Social History of Medicine in Colonial India

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Week 02

Lecture 04

Consolidation of Medical Measures

Hello and welcome to the next lecture - Lecture 9 and this is about the consolidation of the various medical measures that the British had undertaken. We have been seeing how the British had initial misgivings and how they developed confidence in settling down themselves and , it is not about just about them alone. Health came to be one of the important pillars of the entire colonial enterprise. Therefore, there was a need for constant attention to health and disease and medical topography and every kind of effort. Health would always be an important component element of the colonial enterprise. In this lecture we are going to see how, in the early days they consolidated some of the health measures including setting up of medical schools, new medical departments, the gradual opening up to public health - from enclavism.

These are kinds of things we will be considering in this lecture and the next couple of lectures. As I have been mentioning in several lectures, 1857 was a watershed moment and after that, there were all kinds of new concerns and naturally new concerns about health and about health of the British in particular and even generally. Therefore, there were new efforts to improve sanitation, medical facilities and **public health** - that is the key word we will be especially seeing since in the last lecture we were talking about enclaves. We can see it in a sense as two contrasting things enclavism versus public.

Some of these include the establishment of medical schools to train Indian doctors within India. This will be the subject of a separate lecture which is medical education. And then we see the embryonic public health infrastructure taking shape to combat diseases like cholera and malaria - many of which were taking epidemic proportions - as some of them used to be endemic and as they were becoming epidemic (we will see from time to time, how some of these became epidemic due to some of the features of colonialism itself). But whatever the reason, these are diseases which could no longer -given the size dimensions that they were taking - be taken very lightly. Apart from widening curative processes there was also the development of preventive medicine. And, in all of these things, there was a huge influence of European medical professionalism, medical professionals, their training back home in England. All the

baggage of their cultural and intellectual, academic, professional background had their influence here. Many western practices were deployed in the Indian context and some of the very specific technicalities, instrumentalities, departments which were introduced include the coming of the provincial medical boards in the provinces in the 1780s. Medicine was one of the fields which acquired bureaucratic character quite early on. The bureaucratic structure ensured that it had its own hierarchy, its clear set of rules and procedures, service rules and conduct rules and all that. But that should not lead one to believe that the state was very much proactive and took upon itself the role of public health in a very proactive manner. That is a question mark which we will see throughout the course. That is not how it turned out to be. So we will see in a series of lectures about the various reasons the state was not proactive.

But coming back to the technicalities, in each Presidency there were two or three senior surgeons who very bureaucratically regulated the appointments. They maintained discipline and directed the general policy. And there was constant effort to improve the efficiency of the system, the bureaucratic system. There were all kinds of new posts introduced or the nomenclatures being changed or the nature of their responsibilities being changed. For instance the post of provincial Director General was introduced and that was later changed to Inspector General or Surgeon General. These took the place of the medical boards which we were referring to in the previous slides. In 1857, this was a new change. Then, provincial Sanitary Commissioners were introduced in the 1860s. Sanitary measures - when you think of sanitary measures, immediately what comes, to mind is that it is one of the most important dimensions of public health. When we talk about Sanitary Commissioners again that is an indication of, at least, the state's commitment - or expectation that the state would be having a firm leg in public health.

But the problem with the Sanitary Commission or the Commissioners is that they had no executive powers - they were more advisory or they could make studies and could use reports - but not having much of executive powers. At the central level too, there was a Sanitary Commissioner just as in the province. And one of the other things that happened in this march towards public health from enclavism was the constant effort, there was a particular focus on preventive medicine - there were many efforts at disease prevention through various tools like vaccination and improvement of sanitation and general hygiene - which means that these had significant consequences for the Indian population. That is why we have to keep in mind: as much as medicine was an important pillar in colonialism, similarly, as far as the colonized were concerned, medicine was an important avenue through which the colonial power exercised its influence in a very direct way. Here in terms of sanitation or in terms of medication, for instance, Indians were subject to lots of trials and experimentation. There were concerns about medical practices on Indian bodies - for instance, vaccination - the white man touching Indian bodies and putting ‘alien’ things into Indian bodies - and how far was it compatible with

pre-existing Indian systems and Indian customs and what are the kinds of cultural consequences that might leave. These are interesting questions which we will be unveiling in the next set of lectures. And the effectiveness of all of these measures,- whatever we are talking about - whether it is the Sanitary Commission of the Provincial Boards or whatever bureaucratic structures - all of these depended on certain crucial variables, one of which was the availability of resources and the state's willingness to use those resources, especially the financial resources which we will see, the state was not too keen to do. And, the state might have policies - but the success was very much dependent on the cooperation and interest of the colonial officials at different levels and most of all, the engagement of the local communities - either the target, the larger populace itself or the intermediaries, the opinion makers or popular leaders who could play important intermediary roles. That was another important factor - how far they could be convinced, how far they could be expected to have influence on the larger populace. That leads us to reasonably assume that Indians had more significant roles. For instance, at different levels as I said, officials, Indian officials in the sanitary and presidency services played a very crucial part in implementing public health policies and initiatives. And, as we have been insisting, there is always that element of racism, consciousness of race and superiority, all those kinds of racial and cultural barriers which we will be continuously discussing in different dimensions in different subsequent lectures.

And, in course of time, as part of the larger political unfolding, as part of granting of concessions in response to the rising spirit of nationalism, there was room open for Indians to be part of legislatures. There were many Indians who were elected at different levels. They also could play an important role in shaping the public health direction. And many of these policies and practices which evolved in the colonial period had a lasting legacy - which we will be seeing especially towards the last few lectures. We will be particularly highlighting this point - the enduring influence of some of these kinds of measures, these kinds of institutions, this kind of bureaucratic structure, the effect of all these on subsequent development of the medical infrastructure, medical policies which continue to this day.

And, one of the most important instrumentalities or set of institutions in this consolidation of the health measures is the opening of sanatoria and especially hill-based sanatoria. Medical studies of hill stations and other salubrious localities became an important component of topographical studies and reports. They even formed part of the medical journalism. There was a favorable depiction of hill stations and hill station lifestyles, which contrasted with the hardships and challenges of life in general for Europeans in India and the plains. This kind of projection of the virtues of hill station was aimed at helping the European civilians who were anxious to escape the heat and disease of the plains. And this, as I keep repeating, was particularly pronounced after

1858 when there was increased concern about attracting more Englishmen and especially with their families.

Even if you are not settling in the hills permanently - which some people did - for instance, planters who had settled more or less permanently in the hills - even if you are not doing that, but at least, hill stations were good option for temporary recuperation - to go from time to time especially when you feel the body needs that revitalization or what was called the regaining of the 'European vitality'. And, the interest in hills also had other motivations. Hills were also sites for other projects like forestry, scientific forestry, tapping of timber and opening up of plantations like tea, coffee and rubber - different crops which thrived at different altitudes in the hills.

And hills were also sites for summer capital - for instance, Shimla was the summer capital for the entire British establishment. Or for instance in the Madras Presidency Ootacamund or what in short is called Ooty, would be the summer capital of the Madras Presidency - the entire establishment would move from Madras to Ooty (in summer). Hills had different kinds of utilities and from a climate and health point of view, it was a site for general refreshing, a break, recreation or a holiday and for some post retirement settling. We have cases of some authors who settled up the hills. And, even more specifically, from a medical point of view, hills and hill stations are sites of medical establishments like Sanatoria and research stations. We will be having a special lecture on research stations and research institutes where we will be coming back to the hills. But talking about Sanatoria in general - Sanatoria are places which are directly led to health, regaining health, regaining vitality - places which are meant for rehabilitation. They need not be necessarily in the hills. It can be any place where any of these things happen: recuperation or rehabilitation or rejuvenation, regeneration - it can be in the plains also.

The aim was to relocate troops away from unhealthy living conditions or from their diseased states or from particularly dangerous places, to have a special kind of care and attention and rejuvenation. And, as I said earlier, coming here and then having identified, very salubrious, very temperate areas is all fine, but then it is practically impossible to settle down, (all of them to settle down) in such areas. The Medical Board advocated a system of sending troops in rotation to the hill stations. For instance, the Nilgris in the south, and Himalayas in the north were popular destinations for setting up hill sanatoria. These were particularly useful for recuperating the health of sick and disabled troops and especially to bring down the high levels of mortality and morbidity among the European troops. But, all this, on the face of it, sounds very bright and unproblematic from a strictly climate or particularly temperature point of view. But there were all kinds of difficulties. , One is , again, if considerable proportion of the troops is stationed in the hills, in higher altitudes, there is a problem in responding to say 1857 or even smaller versions of such kind of uprising in plains or other areas far from these

kinds of sanatoria. That is why the system of rotation was proposed - only one third of the total force to be garrisoned in the hills which is very small number compared to what was contemplated by the 1859 Royal Commission on Sanitary State of the Indian Army. And , there are other kinds of problems which were very specifically related (these problems which we just mentioned were related to practical /tactical issues, these are problems related to the core issue of climate and its relationship to the factors of health). Hill stations did not always mean salubriousness. Of course, there were salubrious aspects, but then the same elevation can also have counter effects, effects on the opposite direction - especially there were numerous examples of elevated positions - especially those which rose abruptly from alluvial or jungle covered tracks. They had particular health issues - for instance, more chances of succumbing to diseases like malaria. Even such exalted places like Darjeeling which is one of the queens of the hills (it is also famous for its tea, but even beyond tea), places like Darjeeling and Nainital were supposed to be like class hill stations - even they were thought to be very unhealthy because of some empirical findings. For instance the high rate of diarrhea and dysentery in these kinds of places. But all said and done, hill stations definitely played a very crucial role in alleviating the fear of survival. At least they could have an immediate escape in the vicinity without having to go back home - which itself would take a lot of time and anything could happen on the way. At least relatively speaking, these kinds of opportunities were available in relative vicinity to escape the heat and humidity of the plains. With their bungalows, clubs and gardens (because hill stations are not just about the hills and some kind of enclosed spaces with a better climate and health benefits), a whole lot of other things, cultural elements went up the hills - like these tell-tale signs of hill stations - like these bungalows and clubs. They became special centres of social and cultural life for the British in India. And also this was a place to be filled with a sense of nostalgia. As I said, going home for regaining the temperate ambience was not an easy option. As I said, there was a huge separation of the seas and the distance, and anything could happen on the way. So, these were places within the tropics where you could have some sense of rediscovery. One of the ways of doing it was to consciously plant here the kinds of plants, the kinds of fruits, strawberries, raspberries and other kinds of things, particular kinds of flowers, hollies and other kinds of making of hedges and other kinds of things which woud promote that sense of nostalgia, the sense of home away from home. That element was also there - it was not just about some sense of recuperation and some sense of break and all that. It was also kind of rediscovering home away from home. So, that way, there were, apart from the military/strategic elements, apart from plantations, forestry kind of attributes, a whole lot of cultural aspects to the creation of these hill stations – also apart from the medical point of view. But all said and done, this is not something that everyone could afford. Hill stations were there, but then, there were limitations - apart from all the other limitations we have talked about - these are limitations on the part of the people who could afford to go. But, even among the

westerners themselves, the lower classes or lower levels of the military, they could not afford, they had to be happy with or they had to just experience the harsh climate of the plains for the most part. These were some of the kinds of limitations in the exceptional areas. This again you can consider as a different kind of enclave, totally different kind of enclaves. All of them had (just as we saw, there were limitations with regard to those enclaves, these kinds of sanitary and hill stations had), their own limitations from financial and strategic and from climate and health point of view as well, and which also we will be visiting from time to time in future lectures. Bye for now.