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# Interaction Between Western Medicine and Indigenous Medical Systems in Princely States

**Monika[1], Dr. Dinesh Mandot[2]**

[1]*Ph.D. Research Scholar,* [2]*Research Supervisor*

[1]Department of History, Faculty of Humanity & Social Science, Bhagwant University, Sikar Road, Ajmer, Rajasthan–305023, India, Mail Id.: monika141194@gmail.com

[2]Department of History, Bhagwant University, Sikar Road, Ajmer, Rajasthan–305023, India

**Abstract**

The history of public health policy, epidemiological action, and sanitary, medical, and public health administration in late colonial India has been studied almost exclusively in terms of direct British rule. This is unfortunate, because the Indian Princely States, which before 1947 occupied roughly two-fifths of the subcontinent, present an altogether different, and much more complicated, story. The synthesis of Western (allopathic) medicine with indigenous Ayurvedic, Unani and Siddha systems under the indirect rule of progressive states of Travancore, Mysore and Hyderabad, the heavily regulated Rajputana states and Orissan enclaves, is covered, with inference of imperial interests by interrogation of the architecture of the administrative interface. The story is not one of total victory but of negotiation, medical pluralism and institutional hybridization. The report weaves together the struggles of humoral and biomedical epistemologies with the social rupture of Christian medical missions, the manipulation of public health as a vector of modern corporeal consciousness, and the overwhelming economic imperatives that drove Princely rulers' zealous patronage of indigenous medical lineages. The article concludes with a discussion of how these semi-autonomous enclaves funded global-scale biomedical knowledge production and provided infrastructure for post-colonial India's pluralistic AYUSH system.

**Keywords:** Medical Pluralism, Princely States, Indirect Rule, Epistemological Conflict, Institutional Hybridization, Missionary Medicine, Public Health Administration, Chloroform Commissions

## 1. Introduction

Since the 1980s, the historiography of colonial medicine has slowly changed, moving away from narratives focusing on the progress of biomedicine and to more contested views of British colonial medicine

as a tool of imperialism. In South Asia, the majority of studies of colonial medicine have dealt with the presidencies and provinces directly administered by the British Raj. As a result, the long, contested and highly innovative medical histories of the Indian Princely States have been obscured.

The states varied widely in terms of their political economy and size. States such as those of Mysore and Travancore were described in contemporary and later European literature as "progressive" and "enlightened" due to their responsiveness and their heavy investment in social capital. In contrast, the princely states of Orissa were often described as "backward" or "despotic" in colonial discourses, while states such as Rajputana were based on militarised bureaucratic surveillance.[29] Princely States, through careful coordination as to the nature of effective statecraft, operated as laboratories of public health, balancing British paramountcy, sovereign prerogatives, the patronage of an indigenous elite and the cultural practices of the bulk of the population.

The introduction of Western medicine in the subcontinent clearly goes back to the Royal Hospital set up by the Portuguese in Goa in 1510, but an epistemological rupture was not observed.[30] Up until the beginning of the nineteenth century, the theoretical foundations of Western medicine and classical Ayurveda were closest to each other in one respect: Both systems shared humoral pathology. This common frame of understanding engendered some mutual intelligibility, as Western practitioners in this period recognised indigenous pharmacopoeia: European medicine had at the time little to no demonstrable clinical advantage in treating the subcontinent's most devastating endemic diseases, including malaria, cholera, and dysentery.[31]

The medical profession in Europe became professionalised and the acceptance of germ theory of disease around the end of the nineteenth century, along with the rapid expansion of European empires, changed the course of Western medicine. Moreover, biomedicine was more than a healing practice; it was a "tool of empire" that mediated cultural superiority, justified racial discrimination, and mobilised physical intervention to extract economic value from

[29] Ernst, W., Pati, B., & Sekher, T. V. (Eds.). (2017). Health and medicine in the Indian princely states: 1850–1950. Routledge. Taylor & Francis Group. https://www.taylorfrancis.com/books/mono/10.4324/9781315165875/health-medicine-indian-princely-states-waltraud-ernst-biswamoy-pati-sekher

[30] Reddy, B. C. (2024). Medical encounters in colonial India: Indigenous vs western medicines. International Journal of Multidisciplinary Educational Research (IJMER), 13(12), 34-41. Amazon S3 Hub. http://s3-ap-southeast-1.amazonaws.com/ijmer/pdf/volume13/volume13-issue12(2)/4.pdf

[31] Pati, B., & Harrison, M. (Eds.). (2001). The social history of health and medicine in colonial India. Routledge. National Academic Digital Library of Ethiopia. http://ndl.ethernet.edu.et/bitstream/123456789/20917/1/Biswamoy%20Pati.pdf

colonised bodies.[32] Through its successful colonisation of indigenous health systems and its control of the monopoly of force granted to the colonial state, biomedicine produced its own hegemonic systems of understanding the body and disease.

## 2. Historiographical Context

A few words should be said on the historiography of medicine in the semi-autonomous states of the study in order to put into context the highly specific nature of this study. The available sources for this historical study are complex: the state manuals, decennial census reports, administrative records of state institutions, gazetteers of the government, and publications of their monumental legislative commissions.

Gazetteers of the nineteenth and twentieth centuries, such as the Imperial Gazetteer of India and local gazetteers like the Mysore Gazetteer and Rajputana Gazetteer were meant for government officials as reference material.33 These records, intended to assist the colonial government in administering large areas by systematically documenting factors such as endemic flora and demographics, often reflected a Western style of scientific analysis and were biased against the lower strata of society.[34] Historians using these official sources must read them against the grain in order to trace the construction of medical infrastructure, and also unpick the colonial discourse which sought to discredit indigenous forms of healthcare.

The medical commission reports prepared by Koman (1918), Usman (1923), and Bhore (1946) are important as they also extract data about demographics, economics, the intensity of debate, and the perseverance of indigenous practitioners against growing biomedical hegemony.[35] These statistical, ideological, and administrative records have helped show medically the extent to which Travancore's population was affected by the state's medical policies and have revealed changes within the community's social structure resulting from the Travancore census figures of mortality rates, sex ratios, and population increase.[36]

[32] Indigenous and western medicines in colonial South India: Nature of discourses and impact. Academia Academic Sharing Network. (2018) https://www.academia.edu/36981289/Indigenous_and_Western_Medicines_in_Colonial_South_India_Nature_of_Discourses_and_Impact_pdf

[33] Rao, C. H. (Ed.). (1930). Mysore gazetteer: Compiled for government. Government Press. HathiTrust Digital Library. https://catalog.hathitrust.org/Record/001869413

[34] Rare Book Society of India. (2021). State administration and archival documentation of Kota (Raj.). RBSI Digital Library. https://www.rarebooksocietyofindia.org/book_archive/196174216674_10155191919006675.pdf

[35] Wujastyk, D. (2008). The evolution of Indian medicine: Pre-publication text draft. University of Alberta Scholaris Gateway. https://ualberta.scholaris.ca/bitstreams/f0256c00-91e2-48b3-8377-bc42792a779e/download

[36] Pratheep, A. (2024). Body as a site of fight: Women and smallpox vaccination in Travancore. Antrocom Journal of Anthropology, 20(1), 89-98. https://antrocom.net/wp/wp-content/uploads/2024/05/agney-pratheep-women-smallpox-vaccination-travancore.pdf

### 3. Epistemological Conflict and the Revitalization Movement

In colonial India, the public introduction of Western medicine began a conflict over knowledge. For the British medical establishment, native medicine became folk tradition, the arts, and local custom, and not part of the objective and universal field of European science. This artificial binary influenced policies, as exemplified by the Rajputana Gazetteer report that of the estimated three thousand remedies customarily used by pansaris (native druggists), only three hundred had any validity, and the only drugs of "real efficacy" utilised by native practitioners were those that had already been isolated and assimilated into the Western pharmacopoeia.[37]

This hegemonic posture, which intended to colonise indigenous bodies and eliminate customary systems of knowledge, catalysed a counter-movement, in which indigenous medicine doctors initiated a cycle of revitalization, as a thorough response to systematic obsolescence. This counter-movement was characterised by rapid professionalisation, systematisation, and standardisation.

One of the processes through which this was negotiated was through print. Indian practitioners flooded the public sphere with tracts, pamphlets, journals, medical periodicals and books to propagate concepts of diagnosis, disease etiology and pharmacology that directly contested the hegemony of Western biomedicine. Print also transformed education in Ayurveda and Unani - which had previously been transmitted through informal local and hereditary apprenticeship (guru-shishya parampara) - to a more formal setting.[38] Practitioners also took advantage of the structural legitimacy of Western medical colleges in the modernising state bureaucracy. Institutionalisation had a democratising sociological effect on the indigenous system, as a system such as Ayurveda was being secularised and being made accessible to a much wider demographic from its elite caste Hindu origins.

### 4. Travancore: Missionary Zeal, State Intervention, and Corporeal Consciousness

Exciting developments in medical exchange have characterised the Princely State of Travancore in the subcontinent. While social welfare was available without regard to caste, the field of medicine was beset by the entry of Protestant medical missions, the state of Travancore's calculated adoption of

[37] BJSTR Publishers. (2020). Some 19th-century travel writings on Indian medicine and surgery. Biomedical Journal of Scientific & Technical Research. https://biomedres.us/pdfs/BJSTR.MS.ID.010012.pdf

[38] Ramaswamy, S. (2018). Emergence of indigenous medical education in Madras Presidency: A historical analysis. International Journal of Research in Advent Technology (IJRAT), 6(7), 1542-1549. https://ijrat.org/downloads/Vol-6/july-2018/paper%20ID-67201855.pdf

Western public hygiene along with a defensive, institutionalised Ayurveda.[39]

### 4.1 The Social Disruption of the London Missionary Society (LMS)

As was the rest of the region, Travancore's health care system was subject to devastating epidemics of smallpox, cholera, and malaria prior to the mid-nineteenth.[40] The royal family invited Christian missionaries to help, on the grounds that customary methods were no longer sufficient to manage these diseases. The London Missionary Society (LMS) was well established in the region and the first to start a medical center in Nagercoil in 1838 with Dr. Archbald Ramsay.[41]

Over the next decades, the mission grew considerably, with Neyyoor its headquarters. A succession of medical missionaries served at Neyyoor; Dr Leitch's successors included Dr John Lowe, Dr Fry, Dr Thomson, and, in later years, Dr. Howard Somervell, who came to India in 1922, after his first expedition to Everest. By 1854, thousands of patients were being treated each year.[42]

In addition to the medical effects of Western-style treatment of disease, the LMS had sociological effects. The missionary dispensaries were a novel space in a society where caste purity and pollution strictly controlled who could enter where. By 1854, visitors to the hospital noted that Brahmins and Nairs awaited treatment side by side with the most menial of castes, beginning to break down "the middle wall of partition between the high and the low, the pure and the polluted". Auxiliary staff to augment the biomedical healthcare system developed alongside the hospital. As nursing was considered an inferior profession, the LMS brought European lady missionaries and nurses such as Mrs. Jessie Thomson and Mrs. Annie Fry to Travancore, who were the first to train native nurses and midwives in Travancore. As a result, maternal and infant mortality reduced and customary caste and gender restrictions for occupations were broken in Travancore.

### 4.2 Biopolitics, Vaccination, and the State

While the missionaries worked largely with the poor and outcasts, the Travancore royal

[39] Pratheep, A., & Sreejith, K. (2019). Vaccinating against Vasoori: Eradicating smallpox in the 'model' princely state of Travancore, 1804–1946. Indian Economic & Social History Review, 56(4), 361-386. IDEAS/RePEc. https://ideas.repec.org/a/sae/indeco/v56y2019i4p361-386.html

[40] Conference World Network. (2018). Health status of Travancore before the advent of medical missions: A historical rereading. MASHS-2018 Conference Proceedings. http://proceeding.conferenceworld.in/MASHS-2018_Sattur-Conference/Kng3HMnpS559.pdf

[41] Suji, N. (2020). LMS lady medical missionaries and their services in South Travancore. Epitome Journals: International Journal of Multidisciplinary Research, 6(3), 12-24. https://www.epitomejournals.com/VolumeArticles/FullTextPDF/440_Research_Paper.pdf

[42] Tamil Nadu Mission Bureau. (2014). Medical services rendered by London Missionary Society in Tamil Nadu. Asian Review of Social Sciences, 3(2), 21-24. https://trp.org.in/wp-content/uploads/2016/11/ARSS-Vol.3-No.2-July-Dec-2014pp.21-24.pdf

family under the guidance of the British Residents set a precedent in the Travancore state by making early and enthusiastic use of modern biomedical health. The state's policies on smallpox vaccination provide one of the most important instances of intersection between medical history and social history. The state's vaccination policy was thus intended as not only a disease prevention program but also as a means of cultivating a "modern" corporeal consciousness.

The administration of the smallpox vaccine caused a lifelong mark, the Vasoori Keerukal (the vaccination marks), which became the state's most strong monument of conquest and possession of the physical body of its citizens. Biometric management of the population became very efficient. The success of the state vaccine operations in breaking the bubble of local opposition can be gauged from the 1931 census. Populations excluded from contact with the state, such as the Namboothiri women, were still visible in the census and under the biomedical gaze of the state. This is most manifest in the 5 to 12 and 40+ age groups, the numbers for which increased considerably over the 1921 census. Subsequently, Travancore managed to establish absolute public health authority over its subjects by means of vaccination.

### 4.3 Institutional Patronage of Ayurveda

Even under the lofty aims of Western epidemiology, the indigenous tradition was not totally neglected as Travancore was also looking at institutionalising indigenous medicine for its preservation and standardisation. Maharaja Sri Moolam Thirunal Ramavarma established the Ayurveda Patasala in Thiruvananthapuram which is regarded as the first Ayurvedic school in India, established in 1889.[43]

The institution was a revolutionary initiative in Ayurvedic education, and an Ayurveda Hospital was attached to the college in 1917 to impart clinical training and to ensure that the training Vaidyans received would be similar to that of Western medical schools. By 1929, the institution was certified to confer a specialised research degree known as the 'Ayurvedacharya'.[44]

The survival of Ayurveda was heavily subsidised by the state's intervention through a large network of grant-in-aid Ayurveda dispensaries in the rural hinterland. The scale of the intervention was enormous. Historical statistics further state that, in the year 1920-21, no less than 170,641 cases were treated in the grant-in-aid Ayurvedic institutions of

[43] Government Ayurveda College, Thiruvananthapuram. (2024). Main hospital administrative operations. Directorate of Ayurveda Medical Education, Government of Kerala. https://gactvm.kerala.gov.in/index.php/hospitals/main-hospital

[44] Government Ayurveda College, Thiruvananthapuram. (2024). Institutional historical profile. Directorate of Ayurveda Medical Education, Government of Kerala. https://gactvm.kerala.gov.in/

Travancore, including yet another specialty - the treatment of poisoning.[45]

There were economic factors: Western-style clinics, relying on imported medicines and expensive European or foreign-trained practitioners, were far too costly to make common application economically feasible.

**Table 1: Comparative Economic Analysis of Dispensary Maintenance based on data presented to the Usman Committee (1921-1922).**

| Dispensary Type (Madras/Travancore Region) | System of Medicine | Average Cost per Patient per Day | Analytical Context |
|---|---|---|---|
| Bauliah Naidu Dispensary | Western (Allopathic) | 0-3-0 (approx. 36 pies) | High maintenance cost driven by imported drugs and practitioner salaries. |
| Corporation Dispensaries (Average) | Western (Allopathic) | 0-6-2 (approx. 74 pies) | Standard cost for urban allopathic public health infrastructure. |
| Chengalvaraya Naicker's Free Dispensary | Indigenous (Ayurvedic) | 0-0-8 (8 pies) | Highly economical due to reliance on local flora and indigenous practitioners. |
| Madras Ayurvedic College Dispensary | Indigenous (Ayurvedic) | 6 pies | Demonstrated extreme cost-efficiency of institutionalized traditional care. |

Source: PPST Bulletins. (2011). What is the role of indigenous medical sciences in our health care system? Patriotic and People-Oriented Science and Technology Bulletin Hub.

[45] Madras Presidency Committee. (1923). The report of the committee on the indigenous systems of medicine, Madras. Government Press. Internet Archive. https://archive.org/download/b32176946_0001/b32176946_0001.pdf

http://ppstbulletins.blogspot.com/2011/10/what-is-role-of-indigenous-medical.html

As noted in Table 1, the per day per patient cost of an Ayurvedic dispensary was several-fold less than that of a Western dispensary. For a Princely State with a finite agrarian economy, the best way to improve health outcomes for all its citizens was to use the services of a high output, low cost, indigenous medical system, rather than engage in an academic adventure in cultural nostalgia.

5. Mysore: Architectural Modernity and Public Health Administration

The response of the Princely State of Mysore, an Indian territory under the rule of the Wadiyar dynasty, to disease, illness and plague was similar in progressive ambition but pursued through the application of technological modernity and the synthesis of architectural styles. Global epidemiology and the local experience of health crisis in Mysore was shaped by events such as the 1898 outbreak of the bubonic plague.

**5.1 Plague Administration: Resistance and Reconciliation**

The initial Mysore government's response consisted of Western-style sanitary cordons, intrusive house inspections and the forcible segregation of suspected plague-infected people in plague camps. Much of the response was based on contemporary British ideas about controlling epidemics, which resulted in massive public resentment within Mysore. The destruction of their property and the removal of their sick is a major transgression against their religious, bodily, and social customs, so they rose up in a riot.

The state's subsequent turn-around serves as an example of colonial public health governance. The Mysore State went from brute force to opportune reconciliation through a dependance on 'native' administrators. These native administrators had to balance global requirements from the international public health community, and local traditions and requirements. Nevertheless, under their stewardship the state introduced sanitation, potable water supply, and redesigning of urban space without further insurrection, thus modernising Mysore's public health infrastructure between 1881 and 1921.[46]

5.2 The Wadiyar Patronage and the Jayachamarajendra Institute

At the same time the rise of Western sanitary and biomedical institutions, the Wadiyars (Maharaja Chamaraja Wadiyar X, Nalvadi Krishnaraja Wadiyar IV and Jayachamarajendra Wadiyar) were firm patrons of Indian medicine. Nalvadi Krishnaraja Wadiyar established the

[46] International Institute for Population Sciences. (2017). Health and medicine in the Indian princely states: 1850–1950 structural indexing. IIPS India Bookshelf. https://iipsindia.ac.in/sites/default/files/Book_View_Details.pdf

Government Ayurveda Medical College in 1908 which was initially housed in the Maharaja's Sanskrit Pathashala. The institute was initially located in a building and had a physical form which exposed the textual roots and traditions of Ayurveda. As the number of students increased and more modern courses were adopted, the institute was moved to a building of the Chamarajendra Technical Institute and then to its own building on Sayyaji Rao Road.

The synthesis reached its highest point in the establishment of the Sri Jayachamarajendra Institute of Indian Medicine in Bangalore, then still Mysore City, around 1943/1945. The hospital was the most complete synthesis of physical size and customary approach, being planned for 100 in-patients and 1000 out-patients, with facilities for Ayurvedic and Unani medicine. To ensure the uniformity and quality of the medicines, the Government Central Pharmacy was set up by the state. At the same time, the Forest Department was specifically directed to set up and maintain an herb garden in the hospital premises to provide the hospital a reliable, indigenous and high-quality supply of over 200 medicinal plants.

### 5.3 Synthesis of Architecture: Otto Koenigsberger

Another chapter in the history of Sri Jayachamarajendra Institute is the Institute building. The state government entrusted the task of designing the building to Otto Koenigsberger, a Jewish German who fled Nazi Germany in 1939 and served as Government Architect & Town Planner of Mysore. An early proponent of tropical modernism and pre-fabricated housing, Koenigsberger utilised light steel frames and precast aerated concrete panels for the construction of the Jayachamarajendra Institute.[47] By housing these ancient indigenous medical systems in purpose-built, functionalist modernist buildings, Mysore state was able to give a visual structural expression to its claim that Ayurveda and Unani were not relics of the past, but were essential and dynamic components of a scientific modernity.

### 6. Hyderabad: Integrating Unani with Global Biomedical Practices

The Princely State of Hyderabad was the largest and richest princely state of the subcontinent, ruled by the Asaf Jahi dynasty (the Nizams). The medical tradition of Hyderabad was unique, and included state sponsored Tibb (Unani medicine) with state sponsored pioneering advances in Western anesthesiology on a global scale.[48]

[47] Transnational Architecture Group. (2023). Arzenta: Medical infrastructure architecture layouts in South Asia. Transnational History Network. https://transnationalarchitecture.group/author/arzenta/

[48] Osmania General Hospital. (2024). Historical timeline and evolution of state healthcare. Osmania Hospital Administrative Board. https://osmaniahospital.com/history/

6.1 The Legacy of Unani Medicine

Unani medicine, based on Greco-Arabic humoral pathology, was respected, even when all other indigenous medical systems were being marginalised or attacked in British India. The Nizams maintained an enormous network of Hakims, physicians who were paid from the state treasury. It was institutionalised by the first Minister of State (Diwan) Diwan Sir Salar Jung I and expanded massively under the seventh and last Nizam of Hyderabad Mir Osman Ali Khan.[49]

The Government Nizamia Tibbia College, established in 1926, 1927 and 1938, standardised the Unani profession through a thorough and rigorous education curriculum. The state systematically purchased and preserved rare manuscript material on the history of medicine in the Islamic world, which is the core of the medical manuscripts in the Salar Jung Museum Library. The college's clinical facilities were provided by the Nizamia General Hospital, which allowed Unani practitioners to conduct clinical trials, manage large wards and provide mass public healthcare on a scale comparable to the state's allopathic hospitals.[50]

6.2 The Hyderabad Chloroform Commissions (1888-1891)

Another major contribution to Western biomedicine was the Hyderabad Chloroform Commissions established in Hyderabad. In 1888, the commissions were established at the expense of the sixth Nizam of Hyderabad, Mir Mahboob Ali Khan, by his personal physician and Residency Surgeon Dr. Edward Lawrie.[51]

Late nineteenth century, technically based debate in the European medical profession about chloroform could be sharply negative to its use in anesthesia or dismissive, at a time when many still regarded chloroform as a poison.[52] Dr. Lawrie held out strongly for the belief that anesthesia deaths could be prevented with careful administration techniques. To prove the efficiency of his methods, the Nizam funded wide-ranging tests on animals and humans. The state invited skilled medical practitioners like Dr. T. Lauder Brunton, a correspondent of the

[49] Brill Academic Publishers. (2024). Changing face: Oriental education to Western mores. In South Asian administrative shifts. Brill E-Books Network. https://brill.com/display/book/9789004752801/BP000009.pdf

[50] ResearchGate Repository. (2024). Current status of Unani medicine in India. ResearchGate. https://www.researchgate.net/publication/384698824_Current_status_of_Unani_medicine_in_India

[51] Wikipedia contributors. (2025). Hyderabad Chloroform Commission. Wikipedia, The Free Encyclopedia. https://en.wikipedia.org/wiki/Hyderabad_Chloroform_Commission

[52] MedNexus Medical Gateway. (1890). The second Hyderabad Chloroform Commission: Core administrative and research outputs. Chinese Medical Journal, 119-124. https://mednexus.org/doi/pdf/10.3760/cma.j.issn.0366-6999.1890.01.119

world-acclaimed British medical journal The Lancet.[53]

This commission's findings, published in journals worldwide in 1890, and the lengthy report sent to the Nizam's government in 1891, formed the basis of empirically verified and standardised anesthesia safety protocols that became the model for hospitals worldwide, eventually resulting in innumerable lives saved. The commission's work is also important for its break with the imperial pattern of scientific research being conducted solely in the western metropole and merely exported to the "backward" colonial periphery. Instead an Indian Princely State soon financed, hosted and directed the biomedical research that would support the Western standard operating procedures.

6.3 Osmania General Hospital: Monumental Public Health

The commitment of the Nizams to modern public health infrastructure culminated in the construction of the Osmania General Hospital (OGH).[54] After the original Afzal Gunj Hospital (established by Salar Jung I in 1866) was flooded by the Musi River in 1908, Mir Osman Ali Khan commissioned the building of a new hospital. Completed in 1919 at considerable cost, OGH was built in the Indo-Saracenic style designed by British architect, Vincent Jerome Esch, along with Nawab Khan Bahadur Mirza Akbar Baig. With the hospital as the tallest building in the city at the time and 1168 beds, the hospital was a monument to the state's absolute commitment to dominating the landscape through modern medical intervention.[55]

7. Rajputana: Imperial Surveillance and the Marginalization of Indigenous Practice

Unlike the hybridization of Travancore, Mysore & Hyderabad, the medical service in the states of Rajputana (Jaipur, Bikaner, Jodhpur, Kota, Udaipur, Sirohi, Dungarpur, Tonk, Partabgarh, Chhatari), was in large part controlled by British political agents, military engineers and the all-powerful Civil Surgeon, and allowed no scope to the medical officers for clinical practice.

Maharaja Sawai Ram Singh II in Jaipur was more open to British ideas of reform and modernization. The Mayo Hospital, an imposing building designed by British military engineer Sir Samuel Swinton Jacob and Dr. de Fabeck, was built in 1870.[56]

[53] Wood Library-Museum of Anesthesiology. (1890). The Lancet and the Hyderabad commissions on chloroform. Wood Library-Museum Rare Books Division. https://www.woodlibrarymuseum.org/wp-content/uploads/rare-books/S_ADTV.pdf

[54] Live History India Bureau. (2021). Osmania General Hospital: An icon in need of intensive care. Live History India Monuments and Heritage. https://www.livehistoryindia.com/story/monuments/osmania-hospital

[55] Wikipedia contributors. (2026). Osmania General Hospital. Wikipedia, The Free Encyclopedia. https://en.wikipedia.org/wiki/Osmania_General_Hospital

[56] ResearchGate Network. (2013). Mayo Hospital, designed by de Fabeck and Jacob, 1870-5 architectural diagram. ResearchGate. https://www.researchgate.net/figure/Mayo-

Western sanitary engineering, with attention paid to piped purified water supply and a thorough drainage and sewerage system, were introduced to the Jaipur state, as were branch dispensaries following an allopathic model.

They were also a means of showing the superiority of Western medicine in areas thought to be its strong suits: surgery, and the treatment of regional ailments such as bladder stones. The Mayo Hospital's Annual Surgical Reports show that surgical techniques pioneered by Lt.-Col. Keith such as Perineal Litholapaxy had a low mortality rate of only 2.6% in 383 operations compared to other surgical procedures of the time such as Lateral Lithotomy with a 15.7% mortality rate.[57]

**Table 2: Surgical Efficacy and Mortality Rates for Bladder Stone Operations at Mayo Hospital, Jaipur.**

| Surgical Procedure (Mayo Hospital, Jaipur) | Number of Cases | Mortality Rate | Contextual Notes |
|---|---|---|---|
| Perineal Litholapaxy | 383 | 2.6% | Modern procedure introduced by IMS officers; highly successful. |
| Perineal Lithotrity | 11 | 0.0% | Small sample size, but zero mortality indicated high procedural safety. |
| Lateral Lithotomy | 19 | 15.7% | Older, highly invasive procedure; phased out due to high mortality. |

This liberalisation of biomedical knowledge, however, was accompanied by a harsh and uncompromising marginalisation of indigenous medical practitioners, and a deeming of indigenous medical systems. The audience of the Rajputana Gazetteer was explicitly the 'pansaris' (native druggists) and indigenous pharmacological systems. The Gazetteer maintained that most local drugs were worthless, but indigenous theories of the 'heating' and 'cooling' of foods and medicines according to the humours remained popular with patients. State patronage favoured allopathic dispensaries.

Hospital-designed-by-de-Fabeck-and-Jacob-1870-5_fig2_231896075

[57] Semantic Scholar Portal. (1909). Supplement to the Indian Medical Gazette, March, 1909 data files. Semantic Scholar. https://pdfs.semanticscholar.org/3e0c/6ba545ac8e21ebc0d3ea71ae9064b2e588df.pdf

The edict of the British Civil Surgeon was not to be questioned.

## 8. The Orissan Enclaves: Managing Endemic Maladies

Relative to the major states, the princely states of Orissa lacked the developed agricultural and administrative systems typical of the period, and were described as 'backward' in the literature of the colonial period. The medical histories of these princely states present an opportunity to explore local-level control of endemic diseases outside princely political centers. Administration in the Orissan states was almost completely directed at the control of localised smallpox outbreaks and at the management of the socio-medical stigma associated with leprosy. The medical systems between the Orissan states were less often shaped by the grand intellectual and institutional debates that really drove institutions in Madras or Mysore. Instead, they were often minor, highly resisted reforms that introduced Western epidemiological practices and psychiatric ideas to societies that still considered themselves predominantly agrarian and customary.

### 8.1 Institutional Conflict: The Koman and Usman Committees

The ideological conflict between Western and native forms of medicine came together in a series of high-profile legislative and investigatory committees in the early twentieth century whose debates and results shaped medical policy in British India and the Princely States, whose own medical governments used such debates as ideological cover.[58]

The battle was ignited by the Koman Committee Report of 1918 in the Madras Presidency, which had set up a committee under Dr. Koman to study the medical properties of Indian drugs. The report dismissed the theoretical and clinical basis of Ayurveda and Unani, and on the negative findings later concluded that "the science of Hindu medicine is still sunk in a state of empirical obscurity". It dismissed Indian systems of medicine as basically unscientific, although it did attempt to co-opt a few single botanical drugs into the Western pharmacopoeia. The western-trained establishment's strong rejection met with common organised opposition from indigenous practitioners and organizations, such as the Dravida Vaidya Mandal and the Madras Ayurveda Sabha. Practitioners asserted that Western doctors failed to understand customary preparations by attempting to isolate single ingredients rather than studying whole herbal combinations.[59]

[58] Sujatha, V. (2023). Rise of Siddha medicine: Causes and constructions in the Madras Presidency (1920–1930s). Medical History, 67(3), 221-240. PubMed Central (PMC). https://pmc.ncbi.nlm.nih.gov/articles/PMC10357311/

[59] Sujatha, V. (2023). Rise of Siddha medicine: Causes and constructions in the Madras Presidency (1920–1930s). Medical History (Cambridge Core Access Platform). https://www.cambridge.org/core/journals/medical-

The resultant political pressure resulted in what became known as the Usman Committee of 1923, which was chaired by Muhammad Usman. The committee was composed entirely of non-officials, to ensure that its methods of inquiry and analysis were objective and evidence-based, and to counter the assumption that European medicine was the only scientific form.[60]

The conclusions laid out in the Usman Report laid the foundation for this idea, vindicated the Princely States in all respects and clearly stated that from the point of view of science and the theory the systems of India were "thoroughly scientific and logical". Despite noting that indigenous systems were deficient in advanced surgery, the report concluded that they were generally efficient, economical and self-sufficient in treating the enormous majority of cases.14 Western medicine was openly chided for ignorance and the dangerous use of individual indigenous remedies outside the context of their customary systems of knowledge.

Despite the objections of the conservative Western medical establishment, including the views of Surgeon General Giffard that Ayurveda in India was "hopelessly out of date and entirely unscientific", the government accepted the recommendations of the Usman Committee. This acceptance was famously based on the irrefutable demographic and economic evidence of the Princely States, as P.L. Moore put it. However, the report only recognised Travancore and Cochin for establishing state-sponsored Ayurvedic colleges and setting up broad networks of state-helped Ayurvedic dispensaries. The Usman Committee's nod was also important in politically and intellectually legitimating the effort of the Princely States to continue and aggressively expand the patronage of indigenous medicine in their respective regions, without coming under British paramount power's charge of retrogression and anti-modernism.

9.The Bhore Committee (1946) and the Post-Colonial Transition

With the impending independence of the Indian subcontinent, and the need for national-level health planning, the Health Survey and Development Committee popularly known as the Bhore Committee was set up in 1946. The Bhore Report is an interesting document, because it acknowledges the wide-ranging experiments in state encouragement of indigenous systems that were going on in the Princely States of Hyderabad, Mysore, Travancore, Cochin and Gwalior. It also noted that a new class of educated practitioners had emerged,

history/article/rise-of-siddha-medicine-causes-and-constructions-in-the-madras-presidency-19201930s/3828EE68A1FFD7A41629AD33E645E9EE

[60] Usman, M. (1923). Introduction to the Usman Report (1923): Translations of regional submissions. Open University. Open Research Online. https://oro.open.ac.uk/71069/14/71069.pdf

who combined Western and indigenous theoretical knowledge and practical skills.

With a background of modern, universalist biomedical system, the authors of the Bhore Report systematically but subtly underplay the role of indigenous systems, relegating them to the "historical past of global medicine" not as a modern scientific system with contemporary relevance. The report suggested that the appeal and support of these systems was largely due to patriotic pride, nationalism and political expediency rather than medical efficacy, also failing to provide any quantitative evidence of the claimed clinical and economic advantages offered by the Princely States.

Notwithstanding the derision of the central health policy architects of independent India, the physical and institutional infrastructure of the Princely States left a lasting legacy. For instance, institutions such as the Government Ayurveda College in Trivandrum, the Sri Jayachamarajendra Institute of Indian Medicine in Mysore, and the Nizamia Tibbia College in Hyderabad survived the princely states' merger with the Indian Republic. These thriving institutions are the modern education system of AYUSH (Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homeopathy) in India and have ensured the survival and professionalisation of customary medicine in post-colonial India.

**11.** Conclusion

The encounter of the Western and indigenous systems of medicine in the Indian Princely States 1850-1950 cannot be written off as a simple story of colonial imposition and native subjugation. All the empirical evidence shows it to be a highly complex, local process, formed by fierce negotiation, staunch resistance and brilliant institutional hybridization. In modernised, semi-autonomous princely states like Travancore and Mysore, enlightened kings used their prerogative powers and quasi-sovereignty to institutionalise calculated pluralism and modern epidemiology to combat devastating plague, cholera and smallpox epidemics through mass vaccination and sanitary engineering, and to institutionalise Ayurveda to preserve its epistemological core, while harnessing its unprecedented economic efficiency for rural health care. In Hyderabad, the Nizams were able to preserve ancient Unani traditions through the setting up of modern world-class college institutions, and their Chloroform Commissions during the British Raj funded pioneering biomedical research programs, world-class in their day. In otherwise-British-controlled states such as Jaipur, where the civil surgeon's unquestioned authority on all things clinical also meant the humoral belief system prevailed among ordinary people, a decentralised model of care was followed. Professions and institutions for the codification and professionalisation of indigenous systems of medicine were created through colleges, pharmacopoeias and the vigorous defenses

made on regional and national levels before government commissions. This preserved the ancient systems of medicine from the culturally aggressive influence of colonial biomedicine. Under the Princely States, a subject could be vaccinated against smallpox by a state employed vaccination officer, receive complicated bladder surgery in a modern state of the art facility like the Mayo Hospital or Osmania Hospital and have chronic ailments treated with highly effective locally prepared Ayurvedic or Unani medicines prescribed by well trained physicians in a state subsidised dispensary. The ultimate achievement of the medical system put in place by the Princely States was the multi-system healthcare system of independent India.

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