlisted in each district, under the aegis of a district health officer, who was a qualified medical officer with experiences in the public health sector. He had under him sanitary inspectors (one for each *taluk*), and the district vaccination staff. This establishment of a complete self-sustained public health system working under the district board made the healthcare system completely independent of the provincial control in Madras.[86] During the 1920s the government, following their shift in army recruitment policy, was only looking for men 'of European parentage', or those with 'one parent or grandparent of pure European extraction' for recruitment in Madras which further pushed the local residents to alternative careers in healthcare.[87] Anna Greenwood's works speak about the competition and discrimination faced by Indian doctors in African countries, and how these doctors faced racial profiling and segregation and had to depend only on private practice or work within the

[84] V. G. Heiser and W. A. Sawyer, "A Glimpse of South India," Box 49, Folder 3064, 1920, RAC.
[85] Ibid.
[86] *Welfare Problem in Rural India*, 25-30.
[87] V. G. Heiser and W. A. Sawyer, "A Glimpse of South India," Folder-3064, Box 49, 1920, RF, RAC.

state-controlled limits.[88] Her claims resonate with the situation in British India, as the indigenous population in their own country were relegated to live and work as second-class citizens depending entirely on the whims of the colonial government. However, in the context of the Madras Presidency, as will be explained, the local-level politics and the emerging sense of nationalism helped the middle class to take control of most parts of the rural areas in the presidency.

The responsibility of medical relief in rural areas lay ultimately with the local bodies, even though the government assisted these bodies in several ways, either by placing the services of government medical officers at their disposal or by providing grants for hospital buildings and also by providing subsidies to rural medical practitioners. The increase in the number of local fund and municipal institutions was due to a large number of rural dispensaries being opened. The total number of medical institutions in 1880 was 218, while the number of such institutions in 1931 went up to 1,245.[89] In 1934, there was a report explaining the places to have 'superior' medical officers.[90] The term superior created a sense of subservience and humiliation among the people who had equal responsibilities, and it can be claimed that the term was used deliberately to create divisiveness among the medical workers.

Table 2.4.b (i) Location of posting of the European medical officers

Group centres where medical officers were stationed	Districts comprised in the group
Vizagapatam	Ganjam, Vizagapatam

[88] Anna Greenwood, ed., *Beyond the state: The Colonial Medical Service in British Africa* (Manchester: Manchester University Press 2016); Greenwood and Harshad Topiwala, ed., *Indian doctors in Kenya, 1890-1940: the forgotten history* (Basingstoke: Palgrave Macmillan, 2015).
[89] Madras Medical Proceedings, G.O. No. 1559, Public Health, (20 June 1934), APAC, BL
[90] Ibid.

Cocanada	East Godavari and West Godavari
Bellary	Bellary, Anantapur, Kurnool and Cuddapah
Guntur	Guntur, Kistna and Nellore
Tanjore	Tanjore, Trichinopoly and South Arcot
Coimbatore	Coimbatore and Salem
Madura	Madura, Ramnad and Tinnevelly
Ootacamund	The Nilgiris
Calicut	Malabar and North Kanara
Vellore	North Arcot, Chittoor and Chingleput excluding Saidapet (excluding Guindy) and including St. Thomas Mount.

[Source- Local Self-Government Department (PH), G.O. No. 1559, Public Health, 20 June 1934, BL]

The table shows the vast areas which were under the 'superior' officers, but it was not humanly possible for these officers to take up the responsibility for such a large number of patients. This unequal distribution of trained European medics open a door of opportunity for the Indians, and this led to collaborated efforts between the administrative and the medical bodies in rural areas of this presidency. Thus, the local Indian medics had to be relied upon in the rural areas,

taluks and villages as they were the ones accessible in those regions. The population of the presidency was also on the rise, as shown in the following table, and that also forced the government of Madras to depend heavily on the local residents of the presidency, as explained in the first chapter.

The data, collected from the 1931 *Census of Madras*, puts the total population at 47.2 million (approximately). To provide a comparative understanding, the preliminary census report on the *Census* of the population of England and Wales combined stated 39.9 million as the total population in 1931.[91] Thus, the Madras Presidency was larger in terms of population than England and Wales put together, and with its accompanying complexities made it tougher for the British to administer it without relying on the local Indians.

Table 2.4.b (ii) Changes in the population of Madras Presidency

1891	1901	1911	1921	1931	Net variation in the period between 1891 to 1931
36,064,408	38, 653,558	41,870,160	42,794,160	47,193,602	11,129,194

[Source: *Census of Madras*, 1931.]

2.4.c) Female medical administration: a divergence from male centric view

The healthcare provided for women in the presidency was strikingly different from that of men, as the Madras Presidency with its conservative nature was not willing to let women take control of the medical administration or even to freely interact with patients as medics. Moreover,

[91] *Census of England and Wales*, General Report (London: 1931).

there was very little scope for female patients in conservative Hindu or Muslim households to receive western medical care because of the *purdah*. The formation of the Women's Medical Service in colonial India could be traced back to the 1880s when the 'colonial gaze' was beginning to be shifted towards the *zenana,*[92] and the Indian women who until then had remained in most part outside the purview of western medicine. As Sean Lang has mentioned, Madras had been a pioneer in maternity care in the mid-nineteenth century.[93] The care for women began with the establishment of the Kittredge Fund in 1882 and then the Dufferin Fund in 1885.[94] These steps were taken particularly to provide medical care for Indian women living within the *zenana*. Scholarships from the Dufferin Fund for training medical women and creating employment opportunities in Indian *zenana* hospitals were crucial in the early years of the professionalization of British medical women.

The level of flexibility that the colonial government was displaying mirrored the process of negotiation and the extent of compromise that the GoI was willing to make to placate the Indians. Various issues arose following the establishment of the Dufferin hospital. First, it was about the male children who started being admitted to the hospital designated for women. After that, a few hospital committees objected to the presence of those patients considered low-caste or who were employed in menial works.[95] The so-called upper caste took offence in the lack of social distance and apparent degradation of moral standards in the intermixing of women coming from different castes or religions in the *zenana* hospitals. Indian women's health became a general concern only at a much later stage in the presidency as the initial concern was solely for the wellbeing

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[92] *Zenana* was the place secluded for women or the inner sanctum of a household. It was more common for the Muslim households, but Hindus also followed more or less the same tradition. For details on colonial south India see, Eliza F. Kent, "Tamil Bible Women and the Zenana Missions of Colonial South India," *History of Religions* 39, no. 2 (1999): 117-149.

[93] Sean Lang, "Drop the Demon Dai: Maternal Mortality and the State in Colonial Madras, 1840-1875," *Social History of Medicine* 18, no. 3 (2005): 357-378.

[94] Samiksha Sehrawat, "Feminising Empire: The Association of Medical Women in India and the Campaign to establish a Women's Medical Service," *Social Scientist* 41, no. 5/6 (2013): 65-81.

[95] For a detailed understanding of the concept of caste, its evolution, and interpretation during the colonial period see, Susan Bayly, *Caste, Society and Politics in India from the Eighteenth Century to the Modern Age* (Cambridge: Cambridge University Press, 1999); Niels Brimnes, *Constructing the Colonial Encounter: Right and Left Hand Castes in Early Colonial South India* (Richmond, Surrey: Curzon, 1999).

of the English women, and British women doctors were sent to take charge of the staff women's hospitals and dispensaries.[96]

However, there was a distinct difference in the manner in which the opportunities unfolded for men and women within the medical administrative structure in the presidency, particularly in the districts and rural areas. While the male subordinates began to control the local administration, the medical women had to fight discrimination – social, political and gender– to rise up the ranks and establish their names in the presidency. To understand the rural and women's healthcare, it is important to analyse the papers of the RF and follow their surveys in the presidency along with the colonial documents which will be explored in detail in the final chapter.

2.5 Curative to preventive: intervention of the International Health Division

There has been much progress in the way historians deal with what is sometimes termed as colonial medicine, but many areas have been completely neglected in the historiography.[97] Harrison, for example, argues that similar deprivation levels exist in Britain and British India, while, Madras shows assimilation of western and indigenous medical care which helps to rethink the scope and nature of colonial medicine.[98] The RF, along with the International Health Board, which later became the International Health Division (hereafter IHD), carried out several surveys and looked for avenues to fund rural healthcare in Madras.[99] Their main aim, as grasped from the diaries and reports of the officers, was to comprehend the health policies implemented in the colonial setting and how Madras was dealing with that. From the 1920s onwards, Madras

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[96] Anne Witz, "*Colonising Women*," 23-24.
[97] Shula Marks, "What is Colonial about Colonial Medicine? And What has Happened to Imperialism and Health?" *Social History of Medicine* 10, no. 2 (1997): 205-220.
[98] Harrison, *Public health.*
[99] The International Health Commission (IHC) was created on 27 June, 1913 was charged with the, '…promotion of public sanitation and the spread of knowledge of scientific medicine'. Throughout its history, the organisation underwent a variety of mandates and name changes, becoming the International Health Board (IHB) in 1916 and the International Health Division (IHD) in 1927. Ultimately, the organisation-initiated programmes in over 80 countries. To know more details about the IHD see, John Farley, *To Cast Out Disease: A history of the International Health Division of the Rockefeller Foundation (1913-1951)* (Oxford: Oxford University Press, 2004).

welcomed several of the officers, directly or indirectly attached to the RF conducting surveys and visiting several medical institutions within the presidency. They intended to change the attitude of the GoI from being curative to thinking about preventing diseases. This marked a change in the attitude of the colonial government, which translated to them being more open to expanding western medical provisions to the Indian people.

The RF considered a philanthropic organisation by many, was engaged in the advancement of public health and medical education in different countries. However, they have not been spared from criticism, and people like E. Richard Brown has questioned the real motive behind the Foundation's apparent philanthropic goals. He argues,

> The Rockefeller public health philanthropies carried on the imperialist tradition...Rockefeller Foundation public health programs in foreign countries were intended to help the U.S. develop and control the markets and resources of those nations.[100]

These intentions were very apparent when it came to the context of Madras and the way the RF worked in the presidency. Their role in Madras had been that of a propagandist interested in disseminating news and information about western medical advancements rather than putting in an effort to develop the medical infrastructure. The chapter, however, recognises the importance of propaganda work, particularly in semi-urban and rural areas of the presidency where people lacked interest in and exposure to new drugs and advancement in diagnosis or treatment methods. In these instances, propaganda played a significant role. In December 1929, the District Health Officer of Coimbatore received a letter informing that the Foundation would purchase a portable motion picture projector for screening propaganda videos in Madras.[101] W. S.

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[100] E. Richard Brown, "Public Health in Imperialism: Early Rockefeller Programs in Home and Abroad," *Public Health: Then and Now* 66, no. 9 (1976): 897-903.
[101] Letter to A. J. George from Rollin C. Dean, Folder 220, Box 27, Series- 1929/464-464C, RG- 2 (FA 308), RF, RAC.

Carter, who was one of the most prominent of the Rockefeller officers to have surveyed India, wrote that the Foundation would provide the fund to establish medical research institutes, but the government of Madras would require to maintain it and keep it in good shape.[102] The RF recognised the need to train health visitors as the main criticism of the local medical administration stemmed from the lack of training in and experience of actual bedside nursing and all the procedures this job entailed.[103] The newer ideas, as Carter stated, required the training procedure of the medical bodies to be more preventive than curative. As the report stated,

> It simply does not allow for any time being spent on the special forms of preventative work such as tuberculosis, industrial hygiene, health supervision of adults, venereal diseases work, and methods of health education and propaganda. The neglect of these features of health work is a profound weakness in the present course.[104]

A resolution was passed to train health visitors and help with their designated work at a conference of these workers held in January 1932. There was an opening for highly trained health visitors of a superior grade to train students in provincial health schools and to take up the work of supervision. The provincial schools would train students of a lower grade who were required to possess a working knowledge of English.[105] The instruction in nursing was loosely correlated to the course in community health problems, and the nursing trainers had to work closely with the public health workers. The government intended to develop 'teachers of positive health as well as good bedside nurses.'[106] The IHD considered training rural practitioners as one of the greatest needs to tend to the sick Indians. Carter, in a letter to the public health

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[102] Ibid, Letter to Major General J. W. D. Megaw from W. S. Carter.
[103] Suggestions for improvement in the training of health visitors in India, Folder 3792, Box 559, Series-1935/464, RG 2, RF, RAC.
[104] Ibid.
[105] Ibid.
[106] Ibid.

commissioner in India, emphasised, 'it is becoming increasingly evident that a considerable section of the Indian community is thinking seriously on the public health problems'.[107] Although it was not evident from his letters what he meant by 'considerable section', it was evident that the RF could notice a positive change in the outlook and impact of western medicine on Indians. The reports exchanged with the RF evinced the increased involvement of the governor and surgeon-general and other officials in the everyday work of the Madras Presidency, but it needs to be ascertained what piqued that interest.[108]

2.5.a) Survey of the IHD and impact of the RF in semi-urban and rural medical institutes

A perusal of the records in the RAC helped to understand the contribution of the RF and the IHD in the context of healthcare in this presidency. The officers in charge of surveys and dissemination of medical knowledge were sceptical about the social and political conditions in rural and semi-rural regions of the presidency. When they expressed concern about the conditions of the medical institutions and colleges in India, they were in most cases worried about the influence the provincial governments had on these medical institutes. The people Carter spoke with, most of them government officials and medical missionaries, were in favour of providing basic medical training to the masses in the rural districts.[109] Following this agenda, the RF started some fellowship programmes for Indians to study in the United States. One of the first persons to go for this was Dr M. K. Gopala Pillai.[110] He was awarded a fellowship to study public health administration in the United States. Upon completion of studies, he was to

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[107] Carter to Col. J. D. Graham, Folder 32, Box 5, Series- 464/464A India, RG 1.1, RF, RAC,
[108] Emergency Aid for Schools of Nursing, Folder-484, Box 39, Series- 1/1, GC- 1931, RG 6, RF, RAC.
[109] Carter Diaries, 1931. Interview of Dr Firor. August 31, 1931, Folder 32, Box 5, Series- 464/464A India, RG 1.1, RF, RAC
[110] Recommendation for fellowship, Folder 225, Box 27, Series- 1929/464-464C, RG- 2 (FA 308), RF, RAC.

return and join an important position in the public health department of Travancore.[111] The most significant impact of the RF in rural Madras had been the healthcare propaganda work. The local health workers were engaged in incessant propaganda in villages and established their control over the panchayats. People were trying to exert their political influence in the rural areas, and the RF had to remain vigilant to steer clear of such influence while working with the panchayats.[112] The local workers in the rural areas were drawn in by the RF to help in the health propaganda work of the IHD.[113]

The Foundation's understanding of what constituted rural and urban was mired in confusion as is reflected by various letters written during this period. Areas recommended as rural were often within 20-25 miles from the city of Madras.[114] There were many such districts and areas that were about 100 to 300 miles from the city and without any western medical intervention. However, despite a few such issues and the apparent biased motive behind the Rockefeller intervention, Madras received generous support from the GoI and the RF to establish medical centres, and the propaganda work to make people aware of the benefits of embracing western medical treatment and joining the medical services had a significant impact on the presidency. Such shifts and the evolution of medical care in the presidency will be examined in the subsequent chapters in greater detail.

2.6 Conclusion

The medical administration of the Madras Presidency was influenced by its political trends and shifts. GoI, Madras government, IMS and SMS – each had their own political and

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[111] Ibid; The State of Travancore fell under the jurisdiction of the Madras Presidency. But, it was granted the status of a princely or vassal state of the British Empire in India in the nineteenth century. Travancore became the second most prosperous princely state in British India, with reputed achievements in education, political administration, public work and social reforms. For details see, P. Shungoonny Menon, *History of Travancore from the earliest times* (New Delhi; Madras: Asian Educational Services, 1998).
[112] Folder 2519, Box 206, Series-3_464, RG 5, GC-1933-34, RF, RAC.
[113] Ibid.
[114] Report by J. F. Kendrick, September 6, 1932, Folder 596, Box 74, Series-464/464C, RG 2, General Correspondence, RF, RAC.

professional motives to try and control the healthcare services within the presidency. This chapter examines the various factors and groups that were active in the Madras Presidency, making the region distinct in its healthcare measures and discourages the portrayal of the medical structure as a monolithic, homogeneous entity. The medical structure and administration in Madras had been enriched and controlled by a diverse cohort of people, including Indians, Americans, Europeans and the British during this period. The chapter deals with the regional and international contributions in the development and administration of medical services in the Madras Presidency.

The structure explained here has been a continuation of the first chapter that writes about the political administration of the presidency and has been used to explain the close contact between political and medical administration in colonial Madras. The various actors who controlled the medical administration and local politics gradually became independent of their British superiors, particularly in the rural areas. Moreover, the role of international organisations like the RF has been underplayed in the context of colonial Madras. The surveys conducted by the IHD mirrored their substantial interest in this particular presidency. Analysing the role of the IHD has offered a different lens for perceiving the significance of rural and subordinate healthcare in the context of colonial Madras.

The intention of this chapter has been to delve into the various fissures and layers of medical administration that was present in colonial Madras and establish that the subordinates were not at the mercy of the provincial or central medical departments. While this chapter agrees with Arnold's argument that 'colonial medicine could never find their fulfilment in colonial hands alone', it goes beyond to establish how the subordinate Indians, especially those in the rural area, made an informed choice while significantly moulding the nature of western medicine that continued dominating British India.[115] Together with Chapter 1, this chapter provides a

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[115] Arnold, *Colonizing the Body*, 294.

background to understanding the administrative and medical structure in the presidency for the period under review. Now, that the background has been explained, the dissertation will now focus on the transformation and evolution of the medical services in both the military and civilian contexts of Madras in the following chapter. Chapter 3 will unpack the idea of medical transformation and explain how a shift happened in the presidency and will attempt to understand colonial healthcare through perspectives that have scarcely been explored before.

Chapter 3 – From conquest to benevolence? Tracing the role and transformation of healthcare in colonial Madras (1880-1914)

'The lighter the skin, the sharper the sword' [1]

- Victor Kiernan

Victor Kiernan has written extensively about the problematic colonial interpretation of racial superiority based on colour and appearances, as was evident in the army in the context of empire. Colonial governments found it difficult to identify different races or even differentiate between them. As Kiernan states, 'races...melted into one another by every gradation', and so, they classified class crudely based on colour.[2] This chapter will argue that the linking of race and martial prowess was also evident in the context of colonial Madras, which suffered an adverse impact of such complicated understanding of race, as the majority of the people in the southern part of British India were of the so-called Dravidian origin and hence generally darker in complexion compared to the ones in the north.[3] This chapter examines what came to be known as the 'martial-race theory' and the fallout of its implementation in the British Indian army.[4] Following this, the

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[1] Victor Kiernan, *The Lords of Human Kind: European attitudes to other cultures in the Imperial age* (London: Serif, 1995).
[2] *Ibid*, "Conclusion".
[3] In the Madras Army, where most of the men recruited were of 'Dravidian' origin. Here, originated the conflict among the Aryan race theory and the Dravidians who were mostly dark-skinned people in the Southern part of India. Dravidians are native speakers of any of the Dravidian languages. There are around 245 million native speakers of Dravidian languages. They form the majority of the population of the southern part of British India. For a detailed understanding of the origin of Dravidians see, Clyde Winters, "Origin and Spread of Dravidian Speakers," *International Journal of Human Genetics* 8 no. 4 (2017): 325-329.
[4] Martial Race as a theory was imagined and implemented by the British Army officials of colonial India post-1857. The colonisers classified the Indians directly into martial and non-martial categories. The martial races were considered superior by the Army administration and they wanted to recruit mostly from the martial races completely neglecting the non-martial ones which came to be identified as 'Punjabisation of the British Indian Army'. For more details see, Heather Streets, *Martial races: the military, race, and masculinity in British imperial culture, 1857-1914* (Manchester: Manchester University Press**,** 2004).

chapter will examine the transformation of western medical tradition from its military-centric role to a more apparently benevolent, overarching influence in and around the presidency.

This chapter will examine how the demography of this presidency changed during the late nineteenth and early twentieth centuries. It has already been established that the medical and political administration inside the southernmost presidency of colonial India was intrinsically linked; this chapter examines how the transformation was enforced on the people of Madras Presidency, and the health of the army personnel ceased to be the sole motivating factor for the health policy makers. In doing so, this chapter attempts to use largely untapped source materials for studying healthcare in colonial India, mainly the military records. Erica Wald has used some of these sources to effectively examine the military history of British India of an earlier period.[5] This chapter, however, focuses extensively on the Madras Presidency and seeks to utilise the military papers to understand the civilian perspective as well and construct a narrative using those sources. The British governments in India, in the imperial capitals in Calcutta and Delhi, as well as the presidency capitals were careful in keeping their military records unaltered through the ages, and their method of collecting data and maintaining information on India and its inhabitants proved to be an excellent source for understanding the control, complexity, hesitancy, and scepticism that the British government in India, and more importantly for this thesis, in Madras, went through. Thus, the military records remain the most comprehensive, coherent and regimented sources of colonial history. Following the first two chapters, the medical transformation from military to a civilian focussed medical care will be explained here. The apparent discontent among military and medical personnel will be emphasised to bring out the nuances in which Madras experienced a shift in their medical care.

The chapter focusses on the period 1880-1914 and charts the transformation that took place first in the Madras army, and how it had a direct impact on the medical market in the

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[5] Erica Wald, *Vice in the Barracks: Medicine, the military and the making of colonial India 1780-1868* (London: Palgrave Macmillan, 2014), 1-15.

presidency. During this period, the GoI and its miitary department introduced a number of reforms that forced the local residents off the army, as the martial race theory took root. Simultaneously, such reforms created a large labour force interested in joining other government jobs such as administration and health. This chapter is the first systematic attempt in medical history scholarship to establish a direct relationship between the decline of the army and the advancement of the medical services in the Madras Presidency. It will focus on how colonial services were gradually becoming Indianised and how local residents were moulding themselves to fit the demands and requirements in the colonial period. This chapter, as it establishes the connection between medical services and the governments of India and of Madras, takes more of a 'bottom-up' perspective. However, the perspectives from the governments and the top officials have also been analysed. It investigates the social aspects of military services; and their interconnections with civilian social structures of the period. This chapter will conclude with an assessment of the subtle changes in the collective consciousness of the people serving in the Madras army examining their background and how the consciousness was moulded by state-imposed policies in the Presidency.

3.1 British Indian army under the Crown

After colonial India was brought under the direct rule of the British Crown, significant changes in the army structure and command were introduced to make up for the dent to their prestige in the 1857 uprising. The British army serving in India became a part of the Imperial British army and thus the differences between the 'Royal Troops' and the 'Company's European

troops', which had existed for more than a hundred years, were erased.[6] Until 1853, the first appointments to the covenanted service were made by the Directors of the EIC by nomination.[7] To give gradual effect to this objective, the number of young men appointed in England was reduced by one-sixth in 1880.[8] The first stage of reorganisation was completed in 1865 when the Company's European infantry became British regiments, and the Bengal, Bombay and Madras artilleries were amalgamated with the Royal Artillery. Following the Afghan war (1878-80), the GoI became aware of the shortcomings in the army. To rectify those and also to reduce army expenditure, the then viceroy of British India, Lord Lytton appointed a commission in 1879 with Sir Ashley Eden as chairman. The aim of this commission was to implement measures to improve the efficiency of the army.[9] There were some changes like, the addition of one British officer to each Indian cavalry and infantry regiments and, reducing four cavalry and eighteen Indian infantry regiments from the Madras army. But the most significant and lasting impact of the commission was the recommendation to abolish the presidency armies; this took 16 years to come to fruition, and the armies were finally united in 1895.[10]

The evolution of the army in British India and the expansion of medical care had been intrinsically linked. After occupying Kabul in 1879, one of the first things to be established was a hospital in the city where almost nothing existed.[11] Throughout the British rule in India, the services of medical officers had slowly, yet steadily, forged a bond between the conquerors and the

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[6] *The Army in India and its Evolution* (Calcutta: Superintendent Government Printing, India, 1924), 15-30.
[7] The superior servants of the EIC were obliged to enter covenants, under which they bound themselves not to engage in trade, not to receive presents, to subscribe for pensions for themselves and their families, and other matters. This custom has been maintained. Successful candidates, after passing their final examinations, enter covenants with the Secretary of State before receiving their appointments. These people were part of the covenanted service. D. G. Crawford, *A History of the Indian Medical Service, 1600-1913* (London: W. Thacker, 1914); *Roll of the Indian Medical Service, 1615- 1930* (London: W. Thacker & Co., 1930).
[8] *The Army in India and its Evolution*, 18-35.
[9] Brian Robson, "The Eden Commission and the Reform of the Indian Army, 1879-1895," *Journal of the Society of Army Historical Research* 60, no. 241, (1982): 4-13.
[10] *The Army in India and its Evolution,* 18-35.
[11] *Ibid.*

conquered. Colonial India did have access to the so-called modern medicine, but it was used solely for the upkeep and treatment of the British army until the middle or late nineteenth century.

There was no organised army reserve until 1887, and only in the last decade of the nineteenth century, did the GoI come up with the idea of having one.[12] With the intention of reorganising the armies, there were certain moderations and proposals put forward by the Imperial Legislative Council in India.[13] And yet, the Imperial government had chosen to reject almost all the suggested changes on the grounds that they involved a large and revolutionary shift and required immediate replacement of British officers with a large number of Indian officers in the army. The GoI stated that it was not prepared to risk the efficiency and traditional reputation of the Indian army particularly at the time when other European powers were making territorial gains and fast approaching the borders of the British Indian empire. The officials had to bear in mind that the process of Indianisation should not risk the efficiency of the British Indian army.[14]

The medical officers of the RAMC and the IMS were primarily responsible for the healthcare of the armies but were also made available for other positions from the late nineteenth century onwards, such as the civil medical positions; medical education and research, public health and administration of jails.[15] Before the WWI, there were no proper hospitals for Indian *sepoys*, and they were treated in poorly equipped regimental hospitals which were non-dietary institutions.[16] But, this was not the only concern that plagued the Madras army, as the GoI had started making significant cuts to the number of *sepoys* in Madras. This led to a momentous change in the way the army in Madras was recruited and functioned.

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[12] *The Army in India and its Evolution*,15-30.
[13] The Imperial Legislative council was composed of five members appointed by the British Crown from 1869. The Viceroy could appoint a further six to twelve members who could vote on legislation. The Indian Councils Act 1892 increased the number of legislative members with a minimum of ten and maximum of sixteen members. Crawford, *A History of the Indian Medical Service*; *Roll of the Indian Medical Service, 1615- 1930* (London: W. Thacker & Co., 1930).
[14] Sir P. S. Sivaswamy Aiyer, *The Self-Defence of India* (Madras: Methodist Publishing House, 1924), 25-27.
[15] *Ibid.*
[16] *The Army in India and its Evolution*, 15-30.

The Madras army showed noteworthy fighting prowess and its detachments were dispatched to different fronts during the eighteenth and nineteenth centuries by the GoI. However, after the Mysore war and the fall of Tipu Sultan in 1799, the presidency remained a relatively peaceful region, barely resorting to violence and revolting against the British with only a few exceptions. The creation of the British Indian empire had become a reality only with the full cooperation from the Indian *sepoys*. Seema Alavi argues in this context that 'the [army] recruitment of East India Company was central to the development of the company's political sovereignty'.[17] Douglas Peers termed the volatility of the political situation in the highly militarised state as 'Anglo-Indian militarism'.[18] The alternative to employing Europeans in the intermediate ranks was the mobilisation of Eurasians and supplementing them with the *sepoys*.

From the late nineteenth century, emergent nationalisms brought another element into the equation, which further complicated imperial policy – perception of the Indian army as an instrument of colonial oppression. Many Indians, especially the western educated elites, wanted the officer corps to be opened to Indians.[19] However, Madras faced a range of discriminations that stemmed from the practice of recruiting only from martial-races in the British Indian army. The Madras army started experiencing an alternative recruitment policy from the 1880s onwards.The way Madras coped with the evolving recruitment policy of the British Indian army and the chain of events that followed made this particular province so interested and invested in the colonial medical services.

3.2 Examining the implementation of the martial race theory in colonial Madras

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[17] Seema Alavi, *The Sepoys and the Company: Tradition and Transition in Northern India 1770-1830* (New Delhi; Oxford: Oxford University Press, 1995).
[18] Douglas Peers, *Between Mars and Mammon: Colonial Armies and the Garrison state in Early Nineteenth Century India* (London: Tauris Academic Studies, 1995), 1-14.
[19] *Ibid.*

The political scenario in British India during the 1870s was dramatically different from the previous decades, as the GoI felt increasingly threatened by the rise of European powers. As the rising European powers like Russia and Germany began to threaten the external borders of the British empire, the role of the British Indian army had to be modified. Between 1870 and 1914, many officers, government administrators and even civilians came to regard the European powers as the most potent threat to the security of the British empire. Following the Anglo-Afghan wars of 1878-1880, the threat became more imminent to the GoI. This led to a rise in anxiety among the British, who had become desperate to safeguard their empire. The military administrators felt that there should be steps undertaken to strengthen the British Indian army.[20]

The Anglo-Afghan war was projected as an excuse to highlight the ineffectiveness of the Madras *sepoys*. Heather Streets argues that as a result of these altered military circumstances, the period between 1880 and 1914 was marked by a transformation in the way the army was recruited and organised.[21] Increasing tension led the British officers and administrators to propose a reform of the British and Indian armies to make them better equipped to handle European powers. Thus, the changes in India were influenced heavily by the international context; in particular, the power dynamics of Russia, France and Germany acted as a 'third wheel', according to Streets, in shaping the British Imperial military policy towards the end of the nineteenth century.[22] 'This new policy,' according to Streets, 'went from a minority to a hegemonic position within the Indian military administration in direct relation to the perceived Russian threat.'[23] The British were also influenced by the late Victorian racial ideas and also that of Social Darwinism that was inadvertently applicable to the military prowess.[24] This anxiety of the military officials, coming in close contact with the biological concepts of natural selection and survival oft he fittest reflected a change in the British

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[20] *Ibid.*
[21] Heather Streets, *Martial races: the military, race, and masculinity in British imperial culture, 1857-1914* (Manchester: Manchester University Press, 2004), 93.
[22] *Ibid.*
[23] *Ibid*, 92-93.
[24] *Ibid*, 95.

Indian army, which dramatically altered the recruiting base of the army to include the *sepoys* who came only from the martial races. David Omissi has pointed out that during 1861-65, out of the 52 battalions of Madras infantry, 12 were disbanded, and in 1869 the GoI wanted to disband a further eight Madras battalions.[25] Omissi has emphasised that this period marked the beginning of the use of martial race as the GoI suspected that the Madras infantry had been filled with recruits from 'unsuitable races'.[26] The ideological changes and the recruitment policy that evolved until the amalgamation of the presidency armies are examined in the sub-sections that follow.

3.2.a) Ideological Shifts

Ideological changes had the most important influence on the Madras army as the focus of the GoI changed during the latter part of the nineteenth century; this was important in deciding the disbandment of the army regiments in Madras. The GoI in its sessional papers in 1887 stated:

> By the recent advance of Russian, the military problem with which the Government of India has to deal has been profoundly modified. We have now in close proximity to our frontier a great European power with which we may at any time be brought into hostile contact, and consequently, our existing military establishments are no longer adequate for the duties they may have to fulfil.[27]

The late Victorian racial theorists emerged in the late nineteenth century with their ideas of race, and they claimed that human constitutions were negatively affected by hot, humid, tropical areas. The hotter and more tropical the area, the lazier, lascivious, passive, effeminate and degenerate the population was assumed to be.[28] Although, Harrison has pointed out how racial ideas by this period

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[25] David Omissi, *The Sepoy and the Raj: The Indian Army 1860-1940*, (Houndmills; Basingstoke; Hampshire: Macmillan in association with King's College London, 1994), 10-11.
[26] *Ibid.*
[27] House of Commons, Correspondence relating to the increase of the army in India, Sessional Papers, 62 (1887), 26 quoted in Heather Streets, *Martial Races*, 93.
[28] *Ibid*, 94.

had hardened into more fixed position and the influence of climate was seen as more remote rather than direct.[29] Even the 'superior' races, this theory emphasised, could degenerate after too much exposure to tropical climates.[30] On the other hand, colder, more northerly climates were believed to produce and sustain hard working, aggressive and masculine people. Crosses between individuals of 'inferior' and 'superior' races, especially, were believed to pollute the racial stock of the 'superior' race, which in turn could spell biological disaster for all.[31] Mark Harrison has written at length on how the colonial ideas about race and health were evolving in the nineteenth century.[32] Medical topography started playing more important roles in differentiating among Indians, which led to the linking of martial traits to mountains or cold area habitats. Harrison has also argued in relation to the racial understanding of healthcare that the British had created an almost impossible situation for themselves as they wanted to create an atmosphere where the modernisation should not offend Indian sensibilities.[33]

British military commanders feared imminent war with the European – particularly the Russian empire – and held on to these ideas and started using them to justify their change in recruiting tendencies. Even though many military officers praised the *sepoys* of Madras for their loyalty during the 1857 uprising, they argued that it had been scientifically proven that people from the south of British India were inherently unfit for warfare. Men in the southern parts of colonial India, because of environmental and biological factors, were dark-skinned, and their upbringing in the hot and humid southern region made them unsuitable for warfare in the north-west frontier of India in the eyes of the British army officers.[34] People like W. J. Wilson, H. H. Dodwell, and E.

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[29] Mark Harrison, *Climates and Constitutions, health, race, and environment and British imperialism in India, 1600-1850* (New Delhi; New York: Oxford University Press, 1999).
[30] Dane Kennedy, *The Magic Mountains: Hill Stations and the British Raj* (Berkeley: University of California Press, 1996), 32-35.
[31] Mike Hawkins, *Social Darwinism and European and American thought, 1860-1945: Nature as model and nature as threat* (Cambridge: Cambridge University Press, 1997), 187.
[32] Mark Harrison, *Climates and Constitutions: Health, Race, Environment and British Imperialism in India 1600-1850* (New Delhi; Oxford: Oxford University Press, 2002), 210-214.
[33] *Ibid*, 210-214.
[34] Streets, *Martial Races*, 95.

G. Phythian Adams had served or worked closely with the Madras army and came up with their version of how well the *sepoys* used to serve the GoI but the 'Punjabization'[35] of the army continued.[36] What the officers in charge of the Bengal or Bombay presidencies failed to understand was the social structure and the identity of the local population who served in the Madras army, and this drove a wedge among regiments, further alienating the Madras regiments in the process. Roberts argued that anyone was eligible to become a soldier in the Occident, while in the Orient, only some groups were fit to be soldiers because of its peculiar historical and ecological conditions.[37] He claimed that those people dwelling on the northern parts of British India, such as the Gurkhas, Sikhs, Dogras and the Pathans, were better suited for martial engagements.[38] Major MacMunn voiced a similar concern when he said, 'In Europe, as we know, every able-bodied man, given food and arms, is a fighting man of some sort, in the East . . . certainly in India, this is not so'.[39] Thus, there was a rising belief among the British officers regarding the racial prowess and differences of the Indian recruits, and such conversations found their way out of the government, or military files and were also circulated in magazines and journals.[40] Such arguments were based

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[35] The British Indian army recruited half a million from the Punjab province and the process began in the late nineteenth century. Field Marshall Roberts was in total favour of a complete Punjabization of the army, and it meant all the army regiments began to be filled with personnel from the region of Punjab. To know more on how this worked out, Santanu Das, *India, empire, and First World War culture: writings, images, and songs* (Cambridge: Cambridge University press, 2018); Stephen P. Cohen, "The Untouchable Soldier: Caste, Politics, and the Indian Army," *The Journal of Asian Studies* 28, no. 3 (1969): 453-468.

[36] W. J. Wilson, *History of Madras Army* (Madras: Government Press, 1899); H. H. Dodwell, *Sepoy Recruitment in the Old Madras Army* (Calcutta 1922); E. G. Phythian Adams, *The Madras Soldiers, 1746-1946* (Madras: Government Press, 1948), 11-31.

[37] Frederick Roberts, *Forty One years in India, from Subaltern to Commander-in-Chief* (London, 1897; reprint, 1898), 530-534.

[38] *Ibid*; The Gurkhas were the soldiers of Nepalese origin and ethnic Nepali people recruited for the British Indian Army; the Sikhs fought with the British army throughout the colonial period. After the fall of the Sikh kingdom and death of its king Maharaja Ranjit Singh, the British conquered this large territory, and began recruiting Sikhs into their army in large numbers; The Dogras, an Indo-Aryan ethno-linguistic group were the Dogri language speakers. The Dogra Regiment and the Punjab Regiment of the British Indian army primarily consisted of Dogras and Sikhs; the Pathan is a synonym commonly used in South Asia to refer to the Pashtun people, the largest and second largest ethnic group in Afghanistan and Pakistan. They were recruited heavily following the introduction of the martial-race theory. All these four ethnic groups adhered to the British notion of superior race being tall, fair skinned and coming from the mountainous regions. To know more on this, Streets, *Martial races.*

[39] Major General F. MacMunn, *The Armies of India* (1911, reprint, New Delhi, 1991), 129.

[40] Sir S. P. Sinha, "Commissions for Indians in the Army," *The Indian Review* XVII, (1916): 113-115.

on the idea that in the Orient, only a few groups could bear arms because the rest of the communities lacked courage and physical strength. These arguments by established officers were making it harder for the Madras army to prove their mettle to the GoI.

Kaushik Roy and Sabyasachi Dasgupta have argued that the Madras army, unlike its Bengal counterparts, 'had by 1820s evolved a corporate identity of its own and was relatively isolated from its host society'.[41] By 'corporate identity' they referred to the distinctive *sepoy* mentality which overrode the primordial loyalty of the *sepoys* bringing out their military professionalism. In contrast, Manas Dutta argues that the frequent changes introduced in the parade manuals, military registers, and battalion discipline codes point out that disobedience was almost a regular feature among the Madras *sepoys*.[42] It also cannot be assumed that they were completely detached from the civilian population, particularly those close to the cantonments and there were also recruits living with their families in the barracks. John Malcolm points out that the Madras army attracted men of the highest caste and only those families who had distinguished themselves in the military service of the British.[43] The issue of caste played a significant role in the events that unfolded later with the disbandment, and the resultant disillusionment of the people of Madras with the British recruitment process. Understanding the social background of the Madras *sepoys* remains an important part of understanding how Madras experienced the transformation of the medical norm. Frederick Roberts, commander-in-chief of the Madras army from 1881-85, advocated that the army of Madras should be denied posting outside the limits of the southern borders of British India,

> Each cold season. . . I tried hard to discover in them (Madras Army) those fighting qualities which had distinguished their forefathers during the wars of the last and the beginning of the present century. But long years of peace, and the security and prosperity attending it, had evidently had

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[41] Kausik Roy and Sabyasachi Dasgupta, "Discipline and Disobedience in the Bengal and Madras Armies, 1807-1856," in *War and Society in Colonial India, 1807-1945,* ed. Kaushik Roy (New Delhi: Oxford University Press, 2010), 55-81.
[42] Manas Dutta, "A study of the social composition and organization of the Madras Army 1807-1885," (PhD dissertation, University of Calcutta, 2014), Introduction.
[43] John Malcolm, *Sketch of the Political History of India* (London: William Millar…, 1811), 67.

> upon them, as they always seem to have on Asiatics, a softening and deteriorating effect; and I was forced to the conclusion that the ancient military spirit had died in them, . . . and that they could no longer with safety be pitted against warlike races, or employed outside the limits of southern India.[44]

However, the lack of popularity was not the only problem that plagued the Madras army. The heart of the British administration in India was in Bengal and going to the other two presidential army regiments meant the officers were going far from the centre of power and influence. The Madras army hardly ever saw any active duty from the mid-nineteenth century as most of the military conflicts shifted to the north and northwest frontiers. The lack of field duty hurt their agility and significantly blunted their military prowess. While the focus of the GoI shifted to making the army stronger for protecting the external boundaries of the Indian empire, the Madras army was downgraded and was only allowed inside the presidency for internal security and a few skirmishes. The major changes in policies and how exactly the army in Madras was subdued will be examined in detail in the following section.

3.2.b) Changes in the army recruitment policy: decline of the Madras army

> *Sepoys*- The greatest part well-sized men. In the centre rank some low-sized men. In general, pretty well limbed. Sized very well in the ranks, which adds greatly to their appearance. [45]

This was written in 1918 and perfectly portrayed the general tendency of the British people towards the *sepoys* who constituted the largest share of the British Indian military. The majority of the people coming from the southern areas of British India, being of Dravidian origin, were shorter in stature, and this was one of the primary arguments of the British officials while disapproving

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[44] Roberts, *Forty-One Years in India*, 383.
[45] John Travers, ed., *Comrades in Arm: A war book for India* (Bombay: Madras: Humphrey Milford Oxford University Press, 1918), 11.

the Madras *sepoys*. Nevertheless, the factors behind this apparent malaise towards the *sepoys* from Madras were manifold.

Lieutenant R. M. Rainey, commander of the 12th Burma Regiment, argued that the faulty British policy was to be blamed and not the local people, for the gradual decline of the Madras army. He claimed that it was the fault of the GoI that they did not allow the Madras army to participate in the northwest frontier wars and let only a handful of them to participate in the Second Afghan war.[46] Major General Edwin Collen argued, 'since 1891-92, with the object of introducing the warlike races into the army, the GoI opened certain stations, and they appointed special officers from different districts'.[47] He added that there were eight battalions comprising northern races and Gurkhas, and only fifteen corps was composed of men drawn from Madras territories, including Muslims and Hindu groups such as Mappilas, Tamils, and Coorgs.[48] This process had a major impact on the recruitment policy of the army in Madras. Many races of Madras, who used to make good soldiers turned their backs on the military services as they disliked leaving their homes or more importantly were not happy about the unsure nature of the army enlistment.[49] The southern parts of British India were mostly peaceful and remained loyal, barring some skirmishes, and the Madras Presidency had no frontiers to be guarded. According to F. H. Tyrrell, it was natural that Madras would bear the brunt of army reduction and the remaining British officers, native officers and non-commissioned officers were distributed among the remaining regiments.[50] This created serious management problems as promotions completely stagnated, and recruits remained stuck in the same designation for years; a lackadaisical attitude pervaded the entire system

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[46] Lieutenant R. M. Rainey, "The Madras Army," *Journal of the Royal United Service Institution (JUSII* hereafter) 20 (1891): 79-85.
[47] Major General Sir Edwin Collen, "The Administration and Organisation of the Army in India," *JUSII* 48, no.2 (1904): 798-816.
[48] Ibid.
[49] F. H. Tyrrell, "The Reconstitution of our Indian Army," *JUSII* 51, no. 1 (1907): 311-312.
[50] Ibid.

weakening it further. This shift in the recruitment process created a long-term impact on the psyche of the Madras *sepoys*, as they were used to enlisting for long careers in the army with security assurances for their families, including pension and other benefits.

The army adopted a policy to remove the local residents from Madras regiments, pensioning all who had served for the required number of years while simply discharging the rest or transferring them to other regiments.[51] Recruitment of the upper caste men was the norm in the early nineteenth century Madras army, but gradually by the late-nineteenth century, the same regiments were composed of Muslims, middle-caste Hindus, lower castes and only a few higher castes.[52] Those with power and in high positions in the army and in the GoI wanted to safeguard the empire from other European powers. As Streets has argued in this context, the rise of continental European powers post-1870s transformed the thought process of the British and Indian armies.[53]

Colonel Wilson attributed the insecurity of the Madras soldiers partly to insecurities of the impermanence of service caused by frequent reductions between 1860 and 1882, during which period no less than 20 battalions were disbanded, but above all to the systematic way in which the Madras Army had for many years been kept in the background on most occasions of active service.[54] In the latter connection, Lieutenant-General Burton in 1888 wrote:

> If the Madras sepoy is now of less worth than he was in the days of our first struggles for empire in India, it is because of disuse of war and enforced inactivity, to which the dominant policy of the Supreme Government has of late condemned him. The evil to an army which has become mortified and dispirited by neglect and contemptuous treatment is very serious, and no protest against such treatment can be too strong. It is on account of this ill-treatment that the Madras Army needs

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[51] Tyrell, "Reconstitution of our Indian Army," 308.
[52] Ibid.
[53] Streets, *Martial Races*, 87-110.
[54] *Ibid.*

> an advocate. Once let it have a fair share of active service and its turn in the front line with the men of other Presidencies, and it will perform its advocacy in a sufficiently spirited manner.[55]

The British army officers had conflicting views regarding the importance and military capabilities of the Madras *sepoys*. Under the pseudonym of 'Madrassi' an article written in 1906, explained and exposed the conflicting traits in the British military organisation in colonial India. The writer confirms the earlier stated concept of Madras Presidency being one of the most peaceful of provinces, as there was a 'total absence of machine-guns with the battalions' of colonial South India, and that indicated that the units in the south were not intended to be used for direct military engagements.[56] One of the reasons put forward was that the *sepoys* in this presidency were allowed to live with their families, and they were directly dependant on the army recruits.[57] The British officials realised that being from poor families, the *sepoys* of Madras could not manage to feed themselves properly after taking care of their families and hence were treated unfavourably compared to those from the north. But they were considered disciplined, loyal, and responsible as they were taking care of their families and other relatives' dependent on them.[58] Sir Arthur Hope, who was the Governor of Madras throughout WWII, was an ardent champion of the Madras soldier and at an address delivered early in 1945 said:

> I have always felt in reading the history of the Madras Army in the old days that there must be something fundamentally wrong in the attitude of the Army authorities in ignoring madrassis in recent years. When you read the history of the past from 1750 onwards, you will see that Madras troops did a great part of the fighting in India in those days and were nearly always successful.[59]

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[55] Adams, *The Madras Soldiers, 1746-1946*, 262-263.
[56] Madrassi, "The Madras Sepoy," *The United Service Magazine* 32 (1906): 695-700.
[57] J. Michael, "The Native army of Madras: Organization, Equipment, and Interior Economy," *Royal United Service Institute (RUSI hereafter)* 32, (1888): 329-63.
[58] Ibid.
[59] Ibid.

Thus, there was support in favour of the Madras army as well, as many British officers who had the opportunity to serve in the regiments, were sympathetic. The superior officers were also at times, willing to be dignified and respectful towards their subordinates. But, it is hard to say if it was their sense of superiority or a matter of duty that triggered such motivations. In fact, there were people during that period holding important positions with the GoI who were against the practice of referring to Indians as 'natives' and were in favour of discontinuing this derogatory term.[60] It is remarkable to see that there was a manual for the Indian Civil Service with instructions for the officers to act in a dignified manner. A section on '*Relations with subordinates'* recommended the officers to be accessible to his subordinates and not to display favouritism when in office.[61] But, even after these measures, Madras *sepoys* faced discrimination on a constant basis. The majority of the British army officers were antagonistic to the Madras regiments and sought to effectively curb their services, and their opinions prevailed. Between 1890 and 1903 seventeen Madras regiments were transformed into Gurkha or Punjabi majority ones, which were later renamed 1st, 2nd and 8th Punjab Regiments, and the 1/7th and 1/10th Gurkha Rifles. All the regiments were renumbered, and the Madras Infantry and Pioneers added 60 more to their original numbers.[62] Even with a lot of powerful people supporting the martial prowess of the local Madras residents, they ultimately had to face disbandment. The apathy towards the Madras *sepoys* became even more prominent following the army amalgamation of 1895.

3.3 The army amalgamation of 1895 and its aftermath

The history of the Madras army can be categorised into three specific time periods. The first was the period under the EIC until 1858; the second was the period starting from 1858 to the amalgamation of presidency armies in 1895 and the third period deals with the unified British

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[60] *The Indian Civil Service Manual* (Madras: Government Press, 1931), appendix.
[61] *Ibid.*
[62] Ramachandran, *Empire's First Soldiers*, 138-145.

Indian military. This chapter deals with the shifts from 1880 to 1914, and this section will analyse what prompted the army amalgamation in 1895, and the changes that were manifested in the Madras military department following that. In 1879, the Eden Commission was appointed to study the persisting problems with the military in India. Their most important recommendation of the Eden commission in 1879, was finally given due importance as the GoI and the military department realised the need to bring together a common British military force for colonial India. This was also the result of the racial theories that took over the military officers, and they deemed it necessary to have more recruits from the northern and north-western region of India. The new recommendation stated that 'the native army should be composed of different nationalities and castes, as a general rule, mixed promiscuously through each regiment'.[63]

The departmental and auxiliary services of the three armies were, by degrees, amalgamated, and finally the whole military organisation was reconstituted in 1895, with the army in India organised in four corps, each commanded by a Lieutenant-General under the Commander-in-Chief of India, who was relieved from the immediate command of any body of troops.[64] The four army corps were recruited from the territorial areas that they occupied, and it was the same in the case of Madras. Nevertheless, according to Tyrrell, some races such as the Mappilas and the Coorgs who were able warriors and had been recruited for Madras regiments for years, disliked leaving their homes and had an inherent distaste for discipline.[65] Thus, it was not only the GoI recruitment policy, but the amalgamation of the army was also another reason for few local residents of Madras for their reluctance in military service. Thus, military prowess had proved to be less important for those unwilling to shift far from their home, and geographical distance discouraged them from joining the military as the war front had moved to the north-western frontier of British India in the late nineteenth century.

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[63] *Ibid.*
[64] Tyrrell, "The Reconstitution of our Indian Army," 308.
[65] Ibid. 308.

In the context of Madras, this proved to be a watershed moment, as the Eden Commission decided that internal security in Madras was no longer a matter of concern and the 'Madras soldiers are not effective enough to justify extensive recruitment'.[66] This decision of amalgamation marked the decline of the Madras army as their number plummeted on a rapid scale and by 1914 the only people serving were a few Tamils and Muslims from Madras apart from the people drawn from the Punjab region. The following table shows the decline of the regiments in the Madras military and subsequent strengthening of the Punjab army during the period from 1862 until the beginning of the First World War.

Table 3.3 (i) Regiments in the Punjab and Madras Army (1862-1914)

	1862	1885	1892	1914
Punjab	28	31	34	57
Madras	40	32	25	11

[Source: Indian Army, Recruiting in India before and during the War of 1914-18, 7 quoted in Stephen P Cohen*, The Indian Army: Its contribution to the development of the nation,* (Berkeley, London: University of California Press, 1971), 44]

This table reflects the state of affairs in the Madras Presidency and how quickly the regiments were disbanded. Grievances arose in the Madras regiment ranks as reported in the *Times of India* 1902,

> The army men were concerned about their declining prestige, as by 1902 it was a general conception that the term 'Madras Officer' simply meant an officer who was serving with the sepoys, native

[66] Omissi, *The Sepoy and the Raj,* 12-16.

> of the Presidency. The Sepoys showed their grievance in matters of suppression, stating that not a single Madras Staff Corp was found in the Madras command Headquarters. The sepoys showed their desire to climb up the ranks and hold important positions in the Army.[67]

The Madras army continued to serve the GoI even under such adversities, their loyalty still integral, and they were probably trying to convince the military department of their capabilities. The Madras army, or what remained of it, continued serving the GoI in the best possible way. There were major outbreaks or skirmishes in different parts of the British Indian empire between 1895 and 1898 where the Madras troops, both the infantry and sappers, exhibited excellent fighting skills. A company of sappers was part of the force that relieved the besieged garrison of Chitral in western Kashmir.[68] The Madras *sepoys* were among the troops in 1897 in Malakand pass and then also in Turah valley.[69] The Madras *sepoys*, mostly the sappers, were part of various campaigns in 1903 and also in 1911. In 1904-05, a dispute broke out between Lord Curzon, the viceroy of India and Lord Kitchener, the Commander-in-Chief of British Forces in India, and this was the last major civilian-military dispute in India according to Stephen Cohen.[70] This dispute proved vastly unfavourable for the Madras *sepoys*, as further reductions were made and a few battalions were reduced to as little as 600 in strength which made them useful only for garrison duty.[71] Increasing discontent and disputes arising out of this policy further weakened the Madras army significantly, and by this time, the local residents began to look for other job opportunities. Thus, there were still a few brave soldiers in the Madras army who continued to fight for the British, but generally speaking, the strength of the regiments was depleted, and the soldiers realised that they needed to look for other opportunities outside the military.

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[67] "Madras Army Grievances," *The Times of India (ToI)* October 13, 1902, 5.
[68] Ramachandran, *Empire's First Soldiers*, 138-145.
[69] *Ibid.*
[70] Stephen P Cohen, *The Indian Army: Its contribution to the development of the nation* (Berkeley, London: University of California Press, 1971), 22-23.
[71] *Ibid.*

The loyalty and peaceful nature of the people in the southern part of British India and the absence of any foreign frontier close to the Madras Presidency made the continued maintenance of a large military force unnecessary, and the Madras army was also condemned to bear the brunt of reductions rendered necessary by the state of the Indian finances after the 1857 uprising. For a comparative understanding, the Madras Presidency, which at the time of the uprising in 1857, supplied 50,000 'native' soldiers, in 1911 was supplying recruits only for three squadrons of cavalry, nine companies of sappers and eleven battalions of infantry, in total about 10,000.[72] An article 'The Madras Sepoy' has argued in this context that the 'old native families' were unlikely to be happy about the 'numerous abolitions, cuttings and reconstituting' and ceased to be enthusiastic about their kin joining the military ranks.[73] They always had to live with the threat that any morning they could receive an order of disbandment of service with their regiments, and such a situation was not looked at favourably by the locals.[74] Regular changes in policies by the GoI forced the army personnel to look for new avenues of employment, and this was aggravated by the constant threat of caste, class and religion in Madras. The sense of uncertainty among the military men was further aided by the *divide et impera* policy of the British Crown.

3.3.a) Role of caste, class and religion in understanding Madras army

Lieutenant-Colonel Phythian Adams of the Madras Infantry wrote that four great races used to make up the states of Madras, Andhra, Mysore, and Kerala and from these people, the recruits of the Madras regiments were drawn. He acknowledged that there were others in the southern part of British India like Coorgs, the Tulus, and some aboriginal tribes with their own dialects but Tamils, Telugus, Malayalis, and Canarese constituted the largest part of the population,

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[72] F. H. Tyrell, *The services of the Madras Native Troops in the suppression of the Mutiny of the Bengal Army* (S.I., 1907?).
[73] Madrassi, "The Madras Sepoy," *The United Service Magazine*, 32 (1906): 695-700.
[74] Ibid.

and all these people used to be enlisted in the Madras regiments.[75] The Lieutenant-Colonel had hoped that close contact with people across British India while being a part of the army during the wars, would change the popular misconception regarding the Madras *sepoys* and, more importantly, he had hoped that the talk about martial and non-martial classes would not keep the recruits engaged for too long.[76] It did not work out the way Adams expected as the twentieth century brought forth changes motivated by the myth of matial traits, and thus the Madras army continued to play a subdued role in the colonial context.

In the early twentieth century, there were efforts to completely reform the British Indian army as the GoI ceased to identify the 'native army' as the perfect fighting machine, which was how the erstwhile commanders and chiefs referred to them.[77] However, the apparent degrading of the Madras army was not only because of a single factor; rather, it was a culmination of several factors that led to the transformation of the services rendered by the locals in the presidency. The GoI, however, as has been explained, was not always averse to using the Madras *sepoys,* especially in Hong Kong, Singapore, China, Mauritius, and the Far East, thus refuting the theory that they were directly discriminated against.[78] The degradation was not always apparent to outsiders, and there were many internal evils plaguing the condition of the Madras *sepoys*. In the twentieth century, many of the officer posts in Madras were largely occupied, 'not by soldiers, but by civilian native *babus'*.[79] This might also be the reason for a subsequent decline in the quality of the military in Madras. The recruits for the Madras army, instead of being selected from the group most fitted by

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[75] Adams, *The Madras Soldier*s, 11-31.
[76] *Ibid.*
[77] Scrutator, "The Reorganisation of the Indian Army," *United Service Magazine* XXXI, (1905): 367-376.
[78] Madrassi, "The Madras Sepoy," 699.
[79] Ibid; In British India, *babu* often referred to a 'native' Indian clerk. The word was originally used as a term of respect attached to a proper name, the equivalent of 'mister', and was used in many parts to mean 'sir'. Since early 20th-century, the term *babu* was frequently used pejoratively to refer to bureaucrats of Indian Civil Services, and other government officials. For details of this word see, Neelam Srivastava, "Pidgin English or Pigeon Indian? Babus and Babuisms in colonial and postcolonial fiction," *Journal of Postcolonial Writing* 43, no. 1 (2007): 55-64.

nature and education, unfortunately, began to be recruited from those with connections at appropriate places or with friends and relatives placed in important positions. With nepotism and favouritism being constant issues in Madras, there was no penalty for incompetence and no reward for efficient work.[80] Thus, the same officers continued in the office, often blocking the places which could have otherwise been taken by meritorious people.

There seemed to be incompetence also on the part of the Indian officers after coming through the ranks, and they started to be over-reliant on the Europeans officers, and this often resulted in the Indian soldiers becoming incapable of acting on their own.[81] The amalgamation of the whole Indian army and through extensive recruitment from the warlike races the issue had been resolved to a certain extent. Many were not happy with Lord Kitchener's schemes, in particular, his treatment of the 'native army'. The class composition in the army was created by mixing 'non-coalescing elements' in the regiments like Hindus and Muslims, which was effective in forming a smaller section of the army rather than big battalions.[82] The British officers always had a feeling of superiority over the Indian officers, and during wars, Indian officers could never be in a very senior or leading position.[83] Sir S. P. Sinha has written about the rising grievances and resentment of the people of Madras, as their consistent exclusion from the army was bound to make them feel like lesser subjects and that in turn was detrimental to internal peace.[84] The idea of making the Indian army homogeneous sounded beneficial from a military point of view, but politically it was not viable as colonial India was highly heterogeneous in its structure and composition. Such policies impacted the educated local people, and they preferred to turn their attention to other jobs rather than being in the army.

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[80] Scrutator, "The Reorganisation of the Indian Army," 367-376.
[81] Ibid.
[82] Ibid.
[83] Ibid. 370-372.
[84] Sinha, "Commissions for Indians in the Army," 113-115.

3.4 Disillusioned Madrassis: from one government service to another[85]

This section will analyse the shifts taking place in the Madras Presidency, and how they were impacted by the military and medical transformation during the period simultaneously. The recruitment policy adopted by the GoI and the process of consistent disbanding of the Madras army regiments created a sense of panic and uncertainty among the youths in the presidency. This led to discontent, and the young officers began to feel worried about their future in the Madras army. Their discontent was not an abrupt development, although it was only manifested after the appearance of the Royal Warrant of 1887 issued by the Governor-General in Council, which revised the rules for promotion and precedence in the AMD, which had an impact on the IMS as well.[86] This step was taken by the GoI to make similar arrangements for the army and civilian physicians. Along with the youths in the army, the military disbandment also had an adverse effect on the medical practitioners attached to the Madras army. The medical officers serving in the army were agitated that they could now be treated on a par with the civilian medics, and this would affect their fortune and prestige adversely.

Owing to the absence of a connection between the Medical Officers (MO hereafter) and special corps, and their frequent changes in duty, the MOs had fallen out with the army from a professional point of view and were unnaturally disposed to believe that they were not considered an intrinsic part of the service.[87] Some of the officers desired to have army titles pure and simple, without any reference to the medical profession inside the military service. This was directly related

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[85] Madrassi was a demonym frequently used for people from Madras. Although it was used at most times to refer to people from the entire colonial South India. In the recent period, the term has been criticised for over-generalising the people from Southern part of India and pejorative at times. But in the context of colonial India and this thesis, the term Madrassi holds value and must be understood in the way the colonial government treated the section of people they considered Madrassi. Thus, for examining the exact section of people who faced the inequality and discrimination, this thesis will be using the terminology. It will only be used to establish and examine the history of colonialism as it shaped the Madras Presidency. For details to understand this term see, Radhika Chopra, "Invisible Men: Masculinity, Sexuality, and Male Domestic Labour," *Men and Masculinities* 9, no. 2 (2006): 152-167.

[86] "Naval and Military Medical Services: The Indian Medical Service," *BMJ* (November 1887): 1133-1134.

[87] *Ibid.*

to their mixed military-medical titles, and it was prestigious for the medical recruits to have military title as that ensured higher pay and better treatment by the GoI.[88] The number of candidates who made themselves available for the competition in 1887 was significantly lower than the number of candidates in 1883. The government realised that it would be unfair to the MOs of the army and navy and would not go down well with them if the civilian doctors were given equal status and were equally paid.[89] The RAMC was also having a difficult time continuing to work in the colonial state under new regulations which reduced their employment opportunities.[90] With ever-changing regulations, the medical service of the army became so unpopular that by the end of the nineteenth century, there were no candidates willing to join the AMS. In effect, no examination was organised as there were none interested in taking the role.[91]

In 1890, the Secretary of State for India sent a despatch to the Madras government outlining the changes and how the British and the Indian medical personnel were to be assigned differently in the districts, which were classified into first and second-class districts. A deputy Surgeon-General either a British or part of the IMS was assigned in each first-class district while two second-class districts were to be linked together and placed under the deputy surgeon general. A Brigade-Surgeon was to be placed in an administrative charge of the presidency districts. After this decision was made in Madras, the Deputy-Surgeon oversaw five districts – Secunderabad, Bangalore, Southern, Rangoon and Mandalay while the Brigade Surgeon was in charge of Belgaum, Madras and Myingyan districts.[92]

Despatch from the secretary to the GoI, dated 13 March 1895 to the secretary to the government of Madras reminded him that the amalgamation of the Bengal, Madras, and Bombay

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[88] D. G. Crawford, "The Indian Medical Service," IMG (May 1907): 192-198; "India and Medical Progress," *IMG* (1917).
[89] *Ibid.*
[90] *Statement of the position of the officers of the Army medical Staff with special reference to service in India* (London: unknown publisher, February 1888?), 1-7.
[91] *Ibid.*
[92] Public Health Department: Report of the Director of Public Health (Madras, 1911-1920), IOR/V/24/3704, APAC, BL.

branches of the IMS had led to some significant changes in the civil medical administration of the local governments and the GoI.[93] It was also necessary for the IMS, that was almost twice the size of the army medical staff in India, to have a clear idea about their revamped role in the new settlement.[94] There were several deliberations and debates about the role of the central government and the local one in controlling subordinate medical organisations. A letter from the GoI dated 5 July 1894 stated that the Surgeon-General with the GoI would be held directly responsible for recruitment for the military branches. The letter added, 'this will not, however, in any way affect the existing duties and responsibilities of the local Surgeon Major General regarding the civil subordinate medical establishment in this presidency'.[95] This ascertains that consideration for the civilian medical healthcare was on the rise during this period.

The number of hospitals and dispensaries under the local boards were on the rise, but even after that, the proportion of health centres was less than 1 to 1,00,000 persons in many of the districts by 1893. They were still facing problems of getting medical subordinates to work in the dispensaries, which made it impossible for the government to open up new ones at Garabanda and Triprayur in Ganjam and Malabar districts while the building of one dispensary at Bambha in Ganjam was postponed for lack of funds.[96] Many people were required in dispensaries, and the government needed to consider taking some serious steps to convert a few of the existing dispensaries into hospitals.[97] With time, an increasing number of students began to be trained, especially in the last decade of the nineteenth century, and new medical schools were opened in smaller districts and regions. The district boards started taking initiatives to maintain schools in places like Nellore and Tanjore.[98] These steps on the part of the Madras government opened new avenues for the local youths who were looking for prestigious employment opportunities.

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93 Ibid.
94 Ibid.
95 Ibid.
96 Ibid.
97 Local and Municipal Government, 8 November 1893, nos. 2500, 2500L, V/24/308, APAC, BL.
98 Ibid.

The local and union boards began to control the lower level of administration as they started having a say in the recruitment and designation of health officers. The local and municipal records suggested that the district health officer should be the secretary of the health board, with presidents of all *taluk* boards and chairpersons of all municipalities in the districts as members. They also suggested that the district health officer should be the secretary of the health board and its executive officer, but he should not be a member of the board.[99] The vaccinators continued to be paid from local funds under the control of local boards, but their work would hitherto be supervised by the district health inspectors.[100] The district health officers of Bellary, South Canara and Madura, were trained in the Madras Medical College (MMC hereafter) at the cost of the respective district boards, and other three were in the Nellore medical school, with the Godavari district board paying their stipends.[101] The medical subordinates were placed at the discretion of the hospitals and dispensaries in different positions as per requirements of the localities. The number of local residents showing interest in medical training was increasing every year as well.[102] The control of the local inhabitants over the lower level of administration had its impact on the medical boards and health boards in the districts and taluks. Youths belonging to the southern part of British India were becoming educated and trying to control the local politics, rather than joining the military forces where few opportunities remained.

There were about 23 appointments reserved by the government for military assistant surgeons (including the charge of the government house dispensary) initially, but by 1905 the number was increased to 27. This arrangement, which had been in force since 1892, was intended to provide enough reserve of warrant medical officers for duty during wartime. It was an essential part

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[99] Public Health Department: Report of the Director of Public Health (Madras, 1911-1920), IOR/V/24/3704, APAC, BL.
[100] Ibid.
[101] Ibid.
[102] Ibid.

of the original scheme that the local governments did not point out to the GoI in 1896 but accepted the additional charge as they considered it the duty of the provincial governments to assist in the maintenance of a war reserve. The professional qualifications of military assistant surgeons were inferior to those of civil assistant surgeons, but the scale of pay had been considerably higher.[103] Despite the fixed lower pay, working as civilian medical officers proved more financially viable for the local people because of the added advantage of conducting private practice.

With time, new regulations were issued, which made it possible for the local governments not to mandatorily employ military assistant surgeons. This, in turn, diminished the prestige and demand of the medics in military employment. But, the local governments were bound to employ a certain number of officers belonging to the IMS.[104] The focus was slowly but steadily shifting towards giving civilian doctors higher acceptability in the rural areas of Madras. The standard of teaching at the medical schools had been raised significantly during the last decade of the nineteenth century, and a much higher standard began to be expected from candidates for the diploma of Licentiate Medical Practitioners (LMP hereafter). In fact, it had been suggested that the cadre of assistant surgeons could, without any serious inconvenience, be abolished entirely and sub-assistant surgeons appointed in their places.[105] The committee in charge disagreed that the sub-assistant surgeons were competent enough to be considered for positions held by the IMS officers. However, the committee was willing to substitute assistant surgeons with sub-assistant surgeons in a few of the hospitals and dispensaries in the presidency, and the surgeon-general was given the power to appoint competent people for this work.[106]

The medical services were increasingly becoming important in the Madras Presidency and were constantly motivated by the government to undertake health measures. The opening of several medical research institutes from the late nineteenth century like the Pasteur Institute of South

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[103] *Grievances of the Surgeons, Indian Medical Service* (Lahore: Civil and Military Gazettes Press, 1883).
[104] *Ibid.*
[105] *Statement of the position of the officers of the Army medical Staff with special reference to service in India,* 1-7.
[106] Report of the Director of Public Health (Madras, 1911-1920), IOR/V/24/3704, APAC, BL.

India, Coonoor in 1907, and the King Institute of Preventive Research and Medicine, Guindy, in 1899 also point towards the rising prominence of civilian healthcare.[107] A few other specific medical institutes like the ophthalmic hospital was also set up in the twentieth century, with active support from the provincial government.[108]

It has been explained earlier in the chapter that unlike the northern regions of British India, Indianisation of the Madras army took a different route as Punjabis were sent from up north to replace the soldiers from Madras, ensuring the dominance of martial races in all contingents. In the context of Madras, the recruits were mostly seniors who had been in service for a considerable amount of time and were better suited to keep the regiments under control with little engagement in the war fronts.[109] The display of bias against the *sepoys* of the Madras army had become evident with the way the regiments began to be converted if not disbanded. Between 1890 and 1903, 17 Madras regiments were converted into Gurkha or Punjabi dominated ones.[110] Although, during the same period, the Madras Sappers were earning many accolades for the services rendered to the British Crown. By 1911, they were named 'Queen Victoria's Own Sappers and Miners', which as the name suggests, was a very prestigious title.[111] However, the British policy of army recruitment was adopted strategically to their needs of conquest. The southern part of British India acted as their recruiting base when they were fighting in Carnatic and the peninsula, after that it gradually shifted northward following the conclusion of Anglo-Mysore wars. It was easier and more economical for the British to recruit men from the north as they were required for wars fought in the

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[107] These two institutes established within eight years of one another influenced the medical structure and improvement of the Madras Presidency in a massive way.
[108] Report of the Director of Public Health (Madras, 1911-1920), IOR/V/24/3704, APAC, BL.
[109] Major General J. Michael, "The Native army of Madras: Organization, Equipment, and Interior Economy," *RUSI* 32, (1888): 329-63; Major General Sir George MacMunn, "Indianization of the Indian Army," *Blackwood's Magazine* no. MCCCXIII, (1925): 419-428.
[110] *Statement of the position of the officers of the Army medical Staff with special reference to service in India,* 1-7.
[111] Ramachandran, *Empire's First Soldiers*, 138-145.

north and northwest, and the locals of those areas were also willing to join the forces after the Gurkha and Sikh wars.[112]

Captain D. P. Ramachandran has argued that southern parts of British India were more conducive to better education, and this was a major reason that opened up new employment opportunities that were more lucrative and prestigious for the educated youths from the Madras Presidency.[113] The higher level of education among the southern youths also encouraged the British to recruit them for technical purposes or medical purposes rather than as infantry troops, for which they could recruit from anywhere else in the country. Thus, even though the implementation of the martial race theory had provided the base for army reorganisation and change in recruitment strategy, in certain ways, it proved beneficial for the youth of the Madras Presidency.

The British military officers wanted to glorify their own regiments as that would enable them to progress in their career. With more wars and campaigns in the north and north-west of colonial India, many British officers began promoting a myth of the superiority of the *sepoys* from the northern areas, over the recruits from the south, claiming that the former possessed loftier martial traits.[114] This propaganda that began initially, for logistical and economic benefits to the GoI, over the course of a few years began to be completely misinterpreted. Thus, rather than being militarily ineffective, there were more practical immediate reasons for the decline of the Madras *sepoys,* such as the presidency being 'far from the frontier, the traditional training ground of the Indian Army', from the later part of the nineteenth century.[115] The educated youths of Madras were eager to secure their future, and most of them coming from a relatively poor background,

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[112] *Ibid.*
[113] *Ibid*; Stephen P. Cohen, "The Untouchable Soldier: Caste, Politics, and the Indian Army," *The Journal of Asian Studies* 28, no. 3 (May 1969): 453-468.
[114] Ibid.
[115] D. M. Reid, *The Story of Fort St. George* (Madras: Diocesan Press, 1945).

began to join other employment options available under the Madras government including health services, civil services and other administrative departments.[116]

3.5 Colonial medical employment in Madras: military and civilian perspectives

The presidency of Madras witnessed a transformation of medical care and policy in the late nineteenth-early twentieth centuries but a few decades passed by before this phase could reach out to impact the common people. This section, while pointing out the significance of Madras in embracing colonial medical care, does not deny the importance of the state policies that changed the medical scenario in the presidency. The civil medical administration, including sanitation, was entrusted to a singular head in the presidency in 1880. Following this, the GoI, along with each separate civil administration, had at their disposal a medical and sanitary adviser, aided by subordinate officers, controlling and harmonising the work of all medical and sanitary executive.[117] A plan was devised to understand the number of people that could be required by the different presidencies in the medical department. Colonel Balfour, the Surgeon-General of Madras, suggested a few changes regarding the amalgamation of medical services in 1882. For Madras, it was suggested that there would be a requirement of 95 surgeons and 178 assistant surgeons.[118] He estimated that the adoption of his proposed plan would involve – assuming that the increase applied to all medical officers in India – an increase of about Rs.13 lakhs per annum. But, he assumed that the GoI after full consideration would only sanction fewer medics citing financial constraints.[119] The proposal was, however, refuted by the government immediately and wasn't implemented until 1896.[120]

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116 Kaushik Roy, "The colonial Indian army: recruitment and command mechanism, 1859-1913," (PhD dissertation, Jawaharlal Nehru University, 2000), "Introduction".
117 "India in the Victorian Era," *BMJ* (June 1897): 1667.
118 *Report of the Committee appointed by the Secretary of State for India to enquire into the administration and organisation of the Army in India* (London: His Majesty's Office, 1920).
119 *Ibid.*
120 *Committee Report* (Shimla, Government Central Press, 1919), 11.

Most of the subordinate medical appointments in Madras, by the late nineteenth century, were under civil apothecaries, who were a class of officers holding an intermediate position between hospital assistants and assistant surgeons. These intermediaries were educated for the public service at the expense of the Government.[121] In 1888, the Madras government decided to recruit men for the department by public competition among candidates with recognised medical qualifications, but this project was never carried out, and the recruitment of apothecaries had practically ceased. The Governor in Council proposed the replacement of apothecaries by the civil assistant surgeons and assimilated the subordinate recruits in the process.[122]

The increasing interest of the people in western medicine is evident from the increase in public donations in support of the medical institutes and hospitals in the presidency during the period. There was also a significant increase in the number of fees collected from patients by the beginning of the twentieth century.[123] That the Madras government was eager to engage with more local people in the medical service was evident from the increase in the funds they were providing for medical purposes. From Rs 5, 18,580 in 1897, it was increased significantly to Rs 7, 79,525 in 1898, most of which was spent on infrastructure, revealing an institutional push for the development of the medical institutes.[124] Colonel Hendley, who was the Inspector-General of civil hospitals, was thankful to the secretary for putting in extra effort to set up medical institutions and improve their facilities.[125]

With a special army circular, the Governor General authorised certain modifications in the organisation of the apothecary class of the SMD.[126] Members of the apothecary class were to be employed in hospitals of the British troops and military and civil appointments, those in civil

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121 No. 253, 1903, Finance and Commerce Department, NAI.
122 Ibid.
123 India Medical Proceedings, Home Department, March 1900, Reports on Civil Hospitals and Dispensaries in India for 1898, BL.
124 Ibid.
125 No. 141, Public, 11 February 1901, Madras Home Medical Department, BL.
126 Ibid.

employment would be unavailable for serving in the army but for war requirement or any such urgent necessity. Thus, these appointments were made purely civilian with the focus on working for the civilian population.[127] Transfers from military to civil employment and vice versa could only be arranged by the surgeons-generals with the Bengal, Madras or Bombay in communication with the Surgeon-General of the British troops in India. The most important part was that no members of the SMD in civil employment was liable to be remanded to military duty even as punishment.[128] This marked a notable change among Indians, as those who were not willing to risk war or military duty were now relieved at being allowed to work in the medical department without being forced to join the military. The GoI also realised the importance of providing a sense of relief to the families as they did not specify the requirement of serving in the army, which received appreciation in Madras.[129]

In the late nineteenth century, the entire expense of the civil hospitals was borne by the government, but as time passed, municipalities were established, and they covered a portion of the cost. The successful functioning of the hospitals prompted the formation of branch hospitals or dispensaries in the smaller towns as well as villages. In most instances, especially at the outset, the opening of these subsidiary institutions was initiated through the influence or at the mandate of the district civil authorities.[130] As people became aware of the benefits of becoming a medic, numerous applications were made for the establishment of dispensaries. Some of them were established because of the desire of interested persons to extract favours from civil authorities, but most applications were bona fide expressions of the people's demands and aspirations. The government, therefore, instead of defraying the whole cost, was determined to implement a system of 'grant-in-aid rules' by which about one-half of the cost was defrayed by the government. The other part

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[127] Ibid.
[128] No. 617, Public, Ootacamund, 24 August 1894, L/MIL/7/171-180, BL
[129] Ibid.
[130] Home Department resolution listing appointments for commissioned medical officers, (1884-1901), IOR/L/MIL/7/161, BL.

was paid by municipalities, or by 'local funds' where there was no municipality.[131] The government of Madras directly appointed the medical officer and some of the servants, thus ensuring a certain level of qualification, as the medical officers were usually sub-assistant surgeons, 'native doctors', or hospital assistants, who had been educated at the government medical schools.[132] The dispensaries were built for the convenience of the general population of the presidency. The dispensaries had the means to provide good service, but the general consensus was that the civil hospitals offered more benefits than the dispensaries. This was because the latter could take in more in-door patients, who were fed, clothed and medically treated, whereas most of the dispensaries did not take in-door patients, and their capacity was also very limited.[133]

By the late nineteenth century, the AMD was becoming unpopular and was unable to attract enough recruits. The IMS, however, had been flourishing during the same period. The Secretary of State for War (Lord Lansdowne) addressed the Secretary of State for India on this matter, and the GoI eventually proposed a single medical service for the military and another one for the civil.[134] There was also the fascination of elite Indians to be treated by Europeans, which only intensified with the addition of new medical technologies at their disposal. The large hospitals were under direct European supervision and control while the dispensaries, because of their remote locations, were run mostly by Indians who were apothecaries or even compounders at some places.[135] The Madras government contributed 37%, and the remaining 63% came from the local and municipal bodies for the development of the Madras hospitals and dispensaries in 1903. A *BMJ* editorial commented that statistically these medical institutes were doing better every year but added that 'it is impossible to discover how far they adapt themselves progressively to the wants

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131 Ibid.
132 Ibid.
133 "Origin of progress of hospitals in India," *The Imperial and Asiatic Quarterly Review and Oriental and Colonial Record*, Second Series IV, nos. 7&8 (1892): 286-299.
134 No. 253, 1903, Finance and Commerce Department, NAI.
135 Ibid.

of the population and the advance of medical science and practice.'[136] From 1902, it was decided that civilian surgeons would be granted more freedom, and henceforth no officer of the Madras civil medical department would be placed in charge of a regiment without taking confirmation from the provincial government.[137]

There were articles in the *BMJ* about frequent discussions at the British parliament about the health policies to be implemented in Madras during the first decade of the twentieth century. The under-secretary faced questions regarding the employment of military doctors in the hospitals of Madras and for the abolition of race discriminations along with the opening of higher grades of medical service to Indian doctors. The response was not to the satisfaction as the *BMJ* article points out, yet, it was evident that the government was thinking about it.[138] The parliament in London was also discussing the issue of Indian medical men being allowed to be in positions of prominence without being a part of the IMS or be given only minor positions as before. The under-secretary Mr Hobhouse commented that the goal was to expand the number of hospitals and positions without restriction on the posts, but it should depend on individual cases.[139] However, this situation continued only until the outbreak of the WWI, when the GoI was forced to change their policies, and the medical practitioners had to be withdrawn from civilian services for war efforts.

3.6 Conclusion

This chapter attempts for the first time in the historiography of colonial Madras to establish a direct relationship between the army recruitment policy and the growth of medical services. It has been evident from all the evidence examined in this chapter that Indians (including the Brahmins and non-Brahmins) living in Madras experienced and facilitated a transformation of medical

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136 "Indian Hospital Reports," *BMJ* (1903): 819-820.
137 No. 141, Public, 11 February 1901, Madras (Home) Medical Department, APAC, BL.
138 "Medical Notes in Parliament," *BMJ* (1911): 460-461.
139 Ibid, (1909): 1566-1568.

practices in the late nineteenth and early twentieth century. The chapter has situated the context of the changing nature of army recruitment in Madras after the martial-race issue shaped the British policy, and how the local people were forced to leave their erstwhile secure jobs with the military and look for an alternative source of employment. The medical services flourished not only because the Madras government propelled their agenda, but more so as the colonised people were interested in making a mark and the medical services gave them the confidence of landing a long-term, stable, secure job. The people in this presidency preferred working in the medical services as it required better education and enabled more control over the local administration, and this suited their political and social motivation. Thus, Madras can be viewed as the cradle for western medical practices in colonial India, and the region had experienced a distinctive treatment in the context of healthcare under the colonial rule.

Reflecting on the situation in Britain during the period, the hospitals could be seen experiencing a massive overhaul in their nature 'from being marginal in health care, and they were becoming the focus of expertise and high-tech equipment. For doctors, hospitals became the places . . . where they gained experiences'.[140] Even though colonial India was unable to reap most of the benefits of the social and medical reforms that flooded Britain in the early twentieth century, Madras experienced a major change in attitude concerning their health policies. This reflection strengthens the arguments that colonial healthcare should not be understood as a monolithic, homogeneous concept and each presidency under their provincial governments encountered colonial medical care in contrasting ways. This chapter touches upon how the concept of hegemony was worked around, favouring those who knew the right people, and those, particularly in the upper echelons of the society, used it to their advantage. The way these upper echelons of the local population established their hegemony in the medical marketplace, especially in the rural areas will

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[140] Hilary Marland, "The Changing role of the hospital, 1800-1900," in *Medicine Transformed: Health, Disease and Society in Europe, 1800-1930,* ed. Deborah Brunton (Manchester; New York: Manchester University Press, 2004), 31-58.

be examined further in the following chapters where the contribution and changes in the medical services will be discussed. The later chapters will explore the medical services that were established in the presidency and how they evolved over the period under consideration over the extent of this thesis.

Chapter 4 – Monopolising healthcare: medical services in the Madras Presidency (1880-1935)

'The profession of medicine is distinguished from all others by its singular beneficence.'

- Sir William Osler[1]

The First World War marked a watershed in the context of healthcare and medical services in the Madras Presidency. But the War was not the only factor that altered the structure and organisation of the medical departments in Madras. What began as an effort on the part of the GoI towards finding better opportunities for the military officers and gradual disbandment of the Madras Army regiments provided newer avenues for local youths to rise in prominence in the eyes of the colonial government. The medical services experienced a massive trough in 1914, just before the War began due to rapid changes in policies and regulations by the GoI.

This chapter will examine the Madras medical services as they evolved before and after WWI. Medicine, in its so-called western manifestations, was increasingly becoming popular among the local people before the WWI and some sections of the local population in Madras had gradually begun to embrace the new medical advances. The previous chapter argued that the expansion of medical services in the Madras Presidency was intrinsically linked to that of the army recruitment procedure in the region. With the decline of the Madras army, the educated locals, with their comparatively higher standard of education when compared to most of their counterparts in the northern regions of British India, became interested in other government jobs including healthcare and administration. While colonial health efforts in the Madras Presidency have attracted only

[1] W. F. Bynum, "The rise of Science in medicine 1850-1913," in *The Western Medical Tradition, 1800 to 2000,* ed. W. F. Bynum et al. (New York: Cambridge University Press 2006), 211.

sporadic attention, the contribution of its medical services has witnessed even less scholarly interest.

Even though the IMS has received some scholarly attention, its interaction with the civilians and the attachment with the military have rarely been closely examined in the context of Madras. Apart from the elite medical services, the contribution of other so-called minor services like the SMS and the WMS have not been previously examined in the context of colonial India apart from some notable exceptions.[2] However, those important works have been conducted either on an earlier century or on a different province, making Madras a very significant yet predominantly unexplored region as far as scholarly work is concerned. This chapter will begin by examining the two elite medical services and how they catered to the army and civilian services in the context of Madras. With a focus on the medical services, the latter sections will focus on how the IMS ceased to cater to the army and started expressing more interest in the healthcare of both Europeans and wealthy Indian civilians. This, in turn, will examine, using evidence, how the Madras government was facilitating changes in attitude that led to a medical transformation in the presidency.

4.1 Medical services in the Madras Presidency

The medical services had been nurtured and developed throughout the colonial period in India, and it had undergone a regular and systematic transformation in its policies and structure. Following Mark Harrison's suggestion that it is essential to examine the context of medical services in colonial India by understanding their 'aspirations, priorities and grievances', this chapter will

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[2] Niels Brimnes, "Coming to terms with the native practitioner: Indigenous doctors in colonial service in South India, 1800-25," *The Indian Economic and Social History Review* 50, no. 1(2013): 77-109; Maneesha Lal, "The Politics of Gender and Medicine in Colonial India: The Countess of Dufferin's Fund, 1885-1888," *Bulletin of the History of Medicine* 68, no. 1 (1994):29-66; Anne Witz, "'Colonising Women': Female Medical Practice in colonial India 1880-1890," in *Women and modern medicine*, ed. Lawrence Conrad and Anne Hardy (Amsterdam; Atlanta, GA: Rodopi, 2001), 23-52; Madelaine Healey, *Indian Sisters: A History of Nursing and the State, 1907-2007* (India: Routledge, 2013).

offer a more detailed and comprehensive study in the context of Madras.[3] The 1880s experienced profound changes in the administration of public health in British India, and that is partly the reason for beginning this thesis from that period. Under Lord Ripon, the Viceroy from 1880 to 1884, a few 'controversial' changes in the local and judicial systems were introduced, much to the discomfort of Europeans in India.[4] These changes had a lasting impact on the medical administration and also on the way the medical services worked in the Madras Presidency. Historians have tried to examine and focus primarily on the IMS and the RAMC, the latter mainly in the context of the Army.[5] In the context of Madras, the SMD and the medical services for women patients contributed significantly, and they should be studied together in order to understand the real impact of medical services on the expansion of the medical marketplace and western medicine in the Madras Presidency.

Before delving further into the contribution of the IMS, it would be worthwhile to explain the two distinct medical departments that were considered elites and contributed in transforming the consensus about medicine, or to be precise, western medicine in the Madras Presidency.

4.1.a) The Royal Army Medical Corps: a background

The AMS in India was experiencing a difficult time in the 1880s. Their pay in colonial India was becoming considerably inferior compared to the comfort and lifestyle accorded to their counterparts in Britain. They were also required to serve in India for six consecutive years before they could seek transfer to any other preferred location.[6] This began to discourage most educated young

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[3] Mark Harrison, *Public health in British India: Anglo-Indian preventive medicine, 1859-1914* (Cambridge; New York: Cambridge University Press, 1994), 6-7.
[4] Lord Ripon is remembered in Indian context largely as the liberal Viceroy of British India in the early 1880s who applied Gladstonian principles of self-determination and sowed the seeds of provincial politics. For details see, Sarvepalli Gopal, "The viceroyalty of Lord Ripon, 1880-1884," (PhD thesis, University of Oxford, 1951).
[5] David Arnold, *Colonizing the body: state medicine and epidemic disease in nineteenth-century India* (Berkeley: University of California Press, 1993); *Imperial medicine and indigenous societies* (New Delhi; Oxford: Oxford University Press, 1989); Harrison, *Public health in British India.*
[6] D. G. Crawford, *A History of the Indian Medical Service, 1600- 1913* II (London: W. Thacker, 1914); *Roll of the Indian Medical Service, 1615- 1930* (London: W. Thacker & Co., 1930).

people from joining the AMS and resulted in some complaints being published in the *BMJ*. For about two years after 1887, there was not a single applicant in the AMD. Eventually, in 1898, officers and soldiers providing medical services were incorporated into a new body called the RAMC, and the first Colonel-in-Chief was the Duke of Connaught.[7] The discord between the GoI and the AMD in British India was very apparent in this period and has been referred to in various articles, correspondence, and letters in the *BMJ*.[8] Letters to the journal expressly described how the AMD was committed to making the GoI look after the European soldiers posted in India. There were many issues which created a challenging environment for army surgeons in India; the issue of private practice was the most important among them. Army surgeons, who were all Europeans, faced the threat of being debarred if they were caught engaging in private practice.[9] All these factors contributed to the AMD becoming a less impressive job option for the European doctors. This forced the GoI to impart increased responsibilities to IMS recruits and form a separate cadre of medical officers for the army.[10]

From the twentieth century, the RAMC played the most significant part in looking after the British army in India. The RAMC was exclusively military and solely concerned with the care of British troops. It formed part of a powerful and highly efficient corps which was entrusted with the medical and sanitary care of the British army in all parts of the world. In India, its strength was determined by the WO, which nominated the officers detailed for duty. The standard length of service in India for an RAMC officer was five years; extendable to seven years of service.[11] Immediately following the Great War, the sanctioned establishment of RAMC officers in British India was 320 where 15 were in staff appointments, and the rest performed executive duties.[12] The arrangement was such that for every thousand British troops garrisoned in India, four RAMC

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[7] "The Indian Medical Service," *BMJ* (June 1885): 1315-1316.
[8] Ibid; "The Madras Civil Medical Department," *The Hindu* November 21, 1892, 4.
[9] Ibid.
[10] Ibid.
[11] *Medical Services Committee Report* (Shimla, Government Central Press, 1919), 9-15.
[12] Ibid.

officers were covered for leave reserve and casualties but did not provide any war reserve. Thus, it became difficult for the RAMC to have sufficient war reserves, and during the Great War, most of the civilian medics ended up working for the military as well.[13]

4.1.b) Indian Medical Service: role and structure

The IMS was the elite medical service in British India, and according to D. G. Crawford[14], they were a mixed military and civilian service.[15] Disputes arose regarding the role of the IMS officers and whether they were affiliated to military or civilian medical services. Although the IMS recruits were liable for military duty in times of need, they became primarily a civilian medical service from the late nineteenth century with the declining popularity of military medical appointments. One of the major reasons why the AMD lost its prestige and attraction was the lack of private practice and steps taken by the GoI to bestow more importance and power on civilian medical officers. Major McCarrison pointed out, writing for the *IMG* that western medicine was represented in British India by about 1,000 British medical men, the vast majority of whom belonged to the IMS, and that meant 1,000 men had to cater to a population of 300 million.[16] Thus, it was apparent that Indians were required to take up the mantle and the vast majority of them were required for medical services, which were also encouraged by the GoI. The GoI was looking for perfect utilisation of available resources; and keeping a war reserve was not something they were looking forward to.[17] Thus, they were more interested in having the medical corps for the IMS but not for the RAMC, as the IMS recruits could work for civilians and also serve the military should the need arose – as it did during the Great War.[18]

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[13] Ibid.
[14] Dirom Grey Crawford was a British physician and officer of the Indian Medical Service. He rose to the rank of lieutenant colonel before retiring in 1911. For a report on him see, W. R. Le Fanu, "Dirom Grey Crawford, 1857-1942," *Medical History* 2, no. 1 (1958): 66-67.
[15] Crawford, *History of the Indian Medical Service*, 249.
[16] "India and Medical progress," *IMG* (1917).
[17] Ibid.
[18] Ibid.

The IMS was not a monolithic structure either, and recruits acted differently in various provinces and from case to case. After Lord Morley's (Secretary of State for India) intention and proposals were made public, concerns regarding the future of the IMS gave rise to uncertainty among European recruits. The Morley-Minto reforms of 1909 advocated that more Indians should be involved in governing British India.[19] Several articles in medical journals expressed discontent towards the new policies of the GoI, which made medical service personnel develop a sense of animosity towards the government.[20] This led to an increase in the number of Indians joining the IMS, and the Indian private practitioners who had been growing in numbers for some years also received a major boost.[21] GoI reports praised the quality of the Indian doctors and the acceptance that they enjoyed among their fellow-country people.[22] Although the GoI fixed private fees and practice, the lure of private practice and extra money were persuasive enough for Indian doctors to pursue medical services in large numbers.[23]

After the reorganisation of the British Indian army, the medical organisation also experienced wide-ranging changes. The officer at the head of the IMS was designated as the Director-General while the individual civil surgeon generals headed the Madras and Bombay presidencies. Apart from four surgeon-generals, there were twenty-one administrative medical appointments in the army, of which ten were held by RAMC and ten by IMS, and one appointment was reserved for a Lieutenant Colonel of the IMS.[24] This chapter will limit its discussion to the 'elite' section of the medical services, and the subordinate and women medical service will be examined in the latter chapters.

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[19] The Indian Councils Act 1909, commonly known as the Morley-Minto Reforms (or as the Minto-Morley Reforms), was an Act of the Parliament of the United Kingdom that brought about a limited increase in the involvement of Indians in the governance of British India. Courtenay Ilbert, "The Indian Councils Act, 1909," *Journal of the Society of Comparative Legislation* 11, no. 2 (1911): 243-254.
[20] "A History of the Indian Medical Service," *BMJ* 1, no. 2822 (January 1915): 211-213; "Civil Medical Institutions in Madras," *The Hindu* November 19, 1908, 11.
[21] *Committee Report*, 14-15.
[22] *Committee Report*, 15.
[23] *Ibid.*
[24] D. G. Crawford, "The Indian Medical Service," *IMG* (May 1907): 192-198.

4.2 The Indian Medical Service until the Great War

In the years 1879 and 1880, the question of amalgamation of the IMS and the AMD became the centre for discussion among authorities in London and British India. Medical journals such as *The Lancet* discussed how Indian newspapers were arguing in favour of the amalgamation.[25] The GoI was considering uniting IMS with the AMD to form one centralised Imperial Service for British India. This was the time when a rather uncomfortable relationship between the AMD and the GoI became apparent. This became evident from the way GoI was pushing for higher control and changing the medical services in British India. An editorial in *The Lancet* declared in 1885 that, '… the GoI was fully impressed with the necessity for a radical reform of the Medical Service, . . . but were not, however, satisfied with the scheme proposed by the Commission'.[26] The GoI wanted two specific changes, 'first, there should be only one Medical Service for the country and secondly, the complete authority over the Medical Service serving in British India, beginning from employment, distribution to remuneration, should rest with the GoI'.[27] A memorandum was submitted to the GoI drafted by Dr D. G. Crawford, and Dr Cunningham, Surgeon General with the GoI that recommended the single medical department. Crawford, in his book, explained that the idea was to have two separate branches of the department; one for general and another for Indian service.[28] The Indian branch was supposed to be made available for service in any part of the Queen's dominion during times of emergency. Their idea was to form the service, which would primarily be military but would also be allowed to work for civilians. The recruits were liable for military duty during the first two years, and after successful completion of the language test, they could join civilian services.[29] They could be called back to military service at any given time in case of an emergency. During the 1880s, there was no option given to the local Indians to join the IMS,

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[25] "The Services," *The Lancet* 118, no. 3034 (22 October 1881): 731.
[26] "Army and Indian Medical Services," *The Lancet* 125, no. 3210 (7 March 1885): 444-445.
[27] Ibid.
[28] Crawford, *History of IMS*, II. 298-300.
[29] *Ibid.*

and these debates and discussions among the British officials were only to decide on their European recruits. At the local level, as Harrison has argued, public health work was conducted by civil surgeons or, occasionally, by the 'Executive Officers of Health' (modelled on British medical officers), who were employed directly by municipalities rather than the provincial Government.[30]

While top policymakers had heated arguments about their control and authority over the medical and military services, recruits were becoming disillusioned with employment opportunities in the IMS. Harrison has studied complications regarding the salary of IMS recruits during the 1880s and how they were paid almost double the amount offered in Britain.[31] However, a closer look at the sources indicates that grievances were rising among the recruits, even after being paid handsomely as they were paid in full only after their successful completion of a language course.[32] The ones siding with the medical officers were of the opinion that the GoI was inconsiderate and at times the recruits had to travel from as far as to Calcutta in order to get their appointments, and the government on most occasions was unwilling to provide any support.[33] The amalgamation of the IMS and the AMD had long been the source of conflict amidst deliberation within the GoI. On examining the government orders and files of the period, and also as various other historians have suggested earlier, the military department in British India was in charge of implementing new rules and recruiting cadres in terms of medical services until the late nineteenth century.[34] In 1884-85, the IMS military recruits stood at 191 increasing to 206 by 1899; while the civilian recruits received a much higher proportionate growth in the same period from 298 to 328.[35] According to the Secretary of State for India, the increase in the number of civilian IMS officers was because of

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[30] Harrison, *Public Health*, 9.
[31] *Ibid*, 10-11.
[32] "Civil and Military Notes," *IMG* XVIII (26 April 1883).
[33] Ibid.
[34] Wald, Vice in the Barracks, 1-15; Peers, *Between Mars and Mammon*; Wilson, *History of Madras Army*; David Omissi, *The Sepoy and the Raj: The Indian Army 1860-1940* (Houndmills; Basingstoke; Hampshire: Macmillan in association with King's College London, 1994).
[35] Military Department, no. 185, Secretary of State for India to Lord George Francis Hamilton, 1899, NAI.

the change in the GoI policy.[36] The IMS officers were classified broadly into two categories; first, for special appointments in medical colleges and from those places they couldn't be removed even during wartime, the second class of appointment included ordinary appointments, and these positions were handled and controlled by subordinate medical practitioners during wartime.[37] This continued to impact further government policies as there was always the issue of exhausting army reserves in times of war. The Royal Warrant of 1887 revised the rules for promotion and precedence in the IMS. The conflicting demands and requests of the recruits were important in changing the rules, as another Warrant was released in 1889, which allowed extended power to the officers of the IMS to command military hospitals in places.[38]

Another dilemma was burgeoning among medical officers concerning the additional prestige of the military medical officers and the apparent lack of it in civil titles. Initially, medical officers associated with the army were dissatisfied with the use of their medical titles, and they wanted to stick to their military titles, but in 1891, a further Royal Warrant introduced the word 'surgeon', and this was combined with the appropriate army ranks for individual designations of the army and civilian medical officers.[39] This move was made to increase the sense of prestige and importance among the MOs. As Erica Wald argues, British officials were more often concerned about their prestige and were keen to maintain their status quo regarding 'class prestige' during their stay in the colony.[40] There were also detailed discussions in the colonial documents about recruiting a single IMS officer in charge of both the European and 'native' regiments in certain places, and how that would allow the GoI to hire extra local doctors for civilian services in other positions that they considered 'less important'.[41] At the same time, there was also a proposal in

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[36] Ibid.
[37] Ibid.
[38] Military Department, April 1896, no. 1945, NAI.
[39] Donald McDonald, *Surgeons Twoe and a Barbar: some account of the Life and work of the Indian Medical Service (1600-1947)* (London: Heinemann, 1950), 140-151.
[40] Wald, *Vice in the Barracks*, 1-15.
[41] L/MIL/7/181-183, From Lieutenant-Colonel CF Thomas, to the Secretary to Government, Military Department, 27 October 1890, APAC, BL.

place to increase the number of commissioned medical officers in the Madras Presidency, with the rising demand for civil medical care.[42] The idea of prestige as has been mentioned here remained paramount, and so did the division between the covenanted and uncovenanted appointments among medical officers which led to clashes later on.[43]

As has been discussed in Chapters 2 and 3, the military and civilian medical services constantly struggled for supremacy, led on by their officers. In Madras, the situation was getting worse at the turn of the twentieth century. The army was eventually divided into four commands or army corps – Punjab, Bengal, Madras and Bombay in 1895. This necessitated a change in the role of the Surgeon Generals in each presidency. The designation for the person-in-charge of the presidencies was changed, and instead, Principal Medical Officers were appointed from the army medical staff and the IMS.[44] The Royal Warrant of 21 October 1895 allowed exchanges and transfers between officers of the IMS and the AMD as long as they were below the rank of Surgeon-Major with less than seven years of experience.[45] In 1895, the GoI began to think seriously on the question of amalgamation of medical services. The Secretary of State, Lord Hamilton wrote to the Governor-General of India in 1895 stating that the GoI should inform provincial governments of this decision and the Surgeon-General with the GoI would be the head of the amalgamated service, but his designation would be changed into Director-General, IMS.[46] The amalgamation was being planned from 1889 and became effective in 1896, which in turn affected a series of changes in the medical services. The medical and military titles were amalgamated as well, such as the designation of Surgeon-Lieutenant began to be used.[47] The local level public health work was conducted by civil surgeons who were appointed generally by the local municipalities rather than provincial

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[42] Ibid, J. F. Price to secretary to the GoI, September 1892, APAC, BL; "Indian Medical Service," *The Hindu* November 28, 1891, 6.
[43] Ibid.
[44] Wald, *Vice in the Barracks*, 1-15.
[45] *Ibid.*
[46] Military Department, April 1896, Nos. 1945, NAI.
[47] Ibid.

governments.[48] This arrangement, however, was in place across the country but Madras being more dependent on local authorities as described in Chapters 2 and 3, was much more open to getting practitioners from outside the IMS.

With the turn of the new century, local administrators were showing more interest in finding medical practitioners who were not liable to be working with the army and could work independently. Lord Morley was quoted in a despatch by Lord George Hamilton in 1900, which declared:

> It would be of such great benefit to India generally that medical men should establish themselves in private practice in the country in the same way as they do in other parts of Her Majesty's Empire without entering the medical service connected with the Army, that I am unwilling to accept proposals based on the assumption that sufficient medical qualifications will never be found in India or elsewhere outside the Indian Medical Service.[49]

It was explained in Chapter 3 that the GoI was pre-empting a Russian threat to British Indian borders through mobilising the army and strengthening army reserves. However, the importance of private practices and civil surgeoncies' was recognised by them, and British administrators were willing to secure the services of qualified civil medical practitioners without putting the pressure onto medical officers working with the military department.[50]

The amalgamation of the medical services in colonial India ushered in a new era in healthcare services; however, new diseases plaguing the country from the late 1890s stretched the medical services to their limits.[51] New diseases and the continued reliance of local people on wes-

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[48] Harrison, *Public Health*, 9.
[49] Mcdonald, *Surgeons Twoe and a Barber*, 157.
[50] *Ibid,* 158-159.
[51] *Ibid.*

tern practitioners expanded the market for the western-trained officers of the IMS. Growing importance and engagement of the IMS were benefitting Indian recruits, and they continued their hard work and efforts to succeed, eventually beginning to subdue the interest of Europeans in joining the IMS. The IMS constituted one of the most important services under the Home Department, and Indians became eligible for recruitment in that service as late as the end of the nineteenth century. There were shifts in the hierarchy and structure of hospitals and dispensaries in 1898-99, as there were changes depending on the demand of the local hospitals and dispensaries.[52] The period also witnessed shutting down of dispensaries for want of funds, and there has been continuous discontent regarding the reorganisation of medical services.[53] The situation was further aggravated by rising tension in Europe and on 11 December 1908, Lord Morley issued the order to stop further appointments in the civilian department of the IMS.[54] There were some officers in the IMS aware of the rising tension and competition among the Indian assistant surgeons to gain more prominence or to have more control in the administrative set up.[55] However, with the rise in medical recruitments, they were shifted to different departments and civil surgeons no longer felt as important as they had done in the late nineteenth century. In 1912, about five percent of the IMS recruitment was Indians.[56] The table below shows the growing importance of civilian medical officers for specialised departments while there was not much interest and importance given to them being civil surgeons. The IMS was gradually becoming a far less important and attractive job opportunity for the Europeans, because even with the rising number of civil hospitals they still had to compete with a large number of graduates from Indian medical schools, and also with 'doctors' without valid qualifications posing as 'trained' among the local people.[57]

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[52] V/24/308, Local Administration, APAC, BL.
[53] Ibid.
[54] Mcdonald, *Surgeons Twoe and a Barber*, 158.
[55] L/MIL/1-14160, Copy of confidential letter from Lieutenant Colonel Donovan, BL.
[56] Military Department, No. 210, 16 May 1911, NAI.
[57] Harrison, *Public Health*, 12.

Table: 4.2 (i) (Total medical appointments in 1885 and 1912 in Colonial India)

	1885	1912
Administrative officers	7	10
Civil Surgeons	167	165
Professors	24	35
Asylums	2	6
Jail department	19	37
Chemical analysers	4	6
Foreign department	27	36
Sanitary Department	20	24
Resident hospital and other college appointments	5	18

Source: IOR/Q/2/4/14, Notes on IMS and SMS, 1912, APAC, BL.

This move, as has been explained before, was making it harder for the civil surgeons to make a living out of their private practice. Harrison has also pointed out that the slowness of the promotion was another reason for discontent and uncertainty among Europeans about the prospect in the IMS.[58] In 1906, the *Journal of Tropical Medicine* pointed out, 'Once in the service stick to routine work, preferably on the military side, as the civil branch no longer presents any particular pecuniary advantages . . . above all, avoid suspicion of originality or special ability in any direction'.[59] The IMS was becoming an unpopular area of employment, and that was evident from the decline of the recruitment of the IMS officers from 1885 and 1912.[60] Thus, there were divergences

[58] *Ibid*, 13.
[59] "The Depreciation of the attraction of the Indian Medical Service and its remedies," *Journal of Tropical Medicine* (February 1906): 38-40.
[60] Ibid.

in the success story of the medical services, and they were hardly a place of unrestrained progress in colonial India.

4.2.a) Condition in the Madras Presidency – leading up to the First World War

It has been pointed out before that civil surgeons were more extensively recruited in all branches of civil medical employment. In Madras, the civil surgeons were known as 'District Medical and Sanitary Officers' in the districts while in the towns they were known as the 'Presidency Surgeons'.[61] Thus, practically, the civil surgeon was the medical and sanitary officer of a district and had to fulfil many functions; he was the medical attendant of the higher grades of government civil officers who were entitled to free treatment. He was the sanitary officer of the whole district, and was held responsible for vaccination campaigns; alongside he was also the medical officer of the *Sadar*[62] hospital at the headquarter station and had to exercise general supervision over all the dispensaries and their staff.[63] He was also usually the superintendent of the district jail, and this was one of the most onerous of his duties and one which demanded unremitting attention. He was the official medico-legal expert and was constantly brought in contact with the judicial department and the police, and it was not unusual for him to submit a full report on two hundred post-mortem examinations in a year.[64] In addition, civil surgeons sometimes supervised lunatic asylums or acted as the superintendent of medical schools for the education of sub-assistant surgeons.[65]

There were quite a few people assisting the District Medical Officer in his duties, including a staff of subordinates – the military and civil sub-assistant surgeons, compounders, vaccinators and menial hospital staff; the civil surgeon acted as the commanding officer of these people in the district. This chapter has explained how the recruitment of civil surgeons was decreasing in the

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[61] Major B. G. Seton and Major J. Gould, *The Indian Medical Service* (Calcutta and Simla: Thacker, Spink & Co; London: W. Thacker & Co., 1912).
[62] The main hospital at the district headquarters was called the *Sadar* hospital.
[63] Seton and Gould, *The IMS*, 1912.
[64] *Ibid.*
[65] *Ibid.*

twentieth century, but that was not the case with Madras. In 1912, the Madras Presidency had the largest concentration of civil surgeons in British India – the maximum of them being employed in the city. This could also be the result of a significantly low number of army cadres and the increasing importance and expansion of western healthcare practices in the presidency.

Table: 4.2.a (i) (Number of Civil Surgeons employed, 1912)

Bengal	13
Punjab	16
Central Provinces	14
Madras	28

Source: [Major B. G. Seton and Major J. Gould, *The Indian Medical Service*, (Calcutta and Simla: Thacker, Spink & Co; London: W. Thacker & Co., 1912)]

The civil surgeons had their own class distinction too; to graduate into becoming a first-class surgeon, they had to clear the vernacular examination of respective regions.[66] The IMS started becoming more influenced by the policies executed by the GoI, which led to the change in attitude regarding medical registration. There were instances of medical practitioners, adept in Homeopathy, Unani or Ayurveda being subjected to 'unfair' treatment by being refused official recognition.[67] Such cases were prevalent in Madras, but more prominently in suburban areas where the need to reach out to local people was far greater for western medicine to establish its monopoly in the presidency. The local newspapers articles were showing interest in getting more medical aid and provisions for the expansion and betterment of healthcare, reflecting the demand of the local

[66] *Ibid.*
[67] G.O. 409 (Medical), 7 August 1920, TNSA.

population.[68] The medical service was initially opened up to competitive examination in 1855, but in the twentieth century, there had been few applicants. Roger Jeffery has mentioned that by even 1905, only 5% of the IMS recruits were of Indian origin.[69] After 1905, following Secretary of State Morley's decision to limit the number of Europeans recruits, and with more Indians getting trained in western medicine either in India or in Britain, the number of Indians in the IMS increased at a substantial pace until 1914.[70]

The shift to the local and provincial medical services began with the rising Indianisation of the services. The concern over the quality of IMS recruits that stemmed from racial and ethnic issues received support from the GoI, and in 1912, a law was formulated to open up state medical positions for people coming through the provincial services.[71] The *IMG* volumes bear evidence that among the Indian and Anglo-Indian recruits in the IMS, it was a norm to retire early in their career.[72] This table identifies two issues – first, the increasing number of Indians in the IMS service while the other being the decreasing number of IMS recruits while approaching the Great War. This put an additional impetus on the SMS, which provided the incentive to more Indians coming out of Indian medical schools to join medical services in large numbers. They were also aided by the government regulation of employing trained practitioners from the provincial medical services.

Table: 4.2.a (ii) (Total number of Indian recruits in IMS)

	Total number of recruits	Number of Indian recruits	Percentage of Indians in IMS
1896-1900	147	3	3.4

[68] "Medical Aid in Madras," *The Hindu* October 22, 1914, 21.
[69] Roger Jeffery, 'Recognising India's doctors: the establishment of medical dependency, 1918-39,' *Modern Asian Studies* 13 (1979): 301-26.
[70] Ibid.
[71] J. A. Turner and B. K. Goldsmith, *Sanitation in India* (Bombay: The Times of India, 1914), 5.
[72] *IMG* (May 1913): 193; Anglo-Indians were those with mixed Indian and British ancestry. For a detailed understanding of them, particularly in Madras see, S. Muthiah and Harry Maclure, *The Anglo-Indians : A 500- year History* (New Delhi : Niyogi Books, 2013).

1901-1905	229	8	3.5
1906-1910	183	25	13.7
1911-1914	111	29	26.1

Source: Crawford, *Role of Indian Medical Service*, quoted in Harrison, *Public Health*, 32)

At the same time, IMS officers were also becoming wary about the increasing dominance and influence of medical subordinates in the districts, as R. K. Mitter, a Lieutenant Colonel wrote how a school master in Salem had the power to upset the decisions of the district surgeons.[73] So, it can be argued that it also changed the way Indians used to perceive medical services in British India. As Harrison argued, the process of Indianisation was also an attempt by the GoI to pacify the rising tide of nationalism across colonial India.[74] Jeffery also notes that most Indians were not comfortable with military medical services, and so the process of Indianisation was negligible before 1905 because the medical service was formulated primarily keeping in mind the military services of colonial India. When the focus shifted more towards the civilian medical practice, an increasing number of Indians became interested in it as medicine and medical services had traditionally enjoyed a position of reverence in colonial Indian society.[75] Both these arguments of Jeffery and Harrison fail to take into account the individual presidencies and attend broadly to the context of British India.

The IMS passed through both crests and troughs all through its existence until the outbreak of the War in 1914, and its nature changed drastically during the war as the war reserve, and the civilian medics were depleted to support the war efforts, which changed the structure and nature of work of the IMS. The dissatisfaction of British IMS officers initially stemmed from the

[73] Q/2/1/238, The Representation of Lieutenant Colonel R. K. Mitter to the Royal Commission on the Public Services in India, 1913, APAC, BL.
[74] Harrison, *Public Health*, 32.
[75] Jeffery, "Recognising India's doctors," 311.

increasing importance of the military medical officers and of the RAMC; with the Indianisation, reduced recruitment opportunities, and monetary benefits the discontent reached its peak.[76]

4.3 War and its aftermath: the changing role of the IMS

The IMS went through a massive change during the WWI in lieu of changes in its policies, structure and the modus operandi. During the War, most of the medical officers were engaged in treating army personnel, and officers had to be transferred temporarily from the civil sector to meet the rising demand of doctors. The conflict depleted the civil wing of the IMS, as the committee appointed for the reorganisation of the medical services reported. The officers who were involved with the civil medical services were called into action, and this allayed the discontent arising from increasing competition between the two medical services.[77] But, this was hardly a final or even a lasting solution, as the discontentment among IMS officers was not taken into consideration by the GoI. It can be argued that the War only delayed an inevitable rift that was always on the cards; however, the tumultuous period did not allow for the time to mend the weaknesses in the medical and military services which became more pronounced in the process.[78]

The same problems that disrupted the functioning of the IMS before the Great War continued afterwards as well. Demands for better pay and attractive packages were a constant source of disaffection among the administrators, health officials in the GoI and those in Great Britain.[79] The War not only depleted the civil side of the IMS but the grievances which were present until 1914 only became aggravated after it. The official statement for the Secretary of State for India Lord Montagu in 1918 stated,

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[76] *Grievances of Surgeons: Indian Medical Service* (Lahore: Civil and Military Gazette Press, 1883), Extracted from *The Pioneer*, 7 March 1883.
[77] *Committee Report*, 17.
[78] *Ibid.*
[79] Deputation to the Secretary of State for India, no. 56 (enclosure), 27 June 1918, Military Department, NAI.

> We have received a large number of letters containing cold details of the financial position of the writers, showing that they have been living on their savings or on their other sources of private income during the last three-and-a-half years, and are now heavily in debt. They complain that their services have not been used to the best advantage, and that they have been constantly superseded by officers junior to them in other branches of the medical organisation, and that they are not being paid a living wage.[80]

An official document from the provincial government in 1918 'pleaded' with the Secretary of State to pay some attention to the situation as the IMS officers were in a state of 'apprehension, unrest and despair'.[81] In the particular case of the Madras Presidency, Surgeon-General P. H. Benson pointed out the case of the local government. Early in 1918, his statement explained how deep the local politics had penetrated within the medical administration. He wrote,

> As the head of the scientific branch, the Surgeon-General has no access whatever to the Members of Council or the Governor; all his proposals are dealt with as a rule by a junior civilian, and afterwards handed over to the Member of Council who hold the medical portfolio. He not being fully possessed of the technical and scientific knowledge, which is required to deal with these matters, the proposals are generally shelved or are very often shelved, without proper justification. Another point I can speak of in connection, with that is the difficulty experienced by officers in getting leave, not only leave for furlough but leave for study, and that is entirely due as far as I know, to the deficiency in the cadre of the Indian Medical Service.[82]

[80] Ibid.
[81] Ibid.
[82] Ibid.

This explained the very complicated role taken up by the IMS officers as they played their part mediating between the top brass of British administration in India and the group of Indians controlling and commanding local political and medical scenarios. This was, however, specific to the situation in Madras with their strong local control over medical administration. Sir Berkeley, a Surgeon-General, voiced his concern in 1918 about the condition of the IMS and how difficult it had been in the last few years for Europeans to serve there.[83] He added that he had, of late, been sceptical about suggesting IMS as a career option to young European graduates – unlike earlier years.[84] Such trepidation resulted in a decline in the number of recruits showing their interest to join and serve in the IMS.

Following the Great War, the contribution of the civilian medical officers of the IMS was given much more recognition by the GoI and the military department. But a problem between military and civil wings arose when the IMS officers joined back into the civilian medical system of the Madras Presidency. The changes that followed in the administrative set up particularly following the 1919 Montagu–Chelmsford Reforms changed the way medical officers were recruited in Madras. This meant higher control of local administration in appointments of medical practitioners. The number of Indians on the civilian service in the IMS was on the rise, with greater local control.[85] Colonel Alexander Russell,[86] who had been associated with the public health in Madras for a few years, had claimed that the public health department in Madras was 'the best organised

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[83] Ibid.
[84] Ibid.
[85] Ibid.
[86] Colonel Sir Alexander J. H. Russell became the professor of Hygiene and Bacteriology at Madras Medical College between 1912 and 1917, and Professor of Pathology between 1919 and 1921. From 1913 to 1914 he was the Medical Officer of Health for Madras City; he became Director of Public Health in 1922 and between 1933 and 1939 he was the Public health Commissioner with the Government of India. For more details see, Colonel Sir Alexander J. H. Russell, GB 254 MS 131, University of Dundee Archive Services, 1923-1942.

in India'.[87] Colonel Russell and Colonel W. G. King[88] emphasised the importance of prevention in the public health sphere. King had been instrumental in establishing a preventive form of medical care in the presidency and established the King Institute of Preventive Medicine and Research in 1899 with the aim to offer protection against infections and diseases. They wanted to make the locals emerge from the fold of curative medicine and embark on a new path of preventing diseases. Russell later quoted,

> Until fifty years ago, medical science was looking through a glass dimly. Since then progress has been as swift as navigation by air, too swift in fact for a lone man to keep step with it all. Science still has its enemies, its fakes and fakers. During the last half century of discovery and development, curative medicine has made great progress. But we are now in the early morning of a new era, in the profession that of preventive medicine and preventive surgery. To bring modern medicine to the rank and file, to the masses at a cost at which it may be freely utilised was the challenge to the profession and it represented the greatest social and economic problem of the country.[89]

IMG reports maintained that even in the 1920s, what was regarded as modern medicine in the Madras Presidency was not entirely free from traditional beliefs and practices.[90] In colonial Madras, according to some commentators, the indigenous practitioners in rural areas were better than a few poorly trained practitioners of western medicine. Sir Pardey Lukis argued that he would

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[87] Editorial, *Medical Practitioner* 1 (1930): 209.

[85] [88] W. G. King retired from the IMS in 1910. He had worked extensively in Madras Presidency and it was partly through his labours and advocacy the research institute 'King Institute of Preventive Medicine and Research' was established. King Institute of Preventive Medicine and Research is one of the World Health Organisation authorised centres for issuing yellow fever vaccination and certificate. Further details available in the *Reports on the working of the King Institute of Preventive Medicine*, Guindy, Cambridge University Library.

[89] Editorial, *Medical Practitioner* 1 (1930): 209.

[90] "The Indigenous Systems of Medicine," *IMG* (April 1922): 141-142.

like to be treated by a good *Hakim* or *Kaviraj*[91] rather than a bad doctor.[92] This was, in a way, targeted toward the poor quality of recruits in the IMS, and also those acting as doctors without receiving proper degrees. These reflected the declining condition of the IMS and how the standard of the medical service was ebbing gradually. Generally, people in the southern part of British India had a higher level of educational attainment (in English and the vernaculars), and thus they could reach higher positions in administrative or healthcare administrations.[93] Dr T. R. Lakshmana Perumal Pillai was the first medical practitioner to obtain the title of Dewan Bahadur in British India.[94] The people of Madras were moving up in various administrative positions and had begun to display their skill in higher positions. After the Great War, the medical personnel in charge of the Madras city were not altered, but there was a massive change in the districts. Twenty-three headquarter appointments, and one Civil Surgency were formerly reserved for Commissioned IMS officers, and such a system made sure that there was always one trained European medical officer in each district.[95] In the new system from 1923, eight appointments were removed and were reserved for civil assistant surgeons of the provincial service, who were allowed to recruit in these positions.[96] This was also done as the number of European medical officers in the districts was diminishing and a list of 171 officers of the IMS who were available to be selected for appointment in such positions was published. Of these officers, 70 were Europeans and 101 Indians.[97] This shows that even among IMS cadres, the number of Indian recruits looking for employment opportunities were on the rise. There arose a sense of insecurity among the military medical practitioners, as after

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[91] 'Hakims' were the 'native' doctors and used to refer usually to the Muslim medical practitioners. Kaviraj used to refer to the Hindu medical practitioners who were not trained in the western methods and used local herbs and medical plants for treating people. For more information on the indigenous medical practitioners see, Anu Saini, "Physicians of colonial India (1757-1900)," *Journal of Family Medicine and Primary Care* 5, no. 3 (July-September 2016): 528-532.
[92] "The Indigenous Systems of Medicine," *IMG*, 141-142.
[93] Ramachandran, *Empire's First Soldiers*, 138-145.
[94] "Obituary Service Notes," IMG (1923): 239.
[95] Q/11-18, no. 671, Royal Commission on the Superior Civil Services in India, 1923, BL.
[96] Ibid.
[97] Ibid.

finishing their quota of military service when they were looking for civil appointments, the provincial recruitments were taking over most of those posts keeping the military officers still attached to the army against their will.

By 1924, most provincial administrators had realised that medical education in British India was not progressing in the right direction. Moreover, editorial columns of the medical journals were more often than not laden with apprehension and trepidation regarding the future steps in western health policies. The *IMG* demanded certain drastic steps that included gathering together the 'ablest' available men in the country for post-graduate teaching; these men would ideally teach from their own knowledge and experience and not rely only on what they had learnt decades back in medical colleges.[98] This step evinced the desperation of the GoI to look for qualified medical practitioners. There had been a call to look for a better quality of doctors, and this compelled the medical associations to make their effort and force the practitioners to develop themselves. The Director of Public Health, Bengal reportedly quoted,

> Besides being a healer, a saver, or saviour of his fellow men, a medical man must possess certain other special qualities of which we find some indication in our brief study of the derivation of the word medical. We saw that this word was closely related to the Latin word *meditare*, meaning to meditate; and to the Greek word *medos*, meaning care. Obviously, therefore, a medical man should be both a meditative man and a careful man.[99]

In the Madras Presidency, by 1923, the posts such as the director of public health and the assistant directors were converted into provincial posts, and only Indians were recruited for such positions. The director had to be an Indian from the provincial cadre, while all three assistant directors were to be recruited from the provincial service and only one was reserved for an IMS

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[98] "The Future of Medicine in India," *IMG* (1924): 563- 567.
[99] "The aims of a medical man," *IMG* (1925): 332-335.

officer.[100] GoI administrators were constantly facing issues with the IMS, and they were not showing any sign of becoming comfortable with the situation even as late as 1925. In this year the Secretary of State for India, Earl of Birkenhead, expressed his concern over the organisation of the IMS.[101] He believed the 1919 reforms further aggravated the crisis as the responsibility for appointing medical officers shifted under the provincial governments. The Secretary of State would no longer undertake to recruit officers for the provincial civil medical administration in India, or in particular for the civil hospitals as such, nor was he supposed to take responsibility for the medical care of British non-official residents in India.[102] The Secretary of State hoped for a change in attitude for the medical professionals in Great Britain and Ireland.[103]

There was rising discontent about the attitude of the Madras government as the western-educated medical practitioners were feeling undervalued and neglected as the medical marketplace in the city was getting more crowded with unskilled or semi-skilled medical workers controlling the rural areas. European medical personnel started to make their discontent more apparent and to protest against people who were selected provincially.[104] British IMS officers registered their discontent with government policies and went as far as threatening to leave the presidency, '. . . it will have little cause to wonder if the young British-born doctor turns his back on service in the Southern presidency'.[105] The officers were seemingly protesting against the indigenous medical practitioners, but their actual grievance was against the indigenous IMS and SMS officers, which becomes clear after scrutinising their discontent registered in *BMJ* issues.[106] There was a rising concern regarding lack of expansion of western medical marketplace in the mofussil, and attempts

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[100] Q/11-18, no. 671, 1923.
[101] "The Indian Medical Service," *IMG* (1925): 544.
[102] Ibid.
[103] Ibid.
[104] "The Madras Government and Indigenous system of Medicine," letter from R. H. Elliot, *BMJ* 25 (1924): 786-788.
[105] Ibid, 787.
[106] Ibid.

were made to counter in the Madras Presidency by subsidising medical practitioners.[107] The Madras government began to dole out subsidies for the IMS recruits to entice them to move to the rural parts of Madras; this was to spread out the medical market and expand the reach of western healthcare.[108]

There had also been the case of more Indians joining the medical services in the presidency and occupying most of the positions; this along with rising discontent among British medical practitioners gave Madras the license to experience a relatively independent medical profession run by Indians outside the city limits. The table below will point out how Indians were taking control of the IMS.

Table: 4.3 (i) (Number of Indians in the IMS, 1922-32)

	Europeans	Indians	Total
1922	326	35	361
1932	195	97	292

Source: John W. D. Megaw, *Note on Future of the IMS*, (Simla: Liddle's Press 1933?), 9.

The table reflects the changing demand of the IMS officers in British India and the decreasing number of recruits who displayed an interest in joining the department. The process of Indianisation had become more widespread, with a considerable number of recruits coming from the local regions. There was also a significant decrease in the number of Europeans interested in taking up these roles. Moreover, the news about reduced opportunities for wealth generation by private practice contributed to many people expressing less or absolutely no interest in being employed by the IMS in the twentieth century. This resulted in the positions being open to the Indians who found the prospect of civil employment more attractive than military medical ones.[109] Gradually, as the local and provincial governments began playing a greater role in employing medical officers

[107] "The Mofussil Dispensary," *IMG* (1927): 701-703; Muraleedharan, "Rural health," 323-334.
[108] Ibid.
[109] John W. D. Megaw, *Note on Future of the IMS* (Simla: Liddle's Press 1933?), 9-10.

in the districts and *taluks*, they started objecting to the idea of employing IMS officers in civil medical services.[110] These people were provided support by the local doctors who were mostly Indians and wanted to exert their control over positions available in the *taluks* and districts.[111] This idea of political control among Indian medical practitioners and the provincial administrators had become quite apparent, and medical officers began to utilise their roles in commanding control in rural medical marketplaces.[112]

The one major difference in terms of military medical treatment before and after the WWI was the establishment of the station hospitals and segregated facilities. These station hospitals replaced the existing regimental and follower's hospitals and made the situation of the Indian troops much more habitable in the cantonments.[113] It was decided that station hospitals for British troops would be called the 'British Station Hospitals' while the ones specifically designed for Indian troops would be called the 'Indian Station Hospitals'.[114] The system and line of command, however, would be similar in both the Indian and the British ones. It was also decided that all existing hospital arrangements for Indian troops and regimental or departmental followers would be brought under centralised administrative control exercised by the officer commanding the Indian station hospitals.[115]

The Surgeon-General for Madras recommended that all the medical institutions that focused their treatment on women and children at the *taluk* headquarters should be considered a part of the main *taluk* headquarter hospital.[116] Local control over medical administration was increased significantly, and it continued until the mid-1930s when another war was looming on the

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[110] *Taluk* in colonial India used to stand for a sub-division of a district, it was comprised of a group of villages organised for revenue or administrative purposes.
[111] Megaw, Note on future of the IMS, 9-10.
[112] Ibid.
[113] IOR/L/MIL/7/297, 1917-1932, Military Department, APAC, BL.
[114] Ibid.
[115] Ibid.
[116] Public Health, G.O. 897, 17 April 1928, APAC, BL; "Taluk hospitals and dispensaries," *The Hindu* September 19, 1930, 9.

horizon. Even with all the medical changes, the health service officials had always managed to exert their dominance, it started with the European medical practitioners initially, but in the latter period, the Indian practitioners also had their say, and most of it revolved around the control and provision of private practice.[117]

4.4 Role of private practice in shaping medical services in Madras

The medical service in Madras Presidency was attractive to IMS recruits because of the opportunity of private practice. The GoI and the Madras government had to consider cases of private practice and the fees that were charged by the IMS officers. The GoI in the early twentieth century was looking for monopoly; healthcare was one of the major aspects that the colonial state was trying to monopolise in Madras. Their interest in establishing a monopoly was not to bring all medical practitioners under their purview but merely to decide what kind of medical treatment would be accessible to the local residents, and thus set up the base for a western medical tradition. However, to be successful in their endeavour, the GoI had to keep its army of doctors, the IMS medics, in this case, content. Private practice was one of the major sectors that had been luring young graduates to join the IMS, and the relationship between the GoI and the IMS recruits and officers remained highly contentious and often incomprehensible.

The civil surgeon of Coorg wrote to the Madras city commissioner in 1903 that the GoI should not intervene in the issue of remuneration for private practice as it was a major attraction for the civil surgeons. He was of the opinion that there should be no distinction made on the basis of location and the civil surgeons should be allowed to accept the payment as it was given to them, or even charge their fees as they deem fit.[118] The Madras government was interested in making more money and also in spreading awareness about new medical technologies such as X-rays. This was also another way to monopolise the healthcare system of a colonial country. As early as 1906,

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[117] Ibid.
[118] Home (Medical) Department, No. 180, 5 August 1903, BL.

the government started to levy charges on the use of X-ray apparatus. It was fixed at Rs 15-30 depending on the area of diagnosis.[119] The final decision rested on the senior MO to decide the exact amount to be charged. But fees were charged only for private patients, not those admitted at the hospitals. This idea of charging money from patients reflected a change in the attitude of the Madras government, and also how the health policy shifted to a more overarching, institutionalised medical care, albeit being chargeable.

Since 1907, the growth of the IMS department was not that strong, particularly on the civil side. There was seclusion regarding private practice for the civil surgeons. They were classed into three groups – first, those people who were debarred from private practice, the second group of civil surgeons were those allowed only consulting practice, and the third division had no restrictions.[120] All administrative staff appointees, officers of jails, sanitation, asylum, chemical departments and resident physicians, surgeons of certain large hospitals including the professors of pathology, biology and physiology were not allowed to conduct private practice.[121] The rest of the medical practitioners were not allowed to engage in private practice without restrictions. Those who had no restriction on practice were very few in number; Madras had only one such practitioner.[122] Although the medical officers were remunerated for their official services, it was the private practice that they wanted to be engaged in for financial benefits. There were no specific duties of the civil surgeon that could be termed official; it used to depend on the size of the district where they were posted. Analysing the everyday duty of civil surgeons would explain how the appointment of Indians was essential and how they had the opportunity to play significant roles. While the civil surgeons had to attend headquarter and the police hospital daily, as jail superintendents, they had to visit the jails as well. They also had to inspect and report on every hospital and

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119 G.O. No. 750 (Public), 13 October 1906, TNSA.
120 IOR/Q/2/4/14, Notes on IMS and SMS, 1912, APAC, BL.
121 Ibid.
122 Ibid.

dispensaries four times a year which included the municipal, district, canal, railway and forest departments. They were also responsible for sanitary arrangements, water supply, and supervising vaccinations in his district. Thus, while the civil surgeons were engaged in such activities all year round, their official duties were carried out by the subordinates – the civil or military assistant surgeons.[123] The assistants, following the Great War and the changes in the recruitment process, were predominantly Indians, and they were entrusted with most of the medical duties in the absence of the Surgeon General or other higher MOs.[124]

After the Great War, the attention of the government of Madras and the medical officials turned more towards making money from medical treatment and diagnoses. However, the issue that remained persistent was to decide on the ideal rate of private practice provisions for the civil surgeons. Surgeon-General Benson argued that private practice was a privilege and people should be allowed to engage in it despite their positions.[125] The GoI, however, had already debarred a few positions (including that of the professors and sanitary officers) from private practice. The colonial government, however, continued their apparent benevolent nature and kept the treatment free for patients with a family income of less than Rs 50 a month. But, they were charged four annas[126] for every Rs 25 in excess of Rs 50 per month income, and it went up to Rs 2.50 which was decided as the full charge for treatment in the general ward.[127] This group of Indians who were in charge of the district hospitals and treatment became used to handling district medical administration along with local government bodies.

The GoI had classified the cases where private practice could be undertaken and the people who could access it included the families of government servants only by prior arrangements, the

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[123] Ibid.
[124] No. 56, 11 October 1918, NAI.
[125] Ibid.
[126] An *anna* was a currency unit formerly used in India and Pakistan, equal to$1/16$ of a rupee. It was subdivided into four *paisa* or twelve pies (there were 64 *paise* or 192 pies in a rupee). The *anna* was very lightweighted. The term belongs to the Islamic monetary system.
[127] Notes of W. S. Carter on Madras Medical College, Folder 65, Box 8, Series 464/464A India, RG 1.1, 1926, RF, RAC.

general public could be charged any amount, and finally, the workers attached with the mills, factories and railways.[128] Although, the later body of patients was on the decline as medical officers began to be recruited for full time by the factories, mills, and railways which brought down the chance of private practice for the IMS officers in such cases.[129] David Arnold has argued that higher caste Hindus and Muslim women were not willing to visit the hospitals, and their perception of hospitals and dispensaries until the late nineteenth century remained mostly unchanged.[130] While this was the case, these wealthy higher caste people were not completely averse to the idea of having physicians brought to their place for treatment.[131] Most of the educated and wealthy Indians were ready to pay a lot of money to be treated by European IMS doctors.[132] This became an important factor as it led to new opportunities for medical practitioners to flourish financially.[133] This allowed the European IMS officers to secure wealthy patients, especially outside the city limits, including the royal families, zamindars or rural elites.[134]

The Governor-General declared in 1909 that the GoI had fixed the fees for professional medical services by the IMS officers. These fees were unregulated before this, and the IMS officers were at times accused of overcharging their patients. The fee was fixed at Rs 500 for the first three days and Rs 250 every day after that.[135] This was only to be charged after a prior notice given to the local government, and this was done to regularise the income of the medical practitioners via private practice. The MO could only charge this fee in case of their continued absence from his headquarter, but for short visits, the doctors were still allowed to charge as they decided on a case-by-case basis.[136] Local governments were given the power to make their decision on the cases, and

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128 IOR/Q/2/4/14, Notes on IMS and SMS, 1912, APAC, BL.
129 Ibid.
130 Arnold, *Colonizing the body*, 258.
131 IOR/Q/2/4/14, Notes on IMS and SMS, 1912, APAC, BL.
132 Ibid.
133 Ibid; Notes of W. S. Carter on Madras Medical College, Folder 65, Box 8, Series 464/464A India, RG 1.1, 1926, RF, RAC.
134 Zamindars were the landowning rural elites in Colonial India.
135 IOR/Q/2/4/14, Notes on IMS and SMS, BL.
136 Ibid.

they had the right to know about case details from the IMS officers. This regulation, however, was not to the liking of many medical practitioners and the civil surgeon of Coorg wrote to the city commissioners asking the provincial government not to get involved in deciding the fees. He argued that private practice was the reason Europeans were joining as civil surgeons, and there should not be any forcible change in the system.[137] The South Indian Medical Union, consisting of local residents from the presidency, wrote a statement to the Royal Commission on the Public Services, requesting them to stop the formal medical services – both central and provincial – for allowing the private practitioners a space in the hospitals and dispensaries.[138] They argued that both the IMS and the subordinates were under a lot of work pressure while the private practitioners spread across the marketplace were capable enough to treat patients at the government facilities.[139] There was the request for initiating honorary positions at the civil hospitals, where both indigenous and Europeans practitioners could be allowed; the Union, however, knew well that if this system could be implemented most of the positions would be taken over by the local practitioners.

The *IMG* has shed light on the threat perceived by the IMS practitioners in colonial Madras. They were feeling the pressure from the increasing Indianisation as the medical services were getting filled with more and more Indians across the presidency. An idea was floated that the posts of Director-General of the IMS and Public Health Commissioner would soon be abolished and be replaced by two junior officers.[140] The European medical practitioners were distraught by the idea, and they wrote, that a strong medical representative was a necessity and although at that time it was occupied by a European, they 'feared' that it soon might be held by an Indian.[141] It was evident from their displeasure and open display of discontent that being led or commanded by an

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[137] Madras Medical, no. 180 dated 5 August 1903, BL.
[138] Q/SCS/20, Memorandum submitted to the Royal Commission on The Superior Civil Services in India, Venkataramana Raju Garu, 1923, APAC, BL.
[139] Ibid.
[140] "The threat to medical organisation in India," *IMG* (1931): 635-636.
[141] Ibid.

Indian was not something the European medical officers were looking forward to.[142] There were cases when the local government meted out differential treatment to people in terms of private practice, and that was not condoned by the rest of the medical practitioners. The superintendents of different departments were also permitted to engage in private practice, but the local government was vested with the authority to decide if the role was hampering his official duties. This created discontent among the other group of civil surgeons who were not allowed to practice privately.[143] During the 1930s, the focus was not only on the wealthy Indians as there was provision to earn more money from any individual who needed medical attention. More importance was given on institutionalising fee structure and to using new medical technologies as medicine had undergone quite a lot of change over the past couple of decades. [144]

Discussions continued around the quality of doctors and Madras was the perfect place to put the plans into action. A Medical Examination Committee was established in 1929, and they declared that 'the Presidency did not so much need more doctors as better doctors'.[145] They claimed that an average medical man, when not trained properly, would degenerate and eventually would be hardly any better than the quack he was intended to replace.[146] The reach of western medicine, however, could be grasped from the number of medical institutions in the rural parts of Madras Presidency. According to the annual report of 1934, there were 1,091 medical institutions in rural areas and 246 in the urban region.[147] Thus, even though with a constant focus and interest of the medical practitioners to work in the urban spaces, the rural areas had provisions for the expansion of the marketplace. This constant tussle concerning private practice and benefit of the

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142 Ibid.
143 Mcdonald, *Surgeons Twoe*, 140-151.
144 Local Self-Govt. Department, Public Health, G.O. No. 610, March 1932, BL.
145 Mcdonald, *Surgeons Twoe and a Barbar*, 238.
146 *Ibid.*
147 "The annual report on the working of the civil hospitals and dispensaries in the Madras Presidency for the year 1932," *IMG* (1934): 293.

medical practitioners remained one of the chief concerns for the Madras government, and it played a major role in shaping their medical policies until the mid-1930s.

4.5 Conclusion

By the end of the nineteenth century, the institutions and practitioners of medicine were much more closely intertwined with nation-states than they had been half a century before as scholars have argued.[148] That had been manifested with the expansion of medical services for the poor, developing contractual forms of payments, higher regulation in medical licensing and qualifications, the surveillance of infectious diseases, and the policing of international diseases, especially cholera.[149] Nevertheless, this chapter has argued that the initial policy issues featuring the civilian and military medical practitioners tilted the GoI towards developing civilian medical practice over military.

The preventative approach of medical care rather than the old curative one began to draw more attention in the new medical administration. More attention began to be focused on the community rather than on individuals. Physicians and surgeons controlled medical education and naturally educated their pupils to follow in their steps. But imparting medical education became more important than developing public healthcare. Diseases being a calamity essentially required professional attention and advice, but the maintenance of good health and hygiene depended on the individual and also, for the most part, an intelligent and careful lifestyle.[150] Scholars have argued that the imperial government in India was happy to share power with educated, influential Indians in matters of health and medicine which added to the linguistic stipulations for the IMS officers.[151] Discussing it from the point of view of policy changes could lead the discussion in a number of

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[148] Bynum, *Rise of Science,* 228-230.
[149] *Ibid.*
[150] Francis Fremantle, *A Traveller's Study of Health and Empire* (London: John Ouseley Ltd., 1911), 367-368.
[151] Sanjoy Bhattacharya, "Re-Devising Jennerian Vaccines? European Technologies, Indian Innovations and the control of Smallpox in South Asia, 1850-1950," Social Scientist 26, no. 11/12 (November 1998): 27-66.

directions, including how the changes would be financed or how the tension brewed between the civilian and military modes of medical practices. The rationale underlying the Madras government's plan was to create a transient medical service liable to support not just the GoI and the British Indian army but also the combatant personnel of the British military stationed anywhere in the world. While doing so, its impact upon the practice of medicine in British India, especially on the civilian side, was left mostly to the expertise of the Indians, particularly after the Great War. A medical service without regional roots might have suited the military framework as surgeons could travel with regiments and battalions when required in disparate parts of the subcontinent; it appeared to be far less feasible to make such a requirement work in the case of civilian practices.[152]

This chapter, with its diverse range of sources and argument, has tried to explain that IMS officers were enjoying a position of power across the presidency. They were given free rein in both the urban and the rural areas, which included a free choice of private practice on most occasions. Although, they faced stiff competition from the Indians coming in large numbers to join the IMS ranks, they were more or less cocooned in their marketplace. Their influence in the marketplace increased over time, but the situation changed drastically when the area expanded. The medical marketplace started to expand beyond the city limits and elite circles, and this brought a much lower section of the medical practitioners to the forefront of expanding western medicine in districts, *taluks* and villages, ultimately reducing the power and prestige of the IMS officers significantly. Such a vacuum was eventually filled by the medical subordinates who began to dominate the presidency and its healthcare measures, and this will be examined in the following chapter.

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[152] Kieran Fitzpatrick, "Tense Networks: Exploring medical professionalization, career making and practice in an age of global empire, through the lives and careers of Irish surgeons in the Indian Medical Service, c.1850-1920," (PhD dissertation: University of Oxford, 2016), 172-175.

Chapter 5 – Evolution and Contribution of the Subordinate Medical Department in the Madras Presidency (1880-1935)

"Their aim was to produce cheap assistants, they were not so green as to produce anything better and thereby intensify competition for themselves in the market."

S. S. Sokhey[1]

Major-General Sir Sahib Singh Sokhey, at the time of writing the letter to the RF, was the Assistant Director of the Haffkine Institute in Bombay city (now Mumbai) after finishing his post-graduate studies from Harvard University with a RF fellowship.[2] His letter had stimulated enough interest among the officials at the Foundation for it to be one of the letters that was forwarded to W. S. Carter before his much-awaited survey of the medical institutions in British India on behalf of the RF.[3]

This chapter explains the medical services, especially the Sub-Medical Department and its role in preparing the ground for the establishment of the European medical market in colonial Madras.[4] The chapter begins with a background of the SMS and then follows the political shifts chronologically to explain how this medical service evolved during the period under review. It also

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[1] Rockefeller Foundation papers, Box 10, 78, 1926, Series- 464/464A India, Record Group (RG) 1.1, RF, RAC.

[2] Sokhey went on to become a member of the Rajya Sabha in independent India. He was awarded a fellowship by the Rockefeller Foundation to complete his postgraduate at Harvard University in 1923. He wrote a few letters to the Foundation explaining the condition of the medical institutions, this was taken from one he wrote before W. S. Carter was sent to India with the intention of investing in the healthcare of colonial India. Harkishan Singh, "Sahib Singh Sokhey (1887-1971): An Eminent Medico-Pharmaceutical Professional," *Indian journal of history of science* 51, no. 2 (June 2016): 238-247; Mridula Ramanna,"Science and Modern India: An Institutional History c. 1740 to 1947," XV, part 4, in *Project of History of Indian Science, Philosophy &Culture,* ed. Uma Dasgupta (New Delhi: Pearson, 2011), 561-588.

[3] W. S. Carter report, 1926, Box 10, Series- 464/464A India, Record Group (RG) 1.1, RF, RAC.

[4] Sub-Medical Department was another name for the Subordinate Medical department. They had different names attached to them, were also termed as apothecaries in the early days of their existence. In the later part, the chapter will explain the introduction and expansion of this particular department in detail. Ramya Raman and Anantha Narayanan Raman, "Early decades of Madras Medical College: Apothecaries," *The National Medical Journal of India* 29, no. 2, (2016): 98-102.

gives importance to the impact of WWI and explains how lack of personnel and later, finances at the disposal of the GoI opened up new avenues for the local residents in the presidency. The final section weaves a narrative from the perspectives of the British, the RF, and the local residents. The main goal of this chapter is to investigate the contribution and responsibilities of these subordinate medical and non-medical personnel. While doing so, this chapter will argue that rather than a top-down approach, colonial Madras was witnessing, what is usually described in academic parlance, a bottom-up approach in terms of implementing medical policies. This chapter will shift the academic gaze from elites (the European officers, Surgeon General, hospital in charges, Indian elites who were a part of the IMS cadre) and focus more on the sub-assistant surgeons, local and regional dispensaries, hospital orderlies, compounders, and dressers who were, as this chapter argues, the actual pillars of the colonial medical system in the Madras Presidency. It will focus only on the western medical traditions implemented bureacratically in the presidency and the actors who were working to implement and spread this medical tradition in the colonial state.

Through an exhaustive use of colonial official documents, RF papers, local newspapers and journals this chapter aims to explore three major ideas: first, it maps the introduction of the sub-medical department in the context of colonial Madras. Secondly, it outlines the interaction between the British and indigenous population in the presidency both in terms of collaboration and contestation. Third, it shows how the subordinates and those considered minors in the medical services shaped health policies in colonial Madras and brought forth the expansion of western medicine.

5.1 Subordinate Medical Service: a brief historical background

The SMS of Madras was established in 1812, and it was one of the earliest such departments in colonial India.[5] Initially, only the non-commissioned European medical personnel were employed in this department. The Native Medical Institution (NMI) was set up in 1822 by the British authorities to train people for inclusion into the SMS, but it lasted only until 1835 when there was a massive change across British India particularly in medical and healthcare policies.[6] That year saw the establishment of the medical colleges in the three presidencies, and its lectures began to be delivered in English, and gradually, this started making a big impact.[7] This was also the period when the EIC and the Governor-General(s) began to criticise the traditional form of healthcare and started imparting western medical education to the local residents.[8] Roger Jeffery had pointed out that this was not very helpful to the locals as most of the texts were in English even though the EIC was taking some steps to incorporate them in the medical services. There has been very little focus on the SMD, which constituted a significant part in the healthcare structure of colonial India. According to a resolution from the military department, the SMD was considered a part of the IMS, with the recruits coming from both military and civil sections.[9] The general administrative control was a liability of the Surgeon General with the government of Madras while all the members of the SMD serving with the military were under the Surgeon General, Queen Victoria's forces. The Madras Presidency had displayed a more inclusive attitude towards the subordinate medical practitioners, and they even had a specific designation of 'dresser' in addition to

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[5] Ramya Raman and Anantha Narayanan Raman, "Early decades of Madras Medical College: Apothecaries," *The National Medical Journal of India,* 29, no. 2, (2016): 98-102.
[6] Mark Harrison, "Medicine and Orientalism: Perspectives on Europe's encounter with Indian medical systems in Health," in *Medicine and Empire: Perspectives on Colonial India*, ed. B. Pati and M. Harrison (New Delhi: Orient Longman Limited, 2001), 37–87; P. Bala. *Medicine and Medical Policies in India: Social and Historical Perspectives* (Lanham: Lexington Books, 2007), 68-105.
[7] Raman and Raman, "Apothecaries," 99-100.
[8] Roger Jeffery, "Recognizing India's doctors: the institutionalization of medical dependency, 1918-1939," *Modern Asian Studies* 13, no. 2 (1979): 301-26.
[9] L/MIL/7/161-176, Military Department, Administration of the Subordinate Medical Department, APAC, BL.

the 'apothecaries'[10] who were a part of the SMS.[11] As a result, from the very beginning, the Madras Presidency had been more accommodating towards the SMS compared to the other presidencies.

In Madras, it was mandatory for the subordinate medical personnel of the ranks of assistant apothecary and assistant dresser to take an examination (whether written or oral, is not entirely clear) before promotions, and it later influenced the Bengal Presidency to adopt this as well.[12] The Bengal medical board declared:

> We concur in opinion…that it is desirable to introduce in Bengal the regulation which obtains at Madras, for subjecting subordinate medical officers to a searching examination, previous to promotion in the Department.[13]

The access and control of sub-medical personnel in the Madras Presidency were somewhat limited until 1880. They could only practise in the rural and semi-urban areas and in smaller medical institutions. However, they became indispensable as subordindates and hospital assistants taking care of district and *taluk* medical institutions (that is dispensaries) both in districts and villages. This proved an important aspect which contributed to them playing a significant role further up the ladder in the latter part of the history of this presidency. Until the 1880s the SMS did not get as much importance in the medical department as they would have liked, but the political and medical scenarios began to alter during the time of Lord Ripon as has been explained in Chapter 2. This period saw a surge of subordinates who were willing to take necessary actions to become indispensable in terms of medical support and functioning in the hospitals and dispensaries. The IMS was going through a period of great uncertainty, particularly for the European recruits, and the

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[10] The apothecaries were the pharmacists or chemists. But, in the context of colonial India, they were mostly the medical subordinates engaged in practicing healthcare. Raman and Raman, "Apothecaries," 98-102.
[11] Raman and Raman, "Apothecaries", 99-101.
[12] Q/2/8/8, Memorandum on the Civil Apothecaries in the Madras Presidency, APAC, BL.
[13] Raman and Raman, "Apothecaries," 101.

Indians were yet to get into the IMS in large numbers. This helped the subordinate branch of medical services in Madras flourish. The following section will discuss in detail the nuances of rural and urban healthcare and the contribution of the SMS in the Madras Presidency. The control and hierarchy of the SMS will be analysed to understand the role played by the local government in establishing their control over the medical marketplace.

5.2 Local self-government resolution and a shift in the SMS

The medical services in Madras underwent significant changes with the Resolution of 1882 during the Viceroyalty of Lord Ripon.[14] Political and medical administration worked closely, particularly in the case of Madras, as has been discussed in the first two chapters of the thesis. Ripon made it quite evident that he wanted to give the locals better opportunities to work with the government and thus focussed more on decentralising the administration. It is, however, important to note that the idea of local self-government was prevalent much before the late nineteenth century in this region.[15] Like the elite medical service, the SMS was also initially established to look after the British Indian army, but it changed its structure and composition drastically over the years and in the late nineteenth century, with the increased local influence they were looking for opportunities to control the civilian medical administration. One of the main reasons was that in the southern part of British India working for the military ceased to be attractive for the medical corps.[16] There were people voicing support for the subordinates from as early as 1882, which is evident from a letter to the editor of the *IMG* arguing that these medics 'secretly pine away in their degraded condition'.[17] The letter expressed concern about the unqualified practitioners and this

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[14] The Resolution of 1882 led to higher participation of Indians in local administrative matters and led to the establishment of district and local boards. The members of the boards were also to be partly nominated and partly elected. This led to the rise of local influence in local, regional politics of India which changed the political dynamics of India. For more details see, H. Wheeler, "Local Self-Government in India," *Journal of the Society of Comparative Legislation* 17, no. 1/2 (1917): 153-164.
[15] K. K. Pillay, *History of Local Self-Government in the Madras Presidency, 1850-1919* (Bombay: C. D. Barfivala, Director, The Local Self- Government Institute, 1953), 1-5.
[16] For more details on this, check Chapter 3.
[17] "Pay of the Subordinate Medical Department," *IMG* (October 1882): 279-280.

brought to the fore the brewing conflict among different layers of Indians over their access to the medical marketplace.[18]

In 1882, there were 11 hospitals in the districts of Madras, usually located at the *taluk* headquarters.[19] In-patients were not encouraged to visit the dispensaries by the medics as much as out-patients as there were no medical schools attached to such medical institutions. The financial condition of individual residents impacted their decision to get admitted as in-patients. Only the poorer section showed any willingness for this, particularly in high-risk cases such as epidemics.[20] Indeed, it is impossible to understand the subordinate or lower division of the medical services without addressing the conflict of interest among different layers of the local population. The colonized people were not a homogenous entity, and there were divisions based on caste, religion, language, race, and ethnicity among the subject population inside the presidency of Madras. D. G. Crawford's book pointed out that certain roles were prescribed for the uncovenanted medical officers, opened to Indians in the Bengal Presidency, and this applied to all the presidencies.[21] Out of several rules, the one that strictly defined the role of provincial and central governments was the one that allowed provincial government to control the transfers of medical practitioners inside the provinces at their discretion. However, if a transfer had to be made from one province to another, then the GoI had the final say. The GoI found it difficult to control provincial matters, and this permitted the provinces to act independently of the central command sitting in Calcutta.[22] The 1880s contributed to a lot of changes in the medical administration of the Madras Presidency. Until 1881, the GoI had always maintained their intention and inclination towards the covenanted[23]

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[18] Ibid.
[19] Dewan Bahadur S. Srinivasa Raghavaiyangar, *Memorandum on the progress of the Madras Presidency*, 1892.
[20] *Ibid.*
[21] Crawford, *IMS*.
[22] *Ibid.*
[23] The covenanted positions were open to only Europeans while the uncovenanted positions were opened to allow Indians to join the Government services. Thus, there was a clear segregation between the two types of positions. Later, with higher representation of Indians, the uncovenanted position holders were promoted to become covenanted in few cases. For more details on this, *The Medical Reporter: A Record of*

services and the uncovenanted ones had no way to reach covenanted positions.[24] However, the Secretary to the government of Madras enquired, during the period, if they could employ an apothecary named John Norman in a civil medical charge, which alludes to the elevating prestige and fortune of the apothecaries in Madras by 1884.[25] In the same period, the lower strata of the healthcare system in Madras was subtly altered, and while the name 'apothecaries' remained for the medical apprentices, the system of 'stipended pupilage' was discontinued, and the civil apothecary grade was abolished.[26]

To understand the conflict of ideas at the local level, one needs to first investigate the equation between the western and local medical forms that had an impact on the local populace. The most common way of undermining the 'indigenous' form of medicine, by the colonial government, was by highlighting the differences between the two forms of medicine. Indigenous medicine was criticized for being 'unscientific' and attention was drawn to its apparent lack of 'hands-on approach' to portray it as 'inferior' to western medicine. Poonam Bala and Mark Harrison have pointed out how with the aid of scholarships, free medical texts, government backing and well-equipped institutions, the western trained medical practitioners began to provide strong competition to the indigenous medics.[27] Amna Khalid and Ryan Johnson in their edited volume, speak about the importance of understanding the role played by local political leaders in disseminating western medicine in the context of colonies.

Medicine, Surgery, Public Health and of General Medical Intelligence (Calcutta: "Medical Publishing" Press, 1892-1895), 219-221.

[24] Home (Medical), G.O. 428, 11 October 1884, APAC, BL.

[25] Ibid.

[26] Q/2/8/8, Memorandum on the Civil Apothecaries in the Madras Presidency, APAC, BL.

[27] Poonam Bala, *Medicine and medical policies in India: social and historical perspectives* (Lanham; Plymouth: Lexington Books, 2007); Mark Harrison, *Public health in British India: Anglo-Indian preventive medicine, 1859-1914* (Cambridge; New York: Cambridge University Press 1994).

> From local political leaders and interpreters to medical auxiliaries, nurses, matrons, hospital orderlies, pupil midwives, asylum attendants, and sweepers, the cooperation of intermediate and subordinate personnel was key to the functioning of most colonies' public health machinery.[28]

In colonial medical policies, permeated mostly by defiance and dominance, the resistance of subordinates and colonised people have not been given adequate space in the existing literature. This has diminished the subordinates' position, and the existing historiography has underplayed the power they wielded in the lower rungs of the administration.

The SMD in colonial India was divided into two branches, one for the military and other for the civil population.[29] But it had finer divisions as well: the senior branch consisted of apothecaries and assistant apothecaries, nearly all Anglo-Indians, who were usually employed on civil duty or attached to large station hospitals, and the junior branch consisted of three grades of hospital assistants, mostly local Indians.[30] This branch deployed men mostly attached to native regiments, and they usually ranked below native commissioned, but above non-commissioned officers.[31] This demonstrates the important role played by the SMS and the local people who were serving there. In Madras, Men were enlisted as medical pupils between ages of 15 and 19, after qualifying by exam they had to be attached for two years to a civil or military hospital and only after that they were deemed qualified enough for the grade of hospital assistant and were employed in the junior department of Madras Medical College.[32] In 1885, a circular issued from Fort William (Calcutta) instructed that the members of the hospital assistant group could only be employed in hospitals

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[28] Amna Khalid and Ryan Johnson, *Public Health in the British Empire: Intermediaries, Subordinates and the Practice of Public Health, 1850-1960* (New York; London: Routledge, 2012), 1-31; Amna Khalid, "'Subordinate' negotiations: Indigenous staff, the colonial state and public health," in *The Social History of Health and Medicine in Colonial India*, ed. Biswamoy Pati and Mark Harrison (London; New York: Routledge, 2009), 45-73.
[29] IOR/P/1664, no. 12-13, Memorandum of the Army Sanitary Commission 1881, APAC, BL.
[30] Ibid.
[31] Ibid.
[32] Military Department (Medical), Army Circular, 31 July 1885, NAI.

of 'native' troops and followers, in lock-hospitals and in staff appointments.[33] The senior hospital assistants had to oversee the whole group with 1st and 2nd-grade hospital assistants and sub-hospital assistant working as subordinates. This whole group of people were ranked below all the 'native commissioned' officers and medical warrant officers but were above the ranks of all 'native non-commissioned' ones.[34] It is thus evident that medical personnel in Madras were working at various levels. These different layers in the subordinate services were distinct in terms of their responsibilities. Their role was supposed to be mostly for the military, but they were also allowed to work in the lock-hospitals and in the Indian marine division, and an extra 15 percent were kept aside for temporary duties and to work as substitutes of absentees or sick people.[35]

In the late 1880s, a new degree of LMS was introduced which replaced the certificate of civil apothecaries, and the provincial government assured local residents that no special importance was attached to the new degree.[36] The government realised that the pay offered in these positions was far too little to attract people for long. This was also the period when IMS was going through a difficult time because of their tussle with the military surgeons (as explained in Chapter 3). All these factors compelled the Madras government to increase the pay of the subordinates.[37] However, in those initial years, the segregation was intensive, and apothecaries were prevented from ever reaching the level of the civil assistant surgeons and civil hospital assistants. Moreover, in terms of pay and the system was tilted against apothecaries in such a way that only after 28 years of full service were they able to reach their maximum pay grade.[38] They were not allowed to draw their full pension if they retired before 31 years of service. The odds were delibarately stacked apothecaries (details of these people have been explained in Chapter 2). The government persisted

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[33] Ibid.
[34] Ibid.
[35] Ibid.
[36] Q/2/8/8, Memorandum on the Civil Apothecaries in the Madras Presidency, BL.
[37] Ibid.
[38] Ibid.

in treating them only as a temporary solution rather than as having a permanent role in the service until the twentieth century.[39]

5.2.a) A shift in the government policies in the 1890s

The Surgeon-General of Madras stated in his report in 1891 that the districts under the charge of medical officers were much larger in area and contained a far greater number of dispensaries than any other parts of British India, and the District Medical Officers (DMOs) were mostly busy undertaking their administrative duties in such big districts.[40] This resulted in them being absent from the headquarters for a considerable amount of time, and the subordinates taking up their mantle in conducting surgeries or treating people in their absence.[41] This made Madras a unique place from the point of view of rural healthcare in British India. The provincial government of Madras had difficulty explaining to the central government in Calcutta, why they needed to consider the number of dispensaries and not merely the number of patients being treated by the DMOs.[42] Such issues compelled the GoI to increase the number of commissioned medical officers in Madras from being fixed at 122 in 1885 to 136 in 1891. Even this expanded force was still insufficient to meet the needs of such a big presidency with so many dispensaries and district hospitals.[43] Civil appointment for the IMS officers was increased significantly in the late nineteenth century (as discussed in the previous chapter), but they failed to reach beyond the city limits of Madras. The civil requirements were becoming difficult to meet, and thus the assistant surgeons were being positioned in charge of several medical institutions.[44] The GoI and the military department by the 1890s had altered their stance against the civilian medical services. They believed,

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[39] Ibid.
[40] Report of the SG on civil Hospitals and Dispensaries in the Madras Presidency for the year 1889, Indian Medical Proceedings, No. 669, 6 August 1891, APAC, BL.
[41] Ibid.
[42] Ibid.
[43] Despatch from the GoI, Military Department, no. 223, 28 October 1891, APAC, BL.
[44] Military Department, No. 431, 15 July 1891, APAC, BL.

> . . . the requirements should be met by doubling up under one medical officer the medical charges of two or more Native regiments serving at the same station, instead of calling upon the Civil Department to surrender officers to meet their demand.[45]

The GoI, more importantly, the military department, began to comprehend the importance of the civilian medical department by mid-1890s and encouraged more Indians to join the medical force, particularly in Madras where the AMS was passing through a difficult time (as explained in Chapter 3) and military service would force the recruits to move far from their home. The medical officers were overworked, and it was time for the medical subordinates to step up and conduct surgeries in the absence of the senior officers. The table below shows the list of civil apothecaries who were performing major operations alongside IMS officers in the MMC as early as 1894. The Indian apothecaries performed a considerable number of operations and shouldered serious responsibilities.[46] In the process, they steadily became a critical part of the medical marketplace in Madras. This process persisted until the beginning of the twentieth century and benefitted the increasing number of subordinates joining medical services, and they extended the practice in the rural regions.

Table 5.2.a (i) (Medical Subordinates conducting operations in the MMC)

Name of the Officers who performed major operations	Number of Operations
Civil Apothecary M. C. Koman	27
Civil Apothecary C. Dustagheer Khan	1
Civil Apothecary T. Ekambaram Pillay	12
Civil Apothecary C. M. Thirumudisami	45

[45] Ibid.
[46] "Supply of Medicines to Local Fund Dispensaries," *The Hindu* January 11, 1894, 5.

Source: *Annual Report of Madras General Hospital, 1894, BL.*

However, the names of hospital assistants who performed similar important operations usually remained undisclosed in the annual reports and official statements. The Surgeon-General of Madras stated that in accordance with instructions from the Madras government, such lists included no officers below the rank of assistant surgeons.[47] Despite this deliberate omission, the government was generally considerate of local politics and was careful to not antagonise public sentiment. They were careful about any 'breach of conduct' against the subordinates as had been evident in the case of Hunter and his dealings with one Major *Hakim,* where the government dealt with this issue of misbehaviour seriously.[48] It was difficult to find any further details on this particular issue, and therefore is hard to understand if it was a one-off incident or was usually the case in the late nineteenth century Madras presidency. The formal training of apothecaries was stopped by the later decades of the nineteenth century, although informal training continued, especially for army cadets and women in Madras Presidency. Schools in Royapuram (developed later as Stanley Medical college and hospital), Thanjavur and Madurai were created to train medical practitioners and grant the title of LMP.[49]

5.2.b) Urban and rural medical control: an overlapping role

By the end of the nineteenth century, apothecaries had unofficially evolved into general practitioners of medicine in this presidency.[50] The gradual enhancement of the identity of the apothecaries meant the rise of the 'qualified' medical practitioners who distanced themselves from

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[47] Home Department Proceedings, G.O. 209, Part 1, 1899, APAC, BL.
[48] Ibid.
[49] Raman and Raman, "Apothecaries," 5.
[50] *Report of the committee appointed by the Government of India to examine the question of the reorganisation of the Medical services in India*, (Shimla: Government Central Press 1919), 9.

Indians holding lower positions.[51] This exposed the hierarchical segregation among Indians working at different levels of the medical administration. The government intended to change the dynamics of the British system of medical education and 'allow' more people to join the medical department.[52] With the gradual disappearance of the title of the apothecary in the Madras Presidency, the existing practitioners were re-designated as assistant surgeons and were recognised as 'qualified' medical personnel registered under the Indian Medical Act.[53] Promotion from the rank of sub-hospital assistant to that of hospital assistant was made according to seniority, provided the candidate was well connected and was considered efficient.[54] Towards the end of the nineteenth century, the number of dispensaries and population per dispensary in the presidency was highest in the country.

Table 5.2.b (i) (Statistics of the number of dispensaries and the patients)

Province	Number of dispensaries	Area of the provinces in square miles	Square miles per dispensary	Population per dispensary	Number of patients treated per dispensary
Bengal	479	151,543	318	147,527	5941
Madras	475	141,189	297	75,011	8519

Source: No. 1081, Public, dated 25 August 1898, Home Department Proceedings, 1899, APAC, BL.

[51] The term 'qualified' must also be understood in a nuanced way. The Madras government only considered those people as qualified who were willing to contribute to the expansion of western medicine. This led to a competition between Indians to get better opportunities and positions as will be explained later.
[52] The colonial government in Madras by this time was willing to accept more Indians into their ranks and this was evident from the change of their policy; IOR/L/MIL/7/5293, Apothecary Branch: Changes in rank and designation of Members, Military Department, 1893-1894, APAC, BL.
[53] IOR/L/MIL/7/5293, Apothecary Branch: Changes in rank and designation of Members, APAC, BL.
[54] Ibid; S. Cuvaminatan, "அரசியலும்சுகாதாரமும்" (Politics and Health) (V.S. Venkataraman Kempeni, 1900).

With the advent of the twentieth century, the Madras Presidency had dispensaries widely spread out across the region catering to a much larger number of local people in total, as illustrated by the table above.[55] This demonstrates that the people of the presidency were adept at western medical practices and were very receptive to the medical changes and reforms across the presidency. This table shows how Madras had provided access to western medicine in its rural areas, including the district hospitals, *taluks* and dispensaries. The number of dispensaries increased consistently every year, and so did the number of patients visiting the dispensaries. Madras recorded the highest number of patients being treated in the rural sectors starting from 1896.[56] The number of operations conducted in the presidencies also evinced that hospitals and dispensaries in Madras conducted many more operations than any other provinces in 1896 and 1897.[57] These were the initial days when Madras was slowly changing and evolving its medical policies to extend services to more people, particularly in the rural areas. The urban areas were also reaping the benefits of the western medical surge in Madras, and they began to reach out to the districts after the urban regions began to get overcrowded by medical practitioners. The civil medical department began to feel the pressure as the IMS officers were constantly called for military duties. It also made the Madras government realise the importance of a change in attitude and separation of the military and medical sectors to allocate more space for civil medical practitioners in the medical services.[58] Such factors contributed to the changing attitute of the provincial government and alongside the local inhabitants were gradually showing more interest in healthcare, at least in the urban areas.

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[55] Home Department Proceedings, G.O. 1081, Public, 25 August 1898, BL.
[56] Ibid.
[57] Ibid.
[58] Ibid.

5.2.c) Health under the local government

The alarmingly low number of IMS officers in the districts and other sub-divisional hospital charges compelled the government of Madras to look for assistant surgeons and warrant medical officers who were to be placed in the medical charge of civil stations in the absence of the civil surgeons. This became even more essential as the civil surgeons had to devote time to their administrative and other additional responsibilities and rarely had the opportunity to pay attention to the daily activities and healthcare set up of the hospitals.[59] The same period also witnessed the beginning of a consistent shift in the outlook of medical treatment from the military to a more civil centric approach to healthcare. The GoI had agreed to allow the permanent transfer of the warrant medical officers from military to the civilian department in order to reduce the number of supernumeraries and to relieve the stagnation in ranks, particularly outside the presidency town.[60] While the Madras government was looking for an overall transfer from military to civil services, a careful analysis of the reports showed that a conflict was brewing among the Madras officials and the GoI.[61] Although the GoI was repeatedly displaying its intention to retain more medical officers for the army, the Surgeon-General of Madras and the Secretary were, in turn, piling up pressure on the GoI to station more physicians in the civilian hospitals.[62] Within one year, several requests and letters were sent to the GoI requesting resources in the form of both men and money. This highlights that the central and provincial governments were rarely on the same page when it came to providing medical care in the Madras Presidency.

By 1903, proposals were being made to restructure the SMS in Madras. In a letter written to the Secretary of State for India, it was declared that the post of apothecaries for the Madras

[59] Home Department (Public), G.O. 493, Ootacamund, 8 July 1890, APAC, BL.
[60] Home Department, G.O. 4931D, Fort William, 31 December 1890, APAC, BL.
[61] Ibid.
[62] Home Department, G.O. 37, dated 19 January 1891, APAC, BL.

Presidency would be done away with.[63] Apothecaries were a class of officers who held an intermediate position between hospital assistants and assistant surgeons, and until 1888 were educated for the public service at the expense of the government.[64] The Madras government realised that a salary starting at Rs 50 a month with the provision of increasing to Rs 150 per month after 28 years of service was not enough to attract competent men for the job with requisite qualifications.[65] Thus, it was proposed by the Surgeon-General in Madras to assimilate the existing apothecaries with civil assistant surgeons, which would translate to these apothecaries working as assistant surgeons.[66] There was also discontent between the provincial government in Madras and the central government in India regarding the maintenance of the reserve medical force in Madras. Certain local organisations were working to focus on the villages, and *taluk* health issues, and how they were controlled by the indigenous people at ground levels.[67] The central committee decided in favour of the provincial government, thus enunciating that provincial administration was allowed more autonomy than before to act on their own accord in the majority of occasions.[68]

The apothecaries, while in public hospital service, held the rank of warrant officers with authority to issue arrest warrants to soldiers up to the rank of a sergeant, and they were permitted to practise medicine privately. Under these circumstances, the evolution of apothecaries (and dressers) in Madras Presidency was recognised more as a medical force, than a paramedical one (although apothecaries used the title of 'Mister' rather than 'Doctor').[69] There were very stringent rules in place to bind the people to the service. One such rule made it obligatory for the sub-hospital assistants to sign a declaration to serve the government for a period of seven years in the rank of

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63 Finance and Commerce Department, Medical, No. 253 of 1903, NAI.
64 Ibid.
65 Ibid.
66 Ibid. Explained.
67 "கிராமசுகாதாரவிளக்கம்" (Village Health Description), Christian Literature Society for India, 1897; "கிராமமுனிசீப்மான்யூல்" (Village Municipal Manual), Madukaraveni Book Depot, 1900; "Civil Hospitals and Dispensaries in Madras," *The Hindu* September 3, 1906, 1.
68 "Civil Hospitals and Dispensaries in Madras," *The Hindu* September 3, 1906, 1.
69 The reorganisation of the SMD in the Madras Presidency. (Extract from the proceedings of the GoI, Finance and No. 87 Commerce Dept., No 7393, 5 December 1903.)

hospital assistant unless prevented by physical disability. In case they applied for discharge before seven years, they had to refund the amount of salary received during their entire period of service. After the completion of seven years, they could theoretically claim their discharge, but this was allowed only during peacetime.[70]

In the initial years of the twentieth century, the SMD went through a process of reorganisation which, as evident from the records, further strengthened the service and the manner in which it operated in the districts of Madras Presidency. The Secretary of State for India sent a letter approving a scheme that led to the amalgamation of the three existing classes of civil assistant surgeons, temporary assistant surgeons and civil apothecaries, into a single class of civil assistant surgeons, with payments commencing from Rs 100 and rising up to Rs 150-200 per month.[71] It was also simultaneously proposed that more permanent positions would be opened and the temporary ones were to be replaced by civil assistant surgeons.[72] Thus the subordinates were scaling a new rung in the hierarchy in the initial years of the twentieth century.

The Madras government was looking for new recruits in the medical department among the Indians, which directly led the number of subordinate officers to swell.[73] Most of the subordinate medical appointments in Madras began to be held by civil apothecaries by the early 1900s.[74] With the creation of the new designations discussed earlier in this chapter, the civil assistant surgeons became an essential part of the colonial medical set up. Hospital assistants and equivalent grades were eligible for transfer to the military department and were graded, in the first place, according to their standing at that time.[75] All future appointments, it was decided, were to be made from qualified medical pupils, and all were dutybound to serve the military, even if primarily employed in the civil department. This service, as Crawford argued, considerably increased rates

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[70] Finance and Commerce Department, Medical, No. 253 of 1903, NAI.
[71] The reorganisation of the SMD. (Extract dated 5 December 1903).
[72] Ibid.
[73] Army Department, April 1920, 2413-2417, NAI.
[74] Ibid.
[75] Ibid.

of pay by 1900.[76] The senior hospital assistants were granted commissions – the first class ranked as *subadars,*[77] the second class as *jemadars*[78]. All hospital assistants were granted warrant rank but were always junior in rank to all military assistant surgeons. The finance department, however, proposed in 1902 the abolition of the method of dual control of the European and 'native' subordinates. As there was a collusion between the two groups, Madras government feared that the joint responsibility of Europeans and Indians gave rise to illicit methods of making money and decided to take action to stop any malpractice.[79] This was aimed to maintain control over the medical practice as Indians were steadily becoming their competitors, which was not particularly appreciated by the colonial government.

In April 1910, the designation of hospital assistant was changed to the sub-assistant surgeon.[80] With effect from May 1912, the GoI sanctioned the following enhanced rates of pay for military sub-assistant surgeons, as they realised the importance of giving them a hike in order to attract more young Indian graduates.[81]

Table 5.2.c (i) (Salary structure of the medical subordinates)

A) Senior Sub-Assistant Surgeons	Salary
i) First Class, ranking as *Subadar*	Rs. 110
ii) Second Class, ranking as *Jemadar*	Rs. 90
B) Indian Warrant Officers	

[76] Crawford, Hi*story of IMS*, 120.
[77] Subadar was a rank in the British Indian Army. They had an equivalent rank of a British Captain and were placed below British Commissioned officers and above non-commissioned ones. For more details on the British Indian army ranks See, Tarak Barkawi, *Soldiers of Empire: Indian and British Armies in World War II* (Cambridge: Cambridge University Press, 2017).
[78] Jemadar was the lowest rank for Viceroy's commissioned officers in colonial India. For more details on the British Indian army ranks See, Barkawi, *Soldiers of Empire.*
[79] Military Department, September 1902, Nos. 1576-1577. NAI.
[80] *Committee report*. 6.
[81] *Ibid*, 7-9.

i)	Sub-Assistant Surgeons, first class	Rs 70
ii)	Sub-Assistant Surgeons, second class	Rs. 50
iii)	Sub-Assistant Surgeons, third class	Rs. 35

Source: *Committee Report, 1919*.

This enhanced pay for the subordinate service is proof of their rising importance and that of government interest that they had begun to garner. The contribution and control of the local bodies in matters of administration and healthcare were significant even before the Great War. The official correspondences showed caution about the huge influx of subordinates.[82] The war efforts depleted the civil side of the IMS, and these vacant positions were taken up by the medical subordinates, compounders and people with very limited medical knowledge both in the rural and urban areas. The following section will further elaborate on how the SMS began to expand their dominance in the presidency.

5.3 WWI and dominance of the SMS in Madras health services

The Great War triggered a change in the medical hierarchy of the Madras Presidency, and the subsequent shifts made a significant contribution to the way the medical services operated in the region. The local people in the districts of Madras were fast gaining a foothold and obscuring the divisions in the hierarchical structure, much to the discomfort of the IMS officers. In 1913, the medical and sanitary officer of Salem (a district in Madras) voiced his concern regarding the power wielded by the lower level people in the rural areas.[83] Lieutenant Colonel R. K. Mitter of Salem was not subtle in expressing his discontent about the *taluks* and district boards and the people who were controlling these, including *tahsildars*, and sub-inspectors, who were basically subordinates. He went on to say that the 'actual control of medical institutions is vested in the

[82] Crawford, *History of the IMS*, Vol-II.
[83] Q/2/1/238, The Representation of Lieutenant Colonel R. K. Mitter, APAC, BL.

hands of these, and they have the power to reject the District Surgeon's recommendations and upset his arrangements'.[84] This complaint coming from a senior officer strongly indicated the looming discontent among the high ranking officers over the rising power and authority of medical subordinates in the presidency. Apart from the pay, the responsibilities also differed for different designations. The medical charges of small districts and important sub-divisional hospitals as well as lectureships of the medical schools and access of the medical colleges were opened to the civil assistant surgeons and civil apothecaries of the first and second grades by selection.[85]

The War caused a huge dent in the healthcare setup in colonial Madras. The increase in the number of Indian patients, as well as physicians, forced the government of Madras to look for more teachers and trainers, as the number of medical students was increasing as well. This move by the provincial government presented an opportunity for Indians to join the medical service in large numbers and get trained in western healthcare. There was added advantage of knowing one of the 'native languages' and the diseases peculiar to the region.[86] As the importance of local people increased in the SMS, the IMS also started accepting more Indians in its rank. This was primarily the elite and wealthy section of Indians who had the opportunity to access better education and training to break into the IMS ranks.

Table 5.3 (i) (Percentage of Indians in the IMS in Presidencies and Provinces over 20 years)

Area	Total number of IMS officers	Indian IMS Officers	Percentage of Indians to total
Bengal	144	2	1.4
Bombay	33	2	6

[84] Ibid.
[85] Q/2/1/236, Memorandum by Civil Apothecary, A. S. Vittal Rau, February 1913, APAC, BL.
[86] Ramasubbu, "Rural Medical Relief," 20-24.

Madras	50	2	4
L. P	77	12	15.6
U. P	65	10	15.4
B&A	41	10	24.4
M&B	62	8	12.9

Source: Public Department Files (1897,1906-1916), TNSA. [L.P- Lower Province, U.P- Upper Province, B&A- Bengal and Assam, M&B- Madras and Bombay]

The table shows the percentage of Indians joining the elite medical service in colonial India, which illustrates the increasing interest of the local population towards western medicine. This data (first three rows show pre-1897 data, and the rest show ten years' data from 1906-1916) illustrates the increase in participation of the Indians in various matters concerning the medical service over twenty years which resulted in the change of attitude towards western medicine of the poorer section among the local residents of the presidency.[87] Thus, it shows the number of IMS officers were not increasing much, and a slight increase in the number of the indigenous people in the IMS. This resulted in helping the medical subordinates as they being aware of the vacancy in the medical market began to work in tandem with local politics to extend their influence. The next two sub-sections will explore how the Great War changed and affected the SMS in the Madras Presidency.

5.3.a) WWI and the lack of qualified men in the presidency

The WWI depleted the civil side of the medical services, as had been explained in earlier chapters and the government of Madras realised that medical provisions for the presidency were

[87] Ibid.

inadequate. Sir Harold Stuart claimed during a lecture in the MMC in 1916 that the medical provisions present in Madras were 'ridiculously inadequate'.[88] By the end of 1915, in the midst of the Great War, only one hospital or dispensary catered to every six hundred square miles in the presidency.[89] Many villages were far off from any health centres, and there were almost no private practitioners in rural areas.[90] During this period, funds were hard to come by, and it became difficult to receive any provision from the GoI or the provincial government in Madras. The district and municipal boards were unable to take on the entire responsibility of building new dispensaries or hospitals along with the necessary pieces of equipment.[91] This paved the way for a new method of spreading healthcare across rural areas – travelling medics. The sub-assistant surgeons were asked to go on frequent tours equipped with medicine chests and given permission to attend to all urgent cases or minor ailments. Only the more serious cases or those requiring operations were referred to the circle hospitals.[92]

Finding money for infrastructure was equally challenging, given the war time situation. The Madras government with the Surgeon-General G. G. Giffard came up with a plan to involve more private donors to establish hospitals in rural areas and districts. For the proposed hospital in Madurai in 1918, the government memorandum declared that they would name the individual blocks of the hospital after the donors of the hospital.[93] This move encouraged wealthier local residents to donate money for the cause. The amount of control the local population, even in the districts, had on the expansion of western medicine in the Madras Presidency is quite apparent from this decision. There was a plan in place to improve the hospital at Madurai since 1912, but lack of funds during war-time was considered a major deterrent in the process.[94] The number of

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[88] Extract from *The Hindu* dated 15 August 1916, Madras Medical Proceedings, 1917.
[89] No. 68 (medical), Local and Municipal Department,1917, APAC, BL.
[90] Ibid.
[91] Ibid.
[92] Ibid.
[93] G.O. No. 54, Local and Municipal (medical), 8 February 1918, APAC, BL.
[94] Ibid.

Indians opting to study medicine in medical schools was also on the rise. The superintendent of Royapuram medical school proposed to appoint senior grade sub-assistant surgeon Asirvada Nadar, and 4th-grade sub-assistant surgeon P. M. Sridharan attached to first District and Rajah Sir Ramaswami Mudaliar's Lying-in hospital, Madras respectively, as assistant anatomical instructors in the Royapuram Medical School for 9 months from 1 July 1916.[95] The table represents the rise in the number of Indians in medical schools across the presidency and, depicts the steady increase in the numbers for most places. This resulted in more Indians being recruited and trained for imparting medical education and establishing healthcare practices across the presidency.

Table 5.3.a (i) (Number of Subordinates in three districts of Madras from 1915-1918)

Medical School	1915	1916	1917	1918
Royapuram	49	120	117	129
Tanjore	122	123	132	148
Vizagapatam	98	96	112	147

Source: Local and Municipal (Medical), No. 54, 8th February 1918, APAC, BL.

5.3.b) The end of the Great War: a new beginning for the SMS

There were regular contestations between the appointees of the GoI and those of the local governments, that is the medical subordinates. The jail superintendents of the central jails disregarded and discouraged the medical subordinates who were serving in these jails and such actions

[95] G.O. No. 3914, Public Department, 23 June 1916, TNSA.

gave rise to several conflicts among factions.[96] These constant complications forced the GoI to consider removing the medical subordinates working in the jails and replacing them with compounders, thus designating them as subordinate cadres.[97] The compounders were then made responsible for medical scenarios inside the district and sub-jails, and the sub-assistant surgeons by this time were regarded as far too important to be spending their time engaging in conflicts with the jailors and hence began to be placed in higher positions across the presidency. The Madras government could identify the glaring problem of not having enough western medical practitioners in the districts and *taluks* in this period. A survey conducted in 1917-18 revealed that in Madras only one single registered practitioner of western medicine could be found in towns that had around 8,000 inhabitants.[98]

The district boards began to take an interest in recruiting medical officers for the locally funded medical institutions instead of obtaining the services of the officers under the government. With pressure mounting on the government and with the lack of medical practitioners in their employment, the district boards were given the authority to appoint their own medical officers although they were not supposed to exceed more than 25 percent of the posts under them.[99] The provincial government began to realise the importance of encouraging more subordinates to join and hence took the decision of abolishing the mandatory training for the civil assistant surgeons and sub-assistant surgeons. The training was a cause of dissent among the subordinate services, and they considered it their victory when this was abolished, although measures were taken so that the recruits could continue to develop their skills.[100] Even though the number of medical graduates increased manifold, they continued to overcrowd the existing marketplace rather than try to ex-

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[96] "Humiliation of Medical subordinates attached to jails," *Indian Medical Journal* (1922): 45-50.
[97] Ibid.
[98] *Committee report*, 22.
[99] IOR Mss Eur F77/189, The working of the system of Government: Administration of Departments, 125, APAC, BL.
[100] Ibid.

pand its boundaries beyond the urban settlements. At one point, the towns, and in particular Madras city, were teeming with medical practitioners, whereas the districts and villages suffered from a dearth.[101] The expanse of the Madras Presidency made it harder for the locals and the government to understand and administer the province as a single entity. With diverse languages, cultures, religions and classes co-existing in the Madras Presidency, it was problematic to even decide upon a common vernacular that would be understood by all sections of the populace.[102] For example, the district of Ganjam had Oriya speaking people who were not used to Telugu or Tamil language speaker who was in charge of most of the rural medical institutions in the presidency.[103] Thus, imagining the presidency, let alone the whole of British India, as a monolithic structure is not a nuanced approach. Such complications made it more difficult for the British administrators to effectively control the local medical administration and ensure that the medical practitioners operated at their command.

In order to have an effective system of healthcare in place, all district boards were required to employ a health officer in each district as per the government directive. Similarly, municipal councils that generated income of more than one hundred thousand rupees in the previous three consecutive years were required to appoint their own health officers.[104] This particular move enabled local political leaders to exert more control as the district council or the president of the district boards was entrusted with the power of appointing health officers.[105] This move was hastily put together during the Great War but failed to bring any improvement to the district health centres. In 1915, the government again formulated a scheme to appoint health officers in ten municipal towns.[106] Between 1917 and 1920, the government took over the management of almost all district

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[101] *Committee Report*, 22.
[102] More details about the languages and different classes of Madras have been discussed in Chapter 1.
[103] IOR Mss Eur F 77/187, Redistribution of the provincial area: Madras Presidency, 8-9, APAC, BL.
[104] IOR Mss Eur F77/189, 138-139, APAC, BL.
[105] Ibid.
[106] Ibid.

headquarters in order to make them efficient and more importantly, to attract more medical practitioners to the districts and rural areas.[107] Following the end of the War, the government was financially weak, but even more limiting to it than the financial constraints was the severe shortage of people to work in the rural districts and *taluks*.[108] To deal with the mounting pressure of appointing more Indians and having a separate body for treating civilians, a decision was taken to change the name of the SMD. In 1918, it was renamed as the Indian Medical Department to elevate the status of the subordinates and make them more enthusiastic about working in the rural and semi-urban spaces.[109] The local politicians started to take more interest in the development of civilian medical services, and this tilted the power dynamics in favour of the subordinates. This also provided them with space and opportunity to sell their skills in the medical marketplace that was distinctly expanding in Madras. There had also been instances of the GoI not sanctioning grants to indigenous practitioners of medicine on the grounds that they weren't trained in 'modern' medicine; Unani, Siddha or Ayurveda practitioners were discouraged by the government from practising even though the rural areas were in dire need of the indigenous medical expertise.[110] The indigenous practitioners were not allowed any grant or funding to carry on their treatment methods in rural areas.[111] This was also another tactic of the Madras government to encourage western educated Indians to take control of the medical marketplace and eventually establish a medical monopoly in the healthcare system. This encouraged those people trained in western medicine to move to the rural areas and continue with their work with support from the local and municipal council boards.

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[107] IOR Mss Eur F77/189, 125-126, APAC, BL.
[108] Ibid.
[109] *Committee Report*, 22.
[110] Medical Department, G.O. 409, 7 August 1920, TNSA.
[111] S. Ramasubbu, "Rural Medical Relief," *The Medical Practitioner* 1 (1929): 7-15.

The provincial government, however, was forced to become more democratic in their decision making as, by the 1920s, local people had become too invested and dependent on the western medical services in the Presidency. In 1923, the Surgeon-General declared his decision to close the outpatient departments of all district headquarter hospitals on Sundays and weekday evenings to save money and human resources.[112] However, he was compelled to roll back this decision after facing strong mass protest. The introduction of district health scheme in 1923 made a positive impact on the healthcare policy in the rural parts of the presidency. This was much needed after it was reported in 1922 that the number of preventive staffs employed for public health purposes was insufficient and their activities unsatisfactory.[113] Indeed, the prime focus of the government of Madras during the early 1920s was on propaganda work. The local people were engaged in public health work mostly to carry out the propaganda campaigns for the government, displaying considerable interest in such activities.[114] The RF papers also bear testimony to the significant propaganda work conducted in the rural and semi-urban areas of the Madras Presidency during the 1920s. The *IMG* reported that trained Indian practitioners were fighting to gain their foothold within the system and were not too sympathetic towards the practitioners of indigenous medicine.[115] This brought to the fore the hierarchical differences and clashes that were prevalent across the Madras Presidency even among the Indian medical practitioners trained in western medicine.

5.4 Local dominance over provincial control: subordinates seizing power

The next section will delve into both the connection and the discontent between the British administrators and the local leaders in the rural areas. The contribution of and the role played by the RF in this context will also be examined. A big challenge facing the British officials in the 1920s was to identify and segregate the 'qualified' and 'unqualified' practitioners, and this concern even

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[112] IOR Mss Eur F77/189, no. 125-127, APAC, BL.
[113] Ibid., no. 136-137.
[114] Ibid., no. 140-141.
[115] "The supply of rural physicians," *IMG* (May 1925): 223.

found space in several issues of *IMG*. The medical marketplace was evidently becoming crowded with more people joining the medical profession, but the Madras government realised that the field had largely been monopolised by the 'unqualified' practitioners, even though they were allopathic medics.[116] These people more often started originally as compounders with limited knowledge of the medicines and diagnosis and later assumed control in the rural areas.[117] Most patients in the mofussil had no clear idea as to the courses of study undergone and the time and money spent by qualified men in obtaining their qualifications.[118] They regarded equally highly anyone, irrespective of their degree, who managed to keep their dispensary crowded.[119] Further, the unqualified practitioner, who was usually a compounder from the same locality, had better understanding of the area, and created a favourable impression by the use of any means available such as engaging touts and commission agents, winning over influential local people from different castes and creeds, and other controversial or disputable means that qualified medics usually stayed away from.[120] Once their positions were secure and practice established, the unqualified quacks used to undertake all sorts of cases for treatment – practise medicine, surgery and midwifery alike; freely used all sorts of poisons administered intravenous injections, and managed to impress upon the common people their superiority to the qualified ones in the hospitals. Even their serious or fatal mistakes were not even reprimanded let alone punitive measures taken by the local communities.[121]

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116 "Medical relief in rural areas," *IMG* (1925): 193.
117 Ibid; "Public Health in Madras Presidency," *IMG* (1925): 192-193.
118 Mofussil in Urdu, Mufassal in Persian was used originally for areas in British India which were outside the three presidency cities of Bombay, Calcutta and Madras. It usually means the areas outside the urban areas i.e. the rural ones. For more details on the divisions of Madras see, R. Suntharaligam, "The Madras Native Association: A Study of an Early Indian Political Organization," *The Indian Economic and Social History* (1967): 233-263.
119 "Medical Relief", *IMG*.
120 Ibid.
121 Ibid.

In such a situation, the SRMRS was introduced in Madras in 1924. It was essentially a scheme of subsidising private practitioners who were willing to practise in villages.[122] The Madras government expected to spread out the medical marketplace and expand western medical care in rural areas.[123] This scheme employed about forty percent of the registered practitioners as the civil assistant or sub-assistant surgeons in the medical department.[124] However, as Muraleedharan has argued, the task of appointing the medical men and fixing their tenure was left to the local board presidents at their discretion.[125] Correspondences and records from the period reveal that qualified medics were losing their trust in the act and many did not bother to register themselves, while several others put serious thought into getting their names removed from the register.[126] The qualified practitioners were deeply concerned with their absence of influence over the locals and were focussed on convincing the government to modify the rules of recruitment and salaries in their favour.[127] This evidence increasingly points towards how dependent the Madras government was on Indians.

General Hutchinson stated that the cadre for the sub-assistant surgeons in the civil medical services of Madras was reduced by approximately 150 in 1925.[128] This was claimed to be a fallout of the actions taken by the local district boards in assuming the responsibility for medical service in different local hospitals, dispensaries etc. There were 451 sub-assistant surgeons and 30 temporary sub-assistant surgeons in the civil medical service of Madras in 1926.[129] This decrease in the number of sub-assistant surgeons could explain the reason for the decreasing number of students in medical schools. The government was finding it difficult to understand the reason behind this

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122 Muraleedharan, "Rural health," 323-334.
123 G.O. No. 1522, PH, 22.10.1924, TNSA.
124 Ibid.
125 Muraleedharan, "Rural health," 323-334.
126 "Medical relief in rural areas," *IMG* 1925.
127 Ibid.
128 Interview of Major General Hutchinson SG with Madras by W. S. Carter on Madras Medical College, Folder 65, Box 8, Series 464/464A India, RG 1.1, 1926, RF, RAC.
129 Ibid.

as it was well known that Indian students generally looked forward to securing positions within the government.[130] Another reason put forward was the credit system that was introduced for studying physics and chemistry in secondary schools; thus, science subjects began to be given preference for LMP training. The third reason that contributed to a decrease in the number of students was the lack of scholarships after 1925. Only 20 scholarships were made available for women students while the rest were discontinued.[131]

Table: 5.4 (i) (Vacancies, number of applicants and selected candidates in Madras over 4 years)

Year	Number of Vacancies	Applicants	The number selected for admission
1922-23	260	553	262
1923-24	210	349	235
1924-25	300	372	222
1925-26	250	238	143

Source: Folder 65, Box 8, Series 464/464A India, RG 1.1, 1926, RF, RAC.

The decreasing number of applicants prompted the government to take some steps to attract more subordinates. The government of Madras by this period was trying to encourage sub-assistant surgeons to settle in rural districts and had sanctioned the allotment of three subsidies for them in each *taluk*.[132] Although, by mid-1920s, the scholarships for training the subordinates had started to dry up because of the fluctuating financial status of the GoI, as the economic depression

130 Ibid.
131 Ibid.
132 Ibid.

was looming.[133] In 1926, the Madras government declared that local boards should be permitted to appoint their medical officers in the local fund medical institutions apart from those at the headquarters of *taluks*. The maximum number of posts controlled by the local bodies were up to one-fourth of the total posts.[134] The retrenchment committee recommended that the recruitment of the cadres directly by the provincial government should either be stopped or curtailed to give more opportunity to the practitioners aided by the local boards.[135] Later, the number was increased up to 50 percent of the total number of sub-assistant surgeons. But this was done gradually, and after the government sub-assistant surgeons retired, their positions began to be filled up by those nominated or appointed by the local boards.[136] It was decided that the government sub-assistant surgeons would be gradually withdrawn from district and taluk hospitals. The decision transformed the role played by the local fund bodies in employing medical practitioners across the presidency. The policy was intended to continue until 50 percent of all sub-assistant surgeons had been shifted under the local boards' command.[137]

In the absence of IMS doctors who often refused to relocate to villages, the subordinates grew indispensable to running the local dispensaries aimed at treating local people. These shifts and changes that occurred in the Madras Presidency gave rise to a new social category. This category brought together people from diverse caste, religious, linguistic and class backgrounds to create a distinctive bureaucratic community that one can refer to as the ascendant section or the social ascendants in Madras society. These people were not interested in moving outside their locality; they were happy consolidating power and prestige in the area and did not go into direct confrontation with the British officials. But unofficially, the Madras government had to give them

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133 The Great Depression was a severe worldwide economic depression that was the longest and most widespread depression of the twentieth century. This impacted the economy of the British Empire and subsequently colonial India.
134 Local Self-govt. Department, Public Health, G.O. 490, 4 March 1932, APAC, BL.
135 Ibid.
136 Ibid.
137 Ibid.

enough importance and attention when passing any resolution or make any legislative changes in the districts, *taluks* and villages. The subordinates, while functioning within the folds of the government to propagate the superiority of western medicine and collaborating with the seat of power in maintaining the established status quo, also made use of local political power structure to ensure that their exclusive influence remained unchallenged. Such local dominance and control resonates with the concept of thick and thin hegemony by James Scott, as the social ascendants were capable of working together in turning the table and establishing a hegemony of their own.[138] Contrary to the existing literature, it shows a hegemonic influence of the local groups, and how the provincial government was constantly trying to break this 'thin hegemony' to establish their governance. These socially ascendant groups were significant in moulding the medical scene in the rural regions and were quick to establish their influence over weaker sections of Indians and, later, over the district or city administration. The following section will explore the reports from the RF and how they perceived the colonial healthcare system in Madras.

5.4.a) Colonial healthcare from a different perspective: the Rockefeller surveys

The chapter so far has explained the complex nature of the medical scenario in colonial Madras. This section will draw information from another body to explain the colonial understanding and how the RF perceived and portrayed the Madras Presidency. The RF wanted to survey the medical institutions in colonial India with a focus on rural and women health measures, to identify where they could donate and expand a western healthcare system. The RF started this work with a particular focus on Madras realising the thriving nature of western medical care in the presidency. For this, the RF corresponded with people associated with the colonial administration and outside of it. The letters were written to the Foundation before and during the exercise, and

[138] James C. Scott, *Domination and the Art of Resistance: Hidden Transcripts* (New Haven; London: Yale University Press, 1990).

these provide intriguing insights into colonial medical policies and practices in Madras. Their intention was not entirely unbiased, as was the case in the context of Brazil where the RF authorities were eager to claim the credit for the activities taken up by the local authorities and 'native' people.[139] In Chapter 2, it has been explained how some scholars explained the real motive of the RF has always been to extend their imperialist tradition.[140] Shirish Kavadi has also explained how Rockefeller programmes in India were part of a larger process of internationalisation and focussed mostly towards propaganda and explaining the local residents the benefits of choosing western treatment methods.[141] The surveys and letters of the RF, even with their certain flaws and a fair share of critiques, shows a very different side of the colonial rule in the province under study. A careful perusal of the documents, official and otherwise, points towards a definite level of collaboration and certain layers of contestations in rural Madras between the locals, the provincial government, as well as the district and sub-divisional administrations.

Sahib Singh Sokhey, who was associated with the RF, emphasised the good work done by the medical service in British India but claimed that the colonial rulers had orchestrated a façade to conceal the real nature of medical education and the imperial officers working in India. Sokhey put on record the conversation he had in private with colonial officers. He insisted that until 1909, not a single Indian had ever been appointed to the chairs of the medical schools. The Indians were not appointed because they were not considered by the GoI to be sufficiently efficient and capable of discharging these responsible duties. The British medics in charge of departments like Anatomy, Physiology, Physics and Chemistry began to give the chairs up under pressure from the Indians who were coming up as their contenders, but Sokhey claimed this was not the case where the

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139 Andrew Cunningham and Bridie Andrews, "Introduction: Western medicine as contested knowledge," in *Western medicine as contested knowledge,* ed. Andrew Cunningham and Bridie Andrews (Manchester, Manchester University Press, 1997).
140 E. Richard Brown, "Public Health in Imperialism: Early Rockefeller Programs in Home and Abroad," *Public health: Then and Now* 66, no. 9 (1976): 897-903.
141 Shirish N. Kavadi, 'Rochefeller Public Health in Colonial India', in A. Winterbottom & amp; F. Tesfaye (eds.), *Histories of Medicine and Healing in the Indian Ocean World*, Vol. 2 (216), 61-88.

private practice was involved.[142] He stressed that in places where the private practice was retained, the chairs were still held by Europeans. The issue of private practice was a matter of severe contention, and the British India government issued several notices and guidelines over the years to sort that out. There were instances of making changes to the policy and giving preferential treatment to the European physicians and to allow them to make more money by means of private practice. For example, T. W. Barnard, in charge of the Madras x-ray institute, was permitted to collect ninety-six percent of the money from private patients, and the Madras government was happy to get the remaining four percent.[143] The government could never prohibit it completely as a lot of their own physicians, the IMS doctors, were only interested in staying in India for this extra income. Sokhey argued that teachers of the medical schools were so occupied with making extra money through private practice that they found little time to devote to science and experiments.[144]

From the letter of Carter to the RF, it is understood that the Foundation was looking for an area to invest money that would benefit the healthcare system in India. But Carter seemed unconvinced about the ability of Indians to move beyond the regulated British system and not succumb to the social evils including that of casteism, bigotry, and discrimination prevalent in Indian society. So, Carter wanted the Foundation to send more personnel rather than just money as that, he thought, would help produce a group of people who could carry on the work after getting trained by the RF. Carter pointed out that the government was already, trying to encourage sub-assistant surgeons to settle in the rural areas and districts and had sanctioned three subsidies for them in each *taluk*.[145] To attract sub-assistant surgeons to remote rural districts and prevent the overcrowding of LMPs in cities, the government provided a stipend of Rs 400 per annum for medics with the LMP qualification, and Rs 600 for assistant surgeons.[146] The local *taluk* boards

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142 Carter Papers, Box 10, FA 386, Folder 78, 1926, RAC.
143 G.O. No. 776, Public Health Department, (4 July 1921), TNSA.
144 Carter papers, Box 10, FA 386, Folder 78, 1926, RAC.
145 Ibid.
146 Ramasubbu, "Rural Health," 1929.

used to give Rs 360 worth of drugs for the free treatment of indigent sick of the community.[147] A comparative study of the IHD and RF papers reveal that these institutions considered Chingleput a rural area, while the Madras government considered it a semi-urban locality; thus revealing that the Foundation had a very limited understanding of rural and urban segregations in the presidency.[148]

Up to the end of 1925, the provincial government had sanctioned the opening of 235 rural dispensaries, of which 183 were actually opened. In 1926, there were 384, which was a considerable increase, but still not capable of meeting the demands of the rural communities.[149] Carter realised after his survey that none of the *taluks* had their quota of three subsidised sub-assistant surgeons, and some never had more than one or two. Moreover, local bodies controlled the appointments through their political clout. These local bodies, composed both of lower level Indians and Europeans, were acting in their own interest to appoint people while discriminating on the basis of class and religion.[150] Sokhey's letters to the RF raised very interesting questions about the real intention of the British officials in India.[151] His writings enabled the examination of colonial tendencies from the perspective of both the public and private spheres. Sokhey wrote that in a private conversation with him the 'head of the biggest medical school in India' said, "India is a dying country, and we are here to help her die peacefully and without pain and if in the process we can help ourselves, well, why not!".[152] This was, however, just a single instance, but Sokhey gave further examples to prove that this was the mentality of British officials heading most of the medical institutions in India.

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147 Ibid.
148 V/23/309, Madras Local Boards 1903-1910, APAC, BL; Report by JF Kendrick, September 6, 1932, Folder 596, Box 74, Series-464/464C, RG 2, General Correspondence, RF, RAC.
149 Box 8, 464 A, 1926, RAC.
150 Ibid.
151 This letter was written to inform the RF about the real nature of healthcare system in India and how British officials conducted their business in colonial India. Sokhey wasn't eager to provide exact details of the hospitals and the person who mentioned the things that he wrote in the letters. So, it's difficult to take the letter on its face value but the points he made in the letter are very strong. Box 10, 1926, RAC.
152 Ibid.

He gave an example of another medical school, considered one of the best in the country to expose the hollow nature of the British claim that they were working for the betterment of the Indians.[153] Sokhey mentioned, in a whole century of existence of the school, it was unable to produce a single teacher out of the pupils. In Sokhey's words,

> In a hundred years not a single Indian had ever come to this school who possessed sufficient intelligence to acquire enough knowledge to become a teacher . . . or that is the definite policy of these schools to produce no teachers and even prevent such a thing from happening.[154]

Sokhey, however, insisted that it was a conscious effort on the part of the government to prevent the Indians from proving their brilliance in matters of surgery or medical treatment.[155] Regional journals and bulletins also carried reports asking the government to allow more provision for local representatives in the medical institutions.[156] Following the evidence provided earlier in the chapter, it can be argued that more than the schools, this could have been the policy of the Madras government in general. The government wanted fewer people competing for official positions and looking to occupy the higher ranks in the institutions and hospitals. This allowed for far less competition for the posts, and the British officials could hold onto them for a longer duration to make their stay in India more profitable.

A thorough analysis of the documents written to and examined by the RF sheds light on the intentions of colonial officials, that were far from altruistic, despite their undeniable contribution to expanding western medicine in Madras. This sub-section analysed a different angle to the rising control of the subordinates. As it shows, they were still not powerful enough to establish

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153 Carter Papers, Box 10, FA 386, Folder 78, 1926, RAC.
154 Carter Papers, Box 10, FA 386, Folder 78, 1926, RAC.
155 Ibid.
156 "*சுகாதாரவிளக்கசங்கிரகம்*" (Health Illustration Bulletin), Cukatara Vilakka, 1930; "A free dispensary opened," *The Hindu* June 13, 1932, 10.

themselves in research or in the espansion of medical science. But the social ascendants, as explained, were not targetting large opportunities and were not interested in moving outside their local spaces at least until the period under review here.

5.4.b) SMS practitioners at the local level: competition and collaboration

The late 1920s and the beginning of 1930s witnessed a change in the attitude of the British administrators and surgeons in Madras. The subordinates were beginning to earn more respect and prestige regarding cases of surgery or any other medical skills even in the eyes of the British officials. They with their access to local politics coupled with specific skillsets, began to dominate the rural and semi-urban medical marketplace. The Madras government, realising the importance of local collaboration, began to publish public health booklets to encourage the locals to join and contribute to the healthcare system.[157] A Tamil journal reported on a 'native' becoming health inspector of district dispensaries, which shows the locals coming forward to take up more responsibilities even in supervisory roles.[158] There are several instances of Lieutenant-Colonel A. J. H. Russell remaining unavailable in Madras, either for a visit to Britain and being unable to discharge his duties as the Surgeon-General; and this allowed his subordinate Captain N. R. Ubhaya to fill up his position until 1930.[159] The health propaganda work that was given significant importance by the RF was also utilised by the subordinates at the behest of the Madras government.[160] In the Imperial Challenge Shield competition for the best health week celebration in the British empire, four of the seven places commended were from the Madras Presidency – Bezwada, Tuticorin,

[157] *An appeal to the educated men of the country* (Public Health Department Madras: Superintendent, Government Press, 1929).
[158] Kumaran, "சுகாதாரவாரம்" (Health Inspector), 6, 53, 1929.
[159] Public Health Department, Report of the Director of Public Health Madras, 1928-1936, IOR/V/24/3706, APAC, BL.
[160] Ibid.

Tanjore, and Chingleput.[161] This demonstrated the importance of Madras and conveyed how significant a role this presidency was playing, especially in the healthcare sector. The propaganda worked in different ways in its bid to convince local people of the positives sides, when money was in shortage, appreciation worked. The Madras government was willing to fund new rural dispensaries, and it was acknowledged that the SRMRS, first introduced in 1924 was a success.[162] Other such schemes to improve the condition of rural healthcare began to show signs of success such as sending LMPs as health inspectors in certain districts.[163]

The year 1930 marked a significant change to the attitude of the British administrators in Madras, and this had a positive impact on the position and influence of the subordinates working in the presidency. Various district officer ranks (Anantapur, Vizagapatam), and a few in minor hospitals in the city of Madras were made available for the subordinates with effect from 1 July 1930.[164] Such a development elevated the social prestige of the SMS recruits in the eyes of the general public. There were journals published in local languages urging people to take more interest in public and community healthcare.[165] However, the economic depression had a huge impact on the SRMRS scheme, and there was a slowdown in the number of medics subsidised by the local government by 1932.[166] The medical subordinates who were already posted in the rural areas took up the mantle to continue the work that would give them control over the population. In several festivals in the districts of Madura, West Godavari, Nellore, South Kanara, and Tanjore, there were reports that the recommendations of the public health department were not carried out properly.[167] There were certain pieces of evidence that pointed towards the local bodies taking advantage of a

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161 Ibid; "Taluk Hospitals and Dispensaries," *The Hindu* September 19, 1930, 9.
162 *Annual Report of the civil hospitals and dispensaries*, 1931, BL.
163 *Ibid.*
164 *Ibid.*
165 Venkatesa Sharma, "*இல்லாண்மை, அல்லது, குடும்பசுகாதாரபரிபாலனம்*" (Lack of health perception in families) (Gopalakrishnan, 1931).
166 V. R. Muraleedharan, "Professionalising Medical Practice in Colonial South-India," *Economic and Political Weekly* 27, no. 4 (1992): 27-30, 35-37.
167 V/24/3706, Public Health, 1929-35, APAC, BL.

few provisions of the Local Boards Act and of the Districts Municipalities Act in religious matters.[168] There was a sustained interest among the state and IMS officers in charge of the presidency to expand the western healthcare as they were trying to expand the influence and spread of health monopoly. J. R. D Webb, the Director of Public Health in 1932, declared,

> . . . glories of good Public Health will not be achieved by singing "Oh! How beautiful" and sitting in the shade. We must take "our-coats-off" and try and apply the teachings and preachings of our Professors and Research workers by a practical application in that immense field for Public Health endeavour, the "Rural India". [169]

This demonstrates the patronising attitude of the British administrators towards the people in the rural regions. However, rural healthcare scheme was close-knit, and as explained earlier in the chapter was being controlled by the local boards in their individual areas and districts. With their distinct medical and political structure, Madras Presidency witnessed the rise of local pockets of power, explained earlier as social ascendants where a group of local people in the rural areas were collaborating and competing with people from other districts.

In the mid-1930s, the previously watertight division between the urban and the rural was becoming blurred with the expansion of city limits and also medical care – in turn expanding the medical marketplace. Local authorities began to be classified into urban local authorities and 'other' authorities.[170] The urban local authorities consisted of the corporation of Madras, municipal councils, and panchayats specifically notified by the government.[171] Overall, the provincial government was held accountable for all the local activities, but in reality, the local authorities were allowed to

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[168] Ibid.
[169] V/24/3706, Public Health, 1932, APAC, BL.
[170] C. V. Naidu, *The Public Health in Madras province* (Tiruvallur: Rajeswari & Co., 1939), 18-19.
[171] *Ibid.*

function undisturbed in their way of dealing with health matters.[172] However, while this method worked impeccably in favour of the Indians trying to expand their control locally, it did not provide much opportunity for expansion of medical research or extension of research institutes in the rural areas. The public health administration in the 1930s had complete details of the various medical schools, colleges and their infrastructural work, but had strikingly summarised only the details of actual medical research. The medical journals and gazettes of the time largely overlooked or discouraged any medical research by the Indians.

The GoI Act 1935, however, recognised the power these local boards wielded over the provincial administration and they tried to give some control back to the hierarchically superior officers. However, the local boards could maintain their control over these health officers, although they were given the right to appeal against the local boards to higher authorities.[173] The contested role remained the same, if not worsened by the mid-1930s. A minister commented about a town where he knew, 'the sanitary inspectors were asked to collect taxes instead of performing sanitary work. There were municipal councils which had defied the officers of the health department'.[174] Such incidents increasingly highlight the influence of the ascendant sections in the Madras Presidency and how they not only retained their power locally but compelled the government health officials to comply with their demands and actions.

5.5 Conclusion

This chapter has established the crucial role played by the subordinate medical personnel in the expansion of western medical marketplace in the Madras Presidency. The previous chapters have explained how the systematic decline of the Madras army compelled the local residents in the presidency to seek a career in western medical training. While medical bodies like the IMS began

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[172] *Ibid.*
[173] P. R. Aiyar, *The Madras Public Health Act* (Madras: The Madras Law Journal Officer, Mylapore, 1939), 5-7.
[174] *Ibid.*

to accept indigenous doctors into their ranks, and the locals began to dominate those ranks, it is the role of the subordinates and intermediaries that demand our attention.

Borrowing from James C Scott's theory on thick and thin hegemony, this chapter argues that as the medical marketplace began to expand and spread from urban to rural and remote areas, the roles of the subordinates became more critical.[175] In recording the dynamic role of the SMS and recognising them as social ascendants, this chapter adds a new dimension to the study of healthcare structures during the colonial period. Breaking out of the binary of the coloniser and the colonised, this chapter emphasises the collaboration and competition not only between the British and Indians but also various groups of Indians to establish the hegemony of western medicine across the presidency. As the chapter has pointed out, the subordinates in Madras were deeply involved in the colonial medical system, but the involvement was on various levels, and they contributed in very distinct manners. Only by accessing the subordinate perspectives, a more nuanced understanding of colonial healthcare can be attained. The chapter has also shown the need to re-evaluate assumptions about the medical administration of the empire, and how local, regional interests underpinned those administrative processes. Finally, this chapter points out the cultural, social, and linguistic factors that worked in collusion to influence the medical structure in the presidency. The final chapter explores the role of the WMS, with a focus on how the local women were involved in such medical expansion in the presidency. This will also provide a comparative annalysis with the medical subordinates and how the Madras government acted in that context. Such a study aims to bring out the narrative of medical expansion from conflicting yet interconnected angles of both the genders.

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[175] Scott, *Domination and the Art of Resistance.*

Chapter 6 – Western Medical Service for, and by, women in Madras Presidency (1880-1935)

The study of colonial Indian healthcare and medicine began to receive more careful and extensive attention in the 1980s, but a preponderance of the scholarship has focussed on male perspectives and narratives. As a result, women's roles have hardly been analysed and represented in the existing body of work. Some work by scholars such as David Arnold, Mark Harrison and Radhika Ramasubban provides introductory knowledge about the healthcare structure involving women.[1] However, this relative neglect of female contributions to the expansion and management of colonial healthcare should not be seen to be representative of the apparent lower status of the Indian women during the British period and their lack of opportunity or involvement in the health sector. Indian women of this period, as Maneesha Lal points out, have largely been portrayed as victims of cruel practices such as *sati* (the immolation of widows on the funeral pyres of their husbands), female infanticide and child marriage – and this portrayal has dominated the narrative of Indian women of the colonial period.[2] Such incomplete, mostly ill-informed, and lopsided notions about Indian women in the colonial period, particularly those from the Madras Presidency, adversely affected the pursuit of detailed studies in this field. So, the contribution of medical women in colonial Madras has remained largely an under-explored area.

This chapter will limit itself to studying the women medical officials in the Madras Presidency and will make an attempt to analyse their contribution to the history of colonial healthcare

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[1] David Arnold, *Colonizing the body: state medicine and epidemic disease in nineteenth-century India* (Berkeley: University of California Press, 1993); *Imperial Medicine and Indigenous Societies* (Manchester: Manchester University Press, 1988); Mark Harrison, *Public health in British India: Anglo-Indian preventive medicine, 1859-1914* (Cambridge; New York: Cambridge University Press, 1994); Radhika Ramasubban, "Imperial Health in British India, 1857-1900," in *Disease, Medicine and Empire: Perspectives on western Medicine and the Experience of European Expansion*, ed. Roy Macleod and Milton Lewis (Routledge, London, 1988).

[2] Maneesha Lal, "The Politics of Gender and Medicine in Colonial India: The Countess of Dufferin's Fund, 1885-1888," *Bulletin of the history of Medicine* 68, no. 1 (1994): 29-64; For more details on the ritual of *sati* see, John Stratton Hawley, ed. *Sati, the Blessing and the Curse: The Burning of Wives in India* (New York; Oxford: Oxford University Press, 1994); Lata Mani, "Contentious Traditions: The Debate on Sati in Colonial India," *Cultural Critique*, no. 7 (1987): 119-156.

in the expansion of the medical marketplace. This will initiate dialogue and pave ways to understand and explore women's contribution to the healthcare framework and focus on their importance in the western medical narrative. The press, particularly the British, had used the terms 'woman healer', 'doctress', and 'lady doctor' with all possible permutations.[3] However, female physicians categorically declined to use such labels for themselves and opted for 'medical women', both in public and private correspondence and conversations.[4] This chapter will stick to using the term 'medical women' to refer to female physicians. On certain occasions, however, terms such as 'female physicians', 'female practitioners' or 'women doctors' have also been used for alternatives in vocabulary.

Some scholars have attempted to decrypt the medical care for women in colonial India, even though they focussed on the missionary activities, midwives, nurses or the *dhais*.[5] This chapter will consider the role of the Dufferin Fund (established in 1885 by Harriot Dufferin, vicereine of India. DF hereafter) and explain how Madras experienced a very distinct healthcare contribution from the WMS.[6] This chapter also examines the contribution of Indian medical women who were becoming increasingly important in the twentieth century Madras. To explore these complexities, this chapter will adopt a two-pronged approach – first it will examine the DF and the establishment

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[3] Kaarin Leigh Michaelsen, 'Becoming "Medical Women": British Female Physicians and the Politics of Professionalism, 1860-1933,' (PhD Dissertation, University of California, Berkeley, 2003), Introduction.
[4] Ibid.
[5] Madelaine Healey, *Indian Sisters: A History of Nursing and the State, 1907-2007* (London: Taylor and Francis, 2014); Ambalika Guha, "The 'Masculine' Female: The Rise of Women Doctors in Colonial India, c.1870-1940," *Social Scientist* 44, no. 5/6 (2016): 49-64; *Dai* or *dhais* were the traditional midwives who were instrumental in childbirth and maternity care. The Government of India, however, wanted to replace them with Western trained midwives in the mid-eighteenth century. To know more on this check, Sean Lang, "Drop the Demon Dai: Maternal Mortality and the State in Colonial Madras, 1840-1875," *Social History of Medicine* 18, no. 3 (2005): 357-378; Rosemary FitzGerald, "Rescue and redemption: the rise of female medical missions in colonial India during the late nineteenth and early twentieth centuries," in *Nursing history and the politics of welfare*, ed. R. FitzGerald et. al (London; New York: Routledge, 1997), 64-79.
[6] The Countess of Dufferin Fund was established by Hariot Hamilton-Temple-Blackwood, Marchioness of Dufferin and Ava, more commonly known as Lady Dufferin, in 1885 and was dedicated to improving women's healthcare in India. The Fund was established after Queen Victoria gave Lady Dufferin the task of improving healthcare for women in India. For more information see, Margaret Ida Balfour papers, Wellcome Library, PPMIB, 1869- 2000; Antoinette Burton, "Contesting the zenana: The mission to make 'lady doctors for India,' 1874-1885," *Journal of British Studies* 35, no. 3 (1996): 368-397.

of the WMS in Madras, and secondly, it will explore the contribution of the state, local bodies, the RF and the medical women in shaping and expanding the western healthcare for females in the Madras Presidency. This will follow a chronological structure while explaining the changes effected in this presidency in female healthcare. The first section will examine the early days, the initial trepiditions of the medical women, it will be followed by the changes effected by the introduction of the DF, and the final section will evaluate the role of international organisations, and the colonial government working with and against the local residents to establish a functioning healthcare model for women.

6.1 Colonial medical services in the early days in Madras: the female perspectives

The colonial government in India was constantly under pressure, particularly since the 1880s to have more medics in their roster. The pages of medical journals such as the *IMG* reflect the general tendencies of the British officials as well as of the local Indians concerning the recruitment and training of 'lady doctors'. As per the estimate, to appoint one female medical practitioner for every 100,000 women patients, British India required at least one thousand women medics.[7] In the 1880s, it seemed impossible for the GoI to find so many female practitioners, and ongoing financial constraints made the initiative even harder. The DF, as the national association came to be called, was the first systematic attempt to bring Indian women within the ambit of western medicine. The DF was at that juncture, 'the single most important institutionalisation of gender in the history of colonial medicine in India'.[8] The Fund was established after long debates and discussion concerning the health of Indian female patients in colonial India. Several suggestions were floated by the medical officers of varying ranks and designations– most of them male – detailing

[7] "Medical Women for India," *IMG* (August 1883): 225-227.
[8] Lal, "Women, Medicine and Colonialism in British India, 1869-1925," 30.

how they could 'save' millions of Indian women who remained largely outside the purview of the western medicine in the country.[9]

The cost of sourcing trained female practitioners from Britain was becoming increasingly unfeasible for the GoI, as they were channelling their finances mostly to develop the military against other European powers. The GoI started putting more thoughts into making provisions for training female doctors in India, as they realised it would be much less expensive and more adaptable to the necessities and sentiments of the local Indians.[10] This led to the expansion of the medical training centres for women in the big cities like Calcutta, Madras, Bombay and even beyond the city limits. The increasing number of maternal and infant deaths in the 1880s compelled the colonial administrators to acknowledge the serious lack of 'qualified' female medical practitioners in the colonial state.[11] Nursing had always been a profession that was dominated by women, but medical administrators back in the late nineteenth century could not decide on the 'capacity' of the women to acquire the complicated skill of medicine.[12] Women, particularly the locals, were not considered skilful or intelligent enough to handle complex medical care. Thus, the Calcutta Medical College rejected the notion of training women doctors and insisted on continuing to train women in midwifery.[13]

However, as has been explained in the previous chapters, Madras adopted a different attitude towards western medical care. E. Balfour, the Surgeon General of Madras in 1874, started the process of admitting female students into the Medical College.[14] A report published in the *ToI*

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[9] The idea of colonial benevolence has been explored in many scholarly writings. Few such examples are Harald Fischer-Tine and Michael Mann ed. *Colonialism as civilising mission: cultural ideology in British India*, (London: Anthem Press 2004); Niels Brimnes, "Variolation, Vaccination and Popular Resistance in Early Colonial South India," *Medical History* 48, no. 2 (2004): 199-228; Lal, "Women, Medicine and Colonialism in British India, 1869-1925,"; Bhattacharya, Harrison, Worboys, *Fractured States.*

[10] "Medical Women for India," *IMG* (August 1883): 225-227.

[11] Ibid.

[12] Ibid.

[13] Mita Bhadra, "Indian Women in Medicine: An Enquiry Since 1880," *Indian Anthropologist* 41, no. 1 (2011): 17-43.

[14] "Medical Women for India," *IMG* (1883): 225-227.

quoted, '. . . touched by the sufferings of Indian women, victims of the originally Mohameddan practice of seclusion in the *zenanas,* conceived the plan of educating women doctors at Madras'.[15] By 1875, it was generally agreed upon by the MMC that lady candidates should be extended more encouragement to study for a medical degree and a full curriculum was made available specially for women.[16] One of the lady doctors, after finishing her course moved to London for getting the M.B degree at the University of London and others, were mostly engaged in private practice.[17] However, there still were sceptics unsure of the abilities of the female medical practitioners, despite the public opinion slowly beginning to tilt in favour of training and engaging medical women. The *ToI* quoted one vernacular newspaper where they reported on women medical practitioners, 'to the best of our recollection, we have not heard of any movement which has so successfully appealed to the native community as this', while another local newspaper wrote, 'There is hardly an Indian of any respectability who does not feel the want of trained medical women in India'.[18]

The local reports and government resolutions consistently point towards the novelty and apparent liberal outlook of the system of medical training in Madras. The Lieutenant-Governor of Bengal issued a resolution praising Madras that did not show the Bengal Presidency in a good light. He said,

> The educational system of Bengal, progressive in other respects, has been illiberal and retrograde in the medical education of women; and on the other fact that some Bengalee ladies have had to betake themselves to the more liberal presidency of Madras for the prosecution of their medical studies.[19]

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[15] "Medical Women for India," *ToI* October 11 1883, 6; The Zenana in this context referred to the part of a house that belonged to Hindu or Muslims families in colonial India which was reserved only for the women of the household.
[16] Ibid.
[17] "Medical Women for India," August 1883, *IMG*, 225-227.
[18] "Medical Women for India," *ToI* October 11 1883, 6.
[19] Ibid.

Thus, even with the persistence of some doubts that were present in the minds of the medical professionals in terms of introducing women doctors in the country, Madras began to show consistent support for female practitioners. *The Lancet*, the *Medical Press and Circular* and the *IMG* during the 1880s were campaigning for the need to have more medical women in British India.[20] Thus, the state actors along with the non-state actors including the medical professionals, and more importantly the public were enthusiastic about providing local women with the option to consult female doctors as 'the vast majority of Indian women would rather die than submit to treatment at the hands of male practitioners'.[21]

In order to understand the shambolic state of female healthcare in colonial India, rural healthcare measures needed to be examined properly. In the majority of cases, from the time that a female child reached girlhood to the day of her death, she was denied any effective relief by medical science. Even among the sections who desired that their women had this aid; and who were able to pay for it, their examination by a medical man was nothing more than farcical. The Muslim households were stricter in terms of letting male doctors, but the Hindus were also very conservative in their approach. W.W. Hunter in 1889 wrote about the condition under which the medics had to work in the Hindu and Muslim households, particularly while treating their women,

> In a Muhammadan house, the physician cannot himself study the symptoms of the disease he has to treat; he cannot be permitted to behold the appearance of his patient, or even to feel her pulse; he has to depend entirely upon the information communicated to him by the stupid maid-servant, whose language and ideas are generally anything but precise. In Hindu houses, permission is always granted to feel the pulse, but in such cases, the patient remains enveloped in a thick sheet or quilt and only thrusts out her left hand as far as the wrist, and the physician can know nothing of her appearance. The face is rarely exposed, and when it is the eyes are kept firmly closed.[22]

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[20] Ibid.
[21] Ibid.
[22] W. W. Hunter, "A female Medical Profession for India," *The Contemporary Review* 56 (1889): 207-215.

Such cases, particularly in the rural areas, convinced the GoI to seek more female practitioners in India. While such incidents and examples abound, female health services in colonial India, particularly in the late nineteenth century premised on the ideas and efforts of philanthropy, evangelicalism of the local government and that of the colonial state. Most programmes were built on the assumption that Indian women would not go to male doctors and thus needed medical women to administer medical care to them.[23] There has been a good deal of discussions, both written and verbal, in private and public, to identify the level of medical education necessary for the career of medical women in India, the initial impression reflecting that 'a somewhat meagre medical education will suffice for the work'.[24] In practice, however, the training needed was more thorough and complicated.[25] A National Association of Female Medical Aid was also established in the late nineteenth century with the aim to provide aid to women by female practitioners.[26] This chapter will now examine the female healthcare practices under two sections, the first will be on the healthcare for women until 1913, or the establishment of the WMS, while the second section will elucidate more on the medical practices and women practitioners working across the presidency of Madras until 1935.

6.2 Women at work: Medical services in Madras

The system of medical relief in British India had not been one of consistent growth but replete with crests and troughs, and the colonial administrators had a tough time understanding

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[23] Divya N. Roy, "Reforming Mothers, Creating Citizens: The politics of Women's Health and Family Planning in Colonial and Postcolonial South India," (PhD Dissertation, University of Pennsylvania 2014), Introduction.
[24] E. M. Beal, "The Prospects of Medical Women in India," *Littell's Living Age* (1844-1896) (1885): 167.
[25] Ibid.
[26] "The National Association for Supplying Female Medical Aid to the Women of India," *IMG* (December 1888): 371-373.

the process and becoming familiar with it. The GoI realised in the early 1880s that even though the number of local men turning up for treatment in hospitals and dispensaries was low, the women were not even one-third of that number and it was mainly because of the absence of skilled medical women.[27] However, as Hoggan mentioned, the presidency of Madras witnessed a comparatively higher proportion of women being treated at the healthcare centres.[28] There were, however, certain constraints in securing the services of medical women in Madras. In the late nineteenth century, there were not enough Indian women who were interested in becoming medical professionals. Furthermore, there was a lack of government funding to support the training and education of women. It also required a cumbersome effort on the part of women practitioners to find a medical marketplace suitable for their skillset. Although in the Madras Presidency, the local elites expressed interest and extended support to train women, there were not enough medical institutions nor interested patients to secure their services.[29] The government displayed interest in training medical women, and in the rural areas they could get some remuneration or aid, but largely the population was either too poor or considered female healthcare to be a matter of low priority. The GoI realised the importance of making people aware of the western medical tradition so that they would, in turn, be interested in securing the services of medically trained practitioners. Unlike men, who were usually ensured of some remuneration as dispensary officers, women had to fight for their payments in most cases and were at times forced to place fees above professionalism.[30]

In order to understand the shift in the position of women in colonial Madras, this chapter will examine ruling imperial perspectives, which although divided by class prestige and racial identities, largely portrayed Indian women as inconsequential, a burden of the 'white men and women'.[31] The narrative usually focussed entirely on how they needed to be 'saved' or 'aided' by the

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[27] Frances Elizabeth Hoggan, "Medical Women for India," *The Contemporary Review* 42 (August 1882): 267-275.
[28] Ibid.
[29] Ibid.
[30] Ibid.
[31] Hunter, "A female medical profession," 207-215.

colonisers. The University of Madras by the mid-1880s had begun to accept female students in the medical schools, although the infrastructure for western healthcare was not regulated. In the initial years, such an opportunity provided another alternative to the British medically trained women to secure employment and sell their skill in the colonial province.[32] Supplying medical care to the *zenana*, was a source of personal motivation for the medical women trained in Britain, particularly when they were being inspired to institutionalise women healthcare in the 'unhygienic Oriental space'.[33] Antoinette Burton has argued that the responsibility of British medical women to provide medical care to Indian women, imagined as captivated and awaiting liberation, was nothing short of an imperial obligation.[34]

The Madras Presidency was one of the first places to have a hospital for caste and *gosha* women in Madras, and it marked the beginning of something significant.[35] Opening a hospital for women of different religions and castes facilitated the expansion of medical care to the hitherto untouched population, irrespective of their caste and *gosha*.[36] In the 1880s, people, particularly in Madras, began to show enthusiasm in training female medical practitioners. The *ToI* reported in 1885 that a large number of subscriptions were received from Indian elites (including the Maharaja of Vizianagaram, Rajah of Venkatagiri and other wealthy people) for the establishment and development of the women's hospital.[37] The Governor of Madras at that time, Grant Duff commented after opening the hospital for the public in 1885:

> I have presided on many public occasions in Madras, and one of my greatest pleasures in India has been to do all in my power . . . But of these numerous occasions none has, I think, been more interesting

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[32] Hoggan, "Medical Women for India," 267-275.
[33] Antoinette Burton, "Contesting the zenana: The mission to make 'lady doctors for India' 1874-1885,"*Journal of British Studies* 35, no. 3 (July 1996): 368-397.
[34] Ibid.
[35] "A hospital for Caste and Gosha women at Madras," *ToI* March 11 1885.
[36] Gosha women were those who followed the Islamic law of concealing herself from the sight of men, except certain close relatives. It is a synonym for women kept in *purdah* and used in colonial South India.
[37] "A hospital for Caste and Gosha women at Madras," *ToI* March 11, 1885.

> to me than this, when we are met together in hopes of benefitting a most meritorious and deserving class of persons, those women who are precluded by religious feeling or social custom from profiting by the various hospitals open to others of lower caste or differing faith.[38]

While the claims made by Governor Duff seem generous, they point towards how the colonial policy was being shaped and modified over the years in trying to establish a dominating influence over the local residents of the presidency.[39] The locals in Madras, on the other hand, forced the colonial state consistently to mould their policies according to the local demands, directly in some instances while indirectly in others.

The idea of making western healthcare accessible to Indian women began to be seriously considered by the British Crown in 1884 when Queen Victoria commanded the Countess of Dufferin to devise some scheme to provide medical relief to Indian women.[40] Lady Dufferin and her advisers established "The National Association for Supplying Female Medical Aid to the Women of India" in 1885, and it was soon realised from the enthusiasm and encouragement shown by the Indians that this would play an extensive role.[41] With a significant section of women confined in the *zenana,* it became necessary, as Surgeon General Balfour argued, to extend western medical care for women who remained outside the public domain.[42] However, *zenana* healthcare has faced criticism as the DF were only looking at the *purdah-nashin* women while most of the lower caste women used to come out of the house and undergo treatment in hospitals.[43] This was a general statement for colonial India, and Madras with its large concentration of powerful Brahmin families were reliant on medical women for their treatment. Hoggan's argument concerning the benevolence of the colonisers vividly describes the saviour complex of the British:

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[38] "The Madras hospital for women," 6.
[39] Ibid.
[40] Hunter, "A female medical profession for India," 207-215.
[41] Ibid.
[42] Hoggan, "Medical Women for India," 267-275.
[43] Lal, "The Politics of Gender and Medicine in Colonial India,"29-64.

> . . . it would be strange indeed if, in the one item of medical women, protection should be found unnecessary, and the weakest, the poorest, the least self-reliant members of the community - i.e., Indian women - might be trusted to make known their demands, and to take measures to ensure an adequate supply of women- doctors for their use.[44]

However, Hoggan wrote that the women medical department should ideally coordinate with the civil medical services and not be established as subordinate to the men's service. Hoggans' views were not always openly endorsed by the British administrators in India, but there was presence of the people who wanted to save the backward Indian women from their darkness. It becomes harder for a historian to interpret these colonial medical interventions but notes and letters written in the IMG issues bear testimony to this thought process.[45] This period witnessed a massive employment opportunity for British medical women in colonial India. Queen Victoria became the patron of the Dufferin Fund that made sure of its publicity and inspired a lot of women to join this initiative.[46] The social and educated elites in the city of Madras were eager to accept more provisions for women healthcare and the donations began to pour in generously.[47] This extended beyond pecuniary support and the medical women were apparently elevated to a respectable social position in Madras as well, and as far as recognition was concerned, there was no dearth of it in the city.[48] The intention of the DF was to expand medical relief by opening cottage hospitals and dispensaries for women and children, establishing female wards in the hospitals and also getting more female practitioners trained as subordinate in the newly opened medical institutions.

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[44] Hoggan, "Medical Women for India," 267-275.
[45] "The War Medical Manual," *IMG* (August 1917): 286-294.
[46] Harrison, *Public health in British India*, 92.
[47] "A hospital for Caste and Gosha women at Madras," *ToI*.
[48] Hunter, "A female medical profession for India," 207-215.

6.2.a) An inclusive Dufferin Fund? The case of Madras

Madras contributed heavily to the development of female medical education and training, and in the 1880s attention was focussed mainly on the education of local women to become hospital assistants and apothecaries or assistant surgeons in different women hospitals across the presidency. The government of Madras could not afford to establish too many medical institutions because of their financial constraints, and thus private benevolence was appreciated and encouraged by the officials. The previous chapter explained how the government of Madras convinced the local wealthy people to donate for expanding medical practices, and the scenario was similar in the case of female medical training. A record of the DF published in 1888 applauded the role played by the Madras Presidency and their efforts to make their healthcare programme impact the maximum number of people. It further stated that female medical education in Madras no longer remained an experiment, as 'it has been proved to be practical and successful'.[49] Several scholarships were endowed by wealthy patrons and at times religious leaders in Madras like the Mahant of Tirupati, and also by the local and district boards.[50] There was a distinct lack of interest among women candidates in the beginning, and in 1888 only 10 candidates were taken in for 19 apothecary positions. In 1889, however, all the positions were filled up and they had to introduce 5 other hospital assistant positions.[51] The enthusiasm was quite apparent among the locals, and Mr Krishnama Chariar undertook the responsibility of translating the book '*A record of Three years' of work of the Dufferin Fund*' written by the Marchioness of Dufferin.[52] Such show of support and expansion of the boundaries of medical care beyond the city limits demonstrated how the locals

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[49] The Countess of Dufferin, *A record of three years' work of the National Association for Supplying Female Medical Aid to the Women of India* (Calcutta: Thacker, Spink and Co., 1888), 44-48.
[50] *The National Association for Supplying Female Medical Aid to the Women of India (NASFMA* hereafter), Report of the Madras Branch, 1889.
[51] *Ibid*; "The Countess of Dufferin's Fund," *The Hindu* January 24, 1895, 4.
[52] *Ibid.*

were enthusiastic about the development of healthcare for women. The translated work was completed and distributed to the local and municipal boards to trigger the interest of the general public regarding the progress of their work. This was one of the earliest instances of medical propaganda being employed in Madras.

In the late nineteenth century, medical women trained in MMC were sent to different parts of the country and were appointed to high positions in other presidencies. Initiatives of building new infrastructure for women hospitals continued to gather support, and wealthy elites continued to pour in money for such endeavours.[53] New dispensaries and small hospitals were built across the presidency, and the staffing requirement of such institutions was being fulfilled by female practitioners trained in Britain, giving them access to a large section of people to spread the influence of western medical knowledge.[54] The princely states and local ruling classes showed an inclination towards appointing female practitioners for their families following active encouragement from the British authorities.[55] In the Madras Presidency, the local boards began to control the scholarships and employment for trained midwives, and by 1891 there were 208 midwives working under local authorities, but Arnold has argued that the local people reached out to the trained midwives only in 'extreme and difficult cases', and the traditional Indian midwives or the *dais* were the ones handling most of the childbirths in the presidency during this period.[56] Arnold further argued that the intent to replace or reform the *dais* indicated the colonial tendency to incorporate more women into western healthcare.[57] Nevertheless, a contention remained among locals that there were not enough initiatives taken on the part of the DF to draw more Indian women among their midst. Harrison pointed out this flaw quoting the *Bengalee,* which reported that there was a deliberate attempt to 'exclude our country women from occupying posts of high responsibility . . . which act

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[53] *Ibid.*
[54] Hunter, "A female medical profession for India," 207-215.
[55] Ibid.
[56] Arnold, *Colonizing the Body*, 258-259.
[57] *Ibid*, 257.

as a great hindrance to the advancement of Indian people'.[58] Irrespective of such hindrances, Madras continued to show promise in training local women as medical practitioners. Miss Govindarajulu, who was a certified apothecary, was employed in a hospital named after the Maharani (Royal Queen) of Mysore as an Assistant Surgeon.[59] She was trained in Madras and continued in her position and was also engaged in private practice. She wrote about caste and religious segregations that obstructed the higher caste Hindus or Muslims from approaching the hospital as inpatients.[60] However, the initial enthusiasm began to wane gradually, and by 1895 there were not a sufficient number of Indian women imparting medical care. It became quite apparent by mid-1890s that the DF was not making healthcare accessible to all women and was only directed towards benefitting the privileged section of Indians. The fees charged at hospitals and dispensaries were exorbitantly high and local organisations began to express their frustration and discontent. Even after the establishment of the DF, it remained fairly difficult for the colonial state to 'demystify' the *zenana*.[61] The treatment of *purdah-nashin* women turned out to be unusually difficult because of a rule in the DF that required its hospitals to undergo regular inspection by male IMS doctors rendering the locals more sceptical about visiting hospitals regularly.[62] This points out the difficulties prevalent among the locals concerning western medical treatment and more importantly, the issues regarding women being treated by male doctors.

Nevertheless, the provincial government aided by the locals and 'native' princes continued to fund the training of women as apothecaries and hospital assistants in the presidency. In 1896 there was an offer from *Krupabhai Satthianadhan* Memorial Fund to grant scholarships to female

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[58] Bengalee, 18 February 1891 quoted in Mark Harrison, *Public Health*, 94.
[59] *NASFMA*, Report of the Madras Branch, 1889.
[60] *Ibid.*
[61] Harrison, *Public Health*, 93
[62] Margaret I Balfour and Ruth Young, *The work of medical women in India* (London, New York, Madras: OUP, 1929), 39-40; According to Papanek and Minault, "Purdah, [or pardah] meaning curtain, is the term most commonly used for the system of secluding women and enforcing high standards of female modesty in much of South Asia." See Hanna Papanek and Gail Minault, "Foreword," in *Separate Worlds: Studies of Purdah in South Asia*, ed. Hanna Papanek and Gail Minault (Columbia, Mo.: South Asia Books, 1982).

medical students.[63] Notably, this scholarship was available to only the 'native' Indians, and thus the number of women interested in accepting this was less, but the committee was convinced that gradually as the female education expands, more would join in.[64] This period also made the government rethink the fees and stipends for the female medical cohort of students and apothecaries. The local boards, however, gave similar payment to both male and female apothecaries, but the medical college was finding it difficult to admit enough female students in the period leading up to the twentieth century.[65] There were certain irregularities in terms of payment by the local boards, who were usually motivated by the requirement of medical women in the locality and at times were willing to pay large sums of money for their services. However, the city officials comprehended that such inequalities would cease to exist in a few years as they hoped that more medical women would graduate yearly and compete for space in the medical market.[66] Districts such as Tinnevelly had more than one female hospital or dispensary in the locality, and the comparatively smaller one was run by only a compounder, a water-woman and nurse that was later recommended to accommodate a lying-in-ward as well.[67]

The arrangements in the female hospitals prioritised the needs of the Indian women observing female segregation and *purdah*; and in the process, the general female hospitals disregarded a large section of Indian women who were from the lower castes or were religious minorities.[68] Madras, with its investment in the Victoria Caste and Gosha hospital, made sure that there was support for and from all, irrespective of their caste and religion in terms of providing better healthcare for women. This is possibly indicative of the underlying caste and class segregation present in Madras during that period which the provincial government was aware of. That could

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63 *NASFMA*, Report of the Madras branch, December 1896, 10-12.
64 *Ibid.*
65 *Ibid.*
66 *Ibid.*
67 *Ibid.*
68 Samiksha Sehrawat, "Feminising Empire: The association of medical women in India and the campaign to found a women's medical service," *Social Scientist* 41, no. 5/6 (2013): 65-81.

have compelled them to build such a hospital to convince the locals about their intentions to abide by societal traditions. Whereas reports from districts such as Coimbatore signify that even when there was an absence of a female apothecary in the dispensary, there would be a decrease in the number of women coming in, but still a significant number continued to receive medical treatment from a male apothecary for about four months.[69] Even with the locals displaying this level of enthusiasm, the unofficial mouthpiece of the IMS, the *IMG* showed little to no interest in writing about women healthcare in Madras in the late nineteenth century.

Anne Witz argued how the Indian women were brought under the purview of the 'medical gaze' should not be treated differently from the 'imperial gaze' changing the perception of the 'female medical discourse'.[70] Medical practices should not be deemed only as procedures on passive bodies, but the colonial medical practices colonised the bodies as well as the social spaces around them.[71] Such an approach made sure that the medical women in Madras play a significant role in terms of establishing colonial hegemony onto the local women with their contribution in mid-wifery and preventive medicine. The DF has received quite a lot of criticism from scholars in the recent past concerning their real motive behind imparting female medical services in colonial India, and their treatment of local women and their betterment.[72] However, in the Madras Presidency, the control and dominance of the DF were curtailed. Madras received generous funding from the wealthy patrons and different bodies in the presidency that made sure that the Indian women were encouraged and incorporated into the system – particularly with some scholarships reserved only for the local inhabitants.[73] The patrons of the DF in Madras included people such as the Maharaja

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[69] *NASFMA*, Report of the Madras branch, December 1896, 15.
[70] Anne Witz, "Colonising women: Female medical practice in colonial India, 1880-1890," in *Women and Modern Medicine* (Clio Medica), ed. Lawrence I. Conrad and Anne Hardy (Rodopi, 2001), 23- 52.
[71] Ibid.
[72] Lal, "The Politics of Gender and Medicine in Colonial India," 29-64; Lal, 'Women, Medicine and Colonialism in British India, 1869-1925,' ; Witz, "Colonising women," 23- 52; Burton, "Contesting the zenana," 368-397; Sehrawat, "Feminising Empire," 65-81; Samiksha Sehrawat, *Colonial medical care in North India: gender, state and society, c.1830-1920* (New Delhi: Oxford University Press, 2013).
[73] NASFMA, *Report of the Madras branch*, December 1896, 11-12.

of Vizianagaram, Rajah of Bobbili, Zemindar of Devarakota, Rajah of Kalahasti, Justice Mr Subramania Iyer, Rajah of Pudukottai along with the Government of Madras and the municipal boards.[74] Thus, although the DF had their own motivation and aims, the local and municipal boards continued to fund and educate female apothecaries and hospital assistants in the presidency which provided them with a considerable voice in the administration. It will be difficult to compare the respective position of a local government official or landed elite to those in a different province like Bengal or Bombay. Because of their strong caste, and religious identity Madras local wealthy landowners and those from the royal families were more willing to fund hospitals for the local women. It was providing them a sense of fulfilling responsibility as well. The added interest of getting titles, prestige from the British also lured them in large numbers towards patronage. As this chapter will explain later on, such donations and patronage from local residents helped establish awareness among the local residents. The comprehensive record of educating and training medical women in the presidency point towards the novelty of medical education being offered to the locals in Madras. Medical tuition remained the backbone of the DF, and they continued to provide money and resources to impart medical tuition to the maximum number of candidates. The DF, however, continued to have greater influence in the context of appointing new pupils and they did not allow the local boards to have complete control of the appointments. This could be interpreted as a method to maintain control over appointments and to push their idea of benevolent hegemony further.

Table 6.2.a (i) (Number of medical women trained and under training in 1897, Madras)

Organisation	Districts	Trained	Under Training
	Tinevelly	1 female apothecary	2 female apothecaries

[74] *Ibid.*

Local Fund Boards	Bellary		1 Scholar
	Salem	2 female apothecaries	
	Madura	1 female apothecary	1 female apothecary
	Viragapatam	4 female apothecaries	
	Kistna		1 scholar
	Ganjam	2 female apothecaries	1 female apothecary
	South Canara		1 scholar
	Nellore	2 hospital assistants	1 female apothecary
	Coimbatore	2 female apothecaries	
	Tanjore		1 scholar
	Trichinopoly		1 scholar
Municipal Councils	Madura	1 female apothecary	
	Coimbatore	1 female apothecary	
	Negapatam		1 scholar
	Mannargudi		1 scholar
	Trichinopoly		1 scholar

Source: *NASFMA,* Report of the Madras branch, December 1898.

6.2.b) Expanding the role of medical women in Madras

With the advent of the twentieth century, Madras saw a rise in interest among women candidates to be trained and educated in western medical practices. Such enthusiasm was also the result of the work undertaken in the rural areas of the presidency; in particular, the districts of

Coimbatore and Madurai showed exemplary advancement in upholding the standard of the women medical schools in their areas.[75] Of the twenty-two districts in Madras, fourteen had one or more female practitioners at work, and the remaining districts – Anantapur, Chingleput, South Arcot, Trichinopoly, Tanjore, Kurnool, Malabar, and the Nilgiris expressed interest in following suit.[76] Although, of the twenty-two districts, nine had begun training their own practitioners by 1896, endowing scholarships and providing the socially accepted structure such as completely segregating them from the male institutions, and having self-sufficient medical schools.[77]

However, unlike how the DF doctors were given credit for 'popularizing the western medical science among the female population' in Bengal, in Madras the narrative was somewhat different even in the reports of the DF.[78] In Madras, the Governor in his speech, thanked the high ranking British medical officers but mentioned how official and nonofficial people supported their endeavour. The generosity and commitment of the 'native gentlemen' in disseminating medical care across the presidency were recognised.[79] This equation between the provincial government and the local people played out very differently in other presidencies as is evident from Viceroy Lord Curzon's words as he applauded the work of the DF in 1899. He said, they lifted the veil or the *purdah* 'without irreverence' and brought the benefits of western medicine to Indian women.[80] In Madras, apart from the DF, there were other associate bodies who funded the training of medical women – the princely states alongside the district boards showed explicit interest in funding European as well as Indian candidates. The popular sentiment among government officials was against providing any support to the DF as it was not an official body – but was begun as a voluntary organisation. It has been explained earlier in this chapter how it was more difficult for female

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[75] *NASFMA*, Report of the Madras branch, December 1895, 23.
[76] *Ibid.*
[77] *Ibid.*
[78] DF Annual Report 1907, 28 in Arnold, *Colonizing the Body*, 263.
[79] *NASFMA*, Report of the Madras branch, December 1895, 41-43.
[80] "Progress of the Plague," *IMG* (April 1899): 131.

practitioners to establish themselves as independent researchers compared to their male counterparts, and the training continued to be heavily dependent on the employment opportunities created by the state or its 'underfunded surrogate', the Dufferin Fund.[81]

The local boards in the districts, except Chingleput, South Canara, Anantpur, Malabar, the Nilgiris, and North Arcot, either granted scholarships to train medical women from their districts or employed those who were previously trained.[82] Though Arnold mentioned how the Madras branch followed a different approach to the other presidencies; he did not explore this point in greater detail.[83] The officials in Madras realised it was prudent to invest in the training and development of Indian women, as this would win the confidence of the women patients and encourage them to approach the dispensaries and local hospitals. Madras thus witnessed an increasing number of local women expressing an active interest in becoming practitioners as well as being treated as patients. Infrastructural assistance was also being provided by the local and district boards in terms of training and finance – but many of these boards were outside the purview of the DF.[84] However, although the government was apparently not discriminating between the employment of female and male medical practitioners, there were instances when the health administrators were clearly not willing to appoint women in higher positions. In 1901, the governor in council wanted to abolish the office of lady assistant superintendent and wanted to create a position for a junior commissioned medical officer as assistant superintendent instead.[85] In the districts of Anantapur and North Arcot, no steps were taken towards medical training of women supposedly for lack of funds, while in South Arcot no candidate came forward to undergo training in 1903.[86] In the context of Chingleput, a semi-urban locality, the government did not deem it necessary to have a separate plan of action because of its geographical proximity to Madras. There were also reports

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[81] Arnold, *Colonizing the Body*, 264.
[82] V/24/308, Local Administration, APAC, BL.
[83] Ibid.
[84] *NASFMA*, Report of the Madras branch, December 1901, 10-11.
[85] Home Department (Public), No. 939, 14 September 1901, APAC, BL.
[86] V/23/309, Madras Local Administration, 1903-10, APAC, BL.

of Indian medical women resigning from their position because of certain difficulties they faced, although, there were some new positions opening up for women practitioners in dispensaries for women and children.[87]

The collection of money through donations and subscriptions was on the rise throughout the first decade of the twentieth century as it marked a significant increase up to Rs 9,727 in 1906 and it reflected the persistent support provided by the local Indians for the establishment and development of women medical institutions in the presidency.[88] For medical tuition, until 1905, usually European women were given preference, but the approach was discontinued from this period onwards. The DF realised the importance of supporting local women in receiving medical education and began to offer scholarships to 'native ladies' as well.[89] The medical officer in charge of Rajah Ramaswamy Mudaliar's hospital reported that the training went well and among both upper as well as lower caste women, there was a continued interest. This resulted in filling all the vacancies for such positions in the hospitals.[90] The local government and the private benefactors were so dedicated in training local women that Mrs D. Kamalakar even after failing her final examination, was allowed to have her course extended by another year with a full scholarship in the hope that she would qualify in the next examination.[91] However, one major matter of contention remained among Indian medical women. While the European medical women practising in Madras were receiving accolades for their 'brilliant' work in government reports and newspapers, the locals were rarely being mentioned.[92] The British medical women also received accolades from different departments for their service, and also for apparently encouraging the local women to take up this profession and helping the latter get rid of their superstitions. Mrs Nisbet (who worked as Miss Scott in her early career) was applauded for her exceptional work with the small-pox patients in

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[87] Ibid.
[88] *NASFMA*, Report of the Madras branch, December 1906, 6.
[89] *Ibid*, 7-8.
[90] *Ibid*, 7.
[91] *Ibid*, 8-9.
[92] "The women of India: The supply of medical aid," *ToI* March 23, 1903.

parts of the presidency.[93] Despite such recognition, apart from the department of midwifery, there was not sufficient infrastructure for having indoor female patients in most of the district hospitals. However, there was a steady increase in the number of women expressing an active interest in receiving western medical treatment every year.[94]

Table: 6.2.b (i) (Total number of women treated in Madras from 1898-1906)

Year	Total number treated
1898	217,989
1899	225,722
1900	248,881
1901	195,048
1902	305,422
1903	307,986
1904	334,332
1905	352, 255
1906	412, 164

Source: *NASFMA,* Report of the Madras branch, December 1906, 9.

The government introduced many outpatient dispensaries that were mainly in charge of medical women and were completely separated from male hospitals or dispensaries to encourage

[93] Letter from John Smyth, Senior Surgeon and Sanitary Commissioner, Government of Mysore, 29 March 1905, HomeDepartment, Madras (Medical), APAC, BL.
[94] *NASFMA*, Report of the Madras branch, December 1906, 8-9.

women to access the hospitals. This process of educating local women in western medicine was continued for a while as it was hoped that more women would get trained and join the medical structure.[95] Finance, however, remained one of the major obstacles in the way of construction of more in-patient medical centres, and the lack of medical women still remained a crisis that the Madras government was hoping to counter with new training provisions.[96]

The number of medical students began to increase, and by 1912, most of the funds and scholarships in Madras were utilised by local residents.[97] Madras continued to make provisions for out-patients while the number of in-patients was also on the rise during the period. The rising number of in-patients particularly pointed towards the extent and reach of western healthcare practices and the goodwill it had been able to create among those who were considered 'backward and superstitious' even about two decades ago.[98] Even though in the initial years, the call was for the formation of medical service for women on a par with the IMS, a different idea was propagated later on in the build-up to the Great War. Mrs Emma Slater who was the Secretary of the United Kingdom branch of the Association of Medical Women in India commented that there should be 'a central body to control a few women's hospitals in different parts of the country', and she was not in favour of a bigger scale of medical services for women.[99] Under such circumstances, the GoI realised that they needed to take some action to provide more medical relief to the large section of the women who because of social or religious prejudices could not be brought under the purview of western medical care.[100] The following section will expand and explore in greater detail the establishment of an institutionalised female healthcare practice in colonial Madras.

6.3 Institutionalising healthcare for women: the medical services in Madras

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[95] *Ibid*, 9-11.
[96] *Ibid*, 18.
[97] *NASFMA*, Report of the Madras branch, December 1913, 8-9.
[98] *Ibid.*
[99] Balfour and Young, *The work of medical women in India*, 47-49.
[100] *Ibid.*

In 1913, the draft rules of the Women's Medical Service (WMS hereafter) was put forward by a sub-committee that was appointed for this purpose by the GoI.[101] After being approved by the GoI, the new service began to operate formally on 1 January 1914.[102] This new development was not well received in England, as many people had made known their disappointment and frustration over the fact that this new service would be administered by the DF rather than the GoI. What initially began as an alternative career for the medical women in Britain, was deemed unprofitable by many during this period as salaries were limited and not attractive enough for most to leave the shores of England.[103] Recruitments for the service were made by a sub-committee formed both in India and in England. The India section included the Director-General, IMS, the Secretary to the central committee who was a man, and a first class medical woman, while in London, a medical man and two medical women conversant with India were put in charge.[104] Such sub-committees were required to perform the duties of medical boards and examine the candidates for physical fitness and give them permission to return to duty or join them. But in India, occasionally they would delegate their powers to temporary local boards and medical officers for the recruitment process.[105] Continuous support was pouring in from local newspapers in Madras for more medical women in the hospitals.[106] This, in turn, allowed the locals to control most of the recruitment process, particularly in Madras. Such efforts ultimately made the medical women in Britain feel further alienated, and their number was dwindling when it came to joining the WMS in colonial Madras.

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[101] *Ibid*, 50-51.
[102] *Ibid.*
[103] *Ibid*, 52-54.
[104] *NASFMA*, Report of the Madras branch, December 1912, 87.
[105] *Ibid.*
[106] "Lady Doctors in the hospitals of Madras Presidency," *The Hindu* December 18, 1913, 12.

6.3.a) The Great War and expansion of medical care

The WMS in colonial Madras was established during a precarious period internationally as there was rising tension concerning the War that made its impact felt on financial matters and also made it difficult to get people from Great Britain. The initial period witnessed certain appointments and power being entrusted to the local governments that were familiar with the situation with regards to male medical services in Madras. Members of the WMS in independent charge of hospitals or medical institutions had to abide by the rules and regulations not only of the DF but also the provincial government of Madras.[107] The local government was requested to 'frame rules for the appointment, suspension, removal or dismissal of assistant or sub-assistant surgeons, matrons, nurses, subordinate and menial staff' of the hospitals and female dispensaries.[108] In Madras, the Victoria Caste and Gosha Hospital played a significant role in establishing local control over the dominance of DF with their specific interest in treating the caste and *gosha* women in the presidency. As mentioned in Chapter 5, the Madras government continued to look for and encouraged private donations and funding to run the hospitals. The Great War made the government further dependant on private donations and subscriptions to establish and run healthcare centres.[109]

While the major administrative decisions were changing and a new medical service was introduced, the interest of females in Madras in western medical care had always been on the rise, and it continued to grow during this period as well. The following table enumerates the number of minor and major operations from 1908 to 1913.

Table 6.3.a (i) (Number of minor and major operations for females in Madras)

[107] *Ibid.* 89-91.
[108] *Ibid.*
[109] *Ibid.* 105.

1908	1909	1910	1911	1912	1913
768	1766	1959	2347	2417	2756

Source: *NASFMA*, Report of the Madras branch, December 1913, 102.

By minor operations, it meant only those who were not admitted, and got treatment only as out-patients. Major operations are those that required patients to be admitted to the hospitals for surgery or other medical treatment. Such a consistent increase in the number of operations every year reflected how convincingly western medical practices were making inroads among the female population. However, this number, although on the rise was not high enough to have conclusive evidence concerning other far-reaching impacts of western healthcare traditions. There was further concern regarding the caste and religious segregations that adversely affected the treatment and also the intent of the people in getting treated. However, Muslim women, in general, displayed increased interest in getting treated in western medicine during the wartime.[110] Although there was a dip in the number of operations performed during the year 1914, it rapidly shot up and more than doubled from the pre-WWI statistics by 1916.[111] A closer examination of the districts in Madras reveals how the local fund boards and municipal councils continued to contribute towards training local apothecaries or hospital assistants in the rural parts of Madras.[112] Funding was provided for women in the urban spaces as well, including those in the MMC.[113] However, there were significant contradictions among the British administrators in terms of offering employment to Indian women even after they completed their training and education from British institutes. In 1916, Mary Scharlieb had to write to Lady Dufferin to make sure that an Indian medical woman, Miss Poonen was not discriminated against and that she was given adequate salary after completing

[110] *NASFMA*, Report of the Madras branch, December 1918, 84.
[111] *Ibid.*
[112] *NASFMA*, Report of the Madras branch, December 1914, 86.
[113] G.O. No 916, Public, 11 May 1916, APAC, BL.

her degree in London.[114] She was offered an inferior post with a salary of £200 yearly as a subordinate doctor, and this points to the degrading opinion about the Indian medical women who were considered subordinates even if they held higher degrees from London.[115] Between 1915 and 1917, of the 35 female students receiving a stipend to study at the MMC, only two were Europeans, and this was a major achievement for the local women studying medicine and completing their graduation from the college.[116] This increasing number of Indian female candidates was also a result of encouragement in the form of stipends sanctioned by the provincial government. The female subordinates thus trained were not incorporated into government medical services but put under the DF.[117] Further provisions for stipends were made by the Madras government to include more female subordinates and apothecaries.[118] However, even with the huge influx of women medical students, the government had to face questions from Indian newspapers. In particular, the *ToI* reported in 1921, how the government needed to provide more subsidized education for women practitioners.[119] The article further discussed the problems obstructing the natural growth of India's women medical practitioners, including the financial burden and social stigma that prevented many from taking up such roles and positions.[120] There were calls to provide medical training to the local women, but even in the 1920s, they were looking for European medical women to train Indians and there were demands for putting in greater efforts to develop the social structures in colonial India.[121]

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[114] Mary Scharlieb to Lady Dufferin, IOR/L/E/7/859, File 466, Revenue and Statistics Department, 1916, APAC, BL.
[115] Ibid.
[116] G.O. No 916, Public, 11 May 1916, , appendix., APAC, BL.
[117] Ibid.
[118] Ibid.
[119] "Medical work among women," *ToI* May 14, 1921, 8.
[120] Ibid.
[121] Ibid.

6.4 Competition and collaboration for female healthcare: local and imperial perspectives

The onset of the 1920s triggered various changes in the medical administration of Madras, as explained in Chapters 4 and 5, and women healthcare also felt its impact. Faced with financial constraints and lack of adequate female students, the Madras government adopted different methods to ensure the implementation of new policies and increase the salaries of medical women. The responsibility for running the Victoria Caste and Gosha Hospital in Madras was taken over by the provincial government in 1921, and this demonstrated the intention of the government in becoming more involved in providing healthcare to the socially ostracised and neglected women in the presidency.[122] The rates of payment given to the WMS cadres were less than that of the Indian male subordinates and as a result, not sufficient to attract the best of medical women. This was also the period when the WMS went through a phase of acute crisis, as the junior officials in the finance department were contemplating discontinuation of the subsidy provided during the economic crunch.[123] To the lower level officials of the finance department, as Lady Balfour commented, the 'Women's Medical Service was only a name . . . and was eager to rid themselves this'.[124] The GoI Act of 1919 made health a 'transferred subject' and thus entrusted the provincial governments with the responsibility for healthcare. But, Balfour was concerned about how far the provincial governments were prepared to accept the responsibility.

6.4.a) The turbulent 1920s: Madras standing by its medical women

From 1919 to 1924, Madras experienced a steady rise in the number of female students in government institutions.[125] However, most women in Madras were reported to be suffering from

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[122] Home Department (Medical), No. 195, Medical, 27 April 1920, APAC, BL.
[123] Balfour and Young, *The work of medical women in India*, 63.
[124] *Ibid*, 63-64.
[125] Home Department (Public Health), No. 176, 22 January 1925, APAC, BL.

their own social stigma and prejudices and usually ended up staying in the background during dissections or practical demonstrations in the MMC as it was a mixed group of male and female.[126] The requirement of women subordinates in hospitals and out-patient clinics was enormous and on the rise every year, and it compelled Lady Willingdon to express her interest in establishing a medical school only to train women, in particular, women subordinates (grade of sub-assistant surgeons) to be recruited to the civilian medical care.[127] The Madras government showed its commitment to expanding medical care, and with the pressure mounting from locals, in February 1923, the government declared its intention to establish a medical college solely for women. [128] This college had the provision to admit twenty-five pupils per year and students were given a small allowance to encourage them to undertake such education. The course targeted at getting more female subordinates in the grade of sub-assistant surgeons after successful completion of their degree.[129] The government provided a lot of support for this cause, and the women were trained free of cost, and twenty of them had stipends of Rs 20 per month.[130] This was also the period, as explained in Chapter 5 when the government began to become more involved in training and employing more female practitioners, and the stipends and scholarships for male students were gradually discontinued. This hospital was run entirely on funds from the provincial government apart from two endowments used for providing stipends to students.[131]

While there was an apparent collaboration among the wealthy Indians and the colonial administrators of establishing such a medical care institute, the patients, however, had to be segregated based on religion and caste even if that meant examining medical, surgical and obstetrical cases in one ward.[132] There were twenty beds in two separate wards for Hindu and Muslim women

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126 Rural Health, Folder 58, Box 8, Series 464, RG 1.1, 1926, RF, RAC.
127 Ibid.
128 "Women doctors in India: A new school," *The Observer* February 11, 1923, 6.
129 Ibid.
130 Ibid.
131 Ibid, 8-10.
132 Ibid.

as those belonging to *gosha* were not 'allowed' to be seen by any men except their husbands.[133] While such cases point towards the apparently benevolent nature of the colonial administration, it can also be argued that the officials were so removed from the local population that in their bid to save the local women, they ended up casting the latter further aside with such strict distinctions. Such measures, although they maintained peace in the locality, reduced the scope of inter-caste or inter-religious collaboration and communication among the local people even further. However, this could also be as the result of extreme dependence of the colonial officials on the local community to execute their plans. It should also be mentioned in this context that the government undertook the responsibility for supplying books and other instruments to the 'stipended' medical students, thus encouraging more women to join.[134] After successfully concluding their training, the funded students were liable to serve the government for a maximum of five years, and awards were given to the best students in clinical medicine and in midwifery.[135]

The annual report of the DF suggested that there was a notable increase in the work of the hospitals in Madras, and the surgical ward was witnessing increasingly complex surgeries being handled by the medical women.[136] Similar developments were noticed in the Vizagapatam hospital as well with the improvement in infrastructure, and the government also sanctioned grants for the hospital to conduct their regular business.[137] By the end of 1926, there were ten centres to look after female healthcare, and in the mofussil, there were forty-nine alone with thirty others in small municipal towns; the numbers reflect the importance and popularity of healthcare among the female population in the presidency.[138] Much like the male subordinates, female health workers were

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[133] Ibid.
[134] Go. No 524, Public Health, 10 March 1925, APAC, BL.
[135] Go. No. 539, Ibid.
[136] *NASFMA*, Report of the Madras branch, December 1926, 18-20.
[137] *Ibid.*
[138] *Ibid*, 89.

also sent into the mofussil for a shorter period for the purpose of working in the rural dispensaries.[139] But, a significant difference between the male and female subordinates in the context of Madras was the role played by the provincial government. While the male subordinates were coordinating and commanding power in the local areas, their female counterparts were almost entirely controlled by the government.[140] This was also the period when 50 percent of recruits in the WMS were Indians; however, in 1927, because of the financial constraints, there was a requirement to reduce the total number of this cadre.[141] It can also be argued that the existence of the *purdah* system made medical women even more indispensable in the context of colonial India than in western countries. Although there was an ongoing tussle between the provincial governments and the GoI about the nature of the female medical service, each presidency chose to follow its individual plans and policies.[142]

In 1928, it was declared that the Government would take control of a few local fund and municipal medical institutions at the headquarters of taluks for 'development as medical and surgical centres'.[143] This was in complete contrast to the male subordinate services, but it could be argued that the government had the opportunity to exert more control on female medical administration because of the lack of female interventions in the lower levels of medical structure in Madras. In a patriarchal society such as Madras, it was difficult for rural women to come out of their *purdah* and concentrate power locally as was done by the male subordinates. The Surgeon-General of Madras was consulted, not just on paper, and his recommendations were actually taken into account.[144] Thus, the local boards or municipal councils interested in establishing female healthcare were asked to 'hand over' the buildings, the sites, including the furniture and equipment

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139 *Ibid.*
140 IOR/Q/13/1-17, Item 21, Statement for the Indian Statutory Commission by the National Association for Supplying Medical Aid by Women to the Women of India, APAC, BL.
141 Ibid.
142 Ibid.
143 Public Health, No. 897, 17 April 1928, APAC, BL.
144 Ibid.

to the government.[145] This marked a complete departure from the way medical administration was conducted in the Madras Presidency. Barring three municipal bodies, all others complied with the government demand and handed over control, which made the process of transfer less complicated.[146] The Madras government had taken almost the full responsibility for establishing a better healthcare system for women in the presidency. Both in terms of infrastructure and people, the government of Madras continued to invest in expanding the healthcare measures in the region. The Madras government sanctioned new buildings, and sent local medical women to Europe for training.[147] A new post of resident medical officer was created for the women service, and the first woman to hold this position was a lecturer of hygiene at the Victoria Caste and Gosha Hospital.[148] Such measures taken by the government widened the expanse of female medical care in the region. It was not restricted only to the city of Madras but also extended in the districts. The number of patients, labour cases, and surgeries increased significantly in the women's hospital in Vizagapatam as well, and they began to witness a rise in subscriptions and fees along with it.[149]

6.4.b) Expansion of female healthcare – urban and rural comparisons

While interacting with the representative of the Rockefeller Foundation, Lieutenant Colonel J. R. D. Webb, who was the officiating director of public health in Madras lamented the lack of women medics in the presidency. He mentioned that there were only 'six women doctors and fifteen trained lady health visitors employed by local bodies on maternity and child welfare'.[150] The number of female patients was about 70% of that of the male patients getting admitted to various hospitals across the presidency in 1931.[151] The numbers suggested that women were becoming more and more reliant on female healthcare and that the medical and policies were having a far

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145 Ibid.
146 Ibid.
147 *NASFMA*, Report of the Madras branch, December 1929, 22.
148 *Ibid*, 22-23.
149 *Ibid.*
150 Address of J. R. D. Webb, Folder 820, Box 104, Series 464 India, RG 2, 1934, RF, RAC.
151 Local Self-Govt. Department, No. 1114-2, 1931, APAC, BL.

reaching influence on Madras. The locals from Madras became comfortable studying medicine and began to ace the exams and win prizes for their achievements.[152] However, in the 1930s the focus began to be concentrated more on the maternal and child care services, and the DF, as well as the provincial government, began to work together to set aside funds for the training of women interested in midwifery, gynaecology and ante-natal work. Such medical training began to gain more significance as the government wanted to bring down the rates of infant mortality.[153] Such an attempt received support from the local governments too, and a large number of midwives began to advance the work on maternity healthcare.

The support in healthcare was constant and ongoing, and there were new developments every year to keep the women students encouraged in taking up roles in medical schools. But, a close perusal of the government files shows a shift in the tendency and aspirations of the medically trained women. There was a five-year course for medical women sanctioned by the government in 1934, and this aimed to gain more licentiates for the women medical institutions across the Madras Presidency and in other parts of colonial India.[154] The government realised that with the expanding market place, the LMPs graduating from the medical schools were expressing their desire to establish their career as independent private practitioners across the presidency.[155] This was a clear departure from the initial days when the medical women were looking to get into government regulated hospitals and institutes. It also reflects the gradual but significant shift in the attitude of the local people concerning medical women practising independently and taking care of women's health. The government played its role and contributed immensely to curating new courses and training programmes for the women to ensure them more credibility and experience. The five-year course initiated in 1934 began to impart to the LMPs scientific knowledge in

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[152] Local Self-Govt. Department, Public Health, No. 2047, 26 October 1931, APAC, BL.
[153] *NASFMA*, Report of the Madras branch, December 1931, 31.
[154] Public Health, G.O. No. 2442, 22 October 1934, APAC, BL.
[155] Ibid.

Physics, Biology, Chemistry and Biochemistry, and clinical experiences including Pathology, Bacteriology, and other practical experiences of medicine and surgery.[156] Such detailed training enabled medical women to undertake more complex surgeries and diagnosis and establish their name in the medical marketplace.

On the other hand, the upper echelons of the female medical administrations were systematically being occupied by the locals during the period. Dr Maduram was appointed as the in-charge of the surgical unit of the Victoria Caste and Gosha Hospital and was the assistant superintendent.[157] By 1935, the wards began to be overcrowded with both in and out patients, and the big hospitals began to express the need for increasing the number of wards.[158] This led to increasing specialisation in medical treatment and individuals with specific expertise began to be allotted selective responsibilities. However, this was not the same in Vizagapatam where money was scarce, and even the donations had dried up, and it points to how the government began to prioritise the city hospitals over the districts.[159] As explained in Chapter 5, the SMS did not let the governments control the local healthcare in districts or sub-divisional spaces, but the government was controlling most of the female medical services in the presidency, and creating more opportunities for medical women. This resulted in the city beginning to receive more benefits and medics while the districts, on the other hand, lacked the expansion of medical care for women similar to their male counterparts. The WMS and the DF worked together in places, but those women privileged enough to be able to study medicine preferred to remain in the cities and the female medical market in the Madras city was not that crowded as to push such practitioners into the districts. Thus, it can be argued that the WMS in Madras was showing signs of expansion up to 1935, but needed further time to expand more into the districts.

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156 Ibid.
157 *NASFMA*, Report of the Madras branch, December 1935, 45.
158 *Ibid.*
159 *Ibid*, 46.

6.5 Conclusion

This chapter recognises the necessity, at least in the nineteenth century, of colonial intervention and support for the local women to be trained in western medical traditions. However, it also highlights the complete denial of agency to Indian women in the garb of adhering to traditions and expressing solidarity with their belief systems. Through meticulous research based on hitherto unused sources, it has examined the evolution of medical care for women patients in the Madras Presidency and argues how female healthcare in Madras followed a different trajectory to that of male counterparts. Medical care for women, at least in the initial years of the period under review, had to be provided entirely by medical women. Here, examining Madras Presidency as a case-study, it has been explained how the colonial state treated the WMS differently from the male services in the presidency.

It has been discussed in great detail here, what prompted the initial changes in medical training and why it was offered to women in the presidency. It explains the complexity faced by the women practitioners in Madras in relation to different groups cohabiting in the region. This chapter has explained how the single agenda of providing healthcare for the female population brought together the state, a private charity organisation (DF) and the local actors. With the state playing a major role in establishing WMS in Madras, the city space was considered a far more important area than the districts and the political changes continued reshaping women health measures over the period. It also explains how such diverse and complex healthcare strategies co-existed in Madras, and these in together made this region one of the most significant case-studies for discerning female healthcare in this period. While the argument presented here agrees with some of the understandings regarding women's healthcare in the context of colonial India, it breaks new ground in providing a comparative study to that of male medical service. Broadly speaking, this chapter, along with recasting the nature of healthcare in different presidencies, also brings forward the complexities within a single presidency in its approach to medical practices. The chapter here elucidates how gender role determined and shaped colonial state policies, and even though

the governments, both provincial and central, claimed to be the saviour of the 'vulnerable Indian women', in reality, they perceived female medical care merely as a tool to further their agenda of expanding western medicine. It has been explained in this thesis how heterogeneous the presidency was so different groups displayed different attitudes when coming to women health services and education in colonial Madras. These different groups of people were motivated by their own local and regional agenda that shaped their actions.

Conclusion

This thesis has argued that the Madras Presidency provided a favourable ground for local residents from different social backgrounds to become an integral part of the medical marketplace. Rather than focusing merely on the so-called elites, this work also concentrates on the subordinate sections – the intermediaries who took advantage of the fissures in the government structure and tightened their control over local politics and administration. In doing so, I have propounded the existence of a group whom I call the 'social ascendants'. These individuals emanated from diverse social groups and became prominent in light of the expansion of western medicine in Madras Presidency. The fifty five years reviewed in this thesis witnessed a significant transformation in the healthcare sector. Researching and analysing large volumes of primary materials, I have examined how a single presidency in colonial India had worked both with as well as against British administration through different levels of government hierarchies in Madras, Calcuttta (Delhi after 1911), and London. I have argued, first and foremost, that the local population of the Madras Presidency was not a homogenous entity but consisted of members from different linguistic communities, castes, and religions. These groups have been investigated here to differentiate between the rhetoric and reality of state healthcare.[1] While analysing the expansion of western forms of health provision, this thesis has elaborated on how this region was unique in the way it was receptive of colonial medical care.

Along with the medical expansion, the contribution of socio-political factors such as race, ethnicity, gender, religion, and language have been explored in the context of healthcare, and their diverse influences considered. All these factors had a lasting impact on the military recruitment

[1] Mark Harrison, *Public Health in British India: Anglo-Indian Preventive Medicine 1859*-1914 (Cambridge: Cambridge University Press, 1994), 227.

system that, in turn, influenced the transformation of the nature of medical care within the presidency. This thesis considers the role of medical subordinates such as the compounders and dressers in the expansion of western medical care in the presidency. Because of the uneven nature of archival records, especially in a variety of Indian archives, preserving only fragmented traces of subordinate contributions, their role finds almost no mention in the existing literature.[2] Tenacious research enabled me to lay my hands on sufficient archival materials – in English and Tamil – that has allowed me to construct a narrative from the perspectives of medical subordinates. These materials allow me to reveal the distinctive and fragmented nature of the administrative apparatus, in colonial Madras, both urban and rural spaces. The relationship between Madras government, the GoI (in Calcutta, then Delhi), and those different administrative and healthcare officials both at regional and central levels, was generally marked by discord. I have argued here that this disharmony created enough space in the medical marketplace of Madras to accommodate the local residents. The evidence presented throughout this thesis points to the importance of undertaking a careful examination of the very complex nature of health structure and resultant policies in colonial Madras.

A careful assessment of the archival sources available in different countries presents a highly diverse and heterogeneous scenario. Madras Presidency, with its mix of Tamil, Telugu, Canarese, Malayali, and Oriya speakers, renders it impossible to club the local residents under one umbrella community, as has frequently been done in case of Bengal Presidency and Bengalis.[3] Men and women working in western medical services in Madras came from a diverse range of social

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[2] A notable work has been of Amna Khalid, who has worked extensively on subordinates and intermediaries in healthcare in colonial India. See, Amna Khalid, "Subordinate' negotiations: Indigenous staff, the colonial state and public health," in *The Social History of Health and Medicine in Colonial India*, ed. Biswamoy Pati and Mark Harrison (London; New York: Routledge, 2009); Amna Khalid and Ryan Johnson, ed. *Public Health in the British Empire: Intermediaries, Subordinates and the Practice of Public Health, 1850-1960* (New York; London: Routledge, 2012).

[3] Projit Bihari Mukharji, *Nationalizing the body: the medical market, print and healing in colonial Bengal* (London: Anthem, 2009).

backgrounds and displayed a wide variety of skills. The defiance orchestrated by individuals, groups, and the Madras government of the GoI's policies and instructions allow us to peek into the fragmented nature of colonial rule. This work has prioritised the social, political, and economic factors playing their roles within the presidency while elaborating on the medical advancements. However, a complex and vast presidency such as Madras required a thorough background study, and that is why the first two chapters remain crucial to this thesis. Those two initial chapters explain the political and medical hierarchies alongside the administrative structure of the presidency while setting up the next four chapters to signpost and explain the details effectively. These four chapters collectively, and also individually, have explored the history of medical services in a single presidency focussing on the transformation of medical care.

Chapter 3 recasts the relationship of the military with the medical services in Madras Presidency and has argued that the decreasing emphasis on the Madras army compelled the local youth to look for new avenues of employment. In such a critical juncture medical profession became a viable alternative. These new opportunities in medical services offered them a regular job, a social position, and control over regional administration. The final three chapters have focussed on the changes that affected and shaped colonial policies in the capital city of Madras and more importantly in the districts, sub-divisional levels, and villages of this presidency, through a detailed analysis of the so-called elite, subordinate, and women medical services. This study has adopted a 'bottom-up' approach while analysing sources and putting forward arguments but has also given space to the state narrative that traditionally forms the basis of 'top-down' analysis.

Western medical marketplace – local vs national

The medical subordinates or health workers cannot be considered a homogeneous entity, as different socio-political constructs shaped and altered their nature during the period under review. Their social roles, educational motivations, and professional designations changed during the late nineteenth and early twentieth centuries, and in a way, they can be compared to the Bengali

daktars as Projit Mukharji has argued in the context of Bengal.[4] However, the subordinates in colonial Madras were even more heterogeneous, considering that they hailed from diverse linguistic backgrounds, and the heterogeneity was reflected in the social and professional lives of the subordinates. The argument of this thesis has largely been formulated based on previously unreferenced archival materials, virtually unaccessed by historians until this point. In particular, the usage of substantial military documents to construct a narrative from the civilian perspective has rarely been attempted by medical historians dealing with colonial India. This approach to understanding the civilian medical market through military files has allowed me to explore and employ research methods that are novel to colonial healthcare scholarship. With surplus medical labour at hand, the Madras government found it convenient to experiment with healthcare policies and practices in the presidency with the aim of expanding and popularising western medicine. The first three chapters have explained that Madras Presidency provided an apparently conducive environment for establishing and expanding the medical marketplace in the region.

However, the advent of the twentieth century led to further transformations, particularly in the context of western healthcare in this region, as the provincial government began to realise the importance and potential of Madras as a viable market. Even though the provincial government was willing to adapt and utilise the uniqueness of Madras to explore and expand western medical care, it was extremely difficult to convince the central governments – first in Calcutta and later in Delhi – about its potential. The Madras government was involved in consistent collusion and tussle with the GoI as they disagreed on certain policies, particularly about implementing standardised health regulations across the country and expansion of western medical care. The GoI was also not very enthusiastic about recording the contribution of medical subordinates in most cases, while the Madras government recognised their importance. Realising how dependent pro-

[4] Mukharji, Nationalizing the body.

vincial and local governments were on intermediaries, the Madras government insisted on including the statistics of their services at least collectively. Such constant conflicts between the GoI and the Madras government, as this thesis evinces, were indicative of the complicated relationship between different power hierarchies in colonial India. This thesis highlights the importance of understanding local and regional uniqueness, particularly in the context of South Asia, which has always been home to tremendously diverse populations. A thorough study of this region is not possible without accounting for these differences. This research methodology can be useful in analysing colonial contexts in disparate geographic regions.

Re-thinking colonial medical services

The material examined in this thesis allows me to build in orginal ways on the existing historiography dealing with the nature and growth of medical services in colonial India, and the ability of the medical subordinates to command healthcare administration in rural Madras. A further strand added to this study – the WMS – functioned differently to that of the male medical services in many ways, and it has so far remained a considerably under-explored theme in the history of medical care in British India. Unlike the situation in Bengal, as explained by Mukharji, where a few research scientists and wealthy elites could benefit from the advancement of medical care, Madras witnessed the rise of another significant section of population along with the already powerful Brahmins and the royal or landholder families – the social ascendants.[5] While this study does not go into a full-fledged comparison of Madras and other provinces, it highlights that the ascendant section were not a handful of people and the local control and hierarchy coupled with policies made sure that there were various stakeholders or beneficienries of western medical care in the presidency. This study also highlighted other issues ignored in the existing study on

[5] David Arnold, *Colonizing the body: state medicine and epidemic disease in nineteenth-century India* (Berkeley: University of California Press, 1993); *Imperial medicine and indigenous societies* (Manchester: Manchester University Press, 1988); Mukharji, *Nationalizing the body*.

healthcare, including the nature of collaboration and competition the Indians were engaged in at the districts and sub-divisional levels. It brings forward the issues of caste, religious, and linguistic segregations and how the colonial state pandered to and even encouraged traditional beliefs in colonial Madras although purportedly advocating against them, at least on paper. The non-Brahmins were actively encouraged by the provincial government to join medical and administrative services, as by the first decade of twentieth century Brahmins were beginning to become far too powerful in the field of politics for the comfort of the British. A close perusal of the papers and reports at the RAC helps to identify the deep mistrust and competitive nature that have shaped the health policies in the region. The continuous defiance by Madras officials of the GoI's suggestions suggest that political authority in the presidency was far more fragmented than they apparently were in other parts of colonial India. Based on hitherto unused and underused sources on subordinate medical workers, this thesis has built the narrative of colonial medicine from their perspectives. The contribution of local residents should be bestowed greater importance to explore how western medicine became such a powerful force in colonial contexts. As Bhattacharya has argued, different sections of a deeply fragmented state administration turned against one another, and each group had their individual agenda that often conflicted with others, be it the surgeon of a city hospital or the compounder of a rural village.[6] Madras Presidency, as discussed, had ever further complications and such deeply disjointed medical structure required a thorough study without being overshadowed by discourses on other presidencies. The thesis emphasises the role played by regional and local political structures, and relations between these regional/ local and supra-regional/ supra-local structures in shaping healthcare in this presidency.

This thesis also challenges the existing literature by introducing gender into the discussion. The WMS renders this already fragmented structure even more complicated, particularly because in a socially conservative region like Madras, it was very difficult for women to actively take part

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[6] Bhattacharya, Harrison and Worboys, *Fractured States*.

in the medical services. Medical women had to battle stigma, discrimination, as well as their own conservative backgrounds to join the western medical services and aid their expansion in this presidency. This thesis also breaks new ground in studying male and female healthcare structures and policies simultaneously, thus arguing the importance of studying gender segregated case studies, rather than fitting everything into an overarchingly male-dominated narrative. Because the political authority was very disjointed, individuals and groups were significant in shaping and implementing health policies that they deemed necessary at the provincial and local levels. Significant contributions by medical women as doctors and physicians need to be focussed upon, without projecting women only as midwives or subordinates in maternal and childcare wards. Such an investigation aims to elaborate on the importance of studying healthcare and researching medicine with a focus on gender. This work also seeks to add socio-political and historical perspectives to the emerging fields of studies on gender-specific medicine and research.[7] Although the archives generally remain silent about the world of medical women, this thesis has successfully collated pieces of evidence from various archives to stitch together this narrative. This thesis also points towards the importance of accessing the less frequented archives and source materials in developing an account where the indigenous population are not seen as mere subordinates or collaborators but as active policy moulders in the grand scheme of things.

Future prospects

I believe that the findings of the thesis, especially the trajectories of circulation of ideas and historical processes, offer the possibility of further work in two key areas. First is the potential for further exploration of the social ascendant groups in post-colonial Madras, and their subsequent control and dominance of the local and national politics in independent India. The project would

[7] One such example is the organisation called Women's Brain Project. They examine and advocate the necessity of having more women participants for clinical trials, and how medicine should be administered based on gender. While *Nature* has also published pieces on the importance of precision gender based medicine.

emphasise how regional connections and influences enabled the social ascendants to assume a leading role in the emergence and continuation of inclusive healthcare measures, especially in rural areas. This work with a focus on local and regional specificities could carry out a comparative study between colonial and post-colonial healthcare arrangements in colonial India. With a focus on rural health, this project could unveil the lasting significance of western healthcare in the post-colonial context from the perspectives of medical subordinates.

The second strand of exploration is a more extensive transnational project that investigates ways in which Madras paved the way for and actively aided the introduction of western healthcare in other British colonies. With five ports along its coastline, Madras Presidency became one of the most prominent suppliers of medical practitioners to other British colonies in Africa, the Caribbean Islands, and South East Asia in the twentieth century. This project would provide a preparatory framework to study the source of emigration to different colonies offering an effective background to understand the movement of medical practitioners. These medics trained in colonial medical institutions were eager to establish and broaden their medical market, which took them to foreign shores. This study would focus on exploring the transnational nature of Madras Presidency, which has given a significant number of medical practitioners and nurses initially to the Caribbean islands, African countries, and the migration later continued to the UK with the formation and expansion of the National Health Services.

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It is evident that the thesis has only engaged with the history of a single presidency and did not attempt a comparative study or an overall investigation of colonial India, as many studies have already trodden that path. The thesis is, instead, interested in representations, perceptions, and positions taken by medical practitioners with their deep knowledge and command over rural and semi-urban healthcare structures. Employing an archive-oriented study, the main objective of the thesis was to historicise the medical transformation that the presidency had witnessed during the period 1880 to 1935. This was achieved through a precise recontruction of specific sets of events,

people, and policies substantiated by primary sources – accumulated by meticulous archival research – both in English and Tamil.

The thesis has also emphasised the absence of new approaches and methodologies in regional history scholarship and the reluctance of historians to explore Madras' uniqueness in disseminating medical care. It has posited the presidency to the forefront of western medical transitions in late colonial India. The thesis has indicated and explored the richness of source material on Madras, and in places made use of the vernacular sources to bring out the complex nature of the political structure that impacted healthcare in the presidency. This thesis challenged the literature on western healthcare at different levels and emphasised that the lack of regional and local perspectives have hampered our understanding of the aspects of expansion and establishment of medical care in colonial India. The focussed study of healthcare in colonial Madras has provided a new framework to understand the history of this province's colonial encounter that has so far been overshadowed by discourses on other presidencies and generalisations. It has also accentuated the centrality of the archive – in particular, the regional, military, and vernacular souces – to demonstrate that new materials enable the formation of unique perspectives offering insights often overlooked in a bid to pursue global and wider studies.

Select abbreviations

AAPC	Asia, Africa and Pacific Collections
AMS	Army Medical Service
AMD	Army Medical Department
BMA	British Medical Association
BMJ	British Medical Journal
BL	British Library
DF	Dufferin Fund
EIC	East India Company
GoI	Government of India
G.O.	Government Order
IMG	Indian Medical Gazette
IMS	Indian Medical Service
IOR	India Office Records
MMC	Madras Medical College
NAI	National Archives, India
NASFMA	The National Association for Supplying Female Medical Aid to the Women of India
Rs.	Rupees
RAC	Rockfeller Archive Center
RAMC	Royal Army Medical Corps
SMD	Subordinate Medical Department
SMS	Subordiate Medical Service
TNSA	Tamil Nadu State Archives
WMS	Women Medical Service

Glossary

Brahmin- A member of the first Varna, traditionally priests and scholars. From Sanskrit Brahman, 'prayer' or 'praise'.

Canarese – People living in Kanara, a district in south-western India, and part of erstwhile Madras Presidency.

Caste – Ascribed ritual status in the Indian, especially the Hindu social hierarchy. From Portuguese casta, 'race' and Latin castus, 'pure' or 'chaste'.

Company – A body of infantry, usually of between one or two hundred men, normally led by a captain, lieutenant or subedar, and forming part of a battalion.

Coorg – A mountainous province of South India, a high-caste inhabitant of that province.

Dravidian – Pertaining to the non-Aryan people of India, or to their languages.

Furlough – A permit or license given to the soldier to be absent from duty for a stated time.

Jewan – replaced Sepoy, from the Persian Sipah or 'army', during the late nineteenth century as the common term for Indian soldiers in the British led Indian armed forces.

Hakim – Hakeem or Hakim is an Arabic word, which refers to a physician, or more specifically a practitioner of Unani or Islamic medicine.

Havildar – An Indian NCO, equivalent in rank to a sergeant

Jemadar – An Indian company officer, immediately junior to a subedar, and corresponding to a lieutenant.

Mappila – A Muslim fisherman or cultivator of Malabar, of low status and usually landless; also Moplah.

Malayalam – One of the major South Indian languages, the speakers are called Malayalis.

Mofussil – Parts of a region outside the urban centre; the regions, or the rural areas.

Panchayat – Village union, it also means the local council that rules a village.

Purdah – Seclusion or isolation, especially of Muslim women. From Urdu and Persian pardah, 'veil' or 'curtain'.

Raj – Kingdom or principality; rule; often used loosely to denote British rule in India.

Regiment – A body of soldiers, composed of one or more infantry battalions or several cavalry squadrons, and usually led by a colonel.

Sepoy – An Indian soldier employed under European, especially British, discipline; an Indian infantry private. From Persian and Urdu Sipahi, 'soldier' or 'horseman'. The term 'sepoy' was a corruption of the word 'sipahi' and referred to an Indian soldier in British employ.

Siladar – An irregular cavalryman who provides, or pays for, his own weapons, horse and accoutrements. From Urdu, Silahdar, 'armour-bearer' or 'squire'.

Subedar – The senior Indian officer of an infantry battalion.

Tamil – The leading Dravidian language of South India; a speaker of that language.

Telugu – *One of the major Dravidian languages of South India, also the speaker of that language.*

Taluk/ Talook – Subdivision of a district.

Vaid – *Vaidya* or *vaid* is a Sanskrit word-meaning physician; the same word is also used in Hindi. It was and is still used in India to refer to a person who practices Ayurveda, an indigenous form of medicine.

Varna – One of the four caste- Brahmins, Kshatriyas, Vaishyas and Shudras- into which all In

Zamindar – Proprietor of land with whose rights and recognition it was not intended to interfere interposed between the Government and the people in the revenue system.

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