The introduction of western medicine in India

This lecture will deal principally with elements that constituted biomedicine - also known as allopathy - in India. This point needs to be highlighted here, as I am not trying to say that ‘western’ medicine in India, especially as it existed in India during the eighteenth and nineteenth centuries, was never monolithic. Medicine introduced by Europeans into South Asia was pluralistic. However, the practices that constituted biomedicine dominated the healthcare mechanisms put into place by the colonial administration and European individuals.

Western medicine in India was, broadly speaking, introduced by four separate agencies:

(1). The colonial state:

The European colonial powers began to set up hospitals and dispensaries almost as soon as they established their rule in the sub-continent. The earliest of these were earmarked for European use or use by certain class of ‘natives’, most notably military personnel. Hospital and dispensary networks were expanded over time, notably during the nineteenth century, as colonial administrators sought to target larger numbers of Indians. The new institutions took the form of ‘general hospitals’, which were intended to serve the needs of Indian of all classes, religions and castes, as well as facilities for European patients. Broadly speaking, the establishments set up and run between 1750 and 1850 were targeted at members of the colonial administration and indigenous elites. However, those set up from the 1880s onwards tended to be of the ‘general’ variety. Many historians have argued that one of the aims in the setting up of these ‘general’ hospitals and dispensaries was to highlight the technical gap between the biomedicine introduced by the colonial
administration and the ‘unscientific’ indigenous medicine, which was held out to be representative of India’s backward past.

Apart from such facilities of curative care, the colonial authorities also sought to introduce campaigns of preventive medicine, especially immunization campaigns. While elements of these could be seen quite early in the 19th century, especially with regards to smallpox vaccination, the scope of these activities became much more pronounced from the 1880s onwards. This involved a wide variety of work – smallpox, plague and cholera vaccinations, as well anti-malaria and anti-black water campaigns, involving drug treatments and sanitary management. Whilst many of these were targeted at particular sections of society, like plantation and industrial workers, who were considered to be economically important, campaigns were also directed at all members of specific territorial contexts. Generally speaking, these tended to be urban areas between the 1880 and 1920s, while more concerted efforts were made to target rural areas from the 1930s onwards. Apart from the devolution of political power to locally elected bodies, which made these authorities more open to demands for the setting up of new healthcare facilities, the emergent germ theories of diseases powered the implementation of general sanitary and preventive campaigns, in a such situation where human being were seen as important vectors of human disease and unsanitary conditions considered to be a breeding ground for insect vectors.

(2). Missionary societies:

Missionary activity in India became more visible in India after the establishment of European colonialism. Health-work figured quite prominently in missionary establishments, in a situation where this was often considered to be an effective means of winning over converts. There were other aims informing the missionaries’ health related work as well. Indeed, historians have identified four main aims of missionary work as it developed in the 19th century. These were as follows:

- Continuing the work of Christ the healer.
- Protecting the health of missionaries themselves.
- Providing an opening into alien cultures to facilitate conversions.
• Representing the superiority of Western civilization, which was presented as a Christian civilization.

Generally speaking, missionary work was targeted at rural areas, where state-sponsored facilities were relatively thin, if not completely missing. Thus, the colonial administration remained quite happy for these missionary activists to continue with their medical work, and during epidemic outbreaks of infectious disease, sought to use their assistance in popularizing and spreading immunization campaigns. It should be mentioned here that the goal of the missionary societies to win over converts to Christianity from amongst communities they were providing health facilities often did not work out. Conversion remained rare and patients continued to be pluralistic with regards to their health-seeking behavior.

(3). Other private initiative:

This involved both European and Indian initiative, and could be seen in the cities and towns. At one level, this took the form of the growth of specialized hospitals, some of which only treated Europeans and well-to-do Indians. At a different level, the scope of western medicine was extended through the efforts of the increasingly large numbers of Indian medical graduates and licentiates who were qualifying from the colleges and schools set up in the sub-continent. As there were relatively few employment opportunities in government establishments, a great majority of these graduates and diploma holders involved themselves in private practice, which helped extend the scope of biomedicine in India. Private practice of this sort could sometimes be based within the new, fee-charging specialized hospitals that were popping up all over the sub-continent. More common, however, was the setting up of small, private general practices, which too remained dependent on fee-paying patients.

(4). Nationalist organizations:

A related point that needs to be made here is that many of the unemployed doctors joined some of their more successful colleagues in the ever more vocal nationalist
movement. It is worth pointing out here that while certain elements of the main Indian nationalist parties – that is, the Indian National Congress, the Muslim League and the Communist Party of India – were supportive of the growth of indigenous medical systems, like unani and ayurveda, a very strong – and vocal – section also demanded an extension of biomedicine in India. These elements were able to play an active role in the extension of voluntary dispensaries, which offered access to biomedical therapies and immunization facilities (Jawaharlal Nehru, independent India’s first prime minister was a great supporter of biomedicine and the developmental possibilities that it offered).

It is perhaps best to end this lecture with a discussion about the complex nature of resistance to western biomedicine. Most of the existing histories of South Asia have, in my view, presented a far too simplistic argument. It is important to remember that while the degree of indigenous resistance to biomedicine was far more noticeable early on in the nineteenth century, when this medical option was a novelty, one should not ignore the fact that this hostility did decrease over time. This was particularly true with regards to curative care, where the level of Indian patient figures in hospitals and dispensaries during the late 19th and 20th centuries is actually quite startling. Resistance to biomedicine was more visible with regards to preventive campaigns like immunization drives, but here too the picture is far more complex than has been suggested. The level of resistance to vaccination work in urban areas, where the quality of immunization work was relatively higher, was LOWER than in rural areas, where the quality of vaccine operations was low. In addition, the demand for immunization did tend to rise during epidemic outbreaks of dreaded infectious diseases like smallpox and cholera. Resistance, when it existed, tended to limited to specific religious communities, members of whom would react to schemes of compulsory vaccination. Once again, these trends tended to be more noticeable in rural contexts, which leads me to suspect that technical factors – like painful side-effects – were as important determinants as cultural factors like caste- and religiously premised opposition.

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