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HISTORIOGRAPHICAL TRENDS IN COLONIAL MEDICINE: POWER, KNOWLEDGE AND SOCIETY IN BRITISH INDIA

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Abstract: This article examines the evolution of historiographical approaches to colonial medicine in India, tracing the shift from descriptive and institutional narratives to analytically grounded interpretations centred on power, knowledge, and social negotiation. Beginning with the emergence of the social history of medicine, it analyses key contributions by Poonam Bala, David Arnold, and Mark Harrison, situating their work within broader theoretical traditions such as Foucauldian biopolitics, Cambridge School administrative history, and Subaltern Studies. The article further engages with nationalist critiques articulated by Deepak Kumar and Chittabrata Palit, while incorporating recent scholarship on gender, environment, military medicine, and medical pluralism, including contributions by Erica Wald, Sanjoy Bhattacharya, and Waltraud Ernst. It argues that colonial medicine must be understood as a contested and negotiated domain rather than a unilinear project of domination. By mapping these historiographical developments, the article highlights the increasing interdisciplinarity of the field and its significance for understanding colonial governance and social transformation in South Asia.

Index Terms - Colonial Medicine; Historiography; British India; Biopower; Subaltern Studies; Public Health; Medical Pluralism; Empire; Indigenous Knowledge; Social History

I. INTRODUCTION

The study of colonial medicine in India has emerged as one of the most dynamic and theoretically rich fields within modern historiography. What was once a marginal area, largely confined to descriptive accounts of medical progress and institutional development, has now become a central domain for analysing the complex interplay between knowledge, power, and society under colonial rule. This transformation reflects broader shifts within historical scholarship, including the rise of social history, postcolonial critique, and interdisciplinary methodologies.

In its earlier phase, the history of medicine was dominated by an internalist perspective that prioritised scientific discoveries and the achievements of individual practitioners. Such narratives often portrayed Western medicine as a universal and progressive force, implicitly reinforcing colonial ideologies of superiority and civilisational advancement. The colonial context was thus framed as a passive recipient of European knowledge, with little attention paid to indigenous medical systems or local responses.

This approach began to be challenged in the mid-twentieth century, most notably through the intervention of Thomas McKeown, who argued for a sociological approach to the history of medicine.[1] McKeown criticised the field's preoccupation with "great men and great movements" and emphasised the need to situate medical developments within broader social contexts. His call for writing history "to illuminate the present" marked a crucial turning point, encouraging historians to explore the relationship between medicine and society in a more critical and analytical manner.

In the Indian context, this shift coincided with the growing interest in colonialism as a field of study. The emergence of postcolonial theory and Subaltern Studies further enriched this development, providing new conceptual tools to analyse the dynamics of power and resistance. As a result, colonial medicine came to be understood not merely as a technical or scientific enterprise but as a deeply political and cultural process.

This article seeks to trace the major historiographical trends in the study of colonial medicine in India, examining how interpretations have evolved over time. It focuses on key contributions from the late twentieth century onwards, analysing their theoretical orientations, methodological approaches, and substantive arguments. By situating these works within broader historiographical frameworks, the article aims to provide a comprehensive overview of the field and highlight its ongoing transformations.

II. FROM INTERNALIST NARRATIVES TO SOCIAL HISTORY

The early historiography of medicine, both in Europe and in colonial contexts, was largely shaped by an internalist orientation. Historians and medical practitioners alike focused on the development of medical knowledge as a self-contained process, emphasising discoveries, innovations, and breakthroughs. In the colonial setting, this often translated into narratives that celebrated the introduction of Western medicine as a civilising force, portraying it as a marker of progress and modernity.

Such accounts tended to marginalise or dismiss indigenous medical systems, which were frequently characterised as backward, superstitious, or unscientific. This perspective was closely aligned with colonial ideologies, reinforcing the notion of European superiority and legitimising imperial rule. The absence of critical engagement with social and cultural contexts further limited the explanatory power of these narratives.

The emergence of the social history of medicine marked a decisive break from this tradition. Influenced by broader developments in social history, scholars began to examine medicine as a social institution embedded within specific historical contexts. This approach emphasised the role of economic structures, political power, cultural beliefs, and social practices in shaping medical knowledge and practices.

In the Indian context, this shift opened up new avenues for research, enabling historians to explore the interactions between Western and indigenous medical systems, the impact of colonial policies on public health, and the responses of local populations to medical interventions. It also facilitated a more nuanced understanding of the relationship between medicine and empire, highlighting the ways in which medical knowledge was both shaped by and contributed to colonial governance.

III. POONAM BALA AND THE THESIS OF ACCOMMODATION

One of the earliest and most influential contributions to the historiography of colonial medicine in India is the work of Poonam Bala.[2] Her study represents a significant departure from earlier narratives by foregrounding the interaction between indigenous and Western medical systems.

Bala's central argument revolves around the concept of "accommodation."[3] Rather than viewing colonial medicine as a process of displacement or domination, she emphasises the coexistence and mutual adaptation of different medical traditions. According to Bala, neither Western medicine nor indigenous systems such as Ayurveda and Unani achieved complete autonomy during the colonial period. Instead, their relationship was characterised by negotiation, selective appropriation, and pragmatic adjustment.

This interpretation challenges the binary framework that had dominated earlier historiography, offering a more complex and dynamic understanding of medical change. Bala's analysis also highlights the role of the colonial state in shaping medical developments. She argues that public health policies were primarily driven by concerns related to military efficiency and administrative control, rather than the welfare of the indigenous population.[4]

At the same time, Bala draws attention to the agency of indigenous actors, particularly the educated middle classes, who played a significant role in mediating between different medical systems. The emergence

of nationalist movements further influenced this process, leading to renewed efforts to revitalise and modernise indigenous medicine.

Despite its strengths, Bala's framework has been critiqued for underestimating the asymmetries of power inherent in colonial contexts. While her emphasis on accommodation provides an important corrective to earlier narratives of domination, it risks obscuring the structural inequalities that shaped the interaction between Western and indigenous medicine. It is precisely this limitation that subsequent historiography sought to address.

IV. DAVID ARNOLD AND THE POLITICS OF THE BODY

A major turning point in the historiography of colonial medicine came with the work of David Arnold, whose analysis introduced a more explicitly political and theoretical dimension to the field. Drawing on the insights of Michel Foucault, Arnold conceptualised colonial medicine as a form of "biopower," through which the colonial state sought to regulate and control bodies and populations.[5]

In this framework, medicine is understood not merely as a scientific or humanitarian enterprise but as a key instrument of governance. Medical interventions such as vaccination, quarantine, and sanitary regulation are seen as techniques of surveillance and discipline, aimed at transforming indigenous bodies and social practices. The colonial state's engagement with epidemic diseases thus becomes a crucial site for examining the exercise of power.

Arnold's analysis is particularly significant for its emphasis on the cultural dimensions of colonial medicine. He explores how medical discourse constructed India as a land of disease and disorder, thereby legitimising colonial intervention. At the same time, he highlights the role of indigenous beliefs and practices in shaping responses to these interventions.

Through detailed case studies of diseases such as smallpox, cholera, and plague, Arnold demonstrates the limits of colonial authority. Indigenous resistance, whether in the form of refusal of vaccination or opposition to sanitary measures, reveals the persistence of alternative epistemologies and the contested nature of medical knowledge.[6]

Arnold's work thus represents a significant departure from earlier historiography, moving beyond institutional analysis to engage with questions of power, culture, and resistance. However, it has also been critiqued for its heavy reliance on Foucauldian frameworks, which some scholars argue may overemphasise the coherence and effectiveness of colonial power.

V. PUBLIC HEALTH, GOVERNANCE, AND THE LIMITS OF COLONIAL POWER: REASSESSING COLONIAL MEDICINE

While David Arnold's work foregrounded the cultural and political dimensions of colonial medicine through a Foucauldian lens, a somewhat different but equally significant historiographical intervention was made by Mark Harrison. His *Public Health in British India: Anglo-Indian Preventive Medicine 1859–1914* (1994) represents a crucial shift towards analysing colonial medicine through the prism of governance, administration, and institutional practice.[7] If Arnold emphasised the conceptual and discursive dimensions of power, Harrison's work anchors these processes within the everyday functioning of the colonial state, thereby offering a more grounded understanding of how medical policies were formulated, debated, and implemented.

Harrison's contribution can be productively situated within a broader historiographical tendency often associated—albeit loosely—with the Cambridge School. While not formally part of that school, his emphasis on administrative processes, bureaucratic structures, and policy contingencies resonates with its methodological orientation. Rather than viewing colonial power as monolithic or uniformly imposed, Harrison highlights its fragmented, negotiated, and often limited character. This approach complicates earlier interpretations that either celebrated colonial medicine as a civilising mission or condemned it as an all-powerful instrument of domination.

At the core of Harrison's analysis lies the argument that colonial public health policies were shaped by a complex interplay of ideological, financial, and administrative constraints. He identifies two broad and often competing strands within colonial governance: authoritarian paternalism and liberal decentralisation. The former, rooted in utilitarian thought, advocated direct state intervention in matters of public health, emphasising the need to regulate sanitation, control epidemics, and impose medical measures in the interest of collective welfare. The latter, however, stressed the importance of minimal interference, local self-governance, and fiscal prudence, thereby limiting the scope of state intervention.[8]

This ideological tension had profound implications for the development of public health in colonial India. On the one hand, the colonial state recognised the importance of preventive medicine, particularly in the context of protecting European troops and maintaining administrative efficiency. Epidemics such as cholera, plague, and malaria posed a significant threat not only to the indigenous population but also to the functioning of the colonial apparatus. Consequently, measures such as vaccination campaigns, sanitary reforms, and the establishment of municipal boards were introduced.

On the other hand, these initiatives were constrained by a persistent reluctance to invest substantial resources in public health. Financial considerations played a decisive role in shaping colonial policy, as the state was unwilling to allocate funds on a scale comparable to that in Britain. This reluctance was further compounded by the fear that intrusive medical interventions might provoke resistance among the indigenous population, thereby destabilising colonial rule.

Harrison's analysis thus reveals the inherent contradictions within colonial public health policy. While the rhetoric of improvement and civilisation was frequently invoked, the actual implementation of medical measures was often limited, uneven, and inconsistent. This gap between ideology and practice underscores the need to move beyond simplistic binaries of domination and benevolence, towards a more nuanced understanding of colonial governance.

A particularly important aspect of Harrison's work is his examination of the Indian Medical Service (IMS), which served as the primary institutional framework for the implementation of colonial medical policies. Contrary to the perception of the IMS as a powerful and prestigious body, Harrison demonstrates that it occupied a relatively marginal position within the colonial administrative hierarchy. Compared to the Indian Civil Service (ICS), the IMS lacked both authority and influence, which significantly constrained its ability to shape policy.[9]

The internal dynamics of the IMS further exacerbated these limitations. Recruitment patterns, career structures, and professional incentives all contributed to a lack of innovation and initiative within the service. Promotion was often based on seniority rather than merit, discouraging younger officers from pursuing experimental or reformist approaches. Moreover, the relatively low status and remuneration associated with the IMS made it less attractive to highly qualified candidates, resulting in what Harrison describes as a general mediocrity within the service.

These institutional constraints had important implications for the development of public health in colonial India. The limited autonomy of medical officers meant that their recommendations were frequently subordinated to broader administrative priorities. Sanitary reforms, for instance, were often delayed or diluted due to financial considerations or political concerns. Similarly, efforts to expand medical services in rural areas were hampered by a lack of resources and infrastructure.

At the same time, Harrison challenges the view that colonial medicine was uniformly coercive or repressive. While acknowledging instances of forceful intervention—particularly during epidemic outbreaks—he emphasises that the colonial state generally adopted a cautious and pragmatic approach. The memory of resistance to earlier measures, such as the Contagious Diseases Acts and plague regulations, made officials wary of imposing policies that might provoke unrest.[10]

This cautious approach is particularly evident in the case of epidemic control. While diseases such as plague prompted the introduction of more intrusive measures, including quarantine and segregation, these policies were often modified or abandoned in response to popular resistance. The colonial state thus found itself in a delicate balancing act, attempting to reconcile the demands of public health with the imperatives of political stability.

Harrison's work also engages critically with earlier interpretations of colonial medicine, particularly those that emphasise its coercive nature. In doing so, he offers a more differentiated account that takes into account the diversity of experiences across regions and periods. His emphasis on contingency and variability challenges the tendency to generalise about colonial policy, highlighting instead the importance of local contexts and specific circumstances.

However, this emphasis on administrative complexity has itself been subject to critique. Scholars influenced by Subaltern Studies have argued that such approaches risk downplaying the structural inequalities and power asymmetries inherent in colonial rule. By focusing on the limitations and constraints faced by colonial officials, there is a danger of obscuring the broader dynamics of domination and exploitation that shaped the colonial encounter.[11]

This critique becomes particularly relevant when considering the impact of public health policies on the indigenous population. While Harrison acknowledges the limited reach of these policies, he is less explicit about their differential effects across social groups. Issues such as class, caste, and gender receive relatively

little attention, leaving open important questions about the uneven distribution of medical resources and the social consequences of colonial interventions.[12]

Nevertheless, Harrison's contribution remains indispensable for understanding the institutional and administrative dimensions of colonial medicine. By situating medical policies within the broader framework of colonial governance, he provides a crucial counterpoint to more theoretically oriented approaches, demonstrating the importance of empirical analysis and archival research.

VI. TRANSITION: FROM GOVERNANCE TO RESISTANCE

The historiographical developments represented by Arnold and Harrison, while differing in emphasis, share a common concern with the relationship between medicine and colonial power. Together, they mark a significant departure from earlier narratives, introducing new conceptual frameworks and methodological approaches.

Yet, by the late 1990s, a new set of questions began to emerge. Scholars increasingly sought to move beyond the focus on colonial institutions and discourses, turning instead to the experiences and perspectives of the colonised. This shift was closely associated with the rise of Subaltern Studies, which aimed to recover the agency of those marginalised within colonial historiography.

In the context of colonial medicine, this meant paying greater attention to indigenous responses, local practices, and alternative forms of knowledge. It also involved a more critical engagement with the power structures that underpinned colonial medical systems, highlighting the ways in which they reproduced social inequalities and reinforced imperial domination.

The works of Deepak Kumar and others represent a key moment in this transition, offering a more explicitly critical and politically engaged perspective on colonial medicine. It is to these developments that we now turn.[13]

VII. SUBALTERN INTERVENTIONS AND THE RE-CENTRING OF INDIGENOUS AGENCY

By the late 1980s and 1990s, the historiography of colonial medicine underwent another significant shift, influenced by the broader intellectual movement of Subaltern Studies. This approach challenged earlier historiographical traditions—whether colonial, nationalist, or even Cambridge School—by foregrounding the experiences, agency, and voices of those groups that had been systematically marginalised within historical narratives.[14] In the context of colonial medicine, this meant moving beyond state policies, administrative structures, and elite discourses to examine how medical practices were received, negotiated, and contested at the level of everyday life.

The Subaltern perspective introduced a critical reorientation in the study of colonial medicine. Rather than treating indigenous populations as passive recipients of Western medical interventions, it emphasised their active role in shaping medical encounters. Resistance, adaptation, and selective appropriation became central themes, replacing earlier binaries of acceptance and rejection. This shift also brought into focus the plurality of indigenous responses, highlighting the diversity of experiences across regions, communities, and social groups.

Within this emerging framework, the work of Deepak Kumar occupies a pivotal position. Kumar's writings represent a sustained critique of colonial medicine as a hegemonic enterprise, deeply embedded within the structures of imperial power. Drawing on insights from both Subaltern Studies and the history of science, he argues that Western medicine functioned not merely as a tool of governance but as a system of knowledge that sought to establish its authority by marginalising and delegitimising indigenous medical traditions.[15]

Kumar's analysis challenges the notion—present in earlier works such as those of Poonam Bala—that colonial medicine was characterised by accommodation. Instead, he emphasises the asymmetrical nature of the encounter between Western and indigenous systems, arguing that the former achieved dominance through processes of "hegemonisation." This involved not only the institutionalisation of Western medicine through state support but also the reconfiguration of indigenous knowledge in ways that subordinated it to colonial epistemologies.

At the same time, Kumar is careful not to portray indigenous actors as merely victims of colonial domination. He highlights the complex and often contradictory responses of Indian practitioners, who engaged with Western medicine in diverse ways. Some embraced it as a means of professional advancement and social mobility, while others resisted its encroachment by seeking to revitalise indigenous traditions. Still others adopted hybrid strategies, selectively incorporating elements of Western medicine into their own practices.[16]

This emphasis on agency and negotiation aligns Kumar's work with broader Subaltern concerns, yet it also introduces a distinct analytical focus on the politics of knowledge. By examining how medical authority was constructed and contested, Kumar shifts attention from institutional structures to epistemological processes, thereby enriching the historiography of colonial medicine.

VIII. NATIONALIST CRITIQUES AND THE QUESTION OF STRUCTURAL INEQUALITY

Parallel to the Subaltern turn, the historiography of colonial medicine also witnessed the emergence of more explicitly nationalist critiques. These works sought to foreground the exploitative and unequal nature of colonial medical policies, situating them within the broader context of imperial economic and political domination.

Among the most significant contributions in this regard are those of Chittabrata Palit and Achintya Kumar Dutta.[17] Their work represents a sharp departure from earlier interpretations that emphasised either accommodation or administrative complexity. Instead, they present colonial medicine as a fundamentally unequal system, shaped by the priorities of empire rather than the needs of the colonised population.

A key argument advanced by these scholars is that colonial public health policies were structurally limited by the economic logic of imperialism. The colonial state, they argue, was primarily concerned with extracting resources and maintaining political control, rather than investing in the welfare of the indigenous population. As a result, public health measures were underfunded, unevenly distributed, and largely confined to urban centres and military cantonments.[18]

This structural critique is further extended to the environmental and economic dimensions of colonial rule. Palit and Dutta highlight how infrastructural developments such as railways, irrigation canals, and plantations contributed to the spread of diseases by altering local ecological conditions. The expansion of commercial agriculture and the displacement of traditional livelihoods also exacerbated vulnerabilities, creating conditions conducive to epidemics.

In this context, colonial medicine appears not as a solution to public health problems but as part of the problem itself. The failure to address the underlying social and economic determinants of disease, combined with the limited reach of medical services, meant that large sections of the population remained excluded from effective healthcare.

At the same time, these nationalist critiques also engage with the question of indigenous knowledge systems. Like Kumar, Palit and Dutta emphasise the marginalisation of traditional medicine under colonial rule. However, they go further in highlighting the potential for synthesis between Western and indigenous systems, suggesting that a more equitable and effective medical framework might have emerged in the absence of colonial domination.[19]

While these arguments provide a powerful critique of colonial medicine, they have also been subject to scrutiny. Some scholars have pointed out that the emphasis on colonial exploitation can sometimes lead to an overly homogenised view of indigenous society, overlooking internal hierarchies and inequalities. Nevertheless, the nationalist perspective remains an important component of the historiography, drawing attention to the structural dimensions of colonial power.

IX. NEW DIRECTIONS: SCIENCE, TECHNOLOGY, AND THE POLITICS OF KNOWLEDGE

The historiography of colonial medicine has continued to evolve in the twenty-first century, incorporating new themes and methodological approaches. One of the most significant developments has been the growing interest in the history of science and technology, particularly in relation to medical practices such as vaccination.

The work of Sanjoy Bhattacharya represents a major contribution in this area.[20] His studies of smallpox vaccination challenge earlier assumptions about the nature and impact of colonial medical interventions. Rather than portraying vaccination as a straightforward imposition of Western science, Bhattacharya emphasises the complex and contested processes through which it was implemented.[21]

Drawing on a wide range of archival sources, he demonstrates that vaccination campaigns were shaped by negotiations between colonial officials, medical practitioners, and local communities. Issues such as supply chains, administrative coordination, and cultural acceptance played a crucial role in determining their success or failure.[22] This focus on the practical and logistical dimensions of medical interventions adds an important layer of analysis to the historiography.

Bhattacharya's work also engages with broader debates on the nature of scientific knowledge in colonial contexts. He challenges the dichotomy between Western science and indigenous knowledge, arguing that the boundaries between them were often blurred. The production and dissemination of medical knowledge

involved multiple actors and institutions, leading to hybrid forms of practice that cannot be easily categorised.[23]

This emphasis on hybridity and negotiation resonates with earlier arguments about accommodation, yet it is grounded in a more detailed and empirically rich analysis. By focusing on specific case studies, Bhattacharya provides a nuanced understanding of how medical technologies were adapted to local conditions, highlighting the importance of context in shaping their trajectories.

X. INSTITUTIONS, ASYLUMS, AND THE MICRO-POLITICS OF COLONIAL MEDICINE

Another important area of recent historiography is the study of medical institutions, particularly asylums and hospitals. Scholars such as Waltraud Ernst[24] and James Mills[25] have made significant contributions to this field, examining the role of these institutions in the colonial context.

Ernst's work on colonial psychiatry explores the establishment and functioning of lunatic asylums, highlighting their role as sites of both control and negotiation. Drawing on institutional records and case studies, she demonstrates how psychiatric practices were shaped by colonial ideologies as well as local conditions. The classification and treatment of mental illness, she argues, were influenced by cultural assumptions about race, gender, and social order.[26]

At the same time, Ernst emphasises the agency of patients and their families, who often engaged with these institutions in strategic ways. Admissions to asylums were not always the result of coercion; in some cases, they reflected attempts to access care or resolve social conflicts. This perspective challenges earlier views of asylums as purely repressive institutions, offering a more complex and nuanced account.[27]

Similarly, Mills' work focuses on the everyday functioning of medical institutions, examining how they were used and experienced by different sections of the population. His studies highlight the importance of local contexts and social relations in shaping medical practices, moving beyond top-down analyses to explore the micro-politics of colonial medicine.

These institutional studies represent an important methodological shift in the historiography. By focusing on specific sites and practices, they provide detailed insights into the lived experience of colonial medicine, complementing broader analyses of policy and discourse.

XI. METHODOLOGICAL EXPANSIONS: ORAL HISTORY AND MICROHISTORY

A notable feature of recent historiography is the increasing use of new methodological approaches, including oral history and microhistory. These methods have enabled scholars to access perspectives that are often absent from official records, thereby enriching our understanding of colonial medicine.

Oral history, in particular, has been used to reconstruct local experiences of medical interventions, capturing the voices of individuals and communities that were previously overlooked.[28] This approach has been especially valuable in studying practices such as vaccination, childbirth, and indigenous healing, where written sources are limited.

Microhistorical studies, on the other hand, focus on specific events, locations, or individuals, providing detailed and context-specific analyses. By examining particular cases in depth, they reveal the complexities and contradictions of colonial medicine, challenging generalisations and highlighting the importance of local variation.[29]

Together, these methodological innovations have contributed to a more nuanced and inclusive historiography, expanding the range of questions that can be asked and the sources that can be used.

XII. TRANSITION: TOWARDS INTERDISCIPLINARY HISTORIES

The developments outlined above point to an increasingly interdisciplinary orientation within the historiography of colonial medicine.[30] Scholars are now drawing on insights from sociology, anthropology, environmental studies, and gender history to explore new dimensions of the field.

This shift has opened up new avenues for research, including the study of gender and medicine, the environmental determinants of disease, and the coexistence of multiple medical systems. It has also encouraged a more holistic approach, recognising the interconnectedness of different factors in shaping medical practices and outcomes.

The next section will explore these emerging directions in greater detail, focusing on themes such as gender, environment, military medicine, and medical pluralism, and examining how they are reshaping our understanding of colonial medicine in India.

XIII. MEDICINE, MILITARY POWER, AND THE REGULATION OF SEXUALITY

Recent historiography has significantly expanded the scope of colonial medical studies by examining the intersections between medicine, military structures, and the regulation of sexuality. The work of Erica Wald is particularly important in this regard. Her study of venereal disease in the British Indian army demonstrates how medical policies were deeply entangled with concerns about discipline, masculinity, and imperial authority.[31]

Wald situates medical interventions within the broader framework of military governance, showing how the colonial state sought to regulate the bodies of soldiers in order to maintain efficiency and control. Venereal diseases were perceived not merely as medical problems but as threats to military discipline and imperial stability. As a result, policies aimed at controlling prostitution and monitoring sexual behaviour became central to colonial medical practice.

The implementation of measures such as the Contagious Diseases Acts reveals the gendered nature of these interventions. While the health of European soldiers was prioritised, Indian women—particularly those identified as prostitutes—were subjected to invasive surveillance and regulation. Medical examination, confinement, and registration became tools for controlling female bodies, reflecting broader anxieties about race, sexuality, and morality.

Wald's analysis highlights the deeply unequal and coercive dimensions of colonial medicine, while also drawing attention to the ways in which these policies were contested. Resistance to the Contagious Diseases Acts, both in India and in Britain, underscores the limits of colonial authority and the role of public debate in shaping medical policy.

XIV. GENDER, WOMEN'S HEALTH, AND THE POLITICS OF CARE

The intersection of medicine and gender constitutes another major area of historiographical development. Scholars have increasingly examined how colonial medical practices were shaped by and contributed to existing gender hierarchies. The establishment of initiatives such as the National Association for Supplying Female Medical Aid to the Women of India—commonly known as the Dufferin Fund—provides a crucial entry point into this discussion.[32]

The Dufferin Fund sought to address the limited access of Indian women to medical care, particularly within the context of purdah and zenana seclusion. Female medical practitioners were trained and deployed to provide healthcare to women who could not be treated by male doctors. While this initiative has often been presented as a humanitarian effort, recent scholarship has emphasised its political and cultural dimensions.

The provision of medical care to women was closely linked to colonial notions of civilisation and reform. By promoting Western medical practices, the colonial state sought to reshape indigenous social norms and assert its moral authority. At the same time, these initiatives created new opportunities for Indian women to enter the medical profession, thereby contributing to processes of social change.

However, the benefits of such programmes were unevenly distributed. Access to female medical care remained limited to urban and elite populations, leaving large sections of rural women without adequate healthcare. Moreover, the emphasis on Western medicine often marginalised traditional practices related to childbirth and healing, raising questions about the displacement of indigenous knowledge.[33]

Gendered analyses of colonial medicine thus reveal the complex interplay between empowerment and control, highlighting the ways in which medical interventions could simultaneously challenge and reinforce existing hierarchies.

XV. ENVIRONMENT, ECOLOGY, AND THE SPATIAL DIMENSIONS OF DISEASE

Another significant development in recent historiography is the incorporation of environmental perspectives into the study of colonial medicine. Scholars have increasingly recognised that disease patterns cannot be understood in isolation from ecological and spatial factors. Colonial interventions in the environment—such as deforestation, irrigation, and urbanisation—had profound implications for public health.[34]

The case of malaria provides a particularly instructive example. The expansion of irrigation networks and the transformation of landscapes created new breeding grounds for mosquitoes, contributing to the spread of the disease. At the same time, colonial responses to malaria were shaped by evolving scientific theories, including miasmatic and bacteriological explanations.[35]

Environmental history thus adds an important dimension to the study of colonial medicine, highlighting the interconnectedness of ecological change, economic development, and disease. It also underscores the

unintended consequences of colonial policies, which often exacerbated the very problems they sought to address.

This perspective complements earlier analyses by drawing attention to the material and spatial contexts within which medical practices were embedded. It also aligns with broader trends in global history, which emphasise the transnational circulation of knowledge, technologies, and environmental processes.

XVI. MEDICAL PLURALISM AND THE QUESTION OF KNOWLEDGE

One of the most important conceptual developments in the historiography of colonial medicine is the recognition of medical pluralism. Rather than viewing Western medicine as dominant and indigenous systems as subordinate, scholars now emphasise the coexistence and interaction of multiple medical traditions.[36]

This perspective builds on earlier arguments about accommodation but moves beyond them by focusing on the dynamic processes through which knowledge was produced and exchanged. Indigenous systems such as Ayurveda and Unani did not simply survive colonial rule; they adapted, reformed, and engaged with Western medicine in complex ways.

The emergence of hybrid practices reflects the fluid boundaries between different systems of knowledge. Indian practitioners often incorporated elements of Western medicine into their work, while colonial authorities selectively adopted indigenous remedies. This mutual exchange challenges the binary distinction between Western and indigenous medicine, highlighting the interconnected nature of medical knowledge.

At the same time, the concept of medical pluralism does not imply equality between different systems. Power asymmetries remained a defining feature of the colonial context, shaping the terms of interaction and the distribution of resources. The recognition of pluralism thus requires a careful balancing of attention to both diversity and inequality.

XVII. CONCLUSION

The historiography of colonial medicine in India has undergone a remarkable transformation over the past several decades. From its early focus on descriptive and institutional narratives, the field has evolved into a vibrant and interdisciplinary area of research that engages with complex questions of power, knowledge, and society.

The works of scholars such as Poonam Bala, David Arnold, and Mark Harrison laid the foundations for this transformation, introducing new conceptual frameworks and methodological approaches. Subsequent contributions by Deepak Kumar and others further enriched the field by foregrounding issues of power, resistance, and inequality.

More recent scholarship has expanded the scope of inquiry even further, incorporating perspectives from gender history, environmental studies, and the history of science. The work of Sanjoy Bhattacharya, Erica Wald, and Waltraud Ernst, among others, has demonstrated the importance of examining colonial medicine through multiple lenses, highlighting its complexity and diversity.

Taken together, these historiographical developments challenge simplistic interpretations of colonial medicine as either a benevolent force or an instrument of domination. Instead, they reveal it as a contested and evolving field, shaped by negotiation, resistance, and structural inequalities.

As the field continues to develop, it offers valuable insights into the broader dynamics of colonialism and modernity. By examining the intersections of medicine, power, and society, historians can better understand the processes through which knowledge is produced, contested, and transformed.

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