During the First World War the ranks of the Indian Army expanded to over 1.4 million men, swelling what was already the largest colonial army in the world. Although many of the men who joined up during the war were non-combatants, and more than half remained in India, the Indian Army’s role in World War I was more significant than is sometimes claimed. It formed the largest of the Imperial contingents in both Mesopotamia and East Africa, as well as serving in France and Flanders, where some 90,000 Indian troops fought during 1914-15. Thus many thousands of new recruits – some of whom had been virtually conscripted into the Army or who had joined up because of adversity at home – found themselves in some of the most trying conditions ever faced by an army in the field. The mechanised slaughter of the Western Front, which was entirely unlike anything sepoys had ever experienced, was enough to test the mettle of even the best-trained army, let alone one that was poorly led, poorly equipped and of questionable motivation. Mounting civil unrest in India in the decade prior to 1914 had raised the possibility that the Army might be targeted by political agitators. It was feared that any discontent within its ranks would spread to the population at home, where it might easily be exploited by nationalist politicians. Thus, Indian Army commanders and the British government made a concerted effort to monitor levels of discontent among Indian soldiers and to ameliorate its causes.

One area in which there was a good deal of disaffection was that of health and medical care. Medical provisions for Indian soldiers at the beginning of the war compared very unfavourably with those of their British counterparts, and even with those enjoyed by colonial soldiers fighting with the French. Heavy sickness among Indian troops also sapped their morale and fuelled rumours that Indian lives were cheap. In the winter of 1914-15 the lack of medical provisions...
for sepoys contributed to an acute crisis of morale on the Western Front and created a public scandal which severely embarrassed the British government. This paper assesses the nature and extent of this crisis and the British response – a response which often served to undermine rather than to bolster the moral authority of British rule.

**Medicine and authority in British India**

Most scholars who have commented on western medicine in British India have agreed that it was, in some sense, a ‘tool of empire’ but recently our view of ‘colonial medicine’ has broadened to encompass its ‘ideological’ role, in the construction of racial differences, for example, and in establishing cultural bridgeheads between rulers and ruled. This ‘cultural convergence’ has been considered by David Arnold in his book, *Colonizing the Body*, in which he employs Antonio Gramsci’s concept of ‘cultural hegemony’ in order to explain the growing importance of medicine in Indian elite culture from the late nineteenth century. Arnold’s conception of hegemony is a dualistic one, embracing both the state’s promotion of Western medicine, and its appropriation by sections of the Indian elite, for whom it became a symbol of status, reform and modernity. But the concept of hegemony is a notoriously blunt instrument of historical analysis. Apart from the unresolved question of whether the ‘consent’ of the masses arises ‘spontaneously’, or is acquired through more direct intervention on the part of dominant groups, we need to ask whether strategies of control are overt or latent; and, moreover, on which terms the dominant culture is accepted. Might it not be more accurate to speak of ‘negotiation’ between groups rather than simply their domination or subjugation?

In the Indian Army, negotiations over medical intervention centred on the pivotal concepts of honour, duty and dignity. Indian soldiers, I would suggest, came to see the provision of medical care as a duty of the military authorities, as part of an implicit bargain between themselves and the colonial state. But in addition to a sense of reciprocal duties there was also a sense of boundaries and of limits to medical intervention. In order to make sense of this web of customary boundaries and obligations, it is instructive to look again at E.P Thompson’s essay on the ‘Moral Economy of the Crowd’, in which he drew attention to the notions of ‘social justice’ which informed popular protest in eighteenth-century England. Thompson observed among the ‘crowd’ a sense of reciprocal obligations and rights – the ‘moral economy’ – from which arose an uneasy consensus over what were considered legitimate practices in baking, milling,