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The Birth of the "Indian" Clinic: *Daktari* Medicine in *A Ballad of Remittent Fever*

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Abstract: This article locates the clinic as a historically contingent space which faced cultural resistance and remained alien to the colonized population in India. It corroborates the socio-political tension in setting up a clinic within the colony and investigates how the Western clinic as a colonial apparatus was resituated as the "Indian clinic" per se. With the historical emergence of a new class of medical practitioners called "*daktars*" (a Bengali vernacularization of the term "doctor"), the health-seeking behaviour and public health model of colonial India witnessed a decolonial shift. Unlike their English counterparts, *daktars* did not enjoy a privileged position within the medical archives of colonial India. This archival gap within Indian medical history presents itself as a viable topic for discussion through the means of the literature of the colonized. Bengali writer Ashoke Mukhopadhyay's novel *Abiram Jwarer Roopkotha* (2018), translated into English as *A Ballad of Remittent Fever* in 2020, remedies the colonial politics of the archive by reconstructing the lives of various *daktars* and their pursuit of self-reliance. The article takes a neo-historical approach towards understanding and assessing the past of *daktari* medicine and thereby offers comments on its traces in the contemporary public health of India.

Keywords: *daktars*; clinic; *daktari* medicine; public health; colonial India; Indian literature

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1. Introduction

The global process of colonization becomes a peculiar phenomenon when perceived through the critical lens of public health history. In his seminal text *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India* (1993), David Arnold writes about the doubled-up phenomenon of colonization and its display in nineteenth-century India. As the British arrived under the aegis of the East India Company to establish and set up colonies, they met with the harsh reality that India "proved to be the largest disease laboratory in Asia" (Samanta 2018, p. 13). With the rampant emergence of tropical diseases such as malaria and cholera, among epidemics of plague and pox, the sanitary cordons of British cantonments and their colonial establishments remained vulnerable. To protect the health of British troops and strengthen their sovereignty, the British government had to develop medical research laboratories and set up clinics to alleviate the public health crisis. This marks the induction of Western medicine as the state medicine in India, with its administration at colonial enclaves such as prisons, asylums, and dispensaries. Nevertheless, the presence of Indigenous medical systems such as Ayurveda, Unani, and Siddha in the Indian subcontinent over hundreds of years resisted the institutionalized state medicine. The popularity of these Indigenous medical systems relied on local consumption and cheap availability. On the other hand, the label of Western medicine as "white man's medicine" (Arnold 1993, p. 4) disabled any possibilities of collaboration and medical heterogeneity. Such a state of affairs had paved the way for a slow start "[of] one hundred and fifty years of British rule" (Arnold 1993, p. 4) for the assimilation of Western medicine amongst the colonized. Historians have noted how the imperial state would have ceased to

function without proper social consent and collaboration with the locals (Chatterjee 2015). On this note, Pratik Chakrabarti asserts that "networks, collaborations and negotiations were vital to European endurance in these distant lands" (Chakrabarti 2006, p. 36). The article focuses on one such collaborative project taking place in colonial Bengal with the rise of a new class of medical practitioners called "*daktars*"—a vernacularized form of the English word "doctor".

Simply put, *daktars* connote "South Asians practising 'western' medicine" (Mukharji 2009, p. 1). This article reads the representation of these *daktars* in Bengali writer Ashoke Mukhopadhyay's novel *Abiram Jwarer Roopkotha* (Mukhopadhyay 2018), translated into English as *A Ballad of Remittent Fever* by Arunava Sinha in 2020, by juxtaposing it with the historical accounts offered by Projit Bihari Mukharji in his book *Nationalizing the Body: The Medical Market, Print and Daktari Medicine* (2009). Historically, the *daktars* occupied a socially significant identity, given their vital role in combatting the cultural gap between the Western clinic and the Indigenous population. However, unlike their English counterparts, *daktars* did not occupy a privileged position in the medical archive despite their creative role of integrating Western medicine within the local systems. Mukharji points out that the lives of *daktars* were almost elided due to the "politics of archive" (Mukharji 2009, p. 32). The individual lives of many *daktars* remain underrepresented, given "[how] most English language records tend to see the [native] group of physicians as anonymous statistics or [even worse] half-trained quacks" (Mukharji 2009, p. 35). Problematizing this archival gap, Mukhopadhyay reconstructs the obscure lives of *daktars* and the past epidemics and public health crises which populate the medical history of India in his novel. This relatively recent and understudied novel highlights the rise of a composite class of *daktars* fighting deadly diseases and social mores alike during the colonial era. The text narrates the lives of four generations of *daktars* from the Ghoshal family living across a timeline from the 1880s to the late 1960s. It marks their important contribution towards alleviating the cultural anxiety against Western medicine and their labour in establishing the clinic within the colony. Building on this narrative tension, the novel pictures the rich medical history of colonial Calcutta, which "lived in constant fear of deadly diseases" (Mukhopadhyay 2020, p. 6). In terms of the text's structural integrity, *A Ballad of Remittent Fever* is a neatly packaged historiographic metafiction, with its synchronous embedding of real events and historical figures within its fictional narrative. The novel continuously interacts with readers, informing them about the health history of Bengal. Its intense self-reflexivity and intertextual overtones correspond to several historical documents and archives. By incorporating minor "references to various [*daktars*] found fleetingly in the files of the medical department" (Mukharji 2009, p. 59), the fictional capacity of Mukhopadhyay's historiographic metafiction complements the archival limitation and delivers a comprehensive detail about *daktari* medicine.

Our reading of the novel emphasizes the decolonial discourses of medicine and public health in the social history of Bengal. We argue it is essential to conduct a "thorough reexamination of the colonial roots of Western-based modern medicine" (Naidu 2021, p. 9) and historically reflect on our current systems of knowledge surrounding it. The successful rise of native *daktars* in British India reframed the critical label attached to Western medicine as a "tool of the Empire" (Headrick 1981, p. 8)—which ostensibly sought to control and colonize the Indigenous population. Being a part of the diverse local community, the cultural competence of the *daktars* made them effective in introducing Western medicine. This led to the gradual establishment of the clinic and its eventual success within rural parts of India, which displayed strong cultural resistance and apprehensions. Hence, *daktars* were able to break the mould of state medicine as "white man's medicine" by operationalizing the possibilities of medical pluralism. By focusing on *daktari* medicine as an important site of the decolonial paradigm, the article takes a "self-conscious turn to alternative geographies" other than the US and UK "[which are] not usually encompassed by the medical humanities" (Whitehead and Woods 2016, p. 7). A close textual analysis of a postcolonial novel such as *A Ballad of Remittent Fever* reveals such alternative geographies

and facilitates discussion of medicine, decoloniality, and breaking the binary of the "West and the rest".

Through analysis of the chosen text, we raise pertinent questions as follows: Can literature accommodate the historical process of the assimilation of Western medicine vis-à-vis the clinic within the Indian body politic? If so, how does historiographic metafiction as a literary genre offer a suitable platform to narrate and accommodate the contested medical history of India? Finally, but importantly, how does *daktari* medicine, as the potent site of transcultural medical encounters, inform the birth of the Indian clinic?

1.1. Medicine and Metafictions: A Ballad of Remittent Fever

Literature offers a vital space for exploration when it comes to unveiling alternative history or counter-history, as opposed to the politically legitimized state history. In particular, the literature of the colonized encompasses the silenced histories of subalterns within its ambit. In this aspect, this study proposes "a postmodern interest of subjectivity and representation" (Natoli and Hutcheon 1993, p. x) relating to the role of native *daktars* in the medical history of India. It selectively chooses literature that exemplifies alternative histories produced in the postmodern format—something that Linda Hutcheon calls historiographic metafiction. Hutcheon explains the development of this genre, where its "theoretical self-awareness of history and fiction as human constructs is made [possible through] the grounds for its rethinking and reworking of the forms and contents of the past" (Hutcheon 1988, p. 5). *A Ballad of Remittent Fever* rethinks Calcutta as an important historical site which worked as a colonial laboratory of medicine. Thus, the text ethically represents the role of native practitioners within the administrative contexts of colonial rule (Brimnes 2013).

The rich narrative of the novel, in terms of characters and events, covers four generations of *daktars* from the Ghoshal family. This *daktari* lineage begins with the headstrong Dwarikanath Ghoshal, shunned by his family after expressing his desire to pursue medicine in 1884. "Studying medicine meant handling the dead bodies of all castes" (Mukhopadhyay 2020, p. 3), which could potentially lead to social ostracization back then from the upper echelons of Hindu society. The disowned Dwarikanath is later sheltered by Edward John Smith, a British tradesman. Under his care and upbringing, Dwarikanath goes to London to study medicine and comes back with an ambition to establish world-class medical schools and facilities for his fellow countrymen. He begins his practice at his home with a private clinic for himself, where he raises a new class of daktars, starting with his own family. He trains his son Kritindranath Ghoshal to pursue medicine. Kritindranath later on joins the Bengal Ambulance Corps and sets off for the battlefield of Mesopotamia during World War I. Dwarikanath also trains his niece Madhumadhabi, who becomes one of the pioneers of Ayurvedic medicine among the locals. There are several honorific references to characters such as "daktar moshai" (Mukhopadhyay 2020, pp. 27–33) and "daktar babu" (Mukhopadhyay 2020, p. 252) that closely align with Mukharji's identification of the new class of South Asians (particularly Bengalis) practicing Western medicine. Both the terms "*moshai*" and "*babu*" are double honorifics used to address medical officers with a superlative sign of respect and admiration.[1] This also indicates the higher social position occupied by these *daktars* in the local community, which could suggest their possible "*bhadralok*" (elite gentlefolk) status.[2] In his article on "Munisipal Darpan", Mukharji explains how the colonial state extended its public health initiatives as mediated primarily through *bhadralok* functionaries—signifying the colonial state as effectively a *Bhadralok* state (Mukharji 2013, p. 36). The *daktari* lineage of the Ghoshals is renewed by the fourth-generation *daktar*, Dwijottam, who is Punyendranath's son. Punyendranath, a third-generation character in the Ghoshal family, does not pursue medicine but rather chooses to become a teacher of chemistry. It is Punyendranath's son Dwijottam who carries forward the legacy as he benefits from the efforts made by his great-grandfather in establishing a strong medical fraternity at Calcutta.

All these imagined characters, throughout the course of the novel, are on a mission to fight disease and improve health awareness. The independent efforts taken by the *daktars* aimed to cope with the enormous, convulsive changes the city and the country were experiencing during the colonial era. The state of affairs resonated with a body politic that was "doubly-colonized" by contagion and the West, as noted by Arnold. The novel, set across two centuries, is located in and around the province of Calcutta, which grappled with recurrent epidemics and unsanitary crises. The curative role of *daktari* medicine, owing to its vernacularization within the Bengali public sphere, is exemplified through the novel.

The text weaves historical realism with a non-linear narration that constantly switches between narrators. The narration shuffles across the chapters between the omniscient third-person narration and the first-person narration of Kritindranath Ghoshal. For instance, the author asserts the anachronistic tendency of the text through Kritindranath's first-person narration: "The narrative does not obey the rules of chronology. The life of an anarchist like myself can only be known for chaos" (Mukhopadhyay 2020, p. 136). On the other hand, Mukhopadhyay cleverly shifts to an omniscient voice as he ventures to describe the larger socio-cultural milieu of Bengal. The author narrates in the third person the lives of the first-generation (Dwarikanath Ghoshal of colonial India) and the last-generation (Dwijottam of the newly independent India) characters. The fictional character of Kritindranath Ghoshal takes on the task of narrating the in-between events which accounted for the Swadeshi movement and the position of *daktars* in it—which we will discuss later. The first-person narration brings subjective and self-reflexive undertones to the decisive actions taken by the *daktari* protagonist. It is complemented by the omniscient narrator, who covers the familial and social history of *daktari* medicine in Bengal. This dualistic mode of narration complements the historiographic metafiction as it offers significant detail on both the public and the private lives of the *daktars* in discussion. Moreover, the grounding of this text stems from multiple sources, ranging from government records and medical journals to ayurvedic sutras and other cultural and Indigenous texts. The heterogeneous composition of the novel posits the text as a rhizomatic node of reference within contemporary Indian literature dealing with medical history.

1.2. Methodology

This article takes a neo-historical approach towards understanding and assessing the past of *daktari* medicine through the medium of literature. Neo-historicism, a term coined by Stephen Greenblatt, is a form of literary praxis which calls for "an intensified willingness to read all of the textual traces of the past with the attention traditionally conferred only on literary texts" (Greenblatt 1990, p. 4). Such a mode of textual analysis takes the literary and non-literary texts of a particular time and context on the basis of an "equal weighting" (Barry 2018, p. 175). This attempt to develop a parallel reading of sources from literature and history together helps us understand that they are not watertight but, in fact, osmotic. These sources often complement rather than conflict with each other, creating optimal conditions for historiographic metafiction. Drawing on this combinatorial aspect, the study takes two central texts, one being fictional and the other theoretical: Mukhopadhyay's fiction and Mukharji's historical findings. The historical tension generated by "fiction and [its] friction" (Greenblatt 1991, p. 66) directs the objective of close textual analysis, primarily surveying the text's riveting focus on *daktari* medicine. Mukharji argues that "we cannot distinguish between the official archive and the vernacular archive on the registers of truth and falsehood" (Mukharji 2009, p. 28). Writers of historiographic metafiction, such as Mukhopadhyay, deliver a rich resource for critical discussion that helps us to unveil marginalized and alternative histories, which are often delegitimized by the state. Mukharji suggests the reader "situate the medical texts next to the literary" (Mukharji 2009, p. 29) to encapsulate the efficacy of literary presentations in offering a more detailed and comprehensible understanding of medicine and its history. Doing so, we explore the interconnectedness between the common pathways of literature, history, and medicine.

Apart from choosing the neo-historical method, the article employs Edward Said's critical concept of contrapuntal reading. In his seminal text *Culture and Imperialism*, Said explains that reading contrapuntally is to "take account of both processes, that of imperialism and that of resistance to it, which can be done by extending our reading of the texts to include what was once forcibly excluded" (Said 1994, pp. 66–67). As discussed earlier, *daktars* have occupied lower strata in medical ranks due to the covert politics of the archives. It is through reading contrapuntally a postcolonial text such as *A Ballad of Remittent Fever* that we go beyond the archival politics in a colonized culture. Such a reading is important as it throws light on the imperialist attitudes and the *daktari* experience at contestation here. The contrapuntal reading comes "[as] an immediate response in which the colonized voices are adequately and accurately depicted to be read alongside the literature [and archive] of the colonizers" (Said 1994, p. 29; Kouzmenko 2017). The primary text, although postmodern in structure, is postcolonial in its narrative schema and is eligible to be called, in Said's words, a literature of the colonized. This allows us to approach historiographic metafiction as a site of critical interpretation, given its structural capacity to carry, contextualize, and combine literary and non-literary materials. The dual method of reading the text neo-historically and contrapuntally regards the novel as a historical palimpsest. The local and colonial archives embedded in *A Ballad of Remittent Fever* become the direct point of study to unravel possible histories of medical marginality (Hardiman and Mukharji Bihari 2012).

Drawing upon these critical reading methods, Figure 1 visualizes the complex interweaving of several medical systems involving numerous social actors, generating a continuous cause-and-effect relationship within the medical pluralist paradigm of India.

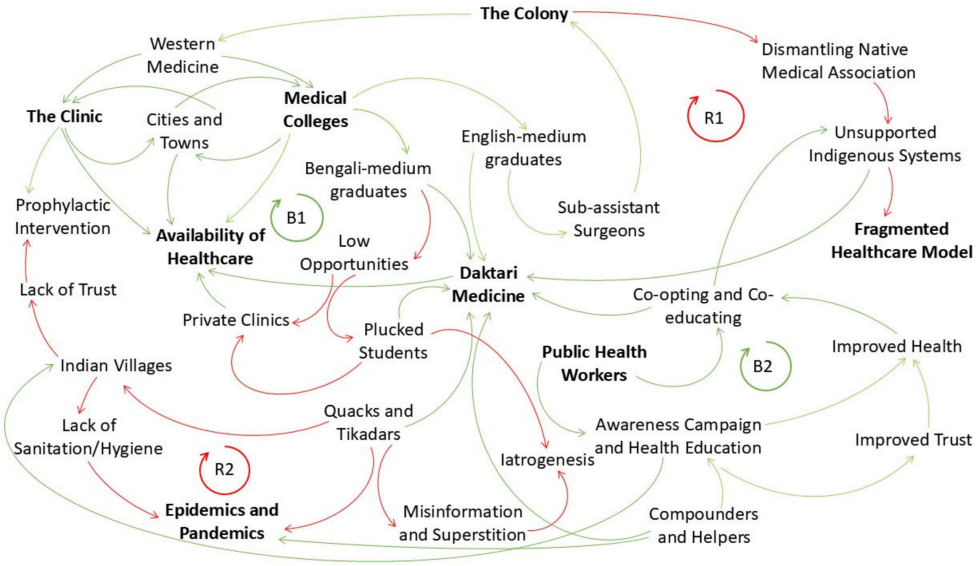

Figure 1. Causal-loop diagram of medical systems in colonial India (figure created by the authors).

The figure portrays a causal-loop diagram to picture these individual processes and events within the larger context of Bengal's medical history. The diagram encompasses several social processes forming loops that reinforce (R1 and R2) and balance (B1 and B2) each other. Through this systems-thinking approach, we will discuss four main social processes in our upcoming sections: 1. The establishment of medical colleges and clinics (B1). 2. The fragmentation of the Indigenous healthcare model (R1). 3. Recurrent crises of pan/epidemics (R2). 4. Improving public health measures (B2). Such a model of systems thinking enables us to understand how the clinical discourse within a postcolonial nation such as India is a package of discursive practices that co-exist in relationship to one another and continually influence each other. Hence, it is through these extensive methods of critical analysis of reconstructed *daktari* lives in the chosen texts that the ethics of representation and vernacular medical histories are discussed.

2. Situating the Indian Clinic in the Colony

Ishita Pande, in her thesis *Curing Calcutta*, argues that Calcutta as a colonial space "was not a mere stage on which a fully formed western medicine arrived, but a productive space, where colonial medicine was shaped by institutional and ideational networks" (Pande 2005, p. iii). Within this context, the city of Calcutta became home to the Calcutta Medical College (CMC), established in 1835 as the second oldest medical college in South Asia after the French colonial establishment of the Ecole de Médicine at Pondicherry (1823). The British medical institution was launched with a motto to train native youths in Western medicine irrespective of caste and creed. The college provided relief from disease and disorders for the city dwellers of Calcutta, particularly British soldiers. The latter often quoted military surgeon James Ranald Martin, who remarked it was "disease and not the enemy that killed them" (Arnold 1993, p. 65; Mukhopadhyay 2020, p. 185).

The growth in medical admissions at the Calcutta Medical College set the scene for the emergence of a new class of *daktars* in Bengal. Mukharji notes the CMC's rapid growth: "Having started in 1835 with a batch of 50 students, by 1873, the CMC had 1226 students" (Mukharji 2009, p. 5). The syllabus in the Calcutta Medical College was taught in both English and local languages, such as Hindustani and Bengali. It offered various degrees, such as a Doctor of Medicine (MD), a License for Medicine and Surgery (LMS), and also a baccalaureate degree in Medicine (MB). The college started functioning after the abandonment of the previous board of the Native Medical Institution (NMI) by the then Governor-General Lord Bentinck. The decision came as a blow to the medical practitioners of Sanskrit College and the Calcutta Madrassa, who had constituted the dichotomous entities of the Native Medical Institution. The defunct native board taught a "mixed syllabus [. . .] drawing upon Ayurveda, Unani and [also] 'Western' Medicine" (Mukharji 2009, p. 80). In Figure 1, the causal-loop diagram represents a reinforcing loop (R1) and a balancing loop (B1). R1 represents the destabilization of the Indigenous medical systems of India and the subsequent fragmentation of the local healthcare model. The B1 loop indicates the possible steps taken by the State to establish colleges and clinics to counter the negative R1 loop with increased *daktari* manpower from local communities to facilitate and practice Western medicine. This decision caused a disjunction between Indigenous medical practitioners of various backgrounds and the state administration. It could be argued that the disregard of colonial authority seeded a decolonial drive among native physicians to establish an "Indian clinic" in Calcutta.

The novel crucially locates the Calcutta Medical College as the founding place for eminent doctors, including Radha Gobinda Kar (famously known as R. G. Kar), Dr Suresh Prasad Sarbadhikari,[3] and the first-generation *daktar* of our fiction, Dr Dwarikanath Ghoshal. Later in the novel, the author highlights how the urgent need to develop an autonomous non-governmental medical college in Calcutta materialized through the efforts of historical figures like Kar and Sarbadhikari. Thirty years after the establishment of the CMC, the Calcutta School of Medicine, currently known as the R. G. Kar Medical College and Hospital,[4] was established in 1866, making it the first non-governmental medical college in Asia. The newly constructed Calcutta School of Medicine motivated Bengalis of various classes "to practice 'western' medicine at various levels of the colonial establishment, ranging from the lowly hospital assistants [to] the grand Edinburgh-or-London-trained MDs" (Mukharji 2009, p. 36). The college was an output of the self-reliance (*swadeshi*) movement that sought to bring autonomy amongst medical practitioners, with due respect offered to the disbanded Native Medical Institution and their teaching. The author also captures the *raison d'etre* of this transformation and expansion of the hospital-cum-college in a context of affective, nationalistic, and linguistic politics. Mukhopadhyay captures this historical shift in the novel through the second-generation protagonist and son of Dwarikanath, Dr Kritindranath Ghoshal, who studies medicine in Bengali at the then-newly founded Calcutta School of Medicine and critiques the explicit bias in the curriculum. The college offered only four years of training for Bengali students as opposed to five years for students studying in English.

In keeping with the conventions of historiographic metafiction, Mukhopadhyay introduces a "fifty-year-old copy of [Bengali newspaper] *Sambad Prabhakar*"[5] (Mukhopadhyay 2020, p. 94) to reflect on the small number of students opting for Bengali-language classes at the Calcutta School of Medicine:

> A total of thirty-one students have joined the Bengali classes at the Medical College of them being ten on scholarship and exempted from the requirement of taking the entrance examination; therefore, only twenty-one out of three hundred and twenty candidates passed the examination. We had surmised from the candidates that a minimum of 150 applicants would be successful in proving their mettle, but all we are left with is regret at our ambition. It proved to be a tempest in a teacup, as readers may judge for themselves. (Mukhopadhyay 2020, pp. 94–95)

The employment of a newspaper article within the narrative, whether real or fictional, brings credibility to Mukhopadhyay's historiographic metafiction. Dwarikanath Ghoshal, one of the eminent doctors of his era, is also aware of the clear-cut hierarchy within the early medical discourse of colonial Bengal. Apart from one's educational merit, Seema Alavi (2008) identifies how one's respectability, family background, and social status were also considered in the recruitment of college graduates as sub-assistant surgeons at state medical institutions. In addition, the choice of one's language of education was another critical factor that influenced the careers of medical students. Going back to the causal-loop diagram in Figure 1, we can identify that many Bengali students failed due to a lack of opportunities and poor training. Mukharji distinguishes between medical graduates taught in English and Bengali by noting that the Bengali-class graduates received relatively "low salaries" and "limited [career] opportunities" even in government services (Mukharji 2009, p. 6). The systemic difference in treatment and acknowledgement of the *daktars* produced led to communal tension and linguistic debate, as iterated in the excerpt from *Sambad Prabhakar*, which asks, "Where then is the scope for improvement in mastering the local language and the concomitant advancement of the nation? It is still *a distant dream* . . ." (Mukhopadhyay 2020, p. 95, emphasis added). This lack of opportunity also explains Dwarikanath's paternal anxiety in refusing his son's request to pursue his medical education in Bengali. Yet Kritindranath's staunch refusal to accept medical instruction in English, choosing instead his mother tongue, echoes the aforementioned "distant dream" of advancing the local health and the Bengali language in parallel. Mukhopadhyay unveils such cultural resistance, which was prevalent among the second-generation graduates of medical colleges in Calcutta, with his textual design of creating generational protagonists in the Ghoshal family.

Again in line with historiographic metafiction, Mukhopadhyay proceeds to depict this historical and cultural tension by introducing prominent real-life individuals who were important in the Bengali medical circle during the late nineteenth century as characters in the novel. As mentioned earlier, Dr. Radha Gobinda Kar is one such character, whom the author brings into the text as a colleague of Dwarikanath and a teacher of Kritindranath. The author posits Kar at a discussion table with the *daktari* characters of his imagination, such as Dwarikanath Ghoshal, to help readers realize Kar's vision for the development of *daktari* medicine through the Calcutta School of Medicine and later the Calcutta Medical "College". While talking about his vision and mission, Kar, in the novel, emphasizes his dedication to nurturing "students [who shall] acquire medical degrees and examine patients with the same authority that English doctors do" (Mukhopadhyay 2020, p. 109), thereby being responsible for the production of a new class of self-reliant *daktars* who will attend to public health, cultural integrity, and medical authority alike.

3. Critique of *Daktari* Medicine

Although the new class of medical graduates shared a vision of nationalist sentiments and rational values within their clinical practice, vernacularized *daktari* medicine, to an ex-

tent, incorporated Indigenous medical practices alongside Western medicine and treatment. Arnold observes the heterogeneity of the medical setup in India:

> [The] issue concerns the nature of the relationship between what for convenience we call "indigenous" and "Western" medicine (as if they were totally independent and internally homogeneous systems of thought and practice) [. . .] The relationship between Western and Indian medicine needs to be looked at in more pluralistic and dialectical terms, terms that allow for a continuing interaction between the two during the long history of colonial rule in India or that express the relationship as a protracted epistemological struggle which says more about the nature of political and economic power under colonial rule than about the abstract merits of two contrasting, competing, but not wholly incompatible, medical systems. (Arnold 1993, p. 13)

A Ballad of Remittent Fever throws light on the power/knowledge hierarchy between surgeons, physicians, clinicians, and helpers that existed in colonial India. Many *daktars* who were outside the colonial establishment practiced medicine privately and were more easily available to the local people. In fact, it was the lowly hospital assistants, compounders, and native doctors who most successfully negotiated the superstitions surrounding sickness, disease, and epidemics. Mukhopadhyay presents several narrative events in the novel as case studies of the lived experiences of people from the then "urban" and "rural" Bengal. The agenda here is to demonstrate the importance of the role played by the not-so-privileged *daktars* in the lives of ordinary people. However, the author also addresses the persistent threat of iatrogenic diseases[6] caused by misdiagnosis by unlicensed *daktars* who comprised "plucked students" (Mukharji 2009, p. 24), "quacks"[7] (Kumar 1998, p. 34), and "witch doctors" (Mukhopadhyay 2020, p. 100). The text educates readers on this public health crisis while also offering creative solutions through communication, education, and affirmation between the colonial authorities, the *daktars*, and the public. Dwarikanath Ghoshal and his niece Madhumadhabi, an ayurvedic practitioner, undertake to bring together characters from non-medical backgrounds to improve public health through training, practice, and goodwill. This project resonates with Volker Scheid's statement that "Opening ourselves up to non-medical traditions [and people], not as objects of inquiry but as resources for thinking critically about the fundamental issues of our time, presents an opportunity" (Scheid 2016, p. 82) to move towards decolonization. The novel shows how trained doctors such as the Ghoshal family played a role in bridging the divide between the state and the public as progenitors of the *daktari* community.

However, the social acceptance of *daktari* medicine was not a straightforward process. The critique of *daktari* medicine as "dangerous" and "foreign"—an antithesis to local practices—prevented its circulation in rural India. The next sections explore such points of criticism and their origins by investigating the tainted identity of *daktars* through case studies of the plucked student or semi-educated quack, and the compounder or hospital mate.

4. Private Clinics: Plucked Students and Semi-Educated Quacks

The limited career opportunities available to many Bengali-class medical graduates pushed them to privately practice medicine or, at worse, drop out of courses. In the second chapter of the novel, titled "Logical Autopsies", Mukhopadhyay introduces Nabinchandra Gupta, a *daktar* in the vicinity of Belgachia,[8] who is called to attend to a young boy with a heavy fever and unbearable body ache. The writer describes Gupta's obscure background by explaining that "no one knew which college Nabin had studied medicine at. Not that anyone was bothered [either], because at that time there were many medical practitioners who had acquired their abilities solely from being in the company of skilled doctors" (Mukhopadhyay 2020, p. 24). Gupta claims to practice all forms of medicine, including Allopathy, Homeopathy, and Ayurveda. Despite his claims, he fails to treat the patient and, in fact, makes matters worse by acquiescing to the ignorant and harmful requests made by the boy's family to rub stale ghee on the stomach to reduce bloating, as well

as providing a problematic prescription of stale rice with lemon juice, thus inducing acidity. As the prescription of a number of red and blue pills by Gupta inevitably causes iatrogenesis, the family of the young boy chooses to call for a "good doctor"[9] from the nearby medical college.

The medical complications caused by unprofessional *daktars* with their reckless treatment is one of the strong critiques laid against them. It further tarnished the trust between the vulnerable community and *daktars* in colonial India. This situation is only remedied by the intervention of Dwarikanath Ghoshal, a reputed doctor who has finished his education and received his license from a recognized medical institution. As a *daktar babu* from a reputable social and educational background, Dwarikanath brings hope to the patient's family with his prompt diagnosis. Despite being curt and strict in his instructions to maintain the health and hygiene of the patient and the community, he displays care and patient-centredness by prescribing appropriate and affordable medicine and a suitable diet. He also notes that Gupta's previous prescription would have aggravated the condition of the patient, who was already suffering from malaria.

Mukhopadhyay offers a subtle distinction between Gupta and Ghoshal, who both fall under the common label of "*daktars*" in the perception of the local community seeking healthcare. While Gupta relies on his positive demeanour, offering constant reassurance and acquiescing to unorthodox treatments to cover for his professional ineptitude, Ghoshal conducts his duties as per the Hippocratic Oath of beneficence and non-maleficence. Another important distinction mentioned in the novel is the fee incurred by each of the two doctors: where Gupta accepts the meagre sum of four rupees, Ghoshal only "accepted his usual fee of ten rupees, which was on the higher side" (Mukhopadhyay 2020, p. 32). Cynthia Klestinec situates such differences in fee as a reflection of "expanding and competitive early modern medical marketplace" (Whitehead and Woods 2016, p. 7) practices. It further demonstrates "how and why patients trust practitioners and comply (or not) with their instruction"(Whitehead and Woods 2016, p. 7), irrespective of the fee incurred. This diversity foregrounds the problematic nature of the term "*daktari* medicine", which includes all sorts of physicians, educated to self-proclaimed, under the same label.

Meanwhile, the manpower for the supply of medical teams to rural and underdeveloped parts was already skewed. These semi-educated yet self-proclaimed *daktars* were quintessential to meeting the demand during any public health crisis. Doctors like Ghoshal looked at this problem of semi-educated quacks as an opportunity to build a skilled human resource who should be professionally trained to attend to and care for patients in emergencies. The notion of situating the plucked students as semi-educated quacks is also to be contested, given that the "quack" is a loose label often designated by the established power structures. Mukharji highlights "quackery" as a historically contingent discourse that "had developed in South Asia since the 1880s" (Mukharji 2009, p. 7), given that there were almost 35,000 people in 1901 practicing in Calcutta without a diploma. Most of them were identified as plucked students from the Calcutta Medical College, who practiced a bowdlerized form of Western medicine. This supports how possibly plucked students like Gupta were also employable as "skilled medical personnel in their own right" (Mukharji 2009, p. 7) when given proper training and supervision during medical missions.

5. Setting up Clinic in the Village: Compounders and *Tikadars*

The novel further illustrates the spread of *daktari* medicine from urban medical colleges to rural parts of Bengal. The college-cum-hospitals of Calcutta played a key role in supplying medical care not only to the colonial enclaves but also to the rural parts of India, as portrayed in Figure 1, where a steady supply of city doctors attempted to counter rural epidemics and sanitary crises. However, there was a problem due to the colonial disregard for native medical institutions and the subsequent strong cultural divide rooted in Indian villages. In Figure 1, in the R2 loop, we can see that the native actors who had a strong cultural presence among the rural populace were also responsible for spreading distrust towards Western medicine through misinformation and superstition. McKim Marriott

(1955) identified this lack of trust and disconnect between the rural population of India and the colonial establishment of clinics. The resistance against the clinic as a state apparatus was not only marked by rising nationalist sentiments but was heavily embedded in the cultural ethos of common people. While the clinic "hardly touched" (Marriott 1955, p. 241) or failed to "penetrate the villages" (Parekh 1989, p. 44), which were considered the core of Indian society,[10] native society was also "touchy" (Arnold 1993, p. 214) in their health behaviour and distrust of Western medicine. Arnold curates excerpts from vernacular newspapers in *Colonizing the Body* to attest to this touchy nature of the Indian body politic. For example, some of the headlines show that the female body was considered sacrosanct and death by illness was seen as preferable to medical support by a male doctor (Arnold 1993, pp. 214–15). The commissioning of plague doctors further enraged the locals as the colonial public health initiatives remained oblivious to their cultural sentiments. One newspaper, *Kaiser-e-Hind*, demonised these public health interventions and the colonial establishment of college-cum-hospitals as "something diabolical which claimed so many victims" (Arnold 1993, p. 220).

The "western" clinic was thoroughly vilified via media and word of mouth, particularly in rural India. The above news excerpts echo the ideological terrain vis-à-vis the collective consciousness that the Ghoshals face in the novel when Dwarikanath, along with his niece Madhumadhabi and assistant-cum-compounder Panchanan, set their mission to the cholera-infested village of Kanaipur "in Konnagar, sixteen miles from Calcutta" (Mukhopadhyay 2020, p. 182). In the chapter "From Calcutta to Kanaipur", Mukhopadhyay introduces another historically important figure, Gopalchandra Chattopadhyay, who was then the secretary of the Anti-Malaria Cooperative Society. Along with Kishori Mohan Bandhopadhyay, who is also dubbed as the "Unsung Indian"[11] behind Sir Ronald Ross's discovery of the malaria parasite (Chattopadhyay 2015), Gopalchandra strived to educate the inhabitants of the villages on the outskirts of Calcutta and conducted anti-malaria campaigns from 1918 onwards. In an imaginary conversation between Gopalchandra and Dwarikanath, the author evinces how they launched awareness campaigns with the help of "slides which are displayed with the magic lantern [and] short dramatic sketches that volunteers perform in the marketplace" (Mukhopadhyay 2020, p. 186). The latter reference to the dramatic sketches being performed at the marketplaces resonates with the *darpan*[12] genre discussed by Projit Mukharji as public health propaganda initiated by the state. Ghoshal's crusade is against the spread of cholera in the village of Kanaipur, which was frequently affected by the deadly pathogen owing to severely contaminated village ponds and tanks waiting for sanitary intervention. These campaigns for improved and sustainable sanitation, nutrition, and housing in local communities are captured in Figure 1's balancing loop B2. Scholars such as Ivan Illich and epidemiologists including Thomas McKeown have notably supported this standpoint, which not only improves health but also develops trust between the state and society (O'Mahony 2016, p. 136).

Dwarikanath Ghoshal trains his assistant Panchanan to take charge of public health hygiene and sanitation at Kanaipur. He describes Panchanan as "[not having] a medical degree but a *minor doctor* in his own right" (Mukhopadhyay 2020, p. 186, emphasis added), echoing Mukharji's description of *daktars* without licenses as "[a group of] skilled medical personnel in their own right" (Mukharji 2009, p. 7). These groups of skilled health workers were assigned to important medical missions during crises, including pan/epidemics (Mukharji 2009, p. 7). Ghoshal further encourages Madhumadhabi, an Ayurvedic practitioner, to set up an Ayurvedic pharmacy at Kanaipur with a space to cultivate medicinal plants and a kitchen garden to extract medicine.

Despite their goodwill and efforts, the pervasiveness of the newer forms of healthcare caused anxiety among locals and triggered their socio-cultural immunity. During one of their public health exercises of vaccinating residents against smallpox at Kanaipur, the Ghoshal family face severe backlash from exorcists, witch doctors, and *tikadars* (inoculators), accompanied by villagers who are easily influenced by superstition. All these groups of healers from South Asia fall under the label of "medical marginality" proposed by

David Hardiman and Projit Mukharji. The term "medical marginality" refers to subaltern therapeutics that were very "important in the everyday lives of the poor" (Hardiman and Mukharji Bihari 2012, p. i). Traditionally, social groups like exorcists and witch doctors are identified as "poorly educated peasants who perform healing rituals as a part-time occupation" (Li and Phillips 1990), primarily on vulnerable populations who perceived disease to be a result of moral and cosmological corruption (Jayagopalan 2022). On the other hand, *tikadars* performed the preventative role of immunizing the local populace using inoculation and later vaccination (referred to as "English *tikas*").

Nonetheless, Arnold notes that *tikadars* were "causing one death for every two hundred inoculations they performed" (Arnold 1993, p. 138), a high mortality rate in comparison to vaccination. In Figure 1, we identify the reinforcing social loop R2, indicating the recurrence of outbreaks within unsanitary rural villages served by quacks and *tikadars* without appropriate training. Further, it is crucial to note that iatrogenesis is only associated with quacks, *tikadars*, and plucked students in Figure 1. Here, we are not seeking to dismiss these figures of medical marginality as unreliable or dangerous, given that iatrogenesis is a commonly noted phenomenon in all domains of medicine. Instead, the diagram suggests that a lack of accountability to the State among the "unlicensed" medical marginality caused higher rates of iatrogenesis (Arnold 2012, p. 183). To eliminate this negative reinforcement of adverse health effects, the colonial administration was ready to suggest that "*tikadars* be licensed and brought under state regulation" (Arnold 1993, p. 139) to counter such risks and support the introduction of the Jennerian vaccine. The decision to issue licenses to a larger body of subaltern therapeutics and self-proclaimed *daktars* was paramount in ensuring that their practice could be checked and balanced by the state.

Situating this context in the novel, the Ghoshals venture to set up a *daktari* clinic at Kanaipur, where villagers still protest against the incorporation of measures such as the smallpox vaccination, asking if they were "rats or dogs [that] have to be vaccinated" (Mukhopadhyay 2020, p. 194). Some even voiced accusations against "the [*daktari* lot for] secretly forcing all this into [their] bodies" (Mukhopadhyay 2020, p. 194), including fears that vaccinations could include pig meat, induce kala-azar, cause infertility, or result in babies being "born lame and pockmarked" (Mukhopadhyay 2020, p. 190).[13] These references to resistance against vaccination can be traced to Ivan Illich's concepts of "social iatrogenesis" and "cultural iatrogenesis" (Illich 1975). Illich's controversial take on modern medicine argues that the institutionalization of medicine leads to the over-medicalisation of ordinary life (social iatrogenesis) and the loss of traditional ways of dealing with suffering (cultural iatrogenesis) (O'Mahony 2016, p. 135). In the Indian context, socio-cultural iatrogenesis and medical iatrogenesis are equally of concern.

To combat such anxieties raised by Illich and others, the Ghoshal family creates an inclusive community that fosters science along with culture in Indian villages. Eager to set up the "Amodini Association for Village Development and Cultivation of Science" at Kanaipur, Madhumadhabi comes forward to confront the apprehensions regarding socio-cultural iatrogenesis. She is well aware that public resistance is being stoked by exorcists, witch doctors, and *tikadars*[14] reliant for their livelihood on attending to those suffering from epidemic diseases, including smallpox, plague, and cholera. *Tikadars*, who usually collected a charge of one or two rupees per head depending on the living conditions and circumstances of the patient (Arnold 1993, p. 129), were also known for spreading rumours and prejudice to maintain their local influence even after the advent of the vaccine. Thereby, these native healers were historically known not only for mitigating the epidemic of disease but also for spreading the epidemic of rumours. In the novel, Madhumadhabi employs what Arnold suggests as an "alternative strategy" (Arnold 1993, p. 259) to combat the resistance posed by medical marginality. Arnold recommends "to co-opt the existing specialists and try to convert them to [modern] ideas and techniques. Rather than ditching [them], it made practical sense to recognize that they already existed in virtually every Indian village, [as] they were cheap, and they were trusted" (Arnold 1993, p. 259). Madhumadhabi narrativizes this idea and executes a sustainable plan:

> I will teach these exorcists and witch doctors how to give basic medical treatment . . . then they can start prescribing medicines and give injections for ordinary fevers . . . they will cure people . . . they will not have to use incantations . . . why should they live on other people's contributions permanently . . . they have their self-respect too. (Mukhopadhyay 2020, p. 198)

These methods of "co-opting" and "co-educating" the medical praxes of the West and the rest within *daktari* medicine reveal that the establishment of the clinic in the colony is a historically contingent scheme influenced by spatial, cultural, and political contexts.

6. *Daktari* Medicine: A Passage Towards the Indian Clinic

Daktari medicine stands as a testament to the medical pluralism that successfully prevails in the Indian subcontinent. Leslie (1980) exemplifies the term "medical pluralism" as suggesting "the co-existence and competition among multiple healthcare systems in a specific region" (Yu 2021, p. 2). This pluralist paradigm promotes modernity in colonial and postcolonial spaces and contexts, forming fluid and multifaceted notions of healthcare. Mukharji's idea of "alternative modernities" (Pati and Harrison 2018, pp. 2–3) encourages an examination of the discursive medical practices produced by the process of vernacularization, for example, *daktari* medicine. Such pluralism in medicine further "repositions the patient—rather than the State—at the centre of medical history" (Mukharji 2009, p. 16), where patients are enabled with power and choice to consult a wide variety of healers. At present, India has established a Ministry of AYUSH, which is an acronym for Ayurveda and Yoga and Naturopathy, Unani, Siddha, Sowa-Rigpa and Homeopathy, to encourage research and practice in these complementary medical disciplines. Recent studies conducted in the wake of the COVID-19 pandemic by Chaturvedi et al. (2020) and Kotecha (2021) emphasize the evidence-based practice of the AYUSH system to promote immunity and, thereby, lower morbidity and mortality rates. These arguments are further suggestive of the long-standing tradition and cohabitation of Indigenous and collaborative medical approaches carried out in India across centuries. Thus, *daktari* medicine serves as a rhizomatic node that connects the West with the local networks of medical cultures and belief systems.

A historically informed metafiction such as *A Ballad of Remittent Fever* opens up multiple sites of exploration in medical history and health humanities. The text, via its genre, explores the medical marginality and completes and complements the archival gap by reimagining the undocumented lives of the *daktars*. Nevertheless, as Mukharji notes, it is a herculean task to "wholly contextualize the [fragments] since not all 'facts' will ever be available" (Mukharji 2009, p. 36), and this article only examines a particular moment in Indian medical history. Hence, Mukhopadhyay's novel, so thoroughly informed on the vernacular history, is part of a larger decolonial project in its representation and legacy of *daktars* and *daktari* medicine in improving public health in India.

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Notes

[1] Madhu Singh (2020), in a translation of Rajinder Singh Bedi's "Quarantine", explains how titles such as "*babu*", "*ji*", and sometimes a combination of both as "*babu-ji*" (the equivalent of "mister" and "sir" together) are used widely in the northern and eastern parts of India. As a translator, Singh also explains how these cultural signifiers are intentionally left untranslated to introduce the character within its cultural space without any modifications.

[2] The term "*bhadralok*" signifies a social class of rich, well-educated and influential Bengalis, as opposed to the "*chotolok*", who does not fit into the ascribed "gentlefolk" status of the former.

[3] Lt. Col. Suresh Prasad Sarbadhikari was conferred the title by King George V for his contribution to the Indian Medical Service and Bengal Ambulance Corps for treating Indian Sepoys in Mesopotamia. It is further interesting to note how the character of Kritindranath Ghoshal personifies the same medical journey and struggle of Dr Sarbadhikari in the novel.

[4] The novel extensively covers the historical journey of the Calcutta School of Medicine and the shift in its name and address over the years. After India's independence in 1948, the hospital was renamed the Dr R. G. Kar Medical College and Hospital, which is still running efficiently.

[5] *Sambad Prabhakar* was the first Bengali daily newspaper, which played a huge role in influencing Bengali print media and culture since its inception in 1839.

[6] The term denotes the illness or injury caused by an improper medical examination or treatment by the doctor. The term "iatrogenic" takes its origin from the Greek words "ἰατρός", meaning doctor and "γένεσις", meaning origin, implying the origin of the illness stemming from the doctor/healer.

[7] The term "quackery" was employed historically as a derogatory term, usually to distinguish those who were practitioners of the so-called "folk-medicine" and alien medicine (including homoeopathy) as different from the elite doctors, reifying a binary hierarchy within the clinical domain.

[8] Belgachia is a locality in North Calcutta, which is the home to the Calcutta School of Medicine. The institute was also known as Belgachia Medical College for a brief period in 1916.

[9] As discussed earlier, the social position of a *daktar* was influenced by a multitude of factors; education at an established medical college marked superiority over the local *daktars*, who were self-taught through apprenticeship and easily available.

[10] See Bhikhu Parekh's *Gandhi's Political Philosophy* for an explanation of the Gandhian thought which affirmed that the roots of Indian civilization were "cradled and nurtured in Indian villages and only the rural masses were its natural custodians" (p. 43), while blaming cities as "soul-destroying" (p. 38).

[11] See Dhrubajyoti Chattopadhyay's (2015) essay, which critiques the exploitation of native workers who were used as laboratory assistants and lab rats. The efforts of Kishori Mohan Bandhopadhyay are still rarely acknowledged in discussions of the Nobel Prize-winning discovery of the malaria parasite, which was credited to Sir Ronald Ross in 1903.

[12] Mukharji (2009) translates *darpan* as "mirror" plays, which "were usually very overtly political" and "had arisen towards the beginning of the nineteenth century to criticise social and political evils" (p. 280).

[13] This controversial collective public health behaviour has been on the rise since the formation of the British National Anti-Vaccination League (NAVL) in 1896, and has resurfaced during the recent "pro-life" protests against COVID-19 vaccination.

[14] *Tikadars* were responsible for inducing immunity against smallpox by giving *tika*, or marks of smallpox variola. The practice warranted religious worship and ceremonies, which were predominantly popular before the discovery of the vaccine and are still in practice in Indigenous households.

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