

## BRITISH-INDIAN MEDICAL SERVICE OFFICERS IN BHUTAN, 1905-1947: A HISTORICAL OUTLINE<sup>1</sup>

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As occurred throughout Asia during the colonial period, the traditional indigenous system of government and statehood in Bhutan altered and the Tsongsa Penlop, Ugyen Wangchuck, was subsequently elected to what became the position of hereditary monarch in 1907. In British sources he is commonly referred to as the Maharaja of Bhutan.

Ugyen Wangchuck had rendered the Government of India great assistance during the 1903-04 Younghusband mission, when British forces fought their way to the Tibetan capital of Lhasa and forced the Tibetan government to enter into treaty relations with British India. The Younghusband mission was in the wider sense, part of the overall British efforts to ensure the security of the northern frontier of their Indian empire against any attempt at Russian or Chinese intrusion. That concern with security was always at the forefront of British-Indian strategic thinking, and during the period from 1905 to 1947 (when the British withdrew from India), the imperial government maintained diplomatic representatives and military forces not only in Nepal, Sikkim, and the Indian Himalayan states of Assam, Kumaon, Kashmir and so forth, but also across the frontier in Tibet. There, bases in Yatung, Gyantse, and, after 1936-37, Lhasa, acted as forward positions to ensure that the British could influence the Tibetan government to follow policies that would, ultimately, enhance the security of British India.<sup>2</sup>

Influence over the government of these states was obtained through various treaty agreements, but more importantly, perhaps, through material and diplomatic support for the indigenous ruling elites who cooperated with British interests. State rulers were assisted both at a

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<sup>2</sup> Regarding the historical role of these British Political Officers, see; Alex McKay, *Tibet and the British Raj; the frontier cadre 1904-1947*, London 1997. The various works of Alastair Lamb may be consulted in regard to the wider diplomatic and political considerations in the Indo-Tibetan Himalayan region, while A.J.K. Singh's *Himalayan Triangle; A historical survey of British India's relations with Tibet, Sikkim and Bhutan 1765-1950*, London 1988, provides a succinct summary drawn from the British archives.

personal level and in the process of state modernisation, and various strategies were used to gain the support of all classes of people within the region. The key agents in this process were the British Political Officers stationed in the Himalayan states, who were in effect the diplomatic representatives of the Government of India. They were charged with the duty of personally befriending the indigenous elites in order to better influence them and the policies they adopted. While problems naturally arose, the British policy was generally a successful one from the imperial perspective, although its effects on the indigenous states and the eventual political stability of the region were by no means entirely positive.

During the 1905-47 period, however, one Himalayan state, Bhutan, did not have a permanent British representative stationed in its capital or leading centres. Instead, the British Political Officer stationed in the Sikkimese capital of Gangtok had responsibility for relations between Bhutan and the Government of India, as he did for Sikkim and Tibet. (In the latter case, so-called 'Trade Agents' were stationed at Yatung and Gyantse, but these were in reality junior officers attached to the Political Department under the Sikkim Political Officer's authority, as was the Head of the British mission in Lhasa when that was eventually established.)

While the Sikkim Political Officers maintained contact with the Bhutanese rulers through correspondence, they paid only occasional visits there. That meant that the general principle of relations between the two governments – that the British guaranteed the security of Bhutan and were responsible for its foreign relations, in return for which they avoided involvement in its internal affairs – did in fact operate relatively smoothly and to mutual benefit. One rarely observed consequence of this situation was that whereas there was a constant procession of British officials and travellers journeying through Sikkim and into Tibet,<sup>3</sup> European visitors to Bhutan in the colonial period were very few in number.

The absence of British Political Officers from Bhutan also meant, however, the absence of British medical personnel. Under the developed Indian Political Department system, when a Political Officer was stationed at a Residency, his support staff included a Medical Officer, who was a member of the Indian Medical Service. The initial intent

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<sup>3</sup>There were well over a thousand British visitors to Tibet during the 1904-47 period; see Alex McKay, 'Tibet. The Myth of Isolation', in *New Developments in Asian Studies: the I.I.A.S. Yearbook 1996*, London 1996, pp.302-16; reprinted in vol.3 of Alex McKay (ed.), *History of Tibet* (3 vols.), forthcoming (2003). On the (almost entirely official) British visitors to Bhutan, see, in particular, the very readable account by Peter Collister, *Bhutan and the British*, London 1987, which has been a valuable guide to me in the preparation of this paper.

behind this policy was to ensure the health of the Political Officer, but it soon became apparent to the imperial strategists that practitioners of medicine were capable of gaining tremendous goodwill from the indigenous peoples through the cure and prevention of illness and disease. Thus by the 20<sup>th</sup> century, the provision of medical services to all classes of the indigenous peoples had become a deliberate political strategy for gaining support for the imperial government system. Medical Officers provided private consultations to the elite classes (for which they were entitled to charge fees), and free treatment to the non-elite groups at permanent medical clinics in the vicinity of the British Residencies. In addition, when they accompanied the Political Officers on tours, they set up medical camps en route, treating all-comers.<sup>4</sup>

Western biomedicine was apparently perceived by the indigenous peoples as being of particular value in the treatment of epidemics,<sup>5</sup> for which the indigenous medical systems were generally inefficacious, with the benefits of vaccination against smallpox of almost immediately apparent value. Thus, while vaccination did produce culturally, and even "nationally"-based resistance in some cases,<sup>6</sup> demand for inoculation was widespread.<sup>7</sup>

The provision of Western biomedicine, and support for the indigenous development of that system, was not only of immediate

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<sup>4</sup>The absence of private or demi-official travellers to Bhutan may also be noted in this context, as these individuals also tended to act as agents for the dissemination of biomedicine, similarly providing medical services (albeit on a smaller, and usually amateur, scale) as a means of obtaining goodwill. One thinks, for example, of Thomas Manning, whose medical skills enabled him to become the first Englishman to reach Lhasa in 1811. Similarly the exclusion from both Bhutan and Tibet of Christian missionaries, who commonly used biomedicine as a means of gaining converts, prevented their acting in that capacity; see Fitzgerald, R. "'Clinical Christianity': The Emergence of Medical Work as a Missionary Strategy in Colonial India, 1800-1914", in B. Pati & M. Harrison (eds.), *Health, Medicine and Empire: Perspectives on Colonial India*, Delhi 2001, pp.88-136. There were, however, attempts by the missionaries to circumvent the ban. In regard to Bhutan a Kalimpong Foreign Mission to Bhutan was founded in 1891, with the aim of using local converts to promulgate Christianity there. The deaths of several of the converts ruined this plan, although a mission was founded at Rungamutti on the southern frontier of Bhutan; see J.A. Graham, *On the Threshold of Three Closed Lands; the guild outpost in the eastern Himalayas*, Edinburgh c.1897, pp.149-54.

<sup>5</sup>This appears to be a common factor. N.E. Gallagher, *Medicine and Power in Tunisia 1780-1900*, 1983, p.11, quoted in C. Leslie and A. Young, (eds.), *Paths to Asian Medical Knowledge*, Berkeley 1992, provides an example from another region of how the acceptance of biomedicine was fostered by its superior capabilities in dealing with epidemics.

<sup>6</sup>David Arnold's works exploring the issue of resistance to vaccination are of particular note; see for example his *Colonizing the Body: State medicine and epidemic disease in nineteenth century India*, Berkeley 1963.

<sup>7</sup>For a discussion of smallpox vaccination issues, see; Sanjoy Bhattacharya, 'Re-devising Jennerian vaccines? European Technologies, Indian Innovation and the Control of Smallpox in south Asia, 1850-1950', in B. Pati & M. Harrison (eds.), *Health, Medicine and Empire: Perspectives on Colonial India*, Delhi 2001, pp.217-69.

political value, but was part of the wider imperial programme of modernisation in South Asia. While generally cautious of introducing cultural change (particularly after the events of 1857-58), the imperial administrators were in absolutely no doubt as to the superiority of biomedicine over the indigenous systems, and aside from its political advantages, the development of biomedicine, like the introduction of the Western education system and certain technological advances, was seen as a gift to the imperial possessions, and in some senses a moral justification for imperialism.

In surveying the British medical missions in Bhutan it is not my intention here to enter into the wider debate over the aims and effect of colonial medical policies.<sup>8</sup> Rather it is to focus on one example of the introduction of biomedicine into a specific Himalayan location, and to discuss prominent features of that process, relying primarily on the reports of the Medical Officers themselves as preserved in the Oriental and India Office Library. This review and its conclusions may, however, contribute to that wider debate.

The British were well aware of potential medical problems in visiting Bhutan. In the 1864-65 campaign, 480 of the 5000 man British force were lost to disease 'on the spot, and nearly as many more subsequently from the effects of the campaign, although 1,300 men were sent away on sick leave.'<sup>9</sup> But when John Claude White, the first Political Officer in Gangtok, visited Bhutan in 1905 to present the K.C.I.E. (Knight Commander of the British Empire) to Ugyen Wangchuck in recognition of his contribution to the Younghusband mission, White was not, apparently for financial reasons, assigned the services of an IMS officer. Instead he was accompanied only by a hospital assistant, and the only mention of this assistant's activities that I have located is contained in White's memoirs, where he is recorded as having treated a murderer who had been punished by amputation. (White notes, incidentally, that the amputation was carried out in as humane a manner as possible.) White, however, was himself able to assist the Maharaja, whose sight was failing somewhat, by gifting him his own glasses, which were fortuitously

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<sup>8</sup>. In a rapidly growing field, there are numerous significant contributions to that debate; of those references that I have to hand at the time of writing, Arnold *ibid*; Mark Harrison, *Public health in British India: Anglo-Indian preventive medicine 1859-1914*, Cambridge 1994; D. Kumar, *Science and the Raj 1857-1905*, Delhi 1995; and, A. Kumar, *Medicine and the Raj: British Medical Policy in India, 1835-1911*, London/New Delhi, 1998, may be cited with confidence. As the latter work notes, however, the debate has focussed on the metropolitan centre(s) of empire and '[m]ore perceptive analysis would require an understanding of local responses as evidenced by local sources and this is yet to be done'; A.Kumar *op cit.*, p.13. In this regard the Himalayan region has been particularly neglected to date.

<sup>9</sup>. F.N. MacNamara, *Climate and Medical Topography of the Himalayan and Sub-Himalayan Districts of British India*, London 1880, p.166.

suitable.<sup>10</sup> White visited eastern Bhutan the following year (1906), accompanied on that occasion by an assistant to carry out smallpox vaccinations. White records that at one location,

I started my vaccinator at work early, and before evening he had vaccinated over two hundred people, who all seemed very pleased, and flocked in for the operation. I had sent the Tsonga a consignment of lymph from Gangtok, as he wished to introduce vaccination throughout Bhutan and his operator met us ... [here] ... to be instructed what to do.<sup>11</sup>

A total of 'over 800' people were vaccinated on this 1906 visit.<sup>12</sup> But it was apparent that there was a far greater demand for medical services than could be provided by an unskilled assistant and the Sikkim state engineer, who apparently took on a medical role during the mission, for White records that at Serpang,

in this camp also people crowded to be vaccinated, and to be treated for various diseases. I did what I could, and Mr Dover [the engineer] was indefatigable in dispensing medicines, but it would have made a very great difference if I had had a doctor with me.<sup>13</sup>

In 1907, on his next mission to Bhutan, White was finally assigned a IMS officer, Captain Hyslop, whose report does not appear to have survived.

White's memoirs record that 'I have never met a native I liked or respected more than Sir Urgyen,'<sup>14</sup> but White's dictatorial methods of diplomacy were in direct contrast to that of his 1908 successor as Political Officer of Sikkim, Bhutan and Tibet, Charles (later Sir Charles) Bell, and when White returned to Bhutan from retirement to private employment by the Bhutanese state, he was dismissed by Sir Urgyen over alleged financial irregularities and died soon after (1918).<sup>15</sup>

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<sup>10</sup> John Claude White, *Sikkim and Bhutan*, London 1909, pp.146, 169.

<sup>11</sup> *ibid*, p.190. While (as a bureaucratic strategy) the Political Officers commonly assigned credit to local rulers for desiring innovations that they had actually themselves suggested, Ugyen Wangchuck's desire to introduce smallpox vaccination may well have been (if not earlier) instilled in him by his observations while accompanying Younghusband. White refers to a distant precedent for a Bhutanese ruler's interest in Western medicine; on his 1783 mission to Bhutan, the East India Company emissary Samuel Turner had found the Deb Rajah had as much knowledge of medicine as anyone there. He displayed a great interest in British medicine although '[t]he interest, however, waned after an overdose of ipecacuanha'; *ibid*, p.251.

<sup>12</sup> *ibid*, p.203.

<sup>13</sup> *ibid*, p.192.

<sup>14</sup> *ibid*, p.233.

<sup>15</sup> See Oriental and India Office Collection [hereafter OIOC], L/P&S/11/1919-2191; also see National Archives of India, Foreign Department 1908, External A, April 33-34, various correspondence.

The appointment of Charles Bell, an ICS officer, marked the end of an era on the frontier. Men such as White, Younghusband, and the Gyantse Trade Agent Captain W.F. O'Connor, had sought to expand British influence on the frontier through dynamic 'forward policies', reflecting the Curzonian certainties of the empire at its height. Bell, however, while not lacking the characteristic ego of the Political Officers, was a quiet and reserved character, who believed that imperial interests were best served - and advanced - by creating an alliance of interests between the Government of India and the indigenous elites. Bell was to serve as Political Officer in Sikkim for most of the period from 1908-1920, and he provided the model followed by most of his successors in that position. As a proponent of gradual modernisation in line with local sensibilities, he was well aware of the value of medicine as a political tool.<sup>16</sup>

Bell visited Bhutan in 1909-10, accompanied by Captain (later Lieutenant-Colonel) R.S. Kennedy IMS, who served as Medical Officer in Gyantse from October 1907 to March 1910 and whose political and Tibetan language skills saw him appointed as acting Trade Agent there for six months in 1909. Kennedy's personal diary contains several references to his medical activities on this Bhutan mission. He records that at Chukha in January 1910

As soon as the people realised I was a doctor a great many people came along for medicine. In all 60 came before tiffin; 19 of these were venereal (apparently this country is even worse in this respect than Tibet) and most of the other cases were trivial....One gained the impression that they had great faith in our English medicines.<sup>17</sup>

Later he noted that

Smallpox sometimes appears in very severe epidemic forms (last epidemic occurred nine years ago) when it kills people in scores. H.H. [His Highness, Urgyen Wangchuk] ascribes the large areas of deserted cultivations, partially at any rate to these two causes ... [the other being malaria] ... He himself has been vaccinated and is a firm believer in it; he is anxious to introduce it into his country. Bell is wiring for some vaccine, and I have promised to teach some men how to vaccinate, if it arrives in time. It appears that White brought a vaccinator with him during one of his visits.<sup>18</sup>

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<sup>16</sup>. On Bell, see especially McKay, *Tibet and the British Raj...*, (*passim*).

<sup>17</sup>. OIOC, MSS Eur F157-224, Kennedy's Bhutan diary 1909-10, entry of 2 January 1910.

<sup>18</sup>. *ibid.*, entry of 9 January 1910.

The vaccine arrived soon after and Kennedy instructed 'one of the Maharaja's men' in vaccination.<sup>19</sup>

Events in Tibet, with the collapse of the Chinese position and the subsequent Simla convention, meant that Bhutanese affairs subsequently took something of a backseat in Bell's thinking, while World War One and its demands for medical officers on the European front produced a great shortage of manpower in the Government of India's British ranks. Thus when a cholera outbreak occurred in Bhutan in 1919, in which year Bell again visited Bhutan, a female medical practitioner, Dr Cousins, accompanied by a Nurse Brodie, were sent to deal with it.<sup>20</sup>

The visit by Dr. Cousins was, in the period under consideration, as far as I can ascertain the only one to Bhutan by a registered practitioner of Western bio-medicine who was not a member of the Indian Medical Service. Had a programme for the introduction of biomedicine into Bhutan been intended that was entirely free of political considerations, civil or private doctors might have been employed, or given permission to practice there. But financial restrictions were also a factor, which limited this possibility. In the absence of a direct threat to the security of India from this direction it was extremely difficult for the Political Officers to obtain the necessary funding from the Government of India to institute these types of measures. The Bhutanese government itself, which relied heavily on the subsidy paid to them by the imperial government, could not afford to employ Western doctors and the only medical practitioners likely to volunteer their services for any extended period there were missionary doctors. As noted, fears – shared by both the Political Officers and the Bhutanese government – of their impact on the local culture, ruled out that option.

The only remaining possibility was to train Bhutanese in the biomedical system, and the use of indigenous vaccinators was the first step in this direction. Given the absence of English-speaking and Western-educated Bhutanese, education was necessarily the first priority if Bhutanese were to be trained in biomedicine, and in 1914 forty-five boys were selected to be educated in the Western system.<sup>21</sup> By 1921, four

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<sup>19.</sup> *ibid*, entry for 24 January 1910: OIOC, MSS Eur F157-224a, Kennedy to Bailey correspondence, contains an obituary of Kennedy (presumably by Bailey) which notes that 'He also vaccinated a large number of the local inhabitants, at first by guile and persuasion, but later at their urgent request.'

<sup>20.</sup> Collister, *Bhutan...*, p.174.

<sup>21.</sup> These endeavours were contemporary with similar initiatives in Tibet, where 4 boys were selected to be sent to Rugby school in England. A historical curiosity with little long-term benefit to either Tibet or the individuals concerned, the experiment was not repeated, and, as with

of the youths had reached Indian university entrance standard, while others were ready for further training. Two of them were assigned to medical training, thus beginning the tradition of Bhutanese trained in biomedicine.<sup>22</sup>

Indian Medical Service officers, however, continued to provide impetus to the introduction of biomedicine, and also to fulfil their usual political role of gaining support for the imperial government by providing free medical services to the non-elite groups, while, in the wider sense, promoting British prestige through the demonstration of scientific supremacy over the indigenous system. A concern with prestige, both of the empire in general and of the individual officer as a representative of that empire, was always a major concern of the Political Department officers and this was matched by the IMS officers. In matters such as dress, behaviour, learning the local language, and so on, these officers deliberately set out to impress the indigenous peoples; although given that the standards they maintained and projected were British rather than Himalayan, the desired effect was not necessarily achieved.<sup>23</sup>

At the beginning of the 20th century, by which time the Indian Medical Service comprised around 600 officers, entrants to the IMS were required, under the 1895 'Regulations for the examination of candidates for admission to Her Majesty's Indian Medical Service', to be aged 21-28, married or unmarried, and British subjects with a diploma under the Medical Act to practice medicine and surgery. They required a certain minimum of marks in medical subjects, modern languages, and natural science, and needed 'a recommendation from some person of standing in society...to the effect that he [the candidate] is of regular and steady habits...and a certificate of moral character from a magistrate, or a minister of the religious denomination to which the candidate belongs.'<sup>24</sup>

Whereas officers in the Royal Army Medical Corps were normally attached to a British military hospital, IMS officers were posted to a regiment. They were required to remain there for at least two years, in sole medical charge of their regiment, thus gaining familiarity with

Bhutanese students, education in India was found more productive. In both the Bhutanese and Tibetan cases, the influence of Charles Bell on the indigenous initiatives may be presumed.

<sup>22</sup> *ibid*, p.174-75. I hope to explore this issue in greater depth in the future.

<sup>23</sup> On prestige in the imperial context, see McKay, *Tibet and the British Raj...*, esp. chapter 10. It is doubtful, for example, that Himalayan society appreciated that as the IMS was a mounted service they were entitled to wear spurs in the mess!; OIOC, MSS EUR C435, H.E. Short, *In the Days of the Raj, and After, Doctor, Soldier, Scientist, Shikari*, unpublished ms., written some time after 1971, pp.6-9.

<sup>24</sup> OIOC, L/MIL/7/1409, Military Department form 125, dated 1895; an earlier version contained here [ref. -420, undated, c. 1880?] had required that 'the Candidate must sign a declaration upon honour that both his parents are of unmix'd European blood' but the Indianisation of the IMS had begun by the period under consideration.



Indian conditions. After that period they were allowed to apply for a posting to a civil medical post in a province or district, (where there were opportunities to increase their income by taking private patients). Alternatively they might apply for Political Department posting, join the Public Health Department or the prison service, or to go into research.<sup>25</sup>

The quality of the IMS officers naturally varied, as might be suggested even by an examination of their reports in this instance. At their best, however, they were dedicated officers with a genuine sense of mission.<sup>26</sup> But aside from a general curiosity, none of them appear to have displayed any real interest in the indigenous medical systems. By the early years of the 20<sup>th</sup> century, imperial certainties and the scientific advances of the late 19<sup>th</sup> century in such matters as germ theory, had given the Medical Officers an overwhelming confidence in Western biomedicine. Towards the end of the colonial period, however, when the unquestioned faith in the superiority of Western science and culture had been challenged by world wars and doubts over the ability of science to conquer all medical problems, there is evidence of their adoption of cultural, if not medical, concessions to the indigenous traditions.<sup>27</sup>

After Bell's final retirement, the next visit to Bhutan by a British Political Officer was made in 1922 by Major (later Lieutenant-Colonel) F.M. Bailey, who was appointed to the Gangtok Residency in June 1921. Bailey, a protégé of Younghusband and O'Connor who had served on the Younghusband mission and as Trade Agent in Gyantse for various periods in 1905-09, visited Bhutan in order to personally invest King Ugyen Wangchuck with the G.C.I.E. (Grand Cross of the Indian Empire). He subsequently crossed into Tibet to make his annual inspection of the Trade Agencies at Gyantse and Yatung. Among those who accompanied him on this mission was Dr J.C. Dyer IMS, an Anglo-Indian doctor who had previously accompanied Charles Bell during his year in Lhasa in 1920-21.<sup>28</sup>

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<sup>25</sup>. Short *ibid*, pp.14-15.

<sup>25</sup>. Although none, perhaps, matched the dedication of the Jesuit Father William Mackey who served in Bhutan in the post-imperial period. In an extreme example of dedication Father Mackey had all his teeth pulled out in Calcutta because he had no access to a dentist while in Bhutan; see Howard Solverson, *The Jesuit and the Dragon: The life of Father William Mackey in the Himalayan Kingdom of Bhutan*, Montreal (Robert Davies Publishing) 1995, pp.169-70. I am indebted to Françoise Pommaret for referring me to this work.

<sup>27</sup>. For example, Dr James Guthrie IMS, the last Civil Surgeon for Sikkim, Bhutan and Tibet, would carry out operations on days selected by the monks as auspicious for that patient; information courtesy of the Guthrie family and Mr Michael Anderson, March-April, 2003.

<sup>28</sup>. The early Political Officers, including Bell, had objected to the employment of 'Indian' [e.g. Hindu or Muslim] doctors in the Himalayan regions under their control, largely for reasons concerned with the projection of European prestige. But the Anglo-Indian Dr. Dyer, who spent several weeks in Lhasa with Bell until Lt-Colonel Kennedy arrived, was, perhaps rather reluctantly, well-rated by Kennedy, who wrote that '[j]udging from the little I saw of him here, I

Dyer subsequently submitted a list of medical conditions encountered on this mission, on the grounds that 'it may prove useful as a guide to the selection of medicines for future occasions' in which similar missions were undertaken.<sup>29</sup> Dyer's report [See Appendix 'A'.] does not, unfortunately, distinguish between cases treated in Bhutan and those treated in Tibet, and we must presume that most of the 433 cases he dealt with were in the latter country. He does record, however, that chronic ulcers, which formed around 30% of the cases he dealt with, were especially common in Bhutan, and that while they were 'said to be the result of the bites of certain insects, undoubtedly a fair proportion of them were of syphilitic origin.' He also notes that 'the lack of facility [*sic*] and the short halts at the camps', made it difficult to carry out any operations, 'although a number of surgical cases necessitating operation came to seek relief and had, unfortunately, to be denied.' In addition, Dyer notes that altitude sickness among members of the mission 'was more or less general over the high passes' and that mission servants who had previously suffered from malaria were temporarily incapacitated by fever.

Bailey again visited Bhutan in 1924 to attend the installation of Sonam Topgay Dorji as Governor of Ha province, but, presumably for financial reasons, without an accompanying IMS officer. In 1927, however, following the death of Sir Ugyen Wangchuck in 1926, Bailey led another mission to Bhutan to attend the investiture of the new king, Jigme Wangchuk. On this occasion, he was accompanied by Major R.L. Vance IMS. Vance was an experienced official who had served as Medical Officer in Gyantse from September 1924 to September 1927 and whose political acumen had been recognised when he acted as the British Trade Agent there between May 1926 and January 1927. To date, however, I have not succeeded in locating Vance's report on this mission.

The next British mission to Bhutan was undertaken by Lieutenant-Colonel J.L.R. Weir, who, having briefly acted in the post as early as 1911, succeeded Bailey as Political Officer in Sikkim in October 1928. In September 1930, while he was in Lhasa on a mission to the Dalai Lama, Weir reported that he had received an invitation from the Maharaja to visit Bhutan – although such invitations were in fact, usually solicited by intermediaries on the Political Officer's behalf when they desired to undertake such a mission.<sup>30</sup>

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think Dyer is quite good professionally - quite above the average of his class ... quite sound as a G.P.' [My emphasis]; OIOC, MSS Eur F157-224a, Kennedy to F.M. Bailey, 28 July 1921.

<sup>29</sup> The reports of the Political Officers and their attached medical reports are to be found in OIOC, L/P&S/12/2222-28; report by Dr Dyer dated 21 September 1922.

<sup>30</sup> See McKay, *Tibet and the British Raj*, esp. chap. 8.

Weir requested permission from the Government of India to be allowed to take up the invitation, particularly on the grounds that it provided an opportunity to invest Jigme Wangchuk with the K.C.I.E. that he had recently been awarded in the King's birthday honours. Weir also requested the services of Lieutenant M.R. Sinclair IMS, who was with him in Lhasa at the time. (Sinclair had served as Medical Officer in Gyantse for 18 months in 1931-32, and again accompanied Weir on a second mission to Lhasa towards the end of his term there.) Weir also suggested that a sub-assistant surgeon should accompany Sinclair, to assist with administering anaesthetics etc., and that medicines to the value of 1,000 rupees be taken.<sup>31</sup> Government financial stringencies were always a factor that the Political Officers had to take into account in their requests for funding on such missions and Weir, well-versed in such matters, pointed out that

The political advantage of these medical officers being with me is too obvious for me to lay further stress on it. My proposals have been framed with a view to gaining a maximum of political advantage with a minimum expense and I would request that they may be granted.

Weir's visit to Bumthang was duly sanctioned by the Government of India, but events in Tibet dictated that the journey was not made until January 1931. Weir's subsequent report included a detailed account of the 'Medical Aspects of a Tour in Bhutan' that painted a bleak picture of health conditions in the kingdom.<sup>32</sup> It began by stating that

Bhutan ...is a country whose inhabitants are poor and the majority of whom are ignorant. Owing to centuries of interbreeding and the prevalence of such diseases as venereal, they are of poor physique and only the fittest can survive. Before many years, however, the survivors, having no knowledge of personal hygiene, suffer from such complaints as pyorrhoea, gastritis and gastric ulcer, gonorrhoea and unsightly goitres. The Bhutanese never cleans his teeth or washes his mouth and his food is, as often as not, rotten meat. The result is that he is slowly and chronically poisoned by a combination of enteritis and toxic absorption from oral sepsis. The percentage of the population suffering from Gonorrhoea and Pyorrhoea cannot be less than 80%. Furthermore, owing to their complete lack of sanitation and to the consumption of badly cooked infected meat, especially pork, Ascariasis and Taeniasis are almost universal.

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<sup>31</sup>.OIOC, Weir report dated 2<sup>nd</sup> April 1931.

<sup>32</sup>.Sinclair's comments are notably more critical than those of John Claude White, who remarks on the cleanliness of Bhutanese houses etc.; see White, *Sikkim and Bhutan*, p.12. This may reflect changing European standards, although White's remarks are made in the context of disagreeing with earlier reports. White's remarks are thus an exception.

The report then noted that, as in various European countries such as Switzerland, villages situated in the valleys of mountainous regions were prone to endemic goitre. Such was the demand for Sinclair's services that the medicines carried proved totally insufficient, and additional supplies were obtained from the British Trade Agency at Yatung during the course of the mission. The demand for vaccination against smallpox, however, did not prove as great as expected, which was attributed to the fact that those previously inoculated considered themselves fully protected. Medical treatment of 1,343 patients, and vaccination of 370 persons was recorded, but it was noted that this was probably an understatement as the 'seething mob' of patients prevented efficient clerical recording. No complete breakdown of conditions treated was given, but it was stated that

[T]he complaints met with were chiefly Gonorrhoea, Goitres, Gastric troubles, Syphilis and joint pains. The goitres are of the Colloid Cystic type, many becoming large and pendulous. Toxic symptoms are rare and I only saw one case of Graves disease. Joint pains are due either to bad Pyorrhoea, to gonorrhoea or to both, and as no cure can be expected in one evening's treatment, Epsom Salts becomes a ready and effective form of treatment for which kudos may be gained. Ringworm and other skin diseases, Chronic Bronchitis, various eye troubles and Intestinal Parasitism, *e.g.*, Round and Tapeworms, make up the remainder of one's cases. Epilepsy, Congenital Heart disease, cretinism and various congenital deformities such as Harelip and cleft palate are not uncommon ... cases of Nodular and mixed Leprosy were seen, but as these were far advanced with large ulcers all over the body, little could be done for them during a night's halt ... [except at] Bumthang [where] the same type of cases were seen, but, as we halted there ten days, much was done in the way of healing ulcers and curing the commoner maladies. One case of Pulmonary Tuberculosis was seen. During the trip, two operations were performed under chloroform anaesthesia and several under local anaesthesia. Among the latter may be mentioned a Harelip, Papillomata, Sebaceous cysts and ganglions. Owing to the Bhutanese custom of squatting cross-legged, large adventitious Bursae form over the external malleoli,<sup>33</sup> Suppuration frequently occurs and large callous ulcers remain.

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<sup>33</sup>. A point that may be noted in regard to the cultural indicators involved in medical conditions.

Given that among the intended readership of these reports were future medical officers visiting the kingdom, the report concluded with further notes and suggestions for the guidance of such readers. It noted that on their return journey patients were waiting in each village and along the roadside. Many of them were suffering from malaria contracted during the winter months when Bhutanese journeyed south to trade, and the report warned that '[t]hey all begged for quinine and unless a considerable quantity be taken, one's stock runs out in a few days.' It concluded by warning future medical visitors to ensure a plentiful supply of medicines were carried, including supplies in case of cholera outbreaks, and noted that it was not necessary to carry supplies of empty bottles as the local people were accustomed to carrying their medicines in bamboo tubes.<sup>34</sup>

Weir's term as Political Officer in Gangtok ended in January 1933. He was succeeded by Frederick Williamson, who unlike his two immediate predecessors, had a civil rather than military background. He had previously visited Bhutan with F.M. Bailey in 1925 and, as was the case with all of the British Political Officers appointed to responsibility for Sikkim, Bhutan and Tibet after the days of John Claude White, he had previously served as British Trade Agent in Gyantse. Williamson visited Bhutan in the summer of 1933 (and again briefly to Ha in 1934<sup>35</sup>) and among his entourage was Medical Officer Captain David Tennant IMS, who began a two-year term as Medical Officer in Gyantse later that year.<sup>36</sup>

As in the case of Weir's mission, a sub-assistant surgeon accompanied Tennant. Also joining the party were Frank Ludlow and George Sheriff, the famous Himalayan botanists. Old friends of Williamson, both men were to serve terms as Head of the British Mission in Lhasa during World War Two, although Williamson himself died of uraemia during a mission to Lhasa in 1935.

Tennant's medical report on this mission, [see Appendix 'B'], was brief and superficial. Other than noting the most prevalent conditions encountered – venereal diseases, alimentary complaints, goitre,

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<sup>34</sup>The most comprehensive analysis of required drugs for medical practitioners in the Himalayan regions in that period is probably, however, that of Major (later Lieutenant-Colonel) J.H. Hislop, I.M.S. who accompanied Major F.M. Bailey to Lhasa in 1924; see OIOC, L/P&S/10/1113-4604, 'Hints to Medical Officers going to Lhasa' by Major J.H. Hislop IMS, attached to Bailey's Lhasa mission report, dated 28 October 1924.

<sup>35</sup> Collister, *Bhutan...*, p.193; on that occasion the Williamson's were accompanied by Dr Hendriks, the Civil Surgeon, and thus their personal G.P. in Gangtok; see Williamson, *Memoirs...*, p.167.

<sup>36</sup>The journey also served as Williamson's honeymoon!; see Margaret Williamson, *Memoirs of a Political Officer's Wife in Tibet Sikkim and Bhutan*, London 1987.

rheumatic disorders and dental conditions, no breakdown of conditions treated was given.

The report records the treatment of a total of 764 patients during the two month journey, although this figure includes an approximated figure of 200 cases drawn from the mission's own baggage coolies. Tennant attributed the comparatively light work-load<sup>37</sup> to two factors; the warm summer weather (the season, in which the Bhutanese were, he claimed 'more concerned about their crops than their ailments'(!)), and the existence at Bumthang of a newly qualified (Bhutanese) doctor, who was treating as many patients per day as was Tennant. The Bhutanese doctor, however, had difficulties in his relations with the 'lamas' and, having unsuccessfully treated the younger brother of the Bhutanese ruler for typhoid, that patient's death had done little for his reputation.

After Williamson's untimely death in Lhasa in 1935, he was succeeded as Political Officer by Basil (later Sir Basil) Gould, who was to remain in that position until 1945, with only one six-month period of leave. Like his mentor, Sir Charles Bell, Gould was a Wykemist who had served in the ICS, and like Bell and Hugh Richardson, who served in Lhasa under Gould's command, he devoted most of his career to the study of the history and culture of the Himalayan peoples.

In both 1935 and 1938 Gould led missions to Bhutan accompanied by Captain W.S. Morgan. I.M.S. Morgan, was the Gyantse Medical Officer and he had previously been part of Gould's 1936-37 mission to Lhasa (which had culminated in the establishment of a permanent British-Indian mission there). While Morgan's medical reports do not appear to have survived, Gould's report on his 1938 mission included lengthy comments on one medical-related matter.<sup>38</sup> Gould, in the wider context of the growing Nepalese population, was concerned that the Bhutanese population was declining, and that the people were 'tending more and more to become sterile, or to produce children who die in early infancy.' There was, he noted

[A] time when it was ... held that ... certain remote races, when confronted with modern civilisation, were apt to die off for no apparent reason except a failure of vital energy. But in most cases investigation has disclosed the fact that such dying off is due to the introduction of some definite new factor such as gin,

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<sup>37</sup>. His efforts may be contrasted to those of Lt M.R. Sinclair IMS and the long-serving Sikkimese doctor Bo Tsering, who on tour in Tibet in 1930 vaccinated 12,199 persons in 2 months, including 2,500 in 2 days in Shigatse; OIOC, L/P&S/10/1113-8573, Lt-Colonel J.L.R. Weir's Report on Lhasa Mission, dated 18 November 1930. Even given the population disparities one might doubt the strength of Tennants' efforts on this mission.

<sup>38</sup>. OIOC, Gould report dated 26 August 1938.

unsuitable clothing or food, or specific disease. In the present case, while in the entire absence of census or other statistics it is difficult to adduce definite proof, there appears to be little doubt that in fact a serious decline has actually set in, and that, while enteric fever and other diseases, and possibly certain social and economic causes, play their part, the decline is in the main attributable to venereal disease, especially Syphilis.

Noting that venereal diseases were 'extremely prevalent in adjacent areas of Tibet and that ... intercourse between Bhutan and Tibet [*sic!*] ... is much more frequent than was formerly the case', Gould suggested that, unlike the Tibetans, the Bhutanese had little resistance to the effects of these diseases. He further noted that the expense and lengthy nature of treatment for venereal diseases made their elimination difficult, 'coupled with the fact that even a few injections are apt to produce such alleviation as to render an average ignorant person unwilling to subject himself to further treatment.' Gould considered, however, that there were grounds for optimism as to the future, given

a determination on the part of the Maharaja and of his right-hand man, Raja Dorji, and also of their wives ... to face the facts, and a social system affecting all of the Bhutanese under which a personal lead given by such persons would be apt to be particularly effective. And I would emphasise the fact in the present instance it is not the case that a British officer is urging a Durbar, or a local authority, to direct attention to health, but that it is those in authority in Bhutan who have, constantly and with great earnestness, directed my attention to the matter, and have pressed me to bring it to the notice of the Government of India.

Yet Gould admitted he could propose no immediate solution to the problem, given that the Government of India had refused the previous request made by Williamson for an increased subsidy for Bhutan 'to counteract syphilis.' He could only state that

Possibly the Government of India may be disposed to consider whether, in place of money, they could see their way to contribute drugs, together with aid in the matter of medical staff. [Or] Possibly there may exist some organisation, or some private individual, to whom the study and cure of syphilis in a circumscribed and hitherto completely undoctored area would [*sic: would*] be matter of such interest as to justify the expenditure involved. If on the other hand it should be considered that the seriousness of the case as represented me by the Bhutan Durbar and by [Medical Officer] Captain Morgan may have been exaggerated and requires further study, I am assured that the Durbar, which is by no

means disposed ordinarily to welcome visitors, would afford to an investigator every facility which he might require.

Other voices, such as that of Dr. Graham, the famous missionary doctor of Kalimpong, added support to Gould's appeal,<sup>39</sup> and the issue was presumably a factor in the reorganisation of the British imperial government's medical organisation in the Himalayas in 1940. In that year the medical arrangements for Bhutan and Tibet were separated from those for Sikkim, and a new position, that of Civil Surgeon, Bhutan and Tibet, was created to oversee medical arrangements in Bhutan and Tibet, while Sikkim became the sole responsibility of a Medical Officer based in Gangtok. The official headquarters of this new post was at Gyantse, and it became, in effect, that of Medical Officer to the British Mission Lhasa, with the officers concerned increasingly spending much of their time in Lhasa. But the first holder of the post, Capt. W.H.D. Staunton IMS, who had previously served in Sikkim, although not in Tibet, visited Bhutan in 1941 in a purely medical capacity, rather than as accompanying Medical Officer to a visiting Political Officer.

Gould was both a strategic thinker and a politically astute bureaucrat who followed the model established by Charles Bell. Bell had been largely responsible for establishing the political and administrative strategies of strengthening the Himalayan kingdoms as bulwarks against threats from Chinese expansion (and the perhaps less realistic, but none-the-less constant concern of the frontier officers; Russian infiltration or subversion). He had also established the tradition among the Sikkim Political Officers of mastering the complex art of promoting policies by maintaining consistent policy aims, and proposing solutions to all manner of problems (some of which were clearly exaggerated) that furthered those aims. Gould followed this model, and he finally succeeded in gaining an increased subsidy for Bhutan in 1942, despite wartime financial stringencies by the Government of India.<sup>40</sup>

After transiting Bhutan with Hugh Richardson en route to Tibet in 1941, Gould paid another official visit to Bhutan in February of 1943. He was accompanied on this occasion, not by the Civil Surgeon for Bhutan and Tibet, but by the Civil Surgeon in Sikkim, Captain St John Hendricks, who had briefly visited Bhutan with Williamson in 1934.<sup>41</sup> The reasons for this are not stated in the official sources, but Hendricks would have been Gould's personal physician at his Residency in Gangtok, whereas

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<sup>39</sup>.Collister, *Bhutan...*, p.192.

<sup>40</sup>.*ibid.*, pp.192-93.

<sup>41</sup>.*ibid.*



there were apparently considerable personal differences between Gould and Major Hislop, then Civil Surgeon in Bhutan and Tibet.<sup>42</sup>

The presence of a Medical Officer on political missions, it must be remembered, was to a considerable extent due to the need to ensure the health of the Political Officer, and Gould, like so many of his contemporaries during the war, was at that time over-worked and under considerable strain due to the lack of leave and of sufficient support personnel. Indeed his health eventually declined to the point where he was forced to leave, though he later recovered.

Hendrick's report on the mission (see Appendix 'C') was purely statistical, but Gould's report notes that 50% of the King's 80 attendants 'presented themselves for treatment for gonorrhoea.' The percentage was lower in the general population, but they suffered heavily from goitre, malaria, and worms, all of which, Gould considered, contributed to decreasing fecundity. The figures drew a definite response, for as Gould reported

As a result of discussions with Captain Hendricks the Maharaja decided to take prompt steps to introduce mass treatment of the population near his home Bumthang for venereal disease and to place a considerable order for drugs of various kinds. His request for a supply of quinine has been referred to the Government of India.

Gould claimed considerable credit for what he considered a growing interest in Western biomedicine among the Bhutanese. There was, he stated

...no doubt that the creation in 1940 of the post of Civil Surgeon, Tibet and Bhutan, and the Civil Surgeon (first Captain Staunton and then Colonel Hislop) have done much to awaken interest in medicine in Bhutan. There has been no opposition on the part of the monks or of any other class and, the more frequent the visits, the more the people seem to respond to them.

Gould concluded his comments with the suggestion that the Assamese authorities might contribute to improving sanitation in the border regions, but it is doubtful that this was acted on. Gould paid a further visit to Paro later that year with the Medical Officer Lieutenant-Colonel E. Elliot IMS,<sup>43</sup> while his successor as Political Officer in Sikkim,

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<sup>42</sup>Hislop, a hard-drinking Scotsman who served as Civil Surgeon for Sikkim, Bhutan and Tibet in 1942-44, was probably the author of an anonymous petition against Gould sent to the Government of India and preserved in the National Archives of India. The Foreign Department indexes give the reference as F.No 30 C.A., although the file is currently closed, as are all Tibet-related files after 1913.

<sup>43</sup>Collister, *Bhutan...*, p.195.

A.J. Hopkinson ICS, who had served in Gyantse in 1927-28, visited Bhutan in 1947 to present the King with a K.C.S.I. Hopkinson was accompanied by a Lieutenant-Colonel L.K. Ledger IMS,<sup>44</sup> but to date I have not succeeded in locating the medical reports of these officers, neither of whom are recorded as visiting Tibet, where the Civil Surgeon for Bhutan and Tibet, Major James Guthrie, the last in the long line of British officers of the IMS concerned with these Himalayan states, was stationed in Lhasa during the period 1945-1950.

In conclusion we may note several points that arise from the above survey. Bhutan (and Sikkim) were a secondary priority to the British Political Officers in Gangtok, who, despite their designation, were primarily concerned with Tibet. Yet in retrospect both of the smaller states derived greater benefit from the British presence than did Tibet, and the nature of their political relationship with the Government of India meant that after the Indian independence in August 1947 Bhutan and Sikkim avoided the devastating impact of Chinese communist rule that was suffered by the Tibetans. While Sikkim's administrative submission to the Government of India saw it absorbed into full Indian statehood after the mid 1970s, Bhutan of course, retained its independent status.

There were a number of agents to whom we might attribute the introduction of biomedicine into the Himalayan regions. These included Christian missionaries, private or demi-official European travellers, commercial interests, and the Government of India. But in Bhutan the policy of excluding missionaries and travellers meant that only the latter agency was a significant factor. The visits by the IMS officers demonstrated the popular demand for biomedicine in Bhutan, due primarily to its obvious, or immediate efficacy, not least in regard to epidemic conditions. The fact that free medical treatment was provided to the non-elite classes must also have been a significant factor in its popularity.

In using local vaccinators, the British demonstrated that biomedicine was not an exclusively European preserve but could be practiced by all, and thus laid the groundwork for the development of the modern indigenous medical system in Bhutan. Naturally the British sources used for this study do not highlight resistance to biomedicine, which, on the basis of Dr Tennant's remarks on the monastic opposition to the Bhutanese biomedical practitioner in the 1930s, we must assume did exist, not least among indigenous practitioners of medicine. But critically

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<sup>44</sup>*ibid.*, pp.195-96.

perhaps, the Bhutanese rulers from Ugyen Wangchuck onwards were keen to introduce biomedicine into their kingdom, and despite the extreme financial restrictions, encouraged its development there, firstly through allocating funds for general education, and then through specialised education and training.

In that Ugyen Wangchuck became an ally of the British and was a prime proponent of biomedicine, this process might be seen by some as located within the concept of the understanding of British imperialism as an exploitive system relying on the support of the local elites who co-operated with the British through narrow class interest. But at least in the medical sphere, the non-elites certainly benefited from this development. While the greatest benefits were to the health of the urban centres and the elite groups there, that situation was and is typical of most, perhaps all, of the world. But for the people of Bhutan the epidemics that had once devastated the land could now be contained, and given that their relationship with Britain was of little or no economic benefit to the imperial power, the introduction of biomedicine there can surely only be criticised from a privileged theoretical position.

Clearly the use of other sources would be needed to adequately analyse the interaction between Bhutanese traditional and biomedical systems as a part of this process, to discuss resistance, or to judge the efficacy of the indigenous system(s); which has not been the intent of this article. We may, however, conclude that in the case of Bhutan, the IMS officers and the political relationship between the Bhutanese rulers and the Government of India were the primary factors in the introduction of biomedicine into Bhutan.

When I wrote this paper, I was considering the British records as useful guides to actual health conditions within Bhutan. On reflection, however, it may be that when the records show the prevalence of a particular disease - venereal diseases for example, this may actually indicate the Bhutanese understanding that biomedicine was particularly effective for that condition, but not for other diseases for which indigenous medicine was regarded as effective.

## Appendix A

List of cases treated in Bhutan and Tibet during the months of June, July and August 1922.

Bronchitis, acute and chronic	4
Conjunctivitis	22
Cretinism	1

Colic, intestinal	4
Constipation	49
Congestion of the liver	1
Diarrhoea	17
Dysentery	3
Dyspepsia	72
Dysmenorrhoea	1
Enteritis, acute	2
Goitre	4
Gonorrhoea	8
Headache	1
Injury, minor	2
Leprosy	1
Malaria	1
Nasal catarrh, acute and chronic	8
Rheumatism	35
Syphilis	12
Ulcers, chiefly chronic	158
Worms, round	1
Wax in ear	22
Surgical Operations	
Amputation of the upper third of thigh for a compound comminuted fracture	1
Removal of tumours	2
Mammary abscess	1
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<i>Total</i>	433
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*J.C. Dyer, Civil Surgeon, to Political Officer Sikkim, 21 September 1922.*

## **Appendix B**

### Medical Report on the Tour through Bhutan, 1933

The tour through Bhutan occupied most of June and July, and while there was a great deal of rain the weather was comparatively warm. Halts were made at various places and in each a dispensary was set up. The total number of patients treated in each of these places amounted to 564. Throughout the whole journey an average of ten cases per day were treated among the baggage coolies of our party, giving a further number of approximately 200. In most places it was noticeable that people were not very inclined to seek treatment, but this may be due in part to the time of the year,

ailments being very much less than in the colder weather. Also most people were more concerned about the crops than their ailments.

In Bumthang a newly qualified doctor is at present available and on enquiry I found that he was treating daily as many patients as were seeking treatment from me. However it seems that he is not getting the support he should as on several occasions the lamas have been allowed to interfere with his patients and his treatment. Shortly after our departure towards Tibet a younger brother of the Maharaja fell ill – presumed Typhoid Fever – and died about a month later, being treated throughout by the young doctor. In view of the above I do not suppose this will enhance the reputation of Western Medicine in spite of the fact that such a disease is of a very serious nature.

In Ha however there is a more or less permanent dispensary, where owing probably to a higher percentage of educated persons, treatment is readily sought after. No major surgery was at any time attempted as no skilled assistance was available, but minor surgery was carried out when required.

The following is a list of cases treated throughout the tour:-

Ha	94
Paro	100
Wangidipodang	90
Tongsa	30
Bumthang	250
Total	564
Treated on the road Total	200
Total number of cases treated	764

The prevalent diseases were as follows:-

- Venereal disease (predominant)
- Alimentary disease – mostly intestinal parasites
- Goitre
- Rheumatic disorders
- Dental conditions, very prevalent.

The hospital orderly from Yatung accompanied the party throughout the tour.

*David Tennant*  
*Captain I.M.S.,*  
*Medical Officer on tour with the Political Officer in Sikkim*  
*Gyantse, Tibet;*  
*October 1933.*

**Appendix C**

Medical Report on Patients Treated at Camp Bhutan

The dispensary was open for 7 days from the 19<sup>th</sup> to the 25<sup>th</sup> February 1943.

A total of 248 cases were treated - made up of the following diseases

Gonorrhoea	71
Malaria	47
Worms and Constipation	55
Goitre	33
Syphilis	6
Minor Injuries	24
Coughs and colds and minor ailments	12

The chief drugs expended during the period

Quinine sulphate	12 ozs
Ext. Filicis Liq.	6 ozs
Santonine	½ oz
Tinct. Iodine	12 ozs
Copaiba	12 ozs
Mag: Sulphas	6 ozs

Small amounts of the following

Tinct:	Senega
Vin:	Ipecac
Sodii:	Salicylas
Tinct:	Hyocyamus
Sodii:	Bicarbonas
Tinct:	Cardoman Co.

Daily Attendance

19th	February	13 cases
20th	February	34 cases
21th	February	30 cases
22nd	February	14 cases
23rd	February	24 cases
24th	February	30 cases
25th	February	<u>103 cases</u>
		Total 248 cases

*Sd/- W.Hendricks*  
*Civil Surgeon, Sikkim Agency*

Dewachu  
*The 25.2.43.*