



Patriarchy and Medicine: A Woman Medical Missionary in the Colonial Punjab

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Abstract

My paper seeks to explore the wide-ranging influence of institutionalized patriarchy and its ideology in constructing and strengthening gendered notions of science particularly medicine in Britain, Europe and United States especially during the First and Second World Wars. Even after the end of these wars and return of peace, women continued to be relegated to the domestic arena despite their conspicuous medical roles. Dubbed as sexualized bodies with inferior intellectual abilities, they continued to be denied admission in medical colleges and jobs. My argument shall be illustrated with examples from women's struggles for medical education in the imperialist countries and the colonized countries namely India. The processes were complex and different in each terrain depending upon the dynamics of cultural and nationalist forces. In the course of discussion, debates regarding women's struggle for medical education and for equal status as full-fledged missionaries and professional identity as institution-builders, surgeons and gynecologists shall figure in. It shall include references to the rabid hostility of their male colleagues and students. The story of Christian Medical College in Ludhiana (Punjab, India), founded and nourished by a Baptist missionary, Edith Brown, provides the best example of the tension between misogynist notions of women's intellectual caliber and their success as medical doctors, professional surgeons and administrators during periods of crisis such as wars and massacres during the partition of Punjab (1947). Their success, though partial, in modernizing notions of disease and women's health, has long-term implications for medical traditions in India.

Keywords

Patriarchy, Medical Missionaries, Gynecology, Hygienic Living, Purdah

Patriarchy has been defined as a social system in which men hold primary power and dominant positions and leading roles in politics, knowledge-production, wield moral authority, social privilege and control over economic resources (Abercrombie, Hill, & Truner, 2000, p. 258; Macinis, 2012; Henstin, 2001, pp. 65-67, p. 240). Some patriarchal societies are also patrilineal implying that property and title are inherited by male lineage. In terms of ideology, patriarchy is associated with an ideology that explains and justifies male dominance and attributes it to inherent differences between men and women. However, sociologists namely Sylvia Walby defines it as "a system of social structures and practices in which men dominate, oppress and exploit women's labour and reproductive powers" (Walby, 1990). Bypassing a detailed discussion of various theories regarding the origin (Pilcher & Whelehan, 2004), growth and institutionalization of multiple patriarchies in the Western and Eastern societies, I shall endorse Gerda Lerner's observation on this issue. In her view, there was no single event and documented history which pinpoint and trace the common path of evolution of patriarchy as a system. She has suggested that patriarchy as a

social system arose in different parts of the world at different points of time (Lerner, 1986, pp. 8-10). The early societies all over the world tended to be egalitarian. Women and men shared all tasks and the former enjoyed respect and prestige for their reproductive role in society.

In this context, it is relevant to discuss the implications of patriarchal structures and ideologies opposing entry of American and European women in medical colleges. Almost impenetrable layers of cultural and professional opposition and resistance to the very idea and prospect of women becoming doctors had rendered their struggle complex, bitter and hard. As my paper has focused on the life and professional career of a British medical missionary Edith Brown, the founder of North India School of Medicine in Ludhiana (Punjab, India), her struggle must be contextualized with the women's medical movement in America and Britain from mid-nineteenth century onwards.

At the outset, it may be pointed out that health of the 'native' women in the Zenana remained the site of contest between various contenders, whether missionary or secular, and imperialist civilizing agencies, patronized by the colonial state. Using a metaphor of the imperialist's civilizing mission, Rudyard Kipling had urged the British to

Take up the 'White Man's Burden
The savage wars of peace
Fill full the mouth of famine
And bid the sickness cease.

'Bidding the sickness cease' in the colonies became an important issue for women in Britain. Based on their second-hand information that women in South Asia refused to consult male doctors, their argument and campaign for admitting British and Indian women to medical colleges gained strength. 'The line of division between missionary and secular aspirants for medical education was clear. The latter were less interested in Christianizing the 'heathen' and more in institutional and social reforms with an imperialist motive, especially in areas affecting women. Both of them whether from Britain or the United States struggled hard for entry of women in medical colleges, training of midwives, nurses and apothecaries as well as for the establishment of exclusive women's hospitals. I shall argue that Western perceptions of Indian society especially the abject and degraded status of Indian women and their frail health played a crucial role in defining missionary feminism. It also shaped their spiritual and social welfare orientation. Narratives of their subjection, deprivation and humiliation in high caste Hindu and *Sharif* Muslim homes were crystallized into an argument for imperialist and missionary intervention. While the British Government used it as a pretext for withholding the grant of self-government to 'effeminate' Indians, the medical missionaries justified their activities under the slogan of 'rescue and redemption'.

In the course of discussion of Edith Brown's (1864-1956) multifaceted contribution as a medical missionary, I shall try to show that her life-long engagement in building the North India School of Medicine for Christian Women (opened in October 1894). Ludhiana, went beyond the missionary rhetoric of 'rescue and redemption.' The trajectory of professionalism, illustrated by her long career of fifty years as a competent surgeon, fund-raiser, institution—builder with a long-term vision, provoked me to explicate how Edith Brown's action-oriented approach had enabled her to acquire a medical degree and to bring changes in the gendered policy of missions and accelerate the process of broadening the scope of their activities, initiated by her predecessors namely, Fanny Butler, Clara Swain, Rose Greenfield and other missionaries. It has been my endeavor to demonstrate and highlight her spectacular ability and boldness involved in establishing her professional identity and dignity as a woman in the patriarchal socio-cultural milieu as well as of missionary institutions, including Home Committee, General Assembly, Commissions and Conferences.

For a clear enunciation of my argument, I shall divide my presentation into six sections. I. Making of a Missionary; II. Euro-American Women's Struggle for Medical Education; III. Women, Missions and Professionalization; IV. Edith Brown: An Institution-builder with a Vision; V. Analyzing Brown's Success Story; VI. Conclusion

1. Making of a missionary

Edith Mary Brown (1864-1956) had been socialized for the life of a missionary through her family connections. Her family roots may be traced to Huguenots who went through the period of persecution of protestants in France—Reverend Peter Petit, her great grandfather, had served as a vicar around 1750. Her maternal grandfather had been brought up in a strict Christian family (Reynolds, n.d., p. 15). Her father George Wightman Brown, a bank-manager of Whitehaven enjoyed great respect in local society. It was in this Christian family tradition that Edith Brown was born on 24 March 1864. Two developments in her early life proved to be a turning point. One was the unexpected death of her father when she was just eight years old. The second, according to an entry in her

diary, was the call from the Lord:

On October 12, 1872 the Lord brought home to my heart the necessity for divine acceptance of His Salvation... (Reynolds, n.d., p. 17).

The correspondence that followed between Brown and her elder sister (who was the wife of a missionary in the Godavari district, India) played a crucial role enabling Brown to choose the missionary career. Brown's decision to take up the career of a medical missionary was just the first step. In order to go to India, she was required to do two things: First was to secure admission in a medical school. Second was to persuade a missionary society to sponsor and fund her travel to India. Being a bright and hard-working student in school, she was offered a scholarship in Girton College, Cambridge in 1882. It was only a year before that the Senate of Cambridge University had recommended to admit women students to the Honours examination of the University. The fact, that Girton College was exclusively for women, reduced the pain and complexity of Brown's struggle for education, which her contemporaries experienced. Her fellow girl-students, who had to attend university lectures along with male students, invited wrath of Plymouth Brethren who resented the new freedom offered to women in the rapidly expanding field of education. Despite mounting social pressure to move to a conservative institution, she remained adamant and stayed on in Girton College. In May 1885, she qualified with second class honors in science. Since Brown needed a medical degree for working as a medical missionary in India, she earned money as a teacher of geography and book-keeping in Exeter High School in Bristol¹. It was a lucky coincidence that she met Mrs. Robinson, the local leader of the Baptist Zenana Mission. Deeply impressed by Brown's commitment to the missionary cause, she facilitated fund-raising for her medical education through an appeal in the Baptist journal *Our Indian Sisters* (1887).

Not being a matriculate from London, and thus not eligible to pursue her medical education there, she decided to acquire further qualifications outside London. She earned L. R. C. P. from Edinburgh and M. D. from Brussels (Blake, 1990, pp. 68-70). In the meanwhile, Brown developed contacts in Croydon where she met E. A. Greenfield. Her sister Rose Greenfield, who had been part of the Baptist Zenana Mission in Ludhiana for the past twenty years, sent an appeal to her sister for help in recruiting a woman doctor to take charge of her small hospital, which had been established ten years back. The Baptist Zenana Mission managed to negotiate with the young and sincere English doctor who agreed to spend her initial years in learning Urdu and understanding India, especially Punjab. Brown's mission in India had yet to begin in 1891 when she sailed for India along with another Baptist woman doctor Ellen Farrer. For a larger and complex picture of the heroic struggle for medical education, waged by Euro-American women, let me recapture it briefly through a stirring narrative. It may be pointed out that Euro-American especially British women, whether secular (including independent or employed through Dufferin Fund) or missionaries had sought to target bodies of purdah woman in British India for gaining clinical experience and gynecological knowledge.

2. Euro-American Women's Struggle for Medical Education

Euro-American women's struggle for medical education had fiercely contested the patriarchal obsession with bio-medical representations of female body and mind as well as the Victorian doctrine of 'separate spheres'. More significant issue was their partnership with the political women who were engaged in a fight against the patriarchal British State for their right to vote. Mutually supportive, a number of pioneer women doctors contributed stories of their painful struggles against misogynist institutional structures, social ostracism and personal loneliness to feminist periodicals such as *English Woman's Journal*. They also funded and helped in strengthening suffrage and repeal societies. In their turn, feminists promoted the progress of women's medical movement through their political influence before and between the two World Wars.

For the political women as well as for the aspiring medical women, Zenanas formed the crucial site and pretext of their respective battles. They took their cue from the argument of imperial civilizing mission in India, which focused upon the Indian women's state of dependence upon men and the latter's 'habitual contempt' for them, leading to exclusion of women from education and parental property (Mill, 1840, pp. 312-13). Like the colonial state, the British feminists, secular and missionary medical women justified their claims for rescuing these purdah women requiring

¹ For a detailed discussion of her educational career see the *British Medical Journal* (Journal of the British Medical Association, London), Vol. II, 1956, July to December, 1490.

‘protection’ and ‘intervention’ on humanitarian grounds. The entire argument was crystallized into a rational justification for the perpetuation of the British rule in India on grounds of moral superiority (Mohan, 2006, p. 71).

Despite sharing their belief in the moral superiority of the Euro-American civilization, feminists and medical women continued to contest and challenge various forms of patriarchy which discriminated on the basis of race, colour, religion and sex. Let me focus upon the hard struggle waged by the British women seeking opportunities for career in medicine. At the beginning of nineteenth century, medical practice in the United Kingdom was regulated by twenty-one licensing bodies. Among others, these included the medical colleges at London and Edinburgh. It seemed to change in 1858 when one of the clauses in the Medical Reforms Act (1858) permitted medical graduates already in practice to get their names entered in the Medical Register. The Act did not exclude women explicitly but the Royal Colleges, universities and medical institutions debarred their entry in practice either by prohibiting women from studying medicine or from appearing in the academic examinations that would permit them to qualify to practice. Despite various male exclusionary strategies in Europe and America, a large number of intelligent and determined young women travelled to the ‘ends of the earth’ (to use T. N. Bonner’s title of the book), and bore hardships and long periods of loneliness in order to get medical education. Elizabeth Blackwell went to Philadelphia to study medicine. Denied entrance into big medical schools, she was finally admitted into the University of Geneva, a small town in the State of New York. When her application was placed before hundred and fifty young male students, it was approved by a unanimous vote. These students pledged to behave graciously to her (Lutzker, 1969, p. 37). However, Elizabeth faced social ostracism in that little town. In 1849, she became the first woman to obtain the Degree of Doctor of Medicine (Lutzker, 1969, p. 39). Taking advantage of the legal loopholes she became the first British woman to register as a medical practitioner (Lutzker, 1969, p. 37)².

Elizabeth Garrett Anderson was the second British woman to register as a doctor in the Medical Register. She completed her study for medical degree through private tuitions and not regular classes in a medical college. Elizabeth Garret Anderson was given her license which entitled her to be registered in 1865 as a licentiate of Apothecaries Hall (later designated as the British Medical Council). From that year onwards, rules were changed in order to prohibit medical students from getting medical education through private tuitions as a substitute for regular instruction in a medical college (Lutzker, 1969, p. 39). Thus, propelled by professional patriarchy and fearful prospects of competition and economic insecurity by the entry of women doctors, male medical professionals and students devised ever-new strategies and arguments: biological unsuitability of women for intellectual study, jeering and insults, institutional and legal barriers to their admission and registration as medical professionals (Bonner, 1995, pp. 130-31)³.

Sophia Jex-Blake was the third women who not only fought for her right to medical education but energized the ongoing struggle, launched by her predecessors despite the extremely hostile socio-cultural and professional environment. Like Elizabeth Garrett Anderson she had been turned down by the University of London. Admitted in the University of Edinburgh in 1869, her admission was rescinded by the University Court, the highest administrative authority on the ground of its “not being advisable for the University to make alterations in the interests of one lady” (Bonner, 1995, p. 126). Frustrated by discriminatory practices owing to male chauvinism, Jex-Blake left Edinburgh and continued her medical studies in Berne where she was awarded medical degree. It enabled her to register with the General Medical Council in Britain.

It was evident that misogynist male professionals had blocked the entry of Jex-Blake and six others to Edinburgh Medical School. They fought hard and their case became famous as “Seven Against Edinburgh”. Edith Peachey was denied the Hope Scholarship, despite topping the list of successful candidates. Despite being defeated in the court of law, Jex-Blake became something of a celebrity (Blake, 1990, pp. 138-49)⁴. Their sexual harassment exposed the worst face of patriarchy.

Undaunted by these obstacles and professional resistance, created by multiple patriarchies, these British women sublimated their anger against unjust laws and institutional practices into a broader goal. The first step in this direc-

² For a comprehensive and critical account of British Women’s fight for their right to excellent medical education in co-educational institutions and against professional patriarchy and gender-bias see Bonner (1995: 121-37).

³ In 1870s, medical men in Britain entered the public debate for the first time. A number of obstetricians and gynecologists warned against the danger to women’s health from excessive study. Particularly effective were the arguments of Henry Maudsley, a Professor of medical jurisprudence in London, who borrowed heavily from a Harvard Professor, Edward H. Clarke, in attacking the unfitness of women for hard study. In the case of women, wrote Maudsley, “A great deal of energy was diverted in puberty to the organic changes taking place in their bodies. When Nature spends in one direction”, he said, “She must economize in another direction”, Cited from Joan N. Burstyn”, ‘Education and Sex: The Medical Case against Higher Education for Women in England, 1870-1900’: *Proceedings of the American Philosophical Society*, 1973, 117: 79-89.

⁴ In January 1872, *The Scotsman*, which had reported the proceedings of the Edinburgh case, published a witty poem lamenting the divisions, created in middle class society in Edinburgh.

tion was opening a medical college for women prior to making co-education in medicine possible in the long run. Thus, the idea of opening the London School of Medicine (later known as Royal Free Hospital) was born. It matured with the co-operation of liberal and progressive politicians namely, William Cowper—Temple, M.P. and a few sympathetic male doctors (Blake, 1990, pp. 138-49). Russel Gurney's Enabling Act 1876, which had demolished legal barriers to medical examining boards for granting licenses to medical women, had facilitated the placement of London School of Medicine for Women (L.S.M.W) on the King's and Queen's list of recognized medical colleges (Bourdillan, 1988). I shall bypass the details regarding its growing popularity not only in the United Kingdom but also in Europe and America. It remained a popular institution for women all over the world despite the availability of choice of admission in Women's Medical College in Pennsylvania, founded in 1850. It may be noted these pioneer medical women remained seriously concerned with the issue of training of highly qualified doctors. It is evident from Elizabeth Anderson's observation, "You want efficient women for India most of all whose native women are now our sisters.... These are at least 40 million who will have only women doctors and who have none." Apart from its relevance as the feminist victory against male chauvinism, its real significance was as a mark of growing hegemony of Western medicine through secular channels for promoting the cause of imperial ambitions (Jex-Blake, 1886: 234). Missionaries, too, utilized medicine for entry into the Zenanas and subsequent consolidation of their authority in the name of Christ and to a lesser degree imperial mission.

2.1. Women, Missions and Professionalization

The preceding discussion has shown that the Euro-American and the British women, acutely conscious of the key-role of education in bringing success and wealth in the emerging class society, had fought for acquiring independent professional and gender identities. Caught in the swirling currents of social revolution and industrialization, male-dominated missions and their ideologies had been compelled to recognize the crucial role of gender as a social category in defining oneself personally and professionally. "It became a significant criteria in the revision of the concept of qualifications as increasing number of women began to get opportunity for education and thus granted entry to job markets" (Perkin, 1969, p. xi; Perkin, 1989, p. xii).

Definition of the profession of a missionary, too, underwent change in the course of nineteenth century. It could be called professional because it provided valuable service and prescribed exclusive qualifications for recruitment to the job of a missionary. In the early part of the nineteenth century, missionaries had been inducted owing to their membership in an 'aristocracy of ecclesiastic office.' Towards the close of the century, various missions assessed needs of their work systematically and defined skills requisite for discharging the functions flowing from these needs; it led to specification of qualifications. The upgrading of social and educational standards of mission workers in general and of women in particular influenced the entire process and direction of professionalization (Cox, 1995, pp. 197-221). Around this time, emergence of faith-missions enlarged the field for the fulfillment of the religious ambitions of the aspirants.

By 1890s, trained and educated middle class aspirants from both sexes had more choices of missions. It may be pointed out that women candidates, despite their growing educational qualifications, were evaluated on different criteria than the male candidates. Their social background rather than their training was given more weightage. However, each mission, its gendered definition of 'professional' work and criss-crossing of religious and secular activities, experienced a number of changes with the recruitment of single women as professionals. It was believed that "to plant the 'home' of God's Church in foreign lands...women are needed. Therefore women must go" (*Authorized Report of the Missionary Conference*, 1875, p. 120). After entering the missionary service, they found their first most important field in the Zenanas of India" (Richter, 1908, p. 339). The prospect of 'unsealing' the Zenana doors by female missionaries with great zeal on a regular basis generated considerable excitement (Hewat, 1960, p. 75) as was evident in the comment of Doctor Watson. After a tour of Indian missions, while reporting to the General Assembly of the Church of Scotland in 1868, he compared the opening of the Zenana by women's work with "the discovery of a new continent."

The "storming of the Zenana", reinforced during the 1860s and 70s by the first contingents of professional female missionaries, no doubt, met with a certain degree of success in Calcutta, Madras and Bombay. However, the lady missionaries often reported that the houses of upper castes and the wealthy persons remained 'fast shut' (Ellis,

n.d.: 62-68)⁵. Doctor William Elmslie, the celebrated pioneer of medical mission in Kashmir, pleaded for a more effective form of missionary strategy. He wrote:

Is there no other key but that of Education with which to open the door to the inner social life of India? We think there certainly is one other such key, and that key is female medical missions.... the practice of medicine by a lady, for the purpose, not merely of curing, but Christianizing her patients... This is a key that may be said to fit every lock.... She would find an entrance where the educational missions would find the door closed (Elmslie, 1873, p. 197).

His call for the development of female medical missions was based on the ground that in India “the state of things is peculiar and exceptional which not only warrants, but demands peculiar and exceptional measures”⁶.

These ‘peculiar’ circumstances referred to Indian sensitivity on the issue of female modesty. Its intensity was reflected in the impression that Indian women would prefer death rather than exposing their body for diagnosis by a male doctor⁷. Interestingly, the similar argument was used by the British women in the public debates on women’s medical education in the West. One female correspondent wrote to the *Scotsman*, 27 May, 1872 regarding female “agonies of shame and female modesty, when submitting to male medical and surgical treatment” (Blake, 1990, p. 147).

Despite missionary awareness about the variations in practice of secluding Indian women, it was argued with exceptional vehemence that Muslim and Hindu women of upper castes were deprived of the benefits of Western medicine owing to the custom of purdah. Even an average woman was reluctant to take male medical assistance in cases of childbirth, and ‘diseases peculiar to women’ (Balfour & Young, 1929, p. 35). Their treatment rested in the hands of traditional midwives who were dubbed by the missionaries as “grossly ignorant ... of most immoral character” (Elmslie, 1873, p. 196). Their ‘barbarous practices’ were believed to be responsible for countless deaths and misery for Indian women.

A definite connection was made between the ‘depressed, neglected and oppressed’ Indian women and urgent attention to them from Western medical doctors which could only be provided by British and American women. Thus, ‘a peculiar and exceptional measure’ i.e. medical education of women was projected as the best alternative for helping women (Elmslie, 1873, p. 182).

It may be pointed out that American missionary societies took initiative in commissioning qualified women doctors to work as foreign missionaries (Bonner, 1995, p. 29)⁸. An American, Doctor Clara Swain, the first woman medical missionary, arrived in India in 1869 and took up work in Bareilly in 1870 (Bonner, 1995, p. 29). However, British women’s battle for medical education was stuck on the issue of co-education or professional instruction in a private manner (Elmslie, 1873, p. 182). Thus, a British woman, desirous of becoming a medical missionary, was caught in a double bind. First, she had to fulfill stringent qualifications for her selection as a professional missionary. Second, she had to acquire a medical degree for being recruited as a medical missionary.

The female medical missionary, commissioned to work in Eastern lands especially India, was enjoined to provide ‘double cure’, i.e. the healing of both bodily and spiritual ‘disease’. It was believed that medical service could be an effective strategy for “breaking down the native wall of pride and prejudice, contempt and hatred” that obstructed the ordinary missionary methods (*Authorized Report of the Second Missionary Conference*, 1877, p. 42). The medical missionary was supposed to be welcomed by all the people, irrespective of their status and perhaps religion; medicine would cure disease and relieve suffering (*Authorized Report of the Second Missionary Conference*, 1877, p. 42). The call for female medical missionary was grounded in the belief that she was doubly armed - the humanitarian power of medicine and the religious conviction of Christianity.

⁵ The current view that “The testimony of pioneer Zenana missionaries, often suppressed at the time, for the fear that if widely circulated it would prove a death blow to the work”, reflects the marked reserve shown by many women towards their Christian ‘Visitors’.

⁶ Revd. Doctor Duff used this rationale in his letter to the Edinburgh Medical Missionary Society (Founded in 1834), written shortly after the publication of Elmslie’s paper in 1873, Cited in Elmslie (1873: 181).

⁷ An official report (1872) estimated that of “the 100,000,000 of women in India at least two-thirds are, by their social custom, debarred alike from receiving the visits of a medical man at their own houses and from attending for gratuitous advice at public hospitals and dispensaries.” *Report by E.G. Balfour*, Inspector-General of Hospitals, Indian Medical Department to W. Hudleston, Chief Secretary to Government of India, 16 April 1872, quoted in *Medical Missions at Home and Abroad*, 3 January, 1879, 47.

⁸ He has pointed out that Elizabeth was the only European woman practising medicine with official approval.

In the meanwhile, the process of change in the missionary theology, implicating realization of the value of women's role in public evangelization, accelerated. Women's fierce battle for medical education, too, got a breakthrough with the opening of medical schools for women. In Britain, the establishment of London School of Medicine for women in 1874⁹ and of three more medical schools in 1886, 1888 and 1890 enabled women to acquire medical qualifications without flouting mission directives and hurting public sentiment. Fanny Butler, one of the first students to be admitted in the London School of Medicine, qualified and had the distinction of recording her name in the Medical Register in Britain in 1880. Under the banner of the Church of England Zenana Missionary Society, she was the first professionally qualified British woman, sent to India. She had been preceded by an American woman physician Clara Swain, who came to Bareilly in 1870.

Hereafter, there was a huge influx of professionally qualified women, especially, medical missionaries for example Sara Seward in Allahabad (1871). Anna Kugler in Guntur (1883), Edith Pechey in Bombay (1883), Edith Brown in Ludhiana (1891) and Ida Scudder in Vellore (1900). These women faced a number of challenges. Assigned a subordinate place in social and religious arenas owing to biblical patriarchy, denied entry into professional colleges and male-dominated medical jobs in their own homelands, these foreign women travelled to Asian countries. They yearned to carve independent identities as women and careers as missionaries and doctors. For these unconventional women, it was a daunting task to construct linkages between indigenous needs and local demands for Western style obstetric care. They had also to reckon with the competition posed by the incoming flow of secular white female physicians in search of professional opportunities.

2.2. Early Medical Work in Punjab

Histories of prominent Zenana missionary societies showed that women medical missionaries had experienced three major challenges in the process of establishing dispensaries and hospitals: (i) Gaining acceptance in the host society, having plural religious traditions, speaking different languages and practising different medical systems; (ii) Building a medical school for women; (iii) Recruiting faculty, student-admission, funding and creating institutional culture.

Within this framework, I have tried to discuss the relevance of the ground-work done by the major missionary societies in Punjab in facilitating the establishment of Edith Brown's North India School of Medicine for Christian Women in Ludhiana.

It may be noted that mission medicine became strikingly popular in Punjab as compared with Bengal. With its population of 46.6 million, the latter had only 9 mission hospitals. The British Punjab with its population of 20 million had 21 mission hospitals, out of which 17 were exclusively for women (*A Survey of Medical Missions in India*, 1929, p. 10). Most of the work was carried out by the American Presbyterian Mission, the Baptist Zenana Mission and the Church of England Zenana Missionary Society. Success of every missionary society was measured by the number of hospitals, it had opened. Going by this criteria, the Church of England Zenana Missionary Society (CEZMS) made history in India and China when after fifty years of its work, it reported establishment of 23 hospitals and 27 dispensaries owing to the hard work of its women doctors (*The CEZMS Jubilee Souvenir 1880-1930*, n.d., pp. 12-13). Their special work was acknowledged by the British Government which awarded *Kaiser-i-Hind* (Silver) to Ms. Sarah Hewlett in 1907, Ms. Anna Singh in 1919 and Jessie Lamb of Amritsar in 1921 (*The CEZMS Jubilee Souvenir 1880-1930*, n.d., pp. 12-13).

I shall bypass the details regarding the medical work done by Sarah Hewlett¹⁰, Jessica Carleton¹¹, Frances Newton¹² and other medical women (belonging to different missionary societies) who won the trust of the inhabi-

⁹ Initially, the London School of Medicine for Women (LSMW) was associated with the missionary movement. The first two women to begin studies in 1874 were under training to be missionaries. The LSMW continued to train women missionaries, keen to acquire medical qualifications. Doctor Elizabeth Garrett Anderson, who joined as lecturer in 1875 and remained Dean of the School for twenty years, changed its character. Under her leadership, the LSMW focused upon professionalism and training of missionaries was no longer its priority. From 1895 to 1897, eight of twenty-one appointments were for mission work but numbers declined from 1897 to 1900. The opening of Edinburgh School of Medicine for Women provided another institution for women, interested in regular professional training. Doctor Griffith's Training School and Hospital for female missionaries (renamed as Zenana Medical College in 1887) was another institution for training aspiring missionaries. This school provided diploma in midwifery.

¹⁰ For a detailed discussion regarding Sarah Hewlett's work at Amritsar see *The Church Missionary Gleaner: C.M.S.*, November, 1893, 160, 123, 131 A.D. (n. d.: 121).

¹¹ For details of Sarah Hewlett's medical work see *The 74th Punjab Mission Report for the year 1907*, 79; see also *92nd Annual Report of the Punjab Mission, 1926*, Introduction and also *The 93rd Annual Report of the Punjab Mission for the year 1927*, 9.

¹² For a detailed account of growth of this hospital see *75th Annual Report of the Punjab Mission for the year 1908*, 62-63; also *93rd Annual Report of the Punjab Mission for the year 1927*, 30.

tants of the rural and urban Punjab and persuaded them to accept treatment by Western women doctors.

The Baptist Zenana Mission Society's medical work, started in Delhi (1867), Bhiwani (1887) and Palwal (1890) in the form of cottage hospitals, became notable for critical abdominal and gynecological surgeries. Having performed as many as 8,952 successful surgeries despite unavailability of even minimal facilities such as hospital structures and sophisticated surgical instruments, Dr Ellen Farrer won confidence of the people in and around Palwal. The Mission Hospital at Palwal became a big hospital in 1928 and was renamed as the Farrer Hospital. She had already been decorated with Kaisre-i-Hind Medal in 1913¹³.

In the long story of establishment of dispensaries and hospitals by the Baptist Zenana Mission, the North India School of Medicine (Later called Christian Medical College) in Ludhiana occupies a significant place because it continues to flourish and expand even after the death of its founder Edith Brown on 6 December 1956.

3. Edith Brown: An Institution Builder with a Vision

The Christian Medical College had been established as an interdenominational institution in Ludhiana. Choice of the town was not fortuitous but well-considered. Its location on the G. T. Road was regarded as strategic because its connectivity was likely to facilitate inflow of patients and students from various parts of India. The second reason for its choice was more significant from the missionary angle¹⁴ as the groundwork for medical service had already been done in the form of dispensaries and a hospital known as Charlotte Hospital for Women and Children by Miss Rose Greenfield from 1875 onwards¹⁵. Her first assignment in the Charlotte Hospital, Ludhiana, made her happy "...because of a daily walk with Miss Pagson who was helping her to learn Urdu and the History of Ludhiana" (French, 1955, p. 12). Her next posting for practice in Palwal, a remote town, where there was no operating room and the patients were just given quinine in the name of medical care. Being a visionary as well as a practical person, she realized that Indian patients could best be approached and treated by Indian doctors who could understand their medical problems in their own language. Thus, Palwal experience made her conclude, "Why should not we have a Christian Medical School attached to one of the Mission Hospitals and ourselves train suitable Indian girls?" (French, 1955, p. 28).

For Edith Brown, the best plan was to found a Christian medical school for Indian women and she moved out of Palwal. In 1893, she convened a Conference of Women Medical Missionaries on 20-21 December in Ludhiana. Fourteen women, belonging to major missionary societies in Punjab and Delhi, participated in the three-day Conference (Cox, 2001, pp. 183, 311, f.n. 124). According to the prospectus, circulated among the missionary societies for financial support, it was pointed out that the proposed institution would be an 'interdenominational medical school to train female native assistants for female medical mission work' (Cox, 2001).

Having barely \$50 in hand with a promise of similar amount each year for the next three years, Brown opened a medical school for women in Ludhiana in January 1894. The School began with four Christian medical students, two dispenser students, five nursing and four midwifery students. In addition to Miss Brown as the Principal, the College staff included Miss Balfour (FES), M.D., L.R.C.P.S., Lecturer (who remained in-charge of the Charlotte Hospital), Miss Allen and Miss Cauldwell (both having M. D. Degree (Cox, 2001). The last two had been loaned by the American Presbyterian mission. Medium of teaching was English and Urdu for the midwifery course (Cox, 2001, pp. 37-38).

Having won the goodwill and trust of the people through her sympathetic medical work, she gained acceptance in the host society. Her networking skills enabled her to mobilize her friends in London to contribute in the form of gifts, bed-linen, invalid comforts, house-hold necessities and even cash (*Journal of the Association of the Medical Women of India*, 1912, p. 24). The local elites namely, Kishan Singh installed a telephone connection between the Doctor's house and the Hospital. He also contributed to the building of the Hindu family wards (*North India School of Medicine for Christian Women*, 1909, p. 25). The donors' family members, often patients of the Hospital, used to

¹³ For a comprehensive idea of the Baptist Zenana Mission Society's medical work see Jean Benzie, *As the Doctor Sees It : Medical Work in India and Pakistan*, 6; also *A Medical Jubilee Pamphlet, 1940*, 3. *Report of the Ladies' Association for the support of Zenana work and Bible Women in India and China, 1894-95*, 54, *A Medical Insider*, 27, *Report of the Ladies' Association 1910-11*, 44, 6.

¹⁴ Initial medical work had been done under the Ludhiana Zenana and Medical Mission, started by Ms. Rose Greenfield. Ms. Rose Greenfield came to Ludhiana on 18th November, 1875 as a missionary under the Society for Promoting Female Education in the East (SPFE). Having had a nurse's training, she devoted herself to the task of aiding 'her suffering sisters' in her early visits to the Zenana. But with the Zenana work "growing on my hands, I found it almost impossible to attend to the many that came for medical advice," wrote Greenfield (1886: 44). With the arrival of Ms. Andrews, she was relieved from Zenana visitations and concentrated upon opening a Women's Dispensary. Opened on 7th May, 1881, it ran successfully for eight years. In 1886, a branch of the city dispensary was opened in Gill and in 1897 in Phillaur.

¹⁵ For a detailed discussion of Ms. Rose Greenfield's medical work in Ludhiana see Reynolds (n.d.: 63-64); also Greenfield (1886: 44, 50, 52-53).

give numerous gifts e.g. clothing for children (*North India School of Medicine for Christian Women*, 1909, p. 25).

In 1898, the first wards of the Ludhiana Memorial Hospital were built¹⁶, staffed entirely by women and serving only women and children. These were inaugurated by the Lieutenant-Governor of Punjab, Sir Mackworth Young and Lady Young. In 1904, the Government of Punjab offered a regular yearly grant for the work and in 1915 women medical students were transferred from Government College, Lahore to Christian Medical College for Women, Ludhiana (French, 1955, pp. 52-63). She had gained credibility among the British administrators through her talent for net-working.

As for the syllabus, a two-year course for training of compounders and a four year course for training hospital assistants was also opened. In both the cases, examinations were held by examiners, appointed by the Committee and successful students received certificates as qualified compounders and medical assistants of the North India School of Medicine for Christian Women. Midwives received a two-year course of training and later appeared in the State Government examination for midwives and dais in Lahore. They had to take an examination in Urdu at the end of the first year and another at the end of the second year (*Magazine of L.S.M.W. and R.F.H.*, 1895, p. 41). By 1931, the School had awarded 210 medical diplomas (licentiates of the State Medical Faculty of the Punjab) and trained 122 compounders, 158 nurses and 329 dais (*Directory of Christian Missions in India, Burma and Ceylon*, 1932, p. 246).

Doctor Brown was fondly remembered by her students whom she had enabled to become self-reliant having independent careers. One of the four medical students, Doctor Ruth Siwasubramanian, often visited the college and spoke of the early days when they lived as a family with Doctor Brown as a Principal, a strict disciplinarian. But she was a friend, too. Addressing a gathering on the Founder's Day, she recalled, "...Doctor Brown set a standard and nothing but best was good enough in our examinations and in case of patients. She taught us the art and patience of careful diagnosis, and expected the best from us" (*Conquest by Healing: Dame Edith Brown Memorial Number*, 1957: 5).

For the Christian Medical College for Women, Doctor Brown had gradually evolved a three-pronged programme. The foremost was to 'train India's own daughters' for their people'. Modernization of maternities and motherhood including surveillance and reform of the lifestyle of married Indian women, their birth practices and health regimen was the second component of her long term plan. Related with it was the third component i.e. tackling tuberculosis which was rampant among Hindus and Muslims, varying in degrees. Her major target was the custom of purdah but in practice, she had accommodated the sensibilities of her patients and their families depending upon their gender, caste and economic status.

4. Analyzing Brown's Success Story

How far was Doctor Brown successful in executing her three-fold agenda? Her success depended upon her ability to communicate with the local people (in urban Ludhiana and its rural periphery) and win their trust. In order to get answer to these questions, we may focus on two points. The first point concerns the composition of her clientele. It requires a close look at statistics of inpatients in the hospital (which was an adjunct of the North India School of Medicine) and outpatients visiting for the treatment of minor ailments. Such an exercise is likely to indicate the extent of the acceptability of mission medicine by the people. Second is to evaluate the work of Miss Brown's School for imparting medical education to girls in pursuit of her agenda of 'Training India's own daughters' for providing health-care to women and children. It is relevant to review data regarding admission in various courses, number of successful candidates and scope of their employment as professionals in missionary and government hospitals.

Despite opposition of various groups of Hindus and Muslims to Zenana Missions in 1880s¹⁷, later on spilling over in the form of suspicion and hostility towards mission hospitals in Punjab, the North India School of Medicine had continued to expand under the dynamic leadership of Edith Brown.

¹⁶ This expansion had been financed by the provision of private rooms for wealthy patients, who were brought to the hospital in closed carriages and housed in a separate wing. For the provision of clinical teaching, arrangements had been made in two hospitals: Charlotte Hospital (30 beds) and Civil Hospital (40 beds); a hospital wing was added to the School which could provide 32 more beds. For more details see *India's Women and China's Daughters*, September 1897, 200.

¹⁷ Direct proselytization by Zenana missions aroused sharp opposition from Muslim and Arya Samaj groups which claimed that foreign women were intruding into homes and threatening the sanctity of marriage. For example, a 'Mohemmadan Manifesto' circulated in Lahore in 1888, argued that a non-Muslim "is the religious equivalent of a man" in purdah-homes. In order to counter missionary teaching by Zenana missionaries, Dev Dharma Samaj formed their own Zenana mission in Lahore. For a detailed discussion see Cox (2002).

In view of the social perception of relationship between the colonial administrators and the Christian missionaries, a guarded response was inevitable in the initial phase of institutionalization of Miss Brown's Medical School. By 1900, a positive response was visible as the hospital was able to admit an impressive number of women patients, belonging to different communities. The annual hospital records showed that out of 1349 inpatients, 500 were Hindus, 521 Mohammedans, 39 low castes and 215 Christians (*North India School of Medicine for Christian Women*, 1909: 20). Interestingly, a number of Mohammedan women regarded a visit to the hospital as an opportunity for an 'outing' from their courtyard' (*North India School of Medicine for Christian Women*, 1909, p. 28). Such observations in the annual reports revealed the nature of missionary perceptions of the oppressive social control of purdah-clad women. In 1902, total number of patients was 16,800, inpatients being 658 (*North India School of Medicine for Christian Women*, 1909, p. 28). Their number for surgical operations was put at 362. The gradual rise in the graph of patients led to the opening of a new dispensary adjoining the E.A. Greenfield Memorial Hospital in 1909. It was named as the Victoria Memorial Dispensary (*The Journal of the A.M.W.I.*, 1912, p. 24).

I would like to draw attention to the growing popularity of surgery as a mode of treatment, especially, for gynecological problems. The positive attitudinal change towards Western medical system especially surgery owed partly to the selfless service of Charlotte Hospital during the plague epidemic in Punjab in 1890s and partly to the trust in Brown's Medical School and hospital. Recognized in 1912 by the Government of India as the Punjab Medical School (*The Journal of the A.M.W.I.*, 1912, p. 24)¹⁸, it opened a number of new departments. Out of these, the surgical department became one of the busiest areas of the North India School of Medicine. The earlier apprehensions of patients to undergo surgery were removed. In fact, the department of surgery became one of the major sources of earning. Doctor Brown described the peoples' view regarding surgical operation in her hospital as 'an honour to be coveted.' She further added, "I recall a case where a young woman had a large tumour removed... her sister was envious of all the interest excited as she told them of the preparation and of the operating theatre... I was asked to see the sister, and I found to her joy, that she, too, required an operation" (*India's Women Doctors*, n.d., p. 7).

Such stories indicated the deep trust of the people in surgery as a mode of treatment as also in the efficacy of Western medical technologies. "In 1909, 1224 surgeries were performed, which included 47 abdominal sections" (*North India School of Medicine for Christian Women*, 1909: 20). Satisfied with the treatment, the patients came back after 3-6 months for follow-up, especially, after an abdominal operation. Annual reports of the Hospital contained effusive impressions of patients, perhaps, a bit exaggerated. Herein, it was almost a regular feature. Even Doctor Pollock as Principal in 1947, had mentioned such an incident. She observed, "A few weeks ago, two patients came into the ward all smiles. They said," 'Salaam, don't you recognize us' and thinking I was somewhat doubtful immediately showed their scars and expected me to recognize them any way" (*North India School of Medicine for Christian Women*, 1945-46, p. 16).

Another evidence of the popularity of Doctor Brown and her hospital as the favourite topic of conversation among women passengers while travelling in a train. One common question, they asked each other was: "Where do you come from?" If the answer was "Ludhiana", the next query was "Miss Brown's hospital", and the reply was, "Yes." (*Conquest by Healing*, 15).

A further evidence of the popularity of Miss Brown's hospital was the inflow of patients from the rural areas of Ludhiana District. In the first decade, out of the 1,225 patients admitted, 490 belonged to the rural areas and 245 came from urban areas (*North India School of Medicine for Christian Women*, 1908: 19). Realizing the need of providing medical aid to rural people, Doctor Brown, herself, staffed and equipped centres which served them until 1948. As it was unsafe for young Indian women doctors to live alone in a village, she organized their stay as a group in a nearby town. The group consisted of an elderly Bible woman, a doctor, a midwife and a teacher (*Links with Ludhiana*, n.d., pp. 6-7). Magic lantern services were provided for the hospital patients on alternate weeks. As a part of medical evangelism, public lantern lectures were organized during village fairs when a large number of villagers could be gathered (*Supra*, 1935-36, p. 30).

It is obvious that Doctor Brown was not only a competent professional but also an excellent mobilizer of public opinion in favour of her hospital and Western medicine, especially, among the rural populace.

Another new department, which benefitted the people, was X-ray department. Doctor Condict was appointed as the incharge when it was started in 1905 for diagnostic purposes (*North India School of Medicine for Christian Women*, 1906, p. 25). The advanced X-ray technology to diagnose tuberculosis was used from 1927 onwards. Besides, a separate ward, called Babyfold for taking care of abandoned infant girls, was opened in 1917. Early care

¹⁸ It was noted that students were admitted to examinations in medicine, held annually at Lahore on the same terms as those of men. Certificated students received the title of sub-assistant surgeon.

and arranging adoption of these orphans, being one of the duties of the Christian institutions, brought a lot of popularity to Miss Brown's Hospital. Admission book for the year 1917 of the Babyward recorded dilemma of a male parent, "What a problem to confront a man and what was he to do with an infant girl? And who was to look after the child? But he had heard that the ladies in the mission hospital took children and cared for...." Invariably, the baby was adopted by a Christian man or woman who later became a teacher in the mission school (*Tales from the Inns of Healing of Christian Medical Service in India, Burma and Ceylon*, 1942, p. 54). Adoption of these abandoned children by members of the indigenous Christian community, which led to their conversion later on, aroused the hostility of Arya Samaj¹⁹. While it aroused appreciation of a number of concerned individuals, it made a dent in the popularity of the work by the hospital (*North India School of Medicine for Christian Women*, 1909, p. 24).

Despite this ugly instance, which caused insecurity among Arya Samaj groups, Doctor Brown's professional reputation as a doctor did not suffer. Her medical services remained in great demand. She was often called to provide medical services by the rulers of Princely States in Punjab. For example, the Nawab of Malerkotla sent his new car to fetch her when one of his wives was ill. Doctor Brown was paid a fee of Rs. 110/- (Reynolds, n.d., p. 115). Similarly; Rani of Jind sent a message about her illness to Doctor Brown. On reaching there she found, "A dozen servants were sitting around her, women doing nothing. Doctor Brown sang some hymns for them and they responded enthusiastically" (Reynolds, n.d., pp. 117-19). She received Rs. 150/- as fee. Besides, a number of wealthy Sikh gentlemen had donated huge sums for the construction of new wards, new gates and improving the plumbing system of the hospital as already discussed. Doctor Brown utilized these fees and donations as well as government grants for the ongoing expansion of her Medical School.

For enhancing the public goodwill and confidence in the mission medicine (nay, Western medicine) and consolidating its authority, Brown's hospital had made a number of concessions and adjustments in its administration as well as in daily routine and rituals of health care. Nature of these concessions and adjustments depended on gender, caste and class of the patients. Missionary perception of Indian sensitivity to the issues of purdah and composition of diet as well as its appropriate preparation remained an important determinant of policy-making in this respect.

These issues had influenced the architecture of hospitals also. It was exemplified by the construction of Hindu and Muslim wards in the Christian hospital in Ludhiana and St. Stephen's hospital in Delhi (French, 1955, pp. 53, 65-66). Besides, separate suites, having two entrances one opening into the separate courtyard of the hospital and second for the family members from the street had also been constructed. Permission for personal cooking arrangements, too, led to modifications of kitchens in mission as well as state hospitals (French, 1955, pp. 53, 65-66).

The second point relates to attitudinal change towards education of girls, especially their entry into a medical school for professional training and employment. Passing through a period of conflict and controversies surrounding the missionary work, the indigenous people realized that Edith Brown's goal was to create a squad of professionally trained Indian women doctors for saving lives of women and children from diseases and death.

In 1900, Edith Brown's School started with four students. According to the Report of 1903, these students qualified as hospital assistants. Soon after, various mission hospitals selected them for training before their appointment by mission and government hospitals. In 1902, 8 medical students, 5 compounders, 6 nurses and 6 midwives had successfully completed their course of study at the School (*The Medical Women's Journal*, 1929: 329). Henceforth, the School was training more than 300 women students in medicine, nursing, pharmacy and maternity care (*North India School of Medicine for Christian Women*, 1909: 22). In 1915, there was a sudden increase in the number of students when women students were transferred from Government College, Lahore to Miss Brown's School, Ludhiana. In 1925, out of 75 girls who passed the matriculation examination of Panjab University, 11 girls had joined the sub-assistant surgeon class at Ludhiana Mission Hospital. In 1926, 19 out of 92 candidates got admission for the same training (*Annual Statements of Dispensaries and Charitable Institutions of Punjab*, 1926, p. 11). By 1933, the following number of students had qualified for the respective courses (*North India School of Medicine for Christian Women*, 1934-35, p. 22):

Course	No. of students
Medical	265
Compounder	136
Nurses	174

¹⁹ For hostile reactions see *Nur Afshan*, 1 June 1897, 244, *The Chaudhvin Sadi*, 26 March, 1898, 189-90; *Zamindar Al Quraish*, 3 January 1920, 193. These are available in *Native Newspaper Press Reports* of noted years.

Nurse dais	418
Midwives	206
Indigenous dais	82
Total	1281

Training of nurses was an important adjunct of medical education. Founded by Sister Kitty Greenfield in 1893 in the Charlotte Hospital, it epitomized humanitarian impulse in medical mission work. The nurses as 'self-less servants' were motivated by spiritual concerns as well (Reynold, 2004, pp. 69-72). It started as a three year course and concluded with the award of a certificate to the trained nurses. In 1894, the first batch of four included Jessie Grant, the pioneer in the College of Nursing, followed by Lillian Carleton, who established a pattern of community health service even before that concept had emerged (Reynold, 2004, p. 72). In 1909, their numbers increased as listed below (Reynold, 2004, p. 41):

Course year	No. of students
Final year	18
Third year	9
Second year	9
First year	15
Total	51

With the expansion of the School, Doctor Brown became well-known not only among the common people but also among the government officials. A state hospital had employed four nurses from the Ludhiana hospital and asked for two more, saying, "We like the Ludhiana nurses better than others" (*North India School of Medicine for Christian Women*, 1933-34, p. 21). These trained nurses were Indian Christians. The story of Nurse Sundari was often cited by Edith Brown in her interviews (Brown, n.d., pp. 12-13). Besides her School, the other mission hospitals throughout India joined hands to supply 90 percent of trained nurses in the World War II (Fitzgerald, 1996, p. 76).

5. Conclusion

The preceding discussion has drawn attention to three strands in Edith Brown's career: (i) assertion of her identity as a full-time single female missionary in the patriarchal mission set-up; (ii) as an institution builder i.e. a medical school for training Indian women in order to provide healthcare for their 'sisters' through reform of current obstetric procedures and practices; (iii) engagement with social and moral engineering of her students as a part of her mission of Christianizing the 'heathen'.

Firstly, Brown's career was a witness to her persistent and definite counterpunch to the Victorian model of an ideal woman who was expected to perform her functions in keeping with the doctrine of 'separate spheres'. Despite a change in the concept of a missionary, nature and scope of his/her work as a consequence of social revolution, industrialization and emergence of professionalism in Britain, Brown had to work hard to be sponsored as a medical missionary by the Baptist Zenana Mission. The prevailing cultural prejudice and male obduracy against women's entry into medical colleges and financial constraints of the family could not prevent the strong-willed young woman to acquire a medical degree and travel to India as a medical missionary. In her own homeland, it was almost impossible to get an equal status with the male missionaries owing to the ingrained belief of the Christian theology regarding inferior intellectual abilities and spiritual subordination of women. Hence, her decision to break the glass-ceiling and assert her identity as a single female missionary revealed her independent thinking and marked a critical point in her life's journey.

Secondly, Brown had developed a clear idea of her goal right from the days of her first posting at Palwal in 1892 where lack of efficient female nurses and medical doctors as well as infrastructure hampered her work. In order to overcome this handicap, she had planned to build a medical school in Ludhiana for 'training India's own daughters' in scientific midwifery for saving lives of mothers and infants. Apart from providing general healthcare for women in child-bearing age, Brown had set her eyes on modernizing the existing concept of gynaecology in accordance with the available scientific knowledge of female body. In this context, it is relevant to highlight her imaginative handling of the multiple processes, involved in the early phase of institution-building such as gaining acceptance in the host society. Her foremost priority was to learn Urdu (which was the widely spoken language) in order to communicate with the ordinary people as well as the elites. Such a step had enabled her to understand their cultural milieu and their practices such as purdah among high castes of Hindus and Muslims and 'purity' of food. Keeping

in view the Indian sensitivity on these issues, administrative procedures of the Ludhiana hospital and its daily routines of medical care were adapted and modified later on. In the second phase, Brown remained engaged in publicizing the advantages of educating girls in a medical institution through wide circulation of the prospectus of her School. In the third phase, she focused upon fund-raising, recruitment of faculty, building infrastructure of the School and its attached hospital.

Thirdly, she engaged herself with the task of character-building and cultivation of moral 'values' among students, believing that these had been completely neglected in the medical colleges in Lahore and Agra, In other words, her foremost concern was social and moral engineering of students in accordance with her own concept of 'values'. It implicated dissemination of Christ's message, inculcation of Western family values and discipline. Right from its founding years, Brown's medical School had a definite agenda in imposing its own brand of moral discipline on its students (drawn from the entire country), teaching faculty, nursing staff and helpers. Personal memories of her colleagues and students conceded that dedicated service and disciplined conduct of Doctor Brown had won students' admiration and trust. Their lives had been influenced to some extent. However, Brown's insistence upon compulsory attendance of students at Sunday service in the church had provoked vehement protest of a number of students. One of the Sikh students in the 1940 batch quit her medical studies in the mid-session (interview with one of the former students Doctor Basant Kaur on 24 October, 2004).

Her passion for inculcating moral values was reflected in the working of hospital and daily routines for patients. With its thorough order and regimen of discipline, Doctor Brown had turned her hospital into a 'moral text-book'. Herein, lessons of physical and moral 'cleansing' were taught. Besides being a 'home of healing', Brown's hospital like St. Stephens hospital in Delhi was designed to reveal to its patients 'a treasure of new ideas' in hygiene, orderliness, and regularity which they were expected to carry back home.

Edith Brown had given a forceful push to the imperialist project of 'colonizing the body' (to use David Arnold's phrase) and mind. By focusing upon women, it was possible to change behavioural norms of educated middle classes and their families. Their acceptance of Western notions of sanitation and personal hygiene had been adopted as a norm in daily life. Obviously, rational thinking of the organic intellectuals in the British Punjab had facilitated attitudinal change among the urban educated middle classes and to some extent in rural areas. There was growing receptivity of surgery as a mode of treatment and latest diagnostic technologies such as X-ray.

It may be conceded that Edith Brown, in collaboration with other medical missionaries, had made valuable contribution to the enhancement of knowledge regarding reproductive functions of the female body. Her sustained advocacy of scientific midwifery and analytical approach to the problem of high rate of mortality of women and children had intensified debate regarding cultural oppression of Indian women. Erosion of stigma of 'pollution', attached to the process of childbirth, was its positive outcome.

However, the missionary project of modernizing, nay, medicalizing the corporeal processes of pregnancy, delivery and aftercare remained incomplete partly owing to the total rejection of indigenous notions of motherhood by the medical missionaries and partly because of their skewed definition of modernity; their perception of modernity was Euro-centric. Their obsession with superiority of Western medical science and technologies, its theory as well as practice, prevented them from appreciating the merits of traditional methods of healing, practised by a large number of women and men.

To sum up, only selective elements of Western medical science found acceptance by the common people and the educated middle classes. They varied in their notions of causative relationship between traditional customs such as purdah and disease especially the incidence of tuberculosis among women. The colonial state and medical missionaries were also selective and sometimes contradictory in the pursuit of their project of modernizing thinking and life styles of the people. Despite their virulent attacks on a number of cultural practices especially purdah, they tended to reinforce it in practice whether in hospitals or other public spaces. Factually speaking, neither European bio-medicine nor the accompanying cultural values, advocated by the medical missionaries namely Edith Brown, had been accepted in a slavish manner by the common people as well as the elites. Thus, women medical missionaries in Punjab made their mark as partial catalytic agents, who brought a fundamental change in notions of hygienic living.

References

A Medical Insider.

A Medical Jubilee Pamphlet, 1940.

- A Survey of Medical Missions in India*. Poona, 1929.
- A.D. (n.d.). *Until the Shadows Flee Away: The Story of the C.E.Z.M.S. Work in India and Ceylon*. London: Church of England Zenana Missionary Society.
- Abercrombie, N., Hill, S., and Truner, Bryan S. (2000). *The Penguin Dictionary of Sociology*. New Delhi: Penguin Books.
- Annual Statements of Dispensaries and Charitable Institutions of Punjab for 1926*.
- Authorized Report of the Missionary Conference*. London, 22 June 1875.
- Authorized Report of the Second Missionary Conference*. Oxford, 2-3 May, 1877.
- Balfour, M. I. and Young, R. (1929). *The Work of Medical Women in India*. London: Humphrey Milford, Oxford University Press.
- Benzie, J. *As the Doctor Sees It: Medical Work in India and Pakistan*.
- Blake, C. (1990). *The Charge of the Parasols: Women's Entry to the Medical Profession*. London: The Women's Press Limited.
- Bonner, T. N. (1995). *To the Ends of the Earth: Women's Search for Education in Medicine*. Cambridge: Harvard University Press.
- Bourdillan, H. (1988). *Women as Healers: A History of Women and Medicine*. Cambridge: Cambridge University Press.
- British Medical Journal* (Journal of the British Medical Association, London), Vol. II, July-December 1956, 1490.
- Brown, D. E. *India's Talk*.
- Burstyn, J. N. (1973). Education and Sex: The Medical Case against Higher Education for Women in England, 1870-1900. *Proceedings of the American Philosophical Society*, 117, 79-89.
- Conquest by Healing: Dame Edith Brown Memorial Number* (Medical Missionary Association, London), vol. xxxiii, no. 1, March 1957, 5.
- Cox, J. (1995). "The Missionary Movement", in D.G. Paz (Ed.). *Nineteenth Century English Religious Traditions: Retrospect and Prospects*. London: Praeger Publishers.
- Cox, J. (2001). *Imperial Fault Lines: Christianity and Colonial Power in India 1818-1940*. Stanford: Stanford University Press.
- Directory of Christian Missions in India, Burma and Ceylon: 1932-33*. Madras, 1932.
- Ellis, H. W. (n.d.). *Our Eastern Sisters and Their Missionary Helpers*. London.
- Elmslie, W. J. (1873). "On Female Medical Missions for India", in *The Female Medical Evangelist*, 1873, vol. 1, (5).
- Fitzgerald, R. (1996). "Rescue and Redemption: The Rise of Female Medical Missions in India during the Late Nineteenth and Early Twentieth Centuries", in Rafferty, A. M., Robinson, J. & R. Elkan (Eds.), *Nursing History and the Politics of Welfare*. London: Routledge.
- French, F. (1954). *Miss Brown's Hospital: The Story of the Ludhiana Medical College and Dame Edith Brown, Its Founder*. London: Hodder and Stoughton.
- Greenfield, R. (1886). *Five Years in Ludhiana : Our Work Amongst Our Indian Sisters*. London: S.W. Partridge & Co.
- Henstin, James M. (2001). *Essentials of Sociology*. Taylor and Francis.
- Howat, E. G. K. (1960). *Vision and Achievement 1796-1956: A History of the Foreign Mission of the Churches, United in the Church of Scotland*. London: Nelson & Sons.
- India's Women and China's Daughters*, April 1895.
- India's Women and China's Daughters*, September 1897.
- India's Women Doctors*, Radio broadcast of Dame Edith Brown. London: Bentley Brothers Ltd. n.d.
- Jex-Blake, S. (1886). *Medical Women: A Thesis and its History*. London: Hamilton & Adams.
- Journal of the Association of the Medical Women of India*, vol. iii, no. 5, February 1912, 24.
- Lerner, G. (1986). *The Creation of Patriarchy*. New York: Oxford University Press.

- Links with Ludhiana*, a pamphlet (n.p., n.d.), 6-7.
- Lutzker, E. (1969). *Women Gain a Place in Medicine*. London: McGraw Hill Company.
- Macinis, John J. (Ed.) (2012). *Sociology*. New York: Prentice Hall.
- Magazine of L.S.M.W. and R.F.H.*, May, 1895, 41.
- Mill, J. (1840). *The History of British India* (with notes by H.H.Wilson). London: James Madden.
- Mohan, K. (2006). *Towards Gender History: Images, Identities and Roles of North Indian Women*. New Delhi: Aakar Books.
- North India School of Medicine for Christian Women, Report for the year 1906*.
- North India School of Medicine for Christian Women, Report for the year 1908*.
- North India School of Medicine for Christian Women, Report for the year 1909*.
- North India School of Medicine for Christian Women, Report for the year 1933-34*.
- North India School of Medicine for Christian Women, Report for the year 1934-35*.
- Nur Afshan*, 1 June 1897.
- Our Indian Sisters: A Quarterly Magazine of the Ladies' Zenana Mission in connection with Baptist Missionary Society*, no.7, January 1887, 156.
- Perkin, H. (1969). *The Origins of Modern English Society*. London: Routledge & K. Paul.
- Perkin, H. (1989). *The Rise of Professional Society in England since 1880*. London: Routledge.
- Pilcher, J. and Whelehan, I. (2004). *Fifty Key Concepts in Gender Studies*. London: Sage Publishers.
- Report for the year ending October 31st, 1945-46*, 16.
- Report of the Ladies' Association 1910-11*.
- Report of the Ladies' Association for the support of Zenana work and Bible Women in India and China, 1894-95*.
- Reynold, C. (2004). *The Holy Tree*. Secundrabad: Om Books.
- Reynolds, C. (n.d.). *Punjab Pioneer*. London: World Book Publishers.
- Richter, J. (1908). *A History of Missions in India*. Edinburgh: Oliphant.
- Supra*, Report for the year 1935-36, 30.
- Tales from the Inns of Healing of Christian Medical Service in India, Burma and Ceylon*. Nagpur: Nelson square; CMAI, Burma and Ceylon, 1942.
- The 74th Annual Report of the Punjab Mission, 1907*.
- The 75th Annual Report of the Punjab Mission, 1908*.
- The 92nd Annual Report of the Punjab Mission, 1926*.
- The 93rd Annual Report of the Punjab Mission, 1927*.
- The CEZMS Jubilee Souvenir 1880-1930*. London, n.d.
- The Chaudhvin Sadi*, 26 March, 1898.
- The Church Missionary Gleaner: C.M.S.*, November, 1893.
- The Journal of the A.M.W.I.*, February 1912, 24.
- The Medical Women's Journal*, 1929.
- Walby, S. (1990). *Theorizing Patriarchy*. Oxford: Blackwell.
- Zamindar Al Quraish*, 3 January 1920.