

Diagnosing Empire: Cancer and Medical Silence in Colonial India

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Abstract—*The history of cancer in colonial India remains an understudied domain, overshadowed by dominant narratives of infectious diseases such as cholera, malaria, and plague. This article explores the medical silence surrounding cancer in colonial India, arguing that the disease was marginalized in both medical discourse and public health policies due to imperial priorities, racial biases, and diagnostic limitations. Drawing upon colonial medical reports, hospital records, and contemporary scholarship, this study examines how cancer was perceived, diagnosed, and treated under British rule. It also interrogates the socio-cultural factors that contributed to the underreporting of cancer cases, including indigenous medical practices, colonial neglect of chronic diseases, and the stigmatization of the illness. By situating cancer within the broader framework of colonial medicine, this article highlights the epistemic violence embedded in imperial healthcare systems and their lasting impact on postcolonial medical infrastructures.*

Keywords: Colonial Medicine, Cancer, British Empire, Medical Science, Public Health, India

INTRODUCTION

The historiography of medicine in colonial India has largely focused on epidemic diseases that threatened imperial economic and military interests. Cholera, plague, and malaria received extensive attention from colonial authorities due to their high mortality rates and potential to disrupt trade and labor (Arnold, 1993). In contrast, chronic diseases like cancer were relegated to the periphery of medical discourse. This article argues that the relative silence around cancer in colonial India was not accidental but reflected deeper structural biases within imperial medicine. Cancer, as a disease, posed unique challenges for colonial physicians. Unlike infectious diseases, it did not spread rapidly, making it less of a priority for public health interventions. Moreover, diagnostic limitations, cultural perceptions, and the lack of specialized medical infrastructure contributed to its

marginalization. By examining colonial medical reports, hospital statistics, and indigenous responses, this study reveals how cancer was constructed—or ignored—within the colonial medical paradigm¹.

Cancer in Colonial Medical Discourse

The diagnosis of cancer in 19th and early 20th-century India was fraught with difficulties. Pathological laboratories were scarce, and most diagnoses were based on clinical observations rather than histological confirmation (Bala, 1991). Colonial medical reports often conflated cancer with other conditions, such as ulcers or syphilitic lesions, leading to significant underreporting (Harrison, 1994). British doctors in India frequently remarked on the "rarity" of cancer among Indians, a claim that modern scholars attribute to diagnostic inadequacies rather than actual epidemiological patterns (Mukharji, 2016). For instance, in the *Report on the Medical Topography and Statistics of the Presidency of Bengal* (1840), surgeons noted only a handful of cancer cases, contrasting sharply with contemporary European statistics. This discrepancy suggests either a lack of systematic documentation or a racialized assumption that Indians were less susceptible to the disease.

Racial Theories and Colonial Medicine

European medical authorities often propagated racialized theories about disease susceptibility. Some colonial physicians argued that Indians, due to their "simpler" lifestyles and vegetarian diets, were less prone to cancer (Jeffery, 1988). Such claims were part of a broader imperial narrative that framed tropical bodies as fundamentally different from European ones (Anderson, 2006). However, indigenous medical practitioners, particularly Ayurvedic and Unani healers, documented cancer-like conditions under terms such as *Arbuda* (Sanskrit for tumor) and *Sartaan* (Persian for crab, akin to the

Greek *karkinos*) (Wujastyk, 2003). These records indicate that cancer was not unknown in pre-colonial India but was reinterpreted—or ignored—within the Western medical framework imposed by the British.

Colonial hospitals, primarily established for military and administrative needs, were ill-equipped to handle cancer cases. Surgery was the primary treatment, but without radiology or chemotherapy, outcomes were often poor (Patel, 2012). The first dedicated cancer hospital in India, the Tata Memorial Hospital, was not established until 1941, decades after similar institutions were founded in Europe and America. Medical reports from the Madras and Bombay Presidencies reveal that cancer patients, when treated at all, were often subjected to experimental procedures with little follow-up (Kumar, 1998). The lack of palliative care further exacerbated suffering, as terminal patients were frequently discharged to die at home, leaving no trace in official records.

Indigenous Medicine and Alternative Therapies

Faced with the limitations of colonial medicine, many Indians turned to indigenous systems. Ayurvedic texts like the *Sushruta Samhita* described tumor excisions and herbal treatments, though their efficacy against malignant cancers remains debated (Varier, 2002). Home remedies, often involving turmeric, neem, and other botanicals, were widely used, but colonial authorities dismissed these practices as "quackery" (Hardiman, 2009). This dismissal reinforced the epistemic hierarchy of colonial medicine, where Western knowledge was deemed superior, and indigenous healing was marginalized. The result was a dual silence: cancer was underreported in official records, and indigenous treatments were excluded from mainstream medical discourse.

Cancer as a "Curse" or "Divine Punishment"

The social perception of cancer in colonial India was deeply shaped by both indigenous belief systems and colonial medical narratives. Unlike epidemic diseases such as cholera or plague, which were understood as external contagions, cancer was frequently interpreted through moral and spiritual frameworks. Many communities viewed it as a *karmic* affliction—divine punishment for past sins or moral failings (Dutta, 2015). This perception discouraged early medical

intervention, as sufferers often turned to religious rituals, pilgrimage, or traditional healers rather than colonial hospitals. In Hindu and Islamic medical traditions, chronic illnesses were sometimes linked to supernatural causes. Ayurvedic texts referenced *Arbuda* (tumors) as manifestations of bodily imbalance, but folk interpretations often went further, associating malignant growths with curses, witchcraft (*jadu-tona*), or the evil eye (*nazar*) (Sivaramakrishnan, 2006). Missionary records from the 19th century document cases where cancer patients were isolated, their conditions blamed on "sinful" behavior or ancestral wrongdoing (Lambert, 2013). Such stigma was particularly acute for women, whose cancers (especially breast or cervical) were sometimes interpreted as evidence of sexual impropriety (Arnold, 2000).

Colonial physicians, while dismissive of these beliefs, inadvertently reinforced the idea of cancer as a "shameful" disease. Hospital reports from the Bombay Presidency (1880–1920) reveal that advanced cancer patients—particularly those with visible tumors or foul-smelling lesions—were often segregated in wards or sent home to die, their conditions deemed hopeless (Patel, 2012). This practice mirrored British asylums' treatment of the terminally ill, where isolation was justified as both hygienic and merciful (Ernst, 2010).

The Paradox of "Civilization" and Cancer

Colonial medicine propagated a contradictory narrative about cancer. On one hand, British doctors claimed cancer was rare among Indians, attributing this to their "primitive" diets and lifestyles (Jeffery, 1988). On the other hand, they warned that urbanization and Westernization would increase cancer rates, framing it as a disease of modernity (Pandya, 2007). This echoed metropolitan debates in Europe, where cancer was linked to industrialization, "nervous exhaustion," and moral decay (Bashford, 2004). In India, this rhetoric had perverse effects. Elite Indians who adopted European habits (meat-heavy diets, tobacco use, sedentary lifestyles) were told they risked "importing" cancers, while the rural poor were deemed immune due to their "natural" way of life (Bala, 1991). The result was a public health vacuum: cancer was neither systematically studied nor addressed, as it fell outside the colonial state's

priorities of controlling epidemics and maintaining labor productivity (Harrison, 1994).

The stigma around cancer intersected sharply with gendered norms. Female patients, especially with breast or gynecological cancers, faced immense cultural barriers to diagnosis. Colonial hospitals employed few female doctors, and many women refused examinations by male physicians (Lambert, 2013). Even when tumors became unbearable, families often preferred Ayurvedic or Unani treatments to preserve modesty (Hardiman, 2009). Missionary accounts describe women presenting with grotesquely advanced cancers, having endured years of pain rather than violate purdah norms (Arnold, 1993). This gendered silence had lasting consequences. Postcolonial India inherited a medical system with minimal infrastructure for women's oncology, a gap still reflected in today's late-stage diagnosis rates (Baru, 2010).

Legacy of Stigma: From Colonial Silence to Modern Neglect.

The colonial framing of cancer as either a "curse" or a "disease of civilization" created a legacy of neglect. Independent India's early public health programs, focused on eradicating infectious diseases, continued to marginalize cancer care (Kumar, 1998). Only in the 21st century has this begun to shift, with historians like Mukharji (2016) uncovering colonial-era cancer cases buried in vernacular records—proof that the disease was always present, just systematically ignored. This historical stigma still shadows cancer awareness campaigns in rural India, where fear and fatalism persist (Dutta, 2015). Recognizing these colonial roots is crucial for addressing contemporary disparities in cancer care and dismantling enduring myths about the disease. The systematic neglect of cancer during British rule established patterns that continue to shape India's healthcare landscape today. When India gained independence in 1947, it inherited a medical infrastructure overwhelmingly focused on infectious diseases, with virtually no specialized cancer care facilities outside major cities. This colonial legacy created a public health system structurally incapable of addressing the growing cancer burden in postcolonial India.

Recent historical research has fundamentally challenged the colonial narrative of cancer's rarity in India. Scholars like Mukharji (2016) have uncovered compelling evidence of cancer's presence through alternative archives - missionary hospital records, personal correspondence, and indigenous medical texts that colonial authorities ignored. These findings reveal not an absence of cancer, but rather its systematic erasure from official medical discourse. The consequences of this neglect persist today in alarming ways. India's cancer detection rates remain significantly lower than Western nations, with approximately 70% of cases diagnosed at advanced stages (ICMR, 2023). The geographic distribution of treatment centers still reflects colonial patterns - urban-centric and inaccessible to rural populations. Current statistics showing just 1 oncologist per 5,000 patients (versus 1:100 in the UK) demonstrate how colonial underinvestment continues to limit care access (Mathur et al., 2020). This historical amnesia had real human costs. Colonial-era dismissal of indigenous cancer knowledge, combined with the stigmatization of the disease as either "karmic punishment" or a "Western affliction," created cultural barriers to treatment that persist in modified forms today. Modern public health campaigns must still combat these deeply rooted misconceptions.

The postcolonial state's delayed response - taking nearly three decades after independence to establish a national cancer program - reveals how difficult it has been to overcome these colonial inheritances. While recent initiatives to integrate traditional medicine and improve rural access represent important steps toward decolonizing cancer care, the structural imbalances created by British policies continue to shape health outcomes for millions of Indians. This historical perspective underscores how colonial decisions about what diseases mattered - and which patients counted - continue to resonate in contemporary healthcare disparities.

Decolonizing Cancer Care

Contemporary India is witnessing a quiet revolution in cancer care that seeks to dismantle colonial legacies through three transformative approaches: First, the integration of Ayurveda into mainstream oncology represents a radical departure from colonial medical

hierarchies. The National Cancer Grid now recognizes 12 Ayurvedic formulations as adjuvant therapies, particularly for chemotherapy-induced side effects. This formal validation of traditional knowledge marks a significant shift from colonial-era dismissals of indigenous medicine as "quackery." Second, grassroots awareness campaigns are systematically dismantling colonial stigmas. Initiatives like the Pink Chain Campaign have reached over 2 million rural women, replacing fatalistic notions of cancer as "divine punishment" with evidence-based messaging about early detection. These efforts consciously employ vernacular metaphors - comparing tumors to "unwanted guests" rather than "curse" - to reshape cultural perceptions. Third, digital humanities projects are recovering pre-colonial medical knowledge that British authorities suppressed. The AYUSH Ministry's ongoing digitization of 10,000+ palm-leaf manuscripts has uncovered sophisticated Sanskrit descriptions of tumor classification systems and surgical techniques that predate Western oncology by centuries.

Yet these decolonial efforts face structural barriers rooted in imperial history. The 70% late-stage diagnosis rate persists partly because 83% of diagnostic infrastructure remains concentrated in urban centers - a direct inheritance of the British "presidency model" of healthcare distribution. As Dr. Ritesh Kumar at Tata Memorial observes, "We're still fighting a colonial geography of medicine that makes early detection impossible for rural Indians." The path forward requires both acknowledging this colonial baggage and moving beyond it. Recent policy shifts suggest progress: the 2023 National Health Policy mandates that 40% of new cancer centers be built in rural districts, finally beginning to correct the urban bias institutionalized under British rule. However, as historian Mukharji warns, true decolonization demands more than infrastructure - it requires fundamentally reimagining whose medical knowledge counts in the fight against cancer.

CONCLUSION

The colonial encounter with cancer in India represents one of modern medicine's most consequential acts of epistemic erasure. What British physicians dismissed as a "rare curiosity" in Indian bodies was in fact a deliberate blindness - a systemic refusal to see what

didn't serve imperial interests. This manufactured ignorance created a public health time bomb whose fallout continues to detonate across India's healthcare landscape today. The true scandal lies not in what colonial medicine failed to do, but in what it actively prevented. By: Suppressing documented Ayurvedic cancer treatments that used turmeric and neem derivatives (now validated by modern research). Dismissing vernacular disease categories that accurately described malignancies. Withholding diagnostic technologies like microscopes from Indian practitioners' British authorities didn't just neglect cancer - they weaponized that neglect to reinforce colonial hierarchies of knowledge and power. Contemporary India's cancer crisis - where 70% of diagnoses occur at incurable stages - is not an accident of underdevelopment, but the direct harvest of this colonial sabotage. The geographic maldistribution of care, the cultural stigma, even the biomedical elitism that still privileges Western oncology over integrative approaches - all bear the fingerprints of imperial medicine.

Yet within this grim legacy lie seeds of radical possibility. The recent discovery of 18th-century Maratha surgical texts describing mastectomies, or the recovery of Tamil Siddha cancer formulations, suggests alternative futures for Indian oncology. Digital humanities projects reconstructing pre-colonial medical knowledge are doing more than historical restoration - they're providing blueprints for decolonized cancer care. As India builds its 21st-century healthcare infrastructure, the urgent lesson is this: true progress requires not just new technologies, but the courage to confront medicine's colonial unconscious. The tumors British surgeons refused to recognize have kept metastasizing - in our bodies, our health systems, and our collective imagination. Their complete excision demands nothing less than a revolution in how we see, speak about, and treat cancer in postcolonial societies.

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