

**The Dispensary Movement in Bombay Presidency: Ideology
and Practice, 1800-1875**

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Abstract

The Dispensary Movement in Bombay Presidency: Ideology and Practice, 1800-1875.

Colonial medical history in India has been a source of growing research during the latter half of the last century. However, historians have tended to situate the dispensaries in a minor role, suggesting that the dispensaries had relatively little to say about the dynamics between Indian and European society during the nineteenth century. But the idea of dispensary institutions in England being applied to India was a challenge to accepted Indian medical practice, compounded by the fact that India had no comparable organisations. Money, or the lack of it, was a constant theme, but this thesis has principally focussed on Bombay Presidency, where uniquely, the early establishments of these institutions were chiefly funded and approved by Bombay council.

The dispensary movement was a decisive factor in the history of colonial medicine in India, shaping attitudes and opinions as to the level of medical care that should be provided, what kind, and for whom. With the intention of promoting western medical science among the people, it was hoped that the mercantile and ruling classes would become involved with the dispensaries; and this they did, but not as patients. The sick poor remained their principle clients. The idea of the dispensaries did however filter through society, and the idea set in motion changes in medical education, charitable gift giving, and the official financing of these units.

This thesis will show how the dispensaries invoked a common interest between the two cultures of east and west, between the rich and the poor. Their importance is examined to see if the idea was adequately related to the needs of Indian society, especially the poor, the very people that the English dispensaries had been opened for; and to what extent a European idea became an integral part of Indian medical practice.

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List of Abbreviations

<u>APGB</u>	Abstract of Proceedings of the Government of Bombay, General Department
<u>BAR</u>	Bombay Administration Reports
<u>BC</u>	Bombay Consultations
<u>BDesp</u>	Bengal Despatches
<u>BGP</u>	Bombay General Proceedings
<u>BDR</u>	Annual Dispensary Reports of Bombay Presidency
<u>BHDR</u>	Annual Hospital and Dispensary Reports of Bombay Presidency
<u>EMMS</u>	Edinburgh Medical Missionary Society
<u>GMC</u>	Annual Reports of Grant Medical College
<u>ICE</u>	Minutes of the Institute of Civil Engineers
<u>IMD</u>	Annual Administration and Progress Reports of the Indian Medical Department, Bombay
<u>MDR</u>	Annual Dispensary Reports of Madras Presidency
<u>MMJ</u>	Medical Missionary Journal
<u>NAM</u>	National Army Museum
<u>PWD</u>	Public Works Department
<u>WCA</u>	Westminster Council Archives

The Dispensary Movement in Bombay Presidency: Ideology and Practice, 1800-1875

Introduction

Sir Henry C. Burdett, (1847-1920)¹, in 1893, claimed that the 'dispensary system of India forms the most striking feature in its medical history.'² As a part of his four volume work Hospitals and Asylums of the World, he considered the hospitals and dispensaries in India. Burdett looked at their funding, development, and construction, claiming that no two hospitals and not many dispensaries were constructed on the same plan;³ and that the individuality of the dispensaries also extended to their relationship with hospitals: they not only supplemented them, but were also separate establishments, possessing the attributes of hospitals but on a smaller scale.⁴ He supported his claim by quoting the official statistics of in-patient and out-patient attendance which illustrated the greater number of Indians who sought dispensary care, when compared to those that applied to hospitals, an impressive argument for their popularity even when the greater number of dispensaries compared to hospitals is taken into account. But his claim has neither been investigated nor taken up by subsequent historical analysis; little attention has been given to the role of the dispensary in nineteenth-century India.

The dispensary movement, however, can be seen as a decisive factor in the history of colonial medicine in India, shaping attitudes and opinions about the level of medical care which should be provided, what kind, and for whom, for example. It provided an inducement, and a convenient site to study the effects of disease on the Indian body, raising hopes that any knowledge gained would in turn provide better protection for those Europeans unused to the heat and different disease environment. The need for staff for these institutions led to a reconsideration of the prevailing strengths and weaknesses of medical education,

¹ Sir Henry Burdett was connected with the Stock Exchange and was the author of Burdett's Official Intelligence. He also wrote extensively on nurse training and pensions, hospitals and their financial affairs, and charities. He was the founder and editor of the journal The Hospital.

² Henry C. Burdett, Hospitals and Asylums of the World, Vol. III, London, 1893, p.318.

³ Ibid., pp.214-15.

⁴ Ibid., p.318.

and the realization that Indians trained in the western tradition could form a bridge between Indians who sought medical treatment, and the British who sought to prove by example what they considered was a superior medical system. The dispensaries provided a springboard for the efforts of European medical personnel to raise their status and influence within the European expatriate community. These men were the original dispensary surgeons, but by an evolutionary process, they were to be eventually replaced by Indians educated in the medical schools and colleges, enabling the Europeans to take on the role of supervisors and inspectors in the new order. This process provided an impetus to the determining of not only medical practice, but also attempts to institutionalize illness, although at times with little success. Dispensary reports frequently relate that patients left of their own volition, uncured, or did not return for further treatment.

In the early part of the century the movement among the middle classes of Britain for providing greater welfare benefits in the shape of poor law workhouses and dispensaries for the working classes and destitute, can be related to the way that dispensaries and hospitals were begun in India. In Madras, the Native Infirmary opened by John Underwood in 1799, was later to metamorphose into the Monegar Choultry, which bore a close resemblance to the function of the workhouses in England and Scotland. In Bombay, in 1803, the Humane Hospitals, opened for the victims of the famine then sweeping through the Presidency, were to provide a model for other units to be opened in response to medical need in the Presidency for the care of the Indian sick and poor. The patients who remained there were eventually admitted to the local hospital, a seamless transfer from one medical unit to another. This process was repeated ten years later. The pattern of funding varied between presidencies and dispensaries. Some had considerable involvement with the English East India Company, and some very little, relying on other sources for their existence. Indian rulers and merchants were invited, sometimes through coercive methods, to make contributions to their construction and running costs. This would lead to them re-evaluating their traditional ways of charitable giving. In mid-century Bombay, an

immense rise in the money available for these institutions, mainly from the Parsi community, was a consequence of this re-appraisal. The Parsi philanthropists insisted on some measure of control over their contributions, and often also demanded similar contributions from the British authorities, thus securing, to some extent, through the administration of these funds, equal footing.

Money, or the lack of it, is a constant theme throughout the history of the dispensaries, and the problems that this deficiency created can be seen in the third quarter of the century when the dispensaries became partly funded by the new municipal authorities. This often left them dependant on the amount of money remaining in the municipal budget for their efficiency and, sometimes, their very existence. A new challenge to their status was also emerging, and this came from the increasingly popular larger hospitals, especially those that grew alongside the expanded, or new, medical schools. But the hospitals were unable to provide the same level of care as the dispensaries, nor as cheaply. The dispensaries therefore continued to be the foremost channel in providing western health care to the inhabitants of the small towns and cities of India. These were also the kind of regions where the medical missionaries settled, often in areas where a government dispensary would be seen as an intrusion, such as in the princely states of Rajasthan. Conversely, some members of the Indian Medical Service occasionally saw the missionaries as encroaching upon their territory, geographically, and professionally, so the two strands of medical aid did not always complement each other.

Despite the financial and other problems that faced the institution, the idea of the dispensary had taken a hold on those who attempted to provide care for the sick. With the expansion of western technology in India, the dispensaries moved with the times. By mid nineteenth-century, they were attached to work camps to provide medical aid to those constructing the railways, the telegraph lines, and the road builders. This was not a new idea, surgeons had been attached to the forestry workforce in Malabar in the eighteenth century to work with the Conservator; as well as medicines, vaccination material was taken to vaccinate the local population, health care provision without an established dispensary. Bombay

Dockyard employed an Indian doctor to provide medical aid for the workers, but in the early century many had to be transferred to Bombay Native Hospital, where agreement had to be reached on who would pay the fees for their stay. Another element in the changing emphasis of dispensary responsibility was that related to the care of Indian women. This was increasingly a subject of consideration, and although more closely associated with missionary enterprise, and the Dufferin Fund in the 1880s, it was also a topic of some deliberation in mid-century, especially in Madras, but not always with a successful outcome.

The role of the dispensaries therefore changed over time. Medical knowledge, professionalism and changing attitudes to the way British India was to be run, attitudes further influenced by the 1857 uprising, made themselves felt. This was reflected not only in the organization and funding of the dispensaries, but also their outward appearance. From humble beginnings in rooms rented in various buildings, the dispensaries came to be housed in modest, but purpose-built units, paid for by local committees comprised of Indians and Europeans, and then in rather grander structures with ornate roofs and spacious verandahs, and with a large part, if not all of the money, coming from wealthy Indian families. Paradoxically, although these structures were acclaimed as examples of a civilizing European influence, the European medical authorities increasingly became a remote overseer. Annual inspections did not always take place, and the Indian surgeons given charge of these institutions, often felt that they were part of a forgotten segment of the medical service, with poor career prospects and pay.

Review of Literature and Sources

Henry Burdett was not a historian, but he was one of the first to record a brief history of the dispensary movement in India. Burdett was interested in the construction and architectural merits of the dispensaries of the late nineteenth century, but the history of the dispensary movement in India commenced largely in the last decade of the eighteenth and the first decade of the nineteenth century. It is the records from this time, such as the records of the English East India Company, and later, those of the Government of India, which provide a useful

source for the numbers and locations of dispensaries and hospitals. These records include the annual hospital and dispensary reports. It was to these sources that Crawford turned when writing his two volume history of the Indian Medical Service⁵ in which he devoted one chapter to the hospitals in India. In this chapter he briefly mentioned a hospital in Bombay for Indians in about 1809, but made few comments regarding dispensaries. His is an uncritical study of medicine and medical authority. Crawford was not untypical of his generation in his presentation of history, and like Henry Burdett, does not go into any detail about the care of the patients, or even why they were there. The philosophy of the dispensary movement was never contemplated. It is useful, however, to observe the recent work of historians who have concentrated their research on topics related to colonial medicine in India, throughout the nineteenth century.

Recent research has revealed increasing interest in small medical institutions as a means of investigating the relationship between illness, especially mental illness, and the attitude of the British to those so suffering. It has enabled researchers to place the institutions within the context of medical practice, and colonialism, particularly at the level of the local community. Other historians have used the idea of the dispensary as a part of their thesis and their conclusions gives us a further dimension to the role of the dispensaries. They have shown how the dispensaries were used by the various branches of the medical services, such as in the promotion of public health measures, and their utility has consequently been assessed. The kinds of issues raised have been related to the nature and purpose of the medical services; the extent to which the service was used as an additional arm to an all pervading colonial administrative structure, and how, through its close, but not intimate contact with the Indian people, this service was able to observe and control parts of the population, especially the poor, for the perceived protection and benefit of those by whom they were ruled.

Waltraud Ernst is one such historian who in recent years has centred her research on small medical institutions. She broke new ground with her

⁵ D.G. Crawford, *History of the Indian Medical Service, 1600-1913, Vols. I & II*, London, 1914.

investigation into the lunatic asylums founded by the Europeans in India,⁶ for those classified as insane, and European, who were considered to be the unacceptable face of European society. Despite the fact that mental illness was not considered distinctive or different from other illnesses, and was treated by physicians who saw it as coming under their domain, the British authorities thought that insane Europeans should be locked away, made 'invisible', hidden from the view of Indians. The insane, which included many European poor and homeless, often deserters from the army and navy, belied any image of a superior race that the government wished to project. Another historian who examined the role of small medical institutions was Kenneth Ballhatchet. He looked at Lock Hospitals within the context of the health of the army, and the subsequent, but not always consistent policy, of the confinement of women suffering from sexually transmitted diseases.⁷ In this instance, however, these small medical institutions were intended to protect the men from further infection, and also guard the investment the Company had expended in bringing the men to India. Thus the medical services and the government colluded in an effort to provide medical care for European soldiers and Indian women, but with the intention of protecting the Company's image, and financial outlay.

James Mills, like Ernst, also based his research on lunatic asylums, but his research was directed on those asylums of the second half of the nineteenth century which were established for Indians. He saw the advantages of using small institutions to look at the level of the community within which they were situated. Mills stated that 'By focusing on the interaction of the local community with the lunatic asylum it will be possible to explore more completely the responses of Indians to the local medical centres set up by the British.'⁸ From the point of view of the dispensaries, direct comparisons in fact cannot be made, as the restraints put upon a patient suffering from mental illness was different from the restraints

⁶ Waltraud Ernst, Mad Tales from the Raj: The European Insane in British India, 1800-1858, London, 1991.

⁷ Kenneth Ballhatchet, Race, Sex and Class Under the Raj: Imperial Attitudes and Policies and their Critics, 1793-1905, London, 1980.

put upon those suffering from diseases of the body. But Mills does usefully examine the role of Indians who were involved in the lunatic asylums, either as patients, employees, or relatives, to evaluate the Indian response to an institution with an overt British character and ethos. Mills research is an illustration of the current trends which indicate that the versatility of these smaller government institutions as a locus for examining and understanding attitudes to illness, Indian philanthropy, and the interaction between the British and Indian communities, is now being realised.

The usefulness of dispensaries as a source of evaluation has increasingly been taken up by historians. Recent publications which have taken an overall view of medical policy and practice in nineteenth-century India, and in which the role of the dispensary has been partly taken into account, include work by David Arnold who stated that his theme was a 'study of a colonizing process, rather than a history of Western medicine in India'.⁹ But, as his statement and field of research suggest, medicine and medical authority played a large and related role in the process. In addition to describing the history of the dispensaries, and the status of those who used them, Arnold also related how the enthusiasm of the Indian doctors, who gained some measure of seniority by being placed in charge of them, 'become, in their turn, enthusiastic propagandists for Western medicine'.¹⁰ Letters to the medical press in the last quarter of the century, however, indicate a dissipation of this enthusiasm, influenced by the poor status of the Indian surgeons.¹¹ The disillusionment affected the efficiency of the dispensaries, and exacerbated an enduring problem throughout the century, the chronic shortage of medical staff.

Mark Harrison also looked at medical policy from 1859 to 1914, but he specifically analysed the reasons and self-interest behind the introduction of public health measures in India, following the high mortality rate of the European

⁸ James Mills, 'Indians into Asylums: Community Use of the Colonial Medical Institution in British India, 1857-1880', in B. Pati and M. Harrison (eds), Health, Medicine and Empire: perspectives on Colonial India, New Delhi, 2001, p.166.

⁹ David Arnold, Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India, Berkeley, 1993, p.7

¹⁰ *Ibid*, p.253.

army through disease, rather than injury, during the Mutiny of 1857.¹² He linked, however, the promotion of vaccination, sanitation and hygiene education, with the role of the dispensaries. For differing reasons, but like Henry Burdett, he also claimed that 'The increasing number of persons treated at dispensaries was one of the more impressive achievements of colonial health policy in India.'¹³ He does admit, nonetheless, that despite the connection he made between public health and the dispensaries, the reception of public health education by visitors to the dispensaries was harder to gauge. For both Arnold and Harrison, then, the dispensaries provided a vehicle to support an argument, but did not provide a definitive conclusion as to their influence and effectiveness.

As other scholars have shown, the belief that dispensaries could be used to promote western ideas of health and sanitation was often conjoined with the promotion of Christianity. This belief infused and motivated missionary thinking and enterprise, especially with respect to Indian female in-patients, whom it was presumed, would learn from the example of the standards of cleanliness and care in the hospitals and dispensaries and apply them in their own homes.¹⁴ Medical missionary work in India is now receiving more attention from historians, such as Rosemary Fitzgerald,¹⁵ and the provision of health care for women, not through missionary channels but via the Dufferin Fund, has been explored by Manesha Lal.¹⁶ Both enterprises, missionary and that of the Dufferin Fund, involved the use of dispensaries as a medium for the promotion of the kind of care that the respective organizations wished to advance. Mridula Ramanna has also recently considered the provision of health care facilities for women, but she has specifically looked at those institutions opened in the last two decades of the

¹¹ See letter to Indian Medical Gazette, 1 June 1874, signed by 'A Poor Sub'.

¹² Mark Harrison, Public Health in British India: Anglo-Indian Preventive Medicine 1859-1914, Cambridge, 1994.

¹³ *Ibid.*, p.89.

¹⁴ J. Rutter Williamson, The Healing of the Nations: A Treatise on Medical Missions, Statement and Appeal, London, 1899, p.83.

¹⁵ Rosemary Fitzgerald, "Clinical Christianity": The Emergence of Medical Work as a Missionary Strategy in Colonial India, 1800-1914', in Pati and Harrison (eds), Health, Medicine and Empire, pp.88-136.

¹⁶ Manesha Lal, 'The Politics of Gender and Medicine in Colonial India: The Countess of Dufferin's Fund, 1885-1888', Bulletin of the History of Medicine, 68, 1994, pp.29-66.

nineteenth century, which were often funded by Indian philanthropists.¹⁷ Lal and Ramanna, therefore, have used the dispensaries for women as a tool to examine attitudes by the government and philanthropists, as to the perceived health care requirements of Indian women.

Roger Jeffery, took a longer term view of health policies than either Arnold or Harrison, when he examined the complexities of the interaction between the colonial administration and medical services, and the legacy that this left for independent India.¹⁸ He noted that dispensaries were cheaper than hospitals and more popular,¹⁹ and observed that the indigenous masses, while not eager to accept western medicine, nevertheless used it in enlightened self-interest.²⁰ As a component of his research into the role of the hospitals and dispensaries in pre-independent India, he reiterated a point raised by Arnold in an earlier article.²¹ Jeffery stated that 'Medical theory in the early nineteenth century advocated removing the sick from their homes and localities on the basis that patients in hospitals were more obviously under medical control and observation.'²² Jeffery thus illustrated two important aspects of the same institution: the expectations of the authorities who wished to confine and observe, and the pragmatism of the patients. These fundamental differences in attitude between the authorities and the patients form an enduring contrast throughout the history of the dispensary movement in India, although an argument could be made that the authorities on the whole preferred patients to be treated as out-patients as it was cheaper. A desire to 'confine' was perhaps a more significant feature in the later century during the plague epidemic, rather than the early segment. Also, Arnold related his claim to the proposed Fever Hospital in Calcutta in 1838, a hospital that was intended for fever victims only and not for the myriad of accident victims and patients with conditions related to

¹⁷ Mridula Ramanna, Western Medicine and Public Health in Colonial Bombay, 1845-1895, New Delhi, 2002.

¹⁸ Roger Jeffery, The Politics of Health in India, Berkeley, 1988.

¹⁹ Ibid, p.87.

²⁰ Ibid, p.99.

²¹ David Arnold, 'Medical Priorities and Practice in Nineteenth-Century British India', South Asia Research, 5:2, 1985, pp.167-80.

²² Jeffery, Politics of Health, p.87.

malnourishment. Many doctors, nevertheless, during this period, in Europe as well as India, sought to establish facilities where the sick could be contained and observed, especially when attached to medical schools. These hospitals were situated in urban areas and were large organizations when compared to dispensaries. Indian patients as records suggest, preferred a locally based institution, and one to which they could return as out-patients, if necessary travelling many miles each day to do so.

Jeffery, as a further dimension to his research, also examined the role of medical education in nineteenth-century India. His research included surveying the number of pupils who entered medical school as private students and who later became private practitioners. The idea of private practitioners was at the heart of Charles Morehead's interpretation of the role of Bombay's Grant Medical College upon its foundation.²³ It was an issue that in 1845 was not practical or economical, and was eventually diluted to meet the demands of staffing the dispensaries and army units. In this thesis, I will show how the dispensary movement was linked to the introduction and expansion of medical education in Bombay, and how the routes to medical qualification and standards of admission to medical schools varied, as did the content of the training. It is within this area that Poonam Bala in her work on Imperialism and Medicine in Bengal, commented on the imperfection of state medical education.²⁴ This failing, she observed, was linked to a system of education that did not acknowledge or make allowances for indigenous medicine. Her research was not related to the role of the dispensaries, but her conclusion is significant. The growth of the dispensary movement in the provinces of western India was, occasionally, checked because of a lack of medical personnel. If there had been permitted a measure of synthesis between western medical education and indigenous medical practice, a synthesis that would have been acceptable and workable in the dispensaries, this route may have proved more successful in attracting new graduates, but it must be argued, not necessarily patients. It had been

²³ Charles Morehead, first Principal of Grant Medical College, 1845.

²⁴ Poonam Bala, Imperialism and Medicine in Bengal: A Socio-Historical Perspective, New Delhi, 1991.

acknowledged in more than one annual dispensary report that Indian patients expected European drugs when visiting the dispensaries, and presumably western medical opinion, not indigenous drugs and advice that could be obtained locally. Nevertheless, an unwillingness to consider a wider application of medical practice could be considered a failing. Although the introduction of indigenous medical practice taught alongside the western tradition was never contemplated, John Hume revealed a rare exception in the training of hakims in the Punjab,²⁵ but even this measure did not have the total support of the medical authorities, or some Indians trained in the western tradition.

Conversely, Christine Dobbin and B.B. Misra suggest that western medical education, despite the perceived inadequacies in its training, was increasingly being viewed by some members of the Indian population as a means of social advancement.²⁶ The dispensaries were to play their part in this process in two ways. As the century progressed, clinical expertise was increasingly associated with hospital practice; but the dispensaries remained popular with Indians, despite the growth in college related teaching hospitals; therefore on the one hand, they offered a reasonably reliable source of employment, but on the other, their popularity did not necessarily benefit the Indian surgeons. To some extent the dispensaries came to be considered useful but second rate compared to the larger, better equipped hospitals where there were few career positions available for Indians; the Indian surgeons were then frequently associated with their institutions second-class status. Despite this, within Indian society, western medicine gained some measure of respectability, not necessarily as a form of treatment, but as leverage into the professional classes.

Historians, then, have been able to use the dispensary movement to illustrate diverse characteristics of the colonizing process. The institution was sufficiently versatile to be exploited to promote a researcher's hypothesis, and has proved a useful analytical tool when placed within the wider sphere of

²⁵ J.C. Hume, 'Rival Traditions: Western Medicine and Yunani-I Tibb in the Punjab 1849-89', *Bulletin of the History of Medicine*, 51, 1977, pp.214-31.

government, economics, power, society and education. The dispensaries, nevertheless, have not previously been adequately considered in their own right, but this thesis will show that their history and development frequently reflected or responded to the prevailing attitudes of men in power at provincial and national level, and influenced the way that the Indian and European communities negotiated a neutral approach in their differing religious and political views.

Incentive for the Dispensaries

So what, we ought to ask, was the rationale behind their adoption and expansion? It was intended in Bengal, for example, that the Indian mercantile and ruling classes would be the beneficiaries of the treatment on offer, and thus, by their example, the poorer members of society would follow. The reality, as this thesis will show, more closely reflected the dispensary movement in Bombay Presidency, where the poor were the primary users. At the onset they were associated with separation of the races, but the link was more closely associated with class as much as race, as the poorer Europeans and Eurasians were as likely to enter their doors as the Indian poor, though this difference was not officially recognized. For example, the separation of the patients was clearly acknowledged in a letter to Francis Warden from George Keir, Secretary to the Medical Board of Bombay, in 1809. He confirmed, 'From the earliest records that the Board have access to, their [sic] appears to have been at this place for obvious reasons, two distinct and separate Hospitals, for European and native sick'.²⁷ The distinctions, however, were not always so transparent. The Civil Hospitals in the provinces provided treatment for the employees of the Company, usually Indian or poor European, and the military hospitals, usually separated into European and sepoy, would also treat the people from the bazaars. Proactive surgeons instituted dispensaries and attached them to these hospitals. Patients too sick to be treated by medicine alone, or requiring surgery, would have a bed provided for them in

²⁶ See Christine Dobbin, Urban Leadership in Western India, London, 1972, especially the chapter 'The Rise of the Intelligentsia'; also B.B. Misra, The Indian Middle Classes: Their Growth in Modern Times, London, 1961.

²⁷ 13 November 1809, BC, 21 November 1809, OIOC.

the hospital. As the surgeon was often paid for the number of patients he treated and was given allowances for the food and bedding he provided, as well as medicine, the disputes that frequently arose give some idea of the complexity of the situation involved.

The dispensaries could influence, and their function be influenced by diverse aspects of the colonial medical process, such as the smallpox vaccination programme. Initially, in Bombay, a district based project was conducted, where a vaccinator would move from village to village within his designated area. But vaccination was, in the second half of the century, increasingly centred on the dispensaries, and became a part of the dispensary reports which in many instances were constructed in terms intended to justify their existence and value for money. This led to much debate among medical officers who questioned whether the dispensaries were the right place for this procedure.²⁸ Changing ideas of public health were promoted in the dispensaries, but as Harrison suggested, the results are difficult to quantify.

Initially, the dispensaries were opened in a haphazard fashion, often at the instigation of a surgeon who was already providing treatment to those who requested it. In the 1820s, Bombay Council became officially involved in the opening of hospitals in the Presidency, but not with any urgency. The revival of medical education in Bombay in the 1840s and the opening of Jamsetjee Jeejeebhoy Hospital, reawakened an enthusiasm for medical care provision for the poor, but much of the money now provided came from Indian purses, especial money that was related to trade. In the second half of the century in Bombay, the authorities continued to support the dispensaries, but the casual, almost *laissez-faire* attitude had disappeared. The Government still wished to retain control and take credit for providing the dispensaries which were popular with the poor, but they had no wish to provide the money as easily as they had done in the first half of the century.

²⁸ See Indian Medical Gazette, 1 August, 1867, pp.198, 204, and 1 December 1869, p.257.

Description of a Dispensary

The early history of the dispensaries in India differed between Presidencies, as also did the idea of what a dispensary should consist of, and what it should be called. Unfortunately, the official reports do not describe what the authorities considered a dispensary, or what constituted a hospital, and in fact some reports interchange the titles when referring to the same institution. In the Madras and Bengal Presidencies, the term dispensary was in more popular usage, even when describing institutions that could have been classified as small hospitals. Bombay, conversely, described small units that would now be considered dispensaries, but which they classified as hospitals. By mid-century, however, when Indian philanthropists began funding, on a grand scale, hospitals and dispensaries in Bombay, there then appeared to be a more definitive classification by size: (the small units being dispensaries and the larger, hospitals), and the grandeur of the building occasionally influenced the unit's designation. In 1852, the Government of Bombay, when making additions to the Bombay Medical Code, made reference to the size, functions, and staffing of the dispensaries. It was suggested that:

The house for the dispensary should contain a receiving room, of not less than 15 feet square, for the patients generally; a similar room, if possible with a separate entrance, for the reception and examination of females; a Dispensary for the preparation of medicines, of the same size as the receiving room; a small airy ward or apartment, for from four to six (male), and another of smaller size for females.²⁹

This then, mid-century, was the ideal, and despite any other official title, it will form a general description of the idea of what contributed a dispensary for the purpose of this thesis. The suggested requirements however, would not always be met and what made a dispensary was a matter of some debate. To eliminate any

²⁹ Annual Report of Grant Medical College, (GMC), 1851-52, p.132.

confusion, I will outline my understanding of what would be termed a dispensary, and so indicate the function and limitations of the institutions that I am analysing.

A dispensary would normally be a place for dispensing medicine, as the title implies, but dispensaries are also places for examining and treating the person whose medicine is to be dispensed. The early dispensaries in Britain were largely institutions run on a similar practical footing to present day out-patient departments or accident and emergency units, with those unable to leave their sick beds occasionally being seen at home (unless they were too ill to benefit from any treatment that was available) by the apothecary employed by the trustees of the dispensary. However, just as the dispensaries were being established in India, they were going into decline in England. The existing hospitals, alert to the danger of losing prestige, not to mention the patients on whom the medical students learnt their trade, made themselves more accessible to the poor. India, in the pre-colonial period, did not have a comparable history of hospital care, nor of dispensaries, so the dispensaries in colonial India tended to be a hybrid of the two types of institutions. Therefore, I am looking in this thesis at a small unit, with basic facilities, and with no means of introducing various specialisms. Until mid-century, this described most of the units; it was only with the increasing professionalization of the medical world and the consequent advent of a more structured medical education for Indian students, that the hospital emerged with its larger number of beds, and medical staff with distinct professional roles. However, because of the immense size of India, its predominantly poor population, and limited finances, dispensaries still remained the primary focus of European medical care well into the twentieth century. Bed numbers varied between dispensaries, but this was influenced more by the money available to fund care and food, for example, than any ideas of the unit being turned into a hospital. Therefore, in the first half of the century, its functional capabilities remained the same, but the number of potential places for patients varied. Numbers could also fluctuate during periods of famine and epidemics.

The Uniqueness of Bombay Presidency and its Dispensaries

This thesis will principally focus on Bombay Presidency where distinctively, the early establishment of institutions for the Indian poor and sick, until mid-century, had chiefly been authorized and funded by the council. From the 1840s there was an increase in monetary donations from the Indian community, and in the latter half of the century, the institutions were partly funded by Local and Municipal Boards, which gave Indians some degree of control over how the money was spent. Bombay Presidency, remote from the administrative control of Calcutta and London, developed a working relationship with the Bombay business class, especially those of the Parsi community. Gillian Tindall claimed that 'Bombay, throughout the eighteenth century, remained provincial, other, isolated... For Bombay, unlike Calcutta, was never essentially a colonial city.'³⁰ Her description could equally apply to the early nineteenth century. The establishing and funding of the first dispensary for the indigenous poor, in Bombay, can be directly related to the 'otherness', as described by Tindall, for its unique nature. As this thesis will show, unlike the dispensaries in Bengal, the dispensary was never formally opened, there were no letters passed between London and Bombay regarding the funding or advisability of opening a dispensary, or any discussions as to the likely class of patient. Mountstuart Elphinstone continued this tradition and made his contribution to medical practice by including the subject of medicine in his plans for educating Indians. Robert Grant, a later Governor, was the driving force behind Grant Medical College, even though he did not live to see its opening. From mid-century the Parsi community played a large role in its funding, especially Jamsetjee Jeejeebhoy, who also financed the hospital named after him. There developed a measure of dynamism between the two communities in the operation of the hospitals and dispensaries, one side not always giving way to the other, and this at a time of increasing industrial growth in Bombay when money and power were of equal importance. Bombay Presidency escaped the destruction of the Mutiny and continued to expand its industrial base. Despite downturns in the economy, it benefited from the introduction and expansion of the railways and

³⁰ Gillian Tindall, City of Gold: The Biography of Bombay, London, 1982, p.92.

telegraph lines, the dispensaries spreading along the routes of the new technology. Public health was a matter of consideration in the Presidency and Bombay City, but the city was to meet its medical nemesis with the outbreak of plague in 1896. Medical science, care, facilities, and respect for tradition and Indian society, by the British, had to be re-evaluated.

Although Henry Burdett considered the dispensaries the most striking achievement in the medical history of India, he was chiefly concerned with structure and statistics, in keeping with other works that he had published, but present day historians now look at history in a different light. As shown, they have increasingly looked at the role of the dispensaries, suggesting that the dispensary was a useful institution, but an institution that would appear to have relatively little to say on its own about the dynamics between Indians and the British. The records suggest otherwise, and indeed, historians have highlighted the role that the dispensaries held in the interaction between the two communities. The people who could have told us more about the effect the dispensaries had on their lives were the patients, but they were largely poor and illiterate, and therefore left no personal memory or opinion of their usefulness for historians to examine. This thesis will show, however, using available records, how the dispensaries invoked a sense of vitality between the two cultures of east and west, between the rich and the poor, influencing perceptions of medical need, charity, philanthropy, and political activism. The dispensaries were never the cutting edge of medicine, were never going to be the means of great medical discoveries, but their early history in Bombay, illustrates how an idea transferred from England, turned the ethos of a humble institution already founded, a medical reception facility for the sick poor and homeless, into a movement that gained momentum over the years, until it was accepted as a recognized system of medical care funded from official sources, and also by Indian philanthropists. So what was the idea, why was it transferred to India, and how can it be described as a movement?

The idea was that of the dispensary systems in England being transferred and adapted to the needs of India. This was quite a challenge since, as already stated, India had no comparable institutions. The surgeons however, even those of

the eighteenth century, saw how a simple means of providing medicine and advice, initially within a unit they were attached to, became not only a means of observing disease, but was also a vehicle for generating goodwill. The idea, because of its promotion by the surgeons, often unofficially, developed into a movement. The chapters of this thesis will examine various issues that influenced the dispensary movement, and how in turn, the movement was enabled to influence and invade Indian and British discourse.

The first chapter looks at the growth of an essentially European idea, free medical care for the poor through the medium of a dispensary. The units which were begun by surgeons were permitted to expand, due in part to a liberal approach by those in power regarding the funding of these institutions. The first chapter, however, will also show how the first seeds of medical professionalism in India began to take root. The men of medicine had little status or influence in the eighteenth and early nineteenth century, but in 1810, as this thesis will show, they gained control of Bombay Native Hospital's budget and admission policy, a small but significant victory that would enable them to increase their authority within, admittedly, the lower echelons of the English East India Company. The second chapter considers British attitudes regarding the education of Indians to enable them to take on more responsible roles within the medical services, including work in the dispensaries. The intentions and expectations of those in authority will be examined as it will be seen that their ideas changed. Some of their initial ambitions were unrealistic, and the needs of the army, rather than the Indian civilian took over the original benevolent objectives. In what was to become a chain reaction following a debate on education instigated by Robert Grant, an opening was made for Indian involvement and money in his plans for a medical school. Money was provided by a Parsi philanthropist to fund a hospital to complement the planned school, a matter of interest to historians and anthropologists who have looked at the role of gift-giving in traditional Indian society. This thesis will show how the ritual of gift-giving was adapted to meet the needs of the dispensaries.

The development of the dispensary movement in Bombay is examined in the light of contemporary history. As well as wars and mutinies, the economy, despite fluctuations, influenced to a great degree that history, as it did the liberality or miserliness of those in authority. This thesis will show how attitudes changed in the second half of the century when the Company ceased to exist, and India had become a part of the British Empire. Bureaucracy turned into a more prominent facet of Indian life, and irrespective of profits or loss, the Indian, through his local taxes, was expected to take on more of the burden of funding the dispensaries. The British still remained eager for the dispensaries to be in place, but not at their expense, thus chapter three will show why the dispensaries were still considered important, but how, on the other hand, the government attempted to circumvent their previous commitment to the movement. From mid-century rules were put in place for funding, and regulations for limiting requests to open dispensaries from only those who could show sufficient income, usually the municipal councils. These regulations would set the pattern for the remainder of the century. But the movement as such took a new course; the idea was adapted to new uses and functions, in tune with changing society, industrialization, and the influence of missionary medicine. The final chapter will show the benefits, and also the disadvantages of this new path.

The themes of this thesis therefore cover more than the dispensary movement itself. One point to consider is the weight that the dispensaries are able to exert in the general argument regarding the influence of western medicine in India. The dispensaries as this thesis will contend were not a negative factor, but neither could a claim be made that their influence was so great that their presence was an outstanding feature. Nevertheless, the dispensary if considered at the local level does show that within their immediate community, a more positive reaction can be seen and their impact on the transfer of western medicine to India and Indians can be measured. The dispensaries, as this thesis will argue, were the 'coalface' of medical activity, not only regarding the care of Indians, but also as the meeting place where ideas and theories of British rule and Indian accommodation could be negotiated. The extent that the idea was adequately

related to the needs of the Indian population, especially the poor, the very people that the British dispensaries had been opened for, will be examined, as also will be to what extent a European idea became an integral part of Indian medical infrastructure.

Chapter 1 - The Development of the Dispensary Idea - 1800-1825

The British in Western India, from the first factory established in Surat in 1608, through to the third and final Maratha War that ended in 1818, were primarily concerned with trade; this involved claiming trade routes by force, or negotiation, and seeking partners and contacts among the indigenous traders with whom they could pursue their business interests. It also involved negotiations between the representatives of the English East India Company and those representing the rulers in India, to acquire *firman*s¹ to enable them to trade in relative security within the area controlled by the ruler whose permission had been sought. The Company representatives were then able to establish factories where goods could be bought and stored until the arrival of an East Indiaman, bringing supplies necessary for the traders, fresh orders from the Court of Directors in London, and further manpower, either traders or writers to ensure that all company accounts and letters were kept up to date, or military men, to defend what had been gained. Of interest is the low priority given to medical men; their numbers were comparatively few and their status low, although there was usually a surgeon or physician attached to the Factory, and they were also employed on the East India Company ships. However, the early traders and Company employees would consult the local *vaid*,² or *hakim*,³ or buy native medicine, following remedies used by the local population. By the beginning of the nineteenth century, and especially after the defeat of the Maratha Confederacy in 1818, the Company was secure enough to have established, by treaty and by war, power bases from which to ply its trade. Within these bases there grew a resemblance of government, and with government, parallel perceptions of responsibility.

This thesis will examine to what extent the English East India Company, and later the British Government, developed a sense of responsibility for the poor and disadvantaged Indians whom they ruled, as shown by the provision of dispensaries and small hospitals in India during the nineteenth century.

¹ Permission, or licence to trade.

² Hindu medical practitioner.

³ Muslim medical practitioner.

Conversely, though, these institutions could be construed as being a medium for the promotion of empire, the propagation of western values, and as a showcase for what was considered superior western science and technology.⁴ It would be presumptuous, however, to assume that there was a rapid transfer of ideology taking place, leading not only to the establishment of legal and fiscal institutions in the three Presidencies, but also the provision of health and social care; indeed this was never the intention of the British merchants and administrators in India during this period. Neither would it have been a reflection of the government in England at that time, as care of the sick and poor, had, since medieval times been the province of the religious houses. From the Elizabethan period, a limited system of support was provided by the passing of the Poor Law, which did not specifically provide for the sick, but rather for the poor and destitute. During the eighteenth century, the institution of dispensaries in Britain gained in popularity, predominantly in urban areas, and largely funded by merchants and philanthropist who limited, by rule and regulation, the number and type of patients who could apply for treatment, with no monies being provided by government. Therefore, for those traders in Bombay in the late eighteenth and early nineteenth centuries, the memory of dispensary care as a new and recently popular outlet for philanthropy in England, was a relevant pointer to the foundation of the movement in the Presidency, but the considerable differences between the two cultures and countries would ensure that the idea of the dispensary had to be adapted to prevailing and constantly changing conditions.

Until 1858 and the abolition of the English East India Company following the passing of the Government of India Act of 1858, when power and authority in India passed over to the Crown, the traders in India were representatives of a joint stock company instituted to exploit trading opportunities in a rapidly expanding mercantile world. They were, therefore, unlikely to be directly concerned with issues relevant to the care and well-being of the poor indigenous population; in fact it is doubtful whether this level of responsibility was ever explicitly

⁴ This view persisted throughout the nineteenth century. A comment in an article published in the Indian Medical Gazette, 2 May 1870, p.78, was typical of official opinion, that 'Dispensaries scattered broadly over the country are teaching the people the benefits of English science'.

envisaged at any time during the early colonial period. Nevertheless, one practical illustration of a European concept of moral and social responsibility for those they considered inferior could be epitomized in the foundation of the dispensary movement in India. As a movement, it was a minor concession, as the numbers of dispensaries and patients treated will later illustrate. Other opinions would suggest that the English had differing considerations when opening dispensaries, such as early hopes of impressing and influencing prominent members of Indian society, to a more prosaic plan of observing and reporting on the diseases prevalent in the Indian sub-continent, of which they had limited knowledge. In some instances, later emanations, such as the work-place dispensary, or those attached to the prisons, for example, would move the emphasis away from the idea of health care provision for the poor by a benevolent government, to one of a more practical character. These issues will be examined and balanced against what was considered ideal dispensary practice, but what in effect could be perceived as control by the state of those least able to defend themselves. Another example of dispensary care with other, not necessarily medical objectives is that of the Christian mission dispensaries, which caused apprehension, among the authorities as well as the indigenous population, regarding the potency of their influence when used as a base for the spread of religious propaganda, and raised fears within those in authority, of possible civil ferment. It is important to recognize that the effect of the dispensaries could be diverse; they could be seen as centres for physical control, political influence, and medical experimentation, as well as being an institution for the healing of the body, and a shelter for those in need.

The Functions of the Dispensaries

To consider the functions of the dispensaries suggests that there was in place a plan, or at least an expectation that dispensary practice would meet some pre-ordained criteria as a measure of their effectiveness. In Bombay Presidency in the first half of the nineteenth-century this was not the case. Many of the functions to be described evolved from an initial objective of providing immediate medical

relief for the poor. The functions of the dispensaries from the 1850s, however, were hedged in by regulations, leading to a more uniform approach to dispensary care. Therefore, what were the primary functions of a dispensary? In Britain the dispensaries were used to provide diagnosis and medicine to those who could be treated by such means, but did not have the money to pay for the services of a physician. Minor surgery was an important part of the work undertaken, and this included tooth extraction, the setting of broken bones, and the removal of tumours. Unlike the dispensaries in India, they would not usually have in-patient facilities. Patients that needed more intensive care and observation would normally be admitted to a hospital, if one was situated in the locality.⁵ In India, hospitals were not an established part of the indigenous medical tradition, although rest-houses for the sick and poor were provided by many local rulers. The function of the new dispensaries in India, therefore, had no precedent, and had to be adapted to a community suspicious of their intentions, and staffed by medical men, who often had little understanding of the local causation of disease. Surgical procedures were regarded, in some respects, as relatively successful because of the expertise of the European medical men. British surgeons involved in the early founding of the dispensary movement carried out surgery as a routine element of medical care. In 1838, surgeon I. McAdam, based at Poona claimed that the beneficial effects of surgery 'which are so frequently immediate and striking' would be appreciated by Indians, and would show the value of the 'European system of practice'.⁶ This same theme was still being propounded in 1876. W.G. Hunter, Surgeon-General of the Bombay Presidency, stated that the British had a 'no more effectual weapon than surgery' for the Indian people to understand the advantages of 'western medical science'.⁷ Surgery had been neglected by the practitioners of Ayurvedic and Yunani medicine, but each territory, however, had its own bone-setters and barbers, a similar situation to that in Europe. These practitioners tended to work in areas away from the hospitals

⁵ For a detailed account of the history of dispensaries in England, see I.S.L. Loudon, 'The Origins and Growth of the Dispensary Movement in England', *Bulletin of the History of Medicine*, 55:1981, pp.322-42.

⁶ I. McAdam, Superintending Surgeon, Poona, letter 1 August 1837, BC, 4 July 1838, OIOC.

and dispensaries, such as in rural areas, and due to this factor, it would be difficult to assess to what extent they were viewed as a source of competition. The similarity of medical hierarchical tradition between the two countries was noted by Assistant Surgeon J. Waller, in 1837, when he emphasized this point with a further distinction. He said 'the Brahmins generally practise as Physicians, and the Barbers as Surgeons...it should be remembered, the two grades of Physician and Surgeon, are quite as distinct as in Europe.'⁸

That the Indian population had recourse to their own 'barbers', could suggest that the care offered in the dispensaries was perceived as being superior, but a further factor needs to be taken into account. These patients, and others who were homeless, or who were considered too ill or infectious to be moved, had to be given shelter as well as treatment, so the dispensaries in India provided a small number of beds as well as a daily clinic for those only requiring medicine. The obligatory amenities for the patient then were provided in the form of medical consultation and care, with shelter and food for those unable to provide it for themselves, or for those individuals whom the doctor considered it necessary to admit as in-patients. A combination of these factors is of intrinsic value when considering the merit and utility of the dispensaries for, and by, the Indian public, and was, to a large extent, the impetus to their development in India which led to them having the appearance of a small hospital, when compared with the European idea of a dispensary. The function of the dispensaries with regard to government needs was of a different nature.

Benefits to Government

Before 1820, there appeared to be some reluctance on the part of government in general to become officially involved in the establishing and funding of the dispensaries, but after this date there evolved various justifications for their development. One reason was that they were an outlet for the 'Christian, philanthropic nature' of the Company and its employees, an attribute that they

⁷ BDR, 1876, p.63.

⁸ J. Waller, Assistant Surgeon and Superintendent Vaccination Department Southern Konkan, letter 21 June 1837, BC, 4 July 1838, OIOC.

later hoped would be emulated by the wealthy Indian traders and merchants, who although not lacking in charitable acts, held different opinions on how their charity should be expressed. Some convictions of those in authority, however, would appear to belie any ideas of a 'Christian, philanthropic nature'. When the Judges in Bombay Presidency were asked for their opinions, in 1822, on the feasibility of providing medical facilities for the Indian population in their own areas, the Judge at Broach, T. Barnarld, replied that one was not required 'because the few cases in which it would be useful would not constitute an object of sufficient importance'.⁹

There was a suspicion that Indians would be reluctant to attend dispensaries, not because of their unproven ability to heal the sick, but because of aspects of Indian culture, such as caste sensitivities, which may be infringed during the preparation of food and medicines and the sharing of rooms and dispensary facilities, for example. These assumptions, at times, engendered thoughts that the Indians, if unwilling to accept what was offered, had only themselves to blame when ill. The Criminal Judge at Ahmedabad, responding to the same enquiry as T. Barnarld, addressed this problem in his reply:

there cannot be a doubt, but that prejudices would, at first, considerably limit the utility of Native General Hospitals but these would certainly give way, when the advantages derived by the sick admitted into the institution become evident... Prejudices are not confined to the natives of India, though there's [sic] are perhaps (more particularly from their division into castes) more difficult to remove than those of others.¹⁰

Within this observation he referred also to the history of inoculation and vaccination, both in India and Europe, where only by perseverance, he suggested, had problems been overcome. He further supported his argument by comparing the records of institutions in England, with those now under discussion:

⁹ T. Barnarld to the Medical Board, Bombay, 25 February 1822, BC, 19 June 1822, OIOC.

¹⁰ W.A. Jones to the Medical Board, Bombay, 29 April 1822, *ibid*.

We can well remember the time, when establishments similar to that now proposed were looked upon with very great dislike by the more ignorant of our country men at home, and when only the greatest poverty combined with acute suffering, could excite a poor man to enter a hospital, yet at this day there does not appear to be any want of patients to fill them; and at the same [time] the good they have been productive of, is beyond dispute.¹¹

Once a patient was admitted however, he provided the means for the representatives of government to observe disease patterns with which they were unfamiliar.

A further component that could be considered as beneficial for the English authorities was the relationship between vaccination programmes and the dispensaries. The fear and dread felt by those in authority, of epidemic disease spreading through the country, combined with the familiarity and knowledge of the smallpox vaccine that they possessed, was to lead to the dispensaries later developing a proactive health role by becoming involved in the various vaccination projects, although debates raged on into the second half of the century as to whether this should be a part of the dispensary function.¹² Another factor was that the government considered the dispensaries as a comparatively cheap method of displaying goodwill, especially if others were prepared to help with the funding, but, of course, there was no other system of free medical care in India with which to make comparisons. The dispensaries did, however, serve not only as institutions for observation of disease, such as cholera, for example, but also provided an environment, and the patients, where the effectiveness of indigenous medicine, which was cheaper than imported European medicine, could be analysed. New drugs or new combinations of drugs were tried and tested in the dispensaries, as were new surgical procedures, the results being

¹¹ Ibid.

¹² See the Indian Medical Gazette, 1 August 1867, for letter from A.C. Nisbet, and editorial comment, pp.198-99, 204.

consequently reported on. Cholera, a disease which affected the European and Indian communities with impunity, overwhelmed what medical services were available during epidemics. The small hospitals and dispensaries were unable to cope with the numbers of those stricken, and treatment was therefore frequently offered in places where people would congregate. Thus, the bazaars, for instance, became the focus for medical treatment afforded 'without the walls of a regularly appointed Dispensary'.¹³ Nevertheless, treatment was organized by the medical officer attached to the nearest hospital or dispensary, using existing staff, or Indian doctors employed for the duration of the epidemic. It was at such times, that the medical officer was able to try out new drugs, or new combinations of existing drugs.

Assistant Surgeon F.S. Arnott, a military surgeon stationed at Baroda in 1842, when faced with an epidemic of cholera, set up a system of offering medicines to the general public, used his own prescription, and bypassed the regular means of procuring supplies to deal with the emergency. It was due to this last factor that his methods are brought to light, because of the ensuing correspondence that this generated between himself and the members of the Medical Board in Bombay. It was not unusual for European doctors, including those of the military, to conduct surgeries at their base hospital for those who applied for treatment;¹⁴ so when the cholera outbreak intensified, Arnott confined the troops to the barracks, and kept the townspeople out of the cantonment unless they were considered vital to the functioning of the army camp. In this way he limited the number of sepoys who developed cholera to four, all of whom recovered. However, once the disease found its way into the bazaar, he let it be known that 'medicine was always in readiness at the hospital for any who applied

¹³ E. Impey, Residency Surgeon and Superintendant, Malwa Medical Institutions, used this term to describe the organization and mode of treating those patients who waited to see him in camp when he was on tour. See Report on the Malwa Medical Institutions for the Official Year 1852-53, p.6. OIOC.

¹⁴ See G.A. Stuart, Garrison and Civil Surgeon, Tannah, 29 July 1830, BC, 11 August 1830, and D. Forbes, Surgeon, 1st. Light Cavalry, letter undated, but written in response to Robert Grant's Minute of 1838, for example, BC, 4 July 1838, OIOC.

for it'.¹⁵ He found nevertheless, that his offer was not fully understood, and that the relatives of the sick were applying too late for the medicine, therefore 'measures were taken to afford the readiest aid to the sufferers, two men being employed by me and stationed in different parts of the Bazaar with medicine'.¹⁶ He also stationed two in Baroda. To meet the demand, after exhausting the supplies he received from Ahmedabad, and realizing that supplies from Bombay would take too long to arrive, he purchased the medicine from unofficial sources. The Medical Board consequently questioned the expense and amount of medicine ordered, the method of doing so, and they also disagreed with his choice of prescription. Arnott's defence was not one that could be strictly related to medical science and drug evaluation; rather his intention had been to provide medicine which was different to the medicine the townspeople could buy for themselves, which, he hoped, would be more effective, and which they would be inclined to use. He claimed nevertheless, that once the medicine was distributed and taken at the onset of the first symptoms, the disease was 'in a majority instances at once cut short'.¹⁷ Twelve years later, at Vizagapatam Dispensary, in Madras Presidency, Assistant Surgeon J.H. Blackwell was prescribing a form of 'Dr Peterson's pills' for those stricken by cholera in his district, but he said that he had the quantity of opium in each pill halved, as 'in one or two cases which were admitted, after several pills had been administered, symptoms very closely resembling the effect of an overdose of opium were apparent'.¹⁸ Blackwall claimed that 40,000 pills were issued from the civil dispensary, and that 'very favourable reports of their efficacy were received from many quarters'.¹⁹

Neither of the efforts of the two surgeons to combat the effects of cholera could be described as a tightly controlled medical experiment, but their efforts were typical of the period. These examples, however, illustrate the usefulness of the dispensaries in times of crisis. The dispensaries provided a base from which

¹⁵ Letter book of Dr F.S. Arnott, letter to Medical Board, Bombay, 27 September 1842. National Army Museum [NAM].

¹⁶ Ibid.

¹⁷ Ibid.

¹⁸ MDR, 1854, p.31.

¹⁹ Ibid

the surgeons could plan their strategy to combat the effects of cholera, coordinate staff, and distribute medical supplies. The next epidemic would see their efforts being emulated, and possibly improved upon in the light of the knowledge and experience gained. The government would follow the progress of the various new proposals for treating disease and controlling epidemics, not least as they may have been of benefit to the European community. At another level, the large numbers that were treated, especially those that survived would provide testimony to the paternalistic nature of the rulers, and focus on the role of the surgeon, and his medical centre, as providing the platform for their treatment and recovery.

Finance continued to get in the way of the government's good intentions, however: the sum that was at the heart of the dispute between Arnott and the Medical Board amounted to Rs.115. To put this in context, Arnott conservatively estimated that almost 9,900 people received medical aid.²⁰ Compare the sum of Rs.115 with that provided four years earlier to Bombay Native Dispensary, which was partly funded by charity; the government then gave Rs.300 per month for an average of 130 daily cases,²¹ approximately 3,900 patients per month. The cost of the cholera outbreak caused consternation among those who controlled the budget even though, when contrasted with that given to Bombay Native Dispensary, it would have had the appearance of a well judged economical gesture. The council, historically, had often appeared ready to give financial help when disease or natural disaster struck in the Presidency, but its help was usually of short duration. The idea of a 'regularly appointed dispensary' may have appeared to offer a more structured and visual monument of their good intentions, and therefore was worthy of higher and sustained financial support. The memory of medical provision in times of distress, they may have considered, may have been only transitory, while a building was a more permanent reminder. Despite this, dispensary practice, without the walls, would be used again, and not just in times

²⁰ Arnott, Letter book, 27 September 1842. NAM.

²¹ Minute by James Farish, 4 April 1838, BC, 4 July 1838, OIOC.

of epidemics. Famine, fairs, and the routes of the railways, canals, and telegraph lines, would all bear substantial testimony to their usefulness.

The functions of a dispensary for government then were of a variable nature, but were also of use to the medical officers. They had a centre for which they took responsibility and which gave them some autonomy to expand their professional knowledge. Many of the physicians and surgeons published their findings in professional journals and pamphlets, and this led to the formation of professional organizations so that their ideas could be debated, increasing the importance and perception of their medical professionalism. The government also benefited from this element, for it added a further dimension to its authority in the shape of a class of men with medical knowledge to whom it could refer. An increase in medical knowledge and technology, throughout the century, initiated an increase in the number of larger hospitals, as it did in Europe, but dispensaries retained one of their original functions, that of providing an outlet for the Company's philanthropic nature, inasmuch as that in the latter half of the century, health care provision was considered the moral responsibility of the government. The enthusiasm, however, in many instances had waned. The funding had become regimented, with much of the money being provided from local taxation via the new municipal boards, and it is at this point that regulations and finance dictated the kind and level of dispensary procedure.

First English Dispensaries in India

The early dispensaries, those of the late eighteenth and early nineteenth century, especially in Madras and Bengal, were established in the hope that they would be patronized by Indians of influence and that such people would be suitably impressed by the level of medical science and knowledge brought by the British. The authorities had hoped that wealthy Indians would be drawn into making regular contributions towards the maintenance costs of the dispensaries, imitating the practice of dispensary funding in England. Neither hope would be fully realized in the way the authorities had envisaged. There was little to choose at the time between European and Indian medical knowledge, if positive results, that is

the successful cure, if not prevention, of prevalent diseases, are used as a guide. There was, therefore, no perception by the Indian population of a superior service being offered. Indians with money, as did their counterparts in Europe, paid for the best medical aid that they could afford, and the most expensive were those deemed to be the most successful. The poor had to make do with what was left, and the dispensary was often their last resort; the dispensary then, frequently came to be associated with care for the poor and hopeless cases. Their mortality rates were high, with many patients dying on the doorstep. This was not the image that the authorities wished to project, but the one which materialized.

The authorities had considered that once opened, the dispensaries would need very little financial input, assuming that the patients would pay for their care, and the success of the institutions would attract money from the affluent indigenous population who would wish to be associated with this success. The authorities, however, were eventually to respond to requests for the funding of dispensaries by agreeing to pay a part of the costs to a maximum per month, if like sum was raised by the public supporters of the dispensary, Indian or European. Thus, in response to a request for a monthly subscription for the establishment of a dispensary in Benares in 1813, the Company agreed to a contribution of Rs150 per month, adding the proviso that this amount must not be increased without the prior consent of the Board.²² A similar request from Farruckabad met with a like response, Rs150 to be subscribed per month, no additional expense to be incurred by the Company, and the hope was expressed that the contribution of the Company would be emulated by 'Individuals whose means may enable them to follow the example thus set them'.²³

In Madras and Bengal, no dispensary or hospital for the indigenous poor appears to have been started purely as a Company initiative. The first in Madras, the Madras Native Infirmary, was built and paid for by John Underwood, a surgeon, in 1799: the East India Company contributed to its running costs, and paid his salary. A dispensary in Calcutta predated the Madras Infirmary by five

²² Public letter from Court of Directors, London, 3 September 1813, BDesp, OIOC

²³ Public letter from Court of Directors, London, 19 May 1815, BDesp, OIOC.

years, and this was paid for by public subscription. Bombay has been credited with having in existence a kind of Native General Hospital in about 1809, funded by the Company,²⁴ but this statement disguises a unique development of dispensary provision, albeit on a lesser scale than that in Madras and Calcutta, and illustrates a philosophy of care that developed almost by default.

Medical Care for the Poor of Bombay

Bombay, at the beginning of the nineteenth century the most recently established of the Presidencies, had very little of the administrative structure that was already in place in Bengal and Madras. Many of the Indian inhabitants were attracted to the area by the chance of trade or employment. The comparatively young and shifting population would bring with them their ideas of medicine and medical practice, but because of the relatively short existence of the city, it would have had no history of an established medical tradition as would be expected in Delhi, for example. Life for the traders was still at a basic level, war still threatened their existence, and despite the best endeavours, and threats, of the Court of Directors in London, many still traded on their own behalf as well as the Company's. It was not a lawless existence, but nevertheless remained relatively free, at the beginning of the century, from the restraints imposed on the other Presidencies. From the governorship of Mountstuart Elphinstone (1819-1827), Bombay presented a picture of a tolerant society, more at ease with the merchants and traders with whom they co-existed. Indeed, when Mountstuart Elphinstone was offered the Governor-Generalship of India his response was:

I suppose, coming after an unpopular man, being myself an Indian, and thinking well of Indians, I should go on smoothly with the service; but I could not expect to be so popular as at Bombay, where we formed almost a family, every man comparatively knowing his neighbour, and where I brought along with me an addition of territory, increase to allowances,

²⁴ The Gazetteer of Bombay City and Island, Vol.III, 1910, p.184.

and a more liberal system of Government.²⁵

This apparently open-minded authority, can be understood in the way that Bombay's first recorded dispensary was begun and officially recognized, and the *ad hoc* way in which others were developed, a system of 'as and when' in relation to perceived need, rather than a systematic development intended to impress or shame the influential indigenous population.

This raises the question of why the Bombay members felt that a dispensary needed to be established. Charles Rosenberg suggests that there are two incentives for founding dispensaries; one is the presence of individuals sick enough to need medical care, but too poor to pay for it, and the second is a conviction - based on religion, humanitarianism, and national self interest - that it was necessary and proper that society provide such care gratuitously.²⁶ The first applied to Bombay, where extremes of affluence and poverty rubbed shoulders, and the deprivation of the poorer members of society was visible in the streets and markets. The second suggestion would also have applied to Bombay, where a blend of benevolence and a tacit requirement, by the Europeans, for some measure of protection for themselves from disease, would have held equal influence. The British cannot have been unaware of the growth of dispensaries in the country they had left behind, and the literature that was printed during the eighteenth century supporting the concept, for various reasons, of health care through the medium of a dispensary.²⁷ As traders, they may have had some sympathy with many of those who supported dispensaries, they may have considered that they not only provided a means of offering care following accidents to the workforce, but that they would also engender feelings of goodwill among the poorer members of Indian society. The condition of these people would have appeared as a reflection of the poor and sick on the streets of London, which were familiar sights to the English traders, and, therefore, may

²⁵ Sir T.E. Colebrooke, The Life of the Honourable Mountstuart Elphinstone, Vol.II, 1884, p.335.

²⁶ Charles E. Rosenberg, (ed.), Caring for the Working Man: The Rise and Fall of the Dispensary. An Anthology of Source, New York, 1989, introduction.

²⁷ W.A. Jones, letter to the Medical Board, Bombay, 29 April 1822. BC, 19 June 1822, OIOC.

have been a factor in encouraging the transfer of the idea of dispensary care to Bombay.

A further influential factor was the magnitude of the hunger and disease during times of famine, which led to the establishment of asylums for those unable to fend for themselves, one such being opened in 1803.²⁸ Other asylums were opened during the famine of 1813.²⁹ The asylums were known as Humane Hospitals and were established as temporary institutions in Bombay.³⁰ They may, however, have provided an impetus for the continuing presence of a permanent institution for the indigenous sick, wholly funded by the East India Company (the only one at the beginning of the nineteenth century, to have this funding), as at the end of the famine periods, the remaining inhabitants from 1803 and 1813, too ill to be discharged when the Humane Hospitals closed, were admitted to Bombay Native Hospital. The two types of institutions therefore appeared to act in concert, the one being an overspill facility, siphon and feeder for the other in times of acute need.³¹

The Bombay City Gazetteer, published in 1910, claimed that patients at the hospital in existence in about 1809, were chiefly paupers sent there by the police, suggesting that it was merely a branch of the penal system, a means to remove undesirables off the street who may also have had an underlying health problem. This suggestion was partly misconceived, but is later unchallenged by D.G.Crawford in 1914,³² and more recently, in 1998, by Anil Kumar,³³ who claimed that there was only a passing reference to its existence. In fact, records show that, far from there being only a passing reference to the hospital in 1809, in

²⁸ Public Letter dated 10 August 1804, described the factors that contributed to the famine in western India in 1803 and the threat that it posed to the inhabitants of Bombay and the neighbouring islands. It stated that an asylum was established for famine victims. BDesp, OIOC.

²⁹ I. Inverarity, Secretary to the Medical Board, 8 January 1813. BC, 20 January 1813, OIOC.

³⁰ The 'several great sheds...erected as hospitals' described by Captain Hall who visited Bombay in the aftermath of the 1802-04 famine, and cited in the Gazetteer of Bombay City and Island Vol.III, p.184, were probably the Humane Hospitals mentioned in subsequent reports. He added 'Numerous surgeons, some military and some belonging to the civil establishment, were called in from various out-stations and placed in charge of these and other infirmaries'.

³¹ Letter from George Keir to Francis Warden, July 27 1807, also extract from Public Letter from Bombay, 14 October 1813, re: the Grain Committee and the famine of that year. BC, 7 August 1807. OIOC.

³² D.G. Crawford, History of the Indian Medical Service, Vol.II., London, 1914, p.399.

that year claims were made that the police maintained too tight a control of the money they were allowed to remit to the hospital, by not having paupers or the sick found on the streets admitted. This culminated in a confrontation between the Police Superintendent, C.J. Briscoe, and the surgeon in charge of the hospital, Dr Dunbar, an action that was used by the Medical Board to try and wrest control of the budget from the hands of the police, so that they would have charge of the hospital and the admissions.

The hospital almost crept into existence, and from the records available no one person appears to have given consent to its opening and funding, but Jonathan Duncan, the Governor of Bombay from 1795 until his death in 1811, must have acquiesced in its operations. Nevertheless, it was an institution of which every Company employee in Bombay must have been aware, but of which very little has been written. By the very tacit nature of its acceptance and unhindered continuing work, it would seem that the ethos of gratuitous dispensary care, for those needing medical aid but unable to pay for such care, was permitted to be a part of the general administration undertaken by the Company in the city of Bombay.

Bombay Native Hospital

Bombay Native Hospital was the point of conflict for the dispute between the surgeon, Dr. Dunbar, and the Police Superintendent, Mr. Briscoe. The main issue revolved around the control of the funds provided by Bombay Council for each patient. The dispute provided not only valuable information regarding the role of the hospital and its patients, but also evidence of an official acknowledgement of its existence, and close association with the police department, whose authority seemed to have gone beyond the boundaries of what was originally intended. Of equal importance is the representation of the medical employees' struggle for power, status, and accountability. Profit and power are the two themes that run through this drama, the outcome of which was ultimately to affect the funding of the hospital and others that followed it, and to change its position from one of

³³ A. Kumar, Medicine and the Raj, New Delhi, 1998, p.93.

association with the penal system, to that of medicine. The non-admission of a woman to the Native Hospital, in 1809, who had been injured at Mahim, was symbolic of the events that acted as a catalyst that set in motion the ensuing enquiry,³⁴ and subsequent administrative changes.

The low status of the medical establishment at Bombay can be illustrated, for example, in its continual pernicious understaffing, with higher priority always being given to the administrators and traders. The medical department must at times have hardly constituted a department at all. A despatch from the Medical Board in 1819, to the Court of Directors, showed them appealing for another member to join the Medical Board, so as to gain parity with Madras and Bengal. They also observed that the Presidency was short of three surgeons (to make thirty-five in all), and twenty-two assistant surgeons (to make seventy-eight in all). They added that in 1818 they had been informed that eighteen medical staff had been appointed for the Presidency, but that only two had arrived.³⁵ Sixteen years earlier the situation had been even more dire. In a letter to the Council in Bombay in 1803, from the Medical Board, they complained that the 'Court of Directors have for several years sent only one or two Surgeons to this Establishment in spite of our frequent and earnest demands for them'.³⁶ In the first decade, then, the department would appear to have held little value, shown not only in the small numbers that were employed, but also in the level of authority that they were entrusted with. The army of the East India Company had its own surgeons, as did its ships, but correspondence would suggest that those employed within the civilian population, apart from some administrative tasks, were there mainly to provide treatment and medicine for the Company employees, and also deal with any accidents in the vicinity of the islands. They were not, apparently, expected to have any influence on Company policy, except within the narrow confines of medical treatment, assigning junior surgeons to new posts, and ordering medical stores. The conflict over the perceived worth of

³⁴ Acknowledgement of letter from Francis Warden to Medical Board, by George Keir, 1 January 1810. BC, 10 January 1810. OIOC.

³⁵ Military, Medical Board to the Court of Directors, 7 July 1819. BDesp. OIOC.

³⁶ BC, 19 October 1803. OIOC.

the medical employees and their status within the Company came to a head in the dispute between Dunbar and Briscoe, and centered on who should have control of the funds for the patients, and who had the authority to decide who should be admitted. The lines were drawn between the medical and the police departments.

It is useful to look, in more detail, at the history of the Native Hospital so that the evidence given to the committee formed, in 1810, to deliberate on the issues, can be seen in the context of what was considered general knowledge at the time. The Humane Hospital, opened in response to the famine of 1803, closed in 1806-07, the remaining patients being transferred to Bombay Native Hospital as a letter from George Keir to Francis Warden shows.³⁷ This letter, written in 1807, confirms, therefore, that the Native Hospital was already established and that the authorities were aware of their commitment to the hospital and the patients, for the remainder of the letter is regarding the funding of each patient. Other evidence shows that the hospital was in existence before 1803, but in various formats and buildings. A letter written in 1809, again from George Keir to Francis Warden, indicates that from the earliest records that the Medical Board had access to, there had been two distinct hospitals in Bombay, one for the European sick and one for the indigenous sick, and that before the establishment of the Medical Board (c.1790), the then senior surgeon was allowed a fixed sum for treating each patient, which it was presumed included cases of accident and prisoners from the police.³⁸ It would appear, then, that the early emergence of Bombay Native Hospital may have been largely connected with the military, with only a minority of patients coming from the civilian population, but during the first decade of the century, the hospital evolved as one for civilians only.

The investigation was the result of a letter of complaint sent by Dr Dunbar, dated 21 July 1809,³⁹ against Mr Briscoe, regarding the maladministration of procedure for admitting patients, or prospective patients, to the Native Hospital. Mr. Briscoe in turn had threatened to sue Dr Dunbar. A committee was established to hear all the evidence. The Medical Board asked for

³⁷ Letter dated 27 July 1807. BC, 7 August 1807. OIOC.

³⁸ Letter dated 13 November 1809. BC, 21 November 1809. OIOC.

³⁹ BC, 10 July 1810. OIOC.

an account of the expenses of the Hospital, and had queried whether the charity could be more extensively used.

Despite the general proof of the long standing existence of the Native Hospital, and the comparatively small community within which it was placed, controversially, under questioning in 1810, James Morley, Deputy Inspector of Police, (the person who had not sent the injured woman to hospital), initially denied knowing of it.⁴⁰ He had later discovered, however, that the Superintendent of Police, his immediate superior, held an allowance for the provision of sick persons. On discovering the nature of the hospital, he had at first thought that only members of the Medical Board had the authority to send patients there, but was later informed that that authority lay with the police.⁴¹ However, the problem of the sick not being sent to the hospital was not a new situation. Dr Thorpe, who was the hospital's medical officer from April 1807 until March 1808, had commented upon the sick being left in the streets during the time of his incumbency.⁴² To support the case of the Medical Board against Superintendent Briscoe, Dr Dunbar questioned an Indian doctor employed in the dockyard, about his experiences when attempting to get patients, which included convicts, into the hospital. He had encountered great difficulty. He stated that he could not get the money from Superintendent Briscoe who had told him 'they might as well die in the Dockyard as in the Hospital'.⁴³ Mr Briscoe, for his part, had previously stated that 'From the earliest institution of the establishment, I believe it has been under the Control of the Police as far as it relates to the Number of Patients only.'⁴⁴ But the crux of the problem was that he also controlled the budget, and too stringently. It was his permission that had to be

⁴⁰ I have singled this woman out to illustrate the grievances of Dunbar because she has to some extent been given an identity, Morley going so far as to describe her injuries. During questioning, he claimed that he had been given permission, by the Governor, to have her admitted to the Native Hospital. Two days later he retracted his statement saying that he had mistaken her for a man who was admitted and who had subsequently died. The woman's non-admission, among others, is symbolic of the chaotic nature ruling the administration of the hospital. For the committees full enquiry see BC., 10 July 1810.

⁴¹ Ibid.

⁴² Ibid.

⁴³ Ibid.

⁴⁴ BC, 31 October 1809. OIOC.

sought before the admission of a patient could take place, not the members of the Medical Board, nor the surgeon attached to the Hospital. There were no accusations of the funding being misappropriated and a fixed allowance was granted for each month's expenditure, but the allowance was always under spent.

Superintendent Briscoe would seem to have been allowed, unconditionally, to impose his authority over the hospital, and above that of the surgeons, an indication of the low status of the medical men, the hospital, and the sick poor.⁴⁵ In financial terms, however, unlike the presidencies of Madras and Bengal, where every rupee given to the dispensaries had to be accounted for, Bombay to some extent appeared to be extremely lax, but at least had maintained the level of funding. The surgeons were not blameless, even allowing for their low status, they had acquiesced to some extent in the deteriorating situation, although Dr Dunbar had been Dr Thorpe's successor, and would appear to have carried on a campaign initially begun by Thorpe when he complained about the sick being left on the streets.

In conclusion, the Medical Board had requested that the monthly bills should be audited by them, that the sum be not fixed as by its very nature the institution was subject to fluctuations, and that they further 'deemed it their duty to recommend that the amount granted should be actually expanded'. Their final request was that 'they should also be vested with authority to send such objects [to the hospital], as may indispensably require the comforts of a Hospital, with the benefit of medical assistance, whether from accident, disease or famine'.⁴⁶ The committee exonerated Briscoe on most points but it was resolved that the monthly allowance granted to the Superintendent of Police for the Native Hospital, and also monies provided for any contingency charges of the Naval Hospital, should now cease, and that all bills were to be audited by the Medical Board. The new arrangement was to be run experimentally for one year, the

⁴⁵ Morley in his evidence admitted that he was aware of the sick and dying in the market at Mahim, but had not had them admitted to hospital, as he claimed that it would be inhumane to move them. BC, 10 July 1810. OIOC.

⁴⁶ BC, 21 November 1809. OIOC.

Board had to provide quarterly statements of expense and give the number of patients treated, so that contrasts could be made with the former system.

The medical services won the argument inasmuch that after the one year experiment they retained control of how the funds were spent, and thus controlled their own professional environment. As for the Company, if they could be seen as paternalistic in this instance, albeit in a half hearted fashion, they nevertheless ultimately controlled the money available for the care of the sick, and the quarterly statements would enable the budget to be examined more rigorously than in the past. Mr Briscoe, however, as a Company representative, was the very antithesis of paternalism. He defended his actions by suggesting that many who sought care were ill through their own fault; they drank or worked in brothels, and he was looking after the Company's money.⁴⁷ There was no evidence presented that he profited from the money that remained unspent, but records of the enquiry suggest that very few of those questioned responded with the level of transparency that would have been expected. It is interesting, however, that James Douglas recorded that a Charles Joseph Briscoe who was high in the employment of Government, was jailed for twelve months in 1810 for accepting a bribe to prevent a trial taking place, and that the clerk and cash keeper of the police were tried for the same offence.⁴⁸ It is most likely that this is the same man. Briscoe's outlook of helping oneself as well as the Company was now being actively discouraged following the impeachment of Warren Hastings which did not draw to a conclusion until 1795.

The comparative youth of Bombay Presidency, unencumbered by the habits and Company attitudes of late eighteenth-century India, enabled the members to be more prepared to set new ideas in motion, influenced by events in Britain. This allowed them to be innovative in their response to the health needs of the poor in Bombay and was reflected in the provisions made for the hospital then in existence, and the hospitals and dispensaries that were opened later. Bombay Council empowered the Medical Board and the surgeons to assume

⁴⁷ BC, 10 July 1810. OIOC.

⁴⁸ James Douglas, Glimpses of Old Bombay and Western India, London, 1900, p.9.

responsibility for the Native Hospital; and not for at least two decades were there any attempts made to set up joint funding of dispensaries and small hospitals as occurred in Madras and Bengal. Quarterly returns had to be handed in by the Medical Board recording the number of patients treated, their ailments, and the cost of staff, food, and medicine, thus ensuring a more transparent method of auditing and rendering the accounts less open to corruption. Patient admissions to the dispensaries never again rested on the authority of the Police Department. Contrary, then, to accepted knowledge, Bombay had, in the first decade of the century, initiated a centre for the reception of the sick and poor of Bombay. The Native General Hospital, financed by the Company, was unhindered by the necessity of appealing for funds from charitable sources and the ground was laid for direct government control. The institution would appear to be even more certain of its future than its contemporaries in Britain, whose very being frequently depended upon the generosity of philanthropists, and for whom the treatment of a patient depended on their ability to acquire a letter of introduction from a subscriber, or was delivered at the guardians discretion, not the Medical Officers. The idea of the British dispensary had travelled to western India, and from this auspicious beginning, a foundation of care in Bombay Presidency was able to progress. The passage was ponderous and the dispensary movement did not grow at the pace of those in Madras and Bengal, but until the third decade, what was provided was provided solely by government. This thesis will consider whether this advantage was to continue, and to what extent government support can be considered an asset.

A Fresh Approach

Following the outcome of the 1810 enquiry, the funding of Bombay Native Hospital was secure, and the Council gave no appearance of expanding the idea of dispensary care to other parts of the Presidency. Nonetheless, throughout the next two decades, government involvement was the key to the progression and growth of the dispensary movement, prompted in part, in 1821, by a new member of the medical establishment.

Assistant Surgeon Joseph Glen, recently appointed to his post in Ahmedabad, wrote a letter to the Criminal Judge suggesting that a dispensary establishment was 'kept up' in the city. His letter was sent on to Bombay, to be considered by the members of the Council. Joseph Glen's letter illuminates the problems of establishing and running this kind of institution within the framework of existing structures of authority. He initially challenged the morality and charitable inclinations of those in power. He claimed that since his arrival in the country he had been 'often struck with circumstances that under a great and liberal Government like the British in this Country, there should be so little opportunity given to the Natives for obtaining efficient Medical assistance in cases of disease or accident'.⁴⁹ Records only show the existence of one such institution, the Bombay Native Hospital, but Glen's letter, in support of his application for a dispensary in Ahmedabad, indicated that not only were dispensaries established in other towns and cities, but that they were not as well used as they could be:

It is true there is a Dispensary establishment kept up here as well as at The other Civil Stations of the Presidency... but were the Dispensaries more frequented than they are, I think that little good can be expected of them unless they were placed on a more extensive footing than they are at present, many do not know that such Establishments exist.⁵⁰

As Joseph Glen claimed that he had been in the country for only a short while, and cannot therefore have visited all the establishments, he must have known of their existence only from the word of others. It is a bizarre reflection of the history of the Bombay Native Hospital, an institution that had been in existence for a number of years before the Medical Board was asked for information about it, that a surgeon revealed that there was a network of medical institutions that

⁴⁹ Letter 15 October 1821. BC, 16 January 1822. OIOC.

⁵⁰ Ibid.

were operating under the auspices of Bombay Council. Glen's letter is useful inasmuch as he highlighted the presence of dispensaries, and outlined the advantages of supporting them, but appeared to suggest that the promotion of hospitals was his first consideration as he further added 'Dispensaries...with all their faults are useful institutions and may be combined with the plan...the Establishment of Hospitals'.⁵¹ Glen in fact was requesting the establishment of dispensaries with beds, as he described in his letter the problems of caring for patients after surgery, for example, and of those who did not return for treatment.

Why did Bombay differ so much in its attitude to providing medical aid for those in need, when compared to Madras and Bengal, where all dealings had to be conducted through official channels, and where strict qualifications were imposed on all eventual agreements? The easy answer would be to suggest that Bombay's relative infancy, and, consequently, as has been suggested, a lack of tradition, or time, to establish an autocratic mode of government, led to them paying more attention to affairs of statecraft and trade. This may have appeared more creditable to their authority, than the less publicized minutiae of local governance, such as the scrutinizing of small unofficial medical establishments that crept into existence. It must be remembered that in the first decade, Bombay Presidency had to struggle to keep Jonathan Duncan as its Governor-in-Council; his removal would have led to the city being demoted to that of an appendage of Bengal and Madras. Furthermore, the Maratha wars, until their end, put a tremendous strain on the financial structure of the city, leaving the Presidency, as such, in a very vulnerable position. The easy answer then, may have been the most accurate, and that an attitude of *laissez-faire* was an overriding factor. The Medical Officers beyond the confines of Bombay City, therefore, would appear to have had far more autonomy in their professional dealings than those in Madras and Bengal, with the cooperation, of course, of those who controlled the budgets allotted to the cities outside of Bombay, the collectors and judges.

It was to the judges that the ensuing correspondence, following Glen's letter, was addressed. They were asked to give their opinions on the establishment

⁵¹ Ibid.



of hospitals, (hospitals, not dispensaries, was the expression used) and whether their districts would benefit from them. The majority was prepared to sanction the establishment of hospitals in their districts, notwithstanding problems of accommodation, and therefore it was decided to open hospitals in the three cities of Poona, Surat, and Ahmedabad, on an experimental basis.⁵² The existing Medical Regulations had to be adapted and extended to meet the needs of organizing the expansion of the medical services, and it is from this time that classification of patient and establishment appears to have taken root, and despite amendments in response to changing situations, provided the character for all succeeding rules and regulations.

Briefly, it was decided that the institutions should be open to cases of accident, those requiring surgery, and those suffering from diseases that could not be cured by the indigenous practitioners. Care would not be provided for those to whom no relief could be given. The institutions would be open on the 'principles of Public dispensary's' [sic], and posters were to be put up in different parts of the cities informing people of their opening times for medical consultation. Emergency cases would be seen immediately. Care was taken in setting up methods of payment for the hospitals by government, as it was implied that there had previously been in Poona a similar establishment. This had been abolished for the reason that it had been liable to great abuses, and had subjected the Government to a 'useless charge'.⁵³ A reflection of the administration of charitable dispensaries in England is suggested in the statement that 'no individual' unless it was an emergency, 'should be admitted into the institution as a pauper, until it is first successfully ascertained by the Judge or Collector... that such patient, and his family or relations, are unable to support him, and this should be certified on his order of admission... and as a voucher for the necessary charges'.⁵⁴ The categorization of patients was finalized into three classes, from class one, the paupers; two, those able to maintain themselves or who had

⁵² Letter from Francis Warden, Secretary to the Governor, 8 November 1822. BC, 27 November 1822. OIOC.

⁵³ Letter from George Keir, to Governor in Council, Bombay, 23 September 1822. BC, 16 October 1822. OIOC.

relatives who could do so; to three, peons or those attached to the public or civil establishments of government. Hospitals were to be of two classes; those which had a daily average of patients exceeding fifty were to be first class, those under fifty, second class.⁵⁵ Lest any surgeon was tempted to turn the funding of the hospitals to his advantage, it was directed that judges and collectors were to make frequent inspections and enquire into the treatment, comfort and diet of the patients, and that magistrates and the Superintending Surgeon were to frequently check hospital and register to look for irregularities. Surgeons who completed the Muster Roll had to be prepared to swear on oath as to its authenticity.⁵⁶

The three hospitals were opened in 1822. They all had dispensaries attached to them, although these institutions may have operated in a semi-autonomous manner, as they each had an Indian hospital assistant allocated to them. To illustrate how the expansion of an idea, once an initial start has been made, can influence other related medical disciplines, it can be noted that in 1823 it was decided that at each hospital, two or three small wards should be opened, possibly through the acquisition of adjoining properties, for the reception of insane patients. It was decided that it was to be considered as 'experimental for Natives only, as Insane Europeans...[should] be sent to the Presidency'.⁵⁷ The patients were to be 'classed, dieted and otherwise provided for'⁵⁸ in the same way as those in the Civil Hospitals. Throughout the century, great importance was to be placed on the categorization of the medical institutions and their patients. It may be an indication of changing attitudes to India and the Indian people that later classifications would concentrate more on their caste and origins, and less on their status as paupers. Hospitals and dispensaries meanwhile would be classified by their means of maintenance. Bombay Native Hospital continued with its unique mode of funding, but the expansion of medical care alerted the authorities to the necessity of controlling the organization of these new units, as

⁵⁴ Ibid.

⁵⁵ Ibid.

⁵⁶ Ibid.

⁵⁷ Letter to Medical Board from Wm. Newnham, 17 March 1823. BC, 19 March 1823. OIOC.

⁵⁸ Ibid

expansion there was, although as before, it appeared at times to be in an *ad hoc* manner.

Such problems as emerged in running these institutions, within the framework of existing structures of authority, appeared in Bombay to have resulted from the duality of control. Responsibility for the budget, on the one hand, lay with members of the judicial and revenue departments, but the day-to-day responsibility of the dispensaries rested with the surgeons, who may also have been accountable to both the civil medical board and the military authorities. The judges and magistrates were, following on from the above recommendations, authorized to inspect the dispensaries and hospitals, but Superintending Surgeons would later take on this role, and they in their turn would be superceded by Inspectors of Hospitals and Dispensaries, who would be responsible for collating annual dispensary reports. Therefore, early in the century, Bombay Council did not appear to exert firm control on new medical institutions, dispensaries or hospitals, as they appeared to be but one part of the administrative and budgetary ramifications of running new territories, but this situation changed as the numbers of medical institutions grew.

The First Charitable Dispensary

In both Bengal and Madras Presidencies efforts were increasingly made to perpetuate their early efforts to achieve shared financing of the dispensaries, and by the fourth decade, the dispensaries would seem to have succeeded to some extent in attracting this type of funding. It is possible that in response to the overtures made to the indigenous population for contributions, and to give the potential donors encouragement, it became common practice for the surgeon in charge of a dispensary, by the middle of the century, to prepare an annual report on its functions and funding. Bombay, in the same period does not appear to have developed this strategy to the same extent, but the dispensaries in western India were at this point still largely financed by official sources, with just a few exceptions. The first dispensary in Bombay Presidency, funded entirely by public subscription, would appear to be Bombay Native Dispensary, opened in 1834.

But reference was made to an institution in Dhule (Dhoolia), by H.R. Elliott, Civil Surgeon at Khandesh, in 1837, who said 'Within the last few years the Gentlemen at Dhoolia have had erected at their own expense, an Hospital for sick paupers, which is supported by voluntary subscription.'⁵⁹ As with the dispensaries that Joseph Glen claimed existed in 1821, the existence of one such institution prior to 1837 may have indicated that there were others, but not apparently in Bombay Presidency. Mention is made of two public dispensaries in Bombay in 1834,⁶⁰ but neither of these appeared to have been for the poor citizens of Bombay; they may have been opened for Europeans and government employees.

As Bombay Native Hospital was still in existence, it raises the question of why it was felt that a charitable institution needed to be considered. The physical structure of Bombay Native Hospital cannot have been ideal, but it was reported in 1834 that a new building for the Native Hospital was in the process of being erected, and in fact that alterations were being proposed to the new unit, in connection with a female ward and dispensary.⁶¹ The clientele were still drawn from those of the poorer classes. It would seem, therefore, that a need was still being met for the indigenous sick and poor in the hospital, and must have been of a satisfactory nature, as it is unlikely that public funds would have been provided for any reconstruction of the hospital otherwise. However, it was claimed in the Annals of India for the Year 1848, when referring to the opening of Bombay Native Dispensary, that 'The very great importance of a native Dispensary was so apparent that it seemed singular none such before this time had come into existence'.⁶² The original motivation for opening the institution however, may not have been prompted by a simple uncomplicated gesture of humanity, but it is the motive that may provide an answer.

⁵⁹ Letter to Robert Grant, 14 July 1837. BC, 4 July 1838. OIOC.

⁶⁰ Letter in response to memorandum of William Newnham, from J. McAdam, Secretary to the Medical Board, 23 August 1833. BC, 23 July 1834. OIOC

⁶¹ See letter from J. McLennan, Surgeon, Native General Hospital, 22 July 1834, BC, 17 September 1834, and letter from Lieut. Col. T. Dickinson, Superintendent Engineer, 19 September 1834. BC, 1 October 1834. OIOC.

⁶² George Buist, Annals of India for the Year 1848, Bombay, 1849, appendix, 'The Jamsetjee Benefactions.'

J. McAdam, in his letter of 23 August 1833, at the same time as disclosing the observations of the Medical Board on the proposed new dispensary, pointed out that the 'Principal Natives...anxious for the establishment by subscription of a Dispensary from which they might not only be able to procure medicines for their own families' added, 'but by application...the poorer class of the Native Community might receive medical advice and medicines.'⁶³ A further dimension is emphasized with another issue that he raised. He noted, 'As however Europeans would indirectly benefit...from the relief it would afford to their Native Servants when sick, it is only reasonable to expect that they, as well as the Natives, would be included to afford it their support.'⁶⁴ The contents of his letter, therefore, imply that the dispensary was to be instituted, primarily for the convenience of the wealthier Indian families, their servants, and the servants of the European community, with the needs of the sick poor being considered last. This last consideration may perhaps have been added to gain some sympathy from the Council, when approval was being sought for the opening of the new dispensary, but a further letter in 1834 from J. McAdam, to the Council, argued that the Native General Hospital afforded all the charitable relief that could reasonably be expected from Government. The manner of staffing the proposed dispensary was also a matter of dispute, as the position of medical officer in charge, would have been filled by a surgeon 'not in the service'. The Board's recommendations were that the proposed dispensary, which was to be supported by private contributions, should be kept distinct from any public institution. The separation between the public institution and the private also extended to recommendations being made regarding the invoicing of supplies from the Medical Stores in Bombay, to protect the public from loss.⁶⁵

Bombay Native Dispensary was opened in 1834, but by 1838 had gained some funding from Bombay Council. James Farish claimed that it had been

⁶³ Letter, J. McAdam, 23 August 1833. BC, 23 July 1838. OIOC.

⁶⁴ Ibid.

⁶⁵ Letter from J. McAdam, Secretary to the Medical Board, Bombay, to Bombay Council, 4 August 1834. BC, 2 September 1834. OIOC.

‘conducted with unexpected success and attendance with the Natives’.⁶⁶ There was an average of 130 cases seen a day, but he stated that there was insufficient hospital accommodation attached to the dispensary. However, he continued, in the hospital facilities that were available ‘have been accommodated natives of different castes, who would on no consideration have entered the Government Native General Hospital’.⁶⁷ This statement suggests that a class of people were admitted to Bombay Native Dispensary who, perhaps, would not be considered paupers. An alternative view may be connected to the status of those who were financial contributors, especially benefactors such as Jamsetjee Jeejeebhoy, who not only contributed to western-style institutions, but also to charities solely for the benefit of the poorer members of the Parsi community. The dispensary may, therefore, have been initially instituted to cater not just for those who had the means and were prepared to pay for treatment for themselves and their servants, but also those of the community to which the philanthropists belonged, to be cared for in an environment sensitive to the needs of their sect. This factor, however, would not entirely account for the numbers seen daily, but it can be no coincidence that Dr Mackie, through whose exertions and the pecuniary aid of Jamsetjee Jeejeebhoy and others, it was reported, the dispensary came into being, had not only been a friend of Jamsetjee Jeejeebhoy, but that a large number of Parsis had been his patients.⁶⁸

George Buist, in 1848, noting the amount of work that had been carried out at the dispensary in the previous fourteen years, and the numbers of patients seen daily, viewed the enterprise as one that was beneficial to the community. He expressed surprise that a similar institution had not previously been opened in Bombay, suggesting that the two medical units operated under different agendas. Over the years, the differences may have blurred. For instance, the Council had not previously funded institutions that limited the care to a particular section of any community, and there is no suggestion that they made the dispensary an exception. Further, in any society or institution, once a need has been met, the

⁶⁶ Minute by James Farish, 4 April 1838. BC, 4 July 1838, OIOC.

⁶⁷ Ibid.

⁶⁸ Buist, *Annals of India*, appendix, The Jamsetjee Benefactions.

idea of its previous non-existence is difficult to reconcile with its obvious necessity. The motivation for its opening may well have rested with a desire to supply aid to a particular section of the community, but this exclusiveness was not unknown in India in the first half of the century, when a western idea of medical care delivery, before the advent of dispensaries for the poor, was solely offered to, and used by Europeans, and government associates and employees.

The Private Dispensaries and Dispensing

Hospital facilities for Europeans had been provided as early as 1664 when a hospital for the soldiers of the English East India Regiment was opened in Madras. Mortality rates of recently arrived military personnel were high, and those that died had to be replaced; therefore a house was rented where the sick could be sent and cared for, or supervised. This was not a purely charitable action, although William Gyfford and Jeremy Sambrooke, writing to London to justify its opening, stated that of 'the fresh souldiers which came forth this year, taking up their habitation in the bleake wind in the hall, fell sick. Four of them are dead: about tenne remain at this time very sick...' ⁶⁹ Following the opening of a second hospital in 1690, the members of the East India Company in London were asked to take over the responsibility for the institution, 'as the hospital was maintained for soldiers and sailors, that is, solely for the Company's benefit'. ⁷⁰ Other hospitals were opened in the three Presidencies of a military nature, for European soldiers, and Indian soldiers in the Company's employment.

As has been shown, there was a gradual assimilation of poor Indians who sought treatment, being attended to in these hospitals; in Bombay this led to hospital space being designated for this class of patient. Although as early as the eighteenth century there had been hospital provision made for Europeans in Bombay, it would be a matter of debate as to what class of person would avail themselves of its service, as common to the English custom that the inhabitants had left behind, those who could afford private treatment would pay for the

⁶⁹ Fort St. George to the Agent, 10 November 1664, cited in H.D. Love, Vestiges of Old Madras, 1640-1800, Vol. I, London 1913, p.216.

⁷⁰ Ibid, p.562.

services of a reputable surgeon or physician, and be cared for at home. The European paupers, the sailors who had deserted or been abandoned and had no income, for example, would form the greater part of its clientele. As the numbers of the European community in India grew, and also those of Indians employed by the Company, a middle way was sought to meet the needs of the community for medicines, if not medical care. This is not to be interpreted as a separate medical construction, rather an appendage to the hospitals and dispensaries already *in situ*. Little is written, certainly in official papers, of this aspect of dispensary care in India.

In a letter of 1807 regarding the possibility of constructing a new hospital for army, navy and general hospital patients, George Keir described the inconvenience of the present site and the close proximity of the dispensary to the wards. 'There have always been objections to the dispensing being in the Hospital the servants of Families going at all hours with prescriptions during the night, disturb the hospital...and on many occasions afford a means of conveying liquor to the patients.'⁷¹ The letter does not reveal from which families the servants came from, and they could be either European or Indian. In 1834 a letter was sent from a number of 'public servants' in Colaba requesting that 'the name of Surgeon W.E. Foot...who now affords medical aid to our families, being included in the list of Surgeons whose prescriptions are authorised to be dispensed in the Government Dispensary'.⁷² The two dispensaries noted by J. McAdam, in 1834,⁷³ were probably run on similar lines, inasmuch as the dispensary attached to Bombay Native Hospital provided medicines prescribed by a physician, with the permission of the authorities. A similar service must have been provided in Madras Presidency until 1853, as the Assistant Surgeon in charge of Triplicane stated that the decrease in out-patients for that year was due in part to the regulation which had come into force that year regarding the issue of medicines at the Presidency. He stated 'Not a few of the East Indian employees, mercantile clerks, and wealthier mahommedans, formerly registered

⁷¹ Letter to Francis Warden, 31 August 1807. BC, 4 September 1807. OIOC.

⁷² Letter from I.I. Vongeyer and 21 others, 15 August 1834. BC, 3 September 1834. OIOC.

⁷³ Letter 23 August 1833. BC, 23 July 1834. OIOC.

as out-patients, now receive advice only...they take the prescriptions to the Druggist shops.⁷⁴ This concern was also reported by the surgeons in charge of Black Town,⁷⁵ and Vepery Dispensaries.⁷⁶

The link in this formula of medical provision, being neither charitable, nor at times official, relates in part to the cost of European medicine and its accessibility. The Medical Stores were under the jurisdiction of the Medical Board, who appointed a store keeper (a medical officer), to order stock and control its distribution. To obtain supplies, permission had to be sought from the Medical Board, which in turn had to seek permission from Bombay Council. Like all other business of the Company, accurate records had to be kept. Controlling the centres of distribution was one such way, as was limiting the numbers of surgeons who could prescribe these drugs to the Company medical officers. This method of prescribing and supplying drugs via the dispensaries may have provided an air of respectability, or convenience, for Indians uncertain as to the advisability of being associated with the English dispensaries. Many of those purchasing drugs were Europeans, but many, such as the patients of Dr Mackie, and the out-patients at Triplicane, were Indian. The dispensing of medicine to Indians who could afford to pay, or were in the employ of the Company, is not a part of the function of dispensary care for the poor, but does illustrate how the institution of the dispensary was utilised and integrated into the towns and cities by other sections of the community, and does indicate that to a limited extent, western medicine was tried by those who did not depend on charity for their treatment.

Conclusion

Bombay showed only hesitant progress in health care provision for the sick and poor, when compared to that of the Presidencies of Madras and Bengal. The members of these two presidencies could not be described as enthusiastic

⁷⁴ Selections from the Records of the Madras Government, No.VII., Madras, 1855. Report on Civil Dispensaries for 1853. Triplicane Dispensary, Assistant Surgeon H.F.C. Cleghorn, M.D. OIOC.

⁷⁵ Ibid.

sponsors of the dispensary movement, but when others took the initiative, they gave limited financial support. Bombay was a comparatively new establishment, still troubled by wars and economic depression, and with a more precarious foothold in the Indian subcontinent. Despite this, care of the sick poor was provided, but it can only have been of negligible benefit for the constantly changing population. The administration of the military hospitals, virtually all that was available in the eighteenth century, was not regimented, especially in respect of the numbers and costs of the civilian population treated, although surgeons had an allowance for them, unlike Madras and Bengal. This may have been a redeeming feature if looked at in the long term. Bombay hospitals did not rapidly expand, but without the tight fiscal control enforced in the other presidencies, neither did those services contract, and on occasions the lax regulation led to 'unofficial' centres being utilized. The disadvantage of this indifferent manner of supervision led to anomalies in the admissions and funding of Bombay Native Hospital in the first decade of the nineteenth century, a situation at odds with the image of a mercantile company ruthlessly run, where every penny and action had to be accounted for.

Close inspection of the police accounts may have been neglected as long as the overall balance was not in deficit. Therefore, until Thorpe and Dunbar raised the issue of patients not being referred to Bombay Native Hospital, money provided for their admission and care would not appear to have been used for this purpose. Despite the success of the inquiry instigated by Dunbar, it only established the right of that money to be focused on the hospital, with no subsequent debates about expanding the service. Conversely, within this period, Madras and Bengal did have a small increase in their medical institutions, but only if subscriptions were raised by committees formed for the purpose, or by individuals; they retained strict control over their contributions, and stipulated the limits of the Company's involvement. Nevertheless, Bombay's lax control did allow medical care to be provided in areas outside the city, sometimes in an unofficial capacity, and if records had been kept, may have shown a larger

⁷⁶ Ibid, p.13.

number of Indians treated than would at first appear. Once Bombay Council was challenged, by Assistant Surgeon Glen, on the lack of medical institutions which would allow more Indians to receive medical assistance, they responded to his challenge by asking officials in the mofussil if they considered that medical facilities were required in their areas. They did not ask who would supply the funding, and what eventually was provided stood independent of charitable donations.

The dispensaries and hospitals did provide a useful role for the authorities inasmuch as they presented a 'caring face' to those they thought would be suitably impressed by such a stance, but they also provided a means of observing disease, and collating information and rudimentary statistics in times of epidemics, useful for Company officials who had only had oral testimony as a guide in the past. Their employees, the medical men, can also be seen to benefit. The hospitals and dispensaries became a repository of material (the patients) enabling them to expand their knowledge and experience. They wrote papers on their findings, and presented them to professional organizations and journals. In Bombay, their status had been low, but the defeat of Superintendent Briscoe had enabled them to be accountable and more in control of their work environment. This was a turning point in the understanding that the Company hierarchy had of the role expected of the Medical Department, and this in turn increased the idea of professionalism within the medical services.

For the very few Indians who were able to take advantage of the care offered, and be discharged cured, or improved, they provided shelter when their need was greatest and at no cost. To some extent they became Indianized due to the fact that when the indigenous practitioner failed, the dispensaries became a part of the round of consultations that would take place by the sick person and his relatives, until a cure was found. This was a measure of some acceptance by the poor community, and largely it was only those from the poorer sections of the community that would go to them. Those sent there by the police continued to be admitted, but they had no choice. Because of this, the hospitals and dispensaries presented a poor image of their worth. Once established however, they did

provide a footing for other forms of medical care, the lunatic asylums that were attached to the new hospitals at Surat, Poona, and Ahmedabad, the 'dispensaries without walls' and the dispensaries partly funded by philanthropists, for example. From mid century this last component was to fundamentally change the structure and means of providing medical care for the poor of Bombay Presidency, and this thesis will show how the humble dispensary would have an impact on the infrastructure of Indian and European relations, beyond their clinical and philanthropic significance.

Chapter 2 – Dispensaries, Education, and Philanthropy - 1820-1865

The dispensaries in England were considered useful but humble institutions, and accordingly took a lowly place in the hierarchy of medical care. The dispensaries in Bombay Presidency were also thought of as humble creations, consistent with the perceived needs of the poor population, but their performance, seen in retrospect, was not merely confined to medical treatment. The influence of the dispensaries was to invade the social space and ideas of Indians, unused to this particular kind of institution, and challenge British ideas on the necessary levels of commitment to the weaker members of a society over which they held some responsibility and authority.

This chapter will look at the influence the dispensaries had on a fluid Indian society, and how they became an integral, if not an impelling factor for change. The needs of the patient have been examined, and if the numbers who attended them were not prodigious, at least there was now, in the larger cities, access to free medical treatment for the poor. But other sections of the community were soon to benefit from the dispensary movement. The middle class and wealthier Indians would be engulfed in a momentum for change that could not have taken place in the time that it did if the dispensaries had not become an established ingredient in the intercourse between the two communities, Indian and British.

Medical education was an early beneficiary of the dispensary movement. The practice of medicine in India, among Indians, had been largely hereditary, the son learning from his physician father, or other member of the family. The surgeons had no status as such, only gaining value from their accomplishments and specialities; below them were the practitioners of folk medicine, uneducated, but accessible to the poor. European demands for medical practitioners versed in the ways of western medicine to staff the military units, and now the dispensaries, was to lead to the realization that these needs, as they were unlikely to be met from Europe, had to come from an educated class of people in India. Thus, institutions for the provision of medical education had to be considered. This

factor opened up the possibility of employment and status to those with a moderate education, but without the financial backing that a wealthy family would provide. The wealthy families, however, often having acquired their wealth through trade, saw that their wealth could be used to provide medical facilities for the poorer members of society, and also be used as leverage in the jostle for trade and contracts. The wealthy inhabitants of western India were to adapt their traditional ideas of philanthropy within the community, to ideas more in tune with those of the British.

Medical Education in Bombay

As the growth and expansion of the dispensaries can, to some extent, be related to the issues raised by Dr Dunbar and Assistant Surgeon Glen, so the development of medical education in Bombay can be associated with two Bombay Governors, Mountstuart Elphinstone, and Robert Grant (1835-38). The first could be said to have foreseen the possibility of medical education being advantageous for the people of India, but he did not necessarily link this to dispensary care; the second, however, was aware of the need for medical staff for the dispensaries and hospitals in Bombay Presidency. Despite the different stance that these two men, Elphinstone and Grant, took, at the centre was a pragmatic belief that more needed to be done, and be seen to be done, for the welfare of the poorer members of society. By 1821, the presence of the dispensaries, and the quarterly returns of Bombay Native Hospital, supplied ample proof that the dispensaries were now very much a part of colonial medical policy and practice, and that a British contribution alone was inadequate to meet, even modestly, the needs of the Indian poor. This, combined with a growing army also needing medical attendants, focused the minds of those in authority on the best means of addressing these problems. Mountstuart Elphinstone and Robert Grant attempted to do this, but also providing an influential contribution to the debate were the European medical men, the physicians and surgeons.

The dispensary movement in Bombay was slow to take root, but did expand, officially or unofficially, and by mid-century, could not have operated

with any level of efficiency without its staffing requirements being met by the members of the subordinate service. Shortages of European medical officers for the army meant that dispensaries would appear to have to take second place, but, nevertheless, once established, the dispensaries still required a level of medical cover. The governments of Calcutta and Madras had established medical schools in their respective presidencies in the early years of the 1820s, but their graduates were primarily intended for military service. Apprenticeship models of training were available in all of the presidencies, but often in an unofficial capacity, the kind and length of training frequently depending on the goodwill and enthusiasm of the European surgeon.

Bombay Council was made aware of medical staffing shortages within the city early in the century. In 1802 members of the Medical Board wrote to the Council to explain that due to the numbers of surgeons required by the Marine, the Military were left short of medical aid, which in turn left the public service 'sometimes distressed'.¹ They suggested that the smaller cruisers could manage without European surgeons, and that 'a Native assistant properly qualified would be sufficient'.² To this end they proposed that apprentices be admitted into the Private Dispensary 'for receiving instruction in the practice of Medicine and Surgery, these will have the advantage of attending the General Hospital'.³ When qualified, they would be appointed to a cruiser on Rs. 30 per month. It was also inferred that in a future period they could be employed as medical assistants in any branch of the public service. The scheme was permitted to go ahead.⁴

Little is mentioned of this scheme or any other system of medical education for Indians in Bombay, until the issue was raised by Mountstuart Elphinstone in his Minute on Education of 1823. This Minute however, must be put in context, and related to what was happening in the field of medicine in Bombay Presidency at that time. The Bombay Native Hospital was now 'officially' accepted as part of the Medical Department's domain, having its own

¹ Letter from M. Moir and H. Scott, 16 December 1802. BC, 17 December 1802. OIOC.

² Ibid.

³ Ibid.

⁴ Correspondence with India, Bombay, public letter, 5 February 1803, para 104. BD. OIOC.

surgeon and budget. Following Joseph Glen's letter of 15 October 1821, three hospitals had been 'officially' opened; these were to be considered as a trial and template for, possibly, further hospitals in western India. Mountstuart Elphinstone was, therefore, aware of the need for these units and the possibility of other units being opened. During this time, shortages of medical staff continued. To maintain the service, both for the civilian population and the army, more Indian medical personnel would have to be trained. Elphinstone's interest lay in general education, but almost as an addendum, he included in his Minute, which was, coincidentally, presented in the year following the opening of the three hospitals, the needs of the medical services.

Mountstuart Elphinstone

Sir T.E. Colebrooke, when writing his account of the life of Mountstuart Elphinstone, was at pains to stress his interest in education, but particularly the education of Indians. He pointed out that a society for promoting education existed in Bombay prior to Mountstuart Elphinstone being appointed to the post of Governor, but that the education of 'the natives formed only a branch, and an inferior branch of its objects'.⁵ Colebrooke claimed that the first society established to address this deficiency dated from a meeting held in August 1820 over which Mountstuart Elphinstone presided.⁶ Elphinstone's interest is borne out by the presentation of his Minute in 1823, but if, however, this was to lead to assumptions that he had any thoughts of medical education beyond an elementary stage, and that this was a strong impetus for his promotion of education, this assumption would be misleading.

The transfer of western medical knowledge to Indians was perceived by Mountstuart Elphinstone as a useful contribution to the general well being of the country, for despite his reputation as a liberal man who interfered as little as possible with Indian institutions, his opinion of indigenous medicine was not high. In his Minute of 1823 he said, 'there is one science [medicine] in which great progress may immediately be made...there are so few sciences in which the

⁵ T.E. Colebrooke, The Life of the Honourable Mountstuart Elphinstone, Vol.II., p.150.

natives have so little to preserve...in which we have so much to teach'.⁷ Conversely, medicine as a profession, did not, for Elphinstone, appear to be one of high status, or one that required its members to have great intellectual aptitude. For example, any British surgeon prepared to take part in the medical education of Indians, whether through personal instruction, or writing an elementary treatise in a native language on a science connected with medicine, could as a reward, Elphinstone suggested, be given an appointment as a civil surgeon, as 'the situation of civil surgeon is, generally, reckoned desirable'. But, he continued, 'it desires no peculiar qualifications'.⁸ The young graduates, however, once they had attained the level of proficiency established by the Medical Board, 'might be employed as a superior class of native medical assistants'.⁹

In the introduction to this paragraph of Mountsuart Elphinstone's Minute, lies an indication that medical education was already being undertaken in the Presidency, or at least was actively being introduced before the debates on the Minute could be concluded. Elphinstone lamented the fact that in Poona, 'The commissioner was not at first able to procure a medical professor for the college...private medicine being more lucrative'.¹⁰ The suggestion arises that as with Joseph Glen's remarks on unacknowledged dispensaries, there was also a comparable level of medical education already existing in Bombay Presidency that the authorities, certainly the Governor, were aware of. It may be no coincidence that attempts had been or were being made to put this on a more official footing by their search for a medical professor, for a city where in the previous year a hospital had officially been opened. The expansion of medical education was also part of Elphinstone's plan, for he decided that for those so educated, as well as having the option of becoming a superior class of medical assistants, might also 'furnish one or two professors for the college'.¹¹ It is

⁶ Ibid.

⁷ Parliamentary Papers. Reports from Select Committee on the East India Company, 1831-32. II Evidence, I Public. Minute by Hon. M. Elphinstone, 13 December 1823. Education of Natives, p.515.

⁸ Ibid.

⁹ Ibid.

¹⁰ Ibid.

¹¹ Ibid.

interesting that Bombay appears to differ in this respect from the other presidencies. It would seem that there was already a level, albeit at a basic grade, of medical education being provided for Indians; and Elphinstone's intention was that, once qualified, the more able graduates would become a part of the education process. In no other presidency, at this time or in the foreseeable future, would there appear to be plans for the instruction of western medical education, to be in the hands of Indians themselves.

Francis Warden, Chief Secretary to Government, responded to the Minute in a largely positive manner. He recommended that 'The students should be obliged to attend the dispensary, to visit the hospitals, and to avail themselves of all those aids in obtaining a proficiency which the Presidency affords beyond any other station'.¹² The link between dispensaries and hospitals, and education, is emphasized by Francis Warden, for without the growth of these institutions in Bombay Presidency, it is debatable whether the need for medical education for Indians willing to undertake the training would have arisen so early in the century. Although staffing levels for the military were always low, a 'hands on' type of training had been deemed to be sufficient for their needs, the medical assistant being but one part of the army's personnel, subject to military discipline. The growth of civil medicine in the form of western-style hospitals and dispensaries reshaped perceptions regarding the needs of the medical services. Without the expansion of these units, medical education would not have gained the importance that it did. The first official medical school, Bombay Native Medical School, opened in 1826.

Bombay Native Medical School

The decision to open a medical school followed long discussions on who would be admitted, take charge of the school, the language(s) of instruction, and the levels of achievement that graduates would be expected to attain. The Medical Board was at the heart of the consultations and James McAdam presented its

¹² Parliamentary Papers. Reports from Select Committee. Minute by Francis Warden, Member of Council at Bombay, 29 December 1823, p.521.

report on 11 November 1825,¹³ by which time it was proposed that the medical school would serve two purposes. The first was the instruction of native doctors for the civil *and* military branches of the service, and the second proposal was that the school was also to be a centre for the diffusion of medical knowledge, proposals that Mountstuart Elphinstone would have been aware of, as he was still in post at this time. The two aims may appear to be the same, but in practice the delivery was different and would lead to problems from the onset. It was decided that a two-tier system of education would have to be instituted. Those registered as students to be trained as native doctors, would be enlisted as soldiers and would succeed, when qualified, to whatever vacancies arose, whether military or civil. They would be attached to the European Hospital and the Native General Hospital, and the Company's regiments for practical instruction. The Superintendent was to be given permission to have free access to the wards to oversee their training, but he would not be allowed to interfere in any way with the running of the hospital or the treatment of the patients. From Elphinstone's Minute of 1823, the emphasis seems to have moved away from a humanitarian intention to provide medical relief for the Indian people, to one of providing trained personnel for the Company. The civilian population, it seemed, would have to compete with the military for the newly qualified doctors.

The second level of training would appear to be a measure to redress this imbalance. Pupils were to be selected for 'general practice'. It was advised that they belong to families residing in the 'principal towns' where it was expected that they would find employment: the towns would benefit from their talents and experience, and they might 'enjoy a better chance of remuneration which may encourage others to adopt the same profession'.¹⁴ Five hospitals had been selected for the education of these pupils who would be supervised by the Medical Officer in Charge. They would be expected to learn the 'first rudiments' of medical education. However, once a pupil had been found to have acquired this level of knowledge, after being examined by a medical committee, he would be admitted

¹³ Report to Bombay Council, 11 November 1825. BC, 4 January 1826. OIOC.

¹⁴ Ibid.

into the Medical School at the Presidency. He would enjoy the same advantages as the other students, and at the end of his training he would be allowed to settle in whatever situation he considered most advantageous. The pupils of this class therefore, were to be the doctors for the people of India, as envisaged by Mountstuart Elphinstone, trained in the presidency hospitals and dispensaries, but not apparently to be formally employed in these institutions once trained. For general practice, the description private practice could be substituted, and may well have been the mode of medical delivery that Elphinstone had understood as the best means of diffusing western medical science among the people. Problems arose with the different standards of educational achievement that were expected of the new recruits. Those from the first level were expected to be better educated than the second, and this factor immediately caused problems regarding the language of instruction. The Superintendent appointed, Dr John McLennan, had linguistic skills, and spent the next few years translating medical texts from English and Sanskrit into Marathi and Hindustani. His output was immense, but even with the assistance of Indian writers, it must have left little time for instruction, and for some time the students would have had to work without textbooks in a language that they were able to understand.

Further problems arose. Despite the fact that it had been suggested that Dr McLennan and his students have free access to the hospitals and dispensaries for clinical instruction, this either cannot in practice have been implemented, or been a satisfactory mode of instruction. McLennan pointed out: 'it is my duty to explicitly state... [the] really practically useful part of the education... cannot be carried on with advantage ... unless they are attached to an hospital for native sick to be under my own care and superintendence'.¹⁵ The response of the Medical Board was to suggest that once a vacancy occurred for a surgeon at Bombay Native General Hospital, Dr McLennan be appointed at the *reduced* salary of 250 rupees.¹⁶ Thus at a stroke McLennan's workload of teacher, translator, and now surgeon in charge of the hospital was increased. He was appointed as Surgeon to

¹⁵ Reports from the Select Committee, p.476.

¹⁶ Ibid.

Bombay Native General Hospital, and was still there two years after the closure of the Medical School.¹⁷ It is doubtful whether he would have been capable of maintaining sufficiently high levels of academic competence, or professionalism, to maintain standards that would have met with approval from those in authority. McLennan admitted as much, as revealed in a Minute by Sir John Malcolm, Mountstuart Elphinstone's successor, dated 10 October 1829.¹⁸ John Malcolm noted that although some of the students had been found military postings, none were considered by Dr McLennan to be as well educated for their tasks as he would wish.

The school was closed in 1832 by the order of Lord Clare, Governor of Bombay, 1831-35. During this time, there did not appear to be any further expansion in either dispensary or hospital numbers. On the contrary, calls for a reduction in the establishment of the civil hospitals were made in 1830.¹⁹ This edict was also intended to include jails and hospitals for the insane,²⁰ and was part of a general call to all departments in Bombay Presidency for economies to be made, excepting the establishment that dealt with the purchase of timber.²¹ A letter from F. Bouschier, Post-Master General, shows that the economies made in his department were dependent on staff reductions.²² The Civil and Insane Hospital in Surat did not see a reduction in staff numbers, but did enforce cuts in the pay of the Indian employees, saving Rs110-2-0 per month.²³ The staffing levels were comparatively low in the hospitals, and any redundancies, as occurred in the Post Office, would inevitably have led to closure, a circumstance that does not appear to have been contemplated. Any action of this kind, if undertaken, would have been a severe setback to any future plans for expansion of hospital

¹⁷ Letter from Dr McLennan, Surgeon, Native General Hospital, regarding proposed improvements to the hospital, 22 July 1834. BC, 17 September 1834. OIOC.

¹⁸ Reports from the Select Committee. Minute of Sir John Malcolm, 10 October 1829, p.537.

¹⁹ See letters to Council from J. Barnard, Session Judge of Surat, 27 July 1830, and from Edward Grant, Session Judge of Ahmedabad, 24 July 1830. BC, 4 August 1830. OIOC.

²⁰ Letter to Council from J. Nisbet, Principal Collector, Dharwar, 27 July 1830. BC, 11 August 1830. OIOC.

²¹ See, letter from J. Farish, Civil Auditor, to the Council, 30 June 1830, and response from J.P. Willoughby, Acting Secretary to Government, 9 July 1830. BC, 14 July 1830. OIOC.

²² Letter to Bombay Council, 7 July 1830. BC, 14 July 1830. OIOC.

²³ Letter from J. Barnard, 27 July 1830. BC, 4 August 1830. OIOC.

provision, and this in consequence, would have lessened the necessity for medical education for Indians.

In 1832, proposals were made to discontinue the 'private tuition of Medical Pupils in the Civil Hospitals',²⁴ but Lord Clare asked the Medical Board to give their opinion whether it would be 'advisable to continue the youths in the several Civil Hospitals to give that degree of instruction which will make them of use in the remote towns and villages'.²⁵ It is most likely that instruction did continue, as letters from the surgeons stationed in the Presidency will later testify to. Following the closure of the school, only one medical unit was to open in Bombay, the Bombay Native Dispensary, funded by private subscription. This dispensary provides an example of the way medical education would continue, undeterred by the lack of a medical school. James Farish observed that Dr Mackie, the Superintendent,

With the aid of some Gentlemen of the Government Medical Service, has been successful in carrying on several of the best educated of the Hindoo and Parsee boys of the Native Education Society's School, in Medical, Surgical and dispensary practice, giving them also opportunity of which they have spiritedly availed themselves, of practical anatomy.²⁶

The latter part of this statement probably refers to the pupils participating in post-mortems. Assistant Surgeon Waller, in Southern Konkan, also refers to apprentices being involved in this procedure. He claimed 'Having been for some years in medical charge of the 6th. Regiment, and having had several apprentices under me, some of whom were promoted to higher grades...I have, by reasoning...induced them to overcome their aversion to the examination of dead

²⁴ Letter from the Civil Auditor, J. Farish, 18 July 1832. BC, 22 August 1832. OIOC.

²⁵ Minute by Lord Clare, 7 August 1832. BC, 22 August 1832. OIOC.

²⁶ Minute by James Farish on the subject of medical education and the proposed medical college, 4 April 1838. BC, 4 July 1838. OIOC.

bodies'.²⁷ The first documented post-mortem in India, by Indians, under the control of the British, was in Calcutta in 1836. Much was made of this, it being viewed as a stepping stone for the advancement of western medical theory in India. Waller's letter, however, written in 1837, suggests that the practice was already in evidence, or was in the process of being established, in western India. His claim also provides additional confirmation of the way medical education carried on, with the goodwill of the surgeons involved and the unobstructed use of the dispensaries, and civil and military hospitals.

Despite efforts to maintain a medical apprenticeship for some Indians following the closure of Bombay Native Medical School, in 1837 a questionnaire was circulated to the surgeons employed in a civil or military capacity, within Bombay Presidency and the adjacent Princely States. The intention was to seek comments on the feasibility of opening another medical school in Bombay. It was initiated by Robert Grant and organized by Charles Morehead through his position as secretary of the Bombay Medical and Physical Society. This society formed in 1835, had as one of its stated aims 'The giving of the permanent benefits of medical science to the people of India, by introducing an efficient system of medical education.'²⁸

Robert Grant

In Britain Robert Grant had been a Member of Parliament for different constituencies, and was by profession a barrister. He was the second son of Charles Grant, East India Company merchant in Bengal, and later a Director of the Company in London. Charles Grant was known as a founder member of the Clapham sect, and promoter of missionary activity in India. Robert Grant does not appear to have been previously involved in medical education, but with the collaboration of Charles Morehead, set in motion a chain of events that was to lead to the opening of Grant Medical College. He may not have held the missionary zeal of his father, but his memoranda, and the wording of the

²⁷ Letter in response to Robert Grant's Minute on Medical Education of 1838, 21 June 1837. BC, 4 July 1838. OIOC.

questionnaire regarding the medical education of Indians, certainly suggest that this ambition of his was more than a utilitarian gesture for the good of Indians in general. However, he remained clear-sighted on the problems that would arise, was critical of the reasons given for the closure of the medical school in 1832, and was determined that the same mistakes would not recur. To this end he sought the advice of the medical officers in western India, and asked for their opinions on the state of indigenous medicine in the country.

Grant's questionnaire was far reaching, and was at times heavily weighted in favour of a negative response being forthcoming regarding the practice of indigenous medical men. For instance, the fourth question asks if the medical practitioners command the confidence of the respectable portion of the native community. This would be a difficult question for a European surgeon to be clear upon, and makes no mention of the poorer classes who could not afford the fees of the practitioners he is referring to. Question nine asks the respondents that, if they do not consider the present state of native medical practice *perfect*, then what occurs to them as being its leading *abuses*?²⁹ Perhaps more portentous, question six asks in an unequivocal manner, 'State generally what your own impression is relative to the state of Native Medical practice, does it tend to good or evil?'³⁰ He is certainly not looking for a fudged response; there is to be no debate about any grey areas that could arise. Interestingly, at this stage, he makes no mention of hospital practice and the use of such facilities by Indians, or as a centre for medical education. When Robert Grant drew on the reports regarding the failure of the first Bombay Medical School, however, this issue was then raised.

Many of the European surgeons, as already shown, were active participants in the provision of medical education for Indians, and many described Indian surgeons who were good examples of what could be achieved, and of their subsequent acceptance by the Indian public. J.W. Purnell, Garrison Surgeon at Surat, for example, claimed that the 'best native medical Practitioner

²⁸ Transactions of the Medical and Physical Society of Bombay. Vol. I., Bombay, 1838, p.xii.

²⁹ My italics.

³⁰ F.S. Arnott letter book. Circular sent from Bombay on behalf of the Governor, 26 May 1837. NAM.

in the City...under the employ of Government under the Civil Surgeon...enjoys in a very high degree...the confidence of all the respectable native Community'.³¹ Assistant Surgeon Waller, whose training of apprentices has already been referred to, also mentions 'Dwarka Deen, a Brahmin', who not only assisted him with minor surgery, but also possessed 'Calm, cool reasoning, has immense influence with Natives'.³² Many were in favour of a hospital-based education. R.H. Kennedy, for instance, viewed this mode as the one that was the most economical. He pointed out that money had been refused in the past for a medical college in Bombay: therefore the alternative was to educate the subordinate hospital establishment, which he estimated was not short of 350 individuals in the Presidency. He also attached a suggestion to his initial observation: 'I would add to the number of apprentices, wherever the school is good; thus in my division, the Civil Hospitals and Jail, Ahmedabad, could usually employ and instruct 4 apprentices'.³³ Some, however, pointed out that medical schools were already established and had produced graduates that were practising within the presidency, such as the Portuguese medical school at Goa.³⁴ James Boyd, Assistant Civil Surgeon, Tannah, claimed that it had been reported to him that Hakims possessed 'some sort of seminaries' at Surat and Hyderabad.³⁵ The reports of these two surgeons would indicate that, despite their colleague's endorsement of training in hospitals, they were also at pains to point out that medical schools were already a constituent of Indian medical infrastructure, and were not the sole prerogative of the British.

Opinions regarding the efficacy of indigenous medicine varied. No respondents exhibited total support for the methods employed, but the vaccinator of the Deccan Division, Mr Gibson, reported that it was his impression that 'for diseases of a simple and determinate character, the practice...is generally more good than bad'.³⁶ Surgery was highlighted as one area where progress could be

³¹ Letter in response to Robert Grants Minute, 9 June 1837. BC, 4 July 1838. OIOC.

³² Ibid., 21 June 1837.

³³ Ibid., 4 July 1837.

³⁴ Ibid., Letter from I. Heddle, Assistant Surgeon at the Presidency, 20 July 1837.

³⁵ Ibid., 30 June 1837.

³⁶ Ibid., Minute of Robert Grant, dated 5 March 1838, signed 27 March 1838, para 19.

made,³⁷ not least because of its immediate impact on the progression of physical ailments and disability. There were negative convictions offered such as that from Mr Barrington, the Civil Surgeon at Broach, 'My own impression is that such a state of Medical Practice positively tends to evil'.³⁸ The assertion by F.S. Arnott 'Their practice probably tends to good in as greater degree as, or a little more than, the knowledge of herbs possessed by old women in remote and wild districts, in Great Britain',³⁹ is in a similar vein. A more optimistic reply came from I. Heddle who claimed that medical practice in Bombay was improving, due, in his opinion, to the 'agency of the Medical institutions of Government, and by the Medical Officers European and Native, connected with these institutions'.⁴⁰ Comments from the Committee of the Bombay Medical and Physical Society were later to support the view that these institutions (the hospitals and dispensaries), were pivotal to the plan for expanding medical knowledge.⁴¹

Robert Grant's Minute on Medical Education

In his Minute, Robert Grant deliberated upon the theme of medical education for Bombay from three perspectives - the past, the responses of the medical officers to his questionnaire, and finally, his ambitions for the future. The past was mainly concerned with the first Bombay Medical School, and its ultimate failure. He described five defects within the organizational framework of the school which he considered were instrumental in its decline – instruction being given in Hindustani and Marathi in which there were few translations of English medical tracts, the low educational achievements of its students prior to their admission, omission of practical anatomy, inadequate and inappropriate board of management, and the lack of practical training for the pupils due to no hospital being attached to the school. Robert Grant laid stress on this defect when he observed:

³⁷ Ibid., Letter from I. McAdam, Superintending Surgeon, Poona, 1 August 1837.

³⁸ Ibid., Minute of Robert Grant, para 6.

³⁹ Ibid., 8 July 1837.

⁴⁰ Ibid., 20 July 1837.

There was no Hospital attached to the Medical School. It followed as a matter of course, that those pupils who were supposed to be in preparation for the situation of Hospital Assistant, could not under such circumstances have been qualified, in any space of time [sic], for their duties as they had never been within the walls of an Hospital.⁴²

Conversely, however, Robert Grant laid some blame for the failure of the first school on the corruption of Mountstuart Elphinstone's original intention of diffusing medical science to Indians, to enable them to return to their districts to put into practice the knowledge they had acquired. This he considered was achieved by the school taking on the appearance of a military establishment, such as had been instituted in Calcutta, and which led to the training of hospital servants for the army becoming its primary consideration. His argument is ambiguous however; on the one hand he decried the lack of hospital training, but then criticized the intention to train hospital servants, albeit for the army. A major issue, that neither Mountstuart Elphinstone nor Robert Grant appeared to acknowledge, or may not even have considered of any importance, was that of young men being trained to practice an alien medical system. Once qualified, they would then have been expected to return to the mofussil, armed only with a few drugs and a certificate, to take on the might of the traditional practitioners, without the back-up of shelter and free care for their patients, such as that provided by the dispensaries and hospitals in the major cities. Therefore, even with the improved training and education that Robert Grant so keenly advocated, the ultimate ambition was already handicapped by this corresponding lack of free medical provision.

This facility had largely been the motivating influence in encouraging Indians to use western medicine, rather than their having great faith in its efficacy. Moreover, most graduates would only be certain of employment within

⁴¹ Ibid., Minute of Robert Grant, para 85.

the civil or military establishments, the hospitals and dispensaries. Only those who had the support of powerful financial backers within their own community would be in a position to fulfil the ambitions of Robert Grant and Mountstuart Elphinstone, of private practice in the mofussil. Further contemplation on the practicalities of medical training and the most efficient use of its graduates would have lent a solid framework to the working ethos of the schools. Nevertheless, Robert Grant saw how the aims of the first medical school fell victim in its attempt to provide two levels of training, 'It neither qualified its pupils for the situation of Hospital Assistants, nor for independent practice in the districts',⁴³ and how the lack of practical training at both levels was to handicap their eventual professional expertise. In his final proposals, he attempted to address this conundrum.

In his Minute, he gave as his opinion that, 'The school...seems to have begun wrong [sic], and never to have worked itself right'.⁴⁴ To eliminate any possibility of the same happening to the school he now proposed, he considered all the information that he had been given following his Circular. He referred to the report of the medical committee which suggested that the English language be the medium of instruction, and that the students should be adequately educated.⁴⁵ He pointed out that in most medical schools in Europe, the period of training lasted for at least four years and he made the assumption that the graduate would still not consider himself efficient, for, as he noted, 'Time, observation, patient application, and the feeling that there is always something to be learned, are essential to the formation of the skillful physician'.⁴⁶ The medical committee supported his opinion that the aim was 'the education of natives, to fit them for the useful and safe practice of Surgery and Medicine, and not the training of the Hospital Servants'.⁴⁷ Hospital servants, whether military or civil, were therefore not to be considered, nor any grade in between, but the thread throughout the

⁴² Ibid., para 77.

⁴³ Ibid., para 70.

⁴⁴ Ibid., para 79.

⁴⁵ Ibid., para 84.

⁴⁶ Ibid., para 79.

⁴⁷ Ibid., para 86.

medical committee's report, and the conclusion of Robert Grant, was the necessity for hospital practice as an integral part of the student's education. To this end, Robert Grant proposed withdrawing the Rs 300 that was given monthly to Bombay Native Dispensary, already referred to, so that this could be transferred to Bombay Native Hospital to enable it to take on a new role as an 'appendage' of the new school, as he 'should not consider the Government justified in incurring the expence and delay of building and forming another...I feel little doubt, that one Hospital properly constituted, is quite equal to the wants of the people.'⁴⁸

The final comment in his Minute, however, was to introduce a further dimension into the dynamics between the dispensaries and hospitals, and medical education; it would place the philanthropic actions of one man in particular, and a community overall, into the history of the dispensary movement in Bombay Presidency. Robert Grant noted 'Since I wrote the preceding Minute, Jamsetjee Jeejeebhoy has placed at the disposal of Government, his splendid donation for a Native Hospital...'⁴⁹ Jamsetjee Jeejeebhoy had been one of the founders of the Bombay Native Dispensary, sat on the committee, and therefore had an interest in keeping the dispensary open and funded. He donated one lakh of rupees for a new hospital, but ultimately he was to donate more than half as much again. The Jamsetjee Jeejeebhoy Hospital was opened in May 1845. Grant Medical College opened its doors in 1843, after Rs 48,000 was raised by private subscription in memory of Robert Grant, and a similar sum was given by the Bombay government.

So was Robert Grant's strategy implemented? In the fourth annual report of Grant Medical College, opened six years after Robert Grant's death, comparison was made with the medical college at Calcutta. It was noted that in Calcutta more than half of the students were not being educated for independent medical practice, but to make them better fitted for the subordinate duties in the regimental and other hospitals of the public service. To assist the government

⁴⁸ Ibid., para 93.

⁴⁹ Ibid., conclusion.

establishments of Bombay Presidency, it was decided that fifteen of the most intelligent medical apprentices would be attached to the Jamsetjee Jeejeebhoy Hospital in Bombay. In addition to the practical experience that they would thereby gain, they would also receive instruction in anatomy, chemistry, materia medica, and elements of surgery and medicine at Grant Medical College.⁵⁰ By the time of the sixth annual report it had been decided that sub-assistant surgeons were to be 'selected exclusively from the most meritorious and highly qualified graduates', for employment in the charitable dispensaries, the same report issuing guidelines on the size and content of these dispensaries, and the duties of the sub-assistant surgeon and his subordinates.⁵¹ Robert Grant had intended that the education of Indians for private practice was to be the primary consideration of the college, the education of medical subordinates for the public service was not on his agenda, but ultimately, as stated, the reality was that once away from the cities, private practice would be unlikely, in this period, to prosper. Robert Grant's statement regarding the first medical school that it 'begun wrong and never worked itself right', could not truly apply to the second. Changing circumstances and the growth of the dispensary movement were to lead to the realization that graduates had to be educated to meet the needs of the country, on a 'practical rather than a theoretical level. Nevertheless, it could be argued that Robert Grant's thorough examination of the first medical school in Bombay gave the second a sounder foundation on which to develop.

Despite this, John Peet, the Principal of Grant Medical College during its sixteenth year, 1861-62, (the year in which the validation of their licences to practice was handed over to Bombay University, thus demoting Grant Medical College to that of an affiliated institution for instruction alone), added a sombre and reflective note to the annual report of that year regarding the success of its graduates and the employment that they subsequently gained. There were thirty-five graduates practising their profession in a private capacity, of whom only two

⁵⁰ GMC, 1849-50, para's 48-49.

⁵¹ GMC, 1851-52, Rules as an addition to the Bombay Medical Code, para's 1&7, and para's 20-29.

were in the mofussil; there were also nineteen in the employment of government or in the Princely states, just over one-third of the graduates. He observed:

No state system can be complete or successful unless the demands of the people in all parts of the country are in progress of being supplied. It must be confessed that up to the present time the country generally has not benefited to any great extent by the existence of the College. It is true that in some of the larger towns, charitable dispensaries have been opened, and placed under the charge of graduates, where the poor classes have received medical aid and medicines; but it cannot be said that a sufficient number of graduates... have established themselves in the Mofussil; to justify the statement the medical profession has been fairly introduced among the people.⁵²

Without a doubt, such numbers were going to make but little impact on the health care needs of the Indian poor, but Grant Medical College's annual reports illustrate a gradual process of change. The opening of medical units, especially dispensaries, influenced the official line of thought, for it was during the twenty years that followed the opening of Grant Medical College that the impetus for their expansion gained ground, with greater influence coming from the Indian community through the influx of their wealth. Therefore, it can be said that the process of change, within the sphere of medical care through the medium of these medical institutions, was a stimulus to other related activities. For instance, the dispensaries needed staff, which led to a greater awareness for the needs of Indian staff trained in western medicine. This in turn generated further debate on the necessity of a professional identity for western-educated Indian medical men. Attempts throughout this period were made to elevate the academic content of medical education, but these ideals had to be constantly amended to changing needs. The problems of education in the vernacular languages versus English, and

⁵² GMC, 1861-62, paras 17-18.

where students were to be employed once they graduated, and their consequent status, still had to be addressed.

First Fifteen Years of Grant Medical College

The fifteen-year period, from the opening of Grant Medical College, to 1860 when Bombay University assumed responsibility for the awarding of diplomas, could be viewed as a time of experimentation, with some methods of training bearing a strong resemblance to the earlier format. The original aim had been to educate young men for the role of private practitioners, but this was amended to include an apprenticeship system offering a less academic course, thus enabling a greater number of students to attain sufficient competence for subordinate duties in the regimental hospitals and the civil hospitals and dispensaries. Fifteen graduates a year was the original intention, but this was never going to be sufficient for the needs of the dispensaries. It may, nevertheless, have appeared as a viable number for those intended for private practice, Robert Grant's favoured outcome, and also that of Charles Morehead, who attempted to maintain this aim throughout his time as Principal of the college. He was aware of the need for a professional identity for the graduates if standards were to be raised. He had envisaged, through the medium of the college, 'the creating of a native medical profession, with the same high qualities which distinguish the medical profession in England'.⁵³

Charles Morehead may have approved of the awarding of degrees by Bombay University, if it gave the recipients a higher standing from which to embark on a medical career. He did not, however, approve of medical education being conducted in any other language than English, so would not have supported the appointment of two lecturers, in the year of John Peet's poignant reflections on the shortcomings of Grant Medical College, to prepare books in Marathi for the instruction of their students. This strategy was an echo of John McLennan's plan of more than thirty years previously, when he too had spent some considerable time translating medical books into the vernacular languages. If

⁵³ H.A. Haines, Memorial of the Life and Work of Charles Morehead, London, 1884, p.21.

viewed in this light, then plans for educating India's young men had not travelled very far, but by experimentation had come full circle, unless it was now considered that different classes of medical men was acceptable within the framework of the medical authorities and colonial expectations. From 1860 onwards, there were two levels of Indian graduates trained to practice western medicine, and three levels of entry; first, a university level, second, a class for those with lesser academic ability, but with instruction being given in English, and lastly, classes that were taught in the vernacular languages. Other schemes reflecting the last two levels led to new schools being opened in the mofussil, with the intention of providing staff for dispensaries and other areas of public service. This combination was to remain relatively unchanged for the remainder of the century, and would appear to have been a compromise between high ideals and practical necessity.

However, Charles Morehead never changed his opinion regarding the education of medical students for private practice and not for public service. Haines records that in a letter written in 1872 to Mr Lisboa, one of his early students, he noted disparagingly,

Judging from the dispensary system now in vogue all over India, medicine and surgery have become very simple matters. It will very soon be found that the only difference between it and the old Weid [Vaid] system which Sir Robert Grant and others wished to correct is that the evil has become extended and bears a Government stamp.⁵⁴

By mid century, dispensaries were firmly endorsed as a means of providing medical care for those unable to obtain it elsewhere, and Indians were undergoing training to provide care in a private capacity and in the dispensaries. The establishment of dispensaries and small hospitals was the starting point for a chain reaction, although a reaction which was often of an indolent nature. Medical education followed the dispensaries, consequently medical graduates

⁵⁴ Ibid., p.57.

needed an institution in which to practise their profession, and the profession required suitable centres as an outward symbol and a solid foundation on which to structure their professional identity. The government in Bombay, who in the past had largely provided dispensary care gratis, now looked to the community at large, especially those with whom they had formed business alliances, to provide help with some, or all, of the funding.

Dispensaries and Indian Philanthropy

Philanthropy was an accustomed part of Indian ritual and tradition, and regarding the dispensaries, the only new concept within this process was the direction in which their money was moved, the reasons for giving, and the ways of doing so. Prior to British involvement in India, the wealthy had provided money for temples, sanctuaries for sick animals, and shelters for the poor and for travellers. There is much documentation about what they gave, and to whom, but little or no personal statements as to why they were generous with their money, except that it was a religious duty, tradition, or was an expected constituent of a responsibility that had to be maintained, consonant with their status in society. This aspect of Indian life among the rulers and merchants, has been a subject of interest by present day historians and anthropologists, and to put the subject into perspective, so that comment can be made on the association between Indian philanthropists, government, and hospitals and dispensaries, in India overall but especially in Bombay, their findings will be briefly surveyed.

David Rudner, examining the concept of religious gifting and inland commerce in seventeenth-century south India, suggests that through endowments given to temples, powerful networks of guild and caste-related alliances were strengthened. Religious gifting and collective worship led to a mechanism for the formation of resource controlling groups and integration of these groups within a common political system.⁵⁵ Nicholas Dirks considers the role of kingship and religious gift giving, also in south India and prior to British involvement, and its

⁵⁵ D.W. Rudner, 'Religious Gifting and Inland Commerce in Seventeenth-Century South India', Journal of Asian Studies, 46:2 (1987), pp.361-79.

transformation under colonialism. He claims that 'caste structure, ritual form, and political progress were all dependent on relations of power'.⁵⁶ He asserts that the royal gift was basic to statecraft in all the kingdoms of the old order in south India, that they were public acts of kingship, and argues that 'On the one hand, ritual was a pervasive political act; on the other, politics was permeated by ritual form.'⁵⁷ The key assumptions are that power and consequently status, whether through kingship or material wealth, are manifested and reinforced through the ritual of gift giving.

As has been established, western India did not necessarily follow the pattern of European and Indian co-existence seen in other parts of the country, and to some extent this applies also to the ways and means of gift giving. Douglas Haynes, who based his investigation on the city of Surat, argues that gifting, in which he includes the building of wells, resthouses, and the support of festivals, changed also in western India in the nineteenth century. He demonstrates that the traditional means of giving was gradually reduced in favour of a more anglicised tradition. Haynes also perceptively notes a distinction between philanthropy and gift giving. Philanthropy was a more commonly used word to describe the funding of not only dispensaries and hospitals in Bombay Presidency, but also donations to and for other charitable institutions and societies. He observes that philanthropy, as opposed to traditional gift giving, led merchants and traders to become engaged in philanthropic activities espoused by the colonial rulers, and he suggests 'philanthropic activities were but part of a large portfolio of symbolic investments that merchants developed in building stable social relationships with members of their community and with their rulers, and which they adjusted as the sociopolitical world around them changed.'⁵⁸

David White, on the other hand, looked specifically at Parsi philanthropy, by outlining the progress of a family, once living in Surat, but who had moved to Bombay. Their philanthropy, in Bombay, was directed initially at providing

⁵⁶ Nicholas B. Dirks, *The Hollow Crown: Ethnohistory of an Indian Kingdom*, Ann Arbor, 1996, pp.4-5.

⁵⁷ Ibid, pp.128-29.

institutions for the new and growing Parsi community within the city; places to worship, to dispose of their dead, and to provide an infrastructure for the community to take its place and maintain its identity. A Parsi Panchayat was established, which would eventually take over this role, but in the first half of the eighteenth century, following disagreements with the East India Company and other traders, David White suggests that to win back the favour the family had lost, they had to emulate their competitors 'they had to use some of their wealth to demonstrate to the Bombay establishment that they were trustworthy and honorable. Philanthropy offered a means both to purchase and maintain honor in English Bombay.'⁵⁹ Thus, David White makes a direct connection between business and philanthropy, with politics, but not necessarily ritual, as an integral part.

Jesse Palsetia describes aspects of Parsi philanthropy in the nineteenth century through his analysis of the causes of the Bombay dog riots in 1832, when inhabitants, mainly from the Parsi community, rebelled against the order to cull pariah dogs in the city, an order which offended Parsi sensibilities. He remarked upon the status of the community in Bombay when good community relations between the British and the Parsis made for favourable economic conditions for both. He claims that Parsi charity was an important marker of their identity, and the growth of their wealth led to their benevolence being expressed beyond the confines of only Parsi charities.⁶⁰ It is useful to bear in mind the varying forms and the philosophy of gift giving and philanthropy, for it certainly affected the sums of money involved in the establishment and running of medical institutions throughout India. In Bombay, the numbers of units involved may not have been as great as at Madras and Bengal, but philanthropic contributions from the community were at times spectacular. It is possible that these contributions provided the impetus for the growth of the dispensary movement to take on a

⁵⁸ Douglas E. Haynes, 'From Tribute to Philanthropy: The Politics of Gift Giving in a Western Indian City', *Journal of Asian Studies*, 46:2, (1987), p.340.

⁵⁹ David L. White, 'From Crisis to Community Definition: The Dynamics of Eighteenth-Century Parsi Philanthropy', *Modern Asian Studies*, 25:2, (1991), p.311.

⁶⁰ Jesse S. Palsetia, 'Mad Dogs and Parsis: The Bombay Dog Riots of 1832', *Journal of the Royal Asiatic Society*, third series, 11:1, (2001), pp.28-29.

second momentum, which had been lost following the recorded opening of Bombay Native Dispensary, a unit partly funded by Parsi contributions. So why did Bombay differ from the other presidencies, and would these differences lead to greater benefits for the community at large?

The Madras and Bengal Presidencies

The first hospital opened for the relief of the Indian poor in Madras, was the infirmary, planned and paid for by John Underwood in 1799. The East India Company made contributions to its running costs. The Company eventually took over the running of the infirmary, and the infirmary was merged with the Monegar Choultry, an institution opened in Madras for the sick and destitute during the famine of 1780-81. The early history of the Monegar Choultry, reflects that of the Humane Hospitals in Bombay, also opened in response to famine spreading through the presidency. But in Madras, unlike Bombay, much of the funding was through charitable agencies, European and Indian. The extent of Indian contributions generally, however, did not meet the expectations of the Directors in London.⁶¹ Madras inhabitants frequently participated in large gift giving arrangements, but did not provide the whole funding for any one unit or scheme. They would subscribe to a larger fund but their subscriptions would not cover wages or the maintenance of the dispensaries, for example. Occasionally, large sums of money were provided for the erection of a dispensary such as the one at Secunderbad,⁶² and at Bellary in 1842.⁶³ More often the funds provided 'extras' or 'comforts' for the patients. In Salem, a 'Samaritan Fund' was set up to aid all patients, but especially poor Indians, so that on their discharge they would have sufficient money to support themselves for a few days without having to work.⁶⁴ Assistant Surgeon Foulis of the Civil Dispensary, Mangalore, assured the government in 1852 that they would soon be relieved of dieting the pauper patients, as two funds had been raised; one through an appeal to the European

⁶¹ Madras Pubs., 11 January 1809. See letter from Court of Directors. OIOC.

⁶² MDR, 1852, p.2. OIOC.

⁶³ Medical Reports Selected by the Medical Board, Madras, 1850. Public Dispensary at Bellary, 1844, p.340. OIOC

residents by him, and a separate appeal made by the Indian surgeon to the Indian inhabitants.⁶⁵

Madras was a presidency where gift giving would have taken the customary forms described by David Rudner and Nicholas Dirks, but in the progress of half a century, the traders had adapted their gift giving to meet the needs and expectations of their new rulers. They did not appear to take the lead in fund raising activities, nor on the whole, give large donations. Regular remittances would appear to be the usual mode, such as guaranteeing the supply of food for the patients, or money to make their discharges from the dispensary easier to cope with. Larger sums were obviously involved when money was raised for the construction of a new dispensary such as that at Secunderbad. If the sums taken as a whole throughout the presidency are considered, however, the money for these institutions would be reasonably substantial, shared by traders and merchants who were behaving in the manner expected of them. Theirs was not a high profile role, but a reflection of their status in a society ruled by a country with different ideas of gift giving. But by the very nature and content of the pattern of their giving, they would be enabled to maintain their role and status within Indian society, giving money to temples, Brahmins, and through their joint funding for the dispensaries, to the Indian poor.

In Bengal Presidency, the first hospital for Indians was opened in Calcutta in 1794 for the 'relief of natives suffering from accidents and sickness', the scheme being proposed by Dr Robert Wilson. In 1792 a meeting had been held by the 'principal inhabitants of Calcutta' to discuss his proposal. It was decided that the 'management of the Hospital be vested in an equal number of European and Native Governors', and that a 'committee be appointed to procure and receive subscriptions for the support of the institution, and to prepare a plan for the management thereof'.⁶⁶ A letter to the Court of Directors dated 17 March 1796, added that after one year, about Rs 54,000 were subscribed, this money coming

⁶⁴ MDR, 1855. Dispensary at Salem, p.21. OIOC.

⁶⁵ MDR, 1852, p.25. OIOC.

⁶⁶ P.C. Gupta, Fort William India House Correspondence, 1796-1800, Vol. XIII, Delhi, 1959, p.542.

from Lord Cornwallis, members of his Council, and Indian gentlemen. The government allowed a monthly allowance of Rs 600. The European residents of Bengal Presidency therefore, involved the Indian merchants and those of influence in the founding of the dispensary, in both supplying subscriptions for its purchase, and assistance with maintenance costs. They also sought their involvement in the management of the unit, whereas Madras appeared only to want the merchant's financial donations as no mention is made of shared responsibility in the running of the Madras Native Infirmary. However, in 1806, a list of elected Governors for the Calcutta hospital for the following three years does not appear to include any Indian names.⁶⁷ This may imply that the intention of Bengal Council to involve the Indian community in the management of the hospital, may have been only rhetorical, principally to encourage their financial donations. Alternatively, it could indicate that after an initial enthusiasm, or coercion, the idea of dispensaries, or even any joint funding of charity with the Europeans, did not accord with a Bengali idea of gift giving.

The Europeans were aggressive in their promotion of shared funding, and must have been largely successful as the two dispensaries at Benares and Farruckabad, already referred to in Chapter One, were only permitted after the 'great advantages which have been experienced from a similar institution at Calcutta', had been considered.⁶⁸ It is almost certain that the funding of the Calcutta institution would have been one of the prime considerations, although funding remained a matter of concern despite other dispensaries being opened in Calcutta and Murshidabad. Indians continued to be involved, however, and not just as providers of funds. A committee appointed to enquire into the feasibility of establishing a fever hospital in Calcutta, and other municipal matters, presented their report on 7 January 1840.⁶⁹ Of the nine signatories, four were Indian. Calcutta thus presented a picture of significant pro-active involvement by

⁶⁷ H.D. Sandeman, Selections from Calcutta Gazettes, Vol. VII, Calcutta, n.d., p. 420.

⁶⁸ BDesp., Public, 3 September 1813. Response from Court of Directors to request for Rs 150 per month to be subscribed for new dispensary in Benares. OIOC.

⁶⁹ Abridgement of the Report of the Committee appointed by the Right Honourable the Governor of Bengal for the establishment of a Fever Hospital and for inquiring into Local Management and Taxation in Calcutta, Calcutta, 1845.

the Indian community in the way that gift giving was performed. It also suggests a distinct move away from traditional gift giving practice. Lieut. Colonel W.H. Sykes, in a report on the Government Charitable Dispensaries of India, read to the Statistical Society of London on 15 September 1846, reinforced this point when he described the expected composition of new committees for proposed dispensaries. As expected there would be representatives from the judiciary, the civil surgeon, and the revenue commissioners who would have a voice when present. Lastly, he claimed, the 'committee might invite the co-operation of any native gentlemen'.⁷⁰ The promotion of co-operation between the Europeans and Indians in Bengal seemed to be tenuous at times, but nevertheless, even in the mofussil, the 'native gentlemen' appear to be wanted, even if only for their money.

The Indian population in Bengal Presidency adapted their tradition of gift giving and provided money, as at Madras, to help the sick poor, but also, as at Madras, the money was directed towards what were essentially English ideas of charity. As the century progressed, the fund raising, and methods of doing so, took on more of a European veneer. The wealthy and influential did not fund one hospital or dispensary on an individual basis, but united their money and time with the English, even if this was in a subordinate role. This they did through the very western medium of committees, chairmen, secretaries etc., with meetings and discussions about the methods of raising money, and the way that money would be used to benefit the dispensaries. The Bengal merchants adopted a more business like attitude to the whole process of gift giving, and this may consequently have led to the collating of dispensary reports in Bengal in this period, from which W.H. Sykes was able to derive his information. This was not the situation in Madras and Bombay. The substance of his lecture was on the charitable dispensaries of *India*, and he dwelt mainly on those in Bengal. He did

⁷⁰ W.H. Sykes, 'Statistics of the Government Charitable Dispensaries of India, chiefly in the Bengal and North-Western Provinces, Quarterly Journal of the Statistical Society of London, March 1847, p.1.

excuse his neglect, however, when he stated 'Of Madras and Bombay I shall say little, for there is little to say.'⁷¹

Bombay Presidency

Madras dispensary reports were published from the mid 1840s, but Bombay dispensaries do not appear to be reported on in the form of a collective annual report until 1853, although, it will be recalled, Bombay Native Hospital had to produce quarterly returns from 1809, and these were acknowledged in the Bombay Proceedings. A record of some description must have been made for Bombay Native Dispensary, otherwise James Farish would not have been able to report that there was 'an average of 130 cases seen a day'.⁷² We are only aware of the dispensary at Dhoolia because its existence was reported by H.R. Elliott, the Civil Surgeon at Kandesh, in 1837.⁷³ Dispensaries and small hospitals were operational for the sick poor in the Presidency, but because of the random manner in which the majority of them were introduced, excepting the hospitals at Surat, Ahmedabad and Poona, there does not appear to be any administrative procedure in place for the civil surgeons to produce annual reports. To some extent, the unofficial manner in which they were established meant that permission from London, which could take up to two years, was apparently never applied for. The financing of the units came from a general district budget, usually held by the judge; therefore the dispensary fund was not accountable as an individual item to be approved by the authorities in London, in the same way as the funds for the dispensaries in Madras and Bengal were. This could be viewed as counter-productive in the long term. The authorities were acquiescent as far as the continuing system of health care delivery was concerned, but this left no desire for expansion; an attitude of *laissez-faire* was unchallenged, unchallenged that is until the joint funding of Bombay Native Dispensary was initiated. The idea of a challenge even, may not be the right description, as reports suggest that the original aim of the committee may not have been to provide care for all Indians

⁷¹ Ibid., p.22.

⁷² Minute by James Farish, 4 April 1838. BC, 4 July 1838. OIOC.

who required treatment, unlike the dispensary at Dhoolia, for example. Nonetheless, whatever had been the original intention in opening the dispensary, its inception was *not* random. The authorities were involved initially in only a small way, but of interest are the people who were involved, the members of the Indian community in Bombay, and in particular the Parsi community.

The Parsis are followers of Zoroastrianism. Originally from Persia, they left in the seventh century to preserve their religious group from the influence of Islam. Many settled on the west coast of India and flourished as traders. They adapted to changing political and social structures, and as the economy increasingly became involved with European commerce during the seventeenth and eighteenth centuries, they developed partnerships with the Europeans, and often traded on their behalf. When Bombay evolved as the focal point for trade on the west coast, and Surat's importance diminished, a substantial number of them migrated to Bombay to take advantage of the opportunities that they hoped would materialize. For some families, their wealth and social standing were established during the eighteenth century, others maintained what status they already possessed, but in their newly adopted area. During this time powerful dynasties emerged prepared to trade and co-operate with the English, often on a more equal footing than that experienced by the traders and merchants in Madras and Bengal.

David White outlined the progress of a Parsi family who moved from Surat to Bombay, a family that was already established as traders and agents for the European community, but possibly the most notable and illustrious Parsi in Bombay in the first half of the nineteenth century was Jamsetjee Jeejeebhoy who came from a humble background. He was born in 1783, after his parents had migrated to Bombay from the Surat region. He entered a relative's business when he was sixteen, and began to digest the intricacies of trade. Eventually he commenced trading with China, initially in partnership with other traders and then on his own account. Part of that trade involved opium, which then was considered neither immoral nor illegal. In the first half of the nineteenth century he had amassed great wealth and he subscribed to the various Parsi charities in

⁷³ Letter to Robert Grant, 14 July 1837. BC, 4 July 1838. OIOC.

the manner described by David White and Jesse Palsetia; no doubt with the same intention of the Rustomji family, of creating an 'aura of honour'.⁷⁴ By doing so, he would be appealing to the Europeans as a man of generosity and influence, and thus would hope to encourage, maintain, and generate trade, and at the same time cultivate a higher social standing within the Parsi community. However, he, possibly more than any other Bombay merchant at that time, developed close alliances with the British in areas other than trade. He supported education in the city, which attracted charitable donations at a time when the hospitals and dispensaries did not. Possibly because of the way the dispensaries were begun and funded, they were not perceived as joint ventures by the authorities for example, whereas the support of schools and colleges was. His name is first associated within a medical context with the history of the Bombay Native Dispensary.

The dispensary was opened by Dr Mackie. George Buist described Dr Mackie as having established himself in Bombay, suggesting that he was a private practitioner rather than a company employee. Many of his patients were Parsis, and Buist claimed that Jamsetjee Jeejeebhoy and his family 'were the earliest and most constant of his friends'.⁷⁵ It is through this friendship, therefore, that Jamsetjee and other Indians became involved in the funding of the dispensary; this association was to continue for many years. It would appear that they held more authority than that enjoyed by their counterparts in Bengal and Madras, inasmuch as they formed a more robust component on the panel of the dispensary committee. For example, in 1841 the committee responsible for Bombay Native Dispensary was composed of six Europeans and nine Indians.⁷⁶ In 1853, although the president and vice-president were English notables, and the committee was much smaller, the Indian constituent was three to one European.⁷⁷ The government officially acknowledged the charity by allowing Rs 300 per month for its maintenance. The continuation of this allowance was threatened

⁷⁴ White, 'From Crisis to Community Definition', p.319.

⁷⁵ George Buist, Annals of India for the Year 1848, Appendix, Jamsetjee Jeejeebhoy Benefactions.

⁷⁶ The Bombay Almanac, Directory and Register, for the year 1842, Bombay Native Dispensary.

when Robert Grant decided to proceed with his plan for a medical college in Bombay.

The Committee formed to report on the surgeons' replies to Grant's survey had strongly recommended that medical education in a college, and clinical practice, were of equal importance. He himself had observed how an absence of hospital beds and patients had had a deleterious affect on the quality and content of medical education in the earlier school. In his report he noted their comments that 'all branches of Medical Knowledge be thoroughly taught, as they are in the Medical Schools of Europe' and that they proposed 'the union of the Medical School, with an Hospital for Natives, and a department for vaccination'.⁷⁸ Grant decided that the Native General Hospital would meet this requirement although it stood in great need of improvement.⁷⁹ As already shown, he therefore proposed transferring the Rs 300 a month currently given by the government to the Native Dispensary, to the Native Hospital as 'by the Dispensary it is not required, the liberal subscriptions of the community to that Institution having placed it beyond the necessity of depending on Government'.⁸⁰ It was at this juncture that Jamsetjee Jeejeebhoy made his offer to Grant to provide a hospital in Bombay

Prior to this there had been a feeling of unease among some of the British in Bombay, who were aware of the contributions to the dispensary by Bombay traders; they considered that the government grant awarded to the Native Dispensary should remain in place. James Farish diplomatically attempted to bring all the threads of the issue together and urged a note of caution. He acknowledged the importance of a dispensary practice being attached to the school, but highlighted the popularity of the existing dispensary, and the unpopularity that would arise if its funding were withdrawn. He thought that as dispensary funding would still have to be met:

it would be undesirable... to risk the diminution in any degree of the

⁷⁷ *Bombay Calender and Almanac for 1853*, p.268.

⁷⁸ Minute of Robert Grant, 27 March 1838, para 85. BC, 4 July 1838. OIOC.

⁷⁹ *Ibid.*, para 93.

favourable feelings which at present influences the classes which supply the patients who seek for healings; the Community who affords considerable pecuniary aid to the Institution; and the pupils who will first seek for instruction in the School.⁸¹

G.N. Anderson however, considered that the establishment of the proposed college should not be put at risk by any particular concerns for the dispensary, as he imagined that it would be made a branch of the proposed hospital (the improved Bombay Native Hospital), 'or...joined to the plan while it should be no separate cost to Government'.⁸² Jamsetjee in fact offered money towards the foundation of a 'Native Hospital in connection with the Dispensary', suggesting that this would be a separate institution but one which would complement the other. He displayed, in his offer, generosity combined with an astute business approach. He donated one lakh of rupees (100,000), provided 'Government will give an equal amount of capital, independent of its present subscription, to the existing Dispensary; and allow such a rate of interest say six percent on his donation as will produce an Annual Income in perpetuity, of Rupees Six thousand per annum'.⁸³ Ultimately he was to donate more than half as much again. The ethos of Bombay Native Dispensary was continued, as a unit, which provided its own annual returns, independent of, but within the larger Jamsetjee Jeejeebhoy Hospital. The Fourth Annual Report of Grant Medical College recorded that 'Many of the students have also assisted in conducting the duties of the Dispensary, for outpatients'.⁸⁴ The number of patients who attended within this period was 8,996.⁸⁵ By 1853, Jamsetjee was no longer a committee member of the Bombay Native Dispensary, but he had risen from being a generous component of a collective whose aim was to raise and maintain funding

⁸⁰ Ibid., para 94.

⁸¹ Ibid., Minute of James Farish, 4 April 1838.

⁸² Ibid., Minute by G.N. Anderson, 6 April 1838.

⁸³ Ibid., Letter to Robert Grant from the Committee of the Bombay Native Dispensary, 30 April 1838.

⁸⁴ GMC, 1849-50, p.6.

⁸⁵ Ibid., p.72.

of one unit, to that of a philanthropist who had given enough to have his name over the door. Jamsetjee can be said to have paved the way for others to follow.

Until the time of Jamsetjee's offer to the authorities, it would seem that the establishing of dispensaries and hospitals in Bombay Presidency had been put on hold, or merely forgotten. It could be argued that the authorities considered that they had done enough. But the opening of the much heralded Bombay Native Dispensary, and the discussion by no less a personage than the Governor of Bombay in the same period, on the value of western medicine in the cities and mofussil, must have driven the issue of dispensary and hospital provision to the forefront of public debate. Dispensaries in the past had been funded on a more local scale than would now be acceptable within the British community and the East India Company. Not least in importance because tighter financial controls were in place restricting the expansion of not only dispensaries, but also the curtailment of civic activities such as at the post office, previously referred to. The Company was in dire financial straits, due in part to mismanagement and fraud, and in part to the costly Burma war. Lord Bentinck was charged with making strict economies and by the time of the passing of the Charter Act of 1833 had had some success; the Company lost its trading monopoly, but remained the agency for British rule in India.

During this period there was a hiatus in the expansion of dispensary care, and the financial uncertainties may even have influenced the eventual closure of Bombay Native Medical School. A happy medium, however, would seem to have been reached with the opening of Bombay Native Dispensary, with a large contribution for the funding and administration coming from the Company's Indian trading partners, partners who were often visibly wealthier than the Company traders and administrators. It is likely that this was one of the reasons that James Farrish, the civil auditor, was reluctant to loose the goodwill of the Bombay supporters of the dispensary, which could have occurred. As an auditor, he, more than most, would have been aware of the need to maintain a system of co-operation between the merchants with money who had been compliant in funding one unit, to fund other units, which, with all the discussions about

western medicine then taking place, were likely to be required. Dissatisfaction with the way that monetary agreements could have been severed, and possibly a perception of high handedness in removing funding from a joint venture without consultation, could have been detrimental to the amity and thus the trading links between Bombay and European merchants. Without the funding, British efforts at promoting western values would have been put at risk. For both factions, 'saving face' and trade were important. For the future expansion of dispensaries and hospitals, it is therefore from this point that a foundation of understanding may have been reached. Indian philanthropy expanded, and spectacularly so throughout the century, but there were rewards for both, and honours for some of the philanthropists.

The Philanthropists

Jamsetjee Jeejeebhoy and his wife continued to support various charities for the remainder of their lives, many concerned with the European practice of medical care. Interestingly, a few years after his original donation for the hospital in Bombay, he approached the British authorities for support for a charity of his choosing and one specifically aimed at his fellow Parsis. It is a measure of his status, and generosity, and his mediating skills between the two communities, that he was awarded a knighthood, the first Indian to gain this award. Jamsetjee exemplified the observations of both Haynes and Palsetia. Haynes suggested that philanthropy, as opposed to gift giving, led traders to become involved in philanthropic activities espoused by the rulers which helped to stabilise social relationships within their own community, and with their rulers. Palsetia claims that charity was an important marker of their Parsi identity, and that their increasing wealth led to their charity being expressed beyond the confines of their own charities. Jamsetjee, in fact, took this concept a step further. He felt confident enough to apply to the British for support for a charity of his choosing, and he was considered important enough for the Court of Directors to agree to his request.

Jamsetjee was followed by others in Bombay Presidency, not all being Parsis. David Sassoon, for example, who was Jewish, founded a hospital in Poona, and Gokuldas Tejpal, a Hindu, in Bombay. Some of the philanthropists were women, not infrequently widows or daughters of wealthy businessmen, and their concerns were often related to the needs of women and children. Dispensaries and hospitals in Bombay city listed in the Bombay City Gazetteer shows that out of fifty-four institutions, twenty opened during the nineteenth century bear the name of a benefactor or the name of the person the unit was named in memory of.⁸⁶ Philanthropy was not just confined to Bombay Presidency, it also extended to the Princely States administered by Bombay. In 1875 it was recorded that throughout the Presidency there were forty-five civil hospitals, some of which would have been constructed by and named after a benefactor, others constructed and maintained by government, but that of 118 dispensaries, only nine were funded entirely by government.⁸⁷ The majority had joint funding, albeit in different degrees. This would suggest that although the wealthy philanthropists were still prepared to finance the larger projects, dispensaries in many instances were now the province of the smaller collectives, the circle of fundraisers being similarly structured to those described in Madras and Bengal, and Bombay Native Dispensary, or formally composed bodies such as the municipal councils. The committee member's aims and rewards are harder to quantify. At a local level, such as in small towns, the philosophy of gift giving as described by Rudner and Dirks, where caste, ritual and power were reinforced through the act of giving, may be more appropriate. But this does not lessen the benevolent act itself, and many benefited from the presence of the dispensaries when access to the larger city units would have been impossible. So from the tentative pioneers of the supporters of the dispensary at Dhoolia, to the better publicised Bombay Native Dispensary, and then to the grand gesture of Sir Jamsetjee Jeejeebhoy, the establishing and funding of medical facilities in

⁸⁶ Gazetteer Bombay City and Island, Vol.III., pp. 206-07

⁸⁷ BAR, 1874-75, Medical Relief, pp.243-45.

Bombay Presidency had taken a tangential course, from one of casual and gradual beginnings, to that of planned and regularly financed units.

Conclusion

This chapter has examined how the dispensary was a catalyst for change, and from two perspectives, medical education and philanthropy. The two were directly linked. From the early nineteenth century there were shortages of medical staff in Bombay for both the civil and military branches of the medical services. Although many dispensaries had been opened, they were nominally under the charge of the European surgeon in whose district they were located, but he in turn had to delegate work to members of the subordinate services, who were few in number and did not possess the necessary skills. Also, vast areas of western India had limited medical help, and poverty frequently restricted the availability of treatment for the Indian poor. Mountstuart Elphinstone, who had little respect for indigenous systems of medicine but a keen interest in education, thought that if suitable candidates could be found, Indians could be educated in the theory and practice of western medicine, and would then return to their home areas and set up in private practice. He considered that his scheme could be self-perpetuating inasmuch as the brighter students could then be employed to train other Indians. After much debate, Bombay Medical School was opened in 1826 but immediately ran into problems, and was consequently closed in 1832, at the same time as growth in dispensary numbers remained static. Education as such did not end however, but was carried on in an understated manner by the surgeons scattered throughout the Presidency, but of course there were no diplomas awarded, no recognition of their studies for the students, and therefore was not a viable vocation to enter by a reasonably educated man. When Robert Grant arrived in Bombay in 1835, he developed strong doubts on the efficacy of indigenous medical practice, and decided that western medical education for Indians was a mission worth pursuing. He compared the dissemination of western medical knowledge as 'the risen sun dispelling the darkness',⁸⁸ and thought that

⁸⁸ Minute by Grant, para 81. BC, 4 July 1838. OIOC.

‘the seeds of instruction sown here, will gradually propagate itself [sic] throughout the Presidency’.⁸⁹ To this end a circular was sent out to the surgeons employed within the presidency for their opinions. The majority supported the idea of a structured medical education.

Crucial, to Grant’s plans was the establishment of a hospital for clinical practice for students, as much of his ideology was based on the principles of European medical education, but to do this he had to reorganise the money that was already earmarked for hospital budgets. This could have left a very much reduced option, with little improvement on the situation that he had criticised for the demise of the first medical school in Bombay. Except for the funding of Bombay Native Dispensary, the government in Bombay had not previously been involved in the joint funding of a medical unit, unlike the governments in Madras and Bengal. It was at this point that philanthropy in Bombay, in the shape of the Jamsetjee Jeejeebhoy Hospital, was to change the landscape of hospital and dispensary funding in western India for the remainder of the century. Rewards there were for the philanthropic gentlemen in the shape of knighthoods, trade agreements, and perhaps, more equality in the day to day routine of living in the city. There were benefits for the communities that they represented also. Jamsetjee Jeejeebhoy Hospital had one ward reserved for Parsis only, and a glance at the origins of the medical students at Grant Medical College will show that lower-class Parsi inhabitants who had received an education, also benefited from the inflow of money. The fourth annual report of Grant Medical College lists 27 students in attendance that year (1849-50), of whom 11 were Parsis. In the tenth year, out of 38 students, 23 were Parsis, more than half. The true beneficiaries however, were the poor of western India who had somewhere to go when sick, and receive treatment that was free. Despite debates about the efficacy of western, Ayurvedic, or Yunani medicine, shelter, food, and a bed were probably reasonably potent healers, except in advanced or terminal cases of disease or severe trauma. For the philanthropists, the ritual of gift giving was being maintained, but the description had changed; shelters for the poor were still

⁸⁹ Ibid., para 100.

being provided, but simultaneously, medicine also. These acts of benevolence would, as in the eighteenth century, have reflected well on the communities of the donors, large or small.

A further consideration is the effect philanthropists had on the rulers, as they adjusted their gift giving to be more in tune with European ideas of charity. On the whole it was favourable. W.H. Sykes who nineteen years earlier had had nothing to say about the dispensaries in Bombay, was certainly impressed. He devoted a whole article, published in the Journal of the Statistical Society in 1867, on the sums provided by 'Native Gentlemen' for charitable and educational institutions.⁹⁰ He covered the years 1862-63, and confined most of his article to Bombay Presidency; many of the institutions listed are hospitals and dispensaries. He was not the only European to be impressed, Sir William Wilson Hunter observed in relation to Bombay, that 'a detailed enumeration of the princely benefactions for hospital purposes would fill many pages...It may be doubted if any city in the British Empire can boast of such a spontaneous and valuable addition to its charities within so short a period.'⁹¹

This chapter has shown how medical education and philanthropy were linked, via the dispensaries, and how, through that connection, medical services were able to expand mid-century. The 'humble' dispensaries that were opened officially or unofficially, in the first thirty years of the century, were a catalyst for change and improvement. Why then can the dispensaries and not the hospitals make this claim? Returning to my earlier description of the role and function of a dispensary, often described as hospitals in Bombay Presidency, but which were essentially small units with basic facilities were, by their very nature, cheaper to run and required less administration than the hospitals. They accommodated the type of patient and provided the level of care concomitant for the period; in fact they were a response to the perceived needs of the poor and homeless. The later larger hospitals, on the other hand, although gaining in importance, were more

⁹⁰ W.H. Sykes, 'Statistics of Sums Given by Native Gentlemen in India for Charitable and Educational Institutions and for Works of Public Utility', Journal of the Statistical Society, Vol.XXX, Part IV, December 1867, pp. 535-47.

costly to operate, and required greater supervision. What the dispensaries did highlight was the lack of manpower needed in the presidency, to staff, efficiently, even such small units as these. Because of the apparent ease with which they could be opened, and the way their funding was taken out of a general budget, they expanded more easily than did the hospitals, thus again emphasising manpower shortages. Despite the hopes of training Indians to practice western medicine, and for them then to return to their own towns and cities, the dispensaries were the only practical option to enable them to do this. Thus the dispensaries led to the idea of education, education required a base in which the practical aspects of medicine could be learnt, and the philanthropists provided the money for the base, and eventually, greater hospital structures. If the few hospitals prior to Mountstuart Elphinstone's, and Robert Grant's periods in Bombay had remained the only institutions, then medical availability would have been curtailed purely to the needs of the European population, army personnel, and the few Indians who approached their doors to be treated as out patients.

⁹¹ Sir William Wilson Hunter, Bombay 1885 to 1890: A Study in Indian Administration, London, n.d., p.326.

Chapter 3 - Expansion and Restrictions - 1850-1870

The previous chapter has shown that at the beginning of 1850 Grant Medical College was in its fourth year and the Indian-funded Jamsetjee Jeejeebhoy Hospital was established, complementing the institutions of longer standing, Bombay Native Hospital, and Bombay Native Dispensary. Other institutions were spread throughout the Presidency, largely funded by the government. By mid-century the merits of the dispensaries had had time to be evaluated, they were considered appropriate for the country and the economy. It is during this period that the dispensaries as identifiable institutions could be said to have come into their own. In the second half of the century European medicine and the dispensaries gained further support from the Indian monied classes, if not for their own ailments, at least as free places for the treatment of their poorer, fellow countrymen. Changes at this time were also affecting the civic infrastructure of the towns and cities throughout the Presidency. Municipal authorities were being formed, to levy rates and to distribute the income into areas expected, after guidance from the government, to be beneficial for the community, such as health and sanitation. To what extent the councils held substantial power is, however, debatable. Despite fluctuations, business retained its momentum, and the co-operation that had long existed between the Indian and European residents in Bombay Presidency remained. By the end of the decade, events in India threatened to strain this relationship, and the goodwill that had proved so decisive in the expansion of the dispensaries.

May 1857 was the beginning of what has become commonly known as the Mutiny, an uprising of the Bengal sepoys. Most of the sepoys in the Bengal army were from Oudh, not from the western regions of India; and much of the perceived justification for the Mutiny centred on their grievances regarding caste sensitivities and army discipline. In contrast, the Bombay Army was made up of men who came from many areas, including northern India, and from many different castes. The conflagration rapidly spread through northern India and was to continue for a further two years before the rebels had been truly routed and a

sense of relative peace prevailed throughout the country. Western India, and especially Bombay, escaped most of the turmoil; threatened uprisings in the Presidency had been quickly suppressed. The British, however, were left with a feeling of insecurity, and an impression that the certainty of rule was gone.

But there were other factors in this period that, although not as dramatic, were to influence the expansion of the dispensaries in western India, such as changes in the political policy of the government, and consequently in the administration of the Presidency. Some of this was aligned with questions of finance. The economy, following the Mutiny, was strained, and new means of raising taxes had to be sought. James Wilson, sent out from Whitehall to India as Finance Member and charged with reining in the financial debt, saw as a remedy financial decentralization. He proposed that local bodies be made responsible for roads and public works,¹ similar in fact, to institutions that were already in place in Britain. But there were already some local bodies like these in India too. By various acts that had been passed, Bombay had had a Board of Conservancy consisting of five members (including three Indians) who first sat in 1845,² but their authority was minimal. They were elected by the Justices of the Peace, but as Chandra Banerjee points out 'The introduction of the elective principle was little more than a formality, for the voters were appointed by the Government'.³

A general act was passed in 1850 which was to apply to the towns in British India enabling Municipal councils composed of the magistrate and some commissioners, to decide the mode of collecting funds.⁴ Thomas Metcalf, however, in describing the motivation behind the government's efforts to draw the Indian population into political and fiscal-decision making, especially after the Mutiny, takes a critical view of the whole proceedings. He suggests that the British, following the scare of the Mutiny, were anxious to mobilize support for themselves from within India, but that this backfired on them later in the century when they had to devise a 'political ideology that would at once accommodate

¹ Hugh Tinker, The Foundations of Local Self-Government in India, Pakistan, and Burma, London, 1954, p.35.

² Anil Chandra Banerjee, The Constitutional History of India, Vol. I: 1600-1858, Calcutta, 1987, p.341.

³ Ibid.

⁴ Ibid., p.343.

Indian participation in a public arena, and yet secure power firmly in British hands'.⁵ The records reporting the debates over the opening and funding of the dispensaries, during the 1860s, will show that this ideology was never far from the surface even then. Metcalf states, like Bannerjee, that municipalities had been founded in some cities in the 1850s and 1860s, but that they remained under the control of the district collector until Lord Ripon's local self-government acts of 1882.⁶ It could be argued that the incentives for constituting municipalities were more of a fiscal nature than political, with the municipalities carrying the responsibility for unpopular taxation. Metcalf aptly describes this situation when he claims that 'local bodies could raise local taxes, and so increase Government revenue while diffusing popular animosity'.⁷ The overall impression, then, is that the municipalities, although they could be counted as another facet of government administration, were in fact an ineffectual body, and this aspect will be illustrated in the examples that follow of applications for the opening of the dispensaries. This discussion will raise two issues, who were the dispensaries for, and who wanted them to be opened?

The Mutiny therefore, although only being but one part in the changing nature of government, did affect perceptions of sovereignty and the national economy. But the local economy also had a bearing on the future of the dispensaries (as indeed it had had in the past, the role of the local philanthropist being testimony to this factor). Part of this expansion is related to the role of the municipal councils, as suggested, but they too had to have money available within their budget to finance new dispensaries, as did individuals who also continued to make contributions to these institutions. Whether they did so through a desire for conciliation following the trauma of the late fifties, or were motivated by the same philanthropic ideals as those philanthropists who had given in the first half of the century, would be difficult to determine. The economy of Bombay was at times mercurial. For example, during the early 1860s the cotton trade did exceptionally well, due to the American Civil War. W.H.

⁵ Thomas R. Metcalf, Ideologies of the Raj, Cambridge, 1997, p.185.

⁶ Ibid., p.190.

⁷ Ibid., p.200.

Moreland and Atul Chandra Chatterjee estimated that the number of cotton mills in Bombay rose from ten in 1861 to over fifty in 1880, the industry also spreading to Ahmedabad.⁸ On the other hand, there were failures in the banking system. Some of the dispensaries opened in the 1860s were in the cotton-growing areas, and therefore their beginning could have had a direct connection with the success of the cotton industry; the dispensary at Gadag-Betgeri, which will be reviewed later, might be one such example.

Further expansion of dispensary numbers was seen in the princely states, where assorted legislation had led to the British holding varying levels of influence in their administration. At times conflicting influences would lead to an overlap of responsibility; at others the ruler had complete control. Many Scottish missionaries opened dispensaries in the Rajput states, and were given unobstructed freedom to do so. Indore in Central India appeared to maintain as many dispensaries after the Mutiny as before, although the Residency was abandoned during the Mutiny, and the history of the dispensaries there during this tumultuous period is unlikely to have been recorded, even if they had remained open.

So despite the, at times, perilous economy and changes in government policy, some of which were precipitated by the Mutiny, the dispensaries remained open and new ones came into being. The British would appear to have achieved a favorable balance between having the dispensaries as a medium for the transfer of western medical science to the Indian people (Elphinstone and Grant had intended this to be done through private practitioners, but the idea of using the dispensaries in Bombay had gained ground as the century progressed, especially following the opening of Grant Medical College) as well as a place of treatment for the poor, and, providentially for the British, partly financed by Indian contributions. It would seem to be an exercise with a happy ending. But the records suggest that this was not the case. Even with financial contributions from Indian sources, and Indian participation in the organization of the dispensaries by sitting on dispensary committees, the British authorities seemed to hinder at

⁸ W.H. Moreland and Atul Chandra Chatterjee, A Short History of India, London 1969, p.379.

times, rather than help, the expansion of the dispensaries. It may be that they found they were in charge of an idea that was taking on a momentum that they had not envisaged, and that even though money was being partly supplied from Indian sources, it was money that had to be matched by them. To try and control this expansion, the British laid down rules for the opening and running of the dispensaries, and appeared to change them from time to time to suit the interests of the government, rather than the Indian people. The rules were published in the Bombay Gazette, but the Collectors and the Magistrates in the districts were often unaware of these changes, and so proposals for new dispensaries had subsequently to be altered or abandoned. The opening of a new dispensary could often only proceed after considerable verbal and monetary fencing.

Dispensary Regulations

Rules had been in place to assist and control the administration of the dispensaries since they were first begun. The early regulations were mainly related to the amount of money that could be claimed by the surgeon for each patient, and the cost of medicines, often in unauthorized dispensaries. The government, in response to increasing interest in dispensaries, and no doubt wishing to regularize the position of the dispensaries and the level (or limit) of their commitment, laid down a new set of rules as a guideline. These were published in the Annual Report of Grant Medical College, 1851-52,⁹ and are listed under the heading of 'Charitable Dispensaries'. The rules first describe the kind of dispensaries acceptable at that time. There were three of these:- 1. Those for which the entire cost was defrayed by the communities by whom they had been established. 2. Those for which part of the cost was borne by the government and part by the community. 3. Those for which the entire cost was borne by the government. With regard to all three kinds of dispensaries, the government retained some measure of command. The first kind was under the sole management of a committee of its own, with the 'only interference' to be on points of medical duty, returns etc., by the Superintending Surgeon and Medical

⁹ GMC, 1851-52, pp.131-42.

Board.¹⁰ The second and third kinds were placed under the control of a local dispensary committee 'of which the following functionaries shall be *ex-officio* members:-Judge, Magistrate, and Collector, or their Assistants, and Civil Surgeon; in the absence of these gentlemen, the Mamlutdar, Moonsiff, Sir-Kharkoon, Muhalkurree, or other public functionary'.¹¹ Indians maintained only minimal influence over dispensaries.

These classifications were changed many times during the remainder of the century. By 1873, dispensary classification was as follows:- 1. Those whose expenditure was entirely defrayed by private endowment, but over which the aegis of government supervision had been conferred, and 2. Those which had been established, partly by government. This latter class was sub-divided into (a) those partly provided for by private endowment, and partly by Government under the rules of 1857 and 1861,¹² and (b) those partly provided for by government by grants-in-aid according to a population test (rule alteration of 1867) and partly by Municipal and Local Funds. For this amendment, a further codicil was added 'The Government contribution has to be paid to the administrators and the expenditure for all dispensary purposes, [and] is to be defrayed by the persons entrusted with the administration of the endowments according to...' (rules passed 4 February 1871 and 6 February 1872). Lastly, (c) the third class of dispensaries which were entirely supported by government, *but* 'these are either attached to civil hospitals or are simply dispensaries for out-patients'.¹³

Therefore, in the years between 1857 and 1873, the government had reduced their commitment to the dispensaries while yet appearing to encourage their development. The first class dispensaries remained unchanged, but in 1873 the 'aegis' of government supervision had been 'conferred' and the communities who financed the dispensaries of this class would now appear to have taken on a subservient role. The second class was dealt with in a like manner. Although there had been a division in the funding arrangements, the administrators who

¹⁰ Ibid., p.133, para 33.

¹¹ Ibid., p.134, para 34.

¹² See The Bombay Government Gazette, Thursday 13 August 1857, and Thursday 4 April 1861.

¹³ IMD, 1871-72, p.93

would be government appointees had overall control of the available money. This could at times lead to misappropriation of funds when other undertakings were considered of greater importance by the appointees who controlled the budget. For instance, in 1870, a request was made by the Public Works Department for a transfer of Rs.139 from the Civil to the Public Works Agency, for road repairs, out of a sum of Rs.52,514 provided for hospitals and dispensaries. A further request was made for Rs.220 out of the same fund for repairing a slab drain on the old Poona and Sattara (Satara) Road. Both requests were sanctioned.¹⁴ There are two points of interest here. One is that the requests for transferring funds from one budget to another, was approved by the Government of Bombay without reference to legal opinion, or to the Government of India in Calcutta, which suggests that by 1870 this was common practice for relatively small amounts of money.¹⁵ Secondly, the person who made the original request was cited as the Collector and Resident, Local Fund Committee, Satara, the person most likely to have been the administrator of the funds for the local dispensary. Such a close affinity between the two roles would always present the possibility, or temptation, for funds to be moved from one project to another as the need arose, leading to inconsistency when estimates for future needs were assessed and applied for.

The third class of dispensaries, following the second round of classification, by 1873 possessed a more distinct agenda. They were to be either attached to civil hospitals, possibly having the function of a trauma unit or out-patient department, whose funding would be merged with the funding of the hospital; or they were to be dispensaries for out-patients only, presumably with no bed facilities, so would be cheaper to run. It was recorded that in 1874 in Bombay Presidency there were 85 grant-in-aid dispensaries, of which 6 were government-funded, and 7 endowed. There were four unclassified.¹⁶ The greatest number was of those with joint funding but whose finances were under the

¹⁴ APGB, General Department, 1871, 11 January, Nos.103-104.

¹⁵ In 1859, an application for money to be provided for a dispensary out of Municipal Funds was referred to the Remembrancer of Legal Affairs, Bombay, for his opinion, see BC, 11 October 1859, and a similar clarification regarding a dispensary in Sukkur was sent to the Government of India. See BC, 25 November 1859. OIOC.

¹⁶ BDR, 1873-74, p.1

control of government representatives. Overall this represents an image of more disparate funding, but tighter financial control by the authorities.

In 1877 there was a further sub-classification based on patient numbers:- Class 1, in which patient attendance exceeded 10,000; Class 2, for 5,000-10,000 patients, and Class 3, below 5,000 patients. Under this classification, at the end of 1878 there were 19 class 1, 48 class 2, and 68 class 3 dispensaries.¹⁷ The large number of dispensaries in class 3 could be a discouraging sign if taken as an indication of the popularity of the dispensaries, but a look at the previous years figures signify an upward trend. On 31 December 1877 there were 13 class 1, 37 class 2, and 80 class 3.¹⁸ The overall number of dispensaries had increased by 5 from the end of 1877 to the end of 1878. There is no indication of the class related to funding that these new additions belonged to, but nevertheless, class 3, the dispensaries with patient attendance below 5,000, was the only classification to show a deficit, the other two classes having increased their number. Bearing in mind the other factors also involved in their classification, funding for example, the overall impression must be that dispensary patient numbers were increasing.

The classification of the dispensaries would seem to have only gradually evolved between 1851 and 1878, but by 1878 the differences had become more sophisticated. The individual tariffs set by the government were gradually to erode the original rulings, and offers of help in funding dispensaries, or pleas for new ones to be opened, were hedged in by various small changes in the rules, often involving the cost of only one part of the dispensary, rather than the whole. In the 1851-52 statement a detailed list of various permissible expenses were listed. For the first type of dispensary listed in 1851, the entire cost of which would be borne by the community, this ranged from the pay of the Sub-Assistant Surgeon and one or two apprentices. A contingent allowance was to be made available for support workers, vaccinators, and stationary. Medicines (both European and 'country'), diets, and rent (where the dispensary was not housed in a government building) were accounted for. For the second type, shared funding, the rules list the extent of the government's contribution, and the kind of

¹⁷ BHDR, 1878, p.1

accommodation that the community should provide, including recommended room sizes, layout, and furniture. The government promised that in the first instance it would provide all meteorological and surgical instruments.¹⁹ It advised that 'The number of in-patients to be under treatment at any one time is to be limited...to eight...therefore only the most interesting medical cases should be admitted...the accommodation should be chiefly reserved for the subjects of surgical operations and severe injuries'.²⁰ This directive suggests that at this time the authorities saw the role of the dispensary as an extension of the classroom for teaching instruction, not necessarily as a refuge for the sick poor, with 'uninteresting conditions'.

The instructions continued with advice to the inhabitants of any town desirous of establishing a dispensary of the first or second kind. Thus, they had to first approach the Collector, the Secretary to Government, General Department, or Medical Board. At the same time they had to give an 'intimation' of the amount of money subscribed. If they were seeking to establish a grant-in-aid dispensary they were permitted to request a particular sub-assistant surgeon, and the Government would nominate him to the appointment, safe in the knowledge that while ever they had some financial input, they would retain control of him. No such undertaking was given for an endowed dispensary, as this control would not necessarily apply to a surgeon employed in a private capacity. In many instances, the pledge could not be fulfilled even for grant-in-aid dispensaries. John Peet raised the issue of the shortage of medical personnel in the Annual Report of Grant Medical College of 1860-61, previously noted.²¹ His accurate observation is borne out by the way dispensary applications during the 1860s could be approved, but the applicants would at the same time be informed that there was no staff available.²² The lack of medical staff was not confined to the dispensaries; the army was also desperately short. F.S. Arnott, by 1858 a

¹⁸ Ibid.

¹⁹ GMC, 1851-52, pp.132-33.

²⁰ Ibid, p.133.

²¹ GMC, 1860-61, paras. 17-18.

²² See APGB, 396 of 1863. Dispensaries - no.749, 15 May 1863, regarding the opening of Joonere Dispensary, for example.

Superintending Surgeon with the Central Indian Field Force, noted that the regiments were short staffed with no cover being available during times of staff sickness. He further observed that the subordinates were as badly off as those in the regiments, and that after supplying staff to the Field Hospital at Jhansi and various Detachments into which the Force had been broken up 'I am able to supply only one apprentice to the wing of the Dragoons and he is sick and the 86th. has only one apothecary who is sick and an apprentice who has a sore foot...' ²³ Some of the shortages described by Arnott may have been directly related to the conflict of the Mutiny then taking place, but nevertheless this is an indication of the overall problem of a lack of trained men with medical knowledge.

The annual report of 1871-72 further outlines the changes in the government's financial contribution to the charitable dispensaries, and some of these changes were to cause confusion when applications were made for the opening of new dispensaries, especially in the time between one regulation being passed and the next. In 1857 it was decided that the government contribution be restricted to the 'pay of Sub-Assistant Surgeon, 2 Native medical pupils, and allowances of Rs.17 per month for contingencies'. By 1861 there was no allowance for contingencies. By 1867 the government was committed to paying a fixed grant, and by 1871 government contributions were on a fixed grant according to the size of the local population, and included a 'Payment system, for advice and medicine, [which had been] introduced and made applicable only to dispensaries established under the rules of 1867, and subsequently.' ²⁴ It was reported that this was an unpopular addition to the regulations. ²⁵ Supporting a dispensary could be a costly and uncertain venture irrespective of the source of the funding, and it therefore can be no surprise that the 1871-72 annual report lists only one dispensary that was fully self-supporting. ²⁶

²³ Second Letter Book of F.S. Arnott, Letter to the Secretary of the Director General Camp Chirgaum [sic], 28 April 1858. NAM.

²⁴ IMD, 1871-72, p.38.

²⁵ Ibid., p.39.

²⁶ Ibid., p.37

At this time, the government of the day was of a totally different character to that of the early century. More rules and regulations restricted government representatives, and those rules that they implemented were of a more countrywide nature than they had been previously. Better communications and transport ensured that the independence enjoyed by those in authority up until, perhaps, the decade 1830-40, when dispensaries could still be opened if a person or community was persistent enough, was now gone. Yet the government could not now back out of its commitment to the expansion of western medicine. To do so would have appeared as an admission that its 'brand' of medicine was not worth promoting, and also would have seemed to be a relinquishing of its acquired role of providing charity for its subjects. The dispensaries were in place, and were on the whole, popular. They continued to provide a haven for those who were sick and poor: where would these people have gone if the dispensaries were shut, or their operations severely curtailed? F.S. Arnott made an appeal in 1861 to the Principal Inspector General of the Medical Department, Bombay, for a dispensary to be opened in Mhow, for, as he pointed out, the nearest hospital for the civilian sick, the people from the Sudder Bazaar and strangers, was at Indore, too far away for them to travel to. The only medical aid that was available was in the Staff Hospital, which was quite inadequate for the numbers requiring treatment.²⁷ If the existing dispensaries were to close, or where a pressing need for an institution was not met, would the situation at Mhow become commonplace? The authorities must have decided that this was a possibility. Dispensaries continued to be opened, but the government did not make the task easy at times.

The opening of a dispensary in a particular district was frequently the result of a combined gesture between the Indian and European population. An offer would be made to the government, who would then negotiate a settlement. The council then had to show that it could fulfill its obligations. For example, the inhabitants of Belgaum had applied to open a dispensary there. They had been told that following the regulations of 1857, they had to provide the necessary

²⁷ Second letter book of F.S. Arnott. Letter dated 7 December 1861. NAM.

furniture and subscribe Rs.30 per month towards the expenses of the dispensary, and for European and country medicines. A Mr Dorabjee had offered a house for the dispensary. The Superintending Surgeon of the Southern Division reported that the inhabitants were prepared to fulfill the conditions, and the dispensary was authorized.²⁸ This institution was maintained as a dispensary for only a short duration, as it was reported nine years later that on 17 September 1867, a new hospital was completed and opened at Belgaum. This was due to the old one (the dispensary), being small and generally unsuitable; a common complaint about those dispensaries founded in buildings not intended for the purpose. It was now designated a hospital, its change in status probably related to its new workload, as the 'sick of the adjacent country, of the Police, and of the Staff of the Belgaum Garrison, are admitted here'.²⁹ In contrast, an offer of Rs 7,000 by Mr Maune D'Souza for the establishment of a dispensary of the second class at Oorum was turned down because the sum when invested would only yield Rs. 29 per month and therefore was insufficient to meet the expenses.³⁰

Occasionally, communities would join forces to ensure that the dispensary was opened. In 1862, Joonere Municipality proposed opening a dispensary, and was prepared to grant-in-aid the sum of Rs.500 out of the Municipal Fund. They were turned down because they were unable to raise the large sum for the establishment of a dispensary, presumably the initial cost of setting up the unit. However Mr Ovans, the 1st. Assistant Magistrate, later reported that he was delighted to inform the authorities that 'the matter has been taken up warmly by the natives of this district; and that contributions from the city, the District, the mission, Mr Dickinson, and myself, have been raised sufficient to establish a dispensary and keep it in working order for a year'.³¹ The dispensary was authorized but no sub-assistant surgeon was available to work there. It was, however, on a list of dispensaries in the annual report of 1871. A more ingenious method of persuasion was that shown by S.S. Gordon, 1st. Assistant Magistrate in

²⁸ BC, 22 June 1859. OIOC.

²⁹ BAR, 1867-68. p.245.

³⁰ BC, Index for 1858, pp.1950-54. OIOC.

³¹ APGB, no. 396 of 1863. Dispensaries – No. 749, 15 May 1863.

Charge, Dharwar, when he applied for a dispensary to be opened at Hubli. The government in this instance had stated that the money that was intended for the dispensary from the municipal funds could only be used if it was shown that it was at the wish of the ratepayers. Mr Gordon therefore circulated a paper outlining a proposal for the dispensary, asking only those who disapproved of the proposal to sign it. In the cut and thrust of what Gordon described as a 'large and most flourishing commercial town', it would have been a brave trader to enter his name on the circular. Gordon was able to claim that 'not a single person has offered the slightest objection to the project'.³² This request, however, was forwarded to the Legal Remembrancer, as described earlier. He in turn sent it to the Secretary to the Government of India.³³ In the meantime, the dispensary was 'permitted to be opened' and was also, like Joonere, still open in 1871.

The procedures for opening dispensaries, therefore, could be a complicated undertaking. Charity was needed on both sides, an attribute the government frequently seemed to be lacking. As late as 1876 an application to open a dispensary in Bansda almost failed because the government refused to supply the instruments for the unit. The opening only went ahead after the acting agent to the Governor, Surat, offered to pay for them.³⁴ Also, the dispensaries of the third class, those 'which were simply for out-patients' and would thus be cheaper to maintain, were not always what they seemed. W.G. Hunter, Surgeon-General of the Indian Medical Department reported that 'some dispensaries not furnished with beds, are yet credited with a certain number of in-patients; in such cases the patients, usually in urgent need of relief, supply their own beds and are generally accommodated on the dispensary verandah'.³⁵ Two years earlier, W. Thom, the then Surgeon-General, when appealing for 'an elected officer... [to be] appointed to superintend the dispensary system' claimed that 'Public charity, such a fruitful source of dispensary support in other parts of India, has never been invoked in this Presidency'. The newly elected officer's remit would be to make

³² BC, 11 October 1859. OIOC.

³³ Ibid., see memo of I.I. Lowndes, 7 July 1859, and letter from H. Young, Chief Secretary to Government, Bombay Castle, to Secretary to the Government of India, 12 August 1859.

³⁴ BGP, Medical, 1876-1878. 9 May 1876, No. 1448, and 23 May 1876, No. 1614.

³⁵ BDR, 1876, p.2.

the dispensaries 'less a burden to Government, and more beneficial to the people.'³⁶ But the examples given have shown that communities were prepared to open and maintain dispensaries out of the municipal funds, which they paid in to, but their requests were often thwarted on a minor issue. To put these issues into perspective, and illustrate the differences between applications, and the government's responses, three cases will be considered. The first illustrates how new changes in the guidelines were either misunderstood or unknown to the officials applying for permission to open a dispensary.

'A Dispensary at their own cost', Guduk

L.H.B. Tucker, Collector and Magistrate of Dharwar, in a letter dated 23 February 1863, and addressed to W. Hart, Revenue Commissioner, Southern Division, gave notification that the then Municipalities of Guduk and Bettigerry (now Gadag-Betgeri) wished to establish a charitable dispensary at Guduk subject to the Bombay Act II of 1862, and in accordance with the rules published in the Government Gazette, 10 August 1857.³⁷ Tucker pointed out that the two places were less than a mile apart, that both sets of municipal commissioners were prepared to provide and furnish a suitable building and defray the cost of medicines. He revealed that the funds of the two municipalities aggregated at about Rs.4,000 a year, and that they had estimated that the annual cost of a dispensary would be not much more than Rs.600. He added that both towns were flourishing commercial towns, but were much subject to epidemic disease and were far from any medical aid.

J.H. Grant, on behalf of the Revenue Commissioner, duly forwarded the letter for the consideration of government, adding that the magistrate had been requested to state what class of dispensary they proposed to establish, the answer being the second class. It was also explained that a sufficient supply of medicines would be provided, the house would be located between the two towns, although until one was built, a building in the Fort at Guduk would be used, and that a

³⁶ Ibid., 1873-74, p.5.

³⁷ APGB, no. 337 of 1863. Dispensaries - no.629, 25 April 1863.

house nearby could be rented by the sub-assistant Surgeon.³⁸ It would appear that every aspect had been considered and planned for.

On receiving the request for his consideration, the Principal Inspector-General of the Medical Department, N. Stowell, pointed out that the rules published in 1857 had been superseded by a further notification of government dated 25 March 1861.³⁹ It will be recalled that the 1857 rules stated that the government would pay for a sub-assistant surgeon and two medical pupils, and a contingent allowance of Rs.17 per month. By 1861 there was no allowance provided for contingencies. If therefore the municipalities desired to establish a Government Charitable Dispensary, Stowell estimated that they would have to provide an income averaging Rs.72 per month. The Rs.600 they had estimated to be necessary to run the dispensary was thus Rs.264 less per year than the expenses now quoted, and Rs.204 of that underestimate can be accounted for by the fact that no contingency allowance would now be provided by Government. Stowell, for some reason, offered what would appear to be an even more expensive alternative when he pointed out that if they desired to establish a 'dispensary at their own cost', they would further have to provide the pay of an assistant-surgeon and an apprentice, and the cost of the instruments. His offer would appear to indicate that he considered that they were able to do this, in other words they were affluent enough to take total responsibility for the dispensary. The municipalities were located in the cotton-growing areas, and this may have sustained his belief that the government need not be responsible for the costs of the institution. But as the municipalities had underestimated their first choice, it does not seem reasonable to assume that they were able or prepared to provide a greater sum; they had indeed stated in the initial application that they were seeking to establish a dispensary of the second class. He did, however, add that there was at present no sub-assistant surgeon available to take charge of the dispensary. Whether this factor related to his suggestion is also speculative, but it has already been noted that the government, as recorded in the rules of 1851, permitted those seeking to establish a grant-in-aid dispensary to request a

³⁸ Ibid.

particular surgeon, whereas those establishing an endowed dispensary had no such choice. However, although the magistrate had requested the services of a sub-assistant surgeon, he had not requested anyone in particular, and as there were no surgeons available anyway, there would have been little point in them opening a dispensary of the first class, unless they were able to procure the services of a surgeon not then in government employment.

Despite Stowell's suggestion, and the lack of an available sub-assistant surgeon, the dispensary in Gadag-Betgeri was opened. It was listed as one of two grant-in aid dispensaries in the Dharwar Collectorate in 1872, and one of eighteen overall in the Poona Circle. The opening at Gadag, however, illustrates that even armed with what the magistrates thought were the necessary qualifications for opening a dispensary, changes in regulations that they were either unaware of, or did not consider relevant to their application, could provide a stumbling block to the whole proposal without the persistence of the proposer. Stowell's counter-proposal also indicates that the surgeons in authority did not have a strict set of guidelines to follow, unusual at this time when regulations were increasingly being implemented in areas where previously a less authoritarian attitude had been the rule. The procedures followed in this instance does raise the question to what extent the authorities were committed to providing the dispensaries, was it merely rhetoric to foster good relations between Indians and the British?

A 'permanent dispensary', Pandharpur

The application to open a 'permanent dispensary' at Pandharpur, not only raised similar difficulties to those seen in the Gadag-Betgeri application, but also brought together two aspects of particular interest to the authorities, pilgrims and cholera. The means of funding the dispensary is also of interest in having a distinct link with traditional ways of gift giving, more associated with the medieval and Mughal periods than the latter half of the nineteenth century.

Cholera was a constant source of anxiety for the European authorities. The disease could have a devastating effect on whole communities, and did not

³⁹ Ibid.

differentiate between Indian and British, especially the British in the lower ranks of the army. The British had always feared the disease, and reports on the location of new outbreaks and the consequent mortality would be forwarded to the council, and thence sent on to London.⁴⁰ Cholera had supplied the impetus for much medical analysis, treatises being written on the virtues of various drugs, recording their costs and effectiveness. Epidemics also led to experimentation, with surgeons trying out a favoured drug, or particular combination. It will be recalled that Assistant Surgeon Arnott in Baroda in 1842 had run foul of the Medical Board in Bombay when he had bought supplies from an unofficial source, and worse, the prescription had not been one that was authorized.

The connection between religious fairs and cholera had also been noted. It was known to follow in the wake of a pilgrimage, and could spread, like a malignant tendril, to villages and towns visited by the pilgrims on their journey home.⁴¹ A serious concern for the citizens of Pandharpur was the after-effects of the disease once the pilgrims had left the area. The Collector at Satara, F.S. Chapman, used the threat of cholera and its impact on the city when he made his case for the proposal for a permanent dispensary. He explained that the city had a resident population of more than 15,000, but this was greatly inflated with the arrival of the pilgrims. There was, he claimed, a constant influx of visitors, but twice a year the population increased by more than one hundred thousand during the period of the main festivals. He noted that, in addition to the usual amount of sickness that would accompany such a large gathering, 'Cholera in a very virulent form almost invariably makes its appearance on the occasion of the two principal

⁴⁰ See Bombay Public Department 6 June 1821, response from the Court of Directors regarding report of 7 July 1819. OIOC. The Directors were 'gratified to learn' that due to the timely precautions taken, out of upwards of 24,000 cases of cholera, only 1,450 proved fatal. They added that the reports they had been sent were presented to the most eminent persons in the medical profession in the country. pp. 640-42. A report from the Medical Board, recorded in the Bombay Publications of 4 February 1824, draft 174, in response to letter dated 14 August 1822, from the Court of Directors, shows the number of casualties from the cholera epidemic between 23 May and 25 July 1821. In this instance out of 4,473 cases, 798 proved fatal. pp.266-67 Neither report indicates how these figures were calculated.

⁴¹ David Arnold, in Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth Century India, 1993, examines in depth the political, religious and moral issues raised by the association between cholera and pilgrimages, see pp.183-89.

Juttras or fairs. The mortality that annually occurs at Punderpoor [Pandharpur] from Cholera is very heavy...⁴²

Chapman further explained that Pandharpur was a considerable distance from Satara and Sholapoor [Sholapur], and was at the centre of a very large district, therefore a dispensary would be an asset for the surrounding country as well as the town itself. The situation of Pandharpur then, except for the funding, would appear to meet any criteria for the establishment of a dispensary; but this was not the first application. Chapman's predecessor in 1861 had also requested assistance with the opening of a dispensary, and must have used a similar argument. He succeeded in gaining the use of the old travellers' bungalow for the purpose, but its use was restricted. It was only to be open two or three times a year, possibly to coincide with the main fairs.⁴³

If the initial request foundered on the lack of funding, Chapman carefully expanded his argument to show that not only would a permanent dispensary be of great benefit to the community, but that the community were able, with help from government, to pay for it. He quoted from the rules set in 1857 that stated that the government would pay for a sub-assistant surgeon, a medical subordinate, and a contingent allowance of Rs.17 per month, and that they would supply, in the first instance, all surgical instruments. The community for its part would supply a suitable house, furnish it, maintain sufficient country and European medicines for the dispensary, and set aside a small sum for contingent expenses. He later added that should government not be happy with the plan of which 'offers have already been made to the Country at large', he would then suggest that the second scale of dispensary (1st. class) be established; that is that the community pay for the services of a 1st. Class Hospital Assistant, four menials, and a contingency fund of Rs.20 per month, the total costing Rs.1,080 per annum.⁴⁴ The collector

⁴² APGB, no. 299 of 1863. Dispensaries – no.588, April 1863.

⁴³ Ibid.

⁴⁴ Chapman's calculations refer to a dispensary of the 1st. class whereby the municipality would be responsible for the pay of a sub-assistant Surgeon (although his calculations are based on the pay of a 1st. class hospital assistant, and four 'menials' instead of two medical pupils). His estimate illustrates how a dispensary of this class would have been an impossible undertaking for the communities at Guduk and Bettigery whose combined annual income was Rs. 4,000. A dispensary 'at their own cost' would have claimed more than one quarter of their budget.

however pointed out that this option would put a strain on municipal funds as it was already paying out large sums for conservancy and sanitary arrangements; he hoped therefore that if this option were chosen, the government would pay for surgical instruments and supply free medicines.⁴⁵

The municipal authority, therefore, appeared to be following government instructions by allocating revenue for conservancy and sanitation projects within the city, imitating to some extent the local government initiatives in England. It was not until 1854 that John Snow in London showed that during a cholera outbreak in Soho, which had a particularly high mortality rate over a short period, only those who had obtained their drinking water from a pump in Broad Street contacted cholera. It was not to be until 1883 that Robert Koch discovered the *vibrio cholerae*, the microorganism responsible for the disease. But, in the meantime, prior to Koch's discovery and despite emerging evidence of the disease being waterborne, many in medical authority, including those in India, clung to the theory of it being airborne. Even before Snow's discovery of contaminated water from the pump in Broad Street, dirt and squalor were associated with cholera, and with other diseases such as typhoid that spread through crowded metropolitan areas. Because of this association, the municipalities in England and Wales were charged with raising revenue to keep the streets clean and remove all human and animal waste, following the passing of the Public Health Act and the Nuisances Removal Act of 1845. In India, the British had always maintained the idea that towns and bazaars were sources of disease, so that conviction, plus the publication in 1863, (the year that Pandharpur made their application for a dispensary), of the 'Report of the Commissioners Appointed to Inquire into the Sanitary State of the Army',⁴⁶ led to an even greater impetus to keep the towns and cities in a better state of cleanliness. The commission was set up to investigate the high mortality rate of the army during the Mutiny due to disease, especially cholera, rather than warfare, the conclusion

⁴⁵ APGB, no. 299 of 1863.

⁴⁶ The Commissioners findings can be seen in:- Report of the Commissioners appointed to inquire into the Sanitary State of the Army in India; with abstract of evidence, and of reports received from Indian military stations. H.M.S.O., London, 1864.

being that poor diet, lack of hygiene, dirt and poor living quarters were the main causes. Living conditions had to be improved for the army, and although the barracks were the primary focus, the army could not live in seclusion from their surroundings, therefore towns and cities had to be cleaner too. This in fact is what the authorities in Pandharpur were attempting to do. Did they then provide a dilemma for the authorities? Was the answer to put a strain on one budget, spent in an attempt to control the disease environment; or give more assistance to enable the municipality to provide a haven, and a place of confinement, for those suffering from these same diseases? The means of funding the dispensary at Pandharpur may have presented a middle way to providing the haven, without necessarily setting a precedent for other municipalities to follow. The government, which appeared to apply rules very strictly, would have been eager to avoid this situation.

Pandharpur Municipality had been assigned the revenues from a village, Shehgoan, which originally had been intended for the feeding of mendicant Brahmins. The Revenue Department, however, in 1860 had allowed the municipality to spend the income, as they thought best for the public good. The income averaged Rs.650 per annum, and had been accumulating since 1858-59.⁴⁷ If the government were prepared to allow the revenues of Shehgoan to be used for such a purpose (and the original idea had been that it was for charitable acts, as was the tradition), then no regulation regarding the amount of money that a municipality could make available for such an undertaking as a dispensary, would be breached. The government decided that the revenue from Shehgoan could be used in this way, but if the municipality wished to run the dispensary under the 1857 regulations, as the village revenues would be insufficient, the community would have to make up the deficiency. This they agreed to do.⁴⁸

The example of Pandharpur illustrates the seemingly parsimonious nature of the Bombay government of the day. The council was funding what was considered desirable by the government in allocating money to sanitation projects, which they were bound to do. A request to have some place for the sick

⁴⁷ APGB, 299 of 1863.

to go to, and a medical officer in the town, especially such a high-risk town, would seem a reasonable request to make. Requests had been refused in other areas when the municipality could not meet the expected contributions, so the village revenue did exert some influence. The government, however, could not be said to have met the authority half way. The municipality was informed that if it wished to retain the 'travellers' bungalow', it could be purchased from the government, using the proceeds from the accumulated revenues.⁴⁹

The last two examples, therefore, illustrate that despite the government's often heralded policy of promoting western medicine among the people, the people, on the whole, would be expected to make a sizeable contribution themselves. This conclusion is endorsed by Roger Jeffery who claimed that the government did not give medical services a high priority, although, significantly, he added that in some ways they were given a higher priority than in Britain where hospital provision was often of a charitable nature.⁵⁰ David Arnold noted that beyond providing basic institutions, the colonial authorities were reluctant to commit themselves. He also included the notion of charity when he observed that the funding of these institutions were to be left to public subscriptions and individual philanthropy.⁵¹ Charitable support, then, is raised by both Jeffery and Arnold, the one being an example of how dispensaries were financed in Britain, and the other suggesting that this is what was expected in India. It could be argued, in fact, that in this instance, not only the idea of the dispensary as a place of treatment for the poor was transferred to India, but also the idea of its mode of support. Mark Harrison placed the change in official policy in Bengal to 1870. He claimed that from that time the government sought to distance itself from the running of dispensaries, after the fortunes of landed gentry who had previously supported them, had waned, and that the government felt that the dispensaries should rely increasingly on local funds.⁵² Bengal, in fact, had largely sought

⁴⁸ APGB, no.386 of 1863. Dispensaries – no. 728, 12 May 1863.

⁴⁹ Ibid.

⁵⁰ Roger Jeffery, *The Politics of Health in India*, Berkeley, 1988, p.101.

⁵¹ Arnold, *Colonizing the Body*, p.247.

⁵² Mark Harrison, *Public Health in British India: Anglo-Indian Preventive Medicine, 1859-1914*, Cambridge, 1994, p.88.

Indian money from the onset, and would appear in 1870, to be endeavoring to ensure that its contribution was replaced by taxation. The conclusions of Jeffery and Arnold, I would argue, applied to Madras and Bengal Presidencies, but not to Bombay until the 1850s. From this point, despite the greater role of Indian philanthropy in medical institutions, the Bombay Government did seek to reduce its level of financial commitment. The last two dispensaries reviewed illustrate this fact, and as has been shown municipal authorities were shouldering a larger burden of health care costs, sometimes out of all proportion to the level of income generated by local taxes.

That is not to say that municipalities paid the largest sums. In 1874, municipal and local funds paid Rs.78,208 towards the running of the dispensaries in Bombay Presidency, and government grants amounted to Rs.1,36,681.⁵³ In 1875 that figure had risen to Rs.2,30,125, partly due to new dispensaries being opened. The total income for that year was Rs.2,140,663, a greater sum than the expenditure. The government's contribution was Rs.1,33,731; local funds Rs.24,491; municipal Rs.57,376; interest of endowed capital Rs.9,891; donations etc. Rs.3,643. Fees from patients and sale of medicine Rs.879.⁵⁴ In Bombay Municipality the expenditure on the Health Department which included the cost of vaccination and of maintaining Gokuldas Tejpal Hospital, a hospital originally financed by philanthropy, but whose running costs had to be paid for by the authorities, was Rs.6,78,707. This was out of a total expenditure of Rs.29,90,663, and was the highest overall budget.⁵⁵

Taking the figures above, and the fact that expenditure on health related projects in Bombay municipality were the highest in comparison to other budgets, the authorities would probably argue that their contribution was generous, and as every request for a new dispensary was investigated thoroughly, they would appear to want to put a limit on their contributions; this equally applied to the presidency as a whole. This is borne out by the way that regulations were changed, each change ensuring that their contribution was less than previously,

⁵³ BDR, 1873-74, p.2.

⁵⁴ BAR, 1874-75, pp.246-47.

⁵⁵ *Ibid*, p.102.

leaving the local councils to find ways to make up the difference. In the first Cambridge History of the British Empire, J.H. Lindsay gave a descriptive account of the early formation of local self government in India. He claimed that Bombay Presidency made use of General Municipal Act XXVI of 1850 to encourage the formation of municipal authorities in the district towns.⁵⁶ Later, Bombay Presidency passed legislation that would enable municipal funds to pay for dispensaries and schools.⁵⁷ The money would be largely from town duties, *octroi*, revenue raised from trade, from goods passing through the town or city, or sold in the markets. Following the Mutiny, when the conflict and disruption to commerce, among other factors, left the country almost bankrupt, the municipal authorities were also expected to find money for roads and public works. Therefore there are two points to consider; how much were the authorities permitted to spend on dispensaries, and given sufficient budgetary and executive freedom, would they have initially spent what money they had on opening dispensaries?

To a limited extent, autonomy would appear to have been gained by Indians in their becoming members of the local councils, but that could also be viewed as a hollow victory. Lindsay stated that in Bombay, following an Act passed in 1845, the work of conservancy was concentrated in the hands of a Conservancy Board comprising of two Europeans, three Indian justices elected by the body of justices, with the senior magistrate of police as chairman.⁵⁸ He claimed that this did not work due in part to poor accounting, but it will be recalled that Banerjee also pointed out that even those who elected the Board were appointed by the Government,⁵⁹ therefore independence in relation to decision making is questionable. It was not until 1865 that local government was of a more democratic nature, inasmuch as one where the ratepayers elected half of the members. The towns and cities outside of Bombay such as Pandharpur and Gadag-Betgeri did not attain the same level of democracy. In 1873 Bombay

⁵⁶ J.H. Lindsay, 'Local Self Government', in The Cambridge History of the British Empire, Vol.V. The Indian Empire 1858-1918, Cambridge, 1932, p.530.

⁵⁷ *Ibid.*, p.531

⁵⁸ *Ibid.*, p.524.

⁵⁹ Banerjee, Constitutional History of India, p.341

classified cities as those with a population above 10,000, and towns above 2,000. This classification had a bearing on their level of operations. Lindsay observed 'It put a large non-official element on the "city" boards and prescribed special conservancy work for these places. The "town" municipalities remained still in the hands of their presidents, the district officers, while even for the "cities" there were no elected members.'⁶⁰ Lindsay suggested that little changed with the new classifications, therefore the situation described must have been similar in the years that the approval for the dispensaries discussed was sought. Accordingly, dispensaries were only as important as the district officers deemed them to be, trade, and consequently roads, for example, may have taken precedence. If this was the case, the dispensaries would have to make do with what was left, and as noted earlier, might even have what funds they possessed, raided for expenditure on other projects.

The requests for the opening of dispensaries always came from the collector or magistrate, which would have been following the correct protocol, but of course this would not allow for any motions of dissent to be acknowledged. Tucker, the Collector and Magistrate of Dharwar, perhaps cared to show that there was no dissent by sending out his circular regarding the opening of the dispensary. The traders, however, which were not necessarily of the council, but who would have been expected to pay for the dispensary through increased taxes, were perhaps silenced by the alternative of having to actively disagree with the proposal. It can, therefore, be fairly said that the final decision on whether to apply for the opening of a dispensary, rested with the British official in charge of the district, with or without the support of the tax-payers, although of course it would be more advantageous for the successful running of the unit, if co-operation between all the members was obtained.

The second point is more difficult to quantify as we have no proof what preferences an unelected, and probably an unrepresentative body, would have shown in the distribution of the council's money. In previous years, certainly before the British began running their affairs, the revenue from Shehgoan would

⁶⁰ Lindsay, 'Local Self Government', p.531.

have been used for traditional 'charity', as it came from a traditional source and in the instance of Pandharpur, this took the form of feeding mendicant Brahmins. But it could be argued, the traders in Pandharpur, like the Parsi philanthropists in Bombay, would amend their ideas of charity so that they were more in tune with those who ruled them, and with whom they conducted trade. *Dharmshalas*, places for travellers and those without shelter, by tradition, were provided by the town and city councils that were in place before the arrival of the British; it therefore could be reasoned that the dispensary was just one step further in that particular genre, they provided shelter to those in need, *and* medical attention. As an act of modernisation, the council members may have elected to support a dispensary, and view it as a dharmshala with medical facilities, which in a town like Pandharpur, which suffered sporadic outbreaks of cholera, may have appeared more appropriate.

Newsary Dispensary

It would take four years of planning and subterfuge, beginning in 1859, before Newsary Dispensary was eventually opened. None of the difficulties of money, or changes in legislation that had bedeviled the opening of the dispensaries discussed were involved in the opening of this dispensary. The issue was more one of politics and power, or, confusion on the part of an old man who was unaware of the legal processes of the rulers that he dealt with. Jamsetjee Jeejeebhoy, the Parsi philanthropist who founded the Jamsetjee Jeejeebhoy Hospital, and provided money throughout the Presidency for various charities, had requested that a dispensary be opened in Newsary, the family town of his wife and himself. He was prepared to pay for the dispensary which it was estimated would cost Rs.8,823 to construct,⁶¹ but had put aside Rs.75,000 for its construction with the interest from the remaining capital to pay for its running

⁶¹ APGB, no. 2894 of 1859 (bound with the Proceedings of 1863). May 1863. Sum quoted in letter from H.W.B. Bell, Captain, Superintending Engineer, Surat, 24 April 1861, to the Chief Engineer and Secretary to Government, Public Works Department, Bombay, p.106.

costs.⁶² The problem lay in the situation proposed for the dispensary, Baroda, one of the Native States.

The state of Baroda was formed after the final defeat of the Peshwa in 1817. The Gujarati lands claimed by the Marathas were divided between the British and the Gaikwads. Baroda was one of many Native States, their territories often completely surrounded by lands dominated by the Company, and were at times fragmented. Alliances between the Native States and the British authorities varied. H.H. Dodwell claimed that in 1858 seven-eighths of the approximately six hundred states had relations with the Company's government that had never been defined. Many were tiny and insignificant, and no treaty or agreement had ever been necessary. Baroda, however, was one of the remaining eighth which did have a treaty. In effect, the treaty 'gave the Company wide powers of interference in the internal affairs of the state, besides transferring to the Company the control of external relations'.⁶³ The Gaikwar, therefore, ultimately had very little power. A Company official was always on hand to oversee the running of the State, and a military presence was also maintained.⁶⁴

Relations between the Gaikwar and the Company were often strained, but the ruling Gaikwar during the period that the Nowsary dispensary was being debated, had appeared to cause the Company little trouble. Khandrao Gaikwar succeeded his brother in 1856, after his brother died without leaving an heir. He had only been in power for one year when the Mutiny erupted. Some of the princes of India sided with the mutineers, but Khandarao Gaikwar remained loyal to the Company. G.B. Malleson, however, noted 'that his power of doing mischief was small, and his interests were bound up with those of the British, for the power of the Gaikwar could never have survived the fall of British rule.'⁶⁵ The Gaikwar must, on balance, have decided that the English were the most likely to succeed, unless by this period, the position of Gaikwar had become

⁶² Ibid. Letter from Jamsetjee Jeejeebhoy to Lord Elphinstone, 27 November 1858, pp.97-98.

⁶³ H.H. Dodwell, 'The Relations of the Government of India with the Indian States, 1858-1918', in The Cambridge History of the British Empire, Vol.V., 1932, p.489.

⁶⁴ F.S. Arnott, at the time of the cholera outbreak in 1842, was the Assistant Surgeon attached to the 18th. Regiment of the Native Infantry, at Baroda.

⁶⁵ G.B. Malleson, An Historical Sketch of the Native States of India in Subsidiary Alliance with the British Government, London, 1875, p.251.

totally ineffectual, and was beyond the state of independent decision making. Following 1859 and the cessation of hostilities, it was decided by the British that the princes and great landholders, including some who had fought against the British, should have a more prominent station within the new post-Mutiny society. This was in part a defensive mechanism of the British as the princes were seen as having a useful role as intermediaries between the British and the lower social orders in India, in other words, they were to provide an insurance of sorts, against another mutiny developing. The princes and landholders were currently seen as allies. Now under the Crown, rather than the Company, Dodwell states that, 'The princes were no longer looked upon as rulers driven by force into an unequal alliance. They had become members of the Empire...' ⁶⁶

Khandrao Gaikwar however, was not a skillful ruler. For example David Hardiman describes how the Gaikwar's efforts to increase the land revenue led to conflicts with the landholders in Baroda and the peasantry. ⁶⁷ It is within this context that the application to open a new dispensary at Nowsary must be viewed, as the state of Baroda was not always a settled, harmonious state. A Resident was in place to control over-zealous kingship, and the government would have been unwilling to place any credit for achievement on the Gaikwar which they may have considered undeserved. There may also have remained, in the years immediately following the Mutiny, a residue of disquiet regarding the ability of the British to maintain total control of the state of Baroda, a state that was vital to their plans for railway expansion.

On 5 March 1859, the Resident at Baroda, R.C. Shakespear, wrote to the Secretary to the Governor of India, regarding the wishes of Sir Jamsetjee Jeejeebhoy to establish a dispensary at Nowsary. As it was in the Gaikwar's territory, he had been consulted on the matter. The Gaikwar, in a *yad*, dated the 22 January 1859, and translated by the Resident, had stated that 'while conscious of the benefits to be derived from such an institution, and appreciating the liberality which has dictated the proposal [he] requested to be furnished with

⁶⁶ Dodwell, *Relations of the Government of India*, pp.494-95.

⁶⁷ David Hardiman, 'Baroda, The Structure of a Progressive State', in Robin Jeffrey (ed.), *People, Princes and Paramount Power. Society and Politics in the Princely States*, Delhi, 1978, pp.112-13.

some information regarding the site...quantity and quality of land...and stipulated that his jurisdiction shall remain unfringed'.⁶⁸ Shakespear then itemized, at length and in legalistic language, various hypotheses where cases might require adjudication and so involve the Gaikwar's sovereignty. This letter implies that the Gaikwar was very carefully safeguarding his right to rule within his own land, and the fact that it was sent to Calcutta, and was not dealt locally in Bombay, suggests that the Bombay authorities were looking for higher counsel. Before being sent on to Calcutta, the Acting Secretary to Government at Bombay added that 'Government are willing to send an Engineer and Medical Officer to determine the site...beyond this...nothing...appears to be necessary the Institution being a private charity'.⁶⁹ Officially, at this time, there did not appear to be any concern about the practicalities of the proposal.

On 12 December 1859, H. Young, the Chief Secretary to Government, Bombay, wrote to the Director-General of the Medical Board, and the Chief Engineer at the Presidency, and asked that they each name an officer for the duty of fixing on a site for the dispensary at Nowsary, and that they should direct their communications to the Resident there. He outlined the original intentions of Sir Jamsetjee, namely that he wanted the construction of the building to be in the hands of a government engineer, and that the institution be considered a government building and under its control. Young suggested that Sir Cursetjee Jamsetjee Jeejeebhoy (Sir Jamsetjee's son) be informed that despite the wishes of the now deceased Sir Jamsetjee, the government would find it impossible to carry out to the letter Sir Jamsetjee's wishes, due to the institution being in foreign territory. He said that the Resident at Baroda had been instructed to consider the institution under his protection, and reiterated the reasons given in B.H. Ellis's letter.⁷⁰ He added, however, 'If the Institution were planted in British territory *near* Nowsary, and not in that town itself (a contingency that seems to have been contemplated as possible by the late Sir Jamsetjee Jeejeebhoy) Government would possibly be able more fully to carry out the wishes of its venerable

⁶⁸ BC, 15 June 1859. OIOC.

⁶⁹ Ibid., letter from B.H. Ellis to the Secretary to the Government of India, 19 May 1859.

⁷⁰ APGB, 1859, No. 2894, but bound with those of 1863. May 1863, p.106.

founder.⁷¹ Jamsetjee Jeejeebhoy, in his letter to Lord Elphinstone had in fact requested that the locality of the proposed dispensary be selected by government 'it being borne in mind that it is desired that the building should be in or near Newsary'.⁷² In just over six months an answer had been found to a problem that had not been apparent at the beginning, nor the solution been noticed in the philanthropist's original instructions, before the Gaikwar had raised doubts about the proposal.

Curtsetjee Jamsetjee responded by declaring that 'my brothers and I, fully aware of the importance which our excellent father attached to the several conditions under which he made the proposal, are of opinion that it will be advisable to fix the site of the Institution *on British territory near Newsary* instead of in that town itself'.⁷³ He stated that, in consequence, the officers who would have to select the site should place themselves in communication with the Collector of Surat. The plans and estimated costs were ready in 1861.⁷⁴ The construction of the dispensary was completed on 10 February 1863, and the Chief Engineer asked whom the dispensary should be made over to. It was decided that as Sir Jamsetjee had stated that it should be considered a government institution, the official trustees therefore would be the Collector and Magistrate of the district, the Deputy Inspector of the district medical department, and one member of Sir Jamsetjee's family.⁷⁵ Three months later this offer to Sir Jamsetjee's family was accepted. The family also requested that the dispensary be put in working order, and when completed the Rs.65,000, which Sir Jamsetjee promised as an endowment, would be paid.⁷⁶

This last notification from the family may have influenced the apparent change of direction by Bombay Government, leaving them to find a means of bypassing the initial request to site the dispensary in the Gaikwar's territory. Considering that they were meticulous about paying as little as possible for the

⁷¹ Ibid.

⁷² Ibid., May 1863, pp.97-98.

⁷³ Ibid., letter to H. Young from Curtsetjee Jamsetjee Jeejeebhoy, dated 19 December 1859, May 1863, p.106.

⁷⁴ Ibid., letter from H.W.B. Bell, Captain, Superintending Engineer, N.C. Surat, 24 April 1861.

⁷⁵ APGB, no.116 of 1863, no. 188, 10 February 1863.

⁷⁶ Ibid., no. 406 of 1863, no. 760, 19 May 1863.

running costs of individual dispensaries, the chance of one that would cost them nothing may have been extremely tempting. There may also have been some fear that Khandrao, who was frequently short of money, may have been able to gain access to the endowment. Sir Jamsetjee, astute businessman that he was, may not have realized the political implications of his request, but had asked for government involvement. This may have been due to his close ties with Bombay government, or he may have anticipated that there would be problems with the district of his choice. If that is the case, it would appear that government also did not, initially, consider the political implications, and only when the matter had been considered, and the Gaikwar had raised issues of sovereignty, was it decided that although Sir Jamsetjee had wanted the dispensary to be sited in Nowsary, his other wishes, plus his suggestion that it could be near Nowsary, outweighed other factors. His sons concurred with the government, and the dispensary was shifted beyond the frontiers of Baroda. The dispensary was named the Victoria Dispensary, as Sir Jamsetjee had requested, and almost ten years later was the dispensary referred to earlier, as being the only one in Bombay Presidency that was self-supporting.⁷⁷

As an interesting footnote to the founding of the Victoria Dispensary, it is worth considering the following. In 1868 it was reported that Rs.22,842 had been spent on a road, half a mile in length, that had been constructed between Nowsary and the Victoria Dispensary at Kalliawaree. This work had been necessary because the road led through ground that was 'frequently overflowed to the depth of from 5 to 7 feet during the rains, necessitating a high embankment throughout its length, a bridge of three 25-feet spans, a 12 feet culvert, a barrel drain, and a dry rubble retaining wall, 700-feet long'.⁷⁸ The necessary works to make the dispensary accessible to the sick was, as stated, Rs.22,842 and thus cost Rs.14,019 more than the cost of its construction. It is unlikely that the ground did not exhibit problems of water-logging prior to the construction of the dispensary, therefore indicating undue haste in the opening of the dispensary once the

⁷⁷ IMD, 1871-72, p.37.

⁷⁸ East India Administration Reports, 1867-1878, Pt. 2, p.155.

implications of locating it in Baroda had been realized. The cost of the new road was met by Mr. Rustomjee Jamsetjee Jeejeebhoy, not the government.⁷⁹

Conclusion

The mid-nineteenth century, as far as the dispensaries are concerned, can be viewed as a distinct dividing line between the old philosophy of responding to need as need arose, and that of a more defined culture of rules and regulations. This was in part due to the after effects of the Mutiny from the late 1850s into the 1860s, but even prior to this, changing attitudes and the replacement of the 'old guard' with new members who, perhaps, did not share or contribute to the more relaxed government of old who promoted, or ignored, a climate of *laissez-faire*. The new order which followed the change from Company to Crown rule attached themselves to a more rigid structure of hegemony in their ruling of Bombay Presidency. The authorities in many respects, and the regulations they passed, became more anglicised. This can be seen in the way that local self government was brought into existence, a system in many ways based on the structure of the municipal authorities in England, but without their power. They were permitted to raise taxes for the improvement of their town or city, but were never in charge of the distribution of that money, and indeed appeared to have very little influence in any matters that would have taken up the time of a councillor in England. To what extent they would have put aside money for a dispensary in their locality, if left to their own decision-making without the influence of the Collector and Magistrate, is debatable, although as I argued in the case of Pandharpur, it may have been an option that they would have chosen.

The municipalities at that time largely replaced the philanthropists in providing the initial income and continuity to open a new dispensary, although philanthropists remained active in this area throughout the century. The dispensaries had also advanced beyond the boundaries of British India, into the Princely States. This was not a new situation: dispensaries in Indore before the Mutiny has already been mentioned, but after the mutiny, the Princes, in keeping

⁷⁹ Ibid.

with the ideas of their new status as Princes of the Empire, opened them in their principalities. The popularity of these institutions as an expression of charity in providing medical welfare for the sick and poor, and a visible means of doing so, meant that the government spent the second half of the century fighting a 'rearguard' action against their advance. On the one hand the British authorities continued in their desire to spread the 'benefits' of western medical science to the people, and the dispensaries were, they considered, one way to achieve this; on the other hand providing free beds and medicine for the poor and uneducated may not have been the avenue that they had intended to take to accomplish their ideal. The impression gained is that in an attempt to limit the number of requests to open dispensaries, which may well, in many instances, have been initiated by their own representatives in the towns and cities of the presidency, they put in place rules and regulations on the exact funding that was required to cover the costs of the building, instruments, wages, medicines, and contingencies. The first regulations, published in the Annual Report of Grant Medical College, were drafted to set standards in line with the new era of medical education and the expected rise in professional qualifications, a new era of medical delivery in fact. The regulations of the 1850s were probably viewed as being liberal, especially as the idea of local self-government was taking hold in the imagination of the authorities. As it was assumed that they would take on the responsibility of providing amenities for the local population, of which dispensaries would be a part if chosen, a regular framework for funding and administering these units would have been necessary.

But the rules were changed, and the changes were invariably to the advantage of government. The Collectors and Magistrates seemed unaware of the changes, or, they were worded in such a way as to be incomprehensible. The changes may at first glance have seemed insignificant. The contingency charges, for instance, no longer being paid for by government may have indicated to the collector that only a little more needed to be put aside, but the situation would often be presented as more complex. The collector at Pandharpur, it will be recalled, put forward his proposal based on offers 'which the Government had

already made to the country at large', and yet he was so unsure of their response that he offered an alternative proposal should his first proposal fail. Did the government assume that the councils could afford more? There was a surplus at Satara, but some of this was taken for road repairs. However, this raises the issue of who decided how much of the available money could be spent. Ultimately, the decision would rest with the government representative, the official who raided the surplus. Was there then covert pressure to keep spending to a minimum, even though there must have been an appraisal of likely expenditure, plus a sum set-aside for emergencies? But to take money away for road repairs suggests that there was more available than would have been necessary for emergencies. Many of the dispensaries, however, were in a poor state of repair; little money would appear to have been spent on their structural maintenance or basic facilities.⁸⁰

As government funding decreased, so their influence and control increased. Even when private funding was involved, the Indian input was marginal. Sir Cursetjee was only given a minor role in the administration of the dispensary at Nowsary, unlike his father thirty years previously, who had been an active member of the committee of Bombay Native Dispensary, a responsibility shared by other Indians. The government made the largest contribution to individual dispensaries, which would have been the cheapest to run, those with no in-patients, but insisted that others were adequately funded by the councils, or individuals. This was a complete change of attitude from that exhibited in the early century. In 1809 the dispute between Dr Dunbar and Mr Briscoe had been based on not what the government actually gave; in fact the government at that time was not totally aware of what it gave! The dispute was about the administration of that money. Following the dispute, the money had to be more accurately accounted for, but there was never any suggestion of the money being reduced or withdrawn.

It could be argued that in the intervening years the authorities themselves were more constrained. The Bombay of Mountstuart Elphinstone that to some

⁸⁰ BHDR, 1877. W.D. Hunter, p.vii, reported that there is 'room for improvement' in the condition of hospital and dispensary buildings. Of the dispensaries, a considerable portion are more or less faulty in some respect.

extent encouraged individualism, and was less concerned with applying to the Court of Directors in London to formalize the opening of the dispensaries, was now irredeemably altered. The increase of centralization of government and power, better transport, and communication links that led to the comparatively rapid transfer of information meant that their insularity was ended. The authorities therefore had to be more accountable, with closer scrutiny of their expenditure. The 'trickle down' effect would have ensured that this also applied to the municipalities.

The dispensaries could never be portrayed as the 'cutting-edge' of medical science, and their status was inevitably linked to that of the status of the medical profession. As the idea of professionalism in medicine grew, like the dispensaries in England, their clinical worth decreased. The British medical men were no longer in charge of individual dispensaries, but was one step away, supervising the Indian assistant surgeons who had taken on the role. Their supervisory role was often of a debatable nature, too, the superintendent making only occasional visits. Who then, was to be responsible for checking the dispensary returns? Municipal committees exercised, W.G. Hunter feared, 'but little supervision in this respect although it would seem to be an important part of the duties of these bodies'. He conceded, however, that fictitious entries in the dispensary registers were comparatively rare occurrences. He added that the Sanitary Officers also acted as a deterrent to the falsification of records, as they visited 'dispensaries when least expected'.⁸¹ The Indian sub-assistant surgeon, by comparison, was now considered second class, despite the early enthusiasm following the opening of Grant Medical College, for a new Indian medical profession. The position of the dispensary surgeon was kept at a modest level giving rise to dissatisfaction and a low retention rate. The surgeon's opinions will be looked at later. Overall, the picture is one of a medical institution, the numbers of which were expanding, but which would appear weaker and less important than it had hitherto been. This could have been a further factor to explain why the authorities, although eager enough to encourage their expansion, were equally as keen to see their own

⁸¹ BDR, 1876, p.2.

contribution decrease, and the Indian councils take on more of the financial burden.

These circumstances then illustrate why the municipal authorities encountered problems with their applications; they were encouraged to apply, but discouraged by the many hurdles put in their way. Minor deviations from the rules could ensure the failure of an application, as could the shortage of a very few rupees. The government took on almost the persona of a Jekyll and Hyde character in its handling of the situation. Their representatives in the cities and towns urged the councils to open dispensaries, their representatives in Bombay tried to deter them!

Ultimately, after the Mutiny, Bombay government had to limit its expenditure. One way of doing this was to restrict the amount of money spent on non-profit making undertakings, one area being that of dispensary provision. This is not to say that dispensary funding would not have been curtailed at some future date, as Bombay now considered that dispensaries for Indians were the responsibility of Indians, an opinion of long standing in Madras and Bengal. Despite this, they would not easily have abandoned the dispensaries entirely to Indians; they would have wished to retain a measure of control. The dispensary movement, nonetheless, could not stand still, therefore it expanded. The dispensaries remained relatively cheap, they were in place and used by the Indian poor, and the government could not, in essence, have withdrawn these facilities.

Chapter 4 – Diversification into the Workplace and the Mission Fields - 1855-1875

It has been established that from the 1850s, the dispensary movement began to gain fresh momentum. Dispensaries were being opened not only in Bombay City, but also further afield in the towns and cities of Bombay Presidency. Despite the problems of Nowsary, discussed in the previous chapter, other Princely states had, or were in the process of constructing dispensaries on their own lands.¹ Those promoting new enterprises in India, such as those involved in the road building industry, the bridge builders, and the railway constructors, were also adopting the idea of providing some health care for their workers, if not from any charitable impulses, then as an economic necessity due to the shortage of labour that followed the spread of disease through the work camps, or as a result of accidents. It was not always easy to attract people to the work camps, so labour was not always plentiful, and the time needed for construction was often also a commodity in short supply. The supervisors and contractors would therefore seek help in the shape of medical assistance from the government, or attach to a site an Indian surgeon who would move with the workers from one construction site to the next. This type of medical delivery would be via a dispensary 'without walls', but dispensaries were constructed, particularly in the later part of the century, and many became permanent, such as those provided by the railway companies for their employees.

The work-place dispensary was not an entirely new idea. At the beginning of the century, forestry workers in Malabar, a region of India then under the administration of Bombay Presidency, were attended by an assistant surgeon attached to the Conservator of the Forests.² It was considered that part of the time of the assistant surgeon, when not tending to the Conservator and his employees

¹ BAR, 1865-1866. Medical – For example, it was reported that in the Northern Division, under the Rajkot Agency, two dispensaries had been opened by Native Chiefs. Further, they were administered by pensioned hospital assistants, thus by-passing the problem of shortage of medical staff. pp.497-98.

² Notification of attachment of Assistant Surgeon Marshall to the Conservator of the Forests in Malabar. Signed Geo. Kerr, Sec. to the Medical Board, Bombay, 16 January 1809. BC, 1809. OIOC.

would be set aside to vaccinate the inhabitants of the forests.³ A dockyard dispensary was also long established at this time, its role in treating dockyard workers and seamen was highlighted during the confrontation between Dr Dunbar and Mr Briscoe in 1809. The later dispensaries, whether 'within' or 'without walls', thus had a precedent. They perpetuated a strategy that had been used to provide medical care for Indians, when it suited the needs of those in authority. Concurrent with the expansion of the workplace dispensaries was the growth in missionary medicine. The missionary dispensaries were a comparatively new occurrence in India, although the missionaries were not, having officially gained permission to preach there in 1813, a decision made by the Court of Directors following intense debate. The idea of dispensary practice in this period, therefore, took on a new, religious, dimension. Dispensaries became more specialized units. The functions of these establishments were adapted to suit the medium of the workplace, the requirements of the missionaries who sought to provide more than just medical care, and also, the needs of the women of India, whether within the walls of the mission dispensaries, or those provided by Indian philanthropy. The previous success of the civil dispensaries was considered a viable precedent on which to base other ideas of taking medical aid to the community.

The Dispensaries of the Workplace

Reference has been made to dispensaries, whether within or without walls, that were opened for those in government employment. It is important to consider those that were without walls as much as those that were within, as by the very nature of the forms of industry that they were attached to, their existence was frequently temporary, and the idea of the dispensary was often solely in the character of the surgeon and the medicine that he carried. The industries that used the person of the surgeon rather than the physical structure of the dispensary walls were often those associated with new technology, such as railways and

³ MSS Eur/D462. Letter from Francis Warden to Capt. N. Williams, Surveyor General, 1 April 1811. OIOC.

telegraph communications. But as with much of the new technology of the Victorian age, it frequently affected the infrastructure of the land. Canals were constructed to increase agricultural production, and new roads were built to give access into the interior and move the extra produce, and the products of industry. Labour had to be attracted to the work sites, and, once trained, it had to be kept relatively healthy. The construction works themselves frequently created unhealthy environments, thus increasing the likelihood of the spread of diseases such as cholera and malaria. Ian Kerr points out that the workforce employed by the railway companies was particularly susceptible to high levels of sickness and mortality.⁴ Because pay barely sustained life, often whole families were employed by the company, with wives and children supplementing the family income, and thus the railways gained even cheaper labour.⁵ But the price for the families was high. Living conditions were dire, and malnutrition was the norm, thus exacerbating the ill-health of the workforce.⁶

Jan Morris claims that 'The railways were the biggest capitalist enterprises in India...The companies were paternalistic in style...all over India stood monuments of their method...It might be one of the railwaymen's hospitals, or the Railway Institutes...'⁷ Morris was describing a time when the railways were already established, as they did by then provide hospitals and schools for the railway communities and their families, but their paternalism was not in evidence during the construction of the railway lines. Further, work was often contracted out, and the contractor's chief priority was profit, not the welfare of their hired labour. Railways were perhaps an extreme example of the connection between work and disease, but disease was not confined only to the railway construction sites. Other industries did not necessarily go to the same extent of providing hospitals and institutes for their workforce, as did the railways in later years, but they often applied to government for help in providing medical aid for their workers or the community in which the labourers lived. For example,

⁴ Ian Kerr, Building the Railways of the Raj, 1850-1900, Delhi, 1995, p.32.

⁵ Ibid., p.87-88.

⁶ Ibid., pp.160-61. Kerr here describes the mobility of disease, and the living conditions of the workforce.

public works were carried out at Kharagora (Kharaghoda) in the Ahmedabad district, where salt was produced, and where two collectors of salt revenue were based. As well as a salt office, superintendent's bungalow, guard house, etc., constructed for the government, a dispensary was added in the new village.⁸ As the Telegraph Department became more established, it too provided permanent medical assistance to its principal outposts. It was reported in 1864 that Dr Ponsonby Adair had been appointed Medical Superintendent of the Sub-marine and Mekran Coast Telegraph Establishments, thereby putting medical aid on a permanent official footing.⁹ In that same year, two dispensaries at Guadur and Fao were established by the department.¹⁰

Bombay Marine maintained medical aid on the ships and in the dockyard almost from its inception. The scheme to train Indians to staff the cruisers in 1802 has previously been discussed, and during the enquiry into the funding of Bombay Native Hospital in 1810, an Indian surgeon employed in the dockyard to deal with accidents and other medical complaints was one of those questioned by Dr Dunbar. It would appear that there was not at that time a dispensary within walls in the dockyard, as the man was questioned on the allowances that he was able to obtain from Mr Briscoe if he wanted to admit a patient into Bombay Native Hospital. In mid-century, a dispensary had been founded.¹¹

Roads and Railways

The operation of the roads and railways best illustrate the prevailing attitudes to health-care provision for the work-force. The road-builders' camps were probably of a more transient nature than those of the railwaymen, as the roads did not normally present the same engineering challenges as railway construction, and medical care was frequently provided on an 'as and when' basis. The construction

⁷ Jan Morris, *Stones of Empire: The Buildings of the Raj*, Oxford, 1983, p.134.

⁸ *BAR*, 1874-75, p.162.

⁹ PWD, Records of, no. 399, 1864. Letter from Indo European Telegraph Department, Bombay, 20 July 1864, to the Secretary of State for India, India Office, London.

¹⁰ *BAR*, 1864-1865, p.320.

¹¹ *The Gazetteer of Bombay City and Island*, Vol. III., appendix III, p.206. List of Medical Institutions shows that the Dockyard Dispensary opened before 1860, but only treated out-patients.

works were usually (from the 1850s) under the control of the Public Works Department, rather than contractors, and therefore requests for medical assistance could be applied for on a more formal footing, although requests were not always dealt with in a sympathetic manner. For example, the Chief Engineer of the Public Works Department asked, in 1863, for an apothecary or hospital assistant to be sent to the Executive Engineer, Kandesh, to attend to the men employed on the Nargaum and Burhanpur road. He was allowed a hospital assistant and a *small supply of medicine*.¹² A similar request for a hospital assistant for Satara met with the same response.¹³ The authorities appeared to agree that medical aid was needed, but the dispensing of medicine was to be restricted. The dispensary 'without walls' was immediately handicapped by the limited supply of medicines necessary to fight disease, or at least give relief to those suffering the effects of such severe ailments as malaria or cholera.

Responses to requests for assistance were not unlike those that followed municipal councils requests to open dispensaries – i.e. help was given, but only after it was ascertained that it was absolutely necessary. In 1857 the Executive Engineer in the Thana Collectorate applied for the services of an apothecary for workers on the Hassind and Thurdee road, where it was reported that there was a great deal of sickness. A 1st. class Hospital Assistant was appointed, and he was charged with reporting on the sanitary conditions of the workers and whether further assistance was needed.¹⁴ It is not clear, however, who decided what level of sickness required the services of a hospital assistant. The native assistant sent to Sholapur reported that 'although the general health of them [the workers] is not good, there is not much sickness amongst them'.¹⁵ He was later withdrawn as 'the sickness has greatly decreased'.¹⁶ Continuing sickness, or the length of time spent on a project, did occasionally merit a temporary dispensary. It was reported that two temporary dispensaries had been 'formed', one being on the Bankapoor and

¹² APGB, 26 January 1863. Memo from the Public Works Department, no. 39, 13 January 1863, reply 16 January 1863.

¹³ Ibid., Memo no. 38, 13 January 1863.

¹⁴ PWD, index of, 1857. Medical Aid, p.240.

¹⁵ Ibid., p.241.

¹⁶ Ibid., p.242.

Huryhut road in the Dharwar Collectorate.¹⁷ This dispensary was withdrawn the following year as the works there had been temporarily stopped.¹⁸

The railways present a different picture of dispensary provision, whether within or without walls, starting from virtually no provision at all, to the more permanent structures referred to by Morris. The railways had a greater and more dramatic impact on the movement of people and goods in India than did the roads, and more money was invested in them. The terrain was difficult and great engineering feats were required to build the lines. It is the engineers themselves, rather than the official medical records, that give a vivid description of the communities involved in building the railways, and the poor conditions in which they existed; in their reports they described the insanitary working conditions of the labourers and their resulting poor health.

The established civil dispensaries were involved in providing medical aid for sick workers if they were in the same locality. In Madras Presidency the Assistant Surgeon at the North Blacktown Dispensary, in 1854, claimed that the increase in attendance figures was due to 'wounds and injuries the latter chiefly owing to bruises and accidents on the railway'.¹⁹ But of course, many of the work sites were not located near towns, and yet they produced large, often temporary communities living and working in unhealthy conditions and in which a by-product of their labour was the eruption and spread of disease. J.R. Bell described the colony of Adamwahan in the 1870s as one as having temporary residences for a large staff, and this included two hospitals. He recorded the colony as having six thousand inhabitants,²⁰ but added: 'The staff will not appear large when the unhealthiness of the place is considered... one year, when a flood had broken into the place, one thousand labourers are believed to have died of pneumonia.'²¹ The two hospitals would have done little to alleviate the sickness of labourers in such great numbers, but at least there were two medical units, and the comments of the engineers may have been influential in their provision. Two decades earlier,

¹⁷ BAR, 1864-1865, Medical Department, p.200.

¹⁸ Ibid., 1865-1866, p.498.

¹⁹ MDR, 1854, p.11.

²⁰ ICE, Minutes of Proceedings, Vol. 65, 1881, The Empress Bridge over the Sutlej, p.257.

James John Berkley described railway work within Bombay Presidency, in particular that connected with the Great Indian Peninsular Railway Company. The Company's Depot at Byculla covered an area of 18¾ acres and included 'work-men's and engine-drivers dwelling houses'.²² He did not mention a hospital or dispensary. He did, however, explain the difficulties encountered by himself and the labourers when working on the Bhore Ghat Incline, and remarked that:

The peculiar difficulties on this incline are the unfavourable nature of the hot and rainy seasons; the fatal epidemics which dismay and disperse the people employed upon it; the lofty and precipitous character of the ground... the extensive and sudden slips upon the mountain sides... the scarcity of water; and the want of necessities and comforts for the men.²³

These two accounts, published in the official minutes of their professional body, may have influenced opinion regarding the necessity of medical aid in these working environments. Berkley's account, published in 1860 does not mention a hospital or dispensary, but Bell's, published in 1881, does. Berkley was involved in the construction of the Great Indian Peninsula Railway, but another company, the Bombay, Baroda and Central India Railway Company, did provide hospital care in the same period, as shown in the annual administration report for the years 1858-59. The report states that: 'The following incidental works have been undertaken by the Railway Company: a hospital at Kotrea; additions to the civil hospital at Kurrachee [Karachi], to provide for railway patients'.²⁴

The provision of medical aid probably fell within the boundaries of the three examples given. The length of time that construction gangs were intended to be on one site, and the levels of sickness involved, directed whether a dispensary

²¹ Ibid.

²² ICE, Minutes of Proceedings, Vol. 19, 1860, On Indian Railways: with a description of the Great Indian Peninsula Railway, pp.592-93.

²³ Ibid., p.595.

²⁴ BAR, 1858-59, p.423.

with walls, albeit a temporary construction, or a dispensary without walls was to be used. The Public Works Department did apply for new units to be opened, and closed, when necessary. In 1865 it was stated that provisional dispensaries at 'Bunkapoor and Kyga Ghaut were withdrawn, the works at these spots [have] been temporarily stopped, but that a dispensary at Parpoolee Ghaut was opened in December for the use of the Public Works Department'.²⁵ The report does not state, however, whether the dispensaries were connected with road or rail construction. I would argue, nevertheless, that the extent of the provision, as a whole, was insufficient, but what was provided was based on the principle of a dispensary, but without the permanence of a solid structure or a tradition of ongoing care for those in need.

The railways did provide permanent dispensaries and hospitals, once the railways had been constructed and towns were settled by those employed to maintain and keep the railways running. The railway companies must also have made use of the civil hospitals and dispensaries, where already established, as by 1874-75, the railways were, along with the municipalities, making a contribution to their running costs.²⁶ The report does not specify how these funds were distributed, but they may have been put in to a general fund to pay for staff members, or for those employed on the construction sites that were treated at the nearest medical centre; it could also have been for the occasional railway passenger. Juland Danvers in a government report published in 1875 said that in the years 1874-75 there were 796 accidents to trains, involving thirteen fatalities and seventy persons injured.²⁷ As he said that there were 24,553,620 ticket holders in the same period this could well be an underestimation, but he did add that 'Several deaths occurred amongst passengers in the carriages or at the stations'.²⁸ These, however, were not directly connected with the operation of the railways, but were due to 'diarrhoea, dysentery, fever, cholera, small-pox, heat apoplexy, sunstroke, etc.' He claimed that the deaths were due to people setting

²⁵ BAR, 1865-66, p.498.

²⁶ BAR, 1874-75, Medical Relief, pp.244-45.

²⁷ Report of the Secretary of State for India in Council on Railways in India, for the Year 1874-75, by Juland Danvers, Government Director of the Indian Railway Companies, p.12.

off on a journey when already ill, or even in a 'dying state in the hope of reaching home or a sacred spot'.²⁹ Those that were ill may have applied to the dispensaries for out-door relief, if not in-door, and so the money contributed to a general medical fund may have paid for the treatment for these railway travellers.

The government, during this time of industrial growth, would seem to have given as little medical assistance as possible. Surgeons and medicine were only provided in sufficient quantity to keep the men reasonably well so that they were able to complete contracts on time, but little thought was given to their welfare in the longer term. Once their lines were completed, the railways did attempt to amend the situation, but of course this was for their permanent employees, not the poor itinerant labourer and his family.

Missionary Medicine

The missionaries initially confined their activities to preaching and education. Medicine was often a minor by-product of their evangelical work. For instance, in 1826 it was reported that at Belgaum, a building had been erected 'for the reception of poor and diseased natives, where, together with medical and other aid, religious instruction is imparted'.³⁰ The building, near 'one of the mission schools', would appear to be an adjunct to the primary business of proselytizing and education. The institution was under the care of a Mr and Mrs Taylor, who were not reported as having any medical expertise, and was supported by 'charitable individuals' at Belgaum. The patients were known as inmates, and the end product of the institution may not have been just that of healing the physical ailments of the inmates, but to provide social welfare for the district, for, the report continued: 'this institution has nearly put a stop to mendicity in the place. Many, who formerly subsisted by begging, are now led to maintain themselves by useful labour.'³¹ This institution would not, therefore, fall within the

²⁸ Ibid.

²⁹ Ibid.

³⁰ The London Report of the Directors to the Thirty-Second General Meeting of the Missionary Society, usually called the London Missionary Society, on Thursday, May 11, 1826. Missionary Register, December 1827, p.55.

³¹ Ibid.

understanding of the role of a dispensary as described in previous pages, but could be described as a forerunner of the later development of missionary dispensaries which intermingled dispensing with preaching. Missionary medicine was not always acceptable to the mission societies themselves. Indeed some were openly hostile to the idea. Eugene Stock reported that as late as 1884 an article was published in the Intelligencer, written by Mr Gray, the Secretary to the Church Mission Society, which asked why 'an expensive medical agency should be employed in countries and districts where the ordinary missionary has free access to the people'.³² He did indicate, however, that 'if from inadvertence the Society had left untried, or had only partially tried, some part of mission machinery which growing experience had shown to be valuable, it [the Society] ought not to be slow...to rectify the omission'.³³ Following representations from the Punjab, it is recorded that a sub-committee was formed to consider the whole subject. One comment among these proposals was that the medical work should always be subordinate to the spiritual.³⁴

The Church Missionary Society was already behind the times when compared to other missionary societies, but Stock's account does illustrate the diversity of opinion within the missionary community as a whole.³⁵ The doctors and surgeons attached to mission societies had frequently been the standard-bearers in promoting missionary medicine; they considered that they could usefully utilize their skills within the framework of their religious beliefs. Support was canvassed from non-medical missionaries and those that formed the committees of the societies. Their appeals were couched in evangelical rhetoric, but the rhetoric was adapted to include the language of the medical world. Dr Cleghorn, a medical missionary in Rajasthan at the Punjab Missionary Conference of 1862-63, stated that 'The object of the Medical Mission is to win the affections and confidence of the people, in imitation of the example of the

³² Eugene Stock, The History of the Church Missionary Society. Its Environment, its Men and its Work. Vol. III. London, 1899, p.309.

³³ Ibid.

³⁴ Ibid., p.310.

Great Physician...³⁶ Dr Valentine, a medical missionary at Jaipur, said in 1873 that the role of the medical missionary was to be seen in the hospital and the sick chamber, and his work is done when he can dismiss his patient, convalescent in body and spirit...³⁷ But the medical missionaries themselves were not always in total agreement. John Lowe, a medical missionary and an ordained minister, who had worked for the London Missionary Society in Travancore, claimed that the primary function of the medical missionary was that of an evangelist. He said 'We emphasize this view of the medical missionary sphere and function; *first* and *foremost* must be his missionary qualifications, and from a missionary standpoint the success of his work must be estimated.'³⁸

The idea of missionary medicine did eventually infiltrate into the landscape of mainstream missionary philosophy, but it was a slow process. The physicians were employed initially to provide care for their fellow-workers and converts, but it was noticed that once established, they attracted the attention of the poor in the area where they were based, and when they moved away from the station, itinerating. However, the qualifications of the missionary were not particularly important, itinerating non-medical personnel were approached for help and medicine as much as the physician. The efficacy of the medicine was important, as was the advice given. It was not always successful, though, as many missionaries only had a rudimentary knowledge of medicine, and would have been of little use had the need for surgery arisen. At the Allahabad Conference of 1872-73, the Rev. W. Shoolbred, of the United Presbyterian Mission, Rajpootana (Rajasthan), described his experience of providing medicine for those he met on his travels. He said: 'In my first itineracies I had begun a little of what among ourselves we familiarly call 'quacking.'³⁹ He explained that he always had a small stock of quinine and simple medicines for his own use and that of the camp followers; but finding illness among the villagers he would treat them the best

³⁵ For a comprehensive overview of missionary attitudes regarding the use of medicine as a tool of evangelicalism, see Rosemary Fitzgerald, 'Clinical Christianity', in Biswamoy Pati and Mark Harrison (eds), *Health, Medicine and Empire*, New Delhi, 2001, pp.88-136.

³⁶ *Report of the Punjab Missionary Conference held at Lahore, 1862-63*, pp.107-8.

³⁷ *Report of the General Missionary Conference held at Allahabad, 1872-73*, p.192.

³⁸ John Lowe, *Medical Missions: Their Claims and Progress*, London, n.d., p.11.

way he could. 'The result', he claimed, 'was most encouraging in opening a wide door to the people's hearts.'⁴⁰ The experiences of the missionaries were but a reflection of the opening of the civil dispensaries, inasmuch as once a European base had been established, the sick poor appealed to them for medicine and advice. The need for a dedicated centre for these people to attend was often the motivating factor in opening a dispensary. The same principle applied to the missionaries, where it was also realized by those in the field, that a dispensary would provide a base where people, who would not necessarily be attracted to a non-medical mission station, would go, and often bring their relatives with them. This then was the beginning of the 'professionalisation' of the medical missionary, who no doubt would have considered his position more as a 'calling' or 'vocation'. Many of the physicians were members of the Edinburgh Medical Missionary Society (EMMS), including John Lowe previously mentioned. The Society was unusual in that it maintained a dispensary in Edinburgh in which their medical missionaries were able to gain the experience of providing dispensary care. This aspect influenced the way in which missionary dispensaries were started and run in India.

The Edinburgh Medical Missionary Society

The Edinburgh Medical Missionary Society was formed in 1841.⁴¹ It was not a religious organization, but its membership supplied physicians to many of the church-based missionary societies to which they personally belonged, predominantly the free churches of Scotland. It is atypical in that it was not affiliated to any one sect, was comprised largely of medical men, and their training ground was the charitable dispensary in Cowgate, Edinburgh. The society was formed to promote the work of medical missionaries, initially at home, but Cowgate dispensary eventually evolved from being a mission

³⁹ General Missionary Conference, Allahabad, 1872-73, p.205.

⁴⁰ Ibid.

⁴¹ The Society is still active today.

dispensary to a medical missionary training institution.⁴² Physicians were actively encouraged to join the Society. In 1849 a series of lectures were given to medical students, on the subject of medical missions. James Miller, who gave the introductory lecture, described how the Protestant Church could 'resolve to assume the entire Evangelistic character...' One way, he suggested to his student audience, was by 'becoming the dispenser of gospel blessings, not only to the people at home, but as speedily as possible to all the unenlightened nations of the earth'.⁴³ Miller was perhaps intimating to his audience that the dispensing of gospel blessings was of equal worth as the dispensing of medicine, and that the two roles could be equitably combined.

The Society did not confine its activities solely to India, and by 1870 was able to claim that it had medical missionaries in China, Madagascar, and Formosa.⁴⁴ In India, John Lowe was a medical missionary at Travancore, a station run by the London Missionary Society, and as already shown, he was a member of the EMMS, as was his successor. An EMMS member also ran a dispensary in Madras, opened in 1858 and partially funded by the Society. They were committed to paying the apothecary's salary, but by 1866 this responsibility had lapsed.⁴⁵ The Society did, however, send medicines to the dispensary. The EMMS were also represented in Rajasthan, and later, Bombay, and it is in these two areas that the missionary dispensary movement will be examined for its diversity, and the interaction between themselves and the supporters of the institutes; on the one hand the Princes of Rajasthan, and on the other the EMMS and a local committee of Bombay European notables. Finally, the influence of the civil dispensaries on the role of the missionary dispensaries will be assessed.

⁴² For a history of the EMMS, see W. Burns Thomson, Reminiscences of Medical Missionary Work, London, 1895. W. Burns Thomson was also the proprietor and editor of the Medical Missionary Journal, (MMJ) the source for much of the information regarding the medical centres examined in this chapter.

⁴³ James Miller, Medical Missions – An address to students. Introductory to a Course of Lectures on this Subject undertaken by Members of the Edinburgh Medical Missionary Society, Edinburgh, 1849.

⁴⁴ MMJ, September 1870, p.80.

⁴⁵ MMJ, February 1866, p.36.

The Princely States of Rajasthan

To some extent, the opening up of the Princely States of Rajasthan to medical missionaries would appear incongruous. Why would they welcome Christian missionaries and permit them to set up dispensaries in their states when many of them could well afford to do so, if they chose, without outside interference? Why did they not cooperate with the English authorities and admit, or contribute to, civil dispensaries, as in Indore for example? One reason could have been that they did not necessarily see the missionaries as infringing their sovereignty, as the Gaekwar of Baroda had felt threatened by the civil authorities of Bombay. They may have felt that they had more control over the situation, which they generally did. Permission given for a medical institution could just as easily be withdrawn. It was recorded in the Indian Medical Gazette in 1868 that the Maharaja had closed down the Medical School at Jyepoor (Jaipur) in favour of a School of Arts. An even greater loss was the closure of the Maternity Institution, which the contributor claimed not only provided a school for midwives, but had led to a decrease in the incidence of infanticide.⁴⁶ This action would probably have been keenly debated if the government in Bombay had held any influence, (and was not contributing any money so that there were no economies to be made), but the Maharaja was unhindered by any interference.

The two medical missionary enterprises to be looked at have one connecting thread in the EMMS, but their activities and long-term prospects are of a totally different nature. The medical missions in Rajasthan were made up of more than one station and dispensary. Although all the physicians were members of the EMMS, they worked under the umbrella of the Scottish United Presbyterian Church. Their first mission station was at Beawar, and this initially was run as a non-medical mission by the Rev. Shoolbred, the missionary who described his medical efforts when itinerating as 'quacking'. Dr Colin Valentine joined him as the station's first medical missionary, and he opened a dispensary close to Beawar at Nya Nugger in 1862. The fourth report of the United

Presbyterian Mission in Rajasthan suggested that the opening was expedited by an outbreak of cholera in the district.⁴⁷ Valentine appears to have been a man of 'character', even a man of 'resourceful character', occasionally causing anxiety to the committee back in Scotland. But he was also innovative and grasped opportunities to make money for the missions. For example, on his arrival at Beawar, he accepted the post of Civil Surgeon, and he was also appointed Medical Officer of the Ajmer and Mairwara Battalion. For these appointments he earned for the mission £240 per annum.⁴⁸ He also spread the idea in Rajasthan of the value of mission dispensaries, occasionally perhaps, unintentionally. It is recorded in the MMJ how in 1864 he had cared for the Raja of Ketri when he was ill. Three years later he again met with the Raja and learned that he had set up a dispensary in his capital, and had also, in the meantime, studied medicine.⁴⁹

In 1866, Valentine, who had been ill, travelled north to the Himalayas for convalescence. His journey took him through Jaipur. While in that state, he was invited by the Maharaja to treat his favourite Rani who was sick. Valentine's treatment led to a cure and the Maharaja invited him to stay and take over the medical and midwifery schools.⁵⁰ John Lowe claimed that 'Dr Valentine gained access, both for himself and his brother-missionaries to [sic] Jeypore, one of the most bigoted and exclusive strongholds of idolatry in Northern India...now a prosperous mission.'⁵¹ He remained there for fourteen years, covering the period, in fact, when the Indian Medical Gazette claimed that the two schools were being closed. Valentine later left for Agra where he was instrumental in setting up a medical school for converts. They were educated at the government funded medical school alongside other Indians, but they lived at the mission station, and worked and gained experience in the mission dispensary, a system similar to that practiced at Cowgate.

⁴⁶ Indian Medical Gazette, 2 March 1868, p.66. This report may not have been accurate (see the following account of Colin Valentine's work in Jaipur), but does illustrate the manner in which the Maharaja's decision (if not its morality) was unchallenged by the editors.

⁴⁷ MMJ, May 1866, pp.61-62.

⁴⁸ MMJ, January 1866, p.30.

⁴⁹ MMJ, January 1867, pp.25-26.

⁵⁰ MMJ, August 1866, pp. 83-85. Also Lowe, Medical Missions, p.26.

⁵¹ Ibid.

Valentine was not the only missionary who gained access to the princely states, but he was situated in a position where his personality, and distance from government, was an asset, and ultimately he may have brought some influence to bear regarding the admission of other medical missionaries in to the princely states of Rajasthan.⁵² He was able to use his political neutrality to the advantage of the missionary body he represented. It is unlikely that a physician employed by government would have been able to go so far with a similar venture, even if he had felt so inclined, and whatever progress that may have been made would inevitably have been constrained by layers of cumbersome bureaucracy. Valentine in the process appears to have ruffled a few feathers. His application to the Committee on Foreign Missions of the United Presbyterian Church for permission to remain with the Maharaja was granted, retrospectively, for one year only!⁵³ One of his successors at Beawar spent two days in Jaipur but only managed to see Valentine for a few minutes. However, he remarked, in a letter to Burns Thomson, published in the MMJ, that 'He [Valentine] lives in a house like a palace, and is himself quite a little king in the place'.⁵⁴

Money does not seem to have been a problem in the establishing of these dispensaries. Initially the missionaries had the support of the Free Church of Scotland with a network of fundraising agencies that they were able to draw on, and certainly in the case of Jaipur, Valentine's activities were supported by the Maharaja. In some instances, they were able to obtain funding, indirectly, from government. For example, a mission station at Indapur was short of medicines, but in 1865 the municipality voted to allow it Rs.300 for medicines, and it was hoped that in 1866 it would pay one third of the medical catechists' salary.⁵⁵ It will be recalled that municipalities at this time had little if any independence; therefore the funding must have had the approval of the government

⁵² Our Churches Work in India. The Story of the Missions of the United Free Church of Scotland in Bengal, Santalia, Bombay, Rajputana, and Madras. Consolidation and Growth, n.d. It is recorded in this work that Mission Hospitals were established in Ajmer, Nasirabad, Udaipur, and Jodhpur. Beawar and Todgarh are also mentioned but it is stated that the medical missionaries there were withdrawn. No dates are given. p.90.

⁵³ MMJ, September 1866, p.93.

⁵⁴ MMJ, February 1871, pp.23-24.

⁵⁵ MMJ, September 1866, p.94.

representative. In Madras in 1868, the missionary medical institutions (of which there was now three), were granted free medicines and instruments in return for a report being presented annually. No application had been made for the grant, and it had been approved by the Governor-in-Council, on the recommendation of the Inspector-General of the Medical Department.⁵⁶ Whether this affected their independence is difficult to assess, but in the long run, the dispensaries may have been enabled to stay open, unlike the dispensaries at Todgur and Beawar which would appear to have been closed down, leaving only non-medical personnel. This, of course, may have been due to staff shortages as much as money.

In Rajasthan, then, the members of the EMMS appear to have been able to gain access to the princely states and be there long enough to establish dispensaries for the ruler's subjects. They were funded by the church, the Maharaja, and occasionally by the government, with apparently more ease than a similar request from a civil dispensary committee in British India would have found. The members of the EMMS went to areas where the government would not have been welcome, and by this period, the government in any event would have been reluctant to fund medical care if they did not consider it their responsibility.

The Dispensary at Bombay

The medical mission to Bombay was not founded in the same way as that in Rajasthan, or any other station where the EMMS had been involved. In 1864, the EMMS was offered £1,000 for a mission to be opened in Calcutta, and an equal sum for one in Bombay, if like money could be raised by the Society. The sum was raised for Bombay but not Calcutta.⁵⁷ This offer came at an opportune moment for the EMMS, as they had considered the possibility of opening an overseas mission based on the principles of the Cowgate Dispensary and Training Institution.⁵⁸ These were that the institution be a local charity having an evangelical character, and that it would be a training institution for students and

⁵⁶ *MMJ*, August 1868, pp.82-84.

⁵⁷ W. Burns Thomson, *Reminiscences*, pp.154-55.

nurses.⁵⁹ The mission, the Society considered, would have the 'broad catholic basis of the society itself, unconnected immediately with any of the ecclesiastical missions, while it will be the friend and ally of them all...' ⁶⁰ The Society had decided to have 'foreign agents of its own', and Bombay would be 'the *first* foreign station taken up by the Society as *bona fide* and *exclusively* its own...' ⁶¹

Two differences, therefore, are immediately apparent between the Rajasthan projects and that of Bombay. The first is that of 'ownership' and consequently, funding, the second is that of location. The Rajasthan institutions, whose medical personnel were all members of the EMMS, were, however, run under the auspices of the Free Church of Scotland; the mission committee of the church was able to direct, to some extent, the expansion of the mission stations. They were able to do this because they provided the funding, unless their medical agents, like Valentine, were able to obtain funding from other sources. Their committee was also familiar with the ways and means of fundraising, and was supported by local fund-raising committees spread throughout the cities, towns and villages of Scotland, in fact wherever a Free Church of Scotland was situated. When they sent out their first medical missionary to India, they directed him to Beawar, where there already existed a mission post. Rajasthan, where Valentine moved to and was followed by other medical missionaries, could almost be described, in the context of western medical care, as 'virgin territory'. In other words, there was no competition from other sources. But Bombay presented a very different picture. The EMMS, after the initial £1,000 donation, decided to fund the institution itself, and base its activities on those of Cowgate, for which they also provided the funding; the dispensary in Bombay was to be sited in a city with a large teaching hospital, and existing dispensaries. The mission developed problems from the beginning as far as funding was concerned, partly due to the higher cost of property than had been estimated for, ⁶² and in the longer term, in

⁵⁸ MMJ, June 1867, p.65.

⁵⁹ MMJ, May 1868, p.60.

⁶⁰ MMJ, August 1866, p.87.

⁶¹ MMJ, June 1867, p.65.

⁶² MMJ, April 1866, p.56.

the wording of the agreements made by the EMMS before the institution was opened.

The surgeon appointed to head the mission, Dr David Young, had previously been Burns Thomson's assistant at Cowgate so he was well versed in the running of a charitable dispensary and training institution. The high costs of rents and living expenses delayed the opening of the establishment, but once open, on Girgaum Road,⁶³ its work rate rose rapidly. Money was raised locally, sufficient to open a hospital, which was additional to the dispensary. The hospital consisted of two wards, albeit in separate buildings, containing six and seven beds respectively, one for males and one for females. It was reported in 1869, however, that demand for beds had not been high.⁶⁴ The same could not be said of the dispensary. In 1868, 4,300 patients applied to the dispensary for medical aid. In 1869 that number had risen to 5,123.⁶⁵ Dr Young estimated that in the course of a year there were nearly twenty thousand visits; patients were only registered once, so their follow-up treatment was not recorded in the statistics.⁶⁶ Four youths were being trained by Young, who, it was hoped, would eventually be sent out to open smaller dispensaries. An unusual feature for this period was not only that Young undertook the training of nurses, but that part of their duties included home visits. Home visits however, were not confined to women. Any poor person within a 'fair distance of the dispensary' but unable to attend in person, would be visited by the superintendent and his students.⁶⁷

The description of the mission station and its activities give an impression of a successful enterprise, not unlike the one at Cowgate, but by 1870-71, the whole undertaking was under threat. In 1870, the MMJ announced that the Bombay Mission is 'No longer attached to the Edinburgh Society; or, in fact to

⁶³ MMJ, May 1868, p.60.

⁶⁴ MMJ, July 1870, pp. 54-56. Second Annual Report of the Bombay Medical Mission.

⁶⁵ *Ibid.*

⁶⁶ MMJ, March 1869, pp.45-48. One of the difficulties encountered in attempting to provide accurate statistics of patient attendance at individual dispensaries, civil and missionary, is the lack of information given about the methods of collating numbers. Unlike the statistics at this Bombay dispensary where it is made clear that the head count is based on first visits only, no such clarity is provided in other official dispensary reports.

⁶⁷ *Ibid.*

any Society.'⁶⁸ The problem related to that of funding. In 1866, despite the enthusiasm of the Edinburgh committee that the Bombay mission would be 'the *first* foreign station taken up by the Society as *bona fide* and *exclusively* its own...', they did not intend that they would fund it to the *exclusion* of others. Further, they had only agreed to employ Young as their 'agent' for three years, the employment to be extended only if the local committee in India did its best to relieve the funds of the EMMS.⁶⁹ The control of the mission by the EMMS expired in July 1869, and Young asked Burns Thomson to take charge of any contributions raised for the Bombay mission.⁷⁰ On 4 March 1871, Young's wife wrote a letter to Burns Thomson's wife, published in the MMJ, which revealed that he was ill, and had been ordered home. With regard to the working of the mission in his absence, she added that 'The medical members take the general superintendence of their part of the work, and the other members are to do all they can until David is able to return...'⁷¹

Unfortunately he was unable to return, but before he departed he was asked by the Bombay Medical Missionary Society that, once back in Scotland, he would request that the EMMS 'will take up the Bombay Medical Mission as a Mission of its own *i.e* assuming the entire control of its operations, and becoming responsible for it in the same way as the Free Church Mission or other Boards are responsible for their Missions in the Bombay Presidency.'⁷² The EMMS declined. The Annual Report of the EMMS of 1871 stated that the original sum raised and donated (£2,000) was only intended for equipping and maintaining the institution for three years. They had undertaken the responsibility of managing the financial affairs of the Mission and in fact had offered to pay one half of the superintendents salary out of the common fund 'if circumstances permit'.⁷³ In the

⁶⁸ MMJ, May 1870, pp.54-56.

⁶⁹ Ibid.

⁷⁰ MMJ, March 1871, pp.31-32.

⁷¹ MMJ, April 1871, p.40.

⁷² MMJ, August 1871, p.65-66.

⁷³ MMJ, May 1870, pp.54-56. In this article it was stated that this money had never been paid.

report it was claimed that there still remained a few hundred pounds still unspent.⁷⁴

A comparison between the two missionary enterprises has already been made apparent regarding the funding and organization. That of location has also been raised and both are pertinent to the problems of Bombay, not just as far as missionary medicine is concerned, but also in the wider context of the perceived need for providing dispensary care in western India. Some of the mission dispensaries in Rajasthan were able to gain funding from sources other than the Church: from the Rajas, municipalities, and occasionally the government. For example, the medical mission at Nasairabad was indirectly supported by government as the Mission Hospital was accepted as a bazaar dispensary, in lieu of one to be built by the cantonment;⁷⁵ this would have attracted the grants that would normally have gone with a dispensary. The Bombay Dispensary did not seem to gain any financial benefit in this way, not even to the extent that the Mission Dispensary at Nya Nuggar benefited from the Rs.25 per month subscribed by the citizens on the recommendation of a British military officer.⁷⁶ One reason could be related to a perception of need. The Rajasthan dispensaries were on the whole the only free medical aid that was available in those areas, and as I have argued, one of the attractions of the civil dispensaries was not just free medicine but also shelter, if it was needed. Bombay mission was one of many institutions within the metropolitan area. On the whole an argument could be made that there were never enough beds for the number of people requiring care, and yet the beds at the mission hospital were not fully used. Whether this was because patients did not object to the preaching if they could leave after their treatment, but would not wish to stay as an in-patient, is a moot point, but whatever the reason, the impression given to those who would have been likely to make a donation may have been that there was not the need for these facilities. The government was unlikely to assist with funding as they were involved in funding the civil dispensaries, and has been shown, did so reluctantly at times.

⁷⁴ Annual Report of the Edinburgh Medical Missionary Society, 1871, pp.10-11.

⁷⁵ Our Churches Work, p. 90.

They were also increasingly looking to the philanthropists for help; they were hardly likely to become the philanthropists themselves at this point.

The Bombay Mission also appeared to be reckless in its level of expansion, when no guarantee of money was forthcoming. The government may have considered the charity imprudent, and therefore would not want to be involved, even though members on the committee of the mission were some of Bombay's British notables such as James Douglas and Thomas Blaney. Further, Young's untimely illness cannot have helped as he appeared to be the driving force in its development. The attitude of the medical establishment may also have been a crucial factor, as they were frequently instrumental in directing final decisions on the subject of funding dispensaries, and some of them were antipathetic to the use of missionary medicine as a means of proselytizing. For example, a debate in the Indian Medical Gazette in 1874 began after an extract was taken from the Annual Report of Surgeon-Major Moore, Superintendent-General of Dispensaries and Vaccination for Rajpootana (Rajasthan). It is paradoxical that his report applied to the mission dispensaries in his area, as his argument could be equally applied to Bombay. He raised two issues. The first was that of using medicine and surgery as a 'lever, or stepping stone, to the so-esteemed more evangelical labour... It may be questioned if it be exactly right to take advantage of the pangs and pains of sickness to endeavor to change the patients religion...' ⁷⁷ His second point was that the missionaries were duplicating existing services. 'But I trust I may be excused in observing that at small places such as Todghur, Deolee, or even Beawur, it seems a pity that mission energy and money, should be unnecessarily expended in dispensaries when the existing institutions are quite sufficient for the wants of the people.' ⁷⁸

The first issue that he raised was taken up by those defending the medical missionaries, with others opposing. ⁷⁹ Moore's opinion however does not necessarily mean that his view was that of the majority, especially in Bombay.

⁷⁶ MMJ, May 1866, p.62.

⁷⁷ Indian Medical Gazette, 1 October 1874, p.264.

⁷⁸ Ibid.

⁷⁹ Ibid, pp.264-65, and also Indian Medical Gazette, 1 December 1875, pp.334-35, for example.

The second point that he raised regarding the duplication of dispensaries is interesting in that Todghur and Beawar were the two stations referred to earlier as having withdrawn their medical missionary. This could be an indication of the fate that threatened Bombay. Moore, in fact, had in mind small towns and cities, but there were successes, he claimed. For instance, he cited the missionary dispensaries in large cities, such as Ajmer where, in his opinion, there was scope for two dispensaries. So was this relevant for Bombay, a large city where there were a number of dispensaries? I would argue that it was and the argument rests on the under-use of the beds at the Bombay institution. The dispensary would appear to have been successful, therefore, Bombay at that time may have required the opening of more dispensaries to meet public demand, but not in-patient facilities. The idea of the Bombay Mission being modelled on that of Cowgate was worthwhile, but in practice it needed to be amended. With regard to civil dispensaries, the efforts of the missionary societies, in emulating their role, including the EMMS who had always used the medium of a dispensary as a means to reach the poor and unconverted, was an indication of the success of their existence, inasmuch that they appeared to the missionaries to be a reliable way of reaching the people. Unfortunately, as far as missionary endeavour was concerned, some of that need had already been met without the religious influence.

As a postscript to the fate of the Bombay Medical Mission which included not just the dispensary and hospital, but also the training institution, Young, in a letter to the EMMS asked for their help, and pointed out that 'If the E.M.M.S. cannot resume the responsibility of the Bombay Mission, the Bombay Committee intend to ask some other Missionary Society to do so'.⁸⁰ Even this declaration, however, was not as straightforward as it would seem, the Society's response would appear to suggest a different path. The EMMS in its Annual Report for 1871 claimed that 'several staunch and liberal friends of the cause in this country

⁸⁰ MMJ, August 1871, pp.65-66.

are making hopeful efforts to continue the enterprise, by establishing it on a firmer pecuniary basis.’⁸¹

The Dispensaries for Women and Children.

The missionary societies have been credited with playing a leading role in bringing health care to Indian women, by introducing women doctors, such as Clara Swain, a medical missionary with the American Methodist Episcopal Mission who set up in practice at Bareilly in 1869, and through the introduction, into India, of the zenana missions, the Church of England Zenana Missionary Society, a society formed in 1880, for instance. Maneesha Lal claims that ‘Women missionaries from the United States and Britain were in fact the first to become actively concerned with providing Western medical care to Indian women’.⁸² Another view is that of Mridula Ramanna who claims that ‘The colonial system of medicine had little to do specifically with women. There was the characteristic reluctance to intervene in matters concerning Indian women.’⁸³ A citation used by Ramanna illustrates another aspect to their claims. She quotes a Dr Rakhmabai as observing, ‘the strictly *purdahnishin* women patients were then absolutely unapproachable to the male doctor, but even the average Indian woman did not dream of showing herself to a man doctor for diseases peculiar to women.’⁸⁴ The point I wish to stress is her use of the phrase *average Indian woman*. If the average Indian woman is someone deemed to be in purdah, or with standards that meant she would not, or could not seek medical aid from a man (Indian or European) when all else had been tried, then I would suggest the description would probably refer to distinctions of class as much as caste.

Even in the first half of the century facilities were provided for women, although not in as great a number as for men. It will be recalled that the dispute in

⁸¹ Annual Report of the Edinburgh Medical Missionary Society, 1871, p.11. (I have been unable to discover the eventual fate of the Bombay Medical Mission Institution).

⁸² Maneesha Lal, ‘The Politics of Gender and Medicine in Colonial India: The Countess of Dufferin’s Fund, 1885-88’, *Bulletin of the History of Medicine*, 68 (1994), p.32

⁸³ Mridula Ramanna, *Western Medicine and Public Health in Colonial Bombay, 1845-1895*, New Delhi, 2002, p.182.

⁸⁴ Ibid. Citation taken from Margaret Balfour and Ruth Young, *The Work of Medical Women in India*, London, 1929, p.35.

1809 in Bombay, was started because of the non-admission of a *woman* to Bombay Native Hospital, the argument being that she should have been admitted. Of course the women, like the men who applied for medical aid, were of the poorer classes, so the poorer women, like the men, had to seek what care they could. The dispensaries were free, and would provide shelter if it was needed.

So what dispensary facilities were provided by the authorities regarding the health care needs of Indian women? In the dispensaries of the three presidencies, beds were provided for women, but some were underused. In the Madras Presidency, the Assistant Surgeon at Mangalore Dispensary decided to open a lying-in hospital, which he said would be separate from the dispensary. He hired a building, engaged a 'competent nurse and other attendants', and placed it under the care of his Indian assistant surgeon, P. Moonesawmy. Despite his decision to allow the women 2 annas a day out of the subscription funds he had in hand, he noted 'I am very sorry to say not the *slightest* advantage was taken of the institution...after two months I gave the matter up'.⁸⁵ In the same year, Surgeon A. Goodall, based at Secunderbad Dispensary, had a bed capacity problem in reverse, a shortage of female beds. He reported that the increase in in-patients in the last half year was chiefly due to the number of females. The erection of a separate building, he continued, had, since the last report, been completed. It was to accommodate 40-50 patients, and was to be appropriated for the reception of females.⁸⁶ Occasionally there were problems when women with sexually transmitted diseases were put in the same ward as those women who had other ailments. Three years before the reported shortage of beds at Secunderbad, a change to the female ward at Vepery Dispensary was proposed by Assistant Surgeon Cleghorn. This was not to enlarge the existing facilities as at Secunderbad. 'I would beg to suggest that the female ward be divided by a partition...one for the more respectable classes, and the other for venereal patients, whose presence...continues to prevent poor but respectable females

⁸⁵ MDR, 1854. Report of Mangalore Dispensary, by Assistant Surgeon B.S. Chimmo, p.35.

⁸⁶ Ibid., Report of Secunderbad Dispensary, by Surgeon A. Goodall, p. 48.

becoming inmates of the Hospital.’⁸⁷ The women who, if there had been one available would have been coerced in to entering a lock hospital, were considered as second class in-patients in a general female ward; it was therefore considered appropriate for them to be kept apart from the ‘respectable females’.

Bombay appears to have accommodated female patients from the early century, as already shown, and this factor did not change. Surgeon McLennan in 1834 requested that he, too, partition a female ward, at Bombay Native General Hospital. By retaining the existing male ward, and using a further room then used as a consulting room, he would achieve four separate units. He wished to do this because numerous patients, male and female, were admitted with diseases of an ‘offensive and loathsome condition’, and he wished to segregate them from the other patients. This would appear to be a request based on clinical necessity, an attempt to keep infection rates to the minimum. His request however highlights the continuing policy to maintain beds for female patients. The numbers of women and children visiting the dispensaries increased throughout the century, as did the units for them to attend. Charles Morehead reported, in 1852, the opening of a separate dispensary for women and children at the Jamsetjee Jeejeebhoy Hospital,⁸⁸ and in the following year, it was estimated that in the Malwa Medical Institutions, there had been an increase in that year of women and children attending the hospitals and dispensaries, from one third to two fifths.⁸⁹ Just over twenty years later, the Malwa dispensaries were also making changes to accommodate the female patients that attended. At Indore Hospital, it was so organized that patients were admitted into the dispensary separately, from the waiting to the prescribing room. They would then take their prescription through to the compounder in the dispensing room and receive their medicines. ‘This arrangement is especially valuable for women, as it prevents any pushing or scrambling for admission or medicines, or any contact with the male patients

⁸⁷ MDR, 1852. Report of Vepery Dispensary, by Assistant Surgeon Cleghorn, M.D., p.12.

⁸⁸ GMC, Sixth Year Session, 1851-52, p.40.

⁸⁹ Report on the Malwa Medical Institutions for the Official Year 1852-1853, by E. Impey, Residency Surgeon, Indore. The dispensary figures however account for only slightly less than one-third of those attending, and of these the largest number were those of children under 14 years, which was reported as 23,371, p.4.

whatever.⁹⁰ Two years later, in Bombay Presidency, the dispensaries had 454 male beds, and 224 female, just over half the total number.⁹¹

In the last twenty years of the nineteenth century, and beyond the period of this thesis, male philanthropists, and sometimes their female relatives, who had provided funds to open hospitals and dispensaries in Bombay Presidency in previous years, were to provide funds to open medical institutions specifically for women and children.⁹² Other concerned individuals set up committees to raise money to staff and open women's hospitals and dispensaries, such as the Medical Women for India Fund, whose committee members included Europeans and Indians, such as Sorabji Shapurji Bengali, and also an American, George Kittredge.⁹³ Later again, the secular organization, the Lady Dufferin Fund, was founded. What was common to these efforts, and set them apart from previous attempts to provide care for women, is that they sought to provide care for women by women. It is at this point that it can be seen that both Lal and Ramanna were correct in their statements regarding health care facilities as provided by the authorities, when compared with that provided by the mission societies as claimed by Lal, and other institutions as described by Ramanna. But it would not be strictly correct to say that Indian women were not catered for. The government did not specifically target women, but they did provide a measure of care for the women of India, but not in the format that many Indian women would consider acceptable, certainly those women who were not destitute.

The role of missionaries in caring for, if not attracting women to their doors, introduced this section on women and children's health care facilities. The missionaries began to take a particular interest in women's health in the second half of the century. If the dispensary at Bombay was typical, their interest can be charted from the 1860s, but it does not appear, at this stage, to be intended as a distinct missionary plan, in fact it was initially on a small, almost casual scale. For example, it was claimed that in the early seventies, a Miss Forrest and a Miss

⁹⁰ Indian Medical Gazette, 1 December 1875, Report of the Malwa Dispensaries for the Year 1874, by Surgeon-Major T. Beaumont, p.320.

⁹¹ BDR, 1876, p.2.

⁹² Ramanna, Western Medicine, 2002. See chapter 6, 'Facilities for women', pp.182-207.

Pattison, both members of the Presbyterian Church of Ireland, after a special course of training in tropical diseases started medical work in Surat. Their work was then carried on by a Miss Roberts 'till the establishment of a Government dispensary and hospital for women in connection with the Countess of Dufferin scheme made the need in Surat less pressing. Miss Roberts was then transferred to Borsad.'⁹⁴ Burns Thomson mentioned this mission in his Reminiscences. He claimed that the ladies arrived there in 1876, and in extracts from their letters it is said that 'Besides the patients who come to us and keep us very busy, we have several Parsee ladies on our sick list whom we visit at their homes'.⁹⁵ A point of interest is that the first two missionaries had attended a course on tropical diseases to assist them in their work, but not a course on midwifery or of ailments peculiar to women, gynaecology then not being seen as a speciality. It could also indicate that they were not intending their ministrations to be of a specialist nature, except that it gave them access to women. This access was important, not just for preaching and healing, but also as a means of education, especially instruction in hygiene and sanitation.

The institution of a mission hospital or dispensary for women therefore was more than a conduit for healing and Christian proselytism. Irene Barnes was moved to claim that 'A Mission Hospital is a moral text-book which can be read and appreciated by the most illiterate.'⁹⁶ As well as their moral stance, the missionaries at that time could almost be said to have taken as their mantra, 'cleanliness is next to Godliness.' J. Rutter Williamson claimed that 'Medical work has been a spur to the higher education of women...for everyone treated in a hospital learns something of cleanliness and care of the sick, and carries away a treasure of new ideas which cannot fail to bring comfort and health to cheerless homes.'⁹⁷ And for the missionaries, 'especially female doctors for women', who

⁹³ Ibid., and The Gazetteer of Bombay City and Island, Vol. III, p.191.

⁹⁴ MS. C 487. Pamphlet enclosed with MS – Surat. Women's Association for Foreign Missions. OIOC.

⁹⁵ Burns Thomson, Reminiscences, p.175.

⁹⁶ Irene H. Barnes, Between Life and Death: The Story of C.E.Z.M.S. Medical Missions in India, China, and Ceylon, London, 1901, p.8.

⁹⁷ J. Rutter Williamson, The Healing of the Nations: A Treatise on Medical Missions, Statement and Appeal, London, 1899, p.83.

visited their patients at home, such as 'patients too sick to return to [the] dispensary...' the opportunity was afforded to them to impart health education on 'cleanliness, hygiene, sanitation.'⁹⁸

The authorities, throughout the century, did provide places of treatment for women. They were able to visit the dispensaries, and in some of these institutions beds were available, but not to the same number as those provided for men. It is perhaps possible to argue that what was provided was concomitant with that of the potential use by Indian women. The Lying-in hospital at Mangalore which however saw no patients and was therefore closed, was competing against the traditional practice of Indian women in using the services of a *dai* (Indian midwife). To have interfered, even if the authorities could have done so, or even been inclined to do so, would have been counter-productive. The physicians may have accused the dais of superstitious and dangerous practice, but they would have been unable to argue that childbirth in a hospital was any safer at that time. The question of caste acceptance, and that of the women suffering from sexually transmitted diseases, also raised difficulties in how the female accommodation was arranged. If, initially, the higher caste and the wives of the influential had used the dispensaries, then it is more likely that this issue would have been addressed, but then, they would have been 'paying patients' and would in effect have provided the facilities themselves. But the higher castes and influential did not use the dispensaries, so the female poor and destitute members of society were provided with the same level of care as the men, which was free at point of contact and provided a bed if necessary. It is the Indian women of this category who were the dispensary patients, like the woman at Mahim who collapsed in the market in 1809, but who in this instance, was not admitted to Bombay Native Hospital; it is these women that are overlooked in present day debate.

⁹⁸ R. Fletcher Moorshead, M.B., F.R.C.S., The Appeal of Medical Missions, Edinburgh, 1913, p.122.

Conclusion

The dispensaries established in the towns and cities of the Bombay Presidency during the 1860s and 1870s provided a template for those that were to follow. It was not just the physical construction of the dispensaries, the bricks and mortar, but the idea of providing care to those in need, whether within or without walls. It was noted how this idea could be used in other fields. For example, the workplace dispensary, with or without walls, temporary or permanent, was seen as a means of providing medical aid to those in the work camps. But then, this was not a new idea, the forestry workers in Malabar had an assistant surgeon in their camp, as did the workforce in Bombay Dockyard.

Missionaries certainly saw the potential of the role of dispensaries in their work, but this did not have the wholehearted support of those that raised the funds for missions; nevertheless it did grow in popularity when they saw the convenience of the medium the dispensaries offered in transferring religious ideology from the chapel to the bedside. The EMMS stepped in to this debate, but they were not aligned with any one church, so did not have the financial support that a church could give. The activities of their members who worked for church mission societies were successful, especially in Rajasthan where they were able to operate openly, and often gained supplementary funding from a friendly Rajah or even the local municipal council. The Bombay dispensary did not fare so well. As well as not having a church society to fund it, another major reason I would argue, is that the dispensary was urban based, in an area where there were other dispensaries and hospitals in close proximity, hospitals and dispensaries that were funded by councils and government. The Bombay mission therefore was unlikely to gain extra funding from government, as did their rural based medical colleagues; as a result they were required to find all the funding from their own resources. The working ethos of the Bombay Dispensary though was based on the training dispensary in Cowgate, and was innovative in its approach to medical care, especially seen in the role of its female employees who paid home visits to their female patients, and acted as advisors, no doubt while they also attempted to

convert their clients to Christianity. But rapid expansion was probably a contributory factor in the financial difficulties they were to ultimately face.

One area where missionary medicine was seen as successful was in its role of caring for women and children, especially women in purdah, although claims that they were the first to do so can be challenged. The care they provided, and the hospitals that were later opened by philanthropists, was essentially women orientated, rather than being but one part of a general dispensary, where many women, especially women of the 'respectable classes' would have been unlikely to go. The facilities that were provided by government for women was as equally poor as that provided for men, except when special efforts were made to attract women to their doors; even then, as has been shown, they were not always successful. It must be said however, that without the mission hospitals and dispensaries, and the women and children's dispensaries funded by the philanthropists, it is unlikely that better facilities would ever have been provided in the nineteenth century.

The idea of the dispensary was adapted in various guises to maintain the momentum in the expanding road, rail, canal, and communication networks. Dispensaries were mobilised to fulfill requirements which varied from site to site, and was constantly subject to change. The medical aid provided was sparse, and on reading the engineers descriptions of living conditions in the work camps, it would seem that medical help was either not provided at all, or what was provided was overwhelmed by the scale of sickness during epidemics, or in the example given, of bouts of pneumonia following flooding in the camp at Adamwahan. Despite the two hospitals, medical aid and knowledge was insufficient to meet the needs of the people. Medical influence seemed negligible, the physicians and surgeons appear to have had no authority regarding the working conditions and sanitary arrangements of the workforce, although by the 1870s, an awareness of the ill effects of insanitary living conditions were very much in evidence, certainly when it related to the cantonments. If the needs of the railway workforce were initially ignored, some thought was given to their passengers. As the railways and the workers became more established, and

railway communities were formed, the idea of medical aid had become 'institutionalized', inasmuch that the railway companies not only provided hospitals and dispensaries within these communities, but also made their contribution, like the municipalities, to the general budget for hospitals and dispensaries; possibly, as I suggested, to pay for the care of sick railway passengers.

So why did the dispensary system move away from an original narrow course of fixed locally sited and locally funded institutions? They were seen as a successful means of providing medical care, and perhaps more importantly as far as the government was concerned, despite their protestations, the medical care was provided reasonably cheaply, otherwise they would have registered a decline, not expansion. The missionaries realized their potential after seeing the relative success of the civil dispensaries in India, although, of course, the EMMS was already familiar with this combination of medical care and preaching, and the dispensary at Bombay was intended to be a second Cowgate. It was a two sided affair, the people needed free medical treatment, and the missionaries needed a point of contact with Indian people if they were ever to realize their ambitions of converting the population to Christianity. The example set by the civil dispensaries also represented a potent argument for their use to attract women to their doors, by missionaries or Indian modernizers and philanthropists, who sought to provide care for women by women. The dispensaries showed that more could be offered in the way of treatment, dispensing, and a bed if required, if adapted to take into account the needs of women in a society where treatment for their particular ailments were unmet, due, in part, to their, and their families reluctance, for them to be treated by a predominantly male medical profession. It must not be forgotten however, as shown, that where beds for women were provided in dispensaries, with some exceptions, they were used, but by women who were too poor, or homeless, to have the choice of other alternatives. Nevertheless, the example was set. The Zenana missions, on the other hand, took the dispensary to the women. Rather like the surgeon and his medical bag who was attached to the labourers on the construction sites, and was the embodiment

of the dispensary without walls, so the Zenana missionaries used the Zenana walls, but took the dispensary within.

Therefore, even when medical aid was basic or temporary, the idea of medical relief was founded on the functions of the dispensaries. They had developed from that of a place of haven for the homeless sick and dying, and those unable to pay for treatment elsewhere, to a more open concept, whereby their function was transferable. To give an example of their progress, it will be recalled that in 1803 and 1813, in response to the hunger and disease of the people suffering the effects of famine, Humane Hospitals were opened. There the people stayed until it was decided that the hospitals use had come to an end, and those unable to be discharged, were sent to Bombay Native Hospital. In other words, the authorities responded to need when it arrived on their doorstep. To illustrate a more proactive role, and with the function of the dispensary as a guiding force, the following preparations for famine relief, possibly in Bengal and Behar, in 1874, are here described.

Extensive preparations for medical relief have been made in connection with the impending famine. Four surgeons, two assistant surgeons and upwards of one hundred hospital assistants and native doctors have been sent to the famine districts. Each relief circle has its dispensary and native medical subordinate. Special supplies of appropriate medicines have been despatched to those dispensaries and the stores of existing dispensaries have been replenished.⁹⁹

The idea of the dispensary had indeed advanced beyond the fixed confines of a permanent structure, or to a dispensary 'without walls' that moved along with the workers, to one instituted in preparation for potential disaster, ready to respond to need before the need arose.

⁹⁹ Indian Medical Gazette, 1 April 1874, p.103.

Conclusion – Ideology and Practice of the Dispensary Movement

This thesis commenced with the opinion of Henry Burdett that the dispensaries were the most striking feature in the medical history of India - a rather ambitious claim for such a humble institution. But a humble institution can often exert an influence beyond its core activities and importance, and touch the lives of all sections of the community within which it exists. The dispensaries in Bombay were destined to make an impact by their originality, and their availability, a circumstance virtually unknown in India. If, however, the idea of the dispensary had not been supported in the early nineteenth century by the British rulers in Bombay, (who had ignored the conventions of the time that dictated that every detail of life in the Presidency, and the consequent expenditure, had first to be approved by the Court of Directors in London), they could also have been short-lived. But the dispensaries were supported and, officially and unofficially, took root in western India. Once established, however, their influence could have been severely limited by the status of their clientele, people without a collective voice, the sick and the poor. But if the dispensary movement in India was a reflection of that in Britain, then these were the people who would be expected to attend them as patients. Bombay acknowledged this similarity, although it was not a universal view across British India. Conversely, without the involvement of officialdom as seen in Bengal and Madras, the dispensary movement in Bombay, with a few exceptions up until mid-century, had progressed in a haphazard fashion. The involvement of the wealthy Indian community, however, accelerated their progress and enhanced their importance and prestige. The Indian philanthropists, like the early British administrators, also turned convention on its head when they diverted the money they usually gave to traditional Indian charities, to a system of medical aid that was not a part of their culture. Their patronage would ensure that the dispensaries remained within the arena of public consciousness,¹ and their contributions would help

¹ Colonel W.H. Sykes suggested that in 1862-1863, a total of R. 361,000 was given by individuals in Bombay Presidency for the founding of hospitals and dispensaries. His figures do not include the money donated for the Victoria Dispensary at Nowsary. 'Statistics of Sums Given by Native Gentry in India', *Journal of the Statistical Society*, Vol.XXX., Part IV., December 1867, pp.535-47.

them to remain in contact with the British with whom they conducted their business affairs.

To what extent were they viewed as important by the British community in Bombay? Initially the Bombay government allowed them to be established, and paid for their maintenance, the money almost appearing to come from the equivalent of a 'petty cash' purse. Although initially, it could be argued, medical care was provided for the poor as a humanitarian gesture, by the period of Mountstuart Elphinstone's governorship, the British were keen to promote what they considered were superior western values, including science, and one science where they expected to do well was that of medicine. It was hoped that this could be achieved through the function of the dispensaries. Madras and Bengal, however, had intended that wealthy and influential Indians would use the dispensaries, and therefore western science would be shown to advantage when compared with indigenous medicine, but this hope was not accomplished as the wealthy did not attend the dispensaries. Bombay government took a more pragmatic stance, and the use of the dispensaries as a vehicle for the promotion of western ideas was not seriously undertaken until mid-century, by which time the larger hospital, and western medical education for Indians was being encouraged, displacing the importance of the dispensaries to that of a second class system. The dispensaries in India, however, were popular with the poor, and the authorities, even if tempted to do so when, as has been shown, expenditure was being closely scrutinised, would have found it extremely difficult to justify any closures. The dispensaries, therefore, met the needs of the poor Indians, where they were established, and through the joint funding of the institutions, provided a means of dialogue for Indians businessmen and the British authorities, a meeting ground to some extent where charity and trade could be discussed and negotiated.

The European medical officers gained some advantage from the dispensaries. They were frequently their most vocal advocates, and not necessarily for reasons of self-interest. They ran them in a manner that reflected the idea of the dispensary that they had known in Britain. The dispensary as an institution repaid them for their support: from the moment in 1810 when the Medical Board gained control of the budget for Bombay

Native Hospital, the medical officers were accorded a more conspicuous role in India. They were consulted, for example, by Robert Grant on the viability of opening a new medical school, and his Minute of 1838 shows that he noted their responses. Eventually, they became not the dispensary surgeons, but their overseers. In the early part of the century, the position of medical officer with the East India Company was not necessarily sought after; by the 1840s, surgeons in England looked for sponsorship so that they could gain an appointment. Robert Haines, for example, was one such surgeon. He was involved in an unsatisfactory professional partnership, and looked for a position as an assistant surgeon with the Company. His fiancé, on his behalf, approached various family members and acquaintances with Company connections. Finally, he was successful; an uncle was able to obtain a position for him. Anne Mohine wrote to her sister, 'At length our troubles and perplexities are ended...he is ordered to Bombay...congenial occupations [sic] is open before him and if his health does not suffer from the climate, I do not doubt our happiness.'² He was for a time an assistant surgeon at Karachi. Contrast their optimism, however, with the thoughts of the Indian surgeons, who viewed their position as being anything but congenial.

The opening of Grant Medical College provided an opportunity for Indians to undertake medical training, and, thereafter, relatively secure employment. But the kind and conditions of employment is a moot consideration. Indian surgeons faced different problems to those of the British. They not only had to prove their worth to their superiors, but also to their fellow countrymen. Thus Balkrishna Chintoba's report, after a few months employment as an assistant surgeon at Poona Charitable Dispensary, referred to 'obstacles' that lay in the way of a good report, 'the universal suspicion with which they [the inhabitants of Poona] regard the practitioners of the medical science of Europe, and their constant want of confidence'.³ His inability to cure his own daughter of hepatitis did not help. In 1871 an article in the Indian Medical Gazette noted that 'sub-assistant surgeons find it impossible to rise above the inferior positions they now occupy of subordinate

² Letters from Anne Mohine to her sister Henrietta, 17 July 1848. Westminster Council Archives.

³ BDR, Report of Poona Charitable Dispensary, 1853-1854. OIOC.

medical officers, or house surgeons to the various dispensaries scattered over the country'.⁴ In response to an item in the Indian Medical Gazette in 1874 that announced that the title sub-assistant surgeon had become obsolete, a letter from 'A Poor Sub' noted that the Hindoo Patriot when reporting the change, had remarked that 'an empty title to an empty stomach is a double misfortune'. The author of the letter added that 'The sub-assistant surgeons are the worst paid of Government officials...as compared with other men of equal standing in other departments of the Public Service...'⁵ His claim was endorsed by the editors. The Indian surgeons, of all the players involved would appear to have done less well out of the dispensary movement. The British surgeons were always better placed than their Indian counterparts; as their status ascended, the Indians found that their ranking did not necessarily fall, but rather it struggled to maintain what it had gained. The dispensaries provided them with employment, but for the most part gave them no access to seniority and status.

Despite the re-introduction of medical education and an increase of Indians with medical qualifications, could this be counted as the guarantor for further expansion of the movement? It would appear so, but because of financial restraints the expansion was very slow. In the second half of the century the Bombay authorities continued to support the idea of dispensary practice, but were not prepared to fund the dispensaries unconditionally. They now considered them to be the responsibility of the Indian community, although, perversely, they had no wish to relinquish control. They began with some success to involve the influential and wealthy members of the Indian community who responded generously, but also laid down their own conditions. But further contributions had to be raised, and the introduction of local government into parts of Bombay Presidency provided an opportune means of doing so. Under the direction of the British representative, the municipal councils could elect to support a local dispensary, but only if they could show that they had sufficient revenue. Even without this money however, it is unlikely that the dispensary system would have ended. The British would have been fearful of stopping an institution that was seen to be

⁴ Indian Medical Gazette, 1 April 1871, pp.75-6.

⁵ Indian Medical Gazette, 1 June 1874, p.163.

of benefit to the community, but conversely, they may not have allowed it to grow further.

With some measure of serendipity, the British, in mid-century, were inspired to use the idea of the dispensaries for their own practical ends. Industrial science and technology were taking root in India, the railways, telegraph lines, and the necessary infrastructure to support these ventures was underway. Time very often could be equated with money and profits, and a healthy workforce helped a contract to be met on time. Thus the government gave the dispensaries a more functional role in relation to meeting their needs as well as the patients. Dispensaries came to be established along the routes of the railway lines, or followed the labourers as dispensaries 'without walls'. But even in this situation, the workforce had to suffer unimaginable hardship before help was given, and as soon as the need was considered met, the funding would be withdrawn. The dispensaries, then, by their very functional simplicity, and mobility, provided another asset for the British authorities, but only a fleeting one for the Indian worker. Their simplicity, and success in India, inspired the missionaries to also use dispensary practice as a further means of reaching out to Indians. Their dispensaries became an integral part of the dispensary movement.

The ideology and practice of the dispensary movement were not, therefore, very far apart. Even when the dispensaries took on new roles, they did not lose their primary function of basic and immediate care for those unable to afford medical aid. The main clientele within the period of this thesis remained the sick poor, including the labourers treated at the work sites. The advantage to the poor is not as easy to convey as the advantages or disadvantages to those already discussed. For one thing, they did not leave a record of their opinions. To what extent they became a part of the Indian medical round of consultations is difficult to analyse, except it was often reported that many arrived for treatment at the dispensary only after all other treatment had failed. But, they were provided in Bombay Presidency for the poor, and like their counterparts in Britain, they used them. Surgeon-Major Patterson made a comparison with those charitable institutions in Britain which were specifically founded for the poor, and which, to some extent,

provided the idea of the dispensaries in Bombay. In 1885 he remarked on the high mortality rates in the charitable institutions, but added:

In charitable hospitals and dispensaries in India...the class of patient ordinarily attending...is not the upper section of the lower classes...[but]the lower section, represented in Great Britain by those coming under the treatment of paid poor law surgeons, and under such officials admitted into poor law infirmaries...⁶

The dispensaries were largely urban based; the ones that were open appeared to be well used, but the number of dispensaries in Bombay Presidency when compared to its population, meant that this group of users was a minority.⁷ It would be useful at this point to have an accurate figure of the number of patients seen to analyse their comparative growth, but throughout the first three quarters of the century, there did not evolve any kind of uniformity in the presentation of the annual dispensary reports. The format of the reports could change from year to year. A further handicap is that the reports do not specify how the attendance figures are formulated. Are the attendance figures presented for first visits only, or do they include those for follow-up treatment? If the latter, this would suggest that even less Indians had access to the dispensaries than would at first appear. Costs are equally difficult to compare as until the 1860s, it is not clear whether monthly allowances for the dispensaries included surgeons pay as well as the cost of food, medicine, etc. By the 1870s, the costs per region are presented in a clearer format.⁸ The number of visits if taken at face value from 1865 until 1875 show a clear level of growth, and this I feel must be accounted for by increased activity, irrespective of whether the visits are related to the opening of new dispensaries, or repeat visits to those already established. It can be

⁶ BHDR, 1885, p.iii.

⁷ Henry Burdett claimed that in 1889, the population of Bombay Presidency stood at 21,888,976, and that it had 244 hospitals and dispensaries. This would allow for one institution per 89,700 of the population. Burdett, Hospitals and Asylums of the World, 1893, p.322.

⁸ For an example see the report of the income and expenditure of the Presidency Division 1873-74, appendices, pp. 179-80.

seen, therefore, between the years 1864/65 and 1874/75, the number of visits more than doubled:

<u>Year</u>	<u>Patients – indoor and outdoor</u>	
1864-65	210,192.	ditto
1869-70	414,776. ⁹	ditto
1874-75	509,266 outdoor, 5,509 indoor. ¹⁰	

These records, however, as indicated, refer to urban based dispensaries, it would seem that the majority rural population had either no, or extremely limited access to western medicine. On the other hand, it is difficult to believe that the plans of Mountstuart Elphinstone and Robert Grant that private practitioners be trained and returned to their home towns and villages, would have been any more successful. Unless the private practitioner was able to support a dispensary out of his income, the idea of the dispensary would not have been transferred, and free treatment was a fundamental element of their acceptance by the poor. The rural population, therefore, continued to use traditional medicine and practitioners: they remained a body of people largely untouched by British medical culture.

So was the dispensary system of India, as Burdett claimed, the most striking feature in its medical history? The assumption must be that Burdett was bound to say that. He was a man who immersed himself in the role and function of the hospital and dispensary in Britain and the world. He would have seen how a system that he admired was transferred to another country, and would have concluded by the number of dispensaries and the patients treated, that it was. He praised their planning and construction, and to complement the four volumes of Hospitals and Asylums of the World, he included a set of drawings of some of the hospitals and dispensaries that he had mentioned. These plans included the staff accommodation, the latrines, and 'dead-houses'. Indeed they had developed a long way from the hired houses in which most dispensaries began life. So, it could be argued, the

⁹ BAR, 1864-65, 1869-70.

¹⁰ BDR, 1874-75.

dispensary movement had made considerable progress, and that their improved construction and planning illustrates this.¹¹ Would the early surgeons and administrators have viewed the dispensaries in this way? It is unlikely in Bombay that they were seeking this type of recognition; they merely carried on a system of medical care with which they were familiar. Glen's comments in 1821 may have impelled them to do more, but there was never, in the first half of the century, an organised regime for change or expansion.

If the transfer of an idea is some indication of success, then the dispensary movement can be accorded some tribute. One such indicator could be the use of the dispensaries as a centre for indigenous medical practitioners, but this was never realized during this period in dispensaries under the control of the British authorities. But the idea was taken up by Indians. Firstly they were adopted by the philanthropists as another branch of their charitable giving, and like many British philanthropists who also supported hospitals and dispensaries in Britain, the units were named after their benefactors. Young Indians used the dispensaries as a means of employment, albeit an unsatisfactory one, but it still remained a source of employment that had not been there before. Most importantly, their success could be counted in the number of the sick poor who used them. Despite the fact that in some instances they were the place of last resort, they were, nevertheless, popular, and far more so than the hospitals. In 1809 there was one dispensary in Bombay Presidency, the Bombay Native Hospital, in 1875 there was 118 dispensaries, and this figure does not include those in the Princely States, or the mission run dispensaries in western India. The dispensaries were therefore popular, and retained their popularity throughout the century. There were too few for the large and scattered population, and some may argue that they may not have been the most striking feature in India's medical history, but they did make an impact on the poor who gained access, and by passing through their doors, they, to some extent, adopted them as their own.

The dispensaries, therefore, provided medical aid to the Indian poor. It was not the kind of aid as we would understand it now, but can be seen as

¹¹ For examples of the changing appearance of the hospitals and dispensaries, see appendices, pp. 181-84.

more aligned with that provided in the British nineteenth-century dispensaries and poor law infirmaries. The early dispensaries established in Bombay Presidency, on the other hand, had less restrictions placed on their work than those in Britain. This perhaps was a measure of their success and acceptance by Bombay government in the early years. As they became much more visible in the public domain, more Indians attended them without necessarily needing a free bed; they had become a part of their medical canon. The dispensaries, in the second half of the century could be viewed as being institutionalized, and subject to ever increasing regulations. Indians with influence and money established dispensaries with areas set aside for members of their own caste, or sect, and some were provided solely for women and children. They, therefore, put forward their own ideas on how a dispensary should be managed, and for what class of person. This could be conceived as running contrary to the idea of dispensaries as charitable foundations for the poor, but, conversely, it could also be viewed as a time when the basic idea was transferred and adopted by the Indian population, but not in a manner that the British would have anticipated.

APPENDICES

*ABSTRACT STATEMENT showing the Cost, Income
Presidency, during the Year*

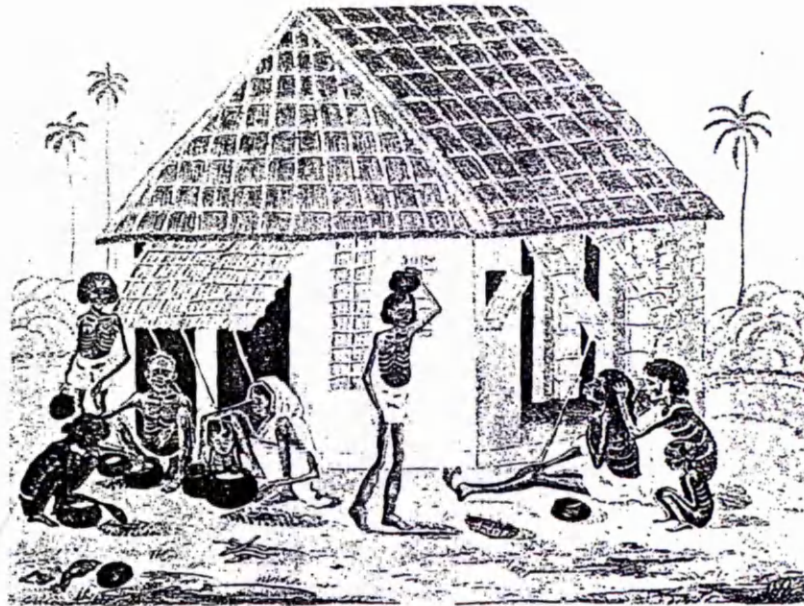
No.		Presidency Division.	
		1873-74.	1872-73.
	<i>Expenditure.</i>	Rs. a. p.	Rs. a. p.
1	Medical Officers' Salary	37,696 6 6	34,652 3 4
2	Medical Subordinates' Salary	12,728 7 2	13,095 14 1
3	Servants' Wages	3,861 2 0	3,490 7 8
4	Cost of English Medicines	11,727 0 7	16,010 4 10
5	Cost of Diets	491 2 8	459 8 1
6	Cost of Wines and Spirits	4 13 0	13 9 0
7	Cost of Bazaar Medicines	1,038 14 2	997 3 3
8	Cost of House-rent (if any paid) and Re- pairs	1,580 14 2	1,939 2 9
9	Miscellaneous, e.g., Clothing, Furniture, Burials, &c.	2,212 10 7	2,444 5 3
	Total Expenditure...	71,341 6 10	73,102 10 3
	Total Number of In-patients treated ...	403	294
	Total Number of Out-patients treated ...	129,223	96,531
	Total Treated...	129,626	96,825

BDR. Abstract of statement of the income and expenditure of the Dispensaries of Bombay Presidency, 1873-74. The Presidency Division is here shown as an example.

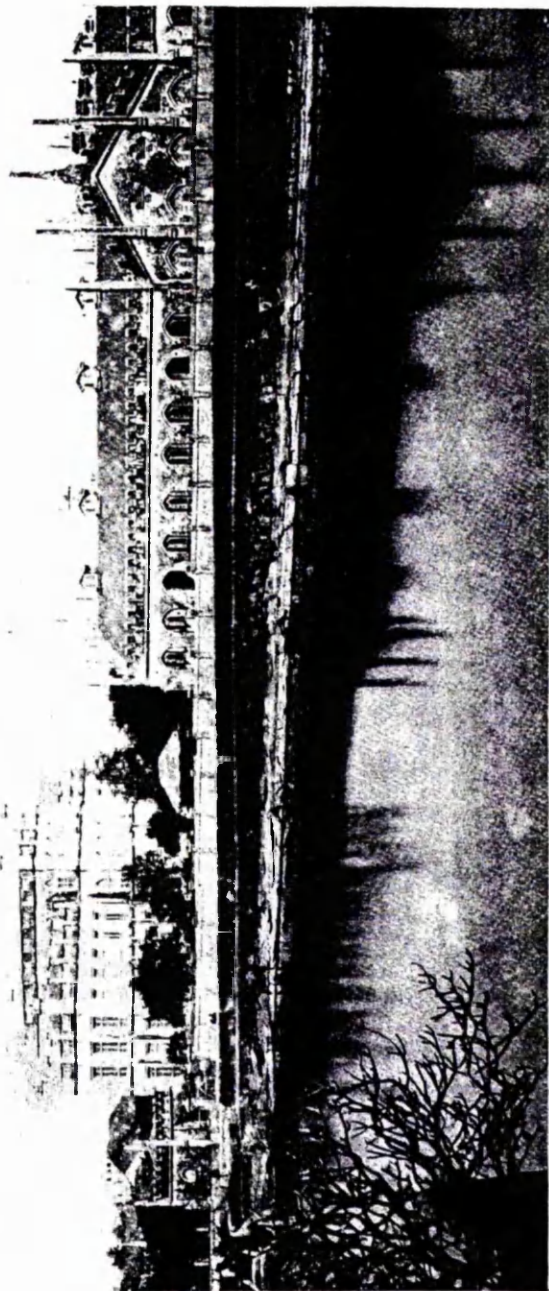
*ABSTRACT STATEMENT showing the C
of the Bombay*

No.		Presidency Division.	
		1873-74.	1872-73.
		Rs. a. p.	Rs. a. p.
	Cost per Patient of Total Treated ...	0 8 9	0 12 0
	Average Number of Daily Sick, In-patients.	16.48	14.62
	Average Number of Daily Sick, Out-patients	1,476.37	1,123.19
	Total Average Number of Daily Sick for In and Out-patients	1,492.85	1,137.81
	Population of Town	300,233	.....
	Cost of Diet per In-patient per day, Ave- rage of all charges per Division and for the whole Presidency	0 2 5½	0 2 6
	<i>Income or Receipts.</i>		
1	Annual Government Grant	48,082 9 8	54,435 5 2
2	Grant from Local Funds	24,197 2 9	23,331 7 1
3	Endowed Capital ... ..	.....	.....
4	Interest on Endowed Capital	7,508 9 6	7,323 13 0
5	Donations and Subscriptions	599 0 0	145 2 3
6	Fees from Patients	444 6 2	117 1 3
7	From Sale of Medicines, &c.	271 14 2	903 15 0
8	From Sale of Empty Boxes, &c. ... ..	.....	.....
9	Recoveries on account of Diets from Eu- ropeans and Natives ... ..	.....	.....
10	Municipal Fund ... ..	.....	.....
11	Amount realized on account of Rent ... ..	.....	.....
	Total Income or Receipts...	81,103 10 3	86,256 11 9

BDR. Abstract of statement of the income and expenditure of the Dispensaries of Bombay Presidency, 1873-74. The Presidency Division is here shown as an example.



A Group of Starving Villagers outside the Pilgrims Hospital, Cuttack.
C.1840. OIOC.
in:- C.A.Bayley (ed.), The Raj. India and the British. 1600-1947.
National Portrait Gallery, London, 1990. p.200.



BABULA TANK. 1864.

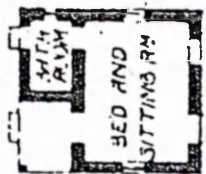
(Showing the J. J. Hospital before the Tank was filled up.)

Jamsetjee Jeejeebhoy Hospital.
The Gazetteer of Bombay City and Island. Vol. III. Times Press, Bombay, 1910, p. 189.

DISPENSARY AT SANGAMNER, BOMBAY, INDIA.

SCALE OF FEET 0 10 20 30 40 50 60 70 80 90 100

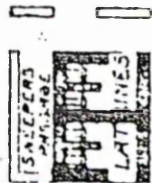
NATIVE DOCTOR'S
QUARTERS, BLOCK C.



MORTUARY
BLOCK G.



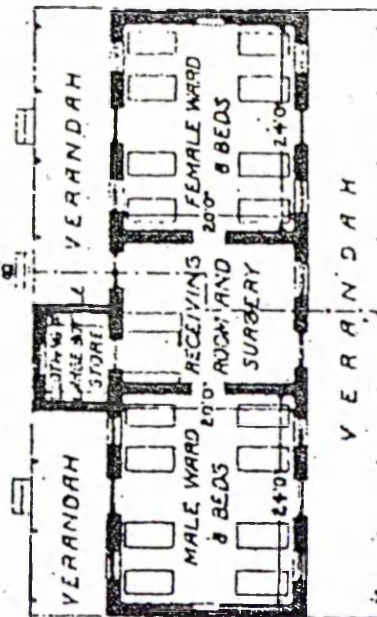
LATRINES,
BLOCK F.



BLOCK PLAN

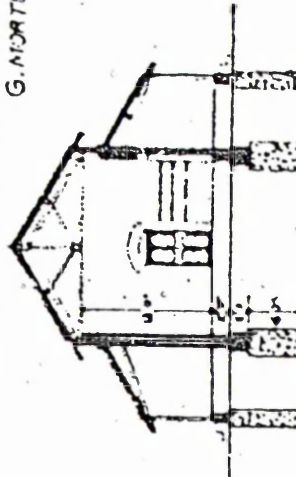


DISPENSARY, BLOCK D.



GROUND FLOOR PLAN

REFERENCE FOR BLOCK PLAN
A. MAGISTRATE'S OFFICE B. STEP WELL
C. NATIVE DOCTOR'S QUARTERS D. DISPENSARY
E. CHAPEL
F. LATRINE
G. MORTUARY



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