CHAPTER 2

Embodiment and Biomedical Authority in South Asia: Reading Objectification and Subversion in the Colonial Clinic[1]

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Abstract

This chapter examines the representation and construction of the bodies of colonial patients and their experience of embodiment. The institutional regulation of racially "othered" bodies of colonial patients required the foregrounding and reification of their ethnic practices in both military and zenana hospitals, often at the expense of providing better medical treatment. Indian soldiers' embodied experience during the First World War is revealed both in their aversion to return to the horrors of trench warfare after hospitalization and from inquiries regarding malingering. However, colonial patients asserted themselves through embodied actions of non-compliance that checked medical authority and transformed colonial institutions.

Keywords: embodiment; biomedicine; colonial India; colonial clinic; military hospital; zenana hospital

Introduction

Colonial medicine has been perceived as both a concrete benefit for the colonized and the means of "colonizing the body". Colonial historians have conceived colonial public health as "the knowledge and regulation of the other", while casting hospitals as sites of colonial hegemony over South Asian elites.[2] Indian historians examining the impact of biomedical therapeutics on the body of the colonized have focused on colonial or nationalist elites laying claims to mediating this new form of

[1] I want to thank the organizers and participants at the "Bodies Beyond Binaries" Conference, Zürich, and Dr Manu Sehgal for contributing to the development of my ideas.

[2] Gyan Prakash, *Another Reason: Science and the Imagination of Modern India* (Princeton: Princeton University Press, 1999), p. 132; David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India* (Berkeley: University of California Press, 1993).

biomedical knowledge and biopower over the South Asian population.[3] However, to fully understand how colonial medical modernity differed from its operation in Europe, it is important to examine embodiment in medical interactions. Foucault's enormously influential account of *The Birth of the Clinic* analyzing the shifts in the interrelationship between the body of the patient, the doctor and the space in which the patient is examined has not been utilized to explore medical institutions and interactions in South Asia.[4] This chapter addresses the crucial transition whereby mediation of biomedical knowledge and power shifted control from patients to professionals—a process referred to as medicalization and medical dominance.[5] Interpreting this from a body studies perspective is especially important given that the interaction of science with culture is central to both medicalization and colonialism. How the medical gaze operated on South Asian bodies under colonialism has not been historically imagined.[6] The history of embodiment thus does not examine how biomedical authority over the colonized body was established or circumvented in South Asia. This chapter subjects colonial medical authority to three embodiment analytical frameworks—Michel Foucault's theorization of the objectification of bodies within the clinic; Maurice Merleau-Ponty's conception of motor-intentionality to ponder patient choices in seeking or leaving biomedical therapy; and analysis of embodied interactions between doctors and patients through conceptions of intercorporeality (Merleau-Ponty), habitus and practice (Pierre Bourdieu). By throwing light on the way medical institutions and discourses treated colonized bodies, this chapter thus furthers understanding of how modern state disciplinary regimes emerged from the representation of the body by positivistic medical science under colonialism.

[3] Prakash, *Another Reason,* pp. 143–158.

[4] Michel Foucault, *Birth of the Clinic: An Archaeology of Medical Perception* (London: Routledge, 2003), trans. A.M. Sheridan. Influential surveys of the colonial clinic in South Asia do not address embodiment. Mark Harrison, Margaret Jones, Helen Sweet (eds.), *From Western Medicine to Global Medicine: the Hospital Beyond the West* (New Delhi: Orient BlackSwan, 2009); Mridula Ramanna, *Western Medicine and Public Health in Colonial Bombay, 1845–1895* (Hyderabad: Orient Longman, 2002).

[5] Peter Conrad and Joseph Schneider, *Deviance and Medicalization: From Badness to Sickness* (Philadelphia: Temple University Press, 1992); Peter Conrad, *The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders* (Baltimore: Johns Hopkins University Press, 2007). The classic account of medical dominance was provided by Eliot Freidson, *Profession of Medicine: A Study of the Sociology of Applied Knowledge* (Chicago: University of Chicago Press, 1970). For a more recent assessment, see M.A. Elston, "The Politics of Professional Power", in J. Gabe, M. Calnan and M. Bury (eds.), *The Sociology of the Health Service* (London: Routledge, 1991), pp. 58–98.

[6] Prakash elaborates how "bodies" of South Asian medical knowledge transformed the relationship between South Asian medical practitioners and South Asian patients, *Another Reason,* p. 143–150 . Projit Mukharji takes a similar approach but eschews questions of professionalization or embodiment, *Nationalizing the Body: The Medical Market, Print and Daktari Medicine* (London: Anthem, 2009).

The first section examines how customary, spatial and institutional controls deployed in colonial hospitals objectified and reified South Asian patients' bodies. Foucauldian perspectives on the patrolling of the body by institutional authorities will be examined here through the discourses surveilling the bodies of female patients entering colonial women's hospitals and by regulating patients' diet in military hospitals through rules that were concerned with dispositions, maneuvers, tactics and techniques linking ethnicity, diet, medical treatment and colonial military service. This section outlines how the medical objectification of the patient's body in hospitals was reconciled with the social regulation of bodies to produce gendered and racial difference. It shows how colonial hospitals became part of the external environment created by colonialism that sought to place constraints on individual action.

Patients' embodied responses to this colonial site where their bodies were regulated medically and socially, are explored in the second section. Phenomenological analysis of the body of colonized patients as a "lived body" is used here to probe why the medical model failed to establish its authority in colonial South Asia despite its success in establishing itself as a sign of modernity. By drawing upon Merleau-Ponty's phenomenology, which insists that only embodied subjects act in the world, it is possible to explore the intentionality of patients through their embodied actions. Analysis of embodied interactions between surgeons and South Asian patients shows the extent to which the practice of biomedicine was transformed by surgeons' attempts to enter an intercorporeal space shaped by South Asian patients' habitus, setting limits to medical dominance.

Objectification in the Colonial Clinic: Regulating Bodies by Institutionalizing Ethnicity

In addition to facilitating the medical gaze through the social regulation of bodies, colonial hospitals were also meant to regulate racially "othered" bodies. After briefly examining the objectification of South Asian patients' bodies by subjecting them to the medical gaze, this section will pivot to those aspects of the colonial "clinic" that made it colonial—the insertion of ethnic practices in institutional rules governing the bodies of both women patients and male soldiers. It will explore how British women doctors' discourses about South Asian women patients regulated their bodies' movements, social interaction and sexuality through the improvised institutionalization of sex-segregation practices in the colonial clinic. It will then analyze how the regulation of sepoy patients within the institutional space of the hospital focused on formulating rules that would address the ethnic and religious customs of patients.

According to Foucault, the medical gaze is necessarily objectifying because it functions by distilling the disease from a visual examination of the patient's body,

to a focus on biophysical symptoms revealed by medical and laboratorial examinations while discounting the patient's testimony as subjective.[7] To demonstrate how the medical gaze penetrated South Asian female patients' bodies, we will consider here a case report about a patient suffering from hypertrophy of both breasts in the *Journal of the Association of Medical Women.*[8] The case history was dominated by a description of symptoms, of the physical examination by the doctor and the measurements of the enlarged breasts. Even though the doctor was unable to diagnose the patient, the case history dismissed the patient's own explanation of the swelling being due to the application of leeches in a move that discounted phenomenological evidence while relying on evidence collected by the doctor and understood through the abstraction of scientific rationality.[9] The account provided assessments of the patient's digestive, respiratory and circulatory systems in accordance with the medical model of the body, which conceptualizes the body as a machine and assumes that illness can be explained in terms of determinate causes operating on the body. Under this model, the body of the patient is an object of scientific inquiry and intervention, with medical professionals treating the body as an ensemble of specialized parts requiring separate specialized interventions. The medical gaze required localized pathological symptoms for specific body parts while disregarding the embodied experience of patients. Thus, diagnosis itself becomes an act of objectification underpinning the doctor-patient power dynamic. The objectification of the patient Ramdessi (described as a "Hindu female") was evident from the dismissal of her phenomenological account of the illness to a minor paragraph marked "previous history" and the illustration of the case by a photograph exposing the patients' swollen breasts to all readers of the *Journal of the Association of Medical Women in India.* What makes the case significant is that the visual illustration of her case disregarded any ethnic rules regarding veiling followed by the patient as well as her privacy and consent. The decision to publish Ramdessi's photograph was at variance with the fact that practices of veiling were a major preoccupation of the *Journal*, which adumbrated on institutionalizing rules of veiling in colonial women's hospitals. Paradoxically, British women doctors were concerned with both opening South Asian women's bodies to an optical hexis *and* with veiling them from the gaze of men prohibited by ethnic customs from beholding them. Indeed, discourses and disciplinary regimes advocated for

[7] Foucault, *Birth of the Clinic.*

[8] Letter to Editor from A.N. De Souza, Medical Officer, Municipal Female Hospital, Amritsar, Punjab, *Journal of the Association of Medical Women in India* [henceforth *JAMWI]*, vol. 1, no. 8, Nov. 1909, pp. 34–5.

[9] Science has been criticized for "restricting experience to zero", Claude Alvares, "Science, Colonialism and Violence: A Luddite view", in Ashis Nandy (ed.), *Science, Hegemony and Violence: A Requiem for Modernity* (Oxford University Press, 1988).

colonial women's hospitals were concerned overwhelmingly in the early twentieth century with the exercise of ethnic practices of sex-segregation on the bodies of women patients.[10]

British women doctors vociferously demanded the institutionalizing of customary regulation of South Asian women's bodies through patriarchal sex-segregation that imposed spatial controls in zenana hospitals. Devices meant to ensure that women patients' bodies were not visible to those outside the hospital were repeatedly canvassed. Reports from the Dufferin Fund (National Association for Supplying Female Medical Aid to the Women of India) commended the "purdah wall"—a high wall surrounding hospitals meant to obscure women patients' bodies from view, while British women doctors advocated installing "chiks" or curtain made of bamboo pairings over windows and doors.[11] Contemporary observations included descriptions of how women entered the hospital without exposing them to view and violating purdah practices.[12] Concern about patients being "ill from long confinement indoors", also led British women doctors to argue that open spaces ought to be provided in women's hospitals to enable South Asian women to "come out and sit about unobserved by men" as an "important element in their treatment".[13] By regulating how female bodies inhabited the space of the hospital, these practices shaped the embodied experience of colonized women.[14] The constitution of the female gender in South Asia was facilitated by the circumscription of female bodies in the space of the hospital in order to preserve the parameters, physical and moral, of the group.[15]

[10] Sehrawat, *Colonial Medical Care,* pp. 109–112.

[11] "Appendix 12: Reports from Native States: Kotah", *Dufferin Fund Report [DFR] 1890*, p. 285; "Appendix 13: Reports from Branches: Patiala", *DFR 1895*, p. 443; "Reports of Branches and Native States: Hanam Konda", *DFR 1907*, p. 265; *DFR 1911,* p. 6. "Report by a Member of the Association on a 'Dufferin Ward' marked as Dispensary on the Map", *JAMWI,* Nov. 1908, p. 20; "Letter to the Editor by Common Sense", *JAMWI,* Nov. 1910, vol. 1 no. 12, p. 31.

[12] Saleni Armstrong-Hopkins, *Within the Purdah, Also in the Zenana Homes of Indian Princes and Heroes and Heroines of Zion: Being the Personal Observations of a Medical Missionary in India* (New York: Eaton and Mains, 1898), p. 32.

[13] Kate Vaughan, "Dufferin Fund", *JAMWI,* Aug. 1910, vol. 1, no. 11, p. 9. Maneesha Lal, "Purdah as Pathology: Gender and the Circulation of Medical Knowledge in Late Colonial India", in Sarah Hodges (ed.), *Reproductive Health in India: History, Politics, Controversies* (New Delhi: Orient Longman, 2006), pp. 85–114.

[14] For literature on embodiment, space and gender, see Seemanthini Niranjana, "Femininity, Space and the Female Body: An Anthropological Perspective", in Meenakshi Thapan (ed.), *Embodiment: Essays on Gender and Identity* (Oxford: Oxford University Press, 1997), pp. 107–24.

[15] Niranjana, "Femininity, Space and the Female Body", pp. 112–16, 118; Meenakshi Thapan, "Introduction: Gender and Embodiment in Everyday Life", in Thapan (ed.), *Embodiment*, p. 6.

British women doctors regulated South Asian women's bodies in hospitals to ensure adherence to codes of morality that veiling practices represented. Considerable stress was given by members of the AMWI to closing men's access to spaces occupied by women patients in zenana hospitals in the interests of morality. One critic argued that "no decent woman" would seek treatment in a hospital that is not "entirely separated from one for men".[16] An authoritative survey of women's medical care in India emphasized the dangers of ignoring the "moral question in Indian hospitals" and warned that scandalous sexual attacks on the bodies of female patients and staff were likely without appropriate supervision and inspection by British women doctors.[17] British women doctors argued that by imposing strict sex-segregation within the hospital, they were making these spaces safe for women patients and staff, protecting them from a society that believed that "young women who take up independent work, or a woman who goes alone to a mixed hospital, is looked upon as of doubtful morality".[18] Women entering public spaces were considered as opening themselves to a wide range of verbal and physical harassment for transgressing social rules about gendered bodily comportment and the established spatial boundaries for women's bodies. The zenana hospital was thus fashioned into an institutional space shaped by the visible and invisible boundaries created by social structures to regulate women's sexualities. While as a public space, the colonial hospital was required to be potentially open to all, discourses about the zenana patient sought to transform it into a public *interior* space. The zenana hospital's ability to accommodate the "public" was limited by the requirement that it accommodate the social regulation of women's bodies through colonial conceptions of sex-segregation in South Asia by making it "more private".[19] Colonial women's hospital rules turned South Asian women's bodies into sites of patriarchal control by regulating their visibility, their spatial access and social interaction within the hospital.

Recent research revisiting links in Foucault's work on the relationship between medicine and surveillance[20] suggests that it would be productive to explore how British women doctors transposed the power dynamics created by the medical gaze to the social surveillance of female bodies in the hospital. While the medical gaze

[16] "Report by a Member of the Association on a 'Dufferin Ward' marked as Dispensary on the Map", *JAMWI,* Nov. 1908, p. 22.

[17] Margaret Balfour and Ruth Young, *The Work of Medical Women in India* (Bombay: Humphrey Milford, 1929), p. 166.

[18] Balfour and Young, *Work of Medical Women*, p. 166.

[19] *DFR 1895,* p. 443. For comparison, see similar efforts to transform public parks into enclosed sex-segregated spaces for the regulation of female bodies in contemporary Iran, Reza Arjmand, *Public Urban Space, Gender and Segregation: Women-only Urban Parks in Iran* (London: Routledge, 2017).

[20] Thomas Osborne, "Medicine and Epistemology: Michel Foucault's Archaeology of Clinical Reason", *History of the Human Sciences,* vol. 5, no. 2, (1992), pp. 63–93.

allowed doctors to identify the location of disease in the patient's body while disregarding the patients' subjectivity, British women doctors were also implying that they had the power to determine which behavior was immoral, thereby rendering the subjectivity of patients insignificant to determining their bodies' visibility within the hospital. While, by wielding the medical gaze, doctors were elevated to the status of specialist and their patients objectified, British women doctors' exercise of authority over sex-segregation rules in the hospital conferred on them the authority to act as specialists on sex-segregation and ethnic practices affecting South Asian women.[21]

The regulation of the body in colonial medical institutions exercised social control on the micro level by also regulating the eating habits of Indian soldiers in military hospitals. Colonial military medical policy showed a sustained preoccupation between the 1860s and 1920s with regulating the cooking and distribution of hospital food in line with ethnic practices of Indian soldiers. How to provide a hospital diet to invalid soldiers without violating the ethnic commensality taboos and dietary proscriptions[22] in military hospitals for Indian soldiers was at the heart of lengthy deliberations that eschewed questions of the quality of health care provision.[23] The hiring of special cooks called "langris" or brahmins to cook hospital food was a central concern for the Lukis Committee formed to consider the improvement of Indian army hospitals.[24] When Indian soldiers were deployed on the Western Front during the First World War, the Kitchener Indian Hospital set up a "standing" caste committee of convalescent Indian officers "to ensure the observance of all caste regulations, especially in the cooking and distribution of food" and to advise hospital authorities "on any doubtful point that might arise". As a result, food cooked for soldiers in hospital kitchens was divided into three parts: for Muslims, meat-eating Hindus and "other Hindus".[25] Colonial military

[21] For the racial and gender politics of this move, see Samiksha Sehrawat, "Feminising Empire: The Association of Medical Women in India and the Campaign to Found a Women's Medical Service", *Social Scientist,* vol. 41, pp. 65–81.

[22] Commensality taboos reflect status relations between different ethnic groups through rules regarding sharing food. Members of an ethnic group would not like their food to be touched by or shared with men from ethnic groups who were believed to be inferior to them in status.

[23] For details of decisions in the 1880s and '90s that claimed that Indian troops preferred the rudimentary regimental hospitals while seeking to reduce military expenditure on Indian soldiers' medical care, see Samiksha Sehrawat, '"Prejudices Clung to by the Natives': Ethnicity in the Indian Army and Hospitals for Sepoys, *c.*1870s–90s", in Biswamoy Pati and Mark Harrison (eds.), *Social History of Health and Medicine in Colonial India* (Abingdon; New York: Routledge, 2009), pp. 151–72.

[24] *Report of the Committee appointed to Consider the Introduction of Station Hospitals for Indian Troops in Place of Regimental Hospitals* (Simla: Government Central British Press, 1910), p. 2.

[25] "A Report on the Kitchener Indian Hospital Brighton", Military Department Library, India Office Records, L/MIL/17/5/2016, British Library, London (henceforth, BL), pp. 9, 12.

officers' claims that this was to accommodate the "prejudices clung to by natives"[26] need to take into account external power relations linked with British imperial security concerns. Indian soldiers were employed for their cheap military labor through patterns of military service that foregrounded their martial ethnicity to ensure their loyalty to British colonial rule.[27] Thus, both the desire to reduce expenditure on medical care and the strong link between military recruitment of Indian soldiers and "martial race" ethnicity influenced decisions to continue with poorly equipped regimental hospitals despite evidence that Indian soldiers were willing to be flexible about their ethnic practices.[28]

The regulation of patients' bodies in colonial hospitals reaffirmed colonial discourses that asserted the primacy of ethnicity in South Asian society. Such essentializing discourses were privileged over concerns about the health of the colonized population despite claims of imperial benevolence and the "white man's burden" that centered on medical care. However, it is important not to see this objectification as totalizing, as traces of its subversion by colonial patients' embodied intentionality exist in the historical record.

For instance, evidence suggests that some South Asian women evaded the extension of patriarchal surveillance of their bodies in the colonial clinic and used access to hospitals in ways that empowered them. Saleni Hopkins-Armstrong, a doctor employed in a Dufferin Fund hospital in Hyderabad, Sind, related an account of the daughter of a revered *peer* (holy man), who evaded the strict seclusion imposed on her. Not only did she carry out a romantic intrigue with a young man against the wishes of her father, the woman also went to considerable lengths to ensure that she was allowed to leave the prison-like sex-segregation of her home to visit the hospital. She feigned severe symptoms to ensure that she was allowed a lengthy visit with the doctor.[29] By deliberately flouting hospital rules and regimes, this woman (unnamed in the account) also undermined the objectification

[26] Letter from AGI to Military Secretary, GoI, 4 May 1877, Prog. no. 607, Military Department Proceedings, Government of India, May–June 1880, IOR/P/1529, BL.

[27] For insightful analyses of the links between martial ethnicity, masculinity and the Indian army, see Mary Des Chene, "Relics of Empire: a Cultural History of the Gurkhas 1815–1987", Unpublished Ph.D. Thesis, Stanford University, 1991; Cynthia Enloe, *Ethnic Soldiers: State Security in Divided Societies* (Harmondsworth: Penguin, 1980); Dirk Kolff, *Naukar, Rajput, and Sepoy: the Ethnohistory of the Military Labour Market in Hindustan, 1450–1850* (Cambridge: CUP, 1990); and Lionel Caplan, '"Bravest of the Brave': Representations of "the Gurkha" in British Military Writings", *Modern Asian Studies*, vol. 25, no. 3, Jul. 1991, pp. 571–97.

[28] The decision to finally introduce central station hospitals equipped with more advanced diagnostic and treatment facilities followed medical breakdowns during the First World War exposing the abysmal medical care provided to Indian soldiers. Samiksha Sehrawat, *Colonial Medical Care in North India: Gender, State, and Society, c. 1830–1920* (New Delhi: Oxford University Press, 2013), pp. 193–241.

[29] Armstrong-Hopkins, *Within the Purdah,* pp. 157–71.

of patients' bodies in colonial hospitals. Her determined efforts to enter the hospital were intentional and agential. Rather than abiding by rules objectifying her body, this woman was in the hospital not to be subjected to the medical gaze, but to assert her personal feelings, autonomy, and unique identity, forcing a recognition of her as a living, subjective individual.

To go beyond the objectifying effect of the medical gaze and related ambitions of social surveillance of colonial patients through the colonial clinic, the next section uses Merleau-Ponty's theorization of motor-intentionality and intercorporeality to explore how patients' embodied actions impacted medical institutions. Utilizing Bourdieu's conceptualization of habitus and practice it explores embodied interactions to interrogate the doctor-patient dynamic beyond its textual representation.

Patient Embodiment as Leaving, Arriving and Interacting: Repurposing the Colonial Clinic

Merleau-Ponty's appreciation of agency as existentially acting in the world is a very useful concept for investigating the agency of colonized patients phenomenologically. By conceiving an intentionality that emanates from bodily existence, he allows us to explore patient embodiment as a "sentient tropism, a tending toward the world".[30] The distinction here is between interpreting agency as the intentionality of action, which privileges the mind as producing judgments that lead us to act in particular ways, and between an operative intentionality which is "apparent in our desires, our evaluation and in the landscape we see, more clearly than in objective knowledge".[31] Merleau-Ponty's conception of the "intentional arc" foregrounds motor agency as being inherently linked with desire, cognition, and perception.[32] Thus, the movement of patients into or out of hospitals reveals a sense of intentionality characterized by their bodily relation to the world rather than through articulation of mentalized intent. Methodologically this opens up new possibilities because it allows us to use colonial sources more effectively, for, despite their elision of the intentions of South Asian patients, these sources document patients' embodied actions. Examining the intentional arc of South Asian patients'

[30] Thomas Csordas, "Embodiment: Agency, Sexual Difference, and Illness", in Frances E. Mascia-Lees (ed.), *A Companion to the Anthropology of the Body and Embodiment* (Blackwell, 2011), p. 139.

[31] Maurice Merleau-Ponty, *Phenomenology of Perception* (London: Routledge and Kegan Paul, [1962] 2005), trans. Colin Smith, xx.

[32] An intentional arc expresses a recursive interlocking of the world, embodied action, and understanding. Merleau-Ponty's conception of intentionality conceptualizes a direct and spontaneous reaction of the body to the things in the world, emphasizing the embodied intentionality of relating to and moving toward various things in the world. Merleau-Ponty, *Phenomenology of Perception*, pp. 157–9.

lived body can reveal to the historian how they participated in sense-making processes that allowed them to use colonial medical facilities.

One of the most widely documented embodied actions by patients in the colonial medical archive was the seasonal surge of patients, especially for cataract surgery. Large numbers of patients traveling to hospitals offering new surgical techniques with rapid recovery and early discharge would lead to a rapid increase in hospital inpatients. It was not unusual for patients attending such surgical centers to increase tenfold within two to three years.[33] Seeking surgery was thus an intentional, meaningful and purposeful act that overcame the general tendency among South Asian patients to avoid both surgery and hospitalization in the nineteenth and twentieth centuries and involved traveling very large distances. The seasonal use of colonial hospitals by large numbers of patients established a pattern of embodied enaction that shaped and changed the environment of the colonial hospitals according to their needs. These needs included avoiding treatment at times of "scarcity and dearness of provisions", or during epidemics, allowing them to "put off such operations as cataract, stone, slowly growing tumours, etc., for a more convenient occasion"[34] when demands for labor by the agricultural cycle were lower.[35] However, descriptions of their rationale for seeking surgery as inferred by colonial medical officers are insufficient to interpret their actions as agential.[36] Since textual evidence of patient intentionality is not available to the historian, motor-intentionality expressed through their embodied actions of movement into and out of the hospital becomes significant, as it employs a "paradigm of enactive embodiment" influenced by Merleau-Ponty, so that the cognizer can be reconceptualized as an embodied being and cognition as enactive.[37] Thus, South

[33] See for example the increase in patients at the Delhi hospital Eye Ward between 1914–16 due to the introduction of a new technique of eye surgery. Similar improvements in cataract surgery at Jullundhur, Amrtisar and Moga also led to an influx of very large numbers of patients. Sehrawat, *Colonial Medical Care*, pp. 73–80. An innovation allowing the operation of lithotrity to be completed in one sitting adopted at the Indore Charitable Hospital led to an eight-fold increase in patients between 1864 and 1881. P.N. Shrivastav, *Madhya Pradesh District Gazetteers: Indore* (Bhopal: Government Central Press, 1971), p. 589.

[34] "Dispensaries", *Delhi Administration Report 1918–19*, p. 26.

[35] Sehrawat, *Colonial Medical Care*, pp. 75–7. Also see Lauren Nauta's extended discussion of the seasonal influx of patients for surgery across the Punjab, Nauta, "Medical Development in Colonial India: Seasonality, Specialization, and Efficacy in the Punjab Plains, 1870–1930", Unpublished Ph.D. Thesis, University of Pennsylvania, 2006, pp. 274–8.

[36] I am interpreting "agency" here in terms of James Scott's focus on infrapolitics or the use of "weapons of the weak" as survival strategies, James Scott, *Domination and the Arts of Resistance: Hidden Transcripts* (New Haven: Yale University Press, 2009), pp. 183–201.

[37] See for example, Christoph Durt, Thomas Fuchs, and Christian Tewes (eds.), *Embodiment, Enaction, and Culture: Investigating the Constitution of the Shared World* (Cambridge, MA: MIT Press, 2017).

Asian patients' motor-intentionality created a seasonal pattern to surgical work in hospitals, with "crowd[ing] …during the autumn and spring months and the hot weather …practically …an off season".[38] This had a measurable impact on colonial hospitals, requiring expansion of hospital accommodation and new equipment.[39]

Another pattern of embodied action—a general aversion to using colonial hospitals, which was a persistent theme in discussions of Indian hospitals and Indian patients under colonialism—can also similarly be rendered meaningful. Patients' decisions to leave the hospital in ways that ran counter to directions by medical personnel can also be interpreted through Merleau-Ponty's conception of the embodied "intentional arc". Accounts of patients in colonial Indian hospitals frequently relate cases of patients who left earlier than advised to, even at times abandoning treatment.[40] So strong was this pattern, that even patients asked to wait for surgery were likely to leave, especially if they were unable to observe the process of surgery itself.[41] This led to changes to surgical procedures meant to reduce waiting times for patients.[42] Patients undergoing cataract surgery at the Civil Hospital in Amritsar, Punjab, were thus operated on within about an hour of their arrival. Sacrificing procedures meant to ensure asepsis during surgery, patients who had walked from a distant village were operated upon while still covered by "the dust of the road".[43] Photographs of the Amritsar operating theatre show patients huddled with their bags, observing the unconscious patient on the surgical table as they waited their turn.[44] Thus, the colonial operating theatre was not a room designed to keep out all infection but one marked by the presence of the

[38] "Preliminary Statement Showing Money Required for Eye, Ear, Nose and Throat Department for Sep.–Mar. 1916", [hereafter, "Preliminary Statement for Expenditure"], CCO, H, F.no. 222B, 1915, DSA, p. 15.

[39] Sehrawat, *Colonial Medical Care,* pp. 77–80.

[40] A representative account reads: "it is very difficult to persuade some of the very ill patients who come to stay in Hospital…. And when a patient has been persuaded to stay in Hospital if she is not well at once she says some relation at home is dead or very ill and she must go; if she has had an operation and her pain relieved she also wants to go…." Agnes Scott, "St Elizabeth's hospital, Karnal", *Delhi Mission News,* vol. 7, no. 6, Apr. 1914, p. 70.

[41] Miriam Young, *Seen and Heard in a Punjab Village* (London: Student Christian Movement Press, 1931), pp. 76–7, p. 83. A.J. Hayes (ed.), *At work: Letters of Marie Elizabeth Hayes, Missionary doctor at Delhi, 1905–8* (London: Marshall, 1909), pp. 241–2.

[42] Derrick Vail, "Cataract Extraction in the Capsule: the Jullundur Patient", *Ophthalmic Record,* vol. 20, no. 2, Feb. 1910, p. 76.

[43] J. Williamson, "Major Smith's Operation for Extraction of Cataract in the Capsule", *Ophthalmoscope,* vol. 5, no. 10, October 1907, p. 555.

[44] This was a widely documented practice. Margaret Rawson, "First impressions", *Herald of the Baptist Missionary Society,* Oct. 1913, vol. 95, no. 10, p. 333; Iris Butler, *The Viceroy's Wife: Letters of Alice, Countess of Reading, from India, 1921–25* (London: Hodder and Stoughton, 1969), p. 83.

dusty bodies of the colonized, who insisted that they be "within sight and sound" of the patient being operated on.[45] Such changes in surgical procedures created disruptions to learned techniques that were deeply ingrained for surgeons. While the hospital was produced as an external environment that burdened patients' bodies with performative priorities embedded in biomedical surgical practices such as asepsis, their sensorimotor engagement with this environment enabled them to limit the power bestowed on the doctor by the medical gaze.

Consideration of the sensorimotor unity of perception and action of individual patients who left or entered the hospital in atypical ways can also be instructive in interpreting their motor intentionality. Many women patients were using their sensori-motor actions for the intersubjective constitution of the hospital as a space where they could have rest, treatment or new experiences. Patients whose "intentional arc" had been impacted by disabling illness were especially likely to atypically favor a stay and return to the hospital, which came to be seen as a place that could restore, however partially, their motility.[46] Such patients' atypical attitude towards colonial medicine may have been shaped by their experience of illness, which Havi Carel argues has the potential to challenge the sufferer's most fundamental beliefs, expectations, and values.[47]

Yet another example of atypical sensori-motor action were visits to the hospital by a group of veiled women curious about the institution of the hospital or dispensary. The intention to visit the hospital was not entirely to seek treatment through subjection to the medical gaze but rather to turn their own curious gaze on to hospital staff, seeking explanation for the embodied actions of the staff in terms that were culturally familiar to South Asian patients. One rural woman who had walked for six miles to a medical mission camp demanded, "Show me the memsahib!" in a reversal of the optical hexis employed by the medical gaze.[48] "Purdahnashin" (those observing veiling) patients were sometimes able to travel to the women's hospital because these spaces were no longer deemed out of bounds due to the regulation of its space to prevent exposure to people deemed undesirable by patriarchal

[45] Surgeons ensured that the patient was with their friends throughout treatment and that patients could see the next step of the treatment/operation as they were being prepared for the operation. Williamson, "Major Smith's Operation", p. 555.

[46] There are numerous cases of patients such as Latifan, suffering from tubercular bone disease, whose partially restored motility after treatment led her to atypically return to the hospital for continued treatment despite a long stay. "Some Patients at St. Elizabeth's Hospital Karnal", *Delhi Mission News,* vol. 8, no. 9, April 1918, p. 19.

[47] Havi Carel, 'Introduction', *Phenomenology of Illness* (Oxford: Oxford University Press, 2016), p. 4.

[48] Miss Bazely, "The Medical Mission: I—Camping", *Delhi Mission News,* Vol. 8, No. 9, April 1918, p. 118.

regulation of their sexuality.[49] For such women, a visit to a women's hospital or a female doctor allowed their bodies to inhabit new spaces and have new experiences—as in the case of women whose purpose was to seek small Western objects such as pins, or the group of women pretending to be ill when "[n]one [of whom] had anything the matter… [yet] went off in triumph, laden with powders and doses, well satisfied with their adventure".[50] Their motor intentionality in visiting the colonial hospital was meant not to subject them to the medical gaze but rather to create liberty, extending their motility (capability for movement). Attention to such employment of motility reveals how South Asians constituted the hospital by disclosing its intersubjective significance for them, allowing us to move beyond constructivist accounts of colonial medicine.

It is also important not to overlook the corporeality of the doctor-patient relationship and implicitly accepting textual evidence of the objectification of the body. Doctors' case histories—such as the one discussed in the first section—are ubiquitous, documenting the doctors' detachment from their personal feelings or attitudes required by the clinical gaze. However, medical treatment is a socially meaningful embodied practice. Focusing on the intercorporeality[51] of interactions during treatment reveals what discursive representations of the medical gaze obscure—how surgeons needed to establish bodily resonance with patients and how it opened them to shaping their medical practice to the needs of South Asian patients despite the existence of power differentials created by colonialism and by an objectifying medical science. Here this conception will be used to query textual traces of patients' embodied action that proved resistant to the medical regulation of the colonized in hospitals. First, we will consider instances when doctors had to adapt their practice to the intractable behavior of patients, referred to as medical "non-compliance".

A well-documented example of South Asian patients' disregard of postoperative instructions was their opening up of bandages to view the body parts that had been operated on.[52] Specifically, the analytical focus will be on cataract patients who opened up eye bandages against injunctions to protect the surgical incision

[49] Miss Mayo, "Some Experiences of Mission Life in Delhi", *Delhi Mission News*, Vol. 4, No. 8, October 1905, p. 96.

[50] F.C. May, "Into the Villages", *Delhi Mission News*, vol. 4, no. 2, April 1904, p. 27.

[51] Merleau-Ponty's ideas on intercorporeality have led to the reconceptualization of social understanding as an embodied interaction that relies on behavior matching, primordial empathy and interactional synchrony to create mutual understanding. Intersubjectivity is thus seen to emerge from a complex layer of embodied responsivity, expressivity and communication through a double embodiment created by the temporary merging of object and subject in embodied interactions. Maurice Merleau-Ponty, *The Visible and the Invisible* (Evanston: Northwestern University Press, 1968), trans. A. Lingis, pp. 259, 307.

[52] Young, *Seen and Heard*, pp. 81–2.

from infection and light. The embodied actions of numerous South Asian cataract patients, even those separated by time and space, followed a persistent pattern: patients would peep from under the bandages to check if they could see some time after the operation. Often, they would leave once they had ascertained that they were able to see despite instructions to stay for continued monitoring.[53] Such non-compliance was seen as arising from patients' ignorance of the importance of asepsis, and as a marker of cultural difference, with a characteristic remark explaining: "it was quite useless expecting them to act as a European would under the circumstances".[54] However, the actions of the patients become meaningful when analyzed as an embodied occurrence arriving from their habitus. In opening bandages after cataract surgery, patients were enacting practices associated with South Asian oculists. Cataract couching was widely practiced in colonial India and had been performed by indigenous practitioners since the time of the Sushruta Samhita, *c.* 800 BCE.[55] Immediately after couching the eye, indigenous practitioners would wave fingers in front of the patient to indicate that the operation had restored vision.[56] This embodied practice of checking the restored vision of the patient had prevailed in Asia since the fifth century CE when an Ayurvedic text described the last step of the cataract surgery as demonstrating its success by "show[ing] …a finger, threads, relatives and friends" to the patient.[57] Accounts of Indian oculists' couching for cataracts underscored the importance of this embodied practice: "Very great stress is laid on this part of the ritual, and the onlookers are not allowed to lose sight of the wonderful results achieved by the operation."[58] Cataract surgery

[53] Andrew Timberman, "Lt. Col. Henry Smith, IMS, and the Environment in Which He Developed the Technique of the Intracapsular Operation. Its Advantages", *Ohio State Medical Journal,* May 1912, vol. 8, no. 5, p. 246. S.E. Maunsell, *Medical Experiences in India, Principally with Reference to Diseases of the Eye* (London: H. K. Lewis, 1886), p. 16. James French, Charles Ducat, Geo Richmond, "Successful Treatment of the Diseases of the Eye in India", *Asiatic Journal and Monthly Register for British India and its Dependencies,* vol. 20, October 1825, p. 409.

[54] Maunsell, *Medical Experiences,* p. 16.

[55] Vijay Thakur, "Surgery in Early India: A Note on the Development of Medical Science", in Deepak Kumar (ed.), *Disease and Medicine in India: A Historical Overview,* (New Delhi: Tulika, 2001), p. 22; O.P. Jaggi, *Medicine in India: Modern Period,* vol. 9, part 1, *History of Science, Philosophy and Culture in Indian Civilization* (New Delhi: Oxford University Press, 2000), pp. 232–7.

[56] P. Breton, "On the Native Mode of Couching", *Transactions of the Medical and Physical Society of Calcutta,* 1826, p. 350. Also see description from the Calcutta Eye Infirmary, "Review" *British and Foreign Medico-chirurgical Review,* vol. 21, no. 41, 1858, p. 110.

[57] Vāgbhata, *Aṣṭāṅga-saṃgraha* (Uttarasthāna, Varanasi: Chaukhambha Orientalia, 2000), trans. K.R. Srikantha Murthy, Vol. 3, pp. 133–55.

[58] R.H. Eliot, *The Indian Operation of Couching for Cataract* (New York: Paul Hoeber, 1918), p. 16. H.E. Drake-Brockman, "The Indian Oculist and his Equipment", *Transactions of the Ophthalmological Society of the United Kingdom,* vol. 40, 1895, p. 251.

in colonial hospitals led patients to repeat the same embodied action: "I had the greatest difficulty, in preventing them [South Asian patients] either from removing the bandage completely, or from lifting up the pad, in order to look out and satisfy themselves of the result of the operation."[59] Patients' "anxious and curious" relatives would also often remove the bandages on the eye to examine the eye.[60] The patients, requiring a sensory confirmation of the success of the operation, were opening the bandage as required by embodied memory linked to cataract surgery and their *habitus*. Pierre Bourdieu conceptualized habitus as the dispositions, skills, styles, tastes, and behavior that are shared by the members of a community. Habitus is acquired by individuals through practical immersion in the life world, by participation in interactive experiences, mimetic learning, implicit routines, and rituals. It is carried by individuals as body memory. According to Bourdieu, this embodied memory is "beyond the grasp of consciousness"—a second nature effectively guiding the behavior of the individual in specific settings.[61] The habitus forms the basis of common sense or "a practical sense of embodied social customs and interactions which constitutes the prereflective background of social life".[62]

Further analysis of cataract surgery in colonial India from a body studies perspective shows that British surgeons were also drawn into the learned dispositional network of the habitus of South Asian patients. This is evident from probing a second set of embodied interactions around cataract surgery focused on the collective examination of the opaque lens removed from the cataract-affected eye. The lens was provided as evidence that the object impeding the vision had been removed and vouchsafed the success of surgery:

> The crowd of expectant natives [waiting outside the operating area were]… specially loud in their acclamations when a lens [surgically removed from the patients' eye] was given them for inspection after its removal. By way of adding to their confidence, each lens was placed on a piece of paper on removal, and sent out to the anxious relatives, by whom it was carefully treasured, after having been passed round for the inspection of the general public.[63]

[59] Maunsell, *Medical Experiences*, p. 16.

[60] Maunsell, *Medical Experiences,* p. 18. Also see French, et al., "Successful Treatment", p. 410.

[61] Pierre Bourdieu, *Outline of a Theory of Practice* (Cambridge: Cambridge University Press, 2013), trans. Richard Nice, p. 14.

[62] Thomas Fuchs, 'Intercorporeality and Interaffectivity', in Christian Meyer, J. Streeck, and J. Jordan (eds.), *Intercorporeality: Emerging Socialities in Interaction*, Foundations of Human Interaction (New York: Oxford University Press, 2017), p. 14.

[63] Maunsell, *Medical Experiences,* pp. 8, 84. For a similar story, see Farrer "Removing bajra", Ellen Farrer Chronicle, 6 March 1917, Indian Missionaries and Institutions, IN/150, Baptist Missionary Society Collection, Regent's Park College, Oxford.

This mirrored the practice of indigenous oculists who would provide patients and their relatives with "manifest proof" of treatment in the form of a membrane *("jhili")*[64] and its reiteration by British surgeons drew them into the habitus of South Asian patients. It is useful to examine this interaction between the surgeon, S.E. Maunsell, and South Asian patients' relatives through "theories of social practice", which analyzes how the performance of a practice involves different participants relating to and interacting with one another's bodies; things involved in the practice; and, artefacts such as techniques, language and images. This approach emphasizes the material and corporeal dimensions of social interaction around the practice. Bourdieu's concept of the practical sense is another useful theoretical lens of analysis.[65] The surgeon's mimetic enaction of the South Asian coucher's practice showed his tacit knowledge of the typical interactive sequences following the removal of the cataract from the patient's eye. Through it he entered an inter-corporeal space within which he was interacting with South Asian patients' and their relatives' habitus. This habitus established the shared body memory of their community and made embodied practices immediately evident or foreseeable in the context of eye surgery. As members of a culture the relatives understood each other intuitively, anticipating the next moves in the context of cataract surgery, knowing how to react, without the need to resort to deliberation, to a theory of mind, or to mentalizing procedures. By entering this shared understanding that the lens should be shown to relatives after the surgery, Maunsell was participating in the coproduction of a social reality that was profoundly influenced by the assumptions of South Asian patients. British doctors' written accounts of eye surgery indicate their dismissal of South Asian patients as ignorant and render medical practice as an exercise of the medical gaze. Such a rendering represents the doctor as exercising power emerging from the untrammeled exercise of his gaze. However, the analysis of the embodied interactions between surgeons and patients reveals uncertainties and "gaps" during medical practice that required adaptation by doctors and the constitution of medical interactions through communication and collaborative interactions with South Asian patients. Doctors were acting agents who were bodily

[64] Eliot, *Indian Operation of Couching* (New York: Paul Hoeber, 1918), p. 16.

[65] Practical sense is a pre-reflective stance that comes from practical mastery rather than abstract knowledge that individuals use to generate empirical cognitive acts in pursuit of their aims. He defines it as "an acquired system of preferences, of principles of vision and division (what is usually called taste), and also a system of durable cognitive structures (which are essentially the product of the internalization of objective structures) and of schemes of action which orient the perception of the situation and the appropriate response" in Pierre Bourdieu, *Practical Reason: On the Theory of Action* (Stanford University Press Stanford, California 1998), p. 25. For a discussion of practical sense as "regulated improvisations" that we draw on here, see Pierre Bourdieu, *The Logic of Practice* (Stanford: Stanford University Press, 1998), trans. by Richard Nice, pp. 57–65.

anchored in and oriented toward their patients' habitus, engaged in a process of incorporating practices meant to accommodate colonized patients' expectations. Thus, structural, functionalist and discursive analysis may indicate the structures, rules and norms that organized doctor-patient relationships, but they fail to consider embodied interaction between historical actors from the viewpoints of the various participants and thus do not reveal how their actions make reference to and influence each other.

Eye surgeons, keen to enhance their surgical skill, required large numbers of cataract patients on whom they could practice surgery.[66] To ensure that South Asian patients would accept cataract surgery in colonial hospitals, surgeons sought to establish a mutual understanding through embodied interactions that mobilized a tacit background knowledge of the practice of couching during their interaction with patients. They were employing what Bourdieu terms the "logic of practice", differing profoundly from the "logical logic" of the medical gaze.[67] Practical knowledge necessary for participating in a practice is held tacitly, carried by the body in the form of certain performative competences. It becomes manifest outwardly in competent responses by participants reacting to situational challenges they encounter while engaged in the performance of a practice. Biomedical surgeons' "practical sense" made room for "organized improvisations" on the professional code governing doctor-patient interactions.

In this and other attempts to adapt surgical practice to patients' embodied actions, surgeons were influenced by a tacit communication between their bodies and that of the colonized, which involved an entanglement of self and other to produce intersubjectivity and sociality. While engaged in interactions with patients, doctors were participating in an overarching corporeality that encompassed the individual bodies and objects involved in it. This intercorporeality established immediate relations among all participants, allowing them to reflexively enable and prompt each other to act, resulting in the incremental attunement of their bodies with each other. Maunsell's intercorporeal interaction with a patient's relative can be examined using Merleau-Ponty's conception of intercorporeality to reveal the extent to which patients were able to shape the practice of medicine: "A serious old Hindoo expressed his delight, astonishment, and unbounded gratitude, when he found placed in his hands, the white object which for years past he had seen in his wife's eye, and which he knew to be the cause of her blindness…."[68] Maunsell's statement conveys an intuitive understanding of the patient's husband's emotions which indicates a *bodily resonance* in their embodied engagement. Resonance is constituted by interrelated

[66] Sehrawat, *Colonial Medical Care,* pp. 68–73.

[67] Bourdieu, *Outline of a Theory of Practice*, p. 110.

[68] Maunsell, *Medical Experiences,* pp. 8, 84.

bodily movements between bodies "attuned to one another, and sensitized to the relevant objects and characteristics of [...] practice".[69] Maunsell's social cognition in this interaction was based on both intercorporeality and interaffectivity.

However, such intercorporeal bonding between participants engaged in a practice does not always result in social solidarity. Given the multiperspectivity of participants, the potential for conflicting interpretations of the practice remains due to the different positions occupied by participants during the performance of the practice. Thus, medical accounts by British doctors could relate these interactions as ones in which their medical gaze had established their power over patients, and dismiss South Asian patients' actions as evidence of the backwardness of the colonized. This was consistent with colonial discourses essentializing the colonized as inherently irrational who required a lengthy tutelage to facilitate their transition to modernity.[70]

A phenomenological perspective on medical modernity thus throws light on the limits of medicalization in South Asia. In Europe, medicalization operated as an effect of modernization. Medicalization has been seen as a process which concentrated power in the hands of medical professionals and extended medical expertise into other areas of society, such as law and governance. In the West the increased use of hospital statistics, diagnostic tools and technologies was accompanied by the consolidation of medical authority over the patient, and through the alignment of the medical profession with the state, over society more widely. This shift in the practice of medicine largely disempowered the patient in relation to the doctor.[71] South Asian patients' actions thus become meaningful as conscious, purposeful and goal-driven activities designed to mediate illness on their own terms rather than in ways determined by biomedicine or associated professional codes. Their embodied actions located biomedical practitioners in a habitus informed by the practice of South Asian oculists, thus effectively treating biomedical surgeons and oculists as on par. Thus, South Asian patients undermined the medical profession's power through their health seeking behavior.[72] In effect, this limited the potential of medical dominance and the medicalization of South Asian society.

[69] Thomas Alkemeyer, Kristina Brümmer and Thomas Pille, 'Intercorporeality at the Motor Block: On the Importance of a Practical Sense for Social Cooperation and Coordination', in Meyer, Streeck and Jordan (eds.), *Intercorporeality*, p. 227.

[70] In medical settings, these discourses have survived as "culturalism", Didier Fassin, "Culturalism as Ideology", in Carla Makhlouf Obermeyer (ed.), *Cultural Perspectives on Reproductive Health* (Oxford: Oxford University Press, 2001), pp. 300–318.

[71] For an overview, see, Kristin Barker, "Social Construction of Illness: Medicalization and Contested Illness", in Chloe Bird, et al. (eds.) *Handbook of Medical Sociology* (Nashville: Vanderbilt University Press, 2010), p. 152.

[72] For contemporary phenomenological analyses of asymmetries in relationships between healers and sufferers and between competing medical systems, see Harish Naraindas, Johannes Quack

Conclusion

The colonial hospital was created as a space for the colonial medical gaze and racialized South Asian bodies by institutionalizing their regulation in conformity to ethnic practices. The implications of this go beyond just considering hospitals to be part of colonizing discourses that essentialized South Asian society as bound to irrational ethnic practices—it reveals how medical and social surveillance were co-constituted under colonialism. Foucault posited that scientific thought emerged as a system establishing positivistic science as the means of knowledge about the human subject, who was created as its locus in the modern world and which made possible the project of creating a system of democratic governance.[73] Thus, by making ethnic groups rather than individuals the object of positivistic science in colonial hospitals created a divergence from this "modern" relationship between the human subject and positivistic science. It bestowed a medical modernity to South Asia that was more interested in social and state control than in ethical and professional treatment of patients or in their pastoral care. The legacy of this divergence continues to haunt medical attitudes to patients in South Asia today. To illustrate this, it may be useful to consider the consequences of British women doctors' appropriation of the right to define and police South Asian women's bodies, which extended their medical expertise to include control over the non-medical bodily and social conduct of the colonized female body. The resulting discourse on zenana medical care proved influential in shaping attitudes towards women's bodies for South Asian nationalists and women's organizations, especially in relation to reproductive health. The consequent medicalization of childbirth in modern South Asia continues to be part of the lived experiences of South Asian women today.[74] Nevertheless, this construction of the patient's body as an object by the medical gaze existed in tension with a hermeneutic parity produced by South Asia's medical pluralism. Colonial patients' embodied action in intercorporeal therapeutic settings established a check on the power of the biomedical profession. By being attentive to how colonized patients used gesture as embodied action, this essay makes an

and William Sax (eds.), *Asymmetrical Conversations Contestations, Circumventions, and the Blurring of Therapeutic Boundaries* (New York: Bergahn, 2014).

[73] Cindy Patton, "Introduction: Foucault after Neoliberalism; or, the Clinic Here and Now", in Cindy Patton (ed.), *Rebirth of the Clinic: Places and Agents in Contemporary Health Care* (Minneapolis: University of Minnesota Press, 2010), pp. ix–xx.

[74] For an overview of the literature on twentieth century medicalization of childbirth that argues for the centrality of British women doctors' discourses in shaping developmental, nationalist and international discourses on maternal mortality, see Samiksha Sehrawat, "Colonial Legacies and Maternal Health in South Asia", in Clémence Jullien and Roger Jeffery (eds.), *Childbirth in South Asia: Old Paradoxes and New Challenges* (Oxford: Oxford University Press, 2021), pp. 40–67.

important intervention in interpreting the subversion of biomedical authority in societies with medical pluralism. It allows us to view colonial patients not merely as socially determined organisms but rather phenomenologically aware, active body-subjects whose corporeal properties enabled them to intervene creatively in medical settings.

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