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# "Ours is a Great Work": British Women Medical Missionaries in Twentieth-Century Colonial India

Beth Bullock Spencer

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“OURS IS A GREAT WORK.” BRITISH WOMEN MEDICAL MISSIONARIES IN  
TWENTIETH-CENTURY COLONIAL INDIA

by

GEORGIA BETH SPENCER

Under the Direction of Ian Christopher Fletcher, PhD

ABSTRACT

Drawing from the rich records of Protestant British women’s missionary societies, this dissertation explores the motivations, goals, efforts, and experiences of British women who pursued careers as missionary doctors and nurses dedicated to serving Indian women in the decades before Indian independence in 1947. While most scholarship on women missionaries focuses on the imperial heyday of the Victorian and Edwardian eras, this study highlights women medical missionaries in the late colonial period and argues for the significance of this transitional moment, a time of deepening change in medical science and clinical practice, imperial rule and nationalist politics, gender relations, and the nature of the missionary enterprise in both India and Britain. Analysis of the relationship between missionaries in India and their managers in Britain

reveals the tensions among women who shared a common commitment, yet brought different perspectives and priorities to women's missionary work. A life-cycle approach to work and career allows examination of individual women's development as healthcare professionals and as missionaries. Telling the stories of missionaries' everyday experiences shows that a sense of purpose, preparation, professionalism, and positive role models sustained those women who were able to meet the great demands of medical missionary work. These missionaries often overcame obstacles and challenges through negotiation and collaboration with patients and their families as well as reflection and learning from experience. Many came to believe they had achieved measurable progress and made a positive difference in the quality of Indian women's lives. The missionaries' commitment to Christian medical service for Indian women reached beyond the colonial era and eventually embraced a transfer of leadership to Indian Christians.

**INDEX WORDS:** Women missionaries, Colonial India, Medical work

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TWENTIETH-CENTURY COLONIAL INDIA

by

GEORGIA BETH SPENCER

A Dissertation Submitted in Partial Fulfillment of the Requirements for the Degree of

Doctor of Philosophy

in the College of Arts and Sciences

Georgia State University

2016

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TWENTIETH-CENTURY COLONIAL INDIA

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August 2016

**DEDICATION**

For my father, Charles S. Bullock, III  
who always hoped I would finish this project

And in memory of Dr. Maureen Flynn and Dr. Blair B. Kling

## ACKNOWLEDGEMENTS

This dissertation would not have been possible without the support, encouragement, and help of many people. I have benefitted from many wonderful teachers at several institutions, but must especially thank several individuals for directly contributing to my ability to complete this project. As an undergraduate at the University of Georgia, I was drawn to major in history by the late Dr. Maureen Flynn's fascinating social history courses. My senior paper advisor, Dr. Thomas Ganschow, motivated me to strive to become a better writer, and to enjoy the process of learning. Although I left the University of Illinois' doctoral program prior to starting my dissertation, this study—completed many years later—owes much to the advice and interest shown by the late Dr. Blair B. Kling, who guided me through the history of colonial South Asia, and directed my independent studies on British women's work in India. Dr. Leslie J. Reagan's graduate seminars on women and medicine exposed me to a field of study I had never considered, leading me to focus on missionaries' work in medicine, midwifery, and nursing. On one of my student evaluations, Dr. Reagan wrote that I “think like a historian.” This simple comment—which, due to my admiration for Dr. Reagan, felt like a great compliment—has helped sustain me through years of wrestling with the challenges of balancing a full-time career with the desire to research and write a history dissertation.

After leaving Illinois, I took nearly a decade “off” before returning to graduate studies in history, making a new beginning at Georgia State University. I could not have completed a Ph.D. in History if it hadn't been for Georgia State's acceptance and support of part-time doctoral students, and the fact that faculty in the Department of History are willing to offer evening classes. Not many people would want to go through coursework and comprehensive



exams at two institutions, but I can honestly say that I thoroughly enjoyed my experiences as a graduate student in the History program at Georgia State—my faculty were great, the seminars were engaging, I made some good friends, and I grew as a writer and researcher. I appreciate my dissertation committee members: Dr. Wendy Venet, Dr. Mohammed Hassen Ali, Dr. Ghulam Nadri, and my Chair, Dr. Ian Fletcher. Their questions and advice at my prospectus presentation, as well as their time, insights, and constructive conversation at my defense have been very helpful in shaping this project. And I thank Ms. Robin Jackson, Graduate Studies Coordinator, for her part in keeping me on track even during the years when I was ABD and never on the Georgia State campus. Finally, I owe much to the University System of Georgia (USG)—in addition to the professional opportunities I’ve had as an employee at four USG institutions, the USG’s Tuition Assistance Program meant I could pursue my full-time career in higher education while completing a degree without paying tuition and fees.

Dr. Ian Fletcher has been more to me than just a wonderful dissertation advisor. I imagine that he has often wondered if I ever would really finish my dissertation, but he has never been anything other than positive, encouraging, and patient. Whenever I have gotten “stuck” in my writing—which has been often—he has been able to ask the right questions, to help me reframe my thinking, and to guide me through the process of organizing and crafting this work. He has given me his time on weekends and evenings—accommodating my work schedule—for meetings and phone conversations. The years that he facilitated the Trans-Empire Research Cluster meetings allowed me—and many other graduate students—the opportunity to share our research, get valuable feedback, and build camaraderie. He has also consistently reminded me and other graduate students of the importance of not neglecting other important areas of our lives while still striving to do well in our academic endeavors. Dr. Fletcher’s sincere interest in

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I completed my coursework, exams, reading and much research while working at Georgia Tech, but I have done all of my actual writing for this dissertation since joining the staff at the University of West Georgia. I am indebted to my supervisor, Dr. John D. Head, Associate Vice President for Enrollment Management, for insisting that I make finishing my dissertation one of my annual professional development goals—and for holding me accountable. John has also been a good role model for me—he is dedicated to his work and responsibilities to the university, but also enjoys a rewarding personal life. The wonderful, hard-working staff in West Georgia's Center for Academic Success have also contributed to this project by cheering me on, and by allowing me to take the time I needed to write—their support has been invaluable. No director could ask for a better staff than Paula Neild, Carrie Ziglar, Darius Thomas, Stephanie Westine, and Chris Black!

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## TABLE OF CONTENTS

<b>ACKNOWLEDGEMENTS .....</b>	<b>vi</b>
<b>ABBREVIATIONS .....</b>	<b>xiii</b>
<b>1 “A Sense of Responsibility to the World: Women, Medicine and Missions in Colonial India INTRODUCTION.....</b>	<b>1</b>
<b>    1.1 <i>Historiography</i> .....</b>	<b>8</b>
<b>        1.1.1 <i>Empire and Missions</i> .....</b>	<b>8</b>
<b>        1.1.2 <i>Women and Missions</i> .....</b>	<b>15</b>
<b>        1.1.3 <i>Colonial Medicine, Medical Missionaries, and Women</i>.....</b>	<b>26</b>
<b>    1.2 <i>Sources and Methods</i> .....</b>	<b>37</b>
<b>    1.3 <i>Plan of Dissertation</i> .....</b>	<b>45</b>
<b>2 “A Most Suitable and Useful Worker: Selection and Shaping Women for Medical Missionary Work.....</b>	<b>51</b>
<b>    2.1 <i>From General Missionaries to Medical Workers</i>.....</b>	<b>57</b>
<b>    2.2 <i>Hopes, Risks, and Realities: The Medical Training Process</i>.....</b>	<b>71</b>
<b>    2.3 <i>Evaluating Potential Missionaries: Backgrounds, Parentage, and Homelife</i> .</b>	<b>76</b>
<b>    2.4 <i>Educational Considerations</i> .....</b>	<b>82</b>
<b>    2.5 <i>“Serious Study” : Knowledge of the Bible, Doctrine, and Evangelism</i> .....</b>	<b>86</b>
<b>    2.6 <i>Financial Considerations</i> .....</b>	<b>89</b>
<b>    2.7 <i>Age and Maturity</i> .....</b>	<b>91</b>

2.8	<i>Health</i> .....	98
2.9	<i>Missionary Training: Leadership, Conviction, and Character</i> .....	105
2.10	<i>Conclusion</i> .....	116
3	<b>“I Chose Not to Turn Back”: Medical Women’s Adjustment to Missionary Life</b>	<b>118</b>
3.1	<i>Embarking on the Work: Plans and Realities</i> .....	125
3.2	<i>Physical Conditions</i> .....	134
3.3	<i>Professional Conditions</i> .....	147
3.4	<i>Emotional Conditions</i> .....	161
3.5	<i>Conclusion</i> .....	179
4	<b>“Great Work”: Woman’s Medical Work for Woman</b> .....	<b>181</b>
4.1	<i>“So Few”: Medical Missionaries and Indian Women’s Medical Needs</i> .....	188
4.2	<i>Gaining Trust and Winning Confidence</i> .....	190
4.3	<i>Establishing Authority and Patient Compliance</i> .....	202
4.4	<i>“Bitter Experiences”: Medical Authority in Matters of Life and Death</i> .....	211
4.5	<i>“In This, Their Time of Greatest Need”: Childbirth</i> .....	216
4.6	<i>Home and Hospital</i> .....	223
4.7	<i>The “Other Side” of the Work: Spiritual Meaning in Medical Work</i> .....	242
4.8	<i>Conclusion</i> .....	249

<b>5</b>	<b>“Where the Need is Greatest”: Women’s Medical Missionary Work in Late Colonial India, c. 1930-1947</b>	<b>253</b>
5.1	<i>First-Class Work</i>	259
5.2	<i>Missionary Nursing Training</i>	266
5.3	<i>Medical Missionaries and India’s Dais</i>	288
5.4	<i>Collaboration</i>	297
5.5	<i>Preventive Care</i>	301
5.6	<i>Conclusion</i>	310
<b>6</b>	<b>EPILOQUE AND CONCLUSION</b>	<b>312</b>
6.1	<i>Not Quitting India</i>	312
6.2	<i>Doctors First, Missionaries Second</i>	317
6.3	<i>Women for Women</i>	319
	<b>BIBLIOGRAPHY</b>	<b>322</b>

**ABBREVIATIONS**

CEZMS	Church of England Zenana Missionary Society
CMS	Church Missionary Society
IMS	Indian Medical Service
L.M.P.	Licensed Medical Practitioner
L.R.C.P.	Licentiate of the Royal College of Physicians
M.B.,B.S.	Bachelor of Science, Bachelor of Surgery
MBE	Member of the Order of the British Empire
M.R.C.S,	Member Royal College of Surgeons
WW	Women's Work (WMMS)
WMMS	Wesleyan Methodist Missionary Society
ZBMM	Zenana Medical Missionary Society





## 1 “A SENSE OF RESPONSIBILITY TO THE WORLD: WOMEN, MEDICINE AND MISSIONS IN COLONIAL INDIA INTRODUCTION

In 1941, a newly arrived Methodist missionary nurse prepared her first annual report on the medical “Women’s Work” in Akbarpur, in the north of India. “In England I worked for several years in a hospital amongst a similar rural population, serving, as far as I can gather, about roughly the same area.” The similarities ended here. In England, her hospital had 300-400 beds, which were always occupied by patients, plus three operating theatres, a maternity ward, an x-ray department, a pathology department, and many outpatient clinics. In Akbarpur, the hospital had only twenty beds, one doctor, and two trained midwives. Like her colleagues engaged in medical missionary work for women across India, she saw immense need for medical care, as “disease, dirt, poverty and malnutrition, ignorance and superstition hold sway.” She found medical work in the nearby villages “revealing and heart-breaking.” There she encountered and attempted to treat endless cases of “sore eyes, running ears, coughs, joint pains, and diarrhea...[a]nd yet one feels the inadequacy of it all.” Her efforts could seem pointless as “[t]he eyes need weeks of treatment and rest, but we can only offer drops and ointment. The coughs may be due to advanced [tuberculosis] and we offer cough drops.” She invited patients to come to the hospital for comprehensive treatment, “but so far no one has taken our invitation.” The hospital’s twenty beds remained empty, and she estimated that the staff had time to do “three to four times the amount of current work.” Nevertheless, in the middle of this gloomy report, this frustrated nurse stated, “And yet in many ways the medical work here is cheering.”<sup>1</sup>

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<sup>1</sup> Unsigned report, “Akbarpur Women’s Work,” December 1941, “Reports,” Women’s Work Collection, Box, 1039, fiche 109, Methodist Missionary Society Archives, Microfiche. Fiche Ms69, Special Collections, Yale Divinity School Library. The archive for this society, consisting of 1,760 boxes of material, is held by the School of Oriental and African Studies. The Yale Divinity School Library has an extensive portion of the archive on microfiche, and this is the collection cited in this dissertation. The following format for citation will be: WW (Women’s Work Collection), MMS (Methodist Missionary Society), with microfiche box and card number included. The Women’s

A few years earlier, in a South Indian medical station, another recently arrived missionary nurse wrestled with her own challenges. “I am very sick at heart about my Kanarese. It is obvious that I am quite unable to cope with the language.”<sup>2</sup> This was Elsie Chapman’s reaction to failing her first language exam. Like her colleagues, Chapman believed fluency in the local language was key “to begin to understand Indian life”; without this understanding, medical missionary work would prove neither fulfilling nor effective.<sup>3</sup> Often overwhelmed by hospital duties while her more experienced British colleague was away, Chapman felt “doubtful of [her] capability.”<sup>4</sup> She offered to resign so that someone else could take her place, yet she also stated that she loved her work and hoped to remain in India, even if she were no longer part of this particular organization.<sup>5</sup> As time passed and Chapman’s language skills improved, she finally felt able to visit Indian women in their village homes, reporting “[t]here is nothing like sitting on the floor of a dark room with a crowd of women and children around and the tail of the family cow swishing on one, to make one feel at home with the people.”<sup>6</sup>

Perhaps Chapman needed to feel “at home” since she was so far from her family, committed to a minimum of five years of continuous service in India. Missionary service often proved lonely, and required women make often difficult emotional decisions about relationships outside of mission life. When her mother experienced a series of strokes, Chapman sought

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Work collection is organized by region, so that is also included. For example, WW, MMS, Madras Correspondence, (box) 1075, (card) 901.

<sup>2</sup> Elsie Chapman to Miss H. M. Bradford, 30 June 1927, WW, MMS, Mysore Correspondence, Box 1075, 901. Although the missionaries referred to the Dravidian language of what is now the state of Karnataka—the princely state of Mysore until 1973—as “Kanarese,” the term is now used to refer to the people while the language is Kannada. In this dissertation, the terminology used by the missionaries and their contemporaries will be used.

<sup>3</sup> Grace Gillespie to Miss M. Freethy, 22 February 1945, WW, MMS, Mysore Correspondence, 1079, 1017.

<sup>4</sup> Elsie Chapman to Miss Bradford, 14 March 1928, WW, MMS, Mysore Correspondence, 1075, 901.

<sup>5</sup> Chapman was working for the Women’s Auxiliary in what was then called the Wesleyan Methodist Missionary Society. Chapman’s offer to resign in order to make space for another missionary was significant since in the 1920s, women’s missionary organizations generally had more applicants than they could accept and support.

<sup>6</sup> Elsie Chapman to Miss Bradford, 8 November 1928, WW, MMS, Mysore Correspondence, 1075, 901.

permission to rush back to Britain, which was granted since missionary societies saw caring for parents to be a natural responsibility for unmarried adult daughters. After a few months, Chapman chose to return to India, knowing her mother would die before the next visit. This surprised and troubled her family. “It has always been difficult for home folk to understand why I should choose the life I have,” she mused.<sup>7</sup>

Grace Gillespie, a physician serving in Chapman’s district, often seemed to ponder why she had chosen this missionary life. “Even now I am not doing good work because there is too much and no rest at all,” Gillespie complained. “It is impossible to do good work at the rate of 18 hours a day.”<sup>8</sup> As was the case at most women’s missionary hospitals, Gillespie was one of at most two doctors, serving a patient population in the thousands. Her colleagues worried that she worked too hard and under too much stress, reporting that she “look[s] absolutely ghastly sometimes and is working night and day. A fine mess the district will be in if she cracks up, as she will do if [she has] to go on working at this rate.”<sup>9</sup> Gillespie’s “work” encompassed much more than merely treating thousands of patients. “What amazing things one has to do. I never thought I should be planning buildings and looking after crops and cattle and drains and every conceivable thing.”<sup>10</sup> Dealing with hospital finances, especially in the later Depression and Second World War years, proved difficult and consumed too much of her time.<sup>11</sup> Throughout her career in India, which spanned from 1930 to 1958, Gillespie frequently wondered whether she was cut out to be a medical missionary.

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<sup>7</sup> Elsie Chapman to Miss Byrom, 9 December 1931, WW, MMS, Mysore Correspondence, 1076, 920.

<sup>8</sup> Grace Gillespie to Miss Byrom, 26 October 1932, WW, MMS, Mysore Correspondence, 1076, 924.

<sup>9</sup> Freda Vale to Mrs. Lillian Letty, 14 September 1932, WW, MMS, Mysore Correspondence, 1076, 944.

<sup>10</sup> Grace Gillespie to Miss Byrom, 7 December 1931, WW, MMS, Mysore Correspondence, 1076, 924.

<sup>11</sup> Grace Gillespie to Mrs. Leith, 30 January 1938, WW, MMS, Mysore Correspondence, 1077, 958.

Women like these nurses and doctor claimed to have chosen missionary work because they wanted to “help” Indian women whom they “loved” and often referred to as their “sisters.” Yet the medical missionaries often found Indian women difficult to help or love. “If it isn’t one thing at Ikkadu [hospital] it’s another,” moaned Dr. Mary Proudlove when a patient developed smallpox immediately after giving birth in the hospital. The staff, hoping to contain this dangerous and highly contagious disease, planned to move the patient to the smallpox isolation ward. Because the morgue was located near the mortuary, and therefore considered inauspicious by the patient and her family, the patient refused to move. After finally agreeing to go to the ward, the patient instead left with her husband, taking both her smallpox and baby back to her village. “They have no concept of preventive medicine here and think nothing of infecting everyone else,” the exasperated doctor complained.<sup>12</sup> Patients routinely ignored medical women’s advice, leaving the hospital for religious festivals, to cook for husbands, or because they saw no reason to wait longer for medical results. The medical setbacks, preventable suffering, and disregard of medical expertise could prove disheartening for the well-intentioned missionaries. “[W]e just have to make ourselves let them go their own ways if they won’t listen to our advice,” reflected one doctor, but neither she nor her colleagues truly accepted this philosophy.<sup>13</sup>

Of those who did remain in the hospital, many resisted missionary rules for patient behavior. When one new nurse fretted about this, she was reassured that she would adjust to patients “being untidy.”<sup>14</sup> But some medical missionaries who worked in India for decades never got used to “untidy” patient behavior. Dr. Olive Monahan, who practiced in India for

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<sup>12</sup> Mary Proudlove to Miss Bradford, 14 March 1928, WW, MMS, Madras Correspondence, 1068, 717.

<sup>13</sup> Alice Musgrave to Miss Freethy, 13 July 1943, WW, MMS, Madras Correspondence, 1070, 778.

<sup>14</sup> Miss Walton to Edith Thomas, 8 January 1940, WW, MMS, Mysore Correspondence, 1079, 1023.

more than thirty years, approached her board for funding to tile the walls in her hospital, justifying the expense as due to the patients' "horrid habits":

[Patients] spit on the walls, they blow their noses with their fingers and then wipe them on the walls—crush any offending beasts against the walls and throw their coffee grounds at them. Only last week a Brahman woman had more milk than her baby could consume, so she drew it off and as it is unlucky to spill human milk on the floor she threw it deliberately at the wall! When we remonstrated with her she said she didn't know why we shouldn't like it.<sup>15</sup> Since maternity patients usually only stayed for a few days,, there was not enough time for the medical women "to make good manners automatic." Although tiling was expensive, it seemed more effective than constantly arguing with patients.

Medical missionary women's work was affected by other difficulties, too. Ironically, they were often very ill. Grace Gillespie was not the only medical missionary reported to "look ghastly" or be on the verge of a physical and mental breakdown. The climate made working unpleasant. One young doctor wrote to her mother that when the dust combined with her sweat in the 112-degree heat, her hair became muddy, which was a nuisance when she performed surgeries. Some women never felt as "at home" with Indians as Elsie Chapman claimed, and instead struggled with loneliness, especially when they were stationed away from other Europeans. Many of these women coped with parents who disapproved of their career choices. Beginning in the First World War years, women's missionary organizations struggled with chronic staffing shortages and financial woes. The Victorian support for women's special mission to other women began to fade. As medicine advanced in the interwar years, the lack of money for equipment, technology, and new medications became an ongoing challenge. And,

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<sup>15</sup> Olive Monahan to Miss Bradford, 6 February 1924, WW, MMS, Madras Correspondence, 1068, 698.

regardless of how hard they worked, or the number of patients they saw, medical women always found more “needs” to meet, but they knew their numbers were too small to ever adequately address them. As Indian nationalism rose and it became clear that India would become independent, the future of their work became uncertain—would they be welcome in a new India? Would their medical work continue if they left? Even with these problems, like the nurse at Akbarpur, Elsie Chapman maintained that “[o]urs is a great work and I would not choose to be elsewhere.”<sup>16</sup>

These glimpses of medical missionary women’s experiences in twentieth-century colonial India imply that the women found the work hard, often frustrating, and the conditions harsh. Chapman’s statement that she “would not choose to be elsewhere” is significant, for, as healthcare professionals working in the post-World War I decades, she and the other women missionary doctors and nurses we have met in these opening pages had chosen missionary careers after they had lost their Victorian popularity, and at a time when their very purpose and viability were questioned by the public at home, in the colonies, and portions of the international missionary community. As a trained nurse with solid credentials and professional experience in interwar Britain, Chapman had other professional opportunities open to her. Her family wanted her to live and work in Britain. Her letters to her Home Secretary indicate that she felt she was on an emotional rollercoaster in India. But she chose to practice as a missionary nurse because she saw herself participating in “great work.” Chapman was not alone. Other women missionaries also commonly used the word “great” to describe their work, often juxtaposing it with situations and events that seemed to contradict such a claim.

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<sup>16</sup> Elsie Chapman to Miss Bradford, 21 January 1930, WW, MMS, Mysore Correspondence, 1076, 918.

During the latter half of the nineteenth century, concern for Indian women's health needs captured the imagination of European women in Britain, North America, and Western Europe. Virtually all of the interest and funding to support the development of health care for women in colonial India during these decades came from philanthropic organizations, most of which were missionary societies.<sup>17</sup> Missionary organizations worked to provide hospitals, clinics and dispensaries, nurses' training schools, various midwifery training programs, and Christian medical education to prepare Indian women to pursue careers as doctors. Rosemary Fitzgerald, one of the very few scholars who has focused on British women medical missionaries, stresses the significant role that women's medical missions played in providing medical care to Indian women. "Even in 1927, when the government had finally begun to get on board," Fitzgerald writes, the ninety-three mission hospitals for women represented more than half of all women's hospitals in India, and missions ran 102 nurses training schools, in comparison with the 55 government-run training schools.<sup>18</sup> Beginning in the 1870s, women like Gillespie specifically trained to realize their goal of serving as a medical missionary. Yet missionary women's medical work is often missing from the historiography of colonialism and medicine in South Asia.

This dissertation has grown out of a desire to understand why women like Nurse Elsie Chapman and Dr. Grace Gillespie believed they were engaged in "great work" as medical missionaries in late colonial India. This study attempts to understand these women's motivations, their sense of purpose, and their perceptions of the meaning and effect of their efforts. In the simplest terms, then, this dissertation explores why the women in this study were

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<sup>17</sup> Rosemary Fitzgerald, "Rescue and Redemption: The Rise of Female Medical Missions in Colonial India During the Late Nineteenth and Early Twentieth Centuries" in *Nursing History and the Politics of Welfare*, ed. Anne Marie Rafferty, Jane Robinson, and Ruth Elkan (New York: Routledge, 1997), 64.

<sup>18</sup> *Ibid.*, 65.

attracted to medical missionary service, and why they remained committed to this work, especially during decades of change and uncertainty.

## ***1.1 Historiography***

This study draws from and contributes to three main bodies of scholarship: missions and empire; women and missions; colonial medicine, medical missionaries, and women. Each of these fields has its own rich historiography, although there is some overlapping of themes and approaches shared by all. A comprehensive analysis of all the fields would prove quite lengthy, so the following sections provide overviews and then focus on the themes and arguments that directly relate to this study.

### *1.1.1 Empire and Missions*

The “great age of missions,” which began in Britain around 1790, developed from the eighteenth-century evangelical revival. The initial focus of evangelism was in Britain, especially among the poor and unchurched in urban centers.<sup>19</sup> Historians and missiologists typically credit William Carey, who sailed for India in 1793, as one of the overseas movement’s founders.<sup>20</sup> Carey, a devout Baptist, dedicated the rest of his life to efforts to convert and therefore “save” the “heathen” in Bengal. India quickly became and remained the main focus of British foreign

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<sup>19</sup> Some scholars, such as Jeffrey Cox, frame their studies with different dates. Cox begins his study of British missions in 1700, which is two years after the Society for the Promotion of Christian Knowledge (SPCK) and one year before the Society for the Propagation of the Gospel in Foreign Parts (SPG) commenced, thus allowing him to analyze the history of missions in the eighteenth century, which paved the way for the larger movement and “high noon” of missions in the nineteenth and twentieth centuries. Jeffrey Cox, *The British Missionary Enterprise Since 1700* (New York: Routledge, 2008). Much of the mission work of the eighteenth century was concerned with providing churches and structure for the settler colonies.

<sup>20</sup> Cox sees the Careys as the beginning of “a new period of missionary endeavor, the period of the private, voluntary missionary society sending missionary couples for purposes of recruitment.” Cox, *The British Missionary Enterprise*, 72.



missionary attentions, and was considered to be the most challenging field in which missionaries worked.

The nineteenth-century expansion of missions coincided with the rapid growth of British imperialism, and therefore “tends to be taken for granted as a reflex of imperialism.”<sup>21</sup> Certainly there are connections between the missionary enterprise and imperialism, for in the roughly 130 years of the movement, thousands of British missionaries set forth to promote the adoption of Christianity, especially across the formally colonized areas of Asia and Africa. European missionaries actively participated in the spread of western culture and civilization, and, in some places, commerce. It is easy for scholars to find examples of missionaries’ support of imperial political control and policies. Missionaries captured the popular imagination at home, where they enjoyed significant support, as, over the course of the nineteenth century, the public became increasingly certain of the Christian mission of empire.<sup>22</sup> Yet historians studying the missionary movement stress that until quite recently, imperial history has ignored or marginalized missionaries.<sup>23</sup>

This absence or oversight is due to a combination of reasons. Jeffrey Cox explains that the imperialists themselves often viewed missionaries as “marginal figures in the imperial enterprise.”<sup>24</sup> Most imperial administrators had little interest in the spread of Christianity; one of the chapters in Jeffrey Cox’s *The British Missionary Enterprise Since 1700* is entitled “Little Detachments of Maniacs,” a quotation from an 1808 attack on missionary activities in India,

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<sup>21</sup> Norman Etherington, “Introduction,” *Missions and Empire* (Oxford: Oxford University Press, 2005), 1.

<sup>22</sup> James Morris, *Heaven’s Command: An Imperial Progress* (San Diego: Harcourt Brace Jovanovich, 1973), 318-321. This work, part of Morris’ trilogy on the British empire, has been reprinted numerous times, and newer editions are under the name Jan Morris as Morris underwent a sex change in the 1970s.

<sup>23</sup> Historians of missions made much of the inclusion of the missionary enterprise in the *Oxford History of the British Empire* series. Norman Etherington pointed out that missionaries only received one dedicated chapter in the series (Volume V, Historiography, chapter 19), and were only discussed in two other chapters across the five volumes. Etherington, *Missions and Empire*, 1.

<sup>24</sup> Jeffrey Cox, *The British Missionary Enterprise*, 4.

which reflects the widely-shared early nineteenth-century perception that missionaries were either “ridiculous or even insane.”<sup>25</sup> Traditional imperial history focuses on diplomatic and military affairs, economics, politics, and government, all of which can be interpreted as entirely secular fields of study, and as separate from the study of the history of religion. Historians interested in religion and empire also stress that academics’ own attitudes toward religion and evangelism strongly influence the way they approach the missionaries: scholarly discomfort with missionaries’ goals and motives, the association of missionaries with imperialism, conservatism, racism, and ethnocentrism, have made these men and women who worked for the conversion of others seem unworthy of serious academic study.<sup>26</sup>

In *The British Missionary Enterprise Since 1700*, Jeffrey Cox notes that his is the first “recent” summary of the entire British missionary movement. His is a comprehensive approach, analyzing the workings of the movement in both the colonized lands and the metropole.<sup>27</sup> Cox stresses that British historians, including those specifically studying religion in Britain, have also traditionally failed to consider missionaries as serious major historical figures. Indeed, Cox reflects that in his 1982 study of the decline of British churchgoing, he ignored much of the evidence he found for British churches’ “deep involvement with the wider world” for he was “interested in British history, not foreign history, and the history of missions took place in foreign countries.”<sup>28</sup> Other recent studies, such as Catherine Hall’s *Civilising Subjects: Colony and Metropole in the English Imagination, 1830-1867*, use missionaries as central characters to

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<sup>25</sup> Ibid. The quoted article was in the *Edinburgh Review*. Chapter Four’s full title is “‘Little detachments of maniacs’: early failures.”

<sup>26</sup> Alex McKay, “Towards a History of Medical Missions,” Review of *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa*, ed. David Hardiman, *Medical History* 51 (4) (Oct. 1 2007): 541-551.

<sup>27</sup> The approach to consider the missionary not only as potentially significant in colonized lands is increasingly common. See, for example, Elizabeth Prevost’s *The Communion of Women: Missions and Gender in Colonial Africa and the British Metropole* (Oxford: Oxford University Press, 2010).

<sup>28</sup> Cox, *The Missionary Enterprise*, 7.

explore the deep connections between colony and metropole, and the many ways the empire impacted British culture.<sup>29</sup>

Cox categorizes historians' approaches to understanding missionaries and their actions into three main lines of interpretation.<sup>30</sup> The first is the marginalization approach traditionally taken by imperial historians. Even imperial historians are taking notice of missionaries, however, as the field has been influenced by the work of anthropologists, gender studies scholars, and academics interested in humanitarianism and empire. Another approach is that of mission studies—or the ecclesiastical tradition of interpretation—which developed from the nineteenth-century missionary narratives, and has been characterized by the centrality of the heroic male cleric, and the uncritical assumption that the study of missions is important. The “anti-imperialists” make up the third line of interpretation. Anti-imperialist scholars lump missionaries in with other types of imperial actors, arguing that missionaries supported colonial governments and initiatives, and that the missionaries' goals were “to colonize the hearts and minds of subject peoples.”<sup>31</sup> In the introduction to *Empire and Missions*, Norman Etherington explains why it is easy to view missionaries as cultural imperialists: they established their stations in colonized areas and preached the superiority of Western religion, culture, science and technology; missionaries also resisted converts' efforts to take positions of leadership or even equality in the church. Their writings can convey racism and ethnocentrism. Nevertheless, Etherington and other historians writing in the twenty-first century argue that none these

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<sup>29</sup> Catherine Hall, *Civilising Subjects: Colony and Metropole in the English Imagination, 1830-1867* (Chicago: University of Chicago Press, 2002).

<sup>30</sup> Cox, *The Missionary Enterprise*, “Introduction.”

<sup>31</sup> Cox, *The Missionary Enterprise*, 4.

interpretations adequately explores missionaries' complex and nuanced relationship with imperialism.<sup>32</sup>

Changing approaches to the study of missionaries have led scholars to develop new understandings of missionaries and their relationship to imperialism. As Etherington and Andrew Porter argue in their overviews of the historiography of missions and empire, missionaries and imperial governments did often work toward similar goals, but missionaries also often consciously distanced themselves from imperial authorities and policies, sometimes subverting that authority.<sup>33</sup> This did not trouble missionaries, for while missionaries' efforts—both men's and women's—may have promoted the “civilizing mission” of imperialism, Andrew Porter stresses that it is important to understand that missionaries were motivated to create Christians, not Christian *subjects*.<sup>34</sup> Cox argues that the missionary experience is marked by repeated examples of unintended outcomes and consequences.<sup>35</sup> Historians often cite the role missionary education played in contributing to the development of indigenous nationalist or feminist movements as prime examples of this.<sup>36</sup> As Porter and Cox explain, missionaries understood the “ephemeral” nature of imperialism. Cox stresses that the institutions these missionaries and the

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<sup>32</sup> Etherington, *Missions and Empire*, 4-5; Andrew Porter, *Religion versus Empire? British Protestant Missionaries and Overseas Expansion, 1700-1914* (Manchester: Manchester University Press, 2004); Jeffrey Cox, *Imperial Fault Lines: Christianity and Colonial Power in India, 1818-1940* (Stanford: Stanford University Press, 2002); Jeffrey Cox, *The British Missionary Enterprise*.

<sup>33</sup> Andrew Porter, Religion, Missionary Enthusiasm, and Empire,” in *Oxford History of the British Empire*, Volume III (Oxford: Oxford University Press, 2001), 222-246. For particular examples, see Anil Kumar, *Medicine and the Raj: British Medical Policy and India, 1835-1911* (New Delhi: Altamira Press, 1998). Kumar notes that missionaries “although belonging to the white race and generally not opposed to the imperial rule” sometimes condemned British policy and behavior that offended morality. Others who make this point include Jeffrey Cox, *Imperial Fault Lines* (2002); David Hardiman, *Missionaries and Their Medicine: A Christian Modernity for Tribal India* (Manchester: Manchester University Press, 2008); Andrew Porter, *Religion versus Empire?* (2004).

<sup>34</sup> Andrew Porter, *Religion versus Empire?*

<sup>35</sup> Cox, *The British Missionary Enterprise*.

<sup>36</sup> See, for example, the chapter on “Christianity and the ‘Westernized Oriental Gentlewoman’” in Kumari Jayawardena, *The White Woman's Other Burden: Western Women and South Asia During British Rule* (New York: Rutledge, 1995) for an exploration of women missionaries' inadvertent contributions to South Asian feminism and nationalism.

communities they helped to create were meant to outlast the European missionary presence, and reminds us that while missionaries were implicated in imperialism, their focus was on building the church and working toward global salvation, which had nothing to do with colonial governance. European missionaries benefitted in some key ways as members of the ruling race, but were nonetheless highly dependent on local people. Recent scholarship has focused on the all-important roles of the indigenous converts in the actual evangelism of local people. As Jeffrey Cox demonstrates in his studies of British missionary work around the world and in colonial India, the vast majority of people sustaining the missionary enterprise were neither British, white, nor male.

Such discoveries have further weakened more traditional academic views of missionaries as cultural imperialists. In the British empire, missionaries did enjoy some level of imperial protection, and, when it was in the authorities' interest, could receive grants to help support their educational and medical work, but for the most part, missionaries were at the mercy of local people for their facilities and resources. They had no power to force conversion, participation in mission-led activities, or utilization of mission services. Missionaries could not require the adoption of any of their teachings or beliefs. Instead of arguing that missionaries imposed behaviors, beliefs, and values onto other cultures, historians increasingly approach missionary activity and endeavors as "encounters" between missionaries and indigenous people. These encounters, according to Cox, took place in "contact zones" that were neither entirely imperial nor indigenous. These encounters resulted in indigenous people adapting aspects of Christianity and Western culture to meet their own needs and ends. These encounters also affected missionaries, causing them to adapt their expectations, strategies, and assessments of the people

and cultures with whom they worked.<sup>37</sup> Negotiation and compromise are therefore common themes running throughout the missionary endeavor.

If scholars studying missionaries rely solely on the official, published missionary materials as primary sources, they will miss much of the compromise and questioning that characterized the missionary experience. Historians often note the great wealth of material missionaries created, including memoirs and biographies, magazines and annual reports, children's literature, poetry and song, histories of missionary societies and institutions, and various writings on their work, goals, and progress. Much of the published materials are discounted by academics as blatant propaganda. Certainly missionaries produced propaganda: their work depended on financial support from people at home who were moved by reports of the urgent spiritual, social, educational, and medical needs of "heathen" and non-Christians.<sup>38</sup> Stories of missionary progress—of actual or potential conversions—brought in donations, as did reports of social problems and suffering that would be ameliorated by conversion to Christianity and the concomitant acceptance of western values and culture. As historians start to delve into the vast collections of unpublished missionary materials, which include letters, reports, and an array of archival records, the richness of the missionary experience begins to unfold, and the simplistic view of missionaries as cultural imperialists unravels.

In *The British Missionary Enterprise*, Cox states that there are many ways to tell the story of missionaries; his story is "full of unintended consequences, arrogance, fanaticism, and self-deception, but also one that pits love and compassion against the brute realities of imperial rule,

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<sup>37</sup> Cox, *The British Missionary Enterprise*; Mary Taylor Huber and Nancy C. Lutkehaus, "Introduction," *Gendered Missions: Women and Men in Missionary Discourse and Practice* (Ann Arbor: University of Michigan Press, 1999).

<sup>38</sup> This point is made by Etherington, "Introduction," *Missions and Empire*; and Elizabeth Prevost, *Communion of Women*.

and post-colonial cultural imperialism.”<sup>39</sup> My dissertation is limited to medical missionary women in the first half of the twentieth century in India, and is thus much narrower in scope than Cox’s analysis of three hundred years of men’s and women’s work around the world. As women interested in social change, and as medical professionals dedicated to improving health and healthcare, the subjects of my study could also be viewed as cultural imperialists, but that would be too simplistic. My study is also the story of many unintended outcomes, deceptions, and compassion, as well as lessons learned, compromise, negotiation, and self-reflection.

### 1.1.2 *Women and Missions*

Over the course of the nineteenth century, the missionary enterprise attracted thousands of women participants, becoming the century’s “largest mass movement of women” in Britain.<sup>40</sup> Women’s involvement in this movement was broad and varied. It included women like those introduced in the opening pages of this study: women who served as foreign missionaries, living and working overseas, often devoting decades of their lives to the missionary cause. These women primarily worked as educators, nurses, doctors, administrators, and evangelists. The movement also mobilized women at home: tens of thousands of women and girls volunteered and raised funds to support the overseas work of women missionaries. Others devoted significant time and resources to the recruitment, selection, and training of women missionaries, as well as to the administration and management of the organizations that supported women’s

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<sup>39</sup> Cox, *The British Missionary Enterprise*, 21.

<sup>40</sup> Susan Thorne, “Missionary-Imperial Feminism,” in *Gendered Missions: Women and Men in Missionary Discourse and Practice*, ed. Mary Taylor Huber and Nancy Lutkehaus, (Ann Arbor: University of Michigan Press, 1999). Scholarly work specifically on British women missionaries continues to lag behind that done on the North American women’s missionary movements, but in all of the Anglo-Protestant contexts, women came to outnumber the men in the field and in the fundraising at home. See Leslie Flemming’s “Introduction” to *Women’s Work for Women: Missionaries and Social Change in Asia*, ed. Leslie Flemming (London: Westview Press, 1989), 1-10, for an overview of the movement.

mission work around the world. European women —especially British and North American— were called to support the “woman’s work for woman,” which included providing education, medical care, and other social services for indigenous women.<sup>41</sup> Although primarily characterized as a middle-class movement, British women’s missionary organizations attracted interest and support from broad segments of society, including working-class and aristocratic women.<sup>42</sup>

Britain sent out more women missionaries than any other nation, and at the start of the First World War, these women comprised approximately 60% of all British missionaries, yet the stories of the missionary experience “marginalize” women’s presence and contributions.<sup>43</sup> But, as Rosemary Seton states in the opening pages of *Western Daughters in Eastern Lands: British Women Missionaries in Asia*, published in 2013, hers is the first comprehensive study of these women. Previous research has largely dealt with North American women.<sup>44</sup> British academics have been less interested in exploring the missionary movement as well as the history of women and religion than have American and Canadian historians.<sup>45</sup> Seton credits this to the decline in

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<sup>41</sup> This study uses the term “European” instead of “western” women. Although this is a study of British women missionaries, it does include some individuals from Canada, Australia, and the United States. Additionally, the majority of studies on women missionaries (in English—there are studies of the German and Scandinavian groups) have been on the North American—American and Canadian—groups. “European” covers all of these women, and helps to move away from the binary categories scholars have used in the past when thinking about colonialism.

<sup>42</sup> Patricia R. Hill, *The World Their Household: the American Woman’s Foreign Mission Movement and Cultural Transformation, 1870-1920* (Ann Arbor: University of Michigan Press, 1985). Rosemary Seton, *Western Daughters in Eastern Lands: British Missionary Women in Asia* (Santa Barbara, CA: Praeger, 2013).

<sup>43</sup> Jeffrey Cox, *Imperial Fault Lines*.

<sup>44</sup> This scholarship includes Jane Hunter, *The Gospel of Gentility: American Missionaries in Turn-of-the-Century China* (New Haven: Yale University Press, 1984); Hill, *The World Their Household*; Ruth Compton Brouwer, *New Women for God: Canadian Presbyterian Women and India Missions, 1876-1914* (Toronto: University of Toronto Press, 1990); Leslie A. Flemming, “New Models, New Roles: U.S. Presbyterian Women Missionaries and Social Change in North India, 1870-1910,” in *Women’s Work for Women*; Dana L. Robert, *American Women in Mission: A Social History of Their Thought and Practice* (Macon, GA: Mercer University Press, 1996); Maina Chawla Singh, *Gender, Religion, and the ‘Heathen Lands’: American Missionary Women in South Asia, 1860s-1940s* (New York: Garland Publishing, 2000); Alwyn Austin and Jamie S. Scott, eds., *Canadian Missionaries, Indigenous Peoples: Representing Religion at Home and Abroad* (Toronto: University of Toronto Press, 2005).

<sup>45</sup> Ruth Compton Brouwer made this observation in her 1990 study of Canadian Presbyterian women missionaries, *New Women for God*.



belief in Christianity and religion's lack of relevance in British people's lives. This, combined with current British academic discomfort with imperialism helps to explain why British women missionaries have been victims of what Seton calls "a collective act of forgetfulness" on the part of British historians.<sup>46</sup>

Research on women missionaries emerged in the 1980s as women's historians began to explore women's experiences in imperialism. Etherington states that "[o]utside the colonies of white settlement European women played a minor role in the imperial enterprise," since few of them held government posts, served in the military, or were engaged in imperial commerce.<sup>47</sup> While women's, feminist, and gender history has produced a body of scholarship that refutes this statement, Etherington's undisputed point is that the missionary enterprise opened doors for European women as missionaries.<sup>48</sup> Throughout his works, Cox reminds us that although the scholarship on missions has until recently portrayed the missionaries as male and the field as masculine, women have always played an important role in the enterprise, both as unpaid and typically unrecognized wives and as official, professional single women.<sup>49</sup>

At the beginning of the nineteenth century, "missionary" work primarily focused on preaching and direct conversion. It was therefore "men's" work since only men were ordained and authorized to do the public work of preaching and baptism. Missionary wives were useful to

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<sup>46</sup> Seton, *Western Daughters*, xxi.

<sup>47</sup> Etherington, "Introduction," 8.

<sup>48</sup> See the collection of essays in Margaret Strobel and Nupur Chaudhuri, eds., *Western Women and Imperialism* (Bloomington: Indiana University Press, 1992) for an early overview of the "new" field of women's agency and experiences within imperialism. Mary Procida's *Married to the Empire: Gender, Politics and Imperialism in India, 1883-1947* (Manchester: University of Manchester Press, 2002) argues that British women were central actors in the imperial enterprise.

<sup>49</sup> See Patricia Grimshaw, *Paths of Duty: American Missionary Wives in Nineteenth-Century Hawaii* (Honolulu: University of Hawaii Press, 1989) for an early and in depth study of women's roles in the missionary field as wives. Catherine Hall's study of the British Baptists' strategies and experiences in Jamaica in *Civilising Subjects* provides a comparative British study of missionary wives. In *The Gospel of Gentility*, Jane Hunter's comprehensive study of American missionaries in turn-of-the-twentieth century China analyzes both married and single women's experiences.

the missionary project in their roles as “passive exemplars of Christian domestic life.”<sup>50</sup> Critical of Indian domestic life and gender relations, missionaries held up the Victorian ideal of middle-class domesticity as appropriate for all Christian and “civilized” cultures. European women were crucial for the spread of these ideals, as they modeled Christian womanhood, motherhood, and the Christian home and family.<sup>51</sup> Most missionary wives accepted this ideal, for, like many other European women and men, they believed their western and Christian culture privileged or “elevated” the female sex while eastern and non-Christian cultures “degraded” women and girls. Historians have shown how missionary wives actively—rather than passively—attempted to influence the non-Christian and non-European women they encountered, both by encouraging interest in Christianity and by modeling western, middle-class values and gender roles.

But women had sought to be more than wives and “passive” examples since the dawn of the foreign missionary movement: the London Missionary Society (LMS) received—and rejected—its first application from a single woman in 1799. By the 1830s, increasing numbers of single and widowed women seeking to serve as missionaries in their own right pushed for access to the mission field; their desire to engage in meaningful work overseas was part of the broader middle-class women’s interest in charity and philanthropic efforts at home.<sup>52</sup> The male-dominated missionary societies gradually broadened their focus on male preaching to include outreach to non-Christian women; in India, the separation of the sexes meant that European women were necessary to “reach” Indian women. Interest in serving overseas only grew as

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<sup>50</sup> Rosemary Fitzgerald, “A ‘Peculiar and Exceptional Measure’: the Call for Women Medical Missionaries for India in the Later Nineteenth Century,” in *Missionary Encounters: Sources and Issues*, ed. Robert A. Bickers and Rosemary Seton (Richmond, UK: Curzon Press, 1996), 177.

<sup>51</sup> Cox, *The British Missionary Enterprise*. Although not a book about women missionaries, Cox intentionally stresses women’s importance in the “enterprise,” including the contributions—rendered “invisible” by missionary leaders until the advent of the single professional women missionaries.

<sup>52</sup> See Frank Prochaska, *Women and Philanthropy in Nineteenth-Century England* (Oxford: Clarendon Press, 1980) for a study of women’s organizations and involvement in charity.

opportunities for women to pursue education and professional lives as teachers, doctors, and nurses began to open up in late Victorian Britain.<sup>53</sup> As imperialism increasingly focused on the “civilizing mission,” missionary women were able to carve out their own niches as providers of education, medical care, and other social services for non-Christian women and girls. The work wives had done as a “labour of love” became professionalized with the advent of the single woman missionary.<sup>54</sup> By around 1880, women outnumbered men in the missionary work in India and many of the missionary fields.<sup>55</sup>

As historians have wrestled with why single women would enthusiastically pursue missionary work, many have explained the phenomenon as a matter of “imperialism as opportunity” for these women. In Geraldine Forbes’ 1986 article about the early British women missionaries, one of her main premises is that the single, professional missionary woman was a “surplus” woman in need of something to do, and India beckoned as exciting, exotic, and acceptable.<sup>56</sup> Missionary service appealed to women because it was respectable and provided a socially-condoned way for “ladies” to independently live abroad. Other scholars have approached these missionaries as “New Women” in search of meaningful outlets to apply their

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<sup>53</sup> See Martha Vicinus, *Independent Women: Work and Community for Single Women, 1850-1920* (Chicago: University of Chicago Press, 1985) for an in-depth study of the development of Victorian women’s professional opportunities. Vicinus’s lens is “community” which doesn’t include the foreign missionary movement, but does examine women’s involvement in Anglican communities in Britain, which contributes to our understanding of why the women’s missionary movement was so popular with these generations of British women.

<sup>54</sup> Jane Haggis, “‘Good Wives and Mothers’ or ‘Dedicated Workers’?: Contradictions of Domesticity in ‘The Mission of Sisterhood,’ Travancore, South India,” in *Maternities and Modernities: Colonial and Postcolonial Experiences in Asia and the Pacific*, ed. Kalpana Ram and Margaret Jolly, 81-113 (Cambridge: Cambridge University Press, 1998). Jeffrey Cox makes the point that when missionary leaders noted the great growth of women missionaries in the last twenty years of the nineteenth century, they were in fact ignoring all of the missionary wives who had always worked to support the missionary goals. He states that the failure of most historians and missiologists to acknowledge and understand the contributions of the missionary wives is one of the greatest oversights in the study of missionaries. See Cox, *The British Missionary Enterprise Since 1700*.

<sup>55</sup> Historians offer various data for this, showing some of the challenges with our understanding of missionary movement. For example, in *The Gospel of Gentility*, Jane Hunter notes that by 1890, women comprised about 60% of the American missionaries in China, while others give the date as closer to 1880.

<sup>56</sup> Geraldine H. Forbes, “In Search of the Pure Heather: Missionary Women in Nineteenth Century India,” *Economic and Political Weekly* XXI, 4 (April 26, 1986).

education, their desire to engage in paid work, and their goal of helping others, all while remaining respectably middle class and feminine. These women were attracted to serving overseas as a way to make positive contributions to others and to the wider world.<sup>57</sup>

The Orientalist notion that in India, women were secluded or at least restricted from contact with men, made missionary women's work possible. The ideal of "the zenana," or women's quarters, gave women's work its name and purpose, for early single women were commonly called "zenana missionaries," and women missionaries engaged in "zenana visits" or work. The Church of England Zenana Missionary Society (CEZMS) and the Zenana Bible and Medical Mission (ZBMM) had no need to include the word "women" in their titles since everyone understood that a "zenana" missionary was a woman working with other women. The belief that Indian women were oppressed and kept in ignorance and subjugation by the zenana, and therefore unable to see doctors, attend school, or even engage with the world, justified missionary women's work to "help" or "save" Indian women. The fact that the majority of Indian women did not observe seclusion was ignored by missionaries and many other Europeans interested in women's issues and reform in India.<sup>58</sup> As Cox notes, most of the women's work with women did not actually take place in the zenana, but the concept of female seclusion remained potent in the European imagination and effective for recruiting support.<sup>59</sup>

Dana L. Robert states that "'Woman's Work for Woman' was the first significant gender-linked mission theory." It was based on the western middle-class women's belief that it was their duty to help "liberate" their "sisters" in non-western and non-Christian cultures by entering into the homes, providing education and medical care. Missionary women also believed that

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<sup>57</sup> Ruth Compton Brouwer, *New Women for God*.

<sup>58</sup> Geraldine Forbes, "Medical Careers and Health Care for Indian Women: Patterns of Control," *Women's History Review* 3 (4) (1994): 515-530.

<sup>59</sup> Cox, *Imperial Fault Lines*.

“conversion to Christianity would not only provide eternal salvation for women everywhere, but it would help raise their self-worth and improve their social positions in oppressive, patriarchal societies.”<sup>60</sup> As Ruth Compton Brouwer explains, “woman’s work for woman” became an effective justification and description of the women’s missionary activities in India and other Asian lands.<sup>61</sup> The phrase was popular, appearing in the titles of several missionary magazines and other publications, and routinely used as an umbrella for the work of single missionary women. As Robert notes, this separatism worked well for both missionary women and for the “gender separate” societies in Asia.<sup>62</sup>

Historians have analyzed many aspects of this “woman’s work for woman.” Some have argued that the opportunities for missionary women must also be seen as highly restricted.<sup>63</sup> These historians have cautioned that while the mission field allowed women to engage in activities more broadly than at home, women never moved into policy-making roles and high-level leadership in the missionary enterprise.<sup>64</sup> And, even with the development of professional

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<sup>60</sup> Dana L. Robert, “Introduction—Historical Themes and Currents,” in *Gospel Bearers, Gender Barriers: Missionary Women in the Twentieth Century*, ed. Dana L. Robert, 1-28 (Maryknoll, NY: Orbis Books, 2002).

<sup>61</sup> Ruth Compton Brouwer, “Canadian Presbyterians and India Missions, 1877-1914: The Policy and Politics of ‘Women’s Work for Women,’” in *North American Foreign Missions, 1810-1914: Theology, Theory and Policy*, ed. Wilbert R. Schenk, 192-217 (Grand Rapids, MI: William B. Eerdmans Publishing Company, 2004).

<sup>62</sup> Robert, *Gospel Bearers*, 8.

<sup>63</sup> Rhonda Semple, who studies several missionary organizations working in colonial India between 1865 and 1910, explains that women missionaries were ultimately constrained by the middle-class values and gendered roles that had allowed women to carve their own space within mission work. Within missionary societies, Semple explains, women—even those with professional training and credentials—were still women doing “women’s work” and this work was always considered less important than the other facets of mission work within the missionary organizations. She also explains that women’s professionalism put them in ironic positions within their societies. Male missionaries wanted single women with professional training and credentials to join the work, but they were afraid that these women would threaten the dominance of the all-male ordained clergy. Rhonda Ann Semple, *Missionary Women: Gender, Professionalism and the Victorian Idea of Christian Mission*. (Rochester, NY: Broydell, 2003). Judith Rowbotham makes similar observations of the British missionary societies. Rowbotham, “Ministering Angels, not Ministers: Women’s Involvement in the Foreign Missionary Movement, c. 1860-1910,” in *Women, Religion and Feminism in Britain, 1750-1900*, ed. Sue Morgan, 179-195 (London: Palgrave, 2002).

<sup>64</sup> Brouwer’s chapter entitled “Gender Politics in a Mission,” in *New Women for God*, illustrates how women had to struggle—fiercely—for years to have the right to exercise authority over their own work in the field or to serve as members of the Mission Council. Susan Thorne reminds us that in neither the nineteenth nor twentieth centuries did women ever have any real control or equality in the processes of formulating mission policy. Susan Thorne, “Missionary-Imperial Feminism,” 45. See also James C. Greenlee and Charles M. Johnston, eds., *Good Citizens:*

missionary women, “women’s work” was considered less important than other facets of work carried out in the broader missionary community.<sup>65</sup> Finally, as Susan Thorne notes, the missionary discourse, which focused on women’s privileged position in western nations, projected the issues of women’s oppression away from home cultures and outward, to the empire.<sup>66</sup>

While missionary women claimed to want to improve the status of women in Asia and Africa, few women’s historians have accepted this premise. This is rejected on both theoretical and practical bases. Much of the analysis of women’s work in Asia has focused on education, for this was the foundation of women’s outreach, and women missionaries established a wide variety of educational institutions for girls and young women across India.<sup>67</sup> Most historians argue that, in reality, even something as seemingly positive and empowering as providing education to Indian girls was not truly liberating, for the education provided by the missionaries reflected conventional western beliefs about women’s proper position in society as submissive and domestic figures. Women missionaries thought they were bringing dramatic and liberating ideas about women’s role in the family and society to places like India, yet their focus on domesticity and wifely submission to husbands meant that they failed to introduce any new ideas—Indian women were already supposed to be domestic and submissive.<sup>68</sup> This does not

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*British Missionaries and Imperial States, 1870-1918* (Ithica: McGill-Queen’s University Press, 1999). Greenlee and Johnston note in their introduction that they devote very little attention to women missionaries because they did not have much influence on decision-making at the middle and certainly not at the higher levels of missionary organizations’ administration.

<sup>65</sup> Rhonda Ann Semple, *Missionary Women: Gender, Professionalism and the Victorian Idea of Christian Mission*.

<sup>66</sup> Thorne, “Missionary-Imperial Feminism,” 45.

<sup>67</sup> Many of these have long outlasted the age of colonialism. For example, Kinnaird College for Women, located in Lahore, was the pride of the ZBMM, and named for Lady Kinnaird. Often called one of Pakistan’s most prestigious universities, it offers bachelor’s and graduate degrees. It is now a secular institution in Pakistan, and its website makes no reference to its missionary background or even the woman for whom it was named. The Kinnaird Girls High School, dating back to the 1860s, is also still in operation as a government institution.

<sup>68</sup> Leslie Flemming, “New Models, New Roles: U.S. Presbyterian Women Missionaries and Social Change in North India, 1870-1910.”

surprise most academics who label missionary women as “conservative.” However, some historians have stressed that missionary women contributed, perhaps unwittingly, to the development of Indian and other Asian feminists and nationalists by establishing boarding schools and opportunities for more advanced education for girls and young women.<sup>69</sup>

Feminist historians have also critiqued the simplistic view that women missionaries liberated their “Indian sisters” or ever established any type of sisterhood. Like “woman’s work for woman,” the phrase “Indian sisters” was routinely used in missionary literature, including magazine titles. As Christians, missionaries were committed to the ideal of sisterhood, as they preached that all were equal before God. As human beings living and working in unequal colonial societies, such ideals were hard to achieve. Much of the scholarship argues that even with the best of intentions, European women missionaries were unable to truly overcome differences of race and culture and see the women they claimed as “sisters” as equals. Instead, some historians have insisted that women missionaries’ entire existence was based on the subordination of their “heathen sisters.”<sup>70</sup> Jane Haggis argues that the middle-class missionary “ladies” in India based their professional freedoms on the low-paid and often unrecognized work of the indigenous Biblewomen—and she stresses that these hard-working, low-paid Indian evangelists could never be “ladies” in the European missionaries’ eyes.<sup>71</sup> European missionary

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<sup>69</sup> Jane Hunter makes this point about Chinese women and the nationalist movement in *The Gospel of Gentility*. Kumari Jayawardena, *The White Woman’s Other Burden*, sees these indirect contributions to Indian women’s feminist consciousness as one of the legacies of women missionaries in South Asia.

<sup>70</sup> Susan Thorne, “Missionary-Imperial Feminism.” Jane Hunter found that women missionaries enjoyed a sense of power and authority—rather than equality—in their relationships with the Chinese. Connie Shemo details the many ways indigenous Christian women, including those who became professionals and missionaries—were treated differently than the European missionaries. Shemo provides examples such as Chinese missionary women doctors living in smaller and inferior housing, for example. Connie A. Shemo, *The Chinese Medical Ministries of Kang Cheng and Shi Meiyu, 1872-1937* (Bethlehem: Lehigh University Press, 2011).

<sup>71</sup> Jane Haggis, “White Women and Colonialism: Towards a Non-Recuperative History,” in *Feminist Post-Colonial Theory: A Reader*, ed. Reina Lewis and Sara Mills Cox, 161-189 (Edinburgh: Edinburgh University Press, 2003). Cox also states that much of the missionaries’ work would not have been possible without the Biblewomen, but his point is that the missionary enterprise was always collaborative, made up of Europeans and indigenous Christians. Cox, *Missionary Enterprise*, 201.

women saw Indian women, including those who worked with the missions, as in need of ongoing guidance, rather than sisterhood. Thus, historians criticize missionaries for assuming the right to speak for Indian and other indigenous women, claiming to know, understand, and represent these women's needs and interests. Finally, historians point out that while the missionaries claimed to want to turn over leadership and administrative control of missionary work to the indigenous Christians, they believed that the Indians were never quite ready for such responsibility.

In *The Communion of Women: Missions and Gender in Colonial Africa and the Metropole*, Elizabeth Prevost challenges the widely accepted view that European missionary women's experiences were based on the subjugation of the women they were trying to convert. This book, published in 2010, is not exculpatory, but draws on local studies, exploits different sources, and engages with new questions. Rather than seeing missionary endeavors as simple cases of missionaries' attempts to control, reform, and change the peoples with whom they worked, Prevost recognizes the dependence of missionaries on the cooperation of indigenous Christians and others. She also acknowledges the ways local cultures adapted the missionary messages.<sup>72</sup> Prevost looks at the missionary women's encounter in the feminine peripheries of colonialism, where British and African women collaborated to create a feminized Christianity, through working relationships characterized by mutual negotiation.

In his analysis of women's interest in the missionary movement in the late nineteenth and early twentieth centuries, Cox introduces Irene Petrie, a missionary to India, who, after her untimely death from typhoid in 1897, was memorialized through a widely-read biography written by her sister. Cox notes that "[Irene's] motives are reasonably transparent. She wanted to make the world a better place by building up Christian institutions in non-Christian parts of

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<sup>72</sup> Andrew Porter, *Religion versus Empire?* 316-317. This is also one of Jeffrey Cox's arguments in *Imperial Fault Lines*.



the world. How many women like Irene Petrie were there?"<sup>73</sup> Other historians have argued that women were attracted to missionary work because they wanted to “do good” and the missionary enterprise offered them a way to do that, but Cox argues that these women were motivated to commit to doing *Christian* work.

The great age of foreign missions, for both women and men, came to an end by the beginning of the First World War; most academic studies of women missionaries also conclude around 1914.<sup>74</sup> Scholars have explained the rapid decline in women’s foreign mission work as the result of a combination of factors, including women’s changing roles and opportunities in Britain and other western nations. They argue that women had new options, including forging careers in the field of social work. More significantly, they posit that western women were no longer motivated by the ideal of working with and for other women, for the paradigm of separate spheres now seemed old-fashioned and unnecessary. Other factors, including the war itself, post-war secularism and modernism, and the weakness of the British economy in the interwar period, also contributed to the loss of interest in—and the decline in the ability of individuals to provide financial support for—women’s missionary work.

But women’s missionary work did not abruptly end in the 1910s. My study of twentieth-century women missionaries begins at the point where most studies end, and my main focus is on women’s work in the 1920s, 1930s, and 1940s. The women in my study chose to apply to missionary societies that provided outreach to Indian women, and to do so in an era when such societies and gender-specific work were declining or disappearing. They also chose to practice as healthcare professionals in what most of their colleagues at home would view as difficult or unacceptable circumstances: in understaffed, under-resourced, under-funded, and outdated

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<sup>73</sup> Cox, *The British Missionary Enterprise*, 195.

<sup>74</sup> Scholars choose the following dates for the end of most studies of women missionaries: 1910, 1914, or 1920.

facilities. While historians considering the women's missionary movement up to 1914 tend to explain women's attraction to it as due to lack of choices combined with women's needs to create opportunities within the middle-class, socially-respectable feminine sphere, I argue that twentieth-century women medical missionaries intentionally chose to pursue their work in India because they wanted to make a difference in Indian women's lives, and believed they were called to do so by working through Christian institutions. As doctors and nurses, they could have chosen to help people and change society at home. They could have also worked in India under various "secular" medical services, with either men or women. But they were drawn to work with women, in India, as medical missionaries. Like Prevost's study of Anglican women's work in colonial Africa, my study explores the meaning missionary women found in their often highly collaborative and negotiated interactions with Indian women. Medical work allowed missionary women to see that they were making positive contributions to Indian women's lives.

### *1.1.3 Colonial Medicine, Medical Missionaries, and Women*

Let us now turn to *medical* missionaries. This is a study of women doctors and nurses who became missionaries. In some studies, and even in the missionary societies, the terms "medical missionary" and "medical women" are reserved for the doctors; in this dissertation, it includes nurses and doctors. As will be explained in Chapter Two, the field of women's medical missionary work developed from the general women's missionary work, and became clearly defined in the first years of the twentieth century. Rosemary Fitzgerald explains how medical work moved from the "fringes" to the center of the missionary endeavor. First, medical work "opened doors" for the more important work of evangelism: Indians who might have no interest in missionaries and their message often accepted medical treatment, which missionaries hoped

would lead to opportunities to spread the Gospel. The advances in science and biomedicine, as well as the professionalization of medical training and practice also helped to make the medical work more effective. The missionary shift away from (male) direct preaching to indirect evangelism was also key, for this strategy included education, welfare work, social services, and, especially, medical work, all of which were open to women while, in most cases, preaching was not.<sup>75</sup> Women interested in medical work were especially attracted to India because “[t]he fascination and the elite female inaccessibility of the East gave it overriding weight in ideology and propaganda, as well as female recruitment.”<sup>76</sup>

The bulk of historical work on medical missionaries has focused on Africa, but Megan Vaughan explains that while missionaries were the “main purveyors” of western medicine at the local level in colonial Africa, most of the literature on colonial medicine is “silent” on missionary work and roles.<sup>77</sup> This is true of India, too; David Arnold, for example, devotes little attention to medical missionaries in his studies of medical history in colonial India. In 1993, he stated, “the extent to which missionaries were successful disseminators of Western medical ideas and practices in India remains, for the present, a matter of speculation as it has yet to receive scholarly attention.”<sup>78</sup> Since then, more scholars have begun to consider how medical missionaries fit into the colonial medical apparatus.<sup>79</sup> But in the growing field of colonial medical history, missionaries are usually approached as a completely separate category, meriting

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<sup>75</sup> Fitzgerald, “Rescue and Redemption,” 66.

<sup>76</sup> Deborah Gaitskell, “Women, Health and the Development of Medical Missions: Some South African Reflections” in *Gender, Poverty and Church Involvement* (2005): 57-78.

<sup>77</sup> Biswamoy Pati and Mark Harrison, “Introduction,” in *Health, Medicine and Empire: Perspectives on Colonial India*, eds. (New Delhi: Orient Longman, 2001), 7. They note that missionaries have been a part of “‘colonial medicine’ which has been little explored in India, by contrast to other colonies”; Megan Vaughan, *Curing their Ills: Colonial Power and African Illness* (Stanford: Stanford University Press, 1991), 55.

<sup>78</sup> David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India* (Berkeley: University of California Press, 1993), 244.

<sup>79</sup> A good overview is David Hardiman, ed., *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa* (Rodopi: Amsterdam-New York, 2006). Hardiman’s introduction includes an in-depth review of the historiography.

a chapter or two in a collection of essays.<sup>80</sup> Other studies make little to no mention of the missionaries, focusing primarily on the government or secular philanthropic services.

Scholarship on women's healthcare in colonial India typically concentrates on the efforts tied to the secular Dufferin Fund, which included women's hospitals, and programs to support the training of Indian women healthcare providers.<sup>81</sup>

As Shula Marks notes, the discussion of colonial medicine in the early twentieth century was “celebratory” and can be summed up as “the triumph of science and sewers over savagery and superstition.”<sup>82</sup> Medical missionaries who worked in Asia, Africa, and the Middle East are criticized by scholars for “their notions of cultural superiority,” for “ridicul[ing] the folk remedies invoked by native healers,” and for interpreting indigenous practices as “fatalism.”<sup>83</sup> While missionaries and other European health practitioners sometimes labeled Indian healthcare practices as “pure superstition” or “quackery,” scholars note that the Hindu Ayurvedic and Muslim Unani medical systems were as scientifically “valid” as medicine practiced in western Europe well into the nineteenth century, until advances in physiology and then an understanding of germ theory set these systems further apart.<sup>84</sup> Deepak Kumar argues that in the eighteenth and nineteenth centuries, European and Indian medical systems “were epistemologically not

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<sup>80</sup> See, for example, the collection in Poonam Bala, ed., *Contesting Colonial Authority: Medicine and Indigenous Responses in Nineteenth- and Twentieth-Century India* (Lanham: Lexington Books, 2012); Deepak Kumar and Raj Sekhar Basu, eds., *Medical Encounters in British India* (Oxford: Oxford University Press, 2013); Pati and Harrison, eds., *Health, Medicine and Empire* (2001).

<sup>81</sup> Samiksha Sehrawat, *Colonial Medical Care in Northern India: Gender, State and Society, c. 1840-1930* (New Delhi: Oxford University Press, 2013); Mark Harrison, *Public Health in British India: Anglo-Indian Preventive Medicine, 1859-1914* (Cambridge: Cambridge University Press, 1994).

<sup>82</sup> Shula Marks, “What is Colonial about Colonial Medicine? And What has Happened to Imperialism and Health?,” Presidential Address, *The Society for the Social History of Medicine*, 1997, 205-219.

<sup>83</sup> Adel A. Ziadat, “Western Medicine in Palestine, 1860-1940: The Edinburgh Medical Missionary Society and Its Hospital,” *CBMH/BCHM* 10 (1993), 271.

<sup>84</sup> Poonam Bala, *Imperialism and Medicine in Bengal: A Socio-Historical Perspective* (New Delhi: Sage Publications, 1990), 17.

dissimilar.”<sup>85</sup> One factor that came to set “western” and “indigenous” medical systems apart was the way colonial governments used medicine, especially what became “public health,” as a “tool of empire.”<sup>86</sup>

In the historiography of colonialism and medicine, a main theme has been “the ways in which colonial states sought to promote biomedical forms of treatment.”<sup>87</sup> As David Hardiman explains, many historians have followed Michel Foucault in analyzing medicine in terms of the “exercise of disciplinary control” and often focused on colonial policies for managing epidemics or sexually transmitted diseases.<sup>88</sup> The dominant way of thinking about colonial medicine has been to look at the relationships between medical knowledge and social power. The colonial state’s public health policies were usually focused on epidemics, and, as Michael Worboys has demonstrated, medical experts tried to manage diseases that could spread rapidly, such as yellow fever, cholera, and plague, or diseases deemed “tropical” such as malaria, “without populations” and sometimes with the use of coercion.<sup>89</sup> Western medicine became sure of its “universalizing truth” and showed “little tolerance” for alternatives.<sup>90</sup> Colonial medicine therefore can be seen as something that was forced on colonized lands and peoples.

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<sup>85</sup> Deepak Kumar, “Unequal Contenders, Uneven Ground: Medical Encounters in British India, 1820-1920” in *Western Medicine as Contested Knowledge*, eds. Andrew Cunningham and Bridie Andrews (Manchester: Manchester University Press, 1997), 173. Note that the British encountered two distinct medical systems: the Hindu Ayurvedic and the Muslim Unani or Yunani systems, both of which are still practiced in South Asia and around the world. David Hardiman notes that the Jesuits took their western medical knowledge with them to Beijing in the late sixteenth century, and to Goa, but that “it was by no means apparent that their skills were superior to those of the Chinese or Indian medical practitioners.” See “Introduction” in David Hardiman, ed., *Healing Bodies, Saving Souls*, 10.

<sup>86</sup> Roy Macleod and Milton Lewis, eds., *Disease, Medicine, and Empire: Perspectives on Western Medicine and the Experience of European Expansion* (New York: Routledge, 1988). See especially the introduction.

<sup>87</sup> “Biomedical” or “biomedicine” are other terms scholars use for “western” medicine. See Hardiman, “Introduction,” *Healing Bodies*, 5.

<sup>88</sup> Hardiman, “Introduction,” *Healing Bodies*, 5.

<sup>89</sup> Worboys’ arguments are discussed in Ilana Löwy, “What/Who Should be Controlled? Opposition to Yellow Fever Campaigns in Brazil, 1900-1939,” in *Western Medicine as Contested Knowledge*, ed. Andrew Cunningham and Bridie Andrews (Manchester: Manchester University Press, 1997).

<sup>90</sup> Shula Marks, “What is Colonial about Colonial Medicine?,” 214.

Scholars frequently criticize the colonial government in India for neglecting the masses' health care needs and for failing to take responsibility for developing adequate public health services. These criticisms were also made by contemporaries, both Indians and Europeans, during the colonial era. As Biswamoy Pati and David Harrison note, most historians have accepted the core argument that colonial medical policy privileged the needs of Europeans and the (mostly Indian) military in India.<sup>91</sup> Fitzgerald's reference to the government's "getting on board" reminds us that for most of the era of colonial rule, the British government invested little money or personnel in the field of women's health care.<sup>92</sup> But this was not a simple case of sexism: the British government did not develop much health care for Indian men or children, either. The Indian Medical Service (IMS) had been formed in the eighteenth century to serve the needs of the Indian Army and Indian Civil Service.<sup>93</sup> Much of the money spent on medical and sanitary work through the early twentieth century continued to be devoted to small European enclaves.

Pati and Harrison explain that blaming the British for negligence in health care is overly simplistic, for "[e]ven critics of the government's medical policy note that its limitations were due as much to indigenous indifference or, even, hostility to medical and sanitary intervention, as to any weakness of official commitment."<sup>94</sup> As Roger Jeffery details, the territorial vastness, the enormous population, and the health care challenges of colonial South Asia meant that there were significant administrative, financial, and technical factors that make it "uncertain how much difference would have been made" regardless of what British policy had been.<sup>95</sup> Additionally,

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<sup>91</sup> Pati and Harrison, "Introduction," in *Health, Medicine and Empire*.

<sup>92</sup> David Arnold notes that well into the twentieth century, the government clearly did not see women's health care as its responsibility. See David Arnold, *Colonizing the Body*, 263-267.

<sup>93</sup> Arnold, *Colonizing the Body*, chapter 6. See also Bala, *Imperialism and Medicine in Bengal*, 16-19.

<sup>94</sup> Biswamoy Pati and Mark Harrison, "Introduction" in *Health, Medicine and Empire*, 4.

<sup>95</sup> Roger Jeffery, *The Politics of Health in India* (University of California Press, 1988), 92.

until fairly late in the imperial era, western medicine really was not very effective in treating or controlling most “tropical” diseases, such as plague, malaria, yellow fever, and cholera. And Indian resistance to British medical and sanitary work was at times quite real. David Arnold, the leading historian of colonial medicine in India, shows government efforts at vaccination, inoculation, and other measures to contain or control epidemics were often challenged and even stymied.<sup>96</sup> Thus resistance to western medicine is another main thread in the historiography of colonial medicine.

Michael Jennings, who studies colonial Africa, explains that medical missions have been ignored or misunderstood in the historiography because of the general belief that missions focused solely on “curative” rather than “preventative” medicine.<sup>97</sup> Curative medicine was seen as “reactionary” whereas “preventive” was progressive and linked to the kind of public health policy needed by developing nations. This perception is partially due to the history of medical missionary work, which developed from women—often missionary wives—who “possessed little more than a first aid box, common sense, and experience” bandaging wounds and providing eye drops to people who came in contact with other aspects of mission work.<sup>98</sup> In the nineteenth and even early twentieth centuries, missionaries with varying levels of training—sometimes as little as a couple of short courses taken when home on furlough—served as “medical” missionaries. Eventually, medical missions required professionally qualified doctors and, later, professionally-trained nurses. Nevertheless, the fact that a lone medical missionary might serve as the entire medical staff for many years, and in remote areas with rustic facilities, little money

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<sup>96</sup> David Arnold, “Smallpox and Colonial Medicine in Nineteenth-Century India,” in *Imperial Medicine and Indigenous Societies*, David Arnold, ed. (Manchester: Manchester University Press, 1988).

<sup>97</sup> Michael Jennings, “‘A Matter of Vital Importance’: The Place of the Medical Mission in Maternal Child Healthcare in Tanganyika, 1919-1939,” in *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa*, ed. Hardiman, 227.

<sup>98</sup> Fitzgerald, “Rescue and Redemption,” 72.

for updating equipment, and little time for ongoing medical training, meant that many medical missionaries could fall behind in terms of knowledge and skill sets when compared to their colleagues practicing in western societies or in government or urban hospitals in colonial countries. Or, even if they were up-to-date in their medical credentials, lack of colleagues, medicines, and technology could mean that such doctors and nurses might not be able to provide the same level of care as a better staffed and stocked facility. Moreover, some medical missionaries maintained the view that providing some care—even if very basic—was better than what their patients would get from indigenous practitioners, and therefore “good enough.”

In the early twentieth century, missionary attitudes towards the role of medical missions began to change. By 1930, missionary organizations were engaged in discussions on the main purpose of medical work.<sup>99</sup> Most mainstream societies no longer felt that medical work was to “open doors.” If such interactions led to conversion or even interest in Christianity, that was a wonderful outcome, but increasingly, missionary organizations came to see their role as setting the example of Christian love and service, without pushing for conversion. This was partially due to the ever increasing professionalism of medicine, which included longer and more extensive training.<sup>100</sup> These doctors now saw themselves as medical professionals, and not as evangelists. This was a significant change, for there was no real distinction between medical and other missionaries up to the 1890s.<sup>101</sup>

Missionary propaganda implies that there was no medical care for women in colonial India, but this was not accurate, for western medical care has a long history in India.<sup>102</sup> Medical

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<sup>99</sup> William Ernest Hocking, Chairman, The Commission of Appraisal, *Re-Thinking Missions: A Layman's Inquiry After One Hundred Years* (New York: Harper & Brothers Publishers, 1932).

<sup>100</sup> Hardiman, *Healing Bodies*, 18-20.

<sup>101</sup> *Ibid.*, 15.

<sup>102</sup> Fitzgerald, “Rescue and Redemption,” 64-65. Fitzgerald notes that colonial administration interest in women's health was “slow to emerge and never more than limited.”



colleges teaching western curricula dated to the early nineteenth century, and Indian women gained access to medical education in the 1880s—roughly the same time as women in Britain. These colleges primarily educated Indians to serve in the “subordinate” levels of the IMS, which reserved the top positions for Europeans. There were also Ayurvedic and Unani medical schools, and many Indian practitioners combined western and eastern medical traditions in their practices. Cities, not just European enclaves, had doctors. But it is true that prior to the early twentieth century, few Indian women used male physicians, even if they were available and the family could afford doctors’ fees. As in the west, most nineteenth-century Indians avoided hospitals. By the early twentieth century, the number of Indian men and women with “scientific” or “western” medical training was rising. After 1919, Health Administration moved from British to Indian control, a development which affected missionary medical work as it now fell under regulation by Indian municipalities and states. Prior to the 1920s, government-funded hospitals, clinics, and dispensaries had begun to spread across the subcontinent and deliver services specifically for women. Missionary medical women had to acknowledge that they were not the only or even the best care providers in many areas.

Medical missionary women served women patients’ general health care needs, but took a special interest in gynecology and obstetrics. As Rosemary Fitzgerald explains, “Indian midwifery evoked the strongest expression of western condemnation of indigenous care.”<sup>103</sup> Depictions of Indian women’s horrific suffering during childbirth, in Indian homes, attended by *dais*, or traditional Indian midwives, were routinely used in medical missionary publications to help gain support for their work, including the recruitment of new doctors and nurses. Missionaries, as well as other medical personnel, blamed “traditional” midwifery for India’s high

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<sup>103</sup> Fitzgerald, “A ‘Peculiar and Exceptional Measure,’” 184.

rates of infant and maternal mortality. Medical missionaries are criticized by historians for pushing Indian women to abandon their *dais* and move to hospitals for births, but missionaries were not alone in these efforts, some of which began as early as the 1860s. Although the British government had little interest in providing infant and maternal healthcare in colonial India, as Judith Richell notes, the infant mortality rate became an accepted measure of the health and prosperity of nations.<sup>104</sup> One of the major causes of infant mortality in colonial South Asia was tetanus, which as early as 1894 was linked by British medical staff in Burma to cutting the umbilical cord “with a dirty piece of bamboo.”<sup>105</sup> Such practices were used by missionaries and the government as evidence of Indian “ignorance” and proof of the need for continued colonial rule.

Ruth Compton Brouwer and David Hardiman have both made significant contributions to the study of medical missionary work in the last years of colonialism, for they have produced two studies that move from the “great age” of missions through the end of colonization and beyond.<sup>106</sup> In *Modern Women Modernizing Men: The Changing Missions of Three Women in Asia and Africa*, Brouwer argues that the decline of “separate spheres” and the rise of professionalism for medical missionaries helped to solidify the transition to the “social gospel” of missionaries living out their faith through their professional work. In his critique of Brouwer’s thesis explaining the reasons for medicine’s rise to the position of dominance in missionary work, Hardiman argues that medicine came to be seen as the final “holdout” for

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<sup>104</sup> Judith Richell, “Ephemeral Lives: the Unremitting Infant Mortality of Colonial Burma, 1891-1941” in *Women and Children First: International Maternal and Child Welfare, 1870-1945*, ed. Valerie Fildes, Lara Marks, and Hilary Marland (New York: Routledge, 1992), 135.

<sup>105</sup> *Ibid.*, 142.

<sup>106</sup> Ruth Compton Brouwer, *Modern Women Modernizing Men: The Changing Missions of Three Women in Asia and Africa, 1902-1969* (Vancouver: University of British Columbia Press, 2002). In this work, Brouwer analyzes the careers of three missionary women, one of whom was an influential missionary doctor in India. David Hardiman’s *Missionaries and Their Medicine* is a comprehensive study of medical missionary work in one region, spanning a century, and is unusual because it includes Indian voices and perspectives.

European missionary dominance in the mission field. As education, social services, and even evangelism moved increasingly into the hands and leadership of indigenous Christians, and as the nationalist movements' triumph became inevitable, medicine in developing countries would continue to lag behind the West. Medical work thus offered missionaries a way to remain in positions of authority as practitioners and as trainers for the still "backward" Indians even after independence.<sup>107</sup>

In *Missionaries and Their Medicine: A Christian Modernity for Tribal India*, Hardiman focuses on an ethnic group—the Bhils—who converted en masse early in the twentieth century. He tells the story of missionaries and their medical work as an instance of the Christianizing "civilizing" process. Hardiman's book is highly complex, but one of the main lines of analysis is the Bhils' evolving relationship with the generations of medical missionaries, and the medical missionaries' evolving relationships with the Bhils, as the two groups negotiated the meaning of medicine and the roles of the medical providers in this Indian Christian community. Hardiman explores the power of religious belief in both groups and its effect on the practice and acceptance of medicine. He also explains how the missionaries eventually lost credibility with the Bhils, even though the missionaries went to great lengths to provide the people with a modern hospital, complete with state-of-the-art technology and a highly-credentialed staff. The Bhils, however, had their own ideas about the need for "modern" biomedicine. Hardiman demonstrates that, although their efforts were to an "extent a form of colonial practice," medical missionaries lacked coercive power over people, often actively distanced themselves from colonial officials, and had to work hard to successfully negotiate local politics. He also illustrates the way

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<sup>107</sup> See Hardiman, *Missionaries and Their Medicine*, especially pages 190-193.

missionaries consciously embedded themselves in local communities, where they “reached out to embrace all classes of the ‘native society.’”<sup>108</sup>

Finally, Hardiman addresses “woman’s work for woman” in the decades after such women’s work had officially lost its appeal. His is a study of the Church Missionary Society, which employed women missionaries, but was not specifically a “women’s” missionary society. But he convincingly shows that medical missionary women worked to “inculcate a sense of self-worth” in their women patients, to raise these women’s position in their own communities, and to improve their health and therefore also the quality of women’s lives. Hardiman states that European missionary women “did not in general regard” Indian women as their equals, but this does not devalue their efforts to “help” Indian women.<sup>109</sup> It was the belief that Indian women were denied health care specifically because they were women—and therefore unworthy of good health—that motivated missionary women to provide women’s medical services. Moreover, Hardiman, Cox, Seton, and Fitzgerald all argue that through their work in nurses’ and midwives’ training programs and women’s medical education, missionary women made important contributions to empowering Indian women as leaders and professionals.<sup>110</sup>

Although interest in the history of women’s healthcare within the field of colonial medicine is growing, the experiences and contributions of women medical missionaries still await discovery. Rosemary Fitzgerald is the pioneering scholar working in this field. She has published several chapters on British women medical missionaries, but her focus is on the nineteenth and early twentieth centuries, and more on the establishment, professionalization, and

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<sup>108</sup> Ibid., 235-237.

<sup>109</sup> Ibid., 238.

<sup>110</sup> See especially Rosemary Fitzgerald, “‘Clinical Christianity’: The Emergence of Medical Work as Strategy in Colonial India, 1800-1914,” in *Health, Medicine and Empire: Perspectives on Colonial India*, ed. Pati and Harrison.

general development of women's medical work within the missionary movement.<sup>111</sup> Rosemary Seton includes one chapter on medical work in *Western Daughters in Eastern Lands*, but it is a broad overview of women's work in China and India. My study builds on these and other works on colonial medicine and missions by focusing on the later imperial years, and analyzing the ways women medical missionaries attempted to adapt their work to the changing social and political environments. While Fitzgerald has highlighted women medical missionaries' contributions to the development of institutions in colonial India, I look more closely at the process of integrating women's missionary work into the "government" healthcare system, the changing perceptions of how to prioritize Indian women's healthcare needs, and how to balance pressures to move toward preventive medicine. Questions related to women missionaries' power to impose western but feminine concepts of healthcare and medicine run throughout this study.

## 1.2 Sources and Methods

This dissertation is heavily based on the records of three women's missionary organizations: the Church of England Zenana Missionary Society (CEZMS), the "Women's Work" (WW) collection of the Wesleyan Methodist Missionary Society (WMMS), and the Zenana Bible and Medical Mission (ZBMM). These organizations were typical of "women's missions" and shared much in common: all were established in the nineteenth century; all initially focused on teacher-training, zenana visiting, and education for girls and women; all

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<sup>111</sup> Rosemary Fitzgerald, "A 'Peculiar and Exceptional Measure,'" (1996); "Rescue and Redemption: The Rise of the Female Medical Missions in Colonial India During the Late Nineteenth and Early Twentieth Centuries," 1997; "From Medicine Chest to Mission Hospitals: The Early History of Delhi Medical Mission for Women and Children, in *Three Centuries of Mission: The United Society for the Propagation of the Gospel, 1701-2000*, ed. Daniel O'Connor, 343-357 (London: Continuum, 2000); "Clinical Christianity": The Emergence of Medical Work as a Missionary Strategy in Colonial India," in *Health, Medicine and Empire*, (2001); "Making and Moulding the Nursing of the Indian Empire,' Recasting Nurses in Colonial India," in *Rhetoric and Reality: Gender and the Colonial Experience in South Asia*, ed. Avril A. Powell and Siobhan Lambert-Hurley, 185-222 (New Delhi: Oxford University Press, 2006).

added medical work for women in the 1880s. The medical work included dispensaries, medical stations, and a few hospitals, as well as training programs for Indian nurses and midwives.

The ZBMM was established in 1852 as the Indian Female Normal School Society (IFNS) with the goal of training Indian Christian women as teachers. Educational work expanded to include industrial work and institutions for the blind, as well as some services just for orphans. In 1881, the IFNS changed its name to the Zenana Bible and Medical Mission to better reflect its current and future work, which had expanded to include medical as well as educational outreach to Indian women and girls. One of its founding members was Mary Jane, Lady Kinnaird, a devout Presbyterian and philanthropist who is better remembered for founding the YWCA. Part of Kinnaird's vision was for this society to be interdenominational, and while the ZBMM was always heavily Anglican in both leadership and membership, it attracted support and missionary recruits from many of the nonconformist denominations in Britain, even after these groups had established their own missionary societies for women, such as the Baptist Zenana Mission. In addition to remaining true to its interdenominational values, the ZBMM was unusual in that it only sent missionaries to India.

The CEZMS was established in 1880, when ongoing tensions between some of the Anglican factions in the ZBMM reached a boiling point, and what became the CEZMS split off, taking much of the ZBMM's finances, membership, and stations in India with it. The CEZMS soon became Britain's largest and best-funded women's missionary society. Like the Church Missionary Society (CMS), Britain's largest "and most successful missionary society," the CEZMS was Anglican, evangelical rather than high church, and maintained close cooperation with the CMS until the two organizations amalgamated in 1957.<sup>112</sup> The CMS began to accept

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<sup>112</sup> Seton, *Western Daughters*, 98.

and send out women missionaries in 1887, providing evangelical Anglican women who wanted to work for an Anglican organization with a choice of societies.<sup>113</sup> The CEZMS, like the ZBMM, focused on zenana visiting, female education, and women's medical work, but also supported significant village work. Unlike the ZBMM, the CEZMS also operated in China, Japan, Ceylon (Sri Lanka), and Singapore.

The women's work carried out by the WMMS underwent several name changes and administrative organizations. What began as the Ladies' Committee in 1858 became the Ladies' Auxiliary for Female Education in 1877 and the Women's Auxiliary in 1900; by that time its medical work was developing. In 1932, the WMMS united with the Primitive Methodist Church and the United Methodist Church to form the Methodist Church of Great Britain, and the women's work of all three came together as a department, the Women's Work of the Methodist Missionary Society (WW). In this study, "WW" will be used throughout. The WW sent missionaries to India, Ceylon, China, Honduras, Italy, and Africa. In addition to education and medicine, the WW engaged in village and mass movement work, women's rescue work, and ran special missions to people suffering from leprosy.<sup>114</sup>

As Jeffrey Cox explains, these missionary societies were institution builders; collecting data and making reports was key to documenting the work. As this dissertation is not an institutional study of any of these three organizations, different types of sources from each have been consulted. I have used several sets of Minutes, which are a rich resource, but require much

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<sup>113</sup> The Society for the Propagation of the Gospel (SPG) was Anglican but high church, and, according to Seton, did not become very serious about developing its women's work until the turn of the twentieth century. Anglican women served in many of the dozens of missionary societies operating in the late nineteenth and early twentieth centuries.

<sup>114</sup> Some of these missions, such as the mass movement and leprosy services, were not restricted to women, but grew from the work of former WW missionaries. The Methodist women missionaries were part of the broader Methodist missions, which also sent out single women missionaries who worked with male missionaries and at stations that served both men and women.

patience and the approach of a sleuth. The ZBMM committee met biweekly for approximately ten months of the year, generating twenty-plus pages of dense, handwritten notes for each meeting. The Minutes include information on society's business and finance, the activities of the dozens of local auxiliaries across Britain, as well as those in Australia, New Zealand, and Canada; very brief updates on plans and pressing issues in the various stations in India; staffing arrangements of stations; travel arrangements for missionaries; fund-raising; publications; and personnel matters. More of the information is about the educational work than the medical work. At first, a reading of the Minutes seems quite mundane and repetitive, and the meetings easily run together. A close reading, and reading the Minutes in chronological order for many years, has allowed me to tease out themes, facts, and details to better understand the goals, challenges, and nature of the medical work, primarily from the committee members' perspectives. The Minutes also contain deliberations on individual missionaries' requests, goals, and personal problems—such as those related to health, family responsibilities, progress in training, or even religious convictions. The WW Minutes, much briefer, have similar applications. For the CEZMS, I used the Medical Committee Minutes which allow the piecing together of the establishment and development of a society's professional medical work for women, which includes ironing out policies and procedures. The CEZMS Candidates Committee Minutes record the ongoing monitoring of the medical candidates from time of application to departure as probationary missionaries, a period which could span years, and included the trials and tribulations of the doctors' and nurses' education and training.

Medical missionaries collected data and created regular reports on their medical work. One purpose of these annual statistics was to show that missionary services were valued by Indians, but they also can reflect changes over time in medical services, treatments, and advances



in local patronage. The published ZBMM Annual Reports include annual statistics, highlights of the medical work from each station, and snippets from individual workers, as well as editorials and overviews by the society's leadership. I have also read the WW reports of the medical work, in their original, unedited, and unpublished form. These include much more detail than the published reports, including types of medical procedures performed, the annual efforts to fight plague or the most recent encounters with village outbreaks of cholera, and the often seemingly futile attempts to cure a "leper" or tubercular family.<sup>115</sup> These yearly assessments of very local progress and purpose, setbacks and triumphs, needs and wants, contribute to the understanding these women's commitment to their work as individuals and as part of a larger effort.

The CEZMS "Blue Packets" are an invaluable source for this study. Each packet contains the application materials, correspondence, interviews, references, and training reports for prospective missionaries. Individual packets include documents ranging from a few to over 100 pages; some files span a decade or longer. The letters between the prospective missionaries and the secretary provide much insight into the motives, goals, and dreams of women who had aspirations for medical work, as well as their personal conceptualization of what was required of missionaries. The correspondence from the committee members, referees and others helping to assess applicants' suitability for service reflect the values and priorities of the societies. These records also shed light on the training and educational experiences of nurses and women doctors in Britain from the early- to the mid-twentieth century.

The WW collection includes the correspondence between the missionaries and their society's secretary. These letters, which span from the time the medical women were preparing

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<sup>115</sup> The missionaries, especially the Methodists, did valuable work to treat patients living with leprosy—the term used then, or Hanson's Disease, to use today's name. Such work was difficult, frustrating, and took a special type of medical worker.

to depart for India through their years in the field, provide details of these women's daily life, work, hopes, fears, successes, failures, and perceptions of the medical and missionary professions in India. As Elizabeth Prevost explains in her study of Anglican women, these letters from the missionaries in the field to their society secretaries "offer a far fuller and more intimate picture of women's life and work in the mission field" than the published and edited materials in the missionary journals and official histories.<sup>116</sup> Historians have made little use of these sources. As informal documents, they can be difficult to decipher due to both handwriting and the lack of context, for they report on people, places, and events without providing any type of guide for the researcher, often containing petty complaints, gossip about colleagues, or in-depth information on policies or local issues that lack any grounding for those not intimately involved in the events and concerns of these women. But it is possible to draw on these letters and other archival sources to tell the stories of these individual women and their experiences as medical missionaries in India. As some historians have explained, the missionary propaganda and "heroic" literature paint a picture of missionaries as martyrs, as constantly fighting "heathenism" and "darkness," and of winning the hearts and minds of those whom they encounter. The sources used in this study tell the everyday stories of medical work and interactions with other women, reflecting missionaries' perceptions of what was worth prioritizing, what they could control or influence, and how their efforts fit into their adopted—and often very temporary—communities. I find these stories interesting and inspiring, but they are not the same stories told in the official published missionary memoirs and biographies. Huber and Lutkehaus argue that the real question for scholars is to determine how colonialism

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<sup>116</sup> Prevost, *Communion of Women*, 21-22.

has left its mark on European women—not how European women have affected colonized women.<sup>117</sup> My reading of these sources allows me to explore this process.

Andrew Porter reprimands fellow historians who attempt to tell the story of missionaries without exploring—or even acknowledging—the importance of religious belief in the missionaries’ lives and work.<sup>118</sup> He specifically cites Catherine Hall’s study of the nonconformists which she frames as a study of their social, cultural, and political world, but not their theology, explaining that she is not a theologian.<sup>119</sup> Others, such as Brouwer, do not discount missionary women’s faith, but still stress that the driving force behind their career choices was the opportunity for a fuller and more interesting life, rather than of carrying out religious conviction. Porter argues that “missionaries viewed their world first of all with the eye of faith.”<sup>120</sup> I also am no theologian, and as historians stress that medical missionaries were essentially “excused” from the responsibility of evangelism by the 1910s, I could easily ignore the topic of religious faith.<sup>121</sup> But one of the questions undergirding this dissertation is how these women juggled the at times conflicting roles of professional missionary versus professional medical woman, as well as what these roles meant to these women’s sense of purpose.

Historians like Prevost and Cox use the concept of “encounters” or “contact zones”—the spaces between the colonizer and the colonized where the “encounter known as the missionary enterprise” took place—as ways to interpret and understand the complexities of missionary work.<sup>122</sup> Thinking about encounters and interactions helps historians explore missionary efforts,

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<sup>117</sup> Huber and Lutkehaus, “Introduction,” *Gendered Missions*, 8.

<sup>118</sup> Porter, *Religion versus Empire?*, 10-11.

<sup>119</sup> *Ibid.*

<sup>120</sup> *Ibid.*, 13.

<sup>121</sup> See, for example, Seton’s short section on “The Changing Role of the Medical Missionary, 1920s-1950s,” in *Western Daughters*, 169-170.

<sup>122</sup> Cox explains the uses of Pratt’s concepts, as well as Homi Babha’s “hybridity” in the introduction of *Imperial Fault Lines* and in *The Missionary Enterprise*.

goals, and perceptions at the local and intimate level and to seek to understand the missionary endeavor through individual experiences and relationships. As Cox repeatedly stresses, the missionaries were institution builders, and institutions are based on relationships. This is a study of European women and their own understanding of the meaning of their work as professional medical missionaries in colonial India. It explores medical workers' assessments and comprehension of their patients and communities. I have made no attempt to include Indian voices or perceptions of these missionaries and their medicine. The missionaries routinely recorded their own views on Indian culture and religion, and could be quick to interpret Indian motives, actions and behaviors, beliefs and values. Their records reflect the missionaries' own understandings of their encounters with Indians, but these are all only missionary interpretations, and their accuracy or truth is not important in this dissertation. This is instead a study of the missionaries' expectations and experiences.

To tell the story of the women medical missionaries, my study uses a life-cycle model to range across the women's experience and interrelations with each other and their societies. Asking questions similar to Seton's in her comprehensive overview of all British women missionaries in Asia, my sharper focus on medical women in the twentieth century allows me to explore how women missionaries functioned, strategized, and adapted during decades of imperial decline and Indian decolonization. This study contributes to our understanding of women, missionaries, and medical work in colonial India. First, this dissertation looks only at the twentieth century, c. 1900-1947, with greater emphasis on the years after 1920. As Brouwer has stressed, there is a dearth of historical work on women missionaries in the interwar years; this is also true of scholarship on "secular" women's experiences in colonial India, nearly all of

which is devoted to the Victorian and Edwardian periods.<sup>123</sup> My study includes women born as early as the 1860s and as late as around 1920, with most years of birth ranging between the late 1890s and the start of the First World War; the majority of these women grew up between the 1900s and the 1930s. I am therefore examining the life choices, motivations, values, and goals of women launching their careers after the demise of the “separate spheres” paradigm and the call of “woman’s work for woman.” Unlike most studies of women missionaries, I am not only conscious of changes over time, but also analyzing changes in medical missionary women’s efforts and ideas in the context of the rapidly changing professional, cultural and social milieu of the late colonial period.

### ***1.3 Plan of Dissertation***

This dissertation covers the period from about 1900 to 1947, with more emphasis on the period following the First World War. It is therefore a study of the late colonial period, which differs from most of the scholarship on women missionaries as well as women and colonialism. The chapters do not take a chronological approach in terms of moving from the beginning to the end of the period, but instead analyze different phases of the missionaries’ lives, as well as the missionaries’ perceptions of change, including developments in their professions, in Indian society and culture, and in their communities.

Chapter Two examines the recruitment, selection, training, and preparation of women medical missionaries. In addition to identifying who these women were, in terms of background, education, and experience, it asks what, from the perspective of the committees and others who

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<sup>123</sup> Ruth Compton Brouwer, *Modern Women Modernizing Men: The Changing Missions of Three Women in Asia and Africa, 1902-1969* (Toronto: University of British Columbia Press, 2002), 8.

participated in the process of selecting missionaries, “made” a good medical missionary. The often ongoing tensions between the women who hoped to pursue the goal of missionary work in India and the people who held these women’s fate in their hands runs through the chapter. The chapter explores the effects of the gradual shift from “general” to “medical” missionaries, meaning fully-qualified physicians and nurses, on the selection and training process. The need for missionary societies to recognize, appreciate, and balance the sometimes competing requirements for both professional women missionaries and professional healthcare providers reflects the ways these Victorian organizations adapted to the changing times.

Chapter Three is about the arrival and adjustment process new medical missionaries experienced as they began their work in India. It explains how the physical, emotional, and professional demands of life as a medical missionary were often different from or harsher than the new arrivals anticipated. The concept of choice runs through this chapter, arguing that medical missionary women saw themselves as professionals with options, and that individuals made conscious decisions about how to adapt to their new environment and realities required of the commitment to a missionaries’ “life work.” Although this chapter is primarily about the experiences of the individual missionaries, the expectations of their societies, families, and colleagues, the role of faith, combined with individuals’ expectations for themselves, help to form the context in which these women made decisions about their careers.

Chapter Four is about “the work”—the daily medical work the nurses and doctors engaged in at their hospitals and clinics, in patients’ homes and villages. In addition to providing descriptions of the work, the chapter looks at ways missionaries’ assessed and made meaning in their work. Noting that by the 1920s the appeal of separate spheres had faded, this chapter explains medical women’s ability to argue that their efforts contributed to the improvement of

Indian women's lives and status. It explores the tensions between missionaries' desire to connect with the Indian women they worked with, noting the barriers they faced as foreigners and missionaries, which limited them in significant ways. As Mary Taylor Huber and Nancy Lutkehaus note, missionaries occupied an interesting space, neither accepted by the colonizers, nor completely trusted by the colonized.<sup>124</sup> The need for ongoing negotiation, compromise, accommodation, and endeavors to gain Indian women's confidence and to build relationships is a unifying theme in the chapter. Often overlooked by historians, the role of spirituality in these women's professional lives is also explored.

Chapter Five focuses on the 1930s and 1940s, delving into the new directions the medical missionaries chose to pursue in response to changing and uncertain circumstances. Missionary women's grappling with curative and preventive forms of medicine, as well as how to strategize to possibly hand the work over to Indian women comprises much of the chapter. The main question these women eventually faced was how to remain relevant to their communities and true to their missionary commitments. This is followed by the epilogue and conclusion.

The title of this chapter, "a sense of responsibility to the world" is a quotation from Miss Freethy, the secretary for the Methodist women's work in the mid-1940s. As the end of the war came into view, Freethy fretted over the task of filling the societies' 77 vacancies for foreign missionaries. The long war years had been hard for the missionaries in India as well as for the administrators at home. Women doctors and nurses who might have considered missionary service had instead been drawn to war service; missionaries who had been on furlough at the beginning of the war had been unable to make the journey back to India due to travel restrictions and safety concerns; missionaries in the field who had approached retirement age had put it off,

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<sup>124</sup> Huber and Lutkehaus, "Introduction," in *Gendered Missions*, 11.

knowing that no one could replace them during the war but hoping new missionaries would take their place as normalcy returned. In the 1920s, the societies in this study had seen a post-war resurgence of interest in missionary work, but Freethy stated that she thought it would take at least ten years for the societies to recover from this war as the demand for doctors, nurses, and teachers for post-war work in Britain was already “urgent.” This interest in serving Britain’s needs saddened Freethy, who mused, “I sometimes wonder whether even devoted Christian people have as yet as great a sense of responsibility to the world as they have to their own land.”<sup>125</sup>

When prospective women missionaries approached the societies, they were asked to explain their interest in missionary work, and why, in particular, they thought they should serve overseas as opposed to at home. The responses on the CEZMS applications were short and simple: “I desire to be a Missionary because I feel that is God’s plan for me. I believe He has called me to work overseas because He is making the great need for such workers more and more clear, and the desire to go more and more strong.”<sup>126</sup> In addition to following the call from God, many cited their youth, good health, and freedom from family responsibilities as reasons to be selected to travel and live abroad: “I believe God needs me overseas while I am young and strong, because of the urgent need of people in other lands, while there are many others who can do the work at home who are not able to go abroad.”<sup>127</sup> Even in the 1940s India held a special place in these women’s hearts, for the belief that British women should devote their lives to

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<sup>125</sup> Freethy to Mary Proudlove, 15 May 1944, WW, MMS, Madras Correspondence, 1070, 784.

<sup>126</sup> Gwendoline Parks, CEZMS application, 1942, “Blue Packet,” CEZMS collection. The CEZMS archives are housed in the University of Birmingham’s library, but much of the collection is available on microfilm, contained in the Church Missionary Archives microfilm collection, which is available at Emory University’s Woodruff Library (MICFILM 3309). The Blue Packets contain missionaries’ application materials and documentation. These are in Section I, Parts 4-9, reels 185-193.

<sup>127</sup> Margaret Gray, CEZMS application, 1932, “Blue Packet,” CEZMS collection. Mabel Ward was more succinct: “Far more need in India, than at home where there are many to help.” Mabel Margaret Ward, CEZMS application, 1937, “Blue Packet,” CEZMS collection.



addressing Indian women's needs remained strong. As Esme Waight explained on her application in 1943, "[t]he need and suffering of the women and children in India is surely greater, and therefore a more urgent call than any at home, great as that might be."<sup>128</sup> Two years later, Cecily Gwendoline Jones hoped to go to India "[b]ecause I believe God has called me to be a missionary, and the need of the women of India has weighed upon my heart for the past year, and I am sure that God has called me to take the Gospel message to the women of India."<sup>129</sup> One nursing applicant wrote in 1947 that "[i]n a recent appeal for workers abroad in our church it seemed as though the message was intended especially for me."<sup>130</sup> A trained nurse and midwife, she had a "desire to be of use to women and children" in either China, or India—wherever the need was greatest. The CEZMS sent her to Bengal. Eight years later, she was brutally murdered on a train in East Pakistan, while traveling to join other missionaries for a short holiday break. And a new missionary nurse arrived to take her place.

As will be seen, medical missionary women were carefully selected on the basis of their promise to become suitable workers in the foreign mission field. Those charged with discerning women's potential as missionaries to India never thought that many women were cut out for such work: many women might be devoted Christians, or keen and competent healthcare providers, but few possessed the other qualities necessary to commit to the life and work of a woman medical missionary. This dissertation argues that much of the commitment to the work was tied to a sense of responsibility to one's faith; to one's profession; to the less fortunate, the oppressed,

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<sup>128</sup> Esme Waight, , CEZMS application, 1943, "Blue Packet," CEZMS collection

<sup>129</sup> Cecily Gwendoline Jones, CEZMS application, 1945, "Blue Packet," CEZMS collection.

<sup>130</sup> Ellen Cox, CEZMS application, 1947, "Blue Packet," CEZMS collection. The Cox file includes many newspaper clippings and letters from the field reporting her murder, how her colleagues processed the horrible event, and how the work went on.

the uneducated; and specifically to other women. The following chapters examine medical missionary women's understanding of this responsibility in the context of a changing world.

2      **“A MOST SUITABLE AND USEFUL WORKER: SELECTION AND SHAPING  
WOMEN FOR MEDICAL MISSIONARY WORK**

Dear Miss Smith,

I have been feeling for the last two years that I am being called to go abroad as a missionary. I have heard about the medical work amongst the women of India & I feel that that is where I am to go. I believe the best way is to be linked to a society & knowing something about the CEZMS I would be glad if you would send me the necessary forms for making an application to be accepted as a candidate.

I am yours sincerely,

Margaret Roberts<sup>131</sup>

With this short letter to the Church of England Zenana Missionary Society (CEZMS), Margaret Roberts, aged seventeen, announced her desire to launch a career as medical missionary serving in India. Her plans were to become a doctor, but no one knew whether she possessed the aptitude for medical study or practice. Roberts was still so young that her mother often wrote on her behalf, negotiating meetings with the CEZMS around her daughter's school schedule; at other times, Margaret explained that she needed several days' notice prior to meetings so she could inform her schoolmistress. As some of the people involved in assessing her application noted, Roberts was too young and inexperienced in life and spirituality for anyone to truly judge as to whether she had “a strong sense of vocation to carry the message of

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<sup>131</sup> Margaret (Peggy) Roberts to Miss Smith, 16 October 1930, letter in Margaret Robert's “Blue Packet” (application files), CEZMS collection. The Blue Packets are arranged in alphabetical order on reels 185-193 (Church Missionary Society Archives, Section 1: East Asia Missions, CEZMS archives, Parts 4-9). All CEZMS archives in this chapter will be referred to as “CEZMS collection,” and all are in this microfilm collection.

salvation.”<sup>132</sup> Yet Roberts felt ready to engage in what the missionary society hoped would become a lifelong relationship and commitment.<sup>133</sup> This simple and sincere letter—merely stating the belief that there was a need for medical work with Indian women, and that doing such work was in obedience to God’s will—is representative of the way many medical women began their missionary careers.

In the late nineteenth and early twentieth centuries, “the condition of Indian women” was a popular topic of concern in Britain, the self-governing British settler colonies, and the United States, and a powerful rallying cry to missionary service.<sup>134</sup> Improving the quality of Indian women’s lives while also promoting Christianity appealed to many young women like Roberts, and medical work rapidly developed as one of the main areas of women’s missionary service. Even in the interwar years, when the prospect of Indian independence loomed ever greater, the call to women to do medical work in India remained constant. During these later imperial years, missionary societies acknowledged that India was modernizing and undergoing significant political and social change, but stressed that the need for missionaries with medical skills was as urgent as ever, and would outlast the empire.<sup>135</sup> Because interwar Britain had a surplus of

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<sup>132</sup> Letter from Adelle Weddington, 1930, in Margaret Roberts’ “Blue Packet,” CEZMS collection.

<sup>133</sup> Suzanne Parry, “Women Medical Graduate and Missionary Service,” *Health and History* 2, no. 1 (2000): 27-51. Parry notes that by the 1930s, American missionary societies usually only required a 3-5 year commitment, but the British and Australian societies still expected lifelong work.

<sup>134</sup> The notion that Indian women were “degraded” and in need of “saving” and that Indian culture needed to be “reformed” motivated missionaries and “secular” women and men. See Margaret Strobel, *European Women and the Second British Empire* (Bloomington: Indiana University Press, 1991), especially Chapter Four, “Missionaries, Reformers, and the Status of Indigenous Women” for an overview of various European women’s views on women in Asia and Africa; Antoinette Burton, *Burdens of History: British Feminists, Indian Women, and Imperial Culture, 1865-1915* (Chapel Hill: The University of North Carolina Press, 1994) demonstrates the ways British feminists used the concept of Indian women’s oppression to justify their own empowerment; Kumari Jayawardan, *The White Woman’s Other Burden: Western Women and South Asia During British Rule* (New York: Routledge, 1995); Jane Haggis, “Ironies of Emancipation: Changing Configurations of ‘Women’s Work’ in the ‘Mission of Sisterhood’ to Indian Women,” *Feminist Review* 65 (Summer 2000): 108-126; Rosemary Seton, *Western Daughters in Eastern Lands: British Missionary Women in Asia* (Santa Barbara: Praeger, 2013);

<sup>135</sup> David Hardiman, *Missionaries and Their Medicine: A Christian Modernity for Tribal India* (Manchester: Manchester University Press, 2008); Patricia R. Hill, *The World Their Housefold: The American Women’s Foreign Mission Movement and Cultural Transformation, 1870-1920* (Ann Arbor: University of Michigan Press, 1985).

general practitioners, there were pressures on medical women to go the imperial outposts to forge careers, leaving the British market less crowded and more lucrative for male doctors.<sup>136</sup> The professional medical and nursing journals also continued to feature articles urging women to consider working in India, either for missionary or secular service. It is therefore easy to see why a young woman like Roberts—who approached the CEZMS in 1930—would assume that becoming a medical missionary was as simple as filling out the “necessary forms.”

At the age of seventeen, Roberts’s naivety is understandable. But women with much more life experience indicated little awareness of the often lengthy and complicated process that lay between making an offer and being selected to serve as a medical missionary in India. Women who claimed to know that God had called them for missionary work sometimes had to accept the missionary societies’ verdict that God must have other plans for them, as many applicants were rejected for reasons ranging from age and health to education or personality. Patience was certainly a virtue for women hoping for missionary careers, as many years could pass between the time of making an offer to serve in India and the moment of actually arriving there. Indeed, the drawn out process caused some women to wonder if their faith was being tested. Ivy Canova, who applied around the same time as Roberts, spent several years waiting and wondering whether she would ever become a missionary. Canova, whose references stressed that her plans for becoming a missionary dated from the age of twelve, first approached the CEZMS in the spring of 1932, hoping to become a missionary nurse. The society asked much of her, but nothing unusual. To demonstrate her commitment to “Christian work,” Canova followed the society’s recommendation and volunteered with organizations serving London’s

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<sup>136</sup> Anne Digby, *The Evolution of British General Practice, 1850-1948* (Oxford, Oxford University Press, 1999), 5. The argument in the metropole was that women physicians should leave the jobs at home for men, and find careers in the colonies. This was essentially the same mindset as in late Victorian Britain. The difference is that after the First World War, fewer women physicians took the overseas route.

poor. To prepare for medical work, Canova devoted several years to rigorous nurse's training. The CEZMS also suggested that she engage in directed religious and Bible study, which she did. All of these actions merely made Canova competitive for acceptance as a candidate for missionary training, for the CEZMS still carefully deliberated her case.

At this point, even Canova noted that with the “difficulties and disappointments all the time ... were it not for the increasing and ever present burden of the need of India's women and girls I should no doubt think God has other plans for my life.”<sup>137</sup> In the months leading up to this statement, Canova's health had collapsed—her nursing supervisor described the problem as “a tired heart”—causing her to submit to a month of physician-ordered rest. She consequently failed parts of the nursing State Examinations, which set her back several months while she waited for the next test date. She also struggled to find a post for the required midwifery training, having unsuccessfully applied to more than a dozen positions. A year before, Canova had written that, “[t]he way at the moment is very difficult but as an act of Faith I would offer knowing that if God so wills the difficulties will vanish & the way will be made clear & certain.”<sup>138</sup> Her perseverance paid off: she was finally accepted into and completed training. Perhaps the debate inside the CEZMS on her suitability was misinformed: nearly thirty years later, Canova was still in southern India, nursing in a Christian hospital.

During the last quarter of the nineteenth century, when the women's foreign missionary movement was at its height, missionary societies received applications from more women than they could accept.<sup>139</sup> Societies could be choosy: at the end of 1904, the Zenana Bible and Medical Mission (ZBMM) committee noted that twenty-six offers of service had come in that

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<sup>137</sup> Ivy Canova to Miss Smith, 21 March 1937, in Ivy Canova's “Blue Packet,” CEZMS collection.

<sup>138</sup> Ivy Florence Canova to Miss Smith, 27 October 1936, in Ivy Canova's “Blue Packet,” CEZMS collection.

<sup>139</sup> Seton, *Western Daughters in Eastern Lands*.

year. Five of the applicants had been sent to India, six were in training, and the rest were deemed “unsuitable.” While the ZBMM—a well-established women’s organization specializing in medical and educational work—seemed optimistic at the beginning of the century, other societies found staffing women’s medical work challenging. The Women’s Auxiliary (WW) of the Wesleyan Methodist Missionary Society (WMMS) already worried about the “serious dearth of missionary candidates” for medical posts, and the CEZMS complained of the “small number of Medical Ladies available for the Society’s work in India.”<sup>140</sup> These organizations saw great potential for the expansion of women’s medical work in the missionary field, but were unsure how to actually develop, staff, and pay for it. These worries were largely due to changes in the medical professions that threatened to affect women’s missionary work, and to tensions that developed between the medical and missionary aspects of the work.

By the 1930s, when Roberts and Canova began the application process, the missionary societies understood that the world now offered numerous possibilities to young, single, educated women, and that few felt called to missionary life. The prospects for finding new missionary doctors seemed so bleak that *The Zenana* magazine, the official voice of the ZBMM, asked supporters to pray for an offer from “just one” suitable medical woman. Societies sometimes commented that if the only stipulation to serve was to want to practice medicine or nursing in a foreign land, they could easily fill their hospitals with highly qualified *medical* women. Likewise, if the desire to be a missionary was the only criteria, there were enough applicants—but, as societies often learned the hard way, not all of them had the aptitude to complete medical training.<sup>141</sup> Societies needed women who had the ability to earn medical or nursing credentials

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<sup>140</sup> Minutes, Medical Committee, 22 January 1907, CEZMS collection; Minutes, 8 April 1902, WW, MMS, 1105, 25.

<sup>141</sup> See Patricia Hill, *The World Their Household: The American Woman’s Foreign Mission Movement and Cultural Transformation, 1870-1920* (Ann Arbor: University of Michigan Press, 1985), 125-126, for a discussion of

and who also had the qualities to become good missionaries. This combination was hard to find. Even so, as Canova's case demonstrates, the societies were unwilling to accept just anyone, and hesitant to rush through the preparation process. Missionary societies adhered to strict requirements and expectations for missionary candidates which either eliminated or discouraged many women. Some were accepted on the basis of their character and their potential to excel as missionaries, only to fail to complete the required health-care education and training which became increasingly necessary and demanding for medical missionaries. Societies also had to compete with the growing professional and personal opportunities open to women with medical and nursing qualifications. While many of the nineteenth-century medical missionary women made missionary service their life-long work, by the 1920s, this was less common, and societies had to accept that a doctor might only work in India for a few years.<sup>142</sup> Indeed, while the CEZMS welcomed overtures from girls like Margaret Roberts—and began the long process of shaping her into a missionary doctor—the committee knew that there was a good chance that she would never serve in the mission field. Nevertheless, the missionary societies remained dedicated to rigorous selection and training processes for their medical workers.

While the committee members harbored some skepticism about Margaret Roberts's likelihood of becoming a medical missionary, they saw the potential in her to become a "suitable steady worker." This was praise, for medical missionaries were workers, like the other women missionaries who specialized in education, evangelism, or other types of work. Societies routinely pronounced that their medical women were "missionaries first, doctors (or nurses)

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American women's societies' process of concluding that desire was no longer enough, and that professional qualifications and education would become important factors in the missionary selection process.

<sup>142</sup> Sara W. Tucker "A Mission for Change in China: The Hackett Women's Medical Center of Canton, China, 1900-1930," in *Women's Work for Women: Missionaries and Social Change in Asia*, ed. Leslie A. Flemming, 137-157 (London: Westview Press, 1989).



second,” emphasizing the spiritual aspects of their work over the scientific or medical. The positive adjectives commonly used by societies when considering these future medical workers were “suitable,” “useful,” “valuable,” “steady,” and “sensible,” rather than terms likely to be associated with medical professionals. Drawing from the CEZMS application packets and the Minutes of missionary societies, this chapter will explore what made an applicant for medical missionary work “useful” or “valuable” in the eyes of the society committees.<sup>143</sup> It will also examine the tensions that developed between the societies’ emphasis on *missionary* qualities and training versus the *professional* qualifications valued and required by the medical field.

### ***2.1 From General Missionaries to Medical Workers***

Although many medical missionary women claimed to have set their sights on medical work early in life, and indeed some pursued years of medical training in specifically to become eligible for medical missionary work, when they applied to the CEZMS, WW, or ZBMM, they applied to become missionaries, and to do the work the society asked of them. The CEZMS application let applicants indicate the type of work they were most interested in, but also asked whether they were “willing to go elsewhere or to another department of work if the Committee thought it desirable.”<sup>144</sup> Until the latter part of the nineteenth century, most women missionaries in India were what would come to be called “general” missionaries or workers. The first professional single women missionaries targeted Indian “ladies,” especially those who practiced female seclusion, thus earning the name “zenana missionaries” after the *zenana*, or woman’s

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<sup>143</sup> The CEZMS applications are contained in the “blue packets” which include correspondence between applicants during the application and pre-leaving period; the application form and supplementary questions; letters of recommendation; the reports from the training centers; and sometimes letters from the field. The WW Minutes end in 1932. The ZBMM Minutes included in the microfilmed CEZMS collection end in 1936.

<sup>144</sup> Although Margaret Roberts specifically applied to medical work, she indicated that she would be “willing to go elsewhere or to another department of work if the Committee thought it desirable.” This is one of the question from the CEZMS application, Margaret Roberts’ “Blue Packet,” CEZMS collection.

quarters. These early women missionaries' work primarily consisted of activities that most middle- or upper-class British women could perform: visiting Indian women in their homes, teaching women and children Bible stories and lessons, working on basic reading and some domestic skills such as needlework. The goal of their work was to make contact with Indian women who, by virtue of observing seclusion, were inaccessible to the male missionaries. This work required neither specialized education nor professional credentials, but could be taught to most middle-class British women as part of their missionary training. The focus on visiting women in their homes proved ineffective for conversion, but such exposure led to new avenues for women's missionary endeavors, including education and medical work.

In the first decades of women's missionary work, the scope and quality of "medical" care was rudimentary and carried out by women who had acquired some basic "medical" training, which could be as little as a few weeks of experience in midwifery and dispensing. This training had no prerequisites, and did not qualify the women as licensed practitioners. But as missionaries discovered that many Indian women were willing to try their services, they opened dispensaries, clinics, and even hospitals, thus taking on significant medical responsibilities. Writing in the 1950s, the author of a history of the ZBMM explained that while none of the medical workers in the 1870s were doctors, their credentials and work as providers of medical care were acceptable since "except for Dr. [Elizabeth] Garrett Anderson and one or two others, they were the nearest approach possible for a woman in Britain" at that time.<sup>145</sup> As the missionaries' main goal was to bring women to Christ—reaching them via eye drops or tonics for coughs was merely a medical means to a spiritual end—their work was good enough. While

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<sup>145</sup> J. C. Pollock, *Shadows Fall Apart: The Story of the Zenana Bible and Medical Mission* (London: Hodder and Stoughton, 1958), 35.

missionaries wanted to relieve physical suffering, the missionary rather than the medical connection was what mattered most to the societies and supporters at home.

By the 1880s, women could complete medical training in Britain. Many of these early women physicians devoted part or all of their careers to missionary work in India; significant numbers of women who entered medical school in the 1880s and 1890s did so with the goal of becoming medical missionaries.<sup>146</sup> Now that missionary societies could include “fully qualified” or “fully trained” medical women, there was reason to reconsider the policies and goals for the work: if societies could send fully-trained doctors to India, then they could also provide more comprehensive care. And if societies had the ability to provide better medical care, they had to ask whether providing the best quality of medical care—rather than enough care to possibly draw a patient to Christianity—should be the goal of the medical work. But if societies started to employ some fully-qualified doctors, could they afford them, and how might they affect the work being done by women without such qualifications? Finally, women who had studied and trained to become physicians—which was no small feat in nineteenth-century Britain—were well-educated, and some saw themselves as scientists; it was conceivable that they might consider themselves to be “doctors” who were missionaries rather than missionaries who did some medical work.

With the rise of professional medical women in late Victorian Britain, North America, and Europe, these are the questions and issues related to medical work and workers that the societies might have pondered in the early decades of the twentieth century, but, for the most part, did not. Instead, for many years the societies continued to focus on finding women with the

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<sup>146</sup> In 1900, approximately one-fourth of all British women medical graduates were working in India. The goal of becoming a medical missionary was also a driving force behind many Australian women’s enrollment in medical school. See Suzanne Parry, “Women Medical Graduates and Missionary Service,” for a detailed analysis of Australian women’s medical training and professional paths.

desire and ability to become missionaries—rather than the ability and qualifications to do medical work. The assumption was that most missionaries could be trained to do medical work, rather than that most medical women could be trained to do missionary work. And during the decades when these societies employed “partially trained” women who could do some medical work, the strategy paid off.

To a researcher, Beatrice Clegg, who applied to the WW in the late 1890s, appears to have been a medical missionary: she held some recognized medical credentials and provided midwifery and medical care in colonial Ceylon. Clegg first emerges in the WW minutes in 1897, introduced as the daughter of Reverend James Clegg—a Wesleyan minister who must have been known to the committee members. At that time, Beatrice Clegg worked as a post office clerk, but she had acquired “some knowledge” of pharmacy and dispensing in her spare time, and she had applied for a paid position at the Holborn Infirmary for two years of formal training. She sought this medical training in order to be “useful” to the missionary society, hopeful that she would be chosen for foreign missionary work. Clegg was under pressure, since the WW told her that if she failed to find a position in a hospital, she should return to the post office, as the committee could not accept all of the “partially-trained” medical workers who applied.<sup>147</sup> The committee knew that Clegg had to earn money to support herself “as she cannot afford to wait doing nothing,” but the WW was slow to offer any financial assistance; as one of many “partially trained” applicants, she offered nothing unique.<sup>148</sup> But the WW eventually supported Clegg with funding for three months of midwifery training, which complimented her knowledge of dispensing, thus providing her with useful skills as a woman missionary. Two years later, Clegg passed her London Obstetrical Society (LOS) exam and was in the middle of additional

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<sup>147</sup> Minutes, 13 July 1897, WW, MMS, 1105, 22.

<sup>148</sup> Minutes, 15 June 1897, WW, MMS, 1105, 22.

dispensing lessons. By early 1900, Clegg found herself in Ceylon practicing midwifery, running a weekly dispensary, and engaging in village evangelical work.

Not long after her arrival in Ceylon, the WW noted that Clegg's work had already become broader than she—and they—had expected. In the home committee's eyes, Clegg's real work was to evangelize village women; the midwifery and dispensing were merely a strategy for building relationships. Yet there were others in Ceylon who saw Clegg as a health care provider. The Colonial Surgeon, who was not in the business of saving souls, wanted her to take on all the medical work for women in the area; Clegg was "anxious" about such a proposition, but "show[ed] courage and skill."<sup>149</sup> The missionary and secular work kept Clegg occupied. Two months later, Clegg reported to the WW that she had opened new dispensaries, but was still communicating through an interpreter—because she was working so hard, she had no time to set aside for language study—and one of her dispensaries lacked not only furniture but also a building. At the end of that first year, Clegg wrote to the WW, requesting midwifery instruments, but her request was denied. The committee reminded her that she was *not* sent to be a medical worker, but as an evangelist "trained to help the women," which happened to include delivering their babies. Another year passed before the WW decided to send money for instruments and drugs as a reward for Clegg's work being "most satisfactory."

Clegg continued her busy schedule of midwifery and dispensing work, but also asked for permission and funds to start a school. This request reveals much about Clegg's perceptions of her work and professional identity: missionary doctors would not have claimed the credentials to teach or run a school; and while the Colonial Surgeon saw her as a medical worker, Clegg did not, but saw her role as serving all areas of her new community. The WW did not consider her

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<sup>149</sup> Minutes, 13 February 1900, WW, MMS, 1105, 24.

to be a “medical” worker, either, but as they did not see her as an educational worker, they denied her request.<sup>150</sup> When Clegg came home for her first furlough in 1905, the committee agreed to pay to send her for additional midwifery training at the Women’s Hospital in Euston Road, to make her more useful. By 1909, the WW realized that Clegg’s work had grown enough that they discussed the possibility of sending a qualified woman doctor to join her since Clegg found that managing the medical work while simultaneously training multiple local Bible Women—a service highly valued by the WW committee at home—difficult. In 1911, when Clegg was seriously ill and incapacitated for weeks, instead of sending a doctor, the WW sent a trained nurse to work as Clegg’s colleague. At this time, trained nurses in the missionary field were rare and highly valued by the women doctors, so sending one to Clegg’s area—which had no doctor, and was not designated as a medical station—was significant. Clegg clashed with Nurse Barrs, but by this point, the committee found Clegg’s experience too valuable to risk losing her. In 1937—nearly forty years after arriving in Ceylon—Beatrice Clegg was still on the island, establishing evangelical work in a new circuit, where she chose to live alone instead of as part of the European missionary community.<sup>151</sup> Even though she had delivered babies and provided basic healthcare across a region for years, she was and had always been an evangelist, and not a true “medical worker.”

Emilie Posnett and Sarah Harris, contemporaries of Beatrice Clegg, began their work for the WW in the princely state of Hyderabad in 1896. They both possessed some nursing training, and at that time the WW considered them to be medical workers. Like Clegg, their missionary

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<sup>150</sup> The SOAS, University of London, Library Special Collections Guide has a list of missionaries involved with medical work, and Clegg’s name is not listed under the Wesley Methodist.

<sup>151</sup><sup>151</sup> The WW Minutes end in 1932, but immigration records show Clegg traveling back and forth to Ceylon in the 1930s, returning to Britain in 1937. This outline of Clegg’s work and experiences was pieced together from the WW Minutes, 1895-1931. Records of her life and work in Ceylon are available in the “Ceylon” collection of the WW archive, but were not consulted in this study.

careers spanned decades, and over the course of their careers, missionary medical work emerged as a distinct field, which affected their self-perception and missionary classification. One major change was the shift from the “dispensary,” which, as Clegg’s experiences show, could be as basic as a missionary with her medical bag standing under a tree, to “hospitals.” By the early twentieth century, anything that counted as a hospital needed to have a doctor on staff—or at least visiting very regularly—and, ideally, also appropriately credentialed nurses. By the 1920s, missionary hospital nurses were expected to have the qualifications of Sister or Matron, which meant significant leadership experience as trained, professional nurses, and the credentials to train and supervise Indian nurses. Posnett and Harris lacked this level of training, and were honest about their expertise and abilities as healthcare providers. As early as 1902, when their mission began to consider building a hospital, Posnett and Harris objected, stressing that if the station were without a woman doctor, there would be no one to run the hospital—they could not fill a doctor’s nor even a Sister’s shoes. Posnett and Harris had no desire to return to Britain to earn these extra credentials, believing they were “more useful” as touring evangelists who could also provide some medical care.<sup>152</sup> Others agreed: in 1920, they were recognized by the Government of India for their pioneering work in villages, famine relief, and service to the public during epidemics, including the plague.<sup>153</sup> By the time they retired in 1939—after more than forty years in India—they were among the last of their kind in the WW, and, like Clegg, were classified as “evangelists,” far removed from the “medical” work, even though many aspects of their careers had mirrored those of missionary nurses.<sup>154</sup>

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<sup>152</sup> Minutes, 8 April 1902, WW, MMS, 1105, 25.

<sup>153</sup> Emilie Posnett and Sarah Harris were awarded the Kaiser-i-hind award, along with fellow WW missionary, Mrs. (Dr.) Olive Macdougall Monahan, in 1920. Many of the medical women in this study received this medal, which was bestowed by the monarch to recognize public service to India.

<sup>154</sup> Georgina Green, whose career began around 1903, often referred to the fact that she, Posnett, and Harris were “old-timers” and of a different generation and “stuff” when compared with the women missionaries arriving in the 1920s and 1930s. Green made comments such as, “Some of the new workers look very washed-out already. We old

As opportunities for women in the health care professions changed, and as medical work developed as a distinct field for missionary service, some women chose different paths than Clegg, Posnett, and Harris. Early “medical” missionary Elizabeth Bielby, a nurse, was sent to India in 1875 by what was then the Zenana Mission Society—later to be renamed the ZBMM. She established “the work” near Lucknow, where the ZBMM’s future Lady Kinnaird Hospital would eventually flourish well into the years of an independent India. Although only trained as a nurse, Bielby ran a dispensary and then a small hospital for Indian women where she provided as wide a range of care as possible, including midwifery services. The Zenana Mission Society was pleased with her work, but Bielby felt limited by her nurse’s training, frustrated by the physical suffering she could not alleviate because she lacked a doctor’s medical skills and knowledge.<sup>155</sup> Bielby was not satisfied to provide “some” care, to merely provide more than what was available to women from their local “traditional” Indian practitioners, nor did she subscribe to the philosophy that medical care’s main purpose was to bring Indians to Christ.

Bielby’s opinions were influenced by the fact that medical education opened its doors to European women in the 1880s. Bielby decided to return to Europe for a few years, taking a much-needed break from the recurrent severe bouts of typhoid fever, to gain her full medical qualifications. By 1885 she was not only a licensed midwife, but also had earned her M.D. at the

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stagers have twice their strength,” to which she added that missionaries in the 1920s had it much easier than she had when she was new and coped without motor vehicles, upper-storied houses, and six months of language study. Green to Bradford, 20 November 1922, WW, MMS, Haiderabad correspondence, 1058, 442. She sometimes closed her letters to Miss Bradford with “I am dear Miss Bradford one of the ancients.” Green to Bradford, 27 November 1929, WW, MMS, Haiderabad correspondence, 1058, 434.

<sup>155</sup> This was a common complaint from the field, from nurses working without doctors. For an impassioned plea for the need of doctors, see Anonymous, *A Nurse’s Indian Log-Book: Being the Actual Incidents in the Life of a Missionary Nurse* (Westminster: The Missionary Equipment and Literature Supply, 1925). In one annual report, the writer remarked that all “the work in the hospital is mostly medical,” meaning curative rather than preventive, and non-surgical, because there had been no fully-qualified doctor there for the past year. “Report on Akbarpur Medical Work,” 1931, WW, MMS, Reports, 1036, 45. Some of the missionaries who were neither doctors nor nurses but were still routinely presented with medical cases begged for any trained workers. Marian Bayton to Miss Bradford, 30 June 1924, WW, MMS, Haiderabad correspondence, 1058, 392.



University of Berne.<sup>156</sup> She became a staunch believer that medical missionaries must be fully-qualified doctors, publicly and vociferously arguing that “[a] little knowledge is insufficient and without a medical education no one should undertake the duties of a medical missionary... We should thoroughly understand our medical work or it must be a sham.”<sup>157</sup> Bielby left missionary service, but returned to India where she spent the rest of her long career, first working for the Dufferin Fund and later as an independent practitioner.<sup>158</sup> Although Bielby is often cited as a critic of missionary work, the ZBMM—the society for which she had worked—soon embraced her views, pronouncing

“the full course of scientific study [is] absolutely necessary for those going out in charge of a medical mission or hospital....As the opportunities available now to English female students are so much better than they formerly were, we feel we should not be contented with the lesser qualifications when the greater are open to us: the risks and responsibilities involved are so serious. Our Medical Missions are only a means to an end—the great end of winning souls to Christ, and ameliorating the suffering conditions of our Indian sisters.”<sup>159</sup>

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<sup>156</sup> Several of the earliest British women physicians got their M.D. qualifications in Berne since that university accepted women when no British M.D. programs would admit them. Elizabeth Bielby also held the Licensed Midwife qualification from King and Queen’s College of Physicians, Ireland, which also admitted women when England did not.

<sup>157</sup> Pollock, *Shadows Fall Apart*, 38.

<sup>158</sup> Bielby worked for the Dufferin Fund for many years, at the Lady Aitcheson Hospital in Lahore. She then left the Dufferin Fund and went into private practice in Northern India, ending a career that spanned more than fifty years. The Dufferin Fund, named for the Vicereine (the Countess of Dufferin), was established in 1885 to supply medical aid—trained medical women—to Indian women by providing scholarships and training for Indian women doctors, nurses, midwives, and hospital assistants, as well as to create women-only hospital wards, and to provide medical relief to Indian women and children. Dufferin hospitals usually had to employ British women as physicians. Scholarship on women’s healthcare in India often focuses on the Dufferin Fund (its formal name was the National Association for Supplying Female Medical Aid to the Women of India) rather than the missionary work. See David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India* (Berkeley: University of California Press, 1993), 262-267, for an overview, and Maneesha Lal, “The Politics of Gender and Medicine in Colonial India, The Countess of Dufferin’s Fund, 1885-1888,” in *Bulletin of the History of Medicine* 68 (1) (Spring 1994), for a more in-depth analysis.

<sup>159</sup> Pollock, *Shadows Fall Apart*, 64.

These “risks and responsibilities” were complex, for the reference was to more than medical outcomes. In addition to relieving physical suffering, medical missionaries felt pressure to gain or preserve their credibility with Indians, as well as to promote Christianity and the superiority of western education and culture. If a patient failed to improve or died, the individual missionary as well as western medicine and Christianity could be discredited. The quality of medical care missionaries should provide proved to be an ongoing debate. Many missionary leaders and missionaries themselves believed that any western medical care was superior to that offered by traditional or “native” practitioners in places like India; the services offered by women like Clegg, Posnett, Harris, and Bielby, prior to earning her medical degree, were therefore sufficient. But as women doctors became realities, many “medical” women shared Bielby’s belief that it was both a sham and a shame to be unable to provide a doctor’s knowledge, skill, and care to patients.<sup>160</sup> Other missionary thinkers argued that because the purpose of the medical work was to bring the patient to Christ, focusing on professional medical credentials was not important—what really mattered was to recruit effective missionaries who could also learn medical skills, and those of women like Clegg were enough. Women’s missionary societies always presented their doctors and nurses as “missionaries first” and “doctors [or nurses] second” to their public—assuring that the medical care was important primarily because it could lead to conversion, promising that the doctors and nurses did not become overly absorbed in the secular aspects of their work.

By the first decade of the twentieth century, the ZBMM, WW, and CEZMS all committed to only sending out fully-qualified medical women. The ZBMM had made the

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<sup>160</sup> For example, in 1921, the Presbyterian women missionaries in Brouwer’s study argued that the Canadian women heading out must have the same medical credentials as people training for work at home. See Ruth Compton Brouwer, *Modern Women Modernizing Men: The Changing Missions of Three Professional Women in Asia and Africa* (Vancouver: University of British Columbia Press, 2005).

decision in the 1880s, and the WW and CEZMS eventually followed suit. In 1892, the CEZMS boasted only one “fully qualified lady doctor,” but the medical staff included eleven women who had completed practical training, while others were “preparing for a diploma.”<sup>161</sup> With this staff, the CEZMS operated several hospitals and dispensaries spread across India. The WW functioned along similar lines, slowly sending out fully-qualified doctors and nurses to supplement the work already being done by “partially-trained” colleagues. The WW committee members exhibited ambivalence about the importance of recognized professional medical credentials. In 1897 the WW justified its decision to spend £40—a considerable sum—to send Miss Drayton, who was neither a nurse nor doctor, to Dr. Annie McCall’s Clapham training home, for a few months’ training “which will be as full as that of any young doctor in obstetrics and dispensing.”<sup>162</sup> In the same year, the WW also considered an offer from a forty-five year old woman, noting that *if* she could obtain an obstetrics certificate, “she might be very useful, as she seems sensible and too good to be lost.”<sup>163</sup> At that point, the process to get an obstetrics certificate was fairly simple and inexpensive, so taking a chance on such an applicant could make sense. This attitude can be attributed both to the still evolving professionalism in medicine, as well as to the real scarcity of women doctors in Britain, but it also reflects the fact that “medical” women missionaries were only in the process of separating from the “general” workers. By 1906, the WW was under pressure from the male-dominated Wesleyan Medical Advice Board, which asked for assurance that the WW stations without fully-qualified medical workers would be re-staffed, and that in the future, no more partially-qualified women would be

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<sup>161</sup> “Women’s Medical Missions in India,” *The Church Missionary Gleaner*, 12 (July 1892), 100. The article mentioned that the ZBMM had 5 fully-qualified women doctors, assisted with English matrons, Indian nurses and other Christian attendants.

<sup>162</sup> Minutes, 9 March 1897, WW. Women’s missionary societies typically had their own system for training prospective missionaries. The WW sent many of their candidates to this training home to get some basic experience in midwifery and dispensing. The ZBMM had a similar resource.

<sup>163</sup> Minutes, 9 March 1897, WW.

appointed. At this point, the WW replied that it could not make such promises, but that it would not send any Board money to stations lacking women physicians and would remove the names of unqualified women from the Wesleyan Medical Advisory Board lists.<sup>164</sup>

Medical missionary Elizabeth Bielby had not been alone in her choice to return to Europe to further her education and qualifications before resuming medical work in India, as many of her colleagues shared her belief that full qualification was necessary, or at least desirable, for the work. Indeed, there were some “partially-trained” missionaries already engaged in medical work who nearly begged to be allowed to pursue full training, but their requests were denied by their societies. The main drive for fully-qualified medical women did not come from missionaries themselves, however. Effective pressure came from people like Colonel H. Hendley of the Indian Medical Service (IMS), “who spoke highly of the work of the [CEZMS] Society’s ladies...and made some useful suggestions, emphasizing the desirability of the Medical workers being fully qualified.”<sup>165</sup> In the WW, the Reverend Goudie, who was based in South India, argued that the Wesleyans should increase medical work for women, and that their focus should be on establishing hospitals—rather than dispensaries—which by definition were coming to require fully-qualified doctors.<sup>166</sup> At the least, Goudie argued for one fully-qualified medical woman at each station, explaining that there was such a “need,” and so many “desperate” cases that having an only partially-qualified medical woman was “very trying” for everyone involved. His appeal was practical in that he pointed out that two qualified women were necessary for procedures like administering anesthesia, as well as for keeping the facilities open when a doctor

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<sup>164</sup> Minutes, 13 November 1906, WW.

<sup>165</sup> Minutes, Medical Committee, CEZMS, 24 November 1903.

<sup>166</sup> As will be explored in Chapter Four, missionary societies saw great value in hospitals because the patients stayed for extended periods, and could hopefully be more open to Christian influence than were women who merely spent hours or even minutes visiting a dispensary.

went on furlough or was incapacitated for an extended period of time. He also noted that while Miss Palmer, one of the early WW medical women, was doing a good job, she often had to call on the Government apothecary for help, and this was bad for her—and the Wesleyans’—reputation: it was important to show the Indians that the missionaries did not need government help, and were not part of the government system.

The societies also encountered some resistance to the conversion to fully-qualified practitioners from their own members. The shift introduced new distinctions and possible divisions among the workers. In 1900 the WW announced that going forward it would call the “medical ladies” with appropriate credentials by the title “doctor” so as to avoid confusion. Prior to that, all the missionary women doing any medical work—including those who were doctors—were referred to as “Miss,” just as were all the other unmarried women in all the other areas of work.<sup>167</sup> The CEZMS also began to wrestle with ways to distinguish their workers possessing full qualifications from the rest. The ZBMM, WW and CEZMS had taken pains to treat and classify all their missionaries equally, but as the role for the missionary doctor changed, so did the relations with the other workers. The doctors took on responsibilities and authority that set them apart from and then over other women, including those who had been doing similar work. Stations designated as “hospitals” came under the administration of fully-qualified doctors, while dispensaries and other work that included medical services could still be under the partially-trained medical workers. As the CEZMS began to introduce doctors into the missionary structure, the Medical Committee used the term “subordinating” when determining that dispensaries could continue to be run by women who were not doctors but that they would be “under” the direction and inspection of the nearest woman doctor—even if the doctor was much

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<sup>167</sup> Minutes, 10 October 1900, WW. The CEZMS seems to have followed the same practice, as the requests for drugs and instruments from each medical station were listed by the missionaries name using only the title “Miss.”

younger and newer to missionary work than the others. Additionally, the Committee made the point that the new distinctions between the fully-qualified “Medical ladies” and the “Medical workers” who could still be in charge of dispensaries was more than just a matter of rank. The Committee resolved that “all cases beyond the powers of the medical worker in charge” would be “referred to the lady in charge of the hospital.”<sup>168</sup> The Medical Committee sought the opinion of the workers on this matter, and seemed surprised when the missionaries carrying out medical work in India deemed the proposal “undesirable.” Not all medical workers were ready to acknowledge their limitations. The Medical Committee explained that it did “not advocate a dual control over subordinate Medical workers and still less the subordination of a fellow Missionary, even though not fully qualified, but they consider that in difficult professional matters the Lady Doctor should be referred to whether for advice or help, and that the care of Instruments, Drugs, etc. in charge of a Medical subordinate should be subject to the inspection of the fully qualified Medical lady.”<sup>169</sup>

For many missionary doctors, their mission assignment would be their first real job after completing their education and required clinical experience. As will be seen in Chapter Three, the women immediately took on much responsibility, including administration and leadership. All new missionaries, regardless of education, status, or role within the missionary society, had to learn to adjust to living and working in India. In many practical ways, the new and usually young doctors had much to learn from older and more experienced missionaries who were their “subordinates.” But while the doctors were to be leaders in the field, they were nonetheless required to be obedient to the society—those committee members far away in Britain—and to

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<sup>168</sup> Minutes of a Meeting of the Medical Committee, CEZMS, 24 November 1903. Underlining is in the original.

<sup>169</sup> See the Minutes, Medical Committee, 1903- 28 March 1905, CEZMS. The underlining is in the original document. The word “difficult” was inserted later, on 5 April 1905, suggesting that this was revisited.

the local male clergy who headed the missionary structures in India. Societies therefore looked for medical candidates with appropriate knowledge, skills, intellect, personalities, and values to serve both as missionaries and as medical professionals.

## **2.2 *Hopes, Risks, and Realities: The Medical Training Process***

In the nineteenth century, many of the women who did medical work had moved into it, adding various levels and types of medical training to supplement their evangelical training and work. As the societies began to require fully-qualified doctors and nurses, they often accepted missionary applicants who expressed a desire to become doctors or nurses, and the societies often agreed to pay for part these women's training and education. The medical course took about five years to complete, and the combination of fees and living costs amounted to a significant sum. As the WW noted, the expenditure on medical missionary candidates was always "above the receipts." In 1919 alone, the WW spent £924 on medical candidates—a huge sum in postwar Britain.<sup>170</sup> And, in addition to the years of medical training, the candidates also required missionary training, which could anywhere from several months to several years of additional financial support. If the woman then served as a medical missionary for many years, this was a smart investment. But what the societies slowly learned was that the road to becoming a fully-qualified medical woman was not easy, and that many promising women failed. By the time Roberts approached the CEZMS in 1930, asking them to sponsor her application for the Society for the Propagation of Christian Knowledge (SPCK) medical scholarship, which would help pay for her medical education, the committee knew that much could happen between a teenager's application and the completion of the degree and missionary training. The CEZMS

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<sup>170</sup>Minutes, 13 April 1920, WW.

did agree to sponsor Roberts, seeing her as brimming with potential, but remarked that “[t]hese candidates for the S.P.C. K. grant are so young that it is not easy to judge from a short interview what they really are in character.”<sup>171</sup>

As noted, societies looked primarily for suitable missionaries, not potential medical students. They therefore occasionally made mistakes, selecting women who wanted to become medical missionaries, but who could not earn their medical credentials. Winifred Kimmins was deemed to be medical missionary material, submitting good religious papers and a desire to become a doctor. The ZBMM agreed to pay for her medical training—including her fees, room, and board. Kimmins encountered one problem after another. First, her studies were temporarily derailed by ocular problems which required long periods of rest. After two years of study, she still had not passed her first professional examination.<sup>172</sup> Ongoing disappointments and setbacks caused the committee to eventually doubt whether Kimmins could ever pass the required exams, let alone cope with working in India. They finally decided to cut her financial support, but stipulated that if she persisted on her own, and passed the exams, they would let the society’s Medical Referees decide “with regard to her fitness to continue the severe strain of Medical study, and subsequently to work in a tropical climate.”<sup>173</sup> Once there was no hope that Kimmins would pass her preliminary medical studies exams, she was asked if she would like to train as a nurse or even as a “zenana” or “general” missionary. Similarly, when Norah Harrison faltered in her medical studies, the CEZMS concluded that she could still be a “reliable and efficient general

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<sup>171</sup> Miss Graham to Miss Roberts, received 12 December 1930; letter in Margaret Robert’s “Blue Packet,” CEZMS collection.

<sup>172</sup> Minutes, 6 March 1895, ZBMM. Kimmins’ fees for that year were just over £23.

<sup>173</sup> Minutes, 6 March 1895, ZBMM.



missionary.”<sup>174</sup> Provided that her doctor would sign a certificate stating that she was medically fit to live and work in a tropical climate, the ZBMM would attempt to find useful work for her.

Less satisfactory outcomes occurred. The minutes include many stories of medical candidates who failed to serve in any missionary capacity. In late 1912, just after an anonymous donor paid off the ZBMM debt and the future seemed bright, Nellie Hughes approached the society for financial help in training as a doctor at the Liverpool University.<sup>175</sup> Hughes’s sister had recently been accepted as a missionary candidate, and Nellie had already completed a year of missionary training, so the Committee was immediately interested in her. Hughes’s parents were “willing to keep her at home” while she studied, “paying all incidental expenses and contributing 10 pounds towards her College fees.” The Committee suggested that £25 be taken from the Candidates’ Training Fund—if a particular committee member and financial supporter agreed—and one of the aristocratic committee members offered to pay the remaining £25, “provided all agree that she would prove a capable Medical Missionary.”<sup>176</sup>

But after such attention, effort, and investment on the part of the society, Hughes not only failed to complete her medical training, she also failed to serve as a ZBMM missionary. Perhaps she abandoned her plans for marriage, which committees knew was always a risk for young women, but when a medical candidate chose matrimony over missionary service, the disappointment was evident, even in the dry and factual writing of the committee meeting minutes. The WW recorded notes such as, “Miss Little, whose progress through medical

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<sup>174</sup> Minutes, Candidates Committee, 24 February 1904, CEZMS collection.

<sup>175</sup> The anonymous gift came at just the right time and seemed to have solved all of the ZBMM’s financial problems. Unfortunately, more financial problems developed during the First World War.

<sup>176</sup> Minutes, 4 December 1912, ZBMM. I cannot find any evidence that Nellie Hughes ever completed her medical training or became a missionary. The Kinnaird family formed part of the core of the ZBMM. Lady Mary Jane Kinnaird had been its founder—as well as the founder of the YWCA—and her daughters, Emily and Gertrude, neither of whom married, continued the work of both societies, with Gertrude’s special work being the ZBMM. At any time, several other aristocrats served on the committee and were often relied upon to help support special needs.

training has been followed, has decided to marry instead of wait for 5 years”; other candidates “married without having written at all.”<sup>177</sup> Over the next few years a spate of broken commitments due to engagements, the WW considered appointing a special woman tutor at Kingsmeade to keep close tabs on the women students.<sup>178</sup> The ZBMM lost many medical women before they ever sailed for India, and eventually stopped accepting those who needed extensive financial support to become qualified. When Katherine Harbord, a young woman with strong family connections to the ZBMM “made enquiries about our work [in 1915] ...it was suggested to her that a medical career would be most valuable”—but no financial support was offered. Taking this advice to heart, six years later Harbord returned to the committee as a qualified doctor, and the committee, satisfied, asked her to “fill in the necessary papers.”<sup>179</sup> The WW had always been cautious. When a Miss Lowe was recommended to the WW in 1902, with a request for financial support for medical school, the WW replied that its funds did not allow for long and expensive training that involved “taking the risks” of never getting the investment back.<sup>180</sup>

When societies helped finance medical training, they felt entitled to decide how far and what type of training a candidate would pursue. For example, when the ZBMM agreed to support Hughes, at the end of her first year of medical school they required a letter from her professor to help determine whether she would continue in her medical studies or to end with the B.Sc.<sup>181</sup> Sarah Smith also caused her committee to wonder if she could pass her exams, so the committee debated whether to require her to only get the Apothecaries license (L.S.A.), as this

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<sup>177</sup> Minutes, 18 January 1910, WW; 8 April 1902, WW.

<sup>178</sup> Minutes, 13 May 1919, WW.

<sup>179</sup> Minutes, 2 March 1921, ZBMM. Harbord had taken the committee’s advice and obtained her M.R.C.S., L.R.C.P. qualification, with plans to take the London M.B., B.S. (the actual degree) within a few months.

<sup>180</sup> Minutes, 10 June 1902, WW. Dr. Lowe did eventually serve for the WW.

<sup>181</sup> Minutes, 4 June 1913, ZBMM.

credential allowed her to do significant medical work at the turn of the twentieth century. But Smith surprised everyone by earning the “Triple Qualification” in medicine and surgery, so had the committee decided on the L.S.A., they would have done both her and their work a disservice.<sup>182</sup>

Monitoring a candidate’s progress for so many years could prove not only financially expensive, but also ate up committee members’ time and resources. Although some young women were still accepted as potential medical workers prior to completing or at least making good headway in their medical or nursing training, by the 1920s, this practice was the exception rather than the rule.<sup>183</sup> Doreen Parks was a teenager working as a nursery maid when she discovered her calling to missionary work. She was encouraged to consider nursing as a good route to acceptance, but was cautioned that “the nursing profession is not one to rush into!” Since Parks was so young, the society recommended she try a short nursing course first, as it would “give [her] some idea of whether she could manage the work, and the exams.”<sup>184</sup> In order to complete the nursing or medical training, applicants had to possess certain intellectual and academic abilities, aptitudes, and stamina. And there was still the question of whether the applicant would remain dedicated to her missionary dreams during the years of medical training. Societies therefore tried to comprehensively assess applicants’ character and abilities.

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<sup>182</sup> The Triple Qualification examination given by the three Scottish medical colleges was established in 1884, and bestowed status equivalent to the medical qualifications of the universities and other medical colleges.

<sup>183</sup> This appears to have been the practice in the three missionary societies featured in this study; it is possible that other societies might have had different policies.

<sup>184</sup> Gertrude Hooton to Miss Smith, 24 February 1936, in Doreen Parks’ “Blue Packet,” CEZMS collection. Parks followed this advice and began her nursing career by spending 19 months training in a London fever hospital.

### 2.3 *Evaluating Potential Missionaries: Backgrounds, Parentage, and Homelife*

Medical missionaries were selected for their potential as missionaries—and not as doctors or nurses. During the application and initial screening process, committees sought information on the applicant’s character, personality, background, and abilities.<sup>185</sup> Historians have noted that until the end of the First World War, few working-class women were accepted by British missionary societies, and have argued that class was an important factor in the selection process.<sup>186</sup> As late as 1920, one of the first questions posed on the CEZMS application—along with the applicant’s date of birth and baptism, nationality, and denomination—was the applicant’s father’s occupation, which suggests that this mattered.<sup>187</sup> After 1920, this query was dropped, and the only questions regarding an applicant’s family were whether the parents were still living, and about the likelihood of them becoming financially dependent upon the applicant. These questions helped the society assess the applicant’s freedom to choose her own future rather than to assess her past. Women missionary doctors hailed from a variety of backgrounds, including families headed by farmers, drapers, cabinet makers, academics, dyers, clerks, chemists, clergy, architects, constables, manufacturers, military men, and even coal miners and the humble “potatoe [sic] seller.”<sup>188</sup> The nurses came from both middle- and working-class families. Class was considered in the selection process, as is

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<sup>185</sup> Rosalind I. J. Hackett, “Beyond Afternoon Tea: Images and Roles of Missionary Women in Old Calabar” in *Maternities and Modernities: Colonial and Postcolonial Experiences in Asia and the Pacific*, ed. Vinson H. Sutlive, Nathan Altshuler, Mario D. Zamora, and Virginia Kerns, 47-54 (Williamsburg: College of William and Mary, 1987).

<sup>186</sup> Judith Rowbotham, “Ministering Angels, not Ministers: Women’s Involvement in the Foreign Missionary Movement, c. 1860-1910,” in *Women, Religion and Feminism in Britain, 1750-1900*, ed. Sue Morgan, 179-195 (London: Palgrave, 2002); Seton, *Western Daughters in Eastern Lands*.

<sup>187</sup> Seton, *Western Daughters in Eastern Lands*, notes that the CEZMS, the main Church of England women’s organization, was able to attract women from affluent backgrounds.

<sup>188</sup> This information is available in the U.K. censuses, as well as from some of the applications to missionary societies. Ethel Bleakley’s father was listed as a “potatoe seller” in her parish’s baptismal records. In her siblings’ record, he is sometimes also recorded as selling onions.

indicated by references who reassured the selection committee that applicants from working-class backgrounds were in fact “ladies”—or, even “not a lady, but quite superior”—but this assessment was based more on accomplishments and behavior rather than upon social class or family origins.<sup>189</sup>

Family influences factored into some women’s decision to become medical missionaries. A significant number of them were the daughters of missionaries or clergy who had served in India. For example, Drs. Annie Banks, Mary Proudlove, Olive Salmon, and Katherine Harbord were daughters of Wesleyan ministers. All of these women became nurses or doctors working for the WW in India, except for Harbord, who joined the interdenominational ZBMM, and eventually became a long-serving pioneer medical missionary to Nepal. Drs. Ethel Douglas, Jessie Gray, and Edith Booth, all of the ZBMM, were the daughters of Baptist ministers. Marie “May” Hayes, Rosalie Harvey, Grace Sherwood, Evelyn Lea-Wilson, Annie Cornall, and the Lamb sisters—Jessie, Florence, and Maud—were from Church of England clergy families.<sup>190</sup> Drs. Alice Hodge, Charlotte Vines, Irene Parsons, Pleasaunce Carr, Ruth Hooton, Constance Slater, Ethelwyn Newnan, and nurses Frances Spencer and Pernette Bourdillon were all born in India while their fathers were serving as missionaries or local clergy. Other women had been born in India, but, like Ethel Landon, whose father was a civil engineer, and Florence Smith, whose father had been a captain in the Indian Army, were from families in different lines of imperial work.<sup>191</sup> Nurse Campbell had been born in and then spent enough time in India as an adult that, at the time of her application to serve as a WW missionary, she still knew some Hindi,

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<sup>189</sup> Nurse Edith R. Simpson was “a nice young woman, not a lady, but quite superior” in Ethel Abbot’s estimation. Abbot to Miss Smith, 30 April 1924, letter in Edith R. Simpson’s “Blue Packet,” CEZMS collection.

<sup>190</sup> May Hayes was Church of England, but was from Ireland. I have not been able to determine the father’s occupation for most of the women in this study.

<sup>191</sup> The census indicates that Hilda Keane and Jane Haskew Birkett were born in India, but it is not possible to know what their parents were doing there.

which enhanced her candidacy.<sup>192</sup> Just as young men who had family ties to India often chose careers that took them to colonial South Asia, so did some young women.<sup>193</sup> Missionary careers could be a form of colonial service, often spanning generations, similar to the patterns seen in families with traditions in the Indian Civil Service or army.<sup>194</sup>

It would seem that missionary societies appreciated applications from women with ties to India or to the church at home, but this was no guarantee for acceptance. Indeed, the committees rarely made any mention of such ties in the minutes, although references pointed out such connections.<sup>195</sup> Frances Spencer had been born and raised in South India, the daughter of a Church of England rector, who belonged “to the strictly Evangelical Church school,” which was what the CEZMS wanted, and her mother was a “really Christian woman, capable, gentle, homely.”<sup>196</sup> Spencer completed her nurse’s training in London with the goal of returning to India as a medical missionary, but the CEZMS refused to accept her as a full missionary when she applied in 1914. In 1929, even after many years of working as a nurse at a mission in India—but *not* as a missionary—and at a reduced salary, the CEZMS still debated accepting Spencer. Pernette Bourdillon’s application was well received, which was not a surprise since her parents were former missionaries to India and the committee believed that her “home training has given her a good foundation and we see in her the promise of a good worker.” But one of the reasons the committee thought this teenaged girl would be useful was because she had “plenty of common sense” and wanted to train as a nurse—not just because of who her parents were.

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<sup>192</sup> Although Campbell had knowledge of Hindi, she served in Mysore, South India, where she had little use for it and still had to learn a new Indian language.

<sup>193</sup> Mary A. Procida, *Married to the Empire: Gender, Politics and Imperialism in India, 1883-1947* (Manchester: Manchester University Press, 2002).

<sup>194</sup> Elizabeth Buettner, *Imperial Families: Britons and Late Imperial India* (Oxford: Oxford University Press, 2004).

<sup>195</sup> Most of the information about these women’s parentage and birthplace was gleaned from the census records or from obituaries.

<sup>196</sup> Dora E. Lockwood to Miss Smith, 3 June 1929, letter in Frances Spencer’s “Blue Packet,” CEZMS collection.

Societies expected to receive letters of reference attesting to applicants' Christian upbringing—and, indeed, references routinely noted that applicants' parents were quite pious or even devoted to the missionary cause—but those who appeared to have overcome less than ideal upbringing could also win favor from committees. Some applicants hailed from families that did not take an interest in the women's foreign missionary movement, and records indicate that some women made offers against their parents' wishes. Such a fact could work for or against an applicant. Missionary societies expected single women to be loyal daughters, ready to put their own work aside if their family needed them.<sup>197</sup> When Mary Cole stipulated that the only condition to her offer was that she be allowed to come home if her parents needed her, no one was concerned. Societies knew that families who did not support a woman's decision to become a missionary would have fewer qualms about calling her home. But societies also hoped that families would be willing to help pay for an applicant's training or even support once in the field, which seemed unlikely if the family opposed missionary service. For example, when Margaret Gray applied, she had to explain that her father had "very little sympathy" for her goal of becoming a missionary nurse. Part of his objection was financial—Gray noted that her father expected her to be financially independent after so many years of nursing training. He also expected Gray to support him in the future, which would be difficult on her missionary salary.<sup>198</sup> When Dr. Bostock, a Canadian completing advanced medical study in London, made her "definite" offer to serve in India, the ZBMM noted that it was "with her parents' consent," yet she was already a professional woman studying and practicing medicine far from home, seemingly leading an independent life.<sup>199</sup> Doreen Parks' parents had both died when she was a

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<sup>197</sup> Seton, *Western Daughters in Eastern Lands*.

<sup>198</sup> Margaret "Peggy" Gray's "Blue Packet," CEZMS collection. Gray went through the application and training process in the early 1930s.

<sup>199</sup> Minutes, 19 July 1922, ZBMM.

child, but she assured the committee that her four adult siblings supported her missionary plans.<sup>200</sup> It was quite common for women to wait until their parents were dead before applying. Some did this because they wanted—or needed—to care for them until they were free. Edith Simpson applied a bit later than she might have due to “home ties.” Dr. Collier was hesitant to commit to a full term of service because her father was eighty-six years old, and she was the only daughter. She wrote that “although my parents will not hesitate to give me to God, this does not lessen my responsibility to them.”<sup>201</sup> Others waited due to parental objection. A reference for one late-blooming applicant stressed that “[h]er desire to become a Medical Missionary is of long standing, but her mother...who was a most peculiar woman and very strong willed, ruling her children with a rod of iron, set her face firmly against the idea.”<sup>202</sup>

Manners, behavior, and the ability to act the part of a respectable missionary were very important to the societies and often seen as tied to an individual’s class or social background. Missionaries—whether doctors, nurses, teachers, or evangelists—lived and worked together in the field in close communal confines and were expected to function harmoniously. Someone with different or “coarse” manners or “loud” behavior could cause friction and awkwardness in the field. When Ethel Douglas, a seasoned missionary doctor, paid a visit to the home committee, she “urged the necessity for being careful in the selection of candidates,” explaining that “it will be easily understood that when the types are too varied, it is extremely difficult for all to fit into a household.”<sup>203</sup> When writing about Ethel Bleakley, an applicant who was clearly from a laboring-class, indeed “poor,” family, a reference wrote that there was “not a trace of

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<sup>200</sup> Her sister Gwendoline, who was a few years older, also became a missionary nurse, following in Doreen’s footsteps.

<sup>201</sup> Florence Collier to Miss Smith, 11 June 1937, in Florence Ivy Collier’s “Blue Packet,” CEZMS collection.

<sup>202</sup> J. B. Blackburn-Brown to Miss Milner, 8 November 1921, Ethel Bleakley’s “Blue Packet,” CEZMS collection.

<sup>203</sup> Minutes, records of Dr. Ethel Douglas’ furlough visit, 21 June 1927, ZBMM.



coarseness, roughness or vulgarity about her” and that she was “quite one of nature’s gentlewomen.” Doreen Parks personally worried about her “elementary education” but her reference assured the committee that “both her speech and manner are very refined.”<sup>204</sup> Edith Simpson’s reference reported that “at first one is a little ‘put-off’ by a rather unusual manner” but this was compensated by her “really nice mind.”<sup>205</sup>

If social class or family background had been an important factor in the selection process of early women missionaries, by the interwar years, the societies were willing to overlook various social deficits in the case of women who brought good nursing and medical credentials. In 1924, the ZBMM amended the Bylaws to specify that all candidates should possess not only the “proper credentials of Christian character,” but also physical fitness and “suitability,” including the proper professional qualifications. The development of the professional and regulated nursing profession, which was open to working-class women, like Ivy Canova and Doreen Parks, eventually drew many women from working-class families into missionary service as missionary nurses. Committees were open to references that described working-class Dr. Bleakley as someone who was “not at home in worldly frivolous society and shuns it.”<sup>206</sup> Instead of focusing on what could be seen as negative, committee members sometimes mentioned an applicant’s “delightful Lancashire accent” or noted that an applicant possessed “the Irish characteristic of being able to get on well with everybody!”<sup>207</sup> This was a positive contrast to another suggestion that an applicant needed “study in grammar and the letter H. She hardly seemed to realize there was such a letter in the way she spoke.”<sup>208</sup> When the Clerical

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<sup>204</sup> Gertrude Hooton to Miss Smith, 24 February 1936, in Doreen Parks’ “Blue Packet,” CEZMS collection.

<sup>205</sup> Harriet Richardson to Miss Smith, 6 July 1924, assessment from the Nurses Missionary League, in Edith Simpson’s “Blue Packet”, CEZMS collection.

<sup>206</sup> From Ethel Bleakley’s “Blue Packet,” CEZMS collection.

<sup>207</sup> Mrs. Nora S. Yarde Martin to Miss Smith, received 14 May 1929, ‘etter in Marjorie Morton’s “Blue Packet,” CEZMS collection.

<sup>208</sup> E. Hodgson’s letter on Lees, 13 May 1921, in Ada Lees’ “Blue Packet,” CEZMS collection.

Secretary opened Ivy Canova's letter, it was with the statement, "Miss Canova has had on one side Italian forbears. Hence her un-English surname." Canova was, however, adequately English, the daughter of a London draper's assistant, and her weak formal education was one of the factors that threatened to keep her from her dream of missionary service and not her working-class background per se.<sup>209</sup>

#### 2.4 *Educational Considerations*

From their beginnings in mid-Victorian Britain, women's missionary societies sought applicants with education, but the requirements did not include formal higher education.<sup>210</sup> The advent of fully-qualified physicians meant that many medical workers would be highly educated. As medical work came to include professional nurses, and as more educational opportunities became available to women from all classes, the educational backgrounds of the medical missionary women became more diverse. Many of the nurses applying for service who were professionally well-qualified lacked strong formal educations, which the societies believed either necessary or at least helpful for an effective missionary. As one committee member stressed, an applicant who had "never studied at all beyond the VI<sup>th</sup> standard must have a somewhat curtailed outlook." The societies faced a dilemma: how to get a woman already in her twenties and with a career better educated? Some nurses had passed their exams and obtained impressive professional credentials even though they only had basic general educations. Societies admired

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<sup>209</sup> The 1911 census shows Canova's parents living in a working-class section of London, keeping five boarders with them in their seven-room house

<sup>210</sup> According to Rosemary Seton, it was hard for British missionary societies to attract women with much education since there was no free and universal education in Victorian Britain. Middle-class American and Canadian women, on the other hand, were well-educated and drawn to missionary society as a way to apply their education to meaningful but feminine work. For more details, see Ruth Compton Brouwer, *New Women for God: Canadian Presbyterian Women and Indian Missions, 1876-1914* (Toronto: University of Toronto Press, 1990); Jane Hunter, *The Gospel of Gentility: American Women Missionaries in Turn-of-the-Century China* (New Haven: Yale University Press, 1984); and Patricia Hill, *The World Their Household*.

their hard work, but still had to wrestle with whether educational shortcomings could be addressed through additional missionary training.<sup>211</sup> What is more, missionary training included structured in-depth study of scripture, doctrine, language, and sociology and psychology, so women were assessed on whether they had the academic preparation and ability to learn “difficult lectures, or training demanding much mental ability.”<sup>212</sup>

In some cases, limited education could render otherwise strong applicants “unsuitable.” For example, Annie Wharton, aged twenty-six, and a devout Wesleyan, was already a certified medical and surgical nurse, and had become a Sister responsible for supervising several junior nurses. These qualifications—especially the professional leadership experience—were sought by missionary societies. But Wharton had left school at age fourteen, and the committee deemed her written responses to questions on religion and doctrine as “feeble in expression and inadequate in knowledge.” They worried that she might not be able to master an Indian language; her written exams were weak; her attitudes toward non-Christian religions were “immature and crude.” Although she was clearly a well-qualified nurse, the WW could not recommend her for foreign missionary work.<sup>213</sup> One of Nurse Ada Lee’s recommenders wrote, “I hope she may be accepted, tho’ I know she is not well educated. But she is most energetic and good at practical work.”<sup>214</sup> Nurse Hilda Mead’s “general education” was also “confined to elementary school” but she impressed the WW with her fondness of studying and her book-list was “better than is often the case with the nurses,” and she was accepted for missionary

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<sup>211</sup> Seton discusses the challenges missionary societies faced in applicants’ educational background in Chapter Two of *Western Daughters in Eastern Lands*.

<sup>212</sup> Gwendoline Parks’ “Blue Packet” contains detailed assessment of her abilities to overcome her “elementary” education and take on “difficult lectures, or training demanding much mental ability.” Gwendoline Parks, “Blue Packet,” CEZMS collection.

<sup>213</sup> Minutes, 12 September 1916, WW.

<sup>214</sup> Dora Lockwood to Miss Millner, 30 December 1920, in Ada Lees’ “Blue Packet,” CEZMS collection.

training.<sup>215</sup> Nurse Rena Bowden's "limited" education had left her with "rather ungrammatical" writing which caused concern regarding not only her ability to learn a foreign language but also to effectively communicate as a missionary. Bowdon was therefore required to spend several terms in training in the hope that she could improve. And women who brought other valued skills could cause committees to believe that their educational shortcomings might be addressed. But for her "missionary gift," Gertrude Mary Wilson's elementary education might have barred her from acceptance. The committee summarized that Wilson's "gifts are rather those of character than intellect. She has more refinement than education is further advanced in Christian experience than in Christian doctrine, and though her Bible knowledge is not great, she knows her Saviour." Florence Priest's interviewers noted that she seemed to be an Evangelical, "though I doubt whether she could define what is meant by evangelical."<sup>216</sup> When the committee considered Nurse Cox, whose education was "only at the village school," they reasoned that her "intellectual equipment is limited and therefore she would always find it difficult to engage in service among those of the student class. She is, however, a very real Christian with deep Christian experience, an evangelical, and she should give most valuable service among children and young people."<sup>217</sup>

After the First World War, the missionary societies found that fewer young women were approaching them, and in consequence the WW discussed the need to influence girls "earlier in their lives," and to be sure not to discourage girls of "small education." They did not plan to settle for women with small education, however, but to push women to overcome such

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<sup>215</sup> Minutes, 10 July 1917, WW. Each missionary candidate submitted a list of books she wanted to purchase as part of her preparation for missionary life.

<sup>216</sup> Mr. Hinde to Miss Hoare, 11 September 1944, in Florence Priest's "Blue Packet," CEZMS collection. Eleanor McDougall noted that Priest "has not read widely yet."

<sup>217</sup> Comments on Wilson are from letters in her "Blue Packet"; notes on Miss Ellen Cox, 25 June 1947, in Ellen Cox's "Blue Packet," CEZMS collection.

disadvantages. The committee resolved to recommend that these women join organizations like the Home Preparation Union (HPU) and to enroll in evening classes to strengthen their eligibility for service.<sup>218</sup> Some successful medical missionaries followed such a path, enriching their education in nontraditional ways. Those who did could earn respect for hard work. Born to a Lancashire coal miner in 1899, Mary Tomlinson left school at age thirteen to first work as a pit-brow girl on the mines, and then in the textile mills. During her life, which spanned one-hundred years, Tomlinson pursued additional education, mostly through evening programs, first becoming a nurse, and then a doctor, gaining these qualifications to realize her dream of becoming a medical missionary. She worked with the WW missions in India from 1932 until the end of the Second World War, when she left to practice medicine in East Africa for several years.<sup>219</sup> Ethel Bleakley, also from Lancashire, was the daughter of a potato seller and a ladies maid. Like Tomlinson, Bleakley attended evening classes to train as a nurse, won a scholarship to qualify as a certified midwife, and later put herself through medical school while working as a clerk in the newspaper office and helping with the small, home-based and family-run confectionary business. One of the reasons Bleakley was chosen by the CEZMS was because the committee believed that she had “won her way up from the bottom” and was therefore “bound to do well.”

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<sup>218</sup> Minutes, 10 December 1918, WW. H.P.U. stands for the Home Preparation Union, an organizations with benefits that included a lending library. The H.P.U. was often suggested to prospective nurses with “limited” education, such as sisters Doreen and Gwendoline Parks. The H.P.U. was launched by the ZBMM to meet the needs of young people for Bible Study by correspondence course. Those who wanted to participate paid an annual subscription.

<sup>219</sup> I do not know if the Wesleyan missionary committee considered Tomlinson’s class when she applied. Mary Tomlinson, who eventually married and became Dr. Mary Alice Roll, was born in 1899 and died in 2000. She served in India from 1932-1945, and then in Tanganyika from 1945-1949. See her obituary in the *British Medical Journal* 321 (11 November 2000): 1229.

## 2.5 “*Serious Study*”: *Knowledge of the Bible, Doctrine, and Evangelism*

The education expected of prospective missionary women was not limited to formal academic or professional training. In her studies of Canadian Presbyterian women missionaries, Ruth Compton Brouwer found that women, unlike men, were not required to complete much “religious” training. Brouwer explains that this was because women’s main purpose was to make connections with illiterate Indian women and to present Christianity simply, so heavy theology was unnecessary. Finally, missionary boards believed that young women with solid Christian upbringing had the requisite knowledge, and these boards were familiar with their applicants and their families.<sup>220</sup> The British societies in this study assessed applicants on their knowledge of Christian doctrine and the Bible—both through written “religious papers” and oral interviews—so women who had time and resources for serious study, or who came from clergy families, had an advantage over women who had little formal education or who had to work long hours. As one reference remarked of Ruth Hooton, “So far as I know, her knowledge of the Bible and her doctrinal views are such as one would expect from the daughter of a keen ‘fundamentalist’ [rector].”<sup>221</sup> Similarly, Eileen Snow’s reference explained that she was “as staunch and true to the old conservative lines of Gospel truths—as her mother is... which is a good deal!” The standards were high. Unlike the Canadian societies, the committee members for the CEZMS nearly always found applicants’ knowledge unsatisfactory. Even those from homes like Hooton’s and Snow’s fell short of society expectations for knowledge and understanding of the Bible and Christian thought. Snow was “staunch and true,” but the Candidates Committee noted that she “knows her Bible fairly well, though she needs guidance in the study of it.” She was also found “rather shaky about the Sacraments, and requires teaching

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<sup>220</sup> Brouwer, *New Women for God*, 63-64.

<sup>221</sup> Bessie M. Stables, (c. 1933), letter of reference for Ruth Hooton, in Hooton’s “Blue packet,” CEZMS collection.

on the subject.”<sup>222</sup> Much to her missionary father’s chagrin, Irene Parsons’s knowledge of the scriptures was also inadequate. “I had expected more from her parents’ daughter,” wrote one of her referees. “She is not very sure where certain passages come from nor does she know the contents of some of the Epistles...[S]he has been trying to get a grip on the Prophets, but I should say, not very successfully as yet.”<sup>223</sup> Many well-educated applicants, including those who had been raised in an “evangelical atmosphere” and “in full sympathy with the views for which we stand” were, like Dr. Lucretia Byrne, deemed to possess “fair knowledge of her Bible from the devotional point of view” but needed “guidance with reference to the doctrine and meaning of the Sacraments.”<sup>224</sup>

Byrne and other medical candidates who failed to impress with their biblical acumen could be excused by committee members’ belief that medical and nursing training was so all-consuming that doctors and nurses had no time for “study”—and by “study,” the societies meant Bible study. Dr. Doris Graham, whose Bible and theological knowledge was deemed “small” by the committee, was given the benefit of doubt since her medical studies meant “lack of time must account for inadequacy.”<sup>225</sup> What these women needed was time set aside for Bible study; the committees sometimes required special breaks or periods of time for such study. Women who had difficulty carving out time for this study could be supervised to ensure that they did it, even if it meant taking away time from their medical education. These competing demands on their time could cause tension between the missionary—who argued she needed to fully focus on her medical studies—and the society, which argued that the spiritual work needed to come first.

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<sup>222</sup> Clerical Secretary’s notes on Eileen Barton Snow, (c. 1928) in Snow’s “Blue Packet,” CEZMS collection.

<sup>223</sup> Letter from a CEZMS committee member (signature illegible), 20 September 1910, in Irene Parson’s “Blue Packet,” CEZMS collection.

<sup>224</sup> Clerical Secretary’s notes on Lucretia “Louie” Byrne, 23 April 1923, in Lucretia H. H. Byrne’s “Blue Packet,” CEZMS collection.

<sup>225</sup> Committee notes on Dr. Doris Graham, 1920, in Graham’s “Blue Packet,” CEZMS collection.

When Madelaine Shearburn wanted to do some medical work while in her missionary training program, the committee decided to give her a grant, believing it was more important to give her more funding than risk her devoting some of her attentions away from her spiritual training.<sup>226</sup> One of the CEZMS committee members summarized the society's position by stating that "all medical candidates whether Dr. or nurse should do regular guided Bible reading under the aegis of CEZ during their years of professional training."<sup>227</sup>

Those who were educated could be assumed to have the ability to learn, while more concerns cropped up for those with less education. In fairness to the nurses, the committees noted that women who had less education experienced greater difficulties expressing themselves on these written and oral inquiries. Nurse Elsie Eckersill's religious paper was deemed "accurate"; Nurse Mabel Cross's answers were "very simple but the tone sincere."<sup>228</sup> To improve their knowledge of scripture and their ability to apply their faith to their work, societies often encouraged nurses hoping to become missionaries to join the Nurses Missionary League as this organization would help them with leadership and also connect them with others for Bible study and prayer. Nurses who were able to incorporate structured scripture study into their hectic work schedules were seen as dedicated to the missionary cause, and potentially useful workers. Committees monitored such study, noting that a couple of nurses devoted forty-five minutes to Ephesians and another ninety to Acts each week.

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<sup>226</sup> Candidates Committee minutes, 4 July 1911, CEZMS collection.

<sup>227</sup> Adelle Weddington's letter on Margaret Roberts' application, 1930, Roberts "Blue Packet," CEZMS collection.

<sup>228</sup> Eckersill's candidacy was considered at the 10 October 1916 meeting, Wharton at the 12 September 1916 meeting, and Cross at the 12 March 1918 meeting, Minutes, WW.



## 2.6 *Financial Considerations*

Financial realities also factored into the missionary application and training process, although possibly not to the extent and in the ways many historians have assumed. In the nineteenth century, women's missionary societies were quite good at raising money; after the First World War, funding was usually tight for British women's societies.<sup>229</sup> Once a candidate was accepted as a missionary, the society had to send her to India—which was expensive—and provide or at least contribute to the costs of her supplies or “outfit.” This included clothes and some personal items, as well as books, and doctors' and nurses' lists included both “religious” and “medical” texts. Doctors also requested professional supplies, including medical instruments, the cost of which often took the committee members by surprise. Women who could fund their own missionary work could be given special and sometimes more flexible consideration than women who could not support themselves.<sup>230</sup>

Some women lacked personal resources to support their missionary work, but had sponsorship from friends or mission-friendly groups. These women were quite valuable to societies; indeed, in some lean years, societies adopted the policy of not accepting any new candidates who were not sponsored or self-supporting. Miss Hallam, who had the LOS certificate, experience in the operating room, caring for children, and a “thorough knowledge of dressings,” was especially attractive to the WW because she also had experience with Sunday schools, Mothers Meetings, and house to house visitation. Hallam had been accepted for a year of training at the Temperance Hospital, which cost her £25—a large sum for Hallam. Her

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<sup>229</sup> Seton discusses this in Chapter Four, *Western Daughters in Eastern Lands*; Brouwer explains the success of the Canadian women's fundraising strategies in *New Women for God*.

<sup>230</sup> Seton, *Western Daughters in Eastern Lands*.

brother was willing to pay part of the fee, and the WW decided to pay the rest since she seemed to be “a very useful worker.”<sup>231</sup> Situations like this seemed to be good risks for the societies.

Funding did not guarantee acceptance, however. In many ways, Hilda Lucy Keane should have been a dream candidate. She had been born in India and educated in Scotland. She had completed her medical training in India, which was not a strong recommendation to these missionary societies, but had returned to Edinburgh for an advanced medical degree and Urdu study. Keane also had the backing of friends in Liverpool who promised to provide £37 per year for at least three years, and if she were accepted, these friends hoped to raise her full salary. Keane had the support of the Reverend Cavalier, who worked closely with the ZBMM in India, but the ZBMM decided to wait on a full report from the Candidate’s Committee before even considering her. In other cases, funding possibly clouded a society’s judgment. When the WW’s advising physician warned the committee that if Miss Richardson—who had volunteered to work in India at no cost to the society—was accepted, she would be “invalided for life” by the Indian climate, the committee had to make a tough decision.<sup>232</sup> When Dr. Elizabeth Dunn applied with a secured salary, and the ZBMM jumped to accept her in July and send her to India in October, this was a very quick turnaround and, in the end, a rushed decision. Dunn first asked to postpone her sailing, and then in October, instead of leaving for India, she informed the committee that she had decided to go to work in New Zealand rather than pursue missionary service in India. But many promises of support were kept. Olive McDougall’s father pledged to pay all her expenses until she became self-supporting in India. McDougall proved to be an

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<sup>231</sup> Minutes, 9 February 1904, WW.

<sup>232</sup> Minutes, 18 May 1897, WW. It is not clear if this Miss Richardson was sent to India, but she may have convinced the society that she could cope with the climate, as a Dr. Richardson served for many years at the hospital in Medak.

excellent risk for the WW, for even though she married a fellow Wesleyan missionary early in her career, she continued to serve—unpaid—at the WW hospitals for more than thirty years.<sup>233</sup>

## 2.7 *Age and Maturity*

Dear Miss Smith,

I have been in touch with Miss R. Hooton (from whom you perhaps will have heard), and she has given me hopes that I might be accepted by your society as a candidate for missionary work. I and many friends are praying that this might come to pass. I do not exactly know what Miss Hooton will have told you but I am 35 years old—belong to the Church of England, have done 8 years training in Fevers—and this last 4 years have been taking my general and midwifery training at [St. Luke's Hospital, Bradford]. Any further information you require I will gladly give you—but this comes just to offer myself as a candidate—praying I may be accepted.

Sincerely Yours,

Margaret Brown<sup>234</sup>

In this, her first letter to the CEZMS, Margaret Brown seems like a good catch: she appears to have faith, is a member of the established church, knows Dr. Hooton, one of the current medical missionaries, and has appropriate nursing credentials. But Brown's letter raises the issue of age in the missionary application process. In terms of age, societies had a fairly

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<sup>233</sup> Missionary wives were expected to not only perform domestic roles and to support their husbands' careers, but also to do things like help with the missionary schools, Bible classes, and even church administration. They were not paid for any of this work, even if they had been full-fledged paid missionaries in their own right prior to marrying a fellow missionary. In addition to Olive McDougall Monahan, several other WW medical women married in the field and continued to serve the society's hospitals without pay.

<sup>234</sup> Margaret Brown to Miss Smith, 14 January 1936, letter in Margaret Brown's "Blue Packet," CEZMS collection.

narrow window for prospective missionaries, seeing the mid-twenties as ideal.<sup>235</sup> Women who applied when they were still in their teens could be viewed as too young to truly know what they wanted from life, while women like Brown—who obviously had committed to a nursing career and was accustomed to making her own way through life—could be automatically discounted as “too old.” At thirty-five, Brown was already too old for acceptance by many societies, which tended to draw the line at the age of thirty.<sup>236</sup> Societies adhered to these guidelines because they believed that as women moved into their thirties their chances of successfully adapting to missionary life decreased, that they were more prone to suffer poor health in India, and that they would struggle to learn Indian languages.

Women’s missionary societies placed great stress on learning to speak the language of the area to which a woman was assigned. In order to become a full missionary, women had to pass language tests and prove their proficiency. Women who seemed unlikely to be successful were therefore carefully scrutinized. Nurse Sadie Jackson, who had been rejected by the CEZMS when she was in her twenties, debated whether she should renew her offer once she was in her thirties, as she assumed she was now “too old.” The society wondered about this, too, but presented their concerns to Jackson’s references by asking them to consider not only her desire to become a missionary, but also her potential adaptability: “The Committee desire only to send abroad those who put first things first, but some who are truly earnest and very keen on the missionary side, might not be able to adapt themselves to the conditions of life abroad, and

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<sup>235</sup> Rhonda Anne Semple, *Missionary Women: Gender, Professionalism and the Victorian Idea of Mission* (Rochester, NY: Broydell, 2003); Seton, *Western Daughter in Eastern Lands*.

<sup>236</sup> Seton, *Western Daughters in Eastern Lands*; a review of the WW minutes shows that this society typically declined applicants past their mid-30s.

unless they are really able to learn the languages of the people among whom they live, they cannot take their full share in the work at the station where they might be located.”<sup>237</sup>

As scholars note, age mattered, but close examination of the women’s missionary society records shows that committees took multiple factors into consideration when potential medical women applied. Although thirty was usually the cut off, the CEZMS, WW, and ZBMM all seriously considered and accepted medical women past that age, and all had great success with some of these “older” women. The ZBMM seems to have placed less weight on age than the others, for the committee often made no comment about applications from women in their thirties. Being more flexible with age requirements appears to have become more common in the 1930s and 1940s; perhaps this was because fewer women in their twenties applied, for once the Second World War was over and missionary societies could once again attempt to recruit doctors and nurses, the WW lamented that so few current offers of service came from “girls under thirty.”<sup>238</sup> The relaxed focus on age was probably also due to changing professional requirements and missionary values that required applicants to have more education and experience. Additionally, societies knew that age did not guarantee good health as a woman could still be in her twenties but “not look too robust” and women of all ages could find language acquisition difficult.<sup>239</sup> Using age as a factor for admission gave societies an easy excuse for declining women found to be “unsuitable,” but merely being older did not automatically make one unsuitable, for many exceptions to the age rules were made for those who seemed especially promising as useful workers.<sup>240</sup>

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<sup>237</sup> Hon. Secretary Foreign and Candidates to Miss Farran, 2 November (no year), letter in Sadie Jackson’s “Blue Packet,” CEZMS collection.

<sup>238</sup> Miss Freethy to Alice Musgrave, 7 May 1945, WW, MMS, Madras correspondence, 1070, 779.

<sup>239</sup> Clerical Secretary’s notes on Ivy Canova, 29 May 1937, in Ivy Canova’s “Blue Packet,” CEZMS collection.

<sup>240</sup> Minutes, 11 March 1902, WW. The WW used the “age” excuse to decline some “unsuitable” women who were as young as thirty.

Older medical applicants who showed ability could be subjected to additional measures to assess their suitability. When Cecily Jones applied at the age of thirty-five, her committee waited for reports from the Oriental School of Languages to determine whether she had the ability to learn languages. Esme Waight, an experienced nurse, completed her application in 1943, at a time when the societies were uncertain of the availability of nurses to send out when the war ended. But Waight was approaching her fortieth birthday. Four of the six committee members stressed that her age was “a serious drawback” before even meeting her. Once she had interviewed, she struck committee members as “quiet and ‘purposeful’...one whom we should be glad to have in hospital work in India.” The final consensus was to proceed “[p]roviding she has good health and capacity for learning the language.”<sup>241</sup> The WW decided to accept Isabel Linforth at the age of 38, which was acknowledged as unusual, and some workers in the field wrote to report that while they had heard “good things” about her, they thought Linforth would have difficulties passing her Telugu exams. World circumstances had made Linforth a stronger applicant, however. She had appropriate training: two years in a fever hospital, four years in a general hospital, four months of maternity training, five years of work as a district nurse in an economically-depressed urban area, a year of private nursing, and the CMB certificate. A nurse at her age could possess such a rich background, but the First World War had given Linforth the opportunity to serve in the British Red Cross in Belgium and France, where working conditions caused her to discover that she was adept at “picking up languages.” The WW determined that “she is considered adaptable.” Nearly thirty years later, Linforth was still working as a nurse in India, at the age of sixty-six.<sup>242</sup>

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<sup>241</sup> I. Heaton’s notes on Esme Waight, 1943, in Waight’s “Blue Packet,” CEZMS collection.

<sup>242</sup> Emilie Posnett to Miss Bradford, 19 April 1917, WW, MMS, Haiderabad correspondence, 1058, 418. Minutes, 9 January 1917, WW. Immigration records show Linforth arriving in England in 1946, after a long career in India. She died in 1957.

Along with age, lack of a strong educational background also triggered worries related to successful language acquisition. Women who were older and lacking much formal education presented special problems for missionary committees. Ivy Canova was twenty-nine when evaluated—older than most of the nurses still in the application stage—and two of her interviewers stressed that she had “very limited” education and that “her ability to learn a foreign language should be tested early”—before the CEZMS invested too many resources in her.<sup>243</sup> Ellen Cox’s training supervisor recommended “help with English grammar” to improve her likelihood of learning an Indian language. The ZBMM also took extra steps to ascertain language potential when an older applicant with a “lack of early educational advantages” proved otherwise promising.<sup>244</sup>

Another age-related concern for societies was the amount of additional training an applicant needed. For example, the Committee regretted that nurse Cecily Jones had not earned the Second Certificate of the Midwives Board, but reasoned that as she was already thirty-five instead of twenty-five, they could not justify asking her to devote more time to midwifery before sailing for India. Gertrude Wilson applied when she was thirty, in the same year that she passed her general nursing examinations. She wrote a long, anxious letter detailing her deliberations over whether she ought to pursue an additional twelve to sixteen months of experience in a maternity hospital, as that would then make her “almost thirty-two” before she could begin her missionary training—which would take more than a year—thus pushing into her mid-thirties before beginning her work in India. When reflecting on Esme Waight’s questionable language skills, the CEZMS stressed that her case was difficult because “she needs [missionary] training

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<sup>243</sup> Letters to Miss Smith from Margaret Greeble and H. Y. Richardson, both from May 1937. In Ivy F. Canova’s “Blue Packet,” CEZMS collection.

<sup>244</sup> Minutes, 18 February 1930, ZBMM.

and that would add considerably to her age.”<sup>245</sup> When the ZBMM considered Edith Booth’s application, noting that she was already thirty-seven years old, the committee recommended that she ought to immediately proceed to India and begin her language study in the hills, where it was cooler—the sentiment was that even waiting a few months would be detrimental to Booth’s success.

Age was not only considered in terms of actual years, but also in the ways maturity could affect personality and behavior. Nurses could be criticized for being too boisterous or frivolous or immature. Such behavior mattered since most missionary nurses were expected to teach and train Indian nurses—who would still be teenagers and in need of strong professional role-modeling.<sup>246</sup> While praised for her ability to behave naturally with teenaged girls, Nurse Rena Bowden was criticized for her inability to discipline them. Her committee hoped that she would develop more “dignity.” Ironically, anyone who embodied traits associated with being “old” could also be faulted: a successful missionary could not be perceived as too rigid or set in her ways. The report on Irene Parsons, aged twenty-two, stated that she was “steady, reliable, consistent, and older than her years.” Another reviewer worried that Parsons might be “a little too old,” recommending that she spend time with others who were older yet still “full of life and spirits” in order to help Parsons become more “natural and unconstrained” and therefore also adaptable.<sup>247</sup> Gwendoline Parks seemed perfect since she was “young enough to be filled with the spirit of adventure and experienced enough to know how to tackle a serious job.”<sup>248</sup>

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<sup>245</sup> Notes on Esme Waight, 1937, Esme Waight’s “Blue Packet,” CEZMS collection.

<sup>246</sup> As will be discussed in Chapter Five, missionaries stereotyped Indian nurses as immature, childish, unable to make decisions, or lead. Attempting to transform these teenaged girls into well-disciplined professionals was an ongoing challenge for missionary nursing programs.

<sup>247</sup> Letters from Parsons’ “Blue Packet,” (undated, but from around 1910), CEZMS collection. Underlining in the original. Several writers made similar comments.

<sup>248</sup> Gwendoline Parks’ “Blue Packet,” CEZMS collection.



Societies' concern about an applicant's age could be alleviated if the applicant had enough financial support to work for no or little salary.<sup>249</sup> The WA seriously considered a forty-five year old woman who offered to go to India to work solely for room and board, but rejected her when she got a negative health report. Even so, the committee asked her to reapply at a future date; it seems unlikely they would have made this suggestion if she had not offered to forego a salary. But the three societies included in this study also made exceptions for medical women who impressed them as highly resourceful or determined. A member of the Nurses' Missionary League reminded committee members that "there are cases when as a Committee we should not turn down a nurse who is older than the candidates we usually take."<sup>250</sup> When Nurse Fleming, aged thirty-one, and still in need of additional professional experience in operating theatre nursing as well as Bible instruction, applied for missionary work, the ZBMM committee enthusiastically endorsed her as they were "much struck with Miss Fleming's humility and her willingness to undertake Evangelistic work if required to do so, expressing herself as first and foremost a Missionary, and secondly a professional nurse."<sup>251</sup> Indeed, the committee scrambled to scrape together the necessary funding to train this valuable applicant. As was previously noted in Ethel Bleakley's journey to become a medical missionary, the CEZMS did not dwell on her working-class background, but the society did devote significant attention to her age, which she acknowledged to be "the greatest difficulty in my path."<sup>252</sup> At the age of forty-four, Bleakley noted that "I know from what I gather from missionaries who have worked abroad that I really am 'too old.'" Bleakley's incredible determination to pursue part-time educational opportunities

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<sup>249</sup> Seton, *Western Daughter in Eastern Lands*.

<sup>250</sup> Harriet Richardson (of the Nurses' Missionary League) to Miss Smith, 19 October 1936. Ivy Canova's "Blue Packet." CEZMS collection.

<sup>251</sup> Minutes, 16 December 1930, ZBMM.

<sup>252</sup> Ethel Bleakley to Miss Milner, 16 April 1921, letter in Bleakley's "Blue Packet," CEZMS collection.

while holding down paid jobs, to first become a Certified Midwife, and then a fully-qualified physician, all funded by herself and hard-won scholarships, while also exhibiting solid dedication to her church work and service to others, was enough to convince the candidates committee that she merited serious consideration. As one of them remarked, “I think her grit out weighs the age difficulty.”<sup>253</sup>

## 2.8 *Health*

An applicant’s health was another factor that, like age, was the basis for policies, but left room for exceptions. Societies had not always considered applicants’ health as part of the selection process, but had gradually learned about the importance of selecting healthy women. In 1873 the ZBMM had proudly sent its first two medical women to India. One was Miss Lucy Leighton, who had been in poor health for some time, but the committee hoped that the Indian climate would make her better. Had Leighton applied thirty years later, she probably would have been rejected on medical grounds, which would have been a blessing both for Miss Leighton and the ZBMM, as Leighton was dead before her ship reached Gibraltar. Leighton’s colleague, Mrs. Crawford, arrived in Bombay, but “[t]hree months later, after a particularly trying day in the heat, with the topi, spine-pad, woolen cholera belt, corsets and other encumbrances dictated by convention and the then state of tropical medicine, she dropped dead,” leaving the society with no medical women in India.<sup>254</sup> Serious illnesses and the occasional death continued to cause setbacks to budding medical work through the rest of the nineteenth century. Missionary life was not for the delicate or sickly. Like most Britons, missionaries believed that the Indian

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<sup>253</sup> Notation by Candidates Committee member J. Macfee, in Bleakley’s “Blue Packet,” CEZMS collection.

<sup>254</sup> Pollock, *Shadows Fall Apart*, 35.

climate was hazardous to Europeans' health.<sup>255</sup> Missionaries also believed that their work in India was especially difficult since living and working as a missionary in India was physically, mentally, and spiritually trying.<sup>256</sup> Societies expected the women to accept that personal illness would be a challenge, and to see enduring it as part of their dedication to "the work." But many who developed chronically debilitating conditions were "invalided" or sent home "on doctor's certificate," unable to return until a physician in Britain verified that they were fit enough for life and work in India. Poor health proved to be one of the main reasons for a medical woman to leave missionary service.

By 1895, so many missionaries had been sent home on health grounds that the ZBMM committee was willing to consider the advice from one of the exasperated secretaries in India, who, having just shipped two more new missionaries back to Britain on medical orders, wrote a letter "urging the Committee to use great care to insure that only Missionaries are sent out to India whose health is likely to stand the climate."<sup>257</sup> The CEZMS application asked missionaries the simple question, "Is your health good?", leaving little room for an explanation, but by 1904 were under pressure for the "insufficiency" of the questions used to for selecting overseas missionaries.<sup>258</sup> By the twentieth century, the societies were unwilling to accept an applicant's self-report—and it seems all applicants claimed to be healthy. In 1905, the CEZMS Medical Committee prepared a paper of "questions as to the health of Candidates offering for Service abroad" to further its attempts to keep a healthy staff of medical workers.<sup>259</sup> The CEZMS

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<sup>255</sup>For a discussion of the changing medical discourse in colonial India, see E.M. Collingham, *Imperial Bodies: The Physical Experience of the Raj* (Cambridge: Polity Press, 2001). Collingham explains that in the early nineteenth century, the British ceased to believe that the European body could truly adapt to the Indian climate. When considering men for the ICS, the ideal came to be manly, muscular and robust.

<sup>256</sup> "Some Missionary Difficulties," *The Zenana: Or, Woman's Work in India* 37, no. 428 (1930): 69-71.

<sup>257</sup> Minutes, 1 May 1895, ZBMM.

<sup>258</sup> Candidates Committee Minutes, 11 July 1904, CEZMS collection.

<sup>259</sup> Minutes, Medical Committee, 24 January 1905, CEZMS, collection.

carefully factored in each applicant's health status, using a scoring system which was part of her application packet. Applicants who were awarded a Class I for health carried special value, but Class II women were also considered acceptable.

Each society required prospective applicants be examined by doctors. In addition to applicants' personal physicians, the CEZMS, WW, and ZBMM came to require medical reports from physicians with ties to these organizations. The ZBMM added a further stipulation in 1911, deciding that "in view of Miss Beatty's breakdown after so short a time in India, we should get two medical opinions on each Candidate in future" as well as the report from the candidate's personal doctor.<sup>260</sup> The doctors who examined missionary candidates for the societies usually did so at no or low cost, as part of their own professional support for medical missionary work. These doctors wielded great power over prospective missionaries' lives, as a negative report could crush a woman's professional plans. Medical experts did not always agree on candidates' fitness for work in India, however, and one negative report might be overturned by a different opinion, as is illustrated by Nurse Ayling's experiences. By the early 1910s, when there was a great demand for "trained English nurses" at missionary hospitals in India, Miss Ayling, a trained and experienced nurse, applied to the ZBMM. The Candidates Committee thought Ayling was a good fit for the Babies' Home in Nasik, a station located near Bombay, which needed a full-time trained nurse.<sup>261</sup> But Dr. Macdonald, who often performed physical examinations for the ZBMM, did not provide a "satisfactory" medical certificate for her. This raised concerns, even though her personal physician had certified her for work in India. The

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<sup>260</sup> Minutes, 5 July 1911, ZBMM.

<sup>261</sup> The missionary organizations required fully-qualified women doctors before setting similar policies for nurses' credentials. By 1908, the British Directory for Nurses set mission societies' expectations for nurses as three years in a recognized training course, and then additional qualifications in midwifery, dispensing and tropical medicine. See Rosemary Fitzgerald, "Rescue and Redemption: The Rise of the Female Medical Missions in Colonial India during the Late Nineteenth and Early Twentieth Centuries," in *Nursing History and the Politics of Welfare*, ed. Anne Marie Rafferty, Jane Robinson, and Ruth Elkan, 64-79 (New York: Routledge, 1997).

committee decided to postpone a decision until “Mrs. Scharlieb” had seen her.<sup>262</sup> Dr. Mary Scharlieb, who had earned her medical qualifications in Madras in the late nineteenth century, was a pioneer woman physician in India and Britain. Although never a missionary herself, Scharlieb was a lifelong supporter of women’s medical missions in India, and served as an advising physician for several of the women’s missionary societies. Her opinion carried great weight. Scharlieb did recommend Ayling for Nasik, pronouncing her “quite fit for work in India.” The Committee “still felt it would be a great risk to accept her in the face of Dr. Macdonald’s report” and sought a third opinion, this time from a Colonel Dinnock, chosen because of his “great experience of the Bombay climate and conditions.”<sup>263</sup> The Colonel declared her unfit for India due to her tendency to rheumatism, and the committee declined her, albeit with regret.

Nurse Ayling may have accepted the WW’s decision and contented herself with a career in Britain, but one rejection did not necessarily mean the death of a dream. Applicants with poor health were sometimes encouraged to get well and reapply.<sup>264</sup> Others merely applied to a different society. The ZBMM was interested in a Miss Hadden, who had been rejected three years earlier by another missionary society on health grounds; she was therefore asked to obtain an additional medical certificate.<sup>265</sup> Eileen Snow applied to the CEZMS at the age of twenty-one, while still in medical school. She noted on her application that she had applied to the CMS but had been “[r]efused on medical grounds. To be seen again in two years. These years are now up.” Her health continued to raise concerns, however. “My chief fear for her is her health,”

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<sup>262</sup> Minutes, 2 October 1912, ZBMM.

<sup>263</sup> Minutes, 16 October 1912, ZBMM.

<sup>264</sup> Miss Comins, for example, was declined after Dr. Scharlieb gave her a very unfavorable health certificate, but asked to apply again at a later date. Minutes, 13 April 1897, WW.

<sup>265</sup> Minutes, 16 June 1920, ZBMM.

wrote one of her references. “She has much more spirit than she has strength and is working too hard at the School of Medicine—I am afraid every term lest she should break down with over strain.”<sup>266</sup> But Snow completed her medical training and did well. Six years later, another reference wrote “it is most encouraging to see how well she stands the physical strain of very strenuous work in spite of her fragile appearance.”<sup>267</sup> The CEZMS gave her a Class I medical report and accepted her.

For the doctors in training, Snow’s fluctuating health was not so unusual as to cause excessive worry. Medical training was considered both mentally and physically rigorous, and several women went on to lead successful medical careers after suffering breakdowns in health during their years of study and training.<sup>268</sup> When deciding to help Irene Parsons with her expenses, the committee recorded that “[s]ome fear was expressed that her health and ability would not prove equal to the strain of the long medical course.” The selection committee often noted that Parsons’ health was “again broken down” and her training spanned years. Societies therefore often intervened in order to protect the health of trainees. Doctors were sometimes ordered by their society to take several weeks of total rest between clinical rotations or after periods of intense study for exams. In addition to the medical reports required at the time of application, societies began to actively monitor women throughout their years of training. The CEZMS Medical Committee recommended that candidates in training should be inspected by the Medical Advisor at the end of each term of study, noting that it would pay the “usual fees” for

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<sup>266</sup> Fred S. Laurence to Miss Smith, 22 February 1923, in Eileen Snow’s “Blue Packet,” CEZMS collection.

<sup>267</sup> H. M. Churchill to Miss Smith, 15 March 1929, in Snow’s “Blue Packet,” CEZMS collection.

<sup>268</sup> For example, Madeline R. Shearburn’s poor health resulted in her taking a break from medical training to work as a governess for a while. A woman physician who reported on Shearburn’s progress noted that “[t]he duties are light and she is getting on happily.” Shearburn was born in 1887, and was still serving in Pakistan in the 1950s. See the CEZMS Candidates Committee records, 1907-1908, CEZMS collection.

any “special cases” that then required further consultation.<sup>269</sup> These regular health updates were presented to the committee for discussion.<sup>270</sup> Possibly because most nursing applicants were already working women, the societies seemed to scrutinize their health less than doctors-in-training, but when nursing Sister Rankin sought permission to engage in language study at the Oriental School, the ZBMM was torn. As part of her missionary training, Rankin was serving as the Night Sister at the Mildmay Medical Mission at Bethnal Green and “state[d] that she does not find the work too heavy”—which surprised the committee, as the work at Bethnal Green proved quite challenging for many. Otherwise promising candidates had “broken down completely after ten days of work” there, and had been promptly declared “unsuitable,” thus ending budding missionary careers.<sup>271</sup> Language study was valuable, but the risk of losing an experienced nurse like Rankin to the strain of overwork had to be weighed. Before the committee decided whether to allow Rankin to pursue her plans, they obtained a medical certificate on the “advisability of [Rankin] undertaking further work.”<sup>272</sup>

In the early twentieth century, the societies also took steps to manage future missionaries preexisting health problems. In 1903, after having dealt with a spate of dental bills, the CEZMS Medical Committee passed a resolution that candidates should “not be accepted for training unless the condition of their teeth is satisfactory.”<sup>273</sup> Dental expenses were so important that the CEZMS also resolved that it needed a “fully recognized Dentist from whom advice could be

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<sup>269</sup> Minutes, Medical Committee, 23 February 1904, CEZMS collection. The CEZMS Medical Advisor at this time was Mrs. Percy Flemming, M.D.

<sup>270</sup> Minutes, Medical Committee, 24 November 1903, CEZMS collection. The Committee also recommended that the Society’s Medical Advisor “be empowered, in communication with the Secretaries, to consult, when necessary, a Physician with special knowledge of Tropical complaints,” and offered to pay that doctor up to one guinea for each opinion.” This was to help evaluate the health of missionaries when they returned to Britain on furlough.

<sup>271</sup> The unfortunate candidate, Miss Hirsch, was consequently deemed “unsuitable” on the grounds of health. Minutes, Candidates Committee, 24 September 1906, CEZMS collection.

<sup>272</sup> Minutes, 18 October 1922, ZBMM.

<sup>273</sup> Minutes, Medical Committee, 26 May 1903, CEZMS collection.

obtained with regard to the dental requirements of Missionaries and Candidates.”<sup>274</sup> The ZBMM did not make the same policy for dental care, but when one missionary wrote asking for help with her “heavy bill” of £15.15, the committee noted that as this woman had “no private means” and had only taken a small furlough allowance, the society should pay the bill in full. “[I]t was suggested however that in future Missionaries should consult the Secretaries before incurring such a large expense, and if possible we should secure the services of an honorary Dentist.”<sup>275</sup> The societies often awaited reports on candidates from “oculists” and “auralists” as they assessed their future workers’ health. Even with such vigilance, these societies would continue to struggle with staffing problems caused by medical women leaving the missionary field due to health-related problems. By the 1940s, the attitude of one committee member—that an applicant could “stand the climate as well as anyone”—came to be acceptable.

Societies assessed an applicant’s background, religious knowledge and views, educational attainments, age and health, and even financial resources. These factors helped a society determine whether a woman was likely to become a useful worker, but there was still more. Prospective medical missionaries also had to have the right sort of personality and related skills to be an effective—and therefore useful—worker in the field. Aspects of these skills could be taught or honed, but not always successfully. This is why the missionary societies placed great faith in the power of missionary training programs.

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<sup>274</sup> Minutes, Medical Committee, 24 November, 1903, CEZMS collection. The next year the Committee resolved that each case of dentistry for missionaries in the Field would be “dealt with separately on its merit.” Minutes, Medical Committee, 31 May 1904, CEZMS collection. Throughout the years 1903-1907, the Medical Committee reviewed requests from several of its missionaries in India asking for grants to pay for their dentistry. See, for example, Minutes from 25 June 1907, when the Committee approved up to Rs. 100 for Miss McCubbin’s dental expenses.

<sup>275</sup> Minutes, 19 June 1912, ZBMM.



## 2.9 *Missionary Training: Leadership, Conviction, and Character*

After 1870, formal missionary training was required by British women's missionary societies as preparation for the missionary field. Institutions including "The Olives," "The Willows," Ridgeland College, Kenneway Hall, and Selly Oak were common places to train women for domestic or foreign missions. Many young women completed training programs by choice and paid their own tuition and board, planning on eventually affiliating with a missionary society. But most of the women applying for medical work with the WW, CEZMS, and ZBMM had not. The CEZMS typically first accepted potential missionaries "for training," sending them to a missionary training institution for one to four terms. If their reports—which were submitted after each term—were positive, they were likely to be accepted to become missionaries. All who entered training were not accepted for service. By the early 1920s, the WW Committee stated that at least one term of study at Kingsmead was "essential as preparation for missionary life" for its workers.<sup>276</sup> The ZBMM did not have as standardized an approach to training as the WW and CEZMS had. Instead, it sent candidates to various places, and sometimes just had them complete a correspondence course in Bible Study; the CEZMS insisted on residential training.

The curriculum and focus varied at each institution, but they all provided Bible and scriptural studies and lectures. Some institutions included introductory language study, Christian doctrine, comparative religion, and lessons on understanding other cultures. Future missionaries were also expected to pick up or hone practical skills, such as learning how to get along with others, how to defend their beliefs, communicate effectively, and to demonstrate spiritual growth. Finally, the training institutions usually included opportunities to engage in more "Christian" or "spiritual" work.

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<sup>276</sup> Minutes, 11 July 1922, WW.

Until the interwar era, most societies expected women to pay for their own missionary training.<sup>277</sup> Early in the twentieth century, many candidates in the CEZMS—which attracted more affluent women than some of the other societies—were able to fund their own training, just as many of the WW candidates were able to contribute up to £50 per year toward theirs. As with the case of salaries, in years when the budget permitted, funds to defray the cost of training might be available, but when finances were tight, societies might tell applicants that they would not be accepted if they could not find ways to pay for their own training. As medical workers became more important to societies, the willingness to fund them increased. As early as 1902, the WW was reminded that “[t]he available daughters of well-to-do-homes are not sufficient for the demand” for women missionaries, and the committee was encouraged to provide financial support to “those of poorer families.”<sup>278</sup> The CEZMS application asked all applicants if they could contribute to the cost of their training, but most of the twentieth-century medical women replied that they could not. Indeed, the doctors often explained that their lengthy medical training had exhausted their financial resources, and societies understood this. Women who were already working as trained nurses had salaries, but usually not enough money to put aside to support themselves if they were unemployed. Parents and relations sometimes went into great detail to indicate what they could spare to train an applicant, which societies appreciated. Other parents stressed that they would not provide support. Influential members of the missionary societies, such as the ZBMM’s Lady Wingate, could request that the Committee pay to send women like Miss Wright, a trained nurse, to Edinburgh for three months of “special training”

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<sup>277</sup> See Chapter Two: “Responding to the Call: Motivation, Selection, Training, and Preparation,” in Seton, *Western Daughters in Eastern Lands*, for an overview of missionary training and preparation.

<sup>278</sup> Minutes, 10 June 1902, WW. The quotation is from a letter from the Reverend Goudie, who was one of the Wesleyan missionaries in South India, working in connection with the WW missionaries.

and then promise to support her during six weeks of Bible Study, and this plan was routine for strong candidates.<sup>279</sup>

“Christian” or “spiritual” work was an important part of missionary preparation. Societies expected applicants to have done things like Miss Hallam: to teach Sunday School, volunteer or fundraise for the missionary cause, or work with the poor. Miss Green, another LOS certificate holder, was attractive to the WA because she had sought out three months of training in the Glasgow Maternity Hospital to be able to help the poor in scattered villages.<sup>280</sup> Dr. Althea Bolton had worked in the Christian Student Union.<sup>281</sup> Volunteering with the YWCA, the Girls Union Study Band, being a member of the Parochial branches of the CMS Gleaners Union were also good prerequisites. This type of initiative helped demonstrate an applicant’s “sympathy” for others and indicated how comfortable these women were when working with people from different backgrounds or who lived in different circumstances. Those who had worked as District Nurses had professional experience with the poor and needy, and references often saw district work as proof an applicant could “get on” with various personalities. As a rule, however, nurses and especially doctors, often lacked these experiences. Societies therefore made excuses for medical women, justifying their demanding academic and work schedules as incompatible for such “practical” work. But they had to get these experiences during training. Women like Nurse Roskilly, who applied with impressive experience in midwifery, general, and even military nursing, but with “undeveloped religious knowledge” and no background in

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<sup>279</sup> Minutes, 6 March 1907, ZBMM.

<sup>280</sup> Minutes, 10 March 1903, WW.

<sup>281</sup> Minutes, 13 November 1917, WW. The committee assumed that Bolton would probably choose to serve in China instead of India. Later the WW was warned not to send Dr. Bolton to any hot climate.

“church work,” were accepted with the understanding that she must complete—and self-fund—her missionary training.<sup>282</sup>

During the decades when the CEZMS accepted many prospective doctors prior to their completing or even starting their medical education, tensions sometimes arose around the issue of training priorities: the society stressed missionary training, the applicant—and sometimes others in her life—stressed the medical training. Noelle Long, an academically talented student, wanted to begin her medical training instead of first completing a term of missionary training, and her father, who was also a doctor, supported this plan. The committee told them both that Miss Long was only accepted as a candidate for probationary training, “and that the question of her entering the Medical Course will have to be considered later on.”<sup>283</sup> When Long was presented with a scholarship for medical training, the committee again denied her request to begin those studies, on the grounds that she would have only had one term of missionary training. Long, like others in the 1910s, was pressed to abide by the committee’s unanimous opinion that “it is most desirable and necessary that a candidate should have her theological training before entering the Medical course.”<sup>284</sup> The committee was also known to accept medical women on the condition that they would enter missionary training for a prescribed amount of time in the middle of their medical training—for example, after the second year. It took the “decided professional opinion” of Mrs. Percy Flemming, M.D. that such a break in the medical course “would almost certainly have disastrous results on her professional education,” suggesting that medical students instead pledge to enter “Theological training” after their

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<sup>282</sup> Minutes, 3 June 1919, WW.

<sup>283</sup> Candidates Committee minutes, 2 December 1913, CEZMS collection. Noelle Long distinguished herself as a medical student—unlike several of her contemporaries supported by the CEZMS who failed their exams—but then died of typhoid in January 1919, and thus never became a missionary. See Candidates Committee, 31 January 1919, CEZMS collection.

<sup>284</sup> Candidates Committee minutes, 11 July 1910, CEZMS collection.

medical studies.<sup>285</sup> Medical candidates also tried to negotiate with the committee when tempted by professional opportunities—such as a short-term post as a House Surgeon—which conflicted with the planned missionary training. In 1916, Grace Sherwood, who had failed her medical school exams on more than one occasion, and had been in training for nine years, told the CEZMS candidates committee that she could not give up her army surgical work and adhere to the plans to go to her missionary training program in order to prepare to leave for hospital work in India. Although the committee sympathized with Sherwood’s conviction that God had called her to surgical work at home during “the present crisis,” they reminded her “to keep in mind the call of God to missionary medical work among the heather which she received many years ago, and to allow nothing to stand in the way of ultimate obedience to that call.”<sup>286</sup> The committee was taken aback by Sherwood’s attitude and belief that she could “make final decisions without their sanction.” By the 1910s, the candidates finishing medical training often argued that postponing missionary training so that they could gain more medical experience prior to heading to India benefitted the missionary work, but they often met with resistance from the committee, which continued to see the missionary training as more valuable. This attitude did not entirely change until after the First World War.

Some doctors were skeptical of or even resistant to the need for missionary training. Doris Graham was already a doctor when she applied, able to fund all her training, and hailed from a family that supported missionary work—her sister was a missionary for the same society. Graham wrote that she expected her missionary training to be “as short as possible,” but the CEZMS thought that Graham needed guidance on how to deal with the spiritual needs of others. This need was on top of her “small” knowledge of the Bible, theology, and Christian doctrine, so

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<sup>285</sup> Candidates Committee minutes, 18 March 1907, CEZMS collection.

<sup>286</sup> Candidates Committee minutes, 29 September 1916, CEZMS collection.

both study and professional growth were part of the plan for her.<sup>287</sup> Those who embraced missionary training were smiled upon, for they helped to bolster the idea of the medical woman as a missionary “first.” Indeed, the ZBMM rejoiced when women like Nurse Nelson, whose “qualifications as a nurse seem to be all that could be desired,” was “anxious” to spend her remaining time in Britain “in acquiring a deeper knowledge of Holy Scripture” so as to be ready for work in India.<sup>288</sup> The WW was impressed when Dr. Constance Snowdon opted to postpone leaving for India because she felt she should first gain a bit more medical experience and take a term at Kingsmead, the missionary training college patronized by the WW candidates.<sup>289</sup> But many doctors did try to manage their missionary training so that they could continue to develop as medical professionals. Some negotiated agreements with their committees to allow them to practice at a clinic in the mornings, take missionary training classes and programming in the afternoons, and keep their evenings set aside for their quiet or spiritual time.

When the CEZMS accepted Dr. Lucretia Byrne as a candidate for training, the committee proclaimed her “just the sort of Candidate we need” because “[s]he appears to have just the qualifications which will be useful and the character which will make a first rate missionary. She is unassuming, straightforward and sensible: she knows her own mind and seems to have the courage of her convictions.<sup>290</sup> Medical women needed “courage of their convictions” to function

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<sup>287</sup> All from the Doris Graham’s “Blue Packet,” CEZMS collection. Graham applied in 1920.

<sup>288</sup> Minutes, 17 July 1901, ZBMM.

<sup>289</sup> Minutes, 11 October 1921, WW. Snowdon eventually married another Wesleyan missionary, the Reverend Frank Whitaker, who remained in South India and served as the first Bishop of Medak. Upon her marriage, Snowdon ceased to be a paid medical worker, but she did continue to do unpaid medical work as well as fulfill all the responsibilities expected of a leading minister’s wife. Her extra training at Kingsmead must have served her well. She was still on the Medical Register, and still in Medak, in 1959. Kingsmead was a training school for Quaker missionaries, but beginning in 1915, the WW began to use it for their candidates.

<sup>290</sup> Byrne was so valued by the CEZMS that they were willing to find a way for her mother to accompany her to her location in either India or China. Miss L. H. Shann, notes on Dr. Lucretia Byrne, 24 May 1923, in Byrne’s “Blue Packet,” CEZMS collection. Byrne was first sent to China, working there from 1924 to 1937, at which time she took charge of the hospital in Bangalore, India, for one year. She later returned to China, leaving only when the Communist government forced missionaries out in 1951.

as missionaries. They needed to be able to take on hostile local leaders or patients' relatives, to hold their own in debates on topics ranging from religion to infant feeding, and to maintain their faith and conviction in the importance of their life's work in the face of difficulties and discouragement. Byrne had strong recommendations for her medical knowledge and skills, and much to recommend her as a missionary, but it was through the training process that the society learned more about her potential abilities once she was sent to the missionary field.

Once immersed in her missionary training at Ridgeland College, problems related to Dr. Byrne's ability to lead as a missionary—and not as a physician—emerged. Although a competent doctor, and one who had pleased her committee by making great strides in her understanding of Church doctrine, in her “public and practical work” she was nervous and self-conscious. “She seems to find it almost impossible to lead in prayer even in our gatherings of students, where so many are much younger and less experienced than herself,” the report from Ridgeland reads, warning that “if she is going to be in charge of a hospital she will need to take a much stronger lead in spiritual things than she did [during her missionary training] at Mildmay [hospital].” The hope was that Byrne would eventually reach the point “where her reserve is entirely yielded, [and] the self-consciousness will cease to be a hindrance.”<sup>291</sup>

Training was also designed to help shape the future missionaries' behavior, attitudes, and outlook. As one missionary stressed, the communal life experience of the training home would “knock out” undesirable personality traits, such as disregard of others' opinions or needs, “inner solitariness,” the tendency to be bossy, or to fail to see other points of view. Sometimes the goal of training was to make trainees more tolerant. Eileen Snow's report explained that “undoubtedly her experience during training, her contacts with others, and her reading have

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<sup>291</sup> Mary Hooker's Ridgeland College report on Dr. Lucretia Byrne, 26 June 1924, in Byrne's “Blue Packet,” CEZMS collection.

developed her, so that, while still absolutely sound on all fundamentals, she is less dogmatic and more tolerant of the views of others than she was six years ago.”<sup>292</sup> Training could therefore prove to be an emotionally difficult process for some applicants. One of Ann Needle’s references had introduced her as a “normal and happy person,” but her training reports remarked that she was “difficult” and “resents discovering things in her that need to be changed.”<sup>293</sup> The ZBMM committee wrestled with concerns regarding Dr. Katherine Rogers: “Information received since her interview with the General Committee tends to show that she would require a great deal of training if she is to learn to live harmoniously with her colleagues in the mission field. She is evidently a girl of exceptional ability and strong character, but one who needs discipline and careful training for missionary service.”<sup>294</sup> Although the ZBMM was in need of doctors, the committee decided that accepting Rogers—with such needs for extensive training to reshape aspects of her personality—would be too expensive. Florence Priest wore a worried expression during an entire term and even developed a nervous twitch.

The ability to “express oneself” was crucial, and women were screened for this throughout the application, selection, and training process. Some women’s training included grammar and speech therapy. All had to learn to make public addresses. They had to be able to discuss matters of faith as well as medicine clearly and confidently, and also persuasively. One of the many reasons the CEZMS knew that Nurse Ellen Cox would never be a leader in the field was due to the fact that she could not “express the Gospel message in a vital and interesting way.”<sup>295</sup> One of the reasons Florence Priest made slow progress in her training was her

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<sup>292</sup> Report on Eileen Snow, 1929, in Snow’s “Blue Packet,” CEZMS collection.

<sup>293</sup> Report on Ivy Ann Needed, c. 1944, in Ivy Ann Needes’ “Blue Packet,” CEZMS collection.

<sup>294</sup> Minutes, 18 June 1935, ZBMM.

<sup>295</sup> Mary Hooker’s notes on Ellen Cox, 30 May 1947, in Ellen Cox’s “Blue Packet,” CEZMS collection. Hooker was the principal at Ridgeland Bible College for missionaries.



“still...very limited ...powers of conversation.” Training included structured reading, lectures, and study to help develop candidate’s thoughts, views, and communication—after all, one could not be an effective missionary if one could not communicate with others. Trainees were assessed on their progress during intense interviews with committee members throughout their terms of study.

Women who were shy or lacked self-confidence were under pressure to prove they could be effective missionary leaders. Rena Bowden was faulted for being “afraid and nervous” and for her tendency “to take the line of least resistance and to remain silent—even with friends.” Gwendoline Parks was “painfully shy and almost unable to make ordinary, normal contact,” suffering from a “deeply rooted sense of insecurity” and inability to trust herself. Her training therefore included working under supervision at the West Ham Central Mission where she could be observe effective “methods of dealing with great crowds of people.”<sup>296</sup> One of Ivy Canova’s interviewers worried that she was “a quiet unobtrusive little person” and another summed her up as “very young and undeveloped for her age which is 29.”<sup>297</sup> Neither doubted that Canova was a “true and sincere Christian” with a real desire to do missionary work, but her harsher critic warned that “unless she develops under training, she does not promise fitness for any post of responsibility or leadership.” For how could the society send a missionary overseas if she were unsure of her abilities to function, to make decisions, to stand up for herself, or to guide others? While experienced nurses who had been Sisters or Matrons had a proven record of leadership, the less experienced ones were still in positions that required blind obedience to not only doctors but their nursing superiors. Missionary training reports recognized this, and therefore had to help

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<sup>296</sup> Term Report for Gwendoline Parks, c, 1946, in Parks’s “Blue Packet,” CEZMS collection.

<sup>297</sup> H. Richardson’s evaluation, 27 May 1937; Margaret Grubb on Canova’s interview, 22 May 1937. Both in Ivy Canova’s “Blue Packet,” CEZMS collection. Richardson was writing for the Nurses Missionary League.

these women develop leadership skills to help them in the missionary context. Ann Needle's "quiet efficiency and capability" which helped her react calmly in difficult situations made her a "born leader."<sup>298</sup> Fiona McLeod was valued because she was "somewhat diffident as to her own powers, but...obviously has powers of leadership just in that inobtrusive way which is so valuable on the Mission Field today."<sup>299</sup>

It seems doctors were expected to naturally develop into good missionary leaders, possibly as outcomes of their rigorous training and education. For many of these women, their missionary assignment would essentially serve as their first "real" job after medical school and their clinical training—so, in most ways, they were untested as leaders. Missionary societies were therefore taking a leap of faith by assuming that these often young women would be able to quickly fulfill all the expectations on their shoulders. Committees received letters of recommendation from medical women's hospital and clinical supervisors which gave them an idea of their professional leadership skills, but serving on a clinical staff in Britain was different than being the lone doctor in charge of a medical station in India. Dr. Marjorie Morton's attending physician was pleased to recommend her by explaining that "[h]er work has been extremely well done and one has been able to delegate to her very much more than to the average house surgeon—indeed I have let her have practically sole charge of my varicose vein and haemorrhoid clinics."<sup>300</sup> How these clinical experiences would help Morton in India—where she would mostly engage in general practice—was unclear.

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<sup>298</sup> Letters on Ivy Ann Needle, 1944, in Needles's "Blue Packet," CEZMS collection.

<sup>299</sup> Fiona McLeod's "Blue Packet," CEZMS collection.

<sup>300</sup> Stuart D. McAusland to the Candidates Committee, 30 November 1936, in Marjorie Morton's "Blue Packet." Stuart adjusted well to India and proved to be a capable leader, whose service was recognized with a silver Kaiser-i-Hind medal in 1916.

At the end of Morton's medical training, it was not clear to the committee that she was destined to be a missionary. Like Margaret Roberts, Morton had applied to the CEZMS as a teenager. She earned the qualifications of L.R.C.P.& S., M. R. C. P., and the Diploma of Tropical Medicine, all the while professing to never doubt her goal of becoming a medical missionary.<sup>301</sup> Even so, when her actual acceptance for missionary training was under committee scrutiny nine years later, Dr. Morton was summed up as "very interesting: fine and capable recruit. Always pulling her weight...Plenty of ideas, resourceful but not self assertive...In many ways she is very immature both in thought and experience—very highly trained in her secular job not highly trained in her religious expression."<sup>302</sup> All of Morton's references were glowing—both personal and professional—yet Morton had to convince the committee that she was worth the risk of the cost and resourced required for missionary training. She sent a long letter detailing the non-medical experiences she had amassed over the past years so as to be ready for missionary work. These included being a member of the Edinburgh Medical Missionary Society, which allowed her to help run a mission dispensary in the slums, and to be involved in leading gospel meetings, a Women's Bible Class, a junior Sunday school class, and a Brownie Pack. She was a worker at various missionary camps and programs, gaining speaking and leadership experience. But this was not enough. One reviewer finally recommended "Bible and doctrinal study, and time to think things out, are what she evidently needs most."<sup>303</sup> After several terms of such study and missionary training—which added more than another year to her preparation—she convinced the CEZMS that she possessed a "strong

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<sup>301</sup> These stand for Licentiate of the Royal College of Physicians and Surgeons, and Member of the Royal College of Physicians. These credentials are exam- rather than degree-based.

<sup>302</sup> Miss Allshorn's notes on Dr. "Margery Norton" (sic), dated 1937, in Morton's "Blue Packet CEZMS collection.

<sup>303</sup> M. C. Outram to Miss Smith, 1 April 1937, in Marjorie Morton's "Blue Packet," CEZMS collection.

sense of missionary call.” She was accepted for missionary service in India once the CEZMS as certain that “[h]er words showed that she wanted to be a missionary and not simply a doctor.”<sup>304</sup>

## **2.10 Conclusion**

In 1904, the ZBMM committee made a list of questions to help guide the Society’s future policies related to training of candidates for medical missionary work. These included counting the number who had been trained, the amount spent on training, the number of years each trainee had then served, and the total cost to the society.<sup>305</sup> The underlying motive was to assess the effectiveness of the selection and training process, the main purpose of which was to avoid “missionary casualties”—those who resigned or could not do the work once they were in India.

At the turn of the twentieth century, the women’s missionary committees tended to see medical and nursing training as a means to an end—a process to provide a skill set and credentials, but not part of the actual shaping of missionaries. Indeed, the healthcare training could pose a threat to budding missionaries, as committees sometimes expressed concern that most medical students were not religious or wholesome companions; others believed that the strain of nursing or medical training proved to be the undoing of many women who might have been good general missionaries. The Clerical Secretary was pleased to report that Pernette Bourdillon—who had applied as a teenager and mainly because her parents pushed her—had “stood the test of training as a nurse well. She has come through as strong as at the beginning in the faith and in her conviction as to her calling.”<sup>306</sup> Throughout her many years of medical and then missionary training, Irene Parsons struggled with health crises and periods of grave concern

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<sup>304</sup> L. B. Butcher to Miss Chapman, 18 May 1938, in Marjorie Morton’s “Blue Packet,” CEZMS collection.

<sup>305</sup> Minutes, 7 December 1904, ZBMM.

<sup>306</sup> Clerical Secretary’s report, 17 June 1924, in Pernette Bourdillon’s “Blue Packet,” CEZMS collection.

about what she termed her lack of “Missionary enthusiasm.” Sustainable senses of calling and enthusiasm were crucial.

For Margaret Roberts, the years of medical training were a “real testing time and she more or less went under.” She admitted to much “backsliding” and enduring seven years of doubt before she chose to “recapture vital faith” and a “renewal of missionary vocation.” The committee were untroubled by this, however, as they believed that both her faith and dedication to her sense vocation were now stronger. In 1942, twelve years after she asked for an application, Roberts felt ready to enter missionary training, which lasted about a year. After that, the committee “sent” her back into private medical practice for three months, as a test to ensure that her missionary training was “well established,” but she again “slipped badly, still saying the right things but...living an almost completely self-centered life.” She was returned to missionary training for a few more months. After that, Roberts herself requested “three months of quiet” in a special missionary house, so she could spiritually ready herself before sailing to India. As had been the recommendation for Morton, “quiet” was crucial for Roberts to truly commit to her impending life as a missionary worker. The committee hoped this quiet time would allow Roberts to “turn the flickering light she now has into a steady flame.”<sup>307</sup> For the committees knew that medical women would need to see their faith and conviction as burning bright in order to become useful workers in India.

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<sup>307</sup> From notes in Margaret Roberts’s file, 1943, Roberts’s “Blue Packet,” CEZMS collection.

### 3 “I CHOSE NOT TO TURN BACK”: MEDICAL WOMEN’S ADJUSTMENT TO MISSIONARY LIFE

Dear Miss Hoare,

I think Miss Waight will do, if she can learn from experience, and I think that she probably can. India will be a shock, I fancy, but perhaps she needs one.

Yours very sincerely,

Eleanor McDougall<sup>308</sup>

This assessment of Esme Waight’s suitability for work as a missionary nurse may seem half-hearted, but was in fact an endorsement to send her to India. Throughout her application and training process, committee members and evaluators had wrestled with their concerns regarding Waight’s age, reserved personality, and difficulties speaking before others.<sup>309</sup> But her strengths included above-average intelligence, the ability to remain calm during crises, and adaptability. A solid nurse, her peers respected her—though not a leader, she promised to be “a good second.” In another letter, McDougall—whose career had spanned over two decades in India—provided additional support for Waight, explaining that she had the all-important sense of purpose, which could prove key in a missionary’s career: “I think that she is a little daunted by the obvious difficulties of understanding the mental habits of Indian women, but she is evidently very sincerely anxious to serve them and to make Christ known to them.”<sup>310</sup>

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<sup>308</sup> Handwritten note on index card in Esme Waight’s “Blue Packet,” n.d. (c. 1944), CEZMS collection.

<sup>309</sup> In addition to the regular cycles of interviews and deliberations, the committee had debated not only whether Waight was too old to adapt to India or possessed the ability to learn a new language, but also the likelihood of her overcoming personality flaws such as “rigidness in her face and hands,” and potentially crippling reserve. Waight’s evaluators found her difficult to talk to. Her unease in speaking before others was serious enough to cause the training institution to arrange for her to work with a speech pathologist.

<sup>310</sup> Eleanor McDougall, 23 November 1944, in Waight’s “Blue Packet”, CEZMS collection.

These qualities—adaptability, calmness, motivation to serve, and even a bit of apprehension about the challenges that lay ahead—helped tip the scales in Waight’s favor with the selection committee members. Her acknowledgement of the value of her training program, which she credited with not only providing her insight on how hard the work in India would be, but also with tools and strength to meet these challenges, reinforced the committee’s positive impression. Nevertheless, Waight, like all new missionaries, remained a risk for the society. She had been cleared as healthy and fit, but could become one of the many medical women who were sent home, certified too ill to work in India. New missionaries brimming with enthusiasm could fizzle out, sometimes unable to adjust to their new lives. Those who promised to be the most dedicated to a life of work could marry, abruptly ending their careers. Some who had the aptitude for study struggled with learning a new language. Nurses and doctors possessing great professional skills did not always work well with their missionary colleagues or with their Indian patients. And there were the women for whom the committees had low expectations, but who surprised everyone. Nothing about the future was certain when a new medical woman sailed for India.

In the nineteenth century, women who chose missionary work understood they were committing for life.<sup>311</sup> By the 1920s, expectations in the foreign missionaries’ community were changing. Many young missionary women viewed missionary service as but one phase of their lives, seeing marriage and other career possibilities open in the future.<sup>312</sup> The American

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<sup>311</sup> For a discussion of single women’s commitment to lives of service-related professional work in the nineteenth and early twentieth centuries, see Martha Vicinus, *Independent Women: Work and Community for Single Women, 1850-1920* (Chicago: University of Chicago Press, 1985).

<sup>312</sup> Sara W. Tucker, “A Mission for Change in China: The Hackett Women’s Medical Center of Canton, China, 1900-1930,” in *Women’s Work for Women: Missionaries and Social Change in Asia*, ed. Leslie A. Flemming, 137-57 (London: Westview Press, 1989). The decade between 1920 and 1930 saw a significant number of missionary women doctors marrying within the first few years of reaching India. Why this happened at this time is an interesting topic for further research.

missionary societies accepted this trend, and moved to require new recruits to commit for periods of as little as three to five years. The Minto Nurses, established by the former Vicereine to provide fully-trained nurses to serve the European community in northern India and Burma, also allowed its nurses to sign contracts for just three or five years. One Minto nurse thought her colleagues committing to five years made a mistake, for “the strain of five years’ hard work” tended to cause them “to become stale and disgruntled in the course of so long a period.”<sup>313</sup> Neither the fact that more women might have applied with less restrictive requirements, nor that the women’s foreign missionary movement was “fading into obscurity” could cause the British committees to lower their expectations.<sup>314</sup> The WW, CEZMS and ZBMM remained true to their ideal that their recruits viewed missionary service as their “life work.” The ZBMM made a small concession to the changing times by shortening the first term of service from six to five years, but that was all.

As the date to begin this “life work” approached, some women became daunted by the reality of this commitment, occasionally becoming ill from the stress or withdrawing the offer. When one doctor had a nervous breakdown on the eve of her departure, the WW called upon Constance Snowdon to go in her place, thus pushing her out a few months sooner than expected. Snowdon, a young doctor who dreaded leaving her mother, bravely responded, “I suppose one always feels a little awe and fear in the face of a big thing like a 5 years ‘contract.’ Such a lot

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<sup>313</sup> Constance. A. Wilson, “Never in Poona/The Memoirs of C. A. Wilson,” British Library, India Office Private Papers, MSS Eur C 251. Minto Nurses, who served as private nurses for European families would have had much lighter work loads, no requirements to learn Indian languages, and much more comfortable lives than would any of the medical missionaries in this study.

<sup>314</sup> Patricia R. Hill, *The World Their Household: The American Woman’s Foreign Missionary Movement and Cultural Change Transformation, 1870-1920* (Ann Arbor: University of Michigan Press, 1985), Introduction. For an overview of developments for British and Australian women missionary organizations in the first half of the twentieth century, see also Suzanne Parry, “Women Medical Graduates and Missionary Service,” *Health and History* 2, no. 1 (2000): 27-51.



may happen in that time but I am not afraid and I know that all will be well with those I leave behind me.”<sup>315</sup> This attitude of acceptance and faith was what the societies expected of their missionaries.

Committing to missionary life demanded this sense of conviction and purpose. The CEZMS and WW were very clear that missionary training was absolutely necessary, believing that it helped to weed out those who were less suitable, and to prepare women for service, but the selection committees and staff at the missionary training institutions knew that much remained theoretical and that in many ways, the candidates were untried. Training included working with the poor, in slums, and with the unchurched, but this would not be the same as working in a foreign land, in trying conditions, with women from other cultures and faiths. As McDougall noted, a successful missionary would have to “learn from experience” once in India. And while missionary publications provided vivid descriptions of conditions and culture in India meant to interest or incense potential supporters at home, these new medical missionary women were often shocked by the difficulties they faced. As Elizabeth Prevost explains, the official missionary publications consciously omitted many of the “harsh realities” of missionary life.<sup>316</sup> And unlike the missionary societies’ carefully crafted propaganda, there was little of the “glamour” or “romance” of missions in day to day missionary life.<sup>317</sup> Societies hoped that the

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<sup>315</sup> Constance Snowdon to Miss Bradford, 30 July 1922, WW, MMS, Haiderabad correspondence, 1058, 420. All was well for Snowdon, but not in the way she or her society had planned. She served as a missionary doctor for only a few years before marrying a fellow Wesleyan missionary. She spent the rest of her life in South India, serving primarily as a pastor’s wife, but still engaged in unpaid medical work.

<sup>316</sup> Elizabeth Prevost, *The Communion of Women: Missions and Gender in Colonial Africa and the British Metropole* (Oxford: Oxford University Press, 2010).

<sup>317</sup> See Hill, *The World Their Household*, for an in-depth analysis of ways the leaders of the women’s missionary societies used printed materials to appeal to middle-class emotions and to increase support at home. Although Hill’s study concerns American women, the same tactics were used in Britain. Judith Rowbotham explains that while missionary women were convinced of the value of their work, we cannot overlook the glamour and romance surrounding missionary work. Judith Rowbotham, “Ministering Angels, not Ministers: Women’s Involvement in the Foreign Missionary Movement, c. 1860-1910,” in *Women, Religion and Feminism in Britain, 1750-1900*, ed. Sue Morgan, 179-195 (New York: Palgrave, 2002).

training's focus on teaching women to see God—and obedience to Him—as the source of their strength, combined with a strong desire to “be of use” to the society and its goals, would keep new missionaries true to their sense of purpose.

At the conclusion of her probationary period, Dr. Mary Tomlinson recalled that when she was still in England, before commencing her work in India, it had been easy for her to imagine that because, as a medical missionary, she was doing God's work, she would become better at her work with every day. After nearly four years of service in South India, Tomlinson bitterly reflected that this had not been her experience.<sup>318</sup> Her life had been so much harder than she had expected “since I came out here and have had to meet trouble alone and afraid.”<sup>319</sup> Tomlinson, like most of her colleagues was nonetheless committed to the work. She credited her ability to do her work to her faith, which she felt was not strong always enough, explaining, “I chose not to turn back even if I wished to—If one could possess always the pure flame of His radiance ... it would be so very different ... sometimes I have it but sometimes—most times alas—it seems to be a flickering light at the end of a long dark road.”<sup>320</sup>

Tomlinson's use of the word “chose” in this comment about her early experiences as a medical missionary is significant. Scholars of the nineteenth-century women's foreign missionary movement have explained its rise and fall as closely related to the choices available to educated Victorian women. Missionary service was popular in the nineteenth century because educated women had so few choices, and it faded by the 1920s as more opportunities opened up for women. In her study of Australian women medical missionaries, Suzanne Parry dispels the myth that medical women who worked as missionaries did so because they had limited choices;

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<sup>318</sup> Mary Tomlinson to Miss Byrom, 29 May 1934, WW, MMS, Madras correspondence, 1069, 767.

<sup>319</sup> Mary Tomlinson to Mrs. Leith, 06 December 1934, WW, MMS, Madras correspondence, 1069, 767.

<sup>320</sup> Mary Tomlinson to Mrs. Leith, 23 September 1935, WW, MMS, Madras correspondence, 1069, 767.

certainly women doctor's professional lives were not always easy, but by the twentieth century, they had ample professional and personal opportunities open to them.<sup>321</sup> This was also true in Britain, where a significant number of nineteenth-century women doctors served as missionaries, but only a fraction of women qualifying as physicians in the twentieth century chose the missionary path—they were a tiny minority in the profession by the 1920s.<sup>322</sup> And those who did choose the missionary path continued to make choices once they were working in the field and faced with illness, loneliness, frustrations, and professional challenges: they could choose to learn to adjust and adapt, or they could choose to pursue other opportunities.

The most common reasons medical women left missionary service prior to retirement were due to poor health and family demands, both of which offered honorable reasons for resignation. But all medical women experienced health problems in India, including those that incapacitated women for weeks or were truly life-threatening, and few medical women voluntarily quit because of these. Many dealt with responsibilities to and demands from parents and other relatives at home.<sup>323</sup> Dr. Christine Willway left India after being plagued by poor health and her distraught mother's incessant demands—communicated both to her daughter and to her society—to come home. It seems understandable that Willway's miserable situation

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<sup>321</sup> As Parry and others note, it is important to remember that women missionaries from Britain probably experienced foreign missionary service differently than their colleagues who were themselves “colonials”—Canadians, Australians, New Zealanders. But Parry's arguments about how twentieth-century Australian women physicians had professional opportunities open to them is also true for those in Great Britain.

<sup>322</sup> David Hardiman writes that by 1900, there were 258 women on the British Medical Registrar, and 45 of these were medical missionaries working in India. See David Hardiman, “Introduction,” in *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa* (New York: Rodopi, 2006). Gaitskell claims that approximately one-fourth of all British medical women were working in India in 1900. Deborah Gaitskell, “Women, Health and the Development of Medical Missions: Some South African Reflections,” in *Gender, Poverty and Church Involvement* (2005). In the 1920s, women made up more than one-fifth of all medical students in Britain, but by the 1930s, their numbers had dropped to about 15 percent. See Mary Ann Elston, “Women Doctors in a Changing Profession: the Case of Britain,” in *Gender, Work and Medicine: Women and the Medical Division of Labour*, ed. Elianne Riska and Katarina Wegar, 27-61 (London: Sage Publications, 1993).

<sup>323</sup> Tucker explains that even the “New Women” who went into medical work often believed they would be able to juggle a career with marriage and family responsibilities, but her study of medical missionary women found that many of them left between 1915 and 1922 to either marry or care for aging parents.

would justify breaking her commitment. In most cases, however, equally serious problems were not enough to force women who wanted to stay to resign. For example, when Elsie Chapman's mother suffered a series of strokes, Chapman was granted special permission to return home to help support her family. It became clear that Mrs. Chapman could not recover, but she lingered for months. Elsie chose to return to her work in India, knowing that her mother would die before the next visit. This surprised and troubled her family, who expected her to see her first duty to her mother. "It has always been difficult for home folk to understand why I should choose the life I have," Chapman mused as she re-immersed herself in missionary nursing.<sup>324</sup> Societies accepted resignations under such circumstances, but expected missionaries to make decisions based on their commitment to missionary service, as Chapman had.

Adelaide Gault, who hailed from a "missionary family," arrived in South India as a young doctor, full of promise, impressing her missionary colleagues with her skills, work ethic, and dedication. But she only lasted about a year, returning home, like many women missionaries, labeled "unfit for work in the tropics."<sup>325</sup> What had happened after her auspicious start? Gault soon found herself the lone doctor at a remote station, lacking adequate medical equipment and drugs, working with no staff and only makeshift accommodations. She became overworked and suffered from health problems. Parry explains that Gault, like many of her colleagues who resigned from medical missionary service, did so because she "found the conditions—physically, professionally and emotionally—too arduous."<sup>326</sup> Gault went home,

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<sup>324</sup> Elsie Chapman to Miss Byrom, 9 December 1931, WW, MMS, Mysore correspondence, 1076, 920. It was common for missionaries to request permission to return home to help with parents, but most indicated that they would return. For example, Dr. Grace Gillespie asked for flexibility once her mother was in her eighties, explaining that although her brothers lived in Britain, she had duties to fill as the only daughter. But Gillespie stressed that she would definitely return to India once any emergencies were over. Gillespie to Walton, 18 January 1945, WW, MMS, Mysore correspondence, 1079, 1016.

<sup>325</sup> Parry, "Women Medical Graduates," 41.

<sup>326</sup> *Ibid.*

where she practiced medicine and maintained a lifelong interest in women's foreign missionary endeavors. Others, like Tomlinson and Snowdon, who experienced difficulties similar to Gault's, chose to persevere.

In Chapter Two, the societies' expectations for women going through the application and training stages were explored. This chapter will examine expectations—both those of the societies and those of the missionaries themselves—for medical missionaries as they began their life work in India. It will also look at how the physical, professional, and emotional conditions challenged these new medical missionaries' expectations, forcing them to make choices about their commitment to their life work.

### ***3.1 Embarking on the Work: Plans and Realities***

Medical missionary women arrived in India brimming with enthusiasm and excited to finally begin their life work. For many, the dream of becoming a missionary dated to their childhood, and the process of becoming a missionary had taken years. It was common for outgoing missionaries to become impatient during the last months or weeks prior to their departure. Dr. Grace Gillespie pressed the committee to arrange for her to sail as soon as possible; she felt that at the age of thirty-one, and after her financial investment in six years of training, she should not lose any more time.<sup>327</sup> She expected to engage in meaningful medical and missionary work as soon as she arrived.

The period before leaving was often a mixture of scripted activity and prescribed rest coordinated by the societies. The committees arranged for medical women to spend time with family or with designees who had special relationships with the society. Societies hoped to

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<sup>327</sup> Grace Gillespie to Miss Bradford, 29 November 1929, WW, MMS, Mysore correspondence, 1076, 923.

ensure supervised quiet time to allow women to recover their physical and emotional strength after the stresses of training, study, and exams; after all, many had experienced setbacks and difficulties during their training period. It was therefore reasonable that the society would want to build up a woman who had suffered periods of illness or struggled with stress before sending her to India, a new environment where many women encountered difficulties. The committees maintained communication during this time, writing letters reminding the women to take care of themselves. Such concern received mixed reactions, as some nurses complained that they could not bear to do “nothing” and doctors fretted that their skills and knowledge could become rusty. But the societies’ goals were to send out women with optimal health and mental calm.

The doctors had a tendency to assume that their medical preparation was the primary preparation necessary for the work—a few blatantly dismissed the notion of needing any additional spiritual training or development. The committees often decided that a bit more structured spiritual preparation was a good investment prior to sailing. Some women had instructions to engage in scriptural study with clergy or to reside in special training facilities designed for fostering quiet and reflection. After enduring several difficult months in India, one nurse remembered that while at her training center she had been unable to appreciate the “rules, quietness, hours of prayers and psalms, and lectures.” At that time, she had believed that, as a trained nurse, her days would have been better spent doing “some active work.” It was only after she, like Tomlinson, had experienced a “long dark road” and had been “alone and afraid” that she understood why her society had wanted her to build her faith and spiritual strength.<sup>328</sup> Those

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<sup>328</sup> Anonymous, *A Nurse’s Indian Log-Book: Being the Actual Incidents in the Life of a Missionary Nurse*, Westminster, 1925, p. 17.

were the last days of “no worries with time for serious thought, prayers and peace,” she recalled.<sup>329</sup> She had not expected the work to be so emotionally demanding.

While some women rested and reflected, others began active work for the society while waiting to sail. Many attended committee meetings and participated in society activities, often taking speaking roles to promote the medical missionary work. These experiences helped them prepare for the deputation work expected of them when they returned home for their furloughs, and also served to enfold them deeply into their society and work. As the departure date drew near, the societies organized formal events to build excitement about leaving home and starting a new life. Each society hosted a special send-off ceremony, which was both solemn and inspiring, complete with guest speakers, well-wishers, and public prayers for those about to embark on their new work.<sup>330</sup> Women often reported being deeply moved and impressed by the magnitude of their commitment.

The committees organized the new missionaries’ journeys, often so that they traveled in pairs or in small groups with seasoned missionaries on their way back to India after a furlough at home. While on board, some had ambitions to engage in language study or serious reading, and some took pains to act the part of a serious missionary, segregating themselves from most of the other passengers, but many admitted to spending the bulk of their time socializing. The ships stopped at ports such as Gibraltar, Tangiers, and Marseilles, allowing for quick excursions to “exotic” places. For the young and untraveled, this was an exciting time. For those prone to seasickness, it was a test of faith and endurance.

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<sup>329</sup>Ibid., 18.

<sup>330</sup> The speeches at these ceremonies were often published in the missionary magazines, and would have served to stir missionary ambitions in readers.

New missionaries disembarked in India with clear instructions on how to begin their new lives. The ZBMM had developed policies in print for all to refer, which included such details as specification of how much money a new missionary traveled with—in the early twentieth century, she traveled around the world and across the Subcontinent with £5 pocket money; the expectations on how she could spend it; to whom she would return the unused portions once she reported to her destination; and to whom she would report. The committees tried to send new women out during India's cooler weather, to lessen the "shock," but factors such as staffing shortages or the price and availability of ship tickets, could dictate that women arrived around the year. But as the goal was to ease these women into work in India, they were often sent first to stay with a clergy family or even to a missionary facility in a cooler place where they could begin to study the language and become familiar with India. Ideally, in addition to time to adjust to the climate, a new medical missionary had a period of lighter responsibilities, leaving her a few hours per day to learn how to be a medical professional and a missionary in India.

Even doctors and nurses with solid professional experience at home benefitted from the chance to observe and learn from missionaries who had been working in India. This philosophy applied to all new women missionaries. The ZBMM regulations stated, "[a]ll Missionaries going out for the first time shall be under the direction of the Senior Missionary at the Station to which they are appointed, and will be expected to regard her wishes with respect to their work, and to conform to any hints given to them as to the preservation of their health, and the prosecution of their studies, and to consider themselves generally under her guidance."<sup>331</sup>

The societies had learned from experience that new missionaries were likely to struggle with balancing the demands of their work with language study, maintaining their health, and

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<sup>331</sup>"Regulations for Missionaries, Assistant Missionaries, and Native Helpers," 1894, filed in ZBMM Minutes.



adjusting to a new environment. New women arrived with experience of how to run a clinic or ward at home; how to relate to patients at home; how to train and supervise nurses at home; or how to do surgery and perform procedures at home; but these strategies and skills would not always translate smoothly to the Indian context. When difficulties arose, some new medical women failed to cope well. By the twentieth century, committees acknowledged this and made efforts to provide appropriate support.

When possible, doctors were sent to spend their first weeks or even months under the tutelage of a more experienced doctor. This practice became policy in the CEZMS. The ZBMM so strongly believed that a new doctor should not have the sole responsibility of running a hospital that the committee sometimes chose to temporarily close a hospital rather than expect or allow a new missionary to take on such responsibilities.<sup>332</sup> For example, when the ZBMM was in the process of opening the new hospital at their station in Nasik, the committee agreed that no new missionary could be sent there without first having “a time to learn Indian experience” at one of the other mission hospitals.<sup>333</sup> The committees strived to carefully match each new missionary doctor with the right veteran to mentor and teach her, taking age, professional experience, and personality into consideration. The usual practice was to send a new medical woman to a station run by a more senior—both in age and experience—medical woman in the same society. Dr. Marjorie Lambert had an unusual breaking-in period, for she was sent to work first with Dr. Greenfield, in Poona, and then under a man, Dr. William Wanless, a pioneering Presbyterian medical missionary. Her committee believed Lambert’s success would be

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<sup>332</sup> For discussions on this topic, see the ZBMM minutes from 1904, especially 18 May and 16 November.

<sup>333</sup> Plans for staffing the Nasik hospital became more complicated when Dr. Evelyn Lea-Wilson’s father—who was providing much of her support—insisted that she be posted there. The nurse, Miss Underhill, who was to accompany her was also a new missionary, so the committee scrambled to find another missionary doctor willing to spend a few months at Nasik to help Dr. Lea-Wilson and Nurse Underhill learn to run the hospital. They asked doctors from other missionary societies as well as attempted to hire an Indian Assistant Doctor.

improved by time with other doctors who knew how to run an Indian hospital in the same geographical, cultural, and linguistic area as Lambert's destination.<sup>334</sup>

The plans for new medical women to arrive before the temperatures soared and to have time to work with and learn from a seasoned colleague was the ideal model, but not always possible. By the second decade of the twentieth century, at the urging of the workers in the field, most societies had committed to the goal of keeping two medical women—meaning doctors—at each station. In addition to avoiding the undesirable situation of having an inexperienced doctor alone, this policy also was to prevent doctors from becoming overworked and to increase each station's capacity and productivity. To best support the work and the workers, the home committees carefully planned furloughs, arrivals, and departures, drafting and approving where each medical missionary would be posted and with which colleagues. But these plans were made by the committees—who were meeting in London and basing their decisions on letters and reports coming from India—and time, distance, and the day-to-day developments routinely derailed the best-laid plans. Staffing shortages linked to financial difficulties, illnesses, resignations, and various demands on the societies and their workers meant that many new women were quickly “alone” and possibly “afraid.” It was therefore something of a leap of faith that the WW committed to sending out Dr. Althea Bolton, whom the Medical Board had cautioned against sending to “too hot a climate or too heavy a post,” for it seemed all the posts could prove “too heavy” for a new medical missionary.<sup>335</sup>

Dr. Constance Slater's short career with the ZBMM illustrates how the work, combined with staffing shortages, could push a new missionary to the point of leaving service. Slater had

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<sup>334</sup> Lambert was destined for Nasik (Nashik), in western India, so sending her to Poona (Pune) and Miraj are all located in the state of Maharashtra. The other ZBMM stations were in the North and Northeastern regions.

<sup>335</sup> Minutes, 12 March 1918, WW.

been born in India to missionary parents, and had reasonable expectations for her work. She began her missionary career in 1904, and due to other doctor's unexpected medical problems, quickly found herself in charge of the Lucknow hospital. During that year—which was a typical year—the hospital had 604 inpatients, 5,497 outpatients, 89 patients treated by home visits, 241 “lady doctor” patients, and 17,503 patient visits at the dispensary. Her first year was also marked by a major outbreak of the plague in the city, which added to the hospital's regular work. Few patients came to the mission's plague camp—which dismayed the staff—but if they had, Slater's case load and work would have been harder. The committee commented from London that this situation was “hard” on a doctor who was so young—she was only twenty-five—and new to medical work in India—she had completed her medical training only the year before. But she received no special concessions.<sup>336</sup> Soon Slater was transferred to run the ZBMM hospital at Benares in order to fill a vacancy at the Victoria Hospital.<sup>337</sup> In January 1907, Slater asked to resign, explaining that her health had suffered excessively for the past two years, and she needed to find a position elsewhere. The society initially ignored her—which they could do since she was under contract—but her parents also wrote stressing that they wanted her to leave service in order to preserve her health; Slater was granted a furlough at home.<sup>338</sup> After a break in England, Slater returned to India, and the ZBMM decided to place her in charge of a newly opened hospital at Jaunpur. The Jaunpur hospital had many problems, and Slater's health quickly broke down.<sup>339</sup> She was replaced by Dr. Harriet Cockburn, who was also a new missionary, and who

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<sup>336</sup> “Lucknow,” *Annual Report*, 1905, ZBMM.

<sup>337</sup> Benares was the British name for Varanasi.

<sup>338</sup> It is not unusual to find letters and even visits to London committee meetings from parents making requests that affected their daughters' work. Some of the CEZMS “Blue Packets” contain more correspondence from parents than the applicants themselves, and these applicants were usually in the 20s or even older. Good examples include Pernette Bourdillon and Irene Parsons. Parents' wishes carried much weight with the committees, possibly more than those of the actual missionaries.

<sup>339</sup> This hospital was never very successful and was quite short-lived.

also quickly had to be replaced due to poor health. By 1909, Slater was back at Lucknow, filling in while the senior doctor was away. But soon Slater reported that the new junior doctor's health had deteriorated to the extent that she had been sent back to England; much of the remaining Lucknow staff was also ill, so the society suggested that Slater take a furlough to Australia to recover. But this break included the condition that Slater would work to build up Australian support for the ZBMM auxiliary—this meant considerable travel, networking, and speaking responsibilities, which many medical women found less than rejuvenating. The committee expected Slater to then return to work at the Benares hospital. Before Slater could sail for Australia, the ZBMM lost another doctor to a serious accident, and Slater chose to stay at Lucknow to keep the hospital open. By 1910, Slater was in Australia, never to return to any ZBMM hospital. She had become one of the many medical women described by her society as “broken down.” It is easy to imagine that the stress of moving around northern India, constantly adjusting to working at different hospitals, and always dealing with staffing shortages and uncertainties would be physically, professionally, and emotionally taxing; and such conditions could be permanent, as Mary Proudlove, a WW doctor, complained during her fourteenth year of service that she had ten “shifts” of location in just four months. Yet Slater proved professionally resilient: her medical career lasted much longer than her career as a missionary in India. She practiced medicine in Australia, she worked in hospitals in Serbia during the First World War, and was still working for the Red Cross and active in the professional world in the 1940s.<sup>340</sup>

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<sup>340</sup> Slater participated in professional conversations as is evidenced by her letters to the editor of the *British Medical Journal* in the early 1940s. She died in England in 1968. Slater, like Cockburn and Dr. Helen Hanson—all discussed in this chapter—served in Serbia and other continental European stations during the First World War. Many British medical women served on the continent because the British War Office dismissed women doctors' offers to staff women's hospitals at home, but they were welcomed if they wanted to serve abroad. See Anne Digby, *The Evolution of British General Practice, 1850-1948* (Oxford: Oxford University Press, 1999), especially 179-186.

Slater's less-than-ideal experiences in her first five years were not unusual. Soon after Dr. Ethel Douglas arrived at Lucknow, Dr. Beatrice Board—who had been sent to relieve Dr. Stillwell, who had also been ill—contracted a nearly fatal case of typhoid. Board was forced to spend several weeks convalescing, leaving the novice Douglas to run the station by herself. The home committee found this situation undesirable for Douglas and hoped to keep the patient numbers down so as not to overwhelm her—how they planned to do this from the London office was unclear, but it was a nice sentiment. When Dr. Ethel Landon first came to Nasik, she was the only doctor there since Dr. Evelyn Lea-Wilson was on furlough. This was a risky situation, but turned into a crisis when nearly the entire staff yielded to a “relapsing fever.” Landon became so desperate that she was forced to close the hospital for a period of six weeks before enough staff had recovered to carry on the work at a minimal level. This would not have been an easy decision for Landon to make, and she came under some criticism for it. When Constance Snowdon came to Medak, she joined Dr. Joan Drake, who had been in India for many years. But by this point, Dr. Drake was nearly blind from an ocular tumor and no one knew whether she could continue to function under the pressure of a busy hospital. Snowdon therefore quickly took the reins.

These types of situations required leadership from women whom the societies considered to be too new to be charged with the accompanying physical, emotional, and professional demands. Although throwing a new arrival into such roles was regrettable, experience had taught the societies that medical missionaries had to be able to cope with any set of demands that might develop. This was why such care to prepare them was taken while they were still at home. Once a new medical woman was sent to India, the society had to hope that the missionary would “come alive” and deal with the “shock” of missionary work.

### 3.2 *Physical Conditions*

By the Victorian era, Westerners had come to characterize India's climate as unhealthy for Europeans.<sup>341</sup> The dangers were believed to be especially rife for white women.<sup>342</sup> Over the course of the nineteenth century, more British men brought their wives to India, but western women living in India continued to have a reputation for poor health, yellowed skin, premature aging, and mental instability—all due to supposed feminine difficulties related to the climate.<sup>343</sup> Missionary societies expected their workers' health to be affected too; hence the attention to medical examinations and ongoing assessments of health during the selection and training process. Nevertheless, poor health posed the greatest risk for losing new missionaries, and anyone could become a victim of illness, injury, or exhaustion. The assessment, "she should stand the climate as well as anyone" was good enough for many selection committee members: in most cases, the key would be not whether the new missionary would get sick, but whether she was willing to work hard and endure despite health problems.

There was no way to know how the new recruits would react to illness until they were in India and sick. Not everyone was like Contance Slater, Beatrice Board and Joan Drake, who became very ill but returned to work as they recovered. Some new medical women lasted less than a year. Dr. Lena Fox arrived in Lucknow in 1900, only to be sent home on medical orders in 1901. Dr. Clelland endured but a few months before she was shipped back to England, never to serve the ZBMM again. Nurse Greenwood had worked in India before, but "broke down"

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<sup>341</sup> For an in-depth study of British changing views on climate and race, see Mark Harrison, *Climates and Constitutions: Health, Race, Environment and British Imperialism in India, 1600-1850* (New York: Oxford University Press, 1999).

<sup>342</sup> In missionary organizations that employed both men and women missionaries, the men argued that women had more difficulties learning languages, more difficulties with the climate, and more problems with their health—all due to the sex. Rhonda Anne Semple, *Missionary Women: Gender, Professionalism and the Victorian Idea of Christian Mission* (Rochester, NY: Broydell, 2003), 231.

<sup>343</sup> Margaret MacMillan, *Women of the Raj* (New York: Thames and Hudson, 1988) revisits this theme throughout her descriptive work on British women's experiences in colonial India

soon after reaching India as a missionary and was sent home. Dr. Donaldson came to Patna in 1919, but was at home on sick furlough before the end of 1920. Dr. Winifred Price required an operation a few months after beginning her work, and was then declared “unfit for the strain of missionary work in the plains.”<sup>344</sup> Dr. Bennet—who arrived in India in the same year as Price—was sent to the rescue, but immediately developed malaria and was therefore no help. Such outcomes—all too common—proved disappointing for the committees which had spent time and money attempting to ascertain that these women had good health and stamina. Ironically, it was often the women who had been forced to prove that they were healthy enough to be accepted who withstood the climate the best. Aileen Pollock, for example, had been turned down more than once for health problems related to her cleft lip, only to then spend twenty years successfully practicing in India before dying from exhaustion.<sup>345</sup> Eileen Snow’s fragile health during her medical training did not translate into poor health in India: after serving the CEZMS for more than twenty years, in 1948, she then assumed the position as Director-Principal at the Christian Medical College, Ludhiana, serving through the 1960s. She died at the age of ninety-two.<sup>346</sup>

Although illnesses could prove serious and life-threatening, missionary culture set the expectation for women to see poor health as a nuisance rather than as an insurmountable barrier to service. Aspiring missionaries would have expected to experience periods of poor health, and perhaps even welcomed it in theory, for some of the most inspirational women missionaries had

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<sup>344</sup> *Annual Report, 1927, ZBMM.*

<sup>345</sup> Seton Pollock and Maureen Pritchard, *Christ’s Servant—India’s Friend: A Memoir of Dr. Aileen Pollock of Ludhiana* (London: Westminster City Publishing, n.d.).

<sup>346</sup> The Christian Medical College, Ludhiana alumni society presents an annual award in Snow’s honor: the Eileen B. Snow Annual Alumni Award for Best All Around Graduate. This goes to a medical students who has also excelled in athletics, arts, and academics. See <http://cmcludhiana.in/alumni/>. In 1960, Snow became an Ordinary Officer of the Civil Division of the Most Excellent Order of the British Empire for her service in the Punjab.

died of illness at the height of their careers.<sup>347</sup> CEZMS missionary Dr. Fanny Butler, famous as the first fully-qualified British women medical missionary, for example, was glorified for sacrificing her life for the cause:

Both as a student, and later on in medical missionary work, there was a finish, a completion in all that she did; nothing was too good, nothing was too costly. Her life shines out more and more unto the perfect day, and indeed, ‘in a short time she fulfilled a long time.’ Born in Cheyne Walk, Chelsea, in October 1850, the sacrifice was completed and accepted in Srinigar, Kashmir, shortly after the completion of her thirty-ninth year.<sup>348</sup>

Butler’s biography—which was widely read—noted that within her first months in India, she had an accident that resulted in a broken collarbone and other injuries, which were followed by surgeries and several weeks of recuperation.<sup>349</sup> She then was struck down by severe dysentery. At her first post, her health was so adversely affected by the climate that she was ordered away before the next rainy season. Her biography details her nine years of missionary work, which were filled with multiple transfers, hard work, and a lengthy struggle with a Maharajah for permission to build a hospital, all marked by bouts of “the chronic dysentery,” which finally killed her. Working through suffering, even dying for the cause, was a glorious end for a missionary.<sup>350</sup>

Missionaries routinely expressed worries over their colleagues’ health, warning that a break-down was imminent, but rarely acknowledged their own illnesses or limitations. Their

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<sup>347</sup> For example, the young Dr. Marie “May” Hayes died in India in less than three years of service, and her edited letters were published by her mother.

<sup>348</sup> Mary Scharlieb, “Introduction,” E.M. Tonge, *Fanny Jane Butler: Pioneer Medical Missionary* (London: CEZMS, n.d.).

<sup>349</sup> The fact that the biography is still easily available in American libraries attests to its popularity when it was printed.

<sup>350</sup> As Gagan neatly explains, our western culture’s historical fascination with the ‘romance’ of missions is based on the fact that altruism and self-sacrifice are still pillars of our value system. Rosemary Gagan, “Gender, Work, and Zeal: Women Missionaries in Canada and Abroad,” *Labour/Le Travail*, 53 (Spring 2004): 223-46.



expectation was to push themselves, working through illness, for the work was so important and so urgent that no one could afford to rest for too long. And while the new missionaries afflicted with health problems might be given some sympathy, they were expected to learn to cope. For example, the Reverend Sawday sent several letters to the WW Home Secretary, urgently requesting another European woman doctor because the new and young Dr. Anne Banks was “not very well” and in need of a colleague to lighten her work load. Having no one to send, the Home Secretary suggested the hospital temporarily close so Banks could recover, but Sawday responded that, regardless of Banks’s health, this was “unthinkable.” He explained that it was true that Banks was unwell; that the burden of running the hospital left little time for her required language study; and that Banks was also dealing with a case of “ophthalmia,” but noted that “we all here get that!”<sup>351</sup> An analysis of the WW medical women reveals that many of them underwent appendectomies within the first years in India.<sup>352</sup> Such an illness and surgical procedure was merely mentioned in an off-hand way in letters, usually as an explanation as to why someone was away from her post for a while—not as something to cause worry.

The role models for new missionaries like Banks were the “old,” or more seasoned, missionaries who were guilty of working when they were sick or to the point that they could not work at all. Dr. Olive Monahan, one of the experienced doctors in Banks’s district, had lost her salary upon her marriage to a fellow missionary, yet she continued to fill the role of a medical missionary while balancing her duties as a clergy wife, mother, and mission hostess. She seemed tireless, but when in her twenty-first year of service, a colleague reported that she had “never

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<sup>351</sup> Ophthalmia was a serious eye condition, caused by infection which was often tied to dust and flies, and was rampant in areas of poverty. Reverend George Sawday to Miss Bradford, 12 June 1921, WW, MMS, Mysore correspondence, 1075, 896.

<sup>352</sup> Troubles with the appendix were probably linked to the change in diet.

seen [Monahan] looking so seedy.”<sup>353</sup> Looking seedy was normal, and Monahan, along with several other colleagues, had dealt with a bout of dengue fever that year—dengue did not result in fatalities, but was quite debilitating. When new missionaries arrived, the “old” ones often commented on how “fresh and rosy and round” they were as compared to the “thin and yellow” veterans.<sup>354</sup> When Dr. Grace Mackinnon’s health had been poor for some time, her colleagues sent numerous reports to the home committee, warning that Mackinnon could not endure another hot season. Yet Mackinnon simultaneously sent conflicting reports, stating that she felt much better than she had in some time, denying the need for rest or a break from India. Finally three other doctors in her society posted a letter with a medical certificate—signed by each of them—attempting to send her home for “a change” before the hot season began, implying that working through another hot season would prove her undoing.<sup>355</sup> Mackinnon remained steadfast in her denial of being too unwell to work, as did most of her colleagues in similar situations. Dr. Joan Drake gradually lost most of her vision to an eye condition, yet she hid her decline from others for as long as possible. Once discovered, she traveled to continental Europe for treatment, and returned to India, finding ways to continue to work with permanently impaired sight. She offered to serve as a retired worker, or to merely help, receiving no salary, even paying for her own passage back to India. “I have plenty of energy and would be glad to expend some of it on India,” she explained.<sup>356</sup> The example and message to new medical women was to put the work before their own comfort and health.

When new medical women did not appear to choose work over their own health problems, they risked failing to meet the expectations of their colleagues and their society. Dr.

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<sup>353</sup> Edith Tucker to Miss Bradford, 9 June 1925, WW, MMS, Madras correspondence, 1068, 712.

<sup>354</sup> Christine Willway to Miss Bradford, 23 February 1930, WW, MMS, Mysore correspondence, 1076, 947.

<sup>355</sup> Minutes, 6 March 1895, ZBMM.

<sup>356</sup> Dr. Joan Drake to Miss Bradford, 27 September 1929, WW, MMS, Haiderabad correspondence, 1060, 431.

Sarah Sommer fell and remained ill from the moment she reached her post. She quickly announced that she required a second doctor to help her cope with the situation, causing her colleagues to conclude that she had “shrunk from [her] responsibility.”<sup>357</sup> She was sick with malaria, which was quite serious, and stayed in bed for seven weeks, followed by another eleven weeks after a brief rally. Her heart was affected, and special arrangements for her nursing and medical care had to be made. But Sommer also managed to become engaged to be married during these months, and no sympathy for her situation can be gleaned in the minutes documenting her brief career with the WW. Miss Georgina Green’s experiences, in comparison, were in line with expectations. Green was sent serve as the lone European medical missionary at the Indur station, the same place Sommer had found so difficult. But as the only European, and as a nurse attempting to run a medical station without a doctor, Green potentially faced a more difficult adjustment process than many of her peers. She quickly contacted a severe case of dysentery and had to be transported to a larger station so others could care for her. Green survived but colleagues reported that “she is not herself mentally.”<sup>358</sup> This was not the end of Green’s missionary career, however; she recovered and was soon sent back to Indur. She remained in the field until 1939, and, in her later years, often made mildly disparaging comments about the lack of stamina in the new and young missionaries.

Although some women who were truly dedicated to missionary work had to leave it due to reasons of health, it is possible that poor health provided a way out for those who became less committed to their decision to become medical missionaries. Enduring bouts of malaria was common, and not necessarily a reason to even cut back on work, let alone resign; Nursing Sister Vera Pitman’s colleagues noted that she had malaria, “but keeps up with her work in spite of our

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<sup>357</sup> Minutes, 10 April 1906, WW. Sommer was well enough to become engaged to marry during this time.

<sup>358</sup> Minutes, 13 September 1904, WW. Green’s training and adjustment are noted in the 1903-1904 minutes.

protests.”<sup>359</sup> Dr. Alice Musgrave developed tuberculosis after a few years in India and had to go to a sanatorium for a month’s rest. She apologized for “deserting my post in this way,” but reassured her society that she felt fine and would be back at her post soon—and she was.<sup>360</sup> Ethilda Meakin’s attitude was different. Meakin had impressed the WW committee as a perfect candidate. First, she had already completed four years of professional practice since finishing her degree, which included experience as an Assistant Medical Officer in a 200-bed hospital for women and children. She had financially supported herself throughout her medical education and training, and such resourcefulness also impressed the committee. As a teenager, Meakin had worked for a mission serving the Glasgow slums, and she claimed to feel called to the work at the Indur station, but hesitated to go to a new hospital where no other “lady” had been sent before.<sup>361</sup> She expressed concerns about the five-year commitment, explaining that should the work prove beyond her capacity, “she would be throwing away her life.” The WW was already £600 in debt, but found £125 for Meakin’s salary—which the WW noted was the highest salary paid by the ZBMM. This salary was significantly lower than what Meakin was earning at home, but she agreed to go out to start the work at Indur. Within her first weeks, she was struck down with two serious cases of dysentery. This required Dr. Elsie Watts, a still-new doctor at the Medak station, to come to care for her. Two months later, Meakin again had dysentery, and it was thought she might need to go home, possibly for good, as the hospital had been closed for two months due to her illnesses. The WW sent Meakin to recuperate at her brother’s home in Calcutta; she then ignored medical advice, returned to work too soon, and once again became too

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<sup>359</sup> Dr. Ida Scudder to Miss Byrom, 5 October 1932, WW, MMS, Madras Correspondence, 1069, 736. Scudder, an American, was one of the most famous medical missionaries. She was the principal at Vellore for many years where Vale served as part of the joint-missionary society endeavor.

<sup>360</sup> Alice Musgrave to Freethy, 20 April 1945, WW, MMS, Madras Correspondence, 1070, 779.

<sup>361</sup> By “lady” she meant European medical woman.

ill to work. Meakin asked the WW to send a second worker to help her—she did find the work too much for a single doctor—but then, only four months later, announced that the sea air agreed with her and that she had decided to accept a post in Bombay. She worked in India, in both Bombay and Calcutta, for several years, in women’s hospitals, but not as a missionary. She married while in Calcutta, and spent many years traveling between India and Europe, where she filled various postgraduate positions at European universities—she apparently traveled well. In 1917, she returned to Britain, where, although married with four children, she became a nationally-recognized psychoanalyst, and remained dedicated to her professional life until her death at the age of eighty-four. Meakin’s biographical sketches make no mention of her brief time as a missionary; it does not appear that she completed the missionary training that her society would come to see as mandatory; perhaps she was never truly committed and ready for the hardships she faced once on her own and sick at Indur.<sup>362</sup>

Acute illnesses were not the only physical challenge medical women had to learn to adapt to, for heat and conditions related to the Indian climate could prove to be formidable obstacles, affecting women’s physical and emotional health, and making their professional lives difficult. The trials of life in India’s climate are a common theme in literature about the British colonial experience.<sup>363</sup> The climate—typically characterized by heat, dust, and other harsh conditions—is credited with, at best, causing European women to become lethargic and depressed, and, at worst, to behave recklessly or to go mad. In memoirs and personal correspondence, the miseries

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<sup>362</sup> Minutes, 10 June, 14 October, 11 November 1902; and 20 January, 12 May 1903, WW. Meakin’s detailed obituary was printed in the 10 November 1956 issue of the *British Medical Journal*.

<sup>363</sup> For example, in Ruth Prewar Jhabvala’s novel *Heat and Dust*, the young bride Olivia’s fate is sealed when she refused to follow protocol to spend the hot season with other European women in the Simla, the fashionable British hill station; as her behavior toward her husband changes, he naïvely attributes her irritability and highly emotional state to the fact that as a western woman, she cannot cope with the heat.

of heat are often highlighted.<sup>364</sup> Medical missionaries were affected by these factors, too. In her report for her first year at Lucknow, Dr. Helen Hanson stressed that the work done by just one doctor at her station would be shared by two resident physicians, three visiting physicians, and two surgeons at a British hospital. At home, these staff members have significant experience—which she, as a young and recently qualified doctor, felt she lacked—and they would not have to cope with Lucknow’s “intense heat” which made everything harder.<sup>365</sup>

European women who could afford to spend India’s hot season in cooler climes—ideally the Simla Hill Station which offered a vibrant social life—typically did so, and many believed it was essential for their health and sanity. The women’s missionary societies also believed India’s heat was debilitating for Europeans and therefore mandated a series of breaks to sustain women during the five or six years between furloughs home.<sup>366</sup> The ZBMM required each missionary take an Annual Holiday of six weeks, with a minimum of one month spent at a hill station, decreeing “[n]o exception to this rule can be allowed unless under very special circumstances.”<sup>367</sup> Most women’s missionary hospitals closed or at least cut back during a few of the hottest weeks of the year allowing the missionaries short breaks to cooler locations to rejuvenate, but even when the hospitals were closed they continued to serve the inpatients, to run the dispensaries and clinics, and to make home visits. With the exception of a few missionary stations located in the hills, medical women had to learn to live and work in the heat.

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<sup>364</sup> See, for example, Macmillan, *Women of the Raj*; John Pemble, ed., *Miss Fane in India* (Gloucester, UK: Alan Sutton, 1985). Pemble’s first paragraph in the Introduction is about India’s heat and how it affected the “English ladies of the nineteenth century [who] were used to leisure; nevertheless leisure was a problem in India, where the climate frequently made even gentle pastimes exhausting.”

<sup>365</sup> “Report from Lucknow,” *Annual Report*, 1905, ZBMM.

<sup>366</sup> A Miss Tremeneere served the WW, and had been born and brought up in India. She therefore was not entitled to a furlough in Britain—and perhaps would not have wanted one. Fellow missionary Dr. Olive Monahan admonished the Home Committee, stressing that Tremeneere “is pure European, not Eurasian” and therefore needed time in England every five years if she was to keep her health. Monahan to Miss Bradford, 15 February 1913, WW, MMS, Madras correspondence, 1068, 681.

<sup>367</sup> “Regulations for Missionaries, Assistant Missionaries, and Native Helpers,” 1894, filed in ZBMM Minutes.

Nothing in their training could prepare British women—used to a cool climate—for these conditions. Those who arrived before the hot season were fooled, often writing home to stress that the heat was not intolerable. As it got hotter, they reassured those at home that they could cope. Nurse Isabel Linforth wrote that she was well and “on the whole prefer Indian climate to England’s, although sometimes it’s hotter than I’d like.”<sup>368</sup> Dr. Alice Musgrave had to take charge of the Madras hospital soon after arriving, but reported feeling amazingly calm, which was made more significant since she pointed out that the temperature had been hovering around 110 degrees. Dr. May Hayes, based on the intensely hot Delhi plain, reported to her mother that although the temperature was above one-hundred degrees, she did not mind and could carry on with her work. Two weeks later, Hayes observed that as the days grew hotter, her appetite diminished. On more than one occasion, acting on the assumption that she had spilled something, Hayes rushed back to her room to change her sodden petticoats, not realizing all she felt was her own perspiration. Soon after that, Hayes complained about the dust storms which made the days so dark that she could not read; on the bright side, she was pleased that the thermometer in her room had dropped to a much more comfortable ninety-five degrees.<sup>369</sup> With time, those who became veterans could adopt an attitude like Dr. Edith Tucker’s, whose only comment about the weather on a 104-degree day was that “it is very warm these days and it is difficult to keep dry.”<sup>370</sup>

New missionaries dedicated to their work did not want to be perceived as “weak” or unable to cope with the heat. Enid Stevenson and Mary Proudlove, both doctors, had arrived in South India together, and in their fourth year, Stevenson suddenly developed active tuberculosis,

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<sup>368</sup> Isabel Linforth to Miss Bradford, 6 July 1920, WW, MMS, Haiderabad correspondence, 1058, 416.

<sup>369</sup> Marie “May” Hayes to her mother, letters from May and June, 1906, in *At Work: Letters of Marie Elizabeth Hays, M.B., Missionary Doctor, Delhi, 1905-1908, Edited by Her Mother* (London: Marshall Brothers, 1909).

<sup>370</sup> Edith Tucker to Miss Bradford, 23 April 1931, WW, MMS, Madras correspondence, 1069, 738.

a threat to both her life and career. When Proudlove wrote to the Home Secretary, she opened by stating that during a spell of 112-degree weather, Stevenson took ill “for no apparent reason.”<sup>371</sup> It seemed important to stress that this was not due to Stevenson’s inability to cope with the heat. Stevenson herself requested that the society keep her diagnosis secret, as she did not want to worry her family. She also reassured the home secretary that she had put on some weight, made arrangements for treatment at a sanitarium, and would soon be better.<sup>372</sup>

As Hayes learned, dust affected working conditions in multiple ways. Hays explained that India’s dust coated every surface of her world, including her eyes and mouth; as the dust combined with perspiration, her hair became caked with mud. As she grew hotter, the mud melted and streamed into her eyes, making the most routine tasks difficult and potentially dangerous. Dust in the eyes—a common problem in much of India—was more than a nuisance: it led to eye infections. Countless Indians suffered from the “sore eyes,” caused by dust and the ubiquitous flies. Left untreated, it could lead to blindness. Medical women could treat their own eyes and did not have to worry about losing their sight, but the ongoing irritation was uncomfortable and tedious. And at least one doctor, Harriet Cockburn, was sent home during her first term due to “ill” eyes. Cockburn later served in Europe during the First World War and was recognized for her bravery and stamina. Before becoming a missionary, she had spent years working in insane asylums on reservations in her native Canada and the American Dakotas. She was a strong person and lifelong professional, but India’s dust and flies temporarily disabled her.

New missionary women also discovered India’s insects and animals as physical forces affecting their working conditions. One recorded that great numbers of black bugs were drawn

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<sup>371</sup> Mary Proudlove to Miss Bradford, 9 July 1928, WW, MMS, Madras correspondence, 1068, 719.

<sup>372</sup> Stevenson did get better. She also married a fellow Methodist missionary, and had two daughters, but did all of this after her first successful term of service.



to their lamps, and that one of the morning tasks was to sweep away masses of carcasses. But this report was as an interesting fact, rather than an expression of horror. The flies and mosquitoes were real health concerns. Dr. Tucker wrote that Dr. Mary Tomlinson, who had come down with dengue fever almost immediately after arrival—but was up and at work again soon—was “suffering much” from the “nuisance of eye flies” but had thus far avoided developing the “sore eyes.” Tucker observed that “[the flies] all seem to go for [Tomlinson] at midday. The rest of us are comparatively free. Like mosquitoes, they seem to like fresh blood in the country, or else they believe in newcomers having their trials and temptations.”<sup>373</sup> In an early letter to her society, Nurse Freda Vale wrote, “My impressions of India at the moment need sorting out. They are numerous and varied, but ‘squitos and insects generally are featuring pretty strongly at the moment, and my blood is already being sucked for the cause of India.”<sup>374</sup> The heat and dust caused Nurse Gladys Holmes to become quickly “smitten with a boil in the ears—a most painful malady,” but was cured by her colleagues without an operation.

Rats, monkeys, and snakes posed unusual problems. The Nasik missionaries complained that “in spite of our constant war against them, rats continue to rush about on the ceilings, and to make raids on the grain and spices in the store room, and on the corks and labels in the compounding room.”<sup>375</sup> In addition to eating grain stores, rats also carried the plague and were therefore even more unwelcome on hospital grounds. Ironically, dead rats signaled a plague outbreak and cued medical women to ready themselves for inoculation campaigns. European medical women, especially those who had done “district” work in urban slums, were accustomed to encountering rodents; none were ready to take on monkeys. The Patna hospital staff battled

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<sup>373</sup> Edith Tucker to Miss Byrom, 26 July 1931, WW, MMS, Madras correspondence, 1069, 738.

<sup>374</sup> Freda Vale to Miss Bradford, 2 February 1930, WW, MMS, Mysore correspondence, 1076, 944.

<sup>375</sup> “Nasik,” *Annual Report*, ZBMM, 1913.

the local monkeys, which seemed to delight in wreaking havoc on the building's roof. The cost of installing a monkey-proof roof was prohibitive, but a ruined roof—which let in rain—was only part of the problem. The monkeys were guilty of throwing roof tiles and other pieces of the roof structure on the patients lying in the beds below. Even the veteran doctor Ethel Douglas struggled to find a solution to the monkey problem, for some of the local people regarded the monkeys as sacred; harming the monkeys was out of the question. Douglas resorted to shouting and shaking her rifle at the monkeys, but with little effect. Snakes were another disturbing feature of Indian life. Miss Hughes wrote of how she dreaded snake-bite season, which accompanied the monsoon rains in Jaunpur. “They became a sort of nightmare to me ... I had barely seen a snake before coming here (except in a zoo) let alone tend to a snakebite case.”<sup>376</sup> With time, some missionaries became quite used to snakes. Upon discovering a very large snake in her bathroom, Mary Proudlove's only comment was “so now I go in quite delicately.”<sup>377</sup>

New missionaries also came to understand that the heat was not all bad. The plague, which wreaked much havoc in the early years of the twentieth century, and which caused the medical women much consternation, faded each year as the temperatures soared.<sup>378</sup> And, when the rains came, the wet and cooler weather brought a significant increase of other illnesses. But as unthinkable as it was to many Europeans, some of these women came to prefer India's climate to that of home. Grace Mackinnon, whose colleagues swore could not survive working through another hot season, adamantly avoided returning to Britain for her furlough. Mackinnon's concession to the concern for her health was to “take duty” at a different hospital in India—she

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<sup>376</sup> “News from the Field,” *The Zenana: Or Woman's Work in India*, April 1932.

<sup>377</sup> Mary Proudlove to Miss Byrom, 24 May 1934, WW, MMS Madras Correspondence, 1069, 761.

<sup>378</sup> Grace Mackinnon, “Report on the Duchess of Teck Hospital,” *Annual Report*, ZBMM, 1901.

preferred this as she dreaded the thought of returning home to face the British cold.<sup>379</sup> Although often ill and in such a state that she caused her colleagues alarm, Mackinnon, like other committed missionaries had adjusted to life and work in India, despite the physical challenges, lasting nearly twenty years before she was ordered home, “over-strained.”

### 3.3 *Professional Conditions*

Newly arrived medical women usually reported to their societies that they were happy to finally be in India and that all was well, but many of them were taken aback by the conditions that greeted them. Their working conditions—the facilities, their accommodations, the instruments, technology, and conveniences—were inferior to those at home, and failed to meet some women’s expectations. The condition of buildings, the rats, the compounds with no drainage that flooded during the monsoons, and the overcrowded hospitals demoralized some women. Olive Monahan wrote that the new nursing superintendent was “aghast” at the sanitary conditions of the old Madras City hospitals for women and children. One year, a large part of the annual report featured the “discomforts” the medical missionaries contended with, which included roofs with such large leaks that umbrellas had to be placed over the babies’ cradles; a mud wall that collapsed in the nurses’ quarters; and walls that were so rotten that nails would not stay, and the bed-head tickets kept falling down.<sup>380</sup> Dr. Edith Tucker reported that Miss Thompson, a new nurse from England, was probably “a little depressed about the Hospital. It

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<sup>379</sup> Minutes, 16 October 1895, ZBMM. Mackinnon eventually changed her mind, and practiced medicine in London from the 1910s until her death in the 1940s.

<sup>380</sup> The bed-head tickets were the medical notes on the patient, tacked to the wall above the bed. Olive Monahan to Mrs. Leith, 4 February 1936, WW, MMS, Reports, 1037, 66.

does look rather hopeless to anyone from Home seeing it for the first time but I think when she is here and in the work she will feel better about it.<sup>381</sup>

Perhaps these women should not have been as surprised as some were. The first sentence of Charlotte Vines's *In and Out of Hospital: Sketches of Medical Work in an Indian Village Mission*, which was published by the CEZMS in 1905, was "Forget entirely your ideas of an English hospital, and try to imagine a Zenana Mission Hospital in India."<sup>382</sup> The medical facilities were not "hopeless" only to those who were new to India. Dr. Ethelwyn Newham, who had been born in Madras to missionary parents and had lived much of her life near her new hospital, nonetheless complained that all the buildings were in need of repair, and the entire station required a good washing as well as new wood work and furniture. Perhaps her years in London for medical school and training had raised her expectations.<sup>383</sup>

What passed for a hospital or clinic or dispensary in India could be dramatically different from the facilities at home.<sup>384</sup> At the most basic, a dispensary was nothing more than an advertised meeting spot under the shade of a tree, a temporary tent, or where the medical worker's van stopped to provide roadside service. The staff at Nasik proudly reported erecting their own dispensary out of corrugated iron. It had four rooms, one each for consulting, compounding, surgical dressing, and examinations, but no windows and only two interior doors

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<sup>381</sup> Tucker was referring to the Ikkadu hospital, which was considered to be a bit of a challenge by nearly all the WW workers in South India. Edith Tucker to Miss Bradford, 16 January 1923, WW, MMS, Madras correspondence, 1069, 701.

<sup>382</sup> Charlotte S. Vines, *In and Out of Hospital: Sketches of Medical Work in an Indian Village Mission* (London: Church of England Zenana Missionary Society, 1905), 15. On the CEZMS applications, applicants were asked what they liked to read, and they typically cited popular missionary texts.

<sup>383</sup> Ethelwyn Newham to Miss Byrom, 18 October 1932, WW, MMS, Mysore correspondence, 1076, 928. According to immigration records, Newham returned to England in 1925 to become a medical student.

<sup>384</sup> "Hopeless" facilities were not unique to women's medical missions. Hardiman's work highlights the mission at Lusidaya, which, in 1925 was in "disarray" with worn out equipment and broken furniture. The tiny staff had abandoned treating patients in the hospital and instead walked to their homes. The new male doctor arrived with equipment for an operating theatre, but the facilities were too rustic with mud floors and a roof that could not keep out the dust. See David Hardiman, *Missionaries and Their Medicine: A Christian Modernity for Tribal India* (New York: Palgrave Macmillan, 2008), 165-66.

as the staff strived to use “utmost economy.” But this was seen as an improvement over the former dispensary, which was an old stable. Early hospitals were often existing buildings—such as bungalows—that the missionaries attempted to convert for medical use.<sup>385</sup> The Ludhiana hospital replaced its old mud houses with new private wards in 1917. Running water and electricity came slowly to most of the stations, in the late 1920s and 30s or even later in remote areas.<sup>386</sup> The water at the Patna hospital came from the Ganges and was “thick with mud,” thus requiring extra cleaning and boiling. Dr. Fleming rejoiced when the “electric lights” were installed at the Nasik hospital in 1931 as it they made it so much easier than trying to perform surgeries by the flickering light of kerosene lamps.<sup>387</sup> In 1939, the Nasik hospital’s challenges included drainage and sanitation. The newly installed septic tank was an improvement, and “modern sanitary arrangements [were] now actually functioning in the different hospital blocks and in the Nurses’ home,” but the European and Indian staff quarters were still without such facilities.<sup>388</sup> But even established, well-constructed hospitals run by these societies were “Indian” hospitals, which the committees had learned required quite an adjustment for most new women to run.

Nurses like Thompson had been trained to exacting standards of cleanliness, order, and what was “best” for patients, which often meant what was most efficient for a hospital staff. In

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<sup>385</sup> “Nasik,” *Annual Report*, 1912, ZBMM. Hardiman explains that until around 1900, most medical missionaries in Africa and Asia either practiced from their homes or used rented building that had been constructed for other purposes. See David Hardiman, “Introduction,” in *Healing Bodies, Saving Souls*.

<sup>386</sup> The Lusidaya hospital did not build a “modern” operating ward—one with electricity and running water—until 1952. See Hardiman, *Missionaries and Their Medicine*, 204.

<sup>387</sup> The new and plentiful water supply was a highlight of the ZBMM 1928 “Patna” report, and Fleming’s electric lights were reported in the “Nasik” section of 1931 *Annual Report*.

<sup>388</sup> “Nasik,” *Annual Report*, 1939, ZBMM. In the missionary societies featured in this study, the usual arrangements were for European missionaries to live together, separate from the Indian doctors, with the Indian nurses separate from both. It seems that these arrangements began to change in the 1940s. In her study of Chinese women physician missionaries, Shemo points out that living arrangements for European and Asians, which were separate and not equal in missionary societies, reflect important divisions. Connie A Shemo, *The Chinese Medical Ministries of Kang Cheng and Shi Meiyu, 1872-1937* (Bethlehem: Lehigh University Press, 2011).

her first report, Dr. Barbara Nicholson discussed the “daily struggle with dirt, superstition, and ignorance,” noting that “[w]hile it is true that we try to make hospital conditions as similar to the people’s home conditions as possible, we do not expect them to have absolutely no regard for our ideas of cleanliness.”<sup>389</sup> Each doctor and nurse had to decide how strict she would be about “cleanliness” and most learned to relent on some of their standards. As the missionaries adapted to life and work in India, they often had to also adjust some of their beliefs about the “right” way to run an Indian medical facility. Nurse Mabel Stringer complained that was “impossible for me to attend to the patients and keep the hospital clean.” She divided her time between patient care and whitewashing, painting, and lacquering while her colleague and station’s senior missionary, Dr. Marjorie Cartledge, washed the windows.<sup>390</sup>

Dr. Charlotte Vines moved most of her patients out on to the verandah for much of the year—it was so much cooler than inside; she also slept outside during the hottest season. By contrast, the hospital at Nagari—“not an ordinary place”—was designed with no outside verandahs because patients there felt unsafe on them.<sup>391</sup> Other arrangements that were unthinkable at home included nurses sleeping on the floors in the halls when the growing inpatient numbers meant there were no beds. A more common challenge for the missionary nurses was overseeing a ward filled with patients sleeping on floors or even under the beds.<sup>392</sup> The new staff also had to accept that they could not observe practices believed to be scientifically sound at home. All the mission hospitals struggled with caring for “phthisis”—or

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<sup>389</sup> Barbara Nicholson, “Lucknow,” *Annual Repot*, 1926, ZBMM.

<sup>390</sup> Mabel Stringer to Miss Bradford, 15 October 1928, WW, MMS, Mysore correspondence, 1076, 910. At this point, Stringer had been in India for two years, had been transferred to three hospitals, and was ready to leave service to get married. Yet she adapted and was apparently quite committed to her work, for she served as a nurse in her society in India from 1926-1965.

<sup>391</sup> Dr. Tucker to Miss Bradford, 2 May 1921, WW, MMS, Madras correspondence, 1068, 692.

<sup>392</sup> Patients could become quite creative in their sleeping arrangements. Those at the Lusidaya hospital resorted to building their own grass huts on the grounds. Hardiman, *Missionaries and Their Medicine*, 197.

tuberculosis—patients. Some placed them on verandahs, both to benefit from fresh air and to keep them away from other patients, but by the second decade of the twentieth century, most medical professionals agreed that they should be isolated. Medical practice also called for isolation wards to cope with the cases of smallpox, plague, measles, and erysipelas, but, due to financial constraints, most missionary hospitals lacked adequate spaces for patients with highly contagious diseases. Missionary pleas for funds to build such wards could go unanswered for years: in 1940, the Ikkadu Hospital still kept typhoid patients on the back verandah.

Instruments and supplies were often in short supply, which could surprise professionals coming from British hospitals. In the early years of medical work, home committees sometimes failed to comprehend that effective medical work required not only a qualified practitioner, but also appropriate supplies. For example, the WW responded to the requests for a woman doctor at the Karim Nagar station, but failed to make any provision for instruments or drugs. Joan Drake complained about how long it took for supplies to arrive from Britain and her inability to get cocaine and morphia locally since they required a special permit. In the late 1920s, Dr. Lambert stressed that patients' needs required the missionaries to try to bring the hospital as close as possible to European standards, and one important step would be the purchase of a new and larger sterilizer—but there was no money for this, just as there had been none in 1906 when the new Dr. Helen Hanson informed the committee that the Lucknow hospital “urgently” needed a sterilizer and asked if steps could be taken to secure one at once.”<sup>393</sup> The Ludhiana medical school had to “continuously” borrow the local Civil Hospital’s sterilizer as theirs kept breaking. The ZBMM committee’s typical response to such needs was to make an appeal “through some medical paper” and wait for someone to make a donation. In the mid-1930s, Dr. Pleasaunce

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<sup>393</sup> Minutes, 16 October 1906, ZBMM.

Carr, who was always positive in her reports, wished that her hospital had an X-ray machine. After she was abruptly transferred to another hospital, her adjustment was smoothed by the purchase of a high-pressure sterilizer and an up-to-date operating table, but these were made possible by a grant from the Inspector-General, and not through the missionary society. In 1931, the new doctor at Hassan found the fact that she had neither a sterilizer nor a microscope and therefore had to send things to another hospital for sterilizing, “an impossible position.”<sup>394</sup> Hospitals in possession of even one new and functional sterilizer were still at a disadvantage compared to those at home since a single small sterilizer limited a staff to but one operation per day.<sup>395</sup> In 1940, one missionary reported that “many of the resources of modern medicine are quite beyond our reach” but noted that her hospital did frequently use its microscope.<sup>396</sup> In the early 1940s, the WW Haiderabad hospitals hoped to eventually obtain an artificial pneumothorax to treat tubercular patients, but this was at the same time that antibiotics were introduced as the new treatment. Another new missionary noted that “[p]reventive medicine, x-ray therapy, electrical treatment are all unknown [at Akbarpur]. I find it difficult to believe that the need is less here than in England.”<sup>397</sup> During her third month in India, Dr. Grace Gillespie announced that “[w]ith £1000 I could make this a first rate hospital. I want £250 very badly.”<sup>398</sup> The new medical women were expected to accept that there would be needs that they would not have the resources to address.

Even while they were still medical students, problems could arise between the medical women and their societies over differences of opinion regarding needs for up-to-date supplies.

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<sup>394</sup> Grace Gillespie to Miss Bradford, 17 March 1931, WW, MMS, Mysore correspondence, 1076, 924.

<sup>395</sup> Hardiman, *Missionaries and Their Medicine*, 194-195.

<sup>396</sup> “Dharapuram Hospital,” 1940, WW, MMS, Reports, 1038, 99.

<sup>397</sup> “Akbarpur Women’s Work,” 1941, WW, MMS, Reports, 1038, 109.

<sup>398</sup> Grace Gillespie to Miss Bradford, 20 May 1930, WW, MMS, Mysore correspondence, 1076, 924.



When the future Dr. Beatrice Board was in medical school, she startled her committee by submitting a bill for medical texts and instruments. The ZBMM agreed to pay it, but moved that in future, all candidates must have prior permission before making any such purchases.<sup>399</sup> Board responded with a request that medical students be allowed to keep instruments and books used in their studies and training, to which the committee agreed. Prior to leaving for India, new missionary women had the opportunity to purchase items to start their new lives. These purchases included clothing and some basic domestic items, and medical workers could also ask for instruments, medications, and medical texts, and the ZBMM provided medical missionaries extra funds to cover the luggage fees to transport their supplies to India.<sup>400</sup> Savvy recruits realized that their future meager wages meant that if they did not make purchases now, they might never have another opportunity to acquire certain medical supplies. In 1924, Nurse Eva Bowes explained that she was taking instruments and a full midwifery outfit with her, irrespective of what was already at her future station, arguing that one could not have too many supplies and the work suffered if anything was missing. Doctors sometimes asked for medical items only to have their requests scrutinized or even denied by the committee. As Dr. Lea-Wilson prepared to head to Nasik in 1904 to serve as that station's first doctor and to open the long-awaited hospital, she asked to spend £25 on drugs; the ZBMM refused to approve this without guarantee of financial commitments from other sources.<sup>401</sup> Although the ZBMM saw this condition as strategic in terms of bringing in funding from other sponsors, had the money not come through, Lea-Wilson would have been in a new hospital with no medical supplies—an

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<sup>399</sup> Minutes, 17 July 1901; 16 October 1901, ZBMM.

<sup>400</sup> In 1895, the ZBMM resolved to allow Medical missionaries—the doctors—an additional £2 over the regular amount of £3—bringing their total to £5. Minutes, 3 July 1895, ZBMM.

<sup>401</sup> Minutes, 15 June 1904, ZBMM. The Nasik Hospital was to be supported in part by the ZBMM Canadian auxiliary. Lea-Wilson was later approved to spend £100 to outfit the hospital, with the understanding that everything was for the hospital and not for her.

impossible situation for a doctor. Nearly twenty years later, when Constance Snowdon requested what the WW considered to be an unusual amount for medical instruments, she was told that if the requests were on behalf of a medical missionary who was already in India, then her list was approved; if the request came solely from her, then it was denied.<sup>402</sup>

The requirement for medical women to go through their societies to gain access to up-to-date medical information became more challenging as changes in procedures, pharmaceutical developments, and techniques became more rapid. In 1901, one of the ZBMM doctors asked for money to buy new medical books for the Lucknow hospital, which was growing. The committee denied the request, explaining that “in the present state of funds no money can be spared for this,” but agreed to list the appeal in the monthly magazine. The doctors’ access to medical information was therefore left to the whim of magazine readers in Britain who would have to choose to make a special donation for this rather unexciting cause.<sup>403</sup> The WW provided their accepted missionaries with a book allowance, which let women request books to help them prepare for their new life. The non-medical missionaries often chose books about the general missionary experience, while doctors and nurses often chose medical texts. All requests had to be approved, which could take time. As Dr. Mary Tomlinson explained, she hoped to spend her money while still in Britain as she “should love to read up on tropical diseases before I meet them.”<sup>404</sup> On the other hand, Freda Vale, a nurse, chose only three medical books, and nineteen texts on religious topics, which impressed the committee more than had she asked for books on nursing topics. The WW on occasion offered book grants to medical women already in the field,

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<sup>402</sup> Miss Bradford to Constance Snowdon, 8 September 1922, WW, MMS, Haiderabad correspondence, 1059, 420.

<sup>403</sup> The appeal was from Dr. Annie Cornall, Minutes, 17 July 1901, ZBMM. Appeals for things like supporting sick babies’ cots or for children’s toys at Christmas were much more likely to catch magazine readers’ attention. The committee did honor Cornall’s request for a Burroughs & Welcome Medical case later that same year.

<sup>404</sup> Tomlinson to Miss Bradford, September 1930, WW, MMS, Madras Correspondence, 1069, 737.

but still required that the requests be submitted to the committees for approval. Dr. Edith Tucker sent home a handwritten list of books she had purchased with the 1923 book grant she received, which included the *British Medical Journal*, the *Medical Annual*, *Manson's Tropical Diseases*, *Twilight Sleep*, Bannerjee's *Cholera*, Freud's *Psycho Analysis*, the *Pocket Dressing Instrument*, and Lady Barrett's *Social Problems*. Some of these titles seem like basic texts for a medical missionary in India, but they were not available to anyone in the area until she ordered them, and the committee did not trust this doctor with experience of working in India to decide on her own what was needed for effective medical work.

The chronic staffing shortages also made life difficult for new women in terms of keeping up professional standards. As Dr. Douglas explained, because her hospital was always understaffed, she was forced to not only work hard to prioritize but to also leave a lot of work “undone.”<sup>405</sup> The revolving medical staff at the Patna hospital in 1914 is a good example of this type of challenge: one medical woman left for her furlough, then another caught a fever and had to be sent to the hills from May to October; then the remaining doctor became so ill that she was sent home to for an operation; and the doctor who came to help left during the year for War service. After that, the nurse and the medical assistants decided to gradually reduce the number of in-patients to half so they could manage the dispensaries, and they made arrangements to send urgent surgical cases to the Civil Surgeon. This was better than closing the hospital, but far from ideal. Doctors also had to make tough choices due to their makeshift conditions. Hospitals without operating rooms had to determine which operations could be safely performed there, which patients needed to be sent elsewhere—often at great risk to the patient—and which cases must do without an intervention that could improve or save a life if they had the money to build

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<sup>405</sup> “Lucknow,” *Annual Report*, 1911, ZBMM.

and equip an operating room. As the government began to provide health care and often erected “magnificently equipped” hospitals near the modest missionary stations, the inadequacies at typical missionary facilities was quite evident to new medical women, causing some of them to question whether missionary practices and priorities were good enough.

Scholars have argued that one of the reasons single women chose missionary life was the freedom it offered them: they could choose an honorable full-time career, live in foreign lands, and make decisions about their lives without the approval of husbands or parents.<sup>406</sup> There was also the “romanticism” of missionary life. And then there was Dr. Claire Thomson’s teenage idealism of choosing to become a missionary because she wanted “to be a martyr.”<sup>407</sup> One challenge that missionary women faced—and that probably did not become clear until in the field—was the fact that becoming a missionary meant joining an organization that dictated many rules about how one lived and worked. Just as tensions emerged between the society and individuals during the training process, they did so again during the adjustment process once in India. And this may have been especially difficult for some medical women. As doctors, these women had been trained to make decisions, give orders, manage patients, and serve as hospital administrators. Nurses had been trained to take and carry out orders, so their perspectives on adjusting to professional life as members of missionary societies may have been different than the doctors’, but both groups were trained as healthcare professionals. They were supposed to use their training and skills to care for patients, according to their professions’ standards. But

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<sup>406</sup> Beidman has also pointed out that missionary women never portrayed missionary work as a route to more freedom—instead they were being obedient wives or obedient to God—but they were often surprised by the amount of freedom and autonomy they enjoyed once in the field. Whether missionary life was “liberating” for women, as Beidman argues, is open to interpretation. See T. O. Beidman, “Altruism and Domesticity: Images of Missionizing Women among the Church Missionary Society in Nineteenth-Century East Africa,” in *Gendered Missions: Women and Men in Missionary Discourse and Practice*, ed. Mary Taylor Huber and Nancy C. Lutkehaus 113-43 (Ann Arbor: University of Michigan Press, 1999).

<sup>407</sup> The societies in this study screened to insure that they did not recruit women who were attracted by the idea of martyrdom; societies admired self-sacrifice, but not martyrdom.

they also had to follow the policies and rules of their societies—which reminded them that they were “missionaries first” and doctors or nurses “second,” as well as defer to the society hierarchy for most decisions.

At the time of application, women had signed documents agreeing to the missionary policies and regulations. Applicants were also asked if they were willing to engage in the type of missionary work their societies determined was most needed by the greater organization. Some medical women agreed—they were willing to leave medical work to go into teaching or evangelism if asked. Doctors were not asked to leave medical work, but nurses did sometimes move into areas of work that were more in the realm of social work than strictly medical work. After spending her first year at one station where she engaged in village touring, Nurse Linforth was philosophical about her unwanted transfer, noting “I feel that kind of work would be much more in my line than the supervision of a boarding school.” She explained she did not wish to complain or suggest that she wanted to choose where she went or the work she did, and that she knew the home committee had made this decision after praying for guidance, and promised “I will pray too that I may be sent to do the work God would have me do.”<sup>408</sup> Others were less gracious with unexpected assignments. Eva Bowes had expected to do village work but soon after arrival was instead sent to work in a hospital, due to another nurse’s illness. “I have tried to keep an open mind regarding work out here so that I shall not take away from the usefulness,” but she admitted on several occasions to be very disappointed.<sup>409</sup>

Some missionary doctors had been trained in areas of medical specialty, such as ophthalmology or surgery, but found themselves assigned to stations where they could not use

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<sup>408</sup> Isabel Linforth to Miss Bradford, 8 August 1920, WW, MMS, Haiderabad correspondence, 1058, 417.

<sup>409</sup> Eva Bowes to Miss Bradford, 9 October 1924 and 12 April 1925, WW, MMS, Haiderabad correspondence, 1059, 394.

these skills. Dr. Donaldson had studied bacteriology, which, she explained, “in these days is so necessary for definite diagnosis and accurate treatment.” She lamented that her abilities to practice had been hampered by poor equipment and unreliable apparatuses.<sup>410</sup> Dr. Bennet, who specialized in conducting pathological examinations, was more fortunate, and able to improve the “efficiency” of her hospital. Elsie Watts, who had earned an M.D. and had special training in ophthalmology, asked for ophthalmic drugs, instruments, and chloroform, none of which she could obtain at her station at Medak. Her request cost £8. The committee refused to pay for anything beyond “necessities.” Although any medical woman in India could testify for the enormous need for ophthalmologic care, Watts’s committee thought of “necessities” as very basic care, and, of all the requests on her list, only approved the chloroform.<sup>411</sup> When Watts protested, she was reminded that the committee was reluctant to make any special investments in her work because she had only agreed to serve at Medak for one year. Others were asked to do work for which they felt unprepared. Dr. Dorothea Wigfield was reported as disliking surgery—or at least feeling unable to “tackle it alone”—and hoped to be placed with a colleague who wanted to do surgical work. But Wigfield was willing to accept the directions from London since “it is the work first and not the workers, so we must leave the appointment to [the committee’s] judgment.”<sup>412</sup>

In addition to asking permission for access to reading and study materials and medical instruments, the home committees continued to affect medical women’s daily decisions once in

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<sup>410</sup> “Patna,” *Annual Report*, 1920, ZBMM.

<sup>411</sup> Minutes, 8 October 1901, WW. Elsie Watts’ ongoing debates with the WW on the needs of the work, and her own professional goals span several years in the Minutes. She frequently threatened to quit, lobbied to be able to work with Muslim women (which would affect which stations the WW could send her to), and surprised the home committee by her efforts to raise £1000 to build and equip a hospital—but without running all her plans through the committee for permission. See Minutes, 1900-1912.

<sup>412</sup> Emilie Posnett to Miss Bradford, 4 May 1922, WW, MMS, Haiderabad correspondence, 1059, 445. Posnett was reporting on Drs. Wigfield and Snowdon. Dr. Dorothea Wigfield served in India from 1921-1965, and must have been quite adaptable.

the field. The control could seem petty or even misguided. When the Committee learned that Dr. Sarah Smith had left the station at Landour to travel to another hill station to care for a European lady who had typhoid, “[t]he Committee were greatly surprised and grieved” that Dr. Smith would “so completely forgotten the rules—no medical missionary will attend European patients.”<sup>413</sup> Exceptions could not be made, even though one might expect Christian compassion to outweigh a rule, and certainly a doctor might argue that it was her professional duty to help anyone who needed it. Perhaps such attitudes were part of the reason Sarah Smith left the ZBMM to marry before her first term was complete. Dr. Landon, who had to cope alone with ninety concurrent cases of fever—a fever which caused patients to be ill for weeks—accepted some boys into the “women’s hospital” and was criticized for it, but argued that she could not ignore their suffering. The WW home committee became outraged when they learned that one of the missionary nurses had moved out of the missionaries’ shared house to a room at the hospital. They eventually learned that the local missionary community had decided that this was best for everyone involved—having a nurse at the hospital at night had proved necessary—but the committee only relented by saying that in future, they needed to be informed of anything like this prior to it happening.

Medical women also had to remember that they were always representing their societies when they spoke publically, published writings, or joined other organizations. Dr. Helen Hanson is remembered for her service during all four years of the First World War. But she is more well-known for her role in the militant branch of the British women’s suffrage movement, for which she wrote articles, made speeches, and even served a short prison sentence. During her three years of work as a doctor at the ZBMM Lucknow hospital, she was reprimanded for

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<sup>413</sup> Minutes, 17 July 1901, ZBMM. The Committee promptly sent Dr. Smith information to remind her of the rules.

writing a letter in support of women's suffrage, which was published and in which she identified herself as a missionary in the ZBMM. It is quite possible that her society's request that she in no way link the organization with suffrage was one of the main reasons she chose to leave missionary work after only three years.<sup>414</sup> Hanson returned home to critique the women's missionary movement for its failure to support women's suffrage. The ZBMM's reaction to Hanson's public stand on suffrage was consistent with the other missionary organizations—it was western women's duty to fight to “elevate” the status of women in India, but not to critique their own status at home.<sup>415</sup>

But all the professional challenges were not bad. Medical women often noted that the positive side of being understaffed meant that they had ample opportunity to push themselves to acquire skills. Had they practiced in Britain, these women would have most likely been limited to careers in community and public health or family planning.<sup>416</sup> The mission hospitals, village

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<sup>414</sup> Hanson served in hospitals across Europe during the First World War, continuing her work in Constantinople into the 1920s. She was a member of the Women's Social and Political Union, the Women's Tax Resistance League, the Women's Freedom League, the London Graduates' Union for Women's Suffrage, and the Church League for Women's Suffrage. See Elizabeth Crawford, *The Women's Suffrage Movement: A Reference Guide, 1866-1928* (Oxford: Taylor & Francis, 1999). Elizabeth Prevost provides a detailed analysis of Hanson's evolution as a feminist Christian, explaining that her experiences as a missionary in India shaped her critique of women's political marginalization in Britain, as well as to chastise the women's missionary movement for its failure to understand that without the women's movement, the educational and medical work done by women missionaries would be impossible. See Prevost, *Communion of Women*, 229-235.

<sup>415</sup> Most scholarship from the 1980s and 1990s on the women's foreign missionary movement stresses this point: European and North American women dedicated their lives to working for change in women's status in Asia and Africa, but were careful to avoid association with women's rights at home. See, for example, Brouwer, *New Women for God: Canadian Presbyterian Women and India Missions, 1876-1914* (Toronto: University of Toronto Press, 1990), 190-195; Leslie A. Flemming, “New Models, New Roles: U.S. Presbyterian Women Missionaries and Social Change in North India, 1870-1910,” in *Women's Work for Women: Missionaries and Social Change in Asia*, ed. Leslie A. Flemming (London: Westview Press, 1989), 35-57. Scholars have moved beyond defining involvement in the suffrage movement as the litmus test for feminism in the missionaries. In *Communion of Women*, Elizabeth Prevost argues that Christian feminism was important throughout the suffrage movement, and uses Helen Hanson as her main example. She then focuses on the movement for women's ordination as the interwar Christian feminist endeavor. Guli Francis-Dehqani, “Medical Missions and the History of Feminism: Emmaline Stuart and the CMS Persia Mission,” in *Women, Religion and Feminism in Britain, 1750-1900*, ed. Sue Morgan, 197-211 (New York: Palgrave, 2002) argues for significant feminism in medical (and other) missionaries' motivations and work. In terms of the ZBMM's censure of Hanson, I wonder if the real issue was a missionary taking any political stance—for the societies tended to avoid association with politics—rather than that the ZBMM opposed women's suffrage.

<sup>416</sup> Rosemary Pringle, *Sex and Medicine: Gender, Power and Authority in the Medical Profession* (Cambridge: Cambridge University Press, 1998), 8.



work, and dispensaries necessitated that they gained wide experience. As Dr. Donaldson explained, “I have discovered that the Medical Missionary, besides acquiring an expert knowledge of most matters of every-day (sic) life, needs to be a specialist in most branches of medical study. To her come opportunities, even in her first year, which would only come after long years of patient waiting at home.”<sup>417</sup> Grace Gillespie, who was often highly critical of the difficult position missionary doctors and nurses were put in due to staffing problems, did acknowledge that “there is plenty of interesting surgery which I like most of all.”<sup>418</sup> The staffing shortages also caused the medical staff to pull together by the “ties of comradeship.” Nurse Bowes, who voiced many complaints during her first year, including those related to the disruptions caused by so much staff illness, noted that sickness drew the medical missionaries together, forcing them to get to know each other quickly. Such relationships could help women endure the difficult emotional conditions of missionary service.

### 3.4 *Emotional Conditions*

In the world of foreign missions, India was widely considered to be the most difficult field in which to work.<sup>419</sup> This was due to a combination of factors, especially the great challenges missionaries faced in terms of making inroads toward conversion. For medical workers, who by the interwar years tended to be open about the fact that little of their work could be seen as directly tied to evangelism, the emotional difficulties were often related to the general

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<sup>417</sup> Dr. Ethel Donaldson, “Patna,” *Annual Report*, 1920, ZBMM.

<sup>418</sup> Grace Gillespie to Miss Byrom, 13 December 1932, WW, MMS, Mysore correspondence, 1076, 924. The variety and opportunities to gain broad experience truly could be rewards despite the difficulties medical missionary women encountered. Had they remained in Britain, they most likely would have attained a clinical post in a hospital, a public appointment in the community, or gone into general practice. See Digby, *The Evolution of British General Practice*. In the introduction to *In the Steps of the Good Physician: Some Glimpses of CEZ Medical Work in India and China* (London: CEZMS, 1913), Charlotte Vines explained that medical missionary work was physically difficult, but never monotonous.

<sup>419</sup> Ruth Compton Brouwer, *New Women for God*, 128

hardships of their daily lives. The physical and professional challenges related to missionary medical work in India could also affect new women's emotional adjustment. While all medical missionary women experienced illness at some, or even many, points in their time in India, all this was a shock for those who had never been truly incapacitated before. Sister Howlett spent five of her first seven months so sick that she was unable to work, and reported that this had been "the longest" she had ever been ill.<sup>420</sup> In less than two years, she was declared "unfit" and went home. They all encountered facilities that were inferior to those at home, and all had to learn to work with limited or outdated supplies. Nearly all were moved around from station to station to enable the organization to compensate for illnesses and the concomitant staffing problems. Many of these women felt that they were asked to assume too much responsibility too soon. The CEZMS committee members' argument that "adaptability" was a key to adjustment became evident as most women coped with these disruptions and setbacks well. But both letters and reports, as well as resignations, indicate that the difficulties women encountered affected their emotional outlook.

Most new missionaries reported feelings of excitement at the prospect of meeting new people, seeing new places, and engaging in new work. As Freda Vale explained, there was "simply no time to be homesick and I keep thinking how jolly fortunate I am to be here."<sup>421</sup> A few were open about their difficulties dealing with emotions tied to the people they had left behind. All accepted missionaries understood that they would be away from their families for years, but it seems that for some women, the reality of being far away could become almost unbearable at times. As one nurse explained, "Please excuse the depression. I'm not always in this mood but 5 years is a very long time to leave your people especially when you remember

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<sup>420</sup> Sister Howlett, "Report from Lucknow," 1930, ZBMM.

<sup>421</sup> Freda Vale to Miss Bradford, 24 March 1930, WW, MMS, Mysore correspondence, 1076, 944.

that one of them will not be there when you return.”<sup>422</sup> Dr. Charlotte Carlisle completed her first term, but then was unsure of committing to a second, because of her family’s opposition to her missionary career, and her father’s open anger at the suggestion that she spend even one more year abroad. She felt she was in a difficult position, for she dreaded returning to her family’s Irish village which offered her no real scope for a professional life, but she wrestled with her sense of responsibility to her kin. Others were affected by romantic relationships. Although missionaries were not required to promise to never marry in the future, the societies chose not to accept any with marriage plans at the time of application.<sup>423</sup> Mary Grace Cole had struggled with committing to her first five years because she felt “it does not seem to be to be fair on Godwin. He is 42 now and it is too long to expect him to wait if I find I loved him.”<sup>424</sup>

Cole was right to worry about the next few years prior to committing, for the societies could exert considerable power over a missionary’s romantic choices. In the 1920s and 1930s, when the WW lost a many new missionaries to marriage, the committee passed a resolution that permission to marry would not be granted to any missionary before the close of three years’ probation. Women who married without permission usually owed the society repayment for their training expenses, which were steep enough to make even a love-struck woman think twice.<sup>425</sup> If the missionary wanted to marry between that point and the end of the first five years of service, she had to inform the committee. The decree also stated that if, after her first three but under the first five years, a woman married another Methodist missionary, and retained connection with the Society, she would be exempt from repayment, but would forfeit her bride’s

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<sup>422</sup> Edith Thomas to Miss Walton, 10 July 1943, WW, MMS, Mysore correspondence, 1079, 1024. It is not clear whom she misses, but it may be that she has lost someone in the war.

<sup>423</sup> The CEZMS application specifically asked about attachments and emotional commitments.

<sup>424</sup> Mary Grace Cole to Miss Chapman, 3 July 1939, in Cole’s Blue Packet, CEZMS collection.

<sup>425</sup> The WW was not alone. In the ZBMM Minutes there are numerous conflicts between missionaries and the committee regarding what women who married without permission or before their term of service was complete. In some cases, the woman’s fiancé or parents are also involved, and the debates span several weeks or even months.

allowance.<sup>426</sup> As British women missionaries' wages were at the subsistence level, a bride needed funds to prepare for her new life. These financial policies were not limited to marriage, but included penalizing women who left in their first term for any reason not granted by their society. The societies could also refuse to cover the costs of a missionary's journey home—another factor that caused a women who wanted to break her contract to reconsider. But some women who had made resolutions regarding romance struggled with the ghosts of past relationships or the end of romantic dreams. Dr. Christine Willway explained that some of her health problems and low mood—which caused much alarm amongst her colleagues—were due to news from home that her former fiancé had died. The engagement had been broken for more than five years, but this news shook her and made her temporarily unhappy with her work in India.<sup>427</sup>

Willway also had the misfortune of having to deal with constant demands from her mother, who begged her daughter to return home. Letters came from not only the mother, but also her family friends and even members of her church in Ireland, describing her mother as “obsessed” with seeing her daughter, and demanding that Willway come home early. Willway completed most of her first term before succumbing to her mother's pleas, but did not return to India, and no one was surprised. Her colleagues had expressed concern that she would have a nervous breakdown. No one could induce her to relax, and her nerves seemed to exacerbate her ongoing poor health. Other missionaries attempted to take her on outings, to play tennis, to find ways to manage her stress, but were unsuccessful. Worries over Willway's frame of mind were

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<sup>426</sup> Minutes, 24 June 1930, WW. Because these women worked at very low salaries, the brides' allowance would have been very welcomed to help pay for the bride's trousseau and to set up her new home.

<sup>427</sup> Willway left India in 1933, officially because her mother needed her. Her colleagues were convinced that she was on the verge of a complete physical and possibly emotional breakdown. Ten years later, she married, at the age of 47. Perhaps marriage was something she had always wanted and this was one of the reasons for her difficulties as a missionary.

enough to cause the home committee to remind her that, “We will pray that you may be given all the strength you need, as we believe you will. We pray too that you and your colleagues may be conscious in an unusual degree of a big power behind you and be given calmness of outlook and a quiet mind in the midst of daily demands.”<sup>428</sup>

Daily demands weighed heavily on some women, and perhaps they were surprised by these challenges. The scope of medical workers’ responsibilities was quite broad. Although many of them spent less time engaging in direct evangelism than they might have expected, big chunks of their time had to be devoted to work that was neither “medical” nor “spiritual.” Some seemed to enjoy the variety and responsibilities, others found it stressful. For doctors, this work included administrative tasks, which were extensive. Dr. Pleasaunce Carr, always cheerful and optimistic, expressed concern when she found herself the sole doctor at the Patna station, commenting, “there is full-time work for two [doctors], and I can hardly visualize how 24 hours a day will be sufficient, when one is alone, to cope with the medical work, some lecturing, and all the administrative work.”<sup>429</sup> Running a station required considerable paperwork. Mary Proudlove mentioned that each year, she had to write to every single contributor, and she spent most of her Christmas doing the station’s financial statements, medical reports, the medical annual government indent, and working on the statistics.<sup>430</sup> Numerous financial supporters were desired, but such correspondence was time consuming.

This work included the management of buildings and facilities, negotiating relations between missionaries and the local people, and dozens of other activities ranging from budget

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<sup>428</sup> Home Committee to Christine Willway, 6 February 1930, WW, MMS, Mysore correspondence, 1076, 948.

<sup>429</sup> “Patna,” *Annual Report*, 1936, ZBMM.

<sup>430</sup> The “indent” is the annual ordering and reporting on all drugs and supplies used by the hospital. This required careful reviewing, accounting, and planning. The directions for the Annual Indent for hospital in the same locale in 2014 are seven pages long.

analysis to event planning. One nurse wrote that new missionaries needed to know how to intelligently discuss agriculture with the locals, understand property law, superintend the building of walls, and manage and drive “a conveyance”—not a skill most British women had in the 1920s—as well as give credible medical advice without seeing the patient. Sometimes the tasks facing medical women could seem daunting; one doctor became very absorbed in weighing the pros and cons of many different sanitation schemes for her hospital. Dr. Ethel Donaldson commented on how well the two more experienced doctors ran the Patna station: “I have been impressed by the capacity of my two seniors in things medical and otherwise—in their understanding of the problems connected with the running of big stations—e.g. sanitation, carpentry, finance, etc.,—in the way they keep their fingers on the varied branches of work, and in the manner in which, in the spirit of Christ, they seem to unite all the dissimilar elements in Him, so that peace and contentment abound among the workers.”<sup>431</sup> Perhaps these looming responsibilities were related to Donaldson leaving for home in less than a year, unfit for missionary service. Dr. Katherine Harbord explained that the Nursing Superintendents in the mission hospitals had “enormous” responsibilities that people in Britain could not imagine, including the poisoning of stray dogs and the drowning of muskrats. They also had to “guide” all the nurses who came from such diverse backgrounds and types of home, including those who had been mission orphans, and were recent converts to Christianity.

Morale could be shaken by seemingly little problems. Although foreign missionaries had to possess some level of zest for travel, moving around to visit patients could take its toll on them. Stations without cars or buses had to send women out on horses, in various carts, including the “bullock carts” that everyone found bone-jarring, and on foot. In some areas,

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<sup>431</sup> “Patna,” *Annual Report*, 1920, ZBMM.

missionaries could use trains and buses, but those with anxious temperaments constantly worried since the public transportation was so unreliable. When journeying to an unfamiliar village, the women had to trust their guides, who often neglected to mention details such as long distances, the need to cross rivers on foot, or the fact that, while they had come to fetch a doctor for a maternity case, the entire village was also engulfed in a plague outbreak. One nurse summarized such situations with the advice to never believe what she was told about distances, and to always travel with her own food and dry tea in her pocket.

Going to patient homes could prove emotionally trying. New medical workers lacked the experience to know what to expect, and could find situations awkward or bewildering. Medical women made social as well as professional visits, which meant graciously accepting Indian hospitality. Dr. Ruth Western warned that in the Sindh, guests were always presented with “sweet tea flavoured with rose-water, which tastes like cold cream warmed up.”<sup>432</sup> She and her colleagues always drank it. Some workers compared Indian homes to those they had visited doing district work in Britain, making the point that people living in poverty were similar around the world. British women medical workers were used to associating poverty with dirty and unhygienic living conditions, and therefore struggled to understand why some “high caste” households seemed dirty or left patients in “dirty old rags.”<sup>433</sup> Even more troubling for newer missionaries was being treated as though they—the medical women—were dirty. May Hayes wrote of visiting a “rich Hindu house” where she was forbidden to touch any of the people or objects in the home. She was expected to examine the patient by making inquiries from several feet away, and when she left, a man paid her by dropping coins into her outstretched hands,

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<sup>432</sup> Ruth Helen Western, *Some Women of Sindh: In Home and Hospital* (London: Church of England Zenana Missionary Society, 1928), 22.

<sup>433</sup>“Canadian Hospital,” *Annual Report*, 1922, ZBMM.

carefully avoiding any physical contact with her. When caught at a home visit too late to make the return journey home, missionaries learned to step outside of the home to eat, and to sleep outside, so as to avoid contaminating a “caste” home. Susan Finch remembered “the look of disgust on the face of the first—and last—Hindu woman whose drinking vessel I touched.”<sup>434</sup> One doctor noticed that as she left the home of a wealthy patient, the servants washed the stairs to the home with water from the Ganges, in order to purify it after her contamination. Seasoned missionaries came to understand that when they were invited into homes, the families had often carefully prepared by removing objects that could be polluted by these foreigners. Charlotte Vines explained that this was one of the reasons why so many Indian homes seemed so bare to Westerners. Similarly, “caste” women who could afford to would change their clothes, wearing silk skirts, since silk could not be defiled, and only used silver utensils, as it was also impermeable to the missionaries’ touch.

Until they had witnessed several deaths in Indian homes, the experience could prove unnerving for medical workers. As missionaries got to know their patients and their histories, some felt overwhelmed by the hardships and losses Indian women endured. Marie Hayes recorded her first village death. “Often as I had heard of it, I was not prepared for the scene that followed,” when the women began wailing, beating their chests, and making noise by clanging their bracelets against their anklets. Hayes feared being attacked, and was relieved to find that, “they seemed to consider it quite natural for us to gather up our things and silently depart.”<sup>435</sup>

Helen Hanson’s committee noted that she had undertaken several years of special study so that she would be fully qualified for mission field; in addition to being frazzled by the heat and feeling overwhelmed by the amount of work her small staff faced, Hanson reported, “Much

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<sup>434</sup> “Lady Kinnaird Hospital,” *Annual Report*, 1920, ZBMM.

<sup>435</sup> Hayes, *At Work*, 10-11.



patience is needed in dealing with these women. They are like children, almost incapable of reasoning.”<sup>436</sup> Missionaries often wrote about how “lovable” Indian babies and children were, but new women could be surprised by the realities of these children’s lives. In some Indian cultures, missionaries had to suppress the urge to make a fuss over children; parents liked to see their children appreciated, but missionaries were warned to avoid saying a “word of direct praise which might be thought to bring the evil eye to bear on them.”<sup>437</sup> Dr. Nelson described the children as “dirty little people—hair matted, faces filthy, hands and feet covered with sores and scratches, their clothes (if any) of an indeterminate colour and extreme age, and surrounding all of them a swarm of flies.” She explained that the children made her think of Jesus’s love for the poor little children of Palestine, and that caring for people in such conditions required more than simple human love.<sup>438</sup> It was not unusual for medical workers to comment on their difficulties caring for Indian babies. Miss Howe, who took on the Nasik “Babies Home,” reflected that all she had known about Indian babies prior to arriving at her station was that they required “special feeding,” and care and treatment that differed from babies in Britain. Her lack of experience “added to [her] difficulties.”<sup>439</sup>

Loneliness and social isolation were trials for some women, and not only in their early years of work. Dr. Harriet Cockburn claimed to find Patna an interesting place because there were no other English people around. Cockburn, a Canadian, had spent the first years of her career as the only woman doctor on the staff at insane asylums, including one on a reservation in the Dakotas, so perhaps her social needs were minimal. Many seasoned missionaries questioned the wisdom of sending young or new doctors to a remote location; it often happened, though, as

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<sup>436</sup> “Lucknow,” *Annual Report*, 1906, ZBMM.

<sup>437</sup> Western, *Some Women of Sindh*, 128.

<sup>438</sup> “Nasik,” *Annual Report*, 1938, ZBMM.

<sup>439</sup> “Nasik,” *Annual Report*, 1946, ZBMM.

was the case for Dr. Louisa Dodge, who found herself “alone” at the Kalyani station from the time of her arrival. In one scenario, missionaries worried about a new colleague on her way to a hospital that had been closed for some time due to the lack of a “satisfactory medical head.” Not only would the work be hard for an inexperienced doctor, but also lonely, a situation that might be made worse by the fact that it “is a place where sand is the prevailing feature!”<sup>440</sup> One new doctor’s colleagues wrote to the home committee hinting that she was not the “right sort of person” to live at a station where she was isolated from other Europeans.<sup>441</sup> If a missionary was at a small station, she might feel very isolated. When one civil servant’s wife discovered she would have to give birth in a place far from any “European” hospitals, she invited the nearest missionary woman doctor to dinner, and was surprised to learn that this was the first time the doctor had been to a European’s house since arriving in India.<sup>442</sup>

The medical women often referred to themselves as being “alone,” but they were never actually the only member of their station or staff. What they meant by “alone” was that they were either the only doctor, or, in other cases, the only European, at their station. Each missionary’s definition of solitude depended on her perspective. When at the Nagari station, Mary Proudlove mentioned the “solitude,” but also noted that one of the nurses came to sleep in the doctor’s bungalow each night so that Proudlove would not be alone. While the European missionaries were quick to compliment the good work done by the Indian sub-assistant doctors, who served on the mission staffs, few found them to be adequate substitutes for European companionship. As will be discussed in Chapter Five, this attitude shifted by the 1940s, but was prevalent before that. And while the missionary societies expected all the missionaries to live

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<sup>440</sup> Olive Monahan to Miss Bradford, 19 December 1924, WW, MMS, Madras correspondence, 1068, 699.

<sup>441</sup> Rose Cullwick to Miss Byrom, 7 June 1932, WW, MMS, Mysore correspondence, 1076, 921.

<sup>442</sup> Indian Political Service Collection, “And the Nights were More Terrible than the Days” (Autobiography, by Margery Hall), British Library, India Office Private Papers, MSS Eur F 226.

together in harmony, this was more of an ideal than a reality. The home committees received complaints about those who did not fit in well. For example, Dr. Monahan devoted more than a page of a letter to listing reasons why one missionary should not return to the station, citing her monthly hormonal depressions and her “silences.”<sup>443</sup> In addition to personality clashes, tensions between doctors and nurses occasionally surfaced. While there were some very close and career-long relationships between doctors and nurses, there were cases of doctors asking to be allowed to live separately from the nurses, implying that class and educational differences made living together difficult.<sup>444</sup>

Claiming to be enchanted with Indian women and children or the landscape was common, but no one found the process of learning an Indian language enchanting. Nevertheless, language skills were an important determinant in whether a missionary would be successful.<sup>445</sup> Prior to becoming missionaries, they had completed their medical training, so they had knowledge of their abilities as professionals. What most of them had not tried to do before was to work in a second language.<sup>446</sup> A knowledge of “school girl” French or Latin was all most possessed.<sup>447</sup> The annual reports and other missionary publications did not focus on how difficult most missionaries found Indian languages to be; had an aspiring missionary perused the letters of missionaries struggling to pass their language exams, such as those sent back to the WW secretary, she would have been bombarded with references to how slow, frustrating, and

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<sup>443</sup> Olive Monahan to Miss Bradford, 5 February 1929, WW, MMS, Madras Correspondence, 1068, 717.

<sup>444</sup> The Methodists had all missionaries—doctors and nurses—living in the same accommodations until nearly the end of the colonial era. Some doctors and nurses seem to have come as a pair—when Dr. Ethel Douglas retired in 1946, the ZBMM *Annual Report* noted that she and Miss Whitaker had offered together, arrived in India together, and had always worked together. They also retired together.

<sup>445</sup> Elizabeth Prevost, *Communion of Women*.

<sup>446</sup> A handful of the medical women sent out by the CEZMS, WW, and ZBMM were speakers of English as a secondary language. The CEZMS had a couple of native German speakers, and Sister Andersen, of the ZBMM, was Danish.

<sup>447</sup> Some of the women actually wrote “school girl French” on the applications to the CEZMS.

stressful language acquisition could be, as well as how challenging many aspects of missionary life were prior to proficiency in the language.

In some cases, medical women could begin to study the language of their future post before arriving in India, but this made little difference in their adjustment process. For example, while in training at Kingsmeade, Nurse Eva Bowes practiced Telugu with an Indian student who had come from Medak for missionary training in Britain. Once Bowes arrived in India, staffing problems meant that she had no time for language study, and she complained that her language difficulties were a real hindrance to her attempted work in the villages. Elsie Campbell had good intentions to practice Telugu while on the boat from Britain, but she admitted that she enjoyed the social life at the expense of language acquisition. This led to regret once she arrived at her station, for she had no luck in hiring a Telugu teacher and reported making little progress.<sup>448</sup> But even if Campbell and Bowes had made some progress before arriving, the words and phrases they might have learned would not have helped them face a courtyard packed with worried Indian mothers and their children, nor for the numerous dialects they encountered in their hospital and village work.

New missionaries itching to go straight to “work” were thrown by the difficulties they encountered attempting to practice healthcare without effective communication skills. Without a word of any Indian language, they could provide many medical services, especially if they had other staff to help with translation. They could also participate in aspects of administration and other work at their station. These abilities meant that while their committees and even colleagues often encouraged or even admonished them to focus on language study, new arrivals commonly became immersed in medical work rather than language study. For most, this was a

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<sup>448</sup> Elsie Campbell to Miss Bradford, 19 February 1925, WW, MMS, Haiderabad correspondence, 1058, 394.

stressful time. If they failed their language exams, they could not remain in the field—their careers as foreign missionaries would be over. But these women also realized that as missionaries—rather than as strictly healthcare practitioners—meaningful communication with those whom they served was key, and this was impossible without language skills.<sup>449</sup> But they were professional doctors and nurses, and their medical skills were in high demand—few could choose to focus on language study when patients crowded into understaffed facilities. Their societies at home and their colleagues in India admonished them to make time for study, but also put pressure on them to work as nurses and doctors. These competing demands, combined with the difficulties most faced learning a language, added to emotional challenges new medical women faced.

Expressing feelings of doubt or inadequacy related to language acquisition frequently surfaced. As Hilda Mottram explained, “It is really impossible to do any language study and try to take one’s place in hospital and yet I feel so useless when I cannot understand what is said.”<sup>450</sup> Dr. Winifred Anderson wrote that her first year left her feeling “inadequate at times,” especially since she was trying to work with “limited language ability” as well as little knowledge of the people and their customs.<sup>451</sup> Elsie Chapman, who stated “[t]he language problem is a very serious one for me,” also mentioned that she felt “doubtful of her capabilities” as a nurse.<sup>452</sup> In her first letter to the Home Board, Dr. Alice Musgrave wrote about how anxious she was to master Tamil as “the more you think of it the more you realise how inadequate just medical work can be if you aren’t able to say those few words that express what you are trying to do.”<sup>453</sup> As a

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<sup>449</sup> In Elizabeth Prevost’s words, “Language skills were often the determinant in successful mission work.” See Prevost, *Communion of Women*, 56.

<sup>450</sup> Hilda Mottram to Miss Leith, 10 November 1933, WW, MMS, Mysore correspondence, 1076, 962.

<sup>451</sup> Winifred Anderson, “Lucknow Report,” *Annual Report*, 1932, ZBMM.

<sup>452</sup> Elsie Chapman to Miss Bradford, 14 March 1928, WW, MMS, Mysore correspondence, 1075, 901.

<sup>453</sup> Alice Musgrave to Miss Leith, 25 November 1938, WW, MMS, Madras correspondence, 1069, 758.

young doctor, Musgrave had found trying to talk to patients at home in English to be hard enough, but in India she was reduced to using sign language.

The inability to speak the language meant that the medical work of an entire station could be hindered, not just that of an individual woman. When a missionary doctor or nurse had to take an interpreter with her to visit patients in their homes, or had to wait on one to join her in the hospital wards, the work seemed inefficient and unsatisfying to both medical staff and patients.<sup>454</sup> Dr. Sarah Smith was of little use in the Lucknow dispensaries without Urdu, and after more than a year of study, she could only “begin to help” Miss Daniel, the Indian Medical Assistant, even though Smith possessed more advanced training and education. Adelaide Gault, a new doctor sent out by an Australian missionary society, came to the Madras district for a short period of training and acclimatization before going to her own assignment. Gault was well liked by the WW staff and there was some talk of finding a way to keep her. But Gault was learning Hindi instead of Kanarese—the primary language of most of the patients—so the WW hospital hired an Indian doctor instead.<sup>455</sup> The staff decided it was too much of a strain on the nurses and even the hospital servants to always have to translate for Gault, as “everything takes twice as long as it should.”<sup>456</sup> May Hayes explained that she was relieved when the dispensary was not busy since she had to spend so much time doing “relays [with] interpreters” unless the patient’s illness was obvious.<sup>457</sup> Since the nurses at most of these societies’ hospitals spoke little or no English, and communication between the European and Indian staff was absolutely crucial for smooth administration, a doctor in Gault’s situation was a hindrance.

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<sup>454</sup> The stress on learning the Indian language was one of the things that set the women medical missionaries apart from the staff in the Women’s Medical Service and the Dufferin Fund. It also gave them more credibility with the communities in which they lived and worked.

<sup>455</sup> The term “Kanarese” is no longer in use, but it was the term the British used for the Kannada language.

<sup>456</sup> Edith Tucker to Miss Bradford, 15 December 1924, WW, MMS, Madras correspondence, 1068, 712.

<sup>457</sup> Marie “May” Hayes to her mother, 1 January 1906, “*At Work*,” 30.

Many of these missionary hospitals served as training centers for Indian nurses, midwives, and health visitors. By the 1930s, the expanding government nurse training programs moved toward English as language of instruction, but some of the women's missionary programs remained dedicated to offering professional opportunities to Indian women who had never had the chance to gain an English education. Sustaining these "vernacular programs" meant the European staff had to be able to instruct and lecture in the appropriate Indian language. Even after Dr. Mary Proudlove was competent in her Tamil daily conversational skills, she admitted that she found lecturing the nurses extremely challenging since trying to explain concepts like protoplasm in Tamil proved "extraordinarily difficult" for her.<sup>458</sup> It is no surprise then that, after working in India for only a year, Dr. Marjorie Lambert could only lecture in English. The pressure was on Lambert since her colleague, albeit much more experienced in India than Lambert, had been transferred from another region and could only lecture in Urdu rather than the local Marathi. So while Lambert's station was fortunate to have two healthy doctors, no one could effectively lecture to the nurses. As Nurse Edith Bronsdon noted, she could not do the work she had been sent to Kalyani to do—train the nurses—until she learned more Tamil. As soon as Sister Cole passed her final language exams, she was put in charge of the Nursing and Matron's Department at her station, and these milestones were essentially promotions.<sup>459</sup> Gladys Holmes wrote that while she was absorbed in her work, and was content with her life at Ikkadu, she would not be able to feel "truly happy" in her work until she could lecture to the nurses in Tamil. Only then could she "know I shall be doing something for the people whom I came out to help."<sup>460</sup>

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<sup>458</sup> Mary Proudlove to Miss Bradford, 14 March 1928, WW, MMS, Madras correspondence, 1068, 717.

<sup>459</sup> "Nasik," *Annual Report*, 1915, ZBMM.

<sup>460</sup> Gladys Holmes to Miss Bradford, 4 April 1929, WW, MMS, Madras correspondence, 1068, 723.

By the late 1930s, some of these societies' teaching hospitals did conduct their lectures in English, but this did not exempt women from their language requirements. Nurse Edith Thomas made very slow progress in Kanarese, and continued to fail her exams even after several years of working in India. Thomas argued that since English was the language of instruction at Mysore, her inability to learn Kanarese should not have been held against her, although she conceded that her limitations affected the rest of the mission since she could not help at the hospital at Hassan where none of the teaching was in English.<sup>461</sup> Since staff illnesses and the furlough schedule required that doctors and nurses move around in their district, Thomas's language limitations rendered her relatively useless. Thomas was defensive, but also deflated by her difficulties. As she thought about her furlough, she recorded "at the moment I feel very uncertain as to the future and wonder if it would be best if I decided not to come back to Mysore." She knew her attitude would have to improve, and hoped a break at home would help: "perhaps my work will lend enchantment to me when I return to England, at the moment it is anything but enchanting to me."<sup>462</sup>

This was no wonder. Until women passed their exams, they remained on probation and could lose their jobs. To help with motivation, beginning in 1900 the ZBMM gave missionaries a raise in salary upon passing their language exams. One of the local clergy administrators urged the committee to reconsider this policy as the stress caused by the exams had a negative effect on some missionaries' health.<sup>463</sup> For those like Thomas, who made slow progress, the language caused extra anxiety.

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<sup>461</sup> Edith Thomas to Miss Freethy, 10 July 1943, WW, MMS, Mysore correspondence, 1079, 1024.

<sup>462</sup> Ibid. Thomas worked through her difficulties, returned from furlough, and remained a missionary nurse until her retirement in 1960.

<sup>463</sup> Minutes, 21 December 1904, ZBMM.



Everyone mentioned the challenges new missionaries faced as they attempted to balance the urgent needs of the medical work with language study, but some new women voiced significant frustration and even anger over their “impossible” situations. Dr. Charlotte Carlisle pointed out the irony in her committee’s wisdom of sending her to a more remote and quiet station “provisionally to study language” with the senior doctor. The nursing sister got sick, and the senior doctor had to leave for a family emergency, so Carlisle was left on her own, and failed her first language exam. She was quick to point out that this was due to the amount of hospital work: their sixteen-bed hospital usually had forty patients crowded in; she had to take over one of the nurse’s responsibilities as well as help with the daily compounding [pharmacy] tasks; as a missionary, she tried to participate in spiritual life of the station; and it appeared her hospital would set a record for annual maternity cases. Carlisle also complained about the lack of a hospital car—the day before writing she had traveled twenty-seven miles in a wooden cart, which was “wearying.” May Hayes had begun her study of Urdu during her missionary training, but her mission’s needs caused her to be constantly moved among the stations and to take on tremendous professional responsibilities before she was ready. When she was called back to a station due to the senior doctor’s “blood poisoning” and a staff of sick nurses, she wrote to her mother in frustration. “And yet here we are alone, with the whole medical work of the place on our shoulders! It means, of course, a knock back again on my poor Urdu, which scarcely gets a chance of progressing. I don’t feel as if I know more than I did at the hostel, and it is such a bother always having to run after someone to interpret for me.”<sup>464</sup> At this point, Hayes had never remained in one place for more than a couple of weeks. She only began to feel like she was improving her skills when she was settled long enough to spend a couple of hours each evening

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<sup>464</sup> Hayes to her mother, 7 January 1906, “*At Work*,” 31.

studying with her munshi, the Indian instructor. Elsie Chapman only made real progress on her Kanarese once the local standing committee arranged for her to spend six weeks at the Union Kanarese Seminary where she had no nursing responsibilities. Gillespie warned that since she had to work sixteen hours a day, she had no time for study. When Nurse Thirza Wooley passed her final language exam, she summarized what most new medical missionaries experienced by writing, “All these three years it has been like duty pulling two ways all the time. If you give all the time you need for study, you know you are neglecting work in the hospital and making it harder on your colleagues but at the same time you know you won’t be of much use without the language ... I suppose everybody has felt the same during their first years.”<sup>465</sup>

And the pressure to reach a level of fluency was not only to lecture or participate in the administration of a hospital, it was also necessary to begin to understand Indian culture and to connect with the community. Hilda Mottram expressed exasperation with her situation: she wanted to give entire focus to the hospital but knew she could not do this because without being able to speak the language, she could not understand “the ways of the people” and therefore would not be an effective nurse. Dr. Susan Finch spent most of her first year studying Urdu “and trying to understand something of the beliefs, customs and thought of the people I meet in Hospital.”<sup>466</sup> Without adequate language skills, new medical women could feel useless, frustrated, and removed from the world surrounding them. The commitment to learn the language of the communities they served set the missionaries apart from the “secular” services. As a British nurse serving at a government plague hospital observed, even minimal language training would have been helpful, as “we should be ever so much more useful to [the patients] if

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<sup>465</sup> Thirza Wooley to Miss Leith, 3 April 1938, WW, MMS, Mysore correspondence, 1077, 983.

<sup>466</sup> Susan Finch, “Lady Kinnaird Hospital,” *Annual Report*, 1920, ZBMM.

we could speak the language.”<sup>467</sup> Some Indian critics pointed out that while Dufferin services were well-intentioned, Dufferin doctors’ inability to communicate in patients’ languages limited their usefulness.<sup>468</sup> Freda Vale, a nurse with a sunny disposition, reported enthusiastically yet with longing that, “India is a great place. I am really loving it and the women and girls are so attractive and friendly ... I am looking forward to the time when I can talk to them more.”<sup>469</sup>

### 3.5 Conclusion

In the early 1930s, the ZBMM congratulated itself on its success in selecting the right candidates for work in India. Although a few women had left missionary service due to poor health or personal factors, most of them were able to overcome the common problems they faced when beginning their work as medical missionaries in India. These challenges included illness, adapting to the climate, learning a language, loneliness, coping with professional demands in a new setting, and adjusting to life in a tightly-knit community. Most medical missionaries could relate to Eleanor McDougall’s comment that India would be “a shock” but they had risen to the challenge. Certainly the characteristics the societies looked for—adaptability, common sense, faith, and the ability to remain calm in stressful situations—served these women well.

In the 1880s, Dr. Fanny Butler had advised that there were three main needs for medical missionary success: patience, patience, and patience. On their applications for missionary service, most women had written about their desire to use their medical skills to “help” Indian women. They did not understand how challenging attempting to “help” would be for them as

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<sup>467</sup> Hester Mary Dowson, “Bombay During the Plague, 1897-1898,” British Library, India Office Private Papers, MSS Eur B 385.

<sup>468</sup> Mridula Ramanna, *Western Medicine and Health in Colonial Bombay, 1845-1895* (London: Sangam Books, 2002), 194.

<sup>469</sup> Freda Vale to Bradford, 21 September 1930, WW, MMS, Mysore correspondence, 1076, 944.

cultural outsiders. New missionaries soon discovered that, in addition to learning the language, their first steps were to build trust and gain confidence. This took time and required learning from experience. As Hilda Mottram explained to the Home Secretary, “I have been out now almost a year, what a wonderful year it has been! A year full of adventures and thrills, continually filled with new things, and yet a year which has made me realise how much I have to learn before I can begin to understand the people ... As you suggest, I feel there is so much to learn in this country that I could spend a life time here and still know very little.”<sup>470</sup>

The next chapter focuses on “the work” these women engaged in on a daily basis. Their work appears to have been straightforward “medical” work—the kind of work doctors and nurses performed across India and in many parts of the world. The chapter explores the ways these women found meaning in their work missionaries and professional healthcare practitioners. This understanding was based on the missionaries’ perceptions of what was possible for them as workers and what Indian women needed from medical work.

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<sup>470</sup> Hilda Mottram to Miss Byrom, 11 March 1934, and to Mrs. Leith, 10 November 1933, Mysore correspondence, 1077, 962.

#### 4 “GREAT WORK”: WOMAN’S MEDICAL WORK FOR WOMAN

The work of missionaries is both deplorably small and magnificently great. It is small because of the vast numbers [of Indians]...whom they [the missionaries] cannot reach because they are so few, and because those they do reach are often so bound by the rules and customs under which they live, and by the conceptions they have acquired in early childhood...It is small, too, because the character of Christ is as yet so imperfectly developed in the Christian workers themselves. But it is great because the goal for which they are working is that the will of God may be done on earth, and His Kingdom established in the hearts of men and women of all races, the goal for which God became Man, and lived, and died.<sup>471</sup>

This quotation is from the conclusion of Dr. Ruth H. Western’s 1928 book, *Some Women of Sindh: In Home and Hospital*. The book is a compilation of sketches on the work, both medical and evangelical, of the CEZMS women’s hospitals in Sukkur and Larkana, Sindh Province, in what is now Pakistan, where Western served as a missionary doctor in the 1920s and 1930s. From reading Western’s descriptions of her experiences with the missionary hospitals, the impression given is that the doctors and nurses spent nearly all of their time performing

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<sup>471</sup> Ruth Helen Western, *Some Women of the Sindh: In Home and Hospital* (London: Church of England Zenana Missionary Society, 1928), 154-155. Western, the daughter of a solicitor, was born in 1879, earned her MB,BS and the an M.D. in London in 1910, after which she left for India to work as a medical missionary. Over the next four decades, she worked at several missionary stations, including Ludhiana, Amritsar, Quetta, and the Canadian missionary stations at Kangra and Palanpur, and nearly twenty years at the CEZMS hospital in Sukkur, Sindh, in what is now Pakistan. During the First World War, she worked at the Army hospital in Bombay, treating soldiers returning from Mesopotamia. After retiring from medical work, she engaged in “Christian publishing,” which included a shortened Bible in Sindhi, and works in Urdu and Punjabi. In 1947, she came out of retirement to help with the medical relief in the areas affected by the violence of partition, before settling in South India to continue her work in publishing. She left for England in 1964, where she died at the age of ninety-eight, in 1977. This information on Ruth Helen Western was gleaned from her obituary in the *British Medical Journal*, 23-30 1978.

medical tasks, that, with the exception of location, would be easily recognizable and comparable with what doctors and nurses did at other small hospitals, both at “secular” facilities in India, and at home. Yet Western’s quotation does not make any specific reference to medical work, and situates all of the “greatness” of the work in what seems to be the evangelical aspects of missionary efforts.

In their publications, women missionaries often referred to their work as “great.” For missionaries, the “great” aspects of the work—doing God’s will—should, at least in theory, have been enough to sustain and provide a sense of meaning and purpose. Medical work was justifiable in missionary circles because Jesus had been a healer, and medical missionaries could claim to be “following in the footsteps of the Great Physician.” The deep religious convictions of these women should not be discounted.<sup>472</sup> As was shown in Chapter Two, in addition to completing medical and nursing education, the doctors and nurses who hoped to become medical missionaries were willing to devote extensive time and resources to demanding training designed to strengthen their faith and clarify their sense of purpose as missionaries. Because these women could have served in India with the Dufferin Fund or through other non-missionary organizations, the fact that they chose to link their medical service with the missionary endeavor is significant. As Dr. Mary Tomlinson explained, Indians “seem to think that one does medicine for one’s own soul and salvation, and it is hard for them to realize that we do it for love.”<sup>473</sup>

In the nineteenth century, it had been easy for missionaries to claim that there was an urgent need for western women to provide medical services in India. From the purely missionary perspective, the primary justification was that medical work “opened doors” for the

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<sup>472</sup> Rosemary Fitzgerald, “A ‘Peculiar and Exceptional Measure’: the Call for Women Medical Missionaries for Indian in the Later Nineteenth Century,” In *Missionary Encounters: Sources and Issues*, ed. Robert A. Bickers and Rosemary Seton, 174-196 (Richmond (UK): Curzon Press, 1996).

<sup>473</sup> Mary Tomlinson to Mrs. Leith, 23 September 1935, WW, MMS, Madras Correspondence, 1069, 767.

real work of missionaries: conversion. Initially, women offering medical care were valued by missionary organizations because they could reach the Indian women who were inaccessible to the missionary men, and, even the women's missionary societies learned that Indians were typically more receptive to medical than educational or other missionary services.<sup>474</sup> As missionary women offering medical care soon realized, the demand for their services could outstrip their capacity, and their focus on medical work took on importance in its own right. Medical women reported great needs for money, staff, and facilities. The nineteenth-century British government, as well as the Presidency governments, were content to let missionary and other philanthropic organizations, such as the Dufferin Fund, set up work in this field of caring for Indian women and children.<sup>475</sup>

By the 1920s, justifications for missionary women's medical work for Indian women could seem less compelling. While missionary and social reform publications continued to stress that the "zenana," or the practice of female seclusion, meant that separate, all-female medical facilities were necessary, most medical missionary women spent the majority of their time serving Indian women outside of their homes.<sup>476</sup> There was demand for services to

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<sup>474</sup> Missionaries were not the only Europeans interested in accessing the women in the zenana, which was conceptualized as "uncolonized space." See David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India* (Berkeley: University of California Press, 1993).

<sup>475</sup> Recent historical studies have argued that the commonly held belief that the British government had no interest in providing health care for Indian women and children is overly simplistic. As Pati and Harrison explain in their "introduction," "even critics of the government's medical policy note that its limitations were due as much to indigenous indifference or, even, hostility to medical and sanitary intervention, as to any official commitment." See Biswamoy Pati and Mark Harrison, eds., *Health, Medicine and Empire: Perspectives on Colonial India* (New Delhi: Longman Orient, 2001), 4. The main problem was that the government preferred to leave much of this work to philanthropy and elite interests. See Maneesha Lal, "The Politics of Medicine and Gender in Colonial India: The Countess of Dufferin's Fund, 1885-1888," *Bulletin of the History Medicine* 68, no. 1 (Spring 1994): 29-66; Samiksha Sehrawat, *Colonial Medical Care in Northern India: Gender, State and Society, c.1840-1930* (New Delhi: Oxford University Press, 2013).

<sup>476</sup> Deborah Gaitskell explains that the zenana had such strong symbolic power that missionary propaganda continued to use the image well after missionaries moved beyond focusing on reaching secluded women. See "Women, Health and the Development of Medical Missions: Some South African Reflections," in *Gender, Poverty, and Church Involvement*, ed. Katharina Hallencreutz (2005).

accommodate “purdah” women, but the majority of women missionaries were posted at stations serving the population of an entire area, and most of their patients—and indeed, most Indian women—did not observe strict or any seclusion.<sup>477</sup> Medical schools educating practitioners in “Western” or, by the twentieth century, allopathic or “biomedicine,” dated to the first half of the nineteenth century, were well-established in India by the 1880s, and the numbers of Indian doctors—including Indian women practitioners—grew with each passing year, weakening the argument that India had an urgent need to import European women physicians.<sup>478</sup> By the 1920s, the Indian government’s process of establishing and expanding medical health services was well underway; indeed, in many areas, local dispensaries had increased significantly in the last half of the nineteenth century. These new hospitals—including some facilities that accommodated women only—often sprang up in the same vicinity as the missionary institutions, causing the missionaries’ to redefine and sometimes justify their presence. And, as David Hardiman’s case study of CMS medical work in Western India shows, within the missionary medical circles, pressures emerged from the Indian Christian medical practitioners, who had expectations for their own roles as care providers in their communities. Finally, by the late 1920s, the international missionary organizations were in the process of reexamining and reevaluating the purpose and goals of their medical work. A major question within the international community,

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<sup>477</sup> Missionaries were not the only Western women using the argument that purdah kept India’s women away from male practitioners. As Maneesha Lal explains in her article on the Countess of Dufferin Fund’s first years, “such claims were misleading.” Lal, “The Politics of Gender and Medicine in Colonial India,” 39-40.

<sup>478</sup> For information on the history of women’s medical education in India, see Margaret Balfour and Ruth Young, *The Work of Medical Women in India* (Oxford: Oxford University Press, 1929); Maneesha Lal, “The Politics of Gender and Medicine.” For background on Indian medical degrees and licentiates, see Roger Jeffery, “Recognizing India’s Doctors: The Institutionalization of Medical Dependency, 1918-1939,” *Modern Asian Studies* 13, no. 2 (1979), 301-326.



as well as for most of the denominational missionary organizations, was whether keeping “women’s work” separate was still important.<sup>479</sup>

These were the overarching challenges facing missionary organizations, which were exacerbated by the financial crises of the interwar years, and then made worse by the Second World War. The doctors and nurses working in India were aware of these issues, but they were absorbed with ongoing personal challenges, setbacks, and frustrations that could cause anyone to question whether their efforts were worthwhile. Missionaries reported feeling tremendous need for their services, yet their medical advice was disregarded; they were denied access to patients who required care; there was never enough staff, money, nor resources to meet the demands on their time. The medical workers could not claim direct credit for conversions, and political unrest, which at times was directed at missionaries, was on the rise. It is therefore easy to see why people might share Elsie Chapman’s relatives’ confusion, for they could not understand why she chose to return to her nursing work in India, rather than remain at home with her family and dying mother, and where she could easily get a job as a nurse. Yet even with all the looming problems, Chapman stated, “ours is a great work and I would not choose to be elsewhere.”<sup>480</sup>

In publications used to promote missionary work and to encourage financial support, such as the missionary magazines, memoirs, and stories of the work of certain societies or localities—such as Western’s *Some Women of Sindh*—much attention is given to the “spiritual” work, even if the writer has to acknowledge that there are no or few converts. When specifically considering the medical work, missionaries used two main frameworks for assessing progress:

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<sup>479</sup> William Ernest Hocking. Chairman, The Commission of Appraisal, *Re-Thinking Missions: A Layman’s Inquiry After One Hundred Years* (New York: Harper & Brothers Publishers, 1932). See also Ruth Compton Brouwer, *Modern Women Modernizing Men: The Changing Missions of Three Professional Women in Asia and Africa, 1902-1969* (Toronto: University of British Columbia Press, 2002).

<sup>480</sup> Elsie Chapman to Miss Bradford, 21 January 1930, WW, MMS, Mysore correspondence, 1076, 918.

the “spiritual” work, and the “practical” work. While reports to supporters at home always attempted to highlight progress toward making conversions, and to reassure readers that the missionary doctors and nurses were “missionaries first” and medical professionals “second,” reading medical women’s letters, diaries, and reports indicate that they found meaning and saw progress in the medical—or practical—work that filled their days, both because they were fulfilling their roles and goals as professional healthcare providers, and they believed their medical efforts improved Indian women’s lives.

Missionary women claimed that their medical work in India was to do more than treat bodies, for it was also to combat the “widely prevalent social customs and the low esteem in which women, as women, stand.”<sup>481</sup> As David Hardiman explains, missionaries believed that Indian women were “oppressed and victimized and were often denied access to modern medical treatment, even when it was available,” because of their status as females. No matter where missionaries lived, no matter what religious groups they encountered—Hindu, Muslim, “tribal”—they were struck by what they saw as patriarchal cultures that devalued women and girls. And they were troubled by Indian women’s acceptance and internalization of such attitudes and treatment. In their publications, missionaries argued that conversion to Christianity and the concomitant adoption of western cultural values, especially those related to gender, would bring sweeping social and cultural improvements to Indian women. As the ZBMM proclaimed, India was in “need of that Gospel teaching which alone can remove the evil customs from which the women of India suffer.”<sup>482</sup> This goal of attempting to change cultural attitudes

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<sup>481</sup> David Hardiman, *Missionaries and Their Medicine: A Christian Modernity for Tribal India* (Manchester: Manchester University Press, 2008). See also Guli Francis-Dehqani, “Medical Missionaries and the History of Feminism: Emmaline Stuart and the CMS Persia Mission,” in *Women, Religion and Feminism in Britain, 1750-1900*, ed. Sue Morgan, 197-211 (New York: Palgrave, 2002) for a similar discussion.

<sup>482</sup> “Benares Victoria Hospital,” *Annual Report*, 1902, ZBMM. The unidentified author was relating a case of a difficult labor for a fourteen year old wife, who was the third bride of a man whose first two child brides had died at childbirth.

and values was a huge task that missionary societies pursued through all branches of their work, including evangelism, education, and medicine. Although medical women spent the bulk of their time engaged in routine medical work, such as treating sore eyes, coughs, and skin conditions, they claimed that their work contributed to the improvement of the “condition” of Indian women. Through their medical work, missionary women hoped to “uplift” these women by “inculcat[ing] a sense of self-worth in their patients as to the value of their bodies and their position in society.”<sup>483</sup>

For medical women missionaries, connecting their medical work to what missionary organizations as well as secular, governmental and other groups interested in “social reform” defined as improving “the condition” or “status” of Indian women was meaningful. As in the case of assessing evangelism, progress toward this could not have been easily evident in their daily routines. As Hardiman notes, working for shifts in individual’s and culture’s mentalities toward women and their value in society was a difficult, slow process and requiring great patience. But this was also true for most aspects of women’s medical work, from convincing patients to agree to inoculations, follow a doctor’s medical advice, or to undergo surgical procedures. In some locations, and by some definitions, medical women missionaries could work for years and have little to show in terms of progress. It was the focus on working toward change in attitudes and expectations related to women’s health as opposed to only providing services that helped make daily work seem “great.”

This broad chapter explores why women like Chapman believed that medical missionary work for Indian women was “great.” Looking at “the work” carried out by medical women in India during the first five decades of the twentieth century, it examines medical women’s

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<sup>483</sup> Hardiman, *Missionaries and Their Medicine*, 237-8.

understanding and assessment of their efforts to provide medical care for Indian women, under what were often difficult circumstances. This chapter covers the chronic, wide-ranging challenges the missionaries faced, and the ways they found to overcome, adapt to, or accept limitations and obstacles. It argues that women like Elsie Chapman were able to convince themselves that their work did make a positive difference in many aspects of Indian women's lives. Among other things, I cover medical missionaries' endeavors to gain the trust and win the confidence of patients; their efforts to establish medical authority with individuals and communities; and the importance of the hospital in missionary work. This chapter primarily draws from the WW medical women's reports and correspondence with the Home Secretary, the *ZBMM Annual Reports*, and committee minutes from these organizations. By studying these records, it is possible to understand these women's goals and objectives, and the ways they made their work meaningful.

#### ***4.1 "So Few": Medical Missionaries and Indian Women's Medical Needs***

Medical missionaries' annual statistics were impressive: across India, medical missionary women treated hundreds of thousands of Indians each year, and in most places, the numbers of patients seen grew. The attendance at the roadside clinics for one set of workers increased by more than 4,500 in just one year; the attendances at the ZBMM dispensaries jumped from 88,609 in 1933 to 95,946 in 1934; the total number of inpatients moved from 5,651 in 1940 to 7,960 in 1941. All of these patients were seen by a relative handful of workers—some dispensaries managed without a dedicated doctor—so the demand for the work could seem staggering. In their annual reports, the missionaries recorded the numbers of patients seen, the setting in which the consultation took place, and classified the types of cases and treatments. By comparing these

from year to year, each station could monitor progress and setbacks. Their goal was to increase their patient base; any declines in annual numbers were explained and justified. By tracking change, such as increases in the numbers of inoculations, inpatients, midwifery cases, or caesarian sections, the women could measure progress over time, for when patients embraced new treatments, the medical work could be seen as developing.<sup>484</sup> When statistics were discussed in missionary publications used to build interest in and support for the work, the tone was often designed to promote a sense of urgency, as in the case of Western's notes that the workers could not meet the "vast numbers" of Indians, but the reports and letters sent by the workers to their home societies usually reflected the desire to receive more resources—staff, medications, money, and supplies—so the work could meet the need. No one ever claimed to want to cut back.

Missionaries always stressed that "the need" for their work was endless, and this was not just for the purpose of propaganda. There were more villages to reach, demand for expanding new clinic locations, erecting new buildings and adding new wings onto existing facilities. As one problem was tackled, new needs quickly emerged: the "V.D. Wards" were full in the new Vellore hospital; as the Home Visitor positions developed, the awareness of "rife" tuberculosis was confirmed; half the patients attending the roadside clinics in one district were found to have leprosy. Women proposed expanding the work into communities through services such as baby shows, health education fairs, and even outreach to "fallen" women. In addition to the demand for medical care, the missionaries also promised their home supporters that the "doors of

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<sup>484</sup> The 1934 ZBMM *Annual Report* for the Lucknow hospital proudly included a photograph of the staff holding 6 babies born by caesarian section. Such medical procedures were considered to be dangerous and had high mortality rates, whether in missionary or civil hospitals in India, as was noted by Constance Wilson, a Minto Nurse who served in India for nearly thirty years in the 1920s-1940s. Constance A. Wilson, "Never in Poona/the Memoirs of C. A. Wilson," British Library, India Office Private Papers, MSS. Eur. C. 251.

opportunity” were open—by this, they meant that Indians were finally potentially receptive to the Christian message. They requested more resources to increase the number of Biblewomen or occasionally asked for another European evangelist, but even without such resources, the medical work would continue to expand.

Dr. Ethel Douglas reminded the ZBMM supporters that although the statistics for the Lucknow medical work were impressive, it was important to understand that numbers alone could not convey the happiness she and the other staff felt when they were able to cure someone, nor the distress they experienced when they failed to save a patient due to the various barriers—what Ruth Western referred to as “rules and customs under which [Indians] live, and by the conceptions they have acquired in early childhood”—which could prevent patients from heeding medical advice. Medical staff also explained that their patient contact was important not only because of the actual numbers, but also because in some cases, they were helping people who lived far from any other medical work, or they were treating people who had come to trust them, but did not have confidence in using the government health services. Patient statistics were important to medical missionaries because they indicated something about Indians’ confidence in them as Christians, foreigners, and bearers of new approaches to disease and health. Missionaries derived great satisfaction from gaining patients’ trust, for without it, they had few patients, and were limited in what they could do for them.

#### ***4.2 Gaining Trust and Winning Confidence***

As regards the medical work I soon discovered that it is absolutely different from work in England, chiefly owing to difficulties connected with Hindu and Mohammedan customs.

For instance, in advising about diet, not only the patient’s disease but her religion must be

considered, and her doctor has to know what food may or may not be taken under certain conditions. Then about medicine, a ‘hot’ medicine may inadvertently be ordered when the patient considers a ‘cold’ one essential; any mention of operation, too, often frightens the patient away. One patient to whom I intended giving only an injection into her arm, ran away after everything had been prepared for the injection; an operation that at home would be done within an hour or two has to wait a day or two while the relatives consult and the patient gets worse.<sup>485</sup>

Medical missionary women had been motivated to come to India by ideals related to “helping” Indian women, believing that there were “urgent needs” that only Western women could address. Doctors and nurses possessing training and “scientific” knowledge expected that their qualifications and services would be welcomed—or at least accepted—and their authority as professionals respected. Much of what they encountered in India—practices and ideas the missionaries often dismissed as “superstition and ignorance”—could seem easy to change. In her first reports for the ZBMM, Dr. Lea-Wilson recorded with wonder that Indians always treated rat bites by covering them with a white wash, which she deemed ineffective, and burns with a “particularly noxious compound of burnt cocoanut...[which] forms a hard coating” and caused the patient to suffer when it was removed.<sup>486</sup> Ethel Landon wrote of mothers who brought ailing babies to her, after having lost five or six other infants. “And *yet* she (the mother) has not learned that the child has not the digestion of an ostrich, that opium is not the best nourishment for it, or that illness should be attended to in its early stages and can often be

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<sup>485</sup> “Lady Kinnaird Hospital”, *Annual Report*, 1920, ZBMM.

<sup>486</sup> “Nasik,” *Annual Report*, 1906, ZBMM. Covering wounds with “hard coatings” of substances, including cow dung, were common and always struck the missionaries as dangerous or pointless.

cured.” Patients questioned medical women’s medical orders, surprising new missionaries with arguments that drinking milk while with fever would cause them to turn into snakes, or by disregarding all instructions and painting patients bright yellow from head to toe. In all of these typical, common examples of missionary surprise and frustration, Indian patients seemed to prefer their remedies over the missionaries’ medical advice; in all cases the medical women saw the Indian practices as either illogical or pointless; in none of these cases was the missionary able to claim that her efforts made any significant impact on the situation.

While medical women might have been certain they knew the best treatments for patients, and that western “scientific” approaches were superior to Indian practices, they discovered that convincing their new patients of this was neither quick nor easy. Before the missionaries’ medicine could be accepted, they had to earn their patients’ trust. As was shown in Chapter Three, most new missionaries quickly perceived that they had to “understand” Indian culture before they could hope to build meaningful relationships with Indian women, and they usually saw learning the language as the first step. But, as the quotation from Dr. Susan Finch indicates, language acquisition was not enough to allow medical missionaries to effectively treat Indian patients. Medical women needed an understanding of patient expectations—which were rooted in the patient’s culture. Ruth Western’s book on medical work with the Sindhi women stressed that missionaries had to learn *each* culture, such as the cultures of the Hindus or Muslims, and then also understand that cultural practices could widely vary from region to region: the “burnt cocoanut” mixture in Lea-Wilson’s Maharashtra might not have been used by women in Bengal or the Punjab. Another new missionary explained that even in her station’s service area, there were differences between the city and rural women which affected the medical staff’s outreach and work with these women.



Attempting to introduce new methods of treatment, such as injections or surgeries—even when the medical women argued that these were necessary to preserve life—could be met with resistance or prove impossible. Medical women therefore set earning trust and gaining confidence as personal goals, believing much of their success hinged on this. Becoming trusted figures took time, much effort, and required that the missionaries reflect upon and learn from experience. Medical women also had to learn to negotiate and compromise with their patients, as well as the patients' families and neighbors. Both new and established medical women could suffer setbacks in their relationships with patients at any time. In some places, with some populations—as well as with many individuals—the missionaries seemed to fail. In other contexts, what seemed like progress was not: patients who agreed to stay in the mission hospital were known to disappear at night, fleeing for fear of being operated on while they slept.<sup>487</sup> Over time, as medical women were able to cite evidence that they were “gaining trust” and “winning confidence,” they could claim that they were making tangible progress, on either individual or local levels, and this motivated them to continue the work.

In her book on the CEZMS hospital at Amritsar, Dr. Charlotte Vines explained that one of the most important purposes of medical work was to do “pioneer work,” thus paving the way for other missionary efforts, such as education and evangelism.<sup>488</sup> Medical missionaries attempting to establish medical work were usually quite aware of their status as pioneers, for there was no way to know how their efforts would be received. In some areas, a line of eager patients immediately formed, while in others places the missionaries had to coax patients, waiting for an opportunity to gain one patient's trust, which could lead others to follow in her

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<sup>487</sup> “Report,” 1936-37, Ludhiana Collection, Yale Divinity School Library Special Collections, HR 491-1.

<sup>488</sup> Charlotte Vines, *In and Out of Hospital: Sketches of Medical Work in an Indian Village Mission* (London: Church of England Zenana Missionary Society, 1905).

steps. The community where one doctor launched her practice initially avoided her due to the rumors that white women kidnapped children. Eventually a few women came to her after all other remedies had failed, found her treatments effective and liked her personality, and then her patient base boomed.<sup>489</sup> But even with a growing patient base, the doctor still had to win over many reluctant individuals. She spent a course of days treating a woman—forced by her husband to attend the clinic—for an infected thumb. The patient was terrified, convinced the doctor planned to amputate the thumb. On the first visit, the doctor only dressed it, although she knew more aggressive treatment was necessary. The patient returned and saw other women there apparently on their own free will. The infection prevented her from grinding grain and earning her livelihood, so the hospital gave her a day’s wages. Gradually she trusted the staff enough to allow them to cure the infection, which resulted in more women from her village coming for treatments.<sup>490</sup> This was a common pattern. The WW Karim Nagar Medical Report for 1926 proudly stated that over 27,000 out-patients had come that year. The staff credited this impressive number to positive word of mouth: patients explained that their decision to visit the station was based on knowing someone who had been to “the English hospital” and had assured them that it was a safe place where people were treated kindly.

Missionaries took pride in their reputations for kindness and patience, seeing these characteristics—which they attributed to their Christian mission—as setting them apart from the “Government” institutions. But even established medical missions could be negatively affected by quickly shifting public opinion due to political unrest or even minor rumors. Engaged in medical work in the city of Patna since 1884, the ZBMM Duchess of Teck Hospital and

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<sup>489</sup> Mrs. W. H. Hinton, Compiler, *Ethel Ambrose: Pioneer Medical Missionary. Poona and Indian Village Mission, Bombay Presidency, India* (London: Marshall, Morgan & Scott, n.d.).

<sup>490</sup> Hinton, *Ethel Ambrose*, Dispensary Notes, March 1914.

dispensaries annually served approximately 20,000 patients at the turn of the twentieth century, including 373 inpatients, 4348 outpatients, 180 at-home patients, 571 Lady Doctor visits, 14,355 dispensary patients, and 128 chloroform operations.<sup>491</sup> These statistics seem to indicate flourishing medical work, and, as the “chloroform” numbers were reported to suggest, confidence in the missionaries as healthcare practitioners. But that year, instead of celebrating their success, the Patna missionaries focused on their failures related to the plague work. The scientific community had only recently identified plague’s transmission—which was not understood by most people—but had developed an effective inoculation. Fear of the missionaries, their motives and medicines kept most people away, thwarting the medical women’s efforts to save lives. In 1900, Dr. Grace Mackinnon reported that the “scare” preceding the seasonal plague outbreaks had caused the numbers of people visiting the mission’s medical facilities for any type of treatment to dwindle. In epidemic areas where the Government wielded enough control, Indians were subjected to quarantine and sometimes forced to remain in plague camps. One British plague nurse, serving at a Government camp, recorded that she felt “dreadfully” for the Indian patients in these plague hospitals, taken by force and “obliged to enter our Hospitals and be treated and drugged by any young English Doctor who may have only lately come out, and who can try pretty nearly any treatment he chooses.”<sup>492</sup> These Government doctors had the authority to go from house to house, and send “a child dying of plague to hospital ... [but] send the mother to the segregation camp ... instead of allowing her to go to Hospital with her child.”<sup>493</sup> Such measures, combined with people’s fears of terrible suffering

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<sup>491</sup> The data for 1901 totaled 19,955 patients and/or procedures or visits. The Lady Doctor visits were tallied separately as these brought in fees. The chloroform operations were significant as using chloroform was still very new, and patients willing to “go under” indicated confidence in the medical staff.

<sup>492</sup> Hester Mary Dowson, “Bombay During the Plague, 1897-1898,” Extracts from the letters of ... H. M. D... Plague Hospital Sister,” British Library, India Office Private Papers, MSS. Eur. B. 385.

<sup>493</sup> Dowson, “Bombay During the Plague.” This secular approach is an example of what Megan Vaughan explains as sweeping and coercive medical campaigns to wipe out a disease, which differed from missionary medical

and death that accompanied plague, meant that city officials' efforts to contain plague often failed, as people's "dogged ignorance"—lack of understanding of disease transmission—and desire to avoid coercion from the government, drove them to hide disease from officials, therefore unwittingly causing it to spread. The women missionaries offered inoculations, medical care, and their own plague camps—which, unlike the government's, were entirely voluntary, and were meant to provide care and prayers—but had little luck convincing people to take advantage of the services.<sup>494</sup> Suspecting missionaries to be part of a British conspiracy, spreading rather than curing the disease via the dreaded inoculations, many Indians consciously avoided the missionaries. Mackinnon explained that communities could move to the “verge of a riot” if inoculation or disinfection were suggested, and some missionaries were warned that “evil would befall our work” if they became involved in efforts to control the plague.

The Patna missionaries made their first inroads with two ends of the social spectrum: with the “more enlightened and better classes” and with the mission station's servants, who were poor but saw the benefits of inoculation first-hand, and began to bring their friends and families to the station for help.<sup>495</sup> This was a common pattern, for in the early 1940s, the Methodist missionaries in South India reported that during an epidemic of plague, cholera, and smallpox, people whom the missionaries had treated years before returned for vaccines, bringing friends

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approaches focusing more on the individual. See “Introduction” in David Hardiman, ed., *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa* (New York: Rodopi, 2006), 5-57.

<sup>494</sup> Missionary reactions to plague differed from the Government's, for the medical missionary women sought to provide relief as well as to try to comfort the dying. Attending their plague camps could also offer the sufferers the promise of salvation, which was not one of the motives for the government camps. Scholars argue that the British colonial government response to epidemics reflected deep-seated anxieties about Africa and India. See Paul Slack's “Introduction” to *Epidemics and Ideas: Essays on the Historical Perception of Pestilence*, edited by Terence Ranger and Paul Slack (Cambridge: Cambridge University Press, 1992) for an overview.

<sup>495</sup> “Patna,” *Annual Report*, 1900, ZBMM. Various missionary stations reported that hospital servants played key roles in promoting the medical work, helping to build up the missionaries' reputations, and encouraging friends and neighbors to use the services.

and relatives with them.<sup>496</sup> This was a sign of progress, for at the turn of the century, such volunteers were atypical, as Mackinnon noted that most “poor and ignorant” people objected to inoculations. Mackinnon was therefore careful only to inoculate women who asked for the injection, and to never do it in the hospital for fear of instigating mass panic.<sup>497</sup> But local attitudes toward the Patna missionaries and their medicine shifted in just one year: Mackinnon recorded providing over 1,200 inoculations during the 1901 plague season, which she proclaimed as great progress. People were less “panic-stricken ... [and] apparently preferred the present evil [the missionaries and their needles] to an unknown horror [possibly contracting the plague].” That year, a group of Patna residents sent a petition to the Government, demanding more plague inoculations for the city. This was cheering, as the missionaries stationed at the not-too-distant ZBMM hospital in Benares (Varanasi) reported one-hundred daily plague casualties. While some trends could be seen across India, each medical station had its own experiences in terms of progress and setbacks in building patient relationships and implementing new medical treatments. In the 1930s, the WW missionaries explained that “[e]ach year sees a difference in the attitude to preventive medicine.” The people in their locale accepted the plague vaccines, but saw cholera inoculations as something new, and therefore suspect, and some villages barred the medical women from attempting to prevent cholera until the death rate spiked.<sup>498</sup>

The women’s missionary hospitals’ policies for treatment could differ from the Government institutions’ rules, resulting in public confusion. While the ZBMM missionaries at Patna dealt with plague, their colleagues at Lucknow took on cholera. Dr. Mary Pailthorpe

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<sup>496</sup> “Redfern Memorial Hospital, Report for 1941,” WW, MMS, Reports, 1038, 107.

<sup>497</sup> “Patna,” *Annual Report*, 1900, ZBMM. Indians were not completely unreasonable in their fear of inoculations. In 1908 when the entire staff of the Benares Victoria Hospital was inoculated, nearly all became ill and one died of the effects three months later. See “Benares,” *Annual Report*, 1908, ZBMM.

<sup>498</sup> “Hyderabad District Medical Report,” 1934, WW, MMS, Reports, 1036, 60.

explained that the epidemic hurt their 1901 statistics, since inpatients fled the hospital when news reached them that cholera had struck someone at home, and during outbreaks, people were too afraid of the disease to leave their houses in search of aid. The ZBMM hospital accepted cholera cases, but, as cholera was so contagious and had such high rates of mortality, the local Government hospitals refused to admit cholera patients. Even with the missionaries' efforts to inform the public that cholera patients were welcome, few came; Pailthorpe attributed this to both confusion over the conflicting messages and most people's desire to die at home.

Overcoming aversion to treatment was therefore an ongoing goal for medical missionary women. While each missionary had stories of gaining a patient's trust, they found no foolproof formula for building relationships with patients. Alice Speight was initially skeptical of the value of spending days "tramping" from village to village in the South India heat in what seemed like a pointless effort to give a couple of doses of medicines to people who needed several weeks of medical supervision in a hospital. But she claimed, "I have been converted," realizing that people were afraid of her, and of leaving their villages to go to a hospital far away; she concluded that it was the missionaries' duty to go out to the villages and first make friends.<sup>499</sup> This process could take years, and could easily be undone. For example, the Christian women's medical school at Ludhiana came under local fire from the "Aryas," who boycotted the hospital and encouraged the Hindu community to build its own hospital after the medical staff accused an Arya mother-in-law of poisoning a patient.<sup>500</sup> In some areas, mission stations had more patients than they could effectively treat, in others, very little interest. The WW station at Mandagadde was

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<sup>499</sup> Alice Speight, letter from Redfern Hospital, December 1934, WW, MMS, Reports, 1036, 62.

<sup>500</sup> "Report, North Indian School of Medicine for Christian Women, 1908," Ludhiana Collection, Yale Divinity School Library Special Collections, HR491-2. The reference is not elaborated on in the report, but by "Arya" the author probably means members of the Arya Samaj, a Hindu religious movement that promotes adherence to the Vedas. At various times in the early twentieth century, the Arya Samaj voiced strong opposition to Christian missionaries in India, and could work to mobilize communities to boycott Christians and their services.

never busy, much to the staff's dismay. Dr. Marjorie Cartledge, who was often depressed, bored, and lonely when serving at this relatively empty and isolated jungle hospital, was certain of ample "need" for medical work in the area, but admitted that after years of effort, she and her colleagues had no idea of how to coax people to come to them for medical care.<sup>501</sup> Dr. Joan Drake noted that many of their patients came from distant villages and had never seen a white person before, and were therefore somewhat apprehensive.<sup>502</sup> Near Benares, the missionaries working with the Doms built a hospital just for this "outcaste group," but never made the headway they anticipated. As late as 1947, only five babies were born in that hospital during the year, a factor contributing to Joy Hoare's declaration that the name "Doms" stood for "depressors of missionary service."<sup>503</sup>

Individual personalities seemed to contribute to missionary medical progress, and it was often the individual and not necessarily the system that overcame resistance to western medical care. Patients formed relationships with or at least were influenced by individual medical women's reputations. While missionary societies—operating from the home base in Britain—may have seen their workers as interchangeable, patients and staff did not. Some medical women became locally well-known as kind and good practitioners, and people were willing to walk miles or wait for long periods to see them.<sup>504</sup> Dr. Ethel Douglas came to be valued by the ZBMM for her "extraordinary influence" which kept the Lucknow hospital "overflowing."<sup>505</sup> When these medical women left, or returned from a furlough, the attendance records at that

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<sup>501</sup> Marjorie Cartledge to Miss Bradford, 13 November 1928, Mysore Correspondence, WW, MMS, 1075, 901.

<sup>502</sup> "Karim Nagar Medical Report," 1926, WW, MMS, Reports, 1035, 26

<sup>503</sup> "Teliya Bagh Hospital Report (Benares), 1946-47," WW, MMS, Reports, 1039, 128. The Doms, widespread in many parts of India, especially Bengal and Bihar, are among the lowest castes in India, looked down upon by most of the "untouchables." Doms women often work as dais, and the men as disposers of the dead. See David Arnold, *Colonizing the Body*.

<sup>504</sup> Hardiman discusses the ways successful missionaries, including Dr. Margaret Johnson, had loyal followings, in *Missionaries and Their Medicine*, 212-215.

<sup>505</sup> Minutes, 4 June 1935, ZBMM.

station reflected local sentiments. For example, after the young Anne Banks, a physician whose “removal [brought] sorrow to very many,” died suddenly of paratyphoid, the numbers of patients at her hospital dropped considerably even though the rest of the staff remained and another competent woman doctor soon replaced her.<sup>506</sup> Banks’ career in India had spanned just eight years, but she had gained the confidence of and was popular with the local women. The Wadiaram medical work saw a drop of 1,000 patients the year that Miss Freeman left. Patients still journeyed to the Kalyani hospital looking for Dr. Olive Monahan more than a year after she had moved to a new location. When the Nasik hospital was without a doctor for six months, the nursing Sister was relieved to have Dr. Katherine Harbord come, even for only a short while, for Harbord had worked there before, and people knew and trusted her. The Nasik people disliked changes in staff, and it always took time for a newcomer to be accepted.<sup>507</sup> Missionaries reported that this was true at most of their stations.

Because earning trust could be so hard, and losing it so easy, workers often complained about the lack of continuity in staff to their home committees—who, along with clergy serving in the Indian locale, made staffing decisions. Missionaries in the field tried to stress that their complaints were not solely about their own inconveniences and disruptions, but also about how staff changes adversely affected relationships with the local population. As she approached the end of her third week in Kamal, Marie Hayes recorded in her diary that was “my longest sojourn in one place in India so far.”<sup>508</sup> Hayes’ experience was extreme, but many women noted that

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<sup>506</sup> Reverend Sawday to Miss Bradford, 6 June 1928, and Marjorie Cartledge to Miss Bradford, 24 September 1928, WW, MMS Mysore correspondence, 1075, 901. Anne Banks was reportedly mourned by hundreds of women in Mysore, and “especially [by] the poor” whose hearts she won not only by her medical skills but also by her “tender compassion.” Tomkinson to Bradford, 14 June 1928, WW, MMS, 1075, 901.

<sup>507</sup> Annual Report, “Nasik,” 1928, ZBMM.

<sup>508</sup> *At Work: Letters of Marie Elizabeth Hayes, M.B. Missionary Doctor, Delhi 1905-8*, (London: Marshall Brothers 1909), 6 February 1906. Marie Hayes, like Anne Banks, died while in service in India. Hayes worked as a medical missionary for less than three years.



they had been transferred to two to three stations in as many years.<sup>509</sup> Grace Gillespie, while still at the beginning of her long career in India, criticized the WW decisions, stressing that the constant movement of staff to cover furloughs was “a waste of work and energy... You have to begin again every time and work loses badly every time.”<sup>510</sup>

Earning patients’ trust was not the end of the story, however. Some missionaries seemed to feel that confidence in their abilities brought increased pressures. Marjorie Lambert, for example, was awed by her perception that after only one year, her patients had faith in her. Miss Green, nursing alone in her station at Valthoha, wrote that when she was away, patients keenly felt her absence, for on her return, women admonished, “If you had been here my baby (sic) had not died.”<sup>511</sup> The Ludhiana patients believed that the key to a cure was due to the doctor’s own goodness and religious powers; these patients were upset if the doctor asked the medical students to write out the prescriptions, rather than do it herself. Some of the doctors found this level of superstition combined with what could be taken as a compliment frustrating.<sup>512</sup> Some made light of situations, such as Sister Morgan, recording her “Baby Week” demonstration designed to instruct the Sholapur women in British and Australian ideas of mothercraft. The “baby” was a doll, sent from New South Wales, and watching the nurses dress and bathe it was so popular that by the end of the week, an arm fell off in the bath, “much to the horror of the crowd who had been looking interestedly toward it, then toward me with an expression of ‘How like its mother!’ on their faces.”<sup>513</sup>

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<sup>509</sup> Nurse Stringer noted that she had been assigned to three hospitals in less than two years of service. Stringer to Bradford, 15 October 1928, WW, MMS, Mysore correspondence, 1075, 910.

<sup>510</sup> Grace Gillespie to Miss Byrom, 8 February 1932, WW, MMS, Mysore correspondence, 1076, 924.

<sup>511</sup> “Valtoha,” *Annual Report*, 1922, ZBMM.

<sup>512</sup> “Report,” Women’s Christian Medical College, 1935-36, Ludhiana Collection, Yale Divinity School Library Special Collections, HR 491-1.

<sup>513</sup> “Sholapur,” *Annual Report*, 1926, ZBMM.

### **4.3 *Establishing Authority and Patient Compliance***

Missionaries faced challenges beyond gaining a patient base. Their goal to become the trusted doctor or nurse meant, in the medical women's minds, that the patients would accept their medical advice, follow directions and accept Western approaches to treatment and health care. Dr. Elizabeth Mahaffy explained that it was harder to work in the inpatient medical department than in the surgical wards because patients did not at first appreciate the value of good nursing, exact diagnosis, and pathological investigations. As was the case for her colleagues at other missionary hospitals, many of Mahaffy's patients argued that if they could just access the medication, they would do as well at home as at the hospital. Patients often chose not to cooperate or exclusively work with the missionaries. Even when Indians appeared to accept western medical care, missionaries sometimes discovered that the patients had yet to abandon their old ways. Missionaries working with the Doms ruefully noted that although their statistics indicated that more Doms were taking western medicine, this did not mean that they were practicing less witchcraft, as the staff had hoped. "Further knowledge of Dom life and thought teaches us that they drink [our] medicine not as a substitute for magic but as an addition to it." Doms called medical women to their homes for treatment, then sent them away to await the wizard's coming. If the patient improved, the wizard got credit, whereas if the patient died, it was the missionaries' fault.<sup>514</sup>

Missionaries especially hoped for patient trust and cooperation during medical emergencies. In instances when a medical woman made a home visit alone, she sometimes needed assistance preparing or handling the instruments, managing other onlookers, or with the administration of anesthesia. Many people participated in the decision-making process for the

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<sup>514</sup> "Benares Medical Work," 1929, WW, MMS, Reports, 1035, 40.

patient, and if they decided to resist the medical woman's advice, she was powerless, or at least hampered. Missionary stories of home visits included dealing with patients' friends and relations who were so opposed to a nurse's proposed procedure that they first hid her medical bag, and later, when she approached the patient, physically forced her to drop her just-boiled instruments on the earthen floor, causing her to start her sterilization process again.<sup>515</sup> In these scenarios, medical women found their success relied upon the luck of finding at least one calm onlooker who was willing to follow directions. Dr. Ethel Landon reported being called to a serious childbirth case, but not until the *dai* and the Civil Hospital nurse had given up. "When I got there the whole house and even the alley, was in a wild hubbub. The patient was moribund, but I turned a few people out of the room, and with the door shut, set to work, helped by two nurses, and about three of the women of the household."<sup>516</sup> Situations such as these were why the societies placed such value on leadership skills, as well as the ability to remain calm and confident.

Patients usually had a group of people closely involved in their care, including family, neighbors, and, in some communities, the village or local leaders. Such participation in medical care seldom helped the medical women. Something as simple—in the missionaries' minds—as asking a patient's caretakers to leave bandages undisturbed could become an ongoing battle. In her thank-you letter to the women in Britain who sent their laundered scraps and rags to the missionaries, one exasperated nurse explained that clean cloth was "unavailable" in Indian homes, and that when the missionaries brought linens for patient care—even with clear instructions—it was usually set aside, deemed too good to use on a sick person. She knew that

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<sup>515</sup> Anonymous, *Nurse's Log-Book: Being the Actual Incidents in the Life of a Missionary Nurse* (Westminster: The Missionary Equipment and Literature Supply, 1925), 58-9.

<sup>516</sup> "Nasik," *Annual Report*, 1914, ZBMM. Ethel Landon often wrote very detailed and interesting reports.

after leaving patient's homes, a relative would remove the clean linens, fold them neatly, and set them aside for a better purpose.<sup>517</sup> Even more worrisome was when patients' friends or relatives ignored missionary's instructions, adding homemade liniments, poultices, or even cow dung—all of which medical women labeled “dirty”—to the prescribed hygienic or “sterile” treatments.

“Dispensing”—providing appropriate medication—was one of the women missionaries' earliest activities in the realm of medical work, predating hospitals and medical stations, and it remained a main area of work throughout the colonial period. Patients came to dispensaries with the goal of leaving with some kind of tangible treatment, and, in terms of sheer numbers, dispensing care was an effective missionary and medical strategy. What dispensary attendance numbers did not reflect was whether patients took their medications correctly—or at all—and followed prescribed medical advice. Patient failure to comply was a complex issue, and could include religious restrictions, cultural beliefs related to food and drink, economics, attitudes toward and understanding of medical technologies and interventions, as well as confidence in the medical women.

Missionaries worked hard to convince Indian women that medications, changes in diet, or surgical interventions could improve their health. Workers treating dispensary patients wrestled with worries as to whether the patients would actually take their medication as prescribed. Charlotte Vines advised “when giving a drug, to order some native remedy to be used side by side. This secures the certain use of the drug given.”<sup>518</sup> The compounders, who prepared many of the medications, were usually Indian, and therefore able to advise the missionaries of religious and dietary restrictions and patient expectations that could affect compliance. Such knowledge

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<sup>517</sup> The nurse's frustration may have been only about “wasting clean” linens on a patient, for linens could be popular at the hospitals. Dr. Douglas noted that the staff had to keep close tabs on the Lucknow station storeroom—otherwise, all their linens and blankets would disappear. “Lucknow,” *Annual Report*, 1938, ZBMM.

<sup>518</sup> Charlotte Vines, *Indian Medical Sketches* (London: Church of England Zenana Society, 1915), 8.

was crucial, as Vines warned, “Woe to the doctor who orders a heating food in a fever, or a cooling drink during a cold or chill!” In some areas, Hindus refused liquid medications since these were mixed with water, and there were caste prohibitions against ingesting water from impure wells or tainted by that touch of ritually unclean people, which included all the missionaries. Sending patients away with medications they had to mix themselves could prove risky. Muslims avoided medications that contained alcohol, which also made liquid treatments suspect. In other regions, Hindus did not observe any restrictions related to water in medication, and would accept medications from nurses’ hands, but not take food from them. Medical women noted that it was harder to treat patients when “custom refuses to let people change their diet.” As middle-class British women, the missionaries put great stock in the power of meat, eggs, and fish oils, which their vegetarian Hindu patients would not eat, even if their medical problems were exacerbated by malnourishment.<sup>519</sup> Although the missionaries in the organizations in this study did not leave records indicating that they had explored Ayurvedic medicine, which closely connects health and diet, the medical women came to understand that their challenges were due not to Indian doubt that food played a role in health—just that the different cultures had different understanding of the power of various foods. As Ruth Western explained, “[t]he Sindhi considers diet an important part of the treatment of any complaint, although his notions of suitable food are often very different from ours.” Her staff struggled with patients believing they should avoid rich foods like butter and milk, while the medical staff urged the patient to put on weight, and thought such foods were the most effective.<sup>520</sup> In other communities, rolling pills in butter proved an effective way to get patients to take them.

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<sup>519</sup> I have not found any missionaries who mention learning about vegetarianism. Some Hindus would accept eggs, but many would not.

<sup>520</sup> Western, *Some Women of the Sindh*, 99. Western was a CEZMS missionary doctor.

Patients who appeared open to medical advice were still found to have misunderstood directions or willfully taken medications incorrectly, mixed in other treatments, shared their medicines with people, or had confused or unrealistic expectations for their medications. When making a village visit, one group of missionaries learned that all of the medications they had prescribed had been thrown out by every villager because the medications for whooping cough had not cured the patients after a couple of doses. The doctor, reflecting on how so much suffering could have been avoided, exclaimed, “The more one sees of village people the more one is convinced of their stupendous need.”<sup>521</sup> Some missionaries explained their strategy of charging a fee—even just a tiny amount—for medications, as it was hoped that if the patients paid something, they would value therefore be more likely to take their medications, rather than politely accept the bottle only to discard it on the way home, fearing contamination by ritually unclean water.<sup>522</sup>

In some cases, medical women saw their problems with compliance as due to the “ignorance” of people living in places deemed “still backward in civilization.” Examples of this were actions such as a mother leaving the dispensary with her child’s head carefully bandaged, and returning the next day with the bandages placed over the child’s bonnet.<sup>523</sup> Finding patients with their mouths so stuffed with small raw onions that they were near suffocation was another. Mary Proudlove reported that the village near her hospital was full cholera, with high mortality, because the Hindus saw no point in taking the prescribed medications, as they believed cholera was due to an angry goddess. The fact that one of the Indian Christian teachers had contracted and died of cholera in less than twenty-four hours—despite the missionaries’ best efforts—did

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<sup>521</sup> “District Medical Report for Kalyani,” 1935, WW, MMS, Reports, 1036, 65.

<sup>522</sup> Charles Reynolds, *Punjab Pioneer* (Waco: Word Books, 1968).

<sup>523</sup> “Patna,” *Annual Report*, 1926, ZBMM; Hinton, *Ethel Ambrose*, report from December 1914.

not help the situation.<sup>524</sup> In other situations, what the missionaries might consider “backwardness” was just a difference of opinion. For example, Eva Bowes, a nursing Sister in the late 1930s, commented that she and her colleagues felt a great sense of accomplishment if they could persuade pregnant women to take any prescribed drugs as the local people were “very opposed to taking medicine while pregnant.”<sup>525</sup> Such aversion to medication or making dietary changes during pregnancy could prove impossible for the medical women. But the most frustrating challenges for the missionaries could be when the reason for noncompliance was harsh economic reality, such as when patients failed to take medicine after meals because they were too poor to afford the proper number of daily meals.<sup>526</sup>

Convincing patients that treatments often took time and might not have any immediate visible results could prove very challenging for the medical women. Nurse Nancy Lines explained that “the simple treatment of good food, rest, cleanliness and fresh air does not meet with [Indian] approval.”<sup>527</sup> Missionaries waged ongoing battles with the patients and their friends to prevent them from applying their own treatments under “sterile dressings just because they think they aren’t getting better fast enough.”<sup>528</sup> Elizabeth Mahaffy therefore declared that progress was being made when more patients agreed to remain in the hospital until they were completely cured; as many of the newer medications were very expensive—and because so many patients could not afford such costs, thus forcing the missions to absorb them—it was a

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<sup>524</sup> Mary Proudlove to Miss Bradford, 9 January 1929, WW, MMS, Madras correspondence, 1068, 717.

<sup>525</sup> “Godavery (Godavari) Medical Mission Report for 1939,” WW, MMS, Reports, 1038, 94. Add cite from the Burma article. In light of the need for studies today to assess mothers’ medications’ risks on unborn infants raises questions as to how “backward” these women were, especially in the decades before any regulated testing to track risk.

<sup>526</sup> Ethel Ambrose noted this challenge in her notes from January of 1914, as this was a time of impending famine in the Poona (Pune) region.

<sup>527</sup> Nancy Lines, letter from Medak Hospital, February 1936, WW, MMS, Reports, 1037, 67.

<sup>528</sup> “Lucknow,” *Annual Report*, 1926, ZBMM.

waste of time and money for the hospital if patients left in mid-treatment.<sup>529</sup> Sister Foster complained about Indian women's unrealistic expectations, explaining, "the children as so undisciplined...[and] even the mother is quite unable to control her child and invariably she expects him or her to be made better after one dose of medicine."<sup>530</sup> Dr. Mary Proudlove worried about a baby brought to one of the Madras dispensaries. He had club feet, which could be treated if the parents would be patient enough to allow the medical staff to "massage and manipulate" him daily for the next few months. Ruth Western was struck by a father who diligently followed her directions for his sick child, commenting, "it seemed a pity that some of his patience could not be transferred to the parents of other children, who, given a fair chance, could have been cured."<sup>531</sup> When the patient's progress was slow, many gave up and returned to their "traditional" treatments. This was especially true of diseases that were tough to treat and took months or even years of ongoing intervention, including osteomalacia, and "spine rickets." No matter how much the five roadside clinic efforts increased, the Vellore efforts to treat "lepers" were often ineffective—treatment was long and many patients ceased to attend the clinics once they felt better, thus quickly losing any progress that had been made.<sup>532</sup>

But these medical women did on occasion admit that their ideas were not always best, and that some Indian approaches to medical needs worked quite well. These realizations that traditional, or even what could be called folk practices are significant, for scholars have criticized the "agents of imperialism"—which usually include missionaries—for "willfully dismiss[ing] even those aspects of local knowledge which might have assisted them in avoiding disease, or

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<sup>529</sup> Elizabeth Mehaffy, "Special Medical Report," 1938, Ludhiana Collection, Yale Divinity School Library Special Collections, HR491-1.

<sup>530</sup> "Canada Hospital," *Annual Report*, 1934, ZBMM.

<sup>531</sup> Western, *Some Women of the Sindh*, 15.

<sup>532</sup> "Principal's Report," August 1932, Friends of Vellore Collection, British Library, India Office Private Papers, MSS. Eur. F 219/1/14.



which could have helped them in coping with it.”<sup>533</sup> Charlotte Vines reported learning about “Indian drugs” from an old woman, and also stated that “Indians know a great deal about treatment, far more than ordinary English people do.”<sup>534</sup> Sister Morgan, for example, conceded defeat in her battle to keep one vulnerable baby clean, and therefore healthy. The baby, an orphan too young to survive without breastmilk, was placed with an Indian foster mother, who was “very dirty.” The baby nevertheless thrived with this woman, whom Morgan credited with saving the infant’s life, concluding, “After all, perhaps it is better to be fat, and lively, and dirty than to be clean and miserable. She certainly did not seem able to thrive on cleanliness.”<sup>535</sup> Similarly, after arguing with the Indian dispenser, a nurse realized that the Indian practice of covering bandages with banana leaves instead of jaconet was indeed cheaper and worked perfectly well.<sup>536</sup> She also came to adopt the practice of rubbing newborns’ bodies with oil, “as Indians do,” before handing them back to settle down with their mother. The staff at the CEZMS hospital in Sindh admitted that while they were unable to ever diagnose and help a sick child, he got much better after his parents took him to see a Muslim hermit. And, while missionaries were known to disapprove of Indian girls wearing jewelry, the Sindh hospital staff provided babies with piercings—three holes in each ear, and one through the nose—in order to avoid infection from home piercings with dirty needles. Susan Finch concluded:

“Custom and ignorance are still great obstacles to the successful treatment of patients who are curable, though in many cases the patients (sic) own inclinations are found to produce better results than strict Western treatment. A typhoid patient can eat monkey-nuts with

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<sup>533</sup> Andrew Cunningham and Bridie Andrews, “Introduction,” in *Western Medicine as Contested Knowledge* (Manchester: Manchester University Press, 1997).

<sup>534</sup> Vines, *Indian Medical Sketches*, 9.

<sup>535</sup> “Sholapur,” *Annual Report*, 1926, ZBMM.

<sup>536</sup> Anonymous, *Nurse’s Log-Book*.

impunity; a patient with heart disease is found, contrary to all book treatment, to benefit much by walking out to sit in the sun, and a pneumonia patient by taking a cold bath the second day after her temperature has fallen.”<sup>537</sup>

Obtaining patients consent to missionary recommendations for surgery—whether minor or major—was another missionary goal. Even after the ZBMM hospital had been in Lucknow for nearly fifty years, Dr. Douglas mused that it was still extremely difficult to convince “purdah” patients—the women who observed female seclusion—to consent to any type of operation.<sup>538</sup> Women who did schedule a procedure were known to postpone them—often at the last minute—because they had discovered that the hour was deemed “inauspicious.” The doctors at Ludhiana claimed that their Muslim patients resisted surgeries due to the belief that the removal of any body part would cause them to be short of it in the next life.<sup>539</sup> But as a population realized that operations could not only benefit them, but also were not necessarily too painful, demand for them could spike. The gift of a “dental syringe” made tooth extractions easy, drawing numerous patients in for this service. In some areas, eye surgeries became normalized, allowing medical women specializing in such procedures to perform more than 1,000 surgeries per year. As was the often the case of local acceptance of inoculations, the WA Madras District report of 1932 noted that most patients now accepted recommendations for operations, and that some patients requested them, even if they were not necessary, thus raising new challenges for doctor/patient relations.

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<sup>537</sup> “Lady Kinnaird Memorial Hospital,” *Annual Report*, 1922, ZBMM.

<sup>538</sup> Missionaries used the terms “purdah”, “zenana” and “gosha” somewhat interchangeably. The ZBMM defined purdah as “Literally a curtain; purdah means ‘screened from the sight of men.’” Women observing purdah therefore practiced female seclusion, and could be said to reside inside the zenana, or women’s quarters. Hospitals that could accommodate women practicing strict seclusion were sometimes called “gosha hospitals.” See J. C. Pollock, *Shadows Fall Apart: The Story of the Zenana Bible and Medical Mission* (London: Hodder and Stoughton, 1958).

<sup>539</sup> Elizabeth Mehaffey, “Special Medical Report,” 1938, Ludhiana Collection, Yale Divinity School Library Special Collections, HR491-1.

#### 4.4 “*Bitter Experiences*”: *Medical Authority in Matters of Life and Death*

“One of the bitterest experiences...is to stand by and see a woman die, who...would have been spared much suffering, if the ignorance or prejudice of relatives had not stood in the way.”<sup>540</sup> Sister Macready’s lament spoke for many of her colleagues who had to accept that they had failed to avoid a preventable death. During epidemics, the preventable deaths could especially tough to accept. When the Doms suffered an outbreak of smallpox in 1934, the epidemic raged since mothers hid their children from the vaccinators, and families refused to isolate sick members. When dealing with cholera, the Doms told the missionaries that nothing could be done until the demons who caused cholera had been propitiated; by the time the medical women were called in to help, it was too late to stem the epidemic.<sup>541</sup> More frustrating for the missionaries were the individual cases involving an Indian woman who could have been “cured” had the relatives and friends, or, in some cases, the patient herself, allowed the medical women to act on their professional knowledge. Because medical missionary women had come to India specifically to “help” Indian women, when they believed that a woman was allowed to die because she was a woman, this was especially “bitter.”

Dr. Ethel Douglas was pleased with her hospital’s progress in operations—there were 455 in 1934—but she did stress that many of their abdominal surgeries were more complicated than necessary due to patients first trying other remedies, and only agreeing to surgery when their situation became dire. People tended to wait until it was too late, which was the reality of the situation all too often for medical women. Sometimes such delays in action were the patients’ decisions, but the missionaries often blamed the patients’ relations. One doctor

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<sup>540</sup> “Patna,” *Annual Report*, 1923, ZBMM; see also *At Work: Letters of Marie Elizabeth Hayes*, letter dated October 9, 1907, 224.

<sup>541</sup> “Benares Medical Work,” 1934, WW, MMS, Reports, 1036, 62

complained of dealing with an entire village where she had been called to see a gravely ill patient who, in her opinion, needed immediate medical intervention. When she made her diagnosis and recommendation, the village elders told her to wait while they “consulted the beads” to determine whether the surgery could be performed. If the beads were an even number, the patient could have the treatment, if odd, she must be left to die.<sup>542</sup> A zenana worker visited an Indian woman in her third day of “great ravages of fever,” but the woman refused to consult a doctor until the fifth day, as that was the day her guru declared auspicious, so she was left without relief. The same worker also attempted to help a mother whose baby was “starving” due to being “tongue-tied” (ankyloglossia) but the mother wanted to wait another month or two to see a relative who was a physician rather than have the child treated by the local doctors; arguing that the wait would cause the baby to suffer or even die did not seem to affect the mother’s plans.<sup>543</sup> Another nurse wrote of following men to a distant village to see a woman who had been in labor for several days. A *dai* had previously performed an “operation” which had become septic, and the nurse determined the situation was so urgent that the patient required a doctor’s care, which meant transporting her to the hospital. She begged the village men to take the patient to the hospital, but they insisted she remain in her village. The nurse countered that keeping the patient in the village meant she would probably die, and they would blame the nurse. The men reassured her that all they wanted was for her to try to save the mother; although she managed to deliver the baby, the mother died within twenty-four hours. This experience haunted this nurse, as she was certain the woman could have been saved but for “superstition.”<sup>544</sup>

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<sup>542</sup> *Annual Report*, 1902, ZBMM.

<sup>543</sup> “Benares City Schools and Zenana Work,” *Annual Report*, 1936, ZBMM.

<sup>544</sup> *Nurse’s Log-Book*, 116-17.

Especially when the medical work was still “new” in an area, medical women were under considerable pressure to avoid any appearance that a patient died as a result of their treatment. A death attributed to them could mean loss of credibility, not only for the individual medical woman, but also for western medicine, western culture, and Christianity: missionaries believed the stakes were high. In Claire Thomson’s hospital in the 1940s, if one patient died, nearly all the other patients—regardless of their condition—immediately “ran away.”<sup>545</sup> This was quite common. Sister Frances Campbell reported that each time a woman at her hospital died in childbirth, “we lose all the patients for a few days.” Nevertheless, Campbell’s colleagues accepted cases that had “any hope of at survival,” placing the possible life of the mother over the negative repercussions that would follow her death.<sup>546</sup> Once the local work could sustain an inpatient death that was not followed by a mass exit from the hospital, the missionaries could report that attitudes toward them and their efforts were improving.<sup>547</sup>

Concerns about patient deaths could put missionaries in no-win situations, for until they were well-established or in an area where “Western” medical care had been accepted, they usually were only called to cases after the local and traditional healers and approaches had been tried and deemed ineffective—at that point, people saw the missionaries as worth trying since they believed the patient was likely to die, and therefore they had little to lose. Women who were eventually brought to the hospital—often carried for miles in the back of a bullock cart, a practice missionaries doubted helped the already fragile and uncomfortable patient—died at high rates because their families and neighbors had waited too long before seeking professional help. When writing annual reports, missionary hospitals commonly noted that the higher mortality

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<sup>545</sup> Claire P. Thomson, “In Those Days: A Worm’s Eye View,” (typescript memoir) Thomson Papers, British Library, India Office Private Papers, MSS Eur D 1102

<sup>546</sup> Frances Campbell to “dear friends”, 13 September 1922, WW, MMS Mysore correspondence, 1075, 890.

<sup>547</sup> “Patna”, *Annual Report*, 1919, ZBMM.

rates for hospital maternity cases were due to the “desperate” and “last-hope” cases brought to them too late to save.<sup>548</sup> Some annual reports noted that the higher in-hospital death rates could be viewed in a positive light, for it meant more people were bringing cases to them. By agreeing to take such critical and often hopeless cases, the cards were already stacked against the missionaries, and they knew it. The residents of one village told the WW missionaries that every maternity case that had been sent to the Ikkadu hospital over the past two years had died, so they had decided not to send any more; the fact that all of these cases had already been given up for dead by the *dai* was irrelevant. On the other hand, workers at Ikkadu reasoned that families were grateful even when the mother died in a childbirth case, as people feared the ghost of an undelivered woman.<sup>549</sup> Although many women recorded that they were glad to have been consulted at all—even if it was too late—their goal was to be the people’s first choice rather than the last resort.

Indian attitudes toward life, death, and fate factored heavily in the decisions as to whether to call the missionaries or to allow them to perform interventions or transport the patient to the hospital. Missionaries commonly told stories of Indian women patients who claimed to be unwanted by their husbands or families, a claim that was often corroborated by the relatives. Dr. Carr explained that many of these poor, sick, and undernourished women relayed that their husbands had said, “Let her die, who cares?” Missionaries and their medical staff found caring for these women to be highly rewarding, even if they could not be cured, for, “[i]t comes as a ray of light to them that there is someone who really cares whether they get better or not—in fact a whole crowd of people who care.”<sup>550</sup> Ethel Landon was affected by a patient who had been

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<sup>548</sup> “Special Medical Report,” 1938, Ludhiana Collection, Yale Divinity School Library Special Collections, HR491-1.

<sup>549</sup> “Ikkadu Report,” 18 December 1946, WW, MMS, Reports, 1039, 123.

<sup>550</sup> “Nasik,” *Annual Report*, 1946, ZBMM.

badly burned after being left alone on the floor of her home after the birth of a baby. The new mother had developed blood poisoning and was brought to the hospital. The patient's aunt visited the hospital for the first couple of days, but then left, saying, "if she dies, she dies." No one else ever came to see her. The hospital staff was unable to console the patient, who cried incessantly.<sup>551</sup> Whether due to "caring" or other reasons for their decisions, families often did choose to "let" a patient die rather than allow the medical woman to try to save her. In her early days in India, Ethel Douglas was surprised when the male relations of a dying midwifery case refused to help move the patient since she was "unclean."<sup>552</sup> Hayes' story of wiring for another mission doctor to come assist her with a serious operation, only to be informed by the woman's people decided that they had decided to let her die instead, was common.

In missionaries' opinion, Indians were crippled by their resignation to accepting sickness and death. Beatrice Board complained of "the callousness and indifference of the people to suffering, coupled with their lack of patience under treatment" that made caring for them difficult or impossible.<sup>553</sup> Board's comment may not have been as harsh it seems, for the medical women routinely cited cases where parents seemed resigned to losing a child—a beloved child—because of cultural understandings of fate and misunderstanding of the possibilities of different outcomes due to medical science. Ruth Western wrote that Sindhi mothers could seem indifferent to the loss of children, but that this was a necessary coping strategy for women whose lives were full of such losses, pain, and sorrow. Missionaries believed that Indian women and children suffered the most because poor health was "looked upon as almost the natural state of affairs in this country," and they worked toward helping

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<sup>551</sup> "Nasik," *Annual Report*, 1912, ZBMM.

<sup>552</sup> "Lucknow," *Annual Report*, 1910, ZBMM.

<sup>553</sup> "Patna," *Annual Report*, 1906, ZBMM.

change this attitude.<sup>554</sup> 1934 was a bad year for plague in the Hassan District, causing the missionaries to cancel their weekly dispensaries to lessen the risk of patients carrying disease from village to village. Some of the purdah women refused to get inoculations from the government doctors, so the missionaries arranged to bring vaccines to the women in their villages. The missionaries' message never arrived at one village, and on the day of their visit, all the men were away at a market. The purdah women then refused inoculations because they did not have their husbands' permission. The missionaries accepted this, but suspected that local fear of the inoculation outweighed the plague, and that the people were highly fatalistic about death. Eva Bowes wryly noted that while she had many patients, she thought it would be a long time before mothers came to her for advice on how to prevent health problems. She noted that "occasionally" women consistently took her advice, but cautioned, "We must remember, however that it will be a long time before people here will pay for this kind of advice and for treatment of minor ailments, advice and treatment they consider quite unnecessary and superfluous."

#### 4.5 *"In This, Their Time of Greatest Need": Childbirth*

"Still more do we deplore the backwardness of women in coming to Hospital for childbirth. When called to attend patients in their homes, we are often aghast at the utterly insanitary conditions which prevail, the lack of ability of even one out of possibly twenty assembled in the Zenana to render any intelligent help, and the difficulty of getting clean hot water and clean clothes for the patient is practically insuperable. It is small wonder that numbers of patients come to us within one to

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<sup>554</sup> Ethelwyn Newham to Miss Byrom, 18 October 1932, WW, MMS, Mysore correspondence, 1076, 928.



four weeks after childbirth, to ask us to try to undo the damage that has been caused by insanitation, ignorance, and maltreatment by unskilled ‘dais.’ We long for the time when India will realize that ‘prevention is better than cure,’ and though prejudice is gradually being disarmed, and ignorance overcome, we are still a long way from complete victory. But we trust that the time will come when Indian women will demand, and Indian men will not be satisfied until their wives receive, skilled help in this time of greatest need.”<sup>555</sup>

Complicated childbirth cases were the most common examples of situations that could have benefited from the “skilled help” offered by medical missionaries had they been called in time, had Indian patients and their families agreed to interventions and hospitalizations, and—in the medical women’s opinions—had the life and well-being of the mother been valued. Pregnancy and childbirth, uniquely female experiences, enabled British women to develop a sense of unity with Indian women, as well as emotional propaganda to justify both women’s missionary medical work and Western medical workers’ presence and leadership in the development of colonial medicine. Describing childbirth in India as an unnecessarily difficult, dangerous, and sometimes brutal process, missionary as well as secular women’s publications presented the Indian woman, dying in agony, undelivered of her child, as a victim of her own culture. In addition to rescuing Indian women on a case-by-case basis, medical missionary women hoped to educate all Indians on the backwardness of their ways and the benefits of the modern medical care in the areas of maternal and infant welfare.

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<sup>555</sup> “Lucknow, Lady Kinnaird Memorial Hospital,” *Annual Report*, 1919, ZBMM.

Although hospital maternity services were offered in some Indian cities in the nineteenth century, Indian women primarily used midwives—always female—and usually the untrained, “traditional” women called “*dais*.” Although they possessed no formal education, they had learned their work through years of practice with more experienced older women. The medical missionary women were not opposed to midwives—indeed many of them were professional nurse midwives—but they wanted Indian women to use midwives who had completed formal training programs. According to the *dais*’s critics—who included medical and secular men and women doctors and trained nurses, government officials, and social reformers--*dais* were typically drawn from the “outcastes” or lowest socio-economic strata of society, were completely illiterate and “ignorant” of the most basic principles of hygiene and practical care, posing serious threats to Indian women’s and infants’ lives.<sup>556</sup> Missionaries labeled *dais* and their implements “germ carriers.”<sup>557</sup> The missionary reports regularly commented that a significant amount of their routine work was “repairing damage done by *dais*.”<sup>558</sup>

A driving goal behind the missionaries’ work was to motivate Indians to overcome their resistance to calling for “skilled” nurses and doctors to midwifery cases. In some locales, developing hospital maternity services proved to be the hardest work for the missionaries. It was not uncommon for women’s hospitals to have to wait years before the local women began to come in to deliver their babies.<sup>559</sup> Claire Thomson explained that people first consulted the elderly women (*dais*), then the traditional practitioners—or “quacks,” as Thomson called them—

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<sup>556</sup> Barbara N. Ramusack, “Women’s Hospitals and Midwives in Mysore, 1870-1930: Princely or Colonial Medicine” in *India’s Princely States: Peoples, Princes and Colonialism*, ed. Waltraud Ernst and Bismawoy Pati, 172-189 (London: Routledge, 2007).

<sup>557</sup> “Ibrahimpnam Medical Work for 1932,” WW, MMS, Reports, 1036, 44.

<sup>558</sup> “Patna,” *Annual Report*, 1931, ZBMM.

<sup>559</sup> This was true across India, as the Canadian Presbyterians had no obstetrical cases between the years of 1888-1896. Ruth Compton Brouwer, *New Women for God: Canadian Presbyterian Women and India Missions, 1876-1914* (Toronto: University of Toronto Press, 1990), 115.

and finally the western-trained women, if they were consulted at all. Commitment to the traditional ways of bringing babies into the world ran deep. In the early 1930s, the staff at the Methodist Ikkadu hospital was asked to participate in a Rockefeller rural development grant by providing four nurse midwives to work in the nearby villages. This they gladly did, expecting that these medical professionals would keep busy, but the Ikkadu nurse midwives—who were Indians, but Christians—had difficulty finding villages willing to accept them. “It seems as if the average caste woman would prefer the attentions of the most ignorant barber woman (*dai*) to those of a fully-trained Christian girl.”<sup>560</sup>

The fact that Indians only called for a western-trained doctor or nurse once they concluded that a baby could not be delivered meant that cases missionaries took were typically complicated. These “abnormal cases” as the medical women classified them, were often already advanced to the “in extremis” level by the time a medical woman saw the patient. If the medical women did not try to help the patient, she would die—“these calls to villages are not to ordinary sick people, but are cases of life and death ... every refusal means two deaths”<sup>561</sup>—but the missionaries knew the patient might die anyway due to the lengthy labor, infections from fruitless interventions, loss of blood, or other complications. For example, Dr. Louisa Dodge reported that of the Akbarpur Hospital’s seventeen maternity cases in 1925, 11 of these were abnormal, and of those, in three cases they lost both the mother and baby.<sup>562</sup> Certainly the missionaries preferred caring for a difficult case rather than allowing the woman to suffer and die, but anger and frustration, as well as a sense of helplessness often surfaced when they reflected on how so much suffering and death could be avoided if only Indians would call for

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<sup>560</sup> “District Medical Report for 1933,” WW, MMS, Reports, 1038, 53.

<sup>561</sup> Vines, *In and Out of Hospital*, 183.

<sup>562</sup> “Akbarpur Hospital Report,” 1925, WW, MMS, Reports, 1035, 32,

help sooner, or, even better, come to the hospital for the delivery. Missionaries hoped to find ways to bring more maternity cases to their hospitals for births, but saw special progress when “normal” cases came in on a voluntary basis, as was the trend during Nurse Holmes first few years at Ikkadu. Margery Hall, the wife of an Indian Civil Service officer, sought out a local women’s missionary hospital when she became pregnant in the early 1940s. She was struck by the staff telling her that they “never” saw normal maternity cases, only those brought to them when it was almost past hope.<sup>563</sup> While the women missionaries worked hard to induce Indian women to come to their hospitals for childbirth, the male doctors and the non-purdah facilities often had an even more difficult time. When Hall was expecting her third child, she and her husband were in a remote area served by only two European doctors. Hall was dismayed to learn that one had “never delivered any babies,” and the other could only recommend himself by saying he has “done seven years in Edinburgh;” once again, Hall reached out to the nearest women’s missionary hospital, which was two-hundred miles away, in Quetta.<sup>564</sup>

Medical women wanted to be called to help with difficult childbirth cases, but these situations and their settings could prove stressful for them. Claire Thomson’s description of a “typical” home delivery highlights the challenges medical women encountered:

“[Once we arrived in the village] a group of men would gather outside [the laboring woman’s home]. The room chosen for the delivery was usually the worst in the house and often the one in which grain was stored. It was always dark and by the time our eyes adjusted to the poor light, we saw the mother lying on the ground in one corner and the rest of the space was taken up by onlookers and huge baskets of grain. The first

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<sup>563</sup> Margery Hall, “And the Nights were More Terrible than the Days,” British Library, Indian Political Service Collection, MSS Eur F 226/11.

<sup>564</sup> Ibid. The Quetta missionaries were probably those at the CEZMS hospital.

thing we did was to ask all but about six of the women to go outside and then we drove out the hens which were clucking around. The mother was often in a bad way and had probably been in labour for several days, because otherwise it wouldn't have been worthwhile to send for us ... We usually used forceps. No one ever wanted to take the baby because childbirth is considered unclean. Finally a low caste woman will step up and wrap [the baby] in a dirty bit of sari. No clothes would have been prepared for the baby because that would have been bad luck ... We carried tea with us and before we left made sure the mother had a good drink of sweet tea.”<sup>565</sup>

The fact that many people other than the laboring woman and her immediate family were involved in the birth made maternity cases in the home especially challenging for medical women. Indeed, dealing with the other Indian women could absorb much missionary attention. Marie Hayes counted twenty-seven women onlookers while she and one nurse attempted to perform an obstetrical operation in a zenana; the young Hayes found this situation disconcerting. Ethel Landon was not as tolerant as Hayes and on occasion “chased the crowd away to the other side of the dusty street, where they sat and waited with as much interest and morbid curiosity as any queue at an Old Bailey murder trial.”<sup>566</sup> Ethel Ambrose longed for an in-patient maternity building as she found the combination of the neighbors lingering as noisy onlookers—which caused her to shut the door to keep them from distracting her—and the heat and dark that was exacerbated once the doors were shut, almost intolerable.<sup>567</sup> When one nurse anesthetized her patient with chloroform, the patient's mother and sister concluded she must have died, and began dancing and singing the “death song,” causing panic amongst the villagers waiting outside the

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<sup>565</sup> Claire P. Thomson, “In Those Days: A Worm's Eye View,” Thomson Papers, British Library, India Office Private Papers, MSS Eur D 1102.

<sup>566</sup> “Canadian Hospital,” *Annual Report*, 1922, ZBMM.

<sup>567</sup> Hinton, compiler, *Ethel Ambrose*, 156.

door, who then crowded back into the room, blocking all the light and making the delivery, which required a “minor operation”—which both mother and baby survived—more difficult and stressful.<sup>568</sup>

Indian practices of placing the laboring mother in a small, dark, and enclosed space bothered medical women, both because it made their own work while physically in the home more difficult, and because they were convinced that these were unnecessarily unhealthy as well as unpleasant conditions for the new mother. They also interpreted aspects of these practices to reflect cultural devaluation of women: missionaries often commented that they were “troubled that so little consideration is shown to mothers by their relatives.”<sup>569</sup> The dark that missionaries complained of was caused by the absence of or closed windows. The smoke from the smoldering coal or dung fire kept near or even under the patient made medical work harder, hotter, and more unpleasant. Occasionally mothers suffered burns from the fires. Some missionaries wrote that Indians used the fire to keep evil spirits away from the mother and infant, but most saw it as irrational, dangerous, and as a nuisance to everyone’s comfort and breathing.

Although maternity cases in villages often took a lot of time and were difficult to medically manage, medical missionary women felt compelled to accept maternity cases. This was due to both the sense of medical urgency and an understanding of the value of motherhood in Indian culture. Missionary women were especially motivated by their wish to help the childless woman become a mother, for they saw cases of women whose families mistreated them for barrenness, or whose husbands were under pressure to take another wife.<sup>570</sup> If they could deliver a live child to a woman who had lost many babies—and they regularly noted that many

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<sup>568</sup> *Nurse’s Log-Book*, 86.

<sup>569</sup> “Benares Medical Work,” I. M. Spencer, 1934, WW, MMS, Reports, 1036, 62.

<sup>570</sup> “Lucknow,” *Annual Report*, 1934, ZBMM.

of their patients had lost numerous previous pregnancies—knew they would help the woman emotionally as well as socially.

While medical missionaries preferred to be called to a home birth rather than to allow an “ignorant” *dai* to manage it, their pressing goal was to move births from the Indian home to the hospitals. In addition to removing both themselves and the patient from the dirt, smoke, floor, and chaos, they also wanted an environment where they had more authority. By moving patients to the hospital, medical women hoped to be in a better position to carry out their own medical orders, demonstrate the benefits of cleanliness and quiet, and combat the “ignorance and superstition” that caused such formidable resistance to their work.

#### **4.6 *Home and Hospital***

The urgent need for hospitals for women in a country like India requires no stressing, in view of widely prevalent social customs and the low esteem in which women, as women, stand.<sup>571</sup>

As the annual statistics for missionary medical work indicate, the majority of contact with patients was through dispensary visits. Missionaries found this type of interaction with patients only partially satisfying. They worried that patients would fail to follow through on prescribed treatments, or would merely add the missionary advice to that of the local healers or traditional approaches. Patients requiring follow-up treatment might not return, especially if they had a long distance to travel, or did not understand that their condition required time and ongoing treatment to cure. Missionaries therefore wanted to establish hospitals and to increase inpatient

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<sup>571</sup> Editors’ opening comments, *Annual Report*, 1928, ZBMM.

numbers. Because most of their patients were leery of hospitalization, medical women saw growth in inpatients as evidence of improved trust and confidence in the missionaries and their medicine. As Ethel Ambrose explained, if the missions pushed patients to stay in the hospital too soon, people's fears and suspicions would have set the work back; each mission had to wait until their reputation was established before advocating that Indians become inpatients.<sup>572</sup>

Practical considerations played into the missionaries' goals of shifting more patients out of their homes and into missionary institutions. The "official" justification for hospitals—presumably popular with their supporters at home—was that having inpatients meant extended time for attempts at evangelism and other "Christian" influences.<sup>573</sup> Missionaries also attempted to engage Indian women in Christian teaching at the clinics and dispensaries where Biblewomen "taught" patients while they waited to see the doctor or nurse, often telling Bible stories under a tree or in the waiting area. In their reports home, missionaries stressed that such efforts were part of dispensary work, even efforts as small as pasting Bible verses on medicine bottles. The sheer numbers of people attending dispensaries made some medical women openly acknowledge that their own attempts to evangelize were unlikely to be effective. Charlotte Carlisle reported that people clustered around the Biblewomen at her "jungle" station every afternoon; Carlisle's main contribution was to attempt to join in the singing, and she felt that the women liked it when she came.<sup>574</sup> The missionaries at the Dharapram Hospital admitted that few patients took an interest in the preaching during the short service held before each dispensary session started, but joined in the prayers for healing and cleansing of the soul.<sup>575</sup> Some doctors and nurses took

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<sup>572</sup> Hinton, compiler, *Ethel Ambrose*.

<sup>573</sup> Hardiman, "Introduction," in *Healing Bodies, Saving Souls*.

<sup>574</sup> Charlotte Carlisle to Miss Bradford, 4 February 1930, WW, MMS, Mysore correspondence, 1076, 914.

<sup>575</sup> In *Missionaries and Their Medicine*, David Hardiman explains that Indians were very open to praying before treatments, but that this did not correlate with any interest in conversion.



leadership roles in services at the dispensaries, but most explained that the medical work in such settings was so demanding that they had no time for taking an active role in direct evangelism. As Charlotte Vines explained, “[W]e had no worker to tell the waiting crowd about the Great Healer. How can we do justice to our patients when we must diagnose, prescribe, dispense, keep in order, and hear the same story over and over?”<sup>576</sup>

According to the reports, Indians were usually polite and not openly opposed to such proselytism, but such short periods of teaching, especially in the chaotic setting of a waiting room filled with sick and anxious people, bore no definite fruit. A lengthy stay in the hospital held more promise for real progress. One year Mary Pailthorpe proudly noted when the increase in the length of the average stay for an inpatient at her hospital jumped from 17.8 to 23.5 days, for the staff were encouraged by the extra time allowed for Gospel teaching. As Pailthorpe explained, every extra day helped since patients were often too afraid and “dazed” at the beginning of their stay to take in anything from these foreigners and strange surroundings. The hospitals doggedly offered daily religious services in the wards, as well as bed-side visits and teaching from the Biblewomen. Although the missionary magazines routinely printed short stories of how such efforts touched Indian women, these reports seem to have been designed to reassure supporters that these medical institutions were doing “missionary” work; they rarely had any compelling evidence that such efforts led to serious interest in Christianity.

Medical women also preferred to work with patients in hospitals because many of them found Indian homes difficult environments in which to work or to manage patients. In Britain and the United States, prior to the rise of germ theory, hospital care was primarily for providing clean and quiet spaces for rest, and nutritious food to promote recovery; in other words, the type

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<sup>576</sup> Vines, *In and Out of Hospital*, 171.

of environment middle- and upper-class people had at home. The hospital, therefore, was for those—usually the poor, or in the United States, the recent immigrants—who did not enjoy a wholesome home environment.<sup>577</sup> The medical women had similar ideas for their Indian patients, seeing the hospital as clean place where the patients could receive care superior to that at home. The average rural or village homes of the poor had dirt floors, burned cow dung as fuel for cooking, lacked screens to keep out the flies, and had no plumbing or outhouses. Poor families brought livestock inside for safekeeping at night. One doctor commented that she tripped over goats in Muslim homes, and bumped into dozing cows in Hindu houses. The medical war against tuberculosis was made more difficult in India due to patients' insistence on remaining in their homes, where, in close quarters, the disease spread. In her two decades of tuberculosis work in India, Dr. Rose Riste noted that even after careful instruction, she continued to find her tubercular patients' homes' floor covered with infectious sputum. Riste acknowledged that some of the families were trying to follow the medical advice, but the poverty contributed to the "appalling conditions" of most of these homes.<sup>578</sup> Medical women learned that it was not feasible to hope to quickly change these practices, but they could try to move the patients who could most benefit from extended care and a controlled environment to hospitals.

Missionary hospitals therefore became settings for not only religious teaching but also for attempts to introduce western or modern ideas about germs, sanitation, and hygiene.<sup>579</sup> Although

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<sup>577</sup> Charles A. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (New York: Basic Books, 1987).

<sup>578</sup> "Report," Women's Christian Medical College, 1932-3, Ludhiana Collection, Yale Divinity School Library Special Collections, HR491-1.

<sup>579</sup> For a discussion of the strategies nineteenth-century women physicians used to carve a niche for themselves in preventive medicine and domestic hygiene—based on their "expertise" as women—see Elaine Thomson's Edinburgh study, "Between Separate Spheres: Medical Women and the Development of VD Services in Edinburgh" in *Medicine and the Public Sphere: Britain 1550-2000*, ed. Steve Sturdy, 107-122 (London: Routledge, 2002). See also Shemo's study of Chinese women medical missionaries, who had the same hopes and challenges as their European counterparts in India. Connie A. Shemo, *The Medical Ministries of Kang Cheng and Shi Meiyu, 1872-1937* (Bethlehem, PA: Lehigh University Press, 2011).

Charlotte Vines brightly reassured readers in Britain that “it is wonderful how soon these rough village-women learn our ways and appreciate our tidiness,” most missionaries complained that Indians did not quickly adapt to their standards.<sup>580</sup> For example, Mary Proudlove doubted that the “wild country” people who came to the Ikkadu hospital would enthusiastically take to the newly installed water closets. Instead, historians argue that hospitals became “site[s] of struggle” among cultural practices and beliefs.<sup>581</sup> And, it was struggle, for these foreign women were not able to simply impose their ideas and practices on “passive” people.<sup>582</sup>

Much has been written about hospitals as sites for control, and instruments of amassing medical power over patients, but building a hospital did not solve the missionaries’ problems related to patient care, patient compliance, or efforts to evangelize. In her studies of missionary nurses, Rosemary Fitzgerald has noted that in many areas of medical care and standards—such as order, hygiene, and discipline—these women were unwilling to compromise. Dr. Barbara Nicholson, for example, explained that while the missionary staff had learned the benefits of making the hospital conditions similar to the patients’ homes, there were some rules that could not be bent, including at least some respect for “our rules of cleanliness” while in the hospital. Enforcing the rules was harder to do in reality, however, as even in the hospital and under the watch of medical women, patients found ways to mix in other treatments. Doctors often complained that patients were so talkative and loud that it could be impossible to hear through stethoscopes, and there was little they could do to achieve their ideal quiet. Many patients seemed only vaguely aware that there were any hospital rules.

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<sup>580</sup> Vines, *In and Out of Hospital*, 26.

<sup>581</sup> Rosemary Fitzgerald, “A ‘Peculiar and Exceptional Measure,’” 193.

<sup>582</sup> This is an ongoing argument in Shemo’s *The Chinese Ministries of Kang Cheng and Shi Meiyu*.

Enforcement of hospital rules could result in letters of complaint from patients or their families, but Ethel Douglas reported that most people were happy with the missionaries' work.<sup>583</sup> Some missionaries questioned the focus on "order" and whether all the improvements and efforts in the hospital were not a waste of time, energy and money: "I sometimes wonder if it seems as if the material side of the work takes too large a place in my thoughts ... cleanliness and tidiness and orderliness makes for health and helps the nurses do their work better—I am sure of that—Beauty and orderliness must also be dear to the heart of God and should draw people to Him. While I remember that, I have no doubts of the rightness of these things we are doing."<sup>584</sup>

As medical staff weighed the pros and cons of sticking to their "Western" or "modern practices"—which not only reflected their own cultural expectations, but had also been ingrained into them during their own years of training—many made compromises in the interest of keeping patients in the hospital. One nurse remarked that she abandoned her plans to insist that patients use sheets, sleep in beds instead of on the floor, and take baths since they would leave if she made too much fuss.<sup>585</sup> Another nurse struggled with whether to require small children to sleep in cots [cribs]; these children were used to sleeping on the floor with their families and found the beds with bars upsetting, as did their mothers. As Ruth Western explained, "villagers in their first visit to the hospital are very easily scared, and one has to let them live as nearly as possible after their own fashion."<sup>586</sup> Because missionaries understood that staying in the hospital was scary for many patients, they were gratified and encouraged when former patients made referrals, often in the form of personally bringing family or friends to the hospital for treatment. Growth in hospital admissions provided a meaningful way for these women to assess progress; for

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<sup>583</sup> "Lucknow," Annual Report, 1944, ZBMM.

<sup>584</sup> Alice Musgrave to Christine Freethy, 23 February 1941, WW, MMS, Madras correspondence, 1072, 777.

<sup>585</sup> *Nurse's Log-Book*.

<sup>586</sup> Western, *Some Women of the Sindh*, 98.

example, in 1925, the Nagari staff reported that they had more inpatients that year, evidence that the village people's confidence in the westerner's methods was growing.<sup>587</sup>

Just as when treating patients in their homes, hospitals also had to accommodate Indian expectations for family involvement. While in Britain, strict rules for visitation—even when the patient was a child—were enforced, these were found to be huge barriers in India. Vines told a story of young woman coming to the hospital for a lengthy stay, and her mother accompanied her, setting up a bed next to the patients, and often having grandchildren and others staying with her as overnight guests. Family and friends also had to be accommodated around the hospital in ways that differed from practices in Britain. For example, the Ludhiana station noted that crowds of people came to wait outside the operating theatre when a “big” operation was scheduled, and would demand to see removed tumors or other medical specimens. In the case of a patient who was a prince's relative, a car arrived to take the specimen back to his state for his viewing. The CEZMS hospitals in the Sindh often had many healthy children staying with their inpatient mothers, because the sick mothers had no one to watch the children while they were away, and would not remain in the hospital without them.

The CEZMS, WW, and ZBMM hospitals also made accommodations to honor patients' religious beliefs and practices. Because many of the missionary hospitals received grants from local or state governments, as well as from private benefactors, their decision to tolerate non-Christian beliefs and practices was preordained. For example, the WA work in Mysore State was supported by the Mysore Council and the Maharaja. The Rs. 200 per month stipend came with the stipulation that all patients must be served and that caste and religious practices and

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<sup>587</sup> “Nagari Hospital,” 1925, WW, MMS, Reports, 1035, 20.

“prejudices” had to be respected.<sup>588</sup> But for the women in the missionary organizations in this study, the goal of providing care and relieving suffering drove the medical women to accommodate patients’ religious needs. Ruth Western explained that the Hindus in her area were very opposed to allowing a family member to die in an “unhallowed” place, so it was common for relatives to take patients home if they seemed likely to die. When one man decided to allow his wife to die in the Sindh hospital, he did so only after the staff agreed to let her die not in a bed but on the ground—in contact with the earth—and to arrange for her mother-in-law to perform rites for the dying and the dead.<sup>589</sup> Other accommodations were less successful. The WW Ikkadu hospital, which also treated males, relayed a story of a pneumonia patient whose relatives became impatient when he failed to quickly improve. The family therefore propped him up against a wall in the hospital and performed a series of ceremonies, which included sacrificing a chicken. Dr. Edith Little thought the stress of all this was too much for the patient, as he died the following night. Little concluded, “It is sad that after 30 years of medical work at Ikkadu, lives can be thrown away on the account of such ignorance and superstition close to the hospital doors.”<sup>590</sup> The Muslim patients at the Victoria Leprosy Hospital constructed a prayer hut on the hospital grounds and then attempted to convert it into a mosque. When the Taluqdar ordered it removed, the patients declared that a mosque had been demolished, which led to rioting and the discharge of most Muslim patients.<sup>591</sup>

The missionaries also had to decide how their hospitals would deal with Indian cultural practices such as observing caste and purdah. On principle, they condemned caste as it went

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<sup>588</sup> For more details on how such arrangements were made and operated, see Barbara N. Ramusack, “Women’s Hospitals and Midwives in Mysore.”

<sup>589</sup> Western, *Some Women of the Sindh*, 124.

<sup>590</sup> “Ikkadu Hospital Report for 1926,” WW, MMS, Reports, 1035, 20.

<sup>591</sup> “Victoria Leprosy Hospital, Dichpali,” 4 December 1946, WW, MMS, Reports, 1039, 124.

against their Christian teaching that all people are equal before God, and purdah because it oppressed women. On principle, they had to wrestle with these practices, and have been criticized by some historians for “legitimizing” or “validating” practices by accepting rather than challenging them.<sup>592</sup> But, as Fitzgerald explains, women missionaries’ willingness to make key concessions to caste, purdah, class concerns, and religious practices are some of the reasons the missionary hospitals were successful in attracting and retaining patients.<sup>593</sup>

Missionaries understood caste as the cause of inherent unfairness, discrimination, and poverty, and argued that Christianity, with its teachings of equality before God, would erase such undesirable divisions in Indian society.<sup>594</sup> Nevertheless, the missionaries in the missionary organizations included in this study accommodated caste observation in their hospitals. As Marjorie Lambert explained, “if one wants to influence them in the right direction, one must meet them half way.”<sup>595</sup> Some larger hospitals built a caste wing, but smaller ones often designated a ward or a few rooms for Brahmins. Others focused on segregating the “low-caste” patients so as to avoid “defiling” the others. In most areas, missionary hospitals that wanted to serve a variety of inpatients had to offer separate cooking facilities for different castes, and had to also accommodate relatives who remained to cook for the patient, as Brahmin and some other “caste” patients would not accept food provided by the hospital or prepared by people of the wrong caste. Hospital grounds added “caste” wells, and nurses learned to navigate hospital wards made extra cluttered with patients’ cooking utensils and drinking vessels stored around the beds. Nurse Holmes wrote “I often long to see the wards in the hospital looking like the ones in

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<sup>592</sup> See Leslie A. Flemming, “New Models, New Roles: U. S. Presbyterian Women Missionaries and Social Change in Northern India, 1870-1910,” *Women’s Work for Women: Missionaries and Social Change in Asia*, ed. Leslie A. Flemming, 35-57 (London: Westview Press, 1989).

<sup>593</sup> Fitzgerald, “A ‘Peculiar and Exceptional Measure.’”

<sup>594</sup> None of the medical women left records indicating that they ever questioned why such inequalities existed in their own home societies.

<sup>595</sup> “Nasik,” *Annual Report*, 1927, ZBMM.

a hospital at home, but as long as cooking utensils and rice are kept at the head of the beds it seems impossible.”<sup>596</sup> The staff did manage to stash away all the pots and rice, as well as the extra relatives, long enough for the hospital to look “very spick and span” for the vicereine’s visit, but then all returned to normal. Because caste patients brought their own food with them, and stashed it all under their beds, hospitals had to cope with cats coming in to drink milk and dogs running through the wards, carrying off bags of rice and sugar; this situation caused requests from the Home Committee for funds to purchase ward lockers.<sup>597</sup> While staff acknowledged patient needs related to caste, it was important to them that patients and their families understand that the missionaries—as Christians—treated everyone equally. Indians did not always understand this. “The hospital tries to be a democratic institution, though it is commonly assumed that the rich or high caste must have the best of everything and the poor are lucky if they get what is left.”<sup>598</sup> An ongoing goal, therefore, was to teach both high-caste and wealthier patients that, in a Christian hospital, all lives were equally precious, and that all patients received the medical staff’s best care and attention. They also had to explain this to the poor, for some poor women—who truly could not afford to pay fees—attempted to find money, hoping that if they paid, they would receive better treatment; some hospitals saw this phenomenon with childless women, desperate for a medical intervention to result in a baby. In such cases, the missionaries had to explain that payment would not make a difference—all were treated equally, and the money would only go to help others. Missionaries could not be sure that any patients believed this, but they often noted that they observed progress in “caste” behaviors in the wards, as when Mary Proudlove explained that no patients reacted negatively when placed

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<sup>596</sup>Gladys Holmes to Miss Bradford, 21 May 1930, WW, MMS, Madras correspondence, 1069, 724.

<sup>597</sup>Mary Proudlove to Miss Byrom, 25 October 1934, WW, MMS, Madras correspondence, 1069, 761.

<sup>598</sup>Western, *Some Women of the Sindh*, 27.



near a sweeper; twenty years before, such a situation would have emptied the ward.<sup>599</sup> By 1940, the Ikkadu Hospital report explained that the wards used to be designated by caste, but the staff had been able to abandon such an organization, and now had patients separated into the maternity septic ward, surgical ward, medical ward, children's ward, and private wards.

Although they intellectually understood the difference between “caste” and social “class,” medical women sometimes mixed these concepts, and while the missionaries had their greatest fortune in terms of conversion with India's poorest and lowest on the caste hierarchy, they tended to see making progress with those who were better off as encouraging. For example, as in Britain and the U.S., Indian women from the “better classes” began the trend of voluntarily choosing hospital births with “skilled” medical professionals as opposed to home births with “traditional” dais. Edith Tucker, pleased with the 1931 statistics for in-hospital maternity cases, credited them to the fact that the Ikkadu hospital now offered a set of private maternity rooms. She believed this meant that some Indian women—at least some of those who could afford a private room—preferred the hospital to the small, dark, and airless rooms relegated for the newly delivered mother at home.<sup>600</sup> Medical missionaries interpreted this as proof that Indians were finally realizing the advantages of western treatment, philosophy, and practices. This was what the missionaries had hoped to achieve for years. They could now claim that their perseverance mattered. Of course, the women opting for private wards were not the average villagers, and certainly not the poor, whom the missionaries targeted, and it is not clear that these women desired a private room because they had been medically “converted” to new ideas of childbirth—it is possible they saw their private room as a status symbol, as a way to better observe caste rules, or as a way to avoid sharing space in the ward with poor women—but the missionaries

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<sup>599</sup> “District Medical Report, Madras,” 1933, WW, MMS, 1036, 53.

<sup>600</sup> “Ikkadu Hospital Report for 1931,” WW, MMS Reports, 1036, 43.

could interpret this trend as a triumph. Offering private rooms also generated much needed income for the missionaries, which was another reason hospitals strived to add such amenities to their stations.

Purdah was also complicated. The missionaries' approach to accommodating purdah was similar to that of dealing with caste—they did not approve of female seclusion, yet they enabled it by catering to the practice in order to serve women who observed it. And this made sense, as it was the argument that purdah kept women from medical care that had first justified women missionaries' work in India. But even women who did not observe seclusion—the vast majority of Indian women—were still drawn to “women's” hospitals that offered a female staff. The hospitals in this study accommodated Indian women's desire for modesty, seclusion, or comfort as local needs dictated. Some of the hospitals were “gosha” or “purdah,” meaning they were completely female domains, designed so that male relatives could access their wives or daughters, but not enter space occupied by other female patients; these hospitals banned male practitioners, even in cases of emergency when calling in a male doctor from the civil hospital could mean saving a life. Most missionary hospitals were women's hospitals that had some rooms, a wing, or spaces that could be designated as “purdah” if needed. The missionary hospitals that focused on obstetrics and gynecology could serve all Indian women, for “[t]he maternity department is necessarily an important part of a ‘purdah’ hospital. Here there is a more urgent demand for women doctors, though even in other hospitals the majority of the patients being country-women prefer one of their own sex.”<sup>601</sup> Some of the Methodist work served both men and women, and the staff created strategies to meet the needs of each local community.

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<sup>601</sup> “Missionary Medical School for Women, Vellore, Incorporated,” pamphlet, n.d. (c. 1930s), Friends of Vellore Collection, British Library, India Office Private Papers, MSS EurF 219.

In their publications, missionaries argued that purdah oppressed women, and that the zenana was a “prison.” This was the official missionary position on the topic, and they claimed that Christianity would automatically end the practice. As medical women, they saw a correlation between observing purdah and suffering from various medical conditions, such as active tuberculosis, linking the lack of fresh air, exercise, and overcrowding that could be hallmarks of zenana life.

Missionary women also hoped that their hospitals could serve as the basis for aspects of social change for Indian women. They strived to do so in various ways, some more direct than others. Early in the twentieth century, the ZBMM had proclaimed, “There are still about 140 millions of women without any intelligent aid or care in sickness!” By 1929, the tone had changed as both more facilities had opened for women, and more women were making use of “intelligent” or “modern” healthcare options. “Despite the large amount of good work done by the Government midwives and the special efforts to get midwifery cases to the General Hospital for teaching purposes, our obstetric cases were only 5 or 6 less than the number in 1928. There is no doubt that Indians are slowly learning the value of western treatment.”<sup>602</sup> Medical missionaries were encouraged by women seeking “skilled” medical care at any facility, not only their own, although they sometimes admitted to feeling some pressure from what could prove to be competition from government facilities. During the 1930s famine years in southern India, the missionaries at the Mysore City hospital mentioned that the maternity cases saw little decrease due to the new Government maternity hospital, even though everything at the Government hospital was free; the missionaries could only provide free food for the very poor. Although the reports typically assured supporters at home that the government hospitals and clinics were no

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<sup>602</sup> “Patna,” *Annual Report*, 1929, ZBMM.

threat to the missionary facilities—and in most cases, their attendance suffered no real setbacks—some areas felt the effects of new options for patients. In 1941, the Khurja staff reported that their dispensary numbers had dipped due to the nearby Government Charity dispensary's opening, and added that the doctors at the men's and women's Government hospitals were better liked and trusted than most government medical staff. On the other hand, the Khurja missionaries could comfort themselves by arguing that the government's Lady Doctor's First Aid lectures had been greeted with considerable local suspicion.

Missionaries believed that because they were missionary hospitals, patients received care that was superior to the government hospitals. By “care,” they did not mean strictly medical procedures and oversight, but care about the patients as women and as individuals. “In a Mission Hospital one can be certain of devoted Christian nursing and sympathetic care which are so much more important than good medicine and many diplomaed (sic) doctors.”<sup>603</sup> Missionaries believed that they were kinder and more sensitive to their patients' needs, fears, and concerns, and that they treated the poor and uneducated with respect and dignity that was absent in many secular hospitals.<sup>604</sup> Missionary societies expected that their workers would see medical work as ministry to express Christ's love to other people, for “in missionaries unloving service is worse than no service at all, and that far more vital than the visible results of our work is the spirit in which we do it.”<sup>605</sup>

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<sup>603</sup> “Hyderabad District Medical Report,” 1937, WW, MMS, Reports, 1037, 80.

<sup>604</sup> Current studies of women's health care in South Asia state that poor, rural, and illiterate women are still treated badly at many urban hospitals and by many practitioners who see them as “ignorant.” See Santi Rozario, “The *Dai* and the Doctor: Discourses on Women's Reproductive Health in Rural Bangladesh,” in *Maternities and Modernities: Colonial and Postcolonial Experiences in Asia and the Pacific*, ed. Kalpana Ram and Margaret Jolly, 144-176 (Cambridge: Cambridge University Press, 1998).

<sup>605</sup> “Hyderabad District Medical Report,” 1939, WW, MMS, Reports, 1038, 93.

They took pride in the fact that patients recognized the missionary work as a calling, and missionaries as people of faith who served patients for reasons other than any personal benefit.<sup>606</sup> Indeed, some patients thought such noble motives gave missionaries special curative powers because they were not seeking.<sup>607</sup> The Hassan Hospital Report for 1937 admitted that “we get a good many disappointments. We do not know God’s ways well enough to understand why our prayers seem to be answered in some cases and not in others,” but reassured the home committee that everyone appreciated the nurses’ care and efforts. Other missionaries argued that surgical cases were cared for in government hospitals, but patients suffering from illness like pneumonia, typhoid, and dysentery were often neglected at such institutions because of the shortage of nurses at government hospitals. Caring for people who might be either rejected or overlooked in other institutions was a way for missionaries to demonstrate their commitment to valuing all life.

The missionary women wanted Indian women to believe that they—as women—were worthy of medical treatment, and that their health and well-being were as important as men’s. Encouraging Indian women to rest in order to recover or preserve their health was an ongoing goal and struggle for the women’s hospitals. As Ludhiana’s Dr. Riste, an expert in tuberculosis, explained, it was challenging to convince nearly all women patients that they needed to get enough rest. This was especially true in more extreme cases when Indian women avoided taking rest for fear of retaliation from their families, such as the tubercular woman Riste found covered in bruises, which she said her husband gave her when he came home and found her in bed rather

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<sup>606</sup> The missionary reports routinely state that even though there are free government services nearby, their wards remain full because patients know they receive better care in mission hospitals. Hardiman frames some of the success of the missionaries in his study as due to local beliefs that the missionaries provide better care because they do their work for religious reasons. See *Missionaries and Their Medicine*.

<sup>607</sup> “Report,” 1935-36, Women’s Christian Medical College, Ludhiana Collection, Yale Divinity School Library Special Collections, HR-491.

than working.<sup>608</sup> Women who were very ill and in the hospital routinely left to go home to cook for husbands, which irritated the missionaries, as they interpreted this as evidence that men had no regard for their women's health. Miss Hockner's description of "what hundreds and thousands of Indian women have to bear" was typical: a gravely ill woman came to the hospital and was finally getting better only to leave when her male relative came to announce that she must immediately return home to care for someone else; the fact that the staff claimed the patient required a few more days of glucose treatments and rest was irrelevant, as was the warning that the patient would die if she left. The patient, barely able to walk, got up to follow the man, who did not help her with her pots and pans or the baby, and who gave her his bundle to carry as well. "He was master and Lord, why should he carry burdens?" Hockner explained that the notion that women should serve their men and families regardless of their own needs was "what we are trying to save them from."<sup>609</sup> To bolster their efforts to encourage women to seek prenatal care, the Medak Zenana Hospital staff rewarded women who came "in good time before birth" with an ample diet, appreciated by poor villagers during the lean months. Some medical staff provided food for husbands as an attempt to bribe them to allow their wives to deliver and then remain in the hospital after the birth of a baby.

Medical women often commented on how hard the average Indian woman's life was—hard labor in fields or trades, numerous and early pregnancies, domestic work and cooking, and all within the context that females were lesser beings than men. Frustrated medical women were known to announce that Indian men viewed women much as they would livestock; some stated

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<sup>608</sup> "Report," Women's Christian Medical College, 1933-34, Ludhiana Collection, Yale Divinity School Library Special Collections, HR491.

<sup>609</sup> "Annual Report: Christian Hospital for Women, Azamgarh," n.d., c. 1936, WW, MMS, Reports, 1037, 75.

that men valued livestock more than their wives.<sup>610</sup> Missionaries disapproved of the common practices of men and women eating separately, and always the women after the men, for they encountered much malnutrition in poor women. Although some missionary writings placed most blame for what they saw as poor medical decisions affecting women on Indian men, others explained that decisions were made by men and mothers-in-law, who could prove to be medical women's formidable foes. When missionaries perceived that mothers-in-law were the main obstacle for another woman's health, they reflected that the solution to overcoming such "ignorance" lay in educating girls, and acknowledged that meeting this need was a complex challenge. They hoped that their work could begin to improve some aspects of Indian culture that negatively affected Indian women's health, and the hospital setting was a key place to try to forge such change.

Patients were not necessarily the captive audience missionaries might hope for, as they could and would leave the hospital at their will, or at the will of their families or neighbors.<sup>611</sup> Women left the hospital without the approval of their doctors for numerous reasons. The patients at one hospital routinely slipped out to visit the bazaar or friends, and then returned, pretending they had never left. When caught and confronted by the staff, the patients laughed off the reprimand. News of a cholera epidemic could empty a hospital as patients packed up to go home to care for sick relatives or to check on their families.<sup>612</sup> Women left to prepare for and attend local festivals or weddings, sometimes obligingly promising to return to the hospital to

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<sup>610</sup> For example, one nurse missed a call to a village to help a sick cow, which died. The dai, who had come for the nurse, accused her of letting the cow die, but the nurse explained that she did not know how to care for cows. The dai—a woman—was very offended, "for a cow counted much more than a woman to a Hindu." See Anonymous, *Nurse's Log-Book*.

<sup>611</sup> In her annual report on the hospital at Benares, Dr. Kate McDowell reported that the staff had "completely restored" 475 patients, "relieved sufferings" of another 28, that 17 had died, and that 15 had left prior to a discharge. "Benares," *Annual Report*, 1901, ZBMM.

<sup>612</sup> "Lucknow," *Annual Report*, 1901, ZBMM.

complete their recovery in a few days. Elsie Chapman complained that the hospital was empty due to a major feast, but that once it was over, pitiful cases would return, with all the previous medical work undone.<sup>613</sup> Missionaries were especially irritated when patients' reason for leaving the hospital was to return home to do the family's cooking. Men got the blame for this, as missionaries believed they considered having a woman cooking at home was more important than allowing her to recover her health. "Even Christian (Indian) husbands have not yet got beyond the German ideal for their women: Children, Church, Cooking... And especially the latter if they, personally, are concerned."<sup>614</sup> Sometimes these other responsibilities were more pressing than cooking for a husband. Most Indian women engaged in paid work, upon which they and their families depended, and the need to return to work outweighed the urge to stay in the hospital to rest. As Nancy Lines explained, "They have to be up and about and earning their livelihood, so they want and expect drastic cures; otherwise they consider us a poor Hospital and express their disapproval by departing."<sup>615</sup>

As the mission hospitals built maternity wards, they hoped that new mothers would choose to remain in the hospital for ten days after the birth of a baby, following the British ideal of keeping a new mother in bed, in a peaceful environment, to recover. Many Indian women either did not want or could not afford the time in the hospital, and informed the missionaries that they needed to return to their work by the third day after the birth. These women either left the hospital early, or chose not to come for fear of having to stay. Some hospitals also built nurseries to keep the newborn babies separately from their mothers, in the current British and American style. The medical staff thought new mothers would appreciate the opportunity to

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<sup>613</sup> Elsie Chapman to Miss Bradford, 26 February 1930, WW, MMS, Mysore correspondence, 1076, 918.

<sup>614</sup> Frances Campbell to "dear friends," 13 September 1922, WW, MMS Mysore correspondence, 1075, 890.

<sup>615</sup> Nancy Lines, letter from Medak Hospital, February 1936, WW, MMS, Reports, 1037, 67.



sleep through the night while being cared for by nurses who also took the burden of looking after the baby, but this did not appeal to many Indian women, who then entirely avoided the hospital.<sup>616</sup> Local reactions to remaining in the hospital after a birth could vary, however. While the Benares WW work saw resistance to hospital births, seventy miles away, the Akbarpur hospital witnessed an increase in childbirth cases because the local Hindus and Muslims had noticed that “hospital” babies did not die during their first week of life due to tetanus poisoning. Rather than realizing that tetanus could be avoided in home births by using a sterilized utensil to sever the umbilical cord, these women credited the lower death rate to remaining in the hospital.<sup>617</sup>

There were many ironic twists to medical missionary women’s work. Initially aiming to bring every Indian woman in to their hospitals and dispensaries for “trained” care, they gradually found that if Indian women did as they were bid, there was no way to adequately serve them. In 1938, Dr. Anderson complained that the “overflowing” hospital “does not give either patients or staff a fair chance.”<sup>618</sup> The wards were so crowded that the staff had temporarily used the surgery for the ante-natal ward. “They have not only got over their fear of a Christian hospital, but they beg to be taken in, though sometimes they don’t even need hospital treatments.”<sup>619</sup> Missionary women’s reputation for doing good work, especially for helping childless women,

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<sup>616</sup> Keeping mothers and babies for the lying in period also allowed Indian nurses in training to practice caring for postpartum women. For example, the Canada Hospital required all nurses in training to spend six months in the midwifery block, delivering at least 20 cases, observing at least 50 more, and caring for at least twenty postpartum cases.

<sup>617</sup> Babies infected with tetanus poisoning typically die within the second week of life, as the incubation period is about 6-14 days. By 1894, British doctors studying tetanus in Burmese infants had made the connection between infection and using a “dirty piece of bamboo” to cut the cord. See Judith Richell, “Ephemeral Lives: the Unremitting Infant Mortality of Colonial Burma, 1891-1941,” in *Women and Children First: International Maternal and Infant Welfare, 1870-1945*, ed. Valerie Fildes, Lara Marks, and Hilary Marland, 133-153 (New York: Routledge, 1992), 142.

<sup>618</sup> “Patna,” *Annual Report*, 1938, ZBMM.

<sup>619</sup> “Lucknow, Lady Kinnaird Memorial Hospital,” *Annual Report*, 1926, ZBMM.

also haunted them in unexpected ways. The ZBMM Patna hospital specialized in obstetrics and gynecological surgeries, and childless women traveled great distances in the hope of help.

Katherine Harbord wrote of her sorrow at seeing women falling at her feet, begging to be admitted even if only to sleep on the floor. These women—who would have fled in fear only a few years earlier—were willing to try any procedure, and typically demanded an operation.<sup>620</sup>

During these same years, the Lucknow hospital had over 500 annual maternity cases. Ethel Douglas wryly noted that after so many years of trying to coax maternity cases to the hospital, they were now often overwhelmed and had to turn the non-emergency—meaning “normal”—cases away, presumably back to the untrained hands of the village dais.<sup>621</sup>

#### ***4.7 The “Other Side” of the Work: Spiritual Meaning in Medical Work***

By the 1930s, many missionary organizations were in the process of shifting the official focus of their work from achieving conversion to providing needed services, through which their members could justify as living out their Christian faith. Indeed, Ruth Western’s quotation at the opening of this chapter can be interpreted as meaning that the missionaries’ purpose was to carry out God’s will through their own lives, which, for medical women, could mean acting as compassionate professional doctors and nurses. Medical missionaries frequently mentioned the “gratitude” they received from patients, which they typically attempted to redirect, explaining that missionaries were only instruments in God’s hands, so patients should please go and thank Him.<sup>622</sup> This way of thinking may not have been presented to Indians as propaganda, for Hardiman found that some missionaries who believed their work was guided by God appear to

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<sup>620</sup> “Patna,” *Annual Report*, 1931, ZBMM.

<sup>621</sup> “Lucknow,” *Annual Report*, 1931, ZBMM.

<sup>622</sup> “Lucknow, Lady Kinnaird Hospital,” *Annual Report*, 1935, ZBMM.

have been far more effective in treating patients than other missionary workers.<sup>623</sup> Western stated that the Kingdom of God should be established in peoples' hearts, which could be very intentional word choice, for the medical missionaries often stated that although they had no actual converts to report, they were sure that their work had changed people's hearts. When writing a report on the "medical and evangelical work" at her station, one nurse explained, "It is not possible to separate these two departments of work, nor would we wish to do so."<sup>624</sup>

How they measured change in Indian hearts is not clear, but they found meaning when previously hostile, suspicious, or timid women warmed up to them. They were also always encouraged whenever Indians seemed to take any interest in Christianity, rarely—at least in their reports and letters to their societies—acknowledging that Indians tended to be curious about religion and that Hinduism, especially, could allow its followers to accommodate various approaches to spirituality. Events as simple as an Indian woman bringing her friend to the dispensary to show off the Bible stories pictures on the walls, perfectly narrating them, warmed missionary hearts and made them feel that their presence and work mattered. The fact that the woman had been a student in the mission schools did not dampen the missionaries' excitement, for neither of the women wanted any medication or medical advice, they had only come to see the Bible story pictures.<sup>625</sup> As more and more patients became literate and could and did read missionary literature, the medical women enjoyed discussing these texts with their patients and families. Women who had lost several babies at birth occasionally followed the missionaries' advice and sought medical help. These women were often very moved to finally have a live

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<sup>623</sup> Hardiman, *Missionaries and Their Medicine*, 175.

<sup>624</sup> "Benares W. W., 1939, Evangelistic and Medical Work," WW, MMS, 1038, 91. Yuet-Wah Cheung, *Missionary Medicine in China: A Study of Two Canadian Protestant Missions in China Before 1937* (Lanham, MD: University Press of America, 1988) Cheung argues that by 1905, the official ethos was medicine first, evangelism second—medicine not as subordinate to evangelism or education, but as a coordinate.

<sup>625</sup> "Nasik," *Annual Report*, ZBMM, 1933.

child—even a girl—and while they did not convert, the missionaries were pleased if the mothers credited Jesu Swami for the baby, and many were happy to do so.<sup>626</sup>

In their reports, medical women explained that although they did very little “direct preaching ... doctors and nurses endeavor to do their work in such a way as to commend the Gospel of Christ.”<sup>627</sup> To them, this meant accepting as many patients as possible, regardless of class, caste, religion, or likelihood of survival, showing compassion, and living a life of service. These women were able to combine professional interests with their call to serve their communities and in some cases, India. Alice Speight was immediately tempted to join committees in Mysore City, and she commented on how she admired her senior colleague, Grace Gillespie, who managed to run the hospital and “serve the city in every way possible, both in and out of hospital.”<sup>628</sup> It also meant behaving in ways that did credit to Christianity, as Dr. Barbara Nicholson explained: “The thought of this makes our responsibility all the greater as we realise how much these silent onlookers are being influenced by our attitude and our actions, even fare more than by our words, and how we, and only we are to them the interpreters of Christ’s religion. It is a privilege for which we thank God constantly.”<sup>629</sup>

The missionaries were open about the fact that Indian women were willing to accept their medical services but rejected the attempts to introduce Christian teaching. One nurse explained that “the educated classes” in her area were quite friendly toward the missionaries—they invited missionaries to homes and attended mission-sponsored social events—and were fond of Dr. Landon, but made it quite clear that they had no interest in Christian teaching. These women had the means to pay for medical care, above the nominal fees missionaries charged, and used this to

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<sup>626</sup> “Hyderabad District Medical Report,” 1943, WW, MMS, 1039, 114.

<sup>627</sup> “Patna”, *Annual Report*, 1928, ZBMM.

<sup>628</sup> Alice Speight to Miss Byrom, 9 August 1933, WW, MMS, Mysore correspondence, 1077, 939.

<sup>629</sup> “Lucknow, Lady Kinnaird Memorial Hospital,” *Annual Report*, 1926, ZBMM.

attempt to bypass any “missionary” aspects of their medical care. Since the poor usually paid nothing, and the patients in the dispensary lines or admitted to hospital served as captive audiences for the Biblewomen’s Gospel lessons or little chats, those who could afford fees were known to make special appointments with the medical staff, thus avoiding the wait time, and the “teaching.” They saw the teaching as the price those who could not afford fees paid for medical care, which frustrated the missionaries, but they did not interpret such situations as failure.

Increasingly in the 1930s, medical women accepted conditions set by Indian patrons who supported the medical—but not the evangelical—work for women. For example, the work at one of the ZBMM stations was able to spread to a village because a Muslim woman donated one of the rooms in her house for a dispensary; this generous woman also donated bottles to patients who needed them to transport medications home.<sup>630</sup> This patron had no interest in Christianity and saw no threat from their presence in her community. This was an important and meaningful endorsement of the missionaries’ work—not their evangelism, but their care for Indian women, which others in the community also supported. This type of cooperation and interdependence was common and became increasingly sought by missionaries looking for ways to collaborate with other groups and organizations, including the government efforts to expand health care.

While medical missionaries seemed to be content with providing care for women, regardless of religious belief or in settings where no proselytism was attempted, this did not mean that these women did not believe that Christianity would “help” Indian women in both spiritual and practical ways. Dealing with death proved quite challenging for the medical women not only from a medical standpoint, but also from the spiritual perspective. As missionaries, they also believed they had a responsibility to share their faith in eternal salvation

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<sup>630</sup> “Jaunpur,” *Annual Report*, 1928, ZBMM.

with both the dying and those who loved them. Due to cultural differences on how to react to death, missionaries were often truly disturbed by what they interpreted to be overwhelming grief when someone died. Some descriptions of Indian reactions to death were summed up as “ghastly performance,” which could include “shouting,” wailing, tearing at hair and clothing, beating of breasts, and sprawling on the floor. One medical report stated that the hospital treated cases of ruptured spleens which were due to patients beating themselves in grief, and not, as in the West, from motor accidents. The missionaries thought that this deep, emotional sorrow was due to a lack of faith in salvation and the afterlife, and that conversion to Christianity would provide Indians with hope and comfort: “A Hindu death; oh, the desolation of it; the despondency thereof; the utter darkness of the beyond. Folks, if you’d seen one such death you would realize anew the urgency of the command, ‘Go ye into all the world and preach the Gospel.’”<sup>631</sup>

In time, most medical women came to understand that the “wailing” was a culturally-specific way to express grief, and just a different form than the stoic British expectations for dealing with loss. But even experienced missionaries still commented that they thought Indians would be more able to cope with deaths if they believed in the Christian salvation and afterlife. Elsie Tucker wrote of the loss of a missionary’s little daughter after a three-week battle with dysentery, noting that “the parents were a great example to us all and more so to the Indian people. They were so beautifully calm and brave.”<sup>632</sup>

Some scholars have interpreted the missionaries’ approach of encouraging Indian women who were interested in Christianity to merely pray for their husbands to convert, rather than to strike out on their own, as missionary failure to challenge Indian women’s traditional roles of

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<sup>631</sup> Dr. Christine McTaggart, “Report,” 1936-37, Ludhiana Collection, Yale Divinity School Library Special Collections, HR 4791-1.

<sup>632</sup> Elsie Tucker to Miss Bradford, 28 February 1927, WW, MMS, Madras Correspondence, 1068, 719.

submission.<sup>633</sup> Missionaries often explained that for an Indian woman to convert on her own—without her husband following suit—would prove ruinous to her. The missionaries were either too practical or too conservative to expect Indian women to leave husbands or their families behind in order to follow a new religion. They instead looked for positive outcomes from instilled hope or faith. For example, one doctor relayed a story of a woman who was abused by her husband, and stayed in the mission hospital for five weeks, during which time she took an interest in Jesus. When the woman left, she reportedly told the doctor that she knew her husband would continue to beat her, but that she was unafraid because she now had the peace of Christ; Dr. Carr saw this as a positive outcome of the mission's evangelism. On the other hand, there were times when the medical missionaries intervened on behalf of Indian women who did not want to accept their situation as women. The Patna missionaries worked with a patient who did not want to marry; the commissioner and other local officials ruled that if the girl was at least sixteen years old, she could choose to live where she liked, and could not be induced to wed. This decision caused such outrage that the hospital, which sheltered the girl, had to be put under police protection, until the next day, when the police arrived with a warrant and the mission had to hand the girl over.<sup>634</sup> The medical women often claimed to know that extended time in the hospital could give an Indian woman a different perspective:

“We know with certainty that there are some who go home with a new outlook, seeing a new light on their horizon; one which keeps bright within them in spite of home degrading conditions ... and sometimes we feel that this quite inward assurance and outward witnessing to Truth and Love is more fruitful in the end than all the hostility raised by the household and all

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<sup>633</sup> Flemming, “New Models, New Roles.”

<sup>634</sup> Gwendoline Winifred Emery Diaries, first volume, 13 and 14 February 1939, Emery Papers, British Library, India Office Private Papers, MSS. Eur. D 1039/2-12.

the harm to Christianity resulting when one member openly confesses and has to leave her kith and kin and roof and be sheltered in the mission school where she has no opportunity of contact with her own people of her old religion.”<sup>635</sup>

Missionaries also found meaning in their efforts to get Indians to agree to pay for medical services. The missionaries often stressed that these “Government” services were free, both in terms of financial costs to patients, and also free of evangelism. Missionaries, on the other hand, usually had the policy that patients should pay if able—even if the amount was so small as to only be a token. They wanted patients to pay for services for several reasons. First, the missionary organizations needed the funds, and not only to keep the work open. As Pleasance Carr explained in 1941, when war made tight budgets even tighter, fees from “rich Indians” counterbalanced the poor, who could only pay “in gratitude.” More significantly, missionaries interpreted the willingness to pay as evidence that communities and individuals believed in and valued the missionaries’ work. This was important to the missionaries, for many Indian families resisted paying for their services: Gwendoline Emery’s diary entry recorded her “private” visit to “Sharma’s wife” included a note that the family refused to pay more than two rupees, even though they stated they could easily pay five.<sup>636</sup> And, even though funds became extremely valuable in the last colonial years, missionaries struggled with knowing, “It is not right to pauperize people by [giving them] everything for nothing, but too great an emphasis on the matter of money does tend to obscure the real motives of our work.”<sup>637</sup> After practicing at the Patna dispensary for many years, the Indian Christian Dr. Gupta had earned “such confidence” from the patients that she was finally able to charge those of the “better class” fees, which was a

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<sup>635</sup> “Lucknow, Lady Kinnaird Hospital,” *Annual Report*, 1926, ZBMM.

<sup>636</sup> Gwendoline Winifred Emery diaries, 25 January 1939, MSS Eur D 1029/2-12

<sup>637</sup> “Ikkadu Hospital, 1943,” WW, MMS, Reports, 1039, 113.



real benefit to the hospital.<sup>638</sup> Because missionaries often encountered families with the ability to pay for their women's medical care, but chose not to, explaining that such an investment in a woman was a waste, medical women could find significance when they believed that such attitudes were changing, as is indicated in the Annual Report from the Lucknow Hospital:

[R]eally wealthy landowners and native gentlemen of good position have called Medical missionaries to their Zenanas, and have been quite prepared to pay the full fees for their visits. This is most cheering, as an indication that they are beginning to attach greater value to the lives of the women.<sup>639</sup>

Nearly twenty years later, Dr. Landon recorded the same views about the progress she saw at the Nasik hospital:

We have ... an increase in the number of well-to-do middle-class patients who like the paying wards. In town also the better classes have given me fair practice, and I can get fees more easily than I could years ago. In fact the standard seems to be rising, and people are taking a more intelligent view of their wives' illness, and are more careful to get proper attention for them.<sup>640</sup>

#### 4.8 Conclusion

“You see that medical work in India is often very discouraging; but there are encouragements too, and it is seldom that the patients' friends fail to recognize the goodwill to help, even if our efforts fail to cure the case.”<sup>641</sup>

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<sup>638</sup> “Patna,” *Annual Report*, 1935, ZBMM.

<sup>639</sup> “Lucknow,” *Annual Report*, 1902, ZBMM.

<sup>640</sup> “Nasik,” *Annual Report*, 1920, ZBMM.

<sup>641</sup> “Canadian Hospital,” *Annual Report*, 1922, ZBMM.

This quotation is from Dr. Ethel Landon's report of her fifteenth year of work in India. She wrote this after a long report discussing the fact that they made no converts that year, and that her buildings had been condemned. Her station had recently acquired a car, so she was able to make more frequent visits to distant places, but the maternity case she had faithfully visited for days, each time making a 52-mile round trip, nonetheless died. She also wrote at length to explain why she believed tuberculosis was on the rise in Nasik, complaining that no matter how many "private demonstrations and public talks" she made on the "life history of 'germs' and the value of sunlight and limewashed walls," her patients would continue to sleep on their "beloved" mud floors, in crowded rooms with carefully closed doors and windows." After her rant, she admitted that for so many tuberculosis sufferers, it was impossible to carry out most of the medical advice—their homes were in bad condition and they lacked the resources to change their circumstances. But she could comfort herself by remembering that with each patient interaction, she could make women aware that help was available at the mission hospital.

Landon's report of the ZBMM work at Nasik in 1922 was typical, and much of it was interchangeable with Dr. Ethelwyn Newham's report for the WW work at the Hassan hospital in 1941, which she summarized as a year of quiet, steady progress with nothing spectacular to report. Medical missionary women did experience much in their work that could be discouraging, but they also found much to make them believe that their efforts made a difference in Indian women's lives. Certainly a review of the numbers of patients they saw and treated could make a doctor's or nurse's work seem valuable and in demand. The fact that the majority of Indian women missionaries served were poor, illiterate, and had various barriers in their lives which prevented them from seeking "western" or "skilled" care—ranging from living in areas without services to purdah to fear of trying something new—made the work more meaningful.

Even though medical missionaries could not claim many conversions as direct results of their work, service to others was a way to live out their own religious convictions. As Sister Ament expressed, missionaries found that it was in giving help to others, “specially to those who are most needy that we get our clearest visions.”<sup>642</sup>

This chapter has examined the aspects of medical missionaries’ experiences that allowed many of them to describe their work as “great,” including gaining trust, making progress in the field of midwifery, and establishing successful hospitals. Most of this “great” work was related to building relationships with communities and helping individual Indian women, either directly, by providing medical aid, or indirectly, through the women’s missionary influence.<sup>643</sup> By the 1930s, medical missionaries’ work, characterized as “reactive” or “curative” rather than “preventive,” came under fire from the international health authorities and from some missionary organizations. Some of the women in these organizations, such as the author of the 1941 report for the Akbarpur mission, also saw new opportunities and needs in India, arguing that India was faced with “disease, dirt, poverty and malnutrition; ignorance and superstition hold sway.” She and her colleagues understood that medical work alone could not address all of these problems, explaining that the desired changes would require education, sanitation, better housing, an improved standard of living “and above all with a Gospel message which will break through superstition and fear and show to the people of this country that they, too, are the promised heirs of ‘more abundant’ life.”<sup>644</sup> Chapter Five will examine the women medical missionaries’

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<sup>642</sup> “Nasik,” *Annual Report*, 1932, ZBMM.

<sup>643</sup> “There’s no doubt that Miss Campbell’s personal influence has done a tremendous lot among these people. The lot of women here is different because of her, and people realize it.” Marjorie Cartledge to Miss Bradfor, 1 September 1929, WW, MMS, Mysore Correspondence, 1076, 916.

<sup>644</sup> “Akbarpur Women’s Work,” Dec. 1941, WW, MMS, Reports, 1039, 109.

strategies and goals in the areas of public health, maternal and infant welfare, and education and training to help Indian women achieve better health and lives.

## 5 “WHERE THE NEED IS GREATEST”: WOMEN’S MEDICAL MISSIONARY WORK IN LATE COLONIAL INDIA, C. 1930-1947

In January 1934, Dr. Winifred Anderson presented a paper at a missionary conference in Allahabad, in which she both outlined her impressions of the current state of missionary medical work in India and made suggestions for its future directions. Anderson had arrived in India in 1932, and was therefore still “new,” seeing the medical work with fresh eyes and from the perspective of a young—she was still in her twenties—and recently-qualified doctor.<sup>645</sup>

Anderson was based at the ZBMM Duchess of Teck Hospital in Patna, a large and bustling city in northeastern India, where the staff served many “purdah patients” and was known for its work in the field of gynecology.<sup>646</sup>

In her speech, Anderson first complimented the missionary societies’ accomplishments by expressing how pleasantly surprised she had been to encounter adequate facilities for applying current medical practices, noting that aseptic work was quite possible in many mission hospitals—as a missionary recruit in England, she apparently had been under the impression that such work was infeasible.<sup>647</sup> She then tempered this by observing that the hospitals required better facilities for isolation treatments.<sup>648</sup> In these few seemingly innocent sentences, Anderson reminded missionary doctors of the importance of attempting to practice the most up-to-date

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<sup>645</sup> The ZBMM Minutes record the committee acknowledging Anderson’s successful passing of her first Hindi exam in January 1934. Minutes, 2 January 1934, ZBMM. She was moved off of probation at about this time.

<sup>646</sup> Patna is now the capital and largest city in the state of Bihar.

<sup>647</sup> Presumably she thought such techniques were not possible at mission hospitals, and not at all hospitals in India, but that is unclear in the article.

<sup>648</sup> The Aseptic Technique, which allows surgical and other procedures to be carried out in a germ-free environment, had been gaining ground since the turn of the twentieth century, but could be quite difficult to practice in hospitals, and even more so in patients’ homes. The need for isolation treatments plagued mission hospitals for decades, for reasons ranging from space as well as patient resistance. In places with many highly contagious infections, isolation was necessary to effectively combat disease and to improve public health.

techniques and to provide modern facilities to protect the health of their patients and communities. She shifted to the topic of India's medical needs and the medical missionaries' strategies, reflecting that "to-day ... conditions are very different from what they were when our hospitals were first opened." In the early years of medical work, missionary dispensaries and hospitals "often constituted the only places where people could get medical help." The situation had changed: Indian cities and towns now usually had services provided by the government and Dufferin Hospitals. Anderson therefore challenged her audience: "The question before us now as medical missionaries is, are we going to remain in the cities where there is medical aid, or are we going to transfer our activities to the villages, that is, to the more needy areas, or if we are to continue to work in the cities, what is to be the position of our hospitals?"<sup>649</sup>

Anderson cautioned that if the missionaries chose to remain in the areas with coverage from the Government and other burgeoning medical services, then missionary facilities must modernize and remain up-to-date in all areas of their work, including buildings, technology, medications and treatments, and staff credentials; they would also need to expand their capacity to accept and treat more patients.<sup>650</sup> These pressures on missionary hospitals would prove formidable, Anderson warned, for "[a]s Christian medicals, if our work is in hospitals, it must be first-class work. We must have the newest and best equipment or else we shall be looked down on by outsiders as second-rate, and we can hear outsiders coupling second-rate work with Christianity. Is our Christian work to be second-rate?" She then explained why missionary work often appeared "second-rate," blaming it on "various handicapping factors," many of which she

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<sup>649</sup> "He Sent Them Forth to Preach...and to Heal the Sick," paper read by Dr. Winifred Anderson at the Missionary Conference in Allahabad in January, 1934, printed in *The Zenana: Or, Woman's Work in India*, 41, no. 472, (May 1934).

<sup>650</sup> The writer of the 1926 report on the medical work in the Negapatam District commented that "There seems to be an epidemic of dispensaries on our side of town." "Negapatam District Report 1926, W.A. Local Committee, Appendix, Work Among Women," Reports, WW, MMS, 1035, 24.

linked to the inadequate staffing at the mission hospitals. Staffing shortages, always a challenge for women's missionary medical work, would become more problematic, Anderson explained, as the government services increasingly included health visitors, district nurses, the development of ante-natal or prenatal work, and baby and child welfare centers. Developing these services required additional staff—more than the mission hospitals boasting only one to three doctors and a Nursing Sister could provide—and this additional staff needed to have top professional credentials. Anderson, like many of her colleagues, stressed that Indians “nowadays” sought the best treatment from whomever could provide it; if the missionaries did not provide the best care, then they would have to accept not only the loss of patients but also the knowledge that Indians would receive care elsewhere and without the benefit of Christian influence and teaching. Even though this teaching had never resulted in the hoped-for conversions, the missionaries believed that their influence set their services apart from others and made a valuable contribution to Indian women's lives.<sup>651</sup>

If missionaries chose to keep up with the Government hospitals, then they would have to locally raise the funds to pay for the expanding and improving services. Although the mission hospitals were already in the business of maintaining some “private” rooms or wings which generated income, and the doctors could earn some money by making special visits to better-off patients desirous of special attention, the medical missions had always primarily relied on money from “home” to support the work, which was supplemented by government grants in India. Anderson ventured that moving away from financial reliance on “Home” was not necessarily an evil, but such a solution meant fighting the temptation to see each patient as “worth so many rupees instead of one to whom we can give help.” Local fundraising would be a dramatic shift in

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<sup>651</sup> David Hardiman, *Missionaries and their Medicine: A Christian Modernity for Tribal India* (Manchester: Manchester University Press, 2008), especially chapter 8.

missionary strategy, and Anderson proposed that the mission hospitals should become self-supporting—but not profit-seeking. She argued that funds should come through Indian financial support, especially the support of the Indian Christian, who “should come to realise his responsibility for his fellows when they require medical aid and not merely rely on the foreigner to supply it free of charge.”

Anderson also challenged her colleagues to “stop merely treating symptoms, but treat disease.” Anderson explained that this—a shift from curative to preventive medicine—required running medical tests, research, and lab work that the current tiny staffs could not perform, as well as diverting time and efforts normally spent on building human relationships to behind-the-scenes work on diagnosis. Curative care—missionaries’ “bread and butter” medical work—might keep the missionaries busy, but preventive care would better meet modern India’s needs.

While stating that for now and for years to come, there was a place for the missionary hospitals located in cities—primarily because many, like Anderson’s own Duchess of Teck Hospital, offered purdah services, and because each hospital had its loyal patient base—Anderson shared her agenda for the future. Rather than pouring money and effort to “augment” their existing hospitals, Anderson encouraged her colleagues to focus on preventive medicine in the cities, villages, dispensaries, and smaller hospitals in areas currently lacking medical help. “Preventive medicine and evangelistic work could well go hand in hand. At the same time we must bear in mind that there may be a day ahead when the Mission Hospitals in cities should close down...Christ’s command was Go, and perhaps this to-day can be interpreted to us to go into the places where the need is greatest.”

The questions Anderson asked were ultimately about the role of women’s missionary medical work in a changing India and in the future. Anderson was not the first to ask them. As



was seen in Chapter Two, Elizabeth Bielby had questioned the wisdom of doing “second rate” medical work as early as the 1880s; medical women had always struggled with issues related to the expectation that they were in fact “missionaries first, doctors second.” And the topics of preventive care and staffing limitations regularly surfaced in missionary writings and reflections. All of these issues moved to prominence in forward-thinking missionary minds during the interwar years. In 1928, the Christian Medical Association of India (CMAI), in conjunction with the National Christian Council of India, Burma and Ceylon (NCC), conducted a major survey on the work of medical missions. The report, with analysis and commentary, was published in 1929 as *A Survey of Medical Missions in India*. Among its conclusions was the verdict that medical work was itself noble Christian work, and not only to serve to “open doors” nor to be carried out with the goal of conversion.<sup>652</sup> In 1932, after an extensive study conducted by the Laymen’s Foreign Missions Inquiry on the purpose and goals of foreign missionary work, particularly that done by British and American missionaries in Asia, the findings and recommendations were published under the title *Re-Thinking Missions*.<sup>653</sup> This study had been conducted and authored by people supportive of Christian missions, but who considered the work through a critical lens and in the context of the global political and social world climate. Although it was met with mixed reviews, the study caused much discussion and reflection in the international missionary community.<sup>654</sup> It shared the CMAI/NCC *Survey*’s verdicts on the value of medical work free of

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<sup>652</sup> *A Survey of Medical Missions in India*, Prepared by the Committee on Survey, Efficiency and Cooperation of the Christian Medical Association of India in Conjunction with the National Christian Council of India, Burma, and Ceylon (Poona: National Christian Council, 1929). Hereafter referred to as “*Survey*.”

<sup>653</sup> William Ernest Hocking, Chairman, The Commission of Appraisal, *Re-Thinking Missions: A Layman’s Inquiry After One Hundred Years* (New York: Harper & Brothers, 1932). Hereafter referred to as “*Re-Thinking Missions*.”

<sup>654</sup> The director of the Ludhiana missionary-run medical school for women (at that time called “Women’s Christian Medical College, Ludhiana”) reported that the college protested the recommendations the Rethinking Missions committee, stating that Ludhiana would not endorse ceasing the evangelical work. The director was Dame Edith Brown, who remained staunchly dedicated to the philosophy that medical missionary work must include evangelism. See Edith Brown, “Report, 1933-34,” Records of the Women’s Christian Medical College, 1908-1947, Ludhiana Collection, Yale Divinity School Library Special Collections, HR-491.

direct evangelism, and stressed that medical work must be of the highest quality, carried out by professionals with top credentials, employing the most up-to-date technology and science available. Medical women, most of whom had been quite open in admitting that they had little time to engage in direct evangelism, now had the official blessing to see their professional medical work as Christian work in its own right. The criticisms and recommendations in *Rethinking Missions* and from the *Survey* may have helped to shape Anderson's paper, which neatly captured the challenges women medical missionaries wrestled with in the mid-1930s.<sup>655</sup>

This chapter revolves around how medical missionary women adapted their work in the context of the 1930s and 1940s, attempting to meet the "greatest" needs. During these years, they focused on developing professionalism for Christian women medical workers, including the European missionaries, Indian nurses, midwives, and *dais*. These efforts were intended to help Christian work "go" by expanding it. Missionaries also strived to devote more attention, time, and resources to the medical needs of India's villages, as well as to the sometimes overlapping task of increasing efforts to provide more preventive medical care. As Anderson stressed, changing times and future possibilities meant that in order to continue to do great and meaningful work in India, medical missionary women should not become complacent. Drawing heavily on the annual reports sent by the WW and ZBMM missionaries, this chapter explores the missionaries' efforts to begin to redefine and redirect efforts in order to determine how to work "where the need is greatest."

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<sup>655</sup> It is impossible to know whether women like Anderson actually read either study. Both were referenced in the ZBMM magazine, and were thus known to missionary supporters in Britain.

### 5.1 *First-Class Work*

Providing “first-class” medical care became increasingly important to the women missionaries in the interwar years. Medical missionaries had always felt the urge to expand the work, thus reaching more people in need, and moving into areas where people had yet to hear the Gospel, but by the 1930s, the international missionary community had begun to question whether such a philosophy was the best approach—perhaps it was more important to concentrate on quality instead of quantity. This position contradicted the Christian command to “Go” to every corner of the world, but, as Anderson noted, perhaps “Go” now required a different focus. The expectations for medical work were changing, and the missionary motto of “missionaries first, doctors second” sounded less noble than it had in the past. Medical women became more open about the fact that they spent little of their time doing “spiritual” work, that their priorities included the ability to offer up-to-date diagnoses and treatments, and to use current technology.<sup>656</sup>

*Re-Thinking Missions* recommended that missionary medical work be on par with medicine offered in the West. This was something many of the women missionaries had advocated for in the past. There had always been some voices from the field calling for improved services and high standards. For example, in 1913, when the ZBMM Patna missionaries requested resources for a maternity ward, they justified such an expense by explaining, “The day has gone past when any makeshifts will do for India, or for Mission Hospitals.”<sup>657</sup> Yet many hospitals at that time were merely doing the best they could with limited resources, and some medical women saw nothing wrong with “making do.” In a 1914

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<sup>656</sup> The fact that missionaries engaged in medical work came to do little direct evangelism is now accepted by scholars.

<sup>657</sup> “Duchess of Teck Hospital,” *Annual Report*, 1913, ZBMM.

letter to the home secretary, Dr. Isabel Kerr apologized for the new missionary nurse, who had complained to the home committee about the lack of instruments at her station; Kerr reassured the committee that she had instruments, but only in a very limited supply. In this same letter, Kerr also mentioned that the dispensary could do nothing for many of the patients suffering from abdominal tumors, explaining that the staff feared attempting treatment with the present set of tools.<sup>658</sup> The new nurse thought such limitations were problematic, while Kerr accepted them as normal. As more members of the international missionary community committed to the goal of providing the best possible services, the requests of women from decades past who had asked for improved facilities, up-to-date instruments, money for current medications, and financial support to continue their studies and add to their professional credentials, were vindicated. By the early 1930s, even long-serving women like Ethel Douglas, who had arrived in India in 1909, had to admit that the missions were understaffed, lacking in up-to-date equipment, and that medical missionaries themselves would be the first to acknowledge that they were often of “limited capacity and outlook.”<sup>659</sup>

Missionary women used various arguments in their appeals for more resources from the home committees, usually linking professional credentials and concerns with how they reflected on the Christian endeavor, for this seemed more important to the people at home than did the actual quality of the work in India. In one of her first letters to the home secretary, Dr. Alice Speight commented that she was impressed by the high standard of the missionary medical work, but noted that this was necessary, as Mysore City also boasted a large and efficient “Government” hospital, only a five-minute walk from the mission hospital’s gate, “Ready to take

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<sup>658</sup> Isabel Kerr to Miss Bradford, 18 May 1914, WW, MMS, Haiderabad Correspondence, 1058, 410.

<sup>659</sup> “The Annual Meetings, Thursday, April 27<sup>th</sup>, 1933,” *The Zenana: Or. Woman’s Work in India*, 40, no. 462 (June 1933).

patients if we fail.”<sup>660</sup> Dr. Grace Gillespie was adamant in her belief that missionary staff and facilities had to be on par with the Government offerings, explaining, “I think we can only justify our existence as doctors and Christians by having a staff that can honourably stand in competition with any hospital. The people here [in India] recognize at once whether the doctor is worth anything and the name of medicine and religion goes down just because our staff is not good enough. The only judgment the people have of our religion is by the work we do, and if it is poorer than it ought to be or than the other hospitals then we haven’t much to say for ourselves.”<sup>661</sup> Winifred Anderson’s views were similar: “Anything less than the best would not be glorifying to God. People will judge our religion by the quality of our work.”

Since the 1880s, when medical education became available to British women, missionaries had attempted to use time away from India to pursue additional formal education, training, and more advanced credentials. This interest increased during the interwar years. How missionaries spent their furlough was not in their own hands, however. The societies expected missionaries to devote part of their time at home to resting, recovering, and rejuvenating their bodies and souls for their next five to six years of service overseas. In addition to taking some time to visit with family, the missionaries were required by their societies to fulfill their responsibilities to “deputation” work, which included traveling around Britain making formal speeches and presentations, attending fund-raising events, and representing the medical work at mission-specific public activities.<sup>662</sup> The amount of travelling, preparation, and emotional energy necessary to conduct the deputation work drained some women, especially those averse

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<sup>660</sup> Alice Speight to Mrs. Leith, 7 December 1933, WW, MMS, Mysore Correspondence, 1076, 939.

<sup>661</sup> Grace Gillespie to Miss Byrom, 13 December 1932, WW, MMS, Mysore Correspondence, 1076, 924.

<sup>662</sup> Missionaries hailing from Australia, Canada, and other countries were expected to travel in those lands. During war years, some British women were sent to Australia for their much-needed furloughs—this was because travel arrangements to Europe were impossible. While in Australia, they became involved in and traveled for their society’s local branch.

to public speaking. Missionary nurses and doctors understood the importance of these duties, but mounting voices argued that spending their precious time away from India engaging in medical professional development rather than deputation work increased in the later years of colonialism. Societies had often denied requests to spend the furlough pursuing more education and training, but began to approve such plans.

The medical women embraced opportunities for continuing their educations and professional medical training. Even small windows for gaining additional knowledge were appreciated. For example, when Dr. Alice Musgrave developed tuberculosis and was sent—as a patient—to a sanitarium in India, she incorporated a ten-day refresher course on the disease while there. While on furlough, Nurse Holmes observed medical and surgical work two or three mornings per week and made visits to local maternal and child welfare centers. Mary Proudlove arranged to have her tonsils removed and to attend a conference on British Social Hygiene when home in 1931; on her next furlough, she took medical courses, explaining that she was learning information not yet in medical textbooks. While taking a course, Proudlove admitted to feeling ignorant of all the new advances. “Missionary work does not allow one to specialize,” she explained, noting that she found keeping up with all branches of medicine challenging. Nurse Bronsdon lobbied to move her furlough dates a bit so she could take the Diploma in Nursing at King’s College. Once at home, she wanted to take the Sister Tutor’s course, and hoped to gain the Home Committee’s approval.<sup>663</sup> Vera Pitman informed the WW secretary that she needed to do work on venereal diseases, radium treatments, and eye, ear, nose and throat while on her next furlough. While on her furlough, Eva Bowes requested funds to take a course on sunlight

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<sup>663</sup> See letters from Bronsdon from 1938 and 1939. WW, MMS, Madras Correspondence, 1069. Bronsdon’s colleagues also sent letters advocating for her to gain this experience, arguing that she would then be a greater asset to the work, and that the work needed another Sister Tutor.

treatment at the prestigious Guy's Hospital.<sup>664</sup> Grace Gillespie looked forward to the possibility of doing post-graduate coursework during her furlough toward end of the Second World War; she managed to attend clinics in Liverpool to add to her knowledge, and she put in a request for new and up-to-date medical texts. Dr. Mary Tomlinson, who had not even begun her medical career until in her forties, started planning for her furlough a year in advance, stating that she needed to take a course in Tropical Medicine and Hygiene, and perhaps a post-graduate course in surgery and gynecology. She had a sponsor in the UK willing to pay for this, which she felt should strengthen her request. Requests from women who did not have to completely rely on their societies for financial support were given extra consideration. Sister Holden, for example, requested to take her furlough early in order to complete a year-long teaching course at Bedford College, London, designed for women holding teaching positions in nursing programs. The ZBMM was willing to approve this provided that Holden's supporter pay the fees and if the Canada auxiliary would pay for Holden's passage home. Had Holden waited until her scheduled furlough, the ZBMM would have paid her travel costs, but required these come from Holden's native Canada if she wanted to change the master furlough and travel plans.<sup>665</sup>

The additional qualifications these women sought could have been interpreted as motivated by self-interest. As Suzanne Parry explains, missionary nurses and doctors assumed professional risks by going out to the field for years, for they could easily fall behind their colleagues at home in terms of staying abreast of medical advancements.<sup>666</sup> And, by the 1920s,

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<sup>664</sup> Eva Bowes to Miss Bradford, 11 December 1928, Haiderabad Correspondence, WW, MMS, 1058, 427.

<sup>665</sup> Minutes, 16 January 1934, ZBMM.

<sup>666</sup> Suzanne Parry, "Women Medical Graduates and Missionary Service," *Health and History* 2, no. 1 (2000): 27-51. The missionary societies occasionally referred to these problems when a nurse had to return to Britain too early to be eligible for her pension, but rather late in her career. In these cases, concerns could be voiced regarding the individual's job and financial prospects, but it is important to note that these individuals appear to have been women who began missionary nursing early in the twentieth century, and therefore had not been trained to the same standards as those who completed training programs in the 1920s and later, or were regarded by their colleagues as less than competent.

fewer medical missionary workers chose to remain in missionary service for their entire careers, so it would have been reasonable for the societies to resist investing in additional professional training and education.<sup>667</sup> But the societies also saw that women who were firmly committed to missionary work were serious about providing the best care possible. For example, in the 1940s, even though the Nasik hospital was more than overflowing and the staff often strained to serve the patients, Dr. Pleasaunce Carr left for a period to learn about new cataract treatments from fellow missionary Sir Henry Holland, a renowned ophthalmologist and researcher.<sup>668</sup> She later happily reported that increasing numbers of patients had begun to come to Nasik for this treatment. Carr had seen a need—terrible suffering due to preventable blindness—and decided to address it.<sup>669</sup> As increasing numbers of medical missionaries came to share Carr’s views, it is possible to detect tensions between the committee members at home, as well as the more senior missionaries in the field, and the newer women like Carr, who commenced their missionary careers in the 1930s and 1940s. For example, the WW corresponding secretary prepared outgoing Nursing Sister Dyer for what lay ahead in South India: “You must not expect a very well equipped orderly modern hospital [at Ikkadu], though a good many improvements have been made recently ... but the people who come to the hospital are very country people, with very primitive ways and it needs a good deal of patience.<sup>670</sup> The secretary, herself a former missionary, reflected the attitude of her generation of missionaries: that conditions in India were what they were, and nothing could be done about them. This attitude stood out when compared

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<sup>667</sup> Sara W. Tucker, “A Mission for Change in China: The Hackett Women’s Medical Center of Canton, China, 1900-1930,” in *Women’s Work for Women: Missionaries and Social Change in Asia*, ed. Leslie A. Flemming (London: Westview Press, 1989), 137-157.

<sup>668</sup> Holland’s obituary in the *British Journal of Ophthalmology* credits him with saving the eyesight of more than 100,000 people in Indian and Pakistan. “Obituary: Sir Henry Tristram Holland, 1875-1965,” *British Journal of Ophthalmology* 49 (1965): 308.

<sup>669</sup> “Nasik,” Annual Report, 1943, ZBMM.

<sup>670</sup> Leith to Vera Dyer, 5 May 1938, WW, MMS, Madras Correspondence, 1069, 749.



with that of Nurse Bronsdon, who wrote in the same year to complain that Ikkadu's conditions, as well as those for nurses and the nurses-in-training in the Madras District were "rather appalling" and should be "altered and not endured."<sup>671</sup>

In addition to altering facilities and other physical aspects of the mission stations, the *Survey* found that medical women believed they needed to increase the efficiency of most aspects of their work. One recommendation to achieve this was to supply each station with a business manager, thus relieving the doctor of the burden of all the administrative work. By the mid-1930s, the ZBMM home committees were busy attempting to recruit and send out missionaries specifically to serve as administrators in the hospitals.<sup>672</sup> Only twenty years before, these same committees had rather offhandedly dismissed missionary doctors' requests for missionary nurses, but they now began to realize that the medical workers should focus on medical work without the distraction of paperwork. The nursing staff also pressed the home committees to understand the needs for better administration. When Freda Vale planned to transition from the WW to serve at the Vellore Christian Medical College for women, she corresponded with the home secretary on finding her replacement, carefully outlining the qualifications the work really needed. She vetoed one recommendation, explaining that while Nurse Edith Thomas had administrative experience, it was limited to running a maternity ward in England, which was not the same as running an entire hospital in India. After dismissing several other options, Vale boldly argued that if a good administrator who also possessed language ability could be found, that woman should be taken without deference to the issue of missionary "seniority," for "one of the things we deprecate in India is the appointment on grounds of

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<sup>671</sup> Bronsdon to Leith, 6 October 1938, WW, MMS, Madras Correspondence, 1069, 748.

<sup>672</sup> This topic was frequently discussed by the ZBMM committee. See Minutes, 18 September 1934 and 2 October 1934, for examples.

seniority rather than ability.”<sup>673</sup> Such an attitude was new, and quite different from the way the society had always been run, for seniority in terms of time served with the society had taken precedence over credentials and specific experiences.

Vale’s attitudes regarding change and fitting missionary programs into the needs of India were representative of the way medical women increasingly approached their work in the 1930s and 1940s. This section has focused mostly on the medical missionary women’s professional development and its linkage to “first class” work in India. The next section will examine the missionaries’ understanding of the changes necessary to provide nursing education and training to best meet needs of both the Indian population and nursing as a professionalizing field for women.

## **5.2 *Missionary Nursing Training***

Historian Rosemary Fitzgerald cites missionaries’ contributions to the development of professional nursing in India as one of their main colonial legacies.<sup>674</sup> In the nineteenth and early twentieth centuries, missionaries were mainly in need of nurses to provide the women’s missionary work, especially the budding hospitals, with low-cost, low-skilled labor. The “needs” related to nursing changed over time as missionaries sought to “raise the profession” and to remain as leaders in Indian nurses’ training. Finally, Indian nurses became increasingly

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<sup>673</sup> Freda Vale to Miss Freethy, 25 March 1945, WW, MMS, Mysore Correspondence, 1079, 1029.

<sup>674</sup> This is an argument Rosemary Fitzgerald makes in her many articles. For example, see “Rescue and Redemption: the Rise of the Female Medical Missions in Colonial India During the Late Nineteenth and Early Twentieth Centuries,” in *Nursing and the Politics of Welfare*, eds. Anne Marie Rafferty, Jane Robinson and Ruth Elkan (New York: Routledge, 1997), 64-79. Madelaine Healey’s study of Indian nursing has two chapters on the development of nursing in the colonial period, which includes much information on the role of the missionaries in nursing training programs, but she does not devote any separate attention to the missionary programs. Healey does cite Fitzgerald and mentions that in 1946, 80% of all Indian nurses had been trained in mission programs. See Madelaine Healey, *Indian Sisters: A History of Nursing and the State, 1907-2007* (London: Routledge, 2013).

important as part of the missionary goals to provide more preventive care and effective medical services in the villages.

Until the twentieth century, “English” nurses were rare in the mission field, so beginning in the 1870s, Indian women, usually Christian converts, performed the crucial but basic tasks of patient care and hospital housekeeping. Recruiting Indians to nursing proved difficult, for Indian culture associated the work of nurses—touching sick bodies, handling bodily fluids, taking care of housekeeping tasks in hospitals—as unclean and therefore fit only for members of the outcastes and other marginal and subaltern castes and classes. This was especially true of Hindus, but Muslims also saw women who performed the tasks of nursing, outside of the home and family, as unrespectable. Even Indian Christians, including those open to educating their daughters, and who theoretically were free of caste prejudices, were resistant to nursing, regarding it a much less desirable path than going into teaching. At the end of an illustrious career, one Indian nurse—a Christian from Kerala—recalled that her father received letters of condolence when she announced her decision to train as a nurse at what became the Vellore Christian Medical College for women, one of India’s most prestigious nursing programs.<sup>675</sup> Most of the early Indian nurses were therefore uneducated and illiterate, and from the poorest groups, including “widows, orphans or destitute converts who had no other option” to support

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<sup>675</sup> Elkatha Ann John, “As She Turns 100, Nurse Takes Walk Down Time,” *Times of India*, July 20, 2014, <http://timesofindia.indiatimes.com/city/chennai/As-she-turns-100-nurse-takes-a-walk-down-time/articleshow/38712135.cms> (accessed 20 February 2016). The interviewed nurse was Anna Jacob, who was recruited to Vellore from her school in Kerala by Vera Pitman. After training at Vellore, Jacob received a scholarship to earn her B.Sc. in Nursing in Canada. She then returned to Vellore where she served as the first Indian Nursing Superintendent. Jacob reported being mentored by Pitman for many years, and, like Pitman, Jacob saw mentoring other Indian Christian nurses as one of her lifelong responsibilities. Jacob was a South Indian Christian, from a group that had been Christian for centuries, and not from the groups of recent converts. The Kerala Christians provided the majority of Indian nurses and Indian Christian women physicians, but even so, many “respectable” families, such as Jacob’s, saw nursing as “low status.” The Christian Medical College, Vellore, has undergone name changes over the years, and its status changed from a “school” to a “college”, and after decades of only training women, it began to admit men in the late 1940s.

themselves.<sup>676</sup> Since these trainees had such limited formal education, their training was quite practical, and their responsibilities included the menial tasks around the hospitals. This was not completely unlike the development of nursing in Britain, where it had taken several decades before the “ignorant untrained servant-nurses were replaced by modern trained nurses and the new vocation became a true profession.”<sup>677</sup>

Many of the early missionary doctors worked without the assistance of a trained European nurse; not until 1921 could the ZBMM proudly note that it had a total of seven doctors and seven nurses at the stations across India. But as nursing became professionalized in Britain and other western countries, the need for trained nurses as part of missionary work became evident. The missionary societies never planned to fully staff all nursing positions with “English” nurses, however, for that would have been prohibitively expensive.<sup>678</sup> Instead, missionaries created their own schemes to train Indians as nurses under the supervision of one or a few European nurses. “Indian nurses” and the “missionary nurses,” who were all European, were two distinct groups, with the missionary nurses in the administrative, leadership, supervisory, and teaching roles. By the 1910s, efforts to professionalize and “raise” the status of nursing in India were underway, which meant that training programs became more standardized, and that programs increasingly expected their nurses to become certificated by passing formal exams. The 1913 ZBMM report on the medical work at Nasik explained that the nurses were trained in “medical, surgical, and monthly nursing” as well as “elementary anatomy, physiology, and hygiene” before attempting to pass three examinations in order to earn their certificate.<sup>679</sup>

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<sup>676</sup> Healey, *Indian Sisters*, 50. This trend continued well into the twentieth century. For example, the Medak Zenana Hospital reported that it had three young widows beginning nurses training in 1928. See “Hyderabad District Medical Report for 1928,” Reports, WW, MMS, 1035, 37.

<sup>677</sup> Isabel M. Stewart and Anne L. Austin, *A History of Nursing from Ancient to Modern Times: A World View* (New York: G. Putnam’s Sons, 1962), 120.

<sup>678</sup> See Fitzgerald, “Rescue and Redemption,” for an overview of the evolution of the British missionary nurse.

<sup>679</sup> “Nasik Medical Mission,” *Annual Report*, 1913, ZBMM.

By 1918 there were Joint Missionary Board Exams for Indian nurses, but, as Madelaine Healey illustrates, at the end of the colonial period, most Indian nurses were still trained in “ad hoc, unrecognized” programs designed by the hospitals in which they worked.<sup>680</sup>

Although the first reports from newly-arrived medical missionaries’ letters and reports typically brimmed with enthusiasm for the Indian nurses, the medical women’s attitudes toward training Indian nurses were complicated. After praising the nurses for performing the menial tasks with a cheerful manner, one missionary noted that it was “hard, at times, to realize how very foreign such work is to the Indian nature.”<sup>681</sup> A new doctor thought that training the nurses ranked among the most difficult of missionary jobs in India.<sup>682</sup> Dr. Constance Slater’s 1908 assessment summarized her colleagues’ typical attitude toward the nurses: “There is much to be desired in the way [Indian nurses] perform even what they have been most carefully taught, and yet on the other hand, one sometimes marvels that such ignorant girls can do so much reliable work.”<sup>683</sup> It was the same sentiment conveyed in Dr. Douglas’s complaint, fifteen years later, of the struggles to make “incompetent, unreliable girls into efficient, trustworthy nurses.”<sup>684</sup> Dr. Alice Musgrave complained that if she and the others on staff were not constantly “pushing” the Indian nurses, they were content to “stay put,” failing to carry on with their evening Bible studies and organized games.<sup>685</sup> The director of the Ludhiana Christian Medical College explained that the probationer nurses wore blue dresses with full bib aprons, because the uniform “does give an air of neatness and efficiency not attained by the Indian girl in an overall [apron],” the more

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<sup>680</sup> Healey, *Indian Sisters*, 74.

<sup>681</sup> “Victoria Hospital, Benares,” *Annual Report*, 1913, ZBMM.

<sup>682</sup> “Lucknow,” *Annual Report*, 1910, ZBMM. The missionary was Dr. Ethel Douglas.

<sup>683</sup> “Patna,” *Annual Report*, 1908, ZBMM.

<sup>684</sup> “Lucknow: Lady Kinnaird Hospital,” *Annual Report*, 1923, ZBMM.

<sup>685</sup> Alice Musgrave to Miss Freethy, 29 January 1942, WW, MMS, Madras Correspondence, 1070, 778.

common uniform in Britain.<sup>686</sup> Others doubted that Indian nurses could improve their efficiency.<sup>687</sup> Some missionary doctors were quite open about their high level of reliance upon the Indian nurses. Dr. Charlotte Carlisle, for example, was posted at a rural hospital as the only doctor and European, and was never very happy there. She initially stated that she found supervising the Indian nurses “a very new experience,” but soon reported that after a rough start, all the nurses were shouldering responsibility, the work was going well, and she found the nurses to be a great help to her.<sup>688</sup> By the next year, she raved about her Indian senior staff nurse.

The depictions of Indian nurses-in-training as undisciplined, unable to shoulder responsibility or make independent decisions, and in need of constant supervision in all aspects of their training, run throughout the decades of missionary women’s commentary on their nursing programs. Such attitudes are partially due to the nature of nurse training at the time. Programs demanded such obedience, discipline, and hard work; as a new missionary nurse sent to train Indian girls in the profession, Sister Howlett reported that she regularly prayed for patience, love and wisdom in her work with the nurses. A well-seasoned missionary commented that the period of breaking in new Indian nurses was always difficult, and she assumed that the recruits must “hate us intensely” for the first few months.<sup>689</sup> According to Madelaine Healey, Indians often equated going into nursing with joining a nunnery.<sup>690</sup>

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<sup>686</sup> “Report, 1936-37,” in Records of the Women’s Christian Medical College, 1908-1947, Ludhiana Collection, Yale Divinity School Library Special Collections, HR-491. This program was based at a college, which meant the training was more formalized. The nurses in the ZBMM and WW hospitals wore “Indian dress” uniforms, such as blue saris with white sari blouses.

<sup>687</sup> Minutes, 03 December 1925, WW, MMS, 1107, 57. Dr. Tucker, when home on furlough, visited the committee and complained about the inefficient nurses, their inability to complete “higher” training, and the problems at the hospital due to its lack of water, gas, and electricity.

<sup>688</sup> Charlotte Carlisle to Byrom, 11 June 1932, 16 August 1932, and 21 February 1933, WW, MMS, Mysore Correspondence, 1076, 915.

<sup>689</sup> Emilie Posnett to Miss Bradford, 16 July 1918, Haiderabad Correspondence, WW, MMS, 1058, 419.

<sup>690</sup> Healey, *Indian Sisters*, 34.

By the 1930s, responsibility for healthcare was moved to the state governments, which set the policies and procedures for nursing programs seeking official recognition as training schools.<sup>691</sup> Although many in the missionary medical community argued that mission standards for nursing in India were generally higher than those set by the government, gaining and maintaining recognition from the non-mission government entities became increasingly important to the missionaries in this study.<sup>692</sup> As Sister Cowdery explained, the ZBMM Lady Kinnaird Hospital hoped, prayed and lobbied for State registration from the Punjab Registration Council, as the missionaries believed this status would give their nurses a greater sense of self-worth as well as professional esteem in India. From a more practical standpoint, Cowdery also noted that the Council planned to pass a law that would allow certificated nurses to register with that Board, and “debar from practice” all unqualified workers.<sup>693</sup> Missionary-run nurse training programs felt special pressures to produce qualified workers to bolster the reputation of Christian programs and to enable their trainees the broadest professional opportunities.<sup>694</sup> Mysore State still had no laws for the registration of nurses in the mid-1930s, so the Methodist hospital at Hassan scrambled to get training school recognition through the Madras Council, explaining that without any registration, the girls trained at Hassan would have difficulty obtaining decent jobs.<sup>695</sup>

In 1931 the North India Board of Examiners for Mission and Other Hospitals began to require that any hospital sending nursing candidates to take exams be modern and up-to-date, meaning they had to meet or exceed minimal numbers of beds for inpatients; treat certain

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<sup>691</sup> Madras was the first to do this in 1926.

<sup>692</sup> *Survey of Medical Missions*, 30.

<sup>693</sup> “Lucknow, Lady Kinnaird Hospital,” *Annual Report*, 1936, ZBMM.

<sup>694</sup> This statement is probably not true of all missionary programs, but the ZBMM and WW definitely were motivated by these concerns.

<sup>695</sup> Hilda Mottram to Leith, 23 June 1935, WW, MMS, Mysore Correspondence, 1077, 962.

numbers of outpatients; possess adequate and current equipment; meet specified ratios of nurses to patients; and be staffed by qualified doctors and nursing sisters.<sup>696</sup> These requirements were similar in other states; from Nasik, Sister Holden expressed great relief after her program passed inspection by the Government Inspection Committee, explaining that training schools had to go through this process every five years.<sup>697</sup> Another hospital proudly reported “[t]his last year especially we have rejoiced in the knowledge that it is not difficult for us to reach the required standard in most respects.”<sup>698</sup> The Ikkadu hospital, however, had three European doctors and a Nursing Superintendent—impressive staff for the missionary stations in the district—but could not gain recognition as a training school until it addressed its lack of adequate equipment and the number of beds in the facilities. Hospitals that could not meet requirements on their own could also seek affiliation with the larger hospitals; as Kalyani attempted to upgrade its training program’s status, one possibility was to affiliate with the larger Ikkadu hospital, which did eventually gain its sought-after status.<sup>699</sup> Such a strategy aligned with the suggestion that missionaries would better serve India if they pooled resources, rather than trying to run so many small programs.<sup>700</sup>

Ironically, the separation of the sexes, which missionaries had long argued was an essential feature in Indian culture, and which also justified the very existence of missionary “women’s work,” became an obstacle for many of the missionary nursing training programs. The mission hospitals that only served women and children could not offer training at the higher-grade level since the state requirements included that nurses’ training include specified

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<sup>696</sup> Clement C. Chesterman, *In the Service of Suffering: Phases of Medical Missionary Enterprise* (London: Edinburgh House, 1940).

<sup>697</sup> “Canada Hospital,” *Annual Report*, 1933, ZBMM.

<sup>698</sup> “Encouragement in the Work,” *The Zenana: Or, Woman’s Work in India* 38, no. 436 (February 1931).

<sup>699</sup> Vera Pitman to Leith, 31 January 1937, WW, MMS, Madras Correspondence, 1069, 760.

<sup>700</sup> This was one of the strong recommendations made in *Re-Thinking Missions*.



experience caring for adult male patients. If these programs sought full-qualification, high-grade status, then they had to affiliate with universities or other hospital programs in order to provide the necessary time and cases in male wards; most mission hospitals did not do this during the colonial years. Indeed many argued that shifting to include male patients or requiring that their nurses complete training that included caring for male patients would only serve to hinder the program's growth, discourage applicants, or negatively affect the quality of applicants. The staff at the ZBMM Patna hospital, which took pride in being a "purdah" hospital, and in specializing in obstetrics and gynecology, feared it would be forced to affiliate with a Government hospital in order to provide the training with male patients, but was able to get the Bihar government to issue a separate certificate for nurses in zenana (women's) hospitals.<sup>701</sup> Other training programs found alternative solutions. In 1929, Dr. Marjorie Lambert reported that the Bombay Presidency Nursing Association would no longer acknowledge the Joint Missionary Board examinations as a qualifying exam for the certificate. The Nasik hospital therefore requested recognition as a training school, and had to write letters, visit the Surgeon-General, prepare for multiple inspections, incorporate new rules and regulations, and offer up many prayers. Their prayers were answered, but the conditions included a course in nursing male patients. The missionary medical school at Miraj, which trained men, agreed to take the Nasik probationers for one rotation in order to prepare for their exams.<sup>702</sup> By the 1940s, even the "purdah" hospitals had a less alarmist attitude toward the state requirements for training school recognition. In 1942, the ZBMM Lucknow hospital was delighted to gain recognition by the State Medical Faculty of the United Provinces as a training school for First Grade nurses, and only commented that now the nurses would need six months of training in a General hospital with male patients if they wanted

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<sup>701</sup> "Patna," *Annual Report*, 1938, ZBMM.

<sup>702</sup> "Canada Hospital, Nasik," *Annual Report*, 1929, ZBMM.

the First Grade certificate. Many of the WW hospitals in South India accepted male patients—in male wards—and therefore faced fewer hurdles.

Year after year, the missionaries reported that they attracted a “better sort” of girl to nursing, which meant that girls with more education applied. This was encouraging for the future of nursing in India, as well as for the immediate supervisors and trainers. By the late 1920s, the ZBMM hospitals could report that interest in the profession had grown, and that in some years, the number of applicants exceeded open spots for probationers.<sup>703</sup> Finding prospects with enough education to succeed was often the greater challenge. In 1919, one Nursing Sister had stressed, “Girls require to have a little more than a love of nursing. It would be a real pleasure to train those who possess ability to apply themselves to the subjects they have to learn in the course of their training, i.e. Hygiene, Anatomy and Physiology, etc. They should at least be educated up to the middle standard.”<sup>704</sup> In addition to facilities and patient case-loads, state recognition of the higher-grade programs required adapting curriculum to include syllabi based on standards such as those that met the General Nursing Council of England and Wales and entrance requirements that included completing education through the Sixth Form.<sup>705</sup> As Nursing Sister Priscilla Carr explained in 1937, the new curriculum at her hospital included much new “book work” which was challenging for her, as the trainer, and the probationers.<sup>706</sup> The Ludhiana Women’s Christian Medical College took pride in reporting in 1937 that for the past two years, all the new nursing candidates had arrived able to study in English, “thus showing that the better educated girl is taking an interest in nursing.”<sup>707</sup> But large, regional

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<sup>703</sup> This was true at Nasik in 1929. “Canada Hospital, Nasik,” *Annual Report*, ZBMM, 1929.

<sup>704</sup> “Lucknow, Lady Kinnaird Hospital,” *Annual Report*, ZBMM, 1919.

<sup>705</sup> The Sixth Form was roughly equivalent to completing junior college.

<sup>706</sup> “Patna,” *Annual Report*, 1937, ZBMM.

<sup>707</sup> “Report, 1936-37,” in Records of the Women’s Christian Medical College, 1908-1947, Ludhiana Collection, Yale Divinity School Library Special Collections, HR-491.

programs like the one at Ludhiana were more able to attract better-educated girls, while small programs in rural areas struggled. From her small hospital in Mysore, Hilda Mottram bemoaned the fact that while she agreed that nursing needed a higher standard of education among the nurses, it was not feasible to insist on this in her district.<sup>708</sup>

Improved academic standards for the probationers correlated with increased demands on the missionary staff. The needs of the evolving training programs for nurses in India affected the selection of prospective missionary nurses by the societies, as it was key to send out nurses who could fulfill the responsibilities to lecture, mark papers, supervise, and prepare the student nurses for their examinations.<sup>709</sup> In 1930, Sister Andersen reported—with excitement—that the Indian nurses trained at Nasik for the first time took the Bombay Presidency Nursing Association exams, which meant they sat with women from other hospitals and schools, and with Europeans.<sup>710</sup> Others found the changes stressful: Sister Fleming experienced genuine anxiety over the new and evolving nursing examination policies. Once several groups of Indian nurses had done well, Sister Cowdery found comfort in her belief that the Government exams must be easier than those set by the missionaries, for the nurses she trained passed more of the Government exams on their first try than they had when taking those set by the mission boards.<sup>711</sup>

To better teach the nurses the theoretical aspects of nursing, which became more important as programs moved closer to the new ideal of “professional” rather than merely “trained” nurses, hospitals needed Sister-Tutors in addition to the ward Sisters who oversaw the

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<sup>708</sup> Hilda Mottram to Miss Byrom, 27 December 1934, WW, MMS, Mysore Correspondence, 1077, 962.

<sup>709</sup> Margaret Balfour and Ruth Young, *The Work of Medical Women in India* (Oxford: Oxford University Press, 1929), Introduction.

<sup>710</sup> “Nasik,” *Annual Report*, 1937, ZBMM.

<sup>711</sup> “Lucknow,” *Annual Report*, 1934, ZBMM.

practical training. The requirement that all recognized training schools have a Nursing Sister on staff also became a real challenge for coordinating staff furloughs—if the Nursing Sister at one hospital left for a year or more, then another one had to fill in for her, otherwise the training program had to close. At the WW and ZBMM hospitals, the Nursing Sisters were all missionaries and European; funding to support additional European Nursing Sisters was unavailable, so the loss of one could prove catastrophic.<sup>712</sup> And the rising standards also meant that having just one Nursing Sister no longer satisfied the missionaries. “I wish I could enable you to realise what it means for one Nursing Sister to be in charge at Kalyani,” Mary Proudlove wrote in 1940, explaining that while the hospital recently had added three “higher-grade” Indian nurses, these women had to devote most of their time to rectifying the errors made by the team of untrained nurses, making it difficult for them to accomplish anything else.<sup>713</sup>

Depending on the hospitals’ European staff and the level of training provided, missionary doctors’ teaching responsibilities also increased with the changing registration policies. Dr. Ethelwyn Newham explained that since the Mysore hospital trained higher-grade nurses, she now had to teach six classes per week.<sup>714</sup> Dr. Effie Stillwell reported that because the nursing standards and difficulty of the exams continued to increase, she viewed training the nurses as burdensome. She qualified this statement by explaining that Indian nurses did not learn on their own; unless every subject was taught in-depth in a classroom setting, the nurses would not master the material. Mary Proudlove also felt overwhelmed by the amount of time she and other staff had to devote to training the nurses, especially since the staff at her hospital had no

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<sup>712</sup> The ZBMM dealt with similar struggles. For example, when faced with a period of no Nursing Sister to cover the Patna hospital, the committee considered taking a Nursing Sister that the CEZMS would “not keep” (due to failure to fit in at any of the CEZMS hospitals). The committee reasoned that this Sister Cook had been working under difficult circumstances and had been frequently moved around, and was probably acceptable. This seems to indicate desperation to just find a Sister. See Minutes, 19 June 1934, ZBMM.

<sup>713</sup> Proudlove to Miss Walton, 28 May 1940, WW, MMS, Madras Correspondence, 1070, 781.

<sup>714</sup> Ethelwyn Newham to Mrs. Leith, 2 December 1935, WW, MMS, Mysore Correspondence, 1077, 963.

experience training nurses and midwives—Proudlove complained that “[n]o one who has not attempted it can have any idea what it means.”<sup>715</sup>

All training programs were not equal. The “higher grade” programs that accepted probationers with more advanced educations moved to requiring proficiency in English, which was necessary since the exams were in English. While this was certainly attractive to many missionaries, as was the goal of increasing nurses’ training program standards, some members of the missionary community remained committed to what was known as the “vernacular training schools.” These programs trained girls without the ability to train in or take exams in English, which usually also meant training girls with much less formal education than the “higher grade” programs. Freda Vale, who thought the Indian nurses “really are a splendid crowd of girls,” took pride in the Hassan hospital’s hard-won status as a Kanarese Training School—the only one in India.<sup>716</sup> Vale supported to efforts to raise nursing standards, but argued it was important to remember that if all the larger hospitals focused on offering “English higher-grade” training, then the missionaries must make provisions “for the vernacular girls,” explaining that many of these women were likely to go into village work, and therefore “country hospitals,” like hers, were good places to train them. Vale, who was quite active in nursing leadership in her region, stated, “I mean to fight for it [keeping vernacular training schools recognized by the CMAI] as hard as I can.”<sup>717</sup> Vale’s colleagues appreciated her efforts, pressing that “there is still room for Kanarese

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<sup>715</sup> Proudlove to Miss Walton, 28 May 1940, WW, MMS, Madras Correspondence, 1070, 781.

<sup>716</sup> Vale to Bradford, 21 September 1930, WW, MMS, Mysore Correspondence, 1076, 944; Ethel Tomkinson to Byrom, 19 August 1931, WW, MMS, Mysore Correspondence, 1076, 942. The WW staff at the Hassan hospital noted that the rules for vernacular recognition had changed several times, that the hospital had increased its number of beds to fifty, and they had raised the requirements for the incoming probationers. But the efforts seemed worthwhile since the Christian Medical Association of India had bestowed the recognition, and some of the Hassan nurses had passed the exams. Dr. Alice Speight, letter dated December 1934, from the Redfern Memorial Hospital at Hassan, filed in Reports, WW, MMS, 1036, 62.

<sup>717</sup> Vale to Byrom, 7 February 1934, WW, MMS, Mysore Correspondence, 1077, 944.

girls as nurses or as girls who cannot attain to English training” but who could be effectively trained as good, capable, practical nurses.<sup>718</sup>

Missionaries knew that even after all the efforts to train Indian nurses, few would follow in the footsteps of their European supervisors and dedicate their lives to careers in nursing. Instead, most of them would marry and leave paid work. But the missionaries did not see this as a “loss” or wasted effort on their part. Instead, they hoped that these former nurses would continue to use their skills and knowledge in the next phases of their lives. Former nurses’ experiences with midwifery, the care of infants and children, and with biomedicine in hospitals, meant that they could provide care in their communities and hopefully also encourage others to utilize and follow the orders of medical practitioners. For example, a number of the nurses trained at the rural Medak Zenana Hospital married catechists, and then combined their nursing skills with evangelism among the women of their new villages.<sup>719</sup> Some of the nurses volunteered with dispensaries or other health-care providers, including missionary efforts, or even returned to mission employment later in life.<sup>720</sup> Those married nurses living close enough to mission hospitals to have access to medications and supplies tended to do better than those without such resources and support.<sup>721</sup> Nurses trained at the level of those at Freda Vale’s hospital—Indian Christians from humble backgrounds possessing only limited educations but armed with basic nursing skills—could therefore help missionary women reach their goal of “go[ing] into the places where the need is greatest.”

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<sup>718</sup> Hilda Mottram to Byrom, 27 December 1934, WW, MMS, Mysore Correspondence, 1077, 962.

<sup>719</sup> “Medical Report of the Medak Zenana Hospital, 1926,” Reports, WW, MMS, 1035, 26.

<sup>720</sup> Nurses often did this, but so did Indian doctors. For example, Mrs. Thomas, an Indian Christian, joined the Akbarpur staff as the sub-assistant surgeon, in 1923 after taking off several years from practice. See “Akbarpur Hospital, 1923,” Reports, WW, MMS, 1035, 30.

<sup>721</sup> “Hyderabad District Medical Report, 1934,” Reports, WW, MMS, 1036, 60.

Missionaries also saw sending mission-trained Indian nurses to the government-run hospitals, municipal and other services, as important service to Indian women, Indian Christians, and Indian nursing. The majority of mission-trained Indian nurses were employed in “government” hospitals which paid much better than the mission jobs. The Ludhiana Women’s Christian Medical College, for example, reported that of the 81 nurses trained there between 1930 and 1938, only eleven worked in mission hospitals; many of them had found jobs in non-missionary women’s hospitals, but the rest were scattered across a variety of institutions.<sup>722</sup> The annual reports routinely included references to the loss of Indian nurses upon passing their exams. This was met with mixed emotions, as the missionaries hated to lose good workers, but were also happy to see their trainees leave for good positions.

As government training programs expanded, the missionaries could have abandoned their programs. Although the missionaries provided the majority of trained nurses through the end of the colonial era, by the 1930s, it was evident that government and eventually university-based programs would soon vastly outpace missionary offerings. But missionaries believed that mission-trained Christian nurses would “imbue their future professional practice with an ethos of selfless service and devotion to duty rather than with a spirit of commercialism” while serving as positive representatives of Christianity to patients and their families, medical staff, and administrators across India.<sup>723</sup> The missionaries often commented on the good examples set by Indian nurses in terms of patience, kindness, and compassion; the missionaries argued that patients came to associate such behavior with specifically with Christian staff. As Marilamma Verghese, an Indian Christian nurse on the staff at Vellore stressed in 1944, nursing was a noble

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<sup>722</sup> These included the following categories: Government, Civil, European General, Health Centers, State, and a number of named hospitals in the region, such as Memorial Hospital. “Report, 1938,” in Records of the Women’s Christian Medical College, 1908-1947, manuscript collection, Yale Divinity School Library, HR491.

<sup>723</sup> Rosemary Fitzgerald, “Rescue and Redemption,” 74.

career for women, as it allowed for “free scope” for women’s inborn qualities of love, kindness, patience, self-sacrifice and a firm and honest character.<sup>724</sup> The nursing superintendent at a government hospital explained to Sister Cowdery that the reason mission-trained nurses were in demand was because they possessed “higher ideals of work and were kinder than” nurses trained outside the missions.<sup>725</sup> The *Survey* reminded mission training programs that “[i]t should be impressed upon [nurses] that the good name of the nursing profession is in their keeping,” and that it was the responsibility of the training programs to weed out any girls deemed unlikely to prove “suitable.”<sup>726</sup> One of the ZBMM hospitals announced that only Indian converts to Christianity—rather than girls raised in Indian Christian families—would be accepted as nursing probationers. The rationale for this was that patients should only witness Christian nurses living out Christ’s message through their work, and therefore “no lack of love, no quarreling nor uncharitable behavior” could be tolerated in nurses; the missionaries believed that those who had converted would be better representatives of the ideal than those born into the community.<sup>727</sup>

Medical women also saw the development of the nursing profession, and the development of Indian women as leaders in it, as contributions to raising women’s status in India.<sup>728</sup> Cultural prejudices against respectable women living away from their families, as well as performing the physically intimate tasks of nursing, associated nursing with prostitution; missionaries and others set on attracting respectable women to nursing therefore had to both fight

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<sup>724</sup> Marilamma G. Verghese to Freethy, n.d.. (1944), WW.MMS, Madras Correspondence 1070, 781. Verghese wrote to Freethy at Vera Pitman’s request to help explain the needs of the Vellore nursing school.

<sup>725</sup> “Lucknow,” *Annual Report*, 1926, ZBMM.

<sup>726</sup> *Survey*, 36.

<sup>727</sup> “Lucknow,” *Annual Report*, 1927, ZBMM.

<sup>728</sup> Sujani Reddy argues that the missionary involvement in the development of nursing in India contributed to the profession’s low status. If this is the case, it was certainly never the missionaries’ intention. See Sujani Reddy, *Nursing and Empire: Gendered Labor and Migration from India to the United States* (Chapel Hill: University of North Carolina Press, 2015).



and make concessions to this perception.<sup>729</sup> Missionaries therefore worked to both protect Indian nurses and also to empower them to be independent women.

When training probationers, hospitals took great care to keep the young Indian nurses away from men or situations where they would be in public on their own. This was done not only as a means to control the nurses but also to preserve the nurses' reputation and physical safety. At hospitals located in areas considered unsafe for single women, such as the Nagari station, which the missionaries described as "very isolated," missionaries took extra precautions to insure that the nurses' quarters were secure; the social conditions were such that no young Indian nurses could be left there with just a Nursing Superintendent or a woman doctor, so other Methodist staff had to be present at all times.<sup>730</sup> In some mission hospitals, the nurses-in-training were forbidden from attending any private cases; others allowed this only under the care of a chaperone. In the family wards, where entire families—including adult male relatives—could visit the patients, the junior nurses were usually banned. The *Survey*, which was administered in 1928, prior to the new state requirements that included nursing experience with both men and women as part of the certification process, found that mission training programs disapproved of training women nurses to care for male patients, believing "neither [Indian] women nor men are ready for that."<sup>731</sup> Instead, most missionaries advocated training male nurses to care for male patients; while experience in midwifery comprised the ideal fourth year of training for women nurses, programs for men nurses instead placed them into a year of compounding training.<sup>732</sup>

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<sup>729</sup> Both Reddy and Healey discuss the challenges to nursing's professionalism posed by its association with prostitution.

<sup>730</sup> The Nagari station included medical work for women, but was not strictly a woman's hospital as men were also cared for. See "Medical Report, Madras District, 1934," Reports, WW, MMS, 1036, 58.

<sup>731</sup> *Survey of Medical Missions*.

<sup>732</sup> Compounders served as "pharmacists," preparing the medications at hospitals or large dispensaries.

The topic of “safeguarding nurses” took up several pages of the published *Survey*, and included concerns for the nurses after the completion of training in the mission hospitals. Missionary doctors and nurses reported “that the need [to safeguard Indian women] is far greater when young doctors, nurses and midwives go into private or government service in municipal hospitals. There they have no protections and are surrounded by temptations that are frequently too great for them to withstand.”<sup>733</sup> The *Survey* blamed this problem on purdah, which contributed to the low status of women: if female seclusion were not “the mark of social prestige,” then an unmarried nurse, working in a hospital and living away from family, would not be seen as a “fallen” or “easy” woman. The missionaries blamed general Indian social customs for the public opinion regarding nurses’ virtue, explaining that even though the Indian Christian community did not observe purdah, the lack of co-education, social intercourse between young men and women, and the lack of “experience of the world” left young women naïve and easy victims. Nurses typically arrived at the protective mission hospital straight from a girls’ school; those who did not marry after training or remain employed in the mission system faced grave dangers if they went to work “under Indian Medical men in private practice or in municipal hospitals.”<sup>734</sup> The *Survey* committee did not focus on the fact that Indian nurses—especially those working at mission hospitals—were paid low, even subsistence, wages, which made them particularly vulnerable to “temptation” in order to help support their families or to survive.

The *Survey* committee offered no real solutions for these problems, but did admonish the missionary community, explaining that “more emphasis” must be laid on the “development of strong Christian character,” along with “[w]ise teaching in regard to sex matters,” on which

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<sup>733</sup> *Survey of Medical Missions*, 33.

<sup>734</sup> *Survey*, 34.

“[w]e have been shy and foolish, embarrassed and reticent about this subject.”<sup>735</sup> Mission hospitals that cared for both men and women often became creative in providing nurses for men, selecting only older women—often widows, who were seen as “off-limits”—and providing special on-site housing, creches and other services to care for the nurses’ children while they worked.<sup>736</sup> But the missionaries realized these strategies were temporary:

“Thinking over this subject we are led to the conclusion that moral danger bears a direct relation to the prevalence of the custom of the seclusion of women . . . no one can dispute that the reason for the existence of such a custom is wrong relationship between the sexes . . . Yet many wise counsellors say that the change must come gradually, for it will have to mean a changed attitude on the part of men toward women and the giving to women a chance to become educated, to lose their inferiority complexes and to develop what one writer called ‘a touch-me-if-you-dare attitude.’”<sup>737</sup>

The *Survey* concluded, “Frequently the nurses are reminded that they are pioneers of the women’s movement in India and are asked to report if any disrespect is shown to them.”<sup>738</sup>

The changing political climate of the 1930s and 1940s pushed missionary nursing leaders to reflect on their goals for Indian nurses, these nurses’ roles in the missionary medical work, and in the future Indian nation. The open acknowledgement that the time had come—or was fast approaching—for Indian Christian women to take their places as equals and leaders in Christian medical work represented a major step in the evolution of missionary work, for missionaries had spent decades arguing that Indian women were far from ready to fill positions of leadership and

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<sup>735</sup> *Survey*, 35-36; Dr. Herbert Gray was quoted on the topic of sex education.

<sup>736</sup> “Creche” is the British term for “day care.”

<sup>737</sup> *Survey*, 33-34.

<sup>738</sup> *Survey*, 34-35.

responsibility.<sup>739</sup> Some missionaries accepted the need for change with resignation. Sister Foster announced that the Nasik hospital intentionally placed increasing responsibility on the Indian staff nurses, as well as on the Indian staff in all the station's departments, because "we feel our duty now is to prepare our Indian sisters for the day when we shall hand over to them, and when the Indian Government does not want Mission hospitals—we do not know when that day will be."<sup>740</sup> Although Foster's tone is perhaps somewhat self-pitying, plans to prepare and train local peoples to take over the European missionaries' work in India and in other colonized lands became accepted policy missionary policy.<sup>741</sup> Historians point out that this "devolution" to Indian hands was especially slow in India and within the field of missionary medical work, but Fitzgerald shows that British medical missionary women were "among those spearheading" the efforts to develop training programs, such as these for Indian Christian nurses. The missionaries believed in the need to prepare the Indian Christian nurses to do the work the European missionaries had long seen as their own.<sup>742</sup> This work included serving those in need as well as maintaining the missionary standards and values.

In order for Indian Christians to move into nursing and medical leadership positions, they needed to be able to earn degrees in these fields—which they could do in medicine, but not at Christian institutions. In medical education, the Christian medical schools only offered the licentiate programs, which qualified recipients to work as assistant or sub-assistant doctors, and

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<sup>739</sup> For an in-depth study of the developments of Indian leadership and the changing relationships between Indian Christians and European missionaries in the Indian church, see Jeffrey Cox, *Imperial Fault Lines: Christianity and Colonial Power in India, 1818-1940* (Stanford: Stanford University Press, 2002).

<sup>740</sup> "Nasik, Canadian Hospital," Annual Report, 1938, ZBMM.

<sup>741</sup> Hardiman, *Missionaries and Their Medicine*; Rosemary Fitzgerald, "Rescue and Redemption."

<sup>742</sup> As Madelaine Healey has explained, the nursing profession in India has always suffered from low pay, low prestige, and exploitative working conditions. The mission hospitals paid very low wages during the colonial period and after independence. But, "Some Christian hospitals have provided more support for the development of nursing, more nurse autonomy and better conditions. [Christian Medical College] Vellore, in particular, made this a founding principle." Healey, *Indian Sisters*, 160.

the certificates in nursing did not qualify women to hold roles such as Sister Tutors, the credential for training probationers in the wards.<sup>743</sup> Although most of the attention from the women's societies at home focused on developing the medical degree—the M.B., B.S.—to produce fully-qualified Indian Christian women doctors, Vera Pitman and like-minded missionary strategists launched campaigns to develop programs at Vellore to produce highly-qualified Christian-trained nursing professionals. Pitman passionately lobbied for the missionary societies to support her proposed Sister Tutor program, explaining that every trained nurse in India must be equipped to meet the “whole need” of the Indian villager, and she believed that Indians would be better at meeting the needs than would Europeans.<sup>744</sup> Pitman and her nursing colleagues at Vellore, following the attempts to make fully-qualified Christian women doctors who could take the place of the European missionary doctors, argued that “devolution of the Medical Profession without devolution of Nursing [to Indians] will make a Christian Medical College in India of little effect.”<sup>745</sup> As the Indian governments began to address the needs for both “quantity” and “quality” in Indian nursing, the societies were forced to reevaluate their policies. Especially in areas where the hospitals and doctors were not thick on the ground, well-trained and competent nurses—but Indian nurses—could provide much care. Pitman announced, “I am very distressed at the attitude of women doctors who have been in India” who were not in support of the development of a four-year B.Sc. course in nursing at Vellore, adding, “I feel that the present Madras Government has more foresight than many missionary doctors.”<sup>746</sup> In order to promote her efforts to increase British support for the Indian nursing programs, Pitman

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<sup>743</sup> Sister Tutors are still used in Indian nursing programs today.

<sup>744</sup> Vera Pitman to Freethy, 22 April 1943, WW, MMS, Madras Correspondence, 1070, 780.

<sup>745</sup> Pitman to Freethy, 8 January 1943, WW, MMS, Madras Correspondence, 1070, 780

<sup>746</sup> Pitman to Freethy, 8 January 1943, WW, MMS, Madras Correspondence, 1070, 780. Indeed, Pitman successfully led Vellore efforts to gain government support for the higher-grade nursing programs, which included Community Nursing. See, for example, “Early Decades of Nursing Education in Vellore,” *CMC (Christian Medical College) Newslines* 46, no. 52 (29 June 2009).

provided statistics on the numbers of doctors and nurses, arguing that nurses vastly must outnumber the doctors, but this was not the case in India.<sup>747</sup>

Pitman's dreams for nursing education at Vellore were realized. A Sister Tutor Course rapidly followed the higher-grade programs, and in 1946, Vellore opened India's first College of Nursing.<sup>748</sup> In addition to standard hospital training, by the early 1940s, the Vellore administration provided nurses with post-graduate experience at places like the Ikkadu hospital, as well as in each nurse's own language areas. Ongoing plans for curriculum included nurses taking courses in "Village Hinduism" and the "faith of Islam," to help these Christian nurses better relate to patients and communities. Like the European missionary nurses, part of the Indian Christian nurses' training would be "the Christian message" and how to present it to village people through their work as healthcare providers.<sup>749</sup> Many of the training programs, at all grades, shared this focus on preparing the Indian nurses for the needs of village India.<sup>750</sup> After all, as one Indian Christian nurse stressed to the WW committee members in London, India "is a land of villages" and most villagers were "hospital shy." India therefore needed Indian nurses with advanced training and leadership skills to "teach the illiterate," combat superstition, and spread understanding of the value of hygiene and diet.<sup>751</sup>

Instilling a commitment to service to India became very important to the missionaries working with nurses' training. As Ruth Compton Brouwer explains, as the nationalist movement

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<sup>747</sup> Vera Pitman to Freethy, 17 October 1944, WW, MMS, Madras Correspondence, 1070, 780.

<sup>748</sup> According to Healey, Vellore, now known as Christian Medical College, Vellore, has maintained this reputation from the 1920s to today.

<sup>749</sup> Pitman to Freethy, 22 June 1942, WW, MMS, Madras Correspondence, 1072, 780.

<sup>750</sup> The missionaries' goals for nursing in India are very similar to those of missionaries working in China at the same time: they also sought to develop modern nursing to support the development of the modern hospital, to serve the needs of rural communities without hospitals, and to make nursing a respected profession. See Connie A. Shemo, *The Chinese Medical Ministries of Kang Cheng and Shi Meiyu, 1872-1937* (Bethlehem, PA: Lehigh University Press, 2011).

<sup>751</sup> Marilamma G. Verghese to Freethy, undated, from 1944, WW, MMS, Madras Correspondence, 1072, 781.

gained ground in the 1930s and early 1940s, missionaries and Indian Christians saw the need to “both upgrade and Indianize Christian medical education,” both for the doctors and the nurses. The “Christian institutions were tainted by their assumed links with colonialism and thus had to demonstrate that they would both have utility and a strong national identity in a future independent India.”<sup>752</sup> It was also important to the future of Christian medical work in India—which the missionaries wanted to be in the hands of Indian Christian medical practitioners—that the work be on the same or even better standard than that of the rest of India. The missionaries themselves had much confidence in the Indian nurses and doctors trained at Vellore, which helped the missionary women to move away from their long-held beliefs that Indian nurses could not manage leadership roles. For example, in 1937, Nursing Sister Bronsdon became exasperated when her society’s Medical Council decided she should fill in at the Ikkadu hospital for a year while Nursing Sister Gladys Holmes went home on furlough. Bronsdon begged to be allowed to take only partial responsibility for Ikkadu, leaving the rest to two higher grade Indian nurses, whom, she stressed, would come specially trained from Vellore. Bronsdon argued that the experience would let the nurses prove themselves and be an important step toward Indians taking more responsibility.<sup>753</sup> Whether the missionaries merely accepted or actively embraced such transitions, by the 1940s, Indian Christian nurses were seen as a key force to sustain and expand medical services in India.

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<sup>752</sup> Ruth Compton Brouwer, “The Legacy of Hilda Lazarus,” *International Bulletin of Missionary Research* 30, no. 4 (2006): 202-206. See also Judith M. Brown, “Who is an Indian? Dilemmas of National Identity at the End of the British Raj in India,” in *Missions, Nationalism, and the End of Empire*, ed. Brian Stanley, 111-131 (Grand Rapids, MI: William B. Eerdmans Publishing Co., Ltd, 2003).

<sup>753</sup> Bronsdon to Leith, 12 September 1937, WW, MMS, Madras Correspondence, 1070, 748.

### 5.3 *Medical Missionaries and India's Dais*

As Rosemary Fitzgerald explains, “Indian midwifery evoked the strongest expression of Western condemnation of indigenous care ... [for] the barbarous practices of traditional midwifery were believed to result in countless deaths and untold misery.”<sup>754</sup> As was shown in Chapter Four, missionaries characterized *dais*, the name commonly used for traditional midwives, as filthy women, spreading germs and disease via hands which were adorned with dirty bangles and rings.<sup>755</sup> Their fingers were sometimes compared to claws, their nails described as long, sharp, and blackened with dirt. Instead of arriving with sterile cloths and instruments, *dais* used grimy rags to receive babies and either stones or rusted metal implements to cut the umbilical cord. Instead of regarding an elderly *dai* as a practitioner possessing knowledge from years of experience, at best *dais* were criticized for ignorant practices such as “stamping” on a laboring woman’s belly if the birth seemed to progress slowly, for stuffing hair in a new mother’s mouth to induce choking to force out a retained uterus, and for introducing earth and cow dung into the birth canal.<sup>756</sup> At worst, European women described the *dai* as crone-like, sometimes verging on sinister, mishandling laboring women and endangering their reproductive health, killing babies and mothers through infection and injury.

Year after year, medical reports from the mission stations highlighted the work generated for them by the “ignorant” or “barbaric” *dais*, as they inherited patients who came to mission hospitals after a *dai*’s intervention failed or left the mother suffering from an infection or

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<sup>754</sup> Rosemary Fitzgerald, “‘A Peculiar and Exceptional Measure’: the Call for Women Medical Missionaries for India in the Later Nineteenth Century,” in *Missionary Encounters: Sources and Issues*, ed. Robert A. Bickers and Rosemary Seton (Richmond, UK: Curzon Press, 1996), 174-196.

<sup>755</sup> In South India, the term “barber women” was also often used, as it was in some predominantly Muslim communities.

<sup>756</sup> Claire P. Thomson, typescript memoir, “In Those Days: A Worm’s Eye View,” Thomson Papers, British Library, India Office Private Papers, MSS.Eur.D.1102. For a perspective on *dais* from the nineteenth through the end of the twentieth centuries, see Supriya Guha, “From Dais to Doctors: The Medicalisation of Childbirth in Colonial India,” in *Understanding Women’s Health Issues: A Reader*, ed. Lakshmi Lingam (New Delhi: Kali for Women, 1998).



complication. In the nineteenth and early twentieth centuries, the missionaries seemed to imply that their goal was to eventually replace *dais*, or, over time, to convince the majority of Indian women to seek care from the western-trained medical community instead of using *dais* for home births. Missionaries carefully counted every hospital confinement and summons to an in-home midwifery case, constantly strategizing ways to get more women to come to the hospital to deliver their babies. In some places, the missionaries made some progress, but not in others. While still referencing the dangerous behavior of *dais*, in the later years of colonialism, medical missionary women came to desire to work closely with Indian traditional midwives as opposed to dwelling on their demise. Missionary goals shifted to training *dais*, and to bringing them into the developing modern medical system, rather than competing with, excluding or eliminating them. The medical women at Ikkadu announced that two of their “most cherished dreams” for their work were to have trained midwives out in the villages and “to get hold of the local barber midwives [*dais*] and give them as thorough training as possible.”<sup>757</sup>

Missionary women were not alone in their focus on saving Indian mothers from the dangers of the *dais*. Providing European or “fully-trained” care as well as training Indian midwives was also the main purpose of non-missionary European medical women’s work in India, including that of the Dufferin Fund, the Women’s Medical Service, and other philanthropic and private services. Midwifery had been added to the curriculum in the Indian medical colleges in the 1840s. The government also took some interest in midwifery and the training of *dais*, often at the local or state level. As early as the 1870s, various governmental efforts were undertaken to attempt to train Indian midwives, and they often incorporated the missionaries’ work in midwifery to help. For example, in Mysore, some of the Wesleyan

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<sup>757</sup> “District Medical Report 1933, Madras,” Reports, WW, MMS, 1036, 53.

missionary stations were funded by the government authorities to provide medical care to women provided that they also trained Indian women as midwives.<sup>758</sup> And, in some areas, women missionaries had been independently involved with efforts to train *dais* and to develop programs to produce qualified midwives since the nineteenth century.

Midwifery became “the backbone of district medical work” by the 1930s.<sup>759</sup> While the missionaries often complained bitterly over the “desperate” cases of botched attempts to deliver babies, increasing numbers of Indian women, especially those who had access to doctors and formally trained midwives, began to adopt medicalized childbirth. The popularity of the maternity wards at some of the mission hospitals made it impossible to serve all who wanted to come. The majority of the Indian women, however, continued to use *dais*, and this was especially true outside the cities and in groups outside the educated and middle classes. India’s high maternal and infant mortality rates drew international attention: Indian women commonly died of sepsis, which was due not only to the “barbarous” practices of birth attendants who had no understanding of germ theory or the cause of infection, but also to the conditions in the homes of the poor, and the weakness of mothers who suffered from malnourishment and anemia.<sup>760</sup> Newborns died of tetanus and other preventable diseases. In Britain, where maternal mortality rates remained troublesome through the 1930s, the strategy to fight sepsis was to provide trained

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<sup>758</sup> Barbara Ramusack, “Women’s Hospitals and Midwives in Mysore, 1870-1920: Princely or Colonial Medicine?,” in *India’s Princely States: Peoples, Princes, and Colonialism*, ed. Waltraud Ernst and Biswamoy Pati (London: Routledge, 2007), 172-189. Ramusack explains that the Mysore darbar was partially motivated to make such arrangements due to concerns about declining population amongst the laborers for the coffee and nut plantations.

<sup>759</sup> “District Medical Report- Synod 1932, Hyderabad District, Ibrahimpatum,” Reports, WW, MMS, 1036, 44.

<sup>760</sup> S. Muthi Chidambaram, “Sex Stereotypes in Women Doctors’ Contribution to Medicine: India,” in *Gender, Work and Medicine: Women and the Medical Division of Labour*, ed. Elianne Riska and Katarina Wegar (London: Sage Publications, 1993), 13-26. Indian maternal mortality and morbidity really was not so different from that in Britain during the same decades. In 1930, the British maternal mortality rate was the same as it had been in 1867, and most deaths were due to sepsis, hemorrhage, and toxemia. See Irvine Loudon, “Some International Features of Maternal Mortality, 1880-1950,” in *Women and Children First: International Maternal and Infant Welfare, 1870-1945*, ed. Valerie Fildes, Lara Marks, and Hilary Marland (New York: Routledge, 1992), 5-28.

midwives. In colonial India, the traditional missionary rallying cry of providing “intelligent care” to a woman in labor—meaning a European nurse, midwife, or doctor—shifted to include providing better-trained Indian women who would continue to serve in their traditional role, especially in rural and village India.

Necessity and practicality therefore helped to motivate the missionaries’ change of heart toward the *dais*. Medical women had to realize that even with their efforts combined, they, the Dufferin Fund, and the growing government system of trained and registered midwives and doctors, could not adequately reach and serve all of India’s women. The missionary and other nurse training programs in India preferred to produce “fully trained” midwives, which, by the 1930s, meant trained nurses who had completed a three-year program followed by a fourth year of midwifery training. There were also shorter and less-rigorous programs that included midwifery for Indian women who did not qualify for the higher-grade nursing programs; like nursing, there were many types of programs, recognized and “ad hoc.” The difficulties in recruiting “the better sort of girl” into midwifery training programs were even more monumental than for nursing, for catching the baby, cutting the umbilical cord, and disposing of the placenta were all considered defiling and tasks only appropriate for the “sweepers,” the “untouchables” and the lowest ranks of society.<sup>761</sup> Women who served as *dais* were typically born into the category, as the status passed from mother to daughter; it was not the type of work anyone wanted to do—as Supriya Guha explains, it was “ascriptive rather than aspirational” work. Finally, as medical women often complained, even in areas where there were fully-trained

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<sup>761</sup> Supriya Guha explains the varying social classifications of *dais* across India. For example, in Bengal, some of the *dais* were poor Muslims, in South India they came from the barber caste, in other areas from the *charmars*, sweepers, or *dom* groups. Supriya Guha, “From *Dais* to Doctors: The Medicalisation of Childbirth in Colonial India,” in *Understanding Women’s Health Issues: A Reader*, ed. Lakshmi Lingam (New Delhi: Kali for Women, 1998).

midwives available, many Indian women preferred *dais* to “skilled” help, so equipping the *dais* with “skill” seemed the best plan to provide competent aid to women in labor.

Convincing *dais* to accept the missionaries’ offers of training proved difficult. *Dais* were illiterate, impoverished, and social outsiders “stuck” carrying out the most distasteful tasks of childbirth. They saw no point in honing their skills, and their clients would not pay the *dais* any extra for completing training. *Dais* were rightfully suspicious of the missionaries’ motives, and feared that the real goal was to put them out of business. And, even if *dais* decided to follow missionaries’ advice, such poor women could not afford the soap and instruments required to practice safe childbirth. More significantly, the missionaries were up against the cultural expectations for childbirth, which included the factors the medical women objected to, such as the presence of neighbors, sealed and darkened rooms, hot coals and fires, and the use of old and unwanted linens and rags. To require *dais* to abandon traditional practices was unrealistic.

Training *dais* hinged first on coaxing them to attend classes or lessons, which was not always easy. Most women who served as *dais* also earned money doing other work, as well as fulfilling their family roles, and therefore had little time to spend at training they did not value. Next, the missionaries had to determine and practice teaching methods that were effective with this group. Then there was the need to find ways to provide *dais* with the supplies deemed necessary for “safer” births, which the *dais* could not afford. Finally, the medical women wanted to devise ways to verify that the *dais* were indeed practicing the new methods. This was important since the missionaries often complained that without some form of supervision, *dais* slipped back to their “old ways.” This was a common concern for the various groups attempting to train *dais* and Indian midwives; the Victoria Memorial Scholarship Fund, established by Lady Curzon, when she was the vicereine, had begun training Indian midwives in 1903, and in 1928

reported that it made “slow progress. Only a small fraction of the midwives of India are trained and these, unless supervised, lapse into their old habits.”<sup>762</sup>

The “Anonymous Nurse’s” experiences with the *dais* in her area illustrate the types of approaches missionary women tried in their attempts to change *dais*’ practices. This nurse was sent by the Society for the Propagation of the Gospel in Foreign Parts to staff a station as the lone European medical worker in a rural area where most of the people she attempted to serve were “aboriginals.” Although part of a mission, she was approached by the local magistrate, who had reviewed the statistics for maternal and child mortality and told her that if she could “just get the *dais* to use cleaner methods [she would have done] some real good for the district.”<sup>763</sup> This motivated her, and she was given a small government grant to support her efforts. She decided to offer classes for the *dais*, whom she liked to refer to as “village midwives.” Her Indian dispenser, whom she believed held her in disdain, thought this was ridiculous, and told her no *dais* would come, even if she used the grant money meant to bribe them, as *dais* disliked “English ways.” She recruited five women “who were very shy and dirty and about the most uncouth I have ever seen.”<sup>764</sup> When she met with them, she attempted to win them over by explaining that she had no intention of interfering with their work or payments, and that she did not mean to condemn their customs and practices. She presented the idea of showing them “some cleaner ways” and “discussing matters in a friendly manner.” She also offered a small bribe to compensate for any work they would miss when meeting with her, which she credited for luring them to class.

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<sup>762</sup> *Survey*, 13. David Arnold makes the same point in *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India* (Berkeley: University of California Press, 1993), 260.

<sup>763</sup> Anonymous, *A Nurse’s Indian Log-Book: Being the Actual Incidents in the Life of a Missionary Nurse* (Westminster: The Missionary Equipment and Literature Supply, 1925).

<sup>764</sup> *Ibid.*, 91-92.

The nurse began by demonstrating sweeping a room, sunning the mats, washing her hands and cleaning her nails with soap. She quickly learned that none of the *dais* had ever handled soap, which solved the mystery of why they never had clean hands. After a hands-on lesson on the virtues of soap, they all discussed Indian attitudes towards people who touched sores, tended wounds, or performed midwifery work, agreeing that these people—*dais* included—were despised by society. The nurse then shared that in England, even the queen’s daughter and other rich people nursed sores, and that Jesus touched the sick and outcasts. She concluding the lecture by telling them “how they must count themselves as belonging to a great class of workers, and must come with tidy hair and clean saris and clean hands” as dirty nails are “not good for nurses.” Subsequent lessons included washing babies’ eyes, using scissors, which she provided to them, and “very, very slowly I learnt their customs and some dreadful practices, and, where I could, tried to persuade them to adopt new methods.”<sup>765</sup> Eventually she bribed the *dais* to let her observe a case, which each performed perfectly. She rewarded each *dai* with a linen bag, a bowl, scissors, disinfectant, and clean rags. When reviewing her work, the nurse concluded, “the chief result was cleanliness in the *dais*, and the fact that they recognized signs of danger in their patients, and sent for me before it was too late. Also, that on my arrival I would find the patient on a *fairly* clean mat, and the usual smoky fire *not* near the patient, a crowd of onlookers absent, and a clean brass bowl of hot water for my hands.”<sup>766</sup> Although *dais* were still delivering babies, and doing it on their own in a context that was acceptable to them and their “patients,” the missionary nurse felt she had succeeded by making small improvements and by establishing trust between herself and this little group of Indian women.

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<sup>765</sup> Ibid., 95.

<sup>766</sup> Ibid., 90-96.

“Anonymous Nurse” served in India in the early 1920s, but her concerns, goals, and approaches were essentially the same as other medical missionary workers’ outreach to the *dais* through the end of the colonial era and into the early years of independence. And her approach was by no means unusual in missionary spheres, nor the first such attempt, as Miss Hewlett, of the CEZMS, had opened a successful *dai* training program in Amritsar in the 1870s. Dr. Edith Brown and the Christian Medical College at Ludhiana had also decided that training and education for *dais*, rather than abolishment or competition, was the best approach for promoting safer childbirth in India.<sup>767</sup> The goals of the missionaries’ programs across the India were simple: to provide some understanding of the sepsis—and the need to try to prevent it; to recognize when a birth became complicated; and then to make informed decisions regarding the complications. These had also been the goals for the Central Midwives Board for England and Wales training, which had only been of three months duration, when the efforts to certify British midwives began in the first years of the twentieth century.<sup>768</sup> One missionary doctor explained that she taught *dais* to call her if they realized the birth required forceps: over the years, she had found that nearly any “failed” *dai* delivery she inherited was a forceps case.<sup>769</sup>

The missionary efforts to train *dais* often did make small inroads and were considered more successful than those of the Dufferin Hospitals, which began *dai* training programs in 1902. The Dufferin Fund’s failures have been explained as due to “incomprehensible” curricula and “teachers patronizing and unfamiliar with the realities of [*dais*]’ lives and the conditions of their work.”<sup>770</sup> The missionaries’ local reputations and relationships with some members of the

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<sup>767</sup> See Catherine N. Cowan, “Western Women Doctors in an Eastern Land: The Work of Female Medical Missionaries in India, 1870-1947,” M.A. Thesis, University of Wisconsin-Madison, 1998.

<sup>768</sup> Jean Towley and Joan Bramall, *Midwives in History and Society* (London: Routledge, Kegan and Paul, 1986), especially 180-199 for training efforts through the First World War.

<sup>769</sup> Claire P. Thomson, “In Those Days: A Worm’s Eye View,” 185.

<sup>770</sup> Guha, “From Dais to Doctors.”

community could help them achieve their training goals. Although missionaries admittedly bribed some *dais* to take training, others *dais* sought western training on their own. One “barber midwife”—another name for *dais* in South India—sent her adult daughter to Ikkadu for training. Dr. Mary Proudlove pronounced her “very ignorant” but also eager to learn. “We hope after a few months of training she will be fully equipped to do good work in her village.”<sup>771</sup> A few years later, Proudlove routinely taught the “untrained girls”—meaning that they were not trained nurses—who took the eighteen-month midwifery course. In 1941, Proudlove noted that she found her group of twelve “rather dull on the whole,” but that they were learning the difficult material and showing improvement.<sup>772</sup> The anonymous nurse’s attempt to appeal to the *dais’* sense of self-respect and to help them completely rethink the status of their work was important to many of the missionaries. While missionaries were guilty of painting a negative picture of the *dais*, and wanted to change much about them, they were motivated by desires to improve their situation and status, as well as to help *dais* help other Indian women.

In 1933, the medical missionaries at Akbarpur were asked to participate in a local exhibition on health. The missionaries’ goal was to demonstrate the differences between “our” method of birth and “theirs.” The missionaries set up a model hospital ward, clean, white, and disinfected, juxtaposing it with a model hut, complete with a straw floor, charcoal and dung fire, a goat, and dirty rusted “*dai* implements.”<sup>773</sup> While this display indicated clear superiority to them, the medical women could only hope that their continued work would eventually bring their intended results. They knew cultural change would take time, but saw much reason for hope. In 1952, missionary Dr. Claire Thomson wrote *Better Health*, which underwent two revisions and

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<sup>771</sup> “District Medical Report for 1933,” Reports, WW, MMS, 1036, 53.

<sup>772</sup> Proudlove to Freethy, 27 March 1941, Madras Correspondence, WW, MMS, 1070, 784.

<sup>773</sup> “Akbarpur Medical Work for 1933,” Reports, WW, MMS 1036, 56.



was published in seven Indian languages. Her chapter entitled “Safety Measures in Childbirth” presented steps pregnant Indian women could take in their homes to avoid complications. Thomson’s passion was preventive medicine, so she outlined the basics of prenatal care, highlighting sound nutrition for both vegetarians and for those who ate meat. She also provided detailed steps on how to plan for a safe birth by cleaning the room and removing all goats and livestock before labor commenced, explaining that this was necessary to avoid puerperal fever, the leading cause of maternal death. While Thomson was targeting a literate population—which excluded much of Indian society—what is important is that she acknowledged that most births would still occur in the home and in a home that was not like a British home, but that even in these Indian homes, women could have safer births.<sup>774</sup>

#### **5.4 Collaboration**

By the 1930s, missionary strategists had begun to recommend that missionaries actively work with the local authorities. This recommendation stemmed at least partially from the realities of the missionaries’ situation: in a world where they would not be the only healthcare providers, and, in many cases, would be unable to afford to provide care comparable to that offered by the government and other organizations, cooperation might be the way to survive. But as a small and underfunded group dedicated to helping the needy, cooperation also allowed missionaries to fill some healthcare needs neglected by other providers.

Missionary health care providers often worked closely with government practitioners, but opinions on the desirability of such arrangements varied with context and over time. At the

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<sup>774</sup> Claire Thomson probably had fairly realistic expectations. She devoted much of her Indian career to fighting hookworm, which was endemic in her region. Because she worked with illiterate people who did not understand how they contracted hookworm, she made her own boardgames illustrating the hookworm’s life cycle and showing how villagers could break it.

dawn of the twentieth century, one of the Wesleyan ministers working with the WW had used the fact that the missionary medical workers often had to rely on help from the civil surgeons as a reason for sending more women doctors—missionary reliance upon others was viewed as detrimental to the credibility of the missionaries and their work.<sup>775</sup> But such opinions were just that: opinions. In other cases, collaborative efforts were seen as successful ventures worth showcasing in their reports. For example, at Sholapur, the ZBMM cooperated with the Poona Society to cover welfare work in the city. The ZBMM trained the midwives, and the Poona Society provided the midwives' hostel. The ZBMM provided the milk centers, and the Society provided a district nurse to identify the needy babies and sick children who benefited from the free milk. Based on that work, the ZBMM hoped to start a day nursery where they would be asked to give lectures and demonstrations on baby care to the local mothers.<sup>776</sup>

Cooperation between the missionary and civil or government hospitals was mutually beneficial. For example, the WW Kalyani Hospital's maternity cases increased dramatically in the 1920s, a fact that especially pleased the staff, partly because the Corporation nurses brought many "difficult" cases to the hospital.<sup>777</sup> Because the women's stations had such small staffs, when there was only one doctor present, complicated surgeries sometimes had to be sent to the government hospitals, or one of the government doctors came to the mission to assist the missionary doctor. Reciprocal arrangements between the missionary women and independent male practitioners, including Indian Christians, also existed. In such cases, the missionary women sent men and older male children to the male doctors, who in turn referred Indian women to the missionaries. Nurse Eva Bowes worked near a government dispensary staffed by a male

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<sup>775</sup> Minutes, 17 July 1900, WW, MMS, 1105, 24.

<sup>776</sup> "Sholapur and Bijapur," *Annual Report*, 1923, ZBMM. What the Poona Society was is not made clear.

<sup>777</sup> "Kalyani Hospital, 1926," Reports, WW, MMS, 1035, 20.

Indian doctor to whom she felt “loyalty.” He, in turn, often called on her to see women and children, which she appreciated since she was not a doctor. Bowes was also gratified when this doctor asked her to attend to his wife during her prenatal care and for her delivery.<sup>778</sup> The work at Akbarpur and Tanda was similarly supported by a Hindu male doctor in private practice but who had been a student at the Wesleyan schools and had “high ideals of service.” He suggested sharing the work and responsibilities of the WW weekly dispensary, and the women missionaries were grateful.<sup>779</sup> Many of the WW small hospitals and stations lacked a European or fully-qualified doctor, and by the 1930s, it seemed unlikely that this situation would change. The missionary nurses at these stations therefore had to refer surgical cases to government services. One nurse explained that she found her local government hospitals a bit dirty and lacking strong nursing, but that they treated the patients with kindness. “[I]t is quite possible to cooperate with the present staff there with very distinct advantage to all.”<sup>780</sup>

Efforts to improve child welfare, as part of the growing interest in preventive healthcare, often involved missionaries working in cooperation with other groups. For example, in 1926 Dr. Joan Drake reported on the new Karim Nagar child welfare center, which was supported by the local Muslims, Christians, and Hindus, who formed a combined effort by establishing a local fund, a donated house, milk for babies, and recruiting local women who volunteered to help. The Taluqdar presided over the opening ceremony, and members of all the religious communities stood while a Muslim cleric intoned a chapter from the Qur’an. The object of the work was explained to the audience in Urdu, English, and Telugu, and poems composed for the event were also read in Urdu and English. In the first few months of its existence, the center

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<sup>778</sup> “Ibrahimpatum Medical Work in 1932,” Reports, WW, MMS, 1036, 44.

<sup>779</sup> “Report on Medical Work in Akbarpur and Tanda,” 1932, Reports, WW, MMS, 1036, 49.

<sup>780</sup> “Godavery Medical Report, 1935,” Reports, WW, MMS, 1036, 67.

treated 2,832 babies, gave 1,856 infant baths, and supplied milk to “all suitable cases.” Drake and the other WW missionaries rejoiced at the endeavor’s success.<sup>781</sup> By the 1920s, missionaries were comfortable with laying the foundations for work they saw as valuable to the community, but not work that would always be their “own.” The Christian Medical College Vellore opened a child welfare center, staffed by one of their trained nurses, with the plans to turn it over to the Municipality once it was well established.<sup>782</sup>

By the later interwar years, funding and support from Indians increasingly expanded or sustained the missionaries’ medical work. For example, the ZBMM Patna hospital received much of its funding in the mid-1930s from the Indian Red Cross, the European Station Church, and from the Union Hindustani Churches of Patna and Gaya.<sup>783</sup> As long-serving Dr. Effie Stillwell’s retirement drew close, the ZBMM’s financial crisis, combined with the expanding needs of the hospital, almost caused it to close, but donations, thank-offerings, and prayers from the Indian congregations and Indian Christian patients kept it afloat.<sup>784</sup>

The missionaries also saw the value of participating in the Indian professional organizations. Sister Holden ran the nurses’ training school at the Canadian Hospital in Nasik while also serving on multiple Government nursing committees.<sup>785</sup> Many of the leaders in the development of professional nursing in India were also missionary nurses.<sup>786</sup> Others served in various community organizations, such as the Nasik Women’s Branch of the Famine Committee, which was composed of the following: four Englishwomen, two of whom were missionaries;

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<sup>781</sup> “Karim Nagar Medical Report for 1926,” Reports, WW MMS, 1035, 26.

<sup>782</sup> Dr. Ida Scudder to the Personal Assistant to the Surgeon-General with the Government of Madras, 14 July 1925, Reports, WW, MMS, 1035, 20. The Kalyani Hospital assisted the neighboring Child Welfare Centers. “Kalyani Hospital Report, 1923,” Reports, WW, MMS, 1035, 20.

<sup>783</sup> “Patna,” *Annual Report*, 1935, ZBMM.

<sup>784</sup> “Patna,” *Annual Report*, 1936, ZBMM. The focus on the importance of prayers from home is interesting, suggesting that the society saw spiritual support as equal in importance with financial support.

<sup>785</sup> “Nasik,” *Annual Report*, 1942, ZBMM.

<sup>786</sup> See Healey, *Indian Sisters*, for detailed narrative of the process of the professionalization of nursing in India.

four Brahmin women; two “Maratha”; and one Indian Christian.<sup>787</sup> While missionary women were often on the fringe of European colonial society, they integrated in their communities and engaged in professional as well as missionary organizations at local and national levels. They believed their collaboration promoted missionary work, helped to diffuse the missionary ethos of service, and better served medical needs.

### 5.5 *Preventive Care*

Both the British colonial state and the missionaries have been criticized for neglecting the development of preventive medicine in India. In addition to the resources devoted to the health of the army, the government approach to medical care was primarily focused on reacting to epidemics. The missionary approach, which was based on using medical care to “open doors” was also “curative”—meaning meant to treat a problem that already existed—rather than “preventive”—designed to keep illness from developing. Scholars explain that preventive medicine was not a priority for the missionaries, as it was not understood as important to the healing of the body and certainly not of the soul.<sup>788</sup> It has also been argued that missionaries preferred to “cure” people as proof of the powers of their god and faith—but merely preventing illness gave them little credibility or power.

Especially in a developing country like India, medical care targeting the needs of the poor, women and children, and those outside the realm of “modern” medicine, which was based in the cities and larger towns, could make a real difference in the health of the people. In her conference presentation, Winifred Anderson noted that working in preventive care was

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<sup>787</sup> “Nasik, Canadian Hospital,” *Annual Report*, 1921, ZBMM.

<sup>788</sup> Yuet-Wah Cheung, *Missionary Medicine in China: A Study of Two Canadian Protestant Missions in China before 1937* (Lanham, MD: University Press of America, 1988).

expensive for the missionaries, for it required technology to do research and testing, up-to-date medications, and more time and effort than the missionary staff could easily provide. And her colleagues across India agreed. “[M]odern treatment demands modern methods and the watchword of our day is ‘thorough’: thorough treatment is expensive and requires more money than the great majority of our patients (than any of our Christians) can afford to give,” the tiny staff at Medak Zenana Hospital reported in 1929.<sup>789</sup> Anderson also discussed the fact that the behind-the-scenes time required to make diagnoses—rather than merely hand out drops or salves to temporarily improve symptoms—could negatively affect the missionaries’ goal of making personal connections with people.

The missionaries were aware of the challenges to providing preventive care, but were nonetheless motivated to try to do more in this field. The staff at all types of medical stations made efforts to promote at least some aspects of preventive medicine. The Medak staff stressed that their pathological work had increased four-fold in the past year, especially now that they were testing patients’ blood for syphilis, and having to follow up with treatment for it and other types of “these dreadful diseases.” This type of work met a definite need in the community, but the staff took pride in their efforts at preventive work, which included child welfare, ante-natal clinics, medical examinations for school children and Biblewomen, and plans to take advantage of the newly built roads in order to expand village preventive work.<sup>790</sup> This was hard work, for many of the health problems the medical women fought, such as the “terrible” mortality among women and children, was “looked upon as almost the natural state of affairs in this country.”<sup>791</sup>

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<sup>789</sup> “Medak Hospitals Annual Report, 1929,” Reports, WW, MMS, 1035, 38.

<sup>790</sup> “Medak Hospitals Annual Report, 1929,” Reports, WW, MMS, 1035, 38.

<sup>791</sup> “Medical Report of the Medak Zenana Hospital, 1926,” Reports, WW, MMS, 1035, 26.

Medical women missionaries felt a special responsibility to provide preventive care to the Indian Christians in their communities and children in their societies' care. They often approached this work in ways that might seem insignificant, but could make a difference in the health of particular groups. The death rate from tuberculosis in missionary schools across India was high—some experts claimed it was worse than in Bombay's slums. In 1918, the WW missionaries were advised to stop accepting children with TB, and to feed them all with more fats, oils, and sugar; those at Medak decided to attempt to do this and to weigh all the children each month.<sup>792</sup> This was similar to Dr. Ethel Landon's 1920 recommendation that all orphanages in India possess weighing machines. Landon lamented the fact that the ZBMM girls' orphanage near her station lacked a way to detect the early warning signs of tuberculosis, and something as simple as a scale could help. At the ZBMM Ella Luce School, tuberculosis and typhoid ran rife. The staff wondered if this were due to the children's "unhealthy backgrounds," unsanitary homes, or the school's buildings. One of the missionary doctors from Lucknow advised the staff on how to identify which children were most vulnerable to disease, how to care for them, and how to recognize disease in its early stages. Caring for the children at the mission schools and orphanages required ongoing close attention from medical professionals, and by the 1930s, the ZBMM had posted trained Indian nurses on staff at their institutions.<sup>793</sup>

Missionaries believed that Indian girls, as future mothers, wives, and managers of households, held the keys to improving health in the country. Missionary women, whether medical, evangelical, or educators, therefore strived to establish programs to instill western-based ideas of prevention in Indian girls. This included integrating preventive health strategies into their curricula and training for Indian girls and young women. At the ZBMM Kinnaird High

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<sup>792</sup> Emilie Posnett to Miss Bradford, 9 January 1918, WW, MMS, Haiderabad Correspondence. 1058, 419.

<sup>793</sup> Minutes, 6 March 1934, ZBMM.

School for Girls, physiology was introduced in all curricula, and the staff proudly announced that they had purchased a model of an eye, ear, brain, and a microscope. At one of the industrial schools, elementary nursing was added to all girls' syllabi. The plan was not to formally train these girls as nurses, but to provide them with the knowledge that would be useful once they were married, running village homes and caring for infants.<sup>794</sup> The Methodists engaged in similar strategies. For example, the Ikkadu Girls' Boarding School curriculum included lessons on hygiene and child care, how to treat sore eyes and running ears, dress wounds, take temperatures, and apply first aid during fainting attacks. Other schools ran anti-rat campaigns, attempting to teach the connection between rats and the spread of certain diseases. "It's hoped that when they return to the villages they'll teach those around them the value of cleanliness and good health," Miss Locklamb explained. To increase credibility, these lessons were taught by an Indian doctor, rather than one of the British medical missionaries.<sup>795</sup>

The ZBMM missionaries had always prided themselves in not attempting to make the Indian children they cared for in their Babies Home, Industrial Schools, and other institutions into British children. These children therefore ate "Indian" diets, learned how to cook and run Indian homes, wore Indian clothes, and were educated in their local languages. New understandings of nutrition, combined with the focus on preventive work, resulted in some changing strategies by the early 1930s. Miss Chapman gushed with enthusiasm as she reported that her staff had "completely altered" the children's diets by adding more fruits, vegetables, and milk, and the results were "little short of marvelous." Chapman explained that the missionaries had long assumed that the children were so sick with sore eyes, skin infections, and running ears

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<sup>794</sup> These types of efforts are common at the ZBMM institutions in the 1920s. See the *Annual Reports*, especially for the years 1920, 1927, 1928 and 1931.

<sup>795</sup> "Girls' Boarding School, Ikkadu, Report for 1924," Reports, WW, MMS Reports, 1035, 23.



because of “the taint of their inheritance,” but now saw that this was untrue.<sup>796</sup> “We did not question their food—it was the food of their country and would of course be right.”<sup>797</sup> But then the staff conducted a study of nutrition, tried various diets, and analyzed the changes in health. The first new diet resulted in worsening conditions, but once a more balanced and nutritious diet was introduced, the children’s health blossomed. Georgina Green, who had been in India since 1903, also began to think about the power of nutrition in the early 1930s, explaining that she now believed much more in nourishment than drugs for “these poor, under-staminated (sic), undersized, underfed people.” Yet even the girls who benefitted from the mission education and care fared poorly as adults, for Green had noticed that after marriage, many of them lost weight, became permanent invalids, and lived on at a “poor dying rate.” Green believed this was because from birth until age six, they had existed on diets deficient in vitamins.<sup>798</sup>

As has been shown in chapters three and four, medical missionaries had less control when attempting to provide preventive care for Indians outside of the mission institutions. Such challenges continued to plague efforts to improve infant and child welfare.<sup>799</sup> The WW and ZBMM began establishing “baby clinics” in the 1920s, but maintaining them often proved difficult. In 1930, for example, Nursing Sister Gladys Holmes and Miss Lockhart began an Infant Welfare Center. One of their goals was to teach the mothers how to prevent babies’ skin conditions, but many of the mothers preferred to send their infants to the center with older

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<sup>796</sup> References to children’s “inheritance” reflect the European beliefs that Indians—or at least the poorer classes—were physically weaker and prone to poor health.

<sup>797</sup> “Sholapur,” *The Zenana*, August/September 1933. The article also stated that once the Indian staff became aware of a study by an Indian nutritionist, they also made changes in their diet and reaped the benefits.

<sup>798</sup> Georgina Green to Bradford, 14 January 1931, WW, MMS, Haiderabad Correspondence, 1058, 435.

<sup>799</sup> By the 1920s, new ideas in sociology and home economics motivated missionary women, as well as social reformers at home, to open baby clinics, maternal and child welfare centers, and to include various types of demonstrations related to domestic hygiene in schools and institutions. Dana L. Robert, “Introduction,” in *Gospel Bearers, Gender Barriers: Missionary Women in the Twentieth Century*, ed. Dana L. Robert (Maryknoll, NY: Orbis Books, 2002).

siblings, rather than bringing the babies themselves. Holmes therefore required that mothers bring their own children, in the hopes of convincing them that taking basic preventive steps could result in healthier babies. After the first six weeks, Holmes reported that the missionaries spent most of their time trying to maintain order and to keep the mothers from standing too close while the nurses washed, weighed, and tended to the babies' sores and mild ailments. Holmes reported that she saw some improvements in these children compared to others, for the local children were covered with skin sores, and suffered from the "sore eyes" and from poor nutrition.<sup>800</sup> But Holmes had to abandon her welfare center during the monsoon season since the mothers refused to bathe their babies in cool weather, due to fear that bathing caused fevers. This exasperated her, but she was pleased to be able to report that some babies were being kept clean and free of "itch" while others appeared to have not been bathed since the nurses had done it.<sup>801</sup> Other missionaries noted that it might take many years before they could sustain a viable child welfare center. The missionaries at Hassan reported that they knew they lagged "behind" most towns of Hassan's size in that there was no child welfare center, but that they lacked the money for a suitable building and maintenance work. In cases like this, the women often attempted to carry out relevant work in the villages. One missionary felt that she had accomplished something significant if she could just teach mothers that when little girls constantly carried younger siblings on their hips, permanent and debilitating curvature of the spine could result.<sup>802</sup>

The technology necessary for bolstering efforts at preventive medicine could also be very basic and not costly. When the Mandagadde hospital, a small rural institution that limped along

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<sup>800</sup> Holmes to Bradford, 21 May 1930, Madras Correspondence, 1069, 724.

<sup>801</sup> Holmes to Bradford, 5 December 1930, Madras correspondence, 1069, 724

<sup>802</sup> Dr. Alice Speight, letter dated December 1934, Hassan, filed in Report, WW, MMS, 1036, 62; "Ibrahimpatnam Medical Work, 1932," Reports, WW, MMS, 1036, 44.

for years without a full-time physician, got a microscope and a doctor who knew how to use it, the staff became aware of the prevalence of hookworm in the district. A possible source of the “dreaded anemia of pregnancy,” which accounted for nearly all of the station’s maternal deaths, suddenly emerged.<sup>803</sup> The staff immediately set their hopes on the government providing them with slides to help teach the local people about health, sanitation, and child welfare; the station had a magic lantern, but lacked the funds to purchase the slides from the Red Cross at Lahore.<sup>804</sup> Financial needs greatly affected the efforts to combat hookworm in this district, for by the early 1930s the missionaries had established that in some of the nearby villages the “prevailing fever” was malaria and to identify the “malarial spot,” while in other locations they could trace the guinea worm infections to a particular well, but “here our best efforts are brought to an abrupt end by financial stringency.”<sup>805</sup> In the Madras District, the WW missionaries were part of the Rockefeller Foundation’s rural development scheme, which supported two trained workers engaged in hookworm investigation using the Ikkadu hospital’s lab as headquarters. Even though ninety percent of all specimens indicated infection, these resources allowed the missionaries to feel hopeful, believing that once people understood how easy prevention was, better village sanitation would soon follow.<sup>806</sup>

In the early years of the twentieth century, the missionaries reported on their battles to convince Indians to be inoculated against the plague. Inoculations continued to play an important role in preventive medicine, and to absorb much missionary time. In 1931, the

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<sup>803</sup> “Wesleyan Mission Women’s Hospital, Mandagadde,” 13 January 1927, and “Mandagadde Hospital,” n.d., probably 1929, Reports, WW, MMS, 1035, 28 and 40.

<sup>804</sup> “Wesleyan Mission Women’s Hospital, Mandagadde,” 13 January 1927, Reports, WW, MMS, 1035, 28.

<sup>805</sup> “Trichinopoly District, 1932,” Reports, WW, MMS, 1035, 47. Barbara Ramusack discusses the fact that the WW missionaries received grants from the Mysore state to open hospitals in the “fertile by insalubrious districts of Shimoga, Kadur, and Hassan” as these were areas with terrible health problems, many of which were directly tied to the high rates of malaria. See Ramusack, “Women’s Hospitals and Midwives in Mysore,” 184.

<sup>806</sup> “District Medical Report, 1933, Madras,” Reports, WW, MMS, 1036, 53.

Methodists opened a new women's village hospital in an area where most people had never seen a hospital. In that first year, Dr. Little administered over 3,000 cholera inoculations, mostly in the "out-caste" areas; those people did not succumb to cholera, while their neighbors in the caste-streets did.<sup>807</sup> In 1934, "a year of unprecedented sickness" in the Hyderabad District, the government hospitals were unable to cope with the demand for inoculations, so the missionaries helped, reporting, "as always, the [Indian] Christians led the way" in coming forward for cholera inoculations."<sup>808</sup>

For the most part, preventive medical work took place outside of the hospitals. There appears to have been ample interest to do this work, but the overall missionary strategy of building and sustaining the hospitals served to undermine efforts to support other types of medical work. For example, the Methodists took a special interest in "touring" villages and outlying areas in their districts, as well as in sustaining the "mass movement" work among the very poor and marginalized groups. Many of the doctors, and even more of the nurses, regularly made reference to their desire to work in the villages, to tour in areas outside of their hospitals' surroundings, and to be given the training and support necessary to serve these populations well. For example, when Nurse Eva Bowes was still a missionary candidate in training in Britain, she received her assignment for the Hyderabad Mass Movement District, which delighted her.<sup>809</sup> She immediately scrambled to gain experience extracting teeth while completing her training at Kingsmeade, explaining that knowledge of basic dental services would be necessary to her

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<sup>807</sup> "Report on the Work of the Women's Department, WMMS, 1931," Reports, WW, MMS, 1036, 43.

<sup>808</sup> Hyderabad District Medical Report, 1934," WW, MMS, 1036, 60.

<sup>809</sup> "Mass Movement" refers to the phenomena of en masse conversion to Christianity, which happened in some areas of India in the later nineteenth and early twentieth centuries. Mass Movement Christians were poor, usually the "dalits" ("untouchables"), or tribal groups. Missionaries devoted considerable resources to working with the Mass Movement converts as these new Christians were uneducated, impoverished, and believed to be in need of intense teaching and support to build and sustain their Christian identity and communities. Many missionaries wanted to work with the Mass Movement communities, seeing this as rewarding and exciting

special work in India.<sup>810</sup> Once in India, staff illnesses caused the local Synod to instead place her in a hospital, which Bowes accepted, but her letters to the home secretary are filled with her disappointment in doing hospital work—she longed to do village work and stated that if she must be in a hospital, then she wanted to have the opportunity to also engage in the “touring.”<sup>811</sup> Five years later, Bowes appealed to the home committee to send another doctor out so that she could devote more of her time to reaching the village women who refused to come to the hospital for confinements; the response from London was to hire an Indian women doctor, as no more European doctors would be sent to her station.<sup>812</sup> Isabel Linforth frequently mentioned her “long cherished goal” of visiting the villages, and complained that her hospital had too many patients who could not be left under the sole care of the Indian nurses, thus preventing Linforth from taking even one day away to serve the villages during the entire year.<sup>813</sup>

There were many women like Bowes and Linforth who desired to practice nursing outside the hospital, and expressed disappointment, frustration, and even bitterness when their societies pulled them from village touring, budding welfare centers or baby clinics, and rural dispensaries to return to traditional hospital nursing. It seems most of the missionary doctors were content to be based in hospitals, but they understood the need to branch out to provide other types of care. When Dr. Joan Drake’s severe eye troubles caused her to have to leave regular hospital work, she was placed at a tiny hospital in a rural area. Drake reported that she was kept quite busy, explaining that it was a “very useful type of hospital ... We need the bigger hospitals too but we could do with many of just this sort. They can be run economically and by a nurse which seems desirable these days. I mean that nurses are easier to get and their requirements are

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<sup>810</sup> Eva Bowes to Miss Bradford, 18 May 1924, WW, MMS, Haiderabd Correspondence, 1058, 394.

<sup>811</sup> Bowes to Bradford, 4 April 1925, WW, MMS, Haiderabd Correspondence, 1058, 394.

<sup>812</sup> Bowes to Bradford, 10 April 1930; Bradford to Bowes, 5 June 1930, Haiderabad Correspondence, 1058, 428.

<sup>813</sup> Isabel Linforth to Bradford, 3 September 1922 and 6 November 1922, Haiderabad Correspondence, 1059, 445.

less in the way of equipment.”<sup>814</sup> Some of Drake’s colleagues argued that the problem with the larger hospitals was that they tended to be out-of-touch with village life, and that maintaining these hospitals pulled staff and resources away from the villages.<sup>815</sup>

In other situations, the lack of resources to keep a small hospital open could mean that the staff instead focused on village work. The Ellareddi Medical Report for 1935 explained that lack of staff had caused the hospital to close for the year, so the missionaries decided to devote the time to visiting approximately thirty villages, making special efforts to see all the Christians in the area. One of the main goals was to teach the Christians to improve the cleanliness and ventilation in their homes, and to clean the village drains, all of which were preventive measures. Dr. Constance Whitaker, a married missionary who worked in the area on a voluntary basis, was pleased to report that when the missionaries made follow-up visits, they often found significant improvements.<sup>816</sup> Certainly missionaries interested in village work could find fulfillment, for, as one missionary noted, “the more one sees of village people the more one is convinced of their stupendous need.”<sup>817</sup>

## 5.6 Conclusion

In the 1930s and 1940s, the women missionaries in the WW and ZBMM could not know what the future held for their work. They remained committed to their hospitals, placing their nurse training programs in the context of hospital work, prioritizing increasing their numbers of inpatients, and attempting to keep up with the new hospital-based technologies and services that

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<sup>814</sup> Joan Drake to Miss Bradford, 19 July 1930, Haiderabad Correspondence, WW, MMS, 1058, 431. According to fellow missionary Georgina Green, Drake’s sight was “frightfully limited.” Georgina Green to Miss Bradford, 2 February 1930, Haiderabad Correspondence, WW, MMS, 434.

<sup>815</sup> “District Medical Report-Synod 1932, Hyderabad District,” Reports, WW, MMS, 1036, 44.

<sup>816</sup> “Ellareddi Medical Report, 1935,” Reports, WW, MMS, 1036, 67.

<sup>817</sup> “District Medical Report 1935,” (Kalyani and Ikkadu), WW, MMS, 1036, 65.

the better-funded and larger government hospitals had as standard equipment, but were very expensive or completely beyond the reach of the small mission hospitals. Missionaries' chronic staffing problems made sustaining the hospitals more challenging, and the determination not only to keep the hospitals open but also to push them to be "first class" meant that other work—village and preventive—frequently suffered.

Although they continued to try to "expand the work" by reaching more people and offering as many services as possible, by the 1930s, medical missionary women began to adapt their work to their circumstances. Rather than retreating in the face of rapid expansion of government services, missionaries sought opportunities to collaborate and to increase their efforts in underserved areas. Although they constantly admonished themselves for not doing enough in the field of preventive medicine, women missionaries were aware of the impact their efforts could make in their communities. They made special attempts to improve women's and children's health through services to schools, baby and welfare clinics, and inoculation campaigns. Realizing the need to incorporate Indian healthcare professionals into the missionary medical endeavors, missionaries made nurses' training a high priority. Through these efforts, medical missionary women hoped to meet the needs of their communities for many years to come.

## 6 EPILOQUE AND CONCLUSION

My study ends in the years of war and independence during the 1940s, but the legacy of British women medical missionaries can be found in the hospitals they founded, which continue to serve patients in contemporary India and other countries in South Asia. What follows are stories and thoughts for a history that is not really over.

### 6.1 *Not Quitting India*

In late 1940, Nurse Thirza Wooley felt frustrated and doubtful. The war made international travel difficult, so she, like many missionary women, waited and wondered when she could obtain a passage to India.<sup>818</sup> Because she was committed to go to India as a missionary, she lost her job at a London hospital—the war had caused the hospital to evacuate half of the wards, and the matron decided to let Wooley go since she was not permanent staff. Wooley shared with the WW secretary that she had always believed that God could use her wherever she was, but the current circumstances made adhering to this belief difficult. She was not alone. The long war years caused the medical missionary a multitude of problems. Staffing shortages increased. Many potential recruits chose national service; many of the Indian women doctors and nurses who had worked at missionary hospitals chose instead to work in military hospitals; donations from supporters at home dropped.<sup>819</sup> Drugs and medical supplies became difficult or impossible to obtain. Prices in India rose, causing Indian patients to rely on the

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<sup>818</sup> Ethel Douglas was on furlough when the war broke out, but immediately rushed back to India in order to avoid being stranded in Britain, for that is what had happened to her during the First World War. Sister Andersen, a Danish national, was on furlough in Denmark during the war, and was unable to get to India or Britain.

<sup>819</sup> Mary Proudlove complained about the Kalyani hospital being in “dire straits” after the previous year’s evacuation, and the missionaries’ inability to compete with the military hospitals’ salaries for nurses. Mary Proudlove to Miss Freethy, 14 October 1943, WW, MMS, filed in Reports, 1038, 113.



hospitals for food, clothing, and many basic necessities; patients' abilities to contribute financially for their care dwindled. Indian nationalism could complicate matters: the staff at Patna noted in 1940 that "Congress feeling makes others unwilling to pay."<sup>820</sup> Riots and unrest in some areas, such as Patna, resulted in curfews and people fleeing parts of the city; in 1946 riots in Bihar filled the Duchess of Teck hospital with casualties.<sup>821</sup> The ZBMM and some of the Methodist hospitals ceased their village outreach due to lack of staff and resources, including gasoline for their vehicles.<sup>822</sup> There were ample reasons for missionaries to worry about the future, but in her reply to Wooley, Miss Freethy simply stated that she and the rest of the committee members were certain that God cared about the missionaries' work, and the work would go forward.<sup>823</sup>

It is possible Freethy made such a statement based solely on faith, but even though the missionaries faced ongoing challenges and setbacks during the 1940s, they also found reasons to feel encouraged. Except when shortages—such as gasoline or a severe lack of staff—made some services impossible, most of the medical work went on as if there was no war or turmoil.<sup>824</sup> Dr. Pleasaunce Carr noted that fees collected from rich Indians counterbalanced the poor, who could only pay in gratitude. In 1946, the Methodist hospital in Mysore City was offered a great sum of money to build a children's ward, and it also reported setting record patient numbers in all its departments. The year was also good for the Lucknow hospital, which reported that it ante-natal

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<sup>820</sup> "Patna," *Annual Report*, 1940, ZBMM.

<sup>821</sup> See, "Patna" and "Lucknow," *Annual Report*, 1942, ZBMM; Dr. Winifred Anderson mentions the Bihar riots in the "Patna" report for 1946.

<sup>822</sup> Many of the reports from the 1940s stress the impact of gasoline shortages. For example, Dr. Little noted that the leper work was discontinued in her district since the clinic car could not be taken to the villages. "Methodist Mission Hospital, Dharapuram, 1944," WW, MMS, Reports, 1039. 117.

<sup>823</sup> Correspondence between Thirza Wolley and Miss Freethy, 1 December 1940 and 4 December 1940, WW, MMS, Mysore Correspondence, 1078, 983.

<sup>824</sup> This was easier in some places—as the missionaries working in South India noted, the impact of the war and social unrest was greater in the north.

work had become so popular that the staff turned away all but the most urgent cases—this was a problem the missionaries could only have dreamed of a few years earlier.<sup>825</sup> Most of the nurses training programs reported successful examination results. Ethel Douglas, who noted that she and one of the nurses had been in India for more than thirty years, complained that “the fact that ‘Quit India’ slogan was heard on all sides was certainly a challenge to our thinking—why should we go on when war conditions increased our problems 30, 60, a hundred fold?” But when Pleasaunce Carr reminded some “Congress men” that soon the medical missionaries would leave India, they reassured her that she and her staff were wanted and needed. Others asked Carr if she were “pure English or a missionary.” Carr believed that there would be room for the medical missionaries in the new India.<sup>826</sup>

The missionaries did not leave India when independence came in August of 1947. The Patna and Lucknow reports included brief descriptions of their activities on August 15, “the dawn of Independence in this land we love.”<sup>827</sup> Dr. Alice Hodge and her staff threw a party, raised the Christian flag, and gave bakhshish to all the patients, staff, and servants. Dr. Winifred Anderson’s station raised the Indian flag and planted trees to commemorate the day. Dr. Bose, an Indian friend, made a special speech on what Independence could mean for Indian Christians. In 1947, Winifred Anderson reported that the departure of Indian Medical Service (European) doctors meant many European patients suddenly sought missionary care. This was quite taxing on the nurses and housekeeping staff, for “[s]ome of [the Europeans] are quite new to the Christian influence of a mission hospital” and did not know how to behave. The missionaries had identified as separate from the ruling Europeans, but were also always outsiders

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<sup>825</sup> “Mary Calvert Holdsworth Memorial Hospital, Mysore City, Report for 1946,” WW, MMS, Reports, 1039, 124; “Lucknow,” *Annual Report*, 1946, ZBMM.

<sup>826</sup> “Canada Hospital,” *Annual Report*, 1946, ZBMM.

<sup>827</sup> “Kinnaird Hospital, Lucknow,” *Annual Report*, 1947, ZBMM.

in India.<sup>828</sup> Now that colonial rule had ended, they would build on their identity as Christians, sharing this identity with Indian Christians who had the same goals and values for the medical work in the new India.

One comment that stands out in the ZBMM reports for 1947 is that a man named John Jeremy, “our overseer and colleague,” had become a registered worker in the missionary society; Dr. Anderson thought that he must be the first male worker in the ZBMM.<sup>829</sup> The Indianization that the women missionaries had begun to seriously discuss in the 1940s rapidly blossomed in the first years after independence, as more focused efforts to put Indian doctors and nurses in positions of greater responsibility and leadership were put into place. But, as missionaries, the goal was not just to appoint Indians—or “nationals,” to use the ZBMM’s term—who only possessed professional qualifications in leadership, but to place those who had the professional medical credentials in addition to “the required spiritual capacity” into key positions.<sup>830</sup> In 1954, the ZBMM proudly reported that Dr. Shanti Lal, “the daughter of the Biblewoman at Khurja in North India, took the medical leadership of the Duchess of Teck Hospital, as a missionary in full connection, directing three Indian doctors, and European and Indian nursing sisters.”<sup>831</sup> When Lal had joined the Patna staff in 1946, Anderson stressed that Lal’s ties meant that she “is really one of ourselves.”<sup>832</sup> Lal’s rise to leadership was therefore slow, but represented great progress for the missionary society. Similar transitions occurred at the Christian Medical College, Vellore, where Dr. Hilda Lazarus, an Indian Christian, served as the Director beginning in 1948,

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<sup>828</sup> Jeffrey Cox, *Imperial Fault Lines: Christianity and Colonial Power in India, 1818-1940* (Stanford: Stanford University Press, 2002).

<sup>829</sup> His name also indicates that he was an Indian Christian, and not a European; no reference to his race, ethnicity or nationality was made.

<sup>830</sup> J. C. Pollock, *Shadows Fall Apart: The Story of the Zenana Bible and Medical Mission* (London: Hodder and Stoughton, Ltd., 1958), 192.

<sup>831</sup> Pollock, *Shadows Fall Apart*, 193. Khurja was one of the ZBMM stations.

<sup>832</sup> “Patna,” *Annual Report*, 1946, ZBMM.

assuming leadership over the staff of both European and Indian doctors and nurses. The Methodist work also rapidly incorporated Indians as missionaries and leaders. By the 1940s, many of the WW reports indicate that only one or two Europeans are on the staff at some of the stations.

As the ZBMM began accepting male missionaries in the 1950s, it changed its name to Bible and Medical Missionary Fellowship—“Zenana” was cut, as the work was no longer only for Indian women, and the society also chose to drop the word “Mission,” replacing it with “Fellowship,” explaining that “‘Mission’ speaks of control and must go. We envisage a fellowship serving with and under Asian leadership.”<sup>833</sup> This ZBMM still exists today, under the name “Interserve.” It is an international Christian organization providing community development across Asia and Arabic-speaking countries in North Africa. The focus of the work is still medical, educational, and community development—all current versions of the work the women of the ZBMM valued. The workers are all Christians with a call to engage in “servant Christianity” and to go where their efforts can help people the most—in other words, today’s organization does what Winifred Anderson suggested in her paper in 1934: “Go!...where the need is greatest.”

The work of the Methodist women in this study also continues in today’s India, including at the Ikkadu Hospital, where Mary Proudlove had complained “if it isn’t one thing, it’s another.” Now these hospitals are administered by the Church of South India (CSI). As was the case when they were run by the WW missionaries, one purpose of the hospitals is to serve and train—in those with training programs—Indian Christians. But they also specifically cater to the

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<sup>833</sup> Pollock, *Shadows Fall Apart*, 194.

poor, the elderly, the neglected, and the needy. Thus the spirit of service that motivated the European women missionaries lives on in the staff and administrators today.

## **6.2 *Doctors First, Missionaries Second***

Dr. Grace Gillespie often commented that she was not certain of her suitability as a missionary. This view may have been influenced by the fact that she was a Presbyterian spending her career working for the Wesleyan mission. Perhaps it was due to her understanding of missionary medical work's roles and needs, for Gillespie consistently argued that medical qualifications and experience were the most important factors for missionaries' success, and she was never a proponent of "making do." She also frequently complained about conditions and criticized decisions and priorities set by her society. In 1945, when the war was over and the societies could once again recruit and send out new medical staff, Gillespie frankly informed her society that it was far more "important" for new nurses to get post-training experience in the operating theatre and hospital administration than to devote a year to training and study at Kingsmeade, the missionary training college favored by the Methodists.<sup>834</sup> She also argued against the policy of requiring missionary doctors to complete missionary training, explaining that a year of spiritual study and time away from the practice of medicine was "such a loss professionally as only a doctor can realise," stressing that spending that year in India engaged in learning the language and gaining more medical experience was "infinitely" preferable.<sup>835</sup> Yet

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<sup>834</sup> Grace Gillespie to Miss Freethy, 24 February 1945, Mysore Correspondence, WA collection, 1017.

<sup>835</sup> Grace Gillespie to Miss Freethy, 27 May 1945, Mysore Correspondence, WA collection, 1017.

even racked with doubts, Gillespie spent nearly thirty years as a missionary doctor in South India, staying on until her retirement more than a decade after Indian independence.<sup>836</sup>

During her long career, Gillespie became a Member of the British Empire (MBE), an award given to honor outstanding hands-on service to the community. After retiring to Britain, she worked in the accident and emergency department of a Liverpool hospital, and then served on the Ministry of Pensions for the medical board. Her obituary in the *British Medical Journal* details her forty-plus years as a doctor and surgeon, an administrator, and as an active member of the church, including her time as an elder in her Liverpool Presbyterian Church in her later years. Medicine, the church, and service to the community were important throughout her long life. She identified as a doctor, but as a doctor motivated to serve others not only by her professional commitments but also by her faith.

As has been discussed in previous chapters, the societies proclaimed that their medical workers were “missionaries first” and doctors or nurses “second,” implying that the spiritual and evangelistic aspects of the work took priority over the medical work. Both supporters and critics of missions had long suspected that the medical missionaries were especially high-risk for focusing on their “professional” interests and tasks at the expense of evangelism. As was seen in Chapter Four, the medical workers were absorbed in health care and administration. In their societies’ publications, the medical work was consistently presented as leading to conversion—even when no evidence that this might actually happen existed. While supporters at home may have believed that medical missionaries’ main purpose was to promote conversion, over the course of the first half of the twentieth century, the missionaries saw their purpose shift first to

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<sup>836</sup>Gillespie’s obituary in the *British Medical Journal* states that she retired from India in 1957, but the Medical Register still has her listed as at the missionary hospital in 1959. The immigration records from 1957 also indicate that she was only on furlough that year, with the intention of returning to India before final retirement.

meeting the medical needs of their patients and communities, especially in India's villages, and, by the late imperial era, to begin to transfer the medical work to the Indian Christian healthcare professionals.

Dr. Winifred Anderson opened her paper on the work of medical missionaries in 1930s India by stressing that she intentionally made no mention of the “evangelistic” work. She explained that evangelism “goes along with medical work,” reminding her audience that Christ did not appoint one person to be an evangelist and another to be a healer. For Anderson, there was no need to discuss the “spiritual side” of the work, for all missionaries should understand the role of medical missions as “no mere adjunct to the work of preaching but an essential and integral part of the mission of the church.”<sup>837</sup> Provided that the work was “first class” and carried out as service to humanity, even if lacking anything overtly Christian or “religious,” it was nonetheless “spiritual” work. Medical missionaries could understand their work in clinics, hospitals and villages, preventive health, the training of dais, nurses, and doctors, and infant and maternal welfare as emulating Christ’s “compassion of God toward suffering humanity.”<sup>838</sup> Even in years of uncertainty and change, these women could see needs and opportunities where their efforts and skills could make a positive difference. This was “great work.”

### **6.3 Women for Women**

This study has explored the lives and work of British women medical missionaries from the beginning of the twentieth century through the end of British colonial rule in India. In

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<sup>837</sup> The Committee explained that it adopted this statement from Dr. Dugald Christie, a well-known pioneer of medical mission work in Manchuria. *A Survey of Medical Missions in India*, Prepared by the Committee on Survey, Efficiency, and Cooperation of the Christian Medical Association of India in Conjunction with the National Christian Council of India, Burma and: National Christian Council, 1929), 2.

<sup>838</sup> *Survey of Medical Missions*, 3.

addition to demonstrating that interest in and commitment to providing medical services for Indian women remained relevant to groups of Christian women in interwar Britain—both those who served as missionaries, and those who supported the work through their labor for the missionary societies—I have analyzed the meaning of this work in a context of challenge and change. Adaptation to change while adhering to ideals and values is one of the main themes of this study. I have analyzed this process for the societies as they adapted to the changing professional standards expected of doctors and nurses; for the missionaries as they adapted to the physical, emotional, social, and professional conditions of work as medical women in India; and for the ways both medical missionaries and their societies adapted to India's changing needs for healthcare in the years of decolonization *before* independence. As a study of British women's experiences as participants in colonial encounters, I have also shown how missionary women adapted their personal and professional expectations and standards in order to both serve and collaborate with Indians as patients, neighbors, and, eventually, as colleagues.

My use of unpublished sources has enabled me to move beyond the commonly accepted stereotypes of missionary women as presented through missionary propaganda. One could make the argument that women committing to missionary work in the 1940s were perhaps more "religious" than those who had done so as Victorians, for choosing missionary life was unusual after the great age of missions. But these women's records indicate that while they certainly carried cultural "baggage," they cannot be easily dismissed as ethnocentric, racist, or conservative. They labored to understand Indian culture and to find ways to fit into the developing Indian healthcare landscape. The missionaries' religious faith sustained them and shaped their goals as healthcare professionals while allowing them to adapt to their local contexts.



David Hardiman argues that the missionaries' "strong focus on women was one of the most radical components of mission medicine, distinguishing it sharply from the medical practice of the colonial state."<sup>839</sup> I have studied medical women dedicated to working with Indian women, through the structure of women's missionary societies, after the era of "woman's work for woman." Like their nineteenth-century predecessors, missionaries working in the 1940s attributed Indian women's many healthcare problems, including access to services, to the devaluation of women. Perhaps some of them truly believed that conversion to Christianity would help to address these problems, but through their engagement with Indian women, missionaries understood that barriers to improving Indian women's health were complex. Their work focused on the practical: providing needed services for women and devising ways to promote women's use of these services.

Missionary medicine also foreshadowed what has become development work. What began as endeavors to "open doors" for conversion evolved into public health initiatives. The efforts at the local level, through collaboration, community programs, and health education, to improve maternal and infant health are strategies still widely used in much of rural India. Thus the study of medical missionary work contributes to more than our understanding of the hopes and goals of missionaries in the past. As Hardiman explains, the missionary legacy is still with us: "Today, such a spirit lives on in the work of dedicated non-governmental workers—Christian and non-Christian alike—throughout the world. In the long term, this may prove to be the most lasting and positive contribution that mission medicine—at its best—has provided for medical practice and the art of healing in general."<sup>840</sup>

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<sup>839</sup> David Hardiman, *Missionaries and Their Medicine: A Christian Modernity for Tribal India* (Manchester: Manchester University Press, 2008), 141.

<sup>840</sup> David Hardiman, *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa* (New York: Rodopi, 2006), 49.

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