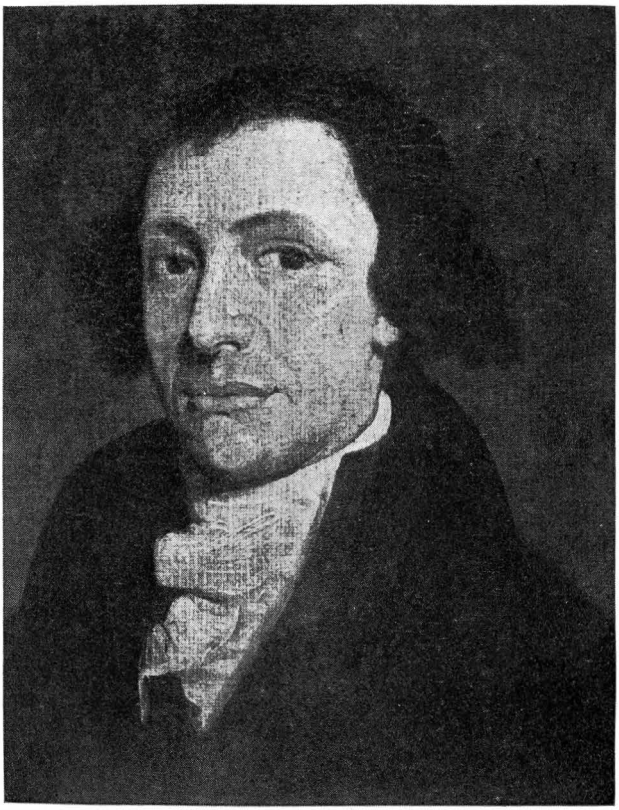

DR. JOHN THOMAS

(from an Oil Painting)

FOR THE HEALING OF THE NATIONS

THE STORY OF BRITISH BAPTIST MEDICAL MISSIONS
1792-1951

BY
MARY I. M. CAUSTON,
B.A., A.R.C.M.

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FOREWORD

THE celebration of the B.M.S. Medical Jubilee in 1951 has occasioned the commissioning and writing of this book. Earlier accounts of British Baptist Medical Missions have taken the story only as far as 1942 in outline and 1929 in some detail. The present account, though far from being exhaustive, is an attempt to show as a whole the development of B.M.S. medical missionary work up to the present day, together with a short study of the fundamental reasons that vindicate its undertaking and maintenance.

To those B.M.S. colleagues, from overseas and in the Mission House, who at all stages have sponsored this book by their encouragement and practical help, I express my warmest appreciation. Special thanks are due to Mrs. Moorshead for her reading of the manuscript and for her comments and suggestions on parts of the history that are so well known to her. For direction in certain medical particulars I am indebted to Dr. Grace Newell and Dr. Ronald Still (both former B.M.S. missionaries).

M.I.M.C.

93, GLOUCESTER PLACE,
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March, 1951.

PROLOGUE

THE SEED AND THE FIELD

" Of the Most High cometh healing."
(Ecclesiasticus XXXVIII, 2)

" Himself took our infirmities and bare our sicknesses."
(Matthew VIII, 17)

IT happened in the second world war that, when Sian, chief city of the province of Shensi, China, was being bombed, a beggar in the street had the lower part of his face blown away. He was taken to the B.M.S. hospital but, on examination, was found to be in such a state of degradation and filth that the Chinese nurses shrank from touching him, and it looked as though it was going to be impossible to treat him in hospital alongside other patients. His misery and need, however, aroused such compassion in the matron's heart that she arranged for him to be put into a small hut in the compound where he received all possible care. He could not take nourishment in the normal way, but had to be fed nasally, and because his repulsive condition made such a slow process particularly trying, the matron went regularly to undertake this ministry herself.

From the window of a comfortable private ward overlooking the courtyard, a high official of the city who was recovering after an operation watched these regular visits with curiosity and astonishment. He plied the doctor with questions. " Why did anyone in the hospital think it necessary to perform such service for a loathsome beggar? " " How did anyone find enough fortitude to continue such service? " " What or who

was responsible for the religion that made it possible?" So great was the impact of what the official had witnessed that the answers to these questions led him into the greatest experience of his life—personal encounter with Jesus Christ and decision to follow Him.

Many similar events have taken place throughout the history of the Christian Church; many of them have occurred in the story of the Baptist Missionary Society. As we look back with thanksgiving upon fifty years of organised medical work overseas, we too are constrained to ask why and how it has been done, and it is to be hoped that the answers will turn us ever towards the person of Jesus Christ, the Saviour of the world and the Lord of all good life.

THE story of human efforts to heal the body and to preserve life is old and widespread. It can be traced back into the pre-Christian era and into many kinds of civilisation, from primitive peoples using herbs and fetishes, to highly developed medical knowledge in countries like ancient Egypt, Arabia, India, China and Greece.

The origin of the desire to heal cannot always be discerned or proved when one is considering non-Christian communities. For the Christian, however, a much clearer light falls upon the purpose and practice of healing because of his study of the New Testament.

It was with a human mind and body that God "stepped into Time from Everlastingness",[1] and the Incarnation bestowed new dignity upon human flesh which could so embody the Word. Not as pure spirit did John and the other disciples behold the glory of the Only-begotten of the Father, but through words and

[1] C. L. O'Donnell: "*In Praesepio.*"

deeds of flesh and blood which shared their own human experience. Thenceforward, for the Christian, the lie could be given to all ideas and philosophies that either exalted the body as an end in itself, or depreciated it as a regrettable necessity and a drag upon man's higher being. It had been uniquely demonstrated to be the temple of God; in differing kind and measure it could still be a temple of God for all who were "in Christ". The well-being, care, discipline and health of the body therefore became a Christian responsibility.

Those who seek in the New Testament for a directive from Christ's earthly life and teaching in regard to human suffering will naturally turn to the miracles of healing; but these are, after all, only part of the whole ministry of Christ and may be understood more helpfully if one tries to see them in that light. All four evangelists record healing miracles. If Luke's Gospel is chosen here, it is because, with his freedom from narrowly Jewish thought-forms and even with his own specially medical standpoint, he makes it particularly clear that Christ's ministry was available for all humanity in all kinds of need, regardless of race, sex, merit, or any other qualification than the need itself.

We are first of all told of Christ's declaration of His own mission in terms that were familiar to His hearers but which for them may have become merely symbolic of Jewish national wretchedness and recovery.

> "The spirit of the Lord is upon me, because he hath anointed me to preach the gospel to the poor; he hath sent me to heal the broken-hearted, to preach deliverance to the captives, and recovering of sight to the blind, to set at liberty them that are bruised, to preach the acceptable year of the Lord."[2]

[2] *Isaiah lxi*, 1-2; *Luke iv*, 18-19.

Christ's use of these words, and His subsequent actions confirming the fact that the prophecy was being fulfilled, show that the categories of folk to whom He declared himself sent—the poor, the broken-hearted, the captives, the blind, the bruised—could not be confined within purely figurative meanings. As soon as He left Nazareth for Capernaum, He came face to face with human personality twisted and imprisoned by an 'unclean spirit', and His word of authority and power brought about deliverance.[3] So it was with fever, leprosy and paralysis.[4] Their victims were not given doctrine only, however liberating that might have been for their spirits; but Christ was concerned to show that a similar principle of evil produced both sin and disease, and that upon sin and disease alike He was ready and able to exert the full power of God. This is most clearly apparent in the story of the man with palsy.

The words of Isaiah which Christ used as a declaration of His mission remind us that the Spirit of God works in a similar way upon all those who are fully called to be missionaries. He awakens a deep sensitiveness to the need of mankind, the need of those who are without hope and without God in the world; and from the never-resting thrust of this divine spur—the sharpened awareness of human need—the real missionary experiences something of this burden of divine compassion. Such a motive is worlds away, both from the impersonal attempts of the tribe or state to safeguard its own corporate welfare, and also from the cool and diffused benevolence that has sometimes been found in social uplift movements. The key to the difference lies partly in Christ's valuing of the individual.

[3] *Luke iv*, 33-36.
[4] *Luke iv*, 38-39; *v*, 12-14; *v*, 18-25.

If welfare work is sometimes mechanical and benevolence vague, it is because disease and other problems are thought of theoretically and in the mass, whereas Christ made a separate approach to every single person who needed Him and, having compassion on them, gave them of His time, strength and very self in outpoured grace and love.

Luke uses the account of Christ's declaration of His mission as if it were some great musical theme, upon which the events that follow are variations. The exposition contains the basic factors of man's need and God's love; the development works out this theme in the teaching and practice of Christ, in parable and miracle alike. Thus we have two such stories as those of the Good Samaritan and the Lost Son.[5] The latter points to the kind of love God has for His sons, even though they may seek fulfilment away from Him and may come to be in direst need. The former shows that the good neighbour relationship between man and man is based upon the spontaneous self-giving of one to meet the need of another. Around and between such simple yet subtle variations Luke gives us still further variety on the same theme by recounting the healing miracles.

Each miracle has its own particular atmosphere and characteristics. Perhaps the patient is portrayed with a sharp definition of need, as in the story of Jairus whose *only* daughter lay dying, or the widow whose *only* son had died:[6] perhaps the story underlines the joy of our Lord in meeting a faith to match His power,[7] or His sorrow over the faithlessness which forced the disciples to hand over their patient to Him.[8] There are the

[5] *Luke x*, 25-37; *xv*, 11-32.
[6] *Luke viii*, 41-56; *vii*, 11-16.
[7] *Luke vii*, 2-10.
[8] *Luke ix*, 37-42.

stories of healing on the Sabbath day which show that 'to do good' and 'to save life' had priority in Christ's scale of values even over accepted religious observances.[9]

With all these fine shades of difference there is, however, another unifying thread that runs through the epilogues of many of the healing miracles. Over and over again the effect is similar, both upon the cured sufferers and upon the bystanders. The cycle which begins with human need and continues with Christ's response to that need is completed by the response in turn, of a man or woman who, utterly amazed and grateful, glorifies God as the author of such compassion and power.

For the disciples, even more than for ordinary bystanders, it must have been a searching experience to be with Christ as He taught this doctrine of a God who loves to the uttermost and as He moved among the needy, demonstrating that love in action. Gropingly they must have realised that compassion of this kind for the sufferer, together with such authority over the forces of disease and death, could only belong to God Himself. Gradually they learnt something of the spirit of our Lord and became able, through faith in Him, to claim the power of God for themselves in order to relieve suffering, though their understanding and faith appear to have been somewhat erratic until after Pentecost. Long before Pentecost, however, they had received direct commission and authority from Christ to preach and to heal, and thus the scope of His mission was first extended.[10]

The record in Luke x. 17 of the general success of their ministry is the only place in the gospels where this

[9] E.g. *Luke vi*, 6-10.
[10] *Luke ix*, 1-6; *x*, 1-20.

extension of our Lord's mission is further mentioned, except for the particular failure referred to in Luke ix, 40. These first apostles may have gone on specific journeys only, perhaps to pave the way for Christ's own follow-up. In any case, to the evangelists writing the story afterwards it must have seemed that their own and the other disciples' part in His earthly mission was unimportant. The high light must needs fall on the central figure Himself, as long as they were narrating the good news of His life in the flesh; the outward pattern would change and human agency would find its own significant opportunity in the life and witness of the Church.

Christ as Teacher, Healer, Example, Leader—in the gospel these are the strong roots of the Tree of Healing. But the soaring majesty of the tree, whose leaves are 'for the healing of the nations',[11] is fully seen only in the Cross and Resurrection of Christ, the Saviour. Those who accept Him as such believe that the secret of all wholeness for humanity lies in His redemptive love:

> "You . . . hath He reconciled in the body of His flesh through death, to present you holy and unblameable and unreproveable in His sight."[12]

Broken for the healing of mankind, Christ in His resurrection sealed that new wholeness with power, and man henceforth had access to completeness in Him, in Whom 'dwelleth all the fulness of the Godhead bodily'.[13]

To the Christian, therefore, the phrase 'integrated personality' represents far more than the usually accepted psychological content. It means, not the human putting

[11] *Revelation, xxii,* 2.
[12] *Colossians, i,* 21-22.
[13] *Colossians, ii,* 9.

together of disjointed parts of a man's life, but the work of grace which salvages, re-assembles and re-creates every human endowment to make a new creature. And Christian healing has as its prime purpose the desire to share in this work of grace, to be Christ's instrument and co-worker in demonstrating God's saving love, and to assist in making man whole in the truest sense of the word, so that he may to his fullest capacity 'glorify God and enjoy Him for ever'.

For the apostles, the commission to heal as well as to preach was never rescinded, so far as we know and, when after the Resurrection Christ told them to wait in Jerusalem until they were endued with power from on high,[14] they assumed quite simply that such power would be available for every kind of activity which would make Him fully known. When the baptism of power came, the Spirit of the Lord was upon *them,* anointing *them* to preach the gospel to the poor, sending *them* to heal the broken-hearted, to preach deliverance to the captives and the recovering of sight to the blind, to set at liberty them that were bruised, to preach the acceptable year of the Lord. The mission had been passed on. The World Church, the new Body of Christ's love and power, was alive, astir and active.

This was indeed a new outward pattern, but the activity working through this new pattern was one with the activity of Christ's earthly life, and the high light was still upon Him, though the preaching and healing were now undertaken with other voices and hands. The chief new factor in this activity was the Church's witness to the Resurrection. The unique power by which Christ had triumphed over death proved His divinity for them and was an overwhelming argument for victory

[14] *Acts i,* 8.

over sin, disease and death for those who believed in His name. The signs and wonders wrought by the apostles were not superimposed upon the rest of their witness, but were accepted by them as a manifestation of this divine and dynamic power. Peter's treatment of the lame man who begged outside the temple was marked by simplicity and conviction and his subsequent interpretation of the miracle was no less simple and convinced. "Why marvel ye at this? or why look ye so earnestly on us, as though by our own power or holiness we had made this man to walk? . . . The faith which is by the Prince of Life, Whom God hath raised from the dead, hath given this man . . . perfect soundness in the presence of you all."[15]

The result of that particular miracle was seen indeed in perfect soundness, for not only was the crippled body strengthened and made whole, but the spirit immediately bounded with thanksgiving, and we have the unforgettable picture of the liberated man going on with his healer into the Temple, walking and leaping and praising God. Throughout the history of the Christian Church, not least in the era of medical missions and the events of our own day, there have been similar instances of physical liberation followed by entry into the Church in the fullest sense of the word.

If further justification of medical missions were needed, it could be found in this kind of result. The medical work of the Baptist Missionary Society, a small pattern and part of the Tree of Healing, is its own best vindication, for it is clear that rich blessing has followed attempts to bring the wholeness of Christ into the broken lives of men and women who would otherwise never have known Him.

[15] *Acts iii*, 12-16.

PART I

SOIL AND SAPLINGS: 1792-1901

CHAPTER ONE

JOHN THOMAS

"To watch for every chance of doing the people good"
(Serampore Charter: Article IV.)

"Do not send men of compassion here, for you will break their hearts. DO send men of compassion here where many perish"
(Letter of John Thomas to Andrew Fuller)

IN 1942 the Baptist Missionary Society celebrated the 150th anniversary of its founding, and Baptists recalled with thankfulness the persons and events that had launched this modern missionary society in 1792. Much was then said about William Carey, the man who, from secluded surroundings, read about heathendom and tried to picture its darkness, contrasted with the light that meant so much to his own soul.

It will always be a matter for wonder that such a deep impact was made upon Carey's young mind through books, even while one recognises to the full the guidance of God in preparing his mind and shaping his choice of books. There were other ways, however, in which that guidance was manifest; and, as a final supplement to the influence of all his preparatory reading, there came into Carey's life the vivid personality of Doctor John Thomas.

As a boy and as a young man, John Thomas had shown little inclination towards hard work or piety, though he came of a sober Baptist family in Fairford, Gloucestershire, having been born there in 1757. Several attempts were made, through apprenticeships, to find him a suitable occupation, but it was not until he was

sent to Westminster Hospital for training that he seemed to discover work which afforded scope for his natural talent and energy. After he had obtained the necessary qualifications, he was employed in turn as an assistant ship's surgeon in the navy, as a surgeon and apothecary in practice in London, and as a surgeon on board one of the East India Company's ships. He seems to have been singularly unpractical in his business affairs, and his various schemes and plans, as well as his sometimes unfounded enthusiasm, must have been a trial to his friends, and in particular to the wife whom he married in 1781.

During the years in which these ventures took place, the state of his mind and soul varied between complete hardness of heart and extreme sensitiveness to God's mercy. In his journal and many of his letters he records his constant failures, his sense of shame and unworthiness, yet withal his recurring ecstasy in the thought of God's redemption. In 1781, while he was living in London, he underwent what he himself thought must be 'the great change of regeneration', and he describes how

> "Many days and nights were spent in the enjoyment of believing that Christ had died for *me* in particular. Me, Me, so insignificant, so worthless! That such a one as *I* should be a partaker of his benefits!—this thought attended me for many days, wherever I was. I had many tears of joy and gladness."

Not long after, however, he laments 'sad instances of declension', realising how grievously his life and conversation differed from 'that of a disciple and follower of Christ'. Quaintly and characteristically he breaks out: "Dear me! who can utter anything

adequate concerning the patience of God?" and he frequently expresses his conviction that his dreams and visions, his hair-breadth escapes from accident and death were signs that God had work for him to do.

He wished for baptism, but the minister whom he approached evidently considered that he should wait until his Christian purpose was more stable, and eventually it was after his first voyage with the East India Company that he was baptized at Soho Chapel in 1784.

It was his earnest desire to become a preacher, and before the ship in which he had been employed made her next voyage to the east, he undertook a good many preaching engagements. He was even invited to become the pastor of the small Baptist church at Hoddesdon, in Hertfordshire, and he seems to have been much more drawn to this than to continuation in practice as a surgeon; but certain friends dissuaded him from the full-time ministry, perhaps feeling that his erratic temperament might bring disappointment in such a calling, perhaps hoping that he could be brought to manage his own affairs better if he kept to a competent secular means of earning his living. At all events, he went back to India for a second voyage with the East India Company, and it was on this visit to the east that the pattern for the rest of his life was decided.

While his ship was in dock at Kedgeree, near Calcutta, he made the acquaintance of various Christian persons living in the neighbourhood, chiefly Englishmen who were connected with government or trade, or who held office in schools or orphanages for the children of European traders. These friends encouraged him to take up mission work, and before long he had given up his post as ship's surgeon, had begun to preach in the

European community, and, sponsored by one or two of these wealthy Christian traders, had embarked upon learning the Bengali language, so that he might be able to preach the gospel to the Indian people whose ignorance and wretchedness appalled him.

As a result of these experiences, he and his friends discussed proposals for the establishment, upon a wider basis, of a Protestant mission in Bengal and Bihar, but although their plans were submitted to, and encouraged by, several influential clergymen in England (including the Archbishop of Canterbury), nothing material resulted, as the local sponsors—apart from Thomas, who could give no financial support to the project—were convinced that they could not succeed without Government protection, and this was not forthcoming. Most of the directors of the powerful East India Company were definitely opposed to the preaching of the gospel to the people of India, and one director was even reported to have said that he would rather see a band of devils in India than a band of missionaries. When John Thomas returned to England in 1792, he therefore felt free to seek help in his own way and from other sources than those already approached in vain. He found that the Spirit of God had been at work, preparing just such an instrument of help as he would have desired most, among the churches of his own persuasion.

Thomas, the missionary, the man with some practical experience of the heathen world, was looking for a supporting society. The Baptist Missionary Society, just coming into being, and actually formed in October, 1792, was looking for a missionary and for practical advice as to the best disposal of its aid. Here, in Dr. Ryland's words, is an account of how these two parties came together:

"This Society was actually formed at Kettering in Mrs. Beeby Wallis's back parlour, October 2nd, 1792. As all the friends of the Baptist Mission know, we began with a subscription of £13 2s. 6d.; but at a second meeting, at Northampton, October 31st, brother Pearce brought the surprising sum of £70 from his friends at Birmingham, which put new spirits into us all. Still, we knew not how to proceed, whom to send, nor where to begin our operations . . . But just at this time, Mr. John Thomas returned from Bengal. He had repeatedly written thence to Dr. Samuel Stennett, to my father, and to Mr. Booth, and had given some account of his conferences with the natives. We found he was now endeavouring to raise a fund for a mission to that country, and to engage a companion to go out with him. At a meeting held at Northampton, November 13th, therefore it was resolved to make some farther enquiry respecting him, and to invite him to go back under the patronage of our Society."

So effective an account was given by Thomas of the need of India for the gospel that Carey and the other pioneers of the young society decided that Bengal must be their field, and that this traveller, practitioner and evangelist must be their ambassador. So it came about that a doctor was accepted as the first B.M.S. missionary, with Carey as his colleague.[1] That a medical man came to occupy such a place in the Society's history was not,

[1] *That Thomas was actually appointed before Carey is proved by a letter of Fuller*:—

"We resolved . . . that if Mr. Thomas concur with this proposal, the Society will endeavour to procure him an assistant . . . Mr. Thomas accepted the invitation of the Committee . . . Brother Carey then voluntarily offered to go with him if agreeable to the Committee."

(Quoted by C. B. Lewis in *The Life of John Thomas*, p. 219).

of course, due to a deliberately devised policy, and it is doubtful whether the supporters of the mission 'made enquiry respecting' Thomas's professional attainments, or envisaged the development of anything as far-reaching as the medical missionary programme of today. For every modern Baptist believer in medical missions, however, there is more than accidental significance in the fact that, at the very beginning of their Society's roll of honour, there should stand one who represented Christian concern for suffering men and women.

Little is known of the exact kind of professional training that Thomas received, or of his precise qualifications as a doctor. No doubt some of his treatments would seem crude in the light of present-day medical knowledge. He was, however, considered extremely competent by those who experienced his help. Carey, commenting on his being instrumental in saving lives, said that "Cures wrought by him would have gained any physician or surgeon in Europe the most extensive reputation".[2]

In addition to this skill, Thomas possessed in high degree the spirit of selfless service which has always been one of the distinguishing marks of Christian medicine. Soon after he and Carey had begun their self-support through indigo planting,[3] Thomas's house became, as C. B. Lewis[4] describes it, "the place of resort for all the sick and poor in the district around . . . The generous assistance of the compassionate missionary was never refused in any case of distress".[5] Thomas himself says in a letter written at that time, "I have patients

[2] C. B. Lewis: *The Life of John Thomas*, p. 320.
[3] 1793.
[4] B.M.S. Missionary in (*a*) Ceylon, 1845-1847; (*b*) India, 1847-1878. Author of *The Life of John Thomas* (published 1873).
[5] *Ibid*, p. 290.

from all parts, all poor and costly, but some of my sweetest moments are spent in giving them relief".

His most famous patient, Krishna Pal, came later, after years spent by Thomas in financial insecurity and debt, in various projects and journeyings, in hopes and fears regarding the likely converts and the success of the Mission, and in 'fits and starts, griefs and hot ecstasies' (to quote his own words) which made up so much of his spiritual experience.

It was on November 26th, 1800, that the events occurred at Serampore which John Thomas described thus in his journal:—

> "I was sent for to set a man's arm, a Hindu. I found it to be a dislocation of the shoulder. I tied his body to a tree, and while brethren Carey and Marshman made the usual extension, I reduced it so that he could move the arm, though it was still painful. This man had heard the gospel. When his arm was set right, he complained still of the pain, but more of himself as a sinner; and with many tears cried out, 'I am a great sinner! A great sinner am I! Save me, Sahib! Save me!' I renounced all power to save him myself, and referred him to Jesus, *my* Saviour, of whose mission and power to save all those who come unto God by Him I spoke many things."

Within little more than a month, Krishna Pal, the Hindu carpenter and *guru,* who in the interval had been visited in his home and had come to the Mission for treatment and instruction, had accepted Christ, broken caste and been baptized. In making his profession of faith, Krishna Pal spoke of his experiences at the time when his shoulder had been set. He dated his real

receptiveness to the gospel from that day—an eloquent reminder of the instrumentality of the doctor who had indelibly imprinted the love of Christ upon the convert's mind, both by word and by deed. Here was the first fruit of the Baptist Missionary Society's work in India, the vanguard of the modern Indian Christian Church; and in that story of achievement and promise one recognises the working of the Spirit through the human agency of a compassionate heart and medical skill.[6]

This was, so far as is known, the only time when John Thomas savoured fully the joy of the medical missionary whose aim it is to bring life to the whole man. Many disappointments had preceded this one satisfaction, some of them common to the lot of medical missionaries to this day, and even traceable in the New Testament record of our Lord's ministry. All too often men and women came because of the 'loaves and fishes', but not for the Bread of Life; they sought miraculous relief for their physical needs, but would have nothing to do with the miracle of new life in Christ. This kind of response, though so disappointing, never deterred Thomas from his continual task of watching for every opportunity to do them good. If they would not receive the total good he had to offer, at least such good as they were ready to take should always be available, and there is no suggestion that he ever used or withheld his medical skill as an inducement to a sufferer to accept the gospel.

This first full experience of missionary joy, represented by Krishna Pal's conversion and baptism, was also the last for Thomas; for almost simultaneously his mind gave way. The strain of his other experiences

[6] A hymn written in 1801 by Krishna Pal and translated by Marshman is found in the Revised Baptist Church Hymnal, No. 155: 'O thou my soul, forget no more
The Friend who all thy misery bore.'

was more than a man of his temperament could bear, and though he made a short recovery, he was eventually broken down again by failure in practical affairs, misunderstanding from friends at home and colleagues on the field, and by physical exhaustion. On October 13th, 1801, he died at Dinajpur in North Bengal, where he had gone for shelter to his friend, Ignatius Fernandez.

"Though not without his failings," wrote Marshman after his death, "yet his peculiar talents . . . and his constant attachment to that beloved object, the conversion of the heathen, will render his memory dear as long as the Mission endures."[7] And during his lifetime Thomas had so greatly impressed John Fountain by his concern for the needy and the untiring readiness with which he sought to help them that Fountain wrote,

> "He has many qualifications which render him the fittest person for a missionary that could anywhere be found".[8]

Among these qualifications might be reckoned adaptability and courage, both of which have over and over again been needed and manifested in no small measure by those who followed Thomas in the medical missionary succession. His determination to master the Bengali language led to early and widespread opportunities for near approach to the people and a better understanding of their need than if he had merely been content to substitute actions for the medium of language. In his indigo planting, in his attempts at Bible translation, in his preaching journeys, he showed a readiness to turn his hand to anything, so that the chief aim of his life might be forwarded—to make known the love of God in Christ and to persuade men to accept

[7] Quoted in *The Life of John Thomas*, p. 398.
[8] *Ibid.* pp. 319-320.

Jesus as Saviour. A passage from one of his letters in the early days of the Mission will strike an answering chord in the mind of many missionaries of more modern times:

> "I act part of the day as a servant, part as a master, doctor, missionary, merchant, justice of the peace, and can even make bread occasionally."

Though Thomas was so adaptable in such ways as these, there were occasions when nothing would move him from a position or principle, and when Christian indignation lent him courage to risk the displeasure of officials, of colleagues or of the Indian people. His faith in Christ and his grief over the superstitious ignorance that caused so much unnecessary suffering made him take such a stand over the question of *suttee* (widow burning) and over the exposure to death of babies who were puny or ailing. On one occasion he rescued such a child who had been put in a basket and hung up in a tree. The baby had cried and tossed about so restlessly that he had fallen out of the basket, and a jackal was just about to carry him off when Thomas, who was passing, rescued him. The missionary was burning with pity and anger that a helpless human being should be so much at the mercy of false beliefs; and though he was bound to encounter resentment and opposition, he was courageous in denouncing the deeds that sprang from such beliefs, while at the same time he used all the means in his power to point to a better way.

Possessed as he was of such admirable missionary qualifications, yet Thomas's mercurial temperament often in fact caused these very virtues to be seen from the reverse side as faults. Boldness of principle came near to aggressiveness, even arrogance, sometimes, when

he was dealing with his missionary colleagues; and his extreme sensitiveness and readiness to spend himself on every kind of opportunity alike inclined him to see trees rather than the wood as a whole. Though his contribution to the spread of the gospel in India can never be overlooked, he lacked the vision and balanced judgment that so notably marked Carey's work in laying the foundations of the modern Christian Church in India. Had John Thomas been capable of statesmanship in Christian medicine equal to Carey's statesmanship in Christian education and general evangelism, who can tell what the outcome might have been for India?

As it is, Thomas is remembered because he was "the instrument employed to lead the Baptist Missionary enterprise in the direction of Bengal", and because "to him it was largely owing that that enterprise was carried into effect amidst all the difficulties which obstructed its early progress".[9] But above all he is remembered for his single-minded compassion for the people of India, for his unshakable faith that nothing but the wholeness of Christ could meet their need, and for the conviction that he, John Thomas, faulty and inadequate though he was, had yet been called of God to this ministry of the Word and of healing. This is the authentic medical missionary vision, and, whatever else were his faults, to that vision Doctor John Thomas was not disobedient.

[9] *The Life of John Thomas.* Preface.

Chapter Two

THE MEDICAL GAP AND HOW IT WAS FILLED

"Such as I have give I thee." (*Acts III*, 6)

". . . such assistance as will preserve life, promote recovery or prevent aggravation of the . . . condition until the arrival of the doctor. The First Aider's responsibilities end as soon as medical aid is available."

(*Textbook of the St. John Ambulance Association on 'First Aid to the Injured'*)

C. B. Lewis speaks of John Thomas's life as one "upon which so many consequences depended".[1] That this is true makes it the more remarkable that there was little or no medical missionary development as a direct result of his life and work. Teachers and administrators, translators and printers—all these were included in the expanding vision of Carey and his colleagues at Serampore; but there was no thought of doctors, as such, for nearly a hundred years after Thomas's meteoric missionary career had closed.

The reason lay partly with Thomas himself, both for what he was and what he was not. As we have noted, he was not far-seeing; and apparently it did not occur to him to do either of the things which might have carried forward Baptist medical missionary work without a break. He did not, when on deputation to the churches in Britain, make any thought-out appeal for medically trained volunteers. Nor did he make plans to pass on medical knowledge, however limited in scope, to Indians themselves, as Carey planned for Indian

[1] *Life of John Thomas*, p. 402.

pastors and teachers. Thus, without recruitment at home or training on the field, the medical heritage was bound to lapse.

Furthermore, Thomas's own erratic temperament may have inclined the minds of his colleagues to suspect the introduction, as a class, of those whose training, interest and work might set them off at a tangent from the central purpose for which the Mission existed. His friends never doubted Thomas's evangelistic zeal, but they did not always approve his methods, especially in later days; and it is quite likely that medical training might, because of Thomas's spendthrift energy and adaptability, represent itself to them as a possible handicap to missionary concentration.

Nor was there money to spare for projects that could not be proved to have priority. The Society's Committee at home, though loyally doing their best to hold the ropes financially, did not always realise how much money on the field was put into the Mission, for example, by Carey, as a result of his own labours; and if the Committee, thinking in terms of what they were able to raise in the churches, queried some of the expenditure in those early days, it is fairly certain that they would not be looking for still further unexpected and expensive developments such as an official medical missionary scheme.

Perhaps, however, the most important reason for the medical gap was that neither at home nor overseas had there yet dawned on Baptist missionary enthusiasts the full implication of ' the whole gospel for the whole man ', nor of the Scriptural command to heal as well as preach. The dominant note in their missionary theology was the life and death importance of man's soul. On the mission field, experience rapidly taught many of the missionaries

that man's mind must also be illuminated and trained, though for some time this process was still regarded by many as merely a means to an end, and having no Christian significance in its own right. It took very much longer to grasp the meaning of bodily health and healing. Even when medicine was used by B.M.S. missionaries in the first hundred years of the Society's history, it was first of all undertaken by individuals following the dictates of their own compassion; then it, too, like educational work, was thought of as an additional means to the end of reaching and converting the heathen. In the Centenary publications of the B.M.S., there are very few references to medical missionary work, and nearly all of them show that medicine was still regarded as a subsidiary tool with which doors were to be opened for the main work of preaching the gospel. Not until the last years of the nineteenth century did the full possibility of medical missions begin to work in the thought and concern of British Baptists.

The fact that, for so many years, there was no over-all scheme of medical work in the B.M.S. did not mean, however, that nothing at all was being done to meet the challenge of disease and suffering. From Carey himself onwards, the story is a noble and thrilling one of individual non-medical missionaries who in a real sense rendered First Aid; who did their utmost to 'preserve life and promote recovery until the arrival of the doctor'. Of Carey it was said that at one time people came almost daily from miles around for medicine and advice,'[2] but in the early Serampore days he had to be a doctor at the week-ends only, since there was, presumably, no other opportunity in the full programme of the week.

[2] Ward: quoted in *William Carey*, by S. Pearce Carey, p. 180.

What medical knowledge he possessed had largely been learnt from Thomas, and to that Carey added his own common sense, the experience he gradually acquired, and the sort of faith that takes incredible risks when confronted by urgent need. A vivid picture is painted for us, by one of the Serampore circle, of the demands made upon him by

> "the maimed, halt, and blind suing his mercy—some to have their wounds dressed, some with the ends of their fingers and toes eaten off by leprosy. He gives them medicine for their bodies, and the best of medicine for their souls."[3]

In the face of all the suffering and ignorance they encountered, the non-medical missionaries might well have been appalled. All that they could offer (even supposing that it were successful) seemed like an infinitesimal drop in the ocean; and they had to reckon with the fact that they were not—could not be—always successful in their attempts to heal and to give simple health instructions. Common sense they might have, which helped them to improvise and to interpret their own accumulated experience: divine recklessness, too, they certainly possessed on occasion; but they were inevitably handicapped by their lack of specialised knowledge.

In many instances, they had insufficient medical knowledge to care properly for their own health. The roll of deaths and the recurring theme of sickness in the early history of the Mission in all fields and particularly in Cameroons and Congo, make this tragically clear.[4]

[3] *Ibid.* p. 238, quoted from Mrs. Grant.

[4] "In the first forty years of the Congo mission, there were 61 deaths, the penalty the mission paid for inadequate medical insurance against ever-present perils." (F. Townley Lord: *Achievement*, p. 45).

Thomas Lewis, writing of his first experiences on the west coast of Africa, said:

> "I wonder how I am alive to tell the tale. We did such irrational things in those days. We were not taught to take precautions for our health, except perhaps not to expose oneself too much to the mid-day sun. There was not a mosquito net in the whole Mission . . . The only medicine we were told to bring with us was quinine, and that was to be used *very* sparingly. Neither Silvey nor I owned a clinical thermometer! . . . We all went out in faith in those days, certainly not with knowledge."[5]

It was bad enough to be so lamentably ill-equipped for their own protection (though the degree of ignorance shared by Lewis and his friends was not universal), but when face to face with the gigantic and complex evil of human suffering among the people to whom they went, the missionaries must often have felt a sense of frustration, even of tragi-comedy, as they sought to tackle it with their imperfect knowledge. Yet tackle it they did. Such as they had they gave; and, looking back now upon their attempts, one feels that the tragi-comedy was changed to epic. For their story of apparently meagre equipment of almost ludicrously simple weapons[6]—has given them something of the glory and achievement of a David pitted against a Goliath, with no more powerful weapon of attack than a few ordinary pebbles and a sling, but in their hearts a sublime confidence in the Lord Who had called them to do battle against evil in every possible form.

[5] *These Seventy Years*, p. 68.

[6] Epsom salts, quinine, a few digestive pills, an eye-wash, various ointments and lotions, and a set of tooth forceps are mentioned by one of the non-medical missionaries in China, A. G. Shorrock (1861-1945).

What sort of situation was it that drove these non-medical missionaries to take such risks, to seek further knowledge and equipment, and to tell the story of the need in such a way that recruits and financial help were eventually forthcoming?

In all the fields into which the B.M.S. missionaries went in the nineteenth century, they found a condition of the whole man that stirred them profoundly and drove them to action. Their experience was not that of a mere emotion caused by the results of famine, flood and plague on a bigger scale than anything known in this country; it was not simply wonder at ignorance that did not know how to prevent disease; nor was it just pity for the more fatal ignorance that attempted to treat disease in grotesque ways. It was a combination of these things, added to the primary certainty that the Christ they preached was sufficient for all the need they met. Thus in many of the missionaries' minds there grew up the conviction that physical effects could not be isolated from mental and spiritual causes, but that cause and effect, ignorance and suffering, sin and pain, were so closely knotted together that no single approach would ever be sufficient.

INDIA, the first B.M.S. field, offered the challenge of a huge population in which human life was cheap and human personality negligible. A poor standard of physical life went hand in hand with little or no education for the majority of the people; and over everything there fell the shadow of the ancient religions —Hinduism, Islam and Buddhism—which, from their different angles, perpetuated these miseries. The doctrine of *karma* with its theory of inevitability, the fatalism of Islam, and the Hindu belief in almost endless rebirth according to merit, each contributed a strand towards

the rope that bound India in physical suffering, for when these faiths were at the height of their influence, few Indians could be found who would think of interfering with the course of pain or disease. To an orthodox Hindu, experience of illness was like one's caste—something conditioned by one's previous life—and both were unalterable.

This kind of deep-rooted spiritual apathy brought in its train a mental blight which, for the orthodox in any of the main Indian religions, precluded, in those days, scientific search for the true causes of physical ill. Overcrowding, lack of sanitation, tainted food and water, were accepted as part of the social picture, and it was a very long time before Indian minds could be induced to see the connection between these evils on the one hand and the incidence of disease and the mortality rate on the other. Though the early missionaries themselves had only an imperfect knowledge of bacteriology, they were horrified by the numbers of diseased and infected cows that wandered at will through cities and villages, battening upon pasture that was scanty enough, in any case, for all the healthy cows there were, and immune from death or segregation because the animal was considered sacred by the Hindus. When these beasts finally died, their carcases were, as a rule, thrown into the river; where no river was available, they were allowed to decay just where they were. The Indians wondered, when typhoid, typhus or cholera came, why the gods were angry. The missionaries, their compassion stirred by the sight of such widespread, patient suffering, knew that these diseases, together with evils such as dysentery and certain forms of blindness, were the result of preventable infection.

Another thing that made a deep impression upon

some of the mission staff in India was the lot of women and girls. This was an extremely difficult problem to tackle, linked as it was with religious tradition at so many points, but there was no doubt that it had a direct bearing upon infant mortality and the general health of the race. The lives of most Muslim women were lived in the strict seclusion of *purdah,* and high-caste Hindu women were treated in a similar way in the zenanas. Interlocked with this way of life, which encouraged wasting and malignant diseases, was the evil of child marriage. By legislation in 1860, the 'age of consent' was raised to ten, and various efforts were made subsequently by the Government and by certain westernised Indians to do away with child marriage and early maternity.[7] This reform was strongly resisted, however, so that as recently as 1928 the Joshi Committee, in an exhaustive report on these conditions, gave it as their official opinion that

> "Early maternity . . . contributes very largely to maternal and infant mortality, in many cases wrecks the physical system of the girl, and generally leads to degeneracy in the physique of the race."

Prostitution, related to certain forms of Hindu temple worship, took high toll, spiritually and physically, of the thousands of girls engaged in it, and was responsible for the spreading of venereal disease.

Because the general condition of Indian women had such far-reaching effects, it is perhaps not surprising that some of the outstanding contributions of non-medical missionaries in India in the nineteenth century should have been by women, for women. In the first place it

[7] The latest development has been the Child Marriage Restraint Act of 1929, when the marriage age was raised to fourteen for girls and eighteen for boys.

was the missionaries' wives—Mrs. C. B. Lewis and Mrs. Sale—who broke through the forbidding curtain into the zenanas, and, realising something of the physical sufferings of Indian women and children, brought to those sufferings what knowledge and medicine they had. Stories of their experiences, told in the home country, led to the sending out of single women missionaries and to the founding of the Baptist Zenana Mission in 1867, and it is to the enduring credit of this organisation which worked for so many years side by side with the B.M.S., and eventually became an integral part of the Society, that it showed sufficient perception of the need to send out two women doctors as comparatively early as 1891.

A different kind of challenge and opportunity was presented to the pioneer B.M.S. missionaries who went to the WEST INDIES from 1813 onwards. Physical suffering abounded; but, whereas in India and the east generally, much of it derived from religious beliefs and customs, so that the majority of the people perpetuated their own wretchedness by acceptance and practice, in the West Indies in the early nineteenth century the condition of the coloured people was largely imposed on them by a pattern of life in the shaping of which they had had no say. The system of slavery denied to the negro all rights as a human being, and if some of the slaves enjoyed better physical conditions than others (including medical treatment), such benefits came as acts of grace and condescension from their owners, or because it was to the owner's interest to keep his human chattels able-bodied. But even if they sickened and died, they were tragically easy to replace. E. A. Payne says:

"The constant demand maintained the supply from Africa. The ready supply made it unnecessary for

the planters to worry about the appalling wastage of life.'[8]

William Knibb fought to remove this system that caused one group of human beings to be so completely at the mercy of another group. With the emancipation of the slaves, however, other problems arose: they were now the responsibility of no one in particular, and when they had been cut adrift from even the measure of security and provision that some of them had known, physical conditions became acutely hard for many of the freed slaves.

From the first days of the Baptist mission to the West Indies, the missionaries sought at all stages to improve the lot of the negroes; and although the verbal preaching of the gospel, the teaching of the ignorant, and the building of chapels and schools occupied the major portion of their time, at least one of them—Thomas Burchell—made it his business to relieve their physical suffering as far as was possible. He had had some instruction in anatomy and physiology while he was doing his theological training at Bristol Baptist College, and contemporary comments on this kind of additional missionary preparation show that even at that time there were some who realised its potential value. The lectures he attended

> "were designed principally for the missionary students to whom such knowledge of these subjects was held to be of great importance."

Both before and after emancipation Burchell worked unsparingly as an amateur doctor, using his own home for his clinic, and giving treatment which included dressings, drugs, and, on occasions, operations. At one

[8] *Freedom in Jamaica*, p. 15.

time an appeal was made by him to the Society at home for developing support of such a venture, but nothing permanent came of it, and as the years passed by and the West Indian Baptist churches became independent in organisation of the B.M.S., there was no further thought of a medical missionary service in that part of the mission field.

The early story of the B.M.S. in CHINA contains many references to physical suffering in that country, and speaks just as eloquently as the records from other fields of the way in which men and women of compassion, though without professional medical training, made some attempt to bring the whole gospel to bear upon China's needs.

It was not that the Chinese were conscious at first that they needed help from the missionaries. Their civilisation was old and great, and some of their most enlightened scholars had considerable knowledge of medicine. It was a subject in which men of learning (Buddhist priests, in particular), had experimented and practised for hundreds of years, so that the taking of the pulse, inoculation against smallpox, and an imposing array of drugs of all kinds were among the subjects treated in a standard *materia medica* of the late sixteenth century. This knowledge was linked, however, with an inadequate and often faulty conception of anatomy and physiology; therefore, however good a pharmacopoeia they possessed, diagnosis was necessarily unscientific, and results uncertain. Lin Yutang, commenting upon certain Chinese traits which persist even in the twentieth century, says:

> "The whole science of Chinese medicine and physiology is based on the Taoistic philosophy of the Five Elements—gold, wood, water, fire and earth.

> The human body is in itself a symbol of the universe in its composition . . . Unchecked by a scientific method, intuition has free room and often borders on naive imagination. Some kinds of Chinese medicine are based on a mere play of words or on some fantastic association of thought. The toad who has a wrinkled skin is used in the cure of skin troubles . . . The local papers in Shanghai have been full of advertisements of a certain lung-shaped plant which is produced in Szechwan and recommended as the best cure for tuberculosis." "Medicine usually occupies the same shelf in ordinary book stores as necromancy and fortune-telling.'[9]

If this was a true picture of the Chinese attitude to medical knowledge in 1936, after years of western scientific influence, it may be imagined how little effect Chinese practitioners of the nineteenth century had upon the vast physical needs of their country. The following story illustrates both the contrast between Chinese and western medical treatment, and also the impression made by the latter even when, as in this case, the simplest devices were employed. E. C. Smyth, a missionary who had had some medical training, was working one day in the room he used as a dispensary, in an inn at Chowping, when he was asked to see a boy who had swallowed a brass ring five days previously. One Chinese doctor had needled the boy's neck all round to produce counter-irritation Another had attempted to treat the patient by shaving and blistering the head in order to draw the ring out. Smyth gave the boy an emetic and went on with his other work. Before long the patient was vomiting, and up came the ring, much to the delight and awe of the other patients and by-

[9] Lin Yutang: *My Country and My People*, p. 87-88, 213.

standers. As a result of this success, the missionary was welcomed when he visited the village where the boy lived. There, some time later, a preaching hall was opened, with twenty baptized Christians meeting for worship. "Even emetics" (to quote Dr. Moorshead) "proved their value in the service of the gospel."

The early B.M.S. missionaries to China found a huge population, thousands of whom lived at or below hunger level, with all the attendant problems of malnutrition and infection. The large-scale import of opium, in which British trade played such a sorry part, had opened up for the Chinese people a supposed way of escape from their physical wretchedness, only to substitute other equally devastating wretchedness in its train. Flood and drought at different times were responsible for famine, and it was in famine relief that Timothy Richard, A. G. Jones, David Hill and J. J. Turner came closest to understanding and helping physical suffering. The movements of population, caused by famine, to some extent conditioned the movements of the missionaries also, and so it was that, besides dispensary work undertaken in centres like Chingchow, Chowping, and Choutsun, and the teaching of health and hygiene through such a medium as the Whitewright Institute, Tsinan, medical treatment was given by the missionaries on their many journeys, either the long treks from province to province,[10] or more local itineration through country districts. These journeys were made on foot or by other almost equally fatiguing methods of travel, yet large areas were covered, and surprising numbers of patients were treated.

Contacts of such a kind made with the Chinese

[10] E.g., the mission opened in Shansi by Timothy Richard as a direct result of famine relief.

people in times of stress and emergency afforded the missionaries fruitful opportunities for acquiring a comprehensive idea of Chinese life. This in turn led to increased effectiveness in evangelism, and also to a more detailed knowledge of medical needs, so that in 1892 a young missionary named Frank Harmon, coming home on furlough, could make plans to attack one of the outstanding physical evils he had found, in the threat to eyesight. He arranged to have instruction in the treatment of eye affections, and returned to China with suitable drugs and instruments to wage an almost miraculous war against this evil. Of 107 operations he performed for cataract, only seven were unsuccessful—an amazing vindication of the faith and daring of a 'specialist' who had had no complete medical training.

What of the need that was found in AFRICA by the earliest B.M.S. missionaries? To the grim effects of tropical and endemic diseases such as leprosy, yaws and sleeping sickness were added, in most districts, all the evils of animism. This primitive belief in spirits governed the African's interpretation and treatment of disease and accident, as well as most of his other experiences. Medicine men, witch doctors and witch hunts, poison cups and fetishes—all had a part in aggravating rather than lessening the burden of physical suffering which bore so heavily upon the native people.

This kind of situation showed yet again how close was the connection between religion and life, between ignorant belief and concrete evil result, and wherever the pioneer missionaries sought to alleviate suffering they did so as part of a total war on the stronghold of darkness in the minds and hearts of their patients.

It has been said that every station opened in the early days of the B.M.S. mission to Congo was founded

upon the medicine chest of the missionary; and there is no doubt that many Congo tribes overcame their initial suspicion of the white man because he had dressed their wounds, set their fractures or cured their fevers. A dramatic illustration of this is found in an incident described by Thomas Lewis in his autobiography.[11] He tells how a Zombo tribesman in the Quibocolo district had been shot in a deer hunt and brought into the village.

> "The wounded man had been laid in the middle of the courtyard, and was surrounded by a yelling crowd. The medicine men were dancing and rushing about for the proper leaves to cure him. The jerking of the improvised hammock . . . had caused his smaller intestines to pass out through a slit in the abdomen where he had been shot . . . We[12] washed them carefully with disinfectant, and gradually pressed them back through the slit . . . Our efforts took a long time, and when at last I closed the wound with three stitches, the crowd could not believe their eyes . . . and they clapped their hands in acknowledgment. We then carried the man into his hut, and bandaged him carefully, giving strict orders that the patient should not be moved until I came to see him next day."

The short-term sequel to this occurred next morning, when Lewis received a visit from the patient himself, carrying the bandages in his hand, and again surrounded by a crowd, including the chief of the tribe, who said, "You have mended him so well that his stomach is now stronger than it ever was before." The long-term sequel was a marked increase of confidence in the missionaries,

[11] *These Seventy Years*, pp. 191-192 (c. 1898).
[12] His companion was John Pinnock.

and, in Lewis's words, " this incident did the Mission an immense amount of good ".

Successful incidents like this might do good to the missionary cause, but at all times there was a considerable risk that things might not turn out so favourably. Lack of training and of systematic medical knowledge were bound to cause some strain and apprehension for the non-medical missionaries, and, though they were prepared to risk personal discredit if their treatments failed, they realised that, especially from folk handicapped by ignorance, there might come serious setbacks to the work as a whole.

As they came to feel this more keenly, together with a growing sense of the magnitude of the task, they took further action in two ways. They sought to equip themselves more thoroughly to cope with the need; and to the Committee of the Society and in the churches at home they described the need on an ever-widening basis. Thus, support was given to proposals for short courses in First Aid and tropical medicine, and a number of missionary candidates, as well as missionaries on furlough, took advantage of the courses arranged by Livingstone College.[13] But the real turn of the tide towards organised medical missionary work in the B.M.S. came with the recruiting of the doctors, as we shall see

[13] Founded in 1893 to equip missionaries with a working knowledge of health and hygiene, First Aid and tropical diseases. Long and short courses were arranged to suit varying needs, and close links were maintained with the fields of missionary work overseas, so that training might keep abreast of changing conditions. Workers with this partial medical training have proved extremely valuable, and short courses are still offered by the College. The natural trend, however, is for such medical helpers to be non-European, and the scope of the College's original aim being thus modified, a co-operative association has been entered into by Livingstone College and the Medical Missionary Association of London, which, since 1878, has helped to prepare doctors for the field.

in the next chapter. And those professional recruits came forward largely as a result of the challenging presentation of the appeal by the amateur medicals who had done so much to fill the gap. It was not by any means the last appearance of the amateurs; but it was one of the greatest services that they performed to the medical cause when they sounded their urgent call to Baptist medical missionaries to come over and help them.

Chapter Three

DOCTORS LEAD THE WAY

"Luke, the beloved physician . . ." (*Col. IV.* 24)
"Luke is with me." (*II Tim. IV.* 11)
"Luke, my fellow labourer . . ." (*Philemon,* 24)
"I will show thee my faith by my works." (*James II,* 18)

Between the founding of the B.M.S. in 1792 and the formation of the Medical Mission Auxiliary of that same Society in 1901, the total of missionaries in its ranks who had possessed medical qualifications could be counted on two hands. They included, moreover, such a man as Doctor Prince who was recruited not from the home Church but from among the Christian community in Jamaica when the freed slaves were moved to send the gospel to their brethren in Africa. Prince, a former slave owner, had so come to sympathise with the aims of the Baptist missionaries in the West Indies that he joined the party which crossed the Atlantic and started evangelistic work at Fernando Po on the west coast of Africa in 1841. Throughout his missionary career there he laboured faithfully for the well-being of the Africans with whom he came into contact; but he cannot really be counted as a symbol of medical missionary concern among the Baptist churches of Britain.

Another name on the list of qualified B.M.S. doctors before 1901 was that of a later William Carey, who followed his famous great-grandfather to India in 1877. At that date there was still no sign of widespread awakening on the part of Baptists to the medical challenge, and this William Carey was not sent out by the Society as a medical missionary. This may cause

us some surprise, but what is even more surprising, especially in view of the needs outlined in the last chapter, is that he does not himself appear to have felt called upon to exercise the healing ministry at all extensively. So once again, as in the case of John Thomas, the coming of a doctor did not bring about the organised medical work that might have been expected.

Various reasons have been put forward for the dearth of doctors in the B.M.S. up to the last decade of the nineteenth century. There was no policy of recruitment for medical work within the Society. In fact, for many years after the launching of the modern missionary movement, there was no clear, over-all recruitment policy in any of the sending Churches. General appeals for service were made by the various mission boards, and these were underlined and pin-pointed by stories of special work and need, told by missionaries on furlough. In some of the theological colleges the fire of overseas evangelism that had kindled certain students became a steady flame of tradition as from each outgoing group of ordained men one or more responded to the call for service abroad. But for a considerable time there was no such missionary tradition in the medical faculties of British universities.

Towards the end of the century it was realised by many church and mission leaders that through student organisations a powerful influence might be exerted upon the vocation of young people who would pass from the universities into the various professions, and with the formation of the Student Volunteer Missionary Union in 1892 there was opened a channel through which for many years there has flowed a wealth of dedicated talent and training.

Baptists in these professional categories were at first far from numerous, however, and it should perhaps be taken into account that it is still a comparatively short time since the door of professional opportunity has been fully opened to Free Churchmen and to those without wealth or influence. It was not until 1877 that all disabling clauses of religious tests were finally removed at Oxford and Cambridge; and though the higher education that had there been denied to Free Churchmen was supplied by other universities and university colleges, there still remained the handicap of long and costly training for those of humble means who wished to become doctors. Though not all Baptists felt this handicap equally, yet it would be true to say that the denomination as a whole in Britain has never been wealthy or privileged, and that some of its best achievements have been attained in the face of financial or cultural disability.

Agencies to which many Baptist medicals have owed a great debt are the Edinburgh Medical Missionary Society, founded in 1842, and the London Medical Missionary Association, dating from 1878. Through these organisations, with their professional and financial help for students, their hostel facilities, affording fellowship and inspiration and the opportunities for practice in evangelistic work, many doctors have been prepared for service overseas.

In the latter half of the nineteenth century, some of the Baptists who were able to obtain the full training and qualifications necessary to allow them to practise felt the call to overseas work. For some of them this call came through the high rate of illness and death among the missionaries already working abroad. Others were stirred by accounts from the fields of the misery,

ignorance, apathy and unscientific treatment that affected the lives of millions. One or two of these men began to be disturbed by the thought—new to most Baptists of that day who possessed evangelistic zeal—that healing might still be an integral part of evangelism, as it had been in New Testament days.

The fact that there were few or none trained to help the sufferer in non-Christian countries, compared with the number of qualified practitioners and specialists in this country, made these B.M.S. doctors turn away from the undoubted prestige and income that they might have obtained at home; and they went out to follow their calling in conditions which could be endured, let alone overcome, only through the power of Christ. Most of them worked for years with limited equipment, without hospital buildings or qualified nursing help. In some instances they had to contend not only with the suspicion and timidity of those they sought to help, but also with the resentment of their rivals, the native practitioners. And in all too many cases, they fought a constant battle against the attack of disease upon their own bodies; for although they had training and knowledge from the fullest resources then available, those resources had not at that time been enriched by the discoveries of more recent years—discoveries which have opened up new worlds in the diagnosis and treatment of almost all disease.

At the time of the Centenary of the Society in 1892 there were four doctors enrolled in its service overseas. Three others had come and gone in recent years—Dr. William Brown who had given four years of valuable work in China,[1] Dr. Seright who had sailed for Africa in 1886 and been obliged to return home the same year,

[1] 1870-1874.

and Dr. Sidney Comber who had survived only one year in the Lower Congo. There remained Dr. William Carey (mentioned above) in India, who, though qualified, was not concentrating upon medical work; Dr. Russell Watson who had been appointed in 1884 to Chingchow, in the Shantung province of China; and two young recruits, actually appointed in the Centenary year—Dr. T. C. Paterson for China and Dr. Sidney Webb for the Congo.

The latter, a lovable and talented personality, was destined to give less than three years of service on the field—but what a rich outpouring was contained in those years! For the greater part of his life he had hoped to become a missionary, and had undertaken medical studies in Edinburgh and post-graduate work in the East End of London with that aim constantly in view. When accepted by the B.M.S. he was appointed to Wathen in Lower Congo. He arrived there when one senior colleague, Holman Bentley, was on furlough, and just before another senior, George Cameron, had to leave for England, taking home his baby daughter after his first wife's sudden death. From the moment of Sidney Webb's arrival, therefore, the utmost demands were made upon him, and not only had he "his proper medical duties to fulfil; but he had also to become teacher in the school, and general adviser and friend to nearly a hundred boys, and to take his share in the superintendence of the workmen."[2]

At first the medical work was little more than simple dispensary treatment, but as Webb's fame spread through the Lower Congo, patients began to come from further afield, and even the King of Congo, whose court was at San Salvador, travelled to Wathen for medical help.

[2] William Brock: *A Young Congo Missionary*, p. 81.

Some itineration was undertaken in the district, and through the contacts made on these journeys, as well as in the widening circle of out-patients, many Congo folk heard and saw the gospel in action for themselves. Perhaps, though, the most far-reaching of Sidney Webb's contributions was made through the intimate personal contacts with his 'boys'—young Africans who served as dressers and carriers, who watched his work and caught something of his spirit.

> "It was one of his great hopes that, with proper training, many of the young natives might be fitted to deal with the simpler cases of disease and accident among their countrymen. He believed that by no other means could the pestilent belief in witchcraft be so effectually arrested."[3]

Here we have one of the earliest expressed convictions that B.M.S. medical work should, as a matter of policy, include native training within its scope, and that such training, especially where it was informed and inspired by the Africans' personal acceptance of Christ, would prove more effective than any other means in penetrating the dark world of evil customs and beliefs. This was the logical development that presented itself to the mind of a young and ardent medical missionary as he considered the need of Congo in the light of Christ's gospel for the whole man. Where this kind of policy has been implemented in subsequent years, there has been ample proof that it is essentially sound and practical.

"A life soon ended but singularly complete" is the Rev. William Brock's summing up of Webb's short span of twenty-eight years, of which so many had been spent in preparation for his life's work, while only one brief

[3] *Ibid.* p. 89.

term of service was granted to him on the field. On his way to the coast when setting out for his first furlough, some of his boys were suffering from fever, and Webb had two of them placed in his own hammock while he himself walked through the forest in the unhealthy tropical heat. The result was that the doctor arrived at Matadi seriously ill, and though he rallied sufficiently to be taken on board the steamer for home, they had not been at sea two days before he died. One of the Africans who had been closest to him wrote, shortly afterwards:

> ". . . My good white man is dead. But not without the will of God being done, though we did not desire it. But happiness to the doctor has come; and my grief is taken away because the riches of God have come to us, and have grown up in my heart; also in the heart of Mvunzi, Mvemba, of Mabika, of many other boys too. Therefore, we are strong in going forward, God helping us, so that we spread the good news in all the country of Congo."[4]

His biographer's comment on the completeness of Sidney Webb's life was true in the sense that there were no reservations about it. The whole man, with his personality, talents and training, was offered so that the wholeness of God might speak through him. But in another sense his life was not a separate and self-contained offering. The apparent end of his service gave a further impetus to missionary endeavour on the field, as is shown by the letter just quoted; while in the Baptist churches of Britain the shock of his passing and the story of his life led to a quickened interest in the work for which that life had been given.

[4] *Ibid.* pp. 118-119.

We have seen something of the influence of one missionary doctor's short career in those formative years at the end of the nineteenth century. What was happening to the others, to whom it was given to think, to plan and to act over a longer period?

In 1884 Dr. Russell Watson was appointed by the Society for service in China. He joined A. G. Jones at Chingchow, the first B.M.S. inland station which had been opened by Timothy Richard in 1875. Here dispensary work had been carried on continuously since the very early days, when opposition to Richard's settlement there had been largely overcome through his successful treatment of Chinese patients during a serious epidemic. Following later upon this success, the famine relief referred to in Chapter Two.

> " did in three years what in ordinary circumstances might have required twenty. It assured them (the Chinese) of the sincere goodness of the Christian missionaries; permitted them (the missionaries) to get close enough for men to discover their intelligence, their sympathy, their worth; . . . made people respectful to a creed which grew such fruit—in a word, brought our brethren into contact with the people."[5]

Thus it was that Dr. Watson and his wife (also a doctor) entered into a field of opportunity which had been opened up as a direct result of medical work done by non-medical missionaries. The doctors took full advantage of this and, in their turn, brought to the Mission enlarged chances of usefulness as well as prestige. With only a rented building and (judged by western standards) very inadequate facilities, Dr. Watson yet

[5] *Centenary Volume of the B.M.S.*, pp. 124-125.

managed to treat 240 in-patients in one year, including cases that required the most skilful surgery, and in the same year his average out-patient attendance was 1,400 per month. An important district official who had apoplexy was "treated in vain and despaired of by fourteen native physicians, but was happily restored to health and work by Dr. Watson." In the Centenary report on B.M.S. achievements in China, Dr. Richard Glover commented on the way in which this use of medical skill commanded the respect and attention of many of the Chinese people:

> "It is Mercy which opens the way for Truth, and the human life of love that renders credible the message of the infinite love of God."[6]

Through his experiences in China, Russell Watson came to feel that, although something was being achieved by the kind of medical relief that he had to offer, much more could and should be attempted in the name of Christ. That Mercy might be an entering wedge for Truth, and medical missions a bridge-head for the preaching of the gospel, had been proved beyond a doubt; but he felt in his heart that there was a broader and deeper basis for the work of healing, and on his furlough in England in 1894 he discussed the question with Dr. Percy Lush who, in practice in the home country, had come to very similar conclusions. These talks were to bear fruit later, but at the time it was felt that B.M.S. policy was not yet ready for such radical changes as they had in mind.

Dr. Paterson, who had been appointed to the China field in the year of the Society's Centenary, also inherited the established goodwill of non-qualified medical work,

[6] *Centenary Volume*, p. 137.

first of all at Chowping and later at Chingchow, The dispensaries that had been set up drew patients from far and near, and they were treated and cared for by the doctor and his wife (who had also had medical training) in buildings that were certainly never designed with hospital accommodation and facilities in mind. It is a marvel that so much of the work of healing was accomplished with so little fuss and complaint on the part of the doctors. The concern they did express on occasion to the Secretaries and Committee at home sprang not from self-pity but from a growing desire to do better work and, in the light of enlarging opportunities, to present more adequately the whole gospel of Christ.

In Shensi, the most remote and most recent province to which B.M.S. missionaries had gone, the need of some established medical work had already been felt, and just before the end of the century the Rev. Moir Duncan took steps to secure in the city of Sian a Chinese building which would serve as a hospital. With this work and its possible development in mind, the Society appointed in 1898 Dr. J. A. Creasey Smith who in Sian laid the foundations of a medical service destined for eventful and heroic history.

In the Indian field during these years, British Baptist medical missionary work was being tested and shaped by three doctors, of whom Dr. Ellen Farrer and Dr. Edith Brown were appointed by the Baptist Zenana Mission in 1891.

Dr. Brown worked at Palwal for three years, and those years taught her what so many medical missionaries have learned from experience—that comparatively little could be achieved by Europeans alone administering direct relief in suffering, and that the

training of native Christian helpers was of the utmost importance. If the B.Z.M. had been able to build and furnish a hospital at that time, a training school might have grown up in close connection with it, which would have afforded Dr. Brown an opportunity to realise in Baptist medical missions the aims that were uppermost in her heart and mind. As it was, she resigned from the B.Z.M. in 1894 in order to work out these particular aims. Her loss to Baptist mission enterprise ultimately became a great gain to mission hospitals of many different denominations, in north India especially, for it was her vision that founded and developed the Women's Christian Medical College at Ludhiana, to which hundreds of candidates have been sent by mission schools for training, and from which qualified nurses, midwives, dispensers and women doctors have gone forth to serve their fellow-countrymen and women.

The missionary career of Dr. Farrer is outstanding in the annals of Baptist medical missions. Her period of service—42 years—on the field set up a record so far unsurpassed by any other medical missionary among British Baptists. During those years she witnessed great changes, in social and educational realms in India as a whole, in the status and outlook of Indian women in particular, and in what touches most closely the subject of this study—the attitude and policy of the churches with regard to medical missionary enterprise.

Dr. Farrer recalls that the Committee of the B.Z.M. who interviewed her were far-sighted enough to recognise that the development of hospitals might be the natural consequence of sending out fully qualified women doctors. But it was some time before that natural consequence came about, and Dr. Farrer's first head-quarters for medical work among women and children

in Bhiwani were in an Indian house built round two courtyards, with no room large or light enough to serve as an operating theatre. The inner courtyard was reserved for any in-patients who might have to be kept for treatment; the outer one (including a very small, dark room) served the combined purposes of waiting-room, surgery and dispensary.

The women sat on the ground in the yard, waiting their turn, many of them half afraid of the mysterious thermometer and stethoscope. Higher caste Hindu patients were loth to accept medicines made up from well water that had been carried by a Mohammedan, and asked instead for pills or powders. The reluctance with which they came, however, gave way to gratitude, confidence and, in some instances, enduring friendship. At the Government hospital and dispensary in Bhiwani there was a male doctor, and these Indian women, dominated by the zenana tradition of seclusion, preferred the discomfort of suffering to the shame of being treated by a man. Skilled treatment from one of their own sex was, therefore, a source of wonder and, as time went on, satisfaction. For the experiences of pregnancy and childbirth there were, of course, native midwives available, but many of these had little or no scientific training and carried on their work by means of verbally acquired tradition. Dr. Farrer early established a valuable contact with this native maternity service, which brought her into intimate relationship with many women in their homes.

"One of the midwives of the town had her grandchild in hospital under Dr. Farrer's skilled care. As was then the custom, a relative always accompanied and stayed with the patient in hospital. As the child was a surgical case, the midwife sat watching and

talking while Dr. Farrer dressed the limb. She told Dr. Farrer of her midwifery practice and its difficulties, and it was suggested that she should call in the doctor next time a case proved beyond her native skill. This led to the lives of many mothers and infants being saved."[7]

The variety of experience accumulated by Dr. Farrer in those early days gave her abundant material from which to formulate principles and to argue the urgent need for a clearer and more comprehensive medical mission policy. At last, in a Baptist mission in India, the fight was on against the whole vast front of sin, ignorance and suffering. That the challenge of this fight should be fully realised and taken up was now to be the privilege and responsibility of Baptists at home. And so in 1897, on the first furlough of this gifted young woman (trained at Bedford College and the London School of Medicine for Women), something of her vision and sense of divine compulsion was transmitted to the Zenana Committee and to the women of the home churches. As a result, contributions were made and plans sanctioned for the building of a hospital with a ward of eight beds, a dispensary and operating room, and one or two smaller rooms. This was opened before the end of the century—in March, 1899—and together with thankfulness to God for what He had wrought already in the eight years of this medical venture in Bhiwani, there was present in the mind of more than one missionary enthusiast a thrill of promise for the future.

Though Dr. Edith Brown had resigned from the B.Z.M. in 1894, that did not mean that Dr. Farrer was thereafter left alone in her profession to continue the

[7] Dr. Mary Bisset in *Fifty Years for Bhiwani Hospital.*

great campaign in India in the name of British Baptists. After a short interval, the Zenana medical work in Palwal was taken up by Dr. Flora Butcher, who did notable work there for ten years. At Berhampur, in Orissa, breaking new ground for skilled medical assistance, the B.Z.M. appointed in 1900 Dr. Nina Ottmann who most effectively developed the service to women and children. Moreover, in the very year of Dr. Edith Brown's resignation, a new male recruit, Dr. Vincent Thomas, had been accepted by the B.M.S. for the India field—an appointment which helped to make B.M.S. medical history, both at that time and later.

Throughout his medical studies in Edinburgh and in the evangelistic experience he had had with the Edinburgh Medical Mission, Vincent Thomas had evidently been doing some hard thinking, with the result that, when he came to the Candidate Board of the Society, it was plain that he had a clear policy in his mind with regard to medical missions, while the Board as a whole had not. For most of its members the full equipping of this candidate meant making good his lack of theological training, so that he would be able first and foremost to expound the faith to non-Christians, while he could please himself as to what extent he used his medical qualifications in 'works' by the way. For him, full equipment meant the securing of every means whereby he would be enabled to show his faith *by* his works and to present the more abundant life of Christ in as comprehensive a way as possible. He was convinced that medical missions were not just an attractive side-line of evangelism but a vital means of helping to set forth the wholeness of the gospel.

His argument that this would necessarily involve the provision of hospitals caused a flutter among the

responsible Baptist ministers and others who were interviewing him. Perhaps taken unawares, and certainly without a full medical missionary policy to guide them, they fell back upon the defence that this was altogether too costly a departure and one for which the Baptist churches of Great Britain had given no mandate. Dr. Thomas's reply to the second part of this objection took the form of two penetrating questions. He asked, in the first place, whether the churches knew enough about medical missions to enable them to give or withhold a mandate; and next, whether there was not sufficient warrant in the example and command of our Lord, without waiting for any lesser authority.

The Candidate Board was impressed by Thomas's sincerity and sense of Christian vocation, even while they felt that, as a Board, they could not give to the supporting churches of the B.M.S. the lead indicated. Dr. Richard Glover and the Rev. Samuel Vincent, in particular, commended his soundness of judgment and urged that he should be encouraged in his full purpose; but when he was recommended for acceptance by the Society it was on the understanding that no promise was being made about a hospital. This seemed to Dr. Thomas such a serious limitation to his service that he almost decided to withdraw his offer. He was persuaded, however, to go out in patience and faith and in the knowledge " that there were those at home who were in agreement with his ideas."[8] He spent eleven years in India before his patience and faith in this particular respect were rewarded and he was provided with a hospital by means of which he could exercise his ministry more fully. In the meantime the seed planted in the minds of those at home had taken root and was being

[8] R. F. Moorshead: *Heal the Sick*, p. 23.

nourished by various agencies, but principally by the achievement and challenge embodied in those beloved physicians who had now taken their place as fellow workers in the gospel alongside preachers and teachers.

PART II
THE TREE TAKES ROOT: 1901-1925

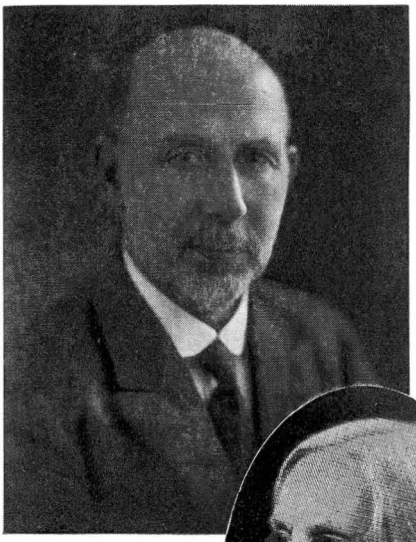
CHAPTER FOUR
THE FORMATION OF THE AUXILIARY

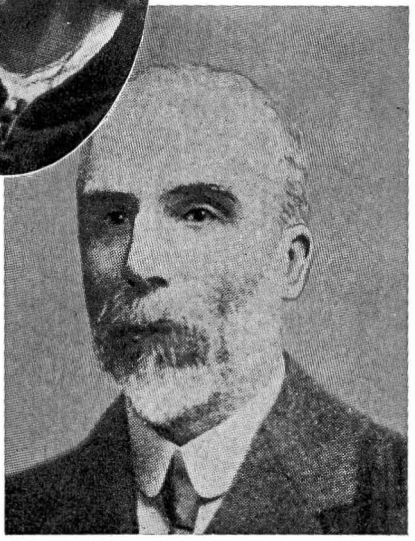
"Diversities of gifts, but the same Spirit . . .
Differences of administrations, but the same Lord."
(*I Corinthians, VII*, 4 & 5)

THE phrase from Ecclesiastes, 'A three-fold cord is not quickly broken,' comes to mind as an appropriate comment on the consultation which took place in London in 1901 and which led to the formation of the Baptist Medical Mission Auxiliary; for the strength of that consultation lay in the lead given by three of the missionary doctors referred to in the previous chapter.

Looking back on the events of that year, surely no one believing in divine ordering of men's lives could say that two significant furloughs 'happened' to fall due together, and that a similar fortuitous chance had brought, also at the same time, a report from the field which played a large part in the consultations.

Among those on furlough were Dr. Ellen Farrer and Dr. Russell Watson, the latter having come home this time with the feeling that he must do something definite to help initiate a Medical Auxiliary. Dr. Farrer, who had been invalided home the previous year, was for several months uncertain whether it would be possible for her to go back to India. There was, on that account, all the stronger concern in her heart that the work she had begun should not lapse but should be firmly established on the broadest possible basis. The contributor of the report from the field was Dr. Vincent





OVERSEAS PIONEERS
OF THE M.M.A.

Dr. F. Vincent Thomas

Dr. Ellen M. Farrer

Dr. J. Russell Watson

Thomas who, as we have seen, had long been of the opinion that British Baptists should seriously ask themselves what they meant by the words 'medical missionary'. He was eager for them to launch out boldly according to Scripture and, as it seemed to him, according to common sense. He was convinced that the New Testament gave the mandate for doing this work—and for doing it fully—and that led him to believe also that its organisation should be, not haphazard and impromptu, but co-ordinated and carefully planned, so that it might be the fittest possible instrument for God's use.

Thus these three doctors, worthy to be leaders in their profession, became leaders in a wider sense; for they helped to give the British Baptists of their generation a new vision and to bring them into new paths of fruitful service.

However much one may deplore the fact that no medical missionary organisation had hitherto been inaugurated by the churches at home, one is bound to recognise the essential soundness of the order of things as they did, in fact, occur. For so it came about that when the Auxiliary was formed it was not a blue-print originating in the mind of a fireside missionary strategist, but the answer to questions arising out of practical experience on the field. It was not a plan superimposed on the existing structure of organisation for missions, but an organism which derived its life from the experience of those who were already in the midst of the fray.

By themselves, however, even in their three-fold solidarity and taking into account the fact that they spoke also for other colleagues, these doctors from the field could hardly have accomplished the actual

formation of such an auxiliary. There had to be a receptive element at home towards which their experience and conviction could be directed. As we have seen, that element was not felt to be ready on Dr. Watson's previous furlough when he had consulted Dr. Percy Lush about the matter. But now it seemed that a definite change had taken place, not ostentatious and not, as yet, very far-reaching, but sufficient to warrant the taking of preliminary steps and at any rate holding an enquiry into practical possibilities.

It is difficult to prove what had happened to change a whole climate of opinion in this way, but one or two general suggestions may be made. In the first place, the Centenary Celebrations of the B.M.S. had stirred many churches and local auxiliaries to fresh interest in missionary work. Thanksgiving for the past led, as it so often does, to a quickened sense of responsibility for the future and to the awareness of new worlds to be won for Christ. It seemed also that news of medical missionary achievement and opportunity was penetrating further into the consciousness of Baptists, helped by the deputation visits of missionaries, both medical and non-medical.

In the wider social life of this country fresh forces were presenting themselves for the total warfare against evil. New scientific discoveries had been made; more accurate knowledge and more effective equipment were available; and with primary education accessible to all, and a gradual increase in scholarships and bursaries, more students were able to understand and appreciate the benefits of science. The discoveries in physical and medical science were producing a greater emphasis upon this whole field of knowledge in secondary and higher education, and this, together with the changes in educational legislation

and in educational opportunities for girls, had brought the vocation of medicine into the realm of possibility for many more young people. Moreover, the last years of the nineteenth century had witnessed great changes in the allied vocation of nursing, to which so much public attention had been called by the Crimean war and the work of Florence Nightingale. As G. M. Trevelyan says, "This idea of nursing as a serious profession . . . spread fast in civil life, and soon made a new era in public health and medical practice."[1]

All these things did not, of course, happen at once, but it is probable that something of their cumulative effect was felt under the natural stimulus provided by the new century. Above all, it is clear that these human agencies and trends were being fashioned into the purpose of God, and that it was by His Spirit that the Baptists of this country were made ready for the challenge that was presented in 1901.

It was to Baptist professional colleagues at home that the doctors from the field went first with the burden on their hearts. Dr. Percy Lush, who was in practice in north-west London, had for a long time shown his awareness of the need for presenting the Christian gospel as a total way of life, doing all he could to further this in his own practice, and adding to his already full programme the weekly visitation of a medical mission in Gough Street, Grays Inn Road, organised by the Baptist Deaconesses' Home and Mission.[2] He was sympathetic towards the idea of a Medical Mission Auxiliary, and he it was who arranged the informal discussions.

[1] *English Social History*, p. 548.

[2] Dr. Lush was known there as "The Penny Doctor". Though treatment was free, a collection was taken at the short gospel service which was an integral part of each Friday afternoon clinic, Dr. Lush and the deaconesses in training taking it in turns to give the address.

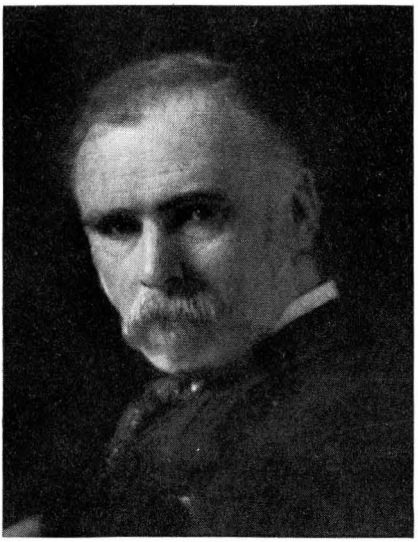
Soon after some of the early talks had taken place, the circle was widened by the inclusion of Mr. Alfred Pearce Gould,[3] partly because of his family connection with Dr. Lush (the latter was his brother-in-law), but still more on account of his eminence as a Christian surgeon. He was at that time still a comparatively young man, yet he was widely known in his profession as the author of a book on surgery,[4] and as a practising, consulting and teaching surgeon. Above all the brilliance of his gifts, however, there stood out a character and life which were moulded by Christ, and in which Christian wholeness or integrity was signally commended to all those who came into contact with him. His sympathy, encouragement and practical advice meant a great deal to the new Baptist Medical Mission venture in those early days of planning and preparation, and it was with the added weight of his professional prestige, personal character and known interest in the missionary cause that the little group of doctors now brought the question of a Medical Auxiliary before the officers of the B.M.S. and the B.Z.M.

Sanction was given for the calling of a meeting at the Mission House in Furnival Street on September 17th, 1901. To that meeting were invited the Committee members of both societies, and in the letter of invitation it was made clear that the Auxiliary which was being contemplated would not be in any way a rival to the B.M.S. and the B.Z.M., but might even work " virtually as a sub-committee of each society ", though if it had power to make separate appeals for funds it might

[3] He was knighted in 1911 and received the decoration of C.B.E. in 1919 in recognition of his work during the first world war, when he had charge of the surgical division of the " Third London " military hospital.

[4] *Elements of Surgical Diagnosis.*

Dr. Percy J. Lush



Sir Alfred Pearce Gould,
K.C.V.O., M.S.

PIONEERS OF THE M.M.A. IN GREAT BRITAIN.

receive "such support as would considerably relieve the funds of the parent Societies".

The immediate practical aims of the Auxiliary (also mentioned in this letter) were simple and clearly defined:

> "The object aimed at is, in the first place, to take over the financial support of the hospitals at present maintained by the two Societies,[5] and then, if the success which we anticipate be achieved, to maintain the entire medical agencies of the two Societies; and, later, as we hope, to multiply them by sending out additional qualified medical missionaries."

This meeting, though not empowered to pass a resolution actually constituting the Auxiliary, was obviously its real starting point. With Dr. Lush in the chair and several missionaries present in addition to the Societies' Committee members, an atmosphere of strong and well-informed advocacy was created for the project in mind. The chief speaker, Dr. Herbert Lankester, who gave an account of the C.M.S. Medical Mission Auxiliary (formed in 1891) contributed what was perhaps the final touch of experience and proof needed to set things in motion. At the time of the Autumn Assembly of the Baptist Union and the Baptist Missionary Society, a few weeks later, the recommendation of the September meeting was accepted and a special committee was set up to draft the constitution of the Auxiliary. The scheme that emerged served as its working basis for many years.

It was decided that the constituent members of the

[5] The use of the word "hospitals" is a general one, as Bhiwani was then the only station with a building that could fully claim such a designation. The other "hospitals" were, in fact, any premises that housed full-time medical missionary work.

Auxiliary should be the officers and medical referees of the B.M.S. and the B.Z.M., together with all fully qualified medical practitioners who were members of the committee of either society. In addition, the committee of each society had the right to nominate members from its own body, the B.M.S. having thirteen nominations and the B.Z.M. three. The committee thus constituted was also given the power to co-opt six more persons who were not committee members of either of the parent societies. In the matter of co-option, it was laid down in the constitution that preference would be given to qualified members of the medical profession.

In looking back over the history of the Auxiliary, it is interesting to note how solidly its foundation was laid by such a constitution. From the very beginning it was not an isolated unit embarking on a separate enterprise but it was integrated with existing missionary work of the two Baptist societies. Those who shaped policy in the B.M.S. and the B.Z.M. had a voice also in the developing policy of the M.M.A., which could thus be viewed as a new and important element in the total missionary situation. On the other hand, the inclusion on the Auxiliary Committee of a fair number of medical men brought to the business of the Auxiliary guidance in all matters of professional detail—such as the training and qualifications of candidates, the types and quantities of equipment required, and advice on new discoveries and drugs as they became known. Such a contribution proved invaluable through the years, keeping the highest possible standards always before the mind of the Committee as a whole, and giving added encouragement to the doctors on the field by the knowledge that their professional needs and problems were understood at home.

The main objects of the Auxiliary were now stated as follows:—

(*a*) To create, maintain and extend an intelligent and generally practical interest in the medical mission work of the two societies among the churches of our denomination.

(b) To raise funds for the financial support of the hospitals at present maintained by the two societies, and ultimately for the adequate maintenance of their entire medical agencies.

These objects were at once comprehensive and precise. The Auxiliary was not launched upon a tide of vague goodwill which expressed only in general terms its support for medical missionary work; nor, on the other hand, was its horizon narrowed to one definable goal only; but there was real wisdom in the decision to aim first at known responsibilities and yet to look ahead to what was hoped would be the inevitable expansion of these. The words 'entire medical agencies' prescribed no limit, and there seems to have been general recognition that new occasions would teach new duties. The Auxiliary was thus given ideal conditions for growth.

It was also recognised that the financial support that was hoped for depended upon interest, and interest depended upon knowledge. If the lifeline *to* the field was to be made up of prayer and money, the line of communication *from* the field needed to be kept open and busy. The dissemination of news had done much to bring the Auxiliary into being, and those who helped to draw up its constitution indicated their conviction that the continuance of live news was an absolute necessity.

A word worth noting in these stated objects is the

word 'intelligent', applied as it was to the interest which was to be promoted among the churches of the denomination. Those who drafted the constitution realised how little reliance could be placed upon interest that came and went with emotional impulse. Of course, people would be stirred by much of the news that the medical missionaries reported from the field; indeed, to be unmoved by some of the stories of suffering and superstition one would need a heart of stone. But the Auxiliary aimed at arousing steadier support than the fitful moment of generosity dependent on a harrowing story; and so, from the first, the attempt was made to base all propaganda on principle, and to keep up a regular flow of news of the work which should illustrate how the principle of medical missions was being applied.

The constituency to which the newly-formed Auxiliary expected to address its appeal was almost identical with that of the B.M.S. and the B.Z.M. If the M.M.A. was to be virtually a sub-committee of these societies, to whom else should it go for help than to the churches of the Baptist denomination in Great Britain? From the first, however, it was envisaged that there should be no diversion of contributions.

> "No one, least of all the officers of the Auxiliary, desired their fund to grow at the expense of the general funds, and it was agreed that subscriptions were only to be obtained for the Auxiliary when such help was an addition to the support given to the Societies."[6]

This agreement underlined the necessity for all early propaganda to be of the most skilful kind, and it was not long before the need was felt for an organising

[6] R. F. Moorshead: *Heal the Sick*, p. 38.

secretary who would be able to devote time and thought to the framing and implementing of the new appeal, as well as attending to the Auxiliary's committee business. The Committee had appointed Dr. Percy Lush as its Chairman, a position which he occupied until his death in 1918; and for the first few months of the Auxiliary's existence, committees were called and minutes taken by Mr. A. H. Baynes, General Secretary of the B.M.S.; but though both these friends had the utmost goodwill towards the new venture they could not, in view of all their other commitments, give it their unlimited service, and it would not have been possible for the Auxiliary to develop so rapidly or with such vigour as in fact it did, had not the right person been found in 1902 for the key job of whole-time secretary.

The name of Robert Fletcher Moorshead, M.B., B.S., later F.R.C.S, became, for thirty-two years of the M.M.A.'s history, almost synonymous with the organisation itself. Writing about him at the time of the Semi-Jubilee, Dr. W. Y. Fullerton said:—

> "He is medical missions incarnate; he thinks medical missions, he dreams medical missions, he lives medical missions. He is never off duty . . . At times when he might with advantage rest, his brain is busy, devising plans to help medical missions; defeated in one plan, he turns to another."[7]

But who would have guessed, when he was appointed, that this connection was going to develop into such self-identification with the cause and to a whole lifetime of such rich service? For this work, humanly speaking, came to his notice in the guise of the second best, an alternative (in which there was at least one serious

[7] *Mid-way to the Jubilee*, pp. 12-13.

drawback) to the dominant ambition of his life. That ambition for years had been that he might become a medical missionary. All his specialised training had been undertaken with that in mind, and it was not until he was half-way through the course of study for his Fellowship of the Royal College of Surgeons that the door to the mission field seemed to close for him. His father died, and Dr. Moorshead, being the only child, felt a moral obligation to stay in England, at any rate for the time being, for the sake of his mother.

It was in the midst of this experience of inevitable disappointment and readjustment that he saw the advertisement in the *Missionary Herald* for an Honorary Organising Secretary for the recently formed M.M.A. He did not find it easy at first to picture himself in such a different kind of activity from that which he had felt sure was God's will for him, and in later years, he described with simple objectivity something of the heart-searching that preceded his appointment:—

> "It was one of life's turning ways, and for a time it was difficult to know whether this was or was not, a call from God. True enough, it was a piece of service directly related to the work for which he had sought to prepare himself, but there was no professional work connected with it, and could it be right that his training . . . was to be laid on one side?"[8]

He could not, however, escape the significance of the barrier in his chosen pathway, while quietly and unobtrusively this other way, so near, so closely connected with the first, yet so full of unfamiliar and thrilling possibilities, had opened before him. He was therefore

[8] *Heal the Sick*, p. 34.

impelled to make further enquiries, and to seek the advice of the Rev. R. Wright Hay, a former B.M.S. missionary with whom he had had some recent personal contact. Mr. Hay felt sure, for his own part, that this was the man for whom the M.M.A. had been seeking, and he had a talk with Dr. Lush. Following correspondence and an interview, the Auxiliary appointed Dr. Moorshead as Honorary Secretary for a period of one year.

That year, as has been noted, became a life-time. The second-best became a primary passion; what had been a somewhat doubtful alternative became *the* way, above all others for him, of fulfilling the purpose of God. As Dr. Moorshead himself said, "The altered plan was God's method of dealing with a life," and, one might add, God's method of dealing with an organisation, for surely the man and the task were divinely designed for each other, and no human hesitancy could persist on either side when it was seen how they grew together and what manifest blessing resulted from this union of man and mission.

Again and again through the years Fletcher Moorshead was called upon to make readjustments, to exercise his adaptability no less strenuously than a missionary working overseas. Such a quality was noted earlier in this chapter in one brief reference quoted from Dr. Fullerton: "Defeated in one plan, he turns to another." It will be recognised again, at later stages of the Auxiliary's history. Here, however, at this crucial point of development in Baptist medical missions, one can trace most clearly the principle that directed all his readjustments—the motive of love for his Lord and consequent determination to find out His way and follow it. The B.M.S. as a whole, and the M.M.A. as a part of that whole, have had reason to be grateful to God

for Dr. Moorshead's central steadfastness and at the same time his consecrated flexibility. But for these the M.M.A. might never have had his services at all, and the story that follows, of the Baptist medical missionary campaign throughout nearly fifty years, would have been very different.

Chapter Five

THE HOME BASE (i)

"This work goeth fast on, and prospereth in their hands." (*Ezra V*, 8)

The members of Baptist churches in Britain had, on the whole, been slow to realise the opportunity afforded by medical missions, but when once the idea had taken a firm hold it was remarkable how surely and swiftly it grew. It was almost as if some supporters were determined to make up in intensity what had been lacking numerically or in duration of time; and this concentrated response was manifest in the increased number of candidates, in a quickened desire to know about the progress of medical work on the field, and, too, in the generous outpouring of 'new' money.

Of candidates there will be occasion to speak when we look more closely at developments on the field; but before that it would be well to consider exactly how the Auxiliary at home acquired the strength that made possible such developments overseas.

In the first place, the nature of the appeal itself created a wide response. It was new, clear-cut, and almost universal in its range. Of course, it was in reality as old as Christianity, but it came at this time with freshness and new meaning to those who had previously thought of evangelism in terms of preaching only. It came with the authority of Scripture, and offered to some people the happiest and most practical bridging of the apparent gulf between religion and science. The deeper theology of medical missions and the more far-reaching

implications of science as a whole may not have been grasped, but it sufficed for many that the work was Christ-like and Christ-inspired, and that it sought to bring the most practical blessings of modern science to those who were without science and without Christ. Then, too, there was an element in the appeal that proclaimed the kinship of humanity in suffering; and the fact that we are all one in this basic human experience has proved, through the years, to be a never-failing key to unlock the interest of men and women of all ages and types in the healing of their fellows.

If the nature of the appeal was the first secret of its success, the second secret lay surely within the personalities who presented it. Many a good cause has failed to achieve its maximum effect because those who have sought to proclaim its challenge have spoken with a half-hearted or diffident voice. It was not so with the principal advocates of the M.M.A. in its formative years. Dr. Moorshead himself, who addressed hundreds of meetings and travelled thousands of miles in the interests of the Auxiliary, did more than any other single person to further the appeal, and the fire of his conviction and enthusiasm set alight the flame of interest in innumerable churches and districts. 'Argument touched into passion' was Dr. Fullerton's description of the appeal as it was made by Dr. Moorshead in writing, and if this was true of his written words, how much more true it was of his spoken appeal, coming with all the energy, and yet humility and grace, of one who cared for God and cared for people! He conveyed in his personal statement of the case for medical missions his concern for two groups of persons at once—those *for* whom he appealed, and no less those *to* whom the appeal was being made. The challenge was therefore

not an intrusion but the offering of a personal privilege.

Though the chief responsibility for speaking at meetings rested for many years with Dr. Moorshead, there were others who gave devoted service in this respect, including the medical missionaries themselves. As more doctors and, later on, nursing sisters, were recruited, it became possible for more churches to have them on official deputation from the parent societies, and their first-hand experiences of suffering abroad, told vividly and with evangelistic fervour, could hardly have failed to rouse a response for the young Auxiliary with which they were now closely linked.

At the Mission House, from time to time, valuable help was given in organisation by those who either deputised for Dr. Moorshead when he was absent or undertook work in addition to his own. Among these, special mention should be made of Mr. Herbert Smith, B.A., who was the first Honorary Treasurer of the M.M.A. Fund and who directed the business of the Auxiliary during Dr. Moorshead's visit to the India field in 1905-06; the Rev. J. Lawson Forfeitt of the Congo who filled the breach most effectively in 1912, when Dr. Moorshead was obliged to have temporary leave for health reasons; Miss F. M. Leonard, who for several years helped both in an executive capacity and as a speaker; Mr. H. D. Cotton, Mr. A. W. Willis, Mr. (afterwards the Rev.) Ernest Hemmens, and—towards the end of the first twenty-five years—the Rev. E. Anstie Bompas, who gave notable service as colleague to Dr. Moorshead in Home Base organisation from 1917 to 1922, and was greatly missed when he returned to the ministry, having accepted a call from West Ealing Baptist Church.

Medical men as well as ministers, missionaries and

non-medical laymen and women took a vital share in presenting this appeal. In many large districts where missionary enterprise was already under way, there were found Baptist doctors who, though unable to go abroad themselves to preach the gospel, had it laid on their hearts to seek support for other doctors who were free to do so. This professional advocacy made a considerable impression, and was the means of securing life-long interest and support from many friends. Prominent among such medical leaders was Dr. Arnold Ingle of Cambridge who, particularly after his retirement from practice, devoted a great deal of time and thought to the practical advancement of M.M.A. affairs. Another colleague who strengthened Dr. Moorshead's hands was Dr. Thomas Horton, of Torquay. When he retired, he chose to live at Hampstead so that he might have speedy access to the Mission House. He was thus able to undertake the medical examinations of many of the missionaries as well as other headquarters duties, leaving Dr. Moorshead freer for deputation.

There is no complete record of the churches and districts where the new appeal was first launched, but Dr. Moorshead, in his book *Heal the Sick,* has mentioned some of the centres from which there came an early response to his own exploratory letters and talks in 1902-04, and to the specially arranged visits of Dr. Vincent Thomas and Dr. Creasey Smith who were on furlough in the latter part of the same period.

> "To the West of England belongs the honour of affording the first platform opportunities for the advocacy of medical missions."[1]

'The West of England' is tantalisingly vague, but

[1] *Heal the Sick,* p. 39.

one may be sure of one city which in Dr. Moorshead's own mind was almost synonymous with the west of England. That city was Bristol, where he himself had been born, educated and baptized, and where he had received his missionary call and entered on his professional training. There is a ring of civic pride and natural gratification in his statement of fact that on his own home ground he was given his earliest opportunity to sound this challenge He was no less delighted, however, to record other names—Birmingham, Leicester, Cheltenham, Liverpool, Manchester, Leeds, Bradford, Newcastle and Plymouth, as well as a number of unnamed London churches, where Baptists rallied to the appeal.

In all the early attempts to widen the circle of interest in the M.M.A., emphasis was laid upon the importance of local consolidation. However much enthusiasm might be generated by the visiting speaker's 'argument touched into passion', it was likely to cool unless measures were taken to replenish and direct it systematically.

> "The aim of securing some local representative who would follow up an address was constantly adhered to, and such success as has followed the organised work of the Auxiliary is, under God, largely due to that method."[2]

Did the local representatives realise how much depended on them? (Do missionary secretaries in churches and auxiliaries today realise the full possibilities of their position, in which it is often they, and they alone, of the human factors, who can determine whether local missionary enterprise is moving vigorously or sluggishly or is quite static?) Presumably there were some who

[2] *Heal the Sick*, p. 39.

did not do all that was hoped for; but there were many more who, for their own day and into the far-distant future as well, justified Dr. Moorshead's belief in this method of local organisation. Incidentally, they were often the justification not only of a method but of the high standards and penetrating judgment that selected them. In most instances it was Dr. Moorshead himself who sought and singled them out on the spot. He knew exactly what qualifications he was looking for, and this sometimes gave his personal method of selection an advantage over more official ways of appointment. Whether these local secretaries were personally chosen or publicly appointed, however, it was made clear by him that only the very best would do; and to this exacting ideal of service, no less than to the fact of setting up local machinery at all, must be attributed no small portion of the Auxiliary's true growth.

With such a strong lead from the Mission House, and the best personalities possible getting to work locally, it is interesting to see what practical steps were taken to foster the appeal.

Regular deputation visits from medical missionaries have already been referred to, but it is worth while calling attention to the arrangement adopted and maintained by many of the auxiliaries that were formed in large centres. This was the plan to hold medical deputation meetings at a different time of the year from the general deputation. Although originally designed to avoid jeopardising the general funds by what might be considered a rival appeal, it was soon discovered to be a useful arrangement on other grounds. It afforded far more opportunity for acquiring medical missionary information than would have been possible otherwise, and indeed these special medical week-ends were often

used solely for education and inspiration, without any appeal for collections at the time.

A point of view which has sometimes been responsible for resisting the separate medical missionary deputation is that which prefers to look at the whole missionary picture at once, if possible, and to regard medical work in its place as a contributory part of the whole. This viewpoint is understandable, arising as it does from the main thesis for medical missions—that they form a facet of the fulness of the love of God and demonstrate in their own particular way His concern for the whole man. Ideal though it would be if the churches would study the working of the gospel as a whole upon man and society, it is nevertheless a fact that a broad view sometimes means a superficial view, and it becomes necessary at times to isolate individual parts for detailed attention and study. At all events, the separate medical missionary deputations proved to be of definite educational value in many groups, and only the difficulty of supplying enough speakers from the doctors and nursing sisters on furlough has prevented this plan from being used more extensively.

From 1904 onwards, exhibitions played a considerable part in spreading medical missionary information, and Dr. Moorshead was able to claim that the Auxiliary had, in fact, introduced exhibitions to the Society and had taught their value as an educational agency. He himself had visited Nottingham soon after assuming secretarial responsibility, and there, in a large united Free Church exhibition, he had been interested to find that the Baptists had the medical court allotted to them. This was but the beginning of great things, for in 1904 Ferme Park Church established a claim to be the first Baptist church to organise its own medical missionary

exhibition, and this resulted in the regular special support of Dr. Edith Young by that church. Groups of churches took up the challenge and, arising out of similar exhibitions in West London and Newcastle-on-Tyne a few months later, chains of support were started for Dr. Vincent Thomas and Dr. Mary Raw respectively. Other exhibitions took place at Burnley, Glasgow, Edinburgh, Perth, Southfields (for the Wimbledon district), Denmark Place (for South London), Cardiff, (for the support of Dr. John Lewis), Newport, Rawtenstall and Dundee—to name only a few. One of the most stimulating exhibitions of those early years was that held in Liverpool in 1909, when the aim of the local Baptist churches was no less than the provision of a whole hospital for Bolobo, on the Congo—an aim which was achieved by dauntless enthusiasm and quite remarkable planning on the part of the organisers.

Among the records of the Auxiliary's development there are several references to lantern lectures, which proved an effective form of visual aid to knowledge, for many years. A greater novelty, much in demand, was the Secretary's bioscope lecture. In the winter of 1905-06 he paid a visit to India to gain some first-hand knowledge of the medical situation, and in order to preserve a record of that visit he filmed scenes of the Indian background, of sufferers from various forms of disease, and of the missionaries at work. These 'living pictures' were employed as illustrations for a special lecture given by Dr. Moorshead in many different churches throughout the country.

Turning to written propaganda, one is impressed by the variety and scope of the output from the Mission House on the subject of medical missions from the earliest days of the Auxiliary. Soon after its formation,

a booklet was prepared entitled *Where is the doctor?* and the minutes of the Committee meeting when Dr. Moorshead attended for the first time as secretary record discussion on the best method of circulating this. The correspondence which began in a small way with local representatives gradually grew to such dimensions that a monthly news letter was devised to meet the need for current information, and this in turn was replaced in 1907 by a monthly magazine, *The Medical Missionary.* This magazine was sold at a halfpenny a copy and reached a circulation of 15,000; it provided much personal news of the doctors and nurses and their patients, as well as a wealth of fact about the situation as a whole on the field and the progress of the campaign at home. Undoubtedly it played a major part in the development of the M.M.A. in its four years of steadily increasing circulation. In 1911, however, the B.M.S. felt it desirable to do away with separate magazines and to concentrate on enlarging the *Missionary Herald,* the principal B.M.S. periodical, to include news of all branches of the work. Dr. Moorshead, looking back afterwards upon this particular change, felt that it marked the beginning of the policy of unification which was more fully developed later, but in spite of his natural reluctance to abandon such a useful instrument of propaganda, he recognised that there might be larger issues at stake, and adapted himself to the new plans with grace and constructive determination.

Besides the arrangement then made for regular medical news to appear in the *Missionary Herald,* there remained to the M.M.A. three main channels of print through which its claims might be made known. The first of these was through annual reports; the second, by special leaflets, each designed to pin-point one

particular aspect of the work; and the third was through the medium of the books written by Dr. Moorshead himself.

In the early years of the Auxiliary, records of its work appeared in the annual reports of the B.M.S. As the work grew, these were usually published separately, in booklet form, a digest of which still appeared within the Society's own Report, along with a statement of M.M.A. accounts. Between these annual records, which were both factual and personal, there appeared various pamphlets which ranged in scope from the apologetic type of medical missionary argument to the human interest story of an individual patient. Many of them were written from the field by missionary doctors and nursing sisters, and conveyed most graphically the challenge of the work as it grew.

It has been noted that, at the time of the Auxiliary's formation, the aim for its propaganda was set at a high level, so that supporters should be induced to act thoughtfully and prayerfully on its behalf. In many of the addresses, articles and pamphlets an outline was indicated of the true nature of medical missions, but such outlines were necessarily fragmentary, and the need was felt for something more co-ordinated and complete. 1913 saw the publication, therefore, of Dr. Moorshead's first book, *The Appeal of Medical Missions.* He himself called it

> "a humble attempt to restate the case for medical missions, and supply to the Christian public the main considerations upon which the enterprise is based, and from which its appeal is made to the heart and conscience of the home churches."

Others had their own comments to make. Dr. F. B.

Meyer found it "the most complete statement of the case, and altogether convincing," while W. Y. Fullerton, noting its "intensity of purpose and mastery of detail", predicted that for years it would be the standard of reference on the subject.[3]

When, about twelve years later, this book had gone out of print, and Dr. Moorshead was urged to have it re-published, he felt that there were new things to be said on the subject and that some of the old things needed saying in a different way; so instead of a fresh publication of *The Appeal,* an entirely new book was written, entitled *The Way of the Doctor.* This was brought out in 1926, the year of the Semi-Jubilee, and in spite of the many changes that have taken place since, both on the mission field and at home, it remains a most comprehensive and stimulating presentation of the medical missionary opportunity.

Heal the Sick, the last book Dr. Moorshead wrote, appeared in 1929, and will be referred to at a later stage. It is sufficient here to note that, although it was not designed for propaganda—being indeed a record of Baptist medical work up to the time of the M.M.A.'s Semi-Jubilee—yet its influence has probably been as far-reaching as that of any propaganda, for the story it told was itself a justification and an appeal.

What of the other means that were devised besides meetings, lectures, personal contacts and publications, to build up support for the Auxiliary? One of the first aids to methodical giving was the collecting card, introduced early in 1903, and soon afterwards this was followed up by the 'Pill-box' for which, as a family collecting box, there continued to be a steady demand for many years. Numerous were the suggestions made

[3] Quoted by H. V. Larcombe in *First the Kingdom,* p. 70.

for the use of the box, such as the putting into it of thank-offerings for health, for recovery from any particular illness, or for skilled help in time of illness. It was also recommended that the box should be put on the family meal table once a week (Sunday breakfast being the time specially indicated), as a reminder that the work needed regular support, in addition to all the occasional gifts that could be made; and many medical missionary supporters today can trace their first awareness of the cause to the presence and regular use of the pill-box in their homes when they were children.

It was soon evident that interest could fruitfully be sought on behalf of special projects and the missionaries associated with them. For the newly accepted medicals about to sail for the field, appeals were made for 'chains' of support, and, as has been noticed, special efforts such as exhibitions forged these chains of support both from auxiliaries and individual churches.

Before the founding of the M.M.A. a few beds and cots had received special support from groups in the home churches. One of the earliest of these was Heath Street, Hampstead, Sunday School, which adopted a bed at Bhiwani when the first hospital was opened in 1899. By 1906, however, there was sufficient of this interest to warrant the organising of a 'Bed and Cot' Department. The Honorary Secretary for this at the outset was Miss G. G. Hayward, who circulated any case reports that came to hand, and regularly published news of outstanding interest in *The Medical Missionary*.

Of the many plans devised to secure personal and regular contributions for medical work, probably none has appealed more widely than the Birthday Scheme. To Melbourne Hall Church, Leicester, belongs the distinction of inaugurating this, for it was Mr. Frank

Salter, a member of that church, who first suggested the scheme, and it was among that congregation that it was first tried out. The Rev. (afterwards Dr.) W. Y. Fullerton, at that time minister at Melbourne Hall, vigorously sponsored the new plan and reported its success to Dr. Moorshead who, quick to recognise a good idea, gave it publicity in the pages of *The Medical Missionary*. The experiment which had thus begun locally in the spring of 1909 was soon adopted by churches in all parts of the country, and was henceforward to be an accepted and valuable means of support for Baptist medical missions.

Original versions often persist long after changes have been made, and in the experimental Birthday Scheme there was one feature which, although almost immediately qualified, has lingered in some quarters, to the detriment of the Scheme's full effectiveness. This feature was the ruling of a standard contribution—a shilling—from all subscribers. Melbourne Hall Church had found it convenient to adopt this ruling, and in order not to hinder the spread of the Scheme the same figure was at first suggested in other churches, but it was suggested as a minimum and not as a fixed rate. It was pointed out that if every Baptist church member joined the Scheme and contributed at least a shilling a year, an annual income of £20,000 for medical missions would be assured by this means. Unfortunately, this goal of universal Baptist membership has never been reached, as there are still many Baptist churches which do not make use of the Scheme, and very few of the churches that do organise it can claim one hundred per cent support from their membership, even at the old minimum rate suggested of a shilling a year. It is a matter for thankfulness that these gaps have been partly

atoned for by the generosity of Birthday Scheme members themselves, many of whom have interpreted the idea of a birthday thank-offering in really noble terms. The disappointment remains however, that such a means of missionary support should be robbed of its effectiveness in any possible way, either by rigidly preserving a standard contribution or by failing to secure the maximum response from our Baptist church membership.

Although from a very early date all Birthday Scheme propaganda stressed the voluntary nature of the thank-offering and made no mention even of a suggested figure, it is likely that the tradition persisted because the Auxiliary had, at one time, another quite separate financial plan called 'The Shilling Scheme'. In this plan, collectors went to subscribers every month for the gift of a shilling, and in churches where at any time this arrangement overlapped with the Birthday Scheme, it is understandable that some confusion should have arisen. The confusion was, no doubt, unfortunate, but it helps to illustrate an important point in the history of the M.M.A.; the Auxiliary did not rely on any one system of securing interest and support, but was fertile in producing a wide range of ideas, so that every type of person might be reached in the most appropriate way. In one leaflet, issued in 1922-3, as many as eight different suggestions were made as to possible methods of support, and secretaries were given every help in planning a varied campaign.

A movement was started in 1905 to capture the interest of children in the work of healing, to keep them informed about it, and to enlist what practical help they could give. The promise had been made in the early days of the M.M.A. that no direct appeal should

be made to Sunday Schools; for that particular constituency would hardly have been able to contribute extra gifts for medical work, and any large-scale diversion of its money would have caused a serious gap in the general fund of the B.M.S. The new scheme, called 'The Children's Red Cross League', sought to make contacts of a more personal kind with boys and girls up to sixteen years of age, whose homes and upbringing were rooted in Baptist churches, and who could be appealed to for the use of their time, brains and pocket money, especially in making things and telling other people about the work of medical missions. (A list of suggestions made in *The Medical Missionary* for September, 1908, recommends, among other things, the keeping of 'missionary hens, bees, etc.'!) From the Mission House, contacts were maintained with these boys and girls, first by Miss L. Fox, and later by Miss Leonard; and thriving branches of the League were formed in several centres, notably at Coventry, Plymouth, and Ramsden Road, Balham. The organisation continued its activities till 1916 when, in the midst of the first world war, it became impossible to maintain the use of the title 'Red Cross League'. Thereafter, it was absorbed into the League of Ropeholders and other general branches of young people's missionary work.

No survey of early Home Base development in Baptist medical missions would be complete without reference to the 'Wants' Department. This came into being in 1904, to promote the contribution of hospital linen, clothing, splints, bandages and dressings. For many years Miss L. Head organised the receipt and dispatch of these, and through her own activity and the aid of a widening circle of working parties and individual helpers she saw the department grow until it was no

longer confined to medical support only, but carried an increasing responsibility for supplies to schools and to the work among women on the field.

It is one thing to enumerate the principal agents—both persons and methods—by which the M.M.A., though still a tender plant in years, developed such vigorous growth. It would be quite another matter to attempt to estimate what it owed to spiritual resources. From the earliest days it was nourished by prayer and personal consecration; and who can deny that these were, after all, the determining conditions in which the windows of heaven were opened and great blessing poured out?

Chapter Six

OVERSEAS GROWTH (i)

" And a great multitude of people . . . came to hear him, and to be healed of their diseases."
(*Luke VI*, 17)

On the field, the practical effect of the formation of the M.M.A. was not immediate or startling. The eight doctors at that time in the service of the B.M.S. and the B.Z.M. continued their work as before, though with considerably more hope of reinforcements in personnel and equipment. The many missionaries without special medical training, who had helped to fill the gap, welcomed with thankfulness the new era which would not only bring more adequate aid for the need constantly pressing upon them, but would also increase their own freedom and fitness for other work that was clamouring to be done. But for the time being—and, in some cases, for many years—they too continued their medical ministrations without any radical change.

A change that was very soon to affect the field, however, was the agreement in 1903, by the parent societies of the Auxiliary, that the term ' medical mission ' should in future only be applied to that portion of the work in charge of a fully qualified doctor. Although this bore some reflection on the past, there was no intention to disparage the medical work done by amateurs; the reflection—which could not be avoided—fell upon the policy which had allowed them to take such heavy responsibilities. For the future, it was to be a help to them to have a clearly defined standard in professional

qualifications, while not abandoning in any way the essential requirement of a missionary purpose in those men and women who should be appointed. To strengthen the effectiveness of this missionary purpose the committees of the B.M.S. and B.Z.M. decided in 1907 to institute special theological examinations for medical missionaries, and although these were never developed to any great extent, other ways were sought in which medical candidates might be adequately prepared for their work on the theological side. The Home Preparation Union and the missionary training colleges (in particular, Carey Hall, Selly Oak, Birmingham, which trains women candidates), have played a large part in this equipment of medicals.

As soon as the challenge of the newly-formed Auxiliary began to make itself felt in the churches, there were enquiries from medical candidates at all stages. With many of these enquirers helpful personal contacts were fostered by Dr. Moorshead, and for several years there was an Association of Baptist Medical Volunteers, united by their common purpose, and meeting occasionally to learn and confer about the mission fields.

Thus, as the years passed, a fairly steady flow of recruits was maintained. From 1901 to 1925 no fewer than fifty-eight doctors were accepted, of whom twenty-nine were appointed to China (where the loss of doctors by death was specially heavy), nineteen to India, and ten to Congo. The first world war to some extent checked the flow of recruits, as only five doctors were sent to the field in the years 1914 to 1918—an average of one a year; whereas for the rest of the period 1901-1925, exclusive of those war years, the average was nearer three for each year.

An important new type of recruit appeared

permanently in 1907. This was the nursing sister. Before the establishment of Baptist mission hospitals on the new basis, a good deal of nursing had been undertaken by missionaries' wives, but much of the burden had fallen upon the doctors themselves, with whatever native help they could secure.

> "In order to realise the immense relief and help it is to have a fully-trained and competent missionary nurse . . . one needs to have had experience of what it means to undertake a serious operation when the doctor must make or superintend all the preparations of instruments, dressings, patient, etc., must be more or less responsible for the administration of the anaesthetic as well as for the operation itself, and may perhaps, when it is over, have to sit up at night to watch beside the patient."[1]

With the coming of the properly-equipped mission hospital, it was vital to have nursing sisters who could not only look after patients and help to organise the general hospital work, but could supervise native helpers and institute their training. The M.M.A. was soon able to strengthen the work of the doctors by sending out women, many of whom had gained their qualifications at the finest nursing training schools in Great Britain. Even under the most difficult conditions these women set splendid standards of efficiency besides bringing to those whom they nursed and trained the invaluable Christian witness of daily and hourly understanding and patience. Between 1901 and 1925 fifty-three sisters were accepted.

We have seen something of the earlier situation overseas in relation to medical missionary work. It will

[1] Dr. Ellen Farrer: *Missionary Herald*, December, 1922.

now be appropriate to turn to the fields again, to trace some of the developments that took place as the M.M.A. gradually lengthened its cords and strengthened its stakes in the first quarter of the twentieth century.

(*a*) INDIA

One of the first concerns of the Auxiliary when it accepted responsibility for existing B.M.S. and B.Z.M. medical work was to strengthen that work as far as possible by improved accommodation and equipment. At the same time, the need for staffing reinforcements could not be overlooked, nor could the Auxiliary turn a deaf ear to all the appeals for new medical missions to be established. As support at home developed, the way opened for something to be attempted along each of these lines.

In the India field, Bhiwani now had its first small hospital for women and children, opened in 1899; but both men's and women's medical work at Palwal and the women's medical work at Berhampur were still handicapped by makeshift premises. The following statement was made by Dr. Vincent Thomas in his report for 1902-3:—

> "Until a hospital is provided, I shall always have to send away the greatest number of patients who come requiring operative treatment."

Dr. Thomas, who had gone to India in 1894, and had served at three other stations before being posted to Palwal, had found in each place as much medical work as he could possibly do, but in none of these stations was the opportunity more pressing than in Palwal. A busy town, centre of a wide village area in the south

Punjab, it afforded contacts with many types of Indians, particularly with the workers of lower castes. F. W. Hale, one of the most outstanding of medical amateurs, had worked there for several years before he was joined by the doctor in 1901, and altogether, the ground had been thoroughly prepared for further medical development. In spite of the inadequate accommodation, Dr. Thomas recorded for the year 1902-3 1,776 surgical cases, including sixteen major operations.

It was, therefore, a matter for rejoicing when the M.M.A. was able to recommend the building, at Palwal, of a hospital for men, the first major piece of consolidation undertaken in the history of the Auxiliary. This was made possible by the generosity of William Toole, of Oldham. His gift was offered in 1903 in memory of his daughter, a missionary enthusiast, who had recently died, and through the years the hospital has continued to be known by its foundation name, *The Florence Toole Memorial Hospital,* while later sectional additions each have their own commemorative names. Among these additions have been the operating theatre, contributed by Acton Baptist Church in memory of Dr. Garrett (a member of that church who had been a keen supporter of the M.M.A.), and the Sir Louis Dane isolation ward, given by the municipality of Palwal in honour of a Lieutenant-Governor of the Punjab.

In the new Palwal buildings which were opened in 1905 there was accommodation for twenty-six in-patients, but even though this was a great improvement on the former cramped dispensary quarters, it often proved inadequate for the many patients who had to be taken in and tended. In an average year of this period, in-patients numbered about 200; but in a year such as 1910-11, when there was an epidemic of phagedaenic

ulcers, close on 600 patients were accommodated and treated.

Additional strain was experienced in this particular outbreak, since Dr. Thomas was on furlough, and it was a plucky non-medical missionary who bore the brunt of the swarming crowds, the endless dressing of the ulcers, and the over-all responsibility. Mr. Hale was, of course, fortunate in having B.Z.M. staff (Dr. Young of the Women's Hospital, Palwal, and Dr. Bisset, from Bhiwani) to do amputations and any other major operating that was necessary; but the whole episode showed how insecure it was to carry on medical work with no margin in premises and personnel. In 1912 this insecurity was partially relieved by the appointment of a second medical man, Dr. A. E. Moore.

The next hospital accommodation to be improved was that at Berhampur, Orissa. Zenana and school work done by Miss Dawson had prepared helpful contacts with the community, among whom there were high-caste Hindus, Muslim cloth merchants and other traders, as well as village folk. These contacts had been strengthened by a young Anglo-Indian doctor, Nina Ottmann, who was appointed in the eighteen-nineties to the local Government Hospital, and who, though originally an Anglican, had applied for baptism and church membership at the Berhampur Baptist Church. In 1900 she joined the staff of the B.Z.M. and began a notable work in medicine and evangelism among women, though at first she was handicapped by having only a small dispensary in the town. The fact that there was a Government hospital close by might have made it seem unnecessary for a mission hospital to be built, but the success of the dispensary, where between seventy and a hundred patients attended daily, proved beyond a doubt

that medical missions were welcomed by these people, and this was confirmed when a group of high-caste Hindu men begged for a hospital for their own wives and children and other needy women of the district.

So, in 1907, under the superintendence of the Rev. F. W. Jarry, a B.M.S. missionary, who was head of the Boys' Orphanage in Berhampur, the hospital was built, with space for about twenty-four in-patients. The dispensary in the town was retained for some time for out-patient work, and the circle of influence widened, both in medical relief and spiritual blessing. Crises in staffing occurred from time to time, causing the hospital to be closed for lack of a doctor, but the nursing sisters and Bible women held the fort bravely and, through the continued service of the dispensary, retained the interest and goodwill of many patients.

Help was given by the Madras Government in at least two notable ways; first, in 1915-16, when new dispensary premises were required in the town, and again in 1924-25, when considerable additions were made to the hospital itself. On both occasions, not only did the Government make grants-in-aid, but real interest and co-operation were shown by their representatives, including the Governor of Madras, who opened the new 'Centenary Block' in 1925. (The centenary referred to was that of the Orissa mission, which coincided with the opening of the new block). These extensions, which principally affected out-patient accommodation, included a preaching hall where waiting patients could listen to the spoken gospel message. There was also a casualty room, equipped anonymously in memory of Sir Alfred Pearce Gould who died in 1922. Some rooms for private paying patients, and a V.D. block completed the

additional buildings, and not the least of the new amenities were a water system and electric light.

The women's hospital at Bhiwani, to which reference was made in Chapter 3, first benefited by the M.M.A.'s policy of consolidation in 1904, when Dr. Mary Raw joined Dr. Farrer. Since the building of the small hospital, opportunities had multiplied rapidly, and it had been found necessary to employ a Ludhiana-trained Indian doctor. An L.M.S. woman doctor had also been lent to Bhiwani at a time when Dr. Farrer's health was uncertain, but this help had to be withdrawn early in 1904, when the L.M.S. missionary was needed to start a hospital elsewhere, so Dr. Raw's appointment filled the gap left by her going.

In 1907-08 several encouragements came together. The first was a further medical recruit, in the person of Dr. Mary Bisset, whose arrival was shortly followed by that of Miss Gautrey, the first nursing sister to be appointed to the hospital. These reinforcements were most welcome, and they came at an appropriate time, for a new wing which had been under construction for some months became available for occupation in November, 1907, and a service of thanksgiving and dedication took place in March, 1908.

Of emergency times Bhiwani had its share, including years when bubonic plague occurred with tragic regularity, but the work developed steadily, with continuous claims upon all kinds of medical and surgical service, with a notable opportunity in maternity work, and greatly valued specialisation by Dr. Bisset in eye treatment. Miss Gautrey began systematic training of nurses soon after her arrival, and though her death in 1914 from typhoid fever was a great personal loss, she had nevertheless left a significant legacy to the hospital

in the tradition of service imparted to her young Indian trainees. So many continued to want training that once more the accommodation became too small, and after delay caused by the war of 1914-18, plans were formulated for a completely new hospital to be built, so that the old one could henceforth be used as a nurses' hostel and out-patient department. In January, 1923, this new hospital was opened, fittingly named after Dr. Farrer, whose whole missionary career was given to the witness of healing in Bhiwani.

It will be remembered that Baptist medical work among women in Palwal dated from pre-M.M.A. days. Though this had been carried on in premises that were not designed for a hospital, the scope of the work attempted was surprising. Dr. Edith Young, the first woman doctor to be accepted by the B.Z.M. after the formation of the Auxiliary, reported in 1908 that the annual total of in-patients had increased in three years from 202 to 315; while a nursing service, begun in 1900, but interrupted the following year when Miss Marion Butcher left for a nursing superintendency at Lahore, was resumed by the appointment in 1907 of Miss Lucy Fergusson. Some of the first impressions of the latter will give a glimpse into hospital conditions at that time:

> "One cannot help contrasting the difficult work and the serious operations which our doctors have to perform single-handed with the work done at home in an English hospital, where there are so many willing assistants . . . The nurses looked bright and attractive in their uniforms, and I was pleasantly surprised to find that they had been taught so much . . . The first patient I nursed was a woman suffering from plague. The difficulty was that we had no isolation ward, and

the only place vacant was the room used as the mortuary, so I prepared that and nursed the patient there. It was not an ideal place, especially as it was only a few yards from our dining-room!"[2]

After years of such restricted facilities, the new hospital of 32 beds, which was built on an open site outside the town and opened in 1914, was a source of much satisfaction. A special M.M.A. appeal secured contributions for this purpose, and the Government of India, in recognition of the work already done, provided funds for half the cost of building. The people of Palwal showed their own appreciation by the name which they gave to the new hospital—*Rahmatpur,* or *Abode of mercy.*

The first entirely new medical work sponsored by the M.M.A. began in 1904 when Dr. Orissa Taylor settled in the Chittagong Hill country in East Bengal. At first he made his headquarters at Rangamati and, with only two rooms in the house of another missionary, began to treat the many patients who came to him. The first major operation was performed on the bungalow verandah, and a bed was made up for the patient in one of the two all-purposes rooms. Later, a temporary dispensary was erected, of bamboo and matting with a grass-thatched roof, and similar small huts were put up near by to take in-patients—until there was no room on the land available for any further buildings. By that time Dr. Taylor had realised the direction in which the work was most likely to grow, and when it became known that money would be available for the building of a permanent hospital, the missionaries chose a site further down the river, at Chandraghona. Here a good brick

[2] *The Medical Missionary,* August, 1908.

building was put up, to accommodate between thirty and forty in-patients, all men or boys. In 1923, an extension was made to the original building, comprising a cholera ward and a special chapel for lepers, the treatment of whom had come to be an important feature of the hospital's work. The following year there was added a women's ward, as by that time it was apparent that general hospital service must be made available, and, in the person of Miss Timmins, the first nursing sister was appointed to Chandraghona.

This hospital, the first of the new medical projects undertaken by the M.M.A., came into being through the allocation of money from the Arthington Fund. Robert Arthington, of Leeds, who during his lifetime had made many contributions to the B.M.S., had left at his death a large sum of money to be spent on new missionary undertakings within twenty-five years. This fund was now being administered by various committees. Other branches of B.M.S. enterprise received great benefit from the fund; and on other fields, as we shall see, the M.M.A. was enabled from this same source to plant new centres of healing. Chandraghona Hospital, being the first of these, took the name of its benefactor.

On the women's side, new work was started in 1908 by Dr. Raw, when her place was taken at Bhiwani by Dr. Bisset. Dholpur, a city of 19,000 inhabitants, was the capital of a state of the same name in Rajputana, and though it possessed a well-equipped State hospital under the care of a Bengali doctor, the familiar story was repeated, that women of the higher castes would not let themselves be treated by a man, and so the hospital availed them little. The B.Z.M. had been asked to open a school for girls to supplement what was already

being done by a native preacher who was supported by the B.M.S., but no suitable worker was available at the time and the opportunity was lost. Dr. Raw, with Miss Eekhout, a woman evangelist, sought to recover some of this loss when they took up residence, first of all in premises that were over-run with rats, and later in a house that was just as much over-run with monkeys! Dr. Raw opened a dispensary with a Hindu woman as a helper, and had to endure the visits of the merely curious, as well as the disgust of those whose arthritic friend was not completely cured within four days. But it was not long before the tide turned, and the factor that popularised this medical venture was an emergency operation performed at the end of a verandah, with instruments and dressings for which Dr. Raw had had to telegraph to Palwal, since the friends would not hear of the doctor's suggestion that the patient ought to be taken to hospital. Though the conditions were so far from ideal—soup plates and tureen being used to hold sutures and instruments—yet the operation was successful, and its influence upon the work was almost instantaneous.

> "In an amazingly short time the news had spread . . . people came from the city in much greater numbers, and even from the villages twenty and forty miles away."[3]

In 1914 this venture received further recognition by the opening of a new building, known as the *Lady Hardinge Hospital.* The building was provided and largely maintained by the State—a token of local appreciation for the work previously carried on—but the missionaries were given freedom in organisation.

[3] *The Medical Missionary,* May, 1908.

The hospital afforded beds for 16 patients, and gave fine opportunities for healing and evangelism, both to Dr. Raw and to her first medical colleague in Dholpur, Miss Marion Henry (afterwards Mrs. J. I. Hasler), who for several years worked there as a nursing sister.

The centres already mentioned were either chosen or retained by the M.M.A. on account of their accessibility and benefit to wide areas, but even so the missionaries realised how many needy people were beyond the reach of this centralised help. Transport was costly for the villager, unless friends would take time and trouble to carry him; the latter method could not be guaranteed, and in any case it was of necessity slow. Many patients reached hospital too late, in similar condition to one who journeyed on his hands and knees two miles a day for twenty-five miles, and on arrival was almost too ill to swallow water. The recurrence of this kind of case influenced doctors to open branch dispensaries in connection with several of the hospitals. Indian Christians with some knowledge of medicines and dressings were placed in charge, as a rule, and regular visits were paid by the doctors so that difficult cases could either be adequately treated on the spot or taken back to hospital.

More concentrated dispensary work was undertaken in selected areas where doctors or nurses went into residence with the purpose of establishing a bridgehead for developing full medical service. Such bridgeheads were located at the following places:—in 1909, by Dr. Ottmann, at Russellkonda, Orissa, from which the earliest medical contacts were made with the people of the Kond Hills; in Balangir, also in Orissa, where a ministry begun by Miss Isabel Angus for the outcastes who had become Christian was taken over in 1921 by Miss Soper

(formerly nursing sister at Berhampur), and greatly strengthened by the arrival of Dr. Muriel Fellows in 1925; in Patna, where for a short time Dr. Newman Darling was stationed; and in the South Lushai Hills.

The last-named of these centres had needed medical aid ever since the earliest days of Baptist pioneering among these hill people, who were then head-hunters and without any but the most primitive knowledge of health. Though evangelism began there in 1903, it was not until 1919 that a trained nursing sister, Miss Dicks, started work in the district. She was joined in 1922 by Miss Oliver, and in 1923 a ward dispensary was opened with room for ten in-patients. It was hoped that a resident doctor would soon be appointed, but that hope has never materialised, and occasional visits from the Chandraghona doctors have been the chief means of dealing with surgical cases. Apart from these, the nursing sisters have carried on an extensive service in maternity and child welfare, in the training of Lushai nurses, and in general health education.

(b) CHINA

As in the India field, so in China from 1901 to 1925 one can trace how M.M.A. policy and support strengthened existing medical work and gradually launched new projects to meet urgent needs.

In point of time, the opening of a new hospital building at Chowping was the first development that took place after the formation of the Auxiliary, but this plan had been in the making for several years. The money had been raised through a special appeal approved by the B.M.S., and in 1897 a site was bought by Mr. Smyth, the evangelistic missionary who had been responsible for the appeal. Dr. Paterson, until then working at Ching-

chow, was appointed to Chowping, and he superintended the building of the hospital. When it was opened in 1903, accommodating 30 patients, the M.M.A. was relieved to know that Dr. and Mrs. Paterson now had better facilities for their work than had been theirs at any time in their previous years in China. Though the hospital was destined to have a comparatively short existence under B.M.S. auspices, it proved its worth in demonstrating the gospel, and in enabling Dr. Paterson to give useful training to a number of Chinese medical assistants.

The oldest B.M.S. medical work in charge of a doctor in China was that at Chingchow, where Dr. Russell Watson and his wife had served since 1885. All that time, however, only rented premises had been available, and there was no opportunity to extend in any way, though Dr. Watson had been assiduous in training Chinese Christian medical helpers, as far as possible. Special funds were allocated by the M.M.A. in 1907-09 for a new building, and this hospital, opened in 1910, was able to house between forty and fifty patients. For the first time in Mrs. Watson's experience in China, provision was made for women in-patients, most of whom had previously had to be turned away, and to help cope with the opportunities and demands of the new building, the staff was strengthened in 1909 by the appointment of a nursing sister, Miss Margaret Logan.

The next of the existing B.M.S. medical missions to be developed by the Auxiliary was that in Sian, the capital city of Shensi, where a strong team of doctors was gradually assembled. Dr. Creasey Smith, who had opened the medical work in 1898, in a Chinese house in the city centre, was joined first of all by Stanley Jenkins in 1904, then by Andrew Young in 1905,

followed by Mrs. Young in 1907, G. A. Charter in 1908 and—last of that memorable group of pioneers—Cecil Robertson, in 1909. Miss Cumstock, the first nursing sister appointed to Sian, unfortunately broke down in health when she had been there only a few months, but before the end of 1908 Miss Helen Watt had been accepted and posted to Sian in her place. The work grew rapidly, and the spiritual influence of the hospital was extended by systematic follow-up visits, paid by the Chinese evangelist to former patients in their homes.

The building up of the staff made it possible for Dr. and Mrs. Young to move to San Yuan, where there was every promise of a fruitful field for medical work, and where a grant from the Arthington Fund should have facilitated the building of a small hospital in 1911. Before they had been able to erect more than a doctor's house and an out-patient dispensary, however, the Chinese Revolution which began in October, 1911, put a stop to all permanent building schemes and created such a state of emergency that Dr. Young and his wife felt obliged to return to help at Sian.

The Sian hospital, which contained about thirty-eight beds and consisted, as Dr. Charlotte Young put it, "of a conglomeration of Chinese houses and court-yards, with intervening walls knocked down and built up to suit the general uses of the place", played no mean part in this emergency, for with combined military and civilian casualties the hospital was inundated with patients. Fifteen hundred people suffering from serious wounds were treated as in-patients in the weeks that followed, while the out-patients, sometimes numbering 600 a day, mounted to a still more staggering total. Dr. Jenkins was on furlough at this time, so that the strain of the emergency fell heavily upon staff as well as on

the accommodation and hospital equipment. Immediately after the disorder began, the city walls were closed, and Dr. Robertson who had been visiting the missionaries in the East Suburb mission premises, outside the gates, found himself cut off from the hospital. He was admitted to the city in unorthodox fashion, being hauled up by rope over the high city wall. This incident was only one among many hazards and tests of faith and endurance common to all the medical staff in those trying weeks, for not only was the hospital itself used to the full, but requests came in for skilled help for the wounded from places as far away as a three days' journey.

What this mission hospital staff accomplished in the dust and heat of emergency was not forgotten by the Chinese people when quieter days returned. Even some who had been violently anti-foreign and anti-Christian acknowledged the quality of this service, which was distinguished by love, integrity and high efficiency from the local medical efforts, even those of the Chinese Red Cross. When the hospital, little more than a year later, experienced sore bereavement in the sudden deaths from typhus of Cecil Robertson and Stanley Jenkins, there were many Chinese who shared in that loss in deep personal measure, and it was in gratitude for such service that the Sian authorities gave the mission a fine site in the city where a new hospital could be built. This new hospital (which had been one of the cherished aims of Dr. Jenkins and Dr. Robertson) was helped by a grant from the Arthington Fund, and was eventually opened in 1917 with these heroes of the faith commemorated in its name—*The Jenkins-Robertson Memorial Hospital.* Thus there came to the Sian medical mission new life out of death.

Medical work in Taiyuan, the chief city in the province of Shansi, had its own story of loss and gain in these years. Though older in origin than the Sian Baptist medical enterprise, it was not linked with the B.M.S. until 1902. In 1880 Dr. Schofield of the China Inland Mission had begun medical work in Taiyuan, but after only three years he died of typhus, and Dr. E. H. Edwards, who had been stationed in Szechwan, was asked to take his place. For fifteen years Dr. Edwards worked there, as a representative first of the C.I.M. and then of the Show-yang Mission after the former society had transferred to the latter that section of its work based on Taiyuan. The Boxer Rising of 1900 was responsible for the death of 159 foreigners in the province of Shansi, among them all the missionaries of the B.M.S. who were at work in the province, and all those belonging to the Show-yang Mission, except Dr. Edwards, who with his wife and family, was on furlough. As both missions were so depleted, it was decided to amalgamate for greater effectiveness. From 1902, therefore, till his retirement in 1922, Dr. Edwards was an associate member of the B.M.S. staff in Taiyuan, and to his leadership must be attributed much of the medical missionary development in that city, especially among men patients.

His first task was to rebuild the hospital which had been destroyed, together with almost all other mission property, in the Boxer outbreak. This he undertook with the help of private funds, and to assist him in the medical service, at the same time as the actual building was going up, he invited two young doctors to join him as associate missionaries of the B.M.S., supported too by private funds. The first of these was Benjamin C. Broomhall, who went to Taiyuan in 1903; the second,

Harold Balme, was added to the team in 1906. By the close of 1907 the Schofield Memorial Men's Hospital was ready for use, and the M.M.A., which had followed all these recent events with the greatest interest, was stirred and challenged to learn that Dr. Edwards had presented this building and its equipment as a gift to the B.M.S. As a result of this challenge, the Auxiliary received sufficient, by way of special contributions during the next two years, to add two new wings to the hospital; and with the appointment in 1909 of Dr. John Lewis (the first M.M.A. missionary from Wales) and Miss Ellis, as nursing sister, the work of the hospital made striking progress. Evangelism was the constant aim of the staff, and for some time a Hospital Enquirers' Class was organised, in addition to the other evangelistic agencies.

The war of 1914-18 brought acute staffing difficulties, and in 1916 and 1919 great sorrow came to the hospital through the deaths of Dr. John Lewis and Dr. George Edwards (son of the hospital's founder). Both these workers had been carrying very heavy burdens of work and responsibility, with no other doctor at hand to share the strain, and the lesson was grimly underlined that full strength of staff, regular reinforcements and furloughs were all essential to keep a medical mission running without breakdown. Mercifully, Chinese medical assistance was forthcoming for a time, and the non-medical missionaries at Taiyuan gave valued help with the finance and general administration; otherwise, the hospital would have had to be closed.

In 1924 a disaster of a different kind occurred. Almost the entire building was destroyed by a fire which burned for about twenty-four hours. All the in-patients were removed to safety, and some stores of bedding and linen were saved, but the laboratory, operating theatre

and four wards were demolished, and the work severely crippled thereby. There was no alternative but to attempt reconstruction immediately as the need for the hospital was so great. A two-fold S.O.S. was sent forth —for funds and for personal practical help—and both met with a heartening response, in China as well as in Great Britain. Particularly moving was the way in which Dr. E. H. Edwards, now retired and nearly seventy years old, accepted the plea of the Taiyuan station committee that he would return to China to help Dr. Clement Stockley and the hospital matron, Miss Cropley, with the work of re-building (for him this being the second experience of radical reconstruction). By 1926 the new building was completed.

Side by side with the medical service for men, there was in Taiyuan from 1907 onwards provision for Chinese women patients. Dr. Paula Maier and Miss Katherine Lane were appointed for that work, being, respectively, the first single woman doctor and the first nursing sister to be sent to China by the Baptist Zenana Mission, though for many years that society had sent women evangelists and teachers there. Plans were passed for the building of a women's hospital, with a grant from the Arthington Fund, and while they awaited the completion of this building, the new recruits made what practical beginning they might in temporary quarters. In one group of patients described by the doctor there were ailments of all kinds—Bright's disease, gangrenous feet (affected by the old Chinese practice of foot-binding), fractured leg, tumour, and tuberculous ulcers. Many of the cases were not brought to hospital until it was too late to do anything for them—the oft-repeated cry from the mission field in those days when there were such mountains of ignorance and lethargy to be moved

—and the women were often the worst sufferers because it was not considered necessary to bother about them. So their wonder and gratitude were sometimes pitiful to see, and their response to the gospel a matter of great joy. The doctor, reporting on what had been done for the wife of an official, said

> "She came to the hospital . . . an opium eater. The amount of opium she took a day was larger than any I had come across. When she left, cured, she looked different . . . for the Word of God had taken hold of her."[4]

The Arthington Women's Hospital was opened in 1912, and about three years later a beginning was made in the training of nurses by Miss Annie Rossiter and Miss Gertrude Jaques. Their first candidate for training was a well-educated girl who had been a patient in the hospital, and it was felt that such an example might bring forward many more Chinese girls for a vocation that was then despised by the Chinese people. In November, 1919, the first Taiyuan graduation ceremony for nurses took place at the hospital when three nurses who had qualified were presented with their certificates.

One of the most interesting developments in China to be sponsored by the M.M.A. in its early days was the founding of a Christian Medical College at Tsinan, the capital city of Shantung province. It was planned that this college should be a unit of Shantung Christian University and that it should be organised jointly by the B.M.S. and the American Presbyterian Mission. The Arthington Committee voted a capital sum for building and equipment, and the B.M.S. sought medical men who would co-operate on the teaching staff of the

[4] *The Medical Missionary*, February, 1911.

college. The first recruit for this special work was Baron von Werthern, a German doctor who had seen something of the need of the east for Christian medicine. He and his wife worked at Tsinan until 1912 when, owing to his enforced retirement through ill-health, his place was taken by Dr. Harold Balme who for sixteen years gave outstanding service to Shantung Christian University in general and to the training of Chinese Christian doctors in particular.

The small hospital attached to the medical college and in use from 1911 was rapidly outgrown, and an appeal was made for a carefully planned and well equipped teaching hospital. Again the Arthington Fund was able to help, but the greater portion of the money came from funds specially raised by the Auxiliary. In 1915 this new hospital of 100 beds was opened, and the opportunities were at once increased for effective medical teaching, for nursing training and for hospital evangelism. Miss Logan, who had moved from Chingchow to Tsinan in 1913, had begun almost at once to train Chinese girl nurses, instituting, in fact, the first nursing training school in connection with B.M.S. work in China. With the advent of the new hospital it became possible to train male nurses too, and generally to improve the standard of training. Co-ordination and advance in hospital evangelism were facilitated by the appointment of the Rev. William Pailing who had theological as well as pharmaceutical qualifications and who served the hospital as chaplain and pharmacist.

The widening influence of the Medical College was felt also in the use made of it by the China Medical Board of the Rockefeller Foundation. This Board, which was the governing body of the Union Medical College, Peking, decided in 1915 to send certain classes

of students to Tsinan and to make appropriate grants in acknowledgement of this arrangement. Teaching at the Peking College was in English, but at Tsinan in Chinese, and for many students the completion of their course in Chinese was an advantage. The following year, as a result of consultation in the China Medical Missionary Association, a decision was taken to concentrate medical school facilities at Tsinan. As this meant the closing of medical schools at Hankow and Nanking, in which other missionary societies had had a share, the help that had previously gone elsewhere now came to Tsinan, so that it developed into a much broader co-operative venture. By the end of the first world war, Joint Boards for Shantung Christian University had been formed in the United States and Great Britain, the British Board including representatives of three other missions besides the B.M.S. Some of the experiences and opportunities belonging to these years of expansion were recorded by Dr. Balme in his book *China and Modern Medicine*, published in 1921. In 1923-24 two further major developments took place—the opening of the Medical College to women students, and the granting of a charter by the Canadian government, giving Shantung Christian University the right to confer degrees of recognised standing. A Board of Governors was appointed representing the United States, Canada, China and Great Britain.

The last of the new medical developments in China in the period under review (1901-1925) came about at Choutsun in Shantung. As far back as 1877 this busy centre had been noted by our missionaries as a promising location for evangelism, but so strong was its anti-foreign mood at that time that it was considered wise to make a beginning elsewhere in the neighbourhood, while hopes

were entertained that the situation at Choutsun would change. By 1903 the door had opened sufficiently for missionaries to take up residence there, and as the opportunities grew it was recognised that there would be far more scope for a medical mission in Choutsun (through which now ran a main railway line) than in Chowping, which for years had served as an alternative. Therefore, to the plea made by the M.M.A. in 1913 for funds for Sian and Tsinan there was added an appeal for about £3,000 more—the sum that was needed (in addition to realisable assets at Chowping) to build a new hospital at Choutsun. This great opportunity called forth great generosity, and the whole sum required for Choutsun was offered almost at once by Charles Foster and his family, of Cambridge. Named after this family, the new hospital was opened in 1915, with Dr. Russell Watson and Dr. John Jones at first in charge. The Choutsun mission work as a whole was strengthened by the hospital, the more so as time went by and an increasing community of patients came within reach of the gospel. Though staffing problems caused the closing down of in-patient work for a time, the reputation of the hospital was steadily built up, not least through the fine tradition of nursing service started by Miss May and carried on in the Nurses' Training School which was established in 1923 by Miss Walker.

The first twenty-four years of the M.M.A.'s life brought certain disappointments in China as well as rejoicing. Plans were made for new medical missions which were either never attempted or else—harder still—were begun in high hope and had to be suspended. The San Yuan medical work was an illustration of promising beginnings whose maturity seemed to be arrested. Started by Dr. and Mrs. Andrew Young in

1911, it had to be abandoned by them until after the 1914-18 war, though Dr. Charter was instrumental in completing some of the hospital buildings and opening them in 1917. Scarcely had Dr. Young settled down there again when the mission was suddenly bereft of him, owing to his death from typhus in 1922. The loss came with especial force to San Yuan because of all that he had hoped to accomplish there; but a rich and positive contribution had been made at Sian, and all who knew anything of his missionary purpose, instead of dwelling upon the disappointment, gave thanks for what he had been enabled to do.

In three other centres, beginnings were made which could not be sustained, chiefly owing to lack of staffing reinforcements. At Sinchow, Dr. Charter worked for three years, outlining most useful possibilities for a dispensary and district service. Taichow similarly had Dr. Kirkwood for a short time in 1914, when he obtained Chinese premises and started to adapt them for hospital work. His breakdown in health obliged him to withdraw, leaving the foundation of a medical mission which was never developed. A third centre was that at Yenan in north Shensi, where medical work was entirely lacking until Dr. Scollay went there in 1914. The fact that the nearest medical help to Yenan was then eight days' journey away made it desirable for the other missionaries there to have the benefit of a resident doctor and hospital. But staffing needs at Sian called the doctor away from Yenan the following year, and before he could return to take up the work he fell a victim to the world scourge of influenza in 1918. No subsequent replacement at Yenan was found possible.

(c) CONGO

The formation of the M.M.A. in 1901 found B.M.S. work in Congo without any qualified doctor. The amateurs, with their dispensaries and district work, had put up a magnificent fight against African disease and superstition, and there had been some remarkable results. At Yakusu, for example, 10,000 cases of one kind and another were dealt with in the year 1902-03, and in reporting this S. O. Kempton added:

> "As we have doctored several chiefs and one medicine man during the year, I think we can truly say we have knocked a few more nails into the coffin of witchcraft."[5]

At Wathen, too, in the same year, John Bell reported more than 11,000 patients who, though there had been no doctor on the station since Sidney Webb's death in 1895, remembered the help that had been available then, and still came crowding to the dispensary for medical assistance.

It was not long before the Auxiliary Committee received appeals to establish medical missions, on the new basis, in the Congo field. The dimensions of the need had grown beyond the power of the non-medical missionaries to cope with, both numerically and in specialisation, and case after case had to be sent away without help, because of the lack of proper hospital facilities. H. Sutton Smith, of Yakusu (where a district population of not less than 150,000 was dependent on one small dispensary manned by non-medical missionaries) described how a patient who should have had hospital care recovered without it.[6] She "made her own

[5] *B.M.S. Report*, 1901-02.
[6] *The Medical Missionary*, November, 1908.

arrangements to stay near the dispensary so that she could have daily treatment", but those arrangements simply meant that she slept in a canoe on the river beach, night after night, without any of the attendance or help that she so much needed. All too many others suffered disappointment and death and, what was hardest knowledge of all for the missionaries, in many instances the patients and their friends reverted to native medicine, with its dark beliefs and equally dark effects.

In 1902-03 Miss de Hailes saw 19,000 patients at the Bolobo dispensary, in the following conditions:—

> "There are many who beg to remain while they are ill, but I am obliged to turn them away until the hospital is built . . . One poor man settled himself for the night under the house and nearly set it on fire. I did not know he was there, having told him to go away, as I had nowhere to put him; but he crawled in and made a large fire, as it was a cold, wet night . . . One seems sometimes to live in the midst of death."[7]

The shadow that, more than anything else, accounted for the impression of being surrounded by death was sleeping sickness. In many parts of Congo this was not simply an incidental disease, recurring occasionally and forming a background to the pattern of African life. It was a deadly and seemingly insatiable scourge that emptied whole areas of population and threatened the existence and future of the young Congo Church. At Upoto, in 1902, William L. Forfeitt reported the spread of this dreaded evil, lamenting the fact that the missionaries were almost powerless to stop it. All they could do was to urge the necessity of guarding against

[7] *B.M.S. Report*, 1902-03.

contagion—a difficult course of persuasion in the closely-knit society of tribal life. The same year this appeal came home from C. J. Dodds:—

> "We would that someone of skill in these days of medical science and investigation would come out and study the hidden plague. Cannot the B.M.S., the largest mission on the Congo, have a medical representative here who will devote his time and energies to the discovery and, under divine blessing, to the cure of this dire malady?"[8]

The specific wish expressed here was to be fulfilled in later years, when the B.M.S. medical missionaries had a considerable share in sleeping sickness research, but in the meantime the general need of Congo was finding a response in medical recruits, and by 1907 the first M.M.A. doctor for Congo was appointed to San Salvador, the oldest B.M.S. station on that field.

Upon his arrival in Africa, the new recruit, Dr. Mercier Gamble, first attended a United Missionary Conference at Stanley Pool, and from there he was taken to his station by R. H. Carson Graham, who described the journey thus:—

> "The people had heard that the doctor was coming, and at many places on the three days' journey between the railway and San Salvador they had carried their sick folk and laid them by the side of the path we should follow, till the doctor almost wept with the pity of it all, for we had few remedies with us, and most of these sick needed extended treatment and careful nursing."[9]

After the doctor's first few months of work there, another missionary colleague stated that never before in

[8] *B.M.S. Report,* 1901-02.
[9] *The Fight for Health in Congo* (booklet), p. 7.

the history of the Congo mission had so many people "felt the touch of Christian human kindness" or heard in such a short time the message of the gospel. Within the first year of the doctor's taking up residence, 25,000 contacts were made with people from a large district round San Salvador.

> "And such people! The fame of the doctor had drawn to San Salvador the human wreckage of Congo . . . There they sit, outside the dispensary, poor, wretched, crippled, disfigured."[10]

The widening opportunities that followed the coming of the doctor were used to still greater advantage when, in 1909, the first nursing sisters, Miss A. Jackson and Miss A. H. Bell, were appointed. As the station was still without a hospital, some of the local Christians offered the shelter of their houses for the care of patients who visited the dispensary and were in need of continued treatment. Miss Bell recalls what a help it was to have these generous offers of accommodation, but at the same time how difficult was the task of nursing patients in scattered huts, where they lay on the ground, perhaps wreathed in smoke from the wood fire and, between the nurse's visits, entirely dependent upon ignorant though well-meaning helpers for the administering of medicine or treatment. Two scenes described by Miss Jackson will serve to show the kind of demand made upon the medical staff before a hospital was provided. By this time (1911) they had a rough and ready native hut which was called 'The Sick House', divided into several minute rooms. A man was brought in late one night with a fractured femur, and the nursing sisters prepared the splint while the doctor got the man into the Sick

[10] The Rev. W. Wooding.

House. A bed had to be improvised on a table; for a pulley they had to use an empty cotton reel and for weights a couple of old flat-irons. To make room for this incoming casualty another patient had to be turned out, and the following day the new patient himself was moved elsewhere because of the arrival of another serious case.[11] The other scene was an operation performed in a native hut, about four by four-and-a-half feet, lit only by candles held by two of the station helpers, one at the head and one at the foot of the bed.[12]

The satisfaction of being able to help sufferers, even under such conditions, must have been very great, but the strain was equally great, and when the hospital arrived there was the utmost relief and rejoicing. It was a literal arrival, for it was sent out from this country in 1,000 sections, was unloaded at the port of Matadi and then carried by porters through the bush to San Salvador. Each load weighed about sixty pounds, and it took the native carriers anything from three to six weeks to complete the journey. The arrival and assembling took place over a period of nearly two years, and by 1914 the hospital buildings were completed, accommodating twenty-four in-patients. The project had been substantially helped by a grant from the Arthington Fund and by the willingness of the Portuguese government to negotiate over land for the hospital site; part of the latter was, in fact, a free gift.[13]

[11] From a letter.

[12] *The Medical Missionary,* November, 1911.

[13] Relations with the Portuguese government were not always so good. In 1913 and 1914 the work of the hospital—as of the whole mission at San Salvador—was seriously affected by the war between the Portuguese and their African subjects, arising from the employment of forced native labour. The missionaries did all that was in their power to secure better conditions for native workers.

With these additions in staff and equipment the medical mission at San Salvador was better able to tackle some of the radical health problems of Portuguese Congo. In the treatment of sleeping sickness and yaws experiments were made which contributed towards a common study of these diseases by British and American missions, and much was accomplished in temporary alleviation and even in partial cures. Best of all, the victims of these diseases were shown Christ-like love and care, and even if they could not be made whole they were no longer all left to die without hope.

Native helpers, both boys and girls, gave assistance in the hospital from the earliest days, and in 1924 systematic training of nurses was begun. The girls and women were most needed for midwifery, while the boys learnt to do dressings and simple dispensing, to give injections and anæsthetics and to use a microscope.

In the same year that Mercier Gamble arrived at San Salvador, the foundations that had been laid for a medical mission at Bolobo received their first direct addition from the M.M.A. in the appointment of Dr. E. C. Girling, who was adopted by the Birmingham churches as their first 'Grenfell Memorial Medical Missionary'. Bolobo was then regarded as being in the Upper River area, and during the twelve years that Miss de Hailes had been working there, patients from all over that area had come in increasing numbers for what help she could give. Though without medical qualifications, she did a remarkable work, and it was to her efforts and appeal that Bolobo owed the erection of 'Melbourne Hall,' a building contributed by, and named after, Miss de Hailes' home church in Leicester, and used first as a dispensary and later as a small temporary hospital.

Dr. Girling's organisation of the medical work showed how great was the need for adequate buildings. A missionary colleague commented on an operation he had seen undertaken by the doctor "in a fearfully hot building, with his patient on an old wooden table which had been made to serve as an operating table by having the leg rest of an old cane deck chair lashed to it." The final comment was: "It is fair neither to patient nor doctor to have to do such things. The crying need is for well-equipped sanitary buildings in which patients can be treated properly."[14]

The call for funds for a new hospital was answered by the Liverpool Missionary Exhibition of 1909 (already mentioned in Chapter 5, though it was not until 1912 that the hospital with thirty-six beds for in-patients, was ready. The year following its completion, the B.M.S. appointed Miss Kate Clappen as Bolobo's first qualified nursing sister, and thus the medical work set out upon a new era of fruitful service. From time to time, and particularly between 1915 and 1920, there were acute difficulties in connection with staffing. For long periods no doctor was available, and the reputation of the hospital was kept bright in the minds of the Congo people by the devoted achievements of Miss Clappen and—when she was absent on furlough—of Miss de Hailes who had already proved herself such a successful amateur of medicine.

By 1925 the total attendances of out-patients had reached a record figure of 57,000, and the key position of Bolobo as a mission centre was revealed, not only by the actual numbers coming for treatment, but by the distances and different directions from which they came,

[14] The Rev. Frank Longland: *The Medical Missionary*, April, 1910.

and the consequent contacts for the gospel with a wide variety of people.

> "About seventy per cent of the cases are strangers, and the medley of languages is amazing. The staff get the opportunity of reaching many hundreds of natives from French Equatorial Africa, who do not otherwise come under the influence of evangelistic work.'[15]

The gratitude of these Congo patients for medical assistance was most frequently expressed in behaviour, by their naive and often pathetic confidence in the doctor's 'magic'; but sometimes they would express in words their indebtedness, both to the sacrificial service they received and to the power of God which sent and sustained the doctors.

> "To my doctor of love, Dr. Girling,—I am with a great desire to write you this little letter to remind you of the palavers of grace which you did for me when I was ill."
>
> "Doctor, God does help you very much indeed in your work."

And again:

> "But for you we should all soon die; we are indeed saved through you."

That this last remark was true in the deepest and best sense was abundantly proved by the staff of the Bolobo hospital who, even in most trying external conditions, were privileged to see Congo men and women submitting to Christ to be made whole.

The exploration of central Africa by George Grenfell and the growing interest of the churches in the Congo Mission made the B.M.S. approve the opening of

[15] *M.M.A. Report*, 1924-25.

stations hundreds of miles from its original Congo work, and by 1896 the Mission was established as far inland as Yakusu. The site chosen was significant—a junction point of routes from north to south and east to west through Africa, and the place where no fewer than five tribes converged. From the outset, B.M.S. missionaries found themselves dealing with an area larger than Wales, and it may therefore be imagined how great was the opportunity for medical work, with its out-patient and district contacts and its magnetic power to draw folk towards the mission station.

Non-medicals like William Millman and Sutton Smith did all that was humanly possible to meet the demands of such a situation, and later on an occasional visit was paid by the Bolobo doctor; but though Bolobo and Yakusu were both considered to be Upper River stations, they were 800 miles apart, and Dr. Girling, in 1909, when on one of those visits, wrote home:—

> "Where is the Yakusu doctor? The opening here . . . is grand. The people are willing for treatment, especially for surgery; a hospital can soon be put up—in fact, the bricks are already burnt. The neighbourhood teems with people . . . and it is no exaggeration to say that a good doctor here might prolong hundreds of lives and give relief to thousands, and be the means of bringing many a heathen soul to the knowledge of the love of Christ."[16]

In 1910 hopes were raised by the appointment of the first B.M.S. woman doctor to Congo, Dr. Daisy Longland. It was intended that she should join her husband, who was already in the service of the B.M.S., and that Yakusu should be their location, but before

[16] *The Medical Missionary*, September, 1909.

these hopes could materialise it was found necessary to retain Frank Longland at Kinshasa, on the lower river, and his wife's skill was therefore directed into dispensary work in that growing trading centre. Once more Yakusu was left to repeat its plea to the M.M.A. for a resident doctor, and even though that particular plea could not be answered at once, other steps were taken to strengthen the medical work in the far Upper River area. A small hospital, built in memory of a former Yakusu missionary, W. H. Stapleton, was put up in 1911, and the same year two appointments were made that influenced general medical developments on the station. The first was that of Miss Rose Gee, a nursing sister, and the second was that of A. G. Mill, a non-medical missionary who had, however, had training at Livingstone College and sought to increase his usefulness by obtaining the Belgian Diploma of Tropical Medicine.

The constitution of Yakusu as a full medical mission was delayed until the arrival in 1920 of Clement Chesterman, who had been appointed the previous year. Though having qualified some years before, he had been engaged in distinguished army service in the first world war. His ability and experience soon marked out Yakusu for notable development in medical missionary work, and by 1924 plans were in hand for at least three major ventures—for a new hospital, for the training of African medical assistants, and for the opening of a series of district dispensaries in the Yakusu area, to be manned by the qualified Christian medical trainees from the hospital, known as 'infirmiers'.

In all this expansion of its work, Yakusu was helped by the co-operative attitude of the Belgian Colonial Administration which, in seeking to establish a health service for the people of Belgian Congo, recognised the

contribution that had already been made by medical missions to that service.

> "The state has rendered considerable financial help already and is evidently prepared to do more."[17]

This forecast has been fully justified by subsequent developments.

Other encouragement was afforded by a grant made annually for several years by the Rockefeller Foundation towards research into the treatment of sleeping sickness, and it was not long before Yakusu established a claim to being the foremost Protestant medical mission in Congo working on this particular subject.

In Lower Congo, the missionaries at Wathen begged the M.M.A. to send a doctor who would re-start a full medical mission on that station, as there seemed to be widespread need for it. In 1910 this became possible through the offer of service made by Dr. E. R. Jones, and for some time hospital work was continued in Wathen and district, though it was felt that the existing ward-dispensary buildings were not situated in the most convenient position for a fully developed hospital. When Dr. Jones (who, during the war, had had to relieve at San Salvador) resigned in 1920, the doctor's place at Wathen was not filled, but qualified nursing sisters, beginning with Miss F. J. Smith in 1919, kept going as much of the work as possible, especially that connected with maternity and child welfare.

In other Congo centres it was found desirable to follow a similar policy—that is, instead of attempting to supply complete hospital service, to keep a bridgehead open, through the establishment of fairly extensive dispensary work, sometimes in charge of a full-time missionary

[17] *M.M.A. Report*, 1924-25.

nursing sister, sometimes supervised by the non-medical missionary who had some knowledge of medicine, hygiene and First Aid. During the period 1901-1925, such work undertaken at Kinshasa[18], Lukolela, Upoto, Quibocolo, Yalemba, Wayika, Kimpese, Thysville and Kibentele[19] assumed considerable importance, for not only were large numbers of out-patients treated, but in some places accommodation was made available for a few in-patients, notably maternity cases, who might need prolonged care. Baby welfare clinics were also set up, through which useful contacts were secured with the homes of the people and some influence obtained over their attitude of mind towards spiritual and physical health. Moreover, many medical helpers were given an initial training in these dispensaries, before being passed on to one of the mission hospitals for fuller instruction. The total value, therefore, of the dispensary-hospital was not to be easily or lightly calculated.

[18] Now Léopoldville.

[19] A distinctive feature of the work at Kibentele has been the leper patients' settlement, developed by Miss L. E. Head.

MEDICAL STAFF 1901 — 1925

	DOCTORS					NURSING SISTERS					Business Managers	PHARMACISTS
	Those serving already	Accepted	Retired or Resigned	Died	Total left	Those serving already	Accepted	Retired or Resigned	Died	Total left		
INDIA	4	19	10	1	12	—	23	9	2	12		
CHINA	6	29	10	8	17	—	17	5	—	12	2	1
CONGO	—	10	5	—	5	—	13	7	—	6		
Totals	10	58	25	9	34	—	53	21	2	30	2	1

DEATHS—

INDIA

Dr. Eva Clark - - - 1922

Sister Emily Gautrey - - 1913 Sister Evelyn Roach - - 1923

CHINA

Mrs. Russell Watson - 1911 Dr. J. Lewis - - - 1916

Mrs. T. C. Paterson - 1912 Dr. T. Scollay - - 1918

Dr. Stanley Jenkins - 1913 Dr. George Edwards - 1919

Dr. Cecil Robertson -- 1913 Dr. Andrew Young - 1922

CONGO—None

Chapter Seven

MATURITY

" When it is grown it . . . becometh a tree, so that the birds of the air come and lodge in the branches thereof."
(*Matthew XIII*, 32)

The survey of the first twenty-four years of the M.M.A.'s existence leads one to note certain salient points. The Auxiliary was now firmly established, both in the affection of many loyal missionary supporters in the home churches and in the life of a large number of mission stations on the field. Interest at home and accomplishment overseas had fed each other with mutual inspiration, and there was no thought but that this work must continue and advance.

At home, organisation had been carried forward as simply as was consistent with attention to detail. Local auxiliaries and churches were exhorted, by correspondence and by visits, to study the medical missionary situation as it developed, to be instant in prayer for it, and to give generously to what was still regarded as the extra arm of B.M.S. enterprise. Central organisation and leadership had undergone certain changes, notably in the loss of Dr. Percy Lush who had been Chairman of the Auxiliary from its formation until his death in 1918. His place was taken by Dr. Arnold Ingle, already mentioned as a staunch supporter of the work in other ways. The first Honorary Treasurer, Herbert Smith, resigned in 1908, and W. Ernest Lord, who was then appointed, carried the office until 1925. A loss that was deeply felt in the inner councils of the Auxiliary, especially in matters of professional advice

and support, was the death in 1922 of Sir Alfred Pearce Gould who had been so closely associated with the formation of the M.M.A.. Miss Head had retired from the 'Wants' Department, and the work was being carried on by Miss M. E. Angus and Mrs. Lush. At the heart of the movement there still remained Dr. Moorshead, who continued to be the master enthusiast and planner and to bear a considerable proportion of responsibility for all branches of M.M.A. activity.

In 1914 a change took place in the women's work which had some bearing on the constitution of the Medical Mission Auxiliary. The Baptist Zenana Mission, which had been a separate organisation, became more closely linked with the B.M.S., taking the new name 'Women's Missionary Association'. Where the M.M.A. had formerly dealt with two separate organisations, it now made slight adjustments to deal with one main body, while, of course, continuing to give close attention to those sections of the medical undertaking which were carried on chiefly or entirely for women.

The Medical Fund during these years had registered a remarkable increase. From £458 in 1903, the figures had mounted, with scarcely perceptible check, to £24,241 in 1925. This, moreover, represented 'ordinary' income. Considerable sums were raised from time to time for capital expenditure, and the Auxiliary received substantial help from the Arthington Fund and from other sources, such as the Baptist United Fund. Legacies, together with specially earmarked contributions, were not included either with the regular gifts from the churches. One of the most interesting of the smaller special funds was that designated 'Medical Aid'. This enabled grants to be made to Baptist medical students who needed financial help during the course of

their training. Akin to this in purpose was the Scholarship Fund launched in 1919 as a memorial to Percy Lush, which was designed to assist in medical training, with particular emphasis on post-graduate courses for medical missionaries on furlough.

On the field, the position of 1901 had been radically changed. Where there had been a total of ten Baptist doctors for all fields (none in Congo), that number was now more than trebled. Where there had been a complete absence of trained nurses, there were now thirty distributed over the medical mission centres of India, China and Congo. The years had witnessed the erection of no fewer than seventeen hospital buildings which, though not all of equal dimensions or convenience, were a vast improvement on previous accommodation. From every field there were reports of ripe opportunities in evangelism, through relationships with in-patients and out-patients alike. Evangelists or Bible women had come to form part of every hospital staff, and where circumstances permitted, contacts were maintained with patients in their own homes. The training of men and girl nurses and medical helpers, sometimes to a high graduation level, had been undertaken on all fields, for the pattern had early been established that the effects of wholeness should not be merely local and individual, but must be transmitted to as wide a circle as possible.

An atmosphere of confidence and goodwill had, for the most part, replaced the earlier distrust of the white man's 'magic' and the missionaries' motive in carrying on their work of healing. One form of expression of this goodwill was seen in the steady growth of mission hospital income from local sources on the field. There had always been instances of grateful patients bringing

voluntary gifts, often in kind—such as a goat or a chicken, rice or vegetables; but in increasing measure patients expected to pay a stated fee for the service or medicine they received. Though all B.M.S. hospitals were built up on the basis of free treatment for those who could not afford to pay, the medical staff found that even a token fee often enhanced the value of the service. Those who had the means to pay were charged fees from almost the earliest days, and some of the hospitals were glad to take a few wealthy paying patients for the additional means that these afforded to give free treatment to the needy and destitute, as well as for the evangelistic opportunities afforded by having these wealthy patients actually living in the hospital. In 1924-25, amounts equivalent to a total of £6,051 were received in local income by B.M.S. hospitals.

Further sources of help on the field had begun to manifest themselves through the interest shown by administrators of welfare and trust funds (such as the Rockefeller Foundation) and colonial development schemes. The latter type of help assumed very considerable proportions at a later date in Belgian Congo, but it had already begun before 1925, and was indicating new opportunities for medical missionary service.

All the points mentioned so far in this summing up can be classed as means to an end, even though their gradual growth brought much satisfaction. What of the actual results of the twenty-four-year-old Auxiliary's activity? It would be difficult to assess these in round figures, remembering that the fundamental end in view was nothing less than the wholeness of men and women. "So many successful operations, so many sleeping sickness patients cured, such-and-such a number of lepers

rehabilitated"—these might contribute one valuable side of the picture; but how could statistics, even of baptisms and church membership (supposing that those could be traced that derived from hospital contacts) present the total effect of these twenty-four years of brain and heart, science and Christlike love, in action?

Though allowance had to be made for the imponderable, the value of surveying the past as critically as possible was realised when in 1922 the milestone was reached of the M.M.A.'s twenty-first anniversary. Over against achievement had to be set the fact that medical income was not matching the necessary expenditure; that for many hospitals the staff was so meagre that over-work, illness and even break-down were all too frequently experienced; that many parts of each field still lacked doctors and nurses, though there were unassailable reasons why such recruits should be sent thither—unassailable, that is, except by the words "Not enough volunteers" or "Not enough money". The medical provision offered by the B.M.S. was recognised to be a mere drop in the ocean, for there were at that time only just over 700 beds in all the B.M.S. hospitals put together; fewer, in fact, than the number of beds then in use at St. Bartholomew's or one of the other large hospitals in this country.

A similar picture emerged three years later from the last report to be published by the M.M.A. in its original status as an independent body. 1925, the year preceding the celebration of twenty-five years' work, was destined to mark the close of an epoch in British Baptist medical enterprise, and it may be useful to notice what kind of situation had been reached before the new era began.

"One hospital has still no doctor, and six have but one doctor apiece . . . Two hospitals are still without

even one nursing sister. And all this leaves out of count those other places, such as the Kond Hills, of India, where a medical mission is so urgently needed. The experience of the year has shown yet more clearly the strain that rests upon our doctors and nurses, and the corresponding importance of the staff being maintained at a high level. During the year three nurses and two doctors have had to have their furloughs expedited on account of ill-health or overstrain . . . We are carrying on work of a very advanced medical order . . . The very fact of this high grade work calls for a staff that is kept properly reinforced."

From Bhiwani came this statement:

"There is still much work to be done among the women of India."

From Palwal:

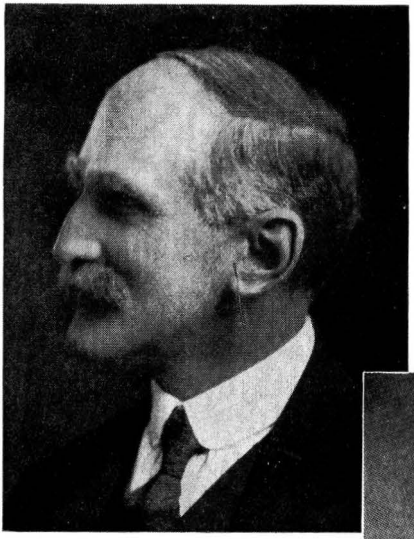
"In the near future there will be a great turning to Christ of scores, if not hundreds, of these low caste villagers of India. Our medical missionary work has a great part to play in such a movement."

From Chandraghona:

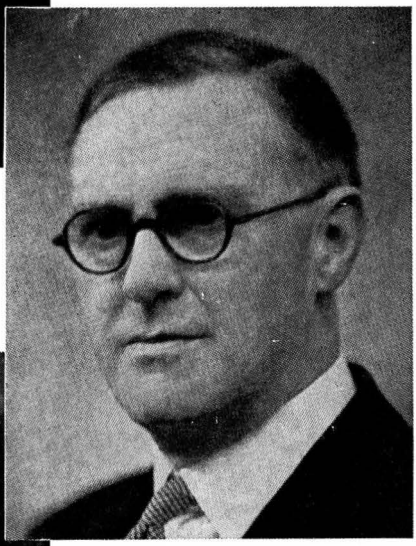
"On the spiritual side there has been much effort in the wards, but the patients leave the hospital and get out of touch . . . The fact that they come from such long distances intensifies the difficulty. Nothing would seem to meet the need except the addition of a second doctor. Such a reinforcement would not only make provision for furloughs, but would permit of the doctors taking it in turn to conduct regular tours throughout the scattered area."

From Taiyuan (Schofield Memorial Men's Hospital):

"The hospital touches intimately large masses of people who come from long distances and from places



LEADERS OF BAPTIST
MEDICAL MISSIONARY
ENTERPRISE



DR. R. FLETCHER MOORSHEAD
DR. C. C. CHESTERMAN, O.B.E.
MRS. FLETCHER MOORSHEAD

where the gospel has never reached. One place I visited this summer was seven days away from the hospital, and no missionary had been there, so the people said, for two years, but during that time several had gone from that village to the hospital."

From Bolobo:

"A wide field of service—but the needful amount of medical itineration has not been possible because there was not more than one doctor present at the hospital during the year."

It was indeed a day of opportunity, a time for advance. B.M.S. deputations that had visited the fields in the course of these years saw plainly where some of the most important needs lay, and again and again the gist of their recommendations was that staffing should be strengthened and that the highest possible standard of excellence should be aimed at, in preparation of candidates, in equipment of hospitals and in the training of native helpers. The first great world missionary conference at Edinburgh in 1910 had foreshadowed such an opportunity and such requirements for medical missions, and the experience of the B.M.S. had proved the accuracy of the forecast.

There was no doubt that the M.M.A. had reached maturity. Its very perception of the work that still waited to be done, no less than its incontestable achievements, showed what kind of growth had taken place since 1901, and the realistic and courageous way in which it had faced the next developments indicated such resilience as could spring only from sturdily-rooted Christian faith.

PART III

A NEW SEASON: 1925-1951

CHAPTER EIGHT

THE HOME BASE (ii)

" God fulfils himself in many ways
Lest one good custom should corrupt . . ."
(Tennyson)

" Revolutions are not to be evaded."
(Disraeli)

WHEN a chronicler in the course of his history approaches the task of recording a revolution, he must beware lest it appear an isolated and sudden happening. Usually there is a chain of events leading up to a turning point, and the turning-point can only be fully understood in the light of those events.

This was, no doubt, true of the revolution which now affected the M.M.A., yet because it involved issues that were not confined to the Auxiliary, it would not be possible or proper to trace the whole story here. Let it suffice to recall the trend, noted earlier, towards unification of the various branches of B.M.S. work, and to note the thin ice of this country's economic situation in the decade following the first world war. The financial crisis sharpened the sense of need for unity, and thus events were accelerated which, spaced over a longer period, might have produced the same changes

so gradually that revolution would hardly have been suspected. The fact, too, that the M.M.A. was still a comparatively youthful movement with a vigorous prime predicted for it, made the effect of such radical change at this stage seem the more startling. The W.M.A. shared in the new conditions experienced by the Medical Auxiliary, but as the women's organisation was much older and had already undergone some modification of independence in 1914, there was probably in that constituency a greater readiness to adapt and to venture upon a new experiment in co-operation. It was as if the M.M.A. had only just begun to taste the joy of successful experiment as an individual; and now it was called upon to sacrifice that for team work. In fact, the Auxiliary had now to learn other aspects of the lesson of wholeness—the lesson which, in one way, it had done so much to teach.

The financial emergency that precipitated the change occurred in the early nineteen-twenties. Reference has been made to the excess of expenditure over income at the time of the M.M.A.'s twenty-first anniversary in 1922. In spite of careful budgeting, and in spite, too, of the small but steady increase in the contributions from the churches, this experience was repeated for three years following. Not only medical work but the whole support of the B.M.S. was subject to this financial crisis, and a special committee was set up in 1924 to enquire into the total situation. Prolonged and detailed discussion took place, and when, in April, 1925, a united deficit of £27,727 was declared, it was decided in General Committee that immediate action must be taken to deal with the emergency and if possible to prevent its recurrence.

One drastic remedy that was adopted was an appeal

to the fields to increase their local support for the hospitals to eighty per cent of the total amount needed. On the home side, the remedy chosen was, as has been indicated, a policy of closer unity between the Auxiliaries and the parent Society. One foreign department was set up, with those who might be called specialist administrators—the Women's and Medical Secretaries—acting as colleagues of the General Foreign Secretary. The specialised work which they represented would now be treated by the Field Committees as parts of the whole enterprise, and it was hoped that such unification would lead to greater strength. Similarly, home organisation of the M.M.A. was henceforward to be a part of the General Home Department, where information, propaganda and the raising of funds would be undertaken as one co-ordinated campaign. The Auxiliary Committee was no longer to be a separately constituted body, but would be appointed with other sub-committees of the B.M.S. It would still have the power to co-opt Baptist medical men and women to advise in professional matters; and it could receive reports and make recommendations to the General Committee regarding medical policy. In this way its responsibility for expenditure on medical work became much more limited and indirect, and the need for a separate treasurer disappeared. Mr. W. Ernest Lord, who for many years had served the Auxiliary as Honorary Treasurer, was invited to become one of the joint Treasurers of the B.M.S. which, as a whole society, would share in decisions involving financial outlay on medical work. On the income side, the Medical Fund was retained, and it was agreed that the special methods of contribution, such as the Birthday Scheme and Bed and Cot support, which had proved so valuable in building up the

M.M.A., should be carried on, accompanied by their own propaganda, within the larger framework.

That Dr. Moorshead at first found the changes difficult to accept is scarcely to be wondered at. It appeared to him that the Auxiliary was losing its life, and uncertainty as to its future was an exacting test of faith for one who had done so much to endow it with a life and identity all its own. It was said of him that the greatest gesture of his life was his agreement to relinquish the part for the sake of the whole; for that part had been his very life. Characteristically, he did not look back when once the decision had been taken, but thought only of making the very best of the new situation, for the sake of the work.

> "Whatever changes might occur in the precise nature of the organisation, the work itself must go forward."[1]

It was in this spirit that the Semi-Jubilee of the M.M.A. was observed. Though the organisation had ceased to exist in name and form, yet the work it represented was very much alive, and those who were concerned for its effectiveness were determined not to break faith with the opportunities that had been entrusted to the Auxiliary. Dr. Fullerton's little booklet *Mid-way to the Jubilee* expressed the joy of the B.M.S. as a whole in what had been accomplished in the twenty-five years of organised medical work; and a service of thanksgiving and commemoration was held at Bloomsbury Central Church, London, on April 22nd, 1927.

The story of the years was told in some detail by Dr. Moorshead in his book *Heal the Sick*, published in 1929. It was hoped that this record would help to retain for a

[1] *Heal the Sick*, p. 163.

new generation the high purpose and sense of adventure which had animated the pioneers and which had run like a bright thread through all the achievements and set-backs since the early days.

This book, together with a statesmanlike argument on medical missionary policy presented to the B.M.S. General Committee in 1931, formed the last surveys of considerable length made by Dr. Moorshead, though he continued to address meetings and to write articles and pamphlets on the theme of medical missions. He also carried on his work as Medical Officer of the Society, and maintained a close personal link with the London Medical Mission, an undenominational movement which sought to bring healing of body and soul to poor folk in the heart of London. His full life was in a remarkable way a balanced life; but the strain of the years was beginning to tell, and in 1933, at his wish, plans were made for the appointment of his successor. Dr. C. C. Chesterman, of Yakusu, was invited to take up the administrative work at home, and it was arranged that the transfer should take place in the early part of 1937. In November, 1934, however, Dr. Moorshead who had travelled north to address the thirtieth anniversary meetings of the Glasgow Medical Auxiliary returned home ill, and within a week he had passed on to higher service. What he did for the medical work of the B.M.S. can never be fully known. What he was to those who carried on the work at home and abroad was an open secret; open, because the effects were acknowledged and apparent; secret, because the source of all his friendship and leadership lay in the depth of his faith in Christ.

The plans that had been made for the Medical Secretariat could not be implemented immediately as

Dr. Chesterman could not be released from Yakusu. An arrangement was made whereby Dr. Stanley Bethell, home on furlough from Choutsun, agreed to do the work of Medical Secretary and Medical Officer until Dr. Chesterman's arrival in 1936. This valuable help was much appreciated.

To the medical administration Dr. Chesterman brought outstanding gifts of personality and professional skill of a high order, particularly as a physician and specialist in tropical medicine. His experience, moreover, during some of the most formative years of medical missionary enterprise on the Congo, had included contacts with state administrators and with missions other than the B.M.S., all of which proved to be of value as he represented his own society in interdenominational circles and also when he spoke for Protestant medical missionary work generally, in deputations to colonial bodies. Dr. Chesterman was one of the official B.M.S. delegates at the meeting of the International Missionary Council at Tambaram, near Madras, in 1938, and he also attended the Council's meeting at Whitby, Ontario, in 1947, both of them occasions from which he brought back inspiration for the whole work of the Society as well as for Baptist medical missions.

In spite of hopes that the Medical Fund would be sustained at the level it had reached before the 1925 re-organisation, there was a falling off in contributions from 1926 to 1932. No doubt this was in some measure due to misunderstanding on the part of supporters who thought that, because of the merger of the M.M.A. in the main society, it was no longer possible to earmark any of their gifts for medical work. From every point of view it seemed necessary to strengthen the appeal and the information service of medical commitments,

and in 1935 an appointment was made in the Home Department with this object specially in mind. The idea was good; the actual appointment was even better; for in Mrs. Moorshead, who was invited to undertake this particular service, the Society secured one who through the years had identified herself whole-heartedly with her husband's work, who shared his hopes and aims for its continuance and, moreover, had definite ideas of her own and a distinctive contribution to make. Before her marriage to Dr. Moorshead in 1909, she had been preparing for a medical career. Subsequently she had kept in close touch with every development of the M.M.A. and had accompanied her husband to China in 1920-21, as an unofficial member of the B.M.S. deputation to that field. Particularly through the hospitality which she and her husband had always generously given to missionaries on furlough, her personal links with the work were many and varied; while for the missionaries' part it was a priceless boon to renew fellowship in the Moorshead home and to be reminded of the community of service.

Mrs. Moorshead went ahead with medical missionary propaganda, with fresh campaigning for the Birthday Scheme and the support of beds and cots. A newer feature which she did much to foster was the observance in Baptist churches of St. Luke's Sunday as a day of special remembrance and prayer for the work of healing, and closely associated with this was the introduction of an annual 'popular' report on medical work. Since the changes of 1925, the separate medical report had been discontinued, but the suggestion that churches should support B.M.S. medical undertakings in thought and prayer brought forth so many requests for information about the work that a pamphlet type of report has been

prepared each year since 1936. In connection with St. Luke's Sunday a copy of this report is now sent to every minister, lay preacher and deaconess in pastoral charge who asks for it, as well as to medical secretaries and others who distribute and use it in various ways.

To many churches Mrs. Moorshead became well known through her visits and her films. She was indefatigable in deputation, and would drive immense distances to visit any church or group, however small, where she thought there was a chance of planting a medical missionary seed. The films were made from shots taken by her in India in 1938-39, when she went to the Kond Hills to open her husband's memorial hospital, and there was no doubt about their popularity and value. The result of this intensified appeal was seen in a deepening of interest and in the reversal of the Medical Fund's recent downward trend. Not until the early years of the second world war was the extension of this financial support again halted temporarily, and since 1942 there has been no break in the steady growth of the Medical Fund. At the time of Mrs. Moorshead's retirement in 1947, she had the joy of knowing that support from the churches for B.M.S. medical work had increased by over fifty per cent in her period of full-time service as its advocate.

The outbreak of war in 1939 affected the life of the B.M.S. in a number of ways. Some of these should be recorded here, since medical work shared in the general experience of upheaval. Service in the Forces, Civil Defence or war industry, together with the evacuation of business firms and mothers and children, had an obviously disruptive influence on church organisation. The black-out and the commandeering of buildings reduced the number of meetings in local churches, while

the scarcity of transport almost wiped out the large united type of meeting which entailed a journey of any distance. The number of missionaries home on furlough was few, so that it was difficult to maintain the full missionary deputation arrangements. Add to these factors the bombing of the big cities, the 'blitz', the flying bombs and the rockets on London and south-east England, and one is astounded that any considerable church organisation was sustained at all. Yet after the first inevitable period of adjustment, a remarkable programme was kept up by many churches and auxiliaries, and one heard heartening fragments of news —of missionary boxes being given their chance in public air-raid shelters, or of fire-watchers knitting old scraps of wool into Wants Box items.

The Ter-Jubilee of the B.M.S., celebrated in 1942-43, might have been observed with more flourishes, had it fallen in peace time, but even the situation as it was could not stifle the inspiration and enthusiasm that warmed so many Baptist churches, as by printed and spoken word they were reminded of the tradition of great things to which they belonged. Not only were special Celebration funds raised, but ordinary income was increased, and by 1944 the Medical Fund had won its way back to the 1925 level of over £24,000.

The Home Base organisation of medical work, in common with other branches of the B.M.S., was conducted from various places in the course of the war. Two evacuations occurred, the first to High Wycombe, and the second (which lasted in lessening degree until after the war was over) to Kettering. For a good proportion of the Kettering period, some of the staff remained in London working at the Mission House, until the occasion in 1944 when 19, Furnival Street

received such final air raid damage that its continued occupation was impossible. Shortly afterwards, B.M.S. headquarters were established in Gloucester Place, near Baker Street, where they have remained ever since. Even if rebuilding the Furnival Street premises had been a practical possibility, it was judged wiser not to return there, and by the vote of a specially-convened meeting of the General Committee in November, 1948, it was decided to dispose of that site.

For some time after an early raid on the old Mission House, the most vital thing in a scene of general dereliction was the portrait of Dr. Moorshead which still hung, unharmed, on the wall of Dr. Chesterman's office. The building had been split open, and the portrait, visible from the street, called forth the following comment from a passer-by:

"Coo! 'e's one up on 'Itler! 'E don't even look annoyed!"

Had Dr. Moorshead heard that, he might have replied that the work to which he had given his life could never be entirely destroyed by violence. 'Not by might, nor by power,' but by the Spirit of Christ in the lives of His servants—there lay the answer of wholeness to the forces of destruction.

Soon after the Ter-Jubilee, the B.M.S. commissioned a special group to consider plans for a re-disposing of committees and staff at the Home Base. It was felt that the work overseas demanded the strongest possible field committees at home, and that the women's and medical undertakings (representing a particular constituency and function respectively) could best be administered through each field committee, rather than through the separate committees for women's and medical work, which had conducted all their own specific business relating

to every field. The recommendations of this special group were presented to the General Committee in 1946, and resulted, on the foreign side, in the almost complete assimilation of medical interests by the Society as a whole. Dr. Chesterman, ceasing to be Medical Secretary, remained as Medical Officer, and was made an Honorary Member of the Society in recognition of his long and distinguished service.

On the home side there was no change in organisation at this time, but a change in staff took place in April, 1947, owing to the retirement of Mrs. Moorshead. Her work had been much valued, both for her own sake and that of her husband, and the appreciation already shown in 1932 by her election to Honorary Membership of the Society was now renewed, with expressions of regret on the occasion of her retirement. The present writer was appointed to her place in the Home Department.

In spite of the contraction of medical missions as a separate function within the B.M.S., it was evident that the work still had an appeal for a fairly large constituency in the home churches. Collecting boxes continued to yield steady results, and after a long period without any distinctive box for medical missionary support, a new design in the form of an ambulance was brought into use. This had been planned during the war, but production was delayed on account of the war situation, and the ambulances were used as part of a general box campaign in 1947-48. Bed and cot interests were retained within a new framework, *A Plan for Partnership*, which was devised in 1948 by the Home Staff, in consultation with missionaries, to include every kind of special support. The Birthday Scheme proved its suitability for yet another generation, when churches

revived it or adopted it for the first time, as a method of gaining extra contributions. This was particularly evident in the Society's two-year campaign for 100,000 new subscribers: a large number of new enrolments between 1948 and 1950 came by way of the Birthday Scheme.

The inauguration of the British National Health Service in July, 1948, focussed a good deal of attention on all medical enterprise. It was realised that grants from the Treasury and from local authorities would in future provide for all hospitals in the Health Scheme, thereby releasing, from the churches in particular, considerable sums which had formerly been contributed to local voluntary hospitals. The B.M.S. made a strong appeal to all Baptist churches to exchange the occasion of local Hospital Sunday for Medical Mission Sunday, and the appeal has met with a certain measure of response.

These special modes of contribution, together with direct subscriptions, built up the Medical Fund until, in the year 1949-50, the total received (exclusive of legacies and special funds) was £39,644. The Society spent, however, nearly £49,000 on its medical enterprise in the same year, so that the target of £50,000 for the Jubilee year (1951-52) is in no way disproportionate.

The Wants Department, though not now confined to the support of medical work, continued throughout the years 1925-1951 to give assistance to the hospitals and dispensaries by sending out all kinds of equipment. In 1938, Miss Mabel Angus and Mrs. Lush, who had shared this task for many years, resigned, and Mrs. W. J. Austin was appointed as Honorary Secretary. Through the restrictive war years and afterwards, through the experiences of clothes rationing, countless Board of Trade

formalities and extreme scarcity of shipping space, Mrs. Austin carried on this work most faithfully. The situation had begun to improve somewhat when she became seriously ill, and in 1950, only a few months before her death, her resignation was received. It was decided that, as so many of the goods on the necessarily curtailed list were connected with medical work, the Wants Department should have its official link with the B.M.S. Home Organisation Committee by way of the Medical Department. Miss Phyllis Lofts, S.R.N., formerly a missionary nursing sister at Yakusu, was appointed as organiser for the receipt and dispatch of 'Wants' goods.

Chapter Nine

OVERSEAS GROWTH (ii)

"My root was spread out by the waters, and the dew lay all night upon my branch. My glory was fresh in me, and my bow was renewed in my hand."

(*Job XXIX*, 19-20)

"... a fruitful bough ... whose branches run over the wall."

(*Genesis XLIX*, 22)

(a) INDIA: 1926-1947

INDIA and PAKISTAN: 1947-1951

The years of B.M.S. medical work in India between the Semi-Jubilee and the outbreak of the second world war were, on the whole, years of unostentatious but steady growth. The hospitals carried on their work of healing, training and evangelising as adequately as was possible with staffing which was more often than not below full strength on the European side. Supplementary medical help in the women's hospitals was available through the services of Indian women doctors, trained either at Ludhiana or at Vellore, the united Christian Medical College which had been started in 1918 and had now begun to send out its qualified students to all parts of India.[1] In nursing, the B.M.S. hospitals reaped the benefit of their own nursing schools, as these provided

[1] This Medical Training School grew out of the hospital for women started at Vellore in 1900 by Dr. Ida Scudder, an American woman doctor. At first only women doctors and nurses were trained, but from 1947 onwards, men students have been admitted too. The medical school is recognised by the University of Madras, and affords full training for a medical degree. Forty missionary societies are co-operating in this work.

them with staff nurses of excellent calibre. The difficulty sometimes was to maintain these training schools. Educational standards in India were gradually rising, and the demand made by nurses' qualifying examinations meant a strain upon the time of the European nursing sisters as well as upon the teaching accommodation and equipment of the mission hospitals.

Many small-scale attempts were made to modernise and enlarge B.M.S. hospital buildings and to provide the up-to-date equipment which even the smallest hospital in Britain would regard as essential. In 1927 some improvements of this kind were made to the Florence Toole Hospital, Palwal, but how much remains to be done may be realised if one grasps the fact that in 1950 that same hospital was still without the benefit of electricity. All operations (let alone the rest of the hospital service) are still performed under the light of an oil lamp, and the power necessary for efficient lighting in the operating theatre entails the generation of heat which the doctor and his assistants could well do without, particularly in the hot season. This is but one example of how medical missionaries, with their high ideals of efficiency, have to make do with the second best.

The outstanding B.M.S. medical development in India in the late nineteen-thirties was the building of a hospital at Udayagiri in the Kond Hills. The need for this hospital had been acutely realised by Dr. Moorshead when he visited India in the early days of the Medical Auxiliary, and, strongly supported by appeals from the workers in that area, he pleaded continually for the launching of a Kond Hills medical mission. A special fund was started for the purpose in 1923, but it was not until after Dr. Moorshead's death in 1934 that the

project took definite shape. It was decided that a hospital should be built and equipped as a memorial to his work, and, superintended by the Rev. Edward Evans, the Kond people themselves had the satisfaction of helping to put up the first buildings.

> " Stone is cut from the hillsides with pick and crowbar (not blasted), and carted some distance by bullock cart (not lorry) for the foundations. Women (not machines) sit patiently breaking it up for concrete with little hammers. Bricks are made one at a time, dried, stacked and burned in kilns with wood gathered from the forests. Timber for doors is sawn laboriously by hand (not circular saw). Most of the labour is unskilled."

So wrote Gordon Wilkins, who was appointed in 1935 as Udayagiri's first doctor, and who, while the foundations of the building were being laid, was himself laying other foundations, and building up a large constituency of patients from the district round about, doing dispensary work in two rooms of the Mission school and using three windowless buildings (which had been cow-sheds) as in-patient wards. At the time when the hospital was being planned, it was officially estimated that it would serve an area containing 650,000 people, most of them ignorant of the simplest rules of health, oppressed by their own superstitious beliefs and practices, and lacking any systematic provision for alleviating their physical suffering, which included malaria, smallpox, leprosy, eye diseases and orthopaedic cases. By 1938 the work had assumed such proportions that a second doctor, Stanley Thomas, was appointed, and when the hospital was opened by Mrs. Moorshead in January, 1939, a new era of hope

began for the Kond Hills people. Sister Jarry, transferred from Balangir in 1936, began the organisation of nursing when the new hospital was ready, and since then many nurses have been trained. In 1949-50 some further building was undertaken, contributing towards completion of the original plans. The provincial government has shown its appreciation of the hospital's work by making some financial grants, but as most of the patients and local Christians are extremely poor, the support of the churches in Britain, through their gifts to the B.M.S., will be needed for some time to come.

The effects of the second world war were felt in various ways in all our hospitals in India. Shortage of supplies and high costs produced many emergencies. Three of the men doctors were away for some time on war service, and Rahmatpur Hospital, Palwal, sustained a severe loss in March, 1941, when the *SS. Britannia,* in which Dr. Hilda Bowser was returning to India after furlough, was torpedoed and shelled, and the doctor was presumed drowned. Anxiety was felt regarding the missionaries and the continuance of their work in Lushai and at Chandraghona when the Japanese forces were advancing through Burma and reached the borders of Assam. Chandraghona did, in fact, experience several bombing attacks on the district, as well as a considerable influx of military casualties. It also had the friendly interest and help of R.A.F. medical officers when Dr. Bottoms was absent on furlough and Sister Gladys Cann was heroically maintaining as much of the hospital work as she could, with the aid of Indian nurses.

The years immediately following the war brought India to the climax of negotiations concerning national independence, and on August 15th, 1947, two new nations, India and Pakistan, came into being. Most

B.M.S. hospitals, together with the ward-dispensary in Lushai, found themselves under the rule of new India, the single exception being Chandraghona, which was within the eastern section of Pakistan. Communal feeling had run high in certain localities, prior to Independence Day, and though, following that day, some places that had been trouble centres were unexpectedly quiet, there was in north India a grim outburst of bloodshed and looting, as well as the wholesale movements of thousands of displaced persons, both Muslim and Hindu. The B.M.S. hospitals at Palwal and Bhiwani were in the front line of this movement, and were almost overwhelmed by the inundation of pitiful cases, both in the hospitals and in the huge refugee camps which were set up to accommodate the homeless Muslims until they could be sent to Pakistan. The hospitals, which had hitherto been served by Muslims in such capacities as water carriers, washermen and house servants, lost these valued helpers, some of whom had been in the work for twenty-five years, and it was not easy to find new workers or to settle down to the altered conditions, especially when such demands were being made on the hospital services. At the same time, those engaged in medical missions had a unique opportunity during that period of terror of witnessing to the love and power of the gospel, and many members of the contending parties recognised that here was a religion that sowed peace, not discord, that strove to bring about wholeness rather than division. Since those days the situation has become more stable, and although one cannot foresee all the changes there may be in store for B.M.S. medical work in India and Pakistan, at present the new governments are disposed to be welcoming and co-operative.

The passing of the years brought to the women's hospitals their own special occasions of sorrow and gladness. In April, 1930, Rahmatpur, Palwal, lost by sudden death a promising young doctor, Janet Hoare, who had arrived from England only about eight weeks previously. Her gay and consecrated personality had already endeared her to missionary colleagues and to the Indian Christian community, and she seemed to be marked out for a future of rich service. The outpouring of her life and gifts might have been interpreted as purposeless waste, but to most of her friends it seemed, even in their loss, a sacred offering. It reminded them of the breaking of the alabaster box of precious ointment, followed by fragrance and invested by the words of Christ with a value far removed from material standards; and it was with this central theme that the story of her life[2] was written by Dr. T. B. Adam. Another friend expressed it thus:

> "She has sown her life and I am sure it will bring forth fruit. I pray she may call out others to fill the gap."

In the native state of Dholpur, various difficulties which had arisen in connection with the work brought about the Society's decision to withdraw its staff from Dholpur city. Thus in 1944 there came to an end the medical mission which had begun so adventurously thirty-six years before.

The Farrer Hospital, Bhiwani, celebrated its Jubilee in 1941, and although it was war-time, the occasion was commemorated both on the field and at home. A booklet[3] was published giving some account of Dr.

[2] *The Alabaster Box*, Carey Press, 1930.
[3] *Fifty Years for Bhiwani Hospital.*

Farrer's work and of the growth of the hospital. The medical staff were encouraged by the support of their local friends, many of whom observed a special 'Hospital Sunday' by contributing some of the goods which could not at that time be sent out from this country.

In 1948, through the generosity of friends at home and on the field, Berhampur Hospital acquired a Prayer Room, erected in memory of Dr. Helen Gregory, who had worked at Berhampur for many years and died in 1947. Further additions were a lecture room and examination hall for the nurses, some private wards and a maternity block. The last-named was called the 'Jubilee' Building, as its opening in 1950 coincided with the completion of fifty years of medical work in Berhampur.

(b) CHINA

Contemporary events in China have produced so much talk of crisis that a younger generation might be forgiven for overlooking an important fact—that for modern China crisis is no new thing. Over the last fifty years, the Christian Church there has been developing within an atmosphere of almost permanent upheaval. Although this fact does not lessen the gravity of the present situation, it does remind us that nearly every advance in Christian witness in that field has been won at rare cost of courage, patience and vision.

Much that affected B.M.S. medical work from 1926 to 1951 was so far-reaching that it touched all kinds of missionary work done by all societies. The spread of ideas let loose by the Revolution of 1911 gradually broke up the old order and, while some excellent reforms were instituted, locally and nationally, the general picture of China from that date was of continuous flux, of conflict-

ing policies and rival personalities and—except for the war period of united national action against the Japanese—of little co-ordination. Mission and Church work, therefore, tended to pass from one crisis to another, with Europeans driven from their stations by Chinese anti-foreign movements, or by the Japanese, and, more than once, by the threat of danger to the Chinese Christians. It was upon these people of the indigenous Church that much ensuing responsibility rested for the carrying on of preaching, teaching and healing; and no small share of the total achievement must be attributed to their fidelity.

Within this kind of setting B.M.S. medical work fulfilled its own special role. In 1926, when Sian was besieged for over seven months, the hospital maintained an unbroken service to civilian and military patients.

> "With a hospital already full we admitted 150 new serious cases in 36 hours . . . wards, verandahs, chapel, and part of the out-patient department were filled with beds."
>
> "It cannot be doubted that the service of this mission hospital during those terrible months constituted a witness that will not easily be forgotten."[4]

Doctors Clement and Handley Stockley, Dr. Ruth Tait, Sister Frances Major and a Chinese doctor[5] bore the burden of this service in a situation that deteriorated daily as food and medical stocks ran short. Two other B.M.S. doctors, E. R. Wheeler of Tsinan and Harry Wyatt of Taiyuan, shared in this chapter of Sian's history. At considerable risk they travelled to Sian and

[4] Letters from Handley Stockley.

[5] Dr. Chang was one of the first five students sent in 1909 from Sian to Hankow Medical College. After training he returned to Sian and has given a lifetime of service to the hospital there.

negotiated with the besieging general for the release of all women and children belonging to the missionary community. They then escorted this party to safety at the coast.

San Yuan Hospital suffered another blow from this chapter of civil war. Since the death of Dr. Andrew Young in 1922, the work had been carried on by a Chinese doctor and by Sister Laura Dillow, but now the threat of the advancing 'Northern' Army caused the defending troops to commandeer the building, which was outside the town; and patients and staff moved to other mission property in the town. Unfortunately the hospital was reduced to such a state that subsequent occupation was impossible, and for many years little more than out-patient dispensary work could be attempted in that centre.

In the period of intensified civil war in 1927, all B.M.S. hospitals were left for a time in charge of Chinese staff when the missionaries, acting on British Consular advice, were evacuated to the coast. A partial return, followed by a second evacuation, denoted unstable conditions that might easily have brought ruin to our medical service in China; but apart from the San Yuan disappointment and the temporary closing of the men's hospital at Taiyuan, a steady witness was preserved by word and deed, which made many Chinese non-Christians examine the Christian faith more closely and accept Christ for themselves. In 1929, when the missionaries were back at their posts, there was great joy in Sian because three men and two girls offered themselves for nursing training. Thus there was started the first Christian nursing school in that part of China.

The rise to power of the Kuomintang under Chiang

Kai-shek brought definite attempts to improve the health and well-being of the Chinese people. Although some anti-foreign feeling remained and the government was committed to the policy of eliminating foreign concessions, missionaries for the most part received nothing but encouragement and goodwill, and this period between 1927 and 1937 was probably the longest time experienced by B.M.S. hospitals without wholesale interruption of their work. In 1931, however, a new cloud had appeared on the horizon in the Japanese invasion of Manchuria, and although the pressure of Japan's intentions was not felt immediately all over China, it gradually increased until the notorious 'incident' of July, 1937, when it was recognised by many of our missionaries that China was committed to a long war.

The winter of 1937 saw the occupation by the Japanese of Taiyuan, Tsinan, Choutsun and Chingchow. Through the following months the B.M.S. hospitals were subjected to all kinds of strain, restriction and shortage of supplies, and many instances might be quoted of fortitude in the face of danger or perplexity. There was the occasion when Dr. Ellen Clow, in the Taiyuan Women's hospital, by her firmness and calm prevented the entry of a rabble of Japanese soldiers looking for women. There was, too, the vivid picture described by Dr. Ronald Still of the little Chinese theatre sister, Miss Ting Hsi-ming who, during an operation preceding Choutsun's occupation, "stood by her instrument table near the theatre window and continued to hand the next instrument that was needed, as near misses shook the building and machine gun bullets cracked the roof tiles."[6]

[6] *Through Toil and Tribulation*, p. 102.

The episode which, for many Baptists, crystallised the tragedy of this period, was the shooting of Dr. Harry Wyatt, Miss Beulah Glasby and a Chinese driver, Hu Shih Fu, on the road between Sinchow and Taichow in May, 1938. It was all a terrible blunder, for their assailants were Chinese who had mistaken them for an enemy party, even though Dr. Wyatt had gone towards the snipers waving a Union Jack. It was in trying to get the wounded driver to safety that Harry Wyatt was hit—a characteristic last action of one whose life had been devoted to the saving gospel of Christ, and who followed his Lord to the end in sacrificial love.

In December, 1941, the Japanese entry into the world war as an ally of the Axis powers brought all B.M.S. missionaries in Japanese-occupied China into the position of enemy aliens. Internment in various centres followed some months later and lasted until the ending of hostilities in August, 1945. Three nursing sisters and five men from B.M.S. hospitals, together with their wives and families, made a much-valued contribution to camp life. They helped to organise the rigorous efforts after cleanliness, the treatment of illness and accident, the careful administering of precious drugs, and the actual nursing of the sick. They were faced with new demands on their initiative and skill in improvisation. They found a new field for demonstrating the gospel for the whole man. Together with the other missionaries, they discovered afresh, in their apparent frustration and amid the daily tests of camp relationships, new resources of power in Christ, so that many non-Christians were impressed by their lives as well as by their verbal witness which, of course, was not neglected. As one nursing sister said afterwards, " There

was no need for any missionary or other Christian to be far from his or her job."[7]

Meantime, the work which these medical missionaries had been forced to leave was, in some cases, brought to a standstill because of the dismantling of the hospitals by the Japanese. The Foster Hospital, Choutsun, suffered in this way, but at Chingchow and Taiyuan the work was faithfully carried on by Chinese staff with, of course, Japanese oversight and occasional intervention. In Tsinan, the Chinese staff of Cheeloo University Hospital also maintained a fine service and witness to the community though in makeshift accommodation.

Sian, though in Free China, experienced many fears of Japanese occupation, and for some time was in the front line of attack from air raids.

> "The hospital received direct hits from five bombs . . . Both operation theatres, the engine-house and the water tower were destroyed, and the rest of the buildings badly shaken and cracked. One Chinese nurse was killed and an evangelist injured."[8]

As it was impossible to continue work in the damaged buildings, the hospital was transferred to school premises in the east suburb of the city, from which the scholars had been evacuated.

Of the medical missionaries neither in internment nor working at Sian, Menzies Clow joined the British Military Mission operating in south China and in India, and was awarded the M.B.E. for his war service; Ellen Clow and Wilfred Flowers, who were on furlough when war broke out, took up work in Britain. Later, Dr. Flowers was invited by the British Red Cross to organise a Hospital Unit for China, and from 1942 until after

[7] Amy Jagger: *Ibid.*
[8] F. S. Russell: *Ibid.* p. 180.

the war he was engaged in this hazardous and responsible task of medical leadership.[9]

Post-war reconstruction in B.M.S. medical centres proved difficult and costly, but it was undertaken with determination, and valuable aid was given in the provision of drugs and equipment by the Red Cross and by the Chinese National Relief and Rehabilitation Administration, a branch of U.N.R.R.A.. A B.M.S. doctor and nursing sister (Dr. Still and Miss Wheal) were sent to join the other co-operating missions in the re-opening of Cheeloo. At Taiyuan, under the leadership of Dr. Handley Stockley, the men's and women's sides of the work were combined in the Schofield Memorial Hospital, the Women's Hospital building no longer being in a fit state for use. At both Tsinan and Taiyuan, in spite of difficulties, the training of nurses was re-started. Though it was not possible for missionaries to take up residence in Choutsun again, the Chinese Church sponsored the re-opening of a partial medical service there, and a similar responsibility was assumed by the Church in Shensi for branch hospital work in San Yuan and other districts near Sian. The latter hospital carried out a courageous re-building and extension programme in 1948, so that it could move back to its former key site in the centre of the city. A part of the extension was made possible by the generosity of Tilehouse Street Church, Hitchin, which lost eight of its members in the war, and as a constructive memorial contributed over £2,500 towards Sian's needs.

During the war, the long-standing disagreement between Chiang Kai-shek and the Communists had temporarily

[9] Vide *A Surgeon in China*—letters written by Dr. Flowers from battlefield, roadside and hospital, outlining unforgettable pictures of physical suffering on a vast scale and of the attempts made through the Red Cross to relieve that suffering.

been set aside owing to the more pressing claim of national solidarity against the Japanese. Not long after the war's ending this disagreement reasserted itself, and Communist armies and guerillas were soon making a bid for power. Chingchow was one of the first B.M.S. stations to be occupied, and the hospital, which for several years had been in charge of Chinese medical staff, was once more placed beyond the range of personal missionary help. Communist occupation is now an accomplished fact throughout China, and B.M.S. missionary doctors and nurses have so far been unable to return to Tsinan or Taiyuan either, though it is known that work goes on in the mission hospitals in both these centres. The People's Government is pursuing in its own particular way a policy that is avowedly for the physical well-being of the Chinese people, and in Sian the new authorities, though not interested in the Christian basis and life of the hospital, have not, up to the present, hindered its witness.

The fact that the B.M.S. is a participating body in the Church of Christ in China has made possible the temporary transfer of some of our medical staff to other mission hospitals. In the project known as the Border Mission, the Church of Christ in China has undertaken the evangelism of a group of primitive tribes in the far west, and in the section of that Mission where B.M.S. staff are at work, medical care is being provided by Chinese doctors and on the B.M.S. side by Mrs. Madge, a qualified nursing sister. The latter has taken the initiative in launching a much-appreciated midwifery service, and through visits to the homes is able to give a good deal of simple health education.

(c) CONGO

In the pioneer years of the M.M.A., Yakusu was one of the last Congo stations for which full medical plans were made. After 1926, however, it entered into its own. It was in the autumn of that year that the new hospital was opened, and as the years passed it became an increasingly important centre of Christian health and healing.

From the first, it was realised that the training of Christians as high-grade infirmiers would be a potential source of strength to the Church as well as to the general well-being of African society, for these infirmiers, working in remote village dispensaries, could fulfil a pastoral office for the more isolated church members, and could exert a far-reaching and effective influence over their non-Christian patients. This policy has proved its worth in every part of our Congo mission. In the Yakusu area there are 17 dispensaries in charge of such men, and other districts too are benefiting from similar appointments. Since Yakusu is the only one of our Congo hospitals to provide the full-length training, the partly-trained candidates from other areas frequently complete their course at Yakusu. The value of its training school alone is therefore considerable.

Further opportunities of service have been found in various ways, such as specialised and successful research in the treatment of yaws and sleeping sickness, the bringing of Christian medical oversight to local trading companies which employ large forces of African labour, the undertaking of periodic district inspections with a view to checking sleeping sickness, and the establishment of a large leprosarium. As was forecast by Dr. Chesterman at an earlier stage of Yakusu's history, the mission

hospital has received increasing encouragement and financial help from the Belgian government. Officials and others in the neighbourhood showed their appreciation in 1939 by contributing a maternity block in memory of Queen Astrid who, when she visited Yakusu, had shown keen interest in what was being done for African women and babies. The growing demand upon all branches of the hospital made it desirable to plan certain enlargements when, in 1944, some rebuilding was found necessary owing to structural damage by white ants. The result has been virtually a new hospital.

The story of medical work in the Upoto-Pimu area is full of marvels, reaching a climax in the opening of Pimu Hospital in 1936. Long before that date, the Rev. Kenred Smith, one of the best-qualified of B.M.S. medical amateurs in Congo, had served Africans and fellow-missionaries in the Upoto neighbourhood, and had sounded the depths of existing need amongst the backward Ngombe people. In the years following, dispensary work was carried on at Upoto, and in 1925 a generous gift by the Smith-Thomas families of Liverpool brought the hospital into the realm of possibility. On the recommendation of Dr. T. B. Adam,[10] a retired officer of the Nigerian Medical Service, who visited the district, the site at Pimu that had been suggested was approved, and preparations were made for building.

The name of the Rev. A. E. Allen will always be remembered in connection with this adventure. He it

[10] For some years after professional retirement, Dr. Adam acted as one of a team of organising secretaries at the Mission House. He made a notable contribution to the work in general, and will be particularly remembered for his initiation and fostering of the B.M.S. Prayer Movement.

was who planned and superintended the work, and experienced the thrill of discovering buried treasure on the very site itself. This treasure was none other than an outcrop of stone, the material so much needed for the foundation and walls of the building, and for lack of which the project had threatened to hang fire and to become much more costly. Kenred Smith, writing in retirement in 1934, felt that this God-given discovery had placed a seal upon all the efforts and hopes of the past.

> "In this new temple of healing, for which God has provided the stones, new hope, new courage, new life will come to stricken men."[11]

This anticipation has been richly fulfilled. The missionary pioneers at Pimu—V. J. G. MacGregor, Ernest W. Price (the first doctors), Leslie Moore (pharmacist), and Mary Jones (the first nursing sister, now Mrs. Moore)—and those who have worked there since could testify to ways in which Pimu Hospital has changed the lives of the people around it.

An offshoot of the Pimu medical work has grown up at Njingo, some distance away. Here, in 1940, a group of lepers was brought together to live in their own self-contained colony; here they have received regular treatment from the hospital staff, as well as encouragement and help in organising their community life. Daily prayers and Sunday services are held, and many lepers have been baptized and received into the Church. The word 'Njingo'—'Hope' has taken on a new and deeper meaning for all who have lived in this village.

For many years the American Baptist Foreign Mission Board had a station in the Middle River area of Belgian

[11] *Missionary Herald*, March, 1934.

Congo, first at Ikoko, and from 1912 at Tondo, both sites being on the shores of Lake Tumba, in the midst of a well-populated district. From humble beginnings in a mud hut, the medical work grew until in 1928 a 40-bed hospital was opened, named *Tremont* after the Baptist church of that name in Boston, U.S.A., which contributed generously to the cost of the buildings. New experiments in co-operation led to the inclusion of a B.M.S. doctor on the Tondo staff from 1939 onwards, and in 1945, by mutual arrangement, responsibility for the entire work in that station and area was transferred to the B.M.S. Dr. Alfred Russell and his wife (also a doctor) and Sister Maisie Chaplin were there both before and after the transfer, and so were able to preserve continuity in the hospital service. There is no doubt that, in general curative treatments, in ante-natal and child welfare clinics, in the care of lepers and the training of native medical helpers, Tondo Hospital has an influential contribution to make to that part of the Congo. The note of evangelism is always predominant in reports and circular letters from the hospital, and there have been good results in the strengthening of the local church through medical witness.

Bolobo's medical work has been carried forward in all its branches, in spite of many staff changes and depletions. In recent years the lack of a second doctor has caused serious interference with itineration, and, partly because of the resulting inadequacy of preventive measures, partly because of immigration from the neighbouring colony, French Equatorial Africa, an increase has been recorded in sleeping sickness in the Bolobo district. Excellent work has been done, however, in the training of 'aides-infirmiers' and in child welfare. The latest building addition to be planned is a Children's

Ward, in memory of Dr. Philip Austin's little girl, Rosemary, who died at Bolobo in April, 1948, and of his wife, Mary, who shortly afterwards lost her life in an air disaster in Congo, as she was returning to England for a short furlough.

The oldest B.M.S. Congo hospital, San Salvador, has continued its ministry to a large area of Angola. The Portuguese colonial authority has not, in recent years, given much encouragement to Protestant medical missions with the result that our hospital and dispensaries in Angola do not enjoy the facilities that are given to B.M.S. medical work in Belgian Congo. Thus, official hitches caused prolonged delay in getting the latest doctor, Rodger Shields, into San Salvador, and our health service might have suffered very seriously, had it not been for the persevering efforts of the nursing sisters, Miss Cheshire and Miss Macintyre. In the face of considerable handicaps, the evangelism and health education provided by the hospital have had a definite influence upon those who come within its orbit.

Two new station dispensaries have been opened since 1926—at Tshumbiri, in Belgian Congo, and Bembe, in Angola. Miss Jessie Lambourne, who with her brother went to develop evangelistic and school work in the Bembe district in 1932, found among the local people a great need for medical help, especially in maternity cases. She was thankful that, years before, she had qualified as a midwife; for all her resources of knowledge and skill were needed, as well as courage and ingenuity, to deal with the cases that were brought to her, far from a hospital and the help of a doctor. The growth of the work called for suitable buildings instead of the earlier mud and grass houses, and in 1936 two small wards, a dispensary, consulting rooms and theatre, were

opened, amid great rejoicing, and a fully qualified nursing sister, Phyllis Jessop, was installed.

Other B.M.S. medical centres have had buildings replaced or added. In 1946, a maternity ward was opened at Wathen. Quibocolo too, where in-patients have hitherto been housed in grass huts, now has plans for better accommodation.

No outline of recent developments in Congo would be complete without reference to the projected Union Hospital and Medical School for the Lower River region of Belgian Congo. While the general idea has been welcomed and a site approved near Kimpese, negotiations have been proceeding very gradually, as many issues are involved, and the launching of such a venture in co-operation must needs take time. The Belgian authorities have offered generous financial help, and among the various mission bodies that are pledged, or hope, to share in the scheme, details as to proportion and type of contribution have yet to be finally settled, but the B.M.S. has agreed to be a fully-participating partner.

MEDICAL STAFF 1926 — 1951

(Figures to end of 1950)

	DOCTORS					NURSING SISTERS					PHARMACISTS					Business Managers				
	Those serving already	Accepted	Retired or Resigned	Died	Total left	Those serving already	Accepted	Retired or Resigned	Died	Total left	Those serving already	Accepted	Retired or Resigned	Died	Total left	Those serving already	Accepted	Retired or Resigned	Died	Total left
INDIA	12	18	15	2	13	12	29	26	—	15	—	1	—	—	1	—	1	—	—	1
CHINA	17	10	20	1	6	12	13	23	—	2	1	1	—	1	1	2	—	1	—	1
CONGO	5	20	17	—	8	6	31	22	—	15	—	2	—	—	2	—	—	—	—	—
Totals	34	48	52	3	27	30	73	71	—	32	1	4	—	—	4	2	1	—	1	2

DEATHS—

INDIA—Dr. Hilda Bowser (by enemy action). Dr. Janet Hoare.

CHINA—Dr. H. G. Wyatt (shot by Chinese guerillas). The Rev. W. P. Pailing, Ph.C., M.P.S., B.D.

CONGO—None

It should be noted that missionaries' wives wh have medical or nursing qualifications are not included in the list of full-time medical staff. Many of them, however, give most valuable help, in nursing and in hospital and dispensary administration.

Chapter Ten

CHANGES OF CLIMATE

"He who hath begun a good work in you will perform it until the day of Jesus Christ."

(*Philippians I*, 6)

Since the formation of the B.M.S. in 1792, and the medical missionary work of John Thomas, much has happened. Not only has the outward scene changed considerably, but forces have been at work producing conditions of thought and approach that have already affected medical missionary planning and must affect it increasingly in the future. Before bringing this survey of B.M.S. medical enterprise to a close, it will be well to notice what special conditions have emerged, both in contrast to the past and having regard to the future.

In the first place, much has been discovered or applied which had no part in earlier medical history. Anæsthesia and antisepsis, developments in the use of the microscope (opening up far wider fields of therapy), greater knowledge of physiology, advances in surgical technique, X-ray photography and treatment, blood transfusion, the widespread use of the sulpha drugs, and the discovery of penicillin—all these things which are now accepted as everyday items in the world of medicine and surgery have not only extended the range of usefulness but have also set a higher standard for our hospitals, together with an increase in costs.

Then, too, there has been a vigorous movement in favour of preventive medicine, which goes hand in hand with health education. Missionaries have warmly welcomed this, as it interlocks closely with the aim that

has always underlain medical missions. That aim has been not only to restore the wholeness violated by sin or disease, but to preserve it, ensuring that, so far as human science can assist the action of the grace of God, preventable ills shall be prevented. Therefore hygiene, practised and taught, has invariably been the handmaid of medical missions, and the modern accent on public health, whether applied through homes, schools, or occupations, has not surprised the missionary.

The present-day mission hospital conducts its campaign for health education by two main methods—one extensive, the other intensive. The former relies on itineration, in which a wide but rapid sweep is made through the district as often as possible, touching a large number of persons and, while administering curative treatment, giving also simple health rules which, it is hoped, the patients and their friends may remember and practice.

Such a method depends on the maintenance of an adequate staff at the hospital, so that the service there shall not suffer in the recurring absence of a doctor. The method also depends partly on the ability of the missionary's hearers to understand what it is all about, and on the relative distance they have travelled from old customs and superstitious beliefs. The advice of a Christian doctor, visiting a remote village, perhaps once a year, does not stand much chance against the tradition of generations among people who are otherwise untouched by the illuminating influence of Christianity. Believing firmly in the value of taking health education to the people, some missions have seconded certain members of staff from their hospitals to devote full time to it; and from the B.M.S. Dr. Gladys Rutherford has, at her own request, and for an experimental period,

linked up with the Indian Village Service in this way.

On the whole, our hospitals are able to do more for health education by the intensive method—that is, by reaching and steadily influencing in the hospital key persons who will in turn influence others. The ante-natal and child welfare clinics fulfil a most important part in this plan, as regular visits paid over a long period by many mothers have a formative influence on homes and children and public opinion.

The training of nurses and medical helpers is another way of applying this method in health education. Whether they afterwards work in mission or government hospitals, take charge of village dispensaries or, in the case of girls, marry and help to fashion their own home, their training makes a far-reaching contribution to the community. That this kind of training should be reckoned among present-day trends may seem unfair to the past; for there has seldom been a time in B.M.S. medical history when it has not been undertaken. The acceptance of it in recent years has, however, been so much more thorough-going, and the scope of the training itself has been so much enlarged, that it can be classed as an intensification, if not a change, of climate.

In the whole range of missionary health work, both curative and preventive, a most significant development has taken place through the years, which may be summed up in the word 'Co-operation'. Whereas, in earlier days, the medical missionary had to be self-sufficient or to take the lead, nowadays it is his or her privilege to work with other agents. Those agents may be trained nationals of the country, qualified people alongside or under whom our missionaries are proud to serve; or they may be the members of other missionary societies. One is glad to remember that co-operation of the latter sort

was successfully attempted even in the early years of the M.M.A. when the Christian Medical College at Tsinan was launched in partnership with the American Presbyterians. There is still greater satisfaction in realising how this kind of partnership has been enlarged. Today, by the contribution of staff or money, or both, the B.M.S. shares with other Christian organisations in the medical work of Ludhiana and Vellore in India, Cheeloo University and the Border Mission in China, has lent members of staff to the American Baptist Mission Hospital at Sona Bata in Congo, and looks forward to joining with other missions in the Union Hospital and Medical School in Lower Congo.

A body to which the B.M.S. owes much for its generous and helpful co-operation is the Mission to Lepers, an interdenominational society which gives grants from its own funds to the specialised care and treatment of leper patients in all parts of the world.

Perhaps the greatest change in medical co-operation has been the growth of encouragement and help on the part of governmental authorities. It is a far cry from John Thomas, forbidden by the East India Company to settle in British India, to the appreciation of medical missions expressed by the present Indian Minister of Health[1]; from the old tendencies of officialdom to ignore or exploit the masses, to the almost universal programmes for their betterment, in which medical missions are seen to have an important place..

So far, actual co-operation of the B.M.S. with state authorities in health services has worked smoothly. That there are possible embarrassments from the missionary point of view has not been overlooked, one of the chief

[1] Raj Kumari Amrit Kaur: "Not to encourage private hospitals would be both narrow and unwise: our need is so desperate."

of these being that missions which, in time past, set the standard of efficiency (and that a high one) may now find themselves outstripped by the wishes and demands of a modern state, and if unable to provide the staff, accommodation and equipment which the state thinks adequate, may be obliged to give up the place they occupy in a comprehensive state system.

Amidst all these changes of climate, so many of which seem to indicate ripening opportunity, while others suggest eventual state absorption of all health services, the question asked by today's supporters of medical missions will be: "What of the future?" Assuming that we are able to meet all reasonable requirements of the governments with whom we must deal, will there still be need and scope for our work?

The first point to be remembered is that the actual need is still very great, whether regarded from the missionary or government standpoint. Our missionaries have overwhelming proof that ignorance and superstition are by no means dead, and that the beliefs of the ancient religions, joined by modern materialism, constitute a weight of despair in physical suffering which only the gospel of Christ can remove. Though much has been accomplished, there are still grim diseases entrenched in their old strongholds and, to the shame of western civilisation, it must be recorded that it has brought additional diseases to Africa and the East, where some of them have hitherto been rare or unknown. As long as there is unalleviated suffering being borne by those who do not know Christ, the B.M.S. will surely hear the call of need.

There is, too, a spiritual challenge in all the public health work that is being attempted by the national and provincial governments on our present fields. Mission-

aries cannot but be glad to see schemes being implemented for a better standard of living, including land development, improved houses, drainage and sanitation, and for better nutrition and longer expectation of life. At the same time, the promotion of all these material improvements, though necessary and right, has its own special danger; for if governments and people set their hopes no further than the mere extension of physical life, only a mockery of Christian wholeness is attained. The motives in a non-Christian state for organising a public health service may, of course, differ from one individual statesman to another, but it is difficult to see how these motives can represent more than humanistic philanthropy at their highest level, or totalitarian preservation of the state at their lowest; and how shall this tree of healing live unless it be grafted on to the root of the gospel? Younger governments, in drawing up their health programmes, are bound to want the flower and fruit of Christian healing, but these must wither without the nourishing of the root. The Christian medical mission is therefore not yet discharged from the function of Christian health education in a non-Christian society.

To the governments of these countries the sheer amount of physical need presents an enormous problem. For the vast populations of India, Pakistan and China, and for the wide distances and remote villages of Congo there are still nothing like enough doctors, nurses or hospitals. It does not seem likely that governments with such a problem to solve will yet dispense with Christian medical aid, provided that it does not create for them problems of another kind, or run counter to their national aims. Not only in the extent of their problem but in certain specialised aspects of it, these governments

recognise that Christian medicine has a continuing contribution to make. Indian provincial Ministers of Health have noted tuberculosis and leprosy as two diseases in which "only the Christian spirit of patience and compassion could induce doctors to invest their lives and continue in the work for long periods."

It would seem, from this reading of the situation, that our medical work is still needed. Whether the scope afforded to it will be equal to the need remains to be seen. There are several groups of people who will have a determining say in this matter.

First of all, there are the patients and their friends who by their attitude do a great deal to create public opinion about the mission hospitals and dispensaries. So far as can be ascertained, the weight of that opinion is all in our favour. Patients who travel as much as sixty miles past a state hospital in order to attend the mission hospital (where, they say, God blesses the medicines and where they receive treatment 'with love') will not easily acquiesce in any limitation of scope for our work if they can prevent it; and many of these are folk who are growing more conscious of their right to have a say in things that affect them.

A second group, and one about which there is less certainty, comprises the governments of the countries where we work. As we have seen, they need all the medical help they can secure, but it might happen that the terms on which they sought to retain it would not be such as we could accept. If a day should come—and in Communist China this is not improbable—when the teaching of the gospel was forbidden though its deeds were still allowed, medical missions would have to face a difficult decision, either to withdraw, leaving behind much need, or to remain, presenting the gospel through

healing, though without the vital counterparts of teaching and worship. Happily in our fields other than China, there is no apparent danger of such a situation. India and Pakistan have laid down the principle of religious toleration in their respective constitutions, and neither in Belgian Congo nor Angola (states which officially adhere to Christianity through the Roman Catholic tradition) has there been any direct attempt to interfere with B.M.S. medical evangelism.

Even, however, if the governments in countries where our work is set are not at present trying to dislodge the missionary element of medical missions, there is the likelihood that the spirit of racial independence will increasingly influence states to seek entire control over educational and medical services within their territory. It may be not by the forbidding of evangelism but by the increasing requirement of national qualifications for medical work that our missionary doctors and nurses will find themselves set aside in the future. Who or what will take their place?

Here we touch the crux of the matter, and we come to the final group which will determine the scope of our work in the future. Even if foreign missionaries were evicted from all fields, the work they have been doing would go on because there is planted there a living branch of the Christian Church. Even if preaching and prayers in our hospitals were forbidden by state rule, the trained national Christian staff would find a way in which to proclaim Christ. And even though present mission health work should ultimately pass into the control of secular authority (as it has done in this country) the members of the younger churches, though a small minority in their countries, might, with a vision of wholeness, and lives embodying that vision, so

evangelise and influence their community that medical undertakings might again become Christian, with a richer contribution to make than ever before.

Do these hopes make too great demands upon our fellow Christians in the younger churches? It is certainly a great deal to expect, and we shall of course want to identify ourselves with them and help them in all the ways we can for as long a time as possible. The work which for all these years we have called 'ours' in a narrow sense is still ours in the much broader sense of the Church which is one and indivisible, older and younger, triumphant and militant; and whatever other forms our particular contribution may take, we can always share in the work to the extent that we are willing to pray for it.

It is, of course, to be hoped that, as long as the younger churches need our help in personnel and funds, we may with these, as well as with our prayer support, witness to the unity which we know to be ours in Christ.

> "In view of their financial and other limitations, the indigenous churches stand at present in need of all the help the other churches can give in funds and personnel for this ministry."

This was the judgment of the Madras Conference in 1938 on the future of medical missions.

In 1945-46, after the years of war, Dr. H. R. Williamson, having visited the B.M.S. fields overseas, brought back an urgent picture of the opportunity that challenged the younger churches and pointed out that opportunity was one thing, readiness and ability to seize it, another matter. He called for an increase in B.M.S. contributions, both of missionaries and money, so that the challenge of the fields to advance might be met.

At the world meeting of the International Missionary Council at Whitby, Ontario, in 1947, a similar need was heightened and underlined by a sense of urgency. The imperative need to evangelise the work called for still "fuller partnership in obedience", as together the younger and older churches realised their opportunities and responsibilities.

What we expect and hope for from the younger churches seems an especially big thing when we realise with shame how small is the total impact of the Christian Church today on secular affairs in our own country, where Christianity has the advantage of acceptance and deep penetration into our way of life. Neither our shortcomings, however, nor the magnitude of the task before the younger churches should be allowed to blur our vision and theirs—the vision in which we realise the holiness of God, the brokenness of sinful man, the healing of Christ's cross, and the relevance of His Church to the whole life of mankind. This was the vision that inspired B.M.S. medical missions from the beginning, that can draw upon infinite resources at the present time, and through all changes can carry the work to its divinely-appointed fulfilment.

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