CHAPTER-4

ON FIRM GROUND: INSTITUTIONALISATION AND MORE

Introduction

In order to understand the social authority displayed by the women missionaries, it is necessary to look at the parameters they worked in. Zenana education, being a more familiar ground became the most expected condition to bring about a social change in India. This helped in acknowledging the significant work done by women in the mission boards that further helped in the beginning of medical expansion within the realm of mission organizations. The chapter largely focuses on the missionary women who as entrepreneurs in medicine made “desperate attempts” for the provisions of moral rescue for the “heathen women.” By focusing on the growth of some mission hospitals, I have attempted to discuss certain themes at length – the processes adopted for evangelization, the indigenous response and the training of the indigenes in western forms of medicine. The recognition of women’s agency and its gendered nature of the mission enterprise became prominent with the activities of this period. The hospital ‘era’ for women started from the late nineteenth century.

Commencing Work

It was not the intention of the early missionary who was trained as physician and surgeon to work as a doctor to preach
Gospel. In the life of a missionary most incidents occurred because of circumstantial demand. The first B.M.S. doctor who came to Malda in 1793 was “compelled by the Sick and dying of India to erect sheds for the use as a missionary hospital”.

Similar incidents came from mission employees for medical work.

It happened that a press moonshee became very ill, and after being treated by the native doctors with no hope of recovery, he asked me to do something for him....? Thought it my duty to do what I could and by the good providence of God my treatment was successful. The news of this soon spread over the city...... so I soon found myself in the, midst of a regular medical practice'.

The work got further consolidated by the patients who refused to avail other help than that offered by the missionaries. “.............they could sometimes reply that they had more faith in my treatment than of the Government doctor, because what I did was done for God’s sake, while what he did was done for the pay he got.” The missionaries somehow didn’t take very long to emphasize the value of the mission medicine, as discussed in the previous chapter.

2 Historical Sketches of the India Missions of the Presbyterian Church in the U.S.A. From the beginning of the work in 1834 to the Fiftieth Anniversary in 1884(Allahabad, 1886, p. 38).
3 Ibid
It may be mentioned that there already was a Medical Missionary Society in the Punjab—one of the fruits of the Missionary Conference held at Lahore, at the end of 1862—a Society, that not only paid the local expenses of some of the Medical Missions, but assisted in educating Native Christians for this work. Practical medical work had started some twenty years prior to the conference. Dr. W. Greene was sent by the Presbyterian Board to take up work at Lodiana in 1842, a stay that lasted for a few months, long enough for him to conclude that the Indian climate did not suit him. This of course did not stop the missionaries to continue with their medical activities. Ludhiana along with Amritsar became the major cities to be associated with medical mission work.

It was noted that the Church of England Societies were quite ahead with the medical work as compared to the Presbyterians. A few names linked with dispensaries and zenana practice in 1880’s were that of the Church of England, Miss Engelmann at Delhi, Miss Hewlett and Miss Sharp at Umritsur, Miss Mitcheson at Peshawur; of an English undenominational Society, Miss Greenfield at Lodiana and Mrs. E.P. Newton at Lodiana from the Presbyterian Society. These women, not all medically qualified, were the initial workers who ventured their way to reach out to women in need of treatment. Miss Greenfield’s efforts were highly recognised in the mission circle.

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4 Historical Sketches of the India Missions of the Presbyterian Church in the United States of America, Known as the Lodiana, the Farrukhabad, and the Kohlapur Missions. From the beginning of the work, in 1834, To the time of its fiftieth Anniversary, in 1884. Allahabad: Allahabad Mission Press, 1886, p.41.
6 Ibid.p.42.
and in the towns where they worked. Her work has been focused along with Dr. Edith Brown in chapter 5. Interestingly, there is a reference of an early medical initiative by Mrs. Clark. The Midwifery Hospital was commenced in 1866 by her, which later was transferred to the Government.7

Needless to say, the beginning years were the most crucial of all. And in most of the cases, the seriousness of the medical work was appreciable if backed with an institution. Small dispensaries took shape of hospitals in the years to come. For instance, St. Catherine’s at Amritsar and the Charlotte Hospital, Ludhaina were the end result of the medical beginning made by Sarah Hewlett and Rose Greenfield, respectively.

Inspite of the progress in the number of women in medical field, a well qualified lady doctor added to the staff of every mission station was a much needed demand.8 She would be the skilled worker, who would professionalise the medical scene in the colonized lands. The impact of her work would be far effective on the local population. Not that we have any instances where the indigenous patient is curious to know about the medical qualifications of the women missionaries, yet the commitment of a fully qualified physician would give a long term benefit to the medical missionary work. Missionaries like Elizabeth Biebly went back to London, only to return with a medical degree, to reach out to indigenous women in a more

8 Historical Sketches of the India Missions of the Presbyterian Church in the United States of America, Known as the Lodiana, the Farrukhabad, and the Kohlapur Missions. From the beginning of the work, in 1834, p.42.
"serious way". The contribution of some women physicians, as medical missionaries finally shaped up the mission hospitals they worked in.

The mission doctor already became a symbol of hope, transcending his profession with prayer. It is not surprising, hence that the zeal of the missionary doctor took shape of hospitals that further enhanced 'his duty towards God and its people.' The hospital was a base by which missionary activity, including evangelization would occur. One of the most interesting analyses of this area of work is Rosemary Fitzgerald's 'Clinical Christianity', which clearly points at the rise of hospitals as an alliance between medicine and missions.9

The popularity and impetus of medical mission work could be seen prominently in Punjab. As compared to Bengal with its largest population (46.6 millions) had only 9 mission hospitals, where as the former with approximately 20 million had 21 mission hospitals run by the missions. Out of which 17 were exclusively for women.10 Most of the work was carried by the American Presbyterians, the Baptist Zenana Mission and the Church Missionary Society.

The sign of success of every mission society was measured by the number of hospitals they opened. Here, too the CEZMS made honorable medical history in the Far East (India and China) when after fifty years of its work it reported of 23

9 See Rosemary Fitzgerald, 'Clinical Christianity': The Emergence of Medical Work as a Missionary Strategy in Colonial India, 1800-1914 in Biswamoy Pati and Mark Harrison, (eds) Health, Medicine and Empire: Perspectives of Colonial India (Hyderabad : Orient Longman, 2001)
10 A Survey of Medical Missions in India (Poona: National Christian Council, 1929, p.10)
hospitals and 27 dispensaries, the credit going to the women doctors.\textsuperscript{11} Their special work was further justified when acknowledged by the British Government. Kaiser-i-Hind (Silver) was rewarded to Ms. Sarah Hewlett in 1907, Ms. Anna Singh in 1919 and Dr. Jessie Lamb of Amritsar in 1921.\textsuperscript{12} The British Officials responded well to the medical mission agents. In a way it covered the drawbacks of the imperial duty towards their lack of medical initiative towards the Indian women and gave reason enough for the missionaries to spread the benefits of western medicine.

\textbf{Rise of Mission Hospitals}

Looking at the histories of some prominent mission hospitals, and bearing these points in mind, there are number of common factors to their development. What came to be seen was a stark similarity in the establishment of the mission hospitals. The founding of an institution was not easy, lack of funds and resources delayed the progress. The initial years of the missionary woman was spent in the verandah, performing her duties in “dust and storm”. If not the open courtyard, a dispensary took shape, again in a rented house. The work of the medical missionary was thus perceived in these years. From the basic dispensary building, the woman medical missionary often set up a small hospital of three or four wards. More permanent building was built as and when she became better established within the local communities. Yet this provides a very simplistic and generalized view of the complex inter-relationships that

\textsuperscript{12} Ibid
influenced the success and failure of each mission hospital—for example between the mission society and the mission hospital, their funding equation, or at the grass root level between the medical missionaries and the patient or between the missionary doctor and the indigenous sub assistant. However the histories of the mission hospitals throws insight on the ways in which these hospitals developed in the colonial framework and the stimuli that worked in the success of some.

The notion of rationality, religion and treatment remained interwined in the discourses. When it came to this context, there was similarity between the missionary ideas of healing and those of the native people, though the former seldom admitted this. Although both firmly believed in the working of the Divine guidance and Christian missionaries from all denominations acknowledged that “God might work cures and miracles”, yet when it came to traditional indigenous beliefs they were gambled as “absurd” notions by the missionaries. The mission hospital was an eye-opener that proved the rationale of the missionaries. As said by Rose Greenfield, ‘We felt that by opening a dispensary we should get hold of the people and be able to teach them, by degrees, some simple truths about themselves and their children that would at least prevent a part of the suffering we saw all around us.”

**St. Catherine Hospital, Amritsar:** One of the principle cities of the Church Missionary Society was Amritsar. Medical missionary work amongst women here was commenced by Mrs.

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Robert Clark in 1867. The idea of a medical mission was supported by Sir Donald Mcleod in 1872 and Amritsar with its large population, its close proximity to Delhi, ‘the most convenient and the most busy and prosperous city in the Punjab’ was chosen for it. Dr. Henry Martyn Clark was placed in charge of the CMS Amritsar Medical Mission in 1882. It comprised of Jandiala, the Beas, Narowal, and Sultanwind. Seeing the positive response from the villagers it was recommended that a central city hospital as a base and from it work in the surrounding districts through branch dispensaries.14

It was in connection of the early work started by Mrs. Clark that was re-established by Miss. Hewlett of the C.E.Z.M.S in 1880 that led to the opening of St. Catherine Hospital at Amritsar. Initially it was opened at a native house, with six beds, it was under the charge of Ms. Hewlett that the hospital expanded. She was joined by Miss Frances Sharp in 1882.15 Within a year the hospital could put figures of patients in its record. In 1883, 180 in-patients were received into the Hospital (the accommodation being twenty beds) and 5960 out-patients were relieved. In July of that year the Municipal Maternity hospital was placed under Miss Hewlett’s care. Considerable addition was made to the hospital in the expectation of more workers. Miss Bartlett and Miss A Sharp were the new non medical helpers, both involved in house to house visitation. The two new workers were able to do zenana visitation, keeping open

houses which the medical workers had no time to visit constantly. In 1908, the zenana mission was removed to a bungalow, and the old fort became the new St. Catherine’s Hospital. A ward was the first beginning of the new hospital, had been built in the garden, where “the beds can be taken outside and put under the trees, or if it is during the cold weather, those who are able to do so in the courtyard of old St. Catherine’s.” The Institution of the Blind in Amritsar was founded in 1887-1888, in connection with St. Catherine’s Hospital. Later in 1903, it was removed to Rajpur.

One of the strong features of St. Catherine’s was the training of native medical women as medical assistants and nurses. Many had passed the necessary Government exam and were certified for actual medical work. These women were mostly the converts of the result of medical mission work itself. One such case was that of Ms. Abdullah in 1893, a Mohammedan convert, who trained and later labored at Jandiala with Ms. Parslee. Incidents as such these were never ignored, on the contrary they were over-emphasized to demonstrate the intensity of the missionary work. Then there were the visits to the sick patients at their homes, in which Ms. Frances Sharp a missionary doctor chiefly occupied this task. In 1893, there were 3,317 such visits in a year by one or other of the ladies of the hospital. The growing authority of the women medical missionaries was a cause of fear among the indigenous

16 Ibid.
17 Ibid, 131
18 Ibid, p.123.
19 The Church Missionary Gleaner, (C.M.S. Nov. 1893, p. 166).
population. Dr. Henry Martyn Clark reported a conversation with a friendly Hindu on the subject of Christian missions. “We do not fear your schools, we need not send our children. We do not fear your books, for we need not read them, we do not much fear your preaching, we need not listen. But we dread your doctors, for your doctors are winning are homes and our hearts and our homes our won, what is there left with us?”

Since the work of this mission comprised the city and district of Amritsar and a portion also adjacent to the district of Sialkot, each dispensary in the district was looked upon as a centre around which the missionaries could itinerate. This policy of the base hospital with branch dispensaries was the best for evangelizing in towns and country. The report for the year ending March 1891 stated that 217 inpatients and 25,421 out patients had been treated in the hospital. Considering the treatment of out-patients, the Amritsar District Medical Mission was the largest medical mission in 1892.

The missions made it clear that “it would be at best a splendid failure from the missionary point of view were it not that these people had been brought under Christian influence, for it was the aim to let no one who came to us for healing, go away without hearing of the Saviour.” The devotion displayed by the hospital staff, thus accounted for their popularity among all communities. It served all classes but these were only about

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20 Ibid, p. 166.
21 *The Church Missionary Gleaner* (July 1892, p. 105).
22 Ibid
23 *The Church Missionary Gleaner* (July 1892, p. 108).
2% of Christians. Hence, the functioning of the hospital relied on public support especially from the non-Christian patients.

The first attempt of support from the Government came in 1892, when rules were issued by them to regulate grants-in-aid to the Mission Hospitals from Municipal and provincial funds. It was reported by the Government that “the institutions which receive this aid are inspected periodically by Government Officers and the uniform testimony to the ability and zeal of our branch doctors, and the efficiency of the mission work is most cheering.”

While referring to the work of Ms. Hewlett, one cannot avoid writing about her contribution in Tarn Taran. In 1883 medical work was begun. Ms Hewlett opened a dispensary, and later on more permanent possession was taken. The medical work was carried on with the help of Miss Abdullah and Miss Phailbus, and it was the means of winning the confidence of the district, for it became widely known. It became impossible to carry on dispensary work, without some shelter in which, house patients wished to stay until they were cured. At one time many were lying in the verandah, determined not to leave till the time they got well. So an old government stable was bought for a nominal sum and made into a hospital ward. This was the foundation of St. Mary’s Hospital. The work grew amazingly around this centre. In Tarn Taran, besides hospital work,

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25 *The Church Missionary Gleaner* (July 1892, p. 106).
26 *Until the Shadows Flee*. p.131.
zenanas, too were opened.\textsuperscript{27} The hospital grew, its fame spread and more buildings were added.

Besides Amritsar, there were references of other CMS centers where medical work carried during the end of the nineteenth century. Not significant in terms of figures but important as mission endeavors in term of popularisation of their own work. Jandiala had a branch that was opened in 1882. Although they faced an extremely difficult environment, within a decade resistance seemed to go down and the medical work penetrated amongst the village ladies.

One of the last branches to set up in early 1890 was the Beas Medical Mission. Here a hotel adjacent to the railway station was bought and work had begun under Ms. Bishop (nee’ Ms. Bird) The Branch was named after Ms. Bishop’s sister ‘Henrietta Bird Memorial Hospital’. The missions were not only enthusiastically welcomed by the low caste but also by the landowners and by the people of the higher castes, this was not noticed in other towns of Punjab.\textsuperscript{28} The C.M.S and the C.E.Z.M.S worked closely in the set up of the medical field. Hospital work was supplied at Amritsar and Asrapur – Attari by the CEZMS and at Narowal and Multan (for women) by the C.M.S, whose missionaries also superintended the leper hospitals at Tarn Taran.

\bibliography{bibliography}
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\textsuperscript{27} \textit{Ibid.}
\textsuperscript{28} \textit{The Church Missionary Gleaner.} (July 1892, p. 107).
Presbyterian Work among Women: The Punjab missionary establishment of the Presbyterian Church in the U.S.A. comprised mainly of two hospitals for women and children, the Philadelphia Hospital, Ambala and the Frances Newton Hospital at Ferozepore. What was common in each of these hospitals was a dispensary. Miss J.R. Carleton, M.D., was largely instrumental in the founding and building of the hospital at Ambala. She belonged to a family of missionaries. Her parents were missionaries before her, and her brother, Dr. M.B. Carleton was in charge of the Leper Asylum at Sabathu. After graduating from the Women’s Medical College in Philadelphia, Ms. J.R. Carleton came to the Punjab Mission in 1886. The Hospital was opened in 1901 and for over forty years she committed herself in the medical work for women in Ambala city and district. Her work being recognized by the Government, Dr. Carleton was awarded the Kaiser-i-Hind medal (First Class) in 1926.

In its initial years, the Hospital built trust through its work and had patients from villages lying out in a radius of forty miles of Ambala city. Government help was clear when Col. Bate, Superintendent General of Hospitals, Punjab, after visiting the hospitals remarked “.............. Ms. Carleton ought to be given twice as much as she now gets to enable her to do justice to her patients.” Number of patients regarding treatment showed a positive response for the missionaries. In 1907, total attendance

30 The 74th Punjab Mission of the Presbyterian Church in the U.S.A. for the year (Ludhiana: Ludhiana Steam Press,1907, p. 79).
of patients coming daily for medical relief was 12,944. The visits for the year were about 2,300.\textsuperscript{31} The numbers were not evenly distributed throughout the year. In the September fever days, Dr. Carleton saw 150 and 160 patients daily. The operations increased to 494 in the year 1926.\textsuperscript{32} The dispensary was an active area of the hospital that showed 3,215 old patients, and 2,636 new patients, 56 minor operations and 2 cataracts were shown on the reports of 1927.\textsuperscript{33} With the passing years, for reasons unknown the zeal of the Ambala hospital lessened in the mission reports. It was overshadowed by the other Presbyterian hospitals in Punjab.

Ferozepore was occupied in 1882. It was considered one of the important missionary stations of the Presbyterians. Besides being a large military centre Ferozepore had a strong background of politics of missionary activities. The medical work commenced on 29 November 1896, with six patients.\textsuperscript{34} The hospital was also the home, amongst other activities, of one of the two hospitals staffed and managed by the Punjab Mission.\textsuperscript{35}

The institution owed its existence to the indefatigable efforts of the late Mrs. Frances R. Newton, who spent 35 years in the Mission service with her husband, of which 26 years were spent in Ferozpore.\textsuperscript{36} The Hospital was made a memorial in the

\textsuperscript{31} The 75th Punjab Mission of the Presbyterian Church in the U.S.A. for the year (Ludhiana: Ludhiana Steam Press, 1907, p. 78)
\textsuperscript{32} Ibid., p. 18
\textsuperscript{33} The 93rd Annual Report of the Punjab Mission of the Presbyterian Church in the U.S.A. for the year 1927 (Ludhiana: Ludhiana Mission Steam Press, 1928, p. 25).
\textsuperscript{34} Medical Mission Work at Ferozepore, North India, (Lahore, 1900 p. 5).
\textsuperscript{35} The 93rd Annual Report of the Punjab Mission of the Presbyterian Church in the U.S.A. For the year 1927 (Ludhiana: Ludhiana Mission Steam Press, 1928 p. 25).
\textsuperscript{36} The 74th Annual Report of the Punjab Mission of the Presbyterian Church in the U.S.A. for the year 1907 (Ludhiana: Ludhiana Mission Steam Press, 1928 p. 113)
founder’s name and was called the Frances Newton Hospital for Women and Children.

In 1907, the hospital was in charge of Miss Maud Allen who became well known in Ferozepore and all the villages of the district as the “Bari doctor Miss Sahiba”.

The facilities of the hospital improved with the government help. In 1900, a dispensary, a waiting room and three small private wards were built. “Modern” equipment improved the facilities of the hospital. X-ray machines and material for the operation theatre gave efficiency to the hospital. In 1907, the record of the hospital showed the following figures. The number of in-patients treated were 233, number of out-patients 6291 and the total number of visits for the year being 8,335. It hence came as no surprise that the medical work for both men and women was the strongest evangelistic agency in Ferozepore.

A common feature that prevailed in the mission hospitals was the evangelistic work carried on a regular basis. It consisted of (1) the indirect influence of the relief afforded to suffering men and women (2) the reading of the Bible to the women waiting their turn at the dispensary.

The most appropriate time for bible reading was when the patients awaited their turn, the Bible women, usually a convert herself took the initiative. Religious literature including the

37 The 93rd Annual Report of the Punjab Mission of the Presbyterian Church in the USA for the year 1927, p. 30.
38 The 75th Annual Report of the Punjab Mission of the Presbyterian Church in the U.S.A. for the year 1908, p. 63.
gospel and the tracts were sold or given away. The main aim of the missionary was to draw attention to Christ teaching to the audience, that at most times remained passive. 40

In 1906, there were three baptisms in hospitals, some others confessed themselves as believers but could not be baptized.41 Such incidents were made to have significant implications, the numbers, small though they may seem, was a visible sign of success for the Christian workers in the hospital.

A step further was taken at “saving” the “heathen women” from their ‘misery stricken life’. The missionary women provided an opportunity to the indigenous women through these hospitals, a stream of professionalism which they had never experienced before. The Frances Newton Hospital trained nurses for which many new applicants came for each year. But the response for the nurses’ school was not always found up to the mark. Some had to be rejected because of ‘insufficient education’ and some because “we find that they are trying to escape from unpleasant home duties”. 42 Over the time, as the issue of training indigenous women gained significance, the process no longer seemed to be the ‘liberating force’ for the missionaries. In this aspect the missionary perception on professionalism hardened. In 1926, Mrs. Ellen John was the only one from the

40 Ibid, p. 113
41 Ibid, p. 114.
42 The 92nd Annual Report of the Punjab Mission of the Presbyterian Church in the U.S.A. or the year 1926 (Ludhiana: Ludhiana Mission Steam Press, p. 31)
whole Punjab who successfully passed the English Midwifery Examination in the spring. 43

**Baptist Missionary Society: medical work in progress:**

‘God shall wipe away all tears from their eyes and there shall be no more death, neither sorrow nor crying, neither shall there be any more pain, for the former things are passed away’. *(The text was inscribed on the wall in Urdu and Hindi when, the small hospital in Bhiwani was built.) 44

In one of its early records, Baptist Zenana Mission involved its Northern work at Delhi (1867) and its daughter station at Bhiwani (1887) and Palwal (1890). Both the places showed an impetus in medical work from the opening of cottage hospitals at Bhiwani and the preparations for building one at Palwal. 45

The beginning was already done in 1887 in Bhiwani by women workers only. 46 The shape of a medical centre took in 1890, when a Delhi School girl named Maryam, who had been trained at the Medical School in Agra came to open a dispensary. The next year Dr. Ellen Farrer arrived and a house in the city was rented to function as “Miss Farrer’s Dispensary”. 47 Like for most of the women physicians, the beginning of their work was seldom smooth. Much valuable work was done in the small dispensary till it was extended in 1908. The makeshift still had a problem of the scarcity of space. Accommodation was only

43 Ibid p. 31
44 A Medical Jubilee, pamphlet, n.p., (Bhiwani: Farrer Hospital. 1940)
45 Report of the Ladies Association for the Support of Zenana work and Bible Women in India and China, in connection with the BMS, for 1898-99, (London: Baptist Missionary Society p.9)
46 Ibid p. 20
47 As the Doctor sees it, BMS Medical Work in India and Pakistan by Jean Benzie (London: BMS, nd, p. 6).
found for the patients by making use of the verandahs. As was common in most of the cases, the hardships of the first operation accounted for a section in the medical reports. "The first operation was done in an open courtyard", recalls Dr. Farrer, "and despite an inopportune dust storm which rendered aseptic precautions useless, the operation was a success and so a firm foothold in the confidence of the people was established." 48

Within the coming years, the hospital could boast of a statistics that showed the detailed treatment of the patients. In 1894-95, the patients increased to 7117. Another encouraging feature was the flow of patients from the distant villages and towns. Around 300 patients came in to the hospital from ninety different places. 49 The confidence of the missionaries grew with expansion of their network. Going by the records, there was gradual upward trend in almost all mission hospitals under treatment. Taking for instance the record of Bhiwani, within the past four decades there was tremendous gain in the number of in patients. 50

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48 *A Medical Jubilee*, pamphlet (Bhiwani: Farrer Hospital, 1940, p. 3.)
49 Report of the Ladies Association for the support of Zenana work and Bible women in India and China in connection with the B.M.S. For 1894-95 (London: Baptist Missionary Society, 1895, p. 54)
50 *A Medical Insider* p.27.
Besides this, a strong number came from the surgical operations performed in the Baptist hospitals. In the year 1910-11, it was stated that 8,952 surgical operations were done in these institutions. And while in the founding years it was the fear of the surgeon’s knife and chloroform that apprehended the patients from coming to the mission hospitals, with the passage of time it was this very non indigenous method of curing that brought the patients to seek treatment in these institutions. Surgery was the most important aspect of western medicine and such figures were the baseline for the promoters of modern medicine.

The hospital staff increased in 1908 when Dr. Bisset joined Dr. Farrer. With her advent, surgery developed and in 1914 she began to specialize in eye work for which she became famous in the district. In recognition of their work for providing medical facilities for women, both were decorated by the colonial government. In 1913, Dr. Ellen Farrer was honored the Kaiser – i- Hind medal by the Government and later in 1919 similar commendation was given to Dr. Bissett.

The premises of the hospital became cramped and negotiations for a new building started. Eventually in 1923, the new hospital building was opened by the wife of the Governor of

52 Ibid p.5
53 Ibid p. 6.
Punjab, and named it the Farrer Hospital. Further extension took place. An added asset of the Hospital was the training of dispensers. In 1928, Ms. Helen Walley joined the staff as a pharmacist and took over this branch of work, trained both men and women dispensers for the BMS hospitals in north India, Government and other hospitals. With this the influence of the hospital became wide spread. In 1929, another hospital for women was build in Bhiwani—gifted by Sir Chhaju Ram, one of the donors to the Farrer Hospital—and an Eye Hospital was established by Rai Sahib Kishan Lal Jalan. The generous action of these two gentlemen made the missionaries believe their work provided an example for opening of other hospitals funded by philanthropists. Activities from indigenous philanthropy, sustained the expansion of the women’s hospitals and their help pushed fundraising roles. After 41 years of service, Dr. Farrer retired in 1933 her work taken over by Dr. Jean Benzie.

With time it was evident that the popularity of the western medicine was not on the grounds of religion but on the medical element itself. Despite the religious resistance, medical response showed that these hospitals had become an important part of the mission of the Church on the one hand and of the indigenous society on the other.
Table 4.1

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Strategising Evangelism

Proselytization was a missionary strategy, however the medical missionary did not directly fall into evangelization. The task was carried by the hospital evangelist who ‘told the patients Bible stories, and taught them hymns and explained their meaning’. Some hospitals such as Multan and Amritsar had special courses in evangelism. In Palwal, the hospital evangelist at work taught the patients to sing hymns. To remove

58 Survey of Medical Missions in India (p. 55).
the initial fear in the minds of the indigenous people, the evangelist was to be seen more as a friend who could and will help them.\(^5^9\) Despite her striving to be successful, the evangelist was not easily acceptable. To reach to “an unresponsive and often critical audience” was a difficult task. But her victory was reflected in her perseverance. “One woman tried to rival her by singing and reading Hindu songs but she had neither the strength nor the inspiration of Florence, Indian Evangelist, and after the second day her effort ceased.”\(^6^0\) The lack of a Bible woman affected the efficiency of the spiritual working at the hospital. Though the ladies did what they could, taking a Bible reading for the out-patients everyday yet they could not spend the whole morning with them. And then there were those who arrived late and consequently missed the lessons altogether.\(^6^1\)

Not in every instance was it to be seen that the Bible woman when appointed, was a Christian. As suggested in one of the reports, at Easter in 1902, the woman for Bible – reading had been on probation for two years when baptized together with her children and her mother-in-law, at Tarn Taran, where she worked with the medical ladies of the C.E.Z.M.S.\(^6^2\)

The mission hospitals did baptism, whenever they could. There were other “proud” instances of patients coming and never going back to their homes. “A young Muhammedan girl who had been taught to read in the Lahore Mission Schools, came as a

\(^{59}\) The 93rd Annual Report of the Punjab Mission of the Presbyterian Church for the year 1927 (Mysore 1928, p. 31).

\(^{60}\) As the doctor sees it, p. 11

\(^{61}\) Ibid

patient, was once removed by her friends, but left her home again, and refused all their entreaties to return, in consequence to which ensued such a scene as I hope to witness. She was sent where she had been trained to teach and is now instructing others in the way of life, came a lofty report from Ferozepore. Conversion was not confined to one party, it was a two-way natural process. The missionary women made it clear that they did not have to mold or manipulate the suffering indigenous women. Badshah Begum resolved to leave her home, her husband, her mother, all she held dear, for Christ's sake. She did so and went to the Mission ladies for protection and was soon baptized. But there were many who were not allowed to stay by the missionaries, some “were persuaded frequently to see us and learn more.”

Another area where the missionaries made their investment was caring for the orphans. It became obligatory for the medical missionaries to “adopt” widows and orphans at their area of work. The rhetoric justification of this particular act complexed the scene of conversion. Taking care of orphans, was the greatest “act of charity” demanded of the missionaries as the followers of Christ. Clouded in the imperial context, scholars like Jeffrey Cox referred to the care of orphans as a defenseless act of “moral blindness”. It is in this sense that David Arnold while writing about the colonisation of the Indian body, refers to the medical intervention of the state as to the concept of rhetoric

63 Medical Missions Work at Ferozepore North India (n.p. Lahore, 1900 p. 17).
64 Ibid p. 6
65 Ibid p. 17
"paternalism" that could be extended even to the colonial impulses of the missionaries. The rhetoric found in "colonization" contributed in the very nature of the missionary work.

The abandoned became a part of "our family" of the mission hospital staff. Instances of adoption being a part of the hospital report. Coming from the Zenana Hospital, Bhiwani, "Our native family now numbers thirteen, including three invalids from the Delhi School, Gaffman's baby boy and two inquirers." 67 It was impossible to separate the association of the medical missionaries from the abandoned widows and orphans. The moral legitimacy of care for "helpless" lay strongly in the interest of the Christian faith. Dr. Allen narrated the beginning of the orphan's work,

Shanti was brought as an infant ten months old to the city dispensary by her father with a request that Ms. Sahib would take her. Her mother had died and he could not take care of the child.... Thus our orphanage began. This was followed by other examples of how motherless babies were kept under the hospital care." 68

67 Report of the Ladies Association for the support of Zenana work and Bible Women in India and China in connection with the BMS for 1897-98 (London: Alexander and Shepheard, 1898, p. 55)
68 Medical Mission Work at Ferozepur, North India, 1900, n.p., p. 14).
As early as 1884, the American Presbyterian Mission counted among the former orphans in the Indian Christian community with six ordained ministers, and a "dozen or more" employed as catechists or teachers.69

"Moral blindness" became further pronounced during the relief work at famine. "During the prevalence of relief several years ago", as pointed out by the Ferozepore report, "we had money sent for us for the relief of the sufferers. We found some work for a large number, who were paid daily wages. I often gathered these together to read and talk to them."70 The women missionaries never really comprehended vulnerability of the situation to spread Christianity. The care of the needy was a part of the parochial work expected of these women missionaries.

At the end of 1901, thirty one of the famine widows who had been received into the St. Catherine’s Hospital of the C.E.Z.M.S. were baptized. Bazaar preaching was carried on with vigor, and also evangelistic work at the two great melas held at Amritsar.71 The widow’s home in Lahore was instrumental in saving three women from their downward course. One widow went to work in the Multan Hospital under Miss Eger, and another woman, apparently a widow, acted as nurse in the Lady Aitchison Hospital. Confrontation with indigenous reform organizations gave the missionary a competitive edge. The Aryas


tried to persuade her to join their hospital at Ferozepore offering as an inducement to double her salary, but she preferred to engage in Christian work.\textsuperscript{72}

Opposition came strongly over the dissemination of Christianity in the hospitals. There were instances when the Districts Boards granted monthly allowance for the maintenance of the missionary women hospitals. Ferozepore District Board sanctioned Rs 30 for the female hospital which was highly opposed to. Indigenous voices raised against the Christianisation process of the medical missionaries were convinced that “Financial assistance of any kind meant giving money to the missionaries, so that they may convert their women and children.”\textsuperscript{73} They further pointed that the “Object of the Government was to propagate Christianity among their through the medium of missionaries.”\textsuperscript{74}

Despite the religious resistance, medical response showed that these hospitals had become an important part of the mission of the Church on the one hand and of the indigenous society on the other. Reviewing their own work in the early decide of the 20\textsuperscript{th} century, the women doctors could happily conclude 'medical mission in India are now an established fact,  

\begin{itemize}
\item \textsuperscript{72} Proceedings of the CMS in Africa and the Far East, 1903-1904, London: Church Mission House p 231).
\item \textsuperscript{73} The Rahbar-i-Hind, N.N.P. Vol. III, No.32, upto 25th July, 1895, p. 441.
\item \textsuperscript{74} Mehar-b-i-Am, N.N.P. Vol. III, No. 23, upto 9th June 1899, pp. 243-244.
\end{itemize}
an acknowledgment and a recognized department of mission work."  

Village Visits

It was a common feature for married women missionaries to accompany men on village tours. And it was an ideal arrangement if itineration were undertaken by medical missionaries. The importance of itineration was well discussed in the Missionary conference. “In India, preaching may either be identified with itinerating towns, or may be the important feature in evangelistic campaigns among the villagers or whatever Churches or stated places of worship are ready to use.” Although itineration, like zenana visits had hardly any fruitful impact yet it was one activity almost every missionary indulged into. On such an account Rev. E. Guilford said,

“It is ideal when the evangelistic and the medical missionaries can work side by side right out among the villages; for while the former is preaching the Gospel of love, the latter can show it in action. Our modus operandi was to settle on a place and make it our headquarters for a week or so. .................. In this way a large area was covered and the doctor got an average of 150 patients daily. To attend

to the spiritual wants of these, a preacher
was always left behind the doctor, while
my wife did all she could to help in the
dressings and in talking to be women
patients."77

The reports concerning the evangelistic work lay a good
deal on the team work consisting that of a preacher, a
missionary doctor, if the latter is a male and his wife, who too
makes valuable contributions in the villages. With the advent of
unmarried women missionaries, itineration became a routine
work of the mission activity. Missionary reports covered a large
portion of the itineration work. The comparison of the initial
visit to that of the later visits was strongly put across. It was not
always, that the initial visit was welcome. Ms. L. Eger, an
assistant at the Multan women’s hospital went to visit a village 2
miles of Multan where she began teaching a young married
woman in her home. Before long however signs of opposition
appeared, and eventually Ms. Eger was requested to cease
visiting the place.78 In another incident from Palwal “A preaching
band crossed the river one evening and began its work in the
same Mahommedan village, under the walls of the little mosque
on the riverside. Very soon question and criticism began.........
In the heat generated by the wordy collision tempers were frayed
.........”79 At such occasions, itineration could not have been

77 Proceedings of the Church Missionary Society for Africa and the East, 1910-1911 (London:
Church Mission Society, 1911, pp. 142-143).
78 Proceedings of the Church Missionary Society, Africa and the Far East, 1903-04 (London:
Church Mission Society, 1904, p. 242).
79 After many days by Dr. Vincent Thomas of Palwal. pamphlet (Baptist Mission Society Medical
Mission Anxillary n.d.)
It was important for the missionary woman to know how itineration would help medically and in evangelization. “We stand the car outside the main gate of the village, and said in word that the Dr. Miss Sahiba has come. In a short time, people start pouring out of their homes. Curiosity in the motor, the medicine, the people bring many who are not ill..... It encourages us a great deal too, when a few days later we see people from those villages coming into the hospital...... with each contact our influence increases.”

It came as no surprise to read the later accounts of itineration repeatedly mentioning the hospitality offered in village after village. Punjab was found as a good centre of work by Ms. Parslee of the CEZMS. “There are around 42 villages and for most part the people are friendly and willing to bear the Gospel. It is pleasant to see how confidence and friendliness of the people measures year by year.” The meeting was counted successful if it ended with “come again, before long, Ms. Sahib!”

When itinerating, the medical missionary always preferred to take a supply of simple medicines. And if she had a compounder, there was always plenty of time to preach.\textsuperscript{83} For others like Rose Greenfield of Ludhiana, distribution of medicines was to be followed later in the tent, after the preaching in the village. She exclaims “It was delightful at our return the place already besieged by applicants and after a hasty cup of tea or soup, I attended to the sick, one by one, while my companion and the Bible-Woman talked with those waiting.”\textsuperscript{84}

The lantern show became distinct part of the visits. “Tamasha” as called by the indigenous audience, was a magic word for the missionary “which opened the door access to the villages.” Under good conditions, it was difficult to think of a more effective method of general teaching. Given a good open space, sufficiently large to accommodate all who wish to come, given a good wall in good shadow and a sheet hung fairly tight across it ... \textsuperscript{85} were the, means of showing the “tamasha”.

Amidst all the chaos of half a dozen dogs and one or two screaming babies.... a couple of noisy quarrelsome women or noisy boisterous men’ the show was not always as expected. It was a consolation

\textsuperscript{83} The 74th Annual Report of the Punjab Mission of the Presbyterian Church in the U.S.A for the year 1907., p. 115.
\textsuperscript{84} Rose Greenfield, Five Years in Ludhiana, pp. 68-69.
\textsuperscript{85} Ibid p. 85
for the missionary women to 'discover the general temper and spirit of one's audience. ... One gets a glimpse of the thoughts and the feelings aroused in some individual heart to heart which may itself be a picture of many hearts.86

The influence of preaching was easier for a person who had been visiting the hospital more often and had already heard about the Gospel. Mrs. Angus, from Bhiwani, on the benefit of the medical work said, “One of the towns, Dadri, was just visited last year but it has really been opened up to us by means of the medical work. Mrs. Farrer has had several patients from there, and, thanks to the news of us they carried, we were well received.”87 On the same account writes Ms. Fletcher of Palwal, “In – patients returning to their villages after consecutive teaching in the hospital have a much better idea of our teaching than our short and far – between visits can convey.” Yet another one conveyed the same excitement of spreading the gospel to areas and people not known to them “One child, living sixteen miles off, had taught verses of two hymns to her relations in a village I had not previously visited”. 88

Every hospital account had a figure that supported the number of visits made to the village. For the year 1912-13, the

86 Ibid, p. 88
missionaries at Bhiwani reported 31 villages regularly visited and 14 occasionally. This piece of information was "proof" of their work for the home audiences.

'Boxes’ and Grants: Collection of Funds

The benefits of medical care were clear to everyone even to the home country from where the missionaries came. But finding institutions was an expensive project and for help the hospital reports carried the message to the West. The desperation of the medical requirement in the "heathen lands" was over-emphasized for the readers to react positively. Dr. Lewis on the visit to Philadelphia Hospital, Ambala wrote

There is a little girl of ten, named Kreshni on her head soft brown churls, in her nose-maggots! You shudder and I shudder too..... Think yourself into little Kreshni's home, and let your pity grow to embrace a million more who need more pity. Then reach for your check and send a 'larger than usual' check to the Mission Board. 90

Not only would such a description draw funds for further expansion of medical centres but they would open a wider field

90 The 92nd Annual Report of the Punjab Mission of the Presbyterian Church in the USA for the year 1926, pp. 15-16.
for other medical missionaries back at home. “Should there be any lady doctor or lady chemist reading these words, may I ask you to enquire of the Lord whether He would have you come here?” was the request of Dr. Edith Brown from the North India School of Medicine for Women, Ludhiana that changed her life.91 Furthermore, there was a financial incentive behind the push for numbers, larger numbers meant continuation of funds, that eventually gave evidence that the missionaries were doing their jobs.92 Raising money involved a considerable effort. Initial help for the founder medical missionary, always came from “friends back home”. Help was in form of cash, gold piece, medicines, invalid chair etc. 93 Voluntary donations were made directly to the Association under which the missionary was recruited. Most of donations came to the Churches. The funds were collected in the boxes attached to the Churches. Items sewn and collected by British women were kept in these ‘boxes’ and send out to India and sold to the English people stationed there. 94

For the medical work at Ferozepore, “in one of the Churches of Philadelphia, a box of hospital requisites were collected.”95 Boxes that were not for the Hospitals were arranged for sales. Items that were felt unattainable in India would be filled by the English ladies ranging from petticoats, toys,

91 Just what they need. Being an Account of the North India School of Medicine for Women at Ludhiana, Pamphlet, Punjab, n.d., p. 19)
93 Medical Mission Work at Ferozepore, North India (Lahore: Albert Press, 1900. pp. 1-3).
95 Medical Mission Work at Ferozepore, North India, nd, np.(p. 3).
children's clothing. It was not always that these items were consumed in a given period. As observed from Ferozepore, “Many hospital requisites brought from home were becoming aged or had passed beyond the stage of usefulness, and it may be, there are those who may wish to renew the supply, hence a small list of useful articles is appended, which if sent to the Board, carriage paid, would reach us and always be acceptable.”96 In many instances, the items of the boxes were distributed at Christmas. At the North India School of Medicine for Christian Women, Ludhiana, patients were gifted handbags dolls, that even became a bone of contention when “the neighbor will bring her doll and point out its deficiencies – supposed or otherwise – and demand a better one.”97 Despite all the “hype” the boxes created at home and in India, they continued to remain a major source of finances for the Hospital.

In acknowledgement of the work of the hospital, frequently handsome donations were received and thanks offering from grateful patients. In 1938, the Biwani Hospital reported of Lala Doongan Mal who gave money to make a staircase to the roof a bungalow...... In 1939, a second waiting hall for out-patients was erected through the generosity of Lal Gajanand Minda...... An additional kitchen for Hindu patients was given in the same year by Jili Bar...... 98Such descriptions paved further grants for the coming years and in a way showed the indigenous acceptability

96 Ibid p. 20

124
towards the missionary treatment offered at the hospital premises.

Financial help came from Government as well. Yearly grant was made by the Bhiwani Municipality and the Hissar District Board of Rs. 1,020 for the year 1940. Similar support came to the Ludhiana Mission Hospital. There were reports when hospitals had to close down due to lack of funds like the ones at Hoshiarpur under the American Presbyterian and Batala under the CMS. This happened very rarely for overall it was seen that the “a very hearty response” was made when mission appeal was made.

**Embracing Indigenous Women: Facilitating Avenues**

Imparting professional education became an agenda of most mission hospitals. Educating “their own sisters” carried messages that derided many a indigenous cultural norms. The hospital actively opened classes for nursing where the government too helped them financially. To this one government official said “We can only expect selfless service from Christians...........” It definitely supported the ideology that Christianity gave “new dignity” in heathen lands. The training of these girls in Punjab was one of the most important branches of the work of the hospital. In addition to the missionary figure the contributions that showed in reports were of their trained subordinates. Rahamatpur held a unique record among the

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100 Survey of Medical Missions in India (National Christian Council. Poona, 1929. p. 38.)
101 Ibid p. 16
BMS hospitals in North India. A team of four – an Indian doctor and nurse a European doctor and sister worked together without a break for thirteen years. 102

For the missionary movement to be successful there had to be fellow feeling between the women missionaries and the “other” women. With the coming of women as professional evangelists, they facilitated awareness where indigenous women could be brought into the mission fold. Missionaries saw their duty as a base to shape the indigenous women with professional and moral efficiency. An examination of the various reports of the hospitals lead to the conclusion that the highest degree of missionary compassion was seen in the profession of nursing. And it was believed that a nurse could be a mediator between the missionary and the “heathen” patient. As observed in one of the BMS reports, the Christian nurse had opportunities for leading the relations of patients while they were in hospital, not only the Gospel but also for hygiene and preventive measures. 103 Ms. Guyton, from Bhiwani wrote of her extensive nursing classes, “More exacting as the standard improved and gradually a better type of girl with more education offered in training.” 104

Intensive work followed. Dr. Farrer did much in translation of text books into the vernacular and helped Ms. Guyton and Ms. Timm to couple nursing and anatomy text books. 105 A similar report came from the Philadelphia hospital, Amabla. Here, in

102 Ibid p. 14
103 BMS Medical Work in India and Pakistan (London, n.d. p. 16)
104 A Medical Jubilee, pamphlet, Farrer Hospital, Bhiwani (1940, p. 19).
105 Ibid p. 19
order to make it comfortable for the indigenous trainers the vernacular texts were much in demand. “Our work is all done in vernacular, and we are much handicapped by lack of text books in urdu. A good deal of our subject matter must be translated from English. Good practice for beginners.........” Mission hospitals created a corps of efficient and high-minded Indian nurses for the people of India. After three years of general training and a year of midwifery, the girls made reliable staff nurses and a few were able to take charge of a ward or superintend the preparation of both the patient and theatre for few a major operations.

The nurses were trained to carry the professional responsibility as the missionaries, as reported by the latter, “It is important and satisfying work to help in the training of these girls, and in doing this there is great contribution be made in Indian future, in trying to make them capable of becoming leaders in whatever community they find themselves and to fit them to continue the work we have begun.” As found in the hospital report nothing gives the staff more pleasure than to be able to stand aside and see “their Indian Sisters” take full charge of a case, say an operation carrying the whole thing through from beginning to end.

106 The 93rd Annual Report of the Punjab Mission of the Presbyterian Church in the US in Connection with the Presbyterian Church in India for the Year 1927 (Mysore: Wesleyan Mission Press, 1928 p. 9)
108 As the Doctor Sees It, p. 9
109 Ibid, pp. 20-21
The missionaries became the best mentor for the indigenous women. It came as no surprise to see an increase in demand for trained nurses especially from mission hospitals. It was observed with pride that 'many of our girls are filling responsible posts in government hospitals'. Furthermore, in 1929, there were thirteen nursing schools as compared to two government schools in the Province of Punjab with a number of 137 students, more than any other province except in Madras.  

The pressure of the nurses' work led the Trained Nurses Association of India to introduce State registration in India. The main aim was to gradually bring the standard of nursing up to that of the General Nursing council of Great Britain. This resulted in the Punjab's Nurses Registration Council instituted in 1934.  

Besides nurse training they learnt to conduct a ward service and to shoulder the responsibilities of Church membership, after all majority of the students preferred were Christians. For it was felt that Christian workers would lay the Gospel more profoundly than the non-Christian medical workers. Furthermore, the indigenous staff had the advantage of de-limiting their periphery. Ms. Dass, the health visitor at Palwal worked for several years, being welcomed in every house in the town, whether Hindu, Muslim or Christian, something the missionaries could never easily gain.

110 A Survey of Medical Missions in India, pp. 92-93
111 A Medical Jubilee, pamphlet, Farrer Hospital, Bhiwani (1940, p. 19
112 Looking East, Dec. 1946 (p. 132).
Network of various professions led to the closeness of missionaries with the indigenous population. The process by which indigenous women turned to mission-run institutions for their new roles was primarily seen as a by-product of the mission agency.

**CONCLUSION**

This study on the missionary approach towards building of medical institutions has by and large shown the reactions of both the heathen patient and the Christian physician from the late 19th century. While Indian response remained ambivalent, the medical missionary remained domineering during the process. Both needed the reason to found hospitals, the medical missionary as an adjunct to the work of preaching and as for the indigenous women, in the mission context felt there was a need to open up work for women and children because of the custom of keeping the higher and middle class women in seclusion. Moreover, opposition to other forms of Christian work was among one of the reasons stated for opening mission hospitals. The promotion of the western system of medicine backed with the power of prayer was viewed as a striking example of the missionary desire to work for the benefit of Indian woman.

Important development that was seen in all the mission institutions was the professional commitment of the single women missionaries. They, consciously and at times subconsciously modeled for Indian women, their radically new
personal freedom. This was followed by a “new” profile of independent Indian women in the medical field in the role of nurses and hospital assistants.