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Dorothea Lüddeckens, Philipp Hetmanczyk, Pamela E. Klassen, Justin B. Stein

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Daniel Midena
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MEDICAL MISSIONARIES AND WITCH DOCTORS

Protestant object lessons in biomedicine in Africa and the South Pacific

Daniel Midena

Introduction

Perhaps no other figure in the Western imagination has more powerfully symbolized modern medicine and religion united than the Protestant medical missionary. In the minds of many, medical missionaries stood at the vanguard of both Western science and Christianity. This view, which only strengthened and spread with the rise of biomedicine in the 1880s, encouraged mission societies to employ increasing numbers of medically qualified missionaries in the nineteenth and twentieth centuries. In 1852, there were an estimated thirteen European medical missionaries worldwide; but by the 1890s they numbered 680. By 1916, there were in India alone some 183 mission hospitals and 376 missionary medical dispensaries treating well over a million patients each year (Hardiman 2006: 10, 16; Fitzgerald 1997: 65, 67).

This chapter examines the historical relationship between religion and medicine by tracing the way Protestant missionaries sought to deploy their knowledge of medicine ‘as a powerful aid to conversion’ (Hardiman 2006: 14) and as a means to ‘produce profound ideological transformations’ (Ranger 1981: 261). I cannot hope to be comprehensive: there were 331 Protestant mission societies just in Germany by the end of the nineteenth century (van der Heyden 2011: 218). And in any case, we already have several excellent overviews of the history of medical missions in colonial contexts (Etherington 2005; Hardiman 2006; Klassen 2011; Vaughan 1991). This chapter will instead focus on a specific belief that had become popular within some Protestant mission circles by the end of the nineteenth century, namely, the belief that demonstrating Western biomedicine in action would win converts to Christianity. For these missionaries, the performance of biomedicine was an important means to dismantle obstacles to Christianity: successful treatments not only endeared the ‘heathen’ to the mission but also, crucially, functioned as an object lesson for ‘animists’ and ‘witch doctors’ in the Protestant medical missionary’s disenchanted account of the aetiology of disease and illness. In this chapter, I draw examples primarily from the history of British and German mission societies who were active in Africa and the South Pacific, where this view was evident across many mainstream Protestant denominations, including Anglicans, Baptists, Lutherans, Methodists, and Presbyterians.
One such example comes from the writing of Fletcher Moorshead (1874–1934), an English physician and the first medical secretary of the Baptist Missionary Society. In 1913, he argued that medical science was uniquely positioned to disenchant non-Christians of their ‘false religious systems’:

no more fatal blow can be dealt at this awful evil, cursing alike body and soul, than by proving by living demonstration the fallacy, fatuity, and powerlessness of the superstitious methods of treatment employed by the medicine man. Destroy the faith of the non-Christian man in his “doctor” and you have very frequently taken the surest and simplest course towards the destruction of his faith in the superstition of his religion. Now this is exactly the work and logic of Medical Missions.

(Moorshead 1913: 76–77)

In recent decades, historians have grappled with such statements, highlighting what they see as a confusing aspect (Vaughan 1991: 59): on the one hand, supporters of medical missions such as Moorshead criticized non-Christians for blending religion and medicine, even as, with their next breath, they encouraged missionaries to perform a ‘living demonstration’ of European medicine for evangelical purposes.

A few historians have resolved this problem by characterizing the missionaries’ adoption of biomedicine as largely ‘strategic’ (Walls 1982) or at times cynical propaganda (McKenzie 2002; McKay 2007: 550). Yet other historians have understood this historical ‘puzzle’ (Etherington 2005: 282) to be evidence of a basic tension within the logic of medical missionaries, between diverging if not conflicting scientific and religious obligations. For example, Michael Worboys argues that ‘missionaries lived with the contradiction of criticizing “primitives” for mixing religion and healing—a combination demonized in the term “witch doctor”—while the same association was the rationale for their work’ (Worboys 2000: 210; see also Hardiman 2006: 5). For Worboys, the missionaries contradicted themselves by treating the two situations differently, when, in reality—by implication—the ways in which medical missions and witch doctors associated religion and healing was (in his words) ‘the same.’

This chapter seeks to complicate this picture by examining why so many Protestant missionaries themselves did not necessarily see a ‘contradiction’ here. I suggest that mainstream Protestant missions at the time often related medicine and health in a uniquely modern way. Regardless of whether it was successful, they adopted a categorical distinction between science and religion—as occupying separate, non-overlapping territories (Harrison 2015)—which, over time, also became central to how they articulated differences between Christians and non-Christians. Missions were thus often drawn to biomedicine’s mechanical account of illness and the body because of their theology of nature—not in spite of it. Tensions between religion and science in the mission approach can therefore also be explained by the failure of the modern project itself to live up to its own aims, that is, the impossibility of dividing the world between the natural and the metaphysical (Keane 2007).

The structure of this chapter is broadly chronological. It begins with evangelical encounters prior to the rise of biomedicine, when the practice and idea of conversion did not generally turn on convincing non-Christians about the existence of inviolable natural laws—even where such ontological differences existed. This changed in the late nineteenth century with the professionalization of medicine in Europe, a bacteriological ‘revolution’ in medical science, new anthropological theories of religion and science, and the retreat of theology to moral and spiritual issues, due, in part, to theological reactions to Darwinism. This chapter shows how
these developments encouraged Protestant missionaries to treat medical procedures as object lessons in natural laws to win converts. The final sections briefly highlight the weakening of this evangelical approach from about the 1960s onwards, as Protestant missions reconsidered the role of medicine in evangelism and administrators grappled with the role of missions in emerging (post-)colonial healthcare systems.

Mission encounters before biomedicine

In the Christian scriptural tradition, God’s chosen representatives have long sought to convert people through demonstrating God’s power over and against the power of local spirits. In the Old Testament, Elijah challenged the prophets of Baal (1 Kings 18)—an encounter which the Methodist missionary and Pacific anthropologist Alan Tippett (1911–1988) regarded as the ‘Biblical prototype’ for all such evangelical encounters (Tippett 1967: 107). These encounters often focussed on healing. In the New Testament, the first disciples evangelized by demonstrating God’s authority over ‘all devils, and to cure diseases’ (Luke 9:1, King James Version). And in recent centuries, European and American missionaries rarely shied away from the chance to compete with non-Christian healing practitioners (Etherington 2005: 281). Anthropologists of Christianity today often refer to these battles as an ‘encounter by challenge’ or ‘power encounters’ (Tippett 1967: 107; Tomlinson 2017). While these encounters inevitably turned on demonstrations of power—that is, the capacity to work certain ends or make correct predictions—the form that these encounters took, however, varied by place and, as I show, over time.

Prior to the late nineteenth century, the idea of a disenchanted natural world did not ordi-
narily play a central role in evangelical encounter narratives. Like the ‘heathens’ they sought to convert, missionary attitudes to illness instead admitted a number of overlapping and conflicting preternatural aetiologies and ontologies: that spirits and demons were very real and dangerous threats to our health (Mohr 2009); that sickness was a moral matter (Comaroff and Comaroff 1997); and that the moral and natural worlds were analogous (Sivasundaram 2005). Thus, a London Missionary Society booklet, The Means of Preserving Health in Hot Climates (1819), advised its missionaries that ‘There are moral as well as medical means of preserving health; and the former are hardly less important than the latter’ (London Missionary Society 1819: 7).

Moreover, missionary therapies sometimes corresponded with those of the non-Christians they lived among. For example, bloodletting, which was a common surgical method to balance the humours, practised by mission doctors in the mid-nineteenth century (Etherington 2005: 278), in fact had historical origins in African techniques (see Forde, this volume). In this environment, aetiologies were not necessarily an important point of contrast. And in some areas, European medical practices were hardly more successful than those they were trying to convert (Shorter 2006: 108). Sources suggest that missionaries were therefore open to dialogue and exchange with Indigenous peoples about alternative ways of treating illness, especially in areas such as pharmacology in which the missionaries had little training or knowledge (Comaroff and Comaroff 1997; Mohr 2009; Douglas 2014: 203). David Livingstone (1813–1873), the most famous of all mission physicians, who had trained in medicine in Glasgow and then London in the late 1830s, himself took medicines that Africans recommended while working for the London Mission Society (Etherington 2005: 278).

Where illness came up prior to the 1880s, Protestant missionaries generally imagined their differences in more spiritual and religious terms. The historian Adam Mohr has shown this in the case of Pietist missionaries from the Basel Mission Society evangelizing in Ghana from
1828 onwards. The Basel missionaries carried with them to Ghana an attitude that it was
demonic and satanic powers that made people who practised ‘idolatry’ physically ill. They
understood idolatry to include the attempt to use traditional folk beliefs and practices to obtain
goods, such as healing (Mohr 2009: 433–435). For these missionaries, the idols could, in a real
sense, possess or enable evil.

Even when missionaries recognized aetiological differences, the non-Christian worldview
was not typically something that could be overturned merely through public demonstrations
of European medical knowledge. This is evident in David Livingstone’s famous dialogue
between a European ‘medical doctor’ and an African ‘rain doctor’ in his *Missionary Travels
and Researches in South Africa* (1857: 23–25). The dialogue was a composite of conversations
that Livingstone had while evangelizing in central Africa. At stake was whether the European
‘medical doctor’ could convince the ‘rain doctor’ that ‘medicines’ were unable to end a local
drought:

*Medical Doctor*: Hail, friend! How very many medicines you have about you this morning!
Why, you have every medicine in the country here.

*Rain Doctor*: Very true, my friend; and I ought; for the whole country needs the rain which
I am making.

*Medical Doctor*: So you really believe that you can command the clouds? I think that can
be done by God alone.

*Rain Doctor*: We both believe the very same thing. It is God that makes the rain, but I pray
to him by means of these medicines, and, the rain coming, of course it is then mine
(Livingston 1857: 23).

Unlike later generations of missionaries, Livingstone sought to show his European readers that
the medical doctor could not win over his African colleague through mere reason and dem-
onstrations of European medicine; Livingstone was himself somewhat ambivalent about the
value of his medical work (Andrew 2018: 33). Nevertheless, the dialogue reflects an emerging
self-confidence among missionaries, a growing belief that their European approach to medi-
cine was based in principles that broke with (and sometimes opposed) traditional medical wis-
doms, at home as abroad. Livingstone’s medical doctor thus appealed to tropes now common
in modern scientific discourse—observation, efficacy, and mechanical causality (italicized in
the following quote, in turn)—to bolster his authority:

*Medical Doctor*: I give medicine to living creatures within my reach, and *can see the
effects*, though *no cure follows*; you pretend to charm the clouds, which are so far
above us that *your medicines never reach them*.

(Livingston 1857: 25, author’s emphasis)

In contrast, the rain doctor—not unlike Worboys in the introduction of this chapter—emphasized
an essential sameness (‘We both believe the very same thing’), insisting that both figures in this
encounter mixed medicine and religion in a broadly comparable way (Porter 1999: 42).

**The variety of reasons for medical missionaries**

As the nineteenth century progressed, Protestant literature increasingly regarded modern med-
icine as central to Christian evangelism. In 1886, the former British colonial administrator and
mission supporter William Muir (1819–1905) explained that modern medical missionaries
were simply ‘following the example of our Saviour, who Himself, and through His disciples, healed the sick simultaneously with the blessed proclamation that the kingdom of heaven was at hand’ (Lowe 1892: vi).

Leading proponents of medical missions argued that ‘the withdrawal of miraculous endowment [of the Apostolic age] renders it all the more imperative that we cultivate and consecrate,

**VALUE OF MEDICAL MISSIONS**

I. *Evangelistic.*
(a) As a Pioneer Agency:
1. By overcoming hostility and prejudice.
2. By destroying superstition.
(b) As a Direct Spiritual Agency:
2. By exhibiting an object lesson of the Gospel.
3. By securing time for repeated presentations of the Gospel both by lip and life.

II. *Social.*
As a Christian Social Agency:
1. By weakening such systems as Caste.
2. By acting as centres for public health reform.
3. By imparting a new standard to human life, especially that of womanhood.

III. *Educational.*
(a) As a Christian Educational Agency:
1. By supplying scientific Medical knowledge.
2. By training Native Medical Students, and raising up Native Medical Missionaries.
(b) As a Christian Philanthropic Agency.
By training the Native Christian Church in true Christian Philanthropy.

IV. *Economic.*
As a Missionary Health Agency:
1. By diffusing a proper knowledge of the preservation of health amongst the Missionary Staff.
2. By treating sick members of the Staff.
3. By guiding the health administration of Missionary societies.

*Figure 18.1*  Fletcher Moorshead’s *The Appeal of Medical Missions* (1913) listed all the ‘ways in which Medical Missions attest their missionary value, and exhibit their striking influence in the propagation of the Christian Faith.’ (The image is an edited compilation of these ways listed on pages 70–71.)
with the utmost energy and devotion, not only the science of philology, but also that of medicine’ (Lowe 1892: 19). Missions offered a wide variety of theological, humanitarian, practical, and evangelical justifications for how and why modern medical practices and knowledge related to the mission calling (Walls 1982).

The focus of this chapter and high among the many justifications that Moorshead (who we encountered in the introduction) provides was an expectation among many Protestant missionaries that practical demonstrations of the efficacy of biomedical therapies might lead to conversions, ‘By destroying superstition,’ in Moorshead’s words.

**Medical and anthropological changes in mission attitudes**

Four developments played key roles in reshaping how Protestant missionaries instrumentalized medicine in the final decades of the nineteenth century. Together they worked to encourage the evangelical use of scientific medicine to disenchant non-Christian worldviews.

The first development was the professionalization of medical practice within Europe, such as through the British Medical Act in 1858. This shifted the authority of diagnosing and treating sickness away from religious authorities and towards qualified doctors and emerging medical institutions (Hardiman 2006: 13–14; Mohr 2009: 434). This change reached the mission field, where, by 1900, missionaries with no medical qualifications were reluctant to involve themselves in healing practices if a medically qualified missionary was on hand (Johnson 2010).

Second, transformations in the understanding and treatment of disease over the nineteenth century had broad consequences for how Europeans generally viewed premodern and non-Western medical knowledges (Worboys 2007). Adam Mohr has shown (2009: 448–452) that Basel missionaries in Ghana became increasingly ‘skeptical of the idea of being spiritually poisoned by malevolent spiritual forces’ in line with the discovery in the 1880s that bacteria caused certain diseases (including typhoid, leprosy, tuberculosis, cholera, diphtheria, pneumococcus, and brucellosis). Consequently, Ghanaian healing practices and remedies were simultaneously demoted and diminished in the minds of the Basel missionaries as superstitious ‘magic’ and mere ‘herbs’ (Mohr 2009: 450–451). Buoyed by the success of vaccinations and the germ theory of disease, Roy Porter argues that ‘Western medicine grew aggressive, convinced of its unique scientific basis and superior therapeutic powers’ (1999: 36). Many Protestant missionaries subsequently viewed competing traditional healing practices in enlightenment and historical terms: as irrational (‘superstitious’) and premodern (‘animistic’), rather than as primarily diabolical or idolatrous (Comaroff and Comaroff 1997: 328; Hardiman 2006).

Third, a teleological or stadial narrative was further encouraged by the emerging discipline of anthropology, which sought to map distinctions between ‘primitive’ and ‘European’ science onto a history of human development (Tilley 2010). Central early figures in anthropology, such as the British anthropologist E.B. Tylor (1832–1917), influentially argued that cultural practices (including medical activities) could be plotted along a single line according to their degree of progress ‘from savagery through barbarism to civilization’ (quoted in Tambiah 1990: 44–45). For Tylor, an important measure of development was the existence of a belief in independent natural laws, with the failure to distinguish the animate from the inanimate characterizing the ‘animistic’ thinking of ‘primitives.’ This thinking filtered into the writing of Protestant missionaries, who classified African and South Pacific views of nature and illness as inferior (magical, superstitious, fetishistic, etc.) because they did not share the missionaries’ modern belief in a categorical divide between the material and the metaphysical (Keane 2007: 83–84, 93–96; Midena 2018: 96).
Theology of nature

Fourth, Protestant theology also increasingly ceded its authority to speak about the mechanisms of nature to the emerging natural sciences (physics, biology, palaeontology, etc.). The historian Frederick Gregory (1992) has shown that the cumulative effect of nineteenth-century scientific materialism and Darwinism was that many traditional Protestants came to accept a neo-Kantian categorical distinction between transcendental and material words, between spirit and body, with the authority of religion limited to the former. This division constrained the ability of Protestant religious authorities to interpret nature, even as it safeguarded their authority on spiritual and moral matters. Within many Protestant circles, there thus developed, according to historian Ueli Hasler, a belief that there existed an ‘amicable juxtaposition’ between religion and science (Gregory 1992: 6).

Even if many Protestant theologians no longer believed that they had the authority to talk about nature, they were therefore, nevertheless, theologically invested in maintaining the distinction between nature and the supernatural (and between science and theology). On matters of healing, many mainstream Protestants were concerned that any failure to recognize this ontological separation between the material and the metaphysical was tantamount to believing that God was immanent in the world and that one could manipulate God through practising rituals. The Swiss physician Dr. Paul Tournier (1898–1986), one of the twentieth century’s most prominent Protestant writers on medicine, explained that ‘God is not at our service. To claim to penetrate His secrets, know His signs, and have His power at our beck and call is not faith, but magic.’ (1954: 87) When the Protestant God acted directly in the world, he only did so miraculously, that is, by breaking natural laws.

In the mission field, many Protestant missionaries believed that an understanding of God’s miracles as miraculous thus depended on a prior belief in the existence of natural laws. In the minds of anthropologist Webb Keane’s Calvinist missionaries on the island of Sumba (Indonesia), ‘a proper understanding of God as creator requires us to take God’s creation as lawlike and ordered’ (2007: 101). The failure of ‘animists’ to distinguish categorically between nature and the spiritual was regarded as both a theological heresy and a scientific error. In this context, modern medical science played a dual role in Protestant evangelism. First, its efficacy was taken to be evidence for the truth of both the Western-scientific and Christian worldviews. And second, the notion of natural laws and disease mechanisms (upon which late nineteenth-century Western science and medicine was premised) was considered a necessary corollary to an orthodox Protestant understanding of salvation by grace alone.

Object lessons and evangelical pedagogy

In the field, these modern narratives emboldened Protestant missions to win converts through forms of power encounter that were shaped by the biomedical age. The stadial views of human progress, for example, encouraged missionaries to adopt pedagogical methods used for young children at home to the colonial contexts abroad. John Lowe (1835–1892), a Scottish medical missionary who wrote the main apologia for medical missionaries while secretary of the Edinburgh Medical Missionary Society, argued that ‘The heathen can best be taught as little children are instructed in our schools—by object lessons’ (Lowe 1892: 9).

The object lesson, as originally practised, was a popular pedagogical approach in nineteenth-century Britain and the United States. It invited children to examine material
objects, making reflections that moved from its material form to abstract meanings. As historian Sarah Carter has explained, it was hoped that a cookie or strands of straw ‘could lead to the study of human ingenuity, the complexity and curiosity of the natural world, or the wonder of God’ (2010: 8). This pedagogical method placed a high value on visual demonstrations as a learning tool for conveying more complex ideas about nature, human beings, and religion (Carter 2010; Sengupta 2011).

Sujit Sivasundaram (2005) has shown in detail how, for British missionaries in the Pacific, nature provided a ready source of objects for lessons about Christianity and thus a basis for conversations about the Gospel with largely illiterate Islanders. Missionaries also figuratively described everyday practical demonstrations as object lessons. In 1893, a member of the London Mission Society explained that the mission house itself was ‘the object lesson of a civilised, Christian home’ (quoted in Langmore 1989: 85). It is in this pedagogical context that Moorshead’s ‘living demonstrations’ of biomedicine hoped to convey practical and abstract information about bacteria, natural laws, mechanical causality, and—ultimately—the superiority of Christianity and Western medicine.

**Case study: biomedical demonstrations in Paul White’s *Jungle Doctor***

The power of the biomedical demonstrations is a central focus, for example, in the encounters fictionalized by the Australian-born missionary Paul White (1910–1992), arguably the most important popularizer of medical missionaries in the immediate post-World War II period.

White served briefly as a medical missionary in Tanganyika in Africa from 1939 to 1941. On the boat back home to Australia, he began writing the first story in what would become the *Jungle Doctor* series. This widely translated and globally successful series drew creatively on White’s African encounters. He represented Christianity through its ‘continual struggles for authority with the witch doctors; and the reward of seeing lives changed through the power of Jesus and Western medicine’ (Schoepflin 2005: 572–573). White’s missionary doctor outwits and astounds African witch doctors with vaccinations and blood transfusions. In the final chapter of *Jungle Doctor Attacks Witchcraft* (1947), the mission doctor demonstrates to local chiefs the power of the microscope in diagnosing a sick boy:

Late that afternoon a group of Chiefs came to me. ‘Behold, Bwana,’ said one, ‘we realise that you have the way of wisdom. Tell us that we may understand that it is not magic, that causes much of our trouble.

‘Right!’ I said. ‘Come, and I’ll show you some of the things in our laboratory. Truly, I will demonstrate this to you, and you can see with your own eyes.’ Two microscopes were put out. . . . ‘You remember Mbuli, the little boy who came in here bewitched? Come and I will show you the cause of his trouble.’

From the cupboard I took a glass slide. On it was some of the material taken during the height of his illness. I focussed the microscope up and down and showed them the germs of pneumonia.

(White 1947: 118–119)

Upon observing the germs, the African chiefs in White’s story immediately proclaim the power of Western science and that the mission doctor’s ‘Master, the Lord Jesus Christ, is stronger than the devil’ (1947: 120). This fictional encounter contrasts with David Livingstone’s scepticism,
a century earlier, that the mere performance of medicine could easily change the basic worldview of non-Christians.

For White, the Christian Gospel and Western biomedicine coexisted happily; indeed, it is Western biomedicine (rather than, say, the missionary or even the Bible) that does the heavy lifting in his story. To reinforce this, the front cover of the 1947 version sports an image of a syringe (containing a modern vaccine, we might presume) impaling the arm of an unhappy African witch doctor.

**Medical demonstrations in the mission archives**

Providing medical services won many converts. One Mrs. Crawford (according to her husband’s diary) reportedly gained ‘fame,’ in 1896, for a successful amputation in the Congo:

> The coming of Mrs. Crawford marked a great advance in the [Garenganze Evangelical] Mission. Gifted with medical knowledge, she used her skill to enforce the Gospel. One case won her fame. A certain huge man . . . rent and tore his arm. For two years he suffered much from native charms. Then Mrs. Crawford, after administering chloroform, amputated the arm, and thus gave the man ease.

(Quoted in McKenzie 2002: 346)

Gendered Indigenous societies meant that women like Crawford often had greater access to perform medicine in the domestic sphere and in relation to births and children (Fitzgerald 1997; Robert 1996; Vaughan 1991: 66–71; Hardiman 2006: 15). Women missionaries were also enthusiastic advocates of biomedicine, though they were not specifically trained in medicine until the turn of the century (Johnson 2010: 555, 557). Terence Ranger tells the story of Mrs. Williams, a combative mission nurse in Zanzibar in 1880, who refused to provide medical treatment to a local child with ‘a horrid skin disease’ until the mother took off charms (‘the medicine of the devil’) adorning the child. Mrs. Williams wrote:

> Eight months or so have passed since then, during which time the child has worn the charms and has been getting very much worse. Over and over again the mother has begged me to cure it. . . . It has been very hard to see the poor little thing growing worse and to hear its piercing screams when they put on native medicine, and yet do nothing to relieve it.

(Quoted in Ranger 1981: 262)

Mrs. Williams described her elation when the African mother eventually relented and removed the charms: ‘I joyfully went in and prepared the ointment. You will be glad to hear that the healing has been very rapid’ (quoted in Ranger 1981: 262).

**Difference and the limits of modernity**

There are reasons for us to be sceptical about simple science-causes-disenchantment narratives (Harrison 2017). In mission encounters, it is rarely clear whether such biomedical demonstrations caused the transformations—let alone performed the kind of disenchanting work—that many medical missionaries hoped they would. Missionaries often had little control over how their audiences interpreted the missionaries’ biomedical demonstrations (Ranger 1981: 265–266; Etherington 2005: 281; Tippett 1967: 101; Tomlinson 2017). In one example, in
Mombasa in 1898, an African man ‘vaccinated’ people against a man-eating lion by marking the skin of his patients with the same vaccination marks as Church Missionary Society (CMS) missionaries had made on people a year earlier, while vaccinating them for smallpox. A CMS missionary admitted that the man ‘could not see the difference between his work and ours’ (quoted in Vaughan 1991: 59).

Figure 18.2  Paul White’s colleague and friend, Reverend Donald Begbie (1912–1980), created this striking front artwork for Jungle Doctor Attacks Witchcraft (1947). Note the medical syringe impaling the arm of the African witch doctor. (Reprinted by permission of Donald Begbie’s family.)
The Mombasa man’s actions return us once again to how missionaries conceptualized difference in evangelical encounters, given that the authority of the medical missionary and the witch doctor was at once both religious and medical. It is often the discourse of modern science that provided missionaries with ready explanations for the reactions of ‘animists’ to biomedicine. In 1900, for example, Reverend James W. Jack’s history of the Livingstonia Mission in British Central Africa gives the following account of anaesthesia:

The ‘sleep medicine’ [i.e. anaesthesia], as the natives called it, was a never-failing wonder to them. . . . To the simple natives the cases were apparently miraculous. So far as they could see, the white man first killed the patient, and then, when quite dead, he cut the trouble out; then he bound up the wound and made it better; and then, finally, he brought the patient back to life again. Every cure, too, was like a nail in the coffin of superstition and witchcraft.

(Quoted in McKenzie 2002: 346–347)

In these moments medical missionaries tended to side with mechanical explanations of healing, against both ‘miraculous’ and ‘superstitious’ explanations. Webb Keane has shown, however, that nineteenth- and twentieth-century Protestant missionaries, as frequent advocates of modern science and medicine, faced the perennial impossibility, in Latourian terms (1993), of neatly dividing the world into the purely natural and the purely metaphysical, between the scientific and the religious. They struggled endlessly with the modern project of purifying the natural world of ‘fetishes’ (Keane 2007: 80).

Case study: Lutheran Edwin Tscharke’s medical demonstrations in New Guinea

These themes continue into the second half of the twentieth century, even if, by then, medical missionaries tended increasingly to focus on improving physical health as an end in itself, rather than as an evangelical tool (Vaughan 1991: 56–66). A prominent medical missionary in the post-war South Pacific context was the Australian Lutheran Edwin Tscharke (1918–2000). Tscharke was inspired to become a medical missionary after he heard Paul White give a talk at St. Andrew’s Cathedral in Sydney (Frazer 1992: 75–76). He worked most of his life practising medicine on Karkar Island, a small New Guinean island, where he established a groundbreaking training hospital for New Guineans, for which he was appointed an Officer of the Order of Australia for medical services.

Tscharke came to regard sorcery-related beliefs as the main obstacle not only to Christianity but also to healthy living in New Guinea. To his frustration, Islanders frequently incorporated the mission hospital’s treatments into their existing repertoire of healing practices, often experimenting with traditional remedies first. In one instance, he was confused when patients presenting themselves at the mission medical clinic with cerebral malaria also had burns on their hands, until he discovered that a traditional treatment for those symptoms was to hold a burning hot banana (Frazer 1992: 138).

In response, Tscharke tried to demonstrate the technologies and techniques of Western biomedicine. He published a picture book in 1952 about Western medicine, sorcery, and Christianity. Thousands of copies were distributed in New Guinea and abroad. Originally entitled the Guide to Better Health and Hygiene for New Guinea, it was translated in 1958 for local New Guineans into their creole language, Tok Pisin, and again in 1993 into ‘simple English’ for use in Namibia, Tanzania, Zambia, and Ghana (Tscharke 1993: xiv). Through cartoons and brief
texts, Tscharke sought to educate readers about the basis for biomedical understandings of disease, with short chapters on ‘The Cell,’ ‘The Microscope Story,’ ‘Organs,’ ‘Yaws,’ ‘Hookworm,’ ‘Aids,’ and ‘More about the Microscope.’ The 1993 translation explained that before the invention of scientific instruments Satan ‘had an easy way of distorting and confusing . . . minds’ (Tscharke 1993: 1).

For Tscharke, the cause of illness needed to be directly observed. He therefore emphasized the authority of scientific tools necessary to identify disease-causing bacteria, like microscopes, that ‘help us to see things which our normal eyes can not see’ (Tscharke 1993: 6). Before an audience of New Guinean medical students, he would conduct autopsies on pigs to show them the effects of pneumonia on the lungs (Frazer 1992: 140).

Figure 18.3 Front cover of Edwin Tscharke’s *A Guide to Better Health and Hygiene for Third World Countries* (1993). This simplified English version, translated from his original 1958 version, was intended for use through Africa and the South Pacific. The cover art was drawn by Shong Babob, a local New Guinean who created many of the drawings for Tscharke’s educational health material. (Reprinted by permission of Mr. Shong Babob’s family.)
The secularization of mission healthcare in the late twentieth century

From the late 1940s, processes of decolonization prompted many mainstream mission societies to re-evaluate their relationship to medicine and healthcare (Grundmann 2015: 119–121; Klassen 2011: 51–55). In May 1964, the Medical Mission Institute at Tübingen hosted a small but important group of healthcare professionals, theologians, and medical missionaries—from across the ‘global denominational and interdenominational’ spectrum of Protestant churches (Grundmann 2015: 125)—for a conference on ‘The Healing Ministry in the Mission of the Church.’ The event, which was organized by the World Council of Churches (WCC), sought to discuss a growing problem, namely, the financial and staffing burden that running hospitals and clinics placed on ‘the Younger Churches’ in underdeveloped contexts. This financial pressure prompted wider theological questions, such as whether the secular welfare state should be considered the proper successor of mission-run healthcare systems in post-colonial contexts. Lesslie Newbigin, WCC Director and a former British Presbyterian missionary to India, posed this problem: ‘Given the fact that we now possess technical means for the mastery of disease undreamed of when the Gospels were written, what is today the relationship between the work of healing and the announcement of Christ’s victory over the powers of evil?’ (quoted in Klassen 2011: 52). For Newbigin, biomedicine’s authority explained, even justified, the secularization of health systems (Hardiman 2006: 22).

Some historians of medical missions have similarly regarded the modern welfare state as the natural successor to mission hospitals and clinics (e.g. Etherington 2005: 261; Hardiman 2006: 5). As with Newbigin, a common assumption underlying these histories is that medical science and physical bodies are ‘secular’ domains of work (e.g. Whiteman 1983: 179). ‘As mission hospitals and clinics became more scientific, their religious role was diminished,’ argues Gary Ferngren (2014: 171; see also Reimer-Kirkham’s depiction of the ‘rise in scientific knowledge’ in this volume). The belief that science causes disenchantment was, in a sense, turned back upon medical missionaries themselves in the form of an assumption that science causes secularization. These accounts, however, tend to overlook two important historical points.

Economic rationalization

First, where welfare states did succeed medical missions, it is at best unclear what role that medical-scientific knowledge played in this shift. The history of the Anglican Melanesian Mission in the South Pacific provides here a useful example. Between the arrival of its first mission doctor in 1888 and World War II, the Melanesian Mission was arguably the most significant biomedical actor across the British Solomon Islands Protectorate (a British colony until independence in 1978) and the neighbouring New Hebrides islands (a joint British-French condominium until 1980). Early British administrators willingly helped fund the Melanesian Mission’s medical activities without expressing significant reservations.

The experiences of World War II, however, raised hopes among Islanders for self-rule, and colonial administrators scrambled to diffuse local anti-colonial tensions through, in part, improving government services. The colonial archives contain extensive post-war discussions about how to structure healthcare systems, including whether secular authorities should continue to subsidize medical missionaries. In 1953, a Dr. Mills prepared a report for the British colonial administrators on the topic of the ‘Rationalization of Medical Services in the New Hebrides.’ He aimed to find ‘the least inefficient, the least uneconomic and the least unsatisfactory possible’ way of organizing healthcare in the then colony. He ultimately argued for
withdrawing all mission subsidies on the grounds that there lacked sufficient oversight to ensure that government subsidies (in money and medical equipment) given to the missions for medical services would be used only for medical purposes. Furthermore, the British administrators decided that it was more economically efficient to devote resources to preventative measures (e.g. vaccination programmes) rather than the expensive curative services (i.e. hospitals and clinics), which tended to be the focus of missions. Economic and administrative considerations formed the main basis for much of subsequent conversations among administrators for reducing the role of missions in healthcare. The relation between biomedicine and missions was not an important consideration.

If science played a role in the secularization of mission health services in the Solomon Islands and New Hebrides, it was only indirectly and primarily through the science of economics (see Evans and Evans 2008; Buckser 1996). The secularization of these health systems was not driven by a conflict between science and religion, as imagined by some historical accounts of the ‘decline’ of medical missions.

Medical missions in the contemporary world

The second problem with science-causes-secularization narratives is that recent decades have seen a resurgence of financial, political, and social support for Christian medical work. For example, the annual Global Missions Health Conference promotes Christian medical organization, while the Christian Journal for Global Health, started in 2014, supports ‘approaches to global health from an integrated Christian perspective.’ Since 2016, half-a-million US dollars has been awarded annually for an African project demonstrating ‘outstanding Christian medical missionary service’ (McNeil 2017).

These can be seen as part of a broader trend towards faith-based health providers (FBHPs) and faith-based organizations (FBOs), the preferred multifaith acronyms today for a broad range of religious medical and health services. This trend was noted in 2000 by the United Nations Millennium Development Goals (MDGs), which explicitly recognized the value of FBOs in giving momentum to healthcare initiatives in local contexts (Clarke and Jennings 2008: 2).

Current medical missions also find support in scholarly literature. For example, sociological surveys measuring efficacy have found that FBOs provide a quality of care in areas such as maternal and newborn healthcare that is comparable to government institutions (Vogel et al. 2012) and might even be superior in some regards (Widmer et al. 2011; Duff and Buckingham 2015: 1786). One identified reason for this is that the local links of FBOs earns the trust of communities. As one report explains:

missionaries are on the cutting edge [in the twenty-first century]. They are aggressively local, often learning the language of the people they are working with, and they stay for years at a time. They are not pulled by the fashion of high-profile diseases, such as HIV/AIDS, but work on primary healthcare issues such as infections and diarrhoea, that are often ignored in the funding priorities of big donors.

(Loewenberg 2009)

Studies like this that regard healthcare as encompassing more than treating an individual sick body and teaching medical ‘facts,’ typically emphasize the potential value of the FBO’s ‘all-encompassing’ and ‘holistic’ approaches, which include ‘social, environmental, physical and spiritual-wellbeing’ (Duff and Buckingham 2015: 1786; see also Klassen 2011: 53–54).
These statistical studies tell us little, however, about the everyday encounters between religion and medicine in these contexts—about whether, and in what new ways, contemporary FBOs might perform biomedical demonstrations to win Indigenous peoples to Christianity or Western science in the post-colonial and post-Tübingen-1964 period. Such topics remain important, particularly given the leading role that Christian organizations continue to play today in addressing widespread violence related to sorcery accusations in the wake of illness in many African and South Pacific contexts (Australian High Commission, Papua New Guinea 2018).

Conclusion

This chapter has sought to show that the figure of the Protestant medical missionary rose to prominence in the late nineteenth century in important ways because of the increasing authority of biomedicine. Medical missionaries’ distinctly modern theology was invested in maintaining what Hardiman (2006: 5) called ‘the ever-growing chasm between religious belief and secular science,’ even as their practices inescapably bridged and unsettled this divide. Their apparent ‘Christian resolution to the challenge of modernity’ was not aimed at dissolving the modern distinction between science and religion; rather, medical missionaries hoped religion could live in harmony with science if both kept to their own sphere of authority.

The missionaries’ changing theology of nature had an inevitable impact on evangelical encounters. The authority which missionaries attributed to Western medicine had the effect of reducing their opinion of Indigenous medical knowledge. Furthermore, Protestant missionaries increasingly described the evangelical frontier—the line that differentiated Christian from non-Christian—as being demarcated by competing aetiologies: on the one hand, the modern Christian worldview, dividing the world into the natural and the supernatural; and, on the other, a plethora of preternatural beliefs and ‘superstitious’ rituals that purportedly ignored and mixed these distinct realms. Thus by 1913, Moorshead could argue that, ‘In the life and thought of the non-Christian man religion and medicine go hand-in-hand. The man who is his fetish is also his medicine man’ (1913: 76). To combat this, many missionaries believed that performing and demonstrating biomedical procedures would disenchant non-Christian worldviews. It is ultimately difficult to ascertain the exact consequences of these biomedical-evangelical encounters on the individual beliefs and practices of non-Christians from extant sources. But we must, at the very least, remain sceptical as to the power of object lessons in biomedicine to disenchant or secularize in the ways their proponents imagined.

Notes

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2 I am using ‘object lesson’ here in the figurative sense of ‘a striking practical example of a principle’ (Oxford English Dictionary Online, March 2020). This pedagogical terminology, in both its literal and figurative usages, was familiar to missionaries at the time, as later examples demonstrate.

3 Due to space limitations, I do not include examples from important missionary destinations such as India and China (see Fitzgerald 2001; Hardiman 2008; Lazich 2006). Missionaries at the time tended to treat the ‘heathen’ in Africa and the South Pacific as a separate problem from dealing with ‘world religions’ (e.g. see chapter layout of Lowe 1892, also p. 69). In addition, this chapter does not include Catholic missions (Dirar 2006), charismatic evangelicals (Brown 2011), or liberal Protestants (Klassen 2011). While it is difficult to generalize, each of these groups tended, by and
large, to encourage different relationships between science, nature, and medicine than those which I am exploring here. Indeed, the Protestant missionaries at the centre of this chapter often defined their view of nature in opposition to the various Catholic and charismatic views (Hardiman 2006: 28). It was also the case that different ideas about healing could coexist within the same church and mission communities. Pamela E. Klassen, for instance, provides an important survey of how certain ‘liberal Protestants thought about “religious healing” in ways that went beyond the miracle’ (2011: xiv) by challenging the view that ‘the supernatural . . . knew no earthly of natural bounds’ (2011: xii). This contrasts in complex ways with the more conservative and evangelical Protestant missionaries in this paper, who tended, on the whole, to emphasize the law-breaking (miraculous) nature of religious healing and the separation of the natural and spiritual worlds. Groups linked with both views were represented at events such as the World Council of Churches meeting in Tübingen in 1964 (Grundmann 2015).

4 Catholic nuns were hindered in the quality of nursing they provided by the Roman Catholic Church, whose canon law prevented members of religious orders of both genders from studying medicine or having contact with bodies. This changed in the 1920s, with the accession of Pius XI (Hardiman 2006: 24).

5 These discussions are part of the Western Pacific Archive at the University of Auckland. See WPHC 6 CF8/33/2.

Bibliography


Medical missionaries and witch doctors


