Women Medicinal Practitioners in Colonial India

Abhinav Kumar Alok[1]
Department of Medieval and Modern History
1

***Abstract*—This article examines the roles of women medical practitioners in colonial India, foregrounding the intersections of race, gender, patriarchy, and missionary influence within imperial structures. It analyzes how both Indian and British missionary women navigated and contested the racialized and patriarchal architecture of colonial medicine. Through a critical study of figures such as Anandibai Joshi, Kadambini Ganguly, and Muthulakshmi Reddy, the article explores how women appropriated Western medical knowledge to assert indigenous agency. It also interrogates the dual role of women doctors one as instruments of empire and other as agents of resistance especially in their engagement with tribal and marginalized populations.**

1. INTRODUCTION

The term "women's medical practitioners" may appear commonplace today, but during the colonial period, it was an anomaly almost surreal. In the context of Victorian Britain, women were expected to remain within the domestic sphere as wives, mothers, and moral guardians of the household. Ambition beyond the hearth was discouraged, and professional aspirations were deemed improper, even dangerous. Women were trained in homemaking, required to observe rigid dress codes covering them from head to toe, and largely excluded from public life. The idea of women dining publicly with men was frowned upon, reflecting broader anxieties about female autonomy and visibility (Jayawardena, 1995). These constraints led to organized resistance in Britain through movements like the suffragettes, who demanded voting rights and access to education and employment. Women who challenged patriarchal boundaries faced not only legal restrictions but also social scorn and misogynistic ridicule from their peers (Burton, 1994).These Victorian gender ideologies were not confined to Britain alone; they were exported to colonial territories as part of the broader imperial mission. The misogyny embedded in Victorian culture became entwined with imperial policy, shaping the lives of women in British colonies, including India. As imperial norms governed speech, dress, and behavior, colonial authorities sought to recreate the moral and social codes of Britain in their overseas possessions (Stoler, 2002). Feminist critiques often aligned with anti-imperialist ideologies such as Marxism in denouncing this oppressive structure. The upheavals of World War I temporarily disrupted gender hierarchies, as labor shortages forced societies to permit women to enter professions once considered male domains. However, this was an exception born of necessity, not a true reversal of patriarchal systems (Bourke, 1996).

Within this broader context, medicine emerged as a complex site of both opportunity and exclusion for women. While caregiving and nursing were associated with feminine virtues like compassion and nurturance, the role of the physician remained male-dominated. Women's entry into medical professions was often routed through missionary and philanthropic channels. The colonial state, combined with missionary zeal, created new spaces for healthcare delivery—particularly in response to the urgent need for female practitioners to treat purdah-observing women and combat high maternal and infant mortality rates among the indigenous population (Hardiman, 2006; Levine, 2003). However, this medical engagement was not merely about care. It was deeply political. As the British sought to justify colonial rule morally, healthcare became a tool of civilizing rhetoric. Missionary doctors especially women were cast as altruistic saviors bringing scientific knowledge and Christian virtue to "ignorant" native women. In reality, the medical project served a dual purpose: to control and reshape the colonized body, and to assert ideological superiority. The "philanthropy" of colonial medicine concealed its disciplinary function—replacing indigenous knowledge systems with Western biomedicine, and embedding colonial values within

[1] Email: abhinavkumaralok@gmail.com
Research Scholar ,University of Lucknow, Lucknow, India

the most intimate spaces of native life (Arnold, 1993; Gandhi, 1998).

At the same time, Indian women faced intense gendered and cultural restrictions. In native society, patriarchal norms positioned women as subordinate to male authority. Their individual identities were often erased; they were known as someone's mother, daughter, wife, or sister, rarely by name. The purdah system and social customs restricted mobility and access to education. The colonial state occasionally enacted reforms such as the ban on sati under Lord William Bentinck or the Widow Remarriage Act championed by Ishwar Chandra Vidyasagar but these were often motivated more by imperial justification than genuine social emancipation (Mani, 1998; Gupta, 2001). Nevertheless, women both British and Indian found ways to subvert these limitations. British missionary women became doctors and nurses in colonies where they were denied such roles at home. Indian women like Anandibai Joshi and Kadambini Ganguly defied both colonial exclusion and indigenous patriarchy to become pioneering physicians (Forbes, 1996; Viswanathan, 1998). These medical practitioners occupied a unique intersection of gender, race, and empire. They were often caught between being instruments of colonial power and agents of social transformation.

This article explores the emergence and evolution of women medical practitioners in colonial India through a critical historical lens. It examines how gendered and racialized hierarchies shaped the profession, how missionary and indigenous women navigated these structures, and how medical spaces became both sites of oppression and platforms for resistance.

2. COLONIAL MEDICINE AND GENDERED EXCLUSIONS

The nineteenth-century British colonial state institutionalized Western medicine in India, embedding it within a broader project of racial and civilizational superiority (Arnold, 1993). Institutions such as Calcutta Medical College (1835) and Grant Medical College in Bombay (1845) excluded women, especially Indian women, from formal education and professional participation. Medicine was constructed as a masculine domain aligned with science, rationality, and public service all coded as male in both colonial and indigenous discourse. Victorian ideals of femininity emphasized domesticity and fragility, marginalizing women as either patients or helpers, but rarely as professionals. These norms transferred directly to the colonial context, where Indian women were portrayed as doubly backward: oppressed by their own traditions and biologically unsuited for professional work (Levine, 2003). Indian women seeking to become doctors faced social scorn and institutional resistance. Anandibai Joshi, the first Indian woman to earn a medical degree in the West (Women's Medical College of Pennsylvania, 1886), had to leave the country for training due to the lack of opportunities in India. Despite her short life, her achievement symbolized a radical departure from gendered expectations and continues to serve as an emblem of indigenous medical modernity (Metcalf, 1994).

3. ZENANA MISSIONS AND THE RISE OF FEMALE MEDICAL SPACES

Despite structural exclusion, the practice of purdah and the seclusion of upper-caste and elite Muslim women created a demand for female medical practitioners. The zenana missions initiated primarily by British Protestant organizations targeted women confined to domestic quarters, offering them healthcare while promoting Christian conversion. Dr. Clara Swain, sent by the Woman's Foreign Missionary Society in 1869, became a key figure in this movement. Her work in Bareilly led to the establishment of the first women's hospital and training schools for Indian female assistants (Swain, 1909). While seemingly humanitarian, such missions served both religious and imperial agendas. Medical care was a vehicle for evangelism and moral reform (Hardiman, 2006). The creation of the Countess of Dufferin Fund in 1885 institutionalized these efforts, funding hospitals, scholarships, and training programs for Indian women. Yet the fund reinforced gendered and racial divisions: Indian women were often trained as nurses or midwives, rarely as physicians, and remained subordinate to their British counterparts (Sinha, 2006). These developments produced what Philippa Levine (2003) calls a "gendered geography of care" where medical spaces for women were simultaneously sites of healing and colonial discipline. Indian women were taught Western hygiene, reproductive norms, and religious morals, all while being constructed as objects of both pity and reform.

4. MISSIONARY MEDICINE AND THE FEMINIZATION OF EMPIRE

The feminization of imperial medicine allowed white women unprecedented autonomy in professional spaces. Missionary women like Edith Pechey and Mary Scharlieb assumed leadership roles in hospitals, surgeries, and medical education roles often denied to them in Britain (Pechey, 1899; Scharlieb, 1924). Their authority, however, depended on their racial superiority and alignment with the empire's civilizing mission. Medical memoirs of these women often portray Indian women as passive, superstitious, and physically degenerate justifying their own intervention as moral and professional necessity (Jayawardena, 1995). The rhetoric of the "white woman's burden" mirrored that of her male counterpart, recasting the colonized woman's body as a site of salvation and reform. In tribal regions, missionary medicine took on an even more overtly civilizational character. Doctors like Dr. Ellen Farrer described tribal midwifery as "dangerous" and "ignorant," advocating its replacement with Western obstetric methods (Farrer, 1893). Yet these interventions were never neutral. They undermined local knowledge systems, erased indigenous authority, and reinforced colonial hierarchies. Training programs for Indian and tribal women were often instrumental. While they expanded healthcare access, they rarely offered pathways to professional advancement. Indian women served as cultural intermediaries' vehicles for extending empire through caregiving, but not as equals within medical hierarchies (Levine, 2003).

5. INDIAN WOMEN DOCTORS AND THE POLITICS OF PROFESSIONAL IDENTITY

The rise of Indian women doctors in the late 19th and early 20th centuries marked a critical shift. These women challenged both colonial exclusions and indigenous patriarchy. Dr. Rukhmabai, for example, famously contested a child marriage in court before becoming one of the first Indian women doctors to practice in India. Her medical work and reformist writings reflected a feminist critique of both British racism and Hindu orthodoxy (Forbes, 1996). Access to medical education remained limited, shaped by caste and class. Women from upper-caste reformist families such as those in the Brahmo Samaj were overrepresented, while lower-caste and tribal women were excluded. Institutions like the Dufferin Fund provided limited scholarships but maintained racialized hierarchies (Sinha, 2006). Nevertheless, Indian women began to build a nationalist medical identity. Figures like Dr. Muthulakshmi Reddy used medicine as a platform for political activism. A gynecologist trained at Madras Medical College, Reddy joined the Madras Legislative Council and campaigned against the devadasi system, aligning medical reform with nationalist morality (Chatterjee, 1993). Indian women doctor increasingly appeared in nationalist journals and women's magazines as symbols of modernity and moral progress. Yet their professional authority remained contested. Even within nationalist circles, they were expected to embody modesty, serve female patients, and remain within the bounds of domestic respectability.

6. MEDICAL MISSIONARIES AND TRIBAL COMMUNITIES

Medical interventions in tribal areas revealed the most complex dimensions of colonial care. Tribals were framed as "primitive," and their women as especially in need of rescue. Female missionary doctors entered these regions under the banner of maternalism and moral uplift. They treated birth complications, introduced hygiene routines, and challenged indigenous customs but often at the cost of erasing local knowledge. Medical missions run by organizations like the Church Missionary Society combined healthcare with religious instruction. Clinics became spaces where the female tribal body was reconfigured through Western norms. The missionary gaze medicalized and moralized indigenous life, often displacing local midwives and herbalists. However, these encounters were not one-sided. Some tribal women were trained as nurses and midwives. Others resisted missionary impositions or blended indigenous and Western practices. While often marginal, their agency reveals a layered landscape of negotiation and adaptation (Burton, 2003). Missionary literature frequently represented these women as grateful beneficiaries, obscuring their strategic navigation of colonial power. As Leela Gandhi (1998) notes, "the ethics of empire often wore a feminist face," masking control as compassion.

7. INDIGENOUS AGENCY AND HYBRID PRACTICES

While missionary medicine opened limited pathways, Indian women practitioners increasingly forged alternative routes. Some, like Haimabati Sen, trained at Campbell Medical School and worked in public hospitals while documenting their experiences in memoirs that exposed both colonial and patriarchal constraints (Sen, 2000). Others engaged with nationalist health campaigns, delivering care in underserved regions.A significant number of Indian women doctors adopted hybrid approaches combining allopathy with indigenous remedies, respecting cultural taboos while advancing public health. Their writings and case notes contributed to new medical epistemologies that reflected indigenous feminist sensibilities. Even informal practitioners such as traditional midwives or herbalists played critical roles in sustaining local health practices. Though dismissed by colonial medicine as unscientific, they continued to enjoy trust and authority within their communities. The nationalist movement increasingly celebrated women doctors as symbols of self-rule and regeneration. Yet this recognition remained selective. Tribal and Dalit women were rarely included in elite medical spaces, and access to healthcare in their communities remained limited.

8. CONCLUSION

The history of women medical practitioners in colonial India is a story of entanglement of race, gender, medicine, and empire. White missionary women carved out professional identities by aligning with imperial maternalism, while Indian women struggled to reclaim agency within both colonial structures and indigenous patriarchy. Their trajectories diverged and intersected in complex ways sometimes reinforcing hierarchies, sometimes subverting them.

Medicine became a battleground for competing ideologies: civilizing missions, nationalist reform, and indigenous resistance. Women practitioners stood at this intersection—simultaneously agents of empire and of empowerment. Their contributions transformed the medical profession, challenged epistemic hierarchies, and laid the foundation for feminist health practice in postcolonial India.

A decolonial feminist reading of this history compels us to move beyond binaries of victimhood and agency. It reveals how women not only those who graduated from elite medical schools but also those who served as midwives, nurses, and healers shaped the contours of colonial medicine. Their legacy demands recognition not only in historical memory but in contemporary struggles for health equity and gender justice.

REFERENCES

[1] Arnold, D. (1993). *Colonizing the body: State medicine and epidemic disease in nineteenth-century India*. University of California Press.

[2] Burton, A. (2003). *Dwelling in the archive: Women writing house, home, and history in late colonial India*. Oxford University Press.

[3] Chatterjee, P. (1993). *The nation and its fragments: Colonial and postcolonial histories*. Princeton University Press.

[4] Farrer, E. (1893). *Medical reports of the Church of Scotland Mission in Central India*. Church Missionary Society Archives.

[5] Forbes, G. (1996). *Women in modern India*. Cambridge University Press.

[6] Gandhi, L. (1998). *Postcolonial theory: A critical introduction*. Columbia University Press.

[7] Hardiman, D. (2006). *Healing bodies, saving souls: Medical missions in Asia and Africa*. Rodopi.

[8] Jayawardena, K. (1995). *The white woman's other burden: Western women and South Asia during British colonial rule*. Routledge.

[9] Levine, P. (2003). *Prostitution, race and politics: Policing venereal disease in the British Empire*. Routledge.

[10] Metcalf, B. D. (1994). Anandibai Joshee and the challenges of women's medical education in colonial India. *South Asia Research*, 14(2), 97–113.

[11] Pechey, E. (1899). *A woman's work in India*. London Missionary Press.

[12] Scharlieb, M. (1924). *Reminiscences*. Hodder and Stoughton.

[13] Sen, H. (2000). *The memoirs of Dr. Haimabati Sen: From child widow to lady doctor* (T. Raychaudhuri, Ed.). Roli Books.

[14] Sinha, M. (2006). *Specters of Mother India: The global restructuring of an empire*. Duke University Press.

[15] Swain, C. A. (1909). *A glimpse of India: Extracts from the letters of Dr. Clara A. Swain*. Woman's Foreign Missionary Society.