**Social History of Medicine in Colonial India**

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**Lecture 01**

Colonial State and Medical Volunteerism

Hello and welcome to yet another lecture - Lecture number 31 and this one is about the question of finance which has been coming almost in every lecture and we know what it is - the reluctance of the colonial state to spend too much. And, on the other hand, the efforts to address the question - because somehow spending has to be done, it cannot be entirely avoided - it has to come from somewhere. One of the important avenues that the colonial state was always having its eye on, was volunteer participation from the beginning. From the company days itself, there was this desire to replicate the model of volunteerism which was actually there in Britain in the domain of healthcare - individuals and societies voluntarily contributing, so that there is a sense of feeling good, of being of some great use to the society. And, medicine is one field where it is particularly felt because it is about the very life of the people. Also not just living, but when there is a suffering, then that produces more empathy and somehow doing something about the empathy, about alleviating the pain of someone, that is something which is happening in front of the eye, this gives a great sense of satisfaction and solace not only to the people being cured but also to the giver in some way - either the giver of the treatment or in this case, the giver of the financial wherewithal. So, the idea was to promote that kind of private charity or institutionalized charity here in the colonial context also. Charity is not something new to the colonies or any society - indigenous societies - where the colonizers went. But it was more associated with rulers - you would have seen about how Ashoka built this so and so, and Harsha built guest houses where travelling people were freely accommodated, were given free food, medical facilities; or about donations made by princes to temples, not only for the temples to be maintained or renovated or more kinds of things added to the infrastructure of the temple or the facilities of the temple - but fund going to the temple, which in turn would go to the public through the charity works done under the auspices of temples or mosques or any kind of religious institutions - like free food for the pilgrims who went there or generally the destitute and others who would congregate in such kind of institutions for alms. So , that has always been there traditionally - we have examples of our own states - however good, efficient, inefficient, good, bad, ugly, -whatever it is - all states or most states had

that measure of charity associated with them. But in the colonial situation, the state did not want to do even that minimum that a state should actually do - forget about extra, going extra mile in terms of charity and all that - but even that minimum that this state should have done especially in an important field like medicine. It wanted to spend minimally and wanted much of that important spending also to be done by charity. Health, as a field, was a good candidate for that kind of a devolution. The colonial state was not eager to spend - not only in health but many other fields - because especially starting with the East India Company as a commercial organization. the primary aim was (especially in the initial days), to make quick money in quick time. Devolution in a sense is like passing on the buck - not the kind of devolution that we will be talking, say when you are talking about the Government of India Act of 1919, dyarchy and all that. For this kind of passing the buck - the kind of activity and trend, health was one fitting candidate - for that kind of charity because as I was saying earlier, that gives a special sense of attachment, satisfaction of having helped lives, helped people in the ailments or even having saved some lives which otherwise would have been lost. And this also, building on such pre-existing kind of sentiments, some of them colored by religious beliefs for instance, like the belief in karma, (the good you do at this time in this world will fetch you some benefits in the next world) - those kinds of religion-based sentiments through which people are naturally predisposed particularly to this kind of field. And apart from those kinds of traditional elements there was also the new element of benefits that will accrue by being seen to be involved in charity. For instance the certification from the colonial state establishment about the public spiritedness of the people who are so munificent. Also on some of them, if they are making very substantial contributions to the building of big institutions, the colonial state would very generously confer titles. In this way, it tried to build, not only kind of individuals giving donations and making contributions but also to encourage people to come together in an associational sense, coming together voluntarily giving their money as well as their time, their efforts towards public causes in general and in this case medicine. And, it is not like because that they were very particularly interested in building some great new social or sociological structures or virtues among Indians. And in any case, it is not like Indians or any other community - indigenous communities that the colonizers encountered - did not have that kind of coming together. Historically, people have had kinds of group organizations - in fact they have had even elections many centuries back in India . People coming together at the town level, at the local level for common causes is not something new. So, it is not like the British wanted to cultivate new kinds of things - like this voluntary associational culture as part of their ‘civilizing mission’ and also the other argument that they were using: ‘this will promote in them a sense of self-reliance rather than depending for everything on the government’. That also is not to be taken too seriously because if that was the case, then from these early days itself, from the say, the 1780s or the early 1800s, the colonial state would have come up with things - with

real devolution of power, training them to be self-reliant and all that - which they did only with say the Government of India Act of 1909 or 1919 Minto-Morley or Montague-Chelmsford Reforms and all those things. Those were supposed to be training the Indians in self-government, self-reliance and all that. Why did they have to wait that long, if this was a case, this could have started even earlier. So, that argument of self-reliance also has to be taken with a pinch of salt - because we know why, what's the reason this kind of voluntary associational culture was sought to be promoted. May be at some level, there was some genuine interest to promote this kind of public spirit among Indians. But we know the actual reason from the financial point of view.

And talking about the contributions by the people of a locality, the contribution may be donations or regular monthly subscriptions to a given cause, the colonial state expected that, more for the local facilities. It is not like you are living in this area and they are expecting you to donate for some all-India thing, or something happening elsewhere. So it was more like what you can call locality-based volunteerism, which is basically the setting up or the maintenance of local dispensaries in the field of healthcare - local dispensaries or hospitals - the expenses - not the entire - but substantial amount of expenses that go to setting up the facilities and the institutions - not only hospitals but even other institutions - training and other facilities and then for the long-term running of those hospitals or institutions in terms of recurring expenses and salaries. It was not necessarily for institutions that had a wider ambit at the national or at the provincial level even beyond the immediate locality. This was all the kind of expectation from the colonial state for the various reasons that we have seen. But what was it on the other side how did the Indians react to all of this. There was considerable level of positive reaction due to several reasons some of which I have already hinted. For instance, this donation and being seen public-spirited was a way of getting close to the centres of power - that proximity to the state apparatus if not to the particular individuals like a Viceroy or Governor or others - especially with regard to the old landed elite who were tied with ties of self-interest because these were the people on whom the colonial state depended a lot in its early days and with whom it set up very favorable land revenue settlement arrangements and all that. In course of time, even after that, when the new elite arose, the colonial state felt more comfortable with this old elite because the new elite, the new educated elite seemed to be a too much of a problem, asking too many questions and talking in their own language and quoting principles of liberalism, quoting Western Constitutions, legal principles and things like that. The new educated elite, in some sense, seem to be a pain created by their own systems. Therefore the old elite were particularly precious, and as you know, the British tried to play the game of divide and rule across various axes - not only with regard to religion. But the new elite also, for their own reason, either the business elite or the educational elite - they also warmed up to these kinds of opportunities. Because of the commercial changes brought about by colonialism (though by and large, they benefited and were all tuned to the requirements

of the East India Company or the colonizers in general or the colonial state) did spawn a new culture of commercial prosperity among at least some of the Indian classes - not only the traditional business classes, but even the classes which are not traditionally associated with business. So there were lots of new avenues that opened. And also due the coming of technologies like steam-driven shipping and railways, telegraph and lot more connectivity, a lot more could be done on the commercial sector which many Indians too capitalized on. This spurt in commercial activities and with vibrant mercantile communities, there was a lot of money. Even people who were not in the local caste structure, even people who are not of high status according to that hierarchy could make money.

Money is there, but then the status would be what what it was. That is the thing about the caste system - one can't change the caste and all the things that go with it - the way you are looked upon and all that. So this volunteerism, this kind of a donation and being associated this kind of public work was another form ( if you can't do anything that's almost fixed - the set of status-related equations with regard to the caste system, at least this provided), a new avenue for status. On the one hand, you have money but but without status, but this is also welcome and which apart from the new stature, the growing stature, also gave a sense of belonging to the larger community and being looked up by the community at large. It was in several ways very profitable in a larger sense beyond the commercial profits. It was very useful to make visible contributions - it should be seen - that's the idea - only when it's seen you get the fruits of it - that stature, the commendation the exaltation -the exalted place in society. Visible contributions to all kinds of organizations like religious organizations or construction of public facilities, motels for travelers and things like - that that spirit was extended to the domain of health also to for building contributing to building of hospitals and dispensaries - what we may call a new culture of medical philanthropy. and As they say, in this case, things were literally set on stone - it's a matter of pride that it's forever for at least a few decades or hundreds of years - your family's name - Dr. Mishra's Block, Radhanrishnan Maternity Ward - it's a sense of pride for the entire family and their children ('oh! this is my grandfather Mishra – he had contributed to this gynecology lab / the ward' and things like that) with their contribution written either on the corridors or wards or even on particular beds (like: 'this.. by the generous contribution of Ramasamy Reddiar' - it's nice). Those kinds of benefits - social benefits – were there. At another level - beyond all this kind of social stature /visibility - in a way, it is also kind of a willing participation in the modern Western culture of science-based public enterprises. For the colonizer it is a double cultural imprint - one was the originally intended volunteerism which they claimed they were implanting /cultivating and the other imprint they are leaving is that indigenous people themselves were voluntarily subscribing to/ contributing to the structure of not just the physical structure, but the accepting the epistemological order of Western medicine based on scientific and secular principles. It's not just the money

which was going. The very fact of that money that people give - they are participating - by that very fact they are also kind of acknowledging accepting something. For instance, if you are donating to a temple it also means that you're a believer. (Of course, it can happen that some people who are not related to religion may give just because of the fact that its being given to temple will raise their stature. But) most often, you give to the causes which are dear to your heart. In this case, although you are, on the one side doing it for social stature, it is also indirectly your acknowledging that you're happy about the kind of new culture. You're also direct or indirect participants – it is not like you are going and doing the the scientific activity or the clinical job - yet you are also kind of subscribing - you're a subscriber not only in money terms but you're also subscribing to that entire worldview, that culture. That is another thing which we have to particularly note in mind.

Based on all this, as I said, there was an expectation on the one side and on the other side there was a eager participation from the side of the Indians. And so started coming the charitable dispensaries to start with. We also have to keep in mind that enclaves were not sustainable - sooner or later, there had to be that move from enclavism - interest in particular enclaves, special enclaves to larger public health. In that kind of a transition, these charitable dispensaries starting from the 1830s, were the earliest entry points or experience of public health for the Indian people -m ore than large state funded or established hospitals. Even in some of these dispensaries – in which, may be, the state had the initiative, there is a substantial amount of charitable contributions involved. But these dispensaries were the first tell-tale signs of public health infrastructure. It is also interesting, given the context of the funders, some of these were also focused on particular communities to which the donors belonged. For instance, they would be particular to have it or name it with so and so, and such name - may be the funder's name or generally with this identification: some Marwari or Hindu Hospital or particular ward - like a Parsi ward in some hospital - similarly some other community. This is particularly important because hospitals or any institutions, when they are acquired or transplanted to another location or a culture, it's not that they maintain the same essentials. In fact as they undergo substantial changes because of the local culture. Hospital is one good example - hospital in England is not the same as hospital in India -just as they said disease in Britain is not the same as disease in India. May be the the kinds of infrastructure, the kinds of techniques, the technologies, the gadgets may be same – but even some of them also have to be customized according to the local climate and availability of electricity and other such things. But in terms of culture, for instance here, the hospitals had to incorporate features like caste-consciousness: people of different kinds of caste can't be indiscriminately put in in a ward - there had to be all these kinds of requirements as a Brahmin ward, this ward and that ward. For instance Parsis particularly, in some cases wanted so. One was the show of their public spirit and it is also natural since they gave it, they wanted some prominence for their community's

name. That was one angle - but there is also angle of separation / segregation - segregation of wards. We are not saying that these are not there other contexts like the Western context. There may be and were other kinds of segregations based on class and colour. But that's the point - in each cultural situation, the same institutions will undergo amendations and changes/ modification - that's something that's a larger element that we have to take from this course and you can find the different examples of it. For instance, the same institutional setup is trying to draw upon the spirit - the charitable spirit which is already existing in the culture - though they (British) claimed that they are creating it almost anew. Apart from the contributions to hospitals and dispensaries directly, they could also be made to corpus funds like the Dufferin Fund and IRFA. In the beginning I was saying that most of the contributions were for particular institutions and that too very local. But here, we are not looking at particular institutions - it's a Fund - the funder at that point will not know that this is going for this particular hospital or this structure or a particular ward.

The Dufferin Fund, as you know was started in 1885 with the larger purpose of providing personnel - particularly women personnel - directed particularly to the health of women and also children. That fund could go to all kinds of things: to recruit people, to train people, to bring them from England to here, to settle them or to even start hospitals - special hospitals, which were meant exclusively for women and children. With regard to the Dufferin Fund therefore, it could go to that corpus or to the particular Dufferin hospitals and which may be actually set up in that locality or elsewhere. Similarly, IRFA is another such fund started in 1911 - but this was basically for raising funds for research - the equivalent of what we call now in the field of medicine the ICMR - Indian Council for Medical Research. Here the funds were collected primarily for recruiting and training researchers. The IRFAs responsibility was also to channelize the funds to particular areas which were seen to be of primary importance. This was funded mainly by an annual grant from the government but considerable contributions to this was also made from private sources. Yet another form of response to the colonial state's expectation for non-state subscription, was from commercial organizations - those again could be both Indian or European ones. For instance. companies like the Bengal Coal Company sponsored some of the local hospitals and salaries for the staff. One of the most exemplary cases is that of the starting of the Calcutta School of Tropical Medicine. Even when its foundations were laid in 1914, we have the Calcutta School of Tropical Medicine Endowment Fund which was basically meant to invite contributions from different sources. As expected, it received contributions not only from individuals and general companies and commercial organizations. There were contributions in particular from specific industries which would actually directly benefit from the work done by this particular school - the School of Tropical Medicine. For instance, the tea industry or the jute or the mining industry. It was a more like a deal - it was not like just giving of out of pure altruism. What was the deal? In return for a fixed annual

contribution - so much rupees for say, 15 years - to the institute, they were promised results from the research or from the activities of the school which would actually go to contribute to improving the working conditions of the labour force - especially those related to health – and the kind of particular diseases – say, for instance, hookworm disease in some of the plantations. These would be addressed by the work done at the school. Therefore, the money given was not just charitable, philanthropic activity - it's also to be seen as a kind of an investment - this amount you are investing in order to save yourself from bigger kinds of expenditure which will happen if some kind of a local endemic, or epidemic happens, which will affect very directly these kinds of industries.

Not only here within the colony itself, even some of the institutions in the metropolis like for instance, the London School of Tropical Medicine also appealed for and received funds - not from companies there (of course, that also would have happened), but from the Indian Railways company here because Indian railways had also its own problems – it was also getting a bad name for some of its own contribution to diseases due to the kind of construction works and digging and the water stagnation and the malaria problem in its construction areas. This is not surprising that School there in London was primarily for research on tropical medicine, and malaria, as we all know, was projected by some as the mother of all tropical diseases. This is then an interesting contribution connection across the seas - what we see is a very interesting combination of commerce, this kind of a public spirited donation, and research. But then, there's always this danger of veering away from public health because once these kinds of industrial interests and commercial interests come in, there is always the danger that they may hijack the lines of research. This pattern - all this while we have been talking about the colonial state and its expectation and as we know, the colonial state was clearly biased to western medical systems and its kind of infrastructure - on the one hand, there was a warm response to that. But the rich – the old rich as well as the new rich (the new rich meaning those who became rich through the new opportunities opened through colonialism - not only the commercial openings, but new avenues like education, law and other such businesses) - all of them, showed patronage towards indigenous systems also however much the colonial state liked or did not like it. Especially in the later days, say, from the early part of the 20th century, when the nationalistic spirit was also rising and also we see medical revivalism among various indigenous medical systems, also aligning with that rising nationalistic fervor - there were considerable donations and funds for setting up Ayurvedic, Unani and other kinds of institutions for learning, or dispensaries. We have to keep that also in mind. On the one hand we saw the participation in the healthcare infrastructure and its development through donations which also meant kind of subscribing to that. But now, this change - it's not a contradiction - somehow with the changed circumstances, the increasing national consciousness and the revitalization movement, the same people who had the money, did not hesitate to contribute to these alternative systems. One final point here is that when they were contributing to these

institutions, there were also free dispensary services at these institutes. This is also something to be noted - since we have been talking a lot about medical institutions training and all that. Apart from the fact that it trains ever-new crop of health professionals for the profession it's also useful for the trainees themselves that the dispensary services were there. Training part is one part but it is important also to have hospitals/dispensaries attached. That's why all, or most of the medical colleges, have hospitals attached to them. It's not that just they are doing a service - most of them do free service, but it's also a benefit to them. The patients - ever new kinds of people - have ever new kinds of diseases - so, ever new like research problems for scientists. So there are new things that you can learn from people's disease and misery. Therefore, that free dispensary service is also one important public contribution to the field of medicine, or largely, to one aspect of medical philanthropy. On this note, we will close this lecture. Thank you