Women, Mission, and Medicine: Clara Swain, Anna Kugler, and Early Medical Endeavors in Colonial India

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The recovery from disease is the kindliest exhibition of divine power, and the Christian medical missionary occupies a lofty vantage ground in his work.

—Mrs. J. T. Gracey
Women’s Medical Work in Foreign Lands (1881)

From the early days of mission, medical work was recognized as an important means of evangelism. Mythologies circulated about missionary physicians and their work in “heathen lands.” For instance, it was said about a certain Dr. Parker that he “opened the gates of China with a lancet when European cannon could not heave a single bar.”1 By the middle of the nineteenth century, missionary men began speaking more and more about the importance of gaining access to the women in non-Christian societies by means of medical ministry. Missionaries on furlough spoke to home churches of “the great value of medical knowledge” as an “aid in reaching the heathen women in their homes.”2 Gradually, mission-inclined men and women, both British and American, were convinced that to gain access to women in non-Christian societies, it was essential to minister to their bodily ailments as an “entering wedge” for the missionary enterprise. As a result, many British and North American women, especially single women, sought mission sponsorship overseas to “save” their “heathen sisters” from “suffering and disease.”

These images, which were pervasive in nineteenth-century missionary writings, overlooked the existence of indigenous systems of medicine such as Ayurveda and Unani that predated Western medicine and were always available to local communities. Missionaries, however, dwelled constantly on the idea that women living in segregated societies, with limited access to public spaces, were “in need” of “Christian Light” which they sought to impart through educational and medical work.3 It was common in missionary writings to encounter stereotypes of Indian women as “languishing in pain,” waiting for the benefits of Western allopathic medicine. In a society like colonial India in the nineteenth century, missionary women had an advantage over their male brethren and were able to access women of the local communities, to whom male missionaries had no access.4 Thus, after the second half of the nineteenth century, Western missionary women working in colonial India had an array of opportunities for medical work and for managing projects independently. This, in turn, had the significant effect of disrupting the gendered hierarchies in the missionary world by providing women missionaries opportunities for professional growth.5

The first qualified woman missionary physician to be sent for overseas work was Clara Swain, a North American. Swain was assigned to India and arrived in 1870, preceding her first British counterpart, Fanny Butler, by ten years.6 The first missionary women to start dispensing medicines, however, were not professionally trained—some were missionary wives, and others, both British and American, were zenana workers. “Zenana,” an Urdu word, was a widely used generic term to denote spaces in households which were marked off exclusively for women, where they would cook, do domestic work, and spend leisure hours. The practice was prevalent in upper-middle-class families among Hindus and Muslims.

Medical work for women in non-Western societies was initially tentative and experimental in nature. It grew as an offshoot of missionaries’ organizing children’s schools, holding sewing and literacy classes for women, and zenana-visiting,7 and these missionary women relied for their prescriptions on medical handbooks and common sense. Although some missionaries dispensing medicines (as opposed to qualified physicians) made a mark by setting up enduring projects, they faced many obstacles. The daunting cultural issues included gaining access to the zenana women, persuading them to try Western medicines in place of traditional remedies, and wooing them from their secluded homes to visit the dispensary, which was perceived as a public space. Even after professionally qualified female physicians began working in India in the 1870s, medical work in cross-cultural contexts offered many challenges. Inadequate surgical equipment, a support staff of mostly untrained assistants, and the constant drain on resources were problems frequently cited in the reports sent home to mission boards. In addition, the caste

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and class realities of the patients constantly challenged Western notions of hospital care and frequently caused the medical work to begin slowly.8

This article describes some of these early scenarios of gendered medical work and the processes by which many such initiatives expanded from little dispensaries to become hospitals with training classes for assistants, midwives, and medical support staff. Although some of the projects were extremely successful and eventually became full-fledged degree-awarding institutions—notably the medical colleges at Ludhiana (North India) and Vellore (South India)—I am not concerned here with the later process of institutionalization, which I have discussed elsewhere.9 Rather, I highlight some of the early challenges that medical women faced in dealing with the paucity of resources, issues of local culture, and indigenous resistance as they sought to combine their goal of evangelism with professional aspirations in a culture that resisted both Christianity and Western therapeutics.

The first part of this essay focuses on the initiatives of missionary women who were not trained as medical missionaries but who began by dispensing basic medicines, often adding to their training by taking medical courses later in their careers. Subsequently, I turn the spotlight on two of the early North American Protestant female missionary physicians: Clara Swain (1834–1910) and Anna Kugler (1856–1930). Swain, sponsored by the Women’s Foreign Missionary Society of the Methodist Episcopal Church, arrived in 1870 to open work in Bareilly (North India), and Kugler founded the missionary medical work in the Guntur district (South India), where she arrived in 1883. Both started medical missionary work for women in regions where there were no precedents for such work, yet they chose very different paths to do so.

Neither Swain nor Kugler attained the heights of professional recognition achieved later by Ida Scudder of Vellore or Edith Brown of Ludhiana. Yet the project of recovering their work is important not only for issues of gender and the history of mission but also for deepening our understanding of the intersections of gender, mission, and the history of Western medicine in non-Western societies.

The Beginnings: Zenana Medical Work

Medical work for women usually began as auxiliary to zenana outreach, because missionary women found it a useful instrument of access to local women living within gender-segregated structures. The pioneers who began organized medical work in India included some British missionaries, prominent among whom were Rose Greenfield, Elizabeth Bielby, and Sarah Hewlett, who were sponsored by three different British missionary societies. Although none of them was a qualified physician, their initiatives nevertheless flourished, bringing to each of them a degree of prestige. The work of these women reveals some typical patterns and processes that marked such early initiatives.

Rose Greenfield, a Scottish missionary sponsored by the Society for Female Education in the East, arrived in Ludhiana in 1875. She set up the Ludhiana Zenana Mission, supported by other female teachers and evangelists. She began by organizing children’s schools and then moved to offering medical help and “prescribing cleanliness” to the women.10 Greenfield was not professionally qualified, but her medical work grew out of zenana work and eventually reached a professional level. Greenfield’s dispensary began in a rented room in 1881. By 1888 the growth of her work enabled her to negotiate with the Presbyterian mission for the use of their small church as a hospital. By 1889 this work grew to become the Charlotte Hospital.11 In 1891 Dr. Edith Brown became the first qualified physician to take over this initiative. Under Brown’s leadership, it became the Women’s Medical School, Ludhiana (1914), and finally a full-fledged medical center, the Christian Medical College, Ludhiana, which exists to this day.12

Elizabeth Bielby, who arrived from Britain in 1876, had some previous medical training before she began her dispensary, and later hospital, in Lucknow (North India). Her experiences in local society convinced her of the necessity of proper medical education and training. In 1881 she returned to England to study medicine. By 1885 she had obtained the license of the Kings and Queens College of Physicians, Ireland, and an M.D. (a postgraduate degree in medicine) in Berne, Switzerland.13 While in Britain, Bielby had an audience with Queen Victoria, during which she described the “sufferings of Indian women.”14 After having attracted considerable attention at home in England, Bielby returned to work in India, this time to Lahore (now in Pakistan). In 1888 the hospital in Lahore under Bielby’s charge was inaugurated as Lady Aitchison Hospital.

Sarah Hewlett of the Church of England Zenana Missionary Society arrived in India in 1877. She first spent six months in Lucknow with Elizabeth Bielby, learning the local language before she began work in Amritsar (Punjab, North India). Equipped with some previous experience in nursing and midwifery, she took charge of the Amritsar Dais School, a modest institution set up in 1866 by the colonial civil surgeon Dr. Aitchison to train local dais (midwives).15 Hewlett subsequently began a class to train girls to serve as medical assistants in hospitals. With her active medical and surgical work over the years, she acquired some repute in the surrounding community.

Early Women Physicians

Clara Swain. In 1869 Clara Swain arrived in India.16 Born the youngest of ten children in Elmira, New York, Swain, like many educated girls from middle-class American families in late nineteenth-century America, began her professional life as a schoolteacher, first in Castile, New York, and later at Canandigua, also in New York. Subsequently changing gears, she began training at the Castle Sanitarium. Following a three-year program there, she entered Woman’s Medical College, Philadelphia, from which she graduated in the spring of 1869.17 In 1868 Swain was one of the first two female candidates to be sponsored for overseas missionary work by the newly founded Woman’s Foreign Missionary Society of the Methodist Episcopal Church; the other was Isabella Thoburn, founder of the Isabella Thoburn College, Lucknow. They sailed from New York on November 3, 1869, reaching India on January 20, 1870.
When a Mrs. Thomas, a missionary wife in the Bareilly region, lobbied her home church to support a woman physician to attend to the welfare of the native Christians in Bareilly (then about thirty families), her main argument was that a “lady physician” would be an effective way to open doors to the upper class families and zenanas of Bareilly, which were otherwise closed to them. Issues of class and access were thus central from the outset. Missionary women were always conscious that for their work to gain credibility, it was important to attract women patients from upper caste and upper class families who were wealthy and enjoyed status and social prestige among the local community.

Swain settled in Bareilly, taking over a medical work already present in embryonic form, begun by a missionary wife who had initiated “a small class of native Christian women” for a “limited course of instruction in medicine.”¹⁸ Like most early women physicians, Swain realized that training local women to join medical work, at least as assistants and perhaps later as qualified professionals, was key to the success of the medical projects. Using a student from her class as an assistant, Swain thus began efforts to train local women in rudimentary medicine. Her first class was modest, consisting of sixteen girls from the missionary orphanage and three disabled women. They were taught anatomy, physiology, and some rudimentary medicine, but their level of professional training reached only a basic certificate level of practice. It took another two decades before formalized medical classes were begun by Edith Brown, the British missionary physician, in Ludhiana (Punjab) in the 1890s. Brown’s initiative finally led to the founding of the Ludhiana Medical College for Women in North India.

The little dispensary Swain started in 1870 grew, and within a couple of years a local princely ruler, the Nawab of Rampur, donated a portion of his estate adjoining the mission property in Bareilly for establishing a hospital for women. This generosity was not unusual, for many of the local princely families in this region were early supporters of mission-sponsored initiatives for female education or medical work for women. Swain moved into the new premises on January 1, 1872. A dispensary building was completed in May 1873, and the first in-house patients were admitted in January 1874.¹⁹ In March 1876 Swain went to the United States on furlough, returning to India on November 6, 1879.²⁰

In March 1885 Swain treated the rani (i.e., wife) of the raja of Khetri, also a local princely ruler in that region. After two weeks of “successful treatment,” Swain was offered the job of being her personal physician. This offer was not unusual, although female missionary physicians usually continued to treat their elite patients alongside their community outreach work. Swain, however, as mission sources narrate, after “much thought and prayer” consented to give up her work in Bareilly and to remain in Khetri to do for the Lord “what she could . . . in this place where there were no Christian influences.” She obtained permission to take her companion Miss P. E. Pannell with her so as to “carry on the work as Christians should.”²¹ In March 1888 Swain took another furlough to America, traveling with Pannell.
Swain’s decision to serve the royal family clearly limited her future career opportunities. She continued to hold Bible classes alongside performing her duties to the family. Her letters reveal that she enjoyed being a close associate of the royal family and that she lived in considerable luxury as compared with other missionaries, who lived either in mission compounds or in simply constructed mission bungalows located close to the rural communities they served. When in October 1895 Swain’s assignment with the royal family came to an end, she sailed from India to retire in the United States.

Several years later, in 1906, Swain revisited India to attend the jubilee celebrations of the Methodist Mission in India (founded in 1856). In April 1908 she returned to the United States, retiring to the sanitarium in Castile, New York. Her health deteriorated gradually, and she died on December 28, 1910. Through the initiative of a friend, the many letters that Swain had written over the years were collected, compiled, and published as *A Glimpse of India* (1909).

Anna Kugler. Born in 1856 in Ardmore, Pennsylvania, Anna Kugler was the daughter of Charles and Harriet Sheaff Kugler. Described in her biographies as “serious-minded” and “sensitive to impressions,” the young Anna was educated at a private school in Bryn Mawr and at Friends’ School in Philadelphia. After graduating from the Woman’s Medical College, Philadelphia, she worked as an assistant physician at the state asylum at Norristown.

In 1882 Dr. Kugler applied to the Board of Foreign Missions of the General Synod of the Lutheran Church in America (later a part of the United Lutheran Church) for sponsorship to do medical work for women in India. Although Clara Swain had preceded her by over a decade, the board officially replied that the organization was “not yet ready to undertake work of this kind”—but she could do “general work.” Although women’s foreign missionary societies began gaining ground within home churches in many denominations in the 1870s, the board’s resistant attitude toward Kugler illustrates the unevenness that marked the policies and attitudes prevailing among the foreign missionary societies in North America at the time. Kugler, however, agreed to be sponsored as a “general” missionary and sailed from Philadelphia in the company of seven other missionaries. They arrived in India in November 1883.

When Kugler arrived in Guntur, Andhra Pradesh (South India), there was no precedent for Western-style medical work among women in that region. She performed her medical work in addition to her more general missionary duties, but when her stock of medicines was depleted, the work had to be discontinued until her fellow missionaries raised $350 to start a hospital. Finally in 1885 Kugler was officially appointed for medical work and there were sufficient funds to rent a house to function as a dispensary. In 1887 two dispensaries were opened at Mangalgiri and Guntur. It took fifteen years, though, for Kugler’s project to become a full-fledged hospital with a children’s ward, maternity block, chapel, and nurses’ home.
During the early years Kugler, like other Western women physicians, was confronted with cultural issues. For instance, Western-style instructions about administering medicine, which assumed literacy among the patients, were mostly ineffective. In addition, the use of a spoon was not common among the local people. Simple directions and ingenious solutions were thus needed to indicate medicine dosage. Strips of paper were pasted on the side of the medicine bottles, with notches or marks on the paper to indicate the amount of each dose. Issues of caste and race, also, impeded medical work at every step, although Muslim and lower-caste Hindus were easier to access than high-caste Hindus. Despite her medical knowledge and success, the white woman physician was widely viewed as the cultural other, without caste and therefore unclean, even for the most basic physical contact. This was a prejudice based on race and religion rather than gender. Male missionaries confronted similar issues in Hindu and Muslim society. As Kugler discovered, even when local women were persuaded to try her medicine, many “would not accept a dose of medicine from her outcaste hand and had to receive it from the hand of a relative.” Liquid medicine (with an alcoholic content) was less acceptable than medicine in powder form. Such conservative Hindu interpretations of “purity” and “pollution” were irksome, even humiliating, for the missionary women, as Kugler recounted: “It was not pleasant to be constantly reminded as one entered high-caste Hindu homes, that one was an unclean object, defiling everything one touched. It was not pleasant to have all the bedclothes put to one side while one examined the patient or to have a very ill patient taken out of bed and brought into the courtyard because the doctor was too unclean to go inside…Neither did one enjoy stooping down and picking up the medicine bottle because one was too unclean to touch it directly from the hand of the Brahman. But it was all in the way of opening up the path for those who came later.”

During 1889–91 Kugler went to the United States on furlough to study hospital-building and equipment. On her return a large plot of land was purchased in Guntur, where a new hospital building, which became functional in 1897. A regular dispensary and hospital evolved out of these beginnings when Dr. Mary Baer took over the work at Chirala. It involved waking up at 2:00 A.M. to take two different trains from Guntur to Chirala in order to reach patients by 7:30 A.M. A regular dispensary and hospital evolved out of these beginnings when Dr. Mary Baer took over the work at Chirala. A nurses’ training program was another important feature of the missionary medical work at Guntur.

Anna Kugler lived in India for forty-seven years. The hospital she founded was celebrated in mission sources as “a beautiful and lasting monument of our Church.” Widely known in the Guntur region, she was highly regarded by colonial officials and sections of the local community. She was twice awarded the Kaiser-i-Hind Medal (an award of distinction bestowed by the British colonial state)—in 1905, and again in 1917. A few days before her death Kugler reportedly said to Dr. Ida Scudder, her colleague and close associate, “I would like to get well and work longer, for I would like to feel I had served India for fifty years, and I have served only forty-seven.” Upon Kugler’s death in 1930, Scudder remembered her as one of “those noble pioneering women who made it easy for us who follow in their trail”; she remarked that “a star of great magnitude has fallen from the galaxy in our medical missionary firmament.”

Dealing with Caste, Class, and Culture

Women physicians like Swain and Kugler, who initiated medical work in a particular region, had no precedents and little previous experience. They had to treat all manner of medical needs, from snakebites and broken bones to childbirth and basic surgery. Their resources were meager, and local conditions challenged them on multiple levels. Learning local languages and attempting to understand local mores, they plodded patiently onward, even as indigenous resistance to Western therapeutics and to themselves as white women persisted in upper-caste Hindu communities. Caste sensitivities operated at several levels: first, in the personal contacts with patients, then within the dispensaries, where ailments were treated and medicines dispensed. When medical work expanded to become a hospital or an institutionalized training center, the logistics became even more complex. Missionaries attempted to avoid caste-related controversies by hiring upper-caste hospital cooks and men to draw water from the well. They also encouraged patients to live and eat together. Christians readily agreed, but Hindu patients were more reluctant, not wanting to defile caste purity. They preferred to be accompanied by a family member who would use their own brass cooking utensils to prepare food for them at the hospital.

Despite the difficulties in treating the upper castes, the missionary physicians were conscious of the need to garner local support and were eager to develop connections with women of the zenanas, especially from the princely families, who often became their donors and supporters. Besides Swain, Kugler also was supported by such local patrons.

Early female medical professionals were inevitably drawn into administrative and organizational roles. Rose Greenfield, Swain, and Kugler worked on the expansion, architectural design, and planning of their hospitals. They all were sensitive to the specific cultural and climatic requirements for a hospital in a South Asian context. Innovative in the planning and organization of their hospitals, they ingeniously adapted local materials and resources for their purposes.

Conclusion

Early women physicians in India chose to modify Western medical practices in order to attract clientele. Over time, they realized that attracting women to Western therapeutics was easier than expecting them to submit to a Western-style hospital, with its imported social and cultural ethos of a highly regulated space. Their strategies to attract patients, dispel local resistance, and conform to local preferences reflected missionary anxieties about how issues of religion and culture needed to be surmounted before their hospitals and dispensaries could become successful.

An important theme that emerges from such a study is that
the histories of these early medical projects reveal a reverse process of acculturation through which female physicians were influenced by their local experiences across race and culture. Their adaptations, born of either cultural compulsions or social pragmatism, paved the way for mission schools and hospitals that had a South Asian flavor. Although they were run by missionary societies and although Western missionary women were visible on the faculties even until the 1960s, their functioning reflected the adaptations missionaries had to make in a non-Christian culture. Many of these early medical ventures still exist today. Clara Swain Hospital, a moderately sized institution in Bareilly, still trains medical assistants and midwives, and the work at Ludhiana, after the 1930s, grew to acquire prestige as a premier national medical institution.

In general, missionary schools and hospitals in modern South Asia grew unevenly. They faced major challenges after the end of British colonial rule in 1947 and subsequently, when the governments of both India and Pakistan began to restrict the access of foreigners for missionary work around the 1960s. The work of the early female physicians and teachers, however, created precedents for subsequent generations of women, both missionary and lay, which they could then adapt to the changing times. Even in the 1970s and 1980s, missionary hospitals and nursing homes, particularly for gynecological and obstetric care, continued to enjoy favor among middle- and upper-class Indians, most of whom associated them with good nursing, competent medical care, and good hygiene. As large numbers of secular medical institutions, both state-sponsored and privately owned, with advanced technology and equipment began to emerge after the 1970s, missionary institutions have been challenged to match new standards.

Understanding these earlier histories enhances our understanding of the ways in which the early female physicians negotiated mission patriarchies and the colonial bureaucracy to carve out spaces for professional work. Their stories enable us to map out how gender and medicine intersected with race and religion in early cross-cultural medical initiatives for Indian women. At another level, they also reveal that, however sporadic or uneven the success of these early female physicians, they did manage to found the first hospitals exclusively devoted to women’s health care. Thus they created models and precedents for other such ventures in the decades to follow.

Notes

5. This was starkly so in the case of single women missionaries who were qualified physicians or educators. See Singh, Gender, chap. 6.
8. I have briefly touched upon some of these issues elsewhere (Singh, Gender, pp. 62–67). Here I focus exclusively on detailed analysis of the early missionary work, which targeted Indian women and had a specifically medical focus.
13. The Kings and Queens College of Physicians, Ireland, was the first licensing board in the British Isles to open its doors to women.
15. Ibid., pp. 13, 200.
16. For biographical information on Clara Swain, see Mrs. Robert Hoskins, Clara A. Swain, M.D., First Medical Missionary to the Women of the Orient (Boston: Woman’s Foreign Missionary Society, Methodist Episcopal Church, 1912); Clara Swain, A Glimpse of India: Extracts from Letters of Clara Swain (New York: James Pott, 1909); Dorothy Clarke Wilson, Palace of Healing (New York: McGraw-Hill, 1968).
17. In a puzzling admission, her biographer claims that “we have no special record of Dr. Swain’s years of study in Woman’s Medical College” (Hoskins, Clara A. Swain, p. 12).
19. This dispensary grew to become the first hospital exclusively for women in India, subsequently named after Swain.
22. Swain lived with Dr. Mary T. Greene, the niece of Dr. Cordelia Greene, who had established the sanitarium. The two women remained deeply involved with the institution.
23. This society had been conducting mission work in Guntur since 1842. See Paul E. Kretzmann, Glimpses of the Lives of Great Missionary Women (St. Louis, Mo.: Concordia Publishing House, 1930), p. 78.
24. In the first four years 8,000 operations were performed and over 1,500 babies were delivered in the hospital (ibid., p. 82). For a detailed account of Kugler’s work, see Anna S. Kugler, Guntur Mission Hospital, Guntur, India (n.p.: United Lutheran Church in America, Women’s Missionary Society, 1928).
26. When the hospital actually opened, Kugler was away in America because of ill health. The first in-patients were accepted by Dr. Mary Baer and Katharine Fahn, who founded the nurses’ training program at Guntur. Kugler took over the work in October 1899. See Kugler, Guntur Mission Hospital, pp. 49, 135.
28. Dr. Lydia Woerner, in ibid., foreword.
29. The ceremonies were hosted by the governor of Madras Presidency in full colonial pomp. Poor health prevented Kugler from being present at the ceremony in 1917.
30. Ida Scudder, handwritten speech (n.d.), Box 3, Scudder Papers, Schlesinger Library, Radcliffe College, Cambridge, Mass. The following comments by Scudder about Kugler are from the same source.
31. Bhuyanga Rao Bahadur of Ellore (now Eluru), a local raja, became a supporter of Kugler’s work after she successfully treated the rani (i.e., wife of the raja) and “saved the life of his son and heir.” At Kugler’s request he funded the construction of a rest house near the mission hospital where the Hindu families could stay while their patients were in the hospital. It is believed that the youngest child of the raja was named Annamma, after Anna Kugler. See Kretzmann, Glimpses, p. 85. Clara Swain’s association with the rani of Khetri was similarly beneficial.