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**Medical Education and Emergence of  
Women Medics in Colonial Bengal**

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# Medical Education and Emergence of Women Medics in Colonial Bengal\*

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## Introduction

Existing accounts of growth of medical education for women in colonial India mostly focus on how it was facilitated by British administrators, missionaries, philanthropists, as well as Indian reformers who were eager to spread western education and health care facilities for Indian women. In such narratives, the wider colonial contexts of institutionalization of western science and medicine and growth of curative medicine, changing patterns of education and health services for women, the broader social impact of growth of women's medical education etc. have received scant attention. I have attempted here to address these issues in my analysis of growth of medical education for aspirant female medics in order to bring out the complexities in the relationship of medicine, gender, politics of colonialism and social reforms in colonial Bengal.

It would essentially involve analyses of the evolution of colonial policies regarding medical education as well as gender and of indigenous views and activities regarding modernizing Indian society. What were the changing contexts of imperial administration which shaped the chief features of colonial policies regarding gender and medicine? How and to what extent did indigenous reformers respond to the changing context and make attempts to reform women's condition by bringing educational and health reforms? What were the social consequences of the spread of women's medical education? These are some of the issues dealt with here.

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### **From Orientalism to Anglicism: Colonial Medical Education**

The earliest official involvement with medical education in British India was prompted by the need to provide low cost, trained Indian hospital assistants to European surgeons attached to different hospitals. Such indigenous helpers were variously addressed as 'native dressers' (Madras), 'country doctors', 'black doctors' (Bengal), and 'black assistants' and 'apothecaries' (Bombay).<sup>1</sup> Later they were more popularly known as 'native doctors.'

In June 1812, a 'Subordinate Military Medical Service' was constituted and the native doctors were termed as third class servants. This factor, along with the passage of the Charter Act of 1813,<sup>2</sup> precipitated the demand for a uniform and proper institutional medical education to those Indians aspiring to become native doctors.<sup>3</sup> This would serve two purposes. These subordinate assistants would help European doctors and surgeons who looked after the health of European civilians and military employees and secondly would reduce company's financial burdens by limiting the appointment of European doctors.

The Governor General's order no. 41 dated June 21, 1822 established the School for Native Doctors or Native Medical Institution where students would learn about Western as well as indigenous medical sciences through a three-year course in vernacular languages. The foundation of the NMI was followed by starting of medical classes at the Calcutta Sanskrit College and Calcutta Madrasa. At the former institution, *ayurvedic* texts including *Charaksanhita* and *Susrutsanhita* were taught while students of the Calcutta Madrasa studied Muslim *UnaniTibb* system of medicine based among others on works of Arab physicians.<sup>4</sup> Thus the medical education provided by the colonial state at this stage involved parallel instructions in western and indigenous medical systems. In fact by the end of the 18<sup>th</sup> century, largely as a result of the efforts of orientalist scholars like William Jones and others, ancient medical texts of India became the subject of critical and systematic enquiry.<sup>5</sup> Some historians have however correctly pointed out that it would be

wrong to assume that the British official policy (or the attitudes of orientalists) ever tried to promote“ indigenous medicine as an equal or alternative to the Western system but (as with Indian Materia Medica) to draw upon what was “useful” from indigenous therapeutics while encouraging students (by teaching the Western and Indian systems side by side) to discover for themselves the superiority of European medicine.”<sup>6</sup>

With the coming of Lord William Bentinck as Governor General in 1828 a distinctive ideology of imperial governance, shaped by the ideals of liberalism gained ascendancy. The liberal view of Indian society (supported more or less coherently by evangelists, free traders, law reformers, educational reformers, and utilitarian theorists) was expressed by James Mill in his *History of British India* (first published in 1818). Mill opposed the view of William Jones and pointed out that the Hindus never possessed ‘a high state of civilization’ and that they were rather a ‘rude’ people.

Towards the end of 1833, following the recommendation of a Committee appointed by the Government of William Bentinck NMI was abolished, and medical classes at the Sanskrit College and the Madrasa were discontinued by the Government order of 28 January 1835. It was followed by the Government order of 20 February which established the Medical College of Bengal or the Calcutta Medical College.<sup>7</sup>

### **Gender and imperialism**

Liberal phase of British administration in India saw, apart from educational change, also an effort at social reform particularly aimed at women. The conceptualization of the difference between India and Britain by the colonizers included-among other things-the basis of gender. According to James Mill the Hindus had ‘habitual contempt’ for their women. A vast body of Anglo-Indian discursive writing which was produced in the second half of the nineteenth century also focused critically on the condition of Indian women in the zenana, the women’s quarters in upper class Hindu and Muslim households. Zenana was considered to be a place of dirt, darkness and disease.<sup>8</sup>

Women missionaries who came to India from the United States and England from the late 1860s attempted to break the seclusion of the zenana or 'uncolonised space'. Many wanted to spread education and wage a battle against disease. Dr. Clara Swain (1834-1910), who graduated from the Women's Medical College of Pennsylvania, was sent by the American Methodist Episcopal Mission to India in 1869. Miss Fanny Butler, the first British medical woman to practice in India arrived in India under the auspices of the Church of England Zenana Missionary Society. These missionaries established private clinics to provide western health care to Indian women and sought to train midwives and nurses.<sup>9</sup> Undoubtedly the missionaries who had gained access to the purdah as teachers were grieved to see their young pupils dying in childbirth.<sup>10</sup> According to the description of a missionary author, in the practices of Bengali village midwives in the mid-nineteenth century, 'unscientific' and 'unchristian' customs seemed to have been indistinguishable.<sup>11</sup> William Ward, one of the Serampore missionaries drew attention to 'traditional customs of childbirth' which apparently contributed to high maternal and infant mortality.<sup>12</sup>

### **Curative Medicine and women**

In Bengal in 1840, a large female (Lying in) hospital containing 100 beds was constructed in the grounds of the Calcutta Medical College by liberal public subscription. It gave training to male medical professionals in midwifery (use of modern techniques including forceps and ether) to make deliveries easier. This was followed by the opening of a large hospital in 1852; designed to accommodate 350 patients.<sup>13</sup>

Initially women patients who were few in number were offered gifts 'in the shape of clothes for themselves and their children when they left'. They also received "an allowance for tobacco and such like indulgences, while in the hospital."<sup>14</sup> Gradually, number of patients rose. Number of female patients in the midwifery department as well as attendance at the outpatient department for diseases of women and children increased in the 1860s. Dr. S. B. Patridge, officiating Principal of Medical College wrote to Dr. Hugh Macpherson, Secretary to the

Principal Inspector–General, Medical Department: “The Midwifery Department has made great progress; there have been no less than 131 confinements, much the largest number in any one year since the establishment of the institution. In the out-patient Department also the attendance at the Dispensary, for the diseases of women and children, has been greater than usual; the excess over the attendance in 1860 amounting to no less than 1,917. Much of the popularity of this Sub-Division of the Hospital is, I believe, due to the appointment of a steady married man as Resident House Surgeon...”<sup>15</sup>

The table below indicates the number of women treated by obstetric physicians in the Calcutta Medical Institutions between 1875 and 1880.

Year	NUMBER OF WOMEN PATIENTS TREATED BY OBSTETRIC PHYSICIANS
1875	1004
1876	1153
1877	1109
1878	1238
1879	1204
1880	1277

The figures denote an increase of 27.29% in the number of women patients of obstetric physicians of the Calcutta Medical Institutions in a span of just five years. According to the reports of 1880 there were as many as 296 deliveries in 1880 as against 247 in 1879 in the various Calcutta Medical Institutions which included not only the Calcutta Medical College Hospital, but also General Hospital, Mayo Hospital and Dispensary, Campbell Hospital, Howrah General Hospital and Municipal Police Hospital. Among the women in-patients in these hospitals, number of native patients was the largest. Among the native patients, East-Indians formed the largest group. Number of women in-patients among the Europeans was the lowest when compared to the other two groups. 23 were Europeans,

88 East Indians, and 185 natives. On the recommendation of Dr. Charles, who administered the Obstetric Hospital for many years with remarkable success, the Lieutenant-Governor decided to establish a certain number of stipends to enable women to study midwifery in the wards. It was pointed out: "There can be little doubt that the want of trained nurses in the interior of the country is severely felt."<sup>16</sup>

In 1881 however the number of in-patients treated by the Obstetric Physician showed a considerable falling-off, being only 1008 against 1277, 1204, 1238, 1109, and 1155 in the five preceding years.<sup>17</sup>

Enthusiasm and applause generated in the official circles in the 1860s about the supposed popularity of hospital treatment among the native population gradually seemed to give way to skepticism. In the eighties the official opinion pointed out that the native races appeared to resort to the hospitals in much the same proportion year after year. Moreover admission of women in hospitals was still a very rare phenomenon when compared with those of men. The proportion of male to female adults was reported to be about 4 to 1 in 1880. 163,925 adult males and 15,584 adult females were treated in different medical institutions in Calcutta. Of them, 40,563 adult males and 4298 females were in-patients. The death-rate among adults was 138.6, and among children 133.<sup>18</sup>

These evidences show that although the number of women patients attending hospitals and dispensaries was rising gradually, still very few actually attended medical institutions. The attendance of female patients in Calcutta medical institutions remained far below expectation. This, in conjunction with other factors, gave boost to the prevailing notion that in conservative Indian society, women, particularly belonging to higher social ranks, would shun treatment by male physicians. Thus there was a general opinion among cross sections of the population that women in India were averse to treatment by male physicians and therefore creation of trained female physicians was urgently needed to attend to their health needs. This logically led to a demand for extension of medical education among women.

### **Indian reformers and the beginning of women's medical education.**

Madras played pioneering role in introducing medical education for women. In 1874, Mary Scharlieb, the wife of an English barrister in Madras who later became a London Gynecologist persuaded authorities in Madras to allow women students to attend classes at the Madras Medical College.<sup>19</sup>

A new chapter in the history of medical education for women opened in 1875 when four students (including Mrs. Scharlieb) were admitted to the three-year certificate course of the Madras Medical College. In 1883, the Bombay University offered medical degrees to matriculates, who pursued a five-year course.<sup>20</sup>

In Bengal, since the mid-1870s a section of the educated reformers started supporting women's entry in the Medical College. Indian reformers' support for introduction of medical training for women would at first glance seem to be very unusual and contrary to the general trend of attitudes regarding the objective of women's education prevalent among the reformers. Despite the fact that females of aristocratic families were often given basic education to enable them to run the property in case of an untimely death of husband, the conservative norms of society in general discouraged women's education. Women who craved for education had to face enormous difficulties.<sup>21</sup>

Where Indian reformers supported female education, it scarcely had anything to do with economic functions or pursuit of employment or growth of professional expertise. The main social utility and commitment of women's educational project was seen as lying in the constructive role expected to be played by the new women in bringing about moral and social welfare of family members.<sup>22</sup>

These new women were expected to develop as companions to men, as scientific nurturers, and as members of civil society, they were to remain a socially distanced class from the common or lower class women inhabiting a world of unrefined, coarse, popular culture.<sup>23</sup>

The Indian middle classes' support for female education was partly prompted by an urge for providing an answer to the imperialist critique of Hindu male behaviour towards women. James Mill's 1820 linkage of Hindu/Indian decadence and the condition of women in Hindu society was only an early, influential example of what would become a general theme in British writing on Indian civilization. Both as a result of the British educational system's "civilizing" message and in response to the changing demand of life under British rule, English-educated and/or Western-influenced Indian men increasingly saw the reform of women's social conditions—most particularly women's literacy and education—as the key to both India's progress and their own. Support for female education was also shaped by the perceived need to reformulate the norms and functions of middle class family life as a site of moral and cultural restructuring of the nation. The objective was to create compatriot-wife who would bring about discipline, order and hygienic practices in middle class home. While individual reformers like Radhakanto Deb, Vidyasagar and others played important roles in upgrading women's condition, the Brahmos as a group—more than any other group—were identified with the social reform of women's conditions in Bengal. Issues like child marriage, the breaking of Purdah, spreading education among women—all were associated with one or another sect of the Brahmo Samaj.

After the first schism in the Brahmo Samaj in 1866 the Brahmo Samaj of India led by reformer and religious leader Keshab Chandra Sen (The other sect was known as Adi Brahmo Samaj) supported social reform more than ever. In 1862 he organized a society, the *Bamabodhini Sabha*, for women's education. Another Brahmo, Umesh Chandra Dutt started publishing the *Bamabodhini Patrika* which carried articles on women's issues and organized a correspondence course for girls through its columns known as *antahpursiksha* or education in the 'seclusion of home'.

In the 1870s Brahmo reformers became divided into two camps regarding the question of women's emancipation including patterns of women's education. In 1871 Kesab Chandra Sen returned from a trip to England enthusiastic about women's education and

committed to the idea of a separate, special education for women, one that would develop their uniquely feminine nature. No need for women to learn “manly” subjects such as geometry or philosophy, natural science, he argued; instead, they should study domestic skills-housework and cooking-skills that would fit them for their future work as wives and mothers.

Keshab's views were diametrically opposite to those of the radical Brahmos who wanted that there should be same opportunity for women in the field of education as was available to the male members of the society. Miss Annette Akroyd who came to Calcutta in 1872 opened a school, the Hindu Mahila Vidyalaya in September 1873 which aimed at spreading a much more equal education to women. Dwarkanath Ganguli, one of the radical Brahmos, became the Headmaster while other progressive Brahmos including Anandamohun Bose, Durgamohun Das, Sivnath Sastri supported the move. They also formed the 'Samadarshi Party' and started a journal called by the same name. With the support of the Samadarshi party, the Banga Mahila Vidyalaya was established in June 1876. Its first few students included women of many Brahmo families like Durgamohan Das's daughters, Sarala and Abala, Jagadish Chandra Bose's sister, Swarna Prabha, Manmohan Ghosh's sister, Binodini, and also Kadambini Basu, daughter of Brajakishore Basu. Kadambini Basu, and Chandramukhi Basu a Christian, became the first recipients of B.A. degree in 1882 from Bethune College. They were the first women graduates in the entire British empire.

In 1875, a Brahmo, Neel Kamal Mitra submitted a petition seeking admission for her granddaughter, Biraj Mohini to the Hospital Assistant course at the Calcutta Medical College. Mitra however insisted that Biraj Mohini should be given a separate curtained-off seat and taught dissection in the presence of her husband or himself. Nothing tangible resulted from it.

That Indian women would remain deprived of western health care if members of their own sex were not provided with medical training was a powerful argument in favour of introduction of western medical education for women.. A number of newspapers

and journals emphasized the need for women doctors trained in western medicine for women patients. *Brahmo Public Opinion* wrote in 1883: "If there be any one country where more than at another, the want of lady doctors is most keenly felt, it is no doubt India. The system of *zenana* seclusion makes it nearly impossible for male doctors to be very useful in treating female patients. Consequently, a very large number of our women face premature death from want of proper medical attendance... Besides, there are diseases peculiar to them, which it is simply impossible for male doctors to diagnose or treat." The *Bamabodhini Patrika* wrote: "Everyone with prudence will admit that as for men, medical education is equally necessary for women. There are certain types of female diseases which can only be appreciated by women and their treatment by males cannot be as effective as by females."

### **Colonial perspective**

In Bengal, in 1876, the Lieutenant-Governor Sir Richard Temple was supportive of the demand for the admission of women to the Calcutta Medical College classes. In 1879, the matter was again discussed; but on neither occasion the discussion had any practical result.<sup>24</sup>

In a letter addressed to the Principal, Medical College, dated 5<sup>th</sup> May, 1882, A.W. Croft, DPI wrote: 'The parents of two or three young ladies, European and native, who have passed the Entrance Exam of the University, have expressed to me their strong desire that their daughters should join the medical College...'<sup>25</sup>

In fact in Bengal, in 1882, Ellen *Barbara* d'Abreu (born in Dacca to an Anglo-Indian family from Patna and Nagpur) and Abala Das (1864-1951, daughter of the renowned Brahmo reformer Durga Mohan Das who later married the scientist, Jagadish Chandra Bose) passed the First Arts and Entrance Examinations, respectively, from the Bethune school and approached A. W. Croft, the Director of Public Instruction in Bengal, to get admission at CMC.

On the 5<sup>th</sup> of May 1882, Mr. Croft asked for the opinion of the Principal and Council of the Medical College on the admission

of females to the Medical College classes. He urged that they should be admitted on the ground of the great alleviation of suffering which would probably result if there were a body of qualified practitioners to whose admission to zenanas there would be no objection. He added that if the Medical College classes were thrown open to females, a career of usefulness would be provided for those ladies, native and others, who were passing the University examinations. Mr. Croft proposed to recommend to the university the admission of female candidates if they passed the Entrance examinations.

Mr. Croft's suggestion was laid before the Council of the Medical College, and at a meeting of the Council in which five members were present, resolutions were passed by a majority of four. It was pointed out that no general demand for female physicians existed amongst the native community. Moreover, the Council members did not hesitate to express the opinion that "extended training in midwifery and diseases of women and children will suffice to meet the requirements of the case". It was also recommended that, if medical education for women was found to be necessary, a separate College for women would have to be established. On one point, that of lowering the qualification for entrance to the College, the whole Council was unanimously adverse.<sup>26</sup>

D'Abreu and Abala Das moved to the Medical College of Madras, which had opened admission to women. D'Abreu entered the BM class (five years) and Abala Das the LMS class (four years).<sup>27</sup>

It was decided by the Lieutenant-Governor of Bengal, Rivers Thompson in 1883 that women should be admitted to the classes in the Calcutta Medical College on the same footing as male students were admitted.<sup>28</sup> The Lieutenant-Governor felt that Bengal's reputation as a leader in educational progress in British India was at stake since Madras and Bombay had already begun to admit women to medical classes and Bengal was lagging behind. It was unacceptable that Bengal, 'progressive in other respects, should be illiberal and retrograde in this'. It should not lag behind in the 'medical education of native ladies',

especially since it was not 'the prejudices of native parents' that was the problem. The lieutenant governor also argued that the members of the Council, in denying women entry into medical education, were encouraging social conservatism, and therefore *zenana* prejudices. He was not willing to stifle 'the natural and reasonable aspirations of Indian ladies to enter a profession which would find in India, of all countries in the world, a wide sphere of action and of beneficent service'. Moreover, he dismissed the objection raised on the ground of teaching mixed classes as obsolete and cited experiences of Europe and America and even of India at Madras which had in fact shown that mixed classes could be taught without adverse results. In Madras there was no sign of moral decline due to mixed classes.<sup>29</sup>

Coates pointed out that authorities in France and Switzerland believed that the presence of women in medical classes did in fact produce a 'refining influence'. During debates regarding women's admission to Calcutta Medical College, policy makers' stated objective was, at least partially, to bring about good governance delivering public good. According to the Lieutenant Governor, the fact that 'some Bengali ladies, fully qualified by educational attainments' had to go to 'the more liberal Presidency of Madras' to study medicine was 'clearly opposed to the public good'.<sup>30</sup>

Finally a resolution of June 1883 declared that women were fully admissible to the CMC.

From the point of view of the colonisers, the imperative of training women doctors was articulated as part of the 'white man's burden'. The British considered themselves to be the "enlightened outsiders" whose moral responsibility lay in upgrading the colonized. The policy makers were convinced that Indian women generally were averse to being treated by male doctors. This formed the powerful basis of an argument in favour of the proposal to train female doctors. According to A.W. Crofts, 'conditions of social life in this country, required a body of thoroughly trained and qualified female practitioners' in order to rescue 'large numbers of the women of India, either

from a life of suffering or from premature death'.<sup>31</sup> The Lieutenant Governor also accepted the view that Indian women 'in every position of life' would prefer death to treatment by a male physician. He argued that 'the misery caused by neglected and unskilfully treated illness' was widespread and 'most lamentable'. The only solution to these problems was to extend medical education to women. Western opinion was thus largely convinced that only female agents could hope to make metropolitan medical care more palatable to Indian women.

Female entry into medical profession, however, was not welcomed by all. The contemporary journals and anonymous letters to the editors of these journals criticized the government for having acted in haste, without scrutinizing the matter intensively, as what was being experimented with was the precious human life. It was frowned upon in IMS circles. The Indian Medical Gazette (IMG) attacked the government in its editorials time and again. Over the beginning of medical education for women in Madras it had rebuked the policy-makers sarcastically that the demand for female doctors by the people of India was a pure assumption to start with; that females of any kind were fit to be doctors was indeed questionable in India; and the manner in which it was being carried out was superficial and unsafe. Another editorial of the same journal expressed its view in 1884 that women were better fitted for nursing than being doctors, and that an agency of educated nurses would fulfil the requirements of the country better than of full-fledged lady doctors. Perhaps, jealousy and fear of competition in a hitherto all-male profession generated such fierce heart-burning and derogatory comments. The early female medical students had to face and overcome even more serious charges of moral turpitude.

Despite all these social discriminations and discouragement, female medical education continued to spread and flourish. The first beneficiary of the new rule was Kadambini Basu, one of the first female graduates in India, who later married the Brahmo reformer Dwarakanath Ganguly. In 1883 Kadambini entered the Calcutta Medical College and was awarded the GBMC degree in 1886<sup>32</sup> instead of the MB because she failed in one part of

her final practical examinations. Professor R.C. Chandra failed her in medicine. It was generally believed to be a vindictive gesture because he was opposed to the inclusion of women in Calcutta Medical College. A scholarship of Rs.20 per month was announced by the government to every female student for her tenure of five years.<sup>33</sup> Kadambini received this scholarship with provision for retrospective effect from July 1883. In 1884, DPI extended the scholarships of Ellen d'Abreu and Abala Das to continue their study at the Medical College of Madras, since they had moved prior to the opening of classes to women in Calcutta. Croft also granted these scholarships to two notable students-Virginia Mary Mitter (Nandy-1856-1945) and Bidhumukhi Bose (Daughter of Bhuban Mohan Bose, a Bengali-speaking Christian from Dehradun; sister of Chandramukhi Bose) after receiving their applications for scholarships to study at the Calcutta Medical College. Miss Virginia Mitter was, later, to prove wrong the anticipated fears of undesirability of the mixed classes and lowering down of the educational standards by heading the list of successful candidates in 1888.

Between 1884 and 1886, these crucial financial measures, together with some substantial private donations, greatly helped the cause of women's education at the Medical College. In 1885, Maharani Sarnamayi, (1827-1897) by her donation of one-and-a-half lakhs of rupees for building a hostel for female medical students, "removed a great obstacle in the way of female students studying medicine in Calcutta."<sup>34</sup>

### **Campbell Medical School**

In 1887 Sir A. W. Croft, Director of Public Instruction wrote to the Secretary of Bengal, General Department: "I have the honour to state that I have been lately in communication with the Superintendent of the Campbell Medical School on the subject of establishing in that institution a vernacular medical class for female students, to be taught the same course, during the same period of three years, as the male students who now reads in that institution. Dr. Coull Mackenzie expresses his entire concurrence in the proposal... It is impossible to say, without a trial, whether the classes would be popular and well attended; but ever since the movement for the medical education

of women in India began, I have had in mind the formation of a school of this kind, and I am not without hope that it would be successful. My original idea was that the medical education of women in this country should be divided into three grades: first, the English course at the Medical College for the degree or the license in medicine; secondly, the purely vernacular classes, such as I now propose; thirdly the classes for the instruction of midwives. The first and third are in successful operation; for the second was substituted the certificate class at the Medical College, in which the instruction is necessarily imparted in English, because the Professors of the College are unable to teach in the vernacular. This class is therefore practically confined to young European and Eurasian women, who will practise in the large towns only. It in no way meets my desire for the creation of a class of medical women for the larger villages of the mofussil practicing under the same conditions and among the same class of people as the young men trained in the vernacular medical schools of Calcutta, Dacca, Patna, and Cuttack. That is the object of my present proposal; and though I am fully aware that it is by no means certain to succeed owing to the general (though I am glad to say diminishing) want of education among women throughout Bengal, and to the obstacles which social conditions impose to their prosecution of an independent career, yet I am of opinion that the practical benefits that would follow from such a measure, if happily it should be successful, justify Govt. in making the experiment. If it succeeds, well and good; if it fails, little or no cost is incurred and no harm is done."<sup>35</sup>

J. M. Coats, the Principal of Calcutta Medical College, claimed that numerous district Boards informed him about their requirements to employ female medical practitioners whom they could pay around Rs. 30-40 per month. They were unable to afford to recruit graduates of Calcutta Medical College who generally expected a minimum salary of Rs. 300 per month. It seemed that there were also eager applicants who wanted to get enrolled in the vernacular programme if offered an opportunity. According to Dr. S. C. Mackenzie, the Superintendent of Campbell Medical School, right at that

moment made available 15 candidates which included... "ladies belonging to the most respectable *Brahmo* families of Bengal-one of them is a relative of a pleader, another-a relative of a Government inspector of schools, another, a relative of the superintendent of a Zoological Garden, and two others are relatives of a teacher of a medical school."<sup>36</sup>

Many however were against this move of admitting female students at Campbell. Surgeon-Major C. J. W. Meadows, Officiating Civil Surgeon of Patna, wrote to the Secretary to the Govt. of Bengal, General Department: "I am.... of opinion that no special demand or need exist for this inferior class of Female Hospital Assistants in the villages, and their employment would tend rather to discredit the western system of medicine and so defeat the object in view."<sup>37</sup>

According to R. L. Dutt, Officiating Civil Surgeon of Rungpore, there was no need for medical women of the Hospital Assistant class in the mofussil. He also pointed out that Indian women who wanted to become doctors should attend Medical College and those with less education should take the midwife course.<sup>38</sup>

It was also pointed out that Indian women were too steeped in ignorance and tradition to want western medical care.<sup>39</sup>

Perhaps most dangerous, these half-trained women would "discredit the Western system of medicine."<sup>40</sup>

In 1888 the Campbell Medical School at Sealdah finally opened its door to female students. Campbell Medical School was originally established in 1872 to accommodate the rising number of applicants who wished to enroll in the Bengali programme of the Calcutta Medical College started since 1853. The first batch of 15 female trainees admitted at Campbell included Hindus, Brahmos, native Christians, and Eurasians. Unlike CMC, Campbell's instructors were Indians who received their medical training in India. Textbooks were written either in Bengali or were translations of English books. Different scholarship schemes were introduced by the Dufferin Fund from 1885 onwards.<sup>41</sup>

## **Impact**

### **Women and traditional care-givers discredited by western medicine**

During the British rule in India women's (as well as men's) health needs were met by women as well as male practitioners of traditional Indian therapies. As discussed elsewhere,<sup>42</sup> there existed a vigorous female domain of healing in early nineteenth century Calcutta. Medical knowledge existed both within the household and among certain recognised women specialists who had commendable skill as practitioners. One very famous female practitioner of traditional medicine in early 19<sup>th</sup> century Calcutta was popularly known as Jodu's mother.<sup>43</sup>

She was the wife of Kasinath Datta, fourth son of Bhabanicharan Datta, who was employed as diwan in the East India Company's Public Works Department. Reportedly, Kasinath learnt about the treatment of many difficult diseases from a sage whom he met in Benaras and started practising as a medicine man in Calcutta. He taught his wife these methods of treatment and remedies who took up her husband's profession after his death and became an expert and popular-healer. The Calcutta Medical College was established not long before her death and there were only a handful of western practitioners at that time, who were apparently surprised to find her commendable skill in doctoring. Her expertise became a subject of pride for educated Calcuttans. Poet Iswarchandra Gupta even wrote a poem mentioning how she did succeed in such difficult cases where even reputed Doctors and kavirajas failed to treat the patients.<sup>44</sup>

Another famous 'name' among women healers was Raju's mother who belonged to the barber caste. She was an expert in surgery and used to earn a comfortable livelihood from practising surgery alone. In Bengal, as in other parts of India, childbirth was attended by indigenous midwives colloquially known as dai. The mother was attended during and after birth by a midwife, usually a woman of the Dom or Bagdi caste.<sup>45</sup>

Many of the Christian missionaries who were the earliest among the outsiders to criticize the deplorable health condition of Indian

women acknowledged that Indian women depended on traditional caregivers who were accessible and acceptable and had far stronger popular appeal than alien substitutes. Elizabeth Beilby, for example, pointed out that Indian women were not entirely bereft of medical care. 'Their own women, dhais as they are called, can do something' she reported. She also pointed out: 'and one or more of these women will always be sent for before an English lady doctor is called in.'<sup>46</sup>

Even Dr. Alice Marston, Beilby's successor at Lucknow, told an international missionary gathering: 'It is quite a mistake to suppose that Indian women are debarred from medical treatment altogether. From our point of view they are certainly debarred from sufficient or effectual Medical aid; but from their own point of view they are, excepting in cases of special emergency, well provided for.'<sup>47</sup>

As the nineteenth century progressed and western medicine received patronage from the rulers, the domain of traditional medicine (and of traditional caregivers) was gradually discredited and marginalized in official medical policies.<sup>48</sup> Colonial medical discourse in 19<sup>th</sup> century British India privileged western medicine based on knowledge of human anatomy and gathered from dissection over indigenous medical systems. Education in scientific medicine and its dissemination were regarded as a cornerstone of the civilizing mission, and underscored the colonizers' cultural authority. With the growth of institutional medical training traditional education in the domains of indigenous healing was no doubt deprived of state patronage. On the other hand, the growth of institutional medical training was not widespread enough to replace indigenous therapists with formally trained female practitioners of western medicine. Patriarchal social norms ensured that at least during the initial days of female medical education very few Hindu and Muslim females joined the profession. Most upper class and upper-caste Muslim and Hindu women were unable to leave the seclusion of the home to become medical students. Women medical students disproportionately consisted of women belonging to European, Eurasian, and Indian Christian communities, which placed fewer restrictions on the employment

and education of women. Wherever the Hindu and Muslim females appeared, they appeared in ones and twos. This pattern continued until the 1930s.<sup>49</sup>

British racism also ensured that medical education in colonial India developed on a tiered basis: Indian men were relegated to the lower ranks as “hospital assistants,” while Europeans and Eurasians received “licentiate of medicine and surgery” or “assistant surgeons” degrees. Indian women, too, were clustered among the “hospital assistant” or “certificate” ranks. Introduction of medical training for women in institutions like Calcutta Medical College and Campbell Medical School created different categories of qualified female medical professionals just as it did among the male trainees. Among women who received training at CMC were many who belonged to enlightened, educated families. Kadambini was a very successful doctor. Virginia Mary Mitter assisted her husband Dr. Purnachandra Nandi but never practiced independently. Jamini Sen belonged to an educated Brahmo family. She was the daughter of Chandicharan Sen who was a sub-judge and sister of poet Kamini Roy. She joined CMC in 1890. In 1912 she received the Diploma of Royal Faculty of Physician and Surgeon, Glasgow. By 1895 CMC produced thirty-four female graduates. The majority belonged to Christian families.

In Campbell in the first two years (1888-1890) there were more Hindu women, mostly Brahmins and Kayasthas. In 1890 there were eight Brahmos, eight Christians and twelve Hindu women entrants. Hindu girls included, apart from Brahmins and Kayasthas, one Vaidya and one Vaisnav.<sup>50</sup>

In 1891 the first Muslim woman was admitted followed by the second one in 1893. Around 1893-94 out of a total of thirty-one female students three were Europeans, seven Hindus, seven Brahmos, two Muhammadans and ten native Christians. From 1890 all candidates were required to pass a special elementary examination in English. After 1896 it became a four year programme. Examinations became more difficult and a greater understanding of English was required. According to

Geraldine Forbes, the number of Bengali women among the student community began to decline gradually after 1896 due to stringent admission rules. More native Christian, European and Eurasian women entered the school.<sup>51</sup>

Outside Calcutta the Dacca Medical School also admitted female students. The number was however very small. During 1916-17 there were two students. Next year the number rose to seven and to ten in 1919-20.<sup>52</sup>

Between 1935 and 1940, the number of Anglo Indian students declined while those belonging to Hindu and Muhammadan community rose as is evident from the table below:

No. of female students admitted;	1936-37	1937-38	1938-39	1939-40
Anglo-Indian Christians	2	1	—	—
Indian Christians	—	—	1	3
Hindu Brahmin	2	6	3	5
Hindu Non Brahmin	24	27	37	38
Muhammadans	3	4	6	6
Others	8	7	7	5

According to the 1904 report of the Bengal branch of the Dufferin Fund, 38 of the Fund's 43 female hospitals and dispensaries were under women hospital assistants who were VLMS degree holders. Majority of them were graduates of Campbell Medical School.<sup>53</sup>

The official view explicitly stated that hospital assistants were supposed to supply cheap medical aid to the country districts but were "not intended to take charge or to be placed on an equal footing with ladies possessing superior qualifications".<sup>54</sup>

After 1885, many hospitals and dispensaries were opened by the Dufferin Fund which provided employment for many women including Kadambini Ganguly. But these hospitals practised racial discrimination. Appointments were given to white doctors even when more efficient Indian female doctors were available. Kadambini Ganguly, who held temporary posts at Calcutta *Zenana* Hospital was not granted a permanent post in 1891. Kadambini also complained that Indian women were arbitrarily

excluded from the best hospital jobs. This prevented them from developing their skills and it was pointed out that Indian medical women would miss all the advantages of such professional duties by their exclusion from the medical charge of important hospitals, or by being placed in an inferior position there, for in the inferior class of hospitals few cases of importance would ever go for treatment. In the large and important hospitals the major operations and other important duties were always likely to be performed by the senior person in charge.

The early female medical students had to face and overcome even more serious charges of moral turpitude. The superintendent of the Temple Medical School, Patna, reported in 1895 that anonymous petitions were frequently received which denounced the morals of the female students. That was due to the want of a hostel or, dwelling house for them, as he pointed out that ‘... at present they had to live in the bazaar, and unless they were living with relatives, that was a most undesirable arrangement’.

Many less prominent lady doctors who took up practices in the mofussil were often subjected to hostile and derisive reactions from the local male population. The “Malda Lady Doctors’ case” of 1902 was an extreme example of male contempt for women doctors. Pramilabala, a lady doctor of Malda, charged Madan Gopal Chaudhuri, zamindar, of abduction with evil intent, and “of having used criminal force with intent to outrage her modesty.” She had been called out at night on the false pretext of attending Madan Gopal’s wife, and been taken to his boat and assaulted. Newspaper reports expressed indignation at the light punishment imposed on the accused—a fine of 1000 rupees. This kind of hostility and occasional aggression made it extremely difficult for female doctors to carry out their professional duties.

In medicine, as in teaching, professional employment gave the *bhadramahila* direct experience of frustration at the discriminatory policies of the colonial govt. The vernacular press voiced strong objections to the amount of public revenue spent on hiring European lady doctors, who did not speak vernacular

languages, when qualified Bengali lady doctors were available in increasing numbers. European lady doctors also charged high fees. The charge was generally about ten rupees a visit, although one Eurasian lady doctor in Chittagong charged eight for a town visit and thirty-two for the mofussil. Posts opened up by the Lady Dufferin Fund, which had been set up to bring medical treatment to the zenana women of India, were monopolized by Europeans and Eurasians. In 1905 there were complaints that the European lady superintendent of the Dufferin Hospital in Calcutta was dismissing native nurses in favour of European nurses from Bombay.

There is ample evidence to sustain the genuineness of these complaints. In broad terms, initial sexual discrimination in England was being turned into racial discrimination in India. Discrimination against women doctors in England forced them to look back to the colonies for employment. In India, English women doctors were able to take advantage of racial discrimination of the colonial power to monopolize all available positions, thereby hindering the advancement of Indian women doctors. Indian women doctors were left to labor under the oppressive effects of double discrimination on grounds of both sex and race.

#### **Importance of medical education for women**

It must be admitted that the growth of medical education for women and emergence of women medics was a slow process and did not mean that the majority did get benefit. Yet it has to be conceded that those who received it gained an occupational or professional identity which was enmeshed with gender identity. A solid foundation for female medical education and their legitimate place in the medical establishment of the country was laid during these struggling years. Moreover, medical education had an emancipatory effect for many of the women who received it. Medical education and employment as a doctor gave women financial security. From the point of view of women patients, they were offered more options of choosing from different kinds of practitioners including qualified male and female practitioners of western medicine as well as those

of indigenous medicine. But it must be remembered that these diverse forms of health care were available to a handful of fortunate women mostly residing in urban and semi-urban areas while the majority of women were deprived of medical care of trained and qualified women doctors who were products of colonial medical education. Majority of Indian women suffered due to economic disadvantage. No doubt factors other than purdah would have been more influential in limiting women's access to health care, whether western or otherwise. Medical care was economically out of reach for the poorer community. Widespread poverty, the need to travel long distances to reach urban-based medical institutions, the fact that Western, Ayurvedic, and Unani medicines were more costly than folk forms of medicines, the systematic discrimination against women in patriarchal society—these were a few of the hurdles that limited Indian women's access to and reliance upon formal medical aid.

Growth of medical education however helped to recognise the fact that women's right to better health as well as right to employment formed an essential component of the broader issue of social development. It also exposed the policy of racial discrimination practised by the colonizers and the sexist outlook prevailing in the society. No doubt it threw a challenge to patriarchal domination and subordination and prepared the background for demanding better and equal opportunities for health care to women.

#### **NOTES**

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### APPENDIX-A

List of lady students who passed out of the Medical College, showing how they were employed (From the Principal, Medical College To The DPI, 30 March, 1893.General Department, Education.)

	Year	Where employed
Miss A. Niebel	1889	Under Dufferin Fund, Bhopal
„ L.E Sykes	1890	Unemployed, Calcutta
„ T. Dissent	„	Gone to England
„ G.T Pareira	„	Dufferin Fund, Chittagong
„ L.B Smith	„	Private Practice, Calcutta
„ J. Perry	„	Dufferin Fund, Gya
„ L.Kirckpatrick	„	„ „ ,Hyderabad
„ A. D'Souza	„	„ Amritsar
„ Ida.m.Dissent	„	„ Allahabad
„ W.Jahans	„	„ Cawnpore
„ Ida Brown	„	Calcutta
„ J. C Muller	1891	„ Delhi
„ H. Forbes	„	„ Rangoon
Mrs. M.Scott	„	„ Birhampore
Miss C.Brooking	„	„ Allighur
Mrs. J.C Smythie	„	„ Meerut
Miss L.M Carroll	1893	.. Agra
„ E.LBridge	„	Unemployed
„ S.EBridge	„	„
„ M.S Martin	„	Calcutta Dufferin Hospital
„ M.J Watts	„	Still studying at Medical College
„ K O'Byrne	„	Nainital, Dufferin Hospital
„ L.B Long	„	Bari Bouki under NWP, Dufferin Fund.
„ D.E Pratt	„	Agra , „

„ I. George	„	Unemployed
„ S. Anthony	„	„
A. Lisle	„	Multan
G.Woods	„	Not known.
Miss. Mitter, M.B	1890	Private Practice Calcutta
B.M. Bose, M.B		„
B.B. Bose, M.B	1891	Dufferin Fund, Cuttack.

Name of Female Pupils Passed 1890-91	Employment
Sreemutty K.B Guha	Private Practice, Rungpur
„ Basanta Kumari Gupta	„ Calcutta
„ Kiron Shoshi Mukerjee	Employed in Kumartuli Charitable Dispensary, pay Rs 60. rising to Rs 80. free quarters +pvt. Practice allowed
„ Hemangini Debi	Bancoorah Female Hospital, pay Rs. 50. free quarters+pvt. Practice allowed
„ Sarat Kumari Mitra	Pvt. Practice Calcutta.
Miss Shosji Mukhi (?)	„ „ Dacca
„ Agnes Cecilia Basteen	Tipperahzenana Hospital, pay Rs. 60, free quarters+pvt practice allowed
Sreemutty Khiroda Sundari Roy	Dhankarbai Hospital, Nasik Bombay. Rs. 100, free quarters+ pvt. practice allowed.
Mrs. S.M Biswas	Pvt. Practice Calcutta
1891-92	Q
Sreemutty Harimati Dasi	Burdwan Female Hospital, pay Rs. 50. free quarters+pvt. Practice allowed

„ Rajlakshmi Debi	Kandi Charitable Dispensary, pay Rs 40. free quarters+private practice allowed
Mrs. Poospomoyee Sircar	Pvt. Practice, Calcutta
1892-93	
Sreemutty Priya Bala Guha	Employed under local board, buckergubge
Mrs. Kadambini Mukherjee	„ in Sitapore Female Hospital, oudh, pay Rs 90. free quarters and private practice
Sreemutty Sushila Debi	Employed in Lady Dufferin Hospital, Bhagulpore, pay Rs 60. horse allowance Rs 15, free quarters+private practice allowed.
Sreemutty Bonotosini Chunder	Not known
Sreemutty Lokhi Moni Debi	Monghyrch. Dispensary, pay Rs 50, free quarters + private practice.

## APPENDIX B

Report of the Campbell Medical School for the year 1892-93:By Brigade Surgeon Lieutenant-Colonel S. Coull Mackenzie, M.D, Superintendent of the Campbell Medical School, who was in charge of the school throughout the year.

Sessions	Remained At The End of the Sessions		Grand Total	No. of Students Appearing at the final diploma exam		% passed	
	M	F		M	F	M	F
1887-88	158		261	58		89.65	
88-89	150	11	285	64		85.93	
89-90	139	20	278	87		86.20	
90-91	151	14	293	47	10	80.85	100
91-92	136	17	293	43	4	97.67	75.00
93-93	177	16	289	54	7	33.33	71.42

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