

Coming to terms with the native practitioner: Indigenous doctors in colonial service in South India, 1800–25

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This article explores the engagements between the colonial state and indigenous medical practitioners in the Madras Presidency in the early nineteenth century; a period characterised by openness and ambiguous relations. An analysis of textual representations of the 'native practitioner' reveals ambiguity. Often the practitioners were portrayed as representing flawed systems of knowledge, yet possessing valuable insight into specific medical practices. Texts written for internal administrative purposes tended, however, to view the native practitioner more as a resource for the colonial state than a representative of worthless bodies of knowledge. Turning to actual engagements with native practitioners a varied, context-sensitive picture emerges. In connection with the campaign to prevent smallpox, the native practitioner was envisaged as both a self-interested entrepreneur and a zealous bureaucratic servant. When an epidemic fever struck the southern part of the Presidency, it was suggested that the colonial authorities continue a pre-colonial practice and distribute native practitioners in the villages through grants in revenue. Finally, when cholera struck dramatically in south India from 1818 the colonial authorities resorted to extensive hiring of practitioners on a short-term basis. The variety of ways in which the colonial authorities came to terms with the native practitioner—from mainly dismissive accounts to praise of their usefulness in specific disease control—reminds us that we need to differentiate our understanding of the colonial encounter not only according to time and place but also according to administrative context.

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*The Indians are almost all Physicians.
From their infancy they are instructed in the
knowledge of some simples, and different receipts*

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*handed down from father to son. These are for them
a resource in their calamity; and they often make a mixture
of plants, of whose property they are ignorant
and their effect equally unknown.*

Pierre Sonnerat, 1788–89¹

*Amongst the whole of the people, muhammadian
as well as hindu, medical science is much in the same state
as taught by Galen seventeen centuries ago.*

Edward Balfour, 1875²

Nearly a century separates these two statements about the south Indian medical practitioner, the Hindu *vythian* and the Muslim *hakim*. Neither the eighteenth-century traveller and naturalist Pierre Sonnerat, nor the highly ranked medical servant of the late nineteenth-century Raj, Edward Balfour, had much respect for indigenous doctors and it is tempting to see their statements as part of a uniform colonial discourse on the backwardness of Indian medicine. This would, however, be a simplification. Studies in the medical history of colonial India continues to impress on us, that in the early phases of colonialism the attitude of Western medical men of Indian traditions and practices was characterised more by curiosity and a readiness to learn than plain contempt and absolute confidence in Western superiority.

David Arnold finds that while Indian knowledge in the first half of the nineteenth century still served as a source of inspiration for colonial medicine, by the second half it had transformed into a dangerous and fraudulent rival.³ C.A. Bayly emphasises the complexity of the relationship between Indian and Western medical knowledge and finds that the British remained fundamentally uncertain of the validity of their own sciences throughout the nineteenth century.⁴ And Mark Harrison claims that it was not until around 1820 that notions of unbridgeable differences between Western and Indian medical systems became predominant among Western observers.⁵ Even writers like Deepak Kumar and Anil Kumar, who tend to see colonial medicine in very critical terms as an instrument of an aggressive imperialism, date the beginning of a hegemonic colonial medicine well into the nineteenth century.⁶ Most recently Pratik Chakrabarti has described the intellectual lives of the surgeons of eighteenth-century Madras as 'eclectic' and ambiguous,

¹ Sonnerat, *Voyage to the East Indies*, Vol. 2, p. 137.

² Balfour, *The Vydian and the Hakim*, p. 9. Balfour was Surgeon General in the Madras Presidency and fellow of the University of Madras.

³ Arnold, *Colonizing the Body*, p. 52.

⁴ Bayly, *Empire and Information*, pp. 281–82.

⁵ Harrison, 'Medicine and Orientalism', pp. 62, 80.

⁶ D. Kumar, 'Unequal Contenders'; A. Kumar, *Medicine and the Raj*.

and their practice as heavily dependent on local 'bazaar' medicine.⁷ Although the assessments of these writers differ on the more specific points, they all seem to agree that up to about 1825—and in some areas probably longer⁸—the relation between the colonial state and indigenous medicine was much more open and ambiguous than later in the century.

In this article I address the ambiguity characteristic for the period between 1800 and 1825. I focus on the relations between the colonial administration and the 'native practitioner' and the knowledge he represented. In this context 'relations with the native practitioner' means two things. First, the way in which the colonial administration represented the native practitioner in various texts and thus ascribed to him a certain position in the wider conceptual universe of early colonialism. Second, the actual usage made of native practitioners in a number of significant attempts to combat disease in the first quarter of the nineteenth century. The first part of the investigation is, of course, an exercise in the study of colonial discourse. It is, however, important for me to emphasise that my analysis of textual representations covers a wide spectrum of texts, ranging from 'orientalist' treatises written to a European audience to less pretentious texts taken from the administrative records of the East India Company. Moreover, as it is my hope to avoid a reading of texts which is disconnected from the historical context in which they were produced, these texts will as far as possible be interpreted in the light of the actual engagements with the native practitioner in early colonial south India.

I have confined my analysis to the Madras Presidency for several reasons. All-India studies often neglect regional differences and collapse the diverse features of Indian society into an unsatisfactory uniform pattern. There is, for instance, some justification for believing that the medical traditions in Tamil-speaking areas had distinctive features, simply because the region had its own medical texts.⁹ Similarly, the medical departments in the three Presidencies were relatively independent of each other and they consequently held different views and developed different practices.¹⁰ The main reason, however, is the organisation of archival material and my own convenience. The Madras Presidency might be an arbitrary unit in terms of Indian regional culture, but it is an administrative area with which I am familiar from earlier work. Moreover, remaining within one Presidency makes systematic use of manuscript sources and thus a more context-sensitive approach towards colonial texts feasible.

⁷ Chakrabarti, 'Neither of Meate', pp. 9–12, 22–23.

⁸ In the Punjab, which did not come under British control until the middle of the nineteenth century, ambiguous relations between colonial authorities and native *hakims* similar to those analysed in this article can be found in the late nineteenth century. See Hume, 'Rival Traditions'.

⁹ Ainslie, *Materia Medica*, p. 63.

¹⁰ Harrison, *Climates and Constitutions*. For a warning against extrapolating regional studies to the all India level, see Bhattacharya, Harrison and Worboys, *Fractured States*, pp. 4–5.

The Native Practitioners—Who Were They?

The term ‘native practitioner’ is vague, but it was one of the standard terms employed for indigenous doctors in the Company records. It lumped together medical men with at least three different roots: practitioners from a variety of indigenous medical traditions, ‘dressers’ who had developed medical skills in the Company’s army and vaccinators employed by the Company in its recent attempt to combat smallpox.

The indigenous medical traditions included the elite traditions of Hindu *ayurveda* and Muslim *unani* medicine with their legacy of ancient texts and connections to the ruling segments of Indian society.¹¹ It was within these traditions that the ‘proper’ *vythians* and *hakims* were to be found. But indigenous medicine also included folk practices performed by barber-surgeons and bonesetters, who sometimes aspired to the title *vythian*. Generally, the British did not distinguish between different types of indigenous medicine and low-status folk practitioners would normally be included in the broad term ‘native practitioner’.¹²

Epigraphic evidence suggests that the medical institutions of medieval south India were well developed. Hospitals and dispensaries existed and doctors received some kind of public support in the form of grants in land.¹³ In the nineteenth century the British did not encounter any Indian hospitals of note, but in certain areas doctors received privileged land tenure or grants in money on account of medical services. Between 1818 and 1821 the colonial authorities made a survey of grants in land (*inams*) or money (*yeomiah*s, *yaumiás*) held by Indian doctors, and this allows us to get a glimpse of the position of the native practitioner in early colonial south Indian society. The distribution of grants to Indian doctors was strikingly uneven. In three districts—North Arcot, Nellore and Trichinopoly—the total value of such grants was 2,000 rupees per year or more. In Masulipatam, Chingleput, South Arcot, Tanjore, Tinnevely and Madurai grants to medical men were known, but on a much more modest scale. In the rest of the districts of the Madras Presidency, collectors reported that *inams* or *yeomiah*s of this type were unknown.¹⁴

A few of the grants given to native practitioners were considerable but most were trifling. North Arcot was the district where grants for medical services were

¹¹ ‘Indigenous’ should not be taken to mean that these traditions developed in isolation in India, but that they were seen by colonial administrators as existing on Indian soil and, therefore, distinct from ‘Western medicine’. *Unani*, in particular, had important connections to the wider Muslim world. For a recent study of how *unani* in nineteenth-century North India engaged with Western medicine and grew more ‘Indian’ in the process, see Alavi, ‘Unani Medicine’, particularly p. 124.

¹² Basham, ‘Practice of Medicine’, p. 38; Patterson, ‘Relationship of Indian and European Practitioners’.

¹³ Reddy, ‘Medical Relief’.

¹⁴ British Library, London. Oriental and India Office Collections (hereafter BL, IOR) P/293/91, Madras Board of Revenue Proceedings (hereafter MBORP), 17 September 1821, fols 8388–91.

most valuable: the reported 74 grants were worth 3,719 rupees per year. But of these 1,908 rupees represented three large grants of entire villages in the Kangudi Zamindari on the border to Salem. In the rest of North Arcot there were another two grants of entire villages amounting to 647 rupees. This left 69 grants worth altogether 1,456 rupees or 21 rupee a year on average. This should be contrasted to the salary of 17.5 rupees paid per month to Indian doctors in British service during the cholera epidemic, which struck south India at the same time as the survey of medical grants were conducted.¹⁵ The situation was similar in neighbouring Chingleput district. Here the British found that a village granted on the favourable *shrotium* tenure to 'Patchayapah the Oculist' was the only important grant in the district. They did identify another 48 grants, but the majority was worth less than 20 rupees a year.¹⁶ In Trichinopoly the British found 25 grants worth 2,030 rupees, the worth of each grant ranging from a few rupees to 700 rupees.¹⁷ In Nellore 40 grants were worth 1,976 rupees, but the three largest benefactors represented more than half of that sum.¹⁸ These figures indicate that the indigenous doctors were a heterogeneous group, including few persons of wealth and local influence as well as a large number of much more humble practitioners, who probably needed to supply their income from other and more important sources.

The names of the doctors are given in the survey, but it does not illuminate much about their status or conditions. It is possible to identify Muslims, Gujaratis and Brahmans among the holders of privileges and in Chingleput district a Kaikolar weaver and a 'barber' were entered in the list of doctors.¹⁹ A 1790 census from the Danish settlement Tranquebar recorded medical practitioners as 'Wadugas' ('northerners'), 'Naudiens' (presumably Naidus or Naiks) and Vellalas. Apart from the elite agricultural caste of Vellalas these designations were, however, imprecise.²⁰ From Trichinopoly, the collector remarked that many grants were given by the Nawabs of Arcot or local *poligars*, and direct links with the ruling segment of Indian society must have lifted the status of these doctors.²¹ In general, however, the Company records does not yield much information, which is more specific about the status and conditions of the indigenous doctors than did Assistant Surgeon Cother, when he wrote from Ramnad in January 1819: 'Vythians and Hakeems of different castes and respectability have been entertained, instructed, and supplied with medicines, &c to administer to the sick in their own houses ...'.²² Cother here informs us that native practitioners came from a wide spectrum of Indian society.

¹⁵ BL, IOR P/293/75, MBORP, 19 February 1821, fols 1343–46.

¹⁶ BL, IOR P/293/59, MBORP, 14 August 1820, fols 6066–74.

¹⁷ BL, IOR P/293/64, MBORP, 28 September 1820, fols 8188–89.

¹⁸ BL, IOR P/293/24, MBORP, 5 July 1819, fols 8214–16.

¹⁹ BL, IOR P/293/59, MBORP, 14 August 1820, fols 6071–72.

²⁰ Jensen, 'Medical Skills of the Malabar Doctors', p. 491.

²¹ BL, IOR P/293/64, MBORP, 28 September 1820, fols 8188–89.

²² Scot, *Report on the Epidemic Cholera*, p. 139.

Although reference was often made specifically to ‘dressers’ or ‘black doctors’ attending to the sepoys in the Company’s growing army, they were also included in the general term native practitioner. Indian dressers were introduced from the 1760s; around 1785 a dresser was attached to each native battalion of the Madras Army and in 1806 one dresser was allowed for each regiment of native cavalry and two for each battalion of native infantry. In the decades around 1800 they were paid a salary of 10 pagodas or 35 rupees a month.²³ The number of dressers in the Madras Army in peacetime in the 1780s was supposed to be around 60, although scarcity of troops possibly reduced the actual number. In 1820 the number of dressers might have been as high as 120 if subsidiary forces and troops stationed in princely states are included. In the 1830s their number seems to have fallen again.²⁴

We know as little about the background of dressers serving in the army as we know of the indigenous doctors who received grants for the performance of medical duties. In 1817 the commander-in-chief of the Madras Army ordered that only ‘natives of caste and respectability’ should be entertained as dressers, but that does not reveal very much.²⁵ From the Regulations of the Medical Department published in 1833, it appears that the ‘native medical pupils’ who sought to qualify as dressers were ‘to be of various castes ... and capable of reading and writing English, and one of the native languages’.²⁶ By the 1830s at least, the profession of dresser seems to be limited to the literate sections of indigenous society. One might speculate that caste barriers required dressers to be recruited from castes agreeable to the sepoys, but there is no evidence to suggest that strict notions of purity and pollution were adhered to in relation to doctors.²⁷ It seems probable that employment as dressers in the army would appeal to the established groups of medical men in Indian society, but again there is no evidence to merit the conclusion that dressers were predominantly recruited from such groups.

It seems beyond doubt, however, that the dressers were more influenced by Western medicine than the practitioners spread throughout the towns and villages

²³ Wilson, *History of the Madras Army*, Vol. 1, p. 237; Vol. 2, pp. 158, 176; Vol. 3, pp. 167, 392. In 1824 a full-time surgeon earned 371 rupees a month, while an assistant surgeon earned 224 rupees a month (in garrison). Crawford, *History of the Indian Medical Service*, Vol. 1, p. 371.

²⁴ Calculated from BL, IOR E/4/291, Abstracts from Fort St George, Military Letter 3. August 1786; *The East India Register and Directory for 1820*, 2nd ed. (London: Cox and Baylis, 1820); Annesley, *Sketches*, pp. 268, 271, 279–80, 286, 294, 303, 312–13, 315, 339; *Code of Regulations*, p. 55.

²⁵ Quoted from Wilson, *History of the Madras Army*, Vol. 4, p. 269.

²⁶ *Code of Regulations*, pp. 100–01.

²⁷ Rather the *vythian* seems to have been explicitly exempted from some of the doctrines of purity and pollution. Basham, ‘Practice of Medicine’, p. 27. In the early nineteenth century there was a discussion between physician General James Anderson and the missionary J.A. Dubois about the usefulness of Brahman inoculators. Dubois argued that the number of Brahman inoculators should be limited because they were ‘prevented by the prejudices of their Cast from communicating the disease to every individual without distinction’. Anderson replied that Brahman inoculators were needed to inoculate Brahmans, and that a primary function of the Brahmans was to ‘conciliate the minds of the people’ to the practice of vaccination. *The Asiatic Annual Register* (Chronicle), pp. 1, 4.

of south India. Dressers in the army were instructed by and were in constant contact with British surgeons; a contact which often took the form of immediate control. As early as 1786 doubts arose over the duties of assistant surgeons attached to native troops in relation to dressers. The Hospital Board did not hesitate to resolve that the assistant surgeon 'shall have the Charge of all the Sick and Wounded, & that the Black Doctor shall be obedient to his Orders'.²⁸ Three decades later, in 1817, the commander-in-chief ordered that dressers should be examined by British medical officers in order to make sure that they were 'well qualified to give medical aid to the followers and families of a corps'. If the dresser were found qualified 'in every respect' he would be issued with a certificate.²⁹ This was a step towards regular training of Indians in Western medicine in the Madras Presidency; further steps in this process were taken in 1827 and 1835 when the government ordered the establishment of medical schools in Madras.³⁰

The last group covered by the term native practitioner was the vaccinators employed in the campaign to combat smallpox from the turn of the eighteenth century. In the following, I shall deal with discussions in the colonial administration about who ought to qualify as vaccinators. Here, it is sufficient to note that although no formal requirements existed, vaccinators must often have been recruited from various groups of indigenous doctors as well as from the dressers in the army. The latter was the case with the highly successful chief native vaccinator in Madras, Sawmy Naik, who had been dresser to the 2nd Madras Native Battalion before pioneering the vaccination programme in and around Madras.³¹

While the vague and general designation 'native practitioner' referred to poorly defined and overlapping groups of *vythians*, *hakims*, folk practitioners, dressers and vaccinators, these groups constituted a crucial human resource for any wider medical intervention in Indian society in the first decades of the nineteenth century. The colonial administrators simply had to come to terms with the native practitioner.

Representing the Native Practitioner to a European Audience

One way of coming to terms with the native practitioner was to describe him. In this section I shall analyse a number of descriptions of indigenous medical practitioners produced in or relating to the Madras Presidency in the late eighteenth and early nineteenth century. As these descriptions were all printed, they eventually

²⁸ BL, IOR P/252/10, Madras Military and Secret Proceedings (hereafter MMSPP), 5 September 1786, fol. 1783.

²⁹ Quoted from Wilson, *History of the Madras Army*, Vol. 4, p. 269.

³⁰ Crawford, *History of the Indian Medical Service*, Vol. 2, pp. 434, 446. See 'The Madras Medical School', a brief 1838 report included in the *Madras Journal of Literature and Science*.

³¹ BL, IOR F/4/153, Board's Collections no. 2613, fols 21–22. See also Sawmy Naik's account of his own career in King, 'Introduction of Vaccination'.

became available for a wider European audience, although not all of them were written with this audience in mind.

Pierre Sonnerat's account of his voyage through parts of Asia was from the outset intended for a European audience: it was written to enlighten Europeans about the societies he passed through. Sonnerat spent some time on the Coromandel Coast and devoted a chapter to describe the indigenous practice of 'Physic'. As the passage quoted at the beginning of this article demonstrates, he was not impressed by Indian doctors. When a severe 'flux' (probably cholera) ravaged for some years previous to Sonnerat's visit, he reported that 'The Indian physician could not save a single person.' Sonnerat made a similar judgement on their treatment of smallpox: 'All those men who were treated by the physicians of the country with diet drink and antidotes, after their fashion, expired.'³² There were, however, also small openings in Sonnerat's text which gave some credit to the Indian physician. They treated fevers quite successfully and they were efficient in dealing with snakebites.³³ The treatment of snakebite in Karikal—performed in the absence of proper indigenous doctors—clearly amazed the otherwise sceptical French observer:

They took a young fowl, and applied its breech to the bite; which had almost the same affect as a cupping glass, and drew out the poison. The fowl expired soon after: a second was applied, which also soon expired, and was replaced by a third: thirteen was successively applied. The last did not die, neither did it appear disordered; and the man was perfectly cured.³⁴

This episode was, however, more an exotic tale from a distant country than it was a genuine credit to indigenous medical knowledge. Readers of Sonnerat's account would expect such marvels, but he and his readers would remain convinced of the superiority of Western medicine.³⁵

T.L. Folly—a surgeon working from the Danish settlement Tranquebar—similarly held that Indians practicing medicine did 'not possess the slightest knowledge of the sciences that belong to it'. Still, Folly found it worthwhile to interrogate itinerant Indian practitioners about their application of mercurial preparations, and to obtain a translation of a passage on mercury from an ancient text belonging to Tamil tradition of *siddha* medicine.³⁶

When the surgeon and botanist Francis Buchanan Hamilton was commissioned to survey the newly acquired territories of Mysore and Malabar in 1800, it was

³² Sonnerat, *Voyage to the East Indies*, Vol. 2, pp. 143, 150.

³³ *Ibid.*, pp. 151, 153.

³⁴ *Ibid.*, pp. 153–54.

³⁵ Snakes were emblems of the dangerous and exotic 'East', and European observers seemed preoccupied with the potential ability of Indians to neutralise snake poison. See the interesting account of the Tanjore 'snake pills' in Chakrabarti, 'Neither of Meate', pp. 19–22.

³⁶ Jensen, 'Medical Skills of the Malabar Doctors', quoted from p. 500. It is unclear to what extent Folly's manuscripts were published, but some appeared in—presumably German—journals. *Ibid.*, p. 499.

not to enlighten a broader audience about the features of these provinces, but to provide the colonial administration with useful information, which could be put to use in agriculture and industry. This included information on ‘those natural productions of the country, which are made use of in arts, manufactures, or medicine’, an account ‘of the prevailing winds, and the effects of the air in its various states of heat, and moisture, on the human body’ and an estimate of the ‘salubrity’ of the country.³⁷ Given these instructions and given that Buchanan was himself educated as a Medical Doctor, he showed surprisingly little interest in medical issues. The only explicit comment on medical practitioners was a casual remark—well in line with Sonnerat’s and Folly’s views—that ‘Medicine, in this country, has indeed fallen into the hands of charlatans equally imprudent and ignorant’.³⁸

The surgeon Benjamin Heyne—a missionary from Tranquebar, who became employed as the Company’s naturalist—followed up on the writings of Sonnerat, Folly and Buchanan. His collection of ‘tracts’ on various aspects of the natural history of south India from 1814 included a discussion of indigenous medicine. Unlike Sonnerat and Buchanan, Heyne approached the field through an unidentified ‘Indian Treatise of Medicine’, which he rendered in a fairly neutral manner. Having finished the summary, he abandoned neutrality and voiced his own unambiguous judgement:

Thus I have finished the translation of this most extraordinary treatise and I dare say my readers are by this time as fatigued as I am myself. It may be considered as a summary of all the medical knowledge of the Hindoos. We see their absolute ignorance of anatomy, and every thing connected with the functions of the human body; that their system is entirely chimerical and connected with their religious opinions.

Heyne further declared that ‘the treatise itself exhibited a banquet of absurdity sufficient to satisfy the most voracious quests’.³⁹ Taking a textual approach Heyne’s denouncement of Indian medicine was more thorough than the criticisms of Sonnerat, Folly or Buchanan. It was not just the specific practices of the contemporary groups he rejected, it was what he identified as the absurd and religious basis of indigenous medical knowledge in general. Yet Heyne decided to ‘intrude on the patience’ of his readers and provide examples of indigenous medicine and now the account becomes more ambivalent. Heyne recommended an indigenous medicine against epilepsy and he admitted that the Indians—‘long considered the wisest of the East’—knew more of the medical virtues of iron than did the Europeans. In contrast to many European doctors, Heyne found the use of small doses of copper useful as a medicine and he based this opinion partly on evidence from the practice

³⁷ Hamilton, *Journey from Madras*, Vol. 1, pp. ix, xi.

³⁸ *Ibid.*, p. 336.

³⁹ Heyne, *Tracts*, p. 165.

of Indian practitioners.⁴⁰ Contempt for the basis of indigenous knowledge did not prevent Heyne from acknowledging the validity of specific medical practices.⁴¹

The critical tone set by Sonnerat, Folly, Buchanan and Heyne was countered to a certain extent by the writings of Whitelaw Ainslie of the Madras Medical Service. Ainslie entered the Company service in 1788 and retired to Britain from the position as superintending surgeon in 1815. His works are often brought forward to demonstrate the open-mindedness of early colonial medicine in India, and they are certainly of prime importance in any account of the regional medical history of south India.⁴² The earliest published work from Ainslie's hand is *Materia Medica of Hindoostan* from 1813. Here Ainslie explicitly took issue with Sonnerat's portrait of the Indian doctor and declared that he wanted to do justice to 'the hindoo Medical of these provinces':

I must say, that either Monsieur Sonnerat has been a little remiss in his enquiries, or that I have been peculiarly fortunate, in meeting with *Vythians* of a very different description from those he alludes to ... Not a few of them I have known, who were not only intimately acquainted with all the medical *Sastrums*, great part of which they had by heart; but who, in other respects, were in their lives and manners correct obliging and communicative ...⁴³

In this passage Ainslie referred both to medical *shastras* and contemporary practitioners, and it is characteristic of his quest to obtain indigenous medical knowledge that he consulted both ancient texts and contemporary learned *vythians*.⁴⁴ The knowledge of the latter, he found, contained more to 'call forth our wonder than excite our contempt'.⁴⁵

Ainslie was, however, sceptical towards the Vedic tradition and like Heyne he bemoaned that ancient medical knowledge had been subjected to religious mythology. This had been 'an insurmountable obstacle to improvement' and was the reason that Indian medicine 'is still sunk in a state of empirical darkness'. Instead, Ainslie preferred the 'valuable professional tracts' used by contemporary *vythians*.⁴⁶ He also praised the regional Tamil medical texts for being 'less shackled by the mythological

⁴⁰ *Ibid.*, pp. 166–68, 170.

⁴¹ See also Chakrabarti, 'Neither of Meate', p. 22.

⁴² Arnold, *Colonizing the Body*, pp. 45–47; Bayly, *Empire and Information*, pp. 271–75.

⁴³ Ainslie, *Materia Medica*, p. 64.

⁴⁴ Ainslie, *Materia Medica* (preface); Bayly, *Empire and Information*, p. 272.

⁴⁵ The phrase appears in the 1826 edition of Ainslie's *Materia Indica*. Here quoted from Chakrabarti, 'Neither of Meate', p. 22.

⁴⁶ Ainslie, *Materia Medica*, p. 61. Ainslie claimed that the *vythians* were Sudras and thus without access to Brahmanical texts. This, of course, does not conform to Ainslie's claim against Sonnerat that *vythians* were well versed in medical *shastras* quoted here, but Ainslie seems to have used the term 'Sastrum' in a loose sense. See also Arnold, *Colonizing the Body*, p. 45 and Bayly, *Empire and Information*, p. 273.

doctrines of the original *Ayurveda*' and which he found contained more valuable formulas and a more minute attention to morbid symptoms.⁴⁷

Although Ainslie had much respect for the native practitioner, he also uttered reservations about their skills. He regretted that he was 'under the necessity of altogether trusting to what information I could collect from such Vytians and Hakeems as appeared to be best suited to assist me'. He found the Indian *materia medica* to be in a state of 'empirical obscurity' and emphasised that much work needed to be done in order to bring the medicine of the Tamils to perfection.⁴⁸ When a revised and enlarged second edition of Ainslie's book was published from London in 1826, this scepticism had developed into a regular warning against applying remedies not properly tested by Western medicine: 'The crude notions of the *Vytians* (industrious and well-meaning, however, those individuals may be) though they may ultimately lead to important truths, are not to be taken without distrust.'⁴⁹ While Ainslie was certainly more interested in learning from indigenous doctors than earlier observers, the *vythian* and *hakim* remained ambiguous figures: possessors of valuable knowledge and yet crude and imperfect medical practitioners.

After his retirement to Britain Ainslie continued to write about medical issues. He still looked with sympathy at indigenous knowledge, although it was not as central as it had been in his earlier writings. In 1825 he published a letter on the epidemic cholera, in which he promoted theories of 'galvanism' in the search for an explanation of this terrifying disease. Although Ainslie looked more towards Western science than Indian knowledge in order to understand the causes of cholera, he still found valuable evidence to support his own ideas on the practice of south Indian doctors.⁵⁰ In 1832, when cholera directly threatened Britain, Ainslie published a series of letters, in which he held the same opinion: the explanation of cholera was to come from the advancing Western science but—although largely ignorant of the underlying causes—the Indian practitioners possessed valuable specific remedies against the disease.⁵¹

Finally, Ainslie published a tract on inoculation for smallpox in 1830. He noted the widespread resistance against vaccination with cowpox virus among Indians, but explained it only partly with the standard reference to the Hindu aversion against innovations of any kind. He equally emphasised the success and efficiency of the variolation with genuine smallpox matter as it had been practised in north India long before colonial rule.⁵² Here, however, Ainslie was treating issues of which he had little specific knowledge, as variolation was largely unknown in the south

⁴⁷ Ainslie, *Materia Medica*, p. 63.

⁴⁸ *Ibid.*, p. 65.

⁴⁹ Ainslie, *Materia Indica*, Vol. 2, pp. xxxv–xxxvi.

⁵⁰ Ainslie, *Observations on the Cholera Morbus*, pp. 53–54.

⁵¹ Ainslie, *Letters on the Cholera*, pp. 10, 12, 24, 42.

⁵² Ainslie, 'Observations Respecting the Small-Pox', p. 64.

where he served throughout his career.⁵³ By now Ainslie had transformed from the medical servant eager to learn from indigenous practitioners to a more distant and critical observer. It was as such he concluded: 'that if, from a powerful empire in the west came an inordinate thirst for domination and the sword of the conqueror, thence also came the sympathising heart and the healing hand'.⁵⁴ Fifteen years after retirement, even Whitelaw Ainslie saw the healing hand as indisputably Western.

The great epidemic of cholera reached the Madras Presidency in 1818, and produced a number of writings, which we would expect to touch upon the native practitioner and the value of indigenous knowledge. Here, I shall consider two important and early treatments. In 1824 W. Scot, secretary to the Medical Board, published a massive report on the cholera in the Madras Presidency, commissioned by the Company for limited publication and future guidance. Scot opened his account emphasising the open-mindedness—or perhaps it was desperation—of the colonial administration:

... our present state of knowledge with regard to cholera did not appear to warrant the absolute rejection of any medical opinion concerning it. Every alleged fact and distinct theory, therefore, which have been recorded, find a place in these papers, and are thus to be left to be tried by the test of time and experience. So scrupulous, indeed, have the Medical Board been in the exercise of their authority, throughout the course of this destructive disease, that even at the hazard of incurring the imputation of empiricism, they have given currency to the notice of remedies and sanctioned their trial, although the exhibition of them might be little supported by any received system of medicine.⁵⁵

Yet, if this alleged open-mindedness extended to indigenous medicine, it is difficult to find any traces of it in Scot's report. He briefly referred the places where cholera was noticed in Hindu medical literature and quoted the various names given to cholera by the Hindus, but paid much more attention to European observations from the preceding centuries.⁵⁶ As far as the treatment of cholera goes, Scot made it clear that while European medicine might have a limited impact if administered early, indigenous cures (which were not specified) had no impact at all. Moreover, the discussion of the causes of cholera contained no references to indigenous knowledge.⁵⁷ The few references to indigenous doctors are not flattering. Scot

⁵³ Ainslie had briefly encountered variolation in the northern parts of the Madras Presidency. *Ibid.*, p. 63.

⁵⁴ *Ibid.*, p. 73.

⁵⁵ Scot, *Report on the Epidemic Cholera*, p. i.

⁵⁶ *Ibid.*, pp. iii–xvii.

⁵⁷ *Ibid.*, pp. xxxi, xlv–lxi. The appendix of original reports from the period 1818–22, which makes up the major part of Scot's report, contains more information on indigenous medicine. This information will be considered later.

quoted the resident at Travancore to the effect that when cholera ravaged there 30 years ago, all the *vythians* ran from their charge. In 1818 the resident had furnished 140 *vythians* with medicine and instruction, but declared 'from the experience I daily have of their general inattention, I much fear that when the day of visitation and trial arrives, the sick will be found too often left to their fate altogether unassisted'. Later in the report Scot added that the accounts of native doctors were unreliable 'either for their veracity, or their qualifications to discriminate the disease'.⁵⁸

James Annesley's *Sketches of the most Prevalent Diseases of India*, published from London in 1825, was in many respects a parallel account to Scot's. Annesley had served in India for 25 years and ended his career in 1823 as garrison surgeon of Fort St. George in charge of the general hospital in Madras. Mainly addressing a British audience, Annesley's account is even blinder to indigenous knowledge than Scot's. At the onset of his account, Annesley declared that the Hindu medical texts contained no references to the epidemic cholera. He acknowledged that the supposedly milder 'sporadic' cholera was noticed, but in a way 'that illustrates neither its pathology nor its treatment'.⁵⁹ Like many of his contemporaries Annesley defined the cholera which raged the Indian subcontinent from 1817 as a *new* disease and this conveniently allowed him to disregard the 'old' indigenous information on the disease.⁶⁰ Having dismissed the relevance of Hindu texts and the practices of indigenous doctors, the rest of Annesley's work contained no reference to indigenous medicine. His account was, indeed, a monologue of Western science about a disease of the East.

This survey of medical texts relating to early colonial south India enables us to organise them in three groups. First, the accounts of Sonnerat, Folly and Heyne, which were highly critical towards the native practitioners and the knowledge they represented but also contained some openings where the usefulness of specific practices was acknowledged.⁶¹ Second, the writings of Whitelaw Ainslie, which were generally sympathetic towards the native practitioners, but still saw them as crude and imperfect. Third, the reports of Scot and Annesley, which were written *after* the cholera epidemic and unambiguously dismissed Indian medical traditions in favour of Western science.

⁵⁸ *Ibid.*, pp. xvi–xvii, xxxi.

⁵⁹ Annesley, *Sketches*, p. 4.

⁶⁰ *Ibid.*, pp. 14, 42. Scot noticed that the general opinion in Madras was that the epidemic cholera was a new disease, but he regarded this as a mistake. Scot, *Report on the Epidemic Cholera*, p. ii. See also the circular letter from the Medical Board to Superintending Surgeons, 3 August 1818. BL, IOR F/4/595 no. 14376, Board's Collections, fols 5–9.

⁶¹ Accounts of this type fitted well with Chakrabarti's observation that bazaar medicine were widely resorted to in the eighteenth century. Bazaar medicine refers here to local products as well as products obtained through trading networks throughout Asia and beyond. See Chakrabarti, 'Neither of Meate', pp. 9–12, 16–19.

There was, however, one text which differed significantly from the texts analysed here. In 1816 an administrative report written by a medical committee headed by Ainslie was published in London. The report had originally been submitted to the Madras Board of Revenue in 1811 and was an investigation into the causes of and possible remedies against a severe 'epidemic fever' in the southern districts of Coimbatore, Madurai, Dindigul and Tinnevely. In this report the native practitioner appeared not as the representative of an elusive and non-scientific medical tradition, but as a potential ally of the colonial administration.

To a large extent the report was a discussion based on prevalent European theories of climatic disease causation and speculations about remote and immediate causes. A positive attitude towards the native practitioner is, however, clearly discernible and attention was paid to indigenous opinions on the causes of the epidemic as well as to indigenous medicaments.⁶² More important, perhaps, was the argument that many deaths had been occasioned by the ignorance of the native practitioners and that a 'concise and distinct' account of the European treatment distributed among them would remove that ignorance. This, of course, reveals that the committee believed in the superiority of European treatment, but it also indicates that the native practitioner was seen as a potential performer of Western medicine: *initially ignorant but easy to educate*.⁶³ The focus of the report was on the potential usefulness of native practitioners because this was a purely administrative report. It was addressing the need for the colonial power to devise a strategy of disease management and in this context it was more important to construct the native practitioner as a potential servant of the British than it was to evaluate the medical knowledge he represented. While authors writing to European audiences had to come to terms with the native practitioner as 'the other' in relation to a still more confident medical science, the colonial administrators—who were sometimes identical with those writers—had to come to terms with the native practitioners as a crucial resource for medical interventions in Indian society.

Smallpox: From Entrepreneur to Public Servant⁶⁴

The first major colonial intervention targeting the health of the inhabitants of south India was the attempt to immunise against smallpox. More than any other medical intervention in early colonial India, the efforts to combat smallpox had the character of a crusade. The British might have seen smallpox prevention as a suitable field to demonstrate the benevolent intentions of their regime. In contrast to the mysterious 'fevers' and 'fluxes' found in India, smallpox was well known from Europe and efforts to combat it did not depend on indigenous knowledge. Smallpox prevention provided a possibility to demonstrate that British rule was,

⁶² *Medical, Geographical, and Agricultural Report*, pp. 108, 130, 161–64.

⁶³ *Medical, Geographical, and Agricultural Report*, p. 169.

⁶⁴ Significant parts of this section is adapted from Brimnes 'Variolation', pp. 222–27.

in Ainslie's words quoted earlier, not only about conquest and domination, but also about sympathising hearts and healing hands.⁶⁵ While the colonial authorities knew they possessed efficient remedies against smallpox, they also sensed that an immense effort was required if these were to be distributed widely throughout Indian society. The obvious condition was that vaccinations had to be performed mainly by Indians and this generated two problems: how to get suitable native agents to carry out the vaccinations and how to control them. The British were not only driven into engagements with native practitioners on an unprecedented scale, but their efforts also ignited a heated debate over the nature of the native practitioner.

The pre-colonial north and east Indian practice of variolation with real smallpox matter was largely unknown in south India and the combat against smallpox before the cowpox vaccine reached Madras towards the end of 1802 was, therefore, primarily an attempt to introduce variolation in these parts of the subcontinent. In September 1800 the Government of Madras decided to launch a campaign to encourage variolation. Extracts from the colonial records were published in Arab, Telugu and Tamil; medical officers were encouraged to promote variolation and collectors were told to assist in convincing the population of the benefits of this practice.⁶⁶ Despite the fact that some Indian inoculators practised independently of the colonial administration—particularly in Guntur district—it does not appear that the colonial authorities seriously contemplated a systematic and extensive use of native practitioners in this effort. Indians willing to be inoculated were told to avail themselves of the gratis assistance of the Company surgeons and consequently the efforts of the colonial administration were halted when the medical officers were occupied with more pressing duties.⁶⁷

It did not take long, however, before indigenous agents were enrolled in the attempt to prevent smallpox. In the 'cold' season of 1800–01, 475 persons (Europeans and natives) were listed as inoculated, 233 of which had been inoculated by two native practitioners. In April 1801 the government in a letter to the Board of Revenue stressed the need to encourage 'a few intelligent Brahmin Doctors in each district to become practitioners of inoculation' and suggested that they be rewarded in relation to the number they inoculated.⁶⁸ In December 1801 the government resolved to reward native practitioners with 20 pagodas (or 70 rupees) for every

⁶⁵ Ainslie, 'Observations Respecting the Small-Pox', p. 64. Before the arrival of the cowpox vaccine in Madras towards the end of 1802, the British promoted variolation, which was a technique which originated in Asia. It was, however, largely unknown in south India and, therefore, as 'foreign' to the Madras Presidency as Jennerian vaccination. See Brimnes, 'Variolation', pp. 206–10, 218–22. For the conceptualisation of immunisation against smallpox as part of a civilising mission, see Brimnes, 'Sympathizing Heart', pp. 192–96.

⁶⁶ BL, IOR F/4/96 no. 1953, Board's Collections, fols 11–12, 15.

⁶⁷ See the 'circular advertisement' from Guntur, dated 27 November 1800. BL, IOR F/4/96 no. 1953, Board's Collections, fols 44–45. For the problem of attending to other duties, see fols 75–76.

⁶⁸ Quoted from a copy of the letter found in the Madurai District Records. Tamil Nadu State Archive, Chennai (hereafter TNSA), Madurai District Records 1181, fols 265–66, 268.

100 patients successfully inoculated.⁶⁹ There is evidence that from 1802 native practitioners in Company employment were active in Canara, Masulipatam and in the Black Town of Madras.⁷⁰ When the cowpox vaccine reached Madras in December 1802 and the campaign against smallpox intensified, a model for the engagement with native practitioners was thus already established. This model envisaged the native practitioner as an enterprising individual, and in a plan for the diffusion of vaccination from January 1803 the notion of self-interested indigenous entrepreneurs was a central feature. Native practitioners were to be instructed by Company surgeons and, when sufficiently informed, to receive a certificate ‘without which none to be sanctioned to inoculate’. The reward was, however, halved to 10 pagodas for every 100 persons successfully inoculated, and it was emphasised that vaccinators were to be subjected to a strict control from superior medical officers.⁷¹

The campaign soon faced severe difficulties. In May 1804 outbreaks of natural smallpox and the loss of the viral vaccine in the northern part of the Presidency led the government to openly criticise the way the system worked.⁷² In November 1804 the Garrison Surgeon of Fort St George, Alexander Mackenzie, attacked the entire campaign against smallpox. In a letter to Governor Bentinck, he pointed out the shortcomings of the system and submitted proposals for revisions. In the debate that followed the character of the native practitioners and the way the colonial administration ought to engage with them immediately became a central issue. In his initial letter to Bentinck, Mackenzie noted that the trust put in the native vaccinators—whom he believed were mainly from ‘inferior Classes’—was so great and the means of control so inadequate that in most areas the system depended entirely on their dedication to the cause. The system of paying the native vaccinators in relation to the number of persons inoculated only encouraged carelessness, because they were likely to consider their private advantage and pay attention only to the number inoculated, not bothering to check whether the operation had been conducted properly. On the other hand, Mackenzie suggested, if the native vaccinators were paid a regular salary ‘They will perform their duties on the fixed Principles of obedience and zeal having no temptations to dishonesty they will direct their attention to the proper object of their Employment.’⁷³

⁶⁹ Quoted from TNSA, Madurai District Records 1182, fol. 444.

⁷⁰ TNSA, Surgeon General’s Records 13A, fols 302, 451–70. BL, IOR E/4/329, General Correspondence: Letters Received from Madras, Public Letter, 20 October 1802, para 138.

⁷¹ BL, IOR F/4/153 no. 2613, Board’s Collections, fols 42–43, 60–63. References to ‘experiments’ with cowpox vaccine was made by the government in a letter to the Medical Board dated 23 December 1802 and indicated the arrival of the vaccine in Madras. See fols 31–32.

⁷² TNSA, Madurai District Records 1190, fols 149–69. The proceedings of the Medical Board from 21 May 1804 was distributed by the Board of Revenue as a ‘circular’ to all district collectors.

⁷³ BL, IOR P/255/43 Madras Military Proceedings (hereafter MMP), 21 December 1804, fols 6404–15, quoted from fol. 6411.

Defending the established system, the Medical Board challenged Mackenzie's perception of the native practitioner. While they agreed that vaccinators like the rest of mankind were motivated by 'considerations of private advantage', they believed that self interest rather than producing fraud would 'afford the best security against it'. They based this on the fact that vaccinators caught in fraud would lose a respectable position in colonial society as well as an attractive salary.⁷⁴ On his part Mackenzie maintained the view that native vaccinators came from the lower sections of indigenous society and that they were 'in general careless, ignorant, and dishonest'.⁷⁵ He also maintained that the transformation of the native practitioners was easily attainable: if they were paid a regular salary, they would feel obliged to perform their duties properly.⁷⁶ Part of the Medical Board were still hostile to Mackenzie's ideas and submitted a list of certified vaccinators from which, they claimed, 'it will appear, that these Practitioners are very properly of the highest and of all Casts, and not uninstructed as Mr. Mackenzie has asserted'.⁷⁷ The list contained the names of 66 certified indigenous vaccinators, but it does not provide a very precise indication of their status in Indian society. A few vaccinations were described through broad caste designations, but the vast majority of the vaccinators were entered as either 'Gentoos' (Telugus) or 'Malabars' (Tamils), linguistic designations covering a wide range of castes with very different status.⁷⁸

Other people entered the discussion. The Jesuit missionary J.A. Dubois, who was entrusted with the superintendence of vaccination in Mysore, proposed a revision of the system of vaccination, which resembled Mackenzie's. Dubois agreed with Mackenzie that the major problem was the lack of control with the native vaccinators: 'One of the most common irregularities among the Native practitioners who are not under a strict control, is to run incessantly from one village to another to find patients without visiting afterwards the persons under infection, nor paying otherwise the least attention to them.'⁷⁹ In line with Mackenzie, Dubois suggested that the vaccinators be paid a regular salary, but that the responsibility to control their practice be vested with the collector and the *tahsildars* employed under him.⁸⁰

Also in April 1805, Surgeon Dalton—highly regarded as one of the pioneers of vaccination in the Madras Presidency—wrote to the government and suggested that the native vaccinators be put on a permanent salary in a quite different way. He

⁷⁴ BL, IOR P/255/43 MMP, 21 December 1804, fols 6309–10.

⁷⁵ BL, IOR P/255/53 MMP, 19 June 1805, fol. 3999.

⁷⁶ BL, IOR P/255/53 MMP, 19 June 1805, fol. 4001.

⁷⁷ BL, IOR P/255/53 MMP, 19 June 1805, fols 3983–84.

⁷⁸ BL, IOR P/255/53 MMP, 19 June 1805, fols 4063–65.

⁷⁹ BL, IOR P/255/53 MMP, 19 June 1805, fol. 4081.

⁸⁰ BL, IOR P/255/53 MMP, 19 June 1805, fols 4082, 4087–89. In a later communication to James Anderson, Dubois also suggested that vaccinators be employed in each *talook* under the immediate superintendence of the *tahsildars*. For some reason Dubois had considerably more trust in indigenous revenue officers than he had in native practitioners. *The Asiatic Annual Register* (Chronicle), quoted from p. 3.

began with a description of the ‘village establishment’, explaining how a variety of services were remunerated through shares in the crop, and went on to suggest

... that vaccination shall form *apart* [sic] of the establishment thus provided for in a proportionate Ratio ... (...) ... as the extent of the Talook, or Village May be; And, that carrying on vaccination, and keeping up the Disease, shall be the tenure, by which they, and their Successors Shall hold the land, that may be granted them by Government.⁸¹

Dalton simply suggested that the vaccinator be transformed from an entrepreneur to a village servant, rewarded *neither in relation to the number of people vaccinated nor by a fixed salary but by rights in land and claims to a share in the village produce*. Dalton envisaged that the office of village vaccinator would be transmitted from father to son and believed that ‘the station of permanent vaccinators’ would ‘induce numberless candidates ... to present themselves’.⁸²

Finally, William Horsman, superintendent of the Vaccine Establishment (and likely to lose his position to Mackenzie if the latter’s plan was adopted), in May 1805 tried to incorporate the criticism in a plan for gradual changes in the system. As a genuine compromise Horsman suggested that the reward was halved to 5 pagodas per 100 persons and supplemented by a low fixed salary. This system was to apply until the ‘superstitious prejudices’ among the Indians had dissolved and the duty of vaccination could—as suggested by Dalton—be vested with the ‘Village Doctors’. This system would, Horsman argued, be cheaper than the present. It would retain ‘the essentially necessary incitement to industry’ and it would at the same time turn the vaccinators into government servants and thus liable to be transferred from area to area according to orders from Superintending Surgeons.⁸³

From this range of suggestions as to how to engage with the native practitioner Bentinck decided in favour of the system proposed by Mackenzie.⁸⁴ Stripping the Medical Board of its responsibilities regarding vaccination, Bentinck put his faith in the judicial system, which was still under establishment, and ordered that each *zillah* get its own department of vaccination consisting of four native practitioners paid 4–5 pagodas a month. They were to be under the superintendence of the European surgeon attached to the Zillah Court. Mackenzie was then appointed Superintendent of Vaccination and referred directly to the government in the Judicial Department.⁸⁵ The Court of Directors approved the steps taken by Bentinck, but ordered that Mackenzie referred to the government through the Medical Board.⁸⁶

⁸¹ BL, IOR P/255/53 MMP, 19 June 1805, fols 4093–94.

⁸² BL, IOR P/255/53 MMP, 19 June 1805, fols 4094–95.

⁸³ BL, IOR P/255/51 MMP, 14 May 1805, fols 3094–99.

⁸⁴ BL, IOR F/4/201 no. 4544, Board’s Collections, fols 22–23.

⁸⁵ Vaccination was to be considered, Bentinck argued, as a ‘civil Regulation rather than a Medical Practice’. BL, IOR F/4/201 no. 4544, Board’s Collections, fols 4, 31, 49.

⁸⁶ BL, IOR F/4/268 no. 5891, Board’s Collections, fols 77–80.

From the position of Superintendent of Vaccination, Mackenzie in the following years had rich opportunity not only to propagate the virtues of the revised system, but also to represent the native practitioner and evaluate his services to diffuse the practice of vaccination among the Indian population. While the number of vaccinations grew, it did not rise as fast as the number of vaccinators, which had grown from the 66 to 177 in 1812.⁸⁷ Attempting to explain the lesser overall efficiency of the new system, Mackenzie emphasised that they were now working under entirely different conditions:

The Native Vaccinators at present act under a regular plan calculated to diffuse vaccination gradually among the people: but those formerly employed were rather encouraged [sic] to practice abuses than to exert their endeavours for the advancement of this object. ... instead of employing Natives of all descriptions upon absurd allowances in propagating Vaccination; a few persons regularly instructed are maintained upon moderate Salaries.⁸⁸

A year later Mackenzie again emphasised how the native vaccinators worked under regular conditions, 'under a regular plan calculated to diffuse vaccination gradually', that they acted on 'the principle of duty, zeal and emulation' and that they were now 'vigilantly inspected by the superintendent'.⁸⁹

What Mackenzie described here was the supposed 'bureaucratisation' of the practice of vaccination. In the early nineteenth century many areas of the Madras administration saw the attempted transformation of indigenous agents from relatively independent entrepreneurs to subordinate and controllable servants. One might, of course, speculate to what extent this transformation actually happened, particularly in areas distant from the colonial centre in Madras.⁹⁰ For Mackenzie, however, the native practitioner was now working in a bureaucratic context and he was no longer careless, ignorant or dishonest, but a zealous civil servant on regular pay.

More than a decade later the problems, which had accompanied vaccination since its introduction, remained: erroneous practice and lack of efficient control with the vaccinators. In 1821 the Superintendent of Vaccination William Scot suggested a number of changes in the system. Echoing the Mackenzie's criticism 17 years earlier Scot identified the almost unlimited trust in 'the fidelity and discretion' of the vaccinators as the major obstacle and suggested that the responsibility for over-seeing the practice of vaccination was moved once again, this time to the collectors

⁸⁷ BL, IOR F/4/201 no. 4544, Board's Collections, fols 9–10; F/4/268 no. 5891, Board's Collections, fols 31, 48–49, 54–55, 60; F/4/382 no. 9625, Board's Collections, fol. 126.

⁸⁸ BL, IOR F/4/268 no. 5891, Board's Collections, fols 39–40.

⁸⁹ BL, IOR F/4/268 no. 5891, Board's Collections, fols 48–50.

⁹⁰ For further discussions of 'bureaucratisation' in early nineteenth-century Madras, see Appadurai, *Worship and Conflict*; Irschick, *Dialogue and History*, pp. 14, 67–69; Brimnes, *Constructing the Colonial Encounter*, pp. 45–46, 143–46, 194, 234–35; Mukund, *View from Below*, pp. 97–135.

and the revenue department.⁹¹ Scot also echoed Mackenzie when he claimed that the native vaccinators were poorly qualified, but unlike his predecessor he suggested that only *vythians* be employed as vaccinators and gave a flattering description of this class of people:

It must be admitted that none but men belonging to the medical Profession can ever be thoroughly successful—their professional Knowledge, and habits, the nature of their intercourse with the people, and even their good will, are all adapted to, and necessary for the prosperity of Vaccination, while it can hardly be supposed that men devoid of these advantages, will ever be able to effect much.⁹²

Following Scot's suggestion it was established that only 'native practitioners' could be selected as vaccinators, an exception being made for the sons of and immediate relations of old vaccinators of 'approved zeal and ability'.⁹³ Although Scot claimed that this provision was already included in the existing regulations from 1805, it appears to be the first time the position as vaccinator was explicitly reserved to representatives of indigenous medical traditions.

The campaigns to immunise against smallpox was not only targeting the virus, it was also directed against the perceived prejudices and superstitions of Indian society. Reference to Indians as 'a superstitious and prejudiced people' was very common in the records of the colonial administration, and the campaign against smallpox was constructed as the humane extension of a benevolent European practice to the people of India.⁹⁴ In a government advertisement published in January 1803 reference was made to 'the spirit of benevolence' of the medical profession in Europe, which

... led to the adoption of the means best calculated to convey the fruits of the happy discovery to India; and this humane object having been after much care effected, the Inhabitants of India may, by following the example of the European Nations be for ever freed from further apprehension or danger from the small Pox.⁹⁵

The notion that the people of India were to follow the example of Europe was particularly true of the native practitioners, who were to be instructed, certified

⁹¹ BL, IOR P/294/1, MBORP, 12 November 1821, fol. 10051.

⁹² BL, IOR P/294/1, MBORP, 12 November 1821, fol. 10055.

⁹³ BL, IOR P/294/1, MBORP, 12 November 1821, fol. 10068; *Code of Regulations*, p. 152. Here we must understand the term 'native practitioner' as a representative of a recognised indigenous medical tradition.

⁹⁴ BL, IOR F/4/153 no. 2613, Board's Collections, fol. 126. This construction ignored the fact that the practice of variolation—which had been encouraged by the colonial administration in the years immediately before the arrival of cowpox vaccine in 1802—had non-European, if not Indian, roots.

⁹⁵ BL-OIOC F/4/153 no. 2613, Board's Collections, fols 71–72.

and controlled by the colonial administration. Agreeing on the superstitious nature of Indian society in general, both Mackenzie and the Medical Board exempted the native practitioner from this construction, although they did so in different ways. While the Medical Board believed in stimulating his self-interest and incitement to industry, Mackenzie envisaged him as a zealous, 'bureaucratic' servant. In both cases he was capable of serving as a central figure in the colonial campaign against smallpox. Indeed, Mackenzie's belief in the sudden transformation of the native practitioner from careless, ignorant and dishonest to zealous and efficient clearly illustrates that in the administrative context and faced with the project of exterminating smallpox the native practitioner was far from being conceptualised in purely negative terms.⁹⁶ Coming to terms with the native practitioner in the field of vaccination was a troubled process, in which he was constructed differently as individual entrepreneur, as part of the village establishment and as a bureaucratic servant, but always as a potential resource for colonial medicine.

Fever: Reinventing the Royal Gift

The next major challenge to the medical branch of the Madras administration was the severe 'epidemic fever'—already referred to earlier—which followed the famine years in 1806 and 1807.⁹⁷ The fever was later estimated to have killed more than 100,000 people in the southern districts of Coimbatore, Madurai, Dindigul and Tinnevely, and it clearly threatened the regular collection of revenue from these districts.⁹⁸ In contrast to the campaign against smallpox the British possessed no efficient remedy against fever and consequently the British intervention was not a self-confident crusade against indigenous superstition. Instead, it was primarily an attempt to make the most of the resources represented by the native practitioner.

In October 1810 the collector of Coimbatore reported that nearly 2 per cent of the population in the district had died within six months and suggested that 'a professional enquiry into the management of the disorder' be conducted. In March 1811 the collector of Dindigul and Madurai submitted a similar proposal and shortly after the Board of Revenue obtained government sanction to dispatch a Medical

⁹⁶This argument is also developed in Brimnes, 'Variolation'.

⁹⁷The fever might have been an epidemic form of malaria, which often occurred when inundations followed shortly after famines. This type of epidemic malaria was, for instance, reported from Punjab in the twentieth century. See League of Nations, *Report of the Malaria Commission*, pp. 37–40.

⁹⁸BL, IOR F/4/382 no. 9685, Board's Collections, fol. 291 and *Medical, Geographical, and Agricultural Report* (advertisement). In Dindigul the revenue collection was reported to have fallen from 77,496 pagodas in 1809–10 (*fusly* 1219) to 43,612 pagodas in 1811–12 (*fusly* 1221). TNSA, Madurai District Records 1156, fols 192–93. For further revenue considerations, see BL, IOR F/4/382 no. 9685, Board's Collections, fols 237–72; F/4/383 no. 9686, Board's Collections, fols 239–60.

Committee headed by Whitelaw Ainslie to the districts affected by the disease.⁹⁹ The committee, blaming both climatic conditions and the poverty of the inhabitants for the epidemic, quickly identified native practitioners as a crucial resource in the attempt to provide some relief to the population. In a letter dated 7 May 1811 the committee informed collectors in the affected districts:

It having appeared to us that one cause of the great Mortality that has for some months past been occasioned by the Epidemic fever which is still prevalent in the districts of Coimbatore, Dindigul, Madura & Tinnevely is the scarcity of intelligent Native Doctors [–] we therefore take the liberty of recommending that every encouragement should be given to settle in the different villages throughout these Provinces and which perhaps could most successfully be accomplished by allowing them certain agricultural rights and immunities.

Until such intelligent native practitioners could be regularly chosen, the committee recommended that an ‘expert and active Duffadar be placed in each village’.¹⁰⁰ In a letter to the Medical Board 10 days later the committee followed up on this issue and suggested that doctors appointed to positions in villages be ‘for a short time instructed in the best mode of treating some of the most common Maladies of these Provinces’.¹⁰¹ The Medical Board supported this suggestion, but in their recommendation to the government they added a general devaluation of Indian medicine, declaring that the present practice ‘unaltered by experience, & regulated by the usage of their Ancestors, or according to shasters, must often be detrimental from not being adapted to existing circumstances’.¹⁰² Thus, within the same letter the Medical Board constructed the native practitioner both as a potential resource in medical interventions and as the representative of an ‘irrational’ and non-scientific medical tradition.

The strategy proposed by the Medical Committee was to distribute native doctors in the villages through government grants in the revenue and then provide for their instruction in basic Western medicine. The native practitioner was here—as I have noted earlier—constructed as a potentially useful ally of the colonial administration: initially ignorant, but easy to educate. The proposals of the committee did not, however, find much favour within the colonial administration. In May 1811 the government declared that it did not ‘concur in the expediency of appointing particular persons in each village’, while the Board of Revenue rejected the idea of providing personal tuition for native practitioners.¹⁰³ And in the final report of

⁹⁹ BL, IOR F/4/382 no. 9685, Board’s Collections, fols 63–73, quoted from fols 66–67.

¹⁰⁰ BL, IOR F/4/382 no. 9685, Board’s Collections, fols 143–44. *Duffadars* or *dafādārs* were petty police officers.

¹⁰¹ BL, IOR F/4/382 no. 9685, Board’s Collections, fols 231–32.

¹⁰² BL, IOR F/4/382 no. 9685, Board’s Collections, fol. 211.

¹⁰³ BL, IOR F/4/382 no. 9685, Board’s Collections, fols 155–56; F/4/383 no. 9686, Board’s Collections, fol. 237.

the committee, the recommendation of personal tuition to native practitioners had been scaled down to the publication in Indian languages of a 'concise and distinct account of the European method of treating fevers'.¹⁰⁴

Despite lack of support from the government, the idea of engaging with native practitioners in the villages through the granting of 'certain agricultural rights and immunities' lived on. In May 1818, with reference to the benefits derived from the employment of native practitioners under the continued epidemic of fever in Madurai and Dindigul and the reported existence of *yeomiah* grants in money to medical men in Nellore, the Medical Board wrote to the government:

With the view of appropriating the services of such persons with the utmost advantage to government and to the relief of the Native Community we would take the liberty with deference to suggest that your Honor in council would be pleased to obtain from the Revenue Board a Statement of all Yeomiahdars or Enamdars who receive any public allowance either in money or in certain favourable Grants of Land—on account of the performance of Medical duties under this or any other former Government.¹⁰⁵

This was the starting signal for the three years long enquiry into the existence of medical *inams* and *yeomiah*s in the districts of the Madras Presidency. I have referred to the main results of this survey in the first section of this article, but the survey also indicates that the practice of granting *inams* or *yeomiah*s to medical practitioners had been in use up to the final decades of the eighteenth century. A few of the grants were still held by the original grantee, and many were held by their sons and grandsons. In Trichinopoly six of 25 grants were still held by the original grantee, while in South Arcot six out of eight grants were held by sons of the original grantee.¹⁰⁶ It is also interesting to note that the practice of granting privileges to doctors seems to have been associated with the Nawabs of Arcot. Both North Arcot and Trichinopoly—the districts where the total annual value of grants were highest—were central areas in the domain of the Carnatic Nawabs. In Chingleput district nine out of the 48 small grants were reported to have been granted by Nawab Saadatullah Khan (1651–1732). In Trichinopoly all the large grants to indigenous doctors were made by either Nawab Anwarruddin Khan (c. 1674–1749) or 'Nabob Walaja'—probably Nawab Muhammad Ali Walajah (1722–95)—while *poligars* were entered as granters in four of the 25 grants. In his report of the grants the collector remarked that 'these Enams were granted by the late Nabobs and Carnatic Rajahs &c as a remuneration for the Medical attendance on them and their family'.¹⁰⁷ Also the officers of the Arcot administration were among the

¹⁰⁴ *Medical, Geographical, and Agricultural Report*, pp. 169–70.

¹⁰⁵ BL, IOR P/292/72, MBORP, 6 July 1818, fol. 8454.

¹⁰⁶ BL, IOR P/293/64, MBORP, 28 September 1820, fols 8188–89; P/293/29, MBORP, 16 August 1819, fols 10111–13.

¹⁰⁷ BL, IOR P/293/64, MBORP, 28 September 1820, fols 8188–89.

donors. In North Arcot Nawabs were only registered as granters two times, while *jagirdars* were registered 17 times and *poligars* eight times. In South Arcot, where eight grants were identified the granters were registered as Arcot *mufties* four times and Arcot *kazis* three times.¹⁰⁸ Granting privileges to indigenous doctors was undoubtedly a way of connecting medical services to the dominant households under Arcot rule and ideas within the British administration of granting *inam* land to native practitioners on account of medical services was, therefore, a reinvention of a royal practice of gift giving, which had been in use immediately before colonial rule.¹⁰⁹

In 1821 the suggestion of connecting to native practitioners through various grants was finally abandoned. But the fact that this way of coming to terms with the native practitioner was promoted throughout the period under investigation here—from Dalton's plan for a better system of vaccination in 1805 to the recommendations of the Medical Committee in 1811 and the survey of 1818–21—indicates that it was seen as a viable strategy within the colonial administration. It further illustrates how important the native practitioner was to any medical strategy in early colonial India.

Cholera: Valuable Day-Labourers

Although cholera had been known in South Asia for centuries, it seems to have assumed a more virulent form with the epidemic that spread from Bengal in 1817. It reached the northern parts of the Madras Presidency in August 1818 and turned out to be the greatest challenge to the medical administration in Madras in the first half of the nineteenth century. While the number of deaths was probably lower than from epidemic fever, the violence and unpredictability of the cholera epidemic put more pressure on the administration to display both control and compassion. The cholera epidemic was—as argued by David Arnold—a test of European authority and this made the native practitioner more important than ever to the British.¹¹⁰ It might be argued that the epidemic of 1818–22 became the moment of colonial glory for the south Indian practitioners.

From the autumn of 1818 several reports describing the alarm caused by the cholera were received in Madras. In October 1818 it was reported from Bellary that, despite every precaution taken by the collector, 'this malady has excited

¹⁰⁸ BL, IOR P/293/75, MBORP, 19 February 1821, fols 1343–46; P/293/29, MBORP, 16 August 1819, fols 10111–13. *Mufties* were expounders of Muslim law, and *kazis* (or *cauzys*) their subordinates supposed to carry out the judgments.

¹⁰⁹ An important difference was, however, that the new rulers wanted doctors to attend to the 'people' in general, thus playing down any personal link between doctor and ruler. For the nature of *inams* as royal gifts in pre-colonial south India, see Dirks, *Hollow Crown*, pp. 111–38.

¹¹⁰ Arnold, *Colonizing the Body*, pp. 159–64, 175.

unusual alarm, and that many infatuated persons have refused all medical aid'.¹¹¹ From Cuddapah the alarm was reported as being 'beyond description', business at the collector's *cutcherry* and the Zillah Court had almost come to a standstill, while the inhabitants deserted their villages for the hills or the jungle. In Tanjore, by contrast, villagers were refusing to leave their villages or to receive strangers and this severely damaged the trade in grain and other articles.¹¹²

The colonial administration reacted with a widespread employment of native practitioners, who were dispatched to the affected areas armed with instructions and medicine from Western medical officers. In a circular letter from August 1818 the Medical Board instructed superintending surgeons in the precautions to be taken in the event of an outbreak of cholera. A *pandal* (tent) should be raised on a healthy spot and furnished with cots and blankets; opium, camphor and arrack was to be procured as medicine and finally: 'Four of the most intelligent Native Doctors, at five pagodas each monthly, to be employed, for the purpose of administering medicine and relief to the sick....'¹¹³ In Madras 12 receptacles were established manned in all with 11 European medical officers and 26 native practitioners.¹¹⁴ Outside the colonial metropolis the number of European surgeons was obviously much smaller. From Ingeram on the northern fringes of the Presidency, Assistant Surgeon Donaldson reported that while he had tended to 125 patients in Ingeram, 12 native practitioners employed by him had tended to 2,124 patients in surrounding villages.¹¹⁵ For Salem, where the attack of cholera was followed by an outbreak of 'fever', the collector in May 1819 asked the Board of Revenue to sanction the employment of five or six native practitioners. The board strongly recommended this to the government, arguing that

... the service of people of this description were found extremely useful in the Madura District and the Board, trusting that the same beneficial effects will result from the employment of them in Salem beg leave to recommend that Authority may be granted to entertain six Native Practitioners ...¹¹⁶

In Nellore the collector initially limited his efforts to the distribution throughout the district of 'very particular directions' for the best treatment of cholera, but due to the 'utmost apathy' among the Indian population he decided in August 1819 to

¹¹¹ BL, IOR P/292/85, MBORP, 22 October 1818, fol. 14255.

¹¹² BL, IOR P/292/86, MBORP, 12 November 1818, fols 15088–89; P/292/91, MBORP, 14 December 1818, fols 16661, 16665–66. See also P/293/32, MBORP, 16 September 1819, fols 11235–36.

¹¹³ BL, IOR F/4/595 no. 14376, Board's Collections, fol. 7. Five pagodas was the equivalent of 17.5 rupees.

¹¹⁴ BL, IOR F/4/657 no. 18252, Board's Collections, fol. 31.

¹¹⁵ BL, IOR F/4/657 no. 18252, Board's Collections, fols 67–69.

¹¹⁶ BL, IOR P/293/20, MBORP, 27 May 1819, fol. 6462; P/293/22, MBORP, 3 June 1819, fol. 7029. The government gave its sanction on 11 June. P/293/23, MBORP, 21 June 1819, fol. 7719.

dispatch native practitioners, a measure later approved by the Board of Revenue and sanctioned by government.¹¹⁷

As cholera both struck and disappeared rather suddenly the colonial administration now developed yet another model for the employment of native practitioners: they were hired on a short-term basis. Nowhere was this more clearly stated than in a letter from the Medical Board to the government in April 1820. The collector in Salem had asked permission to employ a European sub-assistant surgeon, but the board recommended 'the employment only of Native Doctors who can be entertained and dismissed at a moments warning'.¹¹⁸ Thus, in Madras most of the establishment of native practitioners was dismissed after less than two months in December 1818. As the cholera soon reappeared, some of them probably had to be reinstalled and the establishment was finally shut down by the end of August 1820.¹¹⁹ The practice of entertaining native practitioners for short periods also appears from various statements of the costs incurred on account of the cholera. In Salem an account of 952 rupees was submitted to the Board of Revenue in September 1819. Twenty-one rupees was for the employment of two native doctors in Durampoory, while another 106 rupees had been paid to three native dressers with Portuguese names. At the standard pay of 17.5 rupees per month (the equivalent of 5 pagodas) the two doctors in Durampoory could have been employed for less than a month each, while the three Portuguese dressers might each have been employed for two months. The total costs for the following year in Salem was much lower at 222 rupees, of which just 21 rupees was for the employment of native practitioners. In Tinnevely six *vythians* were employed in January 1819; they were paid per day and none of them were employed for more than 22 days.¹²⁰

The most striking example of the short-term employment of native practitioners came, however, from Madurai. Here the precautions taken against cholera was more extensive than in any other district. This was probably due to a precedent for employing native practitioners established during the epidemic fever, which continued in the district till at least 1819.¹²¹ In March 1820 the collector asked the Board of Revenue to sanction expenses of more 10,000 rupees covering the period from November 1818 to January 1820. In this period nearly 40,000 people were reported to have applied for relief through official channels in the districts of

¹¹⁷ BL, IOR P/293/31, MBORP, 2 September 1819, fol. 10602; P/293/32, MBORP, 13 September 1819, fol. 11804; P/293/34, MBORP, 30 September 1819, fol. 11663.

¹¹⁸ BL, IOR P/293/53, MBORP, 18 May 1820, fol. 3466.

¹¹⁹ BL, IOR F/4/657 no. 18252, Board's Collections, fols 32, 88.

¹²⁰ BL, IOR P/293/32, MBORP, 16 September 1819, fols 11237–40; P/293/64, MBORP, 25 September 1820, fols 8029–30; P/245/5, Madras Public Proceedings (hereafter MPP), 23 August 1819, fols 3827–34.

¹²¹ TNSA, Madurai District Records 1164, fols 45, 58–59. BL, IOR P/293/23, MBORP, 21 June 1819, fol. 7795. Native practitioners (perhaps vaccinators) were regularly used in the district in the treatment of fever from at least 1816. TNSA, Madurai District Records 1166, fol. 52 and 1167, fol. 58.

Madurai, Dindigul and Ramnad, of which nearly 4,000 died. In Madurai Fort and Mandacolum *talook* alone 11,383 applied for relief and 543 died.¹²² The epidemic peaked in December 1818 and in January 1819. From March the number of cases remained fairly constant, keeping below 3,000 in the districts and fluctuating around 300 in Madurai and Mandacolum. In Madurai and Mandacolum no less than 22 native practitioners were employed over 14 months, but the vast majority were employed for less than 3 months around the peak of the epidemic and 5 of them for no more than a few weeks. The native practitioners hired to relieve cholera patients had, it seems, become day-labourers for the colonial administration: employed in times of crisis and dismissed as soon as possible.¹²³ This stands in sharp contrast to the long-term employment envisaged in Mackenzie's plan for the diffusion of vaccination or a permanent—even hereditary—position as village doctor on government privilege.

Facing a fatal and unpredictable epidemic, for which they possessed no better remedy than their Indian counterparts, and highly dependent on the service of indigenous agents, it is not surprising that the native practitioner was portrayed in rather flattering terms in the correspondence of the colonial administration.¹²⁴ When cholera arrived in Madras in October 1818 an extraordinary issue of the Government Gazette was published in order to calm the inhabitants. It was not only emphasised that the receptacles established in the Black Town were manned with 'the most intelligent Native Doctors that could be obtained', but the Indians were also urged to consult their 'family doctors' from whom they would 'not only obtain an intimate knowledge of the symptoms of the disease, but [also] of its treatment'.¹²⁵ When, towards the end of November, the epidemic was thought to be on the decline in Madras the Medical Board recommended that 'a certain number of the most meritorious and diligent Native Practitioners' were employed for another month. Moreover, the board suggested—'in consideration of the fatiguing nature of their duty'—that the native practitioners should be paid for the whole of October

¹²² BL, IOR P/293/49, MBORP, 20 March 1820, fols 2163–75. Within the group seeking relief from colonial institutions the mortality was lower than would normally be expected for cholera, but milder cases of diarrhoea and the prevailing fever might have been included in the report. The total number of deaths in the districts (except Sivagangai), including those who did not seek relief through official channels, were reported to be nearly 34,000. The Board of Revenue did not deem it proper to sanction such a large sum and referred the decision to the government. See fols 2175–77.

¹²³ He was not that expensive either; the cost of buying arrack to the diseased in Madurai and Mandacolum were reported to be twice that of employing native practitioners. BL, IOR P/293/49, MBORP, 20 March 1820, fols 2166–67, 2169.

¹²⁴ The situation during the cholera epidemic suggests parallels to the plague emergency around 1900, where indigenous practitioners again seemed to be invited to occupy the ambiguous position as potential partners of colonial medicine. See Arnold, *Colonizing the Body*, pp. 234–35 and Sivaramakrishnan, 'Recasting Disease'.

¹²⁵ *Madras Government Gazette Extraordinary*, 22 October 1818 in BL, IOR F/4/595 no. 14376, Board's Collections, fol. 49.

although not employed for more than two weeks in that month.¹²⁶ In November 1818, it was reported that the collector of South Arcot had 'selected the most intelligent Native practitioners he can procure, supplied them with medicines and directed them to proceed to afford the most prompt assistance to the unfortunate sufferers'.¹²⁷ Looking back at the first outbreak in Madras, Assistant Surgeon Scot in March 1819 speculated:

Many lives might be saved I am convinced, and much good might be done, should the epidemic ever again make its appearance in this place, by employing intelligent native practitioners, who should be required to give their attendance in different places, but instead of being stationed in any particular spot they should be directed to go about and use every diligence in finding out and administering to the sick at the earliest possible period.

Many native patients, Scot continued would benefit from 'the judicious directions of a qualified native practitioner'.¹²⁸ Finally, when the collector in Salem in 1820 was recommended to employ native practitioners instead of a European sub-assistant surgeon, he was told by the Medical Board that native doctors could be found in every district and that 'some of these men are of very respectable requirements'.¹²⁹

During the campaign against smallpox the Indians were constructed as a superstitious and prejudiced people, but in connection with the cholera reference to 'the apathy' of the indigenous population was just as common. As the native practitioner was exempted from the superstitions of the Indians, he was also exempted from the general apathy of the population. Thus, from Ramnad Assistant Surgeon Cother complained: 'It is very distressing to observe the amazing apathy which pervades a very great proportion of these infatuated people, numbers of them having fallen victims to their rejection of the means which have preserved so many of their fellow creatures.' Cother then went on to describe how the *vythians* and *hakims* struggled in vain to overcome the obstinacy of the population. From nearby Palamcottah Assistant Surgeon Turnbull found 'the most disgusting apathy' among sufferers from the lower classes, but expressed great satisfaction with the 'zeal and diligence' of his native assistants.¹³⁰

Some criticism was, of course, voiced against the native practitioner. One issue was that they allegedly sought to impress the colonial authorities with unrealistically high numbers of cholera cases in order to secure their further employment in colonial service. There was a general suspicion against native reports in the

¹²⁶ BL, IOR F/4/657 no. 18252, Board's Collections, fols 22–25.

¹²⁷ BL, IOR F/4/657 no. 18252, Board's Collections, fol. 10.

¹²⁸ Scot, *Report on the Epidemic Cholera*, pp. 56–57.

¹²⁹ BL, IOR P/293/53, MBORP, 18 May 1820, fol. 3466.

¹³⁰ Scot, *Report on the Epidemic Cholera*, pp. 139–40, 167. For more references to 'apathy', see BL, IOR P/293/31, MBORP, 2 September 1819, fol. 10062; P/293/32, MBORP, 16 September 1819, fol. 11236.

southern parts of the Presidency in the spring of 1820 and in Tanjore the collector temporarily refused to pay the bills for the cholera establishment.¹³¹ In November 1820 the same issue was raised in Madras, where the Medical Board observed 'that the Native Doctors are interested in creating an alarm in order that their services may be called into employ as heterofore, on the pay of Government'.¹³²

While straightforward rejections of the medical abilities of the native practitioner were rare, Assistant Surgeon Sutton from Nellore expressed some ambiguity regarding the competence of the native practitioner. He first declared that all cases of 'spasmodic cholera' were fatal if left to the village doctors because they treated the disease as the 'ordinary' *cholera morbus*. If sufficiently instructed by Europeans, however, the native practitioners appeared to be highly successful and Sutton himself emphasised the availability and efficacy of native practitioners when he sought to explain the varying mortality in the different *talooks* of Nellore district.¹³³ The ambiguity of Sutton indicates that the positive attitude towards the native practitioner rested on the presupposition that he was well instructed in and actually performing Western medicine. The issue of control, which had been so important during the discussions of the practice of the vaccination campaign in the first decade of the century, was now largely absent. It was tacitly taken for granted that the native practitioner was the extension of colonial medicine. Given the limited possibilities for control, it is, however, doubtful that this was the case.

It is clear that dressers brought up in the Western medical tradition within the army and vaccinators with a long acquaintance with Western medicine were among the native practitioners treating cholera on behalf of the colonial administration.¹³⁴ The majority of the natives practitioners employed must, however, have been representatives of indigenous medical traditions and there is no reason to believe that they did not to a certain extent continue to treat cholera according to indigenous medicine. The British preferred to stick to the illusion that they were dispatching agents of Western medicine to tend to the civil population in south India. This construction of the native practitioner was appropriately summed up in a story reported by Assistant Surgeon Cother from a tour through the Sivagangai Zamindary. In the village Yaleeangoody

... a great many people have died, and still they refused the assistance which was proffered them. By accident a man happened to be taken ill as I was passing along the road, and having some calomel and laudanum in my palanqueen, I gave him some, and sent him to the native doctor; when I returned the next

¹³¹ BL, IOR P/245/12, MPP, 24 May 1820, fols 2004–09.

¹³² BL, IOR F/4/657 no. 18252, Board's Collections, fols 93–96.

¹³³ Scot, *Report on the Epidemic Cholera*, pp. 40–47.

¹³⁴ For the utilisation of 'dressers' in the treatment of cholera, see BL, IOR F/4/657 no. 18252, Board's Collections, fols 35–37; P/293/32, MBORP, 16 september 1819, fols 11239–40. The utilisation of vaccinators is indicated in BL, IOR P/245/7, MPP, 22 November 1819, fol. 4750.

morning, he was well; and then many of them came to the pandal since which, numbers have been restored to their families, who would in all probability have slept with their fathers, had it not been for this accidental circumstance; such is the terrible prejudice of this darkly ignorant and bigoted race of people.¹³⁵

Here, the native practitioner appeared as the silent and loyal servant of the British, exempted from the prejudices of his fellow Indians. But how he actually treated the fortunate patient during the night—with Western remedies such as calomel and laudanum or through remedies taken from indigenous traditions—we simply do not know.

Concluding Remarks

Coming to terms with the native practitioner in south India in the first quarter of the nineteenth century was an ambiguous process. In texts written for European audiences the attitude was predominantly critical, although specific indigenous medical practices were sometimes recognised. In more practical terms, however, the colonial administration realised that the ‘native practitioner’—a vague designation covering representatives of indigenous medical traditions, army dressers and professional vaccinators—was a crucial and necessary resource for any wider medical intervention in early colonial India. Consequently, they made attempts to connect to the native practitioner in various ways. In the campaign against smallpox the colonial authorities sought to connect to him first as an enterprising individual and then as a servant working within a bureaucratic structure. The epidemic fever in the southern districts made the colonial administrators envisage him as a village servant holding government privileges in revenue; a reinvention of the royal gift of pre-colonial times. Finally, the unpredictable cholera turned the native practitioner into a highly valued servant, but generally employed on a short-time basis.

In this more practical context the native practitioner was conceptualised in less critical terms than in the printed texts. During the smallpox campaign it was discussed how best to stimulate this necessary agent of colonial medicine: through ‘incitement to industry’ or through a secure and well-regulated salary. In connection with the epidemic fever the native practitioner appeared as a figure who might be ignorant, but who was easily educable and thus competent of representing Western medicine in Indian villages. Finally, during the cholera the native practitioner was generally described through terms such as intelligent, meritorious or diligent. No longer did he need to be transformed; he was effectively treated as an extension of colonial medicine and dispatched throughout the districts, where he worked largely beyond the control of Western medical officers. While the Indian population might be constructed as superstitious, prejudiced or struck with apathy, the native practitioner was generally exempted from such constructions.

¹³⁵ Scot, *Report on the Epidemic Cholera*, p. 140.

Does this mean that we can dismiss the self-confident 'orientalist' discourse about the backwardness and irrationality of Indian medicine as unimportant, since studies into the social and administrative 'realities' beneath the orientalist discourse reveals a more positive attitude towards the native practitioner? Such a conclusion might be a little too hastily drawn, because the discourse about the backwardness of Indian medicine was an important feature of the general vocabulary of colonialism. It does, however, remind us that the notion of orientalist discourse not only needs to be differentiated according to time and place—as so many critics have pointed out—but also according to its immediate administrative context.

The native practitioner appears as such an ambiguous figure in the first quarter of the nineteenth century because he was *simultaneously* constructed as a representative of Europe's non-scientific other, and as a crucial, useful and necessary resource for practical medical interventions into Indian society. If we read texts produced for European audiences the representative of a non-scientific 'other' will dominate. If we read the administrative records focus will be on the potentially useful servant. This is why William Scot could praise the *vythian* as vaccinator in an internal administrative document in 1821 and yet silence him in his printed report on the epidemic cholera three years later. And this is why the Medical Board in 1811 could recommend personal tuition of native practitioners and yet within the same letter dismiss the entire indigenous medical tradition as irrational. The two elements in this discursive field interacted and this is why the texts produced for a European audience were rarely unequivocally dismissive, while the more positive attitude in the administrative records was never without reservations.

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