

THE INDIGENISATION OF WESTERN MEDICINE IN SIKKIM

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Introduction

The British imperial Government of India established its direct authority over Sikkim after the conflicts of 1888-89, appointing John Claude White¹ to fill the newly created post of Political Officer Sikkim. As the imperial representative in Gangtok, White enjoyed considerable power - it was difficult for a local state to resist the 'advice' of a Political Officer who so prominently represented the economic and military power of the British Empire - and until his retirement in 1908, White effectively ruled Sikkim through a Durbar that he appointed and controlled; as he put it, 'everything was in my hands'.²

But when White took up his position, Sikkim was of little but strategic value to Britain's Indian Empire. It was impoverished and lacking in most of the structures of modern government - there were no police, no law courts, no public works, no secular education system, and no public health system. White was expected to develop his domain, but imperial government funding for this was limited to a subsidy of 12,000 rupees per annum. This was originally paid directly to the Sikkimese ruler, but with White determined to stamp his authority over the state, the Chogyal was effectively exiled from Gangtok until late 1895, and after his banishment the subsidy went 'towards the expense of management of the State by a British officer'³, suggesting that the Political Officer used this money for his own expenses.

In order to obtain the finance necessary to create and develop the state structures seen by the British as essential to modern government, White initiated a series of revenue-raising measures in Sikkim. A land revenue settlement was made, forestry excise measures were introduced, and, acting through the council that he dominated, White was able to introduce the unpopular measure of increasing immigration from Nepal in order to enlarge the tax base and raise agricultural production. Within a decade the revenue of the Sikkim state (which in 1891 was home to just 30,458 people⁴), had increased from just over £500 to £150,000 per annum.⁵ This income enabled White to begin

financing modernisation initiatives such as the education of Sikkimese youths in British India and the introduction of allopathic, or what is popularly known as ‘Western’, medicine.

This paper, drawing on the records of the imperial government and interviews with Sikkimese medical practitioners, will examine the subsequent development of this new medical system in the wider context of modernisation, and discuss how it came to develop the indigenised character it has in Sikkim state today.⁶ In presenting a narrative of medical progress, it is not my intention to suggest that this was uncontested, or that the process did not involve complex negotiations with practitioners of the indigenous medical systems.⁷ Nor is it to ignore contemporary problems and issues. My concern, however, is primarily with the influence and actions of individuals and institutions on the indigenisation process.

The Early Years (1880-1915)

By the late 19th century, it was established practice in the Empire for Medical Officers (generally from the Indian Medical Service), to accompany Political Officers touring or stationed in remote areas. Originally this had been to ensure the diplomats’ good health, but it had become apparent to the imperial policy-makers that the physicians could make a substantial contribution to the diplomatic success of the Political Officers’ missions by providing free medical services to the indigenous peoples, both elites and non-elites. The goodwill gained from this was seen as an important part of the political project of obtaining indigenous consent to British rule, and this ‘political’ role became the primary reason for the presence of Medical Officers in states such as Sikkim.⁸

When White first took up his post, the military medical staff who had served on the 1888-89 Sikkim campaign remained there under the command of Dr J.K. Close⁹ of the Indian Medical Service (hereafter IMS). After their departure, a Surgeon-Captain, Dr D.G. Marshall,¹⁰ was posted to Gangtok in 1891 to act as White’s Medical Officer, and he was replaced the following year by Surgeon Captain Dr A.W.T. Buist-Sparks.¹¹ In 1893, Buist-Sparks was replaced by Surgeon-Captain Dr G.F.W. Ewens.¹² Like his predecessors an IMS officer, Ewens remained in Gangtok until at least 1895.¹³

These officers were the first biomedical physicians to reside in Sikkim, and given that three of them later reached the rank of

lieutenant-colonel, and that Marshall had topped the examinations in his intake, they must have been among the better-than-average physicians in the imperial service. But Western medicine in such outposts did not then represent the scientific advances of the late 19th century as it would a decade later, and there is little evidence of their making any great impact on the medical world of Sikkim. Indeed their services may have been given only to White and his immediate circle; certainly in the absence of the banished Chogyal it was impossible to implement the usual imperial medical strategy of first impressing the ruling elites.¹⁴

These early physicians do not appear to have had a proper dispensary, and even the conditions in which they lived were primitive. Describing the later development of Gangtok, White refers to an unnamed Medical Officer and his wife in this early period 'who lived in a two-roomed hut built of wattle and dab [sic]', where their wooden furniture was liable to sprout in the rainy season.¹⁵ A Government medical dispensary was finally opened in Gangtok in the 1896-97 administrative year, but this must have been a very basic facility. An account from Sikkim in the 1960s describes how even in that time dispensaries 'usually are housed in small sheds. Half of the space is occupied by the medicine racks and table for dispensing. The remaining portion with a partition wall is being utilised by the compounder as his residence.'¹⁶

There is no record of any European physician having replaced Ewens, and it seems likely that an Indian-trained Sikkimese medical assistant then served in the Gangtok dispensary.¹⁷ Certainly by 1905 the dispensary was under the control of Civil Hospital Assistant H.N. Mitra, who remained there for some years.¹⁸ White does not appear to have submitted any annual report on the Sikkim state until 1902, but that first brief statistical report does provide the daily average number of patients at the Gangtok dispensary,¹⁹ as follows

1896-97	6.5
1897-98	7.4
1898-99	7.4
1899-1900	5.9
1900-01	5.3
1901-02	12.8

The sudden increase in 1901-02 is difficult to account for unless it includes smallpox vaccinations, with the rise consequent on the

epidemic of 1900. But in June 1902 another state dispensary was opened in Chidam,²⁰ and around this time a third dispensary opened at Rungpo. The latter was under the charge of the Public Works Department, suggesting that White, following a common imperial officer's administrative strategy of diverting funds allocated for one department to another, more needy area, was able to use PWD funds for medical purposes. With the establishment of these institutions, a structural basis for future medical developments had been made.

From 1902-03, Sikkim became an important staging post for what is popularly known as the 'Younghusband mission' and White was preoccupied with the mission from 1902 until he returned from Lhasa in the autumn of 1904. Gangtok was increasing in size and population, and the presence of numerous military units, each with their own Medical Officer, in and around Sikkim as a consequence of the Younghusband mission, were a reminder of the unsettled state of medical development there. The question of appointing a permanent European official to oversee medical issues in Sikkim was raised in a series of proposals White made early in 1906, but discussion over whether the resulting charges should fall to the military or civil department lasted for more than two years, not helped by White's characteristic tardiness in answering correspondence.²¹ White reported that the

want of an administrative medical officer over both civil and military matters for the Agency is being more and more felt. There are many pressing questions such as the development and supervision of existing dispensaries, the opening of new ones, vaccination, sanitation, etc., and the organization of medical aid generally, which require special knowledge and which are now suffering from the fact that there is no medical officer attached to this Agency.... All of ... [the dispensaries in Sikkim and Tibet] are under separate management and, although I can visit them occasionally, I am unable to say if the work in each is being properly carried on without a medical advisor. New dispensaries are required to be opened in Sikkim and without proper medical advice it is difficult to say where and how they should be opened. If all the dispensaries were brought under one control they would be worked more advantageously.²²

White requested the appointment of, 'a man of experience and tact' to administer both civil and military medical matters in Sikkim,²³ and it

was eventually agreed to establish a new IMS position of Assistant Civil Surgeon at Gangtok to supervise all medical matters in Sikkim state, including the state and missionary dispensaries, jails, schools, and 'personal attendance on the Chogyal and his family'.²⁴

This latter duty was a regular charge in the various states under a Political Officer, and does not confirm that Sikkimese royals had adopted medicine at that time, although the Chogyal Thubtob Namgyal was now reconciled to British authority, and his Private Secretary, Rai Bahadur Lobsang Choden, had served as a British medical interpreter on the Younghusband mission and might be presumed to have spoken well of medicine. But as it was agreed that the Agency Surgeon should receive extra allowances that nearly doubled his regular pay of 300rps a month, to compensate for the fact that there was 'practically no private practice in Gangtok',²⁵ it appears that at that time few if any of the Sikkimese elites were then liable to resort to medicine.

The first Civil Surgeon appointed to Gangtok was Assistant Surgeon 2nd class John Nelson Turner (*b.*1871), a member of the Indian Subordinate Medical Service, and not a qualified doctor. Turner took up his post in August 1909, and remained in Sikkim until early in 1920, by which time he was a Senior Assistant Surgeon who had been given the honorary rank of Captain during the First World War, when the IMS suffered a considerable shortage of manpower that it alleviated through the use of the Subordinate service officers. When Turner arrived in Gangtok, the three government dispensaries at Gangtok (which had in-patient facilities), Chidam, and Rungpo, had, in the previous year 1908-09 treated around 14,000 patients (of whom 13 died), including 218 in-patients at Gangtok. The figure of around 7,500 patients at Gangtok – compared with that previously given showing around 4,500 patients there in the year 1901-02 – does suggest a gradual increase in the Sikkimese uptake of medicine. In addition, three Church of Scotland Mission dispensaries in the state, to which the Government contributed an annual sum of 250 rupees, had treated more than 9,000 patients.²⁶

The Missionaries

Although the Political Department was actually reluctant to support Christian missionaries, regarding them as liable to upset the indigenous societies and thus create political instability, the establishment of a Political post in Gangtok was of considerable interest to the

missionaries, for whom expansion into Sikkim was a logical consequence of their existing work in Kalimpong-Darjeeling. By the 1880s, missionary strategists were confronting the problem of how best to encourage 'native' conversion, and their initiatives towards Sikkim developed at a time when the provision of medical services was increasingly seen as the most effective tool for conversions to Christianity.²⁷ As a result, both the missionaries and the Government of India contributed to the early development of Western medicine in Sikkim.

Church of Scotland missionaries from Kalimpong made several visits to Sikkim in the 1880s,²⁸ but were unable to obtain permission for a missionary to reside there. So the Reverend MacFarlane used the Lepchas, who had proved so amenable to conversion in Kalimpong district,²⁹ to spread the Gospel among their fellow tribesmen in Sikkim. His efforts enjoyed some success; by 1886 (when MacFarlane himself died), there were 26 Christians in Sikkim, and by 1888 their numbers had doubled.³⁰ The Chogyal continued to resist missionaries establishing a permanent presence until, in the changed political conditions after 1888-89, he was forced to allow them to establish a base in Sikkim. Gangtok itself remained out-of-bounds, but a site was selected in Chidam, in southern Sikkim, just a day's journey from Darjeeling, and a mission house was completed there in 1890, the same year that White moved into the newly built Residency in Gangtok.³¹

The missionaries' earlier initiatives in Darjeeling-Kalimpong enabled them to establish a strong influence over educational developments in Sikkim. While the Chogyal resisted the missionaries' efforts to expand Christianity in his domain, as early as 1880 he allowed the establishment of schools on the Western model - if these were staffed by local teachers -, and by 1890 seven such schools had been opened in southern Sikkim. But qualified local teachers were inevitably those who had emerged from the Christian educational structures in Darjeeling-Kalimpong and, in addition to education in Sikkim, many Sikkimese were educated at the mission's Training Institute in Kalimpong; in 1891, 17 out of the Institute's 37 students were Sikkimese.³² These schools produced a body of youths educated on the Western model, who were thus equipped to become the first generation of Sikkimese to serve in the new state institutions such as schools and medical dispensaries. The existence of such a group was to be crucial to the establishment and indigenisation of medicine in Sikkim.

The missionaries were much less successful in attracting converts. After its initial florescence among the Lepcha community, Christianity seems to have made little impact in Sikkim, with the number of Christians declining from 368 in 1913 to 343 by 1922.³³ The missions responded with a new emphasis on medical activities. In 1901, in describing the missionaries' main activities in Sikkim as 'evangelistic, educational, and vocational training', the Reverend Mackean made no mention of medicine.³⁴ But in January 1921, when he left Sikkim after spending a total of 14 years there, he recommended that his successor should be a medical missionary,³⁵ highlighting the one area where the missions had succeeded. In 1897 the Scottish missionaries had opened a dispensary at Chidam staffed by a compounder, Elatji Matiyas, a Lepcha convert to Christianity.³⁶ By 1906 further dispensaries staffed by local Christian compounders had been opened at Rhenock, Seriyong, and Dentan. In 1906 they dealt with 5,734 cases,³⁷ and by 1910 three more dispensaries had been opened.³⁸ Additional dispensaries followed, and by 1923-24 there were a total of 11 mission dispensaries in Sikkim, including one opened at Lachung in northern Sikkim by the Scandinavian Alliance Mission, which established a base there with two female missionaries in 1894.³⁹

It appears that as in so many other regions, the missionaries had found medical services the most effective way in which to reach the local populace. But whereas in Kalimpong-Darjeeling there were Europeans in day-to-day charge of the biomedical facilities, in Sikkim the dispensaries - like the schools - were under the immediate control of Sikkimese from the time they were opened. While the missionary ideal was the indigenisation of Christianity (and its associated teaching and medical programmes), in practice Europeans tended to retain control of the missions they established throughout the colonial period, with local converts restricted to control over peripheral or isolated mission outposts. But the Sikkimese opposition to the permanent presence of European Christians hastened the rise of indigenous Christians to control over the church, and meant that Sikkimese were the primary agents - and public face - of missionary medicine there.

In this early period, Sikkimese Christians educated on the Western model seem to have been 'generalists', who moved easily between posts as teachers, preachers, or compounders. Those educated by Christian teachers who had not converted were similarly liable to be employed in a variety of posts, including the growing colonial and state government bureaucracy.⁴⁰ But after the initial period there was a growing specialisation typical of the processes of modernisation, and

the move to state hegemony in regard to health and education was reflected in the way in which government employment came to carry greater social status than employment with the missions.

After Mackean's departure, another missionary willing to serve in Sikkim was eventually found. This was the Honourable Mary Scott, and just as the Reverend Graham took on the David Livingston role in Kalimpong, so too does she fill the 'heroic' role in histories of the Sikkim Church, where her arrival is described as 'the most important watershed in the history of Christianity in Sikkim'.⁴¹ Born in Scotland in 1877, a daughter of the 8th Lord Polwarth, Miss Scott travelled to Kalimpong in 1905. She remained there for 18 years, 'in what', one missionary wrote, 'some of us considered to be "insubordinate cooperation" with the Church of Scotland Mission',⁴² and received the Kaiser-i-Hind medal for her medical services to villagers during epidemics such as the influenza outbreak of 1918-19. Miss Scott agreed to fill the vacancy in Sikkim, and although her medical skills seem to have been self-taught, her aristocratic background and established reputation for good works stood her in good stead when she arrived there in April 1923. She was permitted to live in Gangtok, 'a great concession by the Sikkim Maharajah',⁴³ that was apparently a personal tribute to her character and reputation rather than a result of any initiative by the Political Officer.⁴⁴

Mary Scott remained in Sikkim for 16 years, where she was responsible for all missionary and church activities. Despite her lack of qualifications, she devoted much of her time to medical matters, supervising the mission dispensaries, organising medical camps, nursing and relief programmes during kala-azar epidemics, and even caring for the sick in her own home.⁴⁵ Where earlier efforts to spread Christianity into Sikkim focussed on the Lepchas, Miss Scott used a different strategy. While identifying herself with the Sikkimese to the extent of wearing local clothing and living in simple quarters in the Gangtok bazaar, she also deliberately set out to gain the support of the local elites. Doubtless helped by her aristocratic background, she became a friend of the Maharani, accompanied Sikkimese royalty on a tour of India, and even acted as a hostess at the palace.⁴⁶ Before health problems with the altitude forced her to leave Sikkim, her efforts were rewarded when the Chogyal allowed the opening of a Christian Church in Gangtok in 1936.⁴⁷ The Reverend Gavin Fairservice and his wife Ruth replaced her, but were not permitted to reside in Gangtok as missionaries,⁴⁸ and a 1938 regulation requiring Sikkimese to obtain permission from the Durbar to convert to Christianity suggests

Christianity's gains in Sikkim owed more to Mary Scott's personal influence than to any great enthusiasm for the new faith by the Sikkimese rulers.

In the absence of dispensary records or relevant writings by Mary Scott, it is difficult to gauge the impact of missionary medical initiatives on the Sikkimese. But it does appear that during the first two decades of a British presence there, in terms of structures, medical standards, and patients attracted, the missionaries played at least as significant a part in the introduction of medicine into Sikkim as imperial government efforts. Both government and missionary dispensaries were staffed by compounders trained by the missionaries in Kalimpong, and their standards, facilities and resources must have been very similar.

While eventually overtaken by state initiatives, the missionaries continued to be important agents for the spread of medicine, particularly in remote areas, down to the 1930s and '40s. As in Kalimpong and elsewhere, their influence on professional standards and the moral and ethical boundaries of the medical profession was also significant. Demonstrating a strong work ethic and dedication to service, they set high standards of professional care that their Sikkimese trainees were required to emulate, no doubt aided by the fact that the Christian construct of the 'compassionate doctor' and ideals of service to the poor translated without difficulty into similar Buddhist ideals.⁴⁹ In a small and autonomous state, isolated from the extremes of Indian society, such standards and ideals proved easier to maintain in the post-colonial period than they did in India itself.

Medical Development (1915-1940)

By 1915 considerable progress had been made towards the indigenisation of Western medicine in Sikkim. While the colonial state did, in many senses, use medicine as a 'tool of empire',⁵⁰ it was also part of the ideological justification for empire; providing a humanitarian provision to the citizens of the colonial state in return for their assent to colonial rule. It was also a 'tool' that the imperial Government wished to give up. The provision of medical services was expensive, and it became more so as Western medicine developed new therapies and technologies. The indigenisation of medicine was thus both an economic necessity, and (at least from the British perspective) a humanitarian service.

Tibet and Bhutan did not develop any significant indigenous Western medical tradition during the British period.⁵¹ But in Sikkim the indigenisation of medicine proceeded steadily. While Sikkim state's closer treaty links to British India and the political alliance that developed between the British and the Sikkimese aristocracy fostered this process, the key factor appears to have been the number of Sikkimese who had received a Western education.⁵² The government and mission schools in Darjeeling and Kalimpong, and in Sikkim itself from the 1880s,⁵³ provided a small but regular supply of youths, either from the Sikkimese aristocracy or the Lepcha and Nepali Christian communities, who were educated in the Western system. Such an education was an essential precursor to the biomedical training process, imparting the modern scientific world view necessary for the understanding of medicine. The fact that this education was, in state schools, essentially secular, and did not require conversion to Christianity made it more easily acceptable to the Himalayan Buddhist aristocracy, who came to occupy the more powerful positions in the developing medical structures, while the 'native Christians', from traditionally lower status social groups, filled the lower ranks of compounders, dressers, and nurses. Western medicine in Sikkim thus developed local social characteristics.

During White's residency, no Sikkimese appear to have progressed beyond compounder qualifications, but his successor Charles Bell was a much less autocratic colonial officer, who sought to encourage indigenous modernisation in the Himalayan states as a means of strengthening them, and consequently the security of British India's northern border. Bell therefore encouraged the education of Sikkimese medical students, albeit with the primary aim of employing them in Tibet.⁵⁴ Thus, of the first three students sent from Sikkim to Temple Medical College in Patna, two were immediately posted to a Political Department dispensary in Tibet when they graduated. These men (who were not closely related), were Tonyot Tsering and Bo Tsering (Libing family), both Kalimpong educated Sikkimese, who graduated as Sub-Assistant Surgeons in 1913 and 1914 respectively.⁵⁵ However, their contemporary, Bhowani Das Prasad Pradhan, however, a member of the Nepali community, remained in Sikkim after completing training in Patna and was placed in charge of the Chidam dispensary in 1913.⁵⁶

Thus, as the structures of a state medical system began to be developed in Sikkim, vacancies were filled by the emerging Sikkimese medical graduates. Their training was financed from the Sikkim state revenues. Thus we read, for example, that in 1924-25, 'Lobzang

Mingyur, a student who was sent to the Campbell Medical School, Calcutta, at the expense of the Darbar, finished his course of studies and was entertained at the Gangtok hospital as an extra compounder.⁵⁷ Associated aspects of the development of a modern state public health bureaucracy similarly aided the employment of the growing Western-educated administrative class. During the 1920s, registration of births and deaths was made compulsory, while a Civil Veterinary Department was established with a hospital and dispensary at Gangtok under a 'Babu' Bannerjee, and dog licenses were introduced, with orders given to destroy dogs without the appropriate discs.⁵⁸ In addition, sanitary measures were introduced in the Gangtok bazaar.⁵⁹

We have seen that the indigenisation process saw Western medicine take on aspects of traditional Sikkimese social structures, and this was particularly significant in regard to its patronage by the state's traditional ruler. The 9th Chogyal of Sikkim, Sir Thutob Namgyal, was increasingly supportive of modernisation. After his death in 1914, Sidkeon Namgyal Tulku, who had been groomed for the post by the British, succeeded him but died after ruling for just 10 months.⁶⁰ Sidkeong Tulku's younger half-brother, Tashi Namgyal, who had been educated at St Paul's and Mayo College, then became Chogyal in 1915, and ruled Sikkim until his death in 1963. Tashi Namgyal was, according to the British reports 'deeply interested in medical affairs', and in the early 1920s he and his wife ('the Maharani' in British records), made a number of visits to the hospital in Gangtok, 'and rendered every help possible.' The Maharani even joined the Political Officer's wife in organising classes at which local ladies might prepare garments for patients and so forth.⁶¹ This type of patronage continued into the post-colonial period.⁶²

These symbols of royal approval for, and association with, the new medical developments had considerable symbolic significance in Sikkimese society, bestowing royal authority on the new medical system and encouraging others to support it.⁶³ This relationship – and the greatly improved ties between Chogyal and Political Officer after White's departure were clearly articulated in the naming of a new Gangtok hospital built to replace the existing dispensary there.

On 24 September 1917, the new Chogyal Tashi Namgyal officially opened the Sir Thutob Namgyal Memorial Hospital.⁶⁴ Situated on a ridge overlooking Gangtok,⁶⁵ it began with beds for 10 in-patients⁶⁶ and charge of the new facility was given to a state Medical Officer of Sikkimese nationality.⁶⁷ The hospital became the centre of medicine in Sikkim, although it was initially poorly –equipped: not until 1923-24,

for example, did it have a microscope.⁶⁸ But additional specialist wards were gradually added; a tuberculosis ward in the late 1920s and a maternity ward in the late 1930s,⁶⁹ after a trained midwife was first posted to the hospital in 1929-30.⁷⁰

Despite the new hospital, patient numbers at Gangtok do not appear to have increased at this time. In 1923-24, just under 8,000 patients attended the hospital, little more than had attended the dispensary a decade earlier. But in the ensuing decade down to 1933-34, Gangtok outpatient numbers doubled to just over 16,000, although in-patient numbers remained steady, varying from a low of 317 in 1929-30 to highs of 465 in 1924-25 and 455 in 1933-34.⁷¹ The reasons for the increase are not stated in British accounts, but the growing population, biomedical advances, and personnel changes must all be considered as factors apart from a growing acceptance of medicine among the Sikkimese.

On the 1st of November 1922, John Turner was replaced as Gangtok Civil Surgeon by an Anglo-Indian, the Senior Assistant Surgeon Dr John Charles Dyer of the Subordinate Medical Services. As a fully-qualified medical practitioner, Dyer was of higher professional status than Turner, and he was a well regarded medical officer⁷² who had accompanied Sir Charles Bell to Lhasa in November 1920, and remained there for several weeks. When Dyer left Sikkim in January 1928, his replacement was Sub-Assistant Surgeon Dr Kenneth Percival Elloy DCM,⁷³ who remained in Gangtok until February 1932, when he was replaced as Civil Surgeon by Dr W. St A. Hendricks. Like Dyer and Elloy, Hendricks, described by the Political Officer's wife as 'a very fine GP',⁷⁴ was an Anglo-Indian, but he was also a member of the IMS, the first officer of the higher service to hold the Civil Surgeon position.

The IMS officers considered themselves the elite medical service, just as the Political Officers considered themselves the elite government service,⁷⁵ and in the late 1930s the political role of the Sikkim Medical Officers was increasingly to the fore after some decades in abeyance. Thus the emphasis on the modernity of medical practice in Sikkim in reports on kala-azar, the fever which broke out in epidemic form in Sikkim every 15-20 years; it was noted in 1939 that treatment of the fever in Gangtok 'was in every way in accordance with recent teaching', and that the advice of a specialist from the Tropical School of Medicine in Calcutta was being followed.⁷⁶

Yet Sikkim remained an economically insignificant state. Kala-azar was believed to be spread by sandflies, but as the report noted, 'to carry out efficient antisandfly measures in one village would absorb the

whole revenue of the state.’⁷⁷ Most of Sikkim’s medical costs continued to be borne from state revenue, including contributions to the mission dispensaries. The contribution of the imperial Government was small; in 1917-18 they gave just 1,500 rupees for medicine, in addition to indirect costs incurred by the PWD dispensary at Rungpo.⁷⁸ These economic restrictions must have acted as a considerable brake on medical progress in Sikkim state.

One possible source of income was to charge for medical services, and a step in this direction was taken in the 1920s. Initially, as was the case throughout all of those regions where British authority was represented by the Political Department, biomedical services were provided free of cost (as they were at missionary dispensaries). It was stated in regard to Sikkim that ‘The established policy of the State is to place medical aid within the reach of all classes of people in the State’⁷⁹ and in the case of the Chogyal and his immediate family, the Civil Surgeon, as we have seen, received an additional allowance to compensate him for calling on the royal family, while all others could receive free treatment at the dispensaries and hospitals. But just as the wealthier Sikkimese might choose to consult privately with the Civil Surgeon, so too, in the 1920s, was there a demand for private treatment at the hospital. Thus one ward in the Gangtok hospital was converted into a paying ward, where the charge was ‘Rs 1 per day, for the bigger room and annas 8 per day for the smaller.’ The ward had been built as a TB ward, but it was decided to transfer lepers to the existing facilities in Kalimpong – with Rs 200 per annum to be given to that hospice there - and to convert the leper ward into a TB ward.⁸⁰

Nor was any proscription made on private medical practice in Sikkim. In the early years several individuals who had trained as compounders in Kalimpong and worked in dispensaries in the region began private biomedical practice in Sikkim, although it was not until the 1970s that fully-qualified doctors set up private practice there. Until then, any Sikkimese qualifying as a doctor would be absorbed into government service.⁸¹

The question of cost was a complex one. While free biomedical services were available, Sikkimese traditions of etiquette demanded that ‘you should not go empty-handed’ when calling on others, even family members. Thus visitors to medical practitioners would, within this system, bring not only the ceremonial white scarf but also a gift. This might consist of an envelope containing money, but villagers would generally give produce, such as yak butter. Thus one doctor recalls that his fridge was always full of butter (which he didn’t use and

gave away to others).⁸² In the European understanding, therefore, medical treatment was not entirely free.

The Modern Era (post-1940)

The indigenisation of medicine in Sikkim meant that the departure of the British had little medical impact there; the last of the imperial Civil Surgeons, Dr G.F. Humphreys IMS, was an experienced doctor who had served as the Medical Officer in Gyantse from October 1940 to May 1944, and had visited Lhasa in 1942-43 as accompanying physician to two American emissaries. As an Anglo-Indian, he stayed on in Gangtok until the mid-1950s, providing continuity throughout the transitional post-colonial period. The Sikkimese Sub-Assistant Surgeons who had served in the imperial dispensaries in Tibet withdrew back to Sikkim during the 1950s as the Chinese take-over of Tibet intensified, thus increasing the pool of experienced medical practitioners available to the Sikkim state.

Patient numbers continued to increase in independent Sikkim; from 115,060 in 1954 to 188,526 in 1963.⁸³ But throughout the 1950s and '60s, medical development in Sikkim was restricted by the limited state revenues available, and continued to rely on Royal patronage to fund many routine items.⁸⁴ At the time of the Indian take-over in 1975, there were just four district hospitals in addition to the STNM Hospital in Gangtok, and the bulk of medical consultations took place in rural dispensaries and primary health care centres staffed by compounders, who thus remained the principal interface between allopathic medicine and the local patients.⁸⁵

During this period, the Sikkimese health services were heavily reliant on the variable commitment of Indian specialists employed on short-term contracts. But an indigenous class of medical specialists capable of administering and operating Sikkim's medical services was developing. Rather ironically, more indigenous Sikkimese occupy the higher ranks of the public health service today than was the case in independent Sikkim before 1975.

The first generation of Sikkimese practitioners of allopathic medicine were not fully qualified doctors. Men like Bo and Tonyot Tsering were Licensed Medical Fellows, who held the rank of Sub-Assistant Surgeon in government service. But by the 1940s, a new generation of qualified doctors began to emerge, largely from the small group of Western educated Sikkimese who formed a bureaucratic class

serving the Chogyal and colonial governments. This class had come to an accommodation with the British, and with their primary identity being Sikkimese and Buddhist, they were not a part of the nationalist struggles and religio-political divisions developing in India. As a cosmopolitan elite at home both in British and Tibetan society, they were able to benefit from the crucial role they played as intermediaries between their neighbouring powers, Tibet and the British Raj. Thus individuals such as Bo and Tonyot Tsering were crucial to the British medical project in Tibet, and gained advanced social status at home through their activities and through their employment with the leading regional power.

Among the new generation of medical practitioners to arise from this class were the son of Sikkimese medical pioneer Rai Bahadur Tonyot Tsering, Dr Pemba T. Tonyot, who became the first Sikkimese anaesthetist. Another was Dr Pemba Tsering, whose father had served in the Political Department and risen to the important position of Head of British Mission Lhasa. Others from this social class were Dr Tsering Tendup Kazi, who may have been the 1st Sikkimese to qualify as MD.,⁸⁶ and Dr Tsewang Paljor, the first Sikkimese to qualify as a surgeon, whose great-grandfather was the leading aristocrat Raja Tenduk Paljor, whose estates had extended to Darjeeling. Similarly Dr T.R. Gyatso, the present Secretary of the Sikkimese Department of Health and Family Welfare, is a grandson of the well-known Kazi Dawa Samdrup, translator of the Royal *History of Sikkim*.

The close links between members of this class are illustrated by the fact that the first female doctor in Sikkim, Dr Mrs Leki Dadul, who graduated from Calcutta around 1955, married Rai Bahadur Bo Tsering's son, Sonam Dadhul, who became Chief of Police in Sikkim. He recalls that his father was a very social man, throwing so many parties that their house seemed like a hotel, and it does appear that the personal qualities of Bo and Tonyot Tsering were an important factor in their winning acceptance in Lhasa.⁸⁷

The careers of these individuals tended to follow a similar pattern, and they shared ideals of service and duty that had been reinforced by the educational and professional structures of British imperial rule. Dr Pemba T. Tonyot, for example, was born in Yatung and educated at the Gangtok Tashi Namgyal school. His father had hoped his son would follow him into medicine and Dr Tonyot did so, 'being religious minded and seeing it as a noble profession'. After matriculation he obtained a BA in science before going on to qualify as MBBS in Madhya Pradesh, and in 1966 he became the first Sikkimese to

graduate as an anaesthetist, being posted to STNM Hospital in Gangtok to replace an Indian doctor. As the only anaesthetist, he carried on for 10 years without leave, and when, as a Tibetan speaker, he was deputed for three months to care for the ailing Karmapa Lama at Rumtek, no major operations could be carried out in Gangtok. He later became Medical Advisor to the Government of Sikkim before retiring in 2003 and recalls with satisfaction that ‘by God’s grace’ no patient died under his care.⁸⁸

His near-contemporary, Dr Tsewang Paljor, was similarly schooled in Gangtok and then St Joseph’s school in Darjeeling where he studied science. Recognising the shortage of medical personnel in his native land and the opportunity he had to serve there, he then applied to the Government and was selected for medical training in Andhra Pradesh, graduating MBBS in 1968. After returning to Sikkim to serve in the STNM Hospital, he was sent in 1972 to take a masters degree in surgery at the Postgraduate Institute of Medical Education and Research at Chandigarh, then returned to Gangtok as the first Sikkimese surgeon, again replacing an Indian serving on contract.⁸⁹ After 1984, he transferred to Namchi in South Sikkim to establish a new hospital there with specialist services to relieve the burden on Gangtok hospital. He remained there until 1998, when he returned to Gangtok as Principal Chief Consultant and Medical Advisor to the Government of Sikkim, primarily concerned with planning for a new Gangtok hospital. Having married the second daughter of Princess Coo Coo-la, a physiotherapist who had trained at Millfield and Cardiff, he retired in 2003, although he still does some private practice.⁹⁰

A slightly different path was followed by Sonam Dorji, who as a youth was selected by the 1935-45 Sikkim Political Officer Basil Gould to study at High School in Gangtok. Then, in search of adventure, he headed off to join the Gurkhas, fighting at Imphal against the Japanese forces in 1942 alongside Ganju Lama, who won the Victoria Cross.⁹¹ On his return to Gangtok, Sonam Dorji remembered the Political Officer Arthur Hopkinson recognising his services with the offer of any position he sought, and, acting on ‘intuition’, he opted for medical training at Campbell Medical College. He went on to serve at what were now the Indian Government diplomatic posts in Tibet during the 1950s, relieving a Dr Tenzing in Lhasa⁹² and taking the chance to make the *parikrama* of the sacred Mount Kailas in western Tibet while serving at Gartok. After the transfer of the Indian positions to Chinese control in 1954, he spent most of his career serving in north Sikkim, before retiring with wife Namgay Dolma in 1989.⁹³

Dr Lobsang Tenzing was from a somewhat different background. Originally from the village of Mangan in north Sikkim, he was the son of the Christian pastor there, although himself a Buddhist, and a nephew of Dr Norbu, who was killed in the Gyantse floods in 1954. The Tenzing family placed great emphasis on modern education, and after finishing his matriculation in Gangtok in second place on the merit list, he was sent to NRS Medical College in Calcutta, completing his MBBS in 1963, the first of his Lepcha-Bhutia community to do so. He was posted to the STNM hospital that year, and was then posted as Medical Officer at the Mangan hospital from 1967-1971. Dr Lobsang eventually retired as Director-cum-Secretary of Health in 1995, having been the first local doctor to reach this position.⁹⁴

Along with the doctors and licensed practitioners, the (until recently all-female) profession of nursing also developed in Sikkim, albeit that the profession is still not of particularly high status. In 1954, having reached 7th grade in Mary Scott's school, Nurse Mrs Sonam Eden ('Phigoo'), was one of two girls aged around 15-16 who were sent to Kalimpong under the state Five Year Plan to train as nurses. Mrs Sonam Eden, along with Mrs Prabitra Pradhan, trained under the Scottish missionary Dr Albert Craig, a man of very high standards who she remembers as strict and short-tempered in contrast to the 'Mother Theresa' figure of Mary Scott. On her return to Gangtok, Phigoo was posted to the STNM Hospital where she remained until retiring in 1995 after 40 years of service.⁹⁵

A Postscript

In Sikkim today, the STNM Hospital straddles a main Gangtok intersection. As of 2000, it was a 300 bed hospital, with 78 doctors including 36 specialists on staff under the charge of 'Director-cum-Medical Superintendent' Dr H. Pradhan, and in 1999, 351 major and 984 minor surgical operations were carried out there. Plans are advanced for a new 500 bed hospital, as patient numbers continue to increase; reaching around 140,000 in 1999.⁹⁶ While Sikkim is part of India, most of its medical personnel is born in Sikkim⁹⁷. For medical purposes the state is divided into four districts, each under a Chief Medical Officer who is also head of the central hospital in that district. A network of primary health care centres and sub-centres exists in each district,⁹⁸ and medical services remain largely free of cost.⁹⁹ A subjective judgement considering patient-doctor relations, service

morale, non-elite class access, and not least financial probity, as well as numerous statistical indicators,¹⁰⁰ would suggest Sikkimese today enjoy among the best biomedical services in India.

Notes

1 John Claude White CIE., (1853-1918) was born in India and educated in Bonn and at Coopers Hill College of Engineering. His memoirs, *Sikkim and Bhutan*, were first published in 1909 and have been frequently reprinted; for more critical analysis of White's career, see Alex McKay, *Tibet and the British Raj: The Frontier Cadre, 1904-1947*, Richmond, Curzon Press 1997, esp. pp.xxii – 42.

2 White, *Sikkim* ... p.26; the Durbar's insignificance is suggested by the fact that it did not meet at all in at least one year, 1905-06; India Office Library and Records [hereafter, IOR], Microfische 804, Sikkim Annual Report 1905-06, White to India 20 August 1906.

3 *Ibid.*

4 H.H. Risley, *The Gazetteer of Sikkim*, 1928, (Low Price Publications, Delhi reprint edition, n.d.), p.27.

5 White, *Sikkim*, pp.26-27; William McGovern, *To Lhasa in Disguise*, London 1924, pp.30-31.

6 This paper is part of a wider project on the introduction of 'Western' biomedicine into the Indo-Tibetan Himalayas, for which I am pleased to acknowledge the support of the Wellcome Trust Centre for the History of Medicine at University College London. Particular thanks are due to the various medical personnel in Sikkim who assisted me in my research there, most of whom are represented here by interviews, and to Dr Anna Balikci-Denjongpa and Tashi Densapa at the Namgyal Institute of Tibetology in Gangtok. Naturally, however, I am responsible for all conclusions here.

I would be interested to hear from anyone who could add to this project: I may be contacted on DungogAlex@hotmail.com

7 These issues are explored in more depth in a monograph currently in preparation entitled *Footprints remain: The introduction of Western biomedicine into the Indo-Tibetan Himalayas*.

8 "It is a well known principle that medical officers are attached to our Consulates and Agencies in remote localities primarily on account of political considerations"; National Archives of India [hereafter, NAI], Foreign Department [hereafter, FD], External A, 1906 Sept., 40-46, File note by "R.S.B. & R.W.S.", 29 May 1906.

9 Dr Joseph Kinnear Close (b.1864), born in Belfast, Royal University of Ireland, served on Sikkim campaign 1888, retired with the rank of Lieutenant-Colonel.

10 Dr Daniel Grove Marshall (1860-1923) IMS, born Shrewsbury, University of Edinburgh, topped IMS list for February 1888 intake, served at the Siege of Peking, retired with the rank of Lieutenant-Colonel.

11 Dr Arthur William Tremenhoe Buist-Sparks (1866-1925) IMS, born in Scone (Perthshire), Edinburgh University, retired with the rank of Lieutenant-Colonel.

12 Dr George Francis William Ewens (1864-1914) IMS, son of a Kensington wine merchant, Royal University of Ireland and Royal College of Surgeons.

13 *The India List: Civil and Military*, relevant editions.

14 We read that in 1892 the Chogyal's two-year old daughter Kumari Kunzang Wangmo was still treated by indigenous 'propitiatory rites, such as burning of incense etc' when very ill; *History of Sikkim*, compiled by H.H. The Maharajah and Maharani of Sikkim, (Kazi Dawa Samdrup, translator), Gangtok 1908, p.108.

15 White, *Sikkim...* p.36.

16 Mitra, S.K., 'Present-Day Health Organization in Sikkim' in *Indian Journal of Public Health* XIII.1, 1969, p.6.

17 *Thackers* records that an H. Nath Mitra was Hospital Assistant at Gangtok in 1907-10, with the Lepcha Christian Ongden serving in the Chidam dispensary in 1907, but has no earlier entries for this post.

18 IOR, microfische 804, Sikkim Annual Report 1905-06, White to India, 20 August 1906; in 1905-06 Chidam dispensary was staffed by Indu Bhusam Sen Gupta until 7 June 1905, then by Mohan Malakan until 15 September, when a compounder took charge until C.H.A. Ongden arrived on 13 January 1906.

19 IOR, V/27/62/197, *Sikkim State Gazetteer*, Statistics 1901-02, Bengal Secretariat Book Depot, Calcutta 1905.

20 *Ibid.*

21 See NAI, FD, External A, May 1908, 46-49, various correspondence.

22 NAI, FD, External A, Sept. 1906, 40-46, J.C. White to India, 20 March 1906.

23 *Ibid*

24 NAI, FD, External A, May 1908, 46-49, J.C. White to India, 14 October 1907.

25 *Ibid*; White estimated that 'the incumbent of the post is not likely to secure more than Rs 20 or so a month from private practice.'

26 IOR, L/P&S/10/92-1289, *Administration Report of the Sikkim State for 1908-09*, Calcutta Govt. Press 1909: p.7 (chapter VI). The total number of patients given in the report does not properly tally with the breakdown of patients per dispensary given as an appendix. Given that the population of Sikkim was probably around 35-40,000 at that time, the figures must refer to cases treated rather than individual patients. It is unclear whether the 250 rupees was in total or per dispensary, although the latter seems likely. The report appears to have been compiled shortly before Turner's arrival, and the author must be Charles Bell. There were 6,299 out-patients in Gangtok dispensary in 1905-06: IOR, microfische 804, Sikkim Annual Report 1905-06, White to India, 20 August 1906.

27 Rosemary Fitzgerald, "'Clinical Christianity": The Emergence of Medical Work as a Missionary Strategy in Colonial India, 1800-1914', in Biswamoy Pati & Mark Harrison (eds), *Health, Medicine and Empire: Perspectives on Colonial India*, London 2001, esp., pp 89, 104-111.

28 *Evangelical Presbyterian Church, Sikkim: Millennium Celebration Year 2000 Souvineer*, no author; Evangelical Presbyterian Church, Sikkim, n.d [2000?], p.8. The mission to Sikkim was supported by the Scottish Universities Mission (SUM) and was separate from, and not always enjoying good relations with, the CSM, although numerous individuals worked for both missions.

29 J.R. Minto, *Graham of Kalimpong*, William Blackwood, Edinburgh 1974, p.28.

30 Louis Fader, *Called from Obscurity: The Life and Times of a True Son of Tibet, Gergan Dorje Tharchin*, Vol.II, Mirror Press, Kalimpong 2004, pp.8-10: *Evangelical ...* p.8.

31 *Evangelical ...*, p.8. The significance of this symbolic convergence of imperial political and religious power cannot have escaped the attention of the Sikkimese, yet should not be exaggerated; as noted, the Political Officers, White included, were generally strongly opposed to the missionaries proselytisation and gave them little real support. White, for example, certainly had the power to have obtained them the right to reside in Lhasa, but did not do so.

32 Cindy Perry, *Nepali around the World*, Kathmandu 1997, pp.88-93, 120-21 n.46.

33 *Evangelical ...* p.20.

34 *Evangelical ...* p.24, quoting Rev. Mackean to J.C.White, 18 September 1901.

35 Albert Craig, *A Scot in Sikkim*, Board of World Mission and Unity, Edinburgh, n.d., p.10; *Evangelical ...* p.10

36 *Nepali Around ...*, p.93.

37 Dep. 298 (13), Minutes of the Church of Scotland Foreign Mission Committee 1903-06, p.501. *Nepali Around...*, p.93 includes Phambong rather than Seriyong in the list of dispensaries: both are in western Sikkim.

38 *Evangelical ...* pp.9-10.

39 IOR, V/10/1977, Sikkim Annual Report [hereafter, SAR],1923-24. Peripatetic dispensaries were also introduced, set up at the fairs that are meeting grounds for Himalayan populations, while the SUM opened new dispensaries at Vok and Rinchenpong, although it was forced to close Richenpong and Dentam on the dismissal of the compounder in charge of these sites. IOR, V/10/1977, SAR 1912-13.

40 Babu Y. Isaac, for example, who was later employed as a confidential clerk at the British Trade agency in Yatung (Tibet), was baptised and later ordained by the Scandinavian missionaries, and he opened a school in Song in 1901; see *Nepali Around ...*, p120, n.10.

41 *Evangelical ...* p.10.

42 Basil Gould, *Jewel in the Lotus*, London 1957, p.180, quoted in Fader, *Called ...* vol.2, p.423.

43 Craig, *A Scot ...*, pp.1-10, quotation from p.10.

44 The well-known frontiersman Major F.M. Bailey was then the Political Officer Sikkim. Like White, he was opposed to the presence of missionaries, although he skilfully used them as a source of intelligence; on Bailey see A. Swinson, *Beyond the Frontiers: the biography of Colonel F.M. Bailey, explorer and secret agent*, London 1971; for more critical analysis in regard to his Himalayan career, see McKay, *Tibet...* esp. chapter 7.

45 Mary Scott's precise activities are difficult to ascertain; cautious as to Sikkimese opinion and aware that her activities were observed, if not actively monitored, she did not keep a diary or write about her activities in letters; see Craig, *A Scot ...*, p.11.

46 Craig, *ibid ...*, pp.10-15.

47 *Ibid*, pp.14-15. The Hon. Mary H.H. Scott DD, DCS, KIH, remained in Kalimpong working with the blind until 1953 when she returned to Scotland, where she died in 1964.

48 *Nepali Around...*, pp.89, 120 n.13.

49 Interview with Nurse Mrs Sonam Eden ('Phigoo'), Gangtok, 6 June 2004; interview with Dr Tsewang Paljor, Gangtok, 6 June 2004; interview with Dr Pemba T. Tonyot, Gangtok, 4 June 2004.

50 The term is from Daniel Headrick, *Tools of Empire: Technology and European Imperialism in the Nineteenth Century*, Oxford 1981.

51 On which see Alex McKay, 'British-Indian Medical Service Officers in Bhutan, 1905-1947: A Historical Outline', in Karma Ura and Sonam Kinga (eds), *The Spider and the Piglet: Proceedings of the First International Seminar on Bhutan Studies*, The Centre for Bhutan Studies, Thimphu (Bhutan) 2004; (also available online at: www.bhutanstudies.org.bt/publications/spdr-pglt/spdr-pglt.htm); Alex McKay, 'The Politics of Voluntary medicine: India, Tibet and China, 1900-1947', forthcoming in *Imperialism and Medicine in South Asia*, Sanjoy Bhattacharya & Biswamoy Pati (eds), Orient Longman.

52 Something lacking in both Bhutan and Tibet; see McKay, *ibid*, 'The Politics....'

53 By 1915 there were two main schools in Sikkim, the Bhutia and Nepalese boarding schools, along with 20 village schools maintained by the state, 12 Church of Scotland and two Scandinavian Missionary Alliance schools, and three run by private landlords; IOR, V/10/1977, SAR 1914-15.

54 NAI, FD, Internal B, June 57-58, C. Bell to India, 6 April 1909.

55 Interview with Sonam Dadul, Gangtok, 4 March 1994; interview with Tashi Tsering Tonyot, Gangtok, 26 February 1994.

56 IOR, V/10/1977, SAR 1912-13. By this period, the British did not use Nepali personnel in Tibet due to their cultural differences with the Tibetans.

57 IOR, V/10/1977, SAR 1924-25.

58 IOR, V/10/1977, SAR 1922-23; V/10/1978, SAR 1929-30.

59 IOR, V/10/1977, SAR 1923-24.

60 Re Sidkeong Tulku, see Alex McKay, "'That he may take due pride in the empire to which he belongs": the education of Maharajah Kumar Sidkeon Namgyal Tulku', in the *Bulletin of Tibetology*, 39 (2), 2003.

61 IOR, V/10/1977, SAR 1922-23; V/10/1977, SAR 1923-24; also see, re the Chogyal's patronage of a kala-azar treatment centre at Rungpo, IOR, L/P&S/13/449, Government of India Foreign Department to India Office, 1 April 1937.

62 Interview with Nurse Mrs Sonam Eden ('Phigoo'), Gangtok, 6 June 2004.

63 As early as 1905 three beds in the Gangtok dispensary were subsidised by 'Messrs Jetmull and Bhoraj': IOR, microfische 804, SAR 1905-06, White to India, 20 August 1906. In 1913 we read of the willingness of 'some *Kazis* [the Bhutia and Lepcha land-owning aristocracy] and *thikadars* [Nepali landlords] to build suitable dispensaries if drugs etc. are provided [by the Government]'; IOR, V/10/1977, SAR 1912-13.

64 E.C.Dozey, *A Concise History of the Darjeeling District since 1835: with a complete itinerary of Tours in Sikkim and the District*, Jetsun Publishing, Calcutta 1989 (Reprint of 2nd, 1922 edition: 1st published 1916), p.16.

65 It moved to larger premises at its present location in the centre of Gangtok in 1937.

66 Interview with Dr T.R. Gyatso, Gangtok, 5 June 2004.

67 Dr Tsering Tendup Kazi is the first of the hospital superintendents mentioned in records I have sighted. He was replaced by Dr Panchabir Singh around 1931; IOR, V/10/1978, SAR 1929-30; V/10/1980, SAR 1932-33.

68 First introduced in 1923-24; IOR, V/10/1977, SAR 1923-24.

69 IOR, V/10/1977, SAR 1927-28 & 1928-29; Margaret Williamson, *Memoirs of a Political Officer's Wife in Tibet, Sikkim and Bhutan*, Wisdom, London 1987, p.227.

70 IOR, V/10/1978, SAR 1929-30. But it was noted in 1969 that there was no specialist obstetrician or gynaecologist in any Sikkim hospital; see Mitra, S.K., 'Present-Day Health Organization in Sikkim' in *Indian Journal of Public Health*, XIII.1, 1969.

71 IOR, V/10/1977, respective Sikkim Annual Reports.

72 Dyer was promoted to Lieutenant in 1937 and retired in 1938; IOR, L/Mil/14/6895.

73 Dr Elloy, b 1884, retired 1939, served in France, Mesopotamia and Palestine in WW1.

74 Williamson, *Memoirs ...*, p.53.

75 Interview with Dr M.V. Kurian, Coimbatore, 12 January 1994.

76 1939 Government of Sikkim report 'Kala-azar in Sikkim' (apparently compiled by Gould and Hendricks) and 'Second Report on Kala-azar' by L.E. Napier. Copies in possession of the author.

77 *Ibid.*

78 IOR, V/10/1977, SAR 1917-18.

79 IOR, V/10/1978, SAR 1929-30.

80 IOR, V/10/1977, SAR 1927-28 & 1928-29.

81 Interview with Dr Tsewang Paljor, Gangtok, 6 June 2004.

82 *Ibid.*

83 *Ibid.*; Mitra, S.K., 'Present-Day Health Organization in Sikkim' in *Indian Journal of Public Health* XIII.1, 1969, p.5.

84 E.g., the last Chogyal's American wife, Hope Cooke, provided uniforms for the hospital nurses; interview with Nurse Mrs Sonam Eden ('Phigoo'), 6 June 2004.

85 Mitra, S.K., 'Present-Day Health Organization in Sikkim' in *Indian Journal of Public Health* XIII.1, 1969, p.5.

86 Dr Tendup Kazi was Medical Officer in the General Hospital in Namchi, south Sikkim, which opened in 1925; *Souvenir: ...*, n.d.; by at least 1928 he was made State Medical Officer in charge of the STNM Hospital in Gangtok; his precise qualification is uncertain; IOR, V/10/1978 SAR 1929-30;

87 Interview with Sonam Dadul, Gangtok, 3 June 2004.

88 Interview with Dr Pemba T. Tonyot, Gangtok, 4 June 2004.

89 Interview with Dr Tsewang Paljor, Gangtok, 6 June 2004.

90 *Ibid.*

91 Interestingly, Sonam Dorji recalled that the Japanese would sometimes avoid shooting at them, directing fire at the British rather than their fellow Asians.

92 Dr Tenzing, who was en route to Lhasa, died in the floods that destroyed the Gyantse Trade Agency in 1954.

93 Interview with Dr Sonam Dorji, Gangtok, 7 June 2004.

94 Information courtesy of Dr Anna Balikci.

95 Interview with Nurse Mrs Sonam Eden ('Phigoo'), Gangtok, 6 June 2004.

96 *Master Plan for Modernisation of STNM Hospital – a Project Report, August 2000*, Department of Health and Family Welfare, Government of Sikkim, Gangtok, pp.11, 52.

97 There are now at least 10 doctors from Sikkim employed in the U.K., USA, and Europe.

98 T.R. Gyatso & B.B. Bagdas, *Health Status in Sikkim (Survey Conducted by Department of Health & Family Welfare)*, Department of Health and Family Welfare, Sikkim, 1998, p.5.

99 Under article 371F of the Sikkim-India merger agreement added to the constitution of India, Sikkim holds a special status allowing traditional laws to remain effective: thus free medical treatment remains.

100 E.g., Sikkim is ‘possibly the only state in [India] to achieve the notional norm of establishing 1 primary health centre for 20,000 people’; *Sikkim Human Development Report 2001*, p.21.

