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IN NAZARETH NOW

A gunshot patient arriving at the Mission Hospital on camel back

From *Nazareth of To day*. Reproduced by kind permission of Messrs W. Green & Son, Ltd., Edinburgh

THE WAY OF THE GOOD PHYSICIAN

BY

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TO WHICH IS ADDED

THE STORY OF C.M.S. MEDICAL MISSIONS

CHURCH MISSIONARY SOCIETY
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TO MY WIFE

WHOSE FELLOWSHIP IN MY MISSIONARY SERVICE,
BOTH ABROAD AND AT HOME, HAS ENRICHED
IT IN COUNTLESS WAYS, SEEN AND UNSEEN

PREFACE

DR HODGKIN writes as a medical man who has served in the mission field, as an administrator familiar with all the hopes and hardships of a mission board at home, as a member of the Medical Missions Sub-Committee of the World Conference Continuation Committee, but last, and chiefly, as one ever eager to do the work of an evangelist. The book will, it is hoped, afford sufficient, but not too much, material for those who have hitherto done little or no mission study. On the other hand, it is believed that the lines of Dr Hodgkin's treatment are sufficiently generous, and the references to other literature sufficiently full, to make the book an adequate basis for work by advanced students.

Editorial acknowledgments are due in the fullest degree to the author, who to his enthusiasm added patience, and to the many medical friends who rendered help on both the manuscript and the proofs. Among these are Drs Mary Scharlieb, J. W. Ballantyne, R. Cox, J. H. Cook, W. M'Adam Eccles, E. Sargood Fry, T. Gillison, C. F. Harford, R. Fletcher Moorshead, Arthur Neave, G. O. Taylor, H. H. Weir, and F. P. Wigfield. Misses J. M'Fee, M. C. Outram, and Richardson also made valuable suggestions. The use of pictures for the purposes of illustration was kindly granted by Messrs W. Green & Son, Ltd., the B.M.S., C.M.S., L.M.S., S.P.G., W.M.M.S., the Ludhiana College, and the Mission to Lepers in India and the East.

BASIL A. YEAXLEE

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THE WAY OF THE GOOD PHYSICIAN

CHAPTER I

A HIGH CALLING

THIS book has been planned and written at a time when hundreds of thousands of men are offering their lives in willing devotion on the field of battle. Very many of these have seen a vision of personal duty and of national honour which has quickened them to heroic action. When we think of all that this sacrifice means both to those who go and to those who stay, we are constrained to say, "Greater love hath no man than this, that a man lay down his life for his friends."

In these pages must be told the story of a service no less heroic, for an end no less worthy. It ill becomes us to think that the battle-field is the only place where great heroism can be displayed. If it were possible for us to see and to make clear to others the glory and grandeur of the medical missionary's calling, we should be doing something to supply that moral equivalent for war which is so sorely needed if the world is ever to turn into the paths of peace. In studying this great subject may we not recall to our minds the challenge to Christian civiliza-

tion flung down by that brilliant author M. Romain Rolland? "Is there," he says, "no better employment for the devotion of one people than the devastation of another? Can we not sacrifice ourselves without sacrificing our neighbours as well?"

To that question there comes back an answer from the heroes of the mission field. They have found the way. We follow David Livingstone, spending long years in lonely journeys through the heart of Africa. For the sake of the ignorant and degraded heathen, for the sake of the women and children, as well as the grown men, who were being sold into slavery, we see him wearing out his life, and giving his very best, until at last he kneels down in solitude to offer up his soul to God. We see Dr Richard Williams leaving his lucrative practice in Burslem to embark upon the mission to the wild savages in Tierra del Fuego, where, under the leadership of Captain Allen Gardiner, he endured untold privations. Engaged upon an apparently hopeless quest, the six members of that little party laid down their lives in joy and hope. As he lay dying, Williams wrote "Asleep or awake I am happy beyond the poor compass of language to tell." Or we may think of Pennell of the Afghan frontier, carrying all before him in his brilliant career as a medical student, and then deliberately turning from the success so richly deserved and so hardly won to the far outpost of civilization, where by patient labour he was to win the devotion of wild tribesmen and cultured Brahmins. When he died "Hindus, Mohammedans, rugged warriors from over the borders, women, children, schoolboys, beggars, patients, the lame,

the halt, the blind, old and young, foe and friend, all were united by the common sorrow that bowed all heads alike." [1] We remember Arthur Jackson, devoting himself with all the eager enthusiasm of his early manhood to stemming the awful tide of plague in Manchuria, spending himself to the uttermost in unsparing service for obscure Chinese coolies. Thinking nothing of his own danger, he stood to his post, showing constant consideration to the poorest and meanest, until the plague struck him down too. At the age of twenty-six he gave his life without a murmur in the service of his fellow-men.

These are but a few out of many who have shown true heroism in this great calling. They were surrounded by none of the popular enthusiasm that lifts men above themselves in an hour of great national crisis. Here is no sudden act of daring, called out by a stupendous emergency. These are men who have quietly and resolutely made their choice. In the secret chamber they have found their strength; in the silent recesses of their own hearts they have registered the vow. They have gone forth to save men's lives, to work in some unknown mission-station, to give themselves for a cause which the world scarcely recognizes, and of which few understand the true meaning. Artists have not been found to paint their deeds of mercy: poets have not sung the splendour of their service. But in all parts of the world their quiet heroism has been recorded in humble hearts, and to them has been awarded in high heaven the victor's crown.

What is the secret of this service? What is the spirit

[1] *Pennell of the Afghan Frontier*, p. 452.

which has made these men great? What went they out into the wilderness to do? How has their faith been maintained in the long toil of an unseen life?

Such are the questions which we must first answer if we are to understand the meaning of medical missions.

At the outset of such an enquiry we are faced by a serious difficulty. The medical missionary expresses himself in acts. His tale is the simple record of brave service, of countless little kindnesses. He does not enlarge upon his aims and motives. Frequently he is a man of few words. We read the biography of a medical missionary, and perhaps there is scarcely a word that speaks directly of the hidden springs of his life. The spirit breathes through that which he did and was, and finds little if any expression in definite statement. The student of medical missions must indeed go straight to the sources if he is to breathe the true spirit of this great enterprise. As he reads the lives of medical missionaries there will come to him a sense of the greatness of the calling, and of the men—made great indeed in many cases through their calling. He will catch some insight into what they were by understanding what they did. No textbook can take the place of such a study, and the purpose of this chapter will not be fulfilled unless many of its readers turn with eagerness to a first-hand study of the lives of the men themselves.

Perhaps the first impression that we gain from such a survey is a sense of the vocation of the medical missionary. It is doubtless true that some men, and a few women even, enter upon the medical profession merely as a means of

earning their living. But the true physician is one who knows himself called by the need of his fellows, or at least one to whom that knowledge comes in the course of his life's work. A distinguished medical man has recently given us a charming and profound interpretation of vocation as it may be realised in his profession. "Every year," he says, "young men enter the medical profession who neither are born doctors, nor have any great love of science, nor are helped by name or influence. Without a welcome, without money, without prospects, they fight their way into practice, and in practice; they find it hard work, ill-thanked, ill-paid: there are times when they say, *What call had I to be a doctor? I should have done better for myself and my wife and the children in some other calling.* But they stick to it, and that not only from necessity, but from pride, honour, conviction: and heaven, sooner or later, lets them know what it thinks of them. The information comes quite as a surprise to them, being the first received from any source that they were indeed called to be doctors; and they hesitate to give the name of divine vocation to work paid by the job, and shamefully underpaid at that. Calls, they imagine, should master men, beating down on them: surely a diploma, obtained by hard examination and hard cash, and signed and sealed by earthly examiners, cannot be a summons from heaven. But it may be. For, if a doctor's life may not be a divine vocation, then no life is a vocation, and nothing is divine."[1]

If you were to call the medical missionary a hero to his

[1] *Confessio Medici*, pp. 9, 10.

face he would stare at you in blank amazement. "His not to reason why; his but to do and die." Yet underneath the crowded activities of his life there lies the strong sense of vocation without which he could not sustain the pressure for a single year.

In the first place he is called as a doctor to do a doctor's work. In going abroad he finds a free field for the exercise of his gifts. Here in this favoured land men may struggle with one another for the opportunity to help their fellows. Not a few go out into practice at home, year by year, only to drag out a precarious existence, or even to go under in the struggle, not because they are lacking in zeal and skill, but simply because there are so many already in the field, and the competition is too keen for them. A man's desire to serve may never get, under such conditions, a fair chance of expressing itself. His very sense of vocation may die away in the struggle for the necessities of life. Happy is the man whose thoughts have been turned towards the need abroad. There, certainly, there is never any fear of his not having enough to do. The passion to heal disease and to relieve suffering can find its fullest expression. There is no sphere where the doctor with a high sense of vocation finds a larger opportunity.

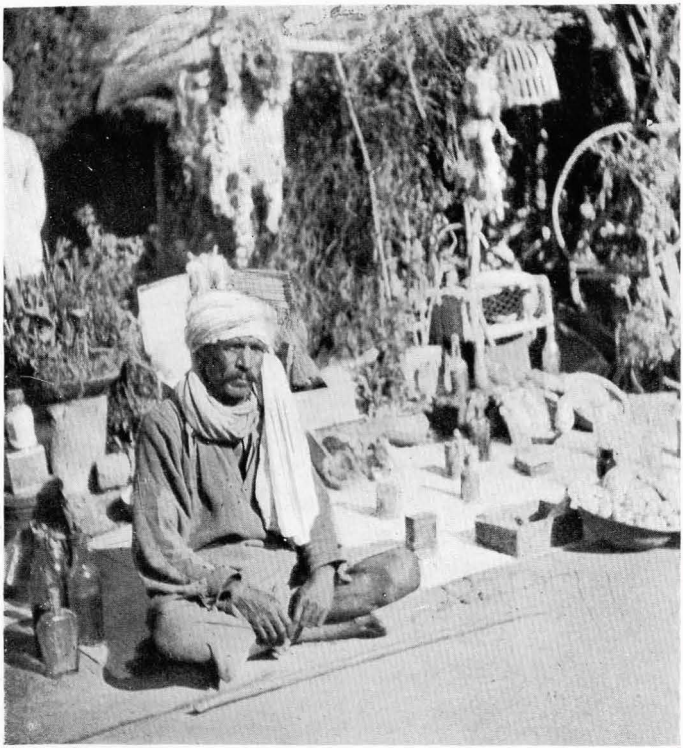
But it is not only this spirit that moves him to enter upon so arduous a career. His love for humanity is but part of his love to God. In his neighbour he sees the brother for whom Christ died. Medical missions are an expression of the whole message of Jesus Christ to the individual, the healing of the body, the enlightening of the mind, the redeeming of the soul. It is this combina-

tion that gives to the enterprise its majesty, and that invests the medical missionary with that peculiar power of appeal to men and women of all types of mind. It has been urged that the medical mission is merely a means of getting into touch with a large circle of persons in order that they may come within reach of the Gospel. This is a wholly inadequate conception of the subject. The medical mission is, in both its aspects, a presentation of the Gospel, and no man can truly claim the title of medical missionary who does not believe that he is proclaiming his message in the acts of healing as truly as in the spoken sermon. To exalt either aspect of the work in antithesis to the other is to miss the inmost meaning of the medical missionary's vocation. If we are to understand his spirit we must not dissect it into its elements and weigh one against another; we must see him as he stands, a follower of One who expressed the nature of His own mission in the words, "The blind receive their sight, the lame walk, the lepers are cleansed, and the deaf hear, and the dead are raised up, and the poor have good tidings preached to them."[1]

"A missionary of the S.P.G. in South India records how a leper who had been treated at their dispensary became to others a never-failing source of interest and cause of enquiry into the motive which inspired such kindness. He had hobbled up to the dispensary a stranger, eighteen months before, on his poor toeless feet, and throwing himself at the missionary's feet, cried out, 'For God's sake give me some poison, for I cannot bear

[1] Matt. xi. 5.

this pain any longer.' The bystanders hurried away to the windward of him. The missionary washed and dressed his sores, which were full of maggots. Gradually he grew stronger, and though he will never be well, he now enjoys life. Soon after he came, and when his sores were very offensive, the missionary and his wife were one morning dressing his feet. A stranger, a Mohammedan, prompted by curiosity, walked quickly up to the spot until he was within smelling range, when he hurriedly ran to the windward. 'Foh! Foh! What a stench!' he exclaimed as he spat the taste out of his mouth. The missionaries were too busy to notice him, but presently he addressed the leper. 'Oh leper,' he said, 'do you know that those white hands are doing for you what the mother who bore you would not do?' 'Yes, I know it,' was the reply. Then there was a long pause. 'Allah! Allah!' exclaimed the Mohammedan, and again he spat, for the taste was still there, 'it passes me how you can touch a man like that.' 'You would do the same for your brother, I am sure,' replied the missionary. 'I don't know,' he said dubiously; 'perhaps I might.' 'Well, this man is my brother,' answered the missionary. 'Oh! come, that won't do at all,' he said incredulously. 'Why he's black and a pariah, and you are white and English.' 'Yet what I say is true. God is my Father, and He is this poor leper's Father, and so he and I are brothers. And you have read the Koran and know something of Isa (Jesus) and the *Injil* (Gospel). Well, Isa says in the *Injil*, "Inasmuch as ye did it unto the least one of these My brethren ye did it unto Me."' 'Well,' he replied, 'I can't



A "DOCTOR'S SHOP" INDEED
Baïd-Doctor of the old school now working in Ludhiana

understand it, but if that is your belief no work can be too difficult for you to do.'"[1]

It is through such incidents as these, which might be brought forward by the score, that we get the truest insight into the secret of the medical missionary's work. He is speaking a language which is not that of one class only, or of one race.[2] Even before he has mastered the intricacies of a foreign tongue, his message will have reached many hearts. During his few months in China, Arthur Jackson was able to learn very few words in that most difficult of languages, yet he has spoken to tens of thousands, to the crowds of coolies who passed through the station where with infinite tenderness and patience he handled each case that came to him, through them to hundreds of homes throughout a wide area, and even to the Viceroy himself. "He worked at the railway station early and late. Whenever a coolie in an inn caught the plague, although the place might be most filthy, he would go himself to treat the case. Alas! he himself caught the infection; he was taken ill on January 24th and died the next day. He was twenty-six years of age, full of life and health. His death in labouring for our country was actually carrying out the Christian principle of giving up one's own life to save the world."[3] Such are the words of a Chinese newspaper, to which may be added those of the Viceroy: "He went forth to help us in our fight daily, where the pest lay thickest; amidst

[1] *What Medical Missions are Doing.*

[2] *Cf. Missions at Home and Abroad*, by Dr Post, pp. 346, 347.

[3] *Eastern Provinces Daily News*, quoted in *Life of Dr Arthur Jackson of Manchuria*, p. 148.

the groans of the dying he struggled to cure the stricken."[1]

Such deeds are more than words. They win their way to hearts which are steeled against the preacher's message, to minds that the teacher strives in vain to penetrate. They are of the very essence of the Gospel of Christ.

It would be easy to give a list of the various arguments advanced in support of medical missions, and the list would be a formidable one. It is difficult, however, to imagine the average medical missionary candidate sitting down to review and balance these. We invariably find that whenever such men and women as those mentioned in the preceding pages tell us what took them to the foreign field, they waste very few words upon secondary issues. David Livingstone put the case in his own concrete way when he wrote home to his father and said that he had been impelled to devote his life to this service because "God had an only Son and He was a missionary and a physician."[2] Equally direct and simple is the testimony of men and women of our own day. Thus Dr J. H. Cook writes: "I think a 'vocation' is, after all, only a consciousness of capacity—capacity to fill the need. I think many of our medical missionaries (myself among the number) would say that they never had any love for the heathen before they went to the mission field, and never had any other vocation than a realization of the literal urgency of Christ's command to evangelize, coupled

[1] *Eastern Provinces Daily News*, quoted in *Life of Dr Arthur Jackson of Manchuria*, p. 146.

[2] Blaikie, *Life of David Livingstone* (Popular Edition), p. 104.

with the consciousness that by their past training they had a capacity which would be of use for this end. It is *after one gets to the mission field* that all the rest comes."

Once we study what has been and is being accomplished, once we catch the spirit of the men and women who are doing this work, we find it hard not to share their conviction that medical missions are absolutely and triumphantly vindicated as a means, perhaps the supreme means, of establishing the kingdom of God upon earth. Nor need we be perturbed by the thought that even during the great days of the pioneers in modern missions at the end of the eighteenth century and the beginning of the nineteenth, this was not seen to be so. It may, indeed, appear strange that during the first part of the modern missionary era medical missions scarcely figured as a definite factor in the enterprise. In part this may be traced to the fact that the medical needs in foreign lands were little known, and that there was less difference then than now between the medical and surgical knowledge in the home country and in non-Christian countries. With the advance of medical science, however, and with the greater knowledge of actual conditions abroad, this branch of the service has come to take a place of very great importance. To Dr Peter Parker, who was sent out to China in 1834 by the American Board of Commissioners for Foreign Missions, belongs more than to any others the honour of awakening the conscience of Christians in England to the great possibilities of medical missions. Huge crowds gathered round his surgery in Canton, and the news of his success encouraged others to take up the work. On his first

furlough he visited Edinburgh, and was the means of inaugurating the Edinburgh Medical Missionary Society,[1] which has done so great a work for the cause in this country. In that year, 1841, there were only three medical missionaries holding British qualifications, and this in spite of the fact that two of the earliest missionaries sent out by British Societies were doctors, viz., Dr Thomas, who went out with Carey in 1793, and Dr Vanderkemp, who went to Africa in 1798.

During the seventy-four years that have intervened since the formation of the Edinburgh Society, medical missions have come to be recognized as an integral part of foreign mission work, until, in our own day, scarcely any missionary society exists that does not use this potent means of presenting the Gospel. The number of patients seen in the year by medical missionaries the world over exceeds four million, and those who have been won for Christ through their labours number many thousands.[2]

So far from needing any elaborate defence, this growth in the work of medical missions becomes itself, like the experiences and achievements of individual medical missionaries, a peculiar vindication of the spirit and power of the faith we profess. A man who has "seen service" as a Christian doctor in non-Christian lands is confirmed in his conviction about the place of medical work in the Christian programme by "things seen and handled," the

[1] See *Life of Peter Parker, M.D.* (now, unfortunately, out of print).

[2] For a brief outline of the history of medical missions (down to 1864) see two articles by Dr J. L. Maxwell in *Mercy and Truth*, Vol. XIX, pp. 8-80. For the history of medical missions of the various Societies see list of books, pp. 141 f.

bare summary of which has not seldom proved the means of winning ardent support for foreign missions from folk at home who have never yielded to any other argument. In later chapters we shall examine these aspects of the work in detail. In this place it is our purpose only to bring out further, by passing reference to the foremost characteristics of that work, the kind of spirit that animates the workers. Every medical missionary finds himself able to claim at least four great reasons for spending and being spent in the foreign field, apart from the great and all-inclusive one put forth by David Livingstone.

1. Medical missions are a means of bringing healing and relief to the bodies of those to whom the missionaries go, and thus of exhibiting the compassion of Christ.
2. They remove the fear of evil spirits by showing how ill-health is due to natural causes, and how disease can be removed by the use of natural remedies. They thus liberate the mind as well as the body.
3. They are the means of breaking down prejudice among the ignorant, and thus securing a kindly attention to the missionary's message. They thus open the way for the entrance of the preacher when it has been closed to all other efforts.
4. They are directly responsible for leading many individuals into the Kingdom of God.

When our Lord was on earth He sent out the twelve

and the seventy to teach and to heal, and when He left His disciples it was with this double commission upon His lips. There is something more in this twofold function of the Christian missionary than is always recognized. It is true that our salvation has been won through the infinite suffering of the Son of Man: but He came to bring men into a life of joy. He never seems to have hesitated to bring to men a full release from bodily ill.[1]

In our Western, clouded atmosphere, we are prone to accept pain too much as a part of our religion, to set the heavenly song in a minor key. The religion of Jesus Christ was born under a clearer sky. The note of joy sounds loud and clear throughout the New Testament. Into the great, glad experience of a new and abundant life men were being born by the operation of the Spirit of God. It is a noteworthy fact that in the mission-field the simpler and more child-like faith leaps forward to a greater sense of release from outward as well as inward ills. The medical missionary is the herald of a great deliverance. Body and soul are to be emancipated. What the apostles did by the healing touch, the missionary surgeon may do with the scalpel or the antiseptic dressing. But the message is not different. There are diversities of ministrations, but the same Lord.

COLLATERAL READING.

Biographies, e.g. Pennell, Jackson, Schofield, Mackenzie, Robertson.
Medical Missions, their Place and Power (Lowe). Chapters I and II.
The Appeal of Medical Missions (Moorshead). Chapters I, II, III.
Mercy and Truth. Vol. XIX, references on p. 12 for brief history.
Also in *The History of Indian Missions* (Richter), pp. 346-355.

[1] Cf. *Christus Futurus*, p. 77.

CHAPTER II

THE REAL TASK

EVEN in these days one sometimes hears it suggested that it would be better to leave the peoples in Africa and the East to the tender mercies of their own "medical men," who have knowledge of native remedies and the native constitution, and who can by their simpler methods achieve many remarkable cures. Such a view is based upon ignorance. It is true that there are certain native prescriptions which have great efficacy, and that in spite of seemingly hopeless conditions a wonderful cure is sometimes effected by the native practitioner. Unfortunately these cases are the exception. While probably few readers of this volume will believe otherwise, it will be well worth while for us to pause a little in order to grasp, in some measure, the extent and depth of the need that still exists for the medical missionary.

The nineteenth century has, of course, seen an unprecedented advance in medical science in this country, and much that was superstitious or due to ignorance in medical practice has, during that period, been eliminated. In most non-Christian lands we find a state of things far more primitive than even that which existed in Europe in the Middle Ages. In the first place there is much suffering that is the result of sheer ignorance. Anatomy is a practically

unknown science; methods have frequently no sort of relation to the cause of disease; the very conception that there is an ascertainable organic cause is scarcely present. A few actual instances of native treatment will best illustrate the literal accuracy of these statements.

"A little child," says Mrs Ashton Bond, of Uganda, "was brought to us with a hole burned right through the chest into the lung, and this was the treatment by a native doctor for a cough."[1]

"One form of treatment which we had not seen before was that of applying very hot sand to an eruption of the face and hand. The poor victim came in with severe burns, for which she had to stay with us for a long time. We were puzzled as to what the trouble was until the story of the sand came out."[2]

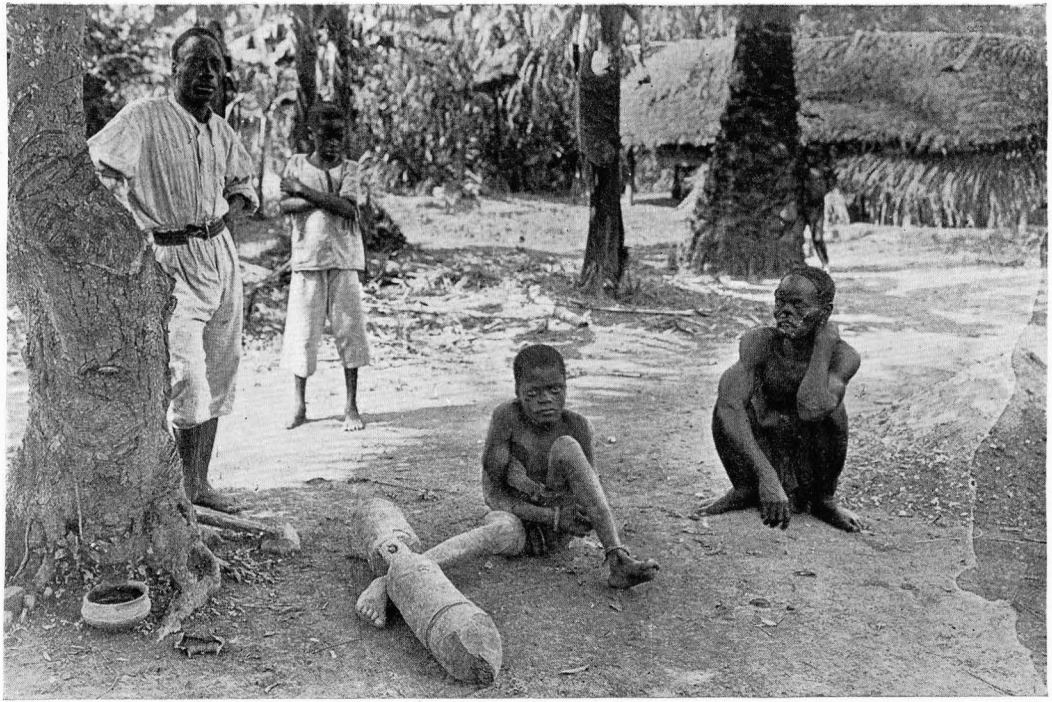
"Dr Rosetta S. Hall gives an account of the visit of a Korean doctor to a sick child. The first thing he did was to make a little pyramid of brownish looking powder upon each breast of the child, and then to set it afire until it burned the tender skin. This was followed by the use of a large darning needle, which was thrust through each little foot, the palms of the hands, the thumb-joints, and through the lips into the jaw just beneath the nose."[3]

"In a recent report of one of the Chinese hospitals . . . an account is given of a woman who had been sick for a long time before she came for treatment, and 'had eaten more than two hundred spiders, and a large number of snakes'

[1] *Mercy and Truth*, Vol. XVI, p. 307.

[2] *Ibid.*, Vol. XIV, p. 234. From Dr Minnie Gomery's report of work at Islamabad, India.

[3] Dennis, *Christian Missions and Social Progress*, Vol. I, p. 190.



CASTING OUT SATAN BY SATAN

Native treatment of a lunatic boy, Batoko, Upper Congo

eggs, without being helped.' A native prescription in Northern China required a wife to take some of her own flesh and, having properly prepared it, to give it to her sick husband to eat. The directions were heroically carried out, but without avail."[1]

"I remember one case of a poor man brought to the dispensary with a big swelling on the left knee, which prevented his straightening the leg. Careful examination convinced me that the case was one of malignant cancer of the thigh bone, and that nothing could be done but amputation. This was explained to the patient and his father, who indignantly rejected the proposed operation. I lost sight of the man, but some weeks later one of my assistants asked me if I remembered the case; on my replying in the affirmative, he informed me that the patient had since died. It seems after leaving the dispensary the father had taken his son to a native surgeon (who combined the exercise of his profession most appropriately with the trade of a butcher). . . . He got the father and other men to hold the unfortunate youth firmly, and some other helper to seize the leg; then seizing a huge slab of stone in both hands, he brought it down with all his force on the bent knee. The leg was straightened . . . and, needless to add, the patient only survived a few days."[2]

The above are a few examples taken at haphazard out of thousands that might be quoted from all parts of the mission-field. We would not be understood as urging the presence of any deliberate cruelty on the part of such

[1] *Ibid.*, pp. 188, 189.

[2] *Behind the Veil in Persia and Turkish Arabia*, pp. 160, 161.

practitioners, but rather as indicating to what a vast amount of needless suffering their ignorance gives rise. The medical missionary is engaged in the work of meeting this ignorance and overcoming its ill-effects.

This, however, is not the whole statement of the case. So far as any cause for disease is sought among non-Christian peoples, the attempt is very often made to fix it upon some individual who is supposed to have cast an evil eye on the sufferer or in some other way malignantly influenced him. Thus others beside the invalid himself are involved in the result of his illness. "An African chief is ill, and the witch doctor's tale is that long years ago an uncle, who is still living, practised witchcraft upon the sick man, and was endeavouring even now to kill him. Not more than a day or two passes after this verdict before that uncle's hut, and all his crops, just reaped, are burned to ashes, and ever since he has been forced to be a fugitive, sleeping in the bush, with his spear beside him, and never daring to seek his rest twice in the same spot."[1]

It has been said, indeed, that among many peoples the first question asked when any one falls ill is not, "What is the cause?" but, "Who is the cause?" This view of the causation of disease is one that at once opens the way to the witch doctor, and is indeed dependent upon his ascendancy. The supposed relation between illness and the work of evil spirits cuts at the root of any rational system of treatment, and lets in the worst forms of quackery. If we are truly to understand the nature of the need that

[1] *Missionary Record* of the United Free Church of Scotland, Sept. 1904, p. 418, quoted in Dennis, *op. cit.*, Vol. III, p. 538.

the medical missionary is meeting, we need a clear understanding of the power of the animism thus expressed, not only among the utterly uncivilized tribes of Africa and the islands of the sea, but also among the relatively civilized peoples of India and China. Disease becomes the means of fixing upon ignorant and superstitious minds the terrible yoke of fear. The missionary doctor in curing disease lifts that yoke. He shows by his healing skill that such fear is groundless. He emancipates the mind while he cures the body.

The extent of this bondage is not easily realized by those of us who are accustomed to think in terms of cause and effect, and whose whole life is influenced by scientific principles. James Chalmers, speaking of conditions in New Guinea, says: "Natives never believe in being sick from anything but spiritual causes, and consider that death, unless by murder, can take place by nothing but the wrath of the spirits. When there is sickness in a family, all the relatives begin to wonder what it means. The sick person getting no better, they conclude that something must be done. A present is given; perhaps food is taken and placed on the sacred place, and then removed and divided among friends. The invalid still being no better, a pig is taken to the spirits; it is then returned and divided to be eaten. When death comes, great is the mourning, and the cause, if not already known, is still enquired into. . . . The older women of the family stand in the grave and receive the body . . . saying, 'O, great Spirit, you have been angry with us. We presented you with food, and that did not satisfy. We

gave a pig, and still that did not satisfy. You have in your wrath taken this. Let that suffice your wrath, and take no more.'"[1]

Very often this belief in the power of the spirits over the bodies of men entails greatly added suffering to the patient, or even results in his death. "Disease is caused by evil spirits. Hence the treatment of the sick aims at driving out the evil spirits. They torture the poor sick man by surrounding him with frightful uproar, hurrying him from one house to another, giving him nauseating or pungent medicines to drink, enveloping him in thick, foul-smelling smoke—all to drive out the spirit that causes the disease. The effect, of course, often is that the patient dies under the treatment. Certain patients, those for example seized by cholera, and lepers, are left to themselves through fear of infection. The Kols are just as heartless towards the sick, because evil spirits are the cause of the disease."[2]

The sense of fear, the tyranny of cruel customs, the bondage of the mind, which are the result of a belief in a world dominated by evil spirits—all these are struck at by the missionary doctor when he comes, with the knowledge and skill which are the direct result of studying natural laws, and effects his cure without attempting to appease any angry deity. The medicine man or witch doctor has a hold over the minds of these ignorant people which it is scarcely possible for us fully to appreciate. He seems to them to hold a mysterious power of life and death.

[1] Chalmers, *Pioneering in New Guinea*, pp. 329, 330.

[2] Jellinghaus, *Kols*, p. 69, quoted in Warneck, *Living Forces of the Gospel*, p. 158.

His commands must be obeyed, whatever cruelty or suffering is involved. His sporadic successes are striking proofs of his supernatural power: his many failures are explained away by fantastic reasons. The medical missionary liberates men not only from the dread of evil spirits, but from the malign influence of the medicine man.

In considering this great need among the people generally, we have not even yet found our way to the worst cases that call for the help of the missionary doctor. When we examine the need of special classes we most clearly hear the call that comes from the sufferings of our brothers and sisters.

No section of the community stands to gain, or has in point of fact gained, more by the work of medical missions than the women, especially in India and in Mohammedan lands, where they are so closely immured in zenana or harem that none but medical women can reach them. In almost all parts of the non-Christian world the woman is regarded as an inferior type of being to the man, or at best created for his use and enjoyment. It is small wonder that even such comforts as are available for the sick man are often denied to his sister or his wife.

In the hour of childbirth she is left in the hands of ignorant women, and frequently suffers wholly unnecessary pain in addition to all that is involved in the course of nature. The lives of countless children, and very many of their mothers, are needlessly sacrificed. The wife is sometimes not even accorded the place given to a dumb animal. Although, as a result of Christian missions, a great change is taking place, there is still too much truth in

the remark of a Hindu quoted by Dr Richter,[1] "that there was at least one doctrine upon which all Hindu sects were agreed: We all believe in the sanctity of the cow and in the depravity of woman." The amount of suffering involved in the one custom of child-marriage alone is more than can be gauged, and when a young bride becomes a widow, even that amount of consideration which has been accorded her is frequently wholly withdrawn.[2] "The more women missionaries," says Dr Richter, "penetrated into the hidden world of the zenanas, the more awful were the pictures they painted of the dire distress and neglect reigning therein."[3]

There are two large classes of patients in non-Christian lands peculiarly deserving of our pity. The first is that of the mentally defective. The idea of demon-possession finds its fullest expression in the treatment meted out to these unfortunate persons. Being supposed to have incurred the wrath of the gods, they are thought of, not as objects of pity, but as fit subjects for further punishment at the hands of their fellow men.

Dr A. Hume Griffith writes: "The usual method of dealing with lunatics in Mosul is, if they are apparently harmless, that they are allowed to wander about freely and are treated kindly; but once they develop symptoms of mania, they are treated as wild beasts, put into a dark room, and chained to a wall. But we possess a specialist in 'mental diseases' in Mosul, belonging to an old

[1] *History of Indian Missions*, p. 350.

[2] See, *e.g.*, an incident related by Miss Irene Barnes and quoted in Moorshead's *Appeal of Medical Missions*, p. 148.

[3] The subjects of child-marriage and widowhood are dealt with in Dennis, *op. cit.*, Vol. II, pp. 119-125.

Mohammedan family, who has a great reputation for the treatment of 'lunatics.' In the courtyard of his house he has had dug several deep wells, and beside each well is placed a large tub, having a hole in the bottom which communicates with the well. The poor madman is made to work from sunrise to sunset drawing water from the well and pouring it into the perforated tub, being told that he may leave off *when* he has filled the tub. If he refuses to work he is unmercifully beaten. Several cures are said to have resulted from this treatment." [1]

From Manchuria we hear that "Madness, epilepsy, and extreme hysteria are usually regarded as being caused by devil possession. Without any enquiry into the origin of the condition, most cruel methods are resorted to in order to drive out the evil spirit, such as forcing the patient to stand barefoot on red-hot iron, and there is always a severe and merciless beating. Fortunately for the poor sufferers, life cannot long sustain such extreme torture, and death brings release. A girl of seventeen was brought to me, evidently a case of extreme hysteria. The witch-doctors, after trying several cruel methods without success, had finally thrust a red-hot poker down her throat to expel the demon. The girl died shortly afterwards." [2]

The second group is that of the lepers.

A year or two ago a dreadful story was told of a Chinese official who ordered his soldiers to surround a leper village, and drive the inhabitants into a trench which had been prepared for them. As soon as the people were inside

[1] *Behind the Veil in Persia and Turkish Arabia*, pp. 326, 327.
[2] *Thirty Years in Moukden* (Christie), p. 38.

the trench the soldiers opened fire, and massacred in cold blood the whole population of that village, completing their task by pouring paraffin oil on the remains, and setting fire to them. The incident must not be regarded as typical, and yet it lets in a flood of light upon the loathing and disgust which seems to be inspired by this particular form of disease. This, again, is a thing that we find it extremely difficult to realize. We think with pity of the leper, the outcast from society, the one to whom Jesus showed such signal kindness when He not only healed him, but stretched forth His hand to touch him. Where leprosy is most widespread, however, it seems to call forth nothing but fear and contempt. The leper, be he rich or poor, is turned out of house and home. He becomes a wanderer on the face of the earth, a beggar and a blackmailer, driven to dishonesty by being denied the right to earn an honest livelihood, and to the misery involved in his disease is added the greater misery of being cut off from his fellows, and made an outlaw by society. One may at least hope that the lunatic is often but dimly conscious of the sufferings inflicted upon him. The leper, retaining his mental faculties, may seem, even though not as a rule treated with open cruelty, to have an even harder lot.

The outline sketched in this brief epitome of actual conditions is one from which we would gladly turn away our eyes. It is not pleasant to think of cruelty and superstition, of unnecessary pain and misery. Yet we cannot gain any true conception of the medical missionary's

gigantic task unless we do allow our eyes to rest for awhile upon this picture. What does it all mean? What relation has it to ourselves in our own sheltered and comfortable lives?

1. First we must remind ourselves of the difference Christ has made. Not only in the African jungle are religion and disease closely associated. Our Faith began in a challenge to both sin and pain. Compassion is at the heart of Christianity. The different attitude towards disease springs out of a different conception of God. Christ brought into the world the transforming idea that God is love. The non-Christian mind is still largely dominated by the idea that God is at enmity with men. The normal attitude towards Him is fear. They imagine Him to be, if not always actively hostile, at least extraordinarily capricious. The Christian missionary is engaged in the stupendous task of completely changing their idea of God, and in seeking to accomplish that task he uses the art of healing as no mere accessory even providentially placed in his hand. He uproots this false view of God by his method of dealing with disease, and above all by his sympathetic touch. What is more, he replaces the false by the true. He gives living expression to that idea which is at the heart of the Gospel message, that God is indeed our Father, and that Jesus Christ, His Son, is our Elder Brother.

2. We sometimes hear the question raised as to whether we are justified, in these days of great world-movements, in devoting so much effort towards work amongst such classes as the lepers and the insane, to the lower strata of society,

especially to those who from their physical condition cannot possibly take any great part in spreading the faith in their country. It is urged that there are very many other claims which can more than exhaust the available resources of the Church, and that these claims have a more direct relation to the future. There are new nations to be built, there are the young and the strong to be reached, in whose hands the shaping of a new age must lie: there are wide open doors for educational activities, for literary work, and for other agencies through which great masses of men and women can be reached. Is it not the true policy of the missionary statesman to turn away, however reluctantly, from the immediate call of humanitarian instinct, and build rather for the future of the whole human race? We are even reminded that our Lord Himself deliberately turned away from the crowds who sought His healing touch and went forth to fresh fields of service (Mark i. 32-39).

In answering this challenge we get back to the heart of Christianity. The present writer would be the last to deny the need for missionary statesmanship, and for that foresight in planning our work which seizes the great opportunity and works for the fulfilment of the largest ideal. But this must never be done at the expense of that genuine Christian instinct which bids us go to the lowest, the most helpless and degraded. That would be to sacrifice the Spirit of Christ in the endeavour to spread the Gospel. It would invalidate the whole missionary crusade. Even though it seem to be a reckless waste of costly material, the whole box of precious ointment must be poured over

the Master's feet. It is of the inner essence of Christianity that we give of our best to those who seem least worth it. We cannot allow the antithesis that sets one over against the other. We can only say, "These ought ye to have done, and not to leave the other undone."

3. The medical missionary, furthermore, has a quite distinctive place in the creation of a new social order in the non-Christian countries. We are accustomed to look upon the educational missionary as the man who is peculiarly marked out for this service. He brings in new ideas. He deals with the young, in whom these ideas may be expected to exert their full influence. He has his pupils under instruction long enough for them to become thoroughly permeated by his teaching. It is therefore but natural to regard the educationist as the chief factor in the working out of the full content of the Christian religion in relation to society. To the medical missionary, however, belongs no small share in this supremely important service. In the first place he speaks a language that all can understand. No new social order can be built only by the small minority who can be reached through the mission schools. They may be the leaders, but they cannot lead unless their spirit is in some measure shared by a larger number. Through the mission hospital and dispensary new ideas are gradually permeating a far wider circle than that which can be immediately touched by the mission school and college. If a new order of society is to be created, the self-regarding instinct must be replaced by the passion for the good of others. It is this changed attitude

towards life and towards our fellows that alone can shape the common life of mankind according to the principles of the Kingdom of God. The missionary doctor is the living embodiment of this principle. Whether he lays down his life in seeking to stem the advance of an epidemic, or whether he lives it out in unwearied ministration to the sick and suffering, he is making this principle a living thing to thousands who could never express in words what he has taught them, and who could never receive the message if it were conveyed to them only by the spoken or written word. The greatness of the world's need is the measure of his opportunity. The utter destitution of the outcast leper, the pitiable state of the neglected maniac, supply him with his supreme chance of making this new spirit visible and intelligible to the mass of the people. Wherefore there shall be given to the medical missionary no small place in the roll of honour of those who have striven to build on this earth of ours the fair structure of the City of God.

COLLATERAL READING.

The Healing of the Nations. Chapters I and II.
Behind the Veil, etc. Part 1, Chapters VII and VIII, XII, XIII, XIV, and Part 2.
Christian Missions and Social Progress, Dennis (various sections). Vol. I., Chapters V, VI–XIII.
The Livingstonian, 1909. Pp. 42 ff.
The Claim of Suffering. Chapters I–III.
Unknown People in an Unknown Land. Chapter XV.
Thirty Years in Moukden. Chapter V.

THE LAST ARRIVAL

A fresh case at the hospital of the Mission to Lepers, Nasik, India

CHAPTER III

WAYS OF APPROACH

In what way is all this vast amount of human misery and disease being met? When the medical missionary first plants his foot in the land of his adoption it is small wonder if he feels almost hopeless. He is at once faced by stupendous difficulties, and it may be that he stands almost alone in the midst of an unfriendly population. Medical missions have indeed removed a vast amount of prejudice and opened the way for the entrance of the Gospel, but their first arrival has usually been signalized by the outbreak of ill-founded rumours, and by the creation rather than the removal of prejudice. In the early stages of missionary work it is only natural that there should be misunderstanding and opposition. The foreigner is suspected because he is a foreigner. His motives are unknown, and supposed to be self-interested. His words are halting, his actions and his method of life unfamiliar. We have only to imagine the effect in a country village in England of the arrival of a colony of Chinese, maintaining their own habits and clothing, to form some idea of the first effect of the arrival of British missionaries in the heart of China. The medical missionary is not less an object of wonder and suspicion. This

is deepened by his introduction of strange new methods in the treatment of disease, and even the fact that he asks for no fee may serve to increase the distrust. The wildest rumours frequently circulate, and there is no limit to the credence obtained for such. Although this stage has long passed in most medical missions it is well that we should realize how grave a difficulty it created in the early days, and may still create where new work is opened.

"Some said," writes Dr Christie of Manchuria, "that he missionaries were but the vanguard of an English host who were coming to invade China. Others were convinced that our medicine could change the hearts of those who used it, and compel them to follow the foreigner and believe his doctrine. A Mandarin came one day to have a painful tooth extracted, and so afraid was he of our drugs that he could not be persuaded even to wash out his mouth with the water provided. The old story was soon set afloat, that the children's hearts and eyes were taken out and used for concocting drugs, and for photographic purposes. 'How can a box see to make pictures,' it was reasoned, 'if it has not eyes inside?'"[1]

An even greater difficulty, and one which is far more enduring, lies in the actual conditions of work. The effort to secure the barest necessities for successful medical and surgical treatment often seems almost hopeless. Cleanliness, fresh air, good food, isolation, rest, proper attendance, the carrying out of instructions—all these at least we take for granted as the conditions of success in hospital work,

[1] *Thirty Years in Moukden*, p. 5, *q.v.* for instances of the kind of story circulated and believed of the medical missionaries in early days.

and to a large extent in private practice, in this country. The skill of the doctor is only one of many factors which make for the recovery of the patient. Especially at the beginning of the work abroad scarcely a single one of these conditions can be secured. Medical men and women who have been trained in an up-to-date and well-managed hospital in England, and who have been accustomed to rely on all these aids to success, are apt to find a sense of helplessness coming over them when they face the facts in India or China. One picture must suffice to help us to realize the actual conditions of work. "Once, in the middle of the night, I was awakened by a message that some Mohammedan gentleman wished to speak to me. . . . He told me that a poor woman had been in labour many days, that no man doctor could be permitted to touch her, and he hoped I would go to her relief. I went, and found my patient lying huddled in a heap in the corner of a bare room in which there was no article of furniture. Her friends told me that she had been there for many hours. I asked them to bring a bed of some description, or better still a table. They had none in the house. I told them to go and borrow one; this they appeared unable to do, and finally a form was procured from the neighbouring school. This made a most uneasy couch for the poor young mother. The next difficulty was light; the only lamp in the place was a picturesque little earthen vessel filled with castor-oil in which floated a mesh of cotton threads; one end of the mesh rested on the top of the vessel, and when kindled gave forth about as much light as a match. Unluckily for me, a hasty movement upset the

tiny lamp. My clumsy assistant in her agitation knocked over a large vessel of cold water, which administered a foot-bath to everyone around, and I was left to attend to my patient and resuscitate a half dead baby in total darkness. . . . Strange to say, this patient and her baby both lived."[1]

Every book on medical missions will supply many instances of the same kind. Common incidents in the work are such as the following: The patients who have been supplied with new beds and bedding are found in the morning to have moved on to the floor; the medicine is taken by the wrong person, or applied inwardly instead of outwardly, or several days' supply is consumed at one gulp; the bandage that has relieved pain on a suppurating leg is removed, and applied in place of an aseptic dressing to a clean wound, or even to an eye, causing total blindness; the clinical thermometer is supposed to have some curative value, and is crunched to powder and swallowed; an emergency operation must be performed in the midst of indescribable filth with men, women, and children crowding round, not to mention dogs and cats and smaller things innumerable.[2]

It need hardly be pointed out that the doctor's first task is to create a new environment in which he shall have some reasonable chance of doing good work. It is for these reasons that the mission hospital becomes a far more vital item in the equipment of the doctor abroad than at home. In the hospital he is able to surround the patient with the conditions that make for success. Not

[1] Dr Mary Scharlieb in *Dedicated Science*, p. 28.
[2] See *The Claim of Suffering*, Chap. IV.

at first indeed, but in course of time, he can secure these conditions as fully as they are secured at home. Some of the great mission-hospitals will compare favourably with any hospital in the world. Well-built, well-aired and well-lighted, with clean bright wards, with efficient nurses under a fully-trained foreign matron, dealing with a volume of work at least as great as and probably far greater than a hospital of equal size in a Christian country, staffed by doctors who have taken the highest honours and who could have won great names for themselves at home had they so desired, these hospitals are at once an object lesson in the principles of sound medicine and surgery, and a witness to the spirit of Jesus Christ. Only those who have faced the initial difficulties, who have poured their vital energy into the erection of such a hospital, and who have seen that immense change in the people themselves without which it cannot be run successfully, can appreciate the full extent of the triumph that it signalizes.

It must not be supposed, however, that all hospitals in the mission-field have yet attained to this degree of excellence. All stages in the process by which it is reached can still be observed.

It would be difficult to believe what the future held for many of the medical missions if we saw only the unpromising beginnings. A few tumble-down native rooms adapted for use as wards, beds put in the verandah of the missionary's house, a dispensary in a Chinese houseboat anchored among the crowded river population,[1] a rough mud and

[1] Such was the actual commencement of the work of the W. M. M.S. at Wuchow, where now there is a hospital with reception room and

wattle building costing some five or ten pounds—such are the seeds out of which these modern hospitals have grown. With what labour and enthusiasm, with what delays and patience, with what alternating fears and hopes the progress has been made, may be more easily imagined than described.[1]

It is worth while considering some of the conditions that must be fulfilled if the ideal is to be realized.

(*a*) Time is an important element, which must be taken into consideration quite apart from the question of time involved in the collection of money and the actual erection of the building. Time is necessary in overcoming prejudice, not only against the doctor and his medicine, but against his ideals of cleanliness, fresh air, and so forth. We take it for granted here that every patient shall have a bath when he enters the hospital, and shall put on the hospital clothes. How different in a country where a bath is an almost unknown luxury, or a yearly ceremony! Again, the patient expects that he shall be attended by his relatives: often the customs of the country render necessary such an arrangement. By this means, indeed, many besides the patient hear the Gospel, but from the medical side it raises the further difficulty of keeping a ward even moderately clean when it is invaded at all hours by the motley throng of patients' friends. Under such circum-

dispensary, operating room, casualty room, twelve private wards and two large ones—an entirely self supporting piece of work.

[1] For the actual growth of a medical mission, begun by an amateur and gradually developed into a fully-equipped hospital, see the racy description in W. E. Soothill's *A Mission in China*, Chap. IX.

stances patience is a virtue required at least as much of the doctor as of the invalid.

(*b*) There is the ever-present lack of funds, which makes it so difficult to do things with the thoroughness desired. It is wonderful that so much can be done with so little. The average annual cost of a bed in a mission hospital is anywhere from £5 to £15, varying with locality as well as with the character of the work done. The corresponding figure in London is £90. The economy is largely, though not wholly, in salaries and cost of provisions; but often considerable saving is effected in appliances and dressings, as for example in Kashmir, where "instead of medicated cotton-wool at a rupee a pound, we substitute to a large extent muslin bags full of sawdust, disinfected in a high-pressure steam sterilizer before use. The sawdust costs about one anna (1/16 rupee) for 10 lbs."[1] Yet even with every conceivable economy we still find the development of the work hampered for lack of funds. Probably there is no cheaper and more fruitful form of Christian philanthropy, and yet there are few which in proportion to the extent of their work are less adequately supported. This is a difficulty which it is our part at home to remove.

(*c*) A third factor of very great importance in securing a thoroughly efficient hospital is the nursing staff. Reference has already been made to the presence of the patients' friends. The only adequate method of dealing with the problem is by providing a staff of well-trained nurses, and for this end it appears essential that every mission hospital should, at the present stage, have *at*

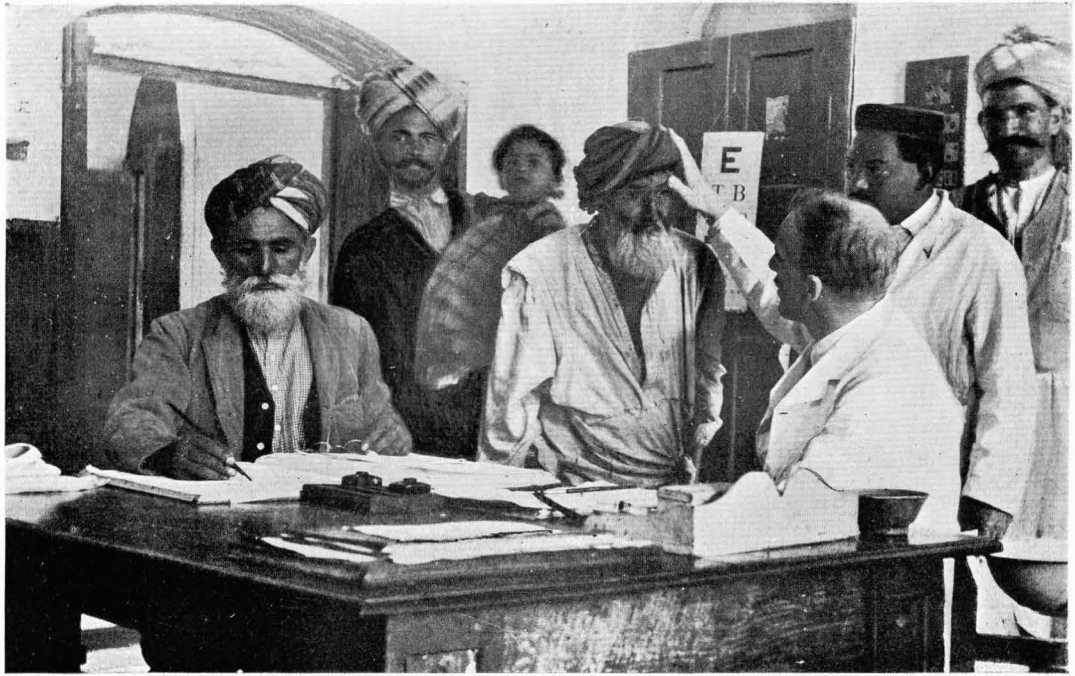
[1] Dr E. Neve, *Beyond the Pir Panjal*, p. 90.

least one fully qualified foreign nursing sister or matron attached to it. Anyone who has visited a number of hospitals in the mission-field will corroborate the view that the difference made by a foreign nursing superintendent can be felt at once. Almost without exception the hospitals so staffed show a higher degree of efficiency than the others, and are more worthy of the aims that we must set before ourselves in this branch of work. Without such help, the doctor in charge is always fighting an uphill battle. "Many missionary hospitals in which a doctor is working alone without a nurse present remarkable-looking wards, but these are the exception, and they represent a heavy burden put on the shoulders of an overworked man."[1]

(*d*) The attitude of the foreign doctor is perhaps the most important single factor in securing the full efficiency of the hospital. It lies with him to keep the whole institution up to the highest level. It is his courage and faith that are responsible for grappling with the difficulties and overcoming them. In some cases conditions are accepted, and it is assumed that patients will not submit to a bath, cannot be got to come if their friends are not allowed to nurse them, and so forth. In other cases, by quiet persistence, under similar circumstances, these difficulties have been overcome one by one.

"In spite of all the difficulties in maintaining ideal wards in China, the ideal may certainly be aimed at and frequently approximated. The importance of cleanliness and order

[1] *Medicine in China*, p. 60. Report of the China Medical Commission of the Rockefeller Foundation, New York, 1914, which see for a full description of actual conditions in mission hospitals in China.



In the Consulting Room at Bannu

in hospital wards cannot of course be over-estimated. Not only is this true from the medical side but it is perhaps more true from the point of view of general education. If the Chinese are to learn what is best in western life, if they are to get the instincts of hygiene and sanitation, if the children are to be brought up to be better, physically and morally, than their fathers, then they must begin with cleanliness. And surely the hospital should be a model teaching institution in this regard, impressing its lesson on each person who enters it."[1] Not only from these considerations, but even more because of its unique advantages as a means of bringing the people under the full influence of the Christian message, the hospital stands first in the equipment of the medical missionary. Those who live under its roof see from day to day the exhibition of Christian love in all the humble ministrations of the daily round, and there too, they hear each day and often in the day the story of the love of Christ. The impression made is of course far greater than in the sporadic teaching received by the out-patients, and the spiritual as well as the physical results are proportionately greater.

Here the nurse can play a unique part. The doctor finds few quiet moments when he is in the wards. The nurse is always there, and enjoys an unrivalled evangelistic opportunity. In an appreciation[2] of the late Miss L. E. A. Fagg, sister in the Bannu hospital, the writer tells "how peculiarly she was suited for a Frontier Medical Mission. . . . Full wards and only a trio of untrained nurses seemed

[1] *Medicine in China*, pp. 61, 62.
[2] *Mercy and Truth*, Vol. XIX, p. 168.

in no way to worry Sister Fagg. With cheery optimism she would greet the incoming patients, and make them so happy and comfortable that the doctors often found it most difficult to recognise their whilom suffering, miserable admissions of the out-patient room in the smiling, clean patients of the wards. She had a gift for nursing, and knew just how to make a patient comfortable even on a sagging string *charpai*, and in a dark, ill-lit, and worse ventilated hovel in the city." But beyond all this she possessed, and used, a still greater power of service. "Her gift for Pushtu made her excellent as a speaker in the out-patient waiting-room and by the patients' beds; but her life spoke more eloquently than a million sermons."

Into the hospital come men, women and children from a wide range of country. When in Madagascar the writer was shown a map on which were marked the places from which patients had come to the mission hospital in the capital during a single year. The whole of that great island, equal in size to France, Belgium and Holland combined, was sprinkled with little red dots. No district seemed to have been unrepresented in the year's work. "In the hospital at Miraj," says Dr Wanless, "eight to nine hundred villages are annually represented in the patients who apply for treatment, many of them coming scores, and in some cases hundreds, of miles."[1] Let us spend a few minutes in the wards of a big mission hospital in order that we may gain some idea of the variety of its inmates and their needs.

[1] *International Review of Missions*, Vol. II, p. 320.

"Here (in the Bannu Mission Hospital) may be seen representatives of all the frontier tribes chatting fraternally together, who as likely as not would be lying in ambush for one another if they were a few miles off across the frontier. But it is generally recognized among them that feuds are to be forgotten in hospital. . . . Great as is the variety of physiognomy, of dress and dialect, even more diverse are the complaints for which they come. Eye diseases form more than a quarter of the whole . . . Here is a Bannuchi *malik* suffering from consumption (a not uncommon complaint in their crowded villages); next to him is a Wazir lad from the hills, suffering from chronic malarial poisoning. . . . Poor fellow! he has lost both his parents in a village raid, and would have been dead long ago himself but for the open door of the mission hospital. In another bed is a fair-haired, blue-eyed boy of twelve from Khost, suffering from disease of the bones of his right leg, which he has not been able to put to the ground for two years. His home is eighty miles away across the mountains: he had no one to bring him to Bannu, . . . and he had accomplished the greater part of the journey crawling on his hands and knees, with an occasional lift from some friendly horseman, and had been six weeks on the road . . . when he arrived his state can be better imagined than described: the weary suffering look on his face, the few dirty rags that covered him, the malodorous wound on his leg, full of maggots, bound round with the last remains of his *pagari*; while now there is no brighter, happier boy in the hospital. . . . Passing on, we see a big swarthy Afghan with fine martial features, in

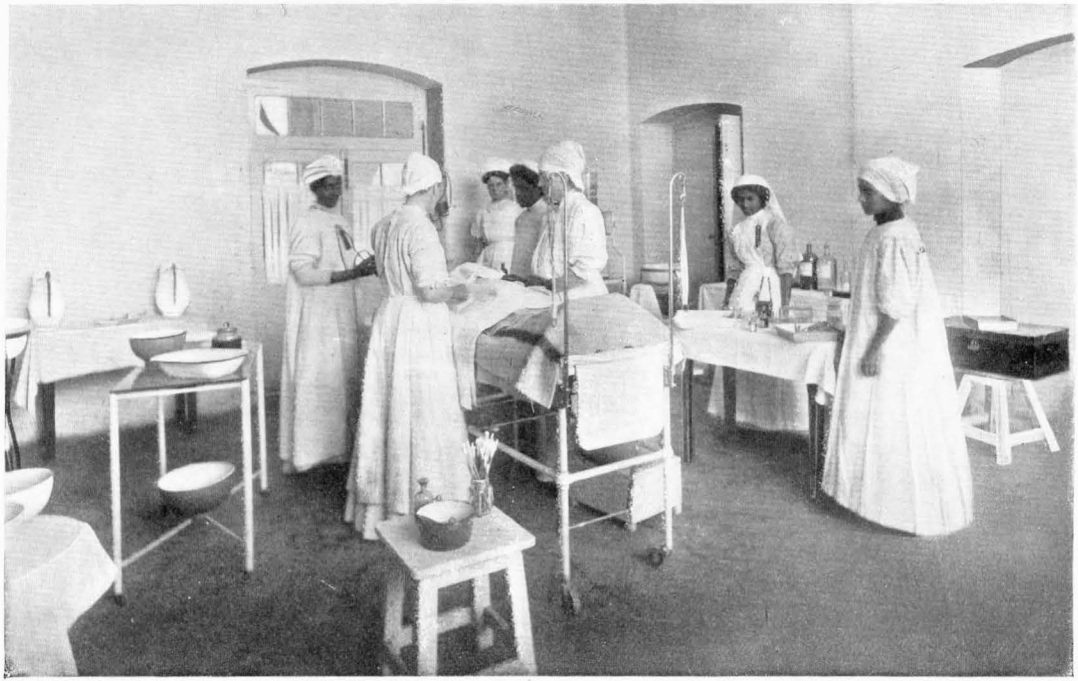
which suffering is gradually wearing out the old truculent air."[1]

Figures give us no true conception of the work that is being accomplished. Each item in the vast total represents one life, marred it may be by sin and suffering, but holding the promise of better things—one soul, dark and clouded perchance, but with the capacity to open out when exposed to the bright rays of the Sun of Righteousness.

When we look at the well-equipped modern hospital in the mission-field we touch what might be called the high-water mark of medical missions. But we must not forget how much is comprised in the life of the medical missionary which lies outside his work in the wards. Let us look at some other aspects of his many-sided activities, remembering that it is in activities such as these that most have begun their work. They are the earlier steps in the evolution of the hospital.

I. *Dispensary work.* It goes without saying that each hospital has attached to it an out-patient department, which keeps up the supply of patients for the wards and ministers to a vast deal of suffering besides. Often the medical missionary has to be content, in the initial stages of his work, with such a dispensary, and is compelled to turn away those who can be helped only by major operations, or prolonged hospital treatment. Even though, from a medical point of view, this is very unsatisfactory, the results of such work are by no means to be despised. Again and again opposition has been removed in this way,

[1] *Among the Wild Tribes on the Afghan Frontier*, pp. 78 ff. See also *Thirty Years in Kashmir*, Dr A. Neve, Chap. XXIV.



WHAT WOMEN CAN DO

British medical women and Indian nurses at work in the operating theatre

and the way prepared for the erection of a hospital later. When the hospital is built, moreover, it is possible through the out-patient department to touch many more people than can be accommodated as in-patients, and all these hear the Gospel and have some practical illustration of what it means. The intensive work is done in the wards, the extensive in the dispensary or surgery. "On a busy day in the summer, before midday, little groups of people may be seen gradually collecting, sitting in the shade of the trees, waiting for the doors to open. An old blind man will be brought upon a rough mountain pony. Four men may be seen staggering up the hill, carrying on a bedstead a man with a broken leg. This little procession with a sedan-chair, with the red curtains flapping in the breeze, is accompanying a *pardah* woman of the better classes. The old man, with hardly any clothes on, and his body smeared with white ashes, is a Hindu *sadhu* from India. Look at the elaborate caste marks on his face! The little group of men with sturdy ponies and long coats, like wadded dressing-gowns, are from Yarkand in Central Asia. See how fair they are, and their cheeks are quite red. They are making the pilgrimage to Mecca. The sprightly little man behind is a Goorkha soldier. His home is Nepal. He is probably "orderly" to some officer. How many creeds and nations are represented here! . . . The room is soon packed, the patients sitting on the floor, and the door is closed. The babel of voices subsides as the doctor comes in and reads some appropriate passage from the New Testament, which he then explains in simple language, and endeavours to apply directly to the need

of those before him. This is listened to attentively. Here and there one audibly assents. There is no feeling of antagonism. Many are doubtless languid or indifferent. But most feel that the combination of spiritual with physical ministration is fitting, and is it not what they have been accustomed to in their own religion?"[1]

What an unrivalled opportunity is here presented to the man whose heart is filled with a message of love! Men and women who know their need have come to one who, they believe, can help them. It is sometimes suggested that it is not "fair" to these sufferers first to preach at them, and to heal them only if they will listen to the message. This is an objection that will not be found to weigh with those who come to the dispensary. It all depends on the spirit of the man who with one passion seeks to heal the sores of the body and to lift the burden of sin from the soul. The words go home with a force peculiar to the special circumstances. There can be no doubt that they are winged by love.

II. *Itinerating.* There is a certain difference of opinion with regard to the place of this type of service. In all cases it is recognized as of value in establishing medical work at the outset. It creates an atmosphere favourable to the enterprise, and before the patients are ready to come to the doctor it is necessary that he should go to them. In some cases itinerating is given up when the hospital is well established, not only because it is difficult to find time for it, but also of set purpose. As compared

[1] *Beyond the Pir Panjal*, pp. 87, 88.

with hospital work it is felt to be a waste of time and money.[1] In other cases, however, and especially in India and Africa, it is recognized as a valuable permanent branch of medical mission work. The hospital is the base from which the doctor starts and to which he sends such cases as need treatment there. But by means of journeys he is continually breaking fresh ground; he reaches many who could not or would not come to the central station; he is able to see that the right cases are sent on to the central hospital; where he has branch hospitals under his care he has an opportunity of dealing with severe cases that are beyond the skill or experience of the native assistants in charge.

This work has its own peculiar interest. The missionary sets out with a travelling equipment of drugs, dressings, and instruments, and is accompanied usually by some of his trained assistants. When he arrives in a village the people soon discover him, if indeed they have not been informed in advance. The maimed, the sick, the halt, the blind gather up from the surrounding countryside. The doctor prepares his table in the open air or in the house of some sympathizer, and before he begins to examine his patients says a few words about the deeper purpose which inspires his service. Some can be dealt with at once, others can be sent to the hospital, a certain proportion cannot of course receive any adequate treatment. But it is wonderful how much can be done. Minor operations may have to be performed in the midst of a wondering crowd. Often the ingenuity of the doctor

[1] *Thirty Years in Moukden*, p. 76.

is taxed to the utmost in adapting to his varying needs such things as can be obtained locally.[1]

One actual experience may give us some idea of what can be done. "It was dusk when three poor blind creatures arrived at my camp. At first I refused to operate and told them to go to Leh; but who would take these women over the pass 17,000 feet high, and provide them with yaks to ride on? We were to start at daybreak, cross the river by ferry, then do a long march up the mountain; but their importunity prevailed, and I said if they would be at the river I would see what could be done. At dawn it was both windy and rainy. At the ferry these poor women had slept with no food but a little raw dough . . . I had my box of instruments, but how could I sterilize them, and how should I light a fire? I told the Ladakis, and they tried to strike sparks with flint and steel, but the tinder seemed moist. One of them then produced a little gunpowder and placed it on a stone, tore off a rag from his shirt and, fraying it out, laid it by the powder, then with flint and steel ignited it. Then a cooking pot was produced, and soon water was boiling. What an anachronism between the aseptic surgery aimed at and the primeval method of fire production. While the instruments were being boiled I cleaned the eyes and instilled cocaine; then, kneeling in the sand, removed the three cataracts, completing the operations just before a gust of wind came, laden with dust and grit, which would have put a stop to the work. The gratitude of the people knew no bounds."[2]

[1] See *Beyond the Pir Panjal*, Chap. IX.

[2] *Thirty Years in Kashmir*, pp. 241, 242.

III. *Visiting in the homes of the people.* A great deal of this falls upon the medical women, and in India especially it is thus that they can best render their unique service. Where women are secluded and are not allowed to leave their homes, the only means for them to obtain medical help is through the visit of the lady doctor. In maternity work especially she can render assistance in thousands of cases where a man would be powerless to help. Very often, too, the conditions are unsatisfactory to the last degree, so that the greater honour belongs to those who face and rise superior to them. In some parts of China a considerable population lives regularly on house-boats, and the visit to a patient here is carried out under circumstances even less propitious than those described by Dr Scharlieb (p. 31). When the doctor arrives, "hands stretched out in the darkness haul her on board and lower her into the hold, where, crawling on hands and knees into the tiny cabin, she finds her patient lying on the floor. So small are the quarters, there is only room for herself, her nurse, and the inevitable wooden tub of water, the roof being so low that she cannot even kneel upright. In this cramped position, by the light of a few wax candles, operations of the most delicate and critical nature have sometimes to be performed."[1] One knows not whether to admire more the skill or the courage of those who gladly face such conditions, and even in the midst of them are able to do surgical work that wins them a high reputation and the lasting gratitude of their patients.

[1] *Dedicated Science*, p. 20.

We have sought to understand something of the high resolve and noble purpose that send forth the missionary doctor upon his great service. We have seen something of the spirit in which his work is accomplished, and of the lofty aims that he sets before himself. We have watched him at work in the splendid hospital which has been erected under his oversight, in order to give him the fullest scope for the exercise of his art. We must not forget, however, that there is another side to the picture. Long years of unremitting toil, contact with the repulsive and the degraded, attention to every little detail, unwearying patience amidst all circumstances—these, too, are part of the medical missionary's life, and upon these foundations alone can he build an enduring structure. Is it worth it? Would it not be better to take the easier course of a comfortable home practice, where it seems likely that, from the professional point of view, better results can be achieved, where there is no prejudice to overcome, and no great obstacle in the path? To ask the question is to supply the answer. Instinctively we feel that those who choose this harder path are the men and women who have most to give to humanity, and whose example shines most brightly before us.

In connection with our study of the actual work they are doing let us hear what one of them says: "The halo of romance which surrounds a sphere of work is not always dispelled by closer contact. But when actively engaged in grappling with obstacles, the eye is focussed on near objects, and for a time more distant things are hazy or unseen. Thus it is with the routine duties and wearing details of medical mission work. Now it is the monotonous and

brain-fatiguing claims of language study that distract. Anon it is the exhausting demands of surgical practice under difficulties. Again it is the spiritual, moral, and intellectual barrenness of the people, or the blatant self-conceited ignorance of their teachers. Nor are there wanting foes from within. In a great undertaking difficulties are inevitable. But the very obstacles in the path of progress spur the traveller to even greater effort. And when success has been achieved, then every drop of previous pain and toil is transformed into the very essence of sweetness, enhancing joy a thousand-fold."[1]

COLLATERAL READING.

Dedicated Science.
Indian Medical Sketches. C. S. Vines.
The Foreign Doctor, especially Chapter XVI.
By the Equator's Snowy Peak. Chapter VI.
A Mission in China. Chapter IX.
In the Steps of the Good Physician. Chapter III.

And books quoted in the chapter.

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[1] *Beyond the Pir Panjal*, p. 173. See also *Thirty Years in Manchuria*, Chap. I.

CHAPER IV

THE VARIETY OF WORK

In the preceding chapters we have seen something of the character of medical mission work as a whole. No one can dwell on the facts there presented without appreciating the importance of having first-rate men and women as medical missionaries. The extent of their work, the weight of responsibility resting on men who have no second opinion within call, the knowledge that one mistake may put back the whole enterprise, awaken bitter opposition, or even produce a dangerous riot,—all these considerations help one to appreciate this point. "The nature of medical work in China," say the Rockefeller Commissioners, "is such that only men of the strongest personalities and of the highest professional training are of value. The man who goes to China needs a much broader training than his brother who remains at home, for he is called to face every conceivable kind of medical work, and usually he must meet it without consultation. . . . Almost every strong medical man in the field knows that his influence in helping the work of Christianity depends principally on his effectiveness in carrying out his job."[1]

While this is an overstatement of the case, since it does

[1] *Medicine in China*, p. 66.

not give sufficient emphasis to the spiritual effect of the doctor's personality, and while nothing should be said to discourage that doctor from offering who does not feel himself to be possessed of any unique qualifications, it is certainly abundantly true that there is ample scope, and indeed urgent need, for the most highly trained men and women. This will become the more apparent as we consider the many special departments of work in which medical missionaries are called upon to exercise their skill.[1]

In some ways medical work in the mission field is simpler than at home, for many of the special diseases that have followed in the train of modern civilization are unknown. The very large class of ailments due to different trades and occupations is at any rate only beginning to make its appearance in India and China, and when we get to a frontier hospital, or to a town in the heart of Africa, we find a total absence of such diseases. On the other hand there is the large class of tropical diseases, many of which are quite unknown in Great Britain, and some of which have never been fully studied and described, much less traced to their origin. There is also a prevalence of certain diseases, such as typhus, which are primarily due to insanitary conditions, and epidemics such as plague and cholera, from which we are happily free. It will thus be seen that the nature of the doctor's

[1] In a volume intended primarily for the lay reader it is not possible to give the wealth of detail for which the professional man or medical student is naturally eager. Reference can be made by the latter, however, to the works suggested for collateral reading and mentioned on pp. 141 f., where much fuller information can be obtained.

practice is by no means the same abroad as it is at home.

I. *Women's Diseases.* Some reference has already been made to the special circumstances of work among women, but it is important to emphasize here this special department. The following facts should be borne in mind:—

(*a*) In many parts of the mission-field, and notably in those chiefly affected by Mohammedanism, it is scarcely possible for a male doctor to see a female patient.

(*b*) The custom of child-marriage is one that adds enormously to the suffering of womanhood.

(*c*) In nearly all non-Christian countries the woman is regarded as inferior to the man, and therefore as worthy of less attention, especially in sickness.[1]

(*d*) The women are even more ignorant and superstitious than the men, and therefore far more subject to malpraxis.

(*e*) Custom is frequently held to justify the most cruel treatment of women by their men-folk.

Every argument that can be used for medical missions may be used with added force for work by women among women. The special women's hospital is, in many parts, an actual necessity if the women are to receive any adequate treatment. Even more with women than with men is it true to say that medical work is frequently the one and only means of reaching those who sit in darkness. A large pro-

[1] Note the views of Mr Kopargaon Ramamurthi, B.A., quoted in *The Claim of Suffering*, p. 37.

portion of special women's work is conducted in the homes of the people, where the woman doctor or nurse alone has access. "Shortly after I reached India, the tyranny of this custom," says Dr Mary Scharlieb, speaking of *pardah*, "was forcibly brought to my notice by the fact that a Mohammedan girl in labour with her first child got into very serious difficulty, which the ignorant woman who was attending her was quite unable to overcome. Her husband was very tenderly attached to her, and having waited long in vain for her relief, he finally went in search of a male doctor. The dying girl dragged herself off her bed and lay down across the door of her room. She told her women friends, who stood by in helpless misery, that she could never submit to such dishonour, and that the man doctor would enter the room only over her dead body, and in spite of entreaties both of husband and of friends, the girl lay there until she died."[1]

It will be readily understood that there is no department of work in which a larger amount of prejudice has to be overcome or in which greater difficulties have to be faced. It is also safe to say that there is none more important, both because of its witness to the unique message of Christianity to women, and because the future of the race depends upon and is moulded so much more by the women than by the men, especially as regards religious belief.[2]

II. *Eye Diseases.* In probably the great majority of medical missions diseases of the eye form quite a large proportion of the whole number of cases treated. For

[1] *Dedicated Science*, p. 26.

[2] Cf. *The Reproach of Islam*, pp. 296-303.

example, in a list of over 400 operation cases given in Dr Cochrane's practice, about 15 per cent. are eye cases.[1] In the hospital at Miraj out of 23,000 operations, 5000 have been for cataract.[2]

These are by no means exceptional cases. Many eye troubles are capable of operative treatment; cures following cataract operations have again and again proved of the greatest value in establishing the reputation of the foreign doctor. The greatness of the need can be gauged, to some extent, from the fact that the last census showed that there are over 460,000 blind persons in India alone. A large proportion of these have been blind from infancy or early childhood. Every physician knows the importance of attention to the eyes of a new-born child, and even those without any special knowledge will realize the danger of a common superstition which forbids the forcible opening of a child's eyes, even when they are infected and need above all else to be opened and washed. For lack of this simple precaution, thousands of infants every year must become totally or partially blind. One hospital records the fact that in a single month over 1000 patients were treated for ophthalmia, and adds "that work alone would justify the establishment of a dispensary."

A few words from the experience of Dr Scrimgeour in Nazareth may serve to bring home this aspect of the work

[1] *The Foreign Doctor*, p. 328.

[2] *Year Book of Indian Missions*, 1912, p. 307. Two months' work in the special eye hospital at Shikarpur are reported on in the *Church Missionary Review*, July 1912, and show 5585 cases and 1315 operations, of which 563 were for cataract alone. In 1914 over 1000 cataract operations were performed in seven weeks in the same place.

even more forcibly. "I would like to tell you," he says, "what is a common occurrence in my consulting room at this time of year. A father and mother bring their baby boy, one year old. The child's face is buried on its mother's shoulder and a shawl is covering his head. I ask what is the matter, and am told that the baby has sore eyes, but exactly what is the state of things they do not know, as he has hidden his face, as he is now doing, for a week or more. The parents have done nothing, and have been waiting to see if the boy would open them again. I take the little patient into the dressing-room, put him on a table, and, after careful washing, manage to get the eyes apart. In both eyes the cornea is white and opaque; the boy is blind for life! Then the mother tears her hair and the father weeps, and when I enquire into the matter I find that the 'wise woman' of the distant village strongly advised the parents against seeking any medical help, and assured them that everything would come right in time if left alone. Such a scene is repeated in our dispensary many times each year, and I know nothing more sad. To try to lessen this evil I have published a little leaflet, in the simplest language, explaining the dangers of delay in seeking proper remedies, and we have given away copies to all our village patients."[1]

Every doctor on the mission-field should be an eye-specialist.

III. *Tuberculosis.* This terrible scourge is widely spread throughout the world, and in the East it seems

[1] *Quarterly Paper* of Edinburgh Medical Missionary Society, November 1911, p. 430.

even more virulent than in our own islands. Often boys and girls at school are attacked and very rapidly succumb. The habits of life of the people are such as to foster it. Dr Caroline O'Meara, of Hazaribagh, says that during five years she has "noticed a rapid increase in the prevalence of this disease in the district, and particularly in the town."[1]

In China,[2] Syria, and elsewhere we read of the terrible havoc wrought by it. In some cases it seems as if it had been introduced by contact with white settlers, and where not previously known, has found the native population incapable of resisting its ravages. Several sanatoria for the treatment of tuberculosis have been erected in connection with mission hospitals. The India National Conference (December 1912) referred to "the considerable and apparently increasing incidence of tuberculosis in the rising generation, especially of the school and college class," and urged the missions to give systematic instruction on this subject.[3] In this connection it is to be noted that Dr A. Lankester (C.M.S.) has recently been appointed by Government Special Commissioner for Tuberculosis throughout India.

IV. *Tropical Diseases, and Investigation.* The medical missionary often works in tropical or sub-tropical countries where many diseases are known which are not found in a temperate clime. These diseases require special study and treatment, and in not a few cases much still remains to be done in investigation of their character and

[1] *The Mission Field*, (S.P.G.), Oct. 1914, p. 312.
[2] *Thirty Years in Moukden*, p. 46.
[3] *Continuation Committee's Conferences in Asia*, p. 146.

causation. In the Schools for Tropical Medicine which have been established in this country much can be learnt that is of the greatest assistance to the doctor going out to face these illnesses for the first time. Moreover, he can here learn methods of investigation that enable him to make valuable contributions to medical science.[1] Already a number of such contributions have been made, and it is an interesting fact that this aspect of the medical missionary's work was distinctly foreseen as long ago as 1861, when Dr Lockhart published one of the first books ever written on medical missions.[2]

The great difficulty that has stood in the way of much more thorough work on these lines has been lack of time, as the medical missionary is so often worked to the utmost limit of his capacity. By means of co-operation much can be done, and proposals have recently been made that the China Medical Missionary Association should undertake, through its members all over China, a united study of the geographical distribution of different types of malaria, and of the relative distribution of filariasis and elephantiasis.[3]

A further line of investigation, which is probably worthy of more attention than it has received, is that relating to the value and use of native drugs. While many of these are at once seen to do more harm than good, there are some that have a real value, and of these a certain proportion might with advantage be introduced

[1] See Dennis, *Christian Missions and Social Progress*, Vol. III, p. 435.

[2] *The Medical Missionary in China*, p. 135.

[3] *China Mission Year Book*, 1914, p. 343.

into our own pharmacopœia, or at any rate made use of by our doctors when practising in these countries.

V. *Leprosy.* Reference has already been made to the deplorable condition of the lepers. Little can be done for them physically, although certainly they can be given a measure of relief. Dr Hobson, one of the earliest medical missionaries in China, made a special study of this disease and contributed a paper on the subject to the *Medical Times and Gazette* in 1860, and ever since then there have been medical missionaries who have done what they could for the lepers. This branch of the work deserves far more attention than it can receive here.[1] Nearly one hundred leper asylums and hospitals have been established in mission lands by the various societies, and of these more than half are in India. In nearly all cases the treatment can only be palliative, though in some the disease is apparently arrested.[2] Even though the body cannot be cured the missionary will never forget the soul. In tending the loathsome wounds he is speaking a language that cannot be misunderstood. Many of these poor men and women have found a new life even in the midst of their pain and deformity. Mr Soothill tells of one such who returned home, gathered his friends and relatives about him, and formed the nucleus of a church. Before his death two other congregations had sprung up as a direct result of the labour of one leper.[3]

[1] For a summary of work among lepers see Dennis, Vol. II, pp. 433-47.

[2] See *Beyond the Pir Panjal*, pp. 102-4.

[3] *A Mission in China*, pp. 154, 155.

FIGHTING THE PLAGUE IN MANCHURIA
A search-party going from house to house

See p. 58

Many of these leper asylums or villages are wonderful evidences of the change which Christianity has made. Here are gathered men and women whose lives have been blasted, outcasts from civilization, spurned and despised by their nearest relatives, regarded as a danger to society. They are taught trades, they learn to read, they are properly clothed and fed, and their children, if uninfected, are segregated and saved from a like fate. We may be inclined to discuss in the abstract the importance of such work. To see it in the concrete, and to compare it with the lot of those who are untouched by it, to realize these deformed specimens of humanity as brothers and sisters, and to know that they are being lifted from a hopeless existence and being given the one message which holds hope for them—this is to know that missions to lepers are a living witness to the Spirit of Christ.[1] It is a notable fact that in Japan, though there is now but little medical mission work, leper asylums are carried on, having, up till now, been established only by Christian missions.[2]

VI. *Epidemics.* Some of the finest service that medical missionaries have rendered has been in dealing with the terrible epidemics which from time to time visit tropical lands. We at home know nothing of the character of these scourges. The improvement in sanitation as well as in medical science has practically stamped out the more virulent form of epidemic, and we have to go back two

[1] See *Lepers Sought His Face, Mary Reed: Missionary to the Lepers in Leper Land.*

[2] *The Spirit of Japan*, p. 221.

and a half centuries, to the Black Death in London, if we are to find anything in this country to compare with the pestilences that still sweep over parts of Asia and Africa. Plague, cholera, small-pox, sleeping-sickness, typhus,—these are some of the most terrible visitors that can come to human beings. Again and again the medical missionary has fought the advancing peril, often aided by the civil surgeon where he is to be found, but not infrequently single-handed. Many a one has offered his own life in seeking to save life. One instance must suffice to illustrate this point.

Nothing of this description has occurred in recent times more terrible than the awful visitation of pneumonic plague in Manchuria during the winter of 1910-11. It arose among some Siberian villages near the Chinese end of the great trans-Siberian railway. It spread to Harbin, and thence down the line of railway into Manchuria, and a few cases were reported from Peking. The peculiar character of this plague was its invariably fatal termination; of some 44,000 persons attacked, not a single one recovered. The medical missionaries in Peking and Manchuria at once realized that a supreme opportunity opened out to them in the fierce onslaught of the enemy. They placed their services at the disposal of the Government, and joined their efforts with the foreign educated Chinese doctors, organizing a complete system for examining all who came in from the north for immediate isolation of infected and suspicious cases, and engaging in a struggle which is worthy to rank with the greatest deeds of history. It was in the midst of this great struggle that Arthur

Jackson gave his life. In face of an unseen horror like this we can well understand the panic that seized the ignorant people, and what it meant to have men of high courage to stand in the breach. The thrilling story of these days, and of the measures taken to stamp out the plague and prevent its recurrence, is told by Dr Christie and should be read in full in order to give a clear idea of this form of work.[1]

VII. *The Prevention of Disease.* In discussing some of the various forms of disease with which the medical missionary must deal, we cannot fail to observe that one of the greatest needs of all is that amount of general education which will enable the peoples in non-Christian countries to take the necessary precautions against disease, or to meet it in the right way in its earliest stages. To promulgate right ideas about the nature of the various complaints, to teach simple lessons of health, to inculcate habits of cleanliness, attention to sanitation, etc. —these are among the most important functions of the medical missionary. It takes a long time, even at home, for us to learn to think of the medical profession as anything but a body of men organized to meet an evil after it has already appeared. But here we are at least beginning to realize that the science of medicine is failing to make its full contribution to the welfare of mankind if it does

[1] *Thirty Years in Moukden*, pp. 234-57. Also *Life of Arthur Jackson*, pp. 121-43. Other accounts of dealing with plague are given in *The Claim of Suffering*, Chap. VI, and a very graphic description of fighting Cholera in Inland China is to be found in the *Quarterly Paper* of the Edinburgh Medical Missionary Society for November 1913, pp. 213, 214.

not go forth to meet the enemy before he has advanced to the city gates.

In the mission-field the need for the medical profession to exercise this function is even greater, and it is a question whether it has as yet been sufficiently realized, either by the home committees or by the doctors themselves. In the case of the latter, it is small wonder, as they are, in practically every case of which we have knowledge, worked to the point at which it is difficult to "see the wood for the trees." Much has already been done. Missionary statesmanship, however, demands an even more serious attention to this part of the problem. In the previous section reference was made to the great fight against the plague in Manchuria. In the latter part of Dr Christie's account of this episode we have a statement of the thorough steps taken to prevent the recurrence of such an epidemic. In many lands, medical missionaries have been the foremost to introduce vaccination, and the great faith of the people in this foreign remedy, greeted in the first place with prejudice and fear, is an eloquent testimony to its value.[1] The Chinese, in many parts, have no idea of the infectious character of tuberculosis, and constantly the infected person is found living in a close, crowded room with uninfected cases. The section on eye-diseases will show how much could be done with a little knowledge to save the children of mission lands from blindness.

[1] "In one mission in China it is stated that 25,000 people were vaccinated in one year, and in Borneo Mrs Dexter Allen, M.B., vaccinated over 2000, and by so doing stamped out a bad outbreak of small-pox in her district." *The Claim of Suffering*, p. 74.

Dr Sharrock (S.P.G., S. India) writes: "The people will not believe that there is death in the foul water that they drink, or take our advice when we urge them to boil it. It is the goddess Mariammai that sends cholera and small-pox, and the only way to stop the mischief is to cut a cock's head off at a shrine! Who is to persuade them that the water oozing from a dunghill and along the open sewers in the roads is full of deadly microbes? How are they to know that one rat will carry fleas impregnated with enough plague germs to kill half a village? How can they believe that one fly—and there seem to be myriads of them in every dirty road—can carry over six million fatal bacteria in the hollow cups of its feet, deposit them in their milk and so give them typhoid fever?"

It must not be supposed that efforts have not been made by medical and other missionaries to educate the people, and especially the Christian community, with regard to these matters.[1] Frequent testimony is borne to the relative immunity of Christians in an epidemic, and one cause of this is certainly the greater attention paid to ordinary sanitary precautions, and to cleanliness. In many places missionaries have prepared literature on the subject, and lessons in hygiene are a normal part of the curriculum in mission schools. The most casual visitor to a mission station can see the difference between the Christian and non-Christian communities in this respect.

The need for this preventive work is especially great among primitive tribes, which are in some cases almost

[1] Some account of the effect of missionary effort in promoting cleanliness and sanitation will be found in Dennis, Vol. II, pp. 458-68.

threatened with extinction through the rapid spread of disease, often introduced from more civilized countries. Among the Eskimo, for example, the witness of the Edinburgh Conference Commission is that "medical missions are increasingly desired to avert the threatened racial decay"[1]

Our purpose here, however, is to lay chief emphasis on this aspect of the medical missionary's work in relation to the building up of a strong Christian Church, with adequate and efficient native leadership. We are not only concerned with saving the lives of individuals, whether Christian or non-Christian, nor simply with the redemption of individual men and women. For the future of the Church the motto *mens sana in corpore sano* has a deep significance. If the leadership is to be adequate to the unique situation that faces the young Church in the mission-field, it is of the utmost importance that attention should be given to the development of body as well as of mind. Every missionary of experience has mourned the premature removal by tuberculosis, or some other preventible disease, of some choice spirit well trained for work among his own people. The proportion of such losses is disappointingly great. To combat the inroads of disease we need to begin in the home, by reforming habits of life, and building up "home-life throughout the Christian community, until fatherhood, motherhood, boyhood, and girlhood grow healthy, become disciplined and pure."[2] From such homes we may expect that there will issue men and women with the physical

[1] *Edinburgh Conf. Report*, Vol. I, p. 267; see also p. 261.
[2] *International Review of Missions*, Vol. I, p. 337.

stamina, as well as the mental and moral background, which will enable them to meet the strain of a great crisis, and to make their full contribution to the building of the City of God.

A word remains to be said about the place of the man or woman who is not able to take a full medical course. This is a much debated question, but on one aspect of it there can be no difference of opinion; where men and funds are available the fully qualified medical missionary should always be sent. The fact remains, however, that societies are not yet able to supply all their stations with doctors. Even those in which hospitals have been built are sometimes understaffed or even temporarily left without a doctor. Many of these unsupplied stations are very far from medical aid. Long and difficult journeys would have to be taken to find the nearest doctor of any kind. The missionary's own life may be in jeopardy, his family may be suddenly attacked by disease, and often, whatever he says to the contrary, the natives turn to him for medical and surgical help. With no knowledge beyond that possessed by every educated person in this country he is able to relieve suffering, to save life, and to help in improving sanitary conditions. There seems, therefore, to be a very good case for giving some training in a careful way to missionaries who cannot take a full medical course, and do not feel called upon to become medical missionaries. If due care is taken to guard against the dangers of a little knowledge, this training can be given, and may be of untold benefit, as is amply proved by the experience of

many who have had a training at Livingstone College. This work cannot take the place of medical missions. Those who have this partial training would be the first to acknowledge their inadequacy to deal with much they see, and to recognize how vastly greater is the help which can be given by fully-trained men. All that is here urged is that in the present stage of development, and probably for years to come, there is and will be scope for this work *in places for which regular medical missionaries are not yet available.*

The fact that such work is of value must not, however, be allowed to take away our sense, deepened by the study of this chapter, of the need of and opportuuities awaiting medical men and women with the highest gifts and qualifications. The work in all its rich variety calls for a variety of experience and training. The medical missionary should be one who can meet these varying claims, who will show by the thoroughness of his work the completeness of his devotion to his Master, who by his sympathy, and care for the least attractive and the weakest, will set forth the meaning of true love, and who will ever have his eye not only on the present and immediate need, but also on the great future for the bringing in of which he is called upon to play so large a part.

COLLATERAL READING.

The Claim of Suffering. Chapter VI.
The Appeal of Medical Missions. Chapter VIII.
And books quoted in text.

CHAPTER V

WORKING FOR THE FUTURE

THE day has gone by when foreign missions were looked at mainly from the point of view of the missionary. His figure stood out unique in the early days, and the possibilities in the future were measured largely in terms of the available foreign staff. The time has now come when we pay even greater attention to the development of native agency. In every department we are called upon to reconstruct our theory of missions in the light of this factor. It is not a question of the number of missionaries and the amount of foreign money that can be supplied which so deeply concerns us, though that is still important. Our whole policy rests upon the assumption that we are primarily concerned with the building of a native church, that the work in each land must in the end be done by its own people, under their own control and with their own funds, and that the foreigner is simply preparing the way for this time. Every method we use and every step we take ought to be clearly related to this aim.

The work of medical missions is no exception. We have now to see how far this aim is being recognized and accepted, and what is being done for its fulfilment, especially in those medical missions which have been

longest established. We may remember two facts of some importance in this connection.

1. Medical missions are a comparatively recent development in missionary policy. Roughly speaking, we may say that the evangelist and the educationist got a clear half-century's start of the physician.

2. Medical missions are a very highly specialized branch of missionary activity for participation in which a very considerable course of training is required, and one for which there was practically no background in the education given by mission schools and colleges before medical missions made their appearance on the scene.

Nevertheless it is safe to say that in no department of missionary work has the necessity of native help been recognized sooner or more generally. In one of the earliest documents on medical missions, the first address delivered on behalf of the Medical Missionary Society in China in 1838, we find the following words: "Another advantage will be the education of Chinese youths in those branches which belong to medicine. Young men thus instructed will gradually be dispersed over the Empire . . . and will dispense the benefits of a systematic acquaintance with the subject whithersoever they go. . . . The effect of such influence will be silent but powerful, for there is something irresistibly impressive in benevolent action, especially when it appears exempt from the imputation of interested motives."[1]

Nor was this only a pious sentiment, for Dr Peter Parker during his first term of service in Canton trained three

[1] Quoted by Lockhart, *The Medical Missionary in China*, p. 139.

Chinese youths, and it was not long before his students and those of Dr Hobson and Dr Lockhart were actually going out into the surrounding districts, where they established themselves in practice. The question of sending some of these young men to England or America for fuller training was also under discussion at this time. The example thus set in the very early stages of medical missions is one that has been consistently followed, and there is scarcely a single medical missionary who has not taken some part in the training of native doctors, dispensers, nurses, and assistants.

This is largely explained by the necessities of the case, for it is obvious that a hospital cannot be carried forward successfully by the unaided efforts of one foreign doctor. As the work has grown it has been necessary to train natives to help in certain ways. But medical men have not stopped at giving the bare amount of training necessary for their own hospital, nor have they trained only such helpers as they have actually needed. From mission hospitals all over the world young men have gone out more or less fully qualified to deal with the diseases of their own people. It is not wonderful that this should be the case. We have but to bring up again before the mind's eye the extent and depth of the need referred to in Chapter II to appreciate the fact that only a veritable army of foreign doctors could cope with it. While in Japan, India, and some other countries Government efforts are meeting a part of the need, it is still true that there are many millions of people beyond the reach of skilled medical assistance. Even in a city like Calcutta

it is estimated that during a single year 6000 people die without being seen by a doctor,[1] and of course the proportion is very much greater in remote districts. In most parts of Africa and China it is the exception for any medical aid (in the sense in which we here use the term) to be available. This constitutes a great opportunity as well as a great need, and the only hope of dealing with the situation lies in the training of native doctors.

When we further consider that it is our policy to prepare for the day when the foreign missionary will no longer be needed, and when the management and staffing of all those hospitals will be entirely in native hands, we are not surprised to find that the question of medical education is rapidly coming to take the very first place in the counsels of medical missionary committees and associations. An eloquent testimony to this fact is provided by the findings on policy submitted by the China Medical Missionary Association to the China National Conference held in Shanghai in March 1913. More than half the recommendations bear directly on this all-important question, and several others which are not primarily concerned with it are manifestly drawn up with this problem in mind. Not only the hospitals but the medical schools themselves are looked upon as established by missions only in order that they may, at the right time, pass over to the Chinese. "We have no desire," says the document referred to, "to create permanently foreign institutions . . . our aim and hope is that these medical colleges will gradually and ultimately be staffed, financed and

[1] *Year Book of Indian Missions*, 1912, p. 373.

controlled by the Chinese themselves."[1] This is a bold statement of policy, and one that will be appreciated by anyone who realizes what it means to build up a great piece of work oneself, and then to hand it over to others who are perhaps far less competent to carry it on. Such risks must be taken if the natives of these lands are ever to be fitted for the discharge of the highest responsibilities.

The problem of building for the future may be considered under the following headings :—

(1) The provision of fully-equipped medical schools, giving a qualification similar to that given by western institutions.

(2) The training of assistants in hospitals, and the provision of "associated hospitals" (*i.e.* directly associated with medical schools).

(3) The training of nurses.

(4) The production of literature.

(5) The development of self-support, and the creation of local committees of management.

I. Historically, the foundation of fully-equipped medical schools is latest in the order of development. If our aim is to establish such schools, however, other aspects of the problem must be related thereto, in order that they may find their right place in one well-considered policy. India and China are the two countries in relation to which this side of the question needs fullest treatment. In some other countries, such as Madagascar, it is not legally possible for missions to take any part in medical education, although in this case they have, in the past, had a notable share

[1] *The Continuation Committee Conferences in Asia*, p. 357.

in the work.[1] In other countries, as for example in Mohammedan lands and in most African missions, the stage at which the problem emerges can hardly be said to have been reached. In the Syrian Protestant College, Beyrout, and in some other similar institutions, medical training of a high order is given as one department of an all-round course. But these institutions relate themselves more to the educational problem than to the medical, as they are the response to a demand for education, of which medical education is one important section, rather than a part of the policy for meeting the physical needs of the country concerned. Full recognition should be given, however, to the valuable work done in these institutions.

It is in India, China, and Korea that the problem is being faced *as a medical one*, and by the medical missionaries themselves, and it is in these countries that the largest progress has been made. The conditions are very different.

(i) In India the Government has made a somewhat extensive provision for medical training. There are a large number of Indians with medical diplomas practising in the country: many of these are very able men. In addition there is a regular system for the granting of certificates to less fully trained men called Hospital Assistants (now known as sub-Assistant Surgeons), of whom there are three distinct grades. These men are valuable helpers, but are seldom put in charge of Government Dispensaries until, by long service, they

[1] For some record of the Medical Missionary Training College in Madagascar see *Life of Dr Burns Thompson*, Chap. XXIV.

have proved their fitness for such appointments. It is always open to the missions to employ men trained in Government medical schools, or to send their own students to such schools under an agreement, or in some other way which will secure their services, when qualified, in mission hospitals. Moreover, as there is no Government regulation preventing it, it is still possible for mission hospitals to train their own assistants and use them in any way they think best. It is generally recognized, however, that the time is not distant when the law will be altered in this respect.

The problem that confronts the medical missionaries in India is therefore concerned with the relative advantages of sending students to a Government medical school and establishing one or more such schools under mission control. In the former case it is possible to care for the lads during training in a mission hostel, and this was done in Agra in connection with the very efficient Government Medical School there. Many missionaries, however, feel "that the various Government Colleges do not provide the best training for the men whom we need as house surgeons and doctors in our mission hospitals and dispensaries,"[1] and there is a growing feeling that something of a different character is required if the problem is to be satisfactorily solved. There is at Miraj an institution which is capable of being developed into a first-class medical school, and in which for a number of years a fairly complete medical training has

[1] *Journal of Medical Mission Association of India,* January 1914, quoted in E.M.M.S. *Quarterly Paper,* May 1914, p. 255.

been given. It began as a private institution for the benefit of a single mission, the American Presbyterian, but has gradually widened its scope in order to meet the needs of medical students connected with other missions in India. The Medical Missionary Association of India has set before itself the hope of developing this medical school in such a way as to enable it to become a thorough training ground for Indian Christian medical men, and a considerable sum of money is now being spent upon it in order to fulfil this aim. Dr Wanless, the Principal, hopes to have accommodation for fifty students, and there is little doubt that the school will receive Government recognition.

It is a matter of special interest that the medical education of women in India has advanced to a still further stage. The North India School of Medicine for Christian Women at Ludhiana was opened in 1894, being itself the descendant and heir of a simpler piece of work which had been carried on for fourteen years by Miss S. S. Hewlett in Amritsar. The Ludhiana School, under Dr Edith Brown, has developed into a first-class piece of work which already commands the support of a number of the missionary societies, being in fact managed by a joint committee. The students are Christian girls sent from different parts of India by the various missions, and some thirty are now taking the full course, while as many more take shorter courses as nurses, compounders and midwives. This school has already been recognized by Government, and its graduates are in great demand in both Government and mission hospitals. Reference should be made in this connection to the very valuable help which has

MEN WITH A VOCATION
Students of the Union Medical College, Tsinanfu

for years past been rendered to this cause by the Edinburgh Medical Missionary Society. Owing to the impending action of the Government, this Society has recently decided that its scholarships (through which so many Indian Christians have already been enabled to secure a medical training) shall in future be given only to those whose course leads up to a Government qualification.[1]

(ii) In China the Government provision for medical education is of very recent date, and is even more strikingly inadequate to the needs of the country than that in India. It is therefore not surprising to find that the medical missionaries have advanced much further than their colleagues in India. Already there are several union medical schools which have made a splendid beginning, and the difficulty now demanding solution is caused by the number of efforts that are being made in this direction. Owing to the great expense of this work it is clear that missionary societies must limit their efforts. Until recently there has been a tendency to develop medical schools wherever two or three doctors were in one place and were alive to the importance of the problem. It is now generally recognized that there is need here for a large exercise of statesmanship, and that it is important to concentrate these efforts upon a few well-chosen strategic centres. The Medical Missionary Association of China has performed a service similar to that rendered by its sister society in India, and has formulated a policy that

[1] For particulars of these schools and the prospects of medical education in India see E.M.M.S. *Quarterly Paper*, May 1914, pp. 254-7; *Year Book of Indian Missions*, 1912, pp. 300-7; and *Internat. Review of Missions*, Vol. II, 326, 327; *Ludhiana Reports*, etc.

aims at a severe limitation of the number of medical schools under missionary auspices. It recommends that no new medical school be started until those in Moukden, Peking, Tsinanfu, Chengtu, Hankow, Nanking, Hangchow, Foochow, and Canton have been adequately staffed and equipped.[1] It may be questioned whether even this number is not too large. The staff of qualified men required for a thoroughly up-to-date medical school is not less than twenty. When we consider that the whole number of European medical missionaries, men and women, in China is about 450, together with some 100 European nurses, the proportion that would have to be engaged on education in order adequately to staff all these institutions would seem to be unduly large. At the present time there are about 57 foreign doctors on the staffs of these schools and about 500 students all told. No single medical school can yet be regarded as thoroughly efficient, the nearest approach being that at Peking, with its 14 doctors and 95 students. In the spring of 1914 the China Medical Commission of the Rockefeller Foundation visited the country and made a very careful study of the situation. In their recommendations they select certain centres which, in their opinion, are worthy of special effort at the present time. While it may be very difficult to obtain a unanimous verdict as to the particular centres on which missions should concentrate for medical education, there can be little doubt that there is urgent need of a considered policy with regard to this vital question.

[1] *Continuation Committee's Conferences in Asia*, p. 357. Cf. p. 113 *infra*.

While on the men's side Christian Medical education in China is equal to if not ahead of that in India, it is, as yet, behind on the women's side. Beginnings have been made in Peking, Canton, and Soochow, in each of which places the intention is to develop a thoroughly efficient medical school for women. Only the first-named is a union college, the co-operating societies being the American Board (Congregationalist), American Methodist, and American Presbyterian.

(iii) In Korea a union medical college has been established whose aim is to train Christian doctors. During the last four years over thirty men have graduated, and a thoroughly good piece of work is being done, so far as it is possible with a staff of ten men. The students are all men who are professed Christians and recommended by their pastors.

II. It has already been pointed out that since the early days of medical missions a certain amount of training has been undertaken by medical missionaries. All grades of proficiency are aimed at in this informal training, but some deserve to rank quite high in the scale both because of the large number who have been benefited by the work and also when we think of the amount achieved in this direction by medical missionaries who were pressed with their hospital and dispensary work almost to the limits of human endurance, and yet found time to train their assistants. Some of this work aims at giving a definite diploma, which has a certain value depending entirely on the reputation and proved success of the school. In India the diploma is similar to that of Government Sub-Assistant Surgeon, the

new name for the old term Hospital Assistant. In other countries it might be well to adopt some similar system so as to co-ordinate the work done; thus a man coming from one part of the country to another would have a recognized standing. It is generally conceded that it will be a long time (for example, in a country like China) before fully trained men and women can be produced in sufficient numbers to deal with the vast need. A very useful work can be done by the less fully-trained man, so long as he knows his own limitations, and is taken for what he is, and not for the final product of the medical school. In a very informal way this system already exists. There is much to be said for regularizing it, and arriving at common standards agreed upon by all the hospitals in any area. In connection with some hospitals, "medical Evangelists" are used, whose primary work is itinerant preaching but who have just enough medical training to treat simple cases and then to know which to direct to the hospital.

This informal or private training may, in yet another way, still have a useful place even in areas supplied by a fully-equipped medical school. It has been suggested that such schools might have a number of associated hospitals where students could be partially trained and sent on to the central hospital, or where, later in their course, they might take some of their clinical work. In this way the sporadic efforts of many individual missionaries could be linked together, and the danger of crowding out this good work by the medical school would be entirely removed.[1]

[1] An interesting discussion of this problem by Dr Balme will be found in *Mercy and Truth*, Vol. XVI, pp. 114-21.

III. The training of native nurses, both male and female, is also an important part of medical mission work, and one that is receiving increasing attention in most European countries. The status of the nurse is less well defined than that of the doctor, and this reflects itself on practice in the mission-field. In mission lands the native nurse's training usually begins at an age which would be considered far too low in this country. Pupils usually find the theoretical part of their work difficult and unpleasant, but many show a great aptitude for the practical side, and become really skilful and devoted nurses. In India they are often drawn from the girls' orphanages. For this important work it is essential to have a fully trained foreign nurse, and it should be clearly recognized that it is a very important part of her duty. She should therefore have some aptitude for teaching, as well as being fitted to do her own work. This function of the foreign nursing sister emphasizes the fact, already referred to, of the importance of such an official in every mission hospital. In India the standard of training for native nurses is becoming more and more satisfactory. Many mission hospitals provide regular and systematic lectures. Boards of Examiners for North and South have been appointed; examinations are duly held and certificates granted. The subject receives careful consideration from the "Association of Nursing Superintendents of India," a body upon which Missionary Nurses are well represented.[1] In China, as also in Korea, a Nurses' Association has recently been formed, one object of which is "to raise the

[1] See Dr Amy Lillingston's pamphlet, *The Work of a Matron in an Indian Hospital.*

standard hospital training in China by the adoption of a uniform course of study and examination for the Chinese."[1]

IV. A large amount of very important work has been done by missionaries in the way of translating and producing medical literature in various languages. In China a publication committee appointed by the Medical Missionary Association raised about £3000 specially for this purpose, and already a number of large standard works such as Gray's *Anatomy*, Osler's *Practice of Medicine*, etc., have been produced in Chinese. The problem of terminology is an extremely difficult one, especially in an ideographic language like Chinese, and it cannot yet be regarded as finally solved, although an Anglo-Chinese Medical Lexicon has been produced. It need not be pointed out that work of this kind makes a large demand on the time of the missionary.[2]

V. If the extensive work of medical missions is ultimately to pass over into the hands of the native Church, it is not enough to train native doctors, medical evangelists, and nurses. The Church itself must be prepared to take up the work. This involves a training in two particulars, viz., in the generosity that will support the work, and in the ability needed to conduct it. In the former particular very great progress has already been made. In many cases large gifts have been received from individuals, and in others regular collections are taken in the churches for this work. The Church members should be accustomed to the idea of helping the hospitals and dispensaries, and they should

[1] See *China Mission Year Book*, 1914, p. 338, and *Mercy and Truth*, Vol. XXII, 268 ff.; *Medicine in China*, pp. 70-4.

[2] See E.M.M.S. *Quarterly Paper*, May 1912, pp. 46, 47.

further be encouraged to visit them where possible. Little has yet been done in the way of training Church members to take an intelligent part in the management of hospitals, and the matter has not received the attention it deserves. There is room for courageous experiment on these lines, and doubtless, as the whole question of control by the native Church is coming into greater prominence, there will shortly be an advance here too.

To some readers it may seem as if an undue emphasis has been laid upon a very special branch of the subject of medical missions. We need, however, again to remind ourselves of its vast possibilities. If medical missions are worth carrying on at all, it is essential that the policy for this department should be on all fours with the whole mission policy, and that plans should be deliberately made for the day when the native Church shall undertake this effort. There exists at the present time, especially in China, a great opportunity of supplying the country on a large scale with Christian medical practitioners. If this opportunity be seized the resultant possibilities for good are beyond calculation. Efficient work in medical education calls for a large expenditure of men and money, and therefore is peculiarly suitable for union effort. What has already been done is only regarded as a beginning, but it is one full of promise for the future.

COLLATERAL READING.

A Medical Missionary in China (Lockhart). Pp. 139-42.
Thirty Years in Moukden. Chapter XXVIII.
Dedicated Science. Pp. 37-40.
Medicine in China. Pp. 17-52 and 81 ff.
Reports of institutions referred to.

CHAPTER VI

WHAT GOD HATH WROUGHT

THE medical missionary goes forth upon his appointed task because "he can no other." He does not consider whether the hardship, the long toil, the loneliness, the risk, are going to be worth while or not. Perhaps if he had the calculating spirit he would not be the man for this great work. The student of medical missions is justified, however, in making a calculation. He must recognize, of course, how great are the difficulties of doing this in things spiritual. But he can attempt to sum up the gains, and in doing so he reaps for himself a rich reward in the inspiration and encouragement that he is bound to draw from the glorious record of the victories of faith. In matters of the spirit it is not safe to say that anything is justified by its success, but we can see how success, in the highest sense, ratifies the choice that has been made on other grounds. No work in the world can show a greater record of true success than the work of the medical missionary.

It is not our purpose here to review those vast results in the relief of human suffering which in themselves will seem to many enough amply to justify all the labour and expense. These can never be forgotten; but our

immediate task is to estimate the deeper and less easily calculated results of medical missions. For convenience let us classify them under four heads :—

I. *Closed doors have been opened.* One of the most signal triumphs of medical missions has been the opening of doors which were absolutely closed to other messengers of the Gospel. Again and again this has happened. The preacher, the teacher, the colporteur, have been denied access: the doctor has been welcomed and invited in. Everyone knows with what prejudice and suspicion the Chinese looked upon all foreigners until very recently. That their dislike was not unnatural in view of the action of many foreign governments and individuals does not alter the fact that it was very deep-rooted, and extended to those who desired to help them not less than to those who sought to fleece them or to force opium upon them. To medical missions belongs a very large share in the opening of this long-closed door. Dr Peter Parker, in establishing his eye-hospital in Canton, was facing a door that seemed to be scarcely ajar. Yet within a few months thousands were flocking to consult him, and his patients were travelling hundreds of miles, from Nanking and even from Peking. The rock which to Xavier seemed as if it would never open was yielding to the irresistible force of health restored and sight regained.

While medical work has a peculiar power of reaching the lowest and most ignorant, it has also proved the means of opening the door into the official *yamen*, where the highest in the land dwelt in supreme contempt of the upstart foreigner. The most notable instance of this is the well-known story

of how Li Hung Chang, at that time Viceroy of Chihli, called in Dr Kenneth Mackenzie to treat his own wife. The Chinese doctors had tried all their drugs and confessed that they would only be able to begin all over again on the same things, when in desperation the Viceroy sought the medical missionary. Lady Li's recovery was the signal for the opening of Tientsin to missionary effort. During her illness many others were treated, and at its close Li Hung Chang himself fitted up dispensaries and provided drugs for Dr Mackenzie and his lady colleague, Dr Howard.[1]

Another such case is that of Dr Allen, who, by saving the life of the nephew of the King of Korea, won for the Gospel an entrance to the most exclusive circles in the Hermit Kingdom.

Turning to India, we find a similar record. No page in missionary history is more deeply interesting than that which concerns the opening up of Kashmir, in which Dr Elmslie played so important a part. The evangelistic missionaries were met by constant opposition. Enquirers were watched and persecuted. Needless difficulties were put in the way of the workers; there seemed little prospect of their ever obtaining a permanent foothold in the country. Robert Clark of the Punjab, who did almost more than any other man to establish the C.M.S. medical missions in India on a sound basis, soon saw that he needed a medical colleague if the door was to be opened. Through the object lesson of medical missions opposition was turned into friendliness, and the restrictions were withdrawn which had hampered all missionary activity in the early

[1] See *Medical Missions, their Place and Power*, pp. 59-62.

days.[1] Even more striking, perhaps, was the opening of Jeypore, "one of the most bigoted and exclusive strongholds of idolatry in Northern India," through the success achieved in the treatment of the Maharanee by Dr Valentine. The doctor was simply passing through the city on his way to a much-needed holiday when the Maharajah told him of his wife's illness. The cure effected in her case was followed by a request to Dr Valentine to settle in Jeypore, a request which was persisted in even although the doctor made it plain that a condition of his acceptance would be perfect freedom to preach the Gospel.

A very recent experience in India illustrates the same point. It cannot be better told than in the words of Dr Arthur Neve. "I should like very briefly to tell you of the way in which a bigoted Hindu town has been opened up by the point of a cataract needle—a delicate instrument for doing it, but it has done it. There was a Hindu who made vows to his gods, and he did not find that much came of them, and so he thought he would try to do good in some other way. He began by paying the expenses of two or three blind men to go up to the Quetta mission hospital, one hundred miles away. Those men came back with recovered sight, and this Hindu then argued with himself, 'Well, I can do much more good if the doctor himself would come down here.' So the doctor himself was called down. A few days later, I received a wire from Henry Holland, 'Come and help me; two hundred out-patients a day, and heaps of cataract

[1] For a brief account of this see episode in *Mercy and Truth*, Vol. I, pp. 173-8; also *Beyond the Pir Panjal*, pp. 68 ff.

cases.' I joined him, and there, day after day we had enormous crowds—four hundred or five hundred patients had to be seen every day, and one of us was hard at work operating on them, chiefly for cataract. In about three weeks we did close upon three hundred cataract cases, and the news of this went far and wide. It was written about in the native papers, some of them anti-British papers, and several of the editors came to see the work and wrote in commendation of it; and at last the trains were bringing up cataract cases from every place. What has happened? That Hindu has built a beautiful eye-hospital at an expense of more than £1000. Recently that hospital was opened by the Collector of Sindh, and at that time all the chief men of the place were present—the chief Mohammedans and Hindu priests, and the leading men of the town. That is a town in which, a few years ago, there was some mission work, but one girl in the mission school began to inquire, and at once the whole of that mission work was stopped, and not a single native agent was left in the town. Now that eye-hospital has been built, and all the expenses paid, and the doors thrown widely open, and on the day that the hospital was opened the city magnates got up and warmly welcomed the medical mission. They saw with their own eyes what a Christ-like work it was."[1]

When we turn to Africa we cannot forget that the greatest of all pioneer missionaries—David Livingstone—was himself a doctor. Although this aspect of his career

[1] E.M.M.S. *Quarterly Paper*, November 1911, pp. 444, 445. For a later report of the same work see footnote on p. 52.

is somewhat overshadowed by his many-sided activities, it must be remembered that he took his medical course as a definite preparation for missionary work, that it was of the greatest service to him in his travels, and in making his way among unfriendly races, and that he maintained his keen interest in his profession.[1] The story of the Uganda mission is intimately connected with the medical work at Mengo and elsewhere, which has been the means of opening many closed doors, and the same may be said of other missions in the dark Continent. One instance may be quoted. Dr Southon, of the L.M.S., was passing through Urambo, when he was summoned by the king, who was suffering from a painful tumour. He responded to the summons, administered chloroform, and relieved the royal patient of his encumbrance. As a mark of his gratitude the king invited Dr Southon to stay at Urambo, gave him a most suitable site, and built thereon a house and hospital which became the centre of a flourishing mission.[2]

It is in Mohammedan countries that some of the most signal triumphs of the missionary doctor have been won. The continuous opposition of rulers and priests has been overcome. In many parts of Africa, in Persia, and in

[1] An extract from Livingstone's Journal in 1852 seems worth quoting in this connection. "I would like to devote a portion of my life to the discovery of a remedy for that terrible disease, the African fever. I would go into the parts where it prevails most, and try to discover if the natives have a remedy for it. I must make many inquiries of the river people in this quarter. What an unspeakable mercy it is to be permitted to engage in this most holy and honourable work!" (*Personal Life of David Livingstone*, p. 155.)

[2] *Medical Missions, their Place and Power*, pp. 68, 69.

the Turkish Empire an effectual door of entrance has been opened by the physician and the nurse. Where the preacher is looked upon with suspicion and hatred, the doctor is received with open arms. The bigoted Moslem, who has constantly inveighed against the Christian missionary, finds his son so seriously ill that no native help avails. In the hour of need he turns to the mission hospital, and ever afterwards his house is open, and he becomes the means of opening the way to fresh villages and homes.[1]

II. *Opposition and prejudice have been replaced by confidence.* Not only has an entrance been effected, through the agency of medical missions, into closed lands, but, as a part of this process, and as a result of it, the whole attitude of mind towards the missionary enterprise has been altered. If the door of the heart is not open it is of little avail that the door of the *yamen* has yielded. It is because the medical missionary is more than a doctor that his entrance has produced this far deeper effect. By sheer skill he might convince the most ignorant and prejudiced that they would do well to try his medicine. Only by sympathy can he win his way to the citadel, and convert the strong defence into friendly forces. A traveller on the Congo takes us to a scene in which we seem to see the process working before our very eyes. "Journeying up the Congo one day we had on board a chieftain who three months before had left his village for an operation at a mission station hundreds of miles below his home. The senior missionary in this man's district had persuaded him to take the journey and run the risk. The man had

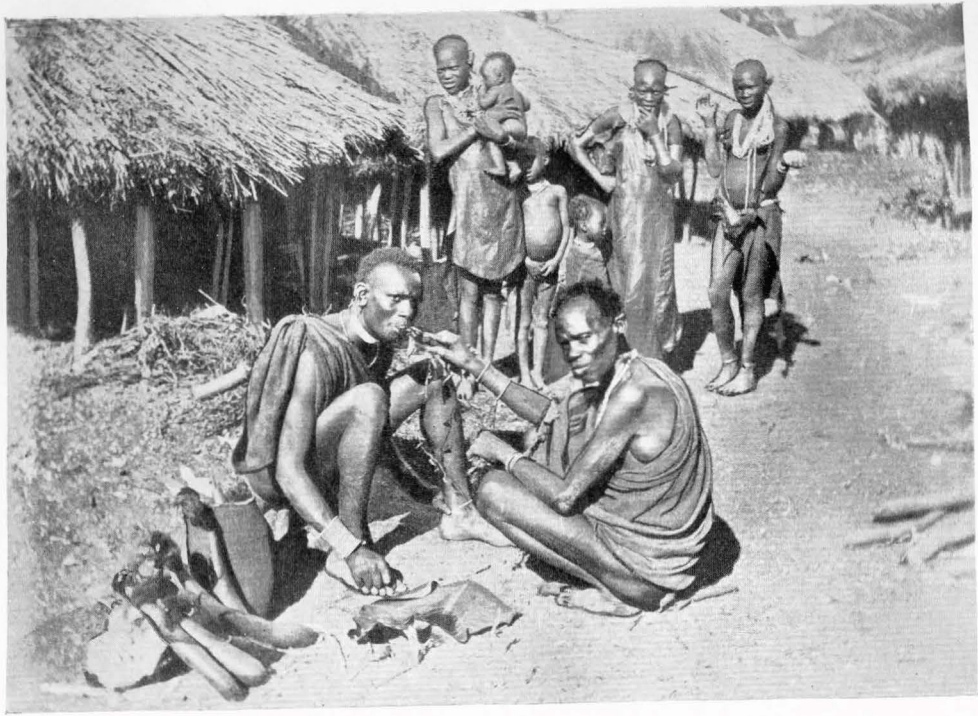
[1] See incident in *The Foreign Missionary*, Chap. XVI.

been bedridden for years with an elephantiasis growth; his wives had forsaken him, and most of his friends had abandoned him. He had long given an obstinate refusal to the missionary's proposal, but ultimately he was prevailed upon to make the journey to the distant mission post. The day for departure came, and with it funeral-loving friends and weeping women who made the track echo with a monotonous death-wail as the man was carried on board the steamer—never, as they believed, to return alive. Two months later the man had come through the operation, and seemed to be in perfect health. He boarded the steamer in full vigour, carrying his own box and sundry goods which the travelling native collects from the long-lost brothers and cousins whom he has a habit of discovering in every town. After three weeks' steam we were nearing the chieftain's home; what a dressing of the hair and anointing of the body took place during several hours before the village itself was sighted! Within hail, lusty voices shouted to the villagers that their chief was aboard and was well and strong. The cry passed from lip to lip, until the beach was lined with incredulous natives. The most hopeful among them anticipated nothing better than that the man would be carried ashore. Fifteen minutes later the ship was at anchor, the gangway run ashore, and lo! the first man to stride off the ship was the erstwhile bedridden chief! It was too much for the majority, who promptly took to their heels and bolted to a safe distance! In a few minutes, however, they realized that it was not a spirit, but the real man returned alive and well. Gradually they surrounded him, questioned him, gesticulated ex-

citedly, rang the drums to inform the countryside that so great a miracle had taken place, and generally made such a din and noise that it was only with difficulty conversation became at all possible. That sort of sermon is more eloquent to the native than many discourses on Christian ethics preached with the inevitable limitations of a foreign tongue, and at the best often misunderstood; moreover, it renders him very receptive to Christian teaching."[1] The best part of it is that this deeper success does not depend upon the cure of the physical ills. Let us listen to an even more eloquent incident.

"The lady doctor was out in camp some twelve miles from her station in S. India. All day long a stream of suffering women and children sought her at the door of her tent, and all day long they received her skilled and loving attention. In the evening, when the sun was setting and she had seen the last of her patients for the day, she began to pack up her drugs and instruments preparatory to returning home in the cool of the night. Looking up, she saw four men carrying a burden towards her little tent and waited to see what new claim on her attention this might be. Presently they laid at her feet an outcaste man, the son of one of the bearers, in the grip of the cholera. What was she to do? I have no need to tell you what she did: love dictated that, and you have already foreseen what happened. Putting away all thought of returning home, she turned to this poor outcaste stranger to see if by any means she might save his life. All night long the woman doctor fought death in an unequal combat. All night long

[1] *Dawn in Darkest Africa*, John H. Harris, pp. 275-7.



THE KIKUYU MEDICINE MAN AT WORK

there was no ministry so repulsive but love hallowed it, and all night long there was no service so lowly that love did not stoop to it.

"In the dawn he died, and as the morning broadened into sunrise the respectable Hindus of the village, the men whose women and children she had been seeking to comfort and to heal during the whole of the preceding day, came out from their homes and saw what had taken place. They spurned the doctor, because, having touched their women folk, she had also touched the filthy body of an outcaste man. They declared that never again should she be welcomed in their village or allowed to touch their people. Even the father of the dead man lifted up the corpse of his son and carried it away without so much as saying 'Thank you.' The woman doctor was left to make her way home over twelve miles of roadless country, with weary limbs and aching head and a heart deeply wounded, for she said, 'I thought to have opened a door of usefulness, but I seem to have closed one, and to have wasted my night's labours.'

"But in six months the family of the dead man—the man whom she had sought to cure—were at the feet of her brother, the missionary, pleading to be taken under his care and taught with a view to entering the Christian Church. 'Why have you come?' said he, not unnaturally; to which they replied: 'We have come because we have seen what love can do. We never knew till then what love was. You thought that we did not care because we did not speak, but our hearts were too full for speech. We want to belong to you.'

"The result was that in a short time the missionary in charge of the station was able to baptize a thousand people in that village, and a little later could report that that new congregation had provided twelve Christian workers — evangelists, teachers, and Bible-women."[1]

Many a missionary has had the experience of speaking to hearts that were utterly unresponsive, seeking by every possible means to find a point of entrance, and realizing all the time that some great misunderstanding or prejudice has barred the way, so that his words never even reached to the consciousness of his hearers. "Only after confidence is established in the missionary does preaching, the Word of God, Law and Gospel, gradually find willing ears, reflection and comprehension. Confidence in the missionary, proved reliable in earthly affairs, passes on to the new teaching he brings. If the one is true and reliable, the other is true and reliable also."[2] The medical missionary has, in thousands of cases, established this confidence, and thus removed not only the outward, but still more important, the inward barriers that have barred the way to the entrance of the truth."

III. *Individuals have been won for Christ.* It is scarcely possible to pick up a single book on medical missions without finding ample proof of this statement. To the

[1] Contributed by the Rev. W. Goudie to L.M.S. *Chronicle*, February 1914, p. 29. See also *Yarns on Heroes of India*, pp. 69 ff. For another case which illustrates the same point see *Thirty Years in Moukden*, pp. 116-22—a most telling story.

[2] Dr Winkler, quoted in *The Living Forces of the Gospel*, p. 170.

medical missionary the supreme result of his work, that which brings to him the liveliest joy and the deepest satisfaction, is the change in the lives of men, women, and children who come under his care. For this, surely, is the crowning triumph of missionary work. We are inclined to-day to place relatively too great an emphasis on the social results of missions, and to forget that the foundation of these larger changes is to be found in the conversion of individuals. Here is where the crux of the whole matter lies. The will, which is the seat of all human activities, whether of single persons or of groups, must be changed by the operation of spiritual forces, turned round from loving the evil to loving the good. Without this change of heart we shall look in vain for large or lasting results in our work. When this change takes place in individuals we may with confidence expect that the life of the community will become transformed.

In the widespread work of the medical mission many are brought into touch with the Gospel, and frequently we hear of those who even after the slightest contact with the missionary have set out to live a new life through faith in Christ. Such a story is that of the Toro princess Maliza, who had been made a slave and was afterwards liberated. On her way home she was treated as an out-patient at the Mengo hospital, and on her return to Toro asked at once to learn more about "a religion which teaches its followers to be as kind as that." Years afterwards the doctor, who had known nothing of her interest at the time, happened to be visiting Bunyoro at the same time as the King of Toro, and found his old patient visiting

the princesses there and seeking to lead them to a knowledge of Christ.[1]

The largest fruitage in this direction is probably seen, however, in those who enter the hospital for treatment. Here they have unique opportunities. It is a cheering sight to be present at a ward-service and see the eager faces of the patients, belonging it may be to many sects or religions, gathered from far distant parts, a large proportion having never before heard the Gospel, some living many miles away from the nearest missionary outpost, and to realize that the truth is here being given a chance to sink in and have its full effect upon darkened minds and hearts. For a very large proportion, this time in hospital is indeed the chance of a life-time—the chance for quiet thought, for hearing the Gospel, for seeing it lived before their eyes, and for getting an answer to their questions. The turning of patients from darkness to light is continually traceable to the personal work of the nurses. Stories of what God has wrought through them are as numerous and striking as can be found in the records of any form of missionary work.

"One man came to us" (in Onitsha, West Africa) "who had been a cannibal, and had had a share in eating nine men. He had cataract and was operated upon and cured. He said to us then, that he "did not see only with his eyes, but with his heart." He is now an evangelist. Another chief, after having gone through a serious operation, expressed his wish to burn his idols. He has since endured great persecutions from his fellowmen."[2]

[1] *Converts through Medical Work*, pp. 20-2.
[2] *Nurses Near and Far*, April 1912, p. 3.

A woman arrived at Lo-yuan in China "with a very bad leg and altogether in a most diseased condition. She stayed for several months, and eventually left actually able to walk, her leg being quite healed. Before this time came, however, she began to take great interest in the Gospel teaching, and when a picture of our Lord as the Good Shepherd, stretching down over the precipice to rescue a lost lamb, was shown and explained to her she said, 'Yes and *I* have got to tell the Gospel to *my* village folk. I tell you no one goes there. My leg must get well and I must go home and tell them.' . . . This great wish was at last fulfilled."[1]

"In 1893 a woman, accompanied by her niece, attended the dispensary (at Julfa, near Ispahan, Persia). The niece was Sakineh . . . at that time a most bigoted Moslem. Coming subsequently for her aunt's medicine, she tried in various ways to get the bottle before prayers, so as not to hear the Gospel. Gradually, however, its message touched her heart and she listened in spite of herself. . . . After witnessing the baptism of an Armenian baby Sakineh said, 'Take me to the clergyman and ask him to baptize me and my baby.' She declared her faith in Jesus as the only Saviour, and renounced all her faith in Islam. Subsequently her faith was put to the test by the fiercest persecution, in all of which she remained true, though scarcely escaping with her life, and being for two years kept in close confinement and not allowed to hold any communication with the missionary."[2]

[1] *In the Steps of the Good Physician*, p. 55.
[2] *Converts through Medical Work*, pp. 43-9.

"A woman of Gaza was recently talking to one of the nurses when the noise of a passing funeral was heard. 'Probably he died a Christian,' said the woman. 'Why do you suppose so?' asked the nurse. 'Many, many die Christians that you don't know of; they believe, but cannot confess it until they die,' came the answer. She went on to tell of a woman who nine years before had been taught while in the hospital, and who, though no missionary ever visited her, was living as a Christian, and telling all around her that she believed in Christ.

"A few years since, the Sheikh of a mosque in Gaza died as a Christian, though he had not been baptized. Just before his death he said that he had been led to be interested in Christianity by the first medical missionary, about fifteen years previously."[1]

So the story passes from land to land. The healing of the body is not enough for the medical missionary and his helpers. Their passion is to redeem the soul, to transform the will. In the midst of their care for the body they are performing this greater work. No estimate of the results of medical missions really meets the case which does not place chief emphasis on this aspect of the work, and which does not allow for the fact that what we see here is the outcome of the double ministration of the medical missionary. These lost ones have been found through the healing touch as well as through the saving word.

IV. *Whole districts are being permeated by Christian ideals.* It may be more difficult to estimate results of this kind, yet there cannot be the smallest doubt of their

[1] *Doctors' Doings in Many Lands*, p. 17.

existence and value. The testimony of many a traveller could be cited as evidence. The process is taking place in two ways:—

(*a*) Through individual converts who go back to distant homes, and there by quiet influence produce great changes.

"*The results?*" says Dr Wills of Tsao-shih. "To the North: a self-supporting church on whose leading member we did a large hydrocele when he was a heathen. To the East: another self-supporting church whose evangelist we operated on for the same thing when a heathen, years ago. To the West: a colporteur whose necrosed tibia we removed fourteen years ago. And to the South: an old student of ours has regular worship in his house: there is no other place of worship in this country town."[1]

"At St Barnabas', Pondoland, the Rev. Dr Sutton settled in 1893, having previously been a medical missionary in Burma. He met with the old difficulties arising from belief in witchcraft, patients being brought to him in a dying state, because it was only after every possible remedy suggested by the witch-doctors had been tried, that they were allowed to come. It took three years to break down the wall of suspicion and superstition, and then a great change came. The chief's son, who had long been a source of trouble and unrest, through his encouragement of witchcraft and his drunken habits, fell ill, as the result of drink. Dr Sutton insisted upon his coming to the mission house for a month, so as to be under constant supervision. He was regarded as a hopeless case, but the doctor pulled him through, and he became a total abstainer

[1] *Dedicated Science.*

and a reformed character, so that his rule became as beneficial as it had been iniquitous. He prevented the illegal sale of brandy, put down witchcraft, and gave up to the mission the entire charge of two of his children."[1]

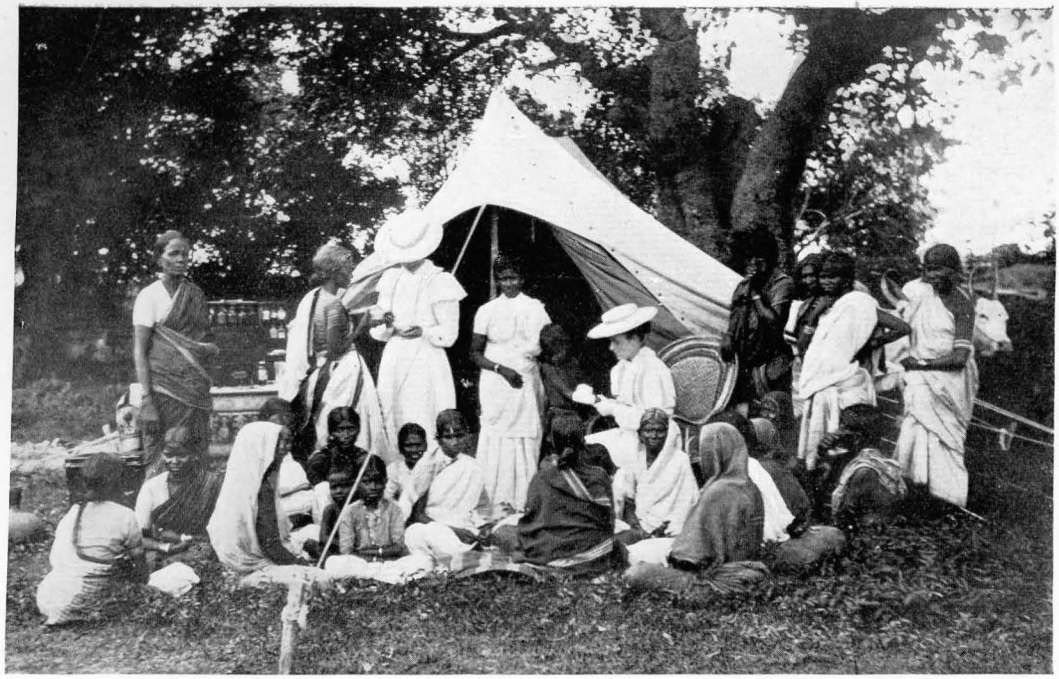
(*b*) Through the influence of the hospital itself in stimulating acts of benevolence and the spirit of kindliness and generosity.

Such work as this cannot be carried on without producing a deep and lasting effect. The large measure of support given to medical missions by non-Christians is an eloquent proof of the effect produced by their presence in the midst of such a community. A typical instance, just to hand from Chinchew, tells of Chinese gentry who are paying for the inoculation against plague of the poorer inhabitants of the town. Tickets are given out, and the medical missionary inoculates all who come to the hospital with a ticket, charging 20 cents per ticket to the Chinese donors. When the American Baptist hospital for men at Madura required rebuilding, the Hindus, with the Prince of Ramnad at their head, collected the whole of the funds required, some 44,000 rupees. The hospital at Udaipur, a beautiful building containing fifty beds, was a present from the Prince of Mervar to the United Free Church of Scotland. And the handsome new hospital at Jodhpur in Rajputana was erected largely at the cost of the Rajah, who earlier had been one of the bitterest opponents of missions.[2]

Instances could easily be multiplied. It would be a

[1] *The Land of Good Hope*, p. 266. See also *Beyond the Pir Panjal*, pp. 170 ff.

[2] Richter, *History of Indian Missions*, p. 352.



When the Doctor goes on Tour

One of the two missionaries in the photograph is the doctor of the story on page 88

mistake to take them only as an indication of a sense of gratitude on the part of the donors. They are also a proof that the spirit which animates the medical missionary is infectious. He deals indeed with the rapid contagion of terrible scourges, he inoculates his patients with anti-toxins to stay their course. But at the same time he is communicating to them by a process of spiritual inoculation a spirit that is bound to spread, and carry its influence from village to village and from home to home. The deadly contagion of disease is now known to be due, in reality, to life—the lives of countless germs which multiply in the body and pass from man to man. The contagion of a good character and of noble deeds has power also, because of the living principle. The life of God is manifested among the sons of men. We may be more sure that this contagion will spread than we can ever be that the missionary doctor, with all his skill, will check the spread of disease and death. He is set in the world not simply to stop the evil, but to multiply the good. We have tried to bring before our mental vision the picture of this process constantly going forward in all the world wherever the missionary doctor has penetrated. Who shall judge the vast total of the harvest that is the result of his long toil and of his dauntless faith?

COLLATERAL READING.

Converts through Medical Work.
The Claim of Suffering. Chapter V.
Medical Missions, their Place and Power. Chapters III, IV, V.
Address by Mrs Bishop. *Mercy and Truth.* Vol. I, pp. 132-9.
Thirty Years in Moukden. Chapter XIV.
Among the Wild Tribes on the Afghan Frontier. Chapter XVI.

CHAPTER VII

OPPORTUNITIES AND PROBLEMS

WE have now made a sufficient study of the actual work of the medical missionary to be able to understand the nature of certain problems with which he is confronted. If we are to gain a truly sympathetic insight into the nature of his work, we cannot pass by these questions. Some of them concern the doctor himself; others primarily concern those at home who have the direction of the work, but in any case a knowledge of them will be a help to a clearer view of the whole picture which it is sought to present in this volume.

I. *The Location of Medical Missions.* The facts considered in the previous chapter indicate, in some measure, the variety of the service which the medical mission is rendering to the whole missionary propaganda. The discussion as to the relative importance of these different classes of result is no idle one, because upon our answer must, to a large extent, depend the policy that is adopted for the development of this important branch of missionary activity. In view of the fact that not all the openings for medical effort can be entered, on what particular need ought we to concentrate? Shall our policy be dictated by the physical needs of the people? This would involve

placing very little emphasis upon centres in which the government provides medical assistance, as, for example, in large parts of India. Are the places in which such provision is now made to be vacated in order that unoccupied centres may be entered? We shall, of course, consider the fact that a hospital in a town already well provided may be dealing with a large number of cases from outlying districts where no such help can be obtained. At the same time, if a government hospital is established in such a centre it would be possible for patients to attend there if the mission hospital were removed.

This brings us to a point of great importance. Very often the native will not go to a government doctor but is willing to consult a missionary. Even from the point of view of supplying the physical need, the mission hospital may have a very real place in such a community. We have yet to hear of a mission hospital which has been established for any length of time, and has any lack of patients. We shall not, however, be misled into thinking that the physical need alone is to be the determining factor in our policy. Even where this is relatively well met, there may be a very large service that can be rendered by the distinctively missionary institution alone. But the question at issue, we must again remind ourselves, is not, "Where will the mission hospital be useful?" but "Where will it be most useful?"

Here we may note certain special conditions which call for medical missionary effort.

(*a*) *Reaching unoccupied fields.* A signal example of the way in which this is being done is found in the strategic line

of hospitals planted by the C.M.S. and C.E.Z.M.S. along the north-west frontier of India. The centres at Srinagar, Peshawar, Bannu, Dera Ismail Khan, and Quetta, with their outposts at Islamabad, Chersadda, Shikarpur, etc., are part of a deliberate policy for the evangelization not only of the large population in the midst of which they are planted, but also of the unreached millions among the border tribes and in Afghanistan, Baluchistan, and even away to Turkestan and Tibet. As patients flock in, year by year, to these hospitals and pass away back into the lonely valleys of their unopened lands, they are carrying with them precious seeds which in not a few cases are already bearing fruit, they are breaking down that hard barrier that shuts the Christian missionary out of these Moslem and Buddhist lands, they are preparing the way of the Lord even in the desert.[1] These hospitals have a plan of interchange and mutual support, so that a temporary need in any one is supplied by the others. This plan of 'linked hospitals' is a very useful one, and might be more widely adopted.

We may think in the same way of the hospital recently opened in Yunnan and of some in Western Szechwan which, besides their mission to the Chinese, are touching and will yet more touch the wild tribesmen in the semi-independent territories on the outskirts of China proper, into some of which no missionary can yet enter. They are also making their contribution from the Eastern side to the great

[1] Of this work S. K. Datta says: "It is the only method that has been devised to reach the untamed border tribes with any degree of success." *Desire of India*, p. 199.

problem of opening up Tibet for the Gospel. In other great and unoccupied territories there is a special need for the medical missionary to do his work as a pioneer. In parts of Moslem Africa (already attacked through the hospitals in such places as Lokoja, Mengo, Toro, Omdurman, Old Cairo, and Tangier), in South America, and in Mongolia there would seem to be a peculiar opportunity for the medical missionary.

(*b*) *Supporting mass movements.* Until recently, quite insufficient attention has been given to this function of the medical missionary. In Chapter II we saw how important a place the doctor takes in breaking down superstition and in liberating the mind from degrading and enslaving fear. In several parts of the mission-field, notably in India, great numbers of people, mostly with a very primitive faith, have been coming to the missionaries and seeking admission to the Church. In these mass movements it is impossible to give the full grounding in Christian principles that is regarded, in the slower development of missionary work elsewhere, as quite essential. Either the Church must accept a measure of responsibility for whole villages and communities, or they must be turned away, probably to go back to sheer idolatry. When the Church accepts such a responsibility, there are very grave dangers. One of these is, of course, that through insufficient teaching and help, there may be serious moral lapses. In particular, when one of these would-be Christians falls ill there is often the very strongest temptation to go back to the superstitious practices which had previously been relied upon. Where no other medical

aid is available this temptation may be almost irresistible, and it is small wonder, especially where a much-loved member of the family is in danger of losing his life, if the witch-doctor or heathen priest is consulted, or if some charm is used or some sacrifice offered. To us it may seem as if this would be a venial offence. To the young convert, however, it often means stepping back into heathenism, the deliberate giving up of Christianity, and the beginning of moral and spiritual decline.

Here would seem to be a very urgent need for medical missions. The need may, in many cases, be met by the use of branch dispensaries, and native medical assistants, but even these require a base hospital and one or more foreign doctors to oversee and support the work. "I plead," says a recent writer on the subject, "that wherever a mass movement towards Christianity takes place there should be a doctor and nurse to co-operate with the other workers. These movements generally occur in just those backward places where government or skilled native work is least likely to be found."[1]

(*c*) *Reaching classes and sections of the community in fields already occupied.* A third determining factor in the planting of fresh medical work will be the relative inaccessibility of certain classes. It is needless to point out further the very great call in this respect for medical work for women by women, especially in India and in Mohammedan lands. In many cases it seems as if this was almost the only means of approach, especially among the upper classes.

[1] *Mass Movements and Medical Missions.* This should be read by all who wish to grasp the full significance of this problem.

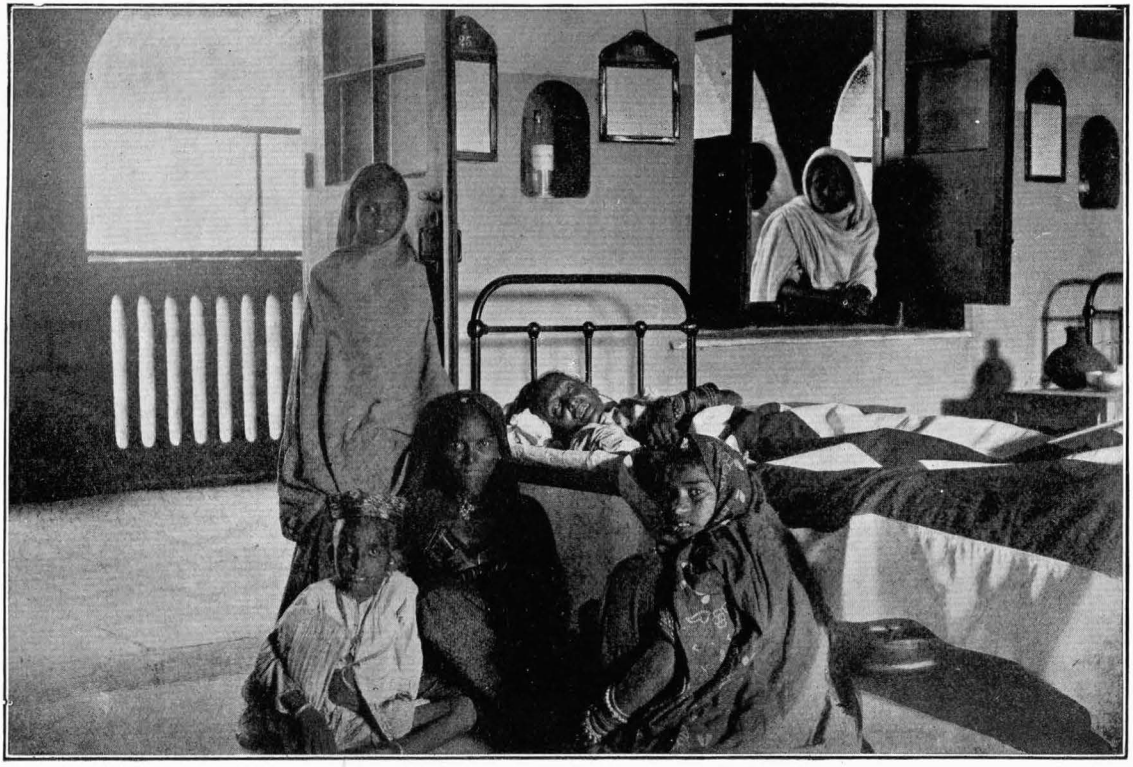
The need for women's hospitals and for general and midwifery nurses for visiting in the homes is an urgent one. Even apart from the considerations urged in the previous sections, the villages in India and China ought to be considered very carefully in plans for medical extension. Of India the *Edinburgh Conference Report*[1] says: "The provision which the Government makes in large centres is regarded as modifying somewhat the need in cities and towns, but there are large outlying regions where medical missions can push into fresh districts. . . . The opportunity presented in the villages . . . is . . . hardly as yet appreciated and used as it should be."

(*d*) *The needs of the missionary staff.* In many cases missionaries are stationed in lonely places, many days' journey from the nearest medical help. They are quite prepared to go forth, facing all the risks involved for themselves and their families. But ought the Church, whose members are so well provided for in this respect, to be content that its servants, the preservation of whose life and health means so much for the Kingdom of God, should be placed in such situations? Many a precious missionary life has been lost simply because no medical advice could be obtained at short notice; many a child has been taken away in infancy whose life might have been spared for as rich a service as his parents'; in many cases health has been ruined and premature retirement necessitated through the same lack. While no missionary would urge that this consideration should take precedence of others in the planting of medical missions, it is one that must rightly

[1] Vol. I., p. 307.

weigh with mission-boards, and it is one which the Church that sends forth her sons and daughters to do her work should seriously lay to heart.

II. *The relation of the medical to the evangelistic functions of the medical missionary.* While we recognize with great thankfulness how many individuals have been won for Christ through the work of medical missions, we should not be giving a complete picture if we did not admit that many medical missionaries are gravely concerned on account of a certain lack, as it seems to them, on the spiritual side of their work. Into some of the articles that have recently appeared there may have crept an undue sensitiveness on this score. After all, if the work is being done honestly and in the right spirit, it cannot fail of result, and the worker may be the person least qualified to measure it. At the same time, there is a real and a difficult problem. Granted that the prime work of the medical missionary is to win souls, he is nevertheless a doctor, and it is his bounden duty to put his best work into the healing of men's bodies. This makes a tremendous call upon time and strength, especially in a country where the doctors are very few and the patients very many. Shall he then give over the direct evangelistic work to others? Shall he call in the ordained missionary or the evangelist to do the preaching, and practically confine himself to his profession? To do this is to surrender the point of vantage which is his because he has been the means of bringing health to the sick. It is now very generally agreed that the doctor should himself be in charge of the spiritual work in his hospital, though, in the



THE PRESENCE OF THE PATIENTS' FRIENDS
Annie Harding Ward, St Stephen's Hospital, Delhi

See p. 35

case of some missions which would only give such a position to an ordained man, it involves an extra preparation.

The real difficulty lies in the choice that must often be made between the claims of the two aspects of the work. "Ought a patient with awakened interest to be sent away in order to make room for another needing attention, or ought he to be pauperized by being kept on as an in-patient, when he is fit to be sent out, in order to fan the flame of interest that has begun to grow in him?"[1] Adequate attention to the evangelistic side of the work makes very heavy demands on the doctor. Says Dr Harrison of Arabia, "It will require a good deal of knowledge of the language, and it will require an organization of the whole work with this end in view, but there is surely nothing unreasonable in this. *The medical missionary came out here for this precise purpose.* It will make severe demands on the doctor's physical strength, but this is a matter of the very greatest importance, and a *little medical work might even be sacrificed if necessary.*"[2] Dr Harrison further urges that in seeking spiritual results the work done should be at least as thorough as in seeking physical, and that careful records should be kept of each patient who has passed through the hospital.

This raises the further question of the following up of patients who have passed through hospital. There are certainly many cases in which the patient, during his stay in hospital, has become truly converted, and goes back to some remote village as a messenger of light. It must be admitted, however, that in many other cases the impression

[1] *International Review of Missions*, Vol. III, p. 733.
[2] *Medical Missions in India*, April 1913, p. 14.

made gradually dies away amidst unhelpful surroundings; the seed has fallen by the wayside, and the birds have come and devoured it. This cannot be wholly avoided, but many of the finest medical missionaries are asking whether we are really doing our best to avoid it. The fact is that our medical work is creating unrivalled opportunities for the Gospel messenger. In hospital you have a congregation prepared in heart, with leisure to listen and think over what is told them. In hundreds of villages opposition has been broken down, and there is a welcome waiting for the missionary because of some cure that has been effected, or some kindness received through the medical man. "None of us," says Dr Balme, "object to a heavy outlay if it enables us to obtain some unique opportunity, procurable in no other way; on the contrary, we regard it as an excellent investment. But if circumstances prevent us from utilizing the opportunity so purchased, we may well look upon our expenditure as having been to some extent in vain, and this, I believe, is just the point at which so many of our medical missions fail. Labour and time and money are poured out to win this special advantage: the advantage is won, but only to be lost again before one's hands have closed upon it."[1]

It is well that all who are interested in medical missions should appreciate the serious nature of this problem, for there is only one way in which it can be satisfactorily solved. The medical missionary may to some extent limit his professional work, but the Chinese proverb quoted by Dr Balme, "the door of charity is hard to open, but

[1] *Where Medical Missions Fail.*

it is also hard to shut," suggests at once the extreme difficulty of finding any relief in this direction. It certainly supplies no final solution. The one answer which meets the case is to staff the hospital more adequately.[1] This will in part be possible by using native doctors, as they are trained, but there is also an urgent need of more missionary doctors and nurses *for the hospitals already opened* if the vast opportunity that they are creating is to be adequately seized.

III. *The relation of medical missions to the other branches of missionary activity.* The discussion of both the previous questions will serve to emphasize the great importance of an intimate inter-relationship between the medical and all other forms of work entered upon by the missionary society. In order to secure greater efficiency on the medical side several large societies have recently organized medical departments or auxiliaries[2] at the home base. In connection with these, medical men and women have done and are doing very valuable work. Skilled attention is given to the problems that arise, the medical missionary or candidate is given expert advice, the Church is kept informed as to the progress of the medical work, and interest is quickened therein. A good many persons who cannot see their way to support other forms of missionary

[1] It is now generally recognised that two foreign doctors should be supplied to each hospital. Hospitals having over thirty beds and the average amount of out-patient work need three fully-qualified men or women, especially if these evangelistic opportunities are to be adequately utilized. This is true even though in some instances (*cf.* page 109 f.) evangelistic workers have been definitely attached to the hospital staff.

[2] See Appendix.

effort are glad to give to medical work, and in this way may ultimately become interested in other branches. This marks a very real step in the right direction, and the plan would be regarded by those societies that have tried it as fully justified by its success.

We must at the same time remember that medical missions are not a separate enterprise; they are and must be intimately related to the whole mission policy. Only in this way can they take their right place. In any forward step which is planned by the mission the medical side must be considered. The planting of a new hospital must be discussed in the light of the whole work of the mission, as for example in relation to mass movements, or peculiarly difficult fields.

More than this, however, is required. In each particular station a very close inter-relation should be the rule. The medical missionary, man or woman, has a contribution to make to all the other work. His other special knowledge should be brought to bear on the schools, in training the girls for motherhood, in giving scientific talks on health and morals, in helping to create ideals of cleanliness, in the production of literature, etc. On the other hand, the evangelistic and educational missionaries have a contribution to make to the medical work. In some cases it may be that only by their aid can the problem last discussed be solved. If we cannot give an adequate medical staff to the mission hospital, much might be done, as Dr Balme has suggested, by attaching an evangelistic missionary to each hospital, whose one duty would be to use to the full the opportuni-

ties provided, both in hospital and in the country, by the medical work. He refers to a case where a Wesleyan missionary was attached to a hospital and in seventeen years, through using these opportunities, had entered 100 villages and baptized upwards of 3000 people. Another such case is that of Peshawar, where the Hon. M. Waldegrave spends several hours each day in personal work among the patients. In some ways such a worker has the advantage of the doctor.

"Suppose," says Dr Balme, "one has a spare half-hour, and wishes to use it simply and solely for spiritual work. You go across to the wards determined to have a quiet chat with some of the patients. You pick your man, and sitting by his side, attempt to draw him into conversation. Nor is it difficult to induce him to talk—but it is not the conversation you are seeking for. It only needs a glance at the man to see what is passing through his mind. 'Ah,' thinks he to himself, 'now I have a nice opportunity of just explaining to the doctor what my disease really is. When I came to the hospital he asked me so few questions that he cannot possibly understand what the root of the trouble is, so I will just tell him.' And with that he launches forth into a detailed description of how he had, on a certain occasion, 'made a great deal of breath' with his mother-in-law, because she had paid half a cash too much per *catty* for the millet, and how he had just been eating some dates at the time, and so of course the 'breath' had got mixed with the dates in his inward mechanism and had produced a fire, which had caused the lump to grow in his left elbow, etc. etc. You try

again and again to switch him off, but even when you have exhausted his long and ingenious account of his own ailment, it is only to be consulted about the mysterious complaints of all his relatives down to the forty-ninth cousin, and the advisability of bringing them to the hospital. It sometimes needs much patience before you can turn his thoughts to the subject about which you are longing to speak."[1]

For results like those cited above to be obtained, a very intimate relationship must be maintained between the different departments of work.[2] The necessary specialization must not result in cutting off medical missions from the rest of the work, but all should grow together as a well-co-ordinated whole. "Great gain will result when through a clearer outlook and a stronger policy medical work is more closely incorporated with the rest. Such incorporation would involve on the one hand a fuller recognition of professional standing, and on the other more readiness to surrender it. A fuller place for lay leadership would have to be allowed than is general in some missions, and a more generous recognition of ministerial responsibilities would have to be cultivated than comes readily to every doctor's mind."[3]

IV. *Interdenominational co-operation in medical missions.* The need for greater efficiency at once suggests the possibility of co-operation. The Medical Missionary Associa-

[1] *Op. cit.*, pp. 21, 22.

[2] See *Continuation Committee's Conferences in Asia*, p. 354, section 13, and p. 81, section 1.

[3] *International Review of Missions*, Vol. I, p. 337.

tions in China and India show something of what has already been done in this direction. A similar organization has recently been started in Syria and Palestine. The chief lines along which such co-operation is possible are:—

(*a*) Medical education.
(*b*) Production of literature.
(*c*) Preventive work.
(*d*) Investigation.
(*e*) Where more than one mission has or contemplates medical work in the same centre.

"We have arrived at a stage in China," says the China Medical Missionary Association, "when all medical and surgical work done in the name of Christianity should be of the highest order, and we therefore recommend, in the interests of economy and efficiency, that wherever possible small and poorly equipped hospitals should unite to form thoroughly equipped institutions."[1] Again, two denominational hospitals in one centre may work together, helping one another by lending members of staff, or by special means, such as one taking male and the other female cases, or one medical and the other surgical.

There is perhaps no department of missionary work in which such co-operation presents fewer difficulties. Little need be said about it here, beyond a recognition of the fact that a very great deal has been done, and that the question is continuing to engage the best thought of medical missionaries. "There is abundant evidence to show that though actual co-operation is rare in one sense, yet there is

[1] *Continuation Committee's Conferences in Asia*, p. 356.

scarcely any mission work in which denominationalism is less obtrusive. While there are not many instances of hospitals which are maintained jointly by more than one mission, the hospitals that exist in the mission field are, for the most part, open to patients of all missions, and throughout the whole mission-field there is free and generous co-operation in medical work."[1] The medical schools in China mentioned on p. 74 above are practically all union schools, in which two, three, four, or as many as eight or nine, societies co-operate. Among the best known are those at Peking (in which the L.M.S., the Church of England Missions, the Medical Missionary Association of London, the American Board, the American Presbyterian, and the Methodist Episcopal join) and that at Nanking, in which eight American societies unite.[2] In training medical missionaries at home there has also been a large measure of co-operation, as is evidenced by the splendid work of the institutions for this purpose, maintained by interdenominational effort, in Edinburgh, London, Battle Creek, Michigan, and Tübingen.

It must not be supposed that in touching upon these problems we have by any means exhausted the questions which perplex the medical missionary. To name but one other, a discussion of which would be found useful if space permitted, we might mention the problem of charging fees and of self-support. Should the medical missionary give his service and his drugs freely? If he makes a charge, how can he avoid turning away some who are in real need?

[1] *Edinburgh Conference Report*, Vol. VIII, p. 75.
[2] For a full account see *China Mission Year Book*, 1913, pp. 293 ff.

If fees are charged, how can we avoid the impression that the medical missionary is out for what he can get? Such are some of the questions that have to be faced. The prevailing opinion among medical missionaries is now in favour of charging for all drugs, except in the case of the destitute, and making a good charge for consultations and visits to well-to-do families. All fees received are, of course, paid to the mission and not to the missionary.[1]

Behind all the technical problems of medical work on the mission field lies for every man or woman engaged in it as doctor, assistant, or nurse, the deeper problem of the hidden personal life. We have seen the doctor at work, pressed on every hand, worn out with doing good, often in a climate which taxes his physical strength to the utmost. The calls upon his strength, his skill, and his patience are often almost more than he can respond to. The tiresome patient, the loathsome case, the direct opposition, the petty difficulties which beset his path—all these tend to lower the high standard he has set before himself. Through it all, can he maintain the attitude towards all whom he meets which can alone win them? Can he manifest quietness of spirit even when working at highest pressure? Can he add to his devotion true gentleness, and to his untiring labour that deep respect, even towards the unlovely, which is never forgetful of the divine possibilities that lie hidden in the most unlikely human heart? It was a saying

[1] Any who wish to study this question should get the numbers of the *China Medical Journal* and *Medical Missions in India* for January 1910, in both of which full discussions on the subject are printed. See also *International Review of Missions*, Vol. II, pp. 325, 326.

of Paracelsus that "there is no one from whom greater love is sought than from the doctor." Of the medical missionary this is profoundly true. If all the problems referred to in this chapter are solved, and this great love is not found, it will profit nothing. For let us remember it is the doctor's attitude, spirit, touch, that count for most. He alone knows how difficult it is to maintain them in all their purity and gentleness under the peculiarly trying conditions of his everyday life. Here is his supreme opportunity and his supreme problem. Here it is that every reader of this volume can render his quota of help by the unseen ministry of intercession.

The weary ones had rest, the sad had joy
That day, and wondered how;
A ploughman, singing at his work, had prayed
"Lord help them now."

Away in foreign lands they wondered how
Their simple words had power;
At home, the Christians, two or three, had met
To pray an hour.

Yes, we are always wondering, wondering how,
Because we do not see
Someone, unknown perhaps, and far away
On bended knee.

COLLATERAL READING.

Continuation Committee's Conferences in Asia. All findings on Medical Missions.
Mass Movements and Medical Missions.
Where Medical Missions Fail.
The Appeal of Medical Missions. Chapter IX.
International Review of Missions. The Place and Policy of Medical Missions in India. April 1913.
Mercy and Truth. Vol. XVI. Ten papers on Principles and Practice, by Dr Harford.

CHAPTER VIII

OUR PART

A STUDY of medical missions is a poor thing unless it awakens within the student certain insistent questionings. The man who cannot see in Christianity anything more than a particular system of thought among the other systems in the world, and who regards the whole missionary enterprise as a piece of presumption or a harmless folly, is faced by a very definite problem. The conditions referred to in the second chapter are almost invariably associated with the non-Christian religions. Towards the weak, the sick, the mentally afflicted, the outcast leper, the woman in her hour of need, little sympathy is shown at the best; at the worst there is a manifestation of cruelty and scorn. The Christian doctor arrives upon the scene. All is changed. The weaker and the more helpless the sufferer, the greater is the tenderness displayed, the more the patience exercised. What accounts for the difference? The facts cannot be controverted, even when full allowance is made for such true kindness as is often enough shown, say within the family, towards a sick child. Speaking in general terms there is a contrast which demands an explanation. In our study of this work we have been brought face to face with the nature and spirit of the men and women who are doing

tinues, through His servants, the same mission of healing of the body, release to the mind, and salvation to the soul as He began during the few short years when He trod the fields of Galilee.

To some is given the possibility of taking a personal part in this service at the front. The medical student is bound to consider, in the light of the facts set forth in this volume, whether his or her life will yield its richest fruitage in adding one more to the ranks of the profession at home, where, at least until the present war made such great demands upon our doctors, our need of medical aid has been met in abundance if not to excess. On the other hand, the medical student cannot fail to remember the understaffed hospitals, creating golden opportunities that cannot be used for lack of men ; the sorely-tried converts from heathenism, tempted to deny their faith in the hour of sickness because the only help they can get involves them in a return to idolatry and superstition; the fields white to the harvest, which the Christian missionary cannot enter because of a deep-seated prejudice removable only by medical work; the medical schools tackling so courageously, yet with such insufficient staff, the stupendous problem of the future. It may be right that students should also remember the unrivalled field for medical and surgical work and for original investigation that is open to the doctor who is keen on his profession. It is difficult to conceive how any medical student who shares the spirit of his Master can fail to be moved and to be deeply moved by such thoughts. For him there awakens a questioning which cannot easily be set aside

unless he is ready to offer up his own life in glad surrender at so great a call.

Not less upon the nurse, trained or in training,[1] there presses a problem not lightly to be solved. The mission-hospitals still without a nursing superintendent call loudly for the help that only she can give. The zenanas of India, the women in travail, the children whose lives are sacrificed to ignorance and superstition—these make their own peculiarly moving appeal. It must shame those who belong to the Protestant Churches to read that "while Roman Catholic Missions have nothing to correspond with the nearly one thousand medical men and women in the service of Protestant Missionary societies, they have in the thousands of Sisters throughout the mission-field a considerably larger force engaged in the nursing and care of the sick."[2] It may be true that until recently many missionary societies have not sufficiently realized the necessity of this kind of help in the mission hospital, and that the conditions of work have not in all cases been ideal. But is it not fair to say that if nurses had come forward in larger numbers, filled with the true missionary spirit, things would have been very different, and the obstacles would have been found to yield to such devotion? In any case the need to-day stands before the nursing profession as a challenge not less great than that to which they have so nobly responded in the service of the sick and wounded in the Great War.[3]

[1] See Appendix.

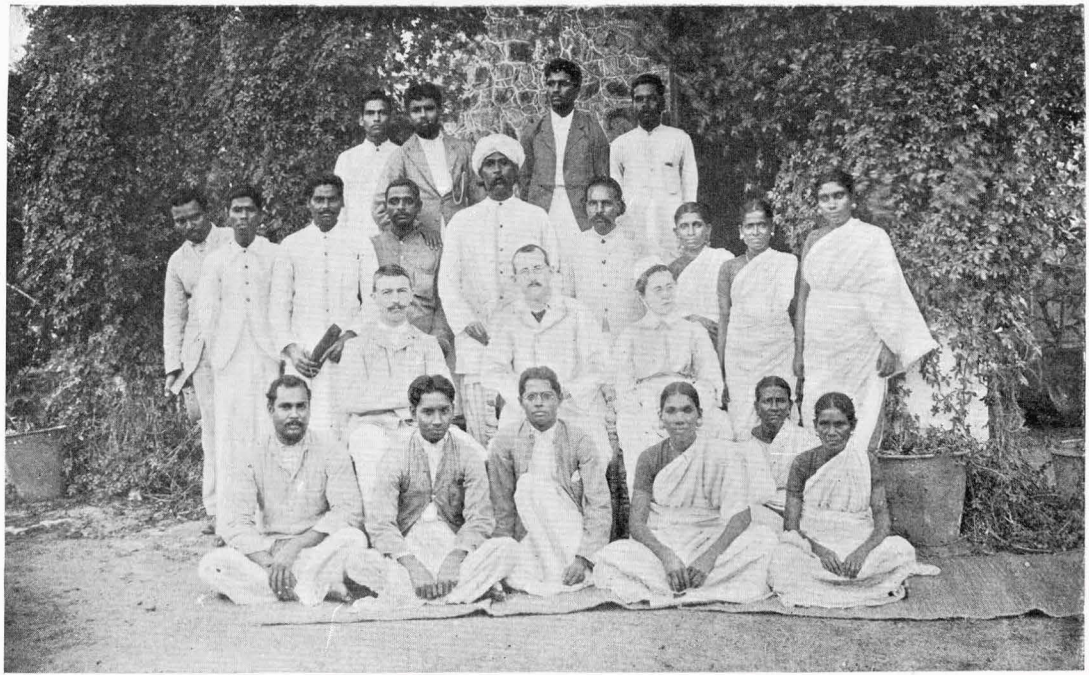
[2] *International Review of Missions*, Vol. I, p. 363.

[3] For a most graphic statement of the situation, by a nurse, see

Perhaps no lesson taught us by the terrible crisis through which our country is now passing (1915) has come home more fully to the ordinary man than the fact that the success of a nation in war depends as much upon the men who make the ammunition, and supply the food and clothing for the troops, as it does upon those who actually face the enemy in the trenches or on the high seas. This lesson has not yet been fully learned by the Church of Christ in her far-flung campaign against the forces of darkness. It is obvious enough to the missionary secretary and committee member, and no less so to the man at the front. This volume will fail to attain its object unless it brings home to its readers the fact that every single member of the Church has a privilege and a duty with regard to medical missions. Not only to the medical student and the nurse do these facts constitute a challenge. To every one of us they are pregnant with a deep and personal significance. No one ought to be able to escape the questioning of his inner consciousness which bids him discover his own particular share in the work of medical missions.

Prayer has already been mentioned. To take our part in this way means preparation of both mind and heart. If we take seriously this form of co-operation, it must be our aim to keep ourselves abreast of what is happening, to be fully informed and alive to the actual difficulties and needs. Let us not forget to link with our intercession the oft-recurring note of praise for all that God is doing in these

Mercy and Truth, Vol. XVII, pp. 397-399, Art., "Nursing Opportunities in China."



THE HOSPITAL STAFF
at Neyoor, including British doctors and matron, Indian assistants, students, and nurses

distant lands. True prayer is itself contagious. The man who talks a great deal about prayer may be very poor at leading others to pray. The man or woman to whom prayer is a daily experience exercises an influence that calls out the spirit of prayer in others. Every student of medical missions has the chance of doing a wide work in this way if he is prepared for the necessary self-discipline.

We should not deceive ourselves, however, by the thought that "our part is prayer" when, in point of fact, we are being called into other service *as well.* Indeed, true prayer makes no such excuse. It leads us naturally into taking every opportunity of personal helpfulness that presents itself, and into the discovery of opportunities which other eyes will not detect. The great opportunities are in daily life. In contact with our own friends, when we touch fresh circles in the varying occupations of work or recreation, can we not discover means of imbuing others with our belief in medical missions? There is no part of the foreign missionary enterprise that makes a wider appeal to all and sundry. Everywhere there are points of contact with life as we know it. Is someone ill? We recall the method of treatment that would be used were he an African negro, or driven to consult an old-time Chinese doctor. Does some deed of heroism thrill us? There springs to mind a parallel from the records of missionary doctors. Does the reference to some outworn superstition evoke a smile? How different it would be if just such a superstition were truly believed, and meant the blindness of our child, or the death of our mother.

Some of us may feel ill-adapted to discuss, defend, or

persuade. We easily get out of our depth. We cannot see how to meet each point. But facts have their own power, apart from arguments, and everyone can acquire a knowledge of facts. They are awkward things to get round, and often they stay behind, evoking an unpleasant sense of the insecurity of the position, when the ablest argument has been quite forgotten. The facts of medical missions only need to be widely known and well used in order to make their own impression. They are the basis upon which argument must rest in any case, and one is often surprised to see the house of cards erected by the skilful but ill-informed critic tumble incontinently to the ground before a few well-placed shots from the man who knows.

Invaluable for the preacher or the teacher are the telling incidents from the mission hospital. Have we made the best use of them? Is there not here a gold-mine from which we have too often failed to extract the rich ore? In the use of these incidents we are creating the atmosphere that makes people believe in missions in spite of themselves. If it comes to argument, have we not the New Testament? It is well for us to begin with a clear statement of the ample Scriptural grounds on which we base our own belief in medical missions. These have not been recapitulated here, for they are well-known to many and are accessible to all.[1] We can go on to a statement of the need on lines similar to those followed in Chapter II. We can further point with

[1] For such a statement see *The Appeal of Medical Missions*, Chap. II.

confidence to the actual success of this branch of work. We can introduce the doubters to some medical missionary through the account of his life, so that they may catch the infection of his spirit, and in spite of themselves be made sharers in his aims and motives. Thus may the torch be passed from one to another. The personal touch is what is chiefly needed, and to every one of us are given opportunities of broadening the basis of support, so that every church in the land may have its own part in this Christ-like work.

We shall not do well to pass from this subject without asking ourselves one further question. Are our gifts to medical missions proportionate either to the greatness of the blessings that we possess in this country through the aid of modern medical science, or to the extent and depth of the need of those less fortunately placed? Does the easily-spared coin, dropped into the collection plate, really represent a response for which we have no cause to feel ashamed? Is it a response which accords with the magnitude of the work we have been studying and which is fit to take its place, however humbly, by the side of the devotion of those splendid men and women who represent us in the field? It is not a question of the amount given, but of the relation of that amount to our possibilities and advantages. The giver of the widow's mite need not creep into the corner and blush with shame at the thought of the self-sacrificing love of these men and women. Was not this all her living? But the "handsome gift" of one who knows that it has cost him not even the smallest luxury to give it, may well bring a sense of shame. There are many

ways of giving. In several of the larger societies the Medical Department or Auxiliary[1] gives ample and varied suggestion. Readers whose connections are with these societies should consult the responsible secretary and find out in what particular way they can best give the kind of help and the amount of help which they are moved to offer. Above all else we need in this service ourselves to share in the spirit of the medical missionary. No grudging offering from one who asks, "What is the least I can decently do?" is worthy to find a place on the roll of honour. That place belongs alone to the joyous gift of one who seeks to do the utmost that lies within his power, and who enters into the truth of Lowell's well-known lines,—

> Who gives himself with his gift feeds three,
> Himself, his hungering neighbour, and Me.

The present is no time for curtailing our efforts. In India the medical missionaries "view with the greatest concern the present falling off in offers for medical mission service," and tell us that "many mission hospitals stand empty for long or short periods owing to the absence, on furlough or from sickness, of the doctors in charge, while numberless pressing opportunities for extensive evangelization are being lost. Rural Bengal and Assam and Orissa, because of their many infected areas, and the prevalence of disease, form one of the most needy parts of the world for such work."[2] In China medical missions touch but a fraction of the need, and it must be many years before the Chinese Government can provide a supply of doctors in the

[1] See Appendix.

[2] *Continuation Committee's Conferences in Asia*, pp. 113, 144.

least adequate to the needs of her immense population. It has been estimated that 200,000 doctors could find ample scope in China alone. Huge tracts of land in Africa and in South America still support populations entirely beyond the reach of skilled medical assistance. The opportunity and possibilities in Moslem lands are quite unique and, as yet, but little realized. Over and above all the calls that come for the planting of new hospitals and dispensaries, there is the urgent need for a thorough medical education of the men and women native to these countries, a need which we are only beginning to meet.

In entering upon the work of medical missions the Church of Christ has set her hand to a task whose magnitude and difficulty she has but dimly seen. She obeyed a true instinct, and it led her as Abraham was led of old into an unknown land. Now, as the larger possibilities open out, as we see the extent of the land to be possessed and the stupendous demands that will be made upon us if we are fully to possess it, we have need of a like courage and faith. If the Church has been called of God to take up this double ministry, it is her bounden duty to do it in a way that is worthy of her Lord. It should be her joy to break on His feet the whole box of ointment, without waiting till she can work out the exact cost. It is in this spirit that men and women are to-day going forth to the ends of the earth. Such love is costly. The fellowship of His sufferings is a necessary part of it. "See all, nor be afraid" is the inevitable challenge. As the medical missionary probes to the depth of human misery, seeking

the root cause of physical and spiritual ill, he may feel the

> Desperate tides of the whole great world's anguish
> Forced thro' the channels of a single heart.

But to him also is given the infinite joy of knowing the healing power of a great love. If the Church that sends him forth is to be a partner in his joy, she cannot turn away from the full cost of an uncalculating love.

COLLATERAL READING.

The Healing of the Nations. Chapter VI.
The Appeal of Medical Missions. Chapter XII.
The Claim of Suffering. Chapter IX.

APPENDIX

A.—PREPARATION OF THE MEDICAL MISSIONARY

THERE will probably be some readers of this volume who seek information on the details of preparation for medical missionary work. Such readers would do well, in the first place, to read the section of the Report on "Preparation of Missionaries" presented to the Edinburgh Conference, which deals with the medical missionary (this will be found in *World Missionary Conference Report*, Vol. V., pp. 134-145).

It will also be well, at an early stage, to get into informal touch with the Secretary of the Missionary Society in connection with which it is desired to go out to the field, or with some individual medical missionary. A few brief suggestions are here given, especially for the sake of those who, for any reason, are unable to get personal advice.

The preparation of the medical missionary may be divided into three parts, each of which can be discussed separately, although, in practice, they may be, to some extent, taken concurrently. These are :—

I. Professional training for diploma, or degree.
II. Special professional training (mainly post-graduate).
III. Missionary preparation.

I. Little need be said on the first point. All regular work for qualification must, of course, be taken, and no one who has read the foregoing pages can doubt the urgent necessity of its being done as thoroughly as possible. Missionary societies do not, as a rule, give financial help to students during their professional training, and the majority of medical missionaries have taken this training like other medical students at a recognized university or medical school. There are, however, two societies in Great Britain which give special help to those wishing to become medical missionaries, viz., the Edinburgh Medical Missionary Society, George Square, Edinburgh, and the London Medical Missionary Association, 49 Highbury Park, N. Both these bodies make grants of money towards the cost of training those who have dedicated their lives to the service of medical missions. Halls of residence for students are provided in Edinburgh (one for men

and one for women), and in London for men only. Many medical missionaries can testify to the value of residence in these halls, and of the help given through the associations.

II. Chapter IV will have served to emphasize the need of post-graduate work. The relative importance of special lines of work will vary in accordance with the field of work. It is, therefore, a great help if the field can be decided shortly before, or at the time of, graduation. To take two examples. The presence of a medical woman in a station would make special work under class (*c*) less necessary for a man: the relative importance of class (*d*) is much greater in Central Africa than in Northern China. Some attempt is here made, however, subject to local conditions, to put the various lines of special professional training in order of importance.

(*a*) A house appointment in a large hospital, especially with good surgical practice. This is, in the writer's opinion, almost a *sine qua non*, except in cases where a medical missionary is going out to join a well-staffed and fully-equipped hospital in the field; even in such cases, however, a house appointment is most desirable, and should always be taken where possible.

(*b*) Special eye work, if possible, with operative experience. Almost every medical missionary has to be an eye specialist, and the advantage of special work, beyond what is required in an ordinary graduation course, is very great indeed.

(*c*) Special study of maternity work and the diseases of women. The relative importance of this varies with the field and local circumstances. For a woman medical missionary it is essential.

(*d*) Tropical Medicine. A three months' course, at either the London or the Liverpool School of Tropical Medicine, should, if possible, be taken, if not before going out, at any rate on the first furlough.

In addition to the above main lines of work, it is worth while giving special attention to bacteriology, of which some additional study beyond that required for graduation may frequently be made during the ordinary course. It is very desirable to take a diploma in Public Health. Some study of methods of research is also certain to prove useful. Dentistry, too, is of much practical value. Medical students should also give careful attention to the work on the compounding and preparation of drugs, and if they can secure some insight into problems of hospital management, it would be of great service to them. Should the missionary candidate be able to ascertain, about the time of his gradnation, the particular hospital to which he is likely to be appointed, he should by all means correspond with the medical missionary in charge of it, in order to discover what special lines of preparation will be of chief value, in view of both the work done at the hospital and the special qualifications of the other members of the staff.

III. Throughout his medical training the medical missionary should follow some regular course of Bible study, and, especially in the earlier stages, when the demands for work are less exacting, it is worth while taking some regular religious work as a training for missionary service.

The importance of developing and maintaining a real practice of prayer needs no comment.

It is, generally speaking, inadvisable for the medical missionary to spend any considerable period of time after he has completed his medical course, and before going to the field, in a course of special missionary preparation, owing to the fact that by doing so he loses touch with his medical work, as, in any case, he must do to some extent while studying the language on the field. If, however, he can secure three months at a missionary training institution, the results will certainly be satisfactory, and this should be done wherever possible. The special study upon which he should there concentrate would depend, to some extent, on the reading that he had been able to accomplish during the time of medical preparation. In any case, some study of the religion of the field to which he is going, and of missionary methods, is most desirable. If there is a probability of his being attached to the teaching staff of a missionary college in the field, he should also take the opportunity of beginning the study of education and educational methods. The Board of Study for the Preparation of Missions now arranges each year for a course of lectures during the month of August at Oxford or Cambridge. Particulars and advice on this side of the medical missionary's training can always be obtained from Rev. J. Steele, D.Lit., Secretary of the Board of Study, 2 Church Crescent, Muswell Hill, London, N.

B.—PREPARATION OF MISSIONARY NURSES.

As in the case of the missionary doctor, the nurse should take a full training, *i.e.* at least three years in a general hospital of not less than a hundred beds with a resident medical officer. In addition to this, it is most essential for her to take the C.M.B. certificate, and, if possible, to get some special experience in children's diseases, either during the regular course or supplementary to it. It is also advisable to get extra experience of surgical work, and to take a short course of anæsthetics and dispensing. Since in practically every case the missionary nurse is appointed as nursing superintendent, with charge of the training of the native nurses, it is most important that she should have some administrative experience. Matrons in hospital are generally quite willing to arrange for this if consulted. What has been said under the previous heading in regard to missionary preparation applies equally to the nurse. The importance of regular Bible study during training cannot be overestimated. In the case of a nurse, it is most advisable for her to have three terms at a missionary preparation college, not only for Bible study, but for learning how to present the Christian message to non-Christians, and as affording almost the only opportunity in her life for quiet meditation and communion with God. Some societies prefer candidates to secure this before starting their professional training.

Advice on these and other points relative to the training of mis-

sionary nurses can always be obtained from Miss H. Y. Richardson, Secretary of the Nurses' Missionary League, Sloane Gardens House, 52 Lower Sloane Street, London, S.W.

C.—MEDICAL DEPARTMENTS OR AUXILIARIES

N.B.—*Space does not admit of statistical tables. Facts and figures may be obtained from the Societies.*

The Society for the Propagation of the Gospel has had a medical mission fund for five years, kept entirely distinct from the ordinary funds. It is responsible for all the medical work carried on by the Society, and since its inception no grant has been made from the general fund towards medical missions. There is, however, a trust fund for building hospitals, which is administered by the governing body and partly meets the needs for hospital buildings. The medical fund is under the direction of a special committee, and in the judgment of the Society, since the policy of having a separate fund and committee for medical work was adopted, the fund has increased at an average rate of £2000 per annum, the medical department has been the means of winning considerable increase in support of the general fund, the efficiency of the work abroad has been promoted. The department has a Secretary (H. H. Weir, Esq., M.B., of Korea, *Secy. pro tem.*), and an Assistant-Secretary.

The Medical Mission Auxiliary of the Church Missionary Society was founded in the year 1891. Previously to that date the medical missionaries of the Society had to depend for the upkeep of their work upon special gifts, assisted by a small grant from the general fund of the Society. The original object of the Auxiliary was to raise money and make grants for special things required over and above the general fund grants, but by 1895 the funds of the Auxiliary enabled it to meet all upkeep expenses of the medical missions without aid from the general fund. Later, the Auxiliary undertook to pay the salaries of doctors and nurses, and finally, all items of expenditure in connection with medical missions, so that it is now responsible for the whole cost of maintaining all the medical missionaries and their work, and no part of the general funds of the Society are allocated for this purpose.

In the year 1898 the Auxiliary was recognized. A new medical committee was formed consisting of about equal numbers of professional and non-professional members and was entrusted with the duty not only of raising funds for the support of medical missions, but of advising in regard to all medical and medical mission matters arising in any of the Society's missions. The latter part of its duty became so absorbing that in the year 1900 the two functions were separated, and the department for the raising of funds, that is the Auxiliary proper, was attached to the Society's regular home organization side, while the medical committee gave its whole attention to matters of administration and policy.

The Auxiliary now has an income of about £45,000 a year (as against £1400 in 1892), a large part of which comes from people who are not particularly interested in missionary work. The Secretary is the Rev. H. G. Harding.

The Baptist Missionary Society Medical Mission Auxiliary was started in 1902, as the medical mission department of the B.M.S., and of its sister mission, the Baptist Zenana Mission (now the Women's Missionary Association of the B.M.S.) Its object was threefold.

(1) To spread a knowledge of, and an interest in, the work of medical missions amongst the Baptist churches of the home-land.

(2) To lead to the going forth of more medical and nurse missionaries and the erection of more hospitals on the mission field.

(3) To raise an adequate fund for the entire maintenance of all the medical work and workers in connection with the Society.

The Auxiliary was to be managed by a representative committee of the Society, upon whom would rest the responsible administration of the various medical missions, and who would include in their number some medical men and women interested in this branch of missions. A medical secretary was appointed and the work of active organization commenced in 1903.

The history of this movement in the years from then till the present time has proved the wisdom of the step that was taken in the formation of this Auxiliary. There has been a steady advance in interest, in workers, and in funds, as can be seen from the following Table:—

	1903.	1915.
Doctors	11	30
Nurses	—	13
Hospitals	5	15
Funds	£432	£11,438

The special appeal has not weakened the interest taken in the general work of the Society, and it may be said that practically speaking the medical mission fund has been made up of new found gifts. The M.M.A., as it is familiarly called, has become a living force in the denomination, and prayer, thought, and effort have been called forth on behalf of medical missions.

The urgent requests for development and extension of the medical work are still, however, very great, and the Auxiliary stands in need of all the support that can be given to it. It is hoped that Baptist study circles may culminate their study of the subject by undertaking some definite practical share in the work of B.M.S. medical missions. As a guide, it may be stated that £5 per year will purchase a "share" in the annual cost of supplying the hospitals with drugs, etc., £7 per

year will support a bed in China, and £10 per year a bed in India. Particulars concerning these and many other methods of helping, as well as literature, will be gladly forwarded on application to R. Fletcher Moorshead, Esq., M.B., F.R.C.S., the Secretary of the Auxiliary.

The Wesleyan Missionary Society has a separate medical fund and finds that many people are willing to give to this work to whom ordinary mission appeals do not come home. At present, this separate fund, amounting to about £7000 per annum, does not come anywhere near the amount annually spent on medical mission work. The balance is taken from the general funds of the Society. The administration of the medical fund is not in the hands of a separate committee, though there is a board of physicians to advise the Society in regard to medical expenditure. "The ideal to which we are working is to obtain a medical fund that will be amply sufficient for the maintenance of all such work that the Society carries on, including the salaries of missionaries, the necessary buildings and all other costs inevitable to such work. When we reach that mark I think it exceedingly probably the committee here would put the management of medical mission work into the hands of a separate committee, having its own secretary and carrying on its own work, subject always to the general committee of the Society; but that is a goal that is at present, I am sorry to say, out of sight." The newly appointed Secretary, who gives his whole time to the work of the Auxiliary, is Dr F. P. Wigfield.

The Wesleyan Methodist Women's Auxiliary started work in 1858. They have hospitals and dispensaries in India and in China. Annual expenditure about £5000.

The London Missionary Society has no medical auxiliary, but possesses a medical council (Secretary, G. Basil Price, M.D., B.Sc., M.R.C.P., D.P.H.) which deals with the personal medical needs of its missionaries and acts in an advisory capacity to the Board of Directors. It is not concerned with the raising of money. The L.M.S. is endeavouring to raise the whole of its expenditure upon medical missions in China, India and Africa by means of an annual "Hospital Week," when the special claims of this work are set before its constituency. Particulars may be obtained from the Rev. W. Nelson Bitton, Home Secretary.

N.B.—*The Church of England Zenana Missionary Society and the Zenana Bible and Medical Mission are independent Societies carrying on medical work in India, Ceylon and China, and in India, respectively.*

D.—A LIST OF USEFUL BOOKS

N.B.—*This selection is necessarily small. Further guidance will gladly be given by Librarians of Mission Houses. No book of which the main relevance lies in the passages quoted in the text is included in this list.*

BIOGRAPHICAL

Beloved Physician of Tsang Chou, The. Letters of Dr Arthur Peill, edited by his father. Headley. 1s. net. Medical Missions in China at the time of the Boxer outbreak.

Foreign Doctor, The. Life of Peter Cochran, M.D. Robert Speer. Revell, 1911. 6s. net.

Jackson, Arthur, of Manchuria. A. J. Costain. Hodder, 1911. 2s. net. The thrilling story of a fight with plague.

Livingstone, Life of David. W. G. Blaikie. Murray, 1911. 1s. net. Full quotations from Livingstone's own letters and journals.

Mackenzie, John Kenneth. M. I. Bryson. Revell. 6s. Standard life of a pioneer in China.

Pennell of the Afghan Frontier. A. M. Pennell. Seeley Service, 1914. 10s. 6d. net. A fascinating pioneer with extraordinary influence over the tribesmen.

Reed, Mary, Missionary to Lepers. John Jackson. Marshall Bros. 1s.

Robertson, Cecil, of Sianfu. F. B. Meyer. Baptist Missionary Society. 2s. net.

Schofield, R. A. A. A. T. Schofield. Hodder, 1898. 1s. 6d.

GENERAL MEDICAL MISSIONARY WORK

A Medical Missionary in China. Dr Lockhart. Hurrell, 1861. 15s. net. See above, pp. 55, 66.

Among the Wild Tribes of the Afghan Frontier. T. L. Pennell, M.D., B.Sc., F.R.C.S., with an introduction by Lord Roberts. Seeley Service, 1909. 5s. net. Dr Pennell's own record of his first ten years' work. Vivid scenes and interesting deductions.

Behind the Veil in Persia and Turkish Arabia. M. E. Hume-Griffith, with narratives of experiences in both countries by A. H. Hume-Griffith, M.D. Seeley Service, 1909. 16s. net. Work among Moslems, especially among women and children.

Beyond the Pir Panjal. Ernest Neve, M.D., F.R.C.S. C.M.S., 1914. 2s. 6d. Life and Missionary enterprise in Kashmir.

By the Equator's Snowy Peak. May Crawford. C.M.S., 1913. 2s. 6d. net. A record of medical missionary work and travel in British East Africa, especially in the Kikuyu district.

Converts through Medical Work. S. W. W. Witty. C.M.S., 1915. 6d. net. Brief biographical sketches of notable men converted through medical work.

Dr Apricot of "Heaven Below." Kingston de Gruche. Marshall Bros. 2s. 6d. net. Breezy sketch of Dr Duncan Main's work at Hangchow.

Medicine in China. Report of the Rockefeller Commission, 1914. Published in America. Best procured on loan through Mission House Libraries.

Nazareth of To-day. F. J. Scrimgeour. W. Green & Son, Ltd., 1913. 3s. 6d. net.

Thirty Years in Kashmir. Arthur Neve, F.R.C.S.E. Arnold, 1913. 12s. 6d. net.

Thirty Years in Moukden, 1883-1913. Dugald Christie, C.M.G., F.R.C.S., F.R.C.P. Constable, 1914. 8s. 6d. net. Particularly valuable sketch of the development from itineration to medical college. Good chapter on principles of medical mission work.

SPECIAL FORMS OF MEDICAL MISSION WORK

In Leper Land. John Jackson. Marshall Bros. 1s. net. Sketch of a tour in India and China.

In the Steps of the Good Physician. Compiled by E. S. Tiley. Marshall Bros., 1913. 6d. net. Some glimpses of C.E.Z.M.S. medical work in India and China.

Lepers Sought His Face. C. Horder. C.M.S., 1909. 6d. net.

Revolution and Other Tales. Margaret Baldwin. C.M.S., 1913. 1s. Work in Foochow amongst women, and with the Red Cross, at the time of the Revolution of 1912.

Village of Hope, The. Kheroth Mohini Bose. Marshall Bros. 2s. net. The story of the growth of C.E.Z.M.S. work at Asrapur.

MEDICAL MISSIONS RELATED TO OTHER MISSION WORK

Christian Missions and Social Progress. J. Dennis. Oliphant. 3 vols., 10s. each. Vol. III. useful for facts about medical work.

Mission in China, A. W. E. Soothill. Oliphant, 1907. 5s. See above, p. 34.

Robert Clark of the Punjab, Missionary and Statesman. H. Martyn Clark, M.D. Melrose, 1907. 7s. 6d. net. Shows how medical work began to take its proper place in N.W. India.

Unknown People in an Unknown Land, An. W. Barbrook Grubb. Seeley Service, 1913. 5s. net. Work in Paraguay.

PRINCIPLES AND CLAIMS OF MEDICAL MISSIONS

Appeal of Medical Missions, The. R. Fletcher Moorshead, M.B., F.R.C.S. Oliphant, 1913. 2s. 6d. net. Specially good on scriptural grounds, purpose, and organization.

Claim of Suffering, The. Elma K. Paget. S.P.G. 1913. 1s. 6d. net. Particularly full of illustrative matter: Textbook for circles.

Healing of the Nations, The. J. Rutter Williamson, M.B. Student Movement, 1899. 1s. 6d. net. Forceful and brief textbook, but now rather out of date.

Medical Missions, their Place and Power. John Lowe, F.R.C.S. Oliphant, 1886. 2s. 6d. net. Statement of principles, by one who was among the earliest medical missionaries to China, and was also among the first to train medical missionaries at home. Exceedingly useful, especially on qualifications and training, though a little old-fashioned.

HISTORICAL

There is no one good general survey. See, however, p. 12 above.

Readers should consult librarians of their own Societies.

C.M.S. Articles in *Mercy and Truth*, 1914-15, and *Church Missionary Review*, 1915.

L.M.S. *Handbook to Medical Missions.* 6d. net.

S.P.G. *S.P.G. Medical Missions.* 3d. net.

W.M.M.S. *Medical Missions in China in connection with the Wesleyan Methodist Church.* W. A. Tatchell, M.R.C.S. Culley. 2s. net.

BOOKS OF REFERENCE

Continuation Committee's Conferences in Asia. Office of the Committee, 1 Charlotte Square, Edinburgh, 1913. 7s. 6d. net.

Report of the Edinburgh Missionary Conference. Oliphant, 1910. 9 vols. 2s. net each.

Year-Book of Indian Missions and *China Mission Year-Book.* 5s. net each issue, from Religious Tract Society.

PAMPHLETS

Dedicated Science. L.M.S. 3d.

Doctors' Doings in Many Lands. C.M.S. 1d.

What Medical Missions are Doing. S.P.G. 1d.

Work of a Matron in an Indian Hospital. Dr Amy Lillingston, C.E.Z.M.S. 2d.

MAGAZINES

The East and the West. (1s. quarterly. S.P.G.) *The International Review of Missions.* (2s. 6d. quarterly. Oxford Press.) Contain frequent articles on Medical Missions.

Magazines devoted specially to medical work are:—*Mercy and Truth.* C.M.S. 1d. monthly. *Nurses Near and Far.* Nurses' Missionary League. Monthly, 1d. *The Quarterly Paper of the Edinburgh Missionary Association.*

INDEX

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THE STORY OF C.M.S. MEDICAL MISSIONS

CHAPTER I

HOW THEY BEGAN

The Rev. Abdul Masih, the "Christian *hakim*"

IN the year 1841, twenty-four years before the first C.M.S. medical mission, an American missionary doctor on his way home from China stayed at the house of the famous Dr. Abercrombie in Edinburgh. What he was able to tell of the marvellous way in which his medical knowledge had helped his missionary work so impressed the great surgeon that he called together a few of his friends, and they formed themselves into an association "to circulate information on the subject, to endeavour to originate and aid such kindred institutions as may be formed to prosecute the same work, and to render assistance at missionary stations to as many professional agents as the funds placed at its disposal will permit." This may be taken as the starting point of modern medical missions, for though there were two or three medical missionaries in the field before this date, it was the Edinburgh Medical Missionary Association, then founded, that first brought home to the Christian Church the true importance and value of this branch of work, and prepared the way for the great developments of recent years.

If we can imagine the state of medical and surgical science at that time, we shall be able to realize to some extent the blessings which God has bestowed upon us since then, and which He calls us to pass on to others. The anæsthetic properties of chloroform, which now rob the operation table of its terrors, had not yet been discovered; the operation for cataract, by which in our mission hospitals thousands of blind people each year receive their sight, was then a serious and doubtful undertaking; Lord Lister's great discovery of antiseptic methods, which has made possible the miracles of modern surgery, was yet in the distant future. On the medical side there was no certain cure for diphtheria, tetanus, or many another disease which has now lost its terrors; small-pox still claimed its thousands, for vaccination was by no means general; many of our most valued modern remedies were unknown.

If a doctor had appeared at that time armed with the knowledge and skill which we possess to-day he would have seemed like a messenger from heaven, working veritable miracles of blessing to the race.

The story of medical missions is the record of the coming of such wonder workers to peoples whose ideas of medicine and surgery are such as obtained, not a hundred, but a thousand years ago.

To find the first mention of medical work in connexion with C.M.S. Missions we must go back much farther than 1841. The name of the Rev. Abdul Masih will be familiar to many; a learned Mohammedan of Delhi, he was converted through the preaching of Henry Martyn, and became the first C.M.S. agent in India. As far back as 1813 we find that he was doing simple medical work at Agra, and was known far and wide as "the Christian *hakim*," so that in a very humble way he may claim to have been the first C.M.S. medical missionary.

During the years that followed many C.M.S. missionaries did work of this kind. A few had been in practice as

physicians or surgeons before going out, and in one or two cases it is evident that they were sent out in the full expectation that their professional skill would be of value in the mission. But these were isolated and individual efforts, and would scarcely be recognized as medical missions in the sense in which we use the term to-day. The first permanent medical mission was that in Kashmir, and Dr. Elmslie, who sailed for India in September, 1864, and opened his dispensary at Srinagar in May, 1865, is regarded as the first regular medical missionary of the C.M.S.

Dr. W. J. Elmslie

The arrival of Dr. Elmslie was the culminating point of ten years of effort to establish a permanent mission in Kashmir. Those ten years cover the most critical period of England's empire in India (the Indian Mutiny was in 1857), and Englishmen may thank God that during that period the confines of the empire were held by men who were as well known for their Christian character as for their statesmanship and courage. John and Henry Lawrence, General Havelock, and Sir Herbert Edwardes are names that at once occur to our minds. The last named took a leading part in founding the Kashmir Mission; with him were Sir Robert Montgomery, Lieutenant-Governor of the Punjab, General Lake, Colonel Martin, Robert Cust, and other prominent Indian officials. It is an inspiring thought that these men while serving their

country so well in a time of grave anxiety and strenuous effort were also planning and consulting as to the extension of Christ's Kingdom in and beyond the districts which they administered. These men were moved by the spiritual destitution of Kashmir, they formed themselves into a committee, raised funds, appealed to the C.M.S. to send a missionary, and negotiated with the Maharajah of Kashmir for his admission to the country. The Maharajah laughingly agreed; the Kashmiris, he said, were so bad that the *padre sahib* could not possibly make them worse, and he would be interested to see whether Christianity could improve them.

However, when the first missionaries, the Rev. R. Clark and his wife, arrived, they met with a reception which would have caused less heroic soldiers of the Cross to beat a hasty retreat. The officials of the Maharajah combined with the people to show them that neither they nor their religion were wanted. They found it difficult to get a house or even to buy food, their very lives were endangered in riots which were connived at if not instigated by the authorities, public preaching was impossible, secret inquirers were spied upon, imprisoned, flogged, or exiled from the country. The mission seemed doomed to failure.

Expectant Patients, Kashmir

But in the meantime the idea of a medical mission had come before the Punjab Committee; perhaps a doctor would be more acceptable than a *padre*; they got into communication with the Edinburgh Society who put them into touch with a young Scotch doctor whose heart was fired with missionary zeal, and finally this young man, Dr. Elmslie, was accepted by the C.M.S. and sent out as a medical missionary to Kashmir, the Punjab friends guaranteeing all expenses beyond his stipend.

The arrival of the doctor produced a speedy change in the attitude of the people. In spite of official prohibition they came in numbers to the dispensary and listened patiently to the preaching of the Gospel, which preaching from the first was a part of the daily routine. But the opposition of the Kashmir officials was in no way abated. Soldiers were posted on the various roads leading to the mission in order to prevent people visiting the doctor; the landlord of the house which had been hired was forbidden to renew the lease, and for many months Dr. Elmslie had to live and work in a tent. Among other things a proclamation was issued and ordered to be read at every wedding in Kashmir, declaring that a visit to the doctor by either the man or the woman should be a sufficient ground for divorce! A sentence in one of the doctor's letters at this time does much to explain why these measures failed, and is eloquent of the sacrifices sometimes entailed through lack of suitable premises. He says, "At present three men are living in my tent who were blind but now they see!"

In 1867 an outbreak of cholera opened many doors to Dr. Elmslie, and led to a formal request from the native authorities to the British Resident that Dr. Elmslie should be forbidden to attend the sufferers. This was no doubt partly prompted by self-interest, for the Maharajah himself was in the field with a "cure" for cholera, consisting of a printed charm, which his agents were selling everywhere for four annas (about 6d.) a piece! Finally, the Maharajah

himself built a hospital, and, finding that the people still flocked to the English doctor, he invited Elmslie to leave the mission and take charge of *his* hospital, promising him a salary equal to £1000 a year. Needless to say the offer was refused.

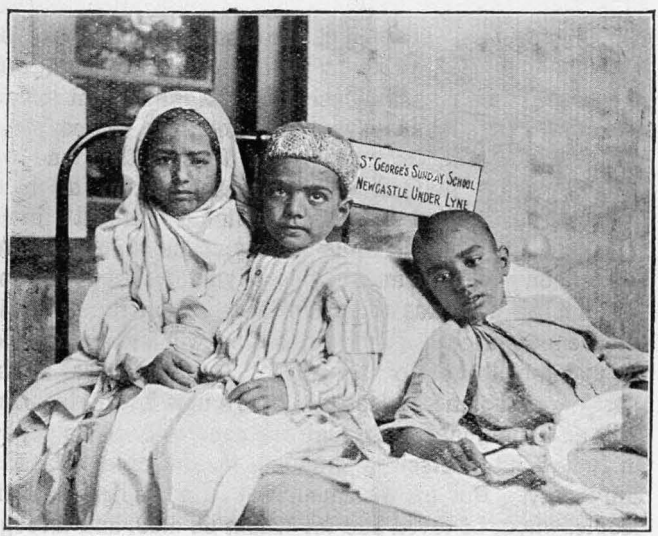
At this time the Maharajah had the right to demand that all Europeans should leave the country during the winter, and in spite of repeated petitions from influential natives that an exception might be made in the case of Dr. Elmslie this was strictly insisted upon. Late in the autumn of 1872, after a long and trying summer—for cholera had again visited the valley—Dr. Elmslie left Kashmir for the last time. As he started on his journey the people came out in crowds to wish him Godspeed and a safe and speedy return. But it was not to be. The season was late, and the hardships and privations of the journey over the rough mountain passes were such as to try the most robust. Elmslie was worn out by his labours, and after a journey, the suffering of which we can faintly realize, he passed away at Gujerat on November 18. The next day the law which compelled him to leave the country was repealed, and the way was open for permanent residence.

But Elmslie's work was done. In the first year of his work the Bishop of Calcutta had written: "I quite believe that Dr. Elmslie is knocking at the one door which may through God's help be opened for the Truth to enter in." The door was now open; Dr. T. Maxwell, who succeeded Dr. Elmslie, had no difficulty in building a small hospital, and the work has been developed under the brothers Neve, until now we have a large and well equipped hospital of 140 beds, and in addition the State Leper Hospital with 120 beds has been placed under the direct control of the missionaries. Moreover, others have entered through the door which Dr. Elmslie opened, and the educational work of the Rev. C. E. Tyndale-Biscoe and others has followed in the train of the medical mission.

CHAPTER II

HOW THEY GREW

THE success of the Kashmir Medical Mission soon led to the establishment of others. In those days work on the north-west frontier of India was by no means without danger. In Peshawar itself an American missionary had been shot by a fanatical servant, and several C.M.S. missionaries had narrow escapes about this time. But it was promptly realized that here was a method by which Christianity might be commended to the wild tribes of the frontier, and in 1868 a dispensary, the gift of a military officer, was opened at Tank, at the mouth of the Gumal Pass on the extreme frontier of British territory. It is worthy of note that the second medical missionary was a native of India, Dr. John Williams, who gave up a more lucrative government appointment to take charge of the new dispensary at Tank, where his work is still being



Child Patients at Peshawar, an Indian Frontier Hospital

carried on by his son and successor, Dr. Nathanael Williams. Other openings followed, and now we have in North-west India a chain of nine medical mission stations with eighteen out-stations. The most important of these are Amritsar (1882), Quetta (1885), Bannu (1894), Peshawar (1896), and Dera Ismail Khan (1899). These hospitals in North-west India are now visited by over 200,000 patients a year, while nearly 10,000 are received into the wards and treated as in-patients. A large proportion of these come from the closed lands beyond the frontier.

Probably the best known of our Indian hospitals is that at Bannu, which will always be associated with the name of the late Dr. Pennell. Theodore Leighton Pennell was one of the most brilliant men of the London medical schools; in his student days he carried everything before him, and might have risen to the very highest place in his profession. But he counted all as loss for the sake of Christ. Appointed to Bannu on the very outskirts of civilization, he won the love of the wild men of the frontier, no less by his personal qualities than by his professional skill, and so great was his influence that a prominent official said that Dr. Pennell was as good as a couple of regiments to the Government of India. His end was almost tragic. A man with a virulent form of blood poisoning had died in the hospital. Pennell's junior colleague, Dr. Barnett, while destroying the highly infected bedding on which the man had been lying, took the infection, and in a few days was at death's door. In operating on him Dr. Pennell pricked his finger, and in two days he followed his young colleague to the grave. As a memorial to this most devoted of medical missionaries a new hospital is being built at Bannu, largely through the generosity of his widow, an Indian lady, herself a graduate in Medicine of London University. But his true memorial is in the hearts of the people, whom he loved and for whom he died, and throughout the vast closed lands of Central Asia the name of the

Dr. T. L. Pennell

great *daktar sahib* of Bannu is remembered and revered.

Meantime a beginning had been made in China. A collector of opium revenue in India, horrified by the results of forcing the opium on China, resigned his post and devoted his official savings to the rescue of the victims of that curse to the country. With this money the C.M.S. founded an opium refuge at Hangchow in 1871, placing a doctor, Dr. J. Galt, in charge. Dr. Galt was succeeded by Dr. D. Duncan Main, under whose vigorous and enthusiastic administration the work has developed into a great medical mission, including hospitals with 250 beds, a leper asylum, a children's home, and a medical school whose graduates are to be found throughout central China.

The Society's second medical station in China was Funingfu, opened in 1878; Pakhoi, in South China, was occupied in 1886; and during the next ten years there followed in rapid succession, Ningpo (1888), Kienning (1889), Taichow (1892), Hinghwa (1895), Ningteh and Futsing, formerly known as Hokchiang (1896). These are all on or near the coast, but in recent years the work has been extended to the interior, and medical work has been begun at Kweilin and Yunnanfu in the south, and at Mienchuhsien in the far west, where the hospital in charge of Dr. Lechler is the only means of medical help not only for the natives over a radius of hundreds of miles, but for the large body of missionaries now working in the isolated regions of Western China.

The events leading to the opening of work at Taichow

form a good illustration of the way in which the Society has been led to open new stations. A few months after the hospital at Ningpo had been opened there sat among the out-patients one day an opium smoker who had come from the district of Taichow, a hundred and forty miles away. As he sat in the waiting room a Chinese Christian was telling the story of the Cross, and as he heard of a Saviour from sin he jumped up and cried aloud, "That's what I want." He was taken into the hospital and while under treatment took every opportunity of learning about the Saviour. Soon he was ready for Baptism, but he did not want to be baptized alone. He thought of his old father at home, still living in ignorance and sin. He sent for the old man, told him the good news, and God touched his heart also. Together they were baptized, together they went back to Taichow, and when a missionary visited that city two years later he found no less than thirty-seven converts waiting for Baptism as a result of the work begun by those two men. Now there is in Taichow a Church of over twelve hundred members; that Church sprang out of the medical work at Ningpo, and their demand for a similar work to be

The Mission Hospital at Taichow

opened in their own city was not only natural but well-nigh irresistible.

In Mohammedan lands (Persia, Turkish Arabia, Palestine, and Egypt) medical missions have done a work which no other agency could have accomplished. A beginning was made in Persia in the year 1879 by sending to that Mission, then in its infancy, the Rev. E. F. Hoernle, M.B., who opened a dispensary at Julfa, the Armenian suburb of Ispahan. It was impossible at the time to get a footing in the city itself, but this has since been accomplished and the present hospital is right in the Mohammedan city. Yezd and Kerman were occupied later, the hospital at the latter place being the only one in the eastern half of Persia.

It is perhaps in Palestine that the missionary value of medical work is most apparent. The Society began work in this country at the invitation of Bishop Gobat in 1851, but it was soon evident that though the Turks had no objection to missionaries working among Christians or Jews they would do all in their power to prevent them from reaching the Moslems, who form the bulk of the population. Every hindrance was placed in their way. Out-door preaching was forbidden, Moslems were not permitted to attend the Church services, private gatherings were viewed with suspicion, people were forbidden to send their children to the schools. But the medical mission once more proved the key to a difficult situation, and in spite of all official disfavour hundreds might be found daily in the waiting rooms of the hospitals listening attentively, even eagerly, to the preaching of the Word of God, while in the wards there were opportunities for steady, consecutive teaching such as could be obtained in no other way.

Regular medical work was begun at Gaza by the Rev. Dr. Elliott in 1886, and later Nablous, Jaffa, and Salt were occupied by doctors. Many obstacles were put in the way. The authorities required that all doctors should have a Turkish diploma, and that the medicines should be dispensed

only by qualified Turkish dispensers. To build a hospital it was necessary to obtain a *firman*, or a special permit, from the Sultan, which was not readily granted. But gradually the local authorities were won over, and the hospitals, both at Nablous and Gaza, have been built under the Sultan's authorization—the former in 1901, the latter in 1908—and are well-equipped and up-to-date institutions. The reply of a former governor of Gaza when urged to get rid of the medical missionaries is worthy of record. He said, "If you

The Out-patient Department, Gaza

will send us a couple of doctors as skilful and devoted as they are we will get rid of them to-morrow, but as it is we can't do without them."

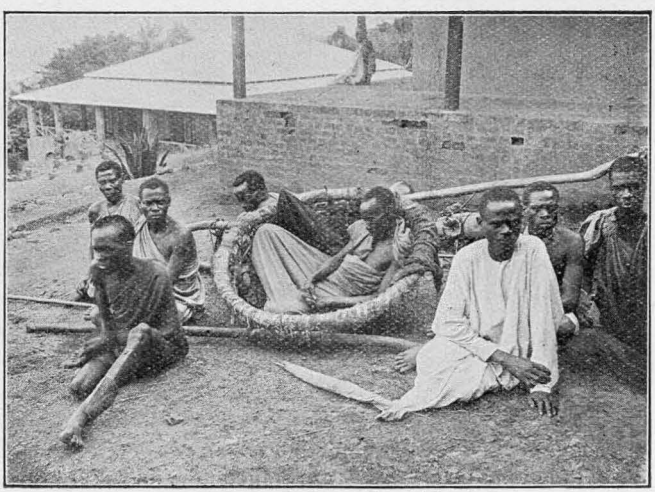
The medical mission at Baghdad was founded by Dr. H. M. Sutton in 1886 and has had a very chequered career. Now, however (1915), a fine hospital is in course of erection on the banks of the Tigris, and a steady development of the work in this city of 200,000 inhabitants may be expected.

Medical work was begun in a native house at Old Cairo by Dr. F. J. Harpur in 1888. A hospital was built and opened in 1897, and this has been enlarged from time to

time till it is now one of the largest and most complete of the Society's hospitals. It owes much to the work of the late Dr. E. M. Pain, a son of the Bishop of Gippsland, and much of its support comes from the Australian C.M. Associations.

The occupation of the Sudan presented special difficulties, owing to the fear of the authorities that the fanatical feelings of the Moslems might be aroused, but again medical missions paved the way, and the hospital at Omdurman has been built with the full approval of the Government.

The best known perhaps of all the C.M.S. Missions is that in Uganda. Medical work was begun there in 1894 by Dr. Gaskoin Wright, but it was not till nearly three years later that the work was permanently established by Dr. A. R. Cook. On the ruins of a hospital burnt down in 1902 rose the present building, which has been added to from time to time, the latest addition being a special section for the accommodation of our Indian fellow-subjects, numbers of whom are to be found in Uganda.



Arrival of a Patient, Mengo Hospital

Lastly we come to West Africa. Long before the C.M.S. thought of regular medical mission work they had been sending doctors to this district, chiefly with a view to the needs of the missionaries in that fatal climate, but also in the belief that their medical skill would be of use among the natives—Henry Graham (1829), Eugene van Cooten (1850), W. C. Hensman (1851), E. G. Irving (1853), A. A. Harrison (1861), and Percy Brown (1883), all did a certain amount of medical mission work, but all died or retired broken in health after a very brief term of service, and no permanent work was established. In 1890, Dr. C. F. Harford-Battersby (as he then was) established a medical mission at Lokoja, but after two years he, too, had to retire and that work came to an end, though it is still represented, in some sense, by the medical missions in Northern Nigeria, which grew out of it. It was not till 1898 that permanent medical work was established at Iyi Enu near Onitsha, where it has been continued (with brief intervals) since, and a permanent hospital has been built.

The Society's first lady missionary doctor was Dr. Kate Cornford, who went out to Old Cairo in 1895. The need for women doctors in lands where it is thought improper for a man to touch or even see a woman is self-evident, and the C.M.S. has now no less than twenty-one fully qualified lady doctors on its roll.

Thus has the medical mission work of the C.M.S. grown to its present dimensions. In this jubilee year, 1915, the Society is carrying on medical work in ninety stations (including branch dispensaries); there are fifty-four hospitals with close upon 4000 beds, and an annual attendance of out-patients totalling a million and a quarter. The missionary doctors number eighty-six and the nurses sixty-nine, besides about 230 native doctors, nurses, and assistants.

Side by side with this growth in numbers there has been a corresponding development in efficiency. Old and un-

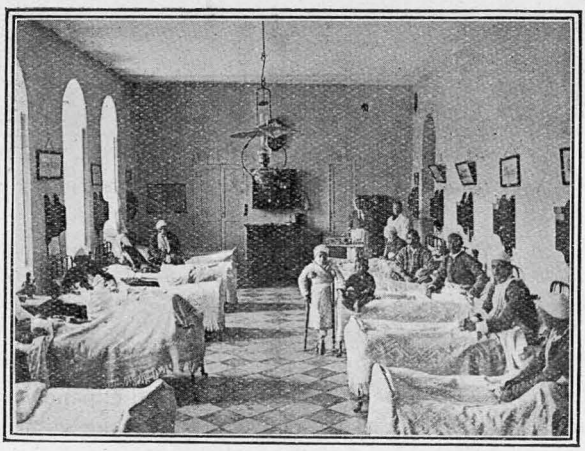
suitable premises have given place to well-built and up-to-date hospitals, and the scanty equipment of even thirty years ago has been replaced by a full provision of all that is needed for modern methods of diagnosis and treatment.

The story of the growth of medical missions would be incomplete without some mention of the Medical Mission Auxiliary, to which this growth is largely due. The Auxiliary was founded in 1891 to raise funds for the special

The Women's Hospital and Nurses' Quarters at Multan.

expenses of medical missions. Before that date these expenses had been met by a small grant from the General Fund of the Society, but this was quite insufficient for the development of the work. Within five years of the formation of the Auxiliary the number of doctors had been doubled, the hospital accommodation trebled, and the available funds quadrupled. So successful was the Auxiliary that in a few years it was able to relieve the Society of all expenditure in connexion with medical missions, including the salaries of missionary doctors and nurses, and now no part of the Society's general income is used for its medical work.

This arrangement has a two-fold advantage; those who wish to help medical work exclusively can ensure, by giving through the M.M.A., that their gifts go wholly and entirely to this work, and if at any time, as has happened, the state of the Society's finances should compel it to retrench in its work generally, it will still be possible to go forward with the medical work, provided that the Auxiliary Fund is well supported. On the other hand if there should be any supporters of the Society who even now do not believe in medical work they can rest assured that no part of their ordinary contributions go to the support of this work. An obvious *dis*advantage is that many supporters of the Society who do believe in medical work fail to realize that, unless they support also the Medical Mission Auxiliary, they are excluding that work from participation in their gifts. The important thing is to realize that the maintenance and future growth of the Society's medical missions depend entirely upon the support accorded to the M.M.A.



A Ward in Nablous Hospital

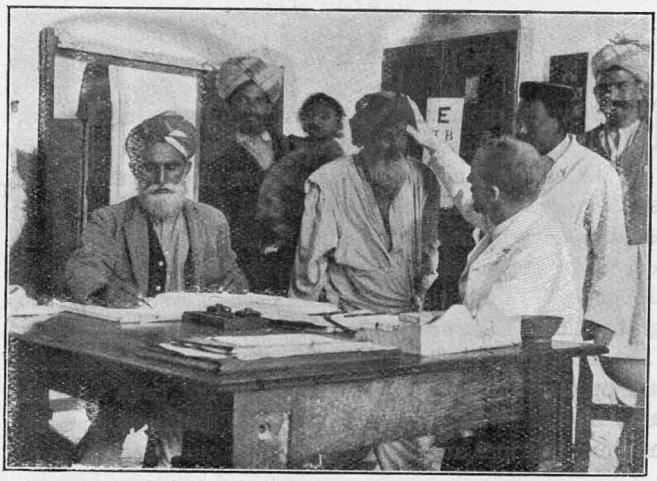
CHAPTER III

HOW THEY WORK

THE work of a medical mission falls naturally into three divisions: out-patient or dispensary work, in-patient or hospital work proper, and itinerating or district work. Of these, the first and last represent from the missionary point of view the broadcast sowing of the seed, while the in-patient work may be likened to intensive cultivation. In addition, there is a certain amount of visiting of patients in their own homes.

The first stage in the establishment of a medical mission is the opening of a dispensary. This is not such a simple matter as it seems. A native house or building of some kind must be hired and adapted for the purpose. It must have a large room in which patients and their friends can assemble, another to be fitted up as a dispensary, and well-lighted rooms for examining the patients, for dressings, and simple operations. In addition, there must be accommodation for the doctor or native assistant in charge. Even when a suitable house has been found the trouble is by no means over. All sorts of explanations have to be given to the owner, who wants to know exactly what the would-be tenants mean to do, and perhaps is not altogether satisfied as to their sanity. Then comes the opposition of the religious leaders, who know very well what the aim of the missionary is, and strongly disapprove. Often, when the arrangement is all but completed, some mullah or priest will veto the transaction, and the search must be started afresh.

But once the dispensary is opened, the crowds come, drawn at first by curiosity, then by the conviction that here is a man who can meet their need. They are an unruly crowd, unused to discipline, and with no idea of order. Very gradually do they fall into the routine, and learn that

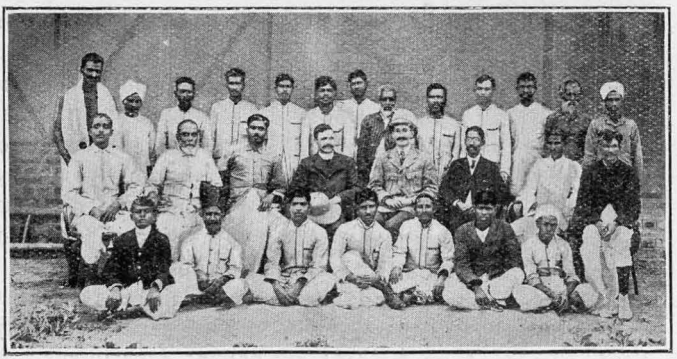


Dr. Cox in his Consulting-room, Bannu

neither arrogant bearing nor strength of lung gives them any advantage over their neighbours. Each man on entering has his name registered, usually paying a small fee of a penny or so, and is given a ticket indicating the order of seeing the doctor. When all have assembled, a short service is held and a Gospel address given by one of the staff; then patients go in one by one to see the doctor, and pass on to get their medicine from the dispenser, or to have their wounds dressed by a nurse or assistant. If an operation is required, the case is perhaps put back to be dealt with at the close of the morning's work. In the meantime, Bible woman and evangelist are at work among the waiting crowd, using the opportunity for further teaching and for pressing home the lessons of the address. Such is the morning's work in a dispensary or in the out-patient department of a regular hospital. Large numbers are reached in this way, and they often come from considerable distances. At Ranaghat, in Bengal, over a thousand out-patients a day attend during the winter months; at Pakhoi,

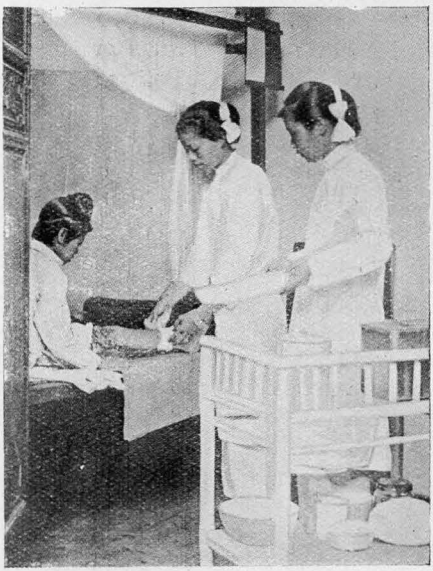
South China, the books show that the patients come from over 500 different villages, and Cairo gives a similar record. During a six weeks' visit to the out-station of Shikarpur, in Sindh, one of the doctors reports an average of eighty operations a day.

But it is in the fully-equipped hospital that the medical mission work is seen at its best. Here the day will begin with the gathering together of the whole staff for prayers. Doctors, assistants, nurses, dressers, evangelists, servants, all who can possibly leave their work for a short time, meet, and together seek God's blessing and help for their work. This possibility of united worship and prayer is one of the priceless advantages of work in a large centre, and one great secret of success. Prayers over, the workers separate to their various duties. While one of the doctors superintends the out-patient work already described, another visits the wards. The patients have already had their breakfast, and both they and their surroundings have been made ready for his visit. Early as it is (perhaps 8 a.m.) the nurses have already had two or three hours' work. A short service is held in one of the wards, those from other wards who are able coming in for the occasion. Then commences the



The Hospital Staff at Ranaghat

round of the beds. The doctor has much more to consider than would fall to his lot in an English hospital. Here is a patient who wants to leave at once, and though it means the undoing of all the benefit he has received, nobody but the doctor can persuade him to stay. Here is a small crowd of appallingly dirty relatives who have come to visit the man operated on yesterday, and something more than moral suasion is required to prevent them from undoing the bandages to see for themselves what has happened. Here, again, is a man whom the doctor yesterday, with infinite patience, persuaded to consent to the operation for which arrangements have been made to-day, but he has changed his mind, and the work of persuasion has to be done all over again. And yonder in the corner is an old friend who takes from under his pillow the Gospel over which he was poring yesterday, and wants his beloved doctor to explain some doctrinal point which troubles him. Almost every case calls for the doctor's personal attention, and no one else will do.



Chinese Nurses at Work, Foochow

In some hospitals, especially in India, there is a department intermediate between the in- and out-patients, namely, the family ward, or resident out-patient department. At Peshawar, for instance, there is attached to the hospital a

large building—the James *serai*—in the form of an eastern inn or caravanserai, with some forty rooms ranged round an open court, each occupied by a patient *and his friends*. Many of these people absolutely refuse to be separated from their families, and the latter, on their part, cannot bear to lose sight of the patient or trust him to strangers, so the family are given a room where they take up their abode with the patient, feeding themselves and him, and looking after him more or less under the doctor's supervision. The arrangement is not ideal, but as the whole family is brought under Christian influence, and all attend the daily services, the results from a missionary point of view are excellent.

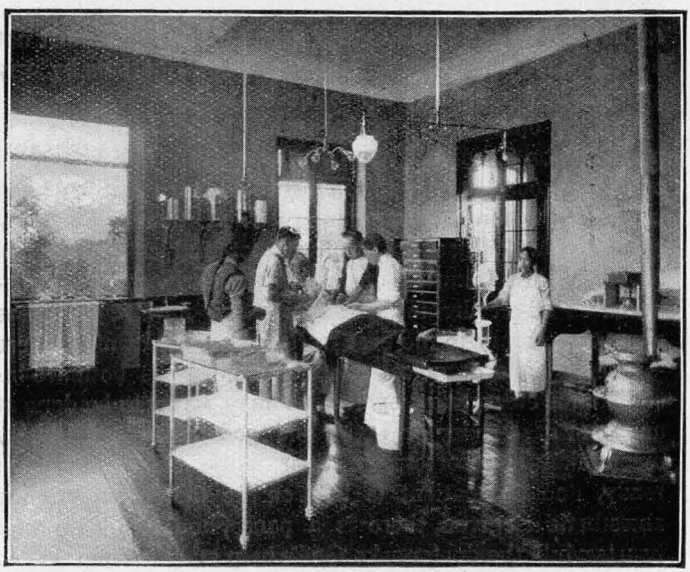
The morning's work over, then comes the time for consultation and the planning of special work. There are serious cases to be considered jointly; operations to be arranged for the afternoon; patients to be visited in their own homes. The latter are chiefly better-class people who cannot or will not come to the hospital, but who must not be left to die, and whose substantial contributions by way of fees will be a great help to the work.

Serious operations are done when possible in the afternoon, or on special days. Here, in the well-appointed operating room, is seen the immense advance that has been made in hospital equipment. Tiled floors, smoothly cemented walls, aseptic furniture, hot and cold water laid on, these are luxuries of which the early medical missionaries never dreamt, but which are now regarded as almost necessary to the best work. For use at night there s electric light or petrol gas; in some cases both are installed, for emergency operations may have to be done at any hour of the day or night, and good light is absolutely essential. The doctors, in their white overalls, are all ready, and the patient is laid on the table; but ere the anæsthetic is given, there is a pause, and all lift up their hearts while the doctor asks God's help and blessing. When the patient wakes to find it all over, his last conscious

recollection will be of the doctor in communion with the Great Healer.

In the afternoon, too, is the time for quiet talks by the bedside, or with convalescent patients on the verandah or in the grounds. Then, after tea, the round of the wards is made once more, prayers are held in the hospital, and the doctor has earned his evening rest. But he seldom gets it. There is laboratory work to be done, reports have to be written, accounts to be made up, and other clerical work incidental to the management of a great institution demands attention. The hospital day is a long day, and it is little time the doctor gets to himself.

In most of the medical missions a certain amount of district work is done, though this can only be developed where there is a sufficient staff. The Committee aim at placing in every medical station at least two doctors (preferably



An Operation at Ningpo Hospital

three), so that one can go away for a week's itinerating while his colleague keeps the work going at the base. "Let no one suppose," says a well-known medical missionary, "that this means rambling about the country with a box of pills in one pocket and a bundle of tracts in the other." A good stock of medicines is taken, in charge of a native dispenser; a plentiful supply of dressings; if possible, a portable operating table; and instruments for any operation that can be safely performed without much regard to subsequent nursing. From village to village the doctor moves his camp; in every place he finds crowds of sufferers, just such crowds as gathered around our Lord when He was upon earth, people who have never heard of the hospital, or, having heard, have never realized what it means until it is brought to their doors. It is, indeed, like the days of the Son of Man.

Dr. A. R. Cook, writing of the crowds who gathered round him in an African village, says:—

> Such crowds they were, moving us to both amazement and compassion. You would hardly have thought it possible that the human form divine could be twisted into such grotesque and distorted shapes. Amongst others there were over forty lepers with fingers and toes dropping off, some blind, alas! and others just starting the fell disease, one a child of only eight or nine. Many had huge ulcers, with a lump of cow dung clapped on for medicine. The heat of the day gradually diminished as the sun at length sank and the moon rose, but the crowds hardly seemed to get less. One after another the dusky forms pressed forward into the circle of light cast by the lamp, now it was a leper waving his or her mutilated stumps of hands, now an anxious mother carrying a sick child, or again a daughter leading her blind father; their language I did not know, but we found a native who knew Luganda and Teso, and so the work went on until at length the last one was seen, and silence fell.

Thus our medical missionaries are following the example set by their Master, healing the sick, giving sight to the blind, causing the lame to walk, and through it all, by deed

as well as by word, preaching the Gospel in a way that can be done by no other agency.

It is very easy to understand the effect of all such work on the minds of those who have only known neglect and ill-treatment in times of sickness, and the practical Christianity displayed in the mission hospitals is bound to bring forth fruit a hundredfold. Need we wonder at the seemingly extravagant terms in which the hospitals are referred to by patients in Africa, India, and China alike, as the apparently miraculous cures are witnessed in them from day to day? The fame of the Christian doctor penetrates into outlying districts where the white man has never been seen, and people drawn by a new hope will journey hundreds of miles to seek that healing of the body which they so sorely need; in the mission hospital they are brought into contact, not only with those who can heal the body but with Him Who can meet the deeper need of their souls, and they carry back to their distant homes the good report of a religion which has a message of salvation for the whole man, body and soul.

Village Patients in Central Africa

CHAPTER IV

WHAT THEY HAVE DONE

IT is often said that the success of missionary work is not to be measured by visible results, but in the case of medical missions the results are so apparent that they might well be content to be judged by these alone.

All methods of missionary work must ultimately be judged by their effect in bringing men and women to Christ. If they do not succeed in doing this, they have failed to justify themselves. To give any detailed account of converts through medical work would require a volume, for there are thousands who could re-echo the words of a dying patient in Mengo Hospital: "Doctor, I have found my God in hospital." A small book[1] has just been published giving the stories of several such converts, and we add here two which do not appear in that book:—

A very interesting case admitted to one of the Society's hospitals in Palestine was that of a young Afghan of about twenty-five, named Haida. He had a father and mother living near Peshawar, and had been a soldier in the Indian Army for nearly four years; he was a great reader and knew the Koran well. He made the pilgrimage to Mecca, and in February, 1911, was shot in the foot, and was taken into the hospital. He was a bigoted Moslem, and when first spoken to about Christianity was very angry and refused to hear anything about it. Gradually, however, he began to listen, and it was not long before he was found reading a Gospel lying beside him; his interest increased, and soon the book was seldom out of his hands. He asked the doctor to give him a New Testament in Urdu, his own language, as he understood it better than the Arabic, and his delight when this was given him was evident. An attack of pneumonia had prolonged his stay in hospital somewhat, but he eventually left, having accepted Christ as his Saviour.

In June he returned to the hospital for a slight operation, and his sincerity was obvious. He continued to grow in grace, and after he had ceased to be a patient still visited the hospital daily for teaching. His life was now in continual danger, as he was

[1] "Converts through Medical Work," by S. W. W. Witty, 6d. net (C.M.S.).

constantly being threatened by his fellow-countrymen. At last their threats were carried out, and Haida was one day brought to the hospital shot through the thigh. He knew the man who had shot him, but refused to prosecute, saying he would pray for him rather, that the Lord would lead him to repentance.

For some days Haida's condition gave no special cause for anxiety, but tetanus set in, and he passed away to be with the Saviour he had learnt to love so truly.

The man who shot Haida became penitent for what he had done, saying that the religion that could enable a man to pray for his murderer must be from God.

The second story comes from the mission hospital at Funingfu :—

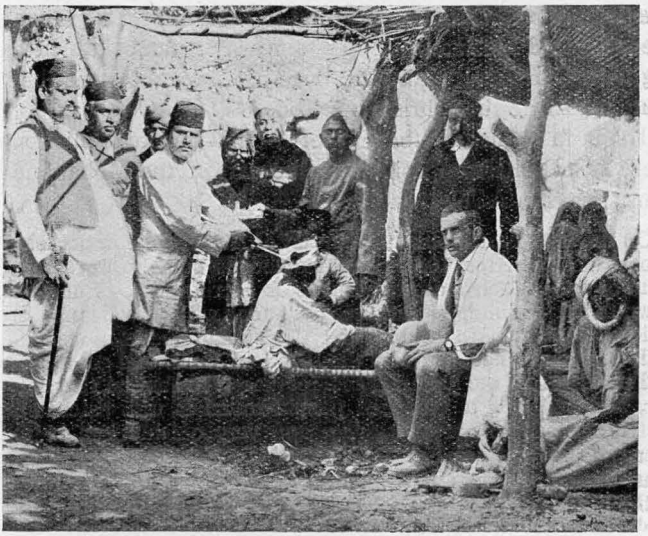
Yuan Muang-Ong was for nineteen years a member of a strolling company of Chinese actors. One day, covered with a loathsome disease, he appeared at the Funingfu hospital. He was taken in, and remained under treatment for a year or more. During that time he learnt to know Christ, and in due course was baptized. It was noticed that he seldom came to church alone, he always brought others. He had a great love for the Bible and was often found reading to any who would listen. His great desire was to be allowed to sell books and tracts, and when he was appointed a regular colporteur, his joy knew no bounds. He had to endure great persecution in his own village, yet in that place he eventually led ten people to Christ, and for a time was privileged to be their catechist.

Yuan Muang-Ong, the "Apostle of Funingfu"

Now, at the age of sixty-eight, he finds himself too old for continual wanderings and has returned to Funingfu hospital to work among the men and to sell his books in the

streets. He has led many to Christ. Not long ago, at the Sunday afternoon hospital service, the doctor asked one of the patients (a convert) to tell what had led him to Christ. "That man," said he, pointing to Muang-Ong. "Twenty-two years ago I first visited the hospital, and then he urged me to worship God." So abundant have been his labours that he has been called "the Apostle of Funingfu," and, under God, his conversion is due to the work of the hospital.

Great as are the direct results of medical work, their indirect influence is even greater. In many places they have changed the whole attitude of the people towards Christianity. A few years ago there was a mission in the city of Shikarpur, in Sindh; but one girl in the mission



Dressing an Eye-case at Shikarpur

school began to inquire, and at once the whole of that mission work was stopped and not a single native agent was left in the town. Then in consequence of some wonderful cures of blind men at Quetta Hospital, Dr. Henry Holland

was invited by a Hindu banker to visit Shikarpur. As a result, this Hindu gentleman built (and subsequently endowed) a small hospital for the missionary doctors, and at the opening of that hospital the leaders of both the Hindu and Mohammedan communities publicly welcomed the missionaries to Shikarpur.

In a bigoted Mohammedan city in Palestine there was a terrible outbreak of cholera. During that epidemic there might have been seen over many Mohammedan doors a red cross painted with the words in Arabic, "Lord, have mercy upon us." To any one who knows the intense hatred and contempt which the Mohammedan has for the symbol of the Christian faith, this simple fact is eloquent. The presence of the Christian hospital in their midst had taught these bigoted Moslems in some dim way to associate healing with Christianity, and the once-hated symbol was their mute appeal to the Christians' God.

Even in Srinagar, the Society's first medical mission, there is still bitter opposition on the part of the Mohammedans; but Dr. A. Neve writes:—

> On the last great Mohammedan day of Atonement, an occasion upon which, perhaps, 10,000 Mohammedans come to worship in front of one of their mosques, and to do sacrifice, two of us went down to that gathering-ground, and we took with us a banner, on which was written in Arabic that Christ had made atonement with His Own blood, not with the blood of bulls and goats, and had entered into the holiest place for us. We showed this banner, and gathered a group of people round it, who listened in perfect silence to our preaching, and very quickly bought up every gospel that we had with us. Next day there was some heart-searching among the Mohammedans ther and they went to the head priest of the town, who said: "We know that the Bible is a holy book, and we know that the doctors are our friends; and so it is better to say nothing at all about it."

Such things show how, by their presentation of practical Christianity, medical missions are changing the whole attitude of the people towards our holy faith, and preparing the way for the entrance of the Truth.

Again, what medical missions have done and are doing for the native Christians must not be forgotten. One of the sorest trials for the native Christian is when sickness falls upon him or his family, and all his friends point to it as evidence of the wrath of the gods whom he has forsaken. Such methods of treatment as they have are inevitably mixed up with idolatrous and superstitious beliefs, and it is hard for them to resist the demands of relatives and friends who want to try their favourite charms, and call in the priest or witch doctor, who is often the only man to whom they can turn for medical aid. A touching story by Dr. J. H. Cook, of Uganda, illustrates the other side :—

Late one Saturday evening a little child of eight or nine years old was brought into hospital, very ill, suffering from convulsive seizures. He was put to bed at once, made comfortable for the night and devotedly watched by his father Zekaliye (a Christian man). A sedative prescription was administered, but at about 3 a.m. the father and hospital boy on duty came to my house to tell me the child was very ill and screaming so loudly that nobody could get to sleep. So I went off at once, and did my best to cheer up the father as we walked to hospital, saying we would pray over the little patient and do what we could for his relief. We found him tossing about and screaming like one possessed. When all that could be done for his comfort had been done we knelt beside his bed and prayed for his recovery, and one noticed that at the close a fervent "Amen" came not only from the father and the hospital boy, but from neighbouring beds as well.

Next morning the father told me: "When I looked at my boy last night I felt sure he was going to die, and I did not like to leave him, for I thought I should not find him living on my return. And then I thought if I do go and fetch the doctor, he will not come all the way to the hospital at night, but he will perhaps only send medicine and it will be too late. But I came, and all the way I prayed that the doctor might come, and as I stood outside your window I still prayed, and when I heard you call out, 'All right, wait a minute for me, and I'll come with you,' then I began to take heart; and still I prayed; and when we got back to the hospital and found my boy still there, I took more courage. And when I saw how you examined him and the many remedies you gave, I took still more courage. And when we knelt in prayer by his bedside and as we prayed his cries stopped and he fell asleep, then I rejoiced."

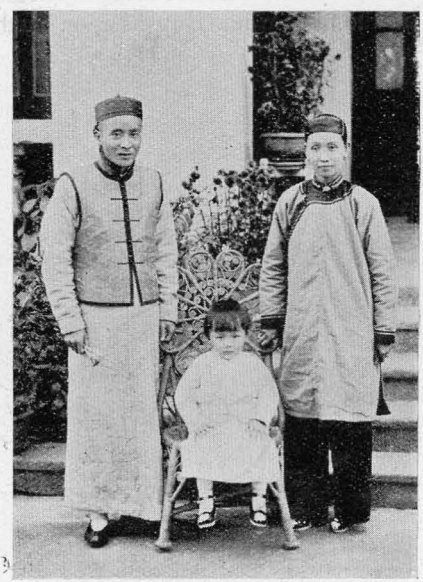
Next day the child was quiet but profoundly unconscious, and the temperature had risen. I gathered several patients, mostly heathen, round the bed, and said to them that here was a case we were taking to the Good Physician to heal, and I told them how the father had already prayed, and when they all expressed their belief that the child was dying I asked them to kneel down by the bedside with me, and we prayed for his recovery both for the father's sake, and to confirm the faith of all who should see. We were conscious that it was a "test-case." For three days the child remained unconscious, hovering on the borderland of death. But slowly and surely God gave back that little life, and I think many in that ward were profoundly impressed by the part that prayer plays in the recovery of the sick.

Another great thing that medical missions have done is the training of native Christians to take up this work themselves. In some parts of the world the tending of the sick is looked on as a degrading occupation. In China, for instance, nursing is left to disreputable old women who can get nothing else to do. Gradually, through medical missions, women are being trained to regard nursing as a noble and lofty calling, and in the women's hospitals at Foochow, Futsing, and elsewhere, there are regular training schools for nurses. Medical education is being taken up seriously in China, and already at Foochow the Society has a well-equipped medical school in which the students receive a full five years' course in medicine and surgery, and are sent forth as fully qualified doctors. These men not only fill posts in the mission hospitals, but some of them enter into practice for themselves, and thus a generation of qualified Chinese doctors is being trained, who will bring to their fellow-countrymen the advantages not only of Western science but of Christian character.

But the most obvious, though not the most important, result of medical work is the relief of suffering. This is the distinguishing work of the medical mission, and its extent almost passes the imagination. Mere figures fail to make an adequate impression, but we think of a thousand operations for cataract in six weeks at Shikarpur, and

remember that nearly every one of these thousand cases means restoration of sight to a man blind in one eye or in both; we think of a thousand out-patients a day at Ranaghat; we think of a man at Peshawar unable to put his foot to the ground for twelve years, cured absolutely and completely by the extraction of a bullet; we think of 600 patients a month in the *ankylostomiasis* department at Old Cairo, coming in victims of a fatal disease, going out at the end of the month cured. As we think of these things we realize that as in the days of the Son of Man, "the blind receive their sight, and the lame walk, the lepers are cleansed and the deaf hear . . . . the poor have the Gospel preached to them."

But though much has been accomplished there remains yet more to be done. The work has as yet attained only a fraction of its possible development, and it must grow to far larger dimensions if it is in any way to cope with the need of the world. In India it is confined practically to one corner of that vast land, in China the Society's hospitals are almost all in the coast towns, while the need of Africa is scarcely to be measured. It is only lack of workers and of money to support them that hinders this work from developing to twice or three times its present extent.



A Chinese Christian Doctor and his Family

At the present time the plans laid

down by the Committee require an immediate increase in the staff of twenty doctors and five nurses. Five new hospitals have been sanctioned by the Committee and some are already in process of erection.

From many quarters there come urgent and piteous appeals to open medical work in new districts, but to these the Committee must sadly turn a deaf ear. They must first see their way to the more adequate equipment of the work that has been commenced ere they begin to take advantage of the limitless opportunities which open before them on every hand.

Power to go forward depends upon the response of the Christian Church. In this response we each have our share; as we do each one his part by gifts, by prayer, by personal service, so, and so only, will our Master be able fully to carry on His work of bringing healing to body and soul as in the days when He was upon earth.