Chapter 4

Two Swiss Female Doctors in Karnataka: Medicine and Religion between India and Switzerland

Philippe Bornet

Abstract: The chapter deals with the biographies of two women doctors who ran mission hospitals in Udupi and Betageri (Karnataka) in the period between the 1920s and 1954: Eva Lombard (1890–1978) and Elisabeth Petitpierre (1893–1983). A focus on the formative years in Switzerland attempts to recontextualize both itineraries within a history of the accessibility of medical studies for women and of missionary vocations in the Swiss-French part of Switzerland. Several aspects of their activity in the mission hospitals of Udupi and Betageri are then analysed: the links between "scientific" medicine and religion in this context, the institution of the hospital as a closed space in which behaviours and values could be propagated, the relations with local medical traditions, and the cultural compromises that had to be negotiated, notably with respect to castes and food. In conclusion, the image of India propagated in Switzerland by the two protagonists is considered, underlining all the ambiguities of their position, between feminism, religious commitment, orientalism and imperialism.

1 Introduction

The Kanarese Evangelical Mission's (KEM) most enduring heritage is probably to be found in the two hospitals it managed and developed, in Udupi and Betageri – still existing today under the names of Church of South India (CSI) Lombard Memorial Hospital and CSI Basel Mission Hospital Gadag Betgeri respectively. Both institutions were supervised for a long period of time by two Swiss French women, Eva Lombard (1890–1978) and Elisabeth Petitpierre (1893–1983), who remained in that position for several decades, until 1954.

Following Headrick's groundbreaking work, many studies have analysed the spread of medical techniques outside of Europe as a "tool of empire," illustrating the hegemony of Western medical institutions over local practices.[1] And indeed, the eighteenth and nineteenth centuries witnessed the progression of a Western medical epistemic culture that claimed a "unique access to truth about

1 Headrick 1981

the body, health, and disease,"[2] in order, first, to heal colonial agents.[3] While not contesting this crucial observation, recent works that deal with the history of medicine in India, especially in the twentieth century, tend to slightly complicate the narrative.[4] At least since the end of the nineteenth century, if not before, the Western medical system was progressively appropriated and contributed to the construction of a "national medicine." It was also criticized and had to compete with revitalized forms of traditional medicine. There is then no clear divide between "colonial" and "national" medicine, the latter emerging at least in part out of the former. In particular, it is striking to observe that in the twentieth century, some Indian elites were perfectly in line with Western discourses about hygiene, revealing deep fractures on these issues within the colonial Indian society itself.[5]

In this framework, the case of Christian medical work carried out by people not directly associated with an imperial power in the early twentieth century provides an interesting example which might shed light on unexpected points of friction and contact. At least three elements deserve a close examination:

1. the medical, but also the cultural and religious frameworks that the Swiss doctors brought with them and tried to implement in the field;
2. the adaptations that had to be made and the possible contacts with local medical practices and cultural conceptions of the body;
3. the potential impact that these activities had back on the Swiss context, in terms of either practices or discourses.

Before addressing these points, it is first necessary to provide a few biographical elements about Eva Lombard and Elisabeth Petitpierre and to introduce the medical institutions in which they worked.[6]

2 Lombard and Petitpierre: From Switzerland to India

2.1 Women in the Medical Field

At the beginning of the twentieth century, the Basel Mission (BM) progressively realized that medical care in India had to be provided separately for men and for

2 Lal 2003, p. 15.

3 See for example Bala 1991; Kumar 1995, 1998.

4 See for example Arnold 1993; Bhattacharya, Harrison & Worboys 2005; Hochmuth 2006; Hardiman 2008.

5 Lal 2003, pp. 30–31.

6 There is only one article on Lombard, that by Tikhonov 2005, and none on Petitpierre. See however Hofstetter's dissertation (Hofstetter 2012) which deals with BM doctors active in Asia and Africa, including Lombard and Petitpierre, and the biographical note in Anderson's dictionary, 1999, pp. 408–409.

women. This created a need for women working as medical specialists and the BM sent nurses, deaconesses and young women as Bible readers with the role of "visiting houses and preaching."[7] The more prestigious role of doctor was, however, still reserved to men. This was characteristic not only of conservative missionary contexts such as that of the BM, but also of medical studies and hospitals back in Europe.[8] Until 1918, roles typically endorsed for women in the BM were those of teachers, nurses and "Bible women," who were specialized in reading passages of the Bible to patients. Other missionary societies were slightly more "progressive:" the American Ida Scudder (1870–1961) worked as a doctor in South India from the beginning of the twentieth century under the aegis of the Reformed Church in America. Things began to change precisely during the KEM time, with the enrolment of single women who progressively took up important roles, especially in the medical domain. For them, these new possibilities can be considered as ways to escape more traditional roles at home.[9]

This evolution is probably related to the fact that Switzerland was one of the rare places where curricula in medical studies were available to women by the end of the nineteenth and beginning of the twentieth century. In Zurich a Russian student, Nadezhda Suslova (1843–1918), was able to take the examinations to obtain a medical degree as early as 1867. As a city marked by a few decades of liberalism, the request found sympathetic ears and was eventually accepted. At the examination, the jury recognized that "[the] thesis proved the aptitude of women for scientific work better than any theoretical discussion of the woman question."[10] Following Suslova's lead, women began to come from America, the UK, Germany and Russia to study medicine in Zurich, and later in Geneva, Bern, and Lausanne. The "recently" opened (1890) University of Lausanne had more women than men in that field, and "by 1900, Switzerland was educating more female doctors than the rest of Europe combined."[11]

7 Valiaparampil 1996, p. 231.

8 See Haas 1994, p. 42 for a discussion on the topic in the BM committee in 1898, and the conclusion that women were not fit to serve as doctors in the mission, and Bonner 1992, p. 11, who underlines Germany's conservative context by the end of the nineteenth century: "By both the divine and the natural order, women lacked the rare ability to work in the natural sciences and especially medicine."

9 See the parallel case of Bertha Hardegger (1903–1979), a Swiss doctor who worked in South Africa and Lesotho and was reluctant to come back to Europe even when prohibited from working in South Africa (Charumbira 2015). More generally, one can relate the present case to that of women moving alone to India, not as wives of colonial administrators or as working in "subaltern" functions such as those of nurses or teachers, but as leaders (see Malinar 2013, p. 1116, on Annie Besant).

10 Bonner 1992, p. 37.

11 Ibid., p. 67.

2.2 Eva Lombard and Elisabeth Petitpierre

Born in Geneva in 1890, Eva Lombard grew up in a family that was involved in both banking and religion (evangelical Christianity): her grandfather was Alexandre Lombard (1810–1887), a banker who had been playing a major role in lobbying to keep Sundays as non-working days,[12] and her father, Victor Jacques, was a bank manager who had given up his career to become a chaplain working in prisons. Her mother, a native of Riga, Elisabeth Tomei, was supervising a prison for women.

Lombard completed her medical studies at the University of Geneva in 1920,[13] during which she had been active in Christian student societies and had attended meetings in Istanbul (1911) and Mohonk Mountain House, New York (1913) as a delegate of the "Universal Federation of Christian Students" – a trajectory very much aligned with the development of international Protestant networks at this time.[14] While participating in a missionary conference for young people in Sainte-Croix (Neuchâtel), she was deeply impressed by the talk of a French missionary, Philadelphe Delord (1869–1947), who did work in New Caledonia. She decided to follow his example, enrolled for medical missions, and went to the London School of Tropical Medicine (1920–1921).[15] From 1921 to 1954 she worked in India, first under the aegis of the KEM and then, from 1928 onwards, under that of the BM. Upon her arrival in India she spent one year at the Mission Hospital of Mysore (a Wesleyan/Methodist mission) to learn the Kannada language and to acquire experience in running a medical institution. In Mysore she also conducted "medical excursions," visiting the homes of patients, and trying to convince some of them to come to the hospital.[16] In June 1923 she became the director of a new hospital in Udupi, funded in large part with a donation from her mother. Lombard returned periodically to Switzerland and took advantage of this opportunity to give lectures about her work for different organizations, including the Swiss Association of University Women. She finally handed over her position in Udupi to an Indian doctor in 1954. She however continued to work in another hospital in the region, that of Mandagadde (Karnataka) from 1957 to 1960, before finally retiring to the abbey of Presinge near Geneva, a home for elder deaconesses, where she died in 1978.[17]

12 On A. Lombard and the Society for the Sanctification of Sundays, see Kirschleger 2009.

13 Bielander 1988, p. 46; Tikhonov 2005, p. 217.

14 Clark & Ledger-Lomas 2012.

15 The school was founded in 1899. It was renamed the London School of Hygiene and Tropical Medicine in 1924. On its history see Hardy & Wilkinson 2001. On the concept of "tropical medicine," still prevalent in the interwar period, see Arnold 1997; 2000, pp. 51–52, p. 198.

16 Lombard 1922.

17 Tikhonov 2005, p. 218.

Born in Saint-Aubin (Neuchâtel) in 1893, Petitpierre grew up in a more modest family than Lombard, one that was closely tied to the life of the local Protestant church.[18] Her father, Fritz Petitpierre (1885–1869), was specialized in the trading of absinth, associated with the Pernod family in Couvet, and a member of the local Protestant parish council. Her mother, Marie Petitpierre-Biollay (1857–1948), had joined the Salvation Army where she had found opportunities that were not available in the local Protestant church[19] – probably she was a minister, a possibility offered to women by the Salvation Army since 1907. One of Elisabeth's sisters, Marie Petitpierre (1885–1869), devoted her life to the Salvation Army, for which she travelled extensively from London to Italy (where she stayed about 20 years) before becoming the head of the Salvation Army's Swiss officers' school in Bern, with the grade of colonel.[20] After working as an auxiliary nurse in a local hospital, Elisabeth Petitpierre became interested in medical work. In 1917 she undertook studies in medicine at the University of Lausanne where she obtained a degree in 1923. After internships in Lausanne and Zurich, Petitpierre went on to the London School of Tropical Medicine. She embarked for India in 1927, arrived the same year and stayed in Udupi for two years, replacing Eva Lombard as the head of the hospital. There is no evidence that they had met each other before working in India. In 1929 Petitpierre moved to Betageri where she took the lead at the hospital and stayed in that position until 1954[21] when she left for Cameroon before finally retiring to Switzerland in 1961.

2.3 The Hospitals in Udupi & Betageri

2.3.1 Udupi

As noted in chapter 3 of this volume, Udupi is an important centre for Vaishnavism, with its gigantic complex of *maṭha*s. Continuing an old tradition, the *maṭha*s in Udupi freely fed visitors who asked for it, carefully mirroring and enforcing social hierarchies by allotting specific spaces to specific groups – a practice still extant today and attracting about 5,000 visitors a day.[22] The complex also offered rituals meant to heal a variety of diseases, such as *maḍe snāna*, con-

18 See BMA Petitpierre personal file, SV 171.

19 Petitpierre 1981, p. 8.

20 Zosso 2017.

21 Although she returned to Switzerland from 1933 to 1934, she went back to India from 1934 to 1936, this time to Udupi, then spent 11 years in Betageri, from 1936 to 1947, and finally from 1949 to 1954.

22 On the opposition of the *maṭha*s to the missionaries see Prabhakar 1988, p. 93. See also Rao 2002, pp. 26–62, and pp. 77–80 (on food distribution).

sisting in rolling oneself on plantain leaves which had been used to present food to the deity or Brahmins and thought to cure skin-related diseases.

A suspicious observer might therefore look at missionary philanthropy – and specifically the missionary hospital – as a way to compete with the *maṭha*s: perhaps the hospital could succeed where the mission had failed.[23] One could also observe that the orthodox lifestyle encouraged by the *maṭha*s had reinforced gender divides and strict practices about bodily purity/impurity. From a missionary point of view, the presence of women trained in medicine would therefore be of particular interest to reach a new audience of Indian women. As a sign that the hospital was indeed answering to a need, its inauguration in 1923 was attended by personalities from different communities. The local authorities seem to have appreciated the fact that at last, cheap medical assistance would be available to women and children in the area. Lombard noted that the ceremony was presided by an official from Mangalore, who, "not sympathetic towards the Christian mission, [was] full of admiration for the medical mission." It included speeches from the supervisor of the KEM, Paul Eduard Burckhardt (1884–1976), "one Muslim and two or three Hindus, of which one was speaking in Canarese," and a speech from a doctor of the Udupi Municipal Hospital, who emphasized the importance of a hospital specifically for women.[24] Lombard also remarked that only men attended the ceremony for this women's hospital, suggesting that their wives stayed at home.[25] Though the officials had promised to give partial financial support to the hospital, the promise was never kept and financial resources were almost exclusively from mission sponsors.

Hospitals and dispensaries attracted a diverse public reported by Lombard in the following table (Table 4.1). The numbers show a clear difficulty to reach out to other groups than people identifying as Christians, who are counting as more than the half of patients:

23 See Prabhakar 1988, p. 164 about the "failure" of the missionary station in Udupi and the gender divide related to the orthodox lifestyle promoted by the *maṭha*s.

24 Lombard 1924, pp. 56–57.

25 See a similar remark by Petitpierre 1931, p. 40, about a ceremony held at another (non-Christian) hospital, to which she had been invited: "Our skin colour would certainly not give us access to the middle of these infuriated Gandhists, who want India to the Hindus and who would allow us to be seated at the table of our two missionary brothers, whereas dutifully married women would not dare to accompany their lord and master." (my translation)

Dispensary	1923–1924	Percentages	1924–1925	Percentages	1925–1926	Percentages
Protestant	2,143	52	2,288	56.5	1,894	56
Catholic	1,345		801		680	
Hindus	2,995	45	2,221	40.5	1,855	40.5
Muslims	193	3	144	2.5	171	3.5
Total	6,676	100	5,454	100	4,600	100
Hospital						
Protestant	53	64	79	65.5	78	74.5
Catholic	20		24		25	
Hindus	41	36	51	32.5	34	24.5
Muslims	0	0	3	2	1	0.5
Total	114	100	157	100	138	100
Dispensary	1923–1924	Percentages	1924–1925	Percentages	1925–1926	Percentages
Protestant	2,143	52	2,288	56.5	1,894	56
Catholic	1,345		801		680	
Hindus	2,995	45	2,221	40.5	1,855	40.5
Muslims	193	3	144	2.5	171	3.5
Total	6,676	100	54,54	100	4,600	100
Hospital						
Protestant	53	64	79	65.5	78	74.5
Catholic	20		24		25	
Hindus	41	36	51	32.5	34	24.5
Muslims	0	0	3	2	1	0.5
Total	114	100	157	100	138	100

Table 4.1. "Statistics of Religions." Source: BMA Personal Files SV 183 (Eva Lombard)

A quick glance at the official census for 1921 for the South Kanara region (Table 4.2) shows that the people seeking medical care from the missionary dispensary or hospital were not representative of the whole population, far from it:

	1891	1901	1911	1921
Christians	7 %	7.5 %	8 %	8.5 %
Hindus	81.5 %	80.5 %	79.5 %	79 %
Others	1 %	1 %	0.5 %	0.5 %
Muslims	10.5 %	11 %	12 %	12 %

Table 4.2. "Distribution by District of the Main Religions: South Kanara." Source: Boag 1922, p. 65.

In 1923 a dispensary was opened in the neighbouring town of Malpe,[26] initially located in the building of the church's school, supervised by Hanna Aeschimann (1907–1995). Malpe was a very small fishing town, but it had a temple dedicated to Balarama and a water tank that was supposed to cure the diseases of its devotees. Given the number of texts warning members of the Christian community to not seek the help of "non-Christian medicine,"[27] it is quite likely that the dispensary was meant as a way to compete with the shrine. Lombard paid a visit there once a week, as did later Petitpierre. In 1925 a maternity section was opened, witnessing a process of medicalization of birth and a progressive displacement from the home to the hospital (see below, section 3.3).[28] A major extension took place in the 1930s, after which the hospital had 800 beds, handled 6,000 ambulatory consultations and had a section for treating men.

2.3.2 Betageri

Specialized in dealing with cholera, the Betageri missionary hospital was inaugurated in 1902 and was active until 1914, when its chief doctor, Paul Voland from Konstanz (1886–1914), suddenly died. The hospital was initially only open to men, with a few attempts to organize visits to individual homes to reach women as well. In 1918 William Stokes, an Anglo-Indian who was married to a Swiss woman and had been living in Switzerland during the war, came back to India and resumed activity at the hospital under the aegis of the KEM.[29] He managed to obtain new medical instruments from Bern with the help of a Swiss doctor, Théodore Kocher-Lauterburg.[30] At this point, the hospital was staffed mostly by Swiss French and Indian medical specialists.[31]

26 Sargant 1987, p. 134.

27 For example, the Constitution of 1931 §65, p. 50.

28 Zimmermann 1930, p. 75.

29 On the work previously achieved by William Stokes see Valiaparampil 1996, pp. 120–153.

30 Zimmermann 1930, pp. 71–72.

31 After Stokes left, a doctor from Neuchâtel, Maurice Emery-Dubois, took the lead. Many nurses came from the French-speaking region of Switzerland: Rose Decosterd, Alice Matthey-

In the first semester of 1921, 106 patients received treatment at the hospital, in addition to 4,414 ambulatory consultations – about double that of Udupi.[32] An Indian doctor, Salathiel H. Eden, was appointed in 1925 and served for forty years, while Petitpierre herself joined in 1929 as the new hospital director. By then the hospital was extended with an aisle dedicated to women and children. It could handle 1,600 patients and about 10,000 ambulatory consultations per year,[33] and was finally integrated into the CSI in 1956.[34]

3 Socio-Religious Aspects of Medical Practice

3.1 Two Swiss Women's Perspectives on South India

With no prior scholarly knowledge about Indian history and culture, Lombard and Petitpierre arrived with a number of preconceptions that were in part inherited from missionary propaganda, and in part the result of their learning in "tropical medicine." On the one hand, they tended to idealize nature and landscapes. Thus, arriving by boat in Colombo (Sri Lanka), Petitpierre noted:

> Wonderful land! Something so beautiful does not even come in a dream. We will have a walk and will then leave tonight, travelling by night – sadly – across this island of the Paradise. […] In such a beautiful nature, one feels oneself closer to God.[35]

On the other hand, this idealized view of nature contrasted with harsh judgements about the state of people. Already on the boat that was taking her to Colombo, Lombard wrote the following about her impressions of the "natives:"

> For now, we already have visions of the Hindu life, just looking at the passengers of the third class who boarded the ship in Port Said and in Aden, and who are installed on the steerage with all their paraphernalia. They cook themselves. They brush and cut their hair in a strange fashion, not to mention the way they brush their teeth, with a finger instead of a toothbrush. Sometimes one reads while the others listen, squatting around him […] As for the dress, it is quite diverse, since all these folks come from different countries.[36]

This text first shows the reality of the different classes aboard a boat, and the dominant role of travellers in the upper two classes, observing and objectifying

Doret (1889–1956), Marguerite Greyloz, Anna Ischi, Geneviève Dessoulavy, Edith Burnand, Lucie Delord.

32 Stokes-Arnold 1921, p. 3.

33 Witschi 1970, p. 282.

34 Sargant 1987, p. 139.

35 Petitpierre 1931, p. 15, p. 35 (my translation).

36 Lombard, "Letter to her sister," 17 December 1921, BMA CC-1, 4 (my translation).

their fellow travellers in the third class from above. This is symptomatic of the lasting asymmetric relation between the European doctor, coming from a well-educated elite in Europe, and her Indian patients. In addition, the text mentions a dimension that comes up regularly in Lombard's writings: that of deficient hygiene as a defining aspect of identity and a cause of most problems in India. Poor hygiene, along with superstition and ignorance, compose the main lens through which Lombard – and to a lesser extent, Petitpierre – perceived and described her working field, so that she could write, in a brochure targeting Swiss women about to leave for India:

> Whoever arrives in a tropical country is struck by ambient uncleanliness, dirt that pervades everything, the lack of hygiene among the natives, ulcers and wounds they are suffering from. […] At the end of a day of work, when one has abundantly sweated, after having visited native huts and walked in the dirt, it is necessary to take a bath and to put clean clothes on.[37]

Considering the Indians' uncleanliness in ontological terms, hygienic rules functioned as a way to create a clear separation between non-Indians and Indians – to the point that any contact is perceived as defilement and implies a purification process. This essentialized vision of Indian medical and social issues corresponding to a "tropical climate" was probably inherited from the curriculum taught at the London School of Hygiene and Tropical Medicine. In the same spirit Lombard added:

> Young [missionary women] should understand that they now live among primitives who have a very different mentality to the Europeans, and who are in many respects similar to children. […] We should try to cultivate, with those among whom we are living and with whom we are working, relations of trust and cordiality. If we have to show affection, we should avoid an exaggerated familiarity and learn to keep in all times the dignity of God's children.[38]

In the beginning, Lombard's and Petitpierre's writings paid little attention to socio-political events happening on Indian soil at the time, outside of the small world of the missionary hospital. Soon however, after having learned Kannada and Tulu, both of them embarked on a long process of "demystification." In general, a difference is perceptible between the early letters, more idealistic, and the later ones, much darker. This is particularly true in the works of Petitpierre, who progressively realized that her ignorance favoured the misunderstanding of

37 Lombard 1939, pp. 11–12 (my translation).

38 Ibid., p. 12 (my translation).

social codes, which themselves, as she also discovered, played an essential role in the healing process.[39]

3.2 "Missionary Medicine:" Body and Soul

The religious specificity of the medical mission resides in the assumption that a bodily sick person is also sick in his or her soul. Consequently, "missionary medicine" involved bringing both bodily (medicine, but also the prescription of daily hygienic practices) and spiritual (the Christian message) comfort, with the conviction that both aspects were connected in mysterious ways.[40] Evangelical medical care can thus be described as "holistic" in that it attempts to combine scientific medical procedures and evangelical efforts. This all paved the way for a narrative according to which, if things are made right again by the providential action of good-willing missionaries, "man will bloom like the plants, in the middle of this wonderful nature."[41] This is perfectly coherent with a religious vision of science in which the world is the result of a God-inspired design, a design that scientists set themselves the task to read and understand, as one reads and understands the Bible.

In this sense, and somewhat ironically, the relation between medicine and religion largely echoed local conceptions about supernatural interventions in the healing process: a working medicine, the sign of a working God, was a powerful argument for conversion.[42] In other words, the discovery and availability of quinine to heal malaria not only saved the lives of many mission workers, but also represented an asset to be used in the evangelical context: many reports mention people converting or defending the mission after the successful treatment of an illness thought to be deadly.[43] Considered by some as spiritual masters endowed

39 Petitpierre 1931, p. 28: "It is not possible to suddenly uproot what has been engrained for generations. It is first necessary to live among them, to see everything that is good in their ways, to adapt to the needs of the climates, of the land and of the race." (my translation)

40 This association of medicine and religion was not specific to the missionary context. Back in Switzerland, one might mention similar institutions staffed by "deaconesses," women working in a Protestant institution with a social or spiritual function. One of the earliest cases in Europe is the institution of the Saint-Loup deaconesses created in 1842 near Lausanne.

41 Ibid., pp. 44–45.

42 Fox Young 2003.

43 See, for example, the Basel Mission Report 1934, quoted by Sargant 1987, p. 134: "Two evangelists went to the verandah of the house of the village *patel* and talked with a few men there. These men tried to convince the evangelists that Krishna is much better than Christ. But suddenly the door of the house opened and a woman came with a child on her arm and said: 'Don't say anything bad about Christ. Look at this child here; last year it was dying. But we went to the mission hospital and Jesus made it well again. I know that Jesus Christ has more

with supernatural powers, missionaries who had no specific medical training were often required to perform basic medical treatment. Thus the missionary Gaston Rosselet, with no medical training, was frequently asked for medicines in his station at Karkala:

> Many ask for drugs, most of the time a potion against rheumatism. I prepare a friction for them made of coconut oil, camphor, essence of turpentine and eucalyptus oil, and recommend that they stay warm. This drug and these few recommendations work miracles: is it the remedy, is it faith …?[44]

Similarly, Petitpierre noted:

> Visiting the sick every day, something was striking: an important number of them had an amulet; and those with an amulet were not reacting to any treatment. Whichever drug we would give them, we were finding them, day after day, in the same state, and they themselves were confirming that "there was no improving." Conversely, the sick without an amulet were responding positively to the very same treatments, to the same drugs, for the same condition.[45]

The extent to which both Lombard and Petitpierre were themselves considered as "spiritual masters" having supernatural powers would certainly deserve further study, with reference to external sources or documents about their activities – but it is clear that their role was understood within local conceptions of healing and that they only had a limited control over this process.

3.3 The Hospital as a "Total Institution"

It is however the "total institution" of the hospital that was the best suited to accomplish the holistic agenda of a missionary type of medicine. More than other institutions, the hospital is a confined space in which the individual is exposed to a regime of truth, along with a pervasive mechanism of control and measurement. As such, it could have an impact on all aspects of a patient: not only the body (through medical interventions and diet), but also social or cultural dimensions. It can be seen, then, as a place from which a number of Western practices (scientific but also social, cultural and religious) could be imposed along a top-down scheme, with little space left for negotiation.[46] It could therefore seem

power than the demons and I believe in Him.' The men stopped their argument and listened to the preaching of the gospel."

44 Rosselet 1929, p. 17.

45 Letter dated 27 April 1939, Petitpierre 1981, p. 53.

46 See Ram 2001, p. 64. This is reminiscent of Goffman's analysis of "total institutions" as violating the "self's boundaries" in many ways, physically as well as mentally (Goffman 1961, pp. 47–48), even if Goffman would not include hospitals in his list of "total institutions."

that hospitals were better equipped than other institutions or activities run by the mission to secure complete control over local epistemic systems. At the same time, it is not difficult to understand why one would not accept the move to an hospital – if only because of practices consisting in keeping women confined (*purdah*).

Hospitals were organized in a highly hierarchical way: despite criticizing caste, Lombard and Petitpierre actually reproduced a kind of bourgeois order and spoke about their "servants" – most of them converts – in rather condescending terms.[47] Even if living in harsh and simple conditions, Lombard and Petitpierre understood themselves as in a position of authority that was legitimated by both science and religion, a leading position that would certainly have been more difficult to achieve back in Switzerland.[48] Indeed, they could take initiatives and practise activities – including in their free time – which would probably not have been possible back in Switzerland.

As Kalpana Ram has noted:

> Obstetrics and gynaecology in the colonies would bring these women less prestige than the fields of sanitation, epidemiology, and tropical disease research. Nevertheless, it provided a sphere of professional expertise unavailable to women doctors in the colonial metropoles of England and America where obstetrics and gynaecology remained fully under male jurisdiction.[49]

From the letters, both Lombard and Petitpierre tried to impart a specific social order embodied by the Western, or perhaps even the Swiss Protestant woman. This "ideal" social order was articulated around values such as cleanliness, diligence and parsimony,[50] echoing once again the notion of a "simple life," in harmony with nature, that we have already encountered (section 3.3.1). This specifically translated into the desire to recreate a little Europe, or rather, a little Switzerland, in the hospital and living in a "biotope" that was as Swiss as possible given the circumstances – wearing Western medical attire, generally eating European meals at the hospital and banning sentimental relations between Swiss

47 See Lombard 1924, p. 54 and her condescending terms: "As to servants, we cannot complain: we have the young Aya, who does not know much but who is full of good will. The cook, Petra, served once the Basel missionaries. He is a bit old, deaf and forgot some of his cooking skills. But he is brave and looks perfectly honest. In addition, there is Esther, the woman who does the major chores: sweeping, laundering, and who works for the hospital as well as for us. There is also Johann, a handyman who transports water and helps here and there." Petitpierre explained with some remorse that all the servants were necessary, so as to "cope with the climate." (Petitpierre 1931, p. 38)

48 On the question of servants as a sign of a bourgeois lifestyle, and on problems encounters in the domestic space, see Konrad 2001, pp. 281–283.

49 Ram 2001, p. 66.

50 Münch 1991.

Figure 4.1. Elisabeth Petitpierre (far right) and her colleagues at Betageri hospital, between 1936 and 1946. Source: BMA QC-30.026.0015. https://www.bmarchives.org/files/fullsize/67214.jpg

and Indian workers.[51] European clothes had of course a functional aspect, but also signalled a relation of authority, warranting a stability in the identities of European staff members.[52] At the same time, there were exceptions, and for specific occasions such as farewell ceremonies, both Petitpierre and Lombard would wear local attires.[53]

3.4 Displacing Traditional Roles and Medicalizing Birth

The concern about hygiene and cleanliness legitimated interventions that broke local sociocultural practices and imposed a new order. The hygienist perspective

51 See Valiaparampil 1996, p. 190: "In eating, as in dressing, they kept European customs. In the hospital, the cook was instructed to prepare European dishes." (my translation) As to "sentimental relations," the nurse Lucie Delord married an Indian doctor, and both had to resign from their position before relocating to Switzerland.

52 See Cohn 1996, p. 111 and his analysis of clothes worn by Europeans in India: "While the British established themselves as the new rulers of India, they constructed a system of codes of conduct which constantly distanced them – physically, socially, and culturally – from their Indian subjects. […] At home, in the office, hunting in the field, or when representing the majesty and authority of power, the British dressed in their own fashion."

53 Petitpierre 1931, p. 32.

can be considered against the background of Switzerland as a country that was then at the forefront in the domain: even if partially influenced by ideas coming from Germany[54] and England, these conceptions were arguably exacerbated in Switzerland where they became national virtues, in particular through the work of such figures as Laurenz Sonderegger (1825–1896) and Adolf Vogt (1823–1907). Correct behaviours were described in local magazines and women were made responsible for their implementation in the whole household.[55] In addition, the development of a health-related tourism with the construction of *sanatoria* in the mountains contributed to fuelling the national imagery of a clean and hygienic country.[56] The focus on hygiene was also related to politics and religion: not only is a clean body the hallmark of a good patriot; it is also required of a good Christian. The tradition of a weekly bath on Saturdays would ensure that one would present him or herself clean for church on Sunday. Thus a pastor from the canton of Bern could preach in 1903:

> We want to be Christians, but we do not even consider the basic prescriptions about purity as binding. We should first keep ourselves and our children in good order and clean, and then speak about Christianity.[57]

It is not surprising, then, that Lombard and Petitpierre used this conceptual framework to describe the situation in India and to locate their own action there. Importantly, and in more subtle ways than either evangelization or the controlling environment of hospitals, hygiene-related practices could be introduced at the level of individual houses and, it was hoped, could be progressively adopted as part of a new, more "modern," lifestyle. This was also connected to religion, since Lombard explicitly dismissed rituals marking the birth – also observed by Indian Christian women – as not only against Christian principles but as unhygienic.[58] As she wrote to her sister:

> When one considers that a fourth of women's mortality in India is related to giving birth, one understands what there is to do from this point of view. More and more, I realize the ravages of superstition, apathy and ignorance, and what one sees here is sometimes frightening – a result not only of dirtiness and carelessness, but also of popular remedies applied indiscriminately![59]

---

54 See Grundmann, 2011, p. 29 for the example of the Halle mission in the eighteenth century.

55 Mesmer 1982, p. 478.

56 Ibid., p. 485. See also Mathieu 1993 on the specific practice of opening windows to help air circulate in the home. On the use of "hygiene" among missionary women see Prodolliet 1987, p. 53; Konrad 2001, p. 13.

57 Müller 1903, p. 93.

58 Maralusiddaiah Patel & Sinha 2003, p. 44.

59 Lombard, "Letter to her sister," 8 February 1922, BMA CC-1, 4 (my translation).

Thus, because they lack a basic instruction in the proper nutrition of their children and believe that traditional ritual practices can heal them, Indian women are seen as the main cause of infant mortality. Moreover, traditional midwives (*dai*s or *dhai*s) were identified as symptomatic of the lack of hygiene and had to be replaced by doctors and midwives.[60] No less critical of the impact of local cultural practices on health, Petitpierre's criticism is more specific, and is based on a pragmatic dismissal of "superstitions" rather than on a systematic association between "ignorance," dirtiness and health issues:

> I discerned in the weak brightness of an oil lamp a young woman, almost still a child, laying on a couch. She was laying with a bandage on the eyes and on the mouth, wadding in the nose and in the ears. […] I was told that the *nanju* [Kannada for "poison," hence "evil spirit"] had to be conjured, since this young woman had suffered a miscarriage in the sixth month. In order to conjure it, the patient had to remain ten days in that state and in obscurity. Two older women were acting as supervisors, making sure that these prescriptions would be exactly followed. They told me all the details about what they had learned in their entourage about the revenge of *nanju.* These are terrible, tragic stories, which can easily scare a fifteen year-old young girl.[61]

In this passage it seems that Petitpierre at least attempted to understand the cultural practice before dismissing it, an attitude less frequent in Lombard's writings.

In any case, and as Shetty has documented, touring houses and taking over the role of the *dai* played an important part in constituting the authority of European women doctors.[62] A parallel process had taken place earlier in Switzerland with the displacement of traditional ways of giving birth and the creation of maternity wards by the end of the nineteenth century.[63] Contrary to what had been happening in Switzerland, however, with obstetrics becoming a specialty reserved to men,[64] the present case shows that female doctors played exactly the

60 "It is not without consequence to leave a parturient patient in the hands of these village-midwives who do not know how to wash their hands and think that everything is granted to them." Petitpierre, "Letter to her family", June 1929, in Petitpierre 1931, p. 114; on which see Hofstetter 2012, p. 128.

61 Petitpierre 1935, pp. 212–213 (my translation).

62 See Shetty 1994 especially on the focalization on the *dai* as the source of all problems, and for a reading of the situation as reflecting a project to "unveil" Indian women by visits or by having them move to a hospital, see pp. 209–210.

63 See Détraz, Delécraz, Golaz et al. 1995, p. 190: "In Switzerland, until the end of the 19th century, most deliveries happened at home with the help of a 'matrone' in remote areas, and, in cities, of a midwife. […] From the end of the 19th century onwards, the 'matrone' was displaced by a graduated midwife, obstetrics became a specialty of [male] doctors and deliveries were moved from the home to the hospital." (my translation)

64 For a reading of this process as a way for men to (re)gain control over a sphere that belonged to women see, for example, Oakley 1980.

same role in the progressive marginalization of local midwives. As Kalpana Ram writes:

> In India, indigenous midwives were displaced not by men, but by white women doctors. In time, the place of white women was taken over by the Indian middle class, in which women again played an important role as medical professionals.[65]

4 Adaptations and Encounters

4.1 Cultural Adaptations of the Medical Practice

The epistemic violence visible in the medicalization of birth was, and had to be, limited, and perhaps the necessity to display marks of Western identity was particularly important precisely because this was not so self-evident. First, it is clear that while the missionaries saw the world view they were bringing as exclusive of other world views, it was not received as such by their audiences. This is clearly reflected in the Constitution of the Mission's Church (1931), which found it necessary to urge members of the Christian community to only seek medical treatment from "scientific doctors," suggesting that combinations between various types of medicine (and hence, between various epistemic orders) was rather the norm than the exception:

> As members of Christ's Church have renounced all works connected with idolatry, they must on no account practice or cause to be practiced, in time of trouble soothsaying, incantations or any other works of darkness such as idolatrous and superstitious folk are wont to follow. On the contrary, they should in time of sickness obtain and follow the advice of scientific doctors [*sic*], taking medicine and treatment from them and above all, they should seek the help of the Lord, the true Healer of the sick and the Hearer and Answerer of prayer.[66]

In addition, while the hospitals had been designed as places where sociocultural differences would theoretically be erased by the superior cause of health,[67] in practice, however, all kinds of arrangements had to be found: the actual care had to be adapted to a number of local constraints, especially in the socio-religious domain. In a letter to her sister, Lombard mentions that in Udupi,

---

65 Ram 2001, p. 66.

66 Constitution of 1931 §65, p. 50. A specific case of friction with traditional medical practices is the participation in Mariamman celebrations, as in the case of the annual Karkala Mari Puja, meant to remove epidemics (on which see Rau 1932, p. 9).

67 See Petitpierre 1981, p. 10: "The missionary hospital was the only place where one would encounter people of all castes and religions under a same roof, a place where one would meet rich and poor people alike."

> [r]ooms are not, as among us, arranged for receiving the patients according to their condition, but according to caste and religion. Thus, there is a room for high caste Hindus, another one for low caste Hindus, one for Muslims and one for Christians.[68]

Thus, the Christian principle of equality had to be traded for a structure that respected the local segmentation of society. Similarly, in a letter dated December 1929, Petitpierre explained to her family a few key differences between the Betageri hospital and a Swiss hospital, and the necessary adaptations that she had had to implement:

> Patients are never left alone in the hospital. In particular, those coming from a remote village are accompanied by their family, and several relatives stay until they have healed completed. All of that crowd spends the night between the beds, under beds or in the small kitchen. In Europe each patient accepts the food of the hospital. It is not the same here, and people only eat what has been prepared by a cook of the same caste. It is then necessary that a member of the family prepares the meals of the patient. To make it possible, we have in the compound several small kitchens that we rent. At the beginning of my stay, it happened once in a private room, where the meal had just been set in front of the patient, that my eyes, directed towards the patient, could not avoid the plate where the food had been placed. It was thrown out for the dogs, since my gaze had defiled it.[69]

Thus not only could the principle of a "central kitchen" controlling and standardizing the patients' diet not be enforced (as was customary by then in Swiss hospitals), but Petitpierre herself had to observe Brahminical purity rules. Things seem to have been slightly different in Udupi, since a report written a few years later states that "the central kitchen [was preparing] food for 90 % of the patients," insisting on the medical advantage to "respect the prescribed diet."[70] While the documents do not tell about the actual food prepared in these kitchen, it is nevertheless clear that the actual practice had to accommodate various aspects from local cultural, religious, and social norms, at least in the spatial arrangements of the patients and in their diet.[71]

---

68 Lombard, "Letter to her sister," 18 January 1922, BMA CC-1, 4 (my translation).

69 Petitpierre 1981, p. 11 (my translation). Petitpierre writes elsewhere: "the patients [coming from villages around Gadag-Betageri] would be lost if they were forced to stay alone in the hospital. […] Except in a few cases, the family itself prepares the food for the family, making meals in small kitchen specifically designed to that end or under a tree. It is thus possible to get interesting insights about local customs within our enclosure." (Petitpierre 1938, p. 10)

70 Petitpierre 1938, p. 1.

71 Cf. Arnold 1993, p. 14: "It is important […] to move away from a purely metropolitan view of an expansionist science and to appreciate the extent to which Western medicine in India was not merely a projection of the medicine taught and practiced in Britain but was constantly engaged in a dialogue with India or, at least, with an 'Orientalist' version of what India – its climate, its peoples, its cultures – represented."

In some cases, however, the kind of medicine proposed by the hospital was rejected outright. This happened with Muslim patients and actual protest movements took place in relation to the Udupi hospital. Lombard wrote in 1922:

> There are other worrying topics. The most important concerns the attitude that Muslims suddenly adopted towards us. Rumour spread that a woman, who stayed by us for a relatively long time was about to become Christian. This is not the case but it was sufficient to alert the most chauvinist among the Muslims. Progressively, all of our Muslim patients left – except for a few, too sick or having recently undergone surgery. Men threaten the women who would nevertheless like to come here for treatment. They threaten that they will have to pay fines and that they will not give them and their families a space in the cemetery. […] It […] shows how strong the anti-Christian opposition is and how difficult it is to reach these people. Brahmins are even more difficult to reach and are a much stronger corporation than the Muslims.[72]

The case shows well that despite a number of cultural compromises, the hospital kept a distinctive Christian and Western identity which could periodically serve as an oppositional reference to develop community-based concerns. In general however, it seems that Petitpierre (and perhaps to a lesser extent, Lombard) managed to find the required compromises. Writing from Betageri, Petitpierre noted however with hope that fewer compromises might be necessary in the future: "new ideas" were being adopted, with railways and buses quickly developing in the country, "forcing the strictest Brahmins to sit next to people of less pure castes."[73] This might well have been the case, given the progressive "urbanization" of the region.

4.2 Encounters with South Indian Medical Traditions?

Despite the impression one gets from reading the missionary texts, the medical mission did not arrive in a medical void. To borrow the words of H. Mabika describing medical missions in South Africa, the hospitals were functioning as a "socio-cultural environment within medical pluralism, where traditional medical knowledge, local practice, and non-Christian beliefs are omnipresent – and therefore one cannot assume that this medical culture has stopped at the hospital gate."[74] Similarly, Karnataka had its own medical traditions and they were undergoing an intense process of revival at the time. Practitioners of Ayurvedic and Siddha medicine were becoming increasing popular by the beginning of the twentieth century, in connection with the progress of "science" as an idiom of

72 Lombard, "Letter to her mother," 13 December 1922, BMA CC-1, 4 (my translation).
73 Petitpierre 1931, p. 97.
74 Mabika et al. 2017, p. 15.

truth.[75] Islamic Unani traditions underwent a similar process of revitalization in the South Indian context, leading to a progressive "institutionalization." In 1917 a commission on the "Indigenous System of Medicine" was appointed by the government of Madras, chaired by Sir Muhammad Usman, resulting in the Usman Committee Report (1923). The secretary, G. Srinivas Murti, focused particularly on Ayurveda and the report established plans to implement indigenous forms of medicine in state hospitals and dispensaries.[76] These revivalist movements were politicized and largely encouraged by the Indian National Congress.[77] While an Ayurvedic institution had been opened in 1902 in Kottakkal (Kerala), the Ārya Vaidya Samājam of P. S. Varier (1869–1944), and while an Unani college was opened by the government in 1928 in Mysore, it is not exactly clear in what measure these ideas reached more remote places such as Betageri and Udupi.

Still, it is striking to read the following statement by Petitpierre, entirely ignoring this major enterprise of Ayurvedic revival, and speaking of Ayurvedic knowledge as a fossilized tradition that would have declined in the present times. Reacting to an article on Indian medicine sent to her by her family, she writes:

> Thank you for the newspaper articles. The extract on "Medicine in ancient India" made me smile. It is a solid paper […] and there is much truth in it. The old Hindus know very well the virtue of plants, but the vestiges of their knowledge, which came up to our generation, are within the hands of dilettantes who are entirely devoid of any sense of observation and of any critical sense. And excellent drugs in themselves are administrated without thinking, without any scrupulous control of the quantity, without any idea about how to apply toxic substances to specific cases and with caution. With practice, one gets the sense that the knowledge existed, but that it died with those who had it.[78]

It is noteworthy that Petitpierre, again, does not entirely dismiss a traditional type of medicine, emphasizing the actual and valid knowledge of the "old Hindus" about the virtues of plants. She however rehearses a classical idea of degeneration from a golden era, in parallel with the affirmation of the providential

75 Arnold 2000, pp. 177–179. Employees of the BM themselves worked at recording the names and properties of local plants, matching their local names to "scientific" names, and the BM Press published a book in Kannada entitled *Sahasrārdha Vṛkṣādigaḷa Varṇane* in 1881 – a work which became a reference for local Ayurvedic practitioners. A few years later, a specialist in Ayurvedic medicine, K. M. Nadkarni, produced a compilation of different remedies based on plants, in a book entitled *Indian Plants and Drugs* (1908); see Madhyastha, Abdul Rahiman & Kaveriappa 1982, p. 265.

76 Arnold 2000, pp. 184–185. The School of Indian Medicine was opened in Madras in 1924, under the lead of Srinivasa Murti. On further and later reports about indigenous types of medicine, some of which were not as enthusiastic as Usman's, see Wujastyk 2008.

77 Chattopadhyaya, 1999, p. 531.

78 Petitpierre 1931, pp. 117–118 (my translation).

scientific progress emerging from the West.[79] This might also suggest that in her daily practice she was not in contact with the medical revivalisms we just mentioned – probably more characteristic of major centres such as Madras and Mysore. In any case, it is quite ironic that this came to her through the mediation of a European newspaper, sent to her in India by her family back in Switzerland.

4.3 Relation to Indian Assistants

As Amrith has aptly remarked,[80] Western medicine was quickly appropriated by Indian doctors and its limits were noted – and eventually instrumentalized for nationalist purposes. An evolution was felt in the field of missionary medicine after the First World War, with medical staff becoming increasingly specialized and a clearer delineation made between evangelical and medical tasks.[81] In parallel, more and more Indians became trained in Western medicine, to a proportion that was not seen elsewhere in Asia. This brought them into a unique position to judge the system organized by the British and to argue for their own particular points of view, especially regarding traditional medicine.[82] An important number of Indian assistants had been partly trained with Western doctors and institutions, without any direct link to missions.[83] From 1855 onwards, they could study in the Indian Medical Service and could become "sub-assistant" surgeons, with salaries of about 100 Rs. In the missionary institutions, indigenous assistant doctors, poorly paid (30–60 Rs. per month), were considered inferior in all regards to their European colleagues. This discrepancy led to major ten-

79 For a similar observation on the rejection of local medical traditions by Swiss missionary doctors in South Africa, see Mabika et al. 2017, p. 17: "It is nonetheless a surprising fact that the management of all three mission hospitals did not (or did not want to) recognize local traditional medicine as part of their medical reality. This stance clearly shows that the mix of Christian 'sense of mission' and biomedical hegemony has led to a very biased and distorted image of 'local culture' of which the hospitals seem to be part. Important health-related practices such as divination and healing, and the knowledge of local herbalists were not perceived – or were refused."

80 Amrith 2006, p. 23: "Debates over 'western' ideas about the body, about diseases and their treatment, particularly in relation to indigenous traditions of thought about these subjects, featured prominently in the press. The output of vernacular literature on health flourished, particularly in Tamil and Bengali. Particular hygienic practices gained an inextricable association with being modern, with escaping 'backwardness' and 'superstition'."

81 On this evolution, see Hardiman 2006, pp. 19–21.

82 Cf. the example of Ram Nath Chopra (1882–1973) of the Indian Medical Service in Arnold 2000, pp. 182–183.

83 Valiaparampil 1996, pp. 193–195. On Indian doctors in government service, see Ramanna 2002, p. 14–18.

sions between the Western doctors and their local staff members in the context of missionary hospitals, as noted by Valiaparampil:

> Significant for the modern reader is the fact that a growing tension developed between the European employees and the Indian staff during the years of medical mission, a tension that stemmed not only from the self-consciousness of Indians who had studied in the West, but also from the absolute pretension of Europeans that they could require subordination without having to acknowledge the quality of the collaborator.[84]

In addition, Indian doctors were often bitter about the implied superiority of Western doctors. For example, Cheriyan Eapen, an Indian doctor who had studied at the London School of Tropical Medicine and who had been met by Petitpierre on her way to India (and who had taught her Malayalam), mentioned to her that he had been deeply offended by the way Indians were spoken of at the school.[85]

Another example is that of a colleague of Petitpierre's working in the Udupi government hospital, Madhava Pai, a Hindu with a Konkani background. Himself a former student at the mission high school, his help was often required by the Udupi missionary hospital. Even if she considered him a capable doctor, Petitpierre seems to regret that he was "still" a Hindu:

> Madhava Pai was a very young doctor, installed in Udipi for barely two years. He knows about the Mission because he went to our high school until he was 18 years old – people say our high school is much better than that of the government – but he remained Hindu, Konkani, a caste only slightly inferior to that of Brahmins, with somewhat less strict rites.[86]

The very need for collaboration with local doctors attests to the modest means available to the Swiss doctors who, like their colleagues working for evangelization, had to rely on local expertise.[87] While this does not necessarily imply rich "exchanges" about the respective medical practices of the Swiss doctors and their Indian colleagues, it did prepare the ground for the eventual takeover of the hospitals by Indian doctors upon the departure of both Lombard and Petitpierre.

84 Valiaparampil 1996, p. 196.

85 See Petitpierre 1931, p. 6. See also p. 15: "The Hindu doctor E*** eats at our table. He is returning to India very disappointed with his experiences in the West. The remarks about natives made by our professors at the tropical school offended him deeply and sowed in his heart a bitterness which a whole life will not suffice to extirpate." (my translation)

86 Petitpierre 1931, p. 39 (my translation).

87 Amrith 2006, p. 22.

4.4 Providing Medical Care to Rich Indian Patients

Contrary to what one might assume, and conflicting with the narrative about missionary hospitals as helping the poor and needy, the expertise of the Western doctors was also sought by rich Indian patients. People who could afford it would often try all the different cures available to them, including Western and non-Western styles of medicine, regardless of the "religious" background.[88] In this framework, Lombard and Petitpierre were occasionally invited to provide medical assistance to rich patients and accepted honoraria for the treatment given.

Interactions with higher caste patients often proved tricky, because they would not easily come to the hospital, and therefore the framework and the rules according to which the interaction was supposed to unfold were not controlled by the Swiss doctors. Here Lombard and Petitpierre were actually forced to do the contrary of what was done in their hospitals: that is, separate the medical action from religious intentions, with the risk of otherwise appearing provincial and themselves "superstitious." Petitpierre writes:

> Yesterday evening, Madhava Pai, my colleague, came to get me for a very challenging and worrying case, one of his rich patients. I would have preferred to avoid this, but it was a case of obstetrics in which I have more experience and a more thorough knowledge than him. I performed the work while he was entertaining the patient, and this interested me greatly to see him, to study the way he behaved; I have everything to learn in the psychology of these people.[89]

We see here Petitpierre and her Indian colleague dividing their tasks: while Petitpierre provided the actual medical care, her Indian colleague entertained the patient, piquing the curiosity of Petitpierre who recognized her ignorance but was interested to learn. This was a setting radically different from that of the hospital, and biblical readings would not even be a remote possibility.

5 Impact Back in Switzerland

Back to the Swiss context, reports and texts about medical activities carried out in India took different forms. The work in India appeared as a continuation abroad of a process of hygienization that was almost complete in Switzerland by

88 We cannot therefore fully agree with Valiaparampil 1996, p. 225: "The poorer and lower layers of population were not as opposed to a culturally foreign therapeutic method as the high castes, since the principle of social and ritual impurity was not playing such an important role." In cases such as those explored here, high caste purity rules could perfectly coincide with the "hygienist" concerns of Western medical practitioners.

89 Petitpierre 1931, p. 49 (my translation).

that time. The image of a technologically and sanitarily backward India could work as a negative mirror in which the Swiss medical system and its high hygienic standards appeared as the hallmark of civilization, justifying the missionary enterprise with a utilitarian argument. This argument, expressed earlier in this chapter, was revived in this period, for example in Katherine Mayo's (1867–1940) (in)famous book, *Mother India* (1927).[90]

More striking perhaps is that the discourse about Indian women became part of the construction of the feminist movement in Switzerland. Lombard was invited to speak about the condition of Indian women at a meeting of the Swiss Association of Academic Women in 1928 – a talk subsequently published in the *Yearbook of Swiss Women* (*Jahrbuch der Schweizerfrauen*). In it, and probably influenced by her personal experience in the ultra-orthodox region of Udupi, she described the life of Indian women living in the countryside as "largely ruled by the Laws of Manu" – as opposed to women living in cities, who were more emancipated and "influenced by currents of modern thought."[91] She distinguished between high and low caste women, emphasizing the difficulties implied by purity rules for the former, and the "strange superstitions" of the latter, even if "they have a healthier and more normal life than a Brahmin woman."[92] She concluded by saying that "the most immediate and urgent task is to bring relief to the physical pains of women; over the long term, the goal is to educate them, by teaching them more rational rules about hygiene for themselves and their children."[93]

Even if this would need a more thorough analysis and, perhaps, a comparison with the image of African women in Swiss publications at the same time, the situation is reminiscent of Antoinette Burton's explorations of "imperial feminism" and her observation that women could "operate [both] in opposition to oppressive ideologies and in support of them – sometimes simultaneously."[94] In the present case, and despite not belonging to an imperial power, Lombard and Petitpierre perceived themselves as agents of progress, as bringers of a world view that could serve the emancipation of the women they were in contact with,

90 Mayo's book stirred a vast controversy and can arguably be considered paradigmatic in the reconfiguration of the British imperial formation in the 1920s (see Sinha 2006, p. 24 who depicts Mayo's book as a product stemming from "the global dynamics of the interwar period that produced a transitional political event"). Petitpierre 1931, pp. 40–41 generally agreed with Mayo, noting however that "she was excessive in her judgements" and that Europe and America were not entirely free from problems either. She added, however, that while in Europe, religion is part of the solution, in India, it is usually part of the problem: "temples are the worst centers of immorality."

91 Lombard 1929, p. 45.

92 Ibid., p. 49.

93 Ibid., p. 55.

94 Burton 1994, p. 211.

notwithstanding the fact that it also involved a violent rejection of local epistemic cultures.[95]

6 Conclusion

In terms of encounters, the outcome might seem somewhat meagre. The supposed epistemic superiority (and universality) of Western science, joined with a confidence in a religious truth, as well as the negative perception of local medical practices, prevented Swiss doctors from becoming more familiar with a number of local health-related practices. Missionary medicine was certainly not an occasion for bringing back healing techniques that could have been learned in India (such as yoga). It is however arguable that Petitpierre, and probably to a lesser extent, Lombard, developed a sensitivity to cultural conceptions of the body (e.g. about food or bodily contact) that contrasted with what they had learned in Swiss medical schools, conceptions that were coming not from textual and/or scholarly sources, but rather from the very imperatives of practice.

More striking however is their own career and the position they managed to build for themselves in these Indian institutions – a position which would have been much more difficult to reach back in Switzerland. As prominent figures in hospitals located in rather rural or traditional regions, they de facto played multiple roles concurrently: that of role models for Indian women; that of persons having some power in the eyes of local politicians; and perhaps (but this would need confirmation from external sources), that of religious leaders or gurus, characterized by their ability to provide healing.

Bibliography

Amrith, Sunil S. 2006. *Decolonizing International Health: India and Southeast Asia, 1930–65.* Basingstoke: Palgrave Macmillan.

Anderson, Gerald H. 1999. *Biographical Dictionary of Christian Missions.* Grand Rapids, MI / Cambridge, UK: William Eerdmans.

Arnold, David. 1993. *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India.* Berkeley: University of California Press.

Arnold, David. 1997. "The Place of 'the Tropics' in Western Medical Ideas since 1750." *Tropical Medicine International Health* 2: 303–313.

Arnold, David. 2000. *Science, Technology and Medicine in Colonial India.* Cambridge: Cambridge University Press.

95 With a similar idea, see the following observation by Kalpana Ram: "Depictions of the atrocious conditions governing 'native-birth' endowed these women [European doctors] with racial power that was in excess of the class-based authority available to them back in Britain." (Ram 2001, p. 66)

Bala, Poonam. 1991. *Imperialism and Medicine in Bengal: A Socio-Historical Perspective.* New Delhi: SAGE.

Bhattacharya, Sanjoy, Mark Harrison, and Michael Worboys. 2005. *Fractured States: Smallpox, Public Health and Vaccination Policy in British India 1800–1947.* New Delhi: Orient Blackswan.

Bielander, Thérèse. 1988. *L'accès des femmes à l'université de Genève et leur entrée dans les professions supérieures 1872–1939.* Geneva: Université de Genève.

Boag, George Townsend. 1922. *Census of India, 1921.* Vol. 13, Part 1. Madras: Superintendent, Government Press.

Bonner, Thomas Neville. 1992. *To the Ends of the Earth: Women's Search for Education in Medicine.* Cambridge, MA / London: Harvard University Press.

Burton, Antoinette. 1994. *Burdens of History: British Feminists, Indian Women, and Imperial Culture, 1865–1915.* Chapel Hill: University of North Carolina Press.

Charumbira, Ruramisai. 2015. "Becoming Imperial: A Swiss Woman's Shifting Identity in British Southern Africa." In Patricia Purtschert and Harald Fischer-Tiné (eds.), *Colonial Switzerland: Rethinking Colonialism from the Margins.* Basingstoke: Palgrave Macmillan, 157–178.

Chattopadhyaya, D. P. 1999. *History of Science, Philosophy and Culture in Indian Civilization: Part 1. Science, Technology, Imperialism and War.* New Delhi: Pearson Education India.

Clark, Christopher, and Michael Ledger-Lomas. 2012. "The Protestant International." In Abigail Green and Vincent Viaene (eds.), *Religious Internationals in the Modern World: Globalization and Faith Communities Since 1750.* Basingstoke: Palgrave Macmillan, 23–52.

Cohn, Bernhard S. 1996. *Colonialism and its Forms of Knowledge.* Princeton, NJ: Princeton University Press.

Détraz, Christine, Christian Delécraz, Eric Golay et al. 1995. *Quand on a la santé, Genève 1900–1960.* Geneva: Musée d'ethnographie.

Fox Young, Richard. 2003. "Reading from Antiquity: Hindu Responses to Science and Christianity on the Margins of the Empire, 1800–1850." In Robert Eric Frykenberg (ed.), *Christians and Missionaries in India: Cross-Cultural Communication since 1500.* Grand Rapids, MI / Cambridge, UK: Eerdmans, 183–222.

Goffman, Erwin. 1961. *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates.* New York: Anchor Books.

Greyloz, Marguerite. 1921. "Aus unserer ärtzlichen Mission." *Mitteilungen der Kanaresischen Mission* 3, no. 1: 12–15.

Grundmann, Christoffer H. 2011. "Pietism, Revivalism, and Medical Missions: The Concern for the Corporeality of Salvation in A. H. Francke, P. Parker, and G. Dowkontt." In Christian T. Winn Collins et al. (eds.), *The Pietist Impulse in Christianity.* Eugene, OR: Pickwick, 296–306.

Haas, Waltraud. 1994. *Erlitten und erstritten: der Befreiungsweg von Frauen in der Basler Mission 1816–1966.* Basel: Basileia Verlag.

Hardiman, David. 2006. "Introduction." In David Hardiman, *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa* (Clio Medica/The Wellcome Institute Series in the History of Medicine 94), Amsterdam / New York: Rodopi, 5–57.

Hardiman, David. 2008. *Missionaries and their Medicine: A Christian Modernity for Tribal India.* Manchester: Manchester University Press / New York: Palgrave Macmillan.

Hardy, Anne, and Lise Wilkinson. 2001. *Prevention and Cure: The London School of Hygiene & Tropical Medicine; A 20th Century Quest for Global Public Health.* London: Kegan Paul.
Headrick, Daniel R. 1981. *Tools of Empire: Technology and European Imperialism in the Nineteenth Century.* Oxford: Oxford University Press.
Hochmuth, Christian. 2006. "Patterns of Medical Culture in Colonial Bengal, 1835–1880." *Bulletin of the History of Medicine* 80, no. 1: 39–72.
Hofstetter, Gabriela. 2012. *Gehet hin und pflegt! Basler Missionarinnen im Dienst der Ärztlichen Mission in Asien und Afrika (1892–1945).* Münster: LIT Verlag.
Kirschleger, Pierre-Yves. 2009. "L'Internationale protestante d'Alexandre Lombard, dit Lombard-Dimanche." *Histoire, économie & société* 28, no. 3: 55–69.
Konrad, Dagmar. 2001. "Missionsbräute – Pietistinnen des 19. Jahrhunderts in der Basler Mission." *Basler Zeitschrift für Geschichte und Altertumskunde* 101: 175–241.
Kumar, Anil. 1998. *Medicine and the Raj: British Medical Policy in India, 1835–1911.* New Delhi / London: SAGE.
Kumar, Deepak. 1995. *Science and the Raj, 1857–1905.* New Delhi: Oxford University Press.
Lal, Maneesha. 2003. "'The Ignorance of Women is the House of Illness': Gender, Nationalism and Health Reform in Colonial North India." In Mary P. Sutphen and Bridie Andrews (eds.), *Medicine and Colonial Identity.* London: Routledge, 14–40.
Lombard, Eva. 1922. *Excursion médicale au pays de Mysore.* Lausanne: Secrétariat de la Mission suisse aux Indes.
Lombard, Eva. 1924. "Inauguration de l'hôpital d'Udipi." *Ténèbres et Lumière* 3: 51–58.
Lombard, Eva. 1929. "Le travail medical parmi les femmes au Sud de l'Inde." In *Annuaire des femmes suisses / Jahrbuch der Schweizer Frauen (1928–1929)*, Basel: Basler Druck- und Verlagsanstalt, 44–55.
Lombard, Eva. 1939. *Quelques conseils d'hygiène à celles qui partent en Mission.* Lausanne: Lien missionnaire de Suisse Romande.
Mabika, Hines, et al. 2017. *Working Paper Research Project "History of Health Systems in Africa" […] (SNIS Final Report).* Basel: Department of History and Institute of Social Anthropology, University of Basel. https://doi.org/10.5167/uzh-150871.
Madhyastha, M. N., M. Abdul Rahiman, and K. M. Kaveriappa. 1982. "A Brief History of Scientific Technology, Research and Educational Progress of South Kanara, Karnataka State." *Indian Journal of History of Science* 17, no. 2: 260–267.
Malinar, Angelika. 2013. "Western-Born But in Spirit Eastern …": Annie Besant between Colonial and Spiritual Realms." *Asiatische Studien / Études Asiatiques* 67, no. 4: 1115–1154.
Maralusiddaiah Patel, M. H., and Rajov K. Sinha. 2003. "Folk Tradition of Karnataka." *Bulletin of the International Committee on Urgent Anthropological and Ethnological Research* 42–43: 41–47.
Mesmer, Beatrix. 1982. "Reinheit und Reinlichkeit: Bemerkungen zur Durchsetzung der häuslichen Hygiene in der Schweiz." In Nicolai Bernard, Quirinus Reichen and Ulrich Im Hof (eds.), *Gesellschaft und Gesellschaften. Festschrift zum 65. Geburtstag von Prof. Dr. U. Im Hof.* Bern: Wyss, 470–494.
Müller, G. 1903. "Die Erziehung der Jugend zur körperlichen Gesundheit." *Das Alpenhorn*, 20 June: 93.
Münch, Paul (ed.). [1984] 1991. *Ordnung, Fleiß und Sparsamkeit. Texte und Dokumente zur Entstehung der bürgerlichen Tugenden.* Munich: München Deutscher Taschenbuch Verlag.

Oakley, Ann. 1980. *Women Confined: Towards a Sociology of Childbirth.* New York: Schocken Books.

Petitpierre, Elisabeth. 1931. *Allez et guérissez.* Lausanne: Secrétariat romand de la Mission de Bâle.

Petitpierre, Elisabeth. 1935. "Zenana = Arbeit der ärztlichen Mission in Indien." In Verband der Vereine für Ärztliche Mission (Deutschland) and Deutsches Institut für Ärztliche Mission (eds.), *Ruf und Dienst der ärztlichen Mission: [zum 25-jährigen Bestehen des Deutschen Instituts für ärztliche Mission in Tübingen].* Tübingen: Erschienen beim Deutschen Institut für ärztliche Mission, 210–217.

Petitpierre, Elisabeth. 1938. "D'Oudipi à Bethghéri et de Bethgéri à Oudipi: Quelques comparaisons." *Bulletin de l'association en faveur des hôpitaux missionnaires aux Indes* 6: 9–12.

Petitpierre, Elisabeth. 1981. *Médecin et missionnaire en Inde: extraits de lettres, 1929–1954.* Lausanne: Editions du Soc.

Prabhakar, Peter Wilson. 1988. "The Basel Mission in South Kanara (1834–1947)." PhD thesis, Mangalore University, Mangalore.

Prakash, Gyan. 1999. *Another Reason: Science and the Imagination of Modern India.* New Delhi / New York: Oxford University Press.

Prodolliet, Simone. 1987. *Wider die Schamlosigkeit und das Elend der heidnischen Weiber: Die Basler Frauenmission und der Export des europäischen Frauenideals in die Kolonien.* Zurich: Limmat Verlag.

Ram, Kalpana. 2001. "Modernity and the Midwife: Contestations over a Subaltern Figure, South India." In Linda H. Connor and Geoffrey Samuel (eds.), *Healing Powers and Modernity: Traditional Medicine, Shamanism, and Science in Asian Societies.* Westport, CT: Bergin & Garvey, 64–84.

Ramanna, Mridula. 2002. *Western Medicine and Public Health in Colonial Bombay, 1845–1895.* New Delhi: Orient Blackswan.

Rao, Vasudeva. 2002. *Living Traditions in Contemporary Context: The Madhva Matha of Udupi.* Delhi: Orient Blackswan.

Rau, Mark Sanjiva. 1932. *Types of Religious Consciousness: Hindu and Christian.* Mangalore: Basel Mission Book and Tract Depository.

Rosselet, Gaston V. 1929. *Un semeur sortit pour semer.* Lausanne: Secrétariat romand de la Mission de Bâle.

Sargant, Norman C. 1987. *From Missions to Church in Karnataka, 1920–1950.* Madras: Christian Literature Society.

Shetty, Sandhya. 1994. "(Dis)locating Gender Space and Medical Discourse in Colonial India." In Carol Siegel and Ann Kibbey (eds.), *Eroticism and Containment: Notes from the Flood Plain.* New York: New York University Press, 188–230.

Sinha, Mrnalini. 2006. *Specters of Mother India: The Global Restructuring of an Empire.* Durham, NC: Duke University Press.

Stokes-Arnold, William. 1921. "Von unserer ärtzlichen Mission." *Mitteilungen der Schweizerischen Hilfskomitees für die Mission in Indien (kanaresische evangelische Mission)* 3, no. 6: 2–4.

Tikhonov, Natalia. 2005. "Eva Lombard." In Erica Deuber-Ziegler and Natalia Tikhonov (eds.), *Les femmes dans la mémoire de Genève*, Geneva: S. Hurter, 217–218.

Valiaparampil, Maya. 1996. "Die Basler ärztliche Mission von 1886–1914 in Südindien – eine Entwicklungsgeschichte im Spiegel ausgewählter Biographien." PhD thesis, University of Heidelberg.

Witschi, Hermann. 1970. *Geschichte der Basler Mission 1920–1940.* Vol. 5. Basel: Basileia Verlag.

Wujastyk, Dominik. 2008. "The Evolution of Indian Government Policy on Ayurveda in the Twentieth Century." In Dagmar Wujastyk and Frederick M. Smith (eds.), *Modern and Global Ayurveda: Pluralism and Paradigms.* New York: State University of New York Press, 43–76.

Zimmermann, Arnold. 1930. *La mission canaraise évangélique, 1918–1927; histoire d'une mission suisse aux Indes.* Lausanne / Chêne-Paquier: Comité suisse de secours pour la mission aux Indes.

Zosso, François. 2017. *Nouvelles du front: une officière neuchâteloise de l'armée du salut en Italie: 1911–1948.* Neuchâtel: Association pour la conservation des Archives de la vie ordinaire.