TALES FROM THE INNS OF HEALING

With the Compliments of the Christian Medical Association of India, Burma and Ceylon

Arriving at the Inn of Healing, Jalalpur-Jattan, Punjab.

Medical Delegates and Conference Medical Staff at the International Missionary Conference at Tambaram, December 1938.

Back Row.—Drs. P. V. BENJAMIN, J. SAVIRARAYAN, S. GAIKWAD, S. JESUDASON, B. C. OLIVER, R. H. H. GOHI
Front Row.—Drs. HILDA LAZARUS, J. FINDLAY, Sir HENRY HOLLAND and Miss PITMAN, S.R.N.
(*Omission.*—Miss H. W. SUTHERLAND, S.R.N.)

TALES FROM THE INNS OF HEALING

of Christian Medical Service in India, Burma and Ceylon

Prepared under the Direction of
the Executive Committee of the
Christian Medical Association
of India, Burma and Ceylon

FOREWORD BY
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FOREWORD

ONE of my earliest and happiest duties in the service of the National Christian Council was to sit in with the members of the Executive Committee of the Christian Medical Association of India when the subject of higher Christian medical education was under consideration. There began that day a new understanding of the nature and function of Christian Medicine, an understanding that grew in range and depth with the passing years. There began also a friendship that fortified my own faith and gave substance to my own dreams; for those at the centre of Christian medical things belonged to the company of those who live by faith and give it happy expression in unself-regarding service. Not only did they see visions: they straightway set out to make them come true. It might truly be said of them, as it was said of William Carey, 'His whole desire went out to meet the Will of God'.

When the International Missionary Council held its historic World Meeting at Tambaram at the close of 1938 it was my privilege to be the one 'lay' member of the section that dealt with the subject of 'The Christian Ministry of Health and Healing'. In the report of that section there is a noble passage that gives Christian Medicine its rightful setting in the Christian enterprise. It runs as follows:

> The Church exists to continue the work Christ began. As He identified Himself with the need and suffering of the world, so must His disciples identify themselves with that need and that suffering, that the redeeming love of God may be mediated through them to the lives of others. Mindful of the value that God has set on human personality, and animated by the spirit of compassion that moved the Great Physician, the Church will follow Him in methods of service that express His mission. It is her privilege, as it is her duty, to give effect in Christ's name to the redemptive purpose of God, whose end is the restoration of the divine image in man. The Ministry of Health and Healing belongs to the essence of the Gospel and is therefore, an integral part of the mission to which Christ has called, and is calling, His Church.

Having had this intimate fellowship with the Christian Medical Association and its officers I count it a privilege to introduce these 'Tales from the Inns of Healing' to what I hope will be an ever-enlarging circle of readers. While not intended primarily to 'keep children from play and old men from the chimney corner', they have that within them that touches the deepest emotions of the human spirit and releases the springs of thanksgiving and prayer. They are

true tales, drawn not from the alluring fields of fiction, but from the facts of everyday life and told by those who have first-hand knowledge of what they speak. Listening to them one is reminded of that profound saying of St. Anselm: 'Not yet hast thou considered the weight of human sin: not yet hast thou considered the strength of the love of God.' The weight of human suffering is heavier than we realize; but thank God, the effort to alleviate it is greater than we knew. It is easy to pass through life with averted eyes and see neither the wounded traveller by the roadside nor the ministering Samaritan, and so these tales come to summon us to look on the fields of human need, even as Christ looked on them in the days of His flesh, and go forth to reap the richest of all harvests in lives redeemed from sickness, want and despair.

The outstanding impression these human documents convey is the wide, varied and successful range of Christian Medical service. No phase of human need, actual or potential, is left untouched. Some of the achievements of modern surgery are a reminder that the age of miracles is by no means past; and equally impressive is the record of achievement in the less spectacular provinces of curative and preventive medicine. We dare not say that the 'hopeless case' is a thing of the past; but this we may say that the prospects of recovery in the general run of cases are brighter now than they have ever been in the long and splendid history of the healing art. It is an occasion for thanksgiving to God that the ancient scourges of mankind are beginning to lose their terrors, and that the time is surely, if slowly, coming when smallpox, leprosy, tuberculosis and malaria shall be exiled from these eastern lands. The new order, for which all good citizens pray and plan, must be an order of good health, and to this end it is imperative that Christian Medicine be given elbow room to maintain and extend its God-given ministry of health and healing.

I note with interest and thankfulness that the highly important subject of Prayer and Healing is given a chapter to itself. With the growing understanding of the inter-relationship of body, mind and spirit comes the conviction that man, and particularly the sick man, cannot live by medicine alone. Necessity is therefore laid on those to whom is entrusted the cure of the body and those to whom is given the cure of souls to work together in one God-given ministry. In so doing the fundamental principle that Christian Medicine is an integral ministry of the Church, for which the Christian Medical Association of India has consistently stood, will be nobly exemplified. Over the gateway of the French College of Surgeons is the arresting inscription, 'I dressed his wounds: God healed him'.

To no branch of Christian Medicine has the Christian Medical Association given more earnest heed than that of higher Christian medical education. The story of Ludhiana, Vellore and Miraj makes

thrilling reading; but how much more thrilling the record would have been had it included the tale that has yet to be told of a golden dream consummated in a Christian Medical College for men and women. India needs, and will continue increasingly to need, Christian doctors of the highest qualifications, both medical and spiritual. Excellent as is the training given in secular institutions, it cannot provide that inner equipment of spirit that the Christian doctor and the Christian nurse need in equal measure with the Christian preacher and the Christian teacher. I greatly hope that whatever shape the present proposals for closer co-operation now engaging the serious attention of missions and churches in India may take, it will include as one of the essential things, adequate provision for higher Christian medical education. Not only does the genius of the missionary enterprise expect this; these fast moving world events, that have taken India in their inexorable sweep, demand it. It is not meet that India should take her place in the new commonwealth of nations maimed in this essential limb of Christian Medicine. I covet no greater joy for my friend and former colleague Dr. Oliver, to whom we owe the compilation of these fascinating Tales, than this: that ere her long working day closes she may see coming into splendid being the Christian Medical College of her dreams.

Whoso reads these Tales, as I do, must needs turn to God in praise and prayer.

J. Z. HODGE

PREFACE

AT the Biennial Conference of the Christian Medical Association which ended on January 1st, 1941, it was suggested:

> That . . . we prepare and publish a report of Medical Missions in India suitable for Church members in India and abroad, and that the statistics to be gathered in 1941 be included in it.

The model for such a report was to be the very interesting and well illustrated report of the Mission to Lepers. Accordingly, letters were issued to all the members of the Association inviting them to share in providing material—human incidents, contrasts between the 'was' and 'is', word pictures of particular events; difficulties and the overcoming of difficulties, God's grace shown in suffering cheerfully borne; incidents to show how much unmet need there still is; stories of changed lives; stories of special workers who have become strikingly

useful through training; stories of failure, too; reports of the healing ministry undertaken by the local Church. Added to this the report is designed to show which lines of work need emphasis, how far the Christian service to the sick is being undertaken by Christian Indians, and the plans that are made for providing still higher training for Christian nurses and doctors in India.

To select and arrange the material sent in, and to make up for material that was not sent in, was no easy task. Should it be arranged geographically or topically? And how was it to be classified to prevent overlapping? The titles of the chapters will indicate how an attempt has been made to answer these questions.

The name is always important. To call a publication a 'Report' awakens no interest. The humble title of TALES FROM THE INNS OF HEALING suggested itself as particularly appropriate to the service on the frontiers of India, but it is suitable for all Christian hospitals where the patients are regarded as guests to be helped in their need. 'Tales' are simple stories. The virtue of those told here is that they are all true. The title is meant of course to recall the parable of the Good Samaritan, which, more than any other of the Master's parables, has been appropriated as their own by those who minister to the sick.

The names of those who have contributed in one way or other to this book, are too numerous to mention. It is a joint effort in nobody's name, but in the name of the Christian Medical Association and with acknowledgement to three 'laymen' whom we regarded as our associates and helpers in the work—Donald Miller, Secretary of the Mission to Lepers, Rev. R. M. Barton, Pathologist at Arogya-varam, and the Rev. J. Z. Hodge, D.D., lately Secretary of the National Christian Council.

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ALONG THE NORTHERN FRONTIERS

'A Samaritan traveller came to where he was and felt pity when he saw him . . . and took him to an inn and attended to him.'—LUKE 10: 33, 34 (Moffatt)

IF the Good Samaritan, coming through one of the northern passes into India, should find by the roadside a man who had been wounded by his enemy in a blood feud, or mauled by a bear, he would be able to take him to a Christian hospital at the mouth of the pass, and could give instructions, 'Take care of him; and whatsoever thou spendest more, when I come again, I will repay thee'. The Good Samaritan is rare, but the Christian hospitals are to be found in a chain a thousand miles long, extending from Quetta in the North-West through Dera Ismail Khan, Tank, Bannu, Mardan and Taxila to Srinagar in Kashmir. They are situated on the roads that lead to the lands as yet closed to the missionary—Afghanistan and Tibet. Still farther east they are to be found near the borders of Sikkim, Bhutan and Nepal. In Burma the American Baptist Mission Hospital is close to the Burma Road.

If we were writing a history of the origin of the work on the Northern Frontiers, we should pay a tribute to the Christian statesmen and soldiers who inspired, petitioned and assisted the Missions in beginning the work. Within the compass of this book we must confine ourselves to more up-to-date narratives. We shall begin with Sir Henry Holland's account of the Quetta Hospital after the earthquake of 1935.

Sir Henry is a specialist in operations on the eye. Each year he leaves his mountain hospital at Quetta, an important military and political centre on the road to Kandahar, and spends six weeks of the cold season on the plains of Sind at Shikarpur, doing cataracts and other eye operations as well as general surgery. To gain experience there come to his clinic eye-specialists from America and Britain. There is a waiting list of those who wish to come. Sir Henry's two sons have joined him in the work at Quetta. Under the title of 'Destruction-Chaos-Reconstruction,' Sir Henry writes:

> Not many years ago a friend of mine said to me, 'The only thing that can possibly save your hospital is an earthquake'. This he said in jest, but he was perfectly correct in what he said.
>
> Anyone who saw the old hospital would have agreed with him, for the old hospital was a collection of old huts, some

pakka and some *kachcha*, with a large *kachcha* building in the centre capable of accommodating some forty patients.

On May 30th, 1935, the hospital was full to overflowing. The books showed that there were 140 in-patients on that date. At 3 a.m. on the morning of the 31st a catastrophic earthquake occurred which brought down the hospital. Over a hundred men were killed and others were taken out seriously injured. The doctors' and nurses' bungalows suffered a similar fate and four of us were buried under the wreckage. Miss Meagill, our dispenser, was killed.

For ten months chaos ruled over the whole of Quetta. The area was encircled by barbed wire and no one was allowed to enter this city of the dead, except to remove hundreds of corpses which lay fully or partially exposed.

What was I then to do?

The reaction of Sir Henry when he saw 'the things he had given his life to, broken' was characteristic. He decided to rebuild. There were no invested funds, no insurance to fall back upon. The C.M.S. Mission, he knew, could not help; and he found out later that they had almost reached the decision to abandon the medical work there. He had so strong a sense of obligation to the people whom he had come to serve, and amongst whom his life had been spent, that he felt that he must provide a new hospital, a hospital built to withstand earthquakes, one which could not in any circumstances be a death trap.

He confessed that his faith was far from robust, but he began to appeal for funds. An appeal was made in *The Times* signed by Lord Halifax, Lord Zetland, Field-Marshal Sir Claude Jacob and Sir Denys Bray. Other soldier friends came to the rescue. Sir Charles Harrington, the Governor of Gibraltar and former G.O.C. in Quetta gave great encouragement by sending £700 collected in Gibraltar, and General Sir Henry Karslake, who was in command at the time of the earthquake, collected over £800 in England by going round addressing meetings. Through many kind friends money continued to come in till nearly four lakhs (about £30,000) was received.

Until the new hospital was built work was carried on in a corrugated iron building, made of material salvaged from the wreckage. In May, 1940, the new hospital was opened by Her Excellency the Lady Linlithgow.

Here is Sir Henry's description of the building:

> The new hospital is a joint men's and women's hospital. Formerly there was a men's hospital under the C.M.S. and a women's hospital under the C.E.Z.M.S. Now we have a combined hospital of 200 beds, 120 for men and 80 for women.

The women's part of the hospital is shut off by a high *purdah* wall, but the central block has access to both sides and we share our chapel, where morning prayer is held, and also our dispensary, laboratory, X-ray department and lecture room.

Each side of the hospital has a *serai* (travellers' inn) which consists of free private wards and there are also some twenty-four paying private wards.

In a sense the earthquake did save our hospital, but at what an appalling cost! Over eighty of our patients were killed in the old building. In our modern up-to-date building we believe we have a hospital built on a steel frame which will stand up to the severest earthquake shocks.

The next hospital in the chain is the C.M.S. General Hospital at Dera Ismail Khan. Nearer the frontier is the C.E.Z. Women's Hospital at Tank—an adventure of faith and courage on the very edge of the turbulent tribal territory. It is beside the road over which every year scores of thousands of Afghans and Ghilzai tribesmen—men, women and children, with all their goods and chattels, trek down into India to graze their herds and to trade. They are called *Pawindahs.* Last year the hospital had over a thousand in-patients. At other seasons the staff go camping to places more distant, to heal the sick and preach the Gospel.

Bannu at the mouth of Tochi Pass will always be associated with that remarkable missionary 'Pennell of the Afghan Frontier', of whom Field-Marshal Lord Roberts said, 'He was worth an extra regiment any day in helping to maintain peace on the Border'. It was here that Dr. Starr fell a victim to a tribesman's dagger, no one knows why, but it is suspected because he taught one of their tribesmen of Christ; and it was from here two years later that Mrs. Starr undertook the recovery from across the border of Mollie Ellis, kidnapped from Kohat by outlaws who first murdered her mother. The story is told in Mrs. Starr's *Tales of Tirah and Lesser Tibet.*

Peshawar stands at the opening of the famous Khyber Pass. Dr. R. J. H. Cox, who served there for thirty years has written a book about the work which he has called *Signpost on the Frontier.* In the Foreword, Lord Halifax says, 'The importance of Peshawar, Tank and Quetta as centres for mission work can scarcely be exaggerated, for they command three of the most important approaches to the heart of Asia—the greatest unevangelized area in the world.' Through the Peshawar valley have come successive armies to overrun India. Through this and other valleys is taking place a reverse movement for the disseminating of Christian influence. Peshawar is a rendezvous for Indian, Persian, Afghan, Armenian and Asiatic Jew.

Let us make rounds with the doctor and see some typical cases.

In one of the beds lies an old Afghan with a smile on his face. When he arrived three weeks ago he was far from being happy. He had swallowed fifty rupees as he did not wish to be robbed when he travelled through the Khyber Pass. At the operation only forty-nine rupees could be found; these were handed over to the old man when he returned to consciousness. Instead of expressions of gratitude, the doctor received demands for the 'stolen' rupee!

Here is a jolly little boy whose arm has been amputated. He fell off his buffalo and broke his arm. A barber-surgeon treated the arm by tying on a splint, but far too tightly so that the limb mortified. After much persuasion the parents consented to amputation, and the nurses were busy preparing the skin above the gangrene with antiseptic dressings. Next day was the day for operation, but when the time came the boy could not be found. Two hours later his mother brought him back with all the clean dressings removed, and the arm from wrist to shoulder plastered with mud from a village shrine near by. The operation took place in spite of all and—wonderful to relate—the wound healed by first intention.

The hospital makes concessions to the preferences of its constituency in providing family wards.

Built on the plan of a camel *serai* (inn), this courtyard is always popular. Women and children who have to be admitted to hospital are housed here, and men too if they have come from far and their friends have to stay with them. All put up together in this *serai*, but only the patient is fed from hospital. The relatives make their own meals in a corner of the yard.

A sad-looking mother is sitting by the bedside of her baby girl. She is brandishing a deadly-looking Afghan knife over the baby's head, 'to keep off the evil eye' she will tell you. In the next bed is another child. The mother had gone off to the bazaar, but under the child's pillow is the knife again.

Pathans are terribly afraid of the powers of evil. Aromatic herbs are burning in some of the rooms, charms are suspended round children's necks—all to keep off the Evil One. Once a child was brought to hospital with an abscess on his scalp. The mother said he had had it for two months and it would not get well. The wound was probed and a foreign body consisting of a small roll of newspaper tied up with thread was removed from the interior of the abscess. The mother explained to us that a ***mullah*** had written words from the holy Koran on the paper and inserted it, telling her that now the abscess would soon be well. It soon got well after the charm was removed.

The hospital at Peshawar has a church, a thirteen-hundred-year-old Moghul tower situated on rising ground above the hospital. The upper storey has been consecrated as a church, and the lower is used as a lecture room. They call this 'The power house of the hospital'. Every morning before rounds the staff meet here for worship. They give the patients good care, and give the Message in the wards and among the out-patients, but they realize that if the love of Christ is not seen in their lives their efforts are vain.

'Not only in the words you say,
Not only in your deeds confessed,
But in the most unconscious way,
Is Christ expressed.

'Is it a beatific smile?
A glory light upon your brow?
Oh no! I felt His Presence while
You laughed just now.

'For me 'twas not the truth you taught,
In you so clear, to me so dim,
But when you came to me you brought
A sense of Him.

'And from your eyes He beckons me,
And from your heart His love is shed,
Till I lose sight of you and see
The Christ instead.'

So far not many open conversions to Christianity among Afghans can be recorded and this is not surprising. If he appears even interested in Christianity an Afghan runs the risk of being murdered. There are some who have had the courage of their convictions and have openly confessed their belief in Christ. Some of them have even paid the supreme price and we revere their memory; they have been signposts that all may see and read, directing men of the border to their Lord and ours.

It is reckoned that over fifty per cent of the thousands of patients who come each year are from beyond the frontiers, and for the majority their stay in the Mission Hospital is the only contact with Christians and their only opportunity of hearing the Gospel. Their lives are for the most part dominated by hatred, revenge and fear.

The hospital trains male nurses. The Government hospitals have recently begun to employ these men trained by the Mission Hospital. No women nurses are used owing to the prevalence of the custom of seclusion of women, and the dangers to which women nurses would be exposed.

At Mardan, a little farther east in the Peshawar Valley, a hospital for women was begun some years ago by women in Denmark. Such was the skill and devotion of the doctors and nurses

that in these dangerous districts men were content to leave their women folk entirely in their care. The Mardan authorities kept a guard round the hospital at nights. Across the road was a reading room for men, and the whole became part of the Danish Pathan Mission. A few years ago a supposed Pathan enquirer who was refused a request, murdered the little son of the Danish missionary and mortally stabbed the Danish sister and an Indian nurse who tried to defend her.

Taxila, just over the border of the North-West Frontier Province in the Punjab, takes its name from the village nearby where recent excavations reveal the history of kingdoms and invaders dating back to 300 B.C. and the time of Alexander the Great. Here there is a hospital carried on by the American United Presbyterian Mission, with a capacity of fifty-five beds, but for months on end accommodating over a hundred men and women, chiefly Pathans and Punjabis. About half the operations are for cataracts for which the hospital enjoys a wide reputation.

And now we visit what some think the most beautiful place in the world, the vale of Kashmir, of which the poet sang, 'If there be a heaven on earth it is here'. But beauty—though its effects are seen in the embroideries and wood carvings of birds and flowers, trees, lakes and mountains—beauty alone cannot transform a people. Into this country where oppression and misrule had resulted in a deterioration of the moral fibre of the people, the first C.M.S. missionaries came in 1864. They were mobbed, but they stayed. Dr. Ernest Neve writes:

> It is interesting to remember that Mrs. Clark carried on women's medical work before there was any other medical institution in the country; and before the end of the summer she had as many as 100 out-patient attendances on a single day.

In May, 1865, Dr. Elmslie, the first medical missionary, arrived. Following him there have been many illustrious names inscribed on the tablets in the hospital chapel. The two most illustrious successors have been the brothers, Arthur and Ernest Neve, arriving in 1882 and 1886, each giving a lifetime of service. Arthur died in 1919, but Dr. Ernest Neve is the beloved honorary consulting surgeon of the hospital and takes part in the chapel services. It is not possible to estimate the great influence of the lives of these two able and devoted servants of the Master. Their chief work was the building up, in a spirit of Christlike service, of the C.M.S. Hospital at Srinagar, and the establishment of a leper home, afterwards taken over by the state. They wrote scientific papers and books of interest to the whole medical profession and books on Kashmir that have been a help to many visitors.

Chapel of the C.M.S. Hospital at Peshawar. It was probably built long ago by a Mogul *wazir* as a tomb for himself, but may never have been used as such. (*p. 5.*)

C.M.S. and C.E.Z. Joint Hospital for men and women as reconstructed after the earthquake at Quetta. (*p. 2.*)

Dr. Gilbert, Central Asian Mission, at his embryo hospital, Shigar, Kashmir. (*p. 8.*)

The Staff of the C.M.S. General Hospital, Srinagar. Trained women nurses are not yet available in Kashmir (*p. 7*).

Dr. Vosper and
party on
a medico-evangelistic tour
in Baltistan (*p. 7*).

Sister Stapleton
and some
of the patients
she describes
(*p. 11*).

From April till the end of October each year Kashmir is thronged with visitors from all parts of India who go there to spend their holidays. The C.M.S. Hospital, and its young sister institution, the Rainawari Hospital for women, provide medical treatment for many of these. But their great work is for the Kashmiris. In the General Hospital there is treated a condition that is peculiar to Kashmir. The people of Kashmir, both men and women, wear loose woollen garments and in winter to keep themselves warm they carry under their garments a small basket with an earthenware pot containing live coals. Consequently there are numerous cases of burns, which heal and leave a scar, often akeloid, in which later on a cancer develops. Bone diseases are common, especially due to tuberculosis and diseases due to poor food and to dirt. Eye diseases also are prevalent. In the women's hospitals, of which there is another at Anant Nag, about thirty-five miles up the river, it is terrible conditions in childbirth that are most evident.

Whenever a white traveller goes to the remote parts of Kashmir, there gather round him people asking for medical relief. Away in Leh and Ledakh the Moravian Mission provides such relief.

Instead of writing of the large work in the hospital at Srinagar, the doctor has sent an account of a 'Medico-Evangelistic Tour in Baltistan':

> Baltistan is a very remote and secluded province of Jammu and Kashmir State, situated on the extreme northern frontier of the Indian sub-continent and consists of the deep valleys and lofty ranges of the northern end of the Himalayas and of the Karakoram Mountains.
>
> The Baltis of today are of mixed Mongolian and Aryan ancestry but their language is Tibetan. In religion they are now mostly Mohammedans and of the Shia sect. There are Buddhist villages but they are found near Ladakh proper, a district we had no time to visit. The country is a dry rocky land with cultivated patches here and there, the villages with their fields of barley and orchards of apricots.
>
> The great majority of the people are extremely poor. We marched a stage a day averaging about fifteen miles, and we usually got in about midday or early afternoon, allowing us good time to see patients most evenings on our outward march. While crossing the Zoji-La (the pass leading from Kashmir into Baltistan) we were caught in a storm of rain and snow, this on the 1st of July!
>
> Usually we only stayed one night at our various halts, but at two centres we stayed several days, namely at Kargil in Southern Baltistan and Shigar about one hundred miles to the north.

We crossed the Indus at Skardu and marched to Shigar. We were able to do some useful surgery here, especially noteworthy patients being two young Baltis operated on for stone in the bladder. Had it not been for our visit they would have continued to suffer for many more years. Our visit to Shigar would have been worth while for the sake of these two patients alone.

Leaving Shigar we made a further tour for eight or ten days visiting about eight other villages where I suppose Western doctors had hardly ever been before. At one of these villages the writer did a large number of eye operations giving much relief and saving eyesight.

We arrived back in Srinagar late in August, having travelled over 400 miles, seen just over 2,000 patients and done 190 operations, major and minor, and preached the Gospel in about a dozen different villages.

Since then the Central Asian Mission has begun medical work at Shigar, from which their doctor was called away for war service. He gives us the following account of a last return visit to Shigar:

The party consisted of three nurses and a doctor. The journey involved eight days' travelling in an approximately northern direction from Srinagar, Kashmir, in the course of which the party travelling on horses and with luggage on packponies, crossed three mountain passes, one 12,000 feet and two close on 16,000 feet,

The doctor writes,

It was the first time we had attempted any major operation there and it was with some trepidation that we reviewed our scanty equipment. An improvised stretcher on two packing cases provided the operating table; a clothes boiler was the steriliser for the towels and bowls and a fish-kettle steriliser over a primus stove did for the instruments. As a preliminary the 'theatre' was well watered with dilute Lysol from a watering can to lay all the dust on the mud floor. The grass mats had been taken up and were washed in the neighbouring stream before being replaced on the floor and everything was made as clean as possibie. After further strenuous preparations on the part of the Sisters we were finally ready for the first patient.

He had come eagerly a day's journey when he heard of our arrival and was waiting with a young friend to look after him for his stay in hospital. The patient was a young Balti who had suffered from a stone in the bladder for the past three years, during which time he had been treated by us and had been given the promise of an operation as soon as there

should be a suitable building and also a nurse to help the doctor. The operation was performed, and by God's grace was successful. The calculus was handed to him and, as he was carried out to the small ward, he proudly showed it to the crowd gathered round the door. He made an excellent recovery. So also did the other two patients operated on in the limited time available.

A married woman doctor of the Moravian Mission, with a family to care for, works at Khalatse and Leh in Ladakh. The removal of cataracts is one of the most satisfying parts of the work. She describes a Christian inn for travellers:

> Several years ago, Choskyid, a Christian widow without children, left her house in the main bazaar of Leh to be used as a Christian inn for pilgrims and other travellers. The original house has been dismantled and a well-built Gospel inn takes its place. Here travellers find lodging for man and beast. They can borrow cooking utensils, read newspapers and books and get treatment at the small dispensary. Since the inn was built three years ago, some 12,000 travellers have received shelter and about a quarter of these have had medical treatment. Conjunctivities and cracks due to the dusty climate are the commonest ailments treated at the Inn Dispensary. Many people get treatment for minor injuries incurred in travel, and ponies, yaks and donkeys with galled backs are also cared for.
>
> When touring in remote parts of the Himalayas, the missionaries are frequently met by people who offer them milk and refuse to accept payment as a recognition of the kindness received at the Gospel Inn or Dispensary.
>
> Although Tibet proper is closed to the European missionary, Tibetans, even from as far as Lhassa, regularly quarter themselves at the Gospel Inn and come under the influence of Christian teaching and example.
>
> We have four evangelists stationed in different parts of Ladakh and these are supplied with small medicine chests so that they can care for their families and help their neighbours when opportunity arises.

The Nursing Sister of the Rainawari Hospital writes of the contrasts between now and thirteen years ago, and states what she believes is the most constructive piece of work.

She came to the hospital thirteen years ago to do a fortnight's holiday duty, and has remained ever since, an honorary and valuable member of the Staff. She retains vivid memories of that first fortnight with its many abnormal midwifery cases requiring operation. There seemed to be much death and destruction about it. Even in her

second year there were but seven normal cases among sixty or seventy. Since then newer discoveries, especially treatment with sulphonamide, have saved the lives of many infected cases.

The woman doctor and the nurse decided that something must be done to get the women to come in time. An ante-natal scheme was begun. Small red cards were issued to pregnant women who consented to be examined, and on payment of a rupee, the card entitled them to free hospital treatment at confinement, provided they had not called in a Kashmiri midwife (dai). Gradually conditions have improved and last year there were seventy-six abnormal and one hundred and thirty normal cases, and besides many whose babies were born at home were saved from disaster through the treatment and advice given at the ante-natal clinic.

The Sister continues:

> In those days we trained Kashmiri dais in midwifery and they entered for the State examinations. When the new building of this hospital was opened in January, 1937, we started a training school for nurses, and were able to get one Kashmiri girl who had some education as a probationer. Since then gradually more Kashmiri educated girls have entered as probationers, staying for varying periods. It is still difficult to get them, and so far only Musalmani girls have taken this progressive step, but we look forward to the day when Brahman parents may be willlng to let their girls serve their country in this way.

Since the above was written a Brahman woman teacher has applied and has been accepted as a probationer. This is an event of great importance in the history of nursing in Kashmir.

> Our first probationer was a village girl who had been married early, and was later deserted, and whose baby had died during this difficult time. After she had been at hospital for six months the husband appeared on the scene, and began to try and get hold of the girl. Not only had he twice deserted her, and given her no maintenance, but we now discovered that he was arranging to sell her; so when he sued the girl in court, we determined to help her to fight the case, in which she was successful. For some months stones were thrown at the Hospital and Nurses' Home at nights and we had quite an exciting though often rather sleepless time.
>
> Through all this tribulation the girl was drawn to Christ. She found that through prayer and trust in Jesus Christ her fears could be overcome. One day she was interviewed by the head *moulvie* of these parts. When he asked her why she wanted to become a Christian she replied, 'All the love and kindness I have ever known have been shown me by Christians,

and if it had not been for them I should not have known how to speak the truth'.

This girl was baptized, and continued her nursing, eventually passing the Punjab Nurse Dais Examination, and our own hospital nursing examination. She has now been accepted as the first Kashmiri trained midwife to work under the State Welfare Association. It has long been her ambition to serve her sisters by doing midwifery in their own homes, and now this great opportunity has come.

As we look back over the past thirteen years, though progress both medical and spiritual has seemed to be so slow and difficult, yet we thank God for what has so far been accomplished, while we look forward to the further prevention of unnecessary suffering, which in our opinion can only come through the rising generation of girls with school education gaining a spirit of service. The training of these girls to be nurses is the best bit of missionary work that we are doing.

A Sister of the C.M.S. General Hospital in Srinagar describes a few sample plastic surgery cases of which she has sent a picture.

The smallest boy came in with a badly smashed leg, infected with gas gangrene. The case looked hopeless. He was given injections of anti-gas gangrene serum, the leg was amputated and a skin graft was later applied. Now he has an artificial leg, locally made, which can be lengthened as he grows.

The youth next to him had his face mauled by a bear. To get material for repairs a roll graft of skin was made from abdomen to chest, from chest to neck and neck to face.

The one sitting had a cancrum oris, his left cheek being eaten away and the teeth exposed. He also was treated by roll skin grafts, and the result is satisfactory. All these have learned to sing hymns and have understood the teaching and will take scripture pictures to their homes.

The deep affection and devotion to the people that is not uncommon in those who have given a life-service to India, has led the footsteps of Miss Newnham and Dr. Minnie Gomery back to 'the land of regrets', which is India. These two worked together as pioneer nurse and doctor in the C.M.S. Hospital for women at Anant Nag, doing most of the service with their own hands because trained Kashmiri nurses were not to be found. After retirement the two ladies have returned and are living in a Kashmiri house in a village some distance from Anant Nag. Dr. Gomery thought at first that in answer to our request she had nothing to write about, but 'after much thought and prayer' she has written in the hope that others may be found, especially of this land, to give a similar service:

I should hesitate very much about writing this little sketch if it were not done in the hope of its being a suggestion to others to follow this method of work, perhaps with modifications. There must be countless villages where there is similar need for help readily available in time of emergency, a need hardly met by doctors and hospitals miles away, or even by weekly or less frequent visits. Ours is not the only such centre, but they are few, and we wish they could be multiplied.

Miss Newnham and I retired from our many years of regular Medical Mission work six years ago, but we felt that in less strenuous and responsible conditions we might still be of use to some needy folk, and so we were led to come back to Kashmir and make our home for a time in a village, living quite close to the people. We happily found a house where we can have sufficient comfort, and accomplish that purpose too. What we do is just private and informal, independent of, but loyal to, the regular mission work in Kashmir.

The Anant Nag Mission Hospital is fourteen miles away, and the nearest State dispensary is five miles from here, and much farther than that from many of those who come to us, and both are too far for the great majority of those needing attention.

Formerly I myself used to think that people were lazy and careless who would not take the trouble to go a few miles to a hospital ready to help them, but I have grown wiser with experience.

The writer goes on to speak of the pain of toothaches, the unexpected arrival of babies, and the various illnesses of infants which are so often acute, sore eyes which are so common and need daily attention, and the various accidents where a stitch in time saves nine. Two industries, the export of walnuts and the cultivation of the silk worm, call for tree climbing and the use of axes to cut branches and consequently to falls and cuts. At threshing time a bit of the husk of the grain sometimes gets into the eyes. An increasing menace due indirectly to the war and the absence of hunters, is the mauling by bears. In the summer of 1941 nine such cases were treated; the mauling always includes the head and face, as well as other parts of the body and frequently results in disfigurement or paralysis. Attention is not limited to women and children; there are quite as many men patients.

All our methods are very simple, suited as far as possible to the conditions around us, and in the medical work we find that in most cases we can get good results with inexpensive remedies.

I think it is practicable for such simple work to be self-supporting, and it is good for the people to make a small payment for medicines. We do not receive any grants or subscriptions, with a rare exception. Our experience is that we receive enough from patients in various ways, to pay for the medicines, but that there is scarcely anything left over for our personal expenses. Being a private practitioner, I ought to make enough for at least a simple way of living, but it is difficult to make the people pay the small fees which they really could and should pay, for they have been accustomed to get so much for nothing, both in Mission and State institutions. They are not well off, but have enough to waste on harmful things.

Of course we meet with difficulties and discouragements, but we feel that this kind of life is one which our Master can use to His glory, and it may be a happy solution to the problem of some who are retiring with great regret from regular mission work. I hope younger people of India will also consider it, but I realise some of the drawbacks which would have to be faced.

Writing from Anant Nag the doctor says they have a hospital of thirty beds for women and children which serves not only the town, but a district embracing a part of the valley and stretching away to the mountains, west, south and east. Outside the town there are no trained midwives in the whole area. Practically half the in-patients are midwifery cases, of which only about a third are normal. Women are frequently brought exhausted after being two or three days in labour, with the unborn child already dead. Forceps and craniotomies for such are frequent, when a Cæsarian section earlier would have saved the baby as well as the mother. The doctor has made great efforts, fruitless as yet, to get the State authorities to co-operate in the training of midwives.

Charteris Hospital of the Church of Scotland at Kalimpong, Bengal, is at the end of the trade route from Tibet.

The road that runs past our hospital is the road to Lhassa, and along this road come long trains of mules carrying wool to India. There is a large Tibetan population in Kalimpong at all times, and during the winter this is increased very much as the muleteers and traders come down. We have a dispensary solely for the treatment of the Tibetan sick in their part of the bazaar. A great many of our in-patients are from Nepal. These men come down to India in search of cooly work on roads and bridges and get malaria very easily. The valley below us, the valley of the Teesta, is notorious for a malignant type of malaria, and it is there unfortunately that these people have to look for work. The other country which lies adjacent to our

> subdivision is Bhutan. We have a dispensary on the frontier, and we find that in this dispensary and in Kalimpong we have contact with people of this country. Three of the countries mentioned, Tibet, Nepal and Bhutan are closed to Christian missions. We meet in Kalimpong great numbers of the people of these countries, both officials and non-officials and we have always found our relations very pleasant.

In these mountainous regions there are no roads for wheeled traffic, no villages but small crofts, so an effort is made to teach responsible persons in the area to recognize the signs of illness so that they can send for help in an emergency or arrange to have the patient carried to a hospital. This usually means that some relative has to carry the patient on his back over the rivers and mountains which lie between his home and the hospital. The people of these little farms are largely Lepchas, an attractive, kindly, hospitable people. Most of the Christian community is drawn from them.

> The diseases we have to contend with are malaria, kala-azar (both very prevalent in the valleys), dysentery (due to almost complete lack of sanitation), hookworm (which infects a very high proportion of all our patients), tuberculosis (our biggest problem). We get very little surgery apart from accidents and from assaults, for all our people carry arms of various kinds, daggers, swords, or kukris and a quarrel very often leads to bloodshed.

The name of Charteris Hospital was recently in the *Statesman*, the paper having the largest circulation in India.

In co-operation with the Charteris Hospital, two English ladies whose husbands are prisoners of war, started a Blood Donation centre, which met with immediate response. Sixty per cent of the offers of blood came from the St. Andrew's Colonial Homes and others from the Church of Scotland Mission School and the industrial workers of the Mission.

From near the border of Burma Dr. Gordon Seagrave wrote the following account of his work, August 21st, 1941, before the allies were at war with Japan.

> Four years ago there was not a hospital between the Harper Memorial Hospital at Namkham in the Northern Shan States of Burma and the C.M.S. Hospital at Kunming. We used to answer medical calls as much as a hundred miles into Yunnan. Christians were very few and far between. The Chinese of Longling were decidedly hostile to 'foreigners'. People who

spoke English just did not exist. Everybody wore the very uninteresting coarse blue costume of the Yunnanese.

But this Western Yunnan constituted a most effective quarantine against disease. Only about once in fifty years did a disease spread from Burma into China to any serious extent and Chinese coolies, coming in on foot, brought in only enough relapsing fever for us to use for demonstration purposes.

Then came the 'Burma Road'.

Two years and a half ago two of our China Secretaries wanted to get to Kunming (Yunnanfu) over this road and we drove them there. The road of the Shan princes in China had been greatly improved. Some of the best engineering in the world had taken the road across the Salween and Mekong Divides and we saw Chinese engineers who had been educated abroad at work everywhere. We actually met a Chinese doctor or two. At Kunming we visited our four-hundred-mile-away 'next door neighbour', the C.M.S. Hospital.

Little hospitals began to spring up. English began to be used after the border was passed. Trucks began to roll over the two branches of the Burma Road into Yunnan, the main branch which runs to the railway at Lashio and the smaller branch, of the same mileage, which runs by the front wall of our hospital to the steamers on the Irrawaddi at Bhamo.

The American Army Malaria Commission to China settled down just across the border and turned over their work to the Rockefeller Institute. Things really began to hum. Streets were crowded with the finest educated Chinese from all over China. A Chinese university or two even moved into Kunming. Chinese Christians were more than well represented in the migration. Local Yunnanese began to adopt the more attractive garb of Shanghai. The Central Government's influence began to be felt. Many towns even had three hospitals each, one built by the Central Government, one built by the Provincial Government, and one built by the 'Southwest Transportation Company', the 'East India' or 'Hudson's Bay' Company of this part of the world. We even added to our Mission hospital staff a fine Christian Chinese doctor who was born in America, trained in Japan, and had crossed China just two steps ahead of the Japanese. After a slight initial setback the prestige of England and America as China's friends went up like a malaria chart.

But we were too important for our own good. I had been operating late one morning and was so tired I lay down for forty winks before starting for the Airplane Factory Hospital. I was having a nightmare about Japanese bombers coming to bomb the factory when my wife finally got me awake to the

fact that the bombers were real. We expected them to save a bomb for us, as seems to be customary with the Japanese, so without waiting to enjoy the beauty of the bomber formation—and it really was very beautiful—we evacuated the hospital.

Some of us piled all the surgical equipment we had, with about twenty nurses, into four cars and hurried over to the factory to sew up as many pieces as we could get together. Our wheels did actually touch a few of the higher spots in the road. Eight hours of operating, first by daylight, then by candle light, then with storm-king lamps. To a surgeon who never operated on anything worse than shotgun or rifle wounds the havoc wrought by a bomb splinter is most astonishing. Practically everyone who was running at the time the bombs dropped seemed to have been hit. Innocent exterior wounds were accompanied by conditions inside as extraordinary as were found in one lady on whom I had to do a Cæsarian section, delivering a boy with a bomb splinter wound across the instep which he had received before birth.

But bombs are not the only unpleasant result of the 'Burma Road'. We are importing disease as well as merchandise and for two years have struggled through each rainy reason to prevent our bubonic plague from being exported to China along with the munitions. From China we have had epidemic meningitis encephalitis lethargica, our first real epidemics of typhoid, and now they tell me a case of scarlet fever has appeared. The truck drivers bring some astonishing forms of venereal disease back with them. So the Mission is now co-operating with the Government in a special programme for the Burma Road, some ninety miles of which is much nearer to us than to any similar Government Hospital. We have one branch hospital on the road to the River and two others on the Main Road to Lashio, and are building now a lovely concrete hospital right at the border. The Government furnished us an ambulance equipped for dispensing work in which with a team of nurses we drive every three days along the ninety miles, visiting and supervising the work of the hospitals, giving preventive quinine to workmen on the road, dispensing to the sick who come to meet us as we pass, and conducting a drive against venereal diseases. On only two of our trips has the ambulance come back without stretcher cases. The doctors and nurses help the women as well as the men, and after all it is the women who suffer most. Our nurses, two by two, foot it to the villages off the road to bring back to the road, and to us and to our hospitals, the people of the villages to whom the road has brought disease.

The Burma Road is here to stay with all the good that it has brought to Western Yunnan. What we are doing is a

small beginning to prevent the potential evil results. No matter what Japanese plans may be it is inevitable that the Government will need much greater co-operation from us as the months pass. I hope we shall not be found wanting.

Since the above was written Dr. Seagrave, with a volunteer group of thirty-five Christian Karen and Shan nurses, was attached to the Chinese army fighting in the Shan States, where they went with their ambulances to the front line to bring back the wounded. Some of the party were later evacuated in a company led by General Stillwell, the American General attached to the Chinese Army. Some of the American Volunteer Group aviators later told an American nurse in Kunming how the nurses went with the stretchers right into the front line, and they added that they had not realized before the value of medical missions.

So we leave the frontiers of India and Burma with a tribute to the men and women who are living dangerously and in the highest degree finding their lives in losing them in the service of Christ. The barriers on the frontiers will be removed, for it is certain that 'He shall have dominion . . . unto the ends of the earth'.

CHAPTER II

HEALING MEN

'Go your way and tell John the things which ye do hear and see: the blind receive their sight, and the lame walk.'—MATT. 11: 4.

IT is a far cry from the Himalayas to Cape Comorin, near which at Neyyoor in Travancore is situated the largest medical mission in India. It is more than a hundred years ago since the L.M.S. began its medical work. It has now a large hospital at the centre and ten branch hospitals. Dr. Somervell, the senior surgeon, came to serve in Neyyoor after having had the adventure of taking part in an attempt to reach the top of Mount Everest. He has written two books of great interest about the work in Neyyoor, *After Everest* and *Knife and Life*. He says that the two gifts he brought to India were scientific surgery and Christ. His surgical work and scientific papers have been of value to the profession in India and abroad. He is interpreting Christ by word and deed through a rich and many-sided personality.

Two goals are set before the mission—to have the work entirely under a capable Indian Christian staff, and to have the Church take over more responsibility.

The Doctor writes:

> Neyyoor hospital has now over 200 beds, and among our new buildings is a block of very well-built private wards presented by a Hindu gentleman who has been attending the hospital and on whose wife a serious operation has been successfully performed. A Cancer Block has also been given to us which we hope to open within a few weeks. This was given by a single anonymous donor.
>
> The whole condition of our work is very different from what it used to be twenty years ago. We have five times as many nurses as we had then, and a constant stream of trained nurses is rendered available for jobs in other places where we hope their Christian spirit will spread the influence of the Gospel in South India.
>
> Nursing equipment is better, water is laid on all our wards and sanitation has much improved. The actual number of our patients has not much increased within the last twenty years, but we can do far more for them than we used to be able to do, and there are now operating theatres and labour rooms in six of our hospitals. One of them, Kundara near Quilon, has

itself developed into a hospital larger than Neyyoor was twenty years ago and it is run entirely by an Indian staff.

We feel that as a medical mission we have two things to do. First of all to be agents of Jesus Christ in taking His love and kindness to the world and especially to those people who do not know Him. Our second object is to give treatment to our patients of a standard which is at once Christian and scientific.

We are not running a hospital in a place where there are already other facilities such as Government hospitals. So many private doctors are now scattered through the country, we feel it is up to us to do what private doctors cannot do, namely to give our patients places where they can get good nursing and treatment as in-patients, as well as the ordinary treatment of a dispensary. This side of our work means that the surgery has developed a great deal at some of our branches, as well as at Neyyoor itself, and we are now doing nearly as many major operations in our combined branches as are done at Neyyoor. The combined total is about 4,000 major and 9,000 or 10,000 minor operations every year.

Of our twenty Indian doctors, five are capable surgeons, and can tackle any of the ordinary surgery of these parts. Gastric operations are done at the rate of about 400 every year, and operations for cancer, especially of the mouth, account for another 500 or more of the total. We have done very little rural reconstruction or similar village hygiene work, because there are other Christian agencies in Travancore, as well as the Government, capable of doing this. The distinctive contribution of our staff is the cure of disease by modern medicine and efficient surgery, rather than preventive work, and we concentrate on these with all the resources at our disposal.

Not far from Neyyoor is the Catherine Booth Hospital of the Salvation Army at Nagercoil with a family of daughter hospitals in the district. It too does a large surgical work.

The founder of this hospital was Dr. Andrews, a colonel in the Salvation Army. He was an unwanted slum child in London, accepted as a personal responsibility by the youthful Bramwell Booth, whilst visiting from door to door. He eventually became a Salvation Army missionary and was engaged in evangelistic work in the south of India. An innate propensity for dealing with sick people led him first to start a small dispensary, then to plead for a qualified person to be sent to develop the work and eventually to obtain a medical qualification himself. He founded three hospitals, at Nagercoil, Anand and Moradabad in India. He was attached to the

I.M.S. during the last war and received the V.C. posthumously in 1919.

They have in addition hospitals at Ahmednagar, Dhariwal and Nidubrolu. The Salvation Army is one of the few groups still in the stage of expansion in spite of financial stringency.

One of the finest mission hospital buildings is the new Willis F. Pierce Hospital for men, of the American Madura Mission. The Medical Superintendent writes:

> Twelve years ago our hospital for men consisted of a single building, with six private kitchens and a dry-soil latrine as out-buildings. The out-patient department, often treating up to 200 patients in the morning, was held in an open hallway in full view of the street. While there were twelve rooms for private patients, the one public ward, made by throwing together four such rooms, held only twenty-two patients closely crowded. Other patients on cots and pallets crowded the verandahs. The single room which served as operation theatre, sterilizing, anæsthetic and scrub-up room was surrounded on two sides by verandahs giving poor light but ample opportunity for the curious to 'see sights'. We rejoiced in electric lights installed the previous year but all the water for the hospital was supplied from the compound tap and had to be carried by hand. Three doctors, one missionary and two nationals, headed the staff which contained not a single trained nurse.
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> Now we have a fine hundred-bed hospital built on a rectangular three-storey plan around a courtyard with a beautiful green lawn. Three private consulting rooms, far from the noisy waiting-room and dispensary, give the out-patient doctors a place for quiet and careful examination. Six ten-bed wards for poor and low fee patients rarely have an empty bed but the verandahs are kept free. In addition, a beautiful, airy ward capable of accommodating twenty-five beds is reserved for patients with pulmonary tuberculosis. At present it contains ten hospital beds maintained and filled by the Municipality. To help the hospital maintain its finances, thirty-one private rooms of varying grades are provided. An entire floor in one block is given to the operating suites. Running water is piped throughout the building. An X-ray plant and an enlarged laboratory give aid in diagnosis and treatment. Two doctors, one a missionary and another national have been added to the staff, but the greatest gain is a nursing superintendent, nine graduate nurses and twenty-four students, all men.

The doctor tells a story which illustrates the long and patient treatment required in some cases:

He was a short, pudgy little man, a mill worker, who had all too patiently borne the pain in his back for four months. It was only when he lost all sensation in his limbs up almost to waist level, with inability to move his legs that he was sent into hospital. Physical examination, confirmed by X-ray, showed a tuberculous spine with compression of the spinal cord. For seventeen months he remained in the hospital while benevolent employers paid for his special food and treatment. For the first five months he lay prone on our one fracture bed with extension to legs and pillows beneath the chest and thighs. It was during this time that his sensation and control gradually returned. At the end of that period a plaster bed was moulded on him in this position and he was then turned on his back in it. Another six months in this position and upright in a jacket and then an Albee bone graft. Then up again in a plaster jacket, waiting till he could safely be discharged from hospital. In the meantime general supportive measures and a long struggle with a secondary cystitis. . . . Finally he was discharged with instructions to eat well. So well were the instructions followed that he developed a 'bay window', which threatened to place too much strain on the reconstructed spine. On his last visit before he returned to work his small son who had waited on him throughout his illness said:

'Sir, when he first came he had such a bulge in his back, and you straightened that all out; can't you do something now for the bulge on his front?'

The Scudder Memorial Hospital at Ranipet was erected in memory of the pioneer doctor, John Scudder. It is nearly a century and a half since the first Dr. Scudder came to India as a medical missionary. He began the work in Ranipet. A few years ago the Scudders in America and India raised money to found and to endow a hospital in his memory, and another Dr. Scudder, a worthy successor and skilful surgeon, is in charge. With X-ray and radium and an excellent nursing staff this hundred-bed hospital in its spacious wards is carrying on a fine service to the sick. It is the aim to entrust the work eventually to the care of the Indian Christian doctors.

The unique general hospital of the Welsh Mission at Shillong on the Khasi Hills is more like a comfortable English hospital than the hospitals on the plains of India. With contributions from Wales, and a generous grant from the local government the hospital was built in this capital of Assam. The Superintendent is a skilful surgeon and physician, and the hospital attracts many patients who can pay for the service rendered. It has a local Christian Khasi who is a mechanical genius and not only attends to installation and repairs of the electrical plant, but also makes much of the equipment

for the hospital. It is unique in having a well-trained nursing staff of Khasi Christian women. In the aboriginal Khasi tribes, who have so largely become Christian, matriarchy prevailed. Naturally the women have a freedom, independence and unself-consciousness that are great assets, and they are quite as ready to nurse men as women, and to undertake work of great responsibility.

Ten years ago, in Nuzvid in the Telugu country it would have been difficult to do surgery among the people of the community.

> A zamindar called the doctor in charge to his home one evening. This man was orthodox and his wife rigorously observed *purdah.* For five years the doctor had been in attendance on one or other of the family. An operation had been advised for the youngest son, a frail little fellow. The mother was at first opposed to it, but at last gave her consent.
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> Arrangements were made for the operation and a few days later the lad was brought to hospital. His father and oldest brother came with him. When all was ready the doctor prayed and asked God to give skill and wisdom in operating. The father bowed his head and was composed. When the prayer was ended another person was seen outside the operating room window in a car. It was the mother. She observed all that was going on and remained there until the operation was finished and then returned home. The patient made a good recovery to the satisfaction of all concerned.
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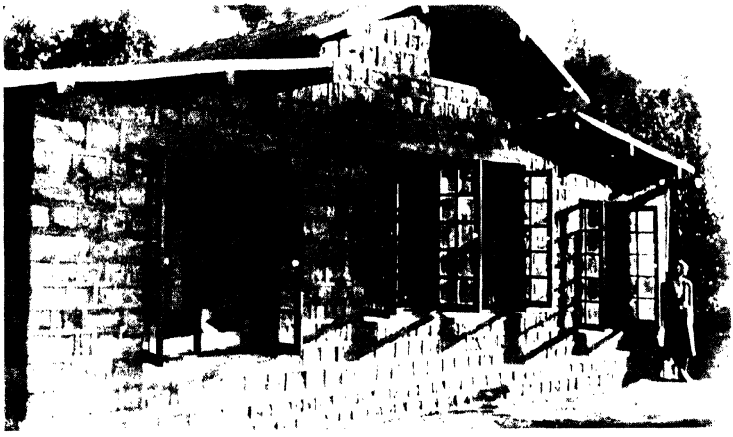
> A few months later there was a farewell service for the doctor and his family going on furlough. The zamindar attended and acted as chairman. He gave a resumé of how he and the community had watched the growth of the hospital. Then he told why he and his wife had allowed us to operate on his son. 'There were very few deaths in the institution. People no longer feared to submit to surgery. The loving care of nurses and attendants was observed. Above all, it was known that in this hospital they prayed to the great God in Heaven for their patients, whether rich or poor. This gave people great confidence that they were under more than ordinary care. This was the determining factor.'

At Miraj, a small city in a small Indian State, there has grown from small beginnings a group of institutions of great usefulness to the whole of India. The new name is the Miraj Medical Centre. It began with Dr. (Sir William) Wanless, continued under Dr. Vail, and is now under the direction of Dr. R. H. H. Goheen.

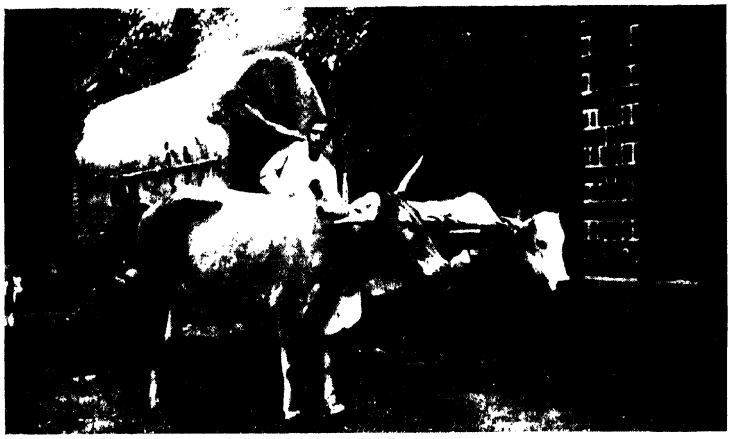
There are a General Hospital of 360 beds, with 4,615 in-patients yearly, a Leper Home for 200 patients, the Wanless Tuberculosis Sanatorium of 210 beds and a Medical School with over 100 students.

The Scudder Memorial Hospital, Ranipet (*p. 21*)

Bamdah Hospital. Selling Gospels after Service (*p. 26*)



The New Eye Hospital of the Kotagiri Missionary Fellowship (*p. 29*)



A jungle ambulance bringing a purdah lady to hospital

A jungle ambulance

This Christian boy was carried ten miles to hospital

Like a healthy plant the centre is always showing new shoots, manifest in new and better arrangements for patients and students. In the X-ray, light and radium department they specialize in the treatment of cancer; surgery has made Miraj famous; the medical section, which has grown much, is under the care of Dr. Carruthers who is the Dean of the Medical School. The obstetrics and gynecology department has responded to intensive cultivation and has an antenatal and child welfare clinic. There is an iron lung which is useful in a few cases. The laboratory does all kinds of work and has established a blood bank of its own. An increasing number of post-mortem examinations has been a help to staff and students in the study of cases. There is also a dental department. For the benefit of all employees a co-operative society has been formed.

An account of the Medical School is given in another chapter.

North of Calcutta over fifty years ago a retired Civil Servant, Mr. Munro, began medical work at Dayabari, Ranaghat, which was later given over to the C.M.S. It is in a very malarious area, and at some seasons as many as 1,000 persons attend the dispensary in a day, eighty per cent probably being cases of malaria. Three waiting-rooms and three consulting rooms are kept going to serve the multitudes. Two hospitals, one for men and one for women, have been built. Nurses training is given for registration under the Bengal Nursing Board. Some students in training for the ministry at Bishop's College, Calcutta, have spent part of their vacation in hospital service, doing menial tasks and giving the Gospel message. The doctor in charge made the constructive suggestion that a theological training class, which may be started in Bengali, should be established at Dayabari, so that hospital and seminary together might be used in training the future pastors.

At Allahabad Dr. Douglas Forman developed the finest outdoor clinic in India. Many young doctors have gone there to study his methods. In the first place, he gave the patients the best treatment possible, whether they could pay for it or not. He kept such records—and not by number but by *names*—that if a patient had once attended there his history and record of treatment was always available. A comment of a patient was 'They listen to what we have to say'. How much this means in India, where in most dispensaries a doctor has to see sixty or a hundred patients in a morning! Dr. Forman enlisted the help of other physicians in Allahabad as volunteers. One of these had served for thirteen years. Others came only till they had got all they could for themselves of the clinical experience, or till their own practice grew too absorbing.

He had a group of workers he trained himself. One became an expert in chest conditions. All were encouraged to read medical magazines, a good supply of which came to Dr. Forman when he was

editor of the *Journal of the C.M.A.I.*, and also because he arranged to pay postage on various journals sent him by medical friends. Cases were discussed by the group; new treatments were tried. Every patient who came had at least three laboratory tests done—and many had more. A class for training laboratory technicians to supply other hospitals was carried on. An instructor of this class was a professor of Chemistry who was under treatment for leprosy, and the first students of the class were the sons and daughters of parents suffering from that disease.

Soon after Dr. Forman began work in Allahabad, closure of the work was threatened for lack of funds. It was so valued that a group of friends came to the rescue and formed a committee of management to share the responsibility. A system of payment was introduced. Charges were made to suit the ability to pay. A 'pay clinic' for those who were able to pay was carried on at a certain time of day. Hours were arranged also to suit the many college students of the two Christian institutions.

It was easy for Dr. Forman also to secure voluntary subscriptions to his clinic, and out of a budget of about Rs. 28,000 only about Rs. 1,000 came from his Board.

A Health Insurance Scheme was introduced for servants and for families, to ensure regular medical attendance at a minimum cost. In connection with this work there was also a social service worker who visited in the homes. Dr. Mabell Hayes, with her village dispensary across the Jumna River, co-operated with Dr. Forman, and conducted a women's clinic in his dispensary.

The work has suffered loss with the removal of Dr. Forman's dynamic and creative spirit. His Board transferred him to another station, and shortly after circumstances led him back to America. It is hoped some day he may be able to return.

Here are a few contrasting pictures sent from the New Zealand Presbyterian Mission Hospital at Jagadhri, Punjab. They show the progress made both in provision of better wards and newer treatments.

> For thirty years in our Hospital most of the men patients were nursed on an open verandah, with the temperature in midwinter almost at freezing point. On one occasion a patient contracted pneumonia and died, much to our distress, but we could do nothing about it as we had no money for buildings. In the hot weather when the temperature for weeks on end soared above 110° at midday, they longed for a ward or a room with a nice high roof where they could get shelter from the scorching heat.
>
> Now there is a fine ward with separate lockers and wall cupboards for each patient, concrete floor, a fireplace to warm

the ward in winter, a high roof to help keep it cool in summer, rooms adjoining for storing beds and patients' clothing, and at the back a fine courtyard with separate kitchens, rooms for the patients' relatives, running water, bathrooms and conveniences —all in one self-contained block. And how did we get it? God put it into the heart of a wealthy Hindu well-wisher to present the whole block to us, complete in every detail. We waited thirty years but God has abundantly answered our prayers.

Ten years ago Gopi Ram was brought to hospital with a bad compound fracture of his leg, the bone ends sticking through his wound which his relatives had covered with dirty dressings. He had a splint applied to his leg, and every morning his wound was dressed to the accompaniment of so much pain that he almost began to wish the morrow would not come. He gradually got weaker, and finally his leg had to be amputated to save his life.

Now Som Nath is admitted with similar compound fractures of both legs. Profiting by the skill and experience of a famous American surgeon, and of the surgeons of the Spanish War, we operate and enclose the whole leg, wound and all, in a hard plaster of Paris case. The wound is not dressed for six weeks. Under the plaster covering God's healing processes are at work without interference from our meddling hands. After two or three changes of plaster the wounds are almost healed and once more Som Nath can look forward to walking. War is a terrible curse, but out of such a tragedy as the war in Spain God brought blessing to countless patients by the lessons learned and practised there.

Som Nath during his stay was much influenced by the Christian message, and when he left was a secret believer in Jesus Christ.

Government medical reports tell us that malaria is the chief cause of death in India. Although diseases of the eyes seldom result in death, they cause an immense amount of suffering and incapacity for earning a livelihood. The chief things for which operations are required are cataracts and painful conditions of the eyelids due to trachoma. Both these diseases are prevalent throughout the country, but more prevalent in North India. In many mission hospitals eye operations are performed, and in a few the numbers run into the thousands. Such is the hospital of the Church of Scotland Mission at Bamdah in Bihar.

The hospital at Bamdah, a village sixteen miles from the railway, has been made famous by the Doctors Macphail, father, mother and son, who have performed thousands of operations on the eye. If

you visit Bamdah in the 'cataract season', in the spring or autumn, you will not only find the hospital buildings full, but the compound full of people with their cooking utensils and bedding hanging from the trees. Dr. Ronald Macphail, who is now in charge of the work begun by his famous father and mother, gives a short account of it:

> The hospital is staffed by a European doctor, with an assistant of the licentiate grade, Paul Kisku, a Santal Christian. It is run on simple lines, and performs the double function of general hospital to the immediate rural area, which is thinly populated but has no other hospital within a twenty-five mile radius, and of eye hospital to a wide area, patients coming from all over Bihar as well as from other provinces. Most of the eye cases come in the cold weather months, and up till the outbreak of the present war, there have been of recent years a constant succession of ophthalmologists from the U.S.A. coming for two to three months to learn and to help. The war has of course put a stop to this.
>
> Every effort is made to make the hospital as homelike as possible to the village people, who form the great majority of in-patients. They bring their cooking-things and bedding, with a friend to look after them, and supply their own food. In the case of poor patients, who cannot supply their own food, or who have to stay on after their supplies are exhausted, a collection is made after the daily hospital service from the assembled patients and their friends and this is distributed on the spot. Sometimes the well-to-do will undertake the whole burden of feeding one or more poor patients during their stay. The custom appeals to Indian ideas of charity, and while even the poorest are fed, the cost is very rarely a debit on hospital funds.
>
> One wealthy man, belonging to a country town some eighty miles away, grateful for the restoration of sight to a member of his family, has chosen a most practical way of showing his gratitude. Every two or three years he collects all the poor blind folk in his town and its vicinity, has their eyes examined by a local doctor, loads those whose eyes are considered fit for operation on to one or more motor buses, and sends them along with two or three attendants to cook for them, and during their stay he also supplies them with food. As many as eighty blind folk at a time have on occasion descended on us in this way; and to see them alight from the bus, a long line of the blind leading the blind, with one in front who can see a little, gather with bandaged eyes a day later in a large circle in the compound to eat their morning and evening meals, and finally, in ten days' time depart, each making his own way to the bus that is to take home, is indeed a 'sicht for sair 'een'!

Two good pictures[1] give us some idea of the work at Bamdah. It should be added that the same mission has two other hospitals, Pachamba and Tisri in the same area among the Santals, a fine, independent aboriginal folk, in the midst of whom a strong Christian Church is growing up.

At Jalalpur–Jattan the hospital was for many years associated with the name of Dr. Lechmere Taylor and earned a reputation for cataract operations. Of the almost 2000 in-patients a year, 600 come for cataract operations.

> From the usual eighty to ninety patients in the wards the numbers soar during the busy spring and autumn seasons to well over three hundred in-patients. If these were all cataract cases it would be a relatively simple matter, but they cover almost the whole field of surgery and medicine. . . .
>
> While I was finishing the typing of this letter, word was brought that a man had been brought in from the foothills, some forty miles away. Yesterday he fell into a well that was being dug. He has a compound fracture of the tibia and fibula, and also of the femur. The right mandible and the right maxilla are smashed into the face, both badly fractured and the right eye is destroyed.
>
> When he arrived, sent in by a doctor, the wounds were still clogged with the earth into which he fell yesterday. He has been carried across the country all the way. Is there still a need?

The doctor of the Disciples Mission Hospital at Mungeli, C.P., writes a description of a morning round in the Hospital from which we take a few notes.

> The hospital is so full that mattresses have to be spread on the floor for the accommodation of the patients and their attendant friends. One is a patient whom the doctor found on a tour he was making to do eye work. It was a case of intestinal obstruction, dying without a chance. In spite of not having equipment for a major abdominal operation, the doctor with what instruments he had gave him a chance and was able to save his life. He now gives the doctor rupees equal to a dollar to show his appreciation.
>
> There is a trio of grandmother, daughter and grand-daughter, all in for eye conditions, the two elder women for cataracts and the twelve-year old for that very prevalent disease, trachoma. The girl waits upon the two women. The old grandmother is a bad patient and *will* remove her bandage, but in spite of this she is doing well.
>
> In the last room is a man who fell into a big vat of boiling

[1] See list of illustrations.

crude sugar and had extensive burns. He is having skin grafts, but it will be months yet before he can leave.

In the work of the British Baptist Mission among the aboriginal tribes of the hills of Orissa, we see what is largely true of all such tribes—that they are open to the influence of the Gospel. Their own religion is animism, and consists largely in the propitiation of the evil spirits of which they are in dread. While superstitions prevail everywhere they are more prevalent among the primitive tribes where education and outside influences have been little felt. The doctor tells the following story:

As has been said of the poor, so we may say of the blind—they are always with us. We in the Khond Hills are constantly seeing these poor afflicted folk and it is one of our greatest joys to be able so often to give back in some measure the power of sight.

An old man, Gupa by name, had become blind from cataracts and had heard of the eye hospital sixty miles away where they could give sight to blind eyes. He decided that this was the place for him to seek help, but how to get there was the problem. By chance he heard that some Christians were making the journey to attend the Church Union Annual Meetings. This was his chance. He attached himself to the party and so made the long journey successfully and when he arrived he found that he was not the only one who had seized the opportunity, for three other men, all blind with cataracts, presented themselves before the doctor with him. In each case the operation was performed and as the four of them waited in hospital they heard day by day the story of the Great Healer. Gupa was not a Christian, nor were there any Christians in his village but what he heard in hospital stuck, and he wanted to know more. What little he did know he told others and soon a little group were clamouring for a teacher. At first the preacher in another village went out as he found opportunity, but this was not enough. They wanted a man of their own and constantly their cry came back to the Church Union until at last a man was appointed. Now there is a flourishing Church and school in the village with Gupa, the first baptized member. With increasing difficulties arising from the war it was found impossible to keep a man at this distant place and it seemed as if the work must stop when God opened a new and wonderful way. Some months back a Labour Corps had been recruited in these hills and more than a hundred of our Christian young men joined up and are now in Lahore doing their bit. Every Sunday they meet for worship and they have decided that they must have a share in the evangelism of their own district. To this end

they have sent a request that a preacher be appointed to some new area with the promise that they will find the larger part of his salary. Thus was it possible to appoint a man to Dagesgura and give to Gupa and his friends one who could lead and teach them in the ways of God.

The Kotagiri Missionary Fellowship is a new plant of vigorous growth. Begun by two ladies who had a vision of the need it was joined by a woman doctor invalided out of her work at the Medical College for Women, Vellore, who came to reside in Kotagiri, 6,000 feet up on the Nilgiri Hills in South India.

She says in a speech delivered at the opening of their new eye hospital:

> A year and half ago when I myself was again very down, a small gift came from a friend and with that money-order was a reference to II Chronicles 25: 9, the last half of the verse. I opened the Bible and read 'The Lord is able to give thee much more than this'.
>
> At that time my hope was low and my vision dim, and it looked as if the building of an eye hospital in Kotagiri was about as remote a dream as any I had ever entertained. But sometimes God works in spite of the hesitation of mortals. This building, erected in five months time, again utters to me the words, 'The Lord is able to give thee much more than this', and I feel humbled that I ever doubted His power.

There is a local committee on which the chaplain, a retired medical officer, and others are serving with the staff of the hospital. The doctor says:

> This is a small hospital given over to a small piece of work. The three words over the entrance each have a meaning and the last of the three is the biggest of them all, 'Kotagiri Medical Fellowship.' Kotagiri has a real need of this little hospital. Medical service is the thing which we are trained to do and which we want to carry out with more and more careful technique, but the Fellowship includes the vision which is all inclusive of our human relationships in this spot and the world over, fellowship in the life of the Kingdom which is eternal—a fellowship which does not allow the eye-sight to grow dim and which does not allow the light of life to fade out of the hearts of men. So really the view from the hillside stretches far beyond this beautiful valley, far beyond the range of 200-inch mirror and telescope: it reaches up into the heart of God Himself.

CHAPTER III

WOMEN'S HOSPITALS

'And Jesus said unto her, Daughter, be of good comfort: thy faith hath made thee whole; go in peace.'—LUKE 8: 48.

IN the days when there were no women doctors in India, women missionary visitors to the zenanas began to do what lay in their power to relieve suffering. Some of them studied simple medical books or took what training they could get when on furlough. The first qualified medical woman who came to India was Dr. Clara Swain from America, who reached Bareilly in the United Provinces on January 2nd, 1870. Others followed. Fifty-five years ago there were only twenty-four women doctors in India; now, in the zenana hospitals of Delhi alone, there are twenty-six, while, besides doctors from abroad, hundreds of India's daughters are serving throughout the land.

How Dr. Elizabeth Bielby was entrusted with a message to Queen Victoria is told in *The Work of Medical Missions in India.* It was in 1881 that Miss Bielby of the Zenana Bible and Medical Mission at Lucknow determined to return to England to take a full medical course. She went to say goodbye to a former patient, the Maharani of Panna.

> 'You are going to England,' said the royal lady. 'I want you to tell the Queen and the Prince and Princess of Wales, the men and women of England, what the women of India suffer when they are sick'. She then gave charge that Miss Bielby herself was to convey the message to the Queen. She asked her to write it down. 'Write it small, Doctor Miss Sahib,' she said, 'for I want you to put it into a locket, and you are to wear this locket round your neck till you see our Great Queen and give it to her yourself. You are not to send it through another.' Miss Bielby duly reached England, when the Queen, hearing of the message, sent for her and graciously admitted her to a personal interview. To what Miss Bielby said of the condition of suffering Indian women Her Majesty listened with much interest, asking many questions, and showing the deepest sympathy. The locket with its writing was given to the Queen, and Her Majesty entrusted Miss Bielby with a kind and suitable reply.'

This incident was one of the causes which led Queen Victoria to ask the Countess of Dufferin, then proceeding to India, to do some-

thing to relieve the sufferings of the women, and resulted in the organization of the Countess of Dufferin Fund, which has many hospitals to supply medical aid by women to the women of India.

Before there were any qualified medical women in India, in 1867 Miss Engleman, who had studied midwifery 'and learned something about eyes', opened a small dispensary in Delhi. From this beginning the work grew into the modern well-equipped St. Stephen's Hospital in Delhi, a hospital of one hundred and forty beds with a training school for nurses and dispensers. Within the last twenty years, in spite of the fact that there are now two other large hospitals for women in the city, the number of in-patients has doubled, the out-patients quadrupled and the midwifery cases increased five-fold. There were in 1939, 3,100 in-patients, 40,745 out-patient treatments and 1,152 midwifery cases.

The picture of the out-patient clinic drawn from real life is rather typical of North India:

> It is 7.30 a.m., and already the benches in the waiting room are filled with patients. It is May and out-patients' service begins early, for to go home during the midday heat is well nigh intolerable. The day begins with prayer and a passage from the Bible read by one of the doctors. Then the clerk in the out-patient department gives out the medical sheets in return for the numbered red ticket which each patient received at her first visit. A few of the patients are taken in rotation into the consulting room where two or sometimes three doctors are ready to treat them.
>
> Both doctors are girls from Travancore State in the far South who have been with us for over five years. This community has responded eagerly to the movement for the higher education of women, and they are found serving as nurses and doctors in every province of India.
>
> The patients are of very diverse types and of varied incomes. Some are well-to-do Hindu or Moslem women who could obviously afford to pay consultation fees but who prefer to wait their turn and pay just the one anna a day for medicines which we charge those able to pay. There are groups of school children, accompanied by a nurse. We treat not only all the school children of our own mission, but those of the Baptist and American Presbyterian Missions too. Christian women from the various parishes are there with their children. There is a pause while men bearing a bundle on a *charpoy* come up the passage and deposit the bed at the entrance. Obscured by bundles of rags lies a woman with an advanced degree of tuberculosis of the spine. The smell of pus exuding from multiple abscesses mingles with the smell of an unwashed body.

The relatives have taken the woman to various *hakims* and local doctors and now, as a last resource, when she is in a hopeless condition, they have brought her to the Mission Hospital.

The ante-natal work at St. Stephen's is especially well developed, as we might expect in Delhi, which has the best centre in India for the training of Health Visitors. The Mission Hospitals employing Health Visitors can be counted on the fingers of one hand. A Friday morning free ante-natal clinic draws patients from distant places. Here a Mohammedan woman wearing her *bourka* steps from her closed and curtained car. There a Hindu lady in voluminous silk skirts steps from her *doolie*, a sort of chair with curtains, which is carried by men. There is a group of village women, of erect carriage. One of them carries a silver dagger, to slash the air in front of her precious baby, to keep the demons away. It is a mistake to admire a baby, lest demons should be attracted to it. This mother has already lost five children in infancy. For the fifth she had come to St. Stephen's after a prolonged labour, and the child was dead. She was told to come early for her next confinement, as she was suffering from a disease of the bones (osteomalacia) that made delivery by natural means impossible. She was safely delivered of this precious baby, a son. It was necessary for her to have a son, as her husband was threatening to take another wife. Though poor, they are Brahmans and it is important that a son perform the last rites.

Besides bone disease the anæmia of pregnancy is a second dangerous condition and, in women who live in seclusion, tuberculosis is often found. Each patient goes to the nurse and doctor for a check up, then goes to the consultation room for instruction. Students from the Lady Reading Health School and nurses in training are given clinical teaching on the cases.

The results of such clinics are seen in the more normal deliveries and the decrease in abnormal cases.

Osteomalacia has been mentioned above. In the beautiful Kangra valley of the North East it is appallingly prevalent. It is a kind of rickets and occurs in under-nourished, pregnant women, who are called upon to supply out of the impoverished resources of their constitution, a whole new bony skeleton for the unborn child. Kangra is not the only place where the disease is prevalent. It is bad in Kashmir and occurs through the whole of North and Central India, but is less in the South. Among the aboriginal tribes in Central India it is rarely if ever seen. Its incidence is greatest in the parts of India where women are kept in seclusion. They are deprived first of sunlight, second of healthful exercise in the open air, and thirdly many are under-nourished. In extreme cases the bones are quite flexible from lack of calcium, the pelvic outlet is

contracted, the legs and arms are painful and deformed. This disease is the most frequent cause of difficult labour, for which Cæsarean section has to be done.

A nurse connected with the Canadian Anglican Mission at Palampur has made a study of this disease in the Kangra Valley and has done much propaganda as well as treatment for relief. No remedy is more effective than cod liver oil, with its very high vitamin content. The Norwegian Red Cross had become interested in her work and gave one or two barrels of the oil, from time to time. Now because of the war many patients have to be told there is none for them. But substitutes are being found such as red palm oil, shark liver oil and other fish liver oils.

The following case described by the doctor at Dholpur, Rajputana, is typical of an advanced condition.

> Savitri was brought in about 10 p.m. one night having been in labour all day with local women unsuccessfully trying to deliver her. She was lame, and very small and rested her hands on her knees as she walked. She had had other diseases but in a six-year interval had contracted osteomalacia and now Cæsarean section was the only hope. This was done in spite of all the risks of sepsis. Labour was well advanced. The baby was delivered with difficulty but soon began to breathe. The mother recovered from the operation and all precautions were taken against sepsis and treatment with sulphonamide was begun at once. The wound did go a little septic, but after a short delay it healed perfectly and made a strong scar.

It is interesting to note that the hospital at Dholpur was built by the Rajah of the State many years ago in consequence of the operation of Cæsarean section performed by Dr. Mary Raw, a British Baptist missionary. Except for the salaries of the missionaries and evangelist the hospital has been maintained by the State.

Relieving the suffering of women in childbirth is one of the great functions of hospitals, especially women's hospitals, in India. It is estimated that 200,000 women die each year at childbirth from preventable causes. All mission hospitals tell the same story of how, at first, only the desperate cases were brought, and it is only through years of patient work and education that the preponderance of normal over abnormal cases is attained.

No matter how good has been the medical course nor how many midwifery cases the young missionary doctor may have conducted during her house-surgeonship, her experience leaves her unprepared for the kind of cases she will meet in India. The text book of midwifery she may keep at hand, even if she has a chance to consult it in emergency, is of little help. As few of the mission hospitals are in large cities there is no consultant available. She

must do her best. She sends up an urgent cry to God for help. She tells herself that unless she can help the patient there is no other person available who can, so she goes ahead and, in the work that requires all her physical as well as mental power, she forgets herself and her fear. It is discouraging to lose a case, after a desperate struggle, when the only consolation is that she has done her best, and has had an opportunity to urge the need of bringing such patients in time for treatment. When a life, and possibly two lives, are saved the young doctor thanks God that she is a woman and in India. There is no part of the work that is a greater test of courage than abnormal midwifery cases.

Not a few women who came out without medical training, have taken a medical course in India or abroad and have come back to serve. The most notable of such is Dr. Ida S. Scudder, the story of whose life has been written by Dr. Pauline Jeffery. There is told with dramatic power the story of how in one night three calls came to Ida Scudder, to help in desperate cases. Her father was a doctor, but they would not have a man. She writes:

> I could not sleep that night—it was too terrible. Within the very touch of my hand were three young girls dying because there was no woman to help them. I spent much of the night in anguish and prayer. I did not want to spend my life in India. My friends were begging me to return to the joyous opportunities of a young girl in America, and I somehow felt that I could not give that up. I went to bed in the early morning after praying much for guidance. I think that was the first time I ever met God face to face, and all that time it seemed that He was calling me into this work.
>
> Early in the morning I heard the 'tom-tom' beating in the village and it struck terror in my heart, for it was a death message. I sent our servant, who had come up early, to the village to find out the fate of these three women, and he came back saying that all of them had died during the night. As a funeral passed our house during the morning, it made me very unhappy. I could not bear to think of these young girls as dead.
>
> Again I shut myself in my room and thought very seriously about the condition of the Indian women and after much thought and prayer, I went to my father and mother and told them that I must go home and study medicine, and come back to India to help such women.

As the Principal of the Missionary Medical College for Women at Vellore Dr. Scudder has devoted her life to training Indian women for Christian medical service, a fuller account of which work is given in a later chapter.

The following incident shows how a young doctor met her first difficult case, and what improvements have been made since then to enable her to care for others.

She had just arrived in Amballa, Punjab, to take the place of an old and experienced doctor who had retired. Weary from the long, hot, train journey from Bombay she lay down to get a little sleep, but was summoned to the hospital to an emergency case. She writes:

> The patient had been in labour four days. She had been hopelessly mangled by untrained midwives. Her septic condition was all too evident. When I walked into the operating room, it was completely dark outside. At the patient's head hung a kerosene lantern on an irrigating stand. Sister sat beneath it giving the anæsthetic. At the foot of the patient a petrol lantern attempted to throw light into the cavity we had to repair. No training at home had prepared me for the shock of that mishandled case, the serious results, or the darkness and inefficiency of our operating room.
>
> I soon learned that such cases would not be uncommon and that it was amazing what one could do by feeling in the dark. Those next few years all babies came at night, it seemed to me. And the last baby born the night before our long-prayed-for electricity was turned on, was delivered by the light of a bicycle lamp (the nurse had forgotten to put oil in the lantern!)
>
> It is the same operating room but a new coat of enamel has made its face brighter by day, and an excellent, overhead electric lamp (though home-made) gives us an almost shadowless operating field. The doubts and fears that always lurk around the edges of such serious cases are pushed a little farther back, and we are thankful for this change. The spinal anæsthetic, used almost entirely now, would have been a blessing then, especially with the lantern light and the old drop ether method, with its potential danger.
>
> A bright new delivery room with modern table replaces the home-made germ-catcher which we had inherited from ancient days. Good light and a fan make the room more comfortable for patients as well as doctors.
>
> A new obstetrical ward is just being completed in memory of our founder Dr. Carleton. We have come a long way from those first days when she had only one untrained sweeper's wife as an attendant. Now we have thirty nurses in training and three assistant doctors and many other staff members. No one came to Dr. Carleton at first in her bazaar office. It was scandalous for a woman to leave her home, and the shining instruments were a constant source of fear. The third patient

I scheduled in this hospital for operation disappeared quietly during the night before. Now no one has run away for years. It was once the common way to avoid the payment of a bill. Now a proper bill (sometimes very small) is presented to all patients and paid to a competent clerk in the office.

The doctor notes the loosening up of *purdah* customs:

Perhaps the most remarkable thing is the way so few women observe *purdah* in the ward where originally a man dared not show his face. We even have a man doctor (in charge of our leper home) who visits freely in the hospital rooms and even operates on many cases. Our latest addition is a male laboratory technician. We had always girls before, but they just will get married and leave us. I was highly amused three days ago to see a *purdah* woman with her veil lightly drawn, but proffering a hand for a blood examination. I said, 'Oh, let me take your picture'. I thought it amusing to record. But when I brought the Kodak she insisted on uncovering her face, and I had to draw her veil again to recapture the effect I had first seen and desired!

One of the most troublesome results of a prolonged and difficult labour, seldom seen where women get good care, is a vesico-vaginal fistula. It sometimes requires repeated operations. A case and its results are described.

It had been a difficult time, but the child had been born, though it had soon died and now she was left with this affliction, that the *hakim's* medicine seemed powerless to touch. How could she endure life like this?

One day her husband came back from visiting his brother in his village and told her that his brother had heard from a man who had heard from someone he met in the big bazaar town that a woman with a complaint like hers had been cured at the mission hospital in the big town of the district. Yes, the cure had lasted and the woman was working again since she was back at home. They had put her to sleep and put stitches in and all the trouble had gone.

Well, the town was a long way off, but was it not worth trying even if it was difficult to manage about the children and to leave the house and buffalo? They went and she, too, was cured; and now the news that such treatment is possible is filtering through the villages and others have followed the two.

From the Report of the Women's Hospital at Akbarpur, U.P., we take the following incident entitled 'Too Late':

One hot and dusty day there came at midday a call from the verandah, 'Miss Sahib, come at once. My wife is ill with

high fever. Ten minutes to catch the train. Please come quickly'. A hurried packing, a short ride in the train, and a long ride in the blazing sunshine on a jolting *ekka* (two-wheeled cart) bring us to the village. What a sight met our eyes! It was a plague encampment, and the whole village was living in straw huts, in one of which was lying a woman in the grip of plague, delirious, and about to deliver a child. 'Why did you not tell us this was plague?' we asked, thinking of the medicine we might have brought if we had known. 'We thought you would not come if we told you.' But it was no time for talk. We set to work and did all that was possible in the circumstances, but after four hours' hard work we saved neither the babe nor the woman. As she passed away, amid wails and shrieks from the crowd gathered outside, we wondered whether it was worth it. But having with great difficulty persuaded two men from the crowd to accompany us to the station, this is what we heard, told over and over again by one man to the other—'They arrived at noon. They hadn't any food. They gave this medicine and they gave that. They did all that was possible, but we did not call them soon enough. . . .' So perhaps after all it was not in vain.

In another chapter there will be some account of the Women's Christian Medical College at Ludhiana. Here we have a picture of what *was* and what *is* in the maternity department of the hospital.

It has meant a long and persistent grind on the part of those who through the years have worked in the maternity block. I can still remember the chill of horror as I heard a man say, 'Yes, she has been in labour in our village for three days, and three doctors and the butcher tried all they could'. By the time I could get to the patient their best had proved too much for her.

In those days perhaps once a week a patient would be brought in a dying condition, but the systematic training of the *dais*, the work of the health visitors and the teaching of antenatal clinics is having its effects as statistics show. One patient recently said in a reproachful tone after a difficult time, 'And I did attend your clinic'. On enquiry it was found she had attended only once, some five months previously.

Statistics show wonderful progress since 1927. The ratio of abnormal to normal has been reversed; the number seen and attended at home has more than doubled; while the maternal clinic has grown from nothing to nearly 17,000 attendances.

After describing some of the terrible cases she had seen as a result of the work of the ignorant but well-intentioned midwives an Indian doctor of Kolar shows how she used such cases as a talking-

point. In some cases she threatened legal action against the *dais*, By persuasion and threat she has induced many of them to bring in their cases without interfering too much. She says, 'I am glad to say that neglected cases are nearly eighty per cent less now and the *dais* are my good friends'.

> The antenatal clinic of the out-patient department also has improved. Formerly it was a task to get the expectant mothers to attend. Now they come voluntarily.
>
> Another department that I want to improve is the Healthy Baby Clinic. Still the mothers are not convinced of its great usefulness. Perhaps when we have our public health work started and our health visitors pay visits to the homes and explain at leisure the value of baby clinics, this part of the work will improve.

About fourteen years ago Miss Karney of the C.E.Z. Mission came to Talawa, Ceylon, to do voluntary service in Christian education, but she found such terrible need of medical work that she, a trained midwife, began to help the expectant mothers. Because the outlook was so depressing she challenged the situation by calling her place The House of Joy. Her coming made a great difference. In 1930 there were seven maternity cases; in 1940 over 366, with a new centre opened. She writes:

> In the twelve years or so, during which we have done maternity work in this province, the improvement in the health of the patients has been marvellous. When first they came to us, swollen and anaemic, with weak hearts, collapses were common. I have spent many hours sitting by a collapsed patient anxiously watching and praying.
>
> Lately I have noticed the improvement not only in the ability of the women to face the ordeal of labour, but also in the health of the expectant mothers. When our Indian doctor came to us about ten years ago she said despairingly, 'I have not seen a healthy woman since I came.' A few months ago a medical officer who was examining our patients said, 'I have never seen such a lot of healthy women in this Province'.
>
> There are many cases deep in the jungle or far away from a hospital where the baby cannot be born without help. Then they come running to us and we send the car down as far as it can go, and a stretcher to carry the patient through the jungle, and bring her to our hospital. We have saved many lives in this way.

Miss Karney is now seventy-three years of age, and her friend and colleague who carries on work at the other centre is nine months older. They are two heroines.

A doctor who has spent a lifetime of service in the treatment of women and children at Narsapur in the Godavary delta also says that in her earlier years she rarely had a normal case to treat. Women used to come in after three or four days in labour. It was the custom to give large doses of crude calomel when the pain began. This was injurious and sometimes fatal to the child and even to the mother. Ante-natal work is now carried on and conditions are improving. Women come earlier and receive treatment for conditions that threaten their safety.

Reviewing the work of eighteen years, a doctor of the Basel Mission, Udipi, finds the greatest change in the midwifery work. After describing how calls came only after long delays she says:

> To reach the house we might have to walk a long way across the paddy fields or go for hours in a boat up or down a river. Finally we would find our patient lying on a mat in the corner of a dark room, surrounded by a crowd of noisy women and children, who had gathered from the neighbourhood to see what was happening. To drive away this crowd was the first difficulty and a second was to find a clean bench or table on which to place the patient for the operation. At last the nurse who accompanied me would start the anæsthetic and I the operation. . . . In these early years the infant mortality was not less than forty per cent. After we had finished the operation and settled the patient on a clean mat, we had to leave her to the care of a neighbour or of a relative and to hurry back to the hospital. No wonder that many women fell victims to puerperal fever.
>
> Gradually people began to bring patients to us, if the labour did not progress normally at home. We could then operate under the best conditions and afterwards give to the patient all the treatment and nursing she required. That was indeed progress, but things have improved still more in these last years. Now women come more and more to consult during pregnancy, and if there is any reason to fear a difficulty they readily follow our advice and come to hospital for confinement. These last years most of the cases we have had in hospital and in homes have been normal.

An interesting account of the contrasts of the present with ten years ago comes from the Basel Mission Hospital at Gadag-Betigiri. The bug-infested, heavy black beds, the scant supply of linen, the soiled garments of the in-patients, the swarming of friends and relatives in and under the beds, the crowded quarters for both patients and nurses—these have all been changed. The hospital is one of the very cleanest in the land. Bugs are rare, the beds are

kept painted white, there are plenty of sheets and clothes for the patients, and the laundry is done in the Mary Magdalene House so that the clothes come back a joy to behold; the patients' friends are excluded to a great extent; alterations and additions have been made to buildings and a nurses' home erected. A pump for the well provides water for daily baths, but there is still a fight to keep windows open for fresh air.

Owing to the exigencies of the war, the Basel Mission hospitals have been in straitened circumstances. They have made this an occasion for special prayer, and like the Macedonians of whom Paul wrote 'in a great trial of affliction the abundance of their joy' has been evident. They have been able to carry on their work in a spirit of joy and gratitude to God.

The work of the C.E.Z. Hospital at Khammamett also gives us a picture of contrasts. The medical work was begun by non-medical missionaries in response to appeals for help by the sick. They gave out simple remedies outside their bungalow. The numbers increased and they gave one room of their three-roomed house for a dispensary. In response to their request for a doctor, Dr. Mary Longmire arrived in 1902.

> The 'Hospital' was then only this small inconvenient building. The only helper was a widow with two children and no medical training; water had to be carried from a mile away. And there was practically no other medical aid within a radius of sixty miles.
>
> Dr. Longmire prayed, schemed and scraped for a proper hospital block. Although the need for medicine was so very great yet the people of Khammamett were still very suspicious. She had a hard time to win their love and confidence. On one occasion she nearly lost her life when out in the town going to visit some sick person. A man ran after her rickshaw and tried to stab her with a long knife. Fortunately, she was able to grasp the man's wrist, and, having a strong hand herself, averted the danger. On another occasion, when cholera broke out in Khammamett, she had to go alone to the stricken homes as no one would go near the people. She had to treat them and also nurse them. Lots of the stricken died, and then a fresh difficulty arose. No one would bury the bodies. They were thrown out and left and Dr. Longmire herself had to go and drag these bodies and bury them as best she could.
>
> After this the love, gentleness and goodness of this doctor won all hearts, and so the hospital passed through its first trying stages to the second stage when confidence was put in the doctor and the hospital.
>
> When she retired in 1929 the hospital had fifty beds for

women and children. Dr. Longmire was the first and only English missionary doctor to be sent to work here in Khammamett. The people still remember her and love her. In February, 1938, she was taking a deputation meeting, speaking on behalf of Khammamett, when at the end of her address she fell down unconscious and died the same evening. We believe by her spiritual presence she still lives to help the work and the hospital that she loved so much. The hospital now has a hundred beds and is also a training school for both nurses and midwives. Just as Dr. Longmire was an outstanding pioneer English doctor, so the one to follow her is an outstanding Indian doctor. Truly the mantle of Dr. Longmire has fallen on the present doctor. Let the once suspicious people of Khammamett speak for themselves. When they were told on one occasion that the doctor could not come to the dispensary until late they said, 'If the doctor cannot see us today then we will come tomorrow; for one word with the doctor means far more to us than any of the best medicine that could be given to us'.

At Krishnagar in Bengal missionary work has been done for the past 106 years. Medical work has been going on for fifty-two years and in that time many social customs have changed.

> Even up to six years ago a Brahman cook had to be kept for Hindu patients, but that is no longer necessary. Eighteen years ago, after attending a confinement case the doctor was regarded as defiled and the patient's relatives would guard themselves against coming in contact with her or anything she had touched. When invited to a Hindu wedding, Christians were fed separately; now they sit with other guests.

Twenty-two miles from Krishnagar, off the railway and in the jungles, with roads impassable for wheels in the rains, is another hospital where a missionary doctor and her staff have been working for twenty years. Besides the centre there are now two branch hospitals specializing in maternity and child welfare work.

> There are many changes since this Mission began. One of the most striking is the change in the attitude of the Mohammedans in the nearest village. While far from accepting the Christian religion they are no longer our bitter enemies; they look upon us as their friends, bring their patients into the hospital and there listen to the message. Once they would have deliberately refused to listen.

A few years ago a group of missionaries had a vision of the need of a community hospital at Landour, a hill station in the Himalayas to which every year hundreds of missionaries resort for

their holidays and where there is a very large school carried on by the Missions chiefly for the children of missionaries, but to which Indian children of various communities are also admitted. Besides the families who reside in Landour there are a great many servants, and besides the servants a great many villagers from the neighbouring hills who leave their homes and come in to do coolie work during the season.

So a co-operative venture was undertaken by the families paying a stated monthly sum, and receiving in return medical treatment at reduced rates. At first work was carried on in rented buildings, but now a compactly built hospital has become an accomplished fact.

The superintendent tells us of one of the village women who benefited by the treatment there. It has become a current belief that the patients of the missionary community in Landour make wonderful recoveries at times because they are prayed for.

The woman in this case showed a faith and independence that perhaps were born of her desire and her hope. Such faith is not altogether rare among the women. Added to their faith they sometimes show an admirable quality of courage. Here is the story:

> A hill woman came from a cottage hardly daring to hope that she might have the joy of nursing a living child. Beyond middle life, it was twelve years since her last child had been born. Several had died at birth. Meantime she had developed osteomalacia, and recourse to Cæsarian section was the only means to help her. She trustfully placed herself in the doctor's care, but her husband, with less faith, refused to consider operation. Strange to say, he did not take her away during the four weeks of waiting. Perhaps after all he had a grain of faith. Anxious days followed the operation, but the mother's hold on life was strengthened by her deep satisfaction and joy in her babe, and she never realized how nearly she had been robbed of her treasure. It was a joyful day for the father when he was able to take his new daughter and his happy wife back to the village.

Another example of courage and faith comes from the Kalyani Hospital, Madras.

> We have recently had two ruptured appendix cases. The first, a young woman, was brought in while her husband was away at work. It was too far to send for permission to operate. So the elder sister and the patient took it into their own hands. At noon we operated and in the evening the husband arrived and scolded the poor woman very severely. She, however, in all her pain and weakness, sent him off saying that if she had not given permission she would be dead by now. She made a

very good recovery, although a little worried that her husband never came back to see her. But at the end she told me he came at last and they had made it up. I thought it most unusual and very brave for her to take responsibility like that.

Among women and children in India burns are unfortunately not infrequent. An open fire in the cooking place on the floor is a constant danger to be guarded against. The thin cotton *saris*, draped so gracefully to form skirt and head covering, easily catch fire and the flame spreads rapidly. The immediate result of extensive burns may be death from shock, or a secondary infection may be superimposed, as in the case reported below. Or the wounds may heal with resulting contractions of fingers or limbs, or adhesions as of the arm to the side of the chest.

From Allahabad comes this incident:

> One morning, a few years ago, a young Brahman walked into my consulting room and said, 'Doctor, Memsahiba, I want you to come to my home and see my wife. Sixteen days ago she got burned badly. We thought she was getting along all right but since yesterday she cannot open her mouth. She cannot speak or take any nourishment. Please come and save her because last year I paid Rs. 500 for her.'
>
> I was not surprised when I reached his home, in a village six miles away, to find that his young wife had tetanus complicating bad burns over the arms, thighs and abdomen. Her clothes had caught fire when she was cooking. She was in a dark room, her face unwashed, her hair matted, and a thick quilt was over her although it was warm weather. An immediate injection of tetanus anti-toxin was given, and repeated at intervals for several days. The patient was cleaned and made comfortable with a mosquito net to protect her from flies and mosquitoes. At last, when she was receiving the last of 60,000 units of antitoxin into her vein she mumbled, 'Oh, I can open my mouth'. She recovered, and though promise of payment had been made, it was only fulfilled after the harvest of the following year, when the husband brought Rs. 9-15-0, three water-melons and nine cucumbers.

It is not always the physically sick we have to treat, for so many come who are in need of mental health. We are realizing increasingly the need of a few Christian hospitals, one in each of the great language areas, to specialize in the treatment of nervous diseases, especially border-line cases. The outstanding need for treatment for tuberculosis and leprosy have been fairly met by Christian bodies. But as yet, though in several provinces the question has been discussed, no practical result has been reached in the establishment of a clinic for nervous diseases. Here is a sphere of service calling

for understanding sympathy and patience and the relating of the soul to God, the source of 'saving health'.

Writing of such a patient a doctor says:

> One case will ever remain in my memory. She came to us after two years of treatment from doctors and *hakims.* Wandering in mind, sleepless, listless, no light in her dull unresponsive eyes. It looked almost hopeless. What could we do that had not already been done? A few medicines, an occasional injection, much love and constant attention. In five days we had her sleeping, in six more we had her walking round the hospital: and from that day she never looked back. She read, she worked, she began to take an interest in the hospital. About six weeks later her husband came to take her home. He said, 'I have not seen her smile for a year and now she even laughs'. This could not have been accomplished without the patience and perseverance of the nurses, and surely it was Christ working through them that enabled that life to be transformed.

Less than three per cent of women can read, and these are chiefly in the cities. The treasures in books are to them unknown and therefore not desired. It is fortunate that during the last decade much has been done in selecting a basic vocabulary, and promoting the teaching of reading by simpler methods. The best known of the methods bears the name of its originator, Laubach, a Christian missionary who worked in the Philippines. His book *India Shall Be Literate* has aroused new interest. The length of time some patients have to stay in our hospitals, sometimes affords an opportunity to teach the patients to read. The two following incidents are from the Methodist Mission Hospital at Madras.

> Last year a young Christian woman was sent in from a distant village. She was suffering from severe anæmia and toxæmia of pregnancy, so we decided to keep her some months until the delivery. Meantime our Bible-woman began to teach her to read from Laubach's chart, and very soon there was a marked difference in her face. Instead of frowning she was now all smiles and used to show me with pride the new words she could read and write. At last the infant arrived, and in due course she was sent home with a Gospel which she was able to read, very proud of her baby and her new accomplishment.
>
> Recently, however, we tried to teach another young woman to read. She had to remain with us for a long time. There would have been ample time for her to learn. But she absolutely refused on the grounds that if she once learned to read we should make her a Christian.

In closing this chapter we mention a few of the other outstanding hospitals for women.

Bareilly will always be remembered in the history of medical missions in India, as the place where Clara Swain began her work, under the American Methodist Mission. Two Mission doctors, man and wife, are now in charge, and the Clara Swain Hospital is lifting up its head again in hope after a decade of changes and discouragements. Here are a few statements from an article on the work:

> On our arrival we found a huge compound, a magnificent historical past, and long lines of sorrowful buildings. We found a staff which welcomed us with open arms and told us to regenerate the institution. We found evidences of those who had laboured here in previous years, valiant nurses and doctors whose health and spirits had broken so rapidly that the record of their mortality was rather disturbing.
>
> We brought several tons of hospital equipment and supplies with us from America. Every bit of it was needed. The hospital is now performing creditably the modern major surgical procedures. Equipped with gas-oxygen anesthesia apparatus, blood transfusion apparatus, all kinds of surgical instruments, sterilizers, the services of a skilled nursing staff and a team of four doctors, operating is becoming a matter of precision and speed.
>
> We can report a fine beginning for the new men's department of the Clara Swain Hospital. Men have not been slow in availing themselves of these facilities, and the word that they are welcome here has been spreading rapidly through the whole district. A male nursing staff has been provided, is already functioning efficiently, and finding quite a sufficient amount of work to do. We have been impressed by the profound change in the attitude of *purdah* women patients toward the doctor sahib. Most of them do not object to his presence as the staff make daily hospital rounds, and some specifically request that he examine and treat them. His surgical activities have been entirely unhampered in this respect.
>
> Plans are being worked out for our new hospital plant proper, to be built in one part of the huge hospital courtyard. We are firmly convinced that as Jesus was the Master Physician, we can become like Him; that as He demands our moral and spiritual perfection, so also He demands our medical and surgical perfection. We find great joy in following in His footsteps.

At Brindaban, under the same mission, there is a fine set of buildings called the Creighton-Freeman Christian Hospital. Like Bareilly it has suffered for lack of continuity of staff, but it too is lifting up its head again and will continue its nurses' school and other work. It is in the midst of one of the holy places of Hinduism,

where there reside thousands of Hindu widows who have come to serve the temples by chanting hymns. It was their need of healing that led specially to the enlargement of the dispensary to a hospital many years ago. The text appropriate is, 'Pure religion and undefiled before God and the Father is this: to visit the fatherless and widows in their affliction and to keep himself unspotted from the world.' There have been widows who have found here a new way of life. It was here, at the hospital, that a Hindu religious leader and philosopher was so moved by the love he saw that the last barriers were broken down and he saw and received Jesus as Lord.

In the city of Bhiwani, situated on the edge of Rajputana desert, in a dry and thirsty land, subject to frequent dust storms, over fifty years ago lived two women missionaries, Miss Angus and Miss Theobald. They spent most of their time in the homes of the people making contacts with the women. They began to pay weekly visits to the municipal hospital; and it was the absence of women—especially of caste women—from the hospital, together with the suffering they saw in the homes, which induced them to ask their mission to send a medical worker. In 1891 the two ladies welcomed Dr. Ellen M. Farrer.

Dr. Farrer retired in 1933 after forty-one years of service. The hospital, now with a capacity of one hundred beds, and training classes for nurses, compounders and midwives, has been called by her name. We reproduce a picture of the gateway. A strange text—yet not so strange—was painted in Urdu, Hindi and English on the first hospital wards erected:

> God shall wipe away all tears from their eyes and there shall be no more death, neither sorrow nor crying, neither shall there be any more pain: for the former things are passed away.

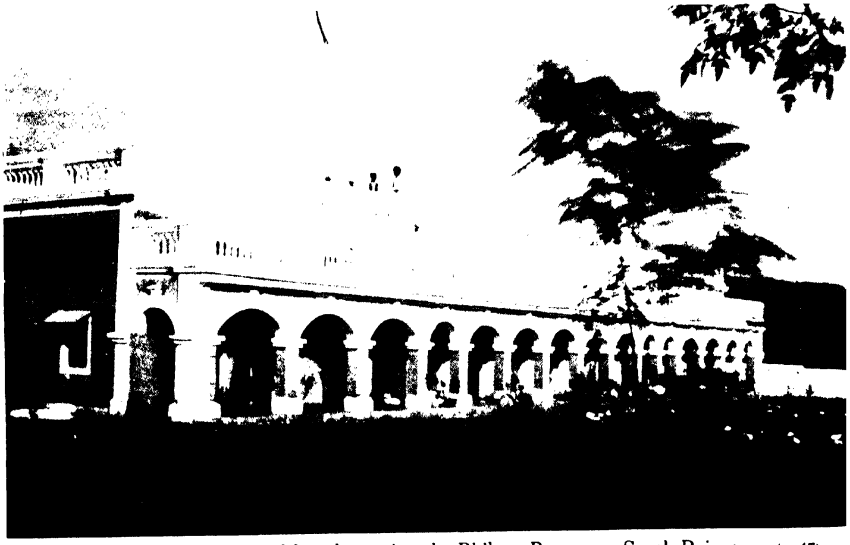
The Farrer Hospital has received many generous donations from Indian friends, among whom is Sir Chhaju Ram, who has built another hospital for women in Bhiwani. Another donor was Rai Sahib Kishen Lal Jalan, who built an eye-hospital. 'The generous action of these two gentlemen may be rightly accredited to Dr. Farrer and Dr. Bissett, who inspired in them the spirit of public service. Were it not for the presence of these two hospitals, the work at the Farrer Hospital would have become overwhelming'.

And what shall I say more? For the time would fail me to tell of the many hospitals set up in Christ's name and for His sake in India by women of far-off lands—the large new hospital at Sialkot in the Punjab carried on by the U.P. Church of America; St. Catherine's of the C.E.Z. at Amritsar with its rural daughter hospitals; the fifty-year old Kinnaird Hospital at Lucknow of the

The Holdsworth Memorial Hospital for Women, Mysore (*p. 47*)

The Gate of the Farrer Hospital, Bhiwani, Panjab (*p. 46*)

Bible-women and patients in the waiting room of the dispensary, Sriratnapur, Bengal (*p. 41*)



A Canadian Mission Hospital largely serving the Bhils at Banswara, South Rajputana (*p. 47*)

Zenana Bible and Medical Mission with its loyal, faithful and beloved staff; the long-established Church of Scotland Mission hospitals in Nagpur, Poona and Madras; the American and Canadian Baptist Mission hospitals in the Telugu country; the five hospitals of the Canadian United Church in Central India; the American Madura Mission Hospital and many others, most of them serving rural areas in more than a hundred centres.

The spirit that characterizes them is seen in a foreword to the report of the thirty years' work of The Holdsworth Memorial Hospital of the British Methodist Mission in the city of Mysore:

> Not many are now left who can recall the fear and distress that prevailed in India when the dreaded bubonic plague made its first appearance. In Mysore City few homes were unvisited by disease and death. Into the lowliest of those homes Mary Holdsworth came like an angel of light. She sat with the frightened women, wept with them in their bereavement, helped them, as only a woman could, to get their homes into a more sanitary condition, and taught them to sing songs of trust and hope. But as the sad panorama of human suffering passed daily before her eyes, she felt that only a Home of Healing could meet needs that would remain after the plague had run its course, and so she set herself to devise a scheme for a hospital for women and children. Plans were prepared, and possible sites inspected before her return to England in 1901. There she, who had comforted so many in their suffering, was herself called to suffer, and she died before the hospital was built. But the plans passed into the capable hands of the Rev. G. W. Sawday, and his skill and devotion have made the hospital what it is—a Home of Compassion.

From such homes of compassion the comforting word is given still, in the spirit of the Master who said, 'Daughter, be of good comfort, thy faith hath made thee whole: go in peace.'

CHAPTER IV

CHILDREN

'Of such is the Kingdom of Heaven'

THERE is a terrible wastage of infant life in India. Even though in the larger cities conditions have been improved by the antenatal and child welfare centres, and by the better training of midwives, the mortality of infants in British India stands at 162 per 1,000. In Delhi, in the area served by the Centre connected with the Health School where it has been possible to get accurate statistics, it is stated that there has been an increase in the mortality rate per 1,000 from 161·4 in 1939 to 181 in 1940 and 221·7 in 1941. The second figure is accounted for by more accurate statistics. The third is unaccounted for. Compare this rate with that of England which is 59, and of New Zealand, 31, the lowest in the world. Ignorance, poverty (which means malnutrition), indifference, fatalism and lack of medical aid are the basic factors. The first risk the baby runs is from undetected antenatal conditions which may endanger its coming into the world. After its arrival, the cord is cut, without antiseptic precautions, with a sickle or old knife. Tetanus or erysipelas may result and cut short the little life. Or the failure to disinfect the eyes may result in gonorrheal infection.

If the mother can nurse her baby its chances of survival are good. But if she cannot its chances are small, for the danger of infection from dirty bottles and nipples and the ignorance in regard to artificial feeding, are great. Added to this are the infections caused by flies and mosquitoes—dysentery and malaria. Little children are often seen in the bazaars, sitting on verandahs with several flies at the corners of their eyes. At the beginning of the rainy season when all forms of germ and insect life multiply in abundance, eye infections are rampant among children. 'Eyes have come' is the usual way of announcing the condition. The polluted water supply is always a menace, bringing dysentery, typhoid fever and cholera. The first rains wash the night soil off the river banks, and water is drunk without being boiled. If the child is suspected of having a pain, it may be branded, with hot iron. Though vaccination against smallpox prevails to a great extent, yet many omit the precaution and the children fall victims. There is a certain feeling of fatalism, as the disease is attributed to a special goddess whose wrath has to be appeased by appropriate offerings. Within a furlong of a hospital to which she had often come, a mother allowed her child to go through smallpox with no medical attention. The child became

blind, and grew up in idleness and ignorance to be a sorrow to his mother.

Mothers often continue the breast-feeding of their children for two years, and even longer. When deprived of mother's milk, few of them get any other milk. The death rate among these 'toddlers' is very high. They play around in the dirt, get infected with intestinal parasites or get skin infections from mangy, mongrel dogs. In a warm country like India, for the most part of the year it does not matter if they have no clothes. Indeed the sunshine on their naked bodies provides nourishing vitamins. But in the cold season the mortality from broncho-pneumonia is very high. The method of cooking over a fire, in a horse-shoe shaped earthen fireplace on the floor, is dangerous to toddlers, who may pull the cooking vessel with its contents over on themselves and get badly burned. Measles is a more fatal disease than in the West, though diphtheria is milder and often undetected.

The Nuitrition Research Institute at Coonoor has done a very great deal in investigating food values, and in spreading information. Many Christian boarding schools have improved their diets with marked benefit to the children. Records of weight are kept and checked often. But there are many people who have not enough income to provide sufficient food. At Alwaye, in Travancore, they prescribe milk and *ragi* porridge for some children, and it is prepared and eaten at the dispensary. There has been a wonderful improve- in the little ones. Even where milk is not obtainable, the *ragi* porridge alone has made a difference.

There are separate children's wards in all the larger hospitals for women, and, in spite of pain and sickness, they are happy places. Sister Simmonds of Multan writes:

> A children's ward in any country is a picture in which there is a great deal of light and shade. In England the children's ward is always the brightest. Its cots with bright ribbons, its flowers, its toys, and the bright faces of the little convalescents are a joy to behold. A children's ward in India is different, although loving hands make the best of what they have to make it bright. Bible pictures and pictures of children often adorn the walls, and toys are provided. The children who come to us are often suffering from neglect, not always from carelessness but often from pure ignorance. Sometimes the young parents would gladly have brought their child to hospital in the early stage of its illness, but Granny insists upon all kinds of village treatment, and until all these have failed, she will not consent to the child being taken to a hospital.
>
> Let me tell you about a few of the children who have come

to us. Pathanri, a little girl of about five years of age, was brought to us in terrible pain by her devoted mother and Granny. She was examined and the trouble was found to be stone in the bladder which she had had for two years. The stone was huge, and the only treatment was an operation to which fortunately the mother agreed. On the appointed day the operation was performed, and the child put to bed. She was wonderfully good except when the very painful dressing was done. She was given a doll which she loved and which kept her happy for hours. The wound healed quickly and Granny, mother and Pathanri went home grateful and happy.

One day a poor, unhappy woman came into hospital to have her baby, and when he was about ten days old she left him and disappeared. It was one of the little unwanted ones, so we kept him as a hospital babe. The nurses loved him and called him Arthur. He had many ups and downs—we nearly lost him more than once—but with very careful nursing and feeding he pulled through. He has now been adopted by a nice Indian Christian family, and we hope he will grow up a healthy, sturdy Christian.

Krishna, a little Hindu boy of eighteen months, was brought to us, a perfect little skeleton, unable to stand and scarcely able to hold up his head. His mother had died when he was born, and his father put him out to be nursed, paying well for him, but the foster mother had starved him; so he was sent to us. He had to be very carefully nursed and fed for some time, but he gradually improved and went home able to stand and beginning to walk.

There was a little girl who became quite at home in the hospital. When she first came to us she was a pathetic little figure. She cried most of the day and for the first week was never seen to smile. Her neck was very painful. Two of the glands had been operated upon by a barber and a dirty rag put over the wounds. It is lovely now to see her sitting up in bed, laughing most of the day. The wounds are much better and she is no longer afraid to go into the treatment room for the bandage to be changed.

One day, when little Mumtaz Hussain was crying at the thought of having his bandage changed, she said, 'You need not cry. In this place the people love us; you won't be hurt. Anyway, there is no need to cry *before* the bandage is changed.' At this he cheered up and came bravely into the treatment room and was delighted when given a piece of barley sugar.

Malaria fever has been very prevalent during the year and we have used pounds of quinine which we gave to bad cases only. One woman brought four little children to the out-patient

department, and before they could be seen and prescribed for, all were lying prostrate in the waiting room. The mother too was shivering with fever. I tried to persuade her to stay in hospital but she said, 'How can I stay, when my two eldest children are lying very ill at home with high fever? I have come for medicine for them too.' She left three of the little ones with us while she dragged herself home to look after the rest of the family.

The following incident from another hospital in the Punjab shows how a girl enjoyed her stay there:

We had a little wife of thirteen who had been knocked down some time before; her elbow had been injured and tuberculosis started. No one had cared and so she had received no treatment. It was her right arm and she had always to walk about supporting it by the left to relieve the weight. How old and weary she looked. After the operation (we had to amputate) as day by day the pain grew less and she realized that she no longer had that aching load to carry, a great change came over her. The years of her lost childhood returned; she went into raptures over a small china doll that she was given and her laugh was often heard. She won over the small solemn child in the bed next to hers. This child had never spoken before but after that she chattered all day long. When the day for her discharge from the hospital came she said, 'I don't want to leave the hospital. Can I come back in the afternoons to hear the Bible-talks?'

'A little child shall lead them' is a saying illustrated by a story sent from the Khond Hills:

There was a lame old woman with double cataracts. Her village is about sixty miles from the hospital and through the visits of an itinerant preacher in her district she had heard of the miracles of healing that were happening. She made up her mind to undertake the journey even though it meant walking every step of the way. With her little ten-year old son to lead her she set out, stumping along on one good leg and one that was sadly bent by an old untreated childhood fracture. At last they arrived, the operation was performed and she sat waiting for the day when her bandages would be removed and she should see again. It was indeed a great day—her eyes were uncovered and she looked round blinking, trees, grass, houses, people, these she could distinguish—and a little boy gazing up into her face, 'Who is this?' we asked. She shook her head, she did not know. 'It is your son,' we said. Her eyes lit up and she flung her arms about him, smothering him with kisses.

In a few days they set out on the long journey home; there was no need now for him to hold her hand all the way, she could see the path and its dangers for herself. She had heard something of the Gospel from the preacher who had visited her village and in hospital she learned a good deal more, so that soon she had found the Saviour and was asking for baptism. It was a happy day for her, and the church, when she made her public profession of faith in the Lord Jesus and began her new life in Him. The story has a sad conclusion. Not many months later she was sitting outside a house in a neighbouring village when a panther attacked and carried her off. It was a tragic end, but we know that for her there was an abundant entrance into the Master's presence. Her blindness had led her to Christ; and now with us is her son, who through the indelible experience of those thrilling days acquired a hunger for the Gospel and is now one of our most earnest enquirers in the district.

From Vellore comes this story of a case of diphtheria:

Mina's father, a doctor, brought her to us one Monday morning, a beautiful child of three years, suffering from diphtheria, toxic and acutely ill. Never having seen a case of diphtheria in all his twelve years of medical practice, the father could not believe his daughter was a victim of the dreaded disease. In spite of antitoxin and other special medicines her croup became more pronounced and by nightfall an intubation was necessary. This gave relief for only a few hours and tracheotomy was advised. The father hesitated all through the night until finally in the morning he could no longer bear to see his child, who was fast becoming tired out, struggling for air. With his consent a tracheotomy was performed and from then on Mina had an uneventful recovery, going home a few weeks later to join a lovely new baby brother who had arrived during her illness. Diphtheria has been considered a rare disease; but with more modern ways of travel it is becoming an increasingly dangerous menace, so that several cases during the last year have been taken care of in our isolation block.

A doctor who was working in Kamdara, among the aboriginal Mundas, tells a story, all too common, of lack of co-operation of the parents.

On my return from holiday, I had a letter from a worker in a neighbouring Mission, where there is neither doctor nor nurse, telling me how much they had been in need of help during the school holidays. One of the girls had fallen down a well, and broken her arm. The parents took her home and in spite of advice to the contrary, let one of the villagers treat her. He

Patient and nurse. Bamdah

Many children are healthy

'And a little child shall lead them.'

This wee child was the main standby to lead the father about

'Eyes have come' (*p. 48*)

Some little patients at Udipi

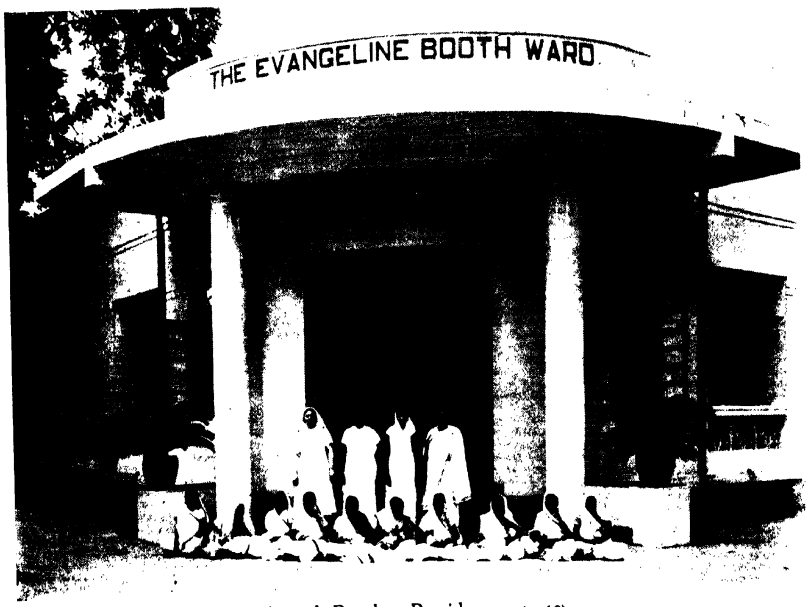
TWO PICTURES OF GAROS, AN ABORIGINAL TRIBE IN BENGAL

Garo funeral posts

When a death occurs in non-Christian homes, a post is placed outside the house. For a man a puggaree is seen on top, for a woman a necklace is put round (*p. 94*)

Ram Singh and his little daughter

Our first in-patients in Agartala Dispensary. Their dwelling (in-patient accommodation) is shown behind them. In spite of their poverty he insisted on paying for all medicines received in addition working at clearing jungle without pay (*p. 94*)



Anand, Bombay Presidency (*p. 19*)

bound her arm up so tightly that gangrene set in. With a good deal of difficulty the worker arranged for a doctor to come over and see her. She was then in such a condition, that only immediate amputation would have given her any chance. In spite of all that could be said the parents continued in their refusal to accept help and the child died a few days later.

But here is a story showing a different attitude:

One Sunday morning I was on my way to Sunday School when a Bhil woman jumped out of an ox-cart and flung herself at my feet weeping and beseeching me to save her son. He had high fever and was unconscious; by evening he was showing definite signs of meningitis. Meningococcic meningitis is endemic around Dhar, breaking out into a small epidemic almost every year, but I dared not do a diagnostic spinal puncture as the parents were very ignorant and apprehensive, and in fact had already tried to run away with the child several times during the day. Happily we had been able to dissuade them. As clinically it appeared to be meningitis, I decided to take a chance, and started to treat the child with sulphanilamide. It worked wonders. In less than two weeks a happy smiling child was ready to walk out of hospital. And how happy and grateful his parents were! The mother told us later that this was her seventh child, and the other six had all died of this same disease.

The doctor of the Salvation Army Hospital at Dhariwal, Punjab, sends us the following account written by a compounder on the staff. It is called 'The Tale of the Finger Tip'.

It was a little after eleven o'clock, and nearly all the staff had gone to take their *hazri*. I had closed the dispensary ready to go off myself, when a young couple approached. They were carrying a child, one of whose fingers was covered with mud, and bound round with a dirty rag.

'Babuji, we want some medicine for our child,' they said.

'What is the matter with the child?' I asked.

The woman began to search her pockets and the corners of her *sari*, but could not find what she sought. Whilst I was talking with the husband, the woman left us, going slowly back over the way by which they had come, earnestly searching the pathway. Suddenly she shouted,

'I have found it, I have found it.'

It was the tip of a finger, which three days previously had been severed from the child's hand by a chopper.

The parents anxiously asked, 'Can this finger tip be put on again?'

'It is quite impossible,' I replied, 'but we can help you by cleaning the child's finger and putting medicine on it. If you

bring him here daily so that we can dress the wound, it will heal in about a week's time.'

But the young couple became very angry at my words, and went away, saying, 'This hospital is no good'.

In connection with very many of the hospitals for women, there grows up a baby fold where unwanted or motherless babies are cared for. In some cases a separate building is provided for the little ones where they will be away from the sights and sounds of the hospital.

The babies of the babyfold at Hassan, Mysore, are indeed a source of joy and delight to us all. They play their part in helping to banish fear and distrust from the hearts of new and timid patients. The women coming from some distant village who have never seen such a place before, are amazed when the children clap their hands and shout for joy when they see us approaching, not at all afraid of these strange people. The women soon learn that there is no need for them to be afraid either, and that that they, too, are the children of God, who is Love.

Ludhiana provides us with a few examples of the value of babyfolds.

What a problem to confront a man, and what was he to do with an infant girl? The gods must be very angry that both his sister and brother-in-law should fall ill so suddenly and die within a week of each other. And who was to look after the child? Obviously he could not take her—it would be sheer madness to take her into his own family—for who knows what the spirit might do? But he had heard that the ladies in the mission hospital took children and cared for them and they did not feel the same about spirits, and she was a lovely child and his own sister's. Yes, that is what he would do—and that is how the entry, 'Parents both dead and brought by the uncle because he was afraid the spirits would be angry if he brought the baby up,' came to be written in the Babies' Ward admission book in October, 1917. Later on the child was adopted by a Christian man and woman, who had no children and longed for one. She grew up with them, and after school-days were over decided that she would like to be a school teacher. Now she is a teacher in one of the big mission girls' high schools, paying back regularly the money lent for her education.

There is the child, who was brought at about the same time, who was also adopted and at seventeen years returned to take her nurses' training, which she did with credit, later becoming a staff nurse. After this she took special post graduate training and is now a sister in a hospital of one of India's largest cities.

Children from the Babies' Ward have grown up to become doctors, nurses and teachers. There is still a stream of babies coming, and who knows what they may be able to do in the future? So the care, the support, or the warm clothes knitted for some tiny child, may have far-reaching effects.

Many little children from these folds have been adopted into childless homes, or a boy or girl added to a family where there are no daughters or no sons. It is better for the child to have even a mediocre home than to be brought up in a boarding school. A most attractive little girl, named Shamin, which means 'a sweet breeze', was transferred from the hospital to the boarding school. Her doctor friend sent her a blanket with which she was so pleased that she went round telling the others, 'Listen, my doctor-ji has sent me a blanket from a far-away country, all the way from America. Are there more blankets in America?' 'Oh, yes, many more.' 'Oh listen, there are many, many more blankets for me in America, my doctor has sent me one.' She and another child had fever and were given ice-cream. After that they used to feel their heads, and say in the Urdu idiom, 'Fever clings to me today.' 'You need quinine.' 'Oh, no, I just need ice-cream'. Shamin got a new pair of shoes and went to bed, hugging these and a large radish.

Her doctor-ji gave her for adoption to a fine Christian couple. The father said later, 'She is the beloved of our hearts and she means to our home just the meaning of her name—a sweet breeze.'.

It is sad to think that for lack of funds babies have to be refused admittance, and some of the babyfolds have been closed. Would it not be more in accordance with the will of the Master who said 'Suffer the little children to come unto me and forbid them not, for of such is the Kingdom of Heaven,' if it were made possible for the disciples of this day to receive all who come, for, 'There are many, many more blankets in America'.

CHAPTER V

THE INFLUENCE OF IGNORANCE, SUPERSTITION AND FEAR

'I sought the Lord and he heard me and delivered me from all my fears. They looked unto him and were radiant and their faces were not ashamed.'—PSALM 34: 4–5 (Amer. Rev. Ver.)

THERE is an increasing awareness of the part that the mind and spirit take in the causation of ill-health, and the necessity laid upon the physician to understand the religious and social as well as the physical environment if he is really to help the patient. In this chapter we shall take note of the influence of ignorance, superstition and fears.

Among the aboriginal tribes in India there is a widespread belief in the existence and power of evil spirits, and much attention is given to placating the spirits or trying to evade their attentions. A similar belief exists among village people. We have seen how a mother carried a dagger to slash the air around her child to keep the evil spirits away. Some parents give very unattractive names to their children so that the evil spirit may not take a fancy to them. Sometimes illness is ascribed to devil possession, and the patient may be taken to an exorcist. At the time of the *Dashera* festival one saw this process of exorcism in a temple in South India. The victims were young women, who were being treated by priests keeping up a constant incantation, the patient coming more and more under the hypnotic influence. The last act was immersion in cold water, producing a shock such as is good for hysterical patients. But the process was exhausting, and the patient was not her normal self for a long period after. There are many who 'through fear of death are all their life-time subject to bondage'.

There is also a great belief in auspicious and inauspicious days, leading to consultation with astrologers before important undertakings. Here is a case in point:

> Tara Bai came to us œdematous and gasping for breath. She had profound secondary anæmia of pregnancy. Carefully we nursed her and had the satisfaction of seeing the swelling disappear and her hæmoglobin slowly rise. Then one day her husband begged to take her home. He promised to bring her in weekly for examination and said that he would certainly bring her in for delivery. She returned weekly for a month. At the last visit she was again having a little swelling of the feet

and was advised to stay in hospital and remain till delivery. Her relatives acquiesced but said that as the day was inauspicious they would have to wait for an auspicious day. Three days later the brother returned to tell me with tears in his eyes that she was dead. She had gone into premature labour at home, and the old grandmother and the mother-in-law did not think she needed to be taken to the hospital, but that they could manage the case at home themselves. One hour after the delivery she died.

The ignorance, especially of the illiterate people, and the prevalent belief in 'quacks' are impediments in the progress of health and healing. Even in cities and larger towns and villages where qualified doctors can make a living, the majority of the people still consult quacks. But things are changing slowly: ignorance is giving way to knowledge, superstition to truth, and fear to faith in more scientific treatment.

The following incident from the Kangra Valley illustrates a fairly common belief in regard to a woman who dies undelivered:

Last week a woman was brought in dying. She was suffering from anæmia of pregnancy complicated with a kidney condition. She was twenty-three years of age and she was expecting her eighth child. She died a few hours after her admission to hospital. I wondered why her family had brought her the ten miles to hospital when they must have known that she was dying. Moreover, the Hindu death ceremonies which are considered so necessary could not be carried out at hospital. I learned later the reason of their coming and this is it.

When a woman who is pregnant dies she becomes a most dreaded spirit, the Chirail. By bringing the girl to hospital to die they hoped that, so far away from her home, the Chirail would be unable to find its way back to their village. They were trying to save themselves from the visitations of this terrifying spirit.

I have a painting of a Chirail painted by a famous Rajput artist, the last of the Court painters of this district, some of whose pictures are in the British Museum. The picture shows a woman who is hurrying along with a baby at her breast. Her long hair is streaming behind her. As her feet are turned backwards she cannot make much progress towards the woman that she is trying to catch. It is a dark night, rain is falling and there are streaks of lightning in the sky. There are snakes about her feet. It is a gruesome picture, and if this is what they believe a Chirail to look like I do not wonder that they do all they can to prevent its visits.

There are other superstitions as well.

I have found in several of our Christians a superstitious belief in the power of the Bible itself. One woman told me that when she cannot sleep she puts her Bible under the pillow and then she immediately goes to sleep. I tried to explain to her that although the Bible is our sacred book and tells us of God and of Christ, our Saviour, the book as a book has no power to heal the sick, bring rest to the weary or to protect one; that it is our Heavenly Father about whom we read in the book who watches over us at all times, whether we wake or sleep, whether in sickness or in health. He is present and hears us when we call upon Him.

The following incident illustrates the fatalism that cuts the nerve of effort to get well.

Bhagwant wanted another cow, and prayed to his god for one. His method was to light a fire and walk around it hundreds of times calling the name of his god. Five days later he was brought to the hospital suffering from severe and extensive burns, and his relatives told us that he had been 'picked up by a demon and thrown into the fire!' This is what the man himself thoroughly believed, and his first words to us were, 'I didn't want to be brought here. You can't do anything for me, for a demon has touched me.' His condition was such that he might have recovered if he had himself made an effort to recover; but he was hopeless, and two days later died.

A doctor among the aboriginal Khonds sends the following:

The patient was a non-Christian girl who went down with fever, which, unlike malaria with which our people are so familiar, did not subside in a few days but got worse and worse until she seemed likely to die. A native medicine man was called in. He began his incantations and, chanting and swaying, called upon the gods to reveal what had displeased them. Deciding that there was poison inside the abdomen (quite a good diagnosis, though made in ignorance!) he applied the vigorous treatment of pummelling, biting and sucking at that part of the anatomy with a view to extracting the cause of the trouble. At last he produced a piece of goat's meat, previously secreted in his mouth, and pronounced triumphantly that a cure had been accomplished. The fever remained, however, and the patient grew weaker, and at this stage they began to listen to the pleadings of their one Christian relation, a teacher in one of our schools. He knew the foolishness of their old practices and had begged that the girl be brought into hospital. They would not listen until all else had failed and then allowed him to have her carried to hospital. For weeks she lay desperately

ill and nobody, save her Christian brother, came to see her. He watched her day and night, ready to do whatever he could, and constantly prayed for her recovery. Slowly she began to improve and then her old mother, plucking up courage, came in and stood speechless beside the bed as she realized that the Christian hospital had done what witchcraft had miserably failed to do. It was not long before Lijingi was up and about again and ready to take her part in the work and life of the home, and there was great rejoicing in her village when she arrived back there again. We do not know the end of the story yet, but we do know that only a month ago she came to the hospital again, bringing another patient, and she was so well that none of us recognized her. We rejoice that in this way the old prejudices are slowly being broken and a new spirit of understanding is springing up and that people are daily seeing that the way of Jesus is a way that means healing and joy.

Many believe in the efficacy of curses. A religious beggar is often given alms to prevent his curse falling on the house. A doctor in South India related an incident which illustrates the mental effect produced by a curse, and incidentally also the unhappiness resulting from plurality of wives. The senior wife had no sons, only a daughter, so a second wife was taken by the husband, and in course of time the latter had several children. The first wife was jealous and purchased a heavy curse against her rival. But the junior wife purchased a still heavier curse. This was made known to the senior wife, who became ill. She was taken to the hospital, but the experienced and able doctor could find no diseased condition except the fear of the curse, by which the patient was so much obsessed that she died in spite of all that could be done for her.

Numerous examples could be quoted to show how the fear of a wife that she may be put away because she has no sons, or because her children have died, has been the root cause of the ailment for which she sought relief. A reassurance from the husband in such cases is the most effective restorative.

A doctor of the Basel Mission, Udipi, writes:

> Our Hindu women patients come chiefly from the villages. They belong to the landowners, farmers, toddy-drawers or fishermen castes. They are not confined by *purdah* and are allowed to go about freely. Nevertheless their horizon is very limited and they know nothing of what is going on in the world. For the most part they have never had an opportunity of hearing anything of the Gospel before they came to the mission hospital. They do not know much of the Hindu religion either. What they worship and fear are the demons who come at night to trouble them and who are, as they think,

the cause of most of their diseases. Much money is spent to pacify them, and when all this proves to be in vain, the patients come finally to hospital as their last hope for recovery. They arrive in a state of complete exhaustion due to the fear they live in and to the long struggle against the evil powers. The atmosphere of friendliness and of peace which they find in the hospital is a revelation to them. Then they hear the message of the Gospel and of how Christ is able to overcome devils. Fear goes away, quietness of mind and peace return. An utter change occurs in their whole condition and recovery sets in soon. This is due much more to Christ's power than to the treatment we have given. The time comes for the patients to go home and we have to let them go, without knowing if we shall be able to keep in touch with them and to help them to keep up what they have received during their stay in hospital. The houses are so far away and scattered in the paddy fields, that it is no easy matter for the Bible-woman to go and visit them.

The gods or the priests are sometimes consulted for guidance. The Indian Christian doctor at Nipani, B.P., says,

> At times it is interesting to note that the village gods by means of their devotees direct tetanus cases, and other difficult cases, to go to our Christian institution for cure.

In another place quite often the Mohammedan *moulvies* directed patients to get intramuscular injections at the mission hospital. Such spectacular improvement had taken place in some patients who had received the arsenical treatment for syphilis, that a belief in 'the needle' became a sort of superstition.

Ignorant people often expect immediate results.

> A Bhil mother came in crying; her son aged four was very ill. Would we please do something for him? We explained that the child had pneumonia, and must be hospitalized; was she willing to stay in the hospital? Yes, she would do anything, if only we could relieve his terribly laboured breathing. The child was admitted, and the first dose of Dagenan given. A few minutes later she was back at my side weeping. 'They have given the baby the medicine but he isn't any better.' We tried our best to explain to her that it would be a long hard pull for the little one, but that we had hopes of his recovery. She sat by his bed until noon. Then, when the nurse was elsewhere, she picked him up and ran away!

Sometimes the most weird stories are told and believed about what is produced by a woman at childbirth.

> Janki came to the hospital because the village women had

frightened her. Some said that there were twins. Others said that it was an inhuman monster within her and not a baby at all. Along with her came her husband, her brother-in-law and her three living children. She had had eight children. After two days in hospital a fine son was born and, as with every maternity case, we watched the clock to note the exact minute of the child's birth.

On the time of the birth depend so many events of the child's life, especially if the child is a boy. The family priest makes out the horoscope and throughout his life the priest is consulted about the proper time for certain ceremonies, the time for hair cutting when he is about six years old, the time for putting on the sacred cord, the time for his wedding and the time for many other things throughout his life.

An illustration of suffering from treatment by ignorant practitioners is given by a doctor in South India:

> Most of the patients coming to the dispensary are from the villages around, and one cannot help being struck by the ignorance, neglect and superstition which aggravate the suffering. Just lately we have seen cases of diabetes with advanced sepsis and gangrene of limbs, operated on in villages under conditions which tended to increase the septic condition. The patients did not know they were diabetics, the village doctor did not know, and *they* suffered.

Ignorance in regard to the effect of drugs is illustrated by the following:

> The custom of giving mercury in huge doses to pregnant women prevails largely in this area.
>
> A young woman was brought in to us with a septic mouth, profound anæmia, and other grave signs of severe delayed poisoning. Despite all efforts she did not recover and died after delivery. She was a young girl of nineteen whose death was solely due to this disastrous treatment. The original ailment, as is often the case, was slight and unimportant, but the cure caused her death.

And again:

> Nathaniel came into our hospital suffering from an overdose of mercury given by a *vaid* (native doctor) to cure some bodily complaint that was a purely physical matter. But his progress was hindered by an unhappy mind. He had been cursed by someone and feared that the curse was responsible for his misfortunes. His mind needed healing as well as his body.

Another illustration of drastic but ignorant treatment is the following:

> One in whom we were particularly interested was a young married girl of sixteen who was brought to dispensary by her mother-in-law, because she had a pain in her back. X-ray showed that she had a transverse fracture of the body of one of the lumbar vertebræ. The story was that she had been massaged with a stone to take the pain out of her back, and massage took the form of pounding—with this consequence. At first it was thought that she might require surgical treatment but, instead, a plaster cast was made for her. She was in hospital for months and was finally allowed to go home, free of pain and apparently well. She came back two or three months later, however, with a psoas abscess and has again been under treatment. She is now almost well.

Ignorance, suspicions and rumours spread by interested persons were responsible for the boycotting of a Christian hospital:

> There had been writing on the walls to the effect that, owing to the war, we had no medicines and gave only one medicine for every condition. This was bazaar talk, which means that every family in this town and for miles around took it as a fact. Two private doctors set up establishments, taking our oldest patients from us. One had his consulting verandah on the road leading to a very big village from which large numbers of patients were in the habit of coming to us. He stopped them all, saying that he had a lot of good medicines and we had none, so it was no use going the extra one and a half miles to the mission hospital.
>
> Some of our own innocent actions were also given as proof against us. Why had we stopped out-patients from visiting in-patients if we had nothing to hide or be ashamed of? Why were patients not now allowed into the dispensary unless for the reason that we wanted to hide the emptiness of our bottles? Why did we keep babies in a room apart from their mothers if we had no ulterior motive? These things were never done in the past! So we have relaxed, to some extent, these new rules. Within reason, we again allow out-patients to visit in-patients during non-visiting hours to prove we are not ill-treating patients or keeping them against their will as in a prison, which was one of the accusations against us. We now allow the mothers, who wish it, to have their babies beside them at night. We personally conduct patients into the dispensary and show them all our medicines. Every day we sent one or two nurses out with the Bible-women visiting the Moslem houses in

the villages. It was during these visits that the nurses learned all the reasons why patients had stopped coming to hospital. They were able to speak with authority on the untruthfulness of rumours and to persuade people to come and see for themselves. The very fact of seeing our nurses in their uniforms gave confidence. They came, they saw, we conquered. This visiting had a most impressive reaction on our nurses. Previously, they had only prayed about our lack of patients, now they were taking an active part in making their own prayers come true. This thrilled them. The visiting will be a most valuable part of our work and probably lead to preventive work, post-natal care, and public health service.

On our inquiring from several educated Hindus the meaning of the custom of cutting a child's first hair and presenting it to the god, we are led to believe that it is performed to promote strength, long life and health.[1] Here is an illustration of the adaptation of the practice to Christian use:

> Sunday we had an interesting ceremony in the Hospital Prayer Room at the patients' morning service. A woman of the carpenter caste who, in answer to prayer, had had a baby daughter after an operation, wanted the child's hair cut for the first time as an offering to our God who had given her the little one. The Rev. E. T. Burd prayed with the parents and cut off a lock of the baby's hair, which was placed on the Lord's Table, with the four-anna bit, plate of sugar and coconut which they had brought as a thankoffering. Twice before we have had a hair-cutting ceremony in the Prayer Room at the request of Christian parents, but this was the first time non-Christians had asked for it.

A doctor who has been interested in tracing how 'knowledge grows from more to more' has depicted the growth, over a period of ten years, of the idea of hospital and medical treatment in the mind of a Mohammedan man. This man worked for a missionary who gave him advice about diets and persuaded him to get treatment for himself at the Government hospital. But he refused the suggestion of treatment for his wife saying, 'It is not our custom'. But a favourite child became ill, and it was suggested he be taken to the Mission hospital. This time he agreed and was overjoyed at the boy's recovery. By this time he had learned enough to give some instructions to the midwife who attended his wife. Finally, for the next child, he brought his wife to the hospital. He is now recommending others in his village to go, and undertaking to make arrangements for them.

Thus, through doctors and nurses who have scientific skill,

[1] Skrt. *Bala, Ayur, Arogya.*

combined with love for God and for their fellowmen, ignorance, superstition and fear are giving way to understanding and confidence—first in those who help them, and then, sometimes, in God Himself—so that these needy ones too can say, 'I sought the Lord and He heard me and delivered me from all my fears'.

CHAPTER VI

CHANGED LIVES

'Why, look at your own ranks, my brothers; not many wise men (that is judged by human standards), not many leading men, not many of good birth, have been called! No,
God hath chosen what is foolish in the world to shame the wise;
God hath chosen what is weak in the world to shame what is strong;
God hath chosen what is mean and despised in the world—things which are not, to put down things that are:
That no person may boast in the sight of God.'

I Cor. 1: 26–28 (Moffat).

It is interesting to recall that the word salvation is derived from the Latin word *salus*, 'health'; and the word 'health' is related through its Anglo-Saxon root to the word 'holy'. Thus we see how closely associated in origin are the ideas of religion and health. Our attention is called to this relationship in *The World Mission of the Church* where, in the section on 'The Christian Ministry of Health and Healing', hospitals are asked to give more attention to 'the relationship of religion and health'. 'The hospital would thus become a centre where search could be made for ways in which spiritual ministry might aid in bringing full health to patients. We have scarcely crossed the threshold of such a quest as this.'

Most medical missionaries have come to realize that the ministry of healing is a real part of the Gospel message, that God is on the side of health, that disease is an intruder and that to heal the sick is a part of the work of the Kingdom. We have not yet fully realized that in the fundamental constitution of things sound health is based on right relations to God and to our fellowmen as well as to nature.

The so-called 'Evangelistic work' (though we think of all the work as evangelistic) in the hospitals and dispensaries is specially done by men and women trained for the work. But doctors and nurses also have a share in it. A doctor in the Punjab thus describes the services:

> Hospital services are on a happy note. The belief of the doctors and the staff in the power of God to heal; and in His love, are frankly stressed. An effort is made to get the relatives and helpers to join in a simple, real service of intercession for their own patients and for others, particularly those who are without helpers. In the evening hospital service, generally taken

by one of the doctors, prayer is offered for operation cases or others seriously ill—this in the name of Him of whose love and endless service for others we have been telling in our talks with the patients. Such a hospital service is welcomed by all alike.

He goes on to say:

If we are to measure the value of a lifework by the number of those who openly accept Jesus as Lord and Master we have little to show, but this we know, that among those who gather with us in the evening to pray for their sick folk, some at least go away with a new vision of the Heavenly Father who loves and cares for His children. And having given them that thought may we not leave it to Him to draw them still closer? In recent months several have come to speak of the stressing of the spiritual side of our medical work, and they have spoken with very real gratitude.

From another hospital comes a similar statement:

Our hospital work goes forward steadily, nothing spectacular about it, yet miracles of healing are taking place constantly. Patients we thought could never recover have done so in answer to prayer, right treatment, and careful nursing. Mothers, who had to their great sorrow lost child after child, have gone home full of joy with a living babe, and many who when they came to hospital knew nothing about the Great Physician, have gradually learned to revere and perhaps to love Him; anyway their attitude to our teaching has altered tremendously. I wish I could tell you of outright conversions and baptisms. That I cannot do, but I can assure you that the regular teaching from God's Word is not allowed to take a second place either in the wards or out-patient department of our hospital, and it is nothing unusual for women not needing treatment to come to the evangelist in the out-patient department to talk with her or to listen to the teaching and singing. Who can say what the result will be? God has said, 'My Word shall not return unto me void', and we believe it!

A short time ago I had a letter from an unknown woman saying it was the desire of her heart to become a Christian. She was one who had heard the Word in hospital, but latterly had not been able to come because her husband, suspecting this, had kept her in the house, not allowing her to go out. There was no address on her letter so I could do nothing, not even answer it, which troubled me a good deal. Prayer is being offered for her.

A Christian Indian doctor, in charge of the American Baptist Mission Hospital at Udaiyagiri, writes of a woman who was greatly

influenced by a dream. Like the people we read of in the Bible, the people of this land believe that dreams have great significance.

A young Golla woman, expecting a child, had for a month suffered from an infectious condition which caused her such suffering that she could not sleep. She was admitted to hospital. The Bible-woman, in her visit to the ward, sat beside her and tried to soothe her pain, telling her Bible stories and speaking of God's love in Christ for mankind. The sick woman was so attracted by what she heard that she forgot her pain and had a sound sleep. Next morning she told the doctor that in a dream she saw Christ standing by the bed and her pain decreased. 'After her recovery,' writes the doctor, 'she visited some of our Christian homes and gave her experience of Jesus and affirmed her strong faith in His healing and saving power. In token of her love and gratitude she named her daughter Mariamma.'

It is true today, as in the time St. Paul wrote, that the most of those who accept the call of God are humble folk, the weary and heavy-laden who come and find rest. Paul says 'not *many*' noble are called, but there are some of that class who do respond.

The case of James Stephen shows how school and hospital contributed their part in his spiritual development. The story is from Madura:

> Before he came a Christian, James Stephen went by the name of Alwar, after one of the popular Hindu gods. He came from an orthodox Hindu family of small land-holding farmers, proud of their caste and of their religion. As a student in his teens, in one of the Mission boarding schools, young Alwar was called on by God to renounce his old faith and to become a Christian. Alwar obeyed God and thenceforth he was called James Stephen.[1] What this decision cost the young student can easily be imagined, because he was the only one of a family of staunch Hindus to 'fall from the superior traditional religion into the degraded society of Christians'. The estrangement from his family was soon to be followed by a severe testing of faith through pain and suffering stretched over a period of ten years. While yet at school he developed a deep bone abscess involving a large part of the humerus which took many months in hospital and a few operations to heal. This painful experience soon after his conversion only made James more passionately attached to the Gospel of Christ than before. So when he fell ill again with a deeper and bigger bone abscess in the femur, and his fellow villagers derided him for the curse he had brought on himself by forsaking his old religion, it made him only more

[1] These Bible names have their forms in the vernaculars in India—*Ed.*

stubbornly rooted in Christ. After months again in hospital James went back to the village apparently hale and hearty. He was now of age to get married and his relatives tried all means of persuasion and coercion to make him take a Hindu girl, a relative, for a wife as he was bound to according to Hindu social customs. This was to be the means of weaning him from his mad love for Christianity. James promptly responded by marrying a Christian girl whom he selected with the counsel of the hospital chaplain who had become his friend and guide during the course of his repeated visits to the hospital. This happy event was within six months followed by the climax of suffering to this young Job. The old infection which had been quite dormant in some hidden region of the body, flared up again. His relatives thought this was the beginning of the end, and wanted to take him home. In silence, the young wife ministered to his needs, her heart full of sorrow. But the faith of the convert never wavered. The cheerful smile with which he greeted the doctors and nurses never failed. This is what he used to tell one of the doctors, 'God should put me on my feet again, so that I can go back to my village of unbelievers and witness to the power of Christ to save and restore'. His prayer was heard and his faith made him whole. It was a miracle of healing wrought by the power of faith in Jesus Christ.

It is now two years since James Stephen left the hospital. He is a leading member of his village church, elected unanimously by his fellow Christians to be a member of the Pastorate Committee. The Christian community in his village has gained a new status in the eyes of the non-Christians there as the result of his witness for Christ, a witness not merely of words but of experience.

The chaplain of the same hospital gives this story from his diary:

A middle-aged man from an orthodox Hindu community was an in-patient in the hospital. On his sick bed he used to attend carefully to the ward prayers. Apart from that he did not seem eager to discuss religious matters. But it was revealed later that a spiritual struggle was going on in his mind.

On his discharge he bought a New Testament. On his reaching home the first man to visit him and to enquire about his health was the village catechist. The patient then thought that the hospital had arranged for this meeting and wondered how this was possible just at that moment.

When he next came to hospital he was a baptized Christian and had in his hand a prayer book of which he had learned much by heart. He was greatly surprised to know that the hospital had

nothing to do with his meeting the catechist and felt that it was a Divine arrangement.

From the Methodist Hospital at Sarenga comes the story of one of the humble souls who 'gladly received the Word'.

> Radhu came to us suffering very acute pain from several deep bone abscesses. He was seriously ill and ordinary sedatives barely touched his pain. From the first he seemed to have a real hunger to hear the story of Jesus and His love. Like a flower opening to the sun, so his life opened readily and steadily to the Gospel. Shortly after his admittance he told the doctor that he had found a new method of dealing with his pain. 'Sahib,' he said, 'When I feel the pain coming I pray to Jesus and He now gives me more strength to bear my suffering.' Some little time later, Hindu relatives visited him and he told them some of the good things he had heard. He told them about Jesus, whose Name and Message he heard for the first time on coming to the hospital. Finally he said this to them: 'When I get better I can never go back and live as I did before—I have seen the light now, and can no longer live in darkness.' Radhu had further teaching, came to have a real faith in Jesus, had a very genuine conversion, and was finally baptized. About the time of his baptism his physical condition had improved but he had to be kept under observation. He was given the charge of the hospital chapel, and the pride and love with which he did that work showed he had a deep appreciation and understanding of Christian service. Not only did he do this task faithfully and lovingly, but he also found time to sit with patients and tell them of the life he had found in Christ. Also, if he could help in the more menial and unpleasant ministrations to patients he was ready to do it. As one watched him at work in hospital chapel one thought of the words of the Psalm—'I had rather be a door-keeper in the House of my God, than to dwell in the tents of wickedness'. He was anxious to have further teaching and become a full member of the Church. It was a memorable day when he was received into the full fellowship of the Church, and knelt with the medical staff and others, when he received Communion for the first time. One more thing worried him and he set out to conquer that. He was illiterate. By steady and conscientious study he has now become literate and is proving himself increasingly useful in Christian service. Radhu knew nothing about Christ until his visit to hospital. Today he is one of the finest witnesses in the hospital, probably more by his life than his words, and to use an old phrase, he has 'the root of the matter' in him.

Not a few of the best workers in the Christian hospitals are

those whose lives have been changed there. The following touching story comes from the Church of Scotland Mission Hospital at Nagpur:

> Many years ago a poor woman, with her little children, arrived tired and helpless on the verandah of our doctors' bungalow. She said that she was trained for nothing, but wished to work. The doctor offered her the only work available and she gladly sat down to pull the punkha. As the days passed it became apparent that a strong personality was concealed behind the somewhat unprepossessing exterior. As she learned more and more of the love of Christ, more and more she gave her heart to Him, and became His faithful servant till her life's end.
>
> Soon it became possible to offer her training as a midwife, and in this by no means easy work she became extraordinarily adept. The present writer well remembers the quiet but insistent voice which used to summon her out of bed, with the statement that she must come now for the case was of such and such a nature, and of such a nature it invariably was. Everybody loved their midwife, rich and poor alike, for in everybody's home she was at home, and everybody's need had to be fully met ere she would rest.
>
> When we started a small maternity home in the City she was placed in charge of it, and many of us still remember that gentle voice at morning prayers, beginning with 'Holy, holy, holy, Lord God Almighty', in Marathi, and going on to pray for the sick and sad, and all those in prison—for one whom she loved had been in prison—and for those who 'were entangled in any kind of difficulty'.
>
> Towards the close of her life a friend in Scotland sent out £5 for her with a note that she was to spend it as she wished. This realized over Rs. 60, so she was summoned and the money was offered to her. She felt it too large a sum to treat hastily, so asked that it should be put aside for her. In a week she returned and, spreading a large white handkerchief over her knee, she took the money. First one ten-rupee note was laid aside for the poor in the hospital, and another for the Girls' High School, and another for little David in whom she was interested. Then a pause and a statement that she would have to think about the rest. When we asked if she would not buy anything for herself at all, she was really astonished, and replied 'Why, no! Haven't I two *sáris*? If I am ill won't I come into hospital? And there's money for my funeral. What more could I want?' Not very long afterwards her brave soul passed to the One who waits to welcome all such simple, devoted and self-regardless lives as hers.

The doctor at Seoni tells of three aboriginal Gond women who found their sphere of service with her.

> Nearly thirty years ago, a middle-aged woman slipped into the waiting room of the dispensary, with a disease which made her hesitate to join the group around the Bible-woman. But her ears were open to what was being said, and the Word fell so sweetly upon her troubled spirit that she determined to hear and learn more, and ultimately joined the Christian community. She made a wonderful recovery from her disease. At the age of fifty she learned to read Roman Urdu, and with such success that she could read the Bible fluently. For twenty years she served in the girls' orphanage, until the frailties of old age overtook her.
>
> A much younger widowed woman, diseased and friendless, appeared at hospital about sixteen years ago. She was admitted as an indoor patient and, as in the former case, the Word found a ready entrance into a heart which seemed to have been prepared for it. She also professed her faith in Christ and, after some spiritual vicissitudes, found a footing on 'the Rock that is higher than I'. Eager for knowledge she soon learned to read Hindi and Roman Urdu. The latter is a necessity here, as the metrical version of the Psalms, which alone is used in worship, is published in that character. When the first-mentioned woman resigned, she stepped into her place and is proving an efficient, faithful matron.
>
> The third was admitted into the orphanage as a girl of fifteen years. Practically blinded as a child of ten months, with smallpox, she was gifted with a retentive memory and an understanding of spiritual realities beyond that of many educated people. Five years ago she was appointed Bible-woman in the hospital, and continues as such to our entire satisfaction.

It was famine that brought Jamnabai to the doors of the Mission Hospital at Indore.

> During a great famine there came to Indore from a district in the Central Provinces, a family consisting of the father, mother and three children. They found their way to the Mission hospital where they were given food and taught and they received the Message gladly. After some time this woman, Jamnabai, was given employment as general helper and messenger. She proved to be trustworthy, and for years she brought from the bazaar much of the food and many articles needed for the hospital. She was never too tired to undertake extra service, often after regular work hours. She was so eager to give to the patients the Gospel message that had meant so much to her that very often in the evenings she would be found

among the patients and their friends, telling them the Old, Old Story and singing to them. On Sunday she might walk away to a village and give the message there. When she was too old for work in the hospital she would still be found teaching those with whom she came in contact. Last year after a short illness she passed on quietly to her reward in the Better Land. One of her daughters was trained in the hospital and served as head nurse and teacher of nurses till her marriage.

There are a few Mission hospitals in India where there are blind evangelists employed.

In the Mission Hospital at Bhiwani in 1910 a blind patient named Jannat was baptized and, after receiving training she became the hospital evangelist until her death in 1931. She also learned to do massage. To succeed her, another blind girl was appointed; and now there is a third, Florence, who has been at work for nine years.

Two men who heard and saw the Gospel interpreted at the hospital in Dhond afterwards became witnesses to others.

> Nama, a man of forty years, was brought to us on a bullock-cart from a village thirty miles away. He was in a very bad state, suffering from tetanus. The case appeared hopeless, but at the earnest request of the relatives we admitted him to the ward and did what we could for him. God blessed the efforts, and three weeks later it was seen that the patient would recover. Then the patient's brother came to the doctor in charge and said, 'Doctor Sahib, I want you to baptize me. I have heard of Jesus from your preachers when they have occasionally come to my village, but I have now *seen* what Christianity means and I want to be a Christian'. A little while later the patient himself came with the same request. The life in a Christian hospital where the work done is done in the spirit of love had made the message previously heard a real thing, and two lives were changed. These two are now witnessing in their village, and others are interested in their witness to the power of Christ. God has used the medical work to answer the prayers of the missionary in charge of that district, and the nucleus of a Christian Church is now in existence there.

Owing to the caste restrictions in India, it is often impossible for a convert to remain at home after confession of Christ.

A doctor tells of a bright little caste woman who came to her dispensary one day. She had had a little son who had lived but a few days, and she had not been well since his birth. The doctor found she needed daily treatment and invited her to come in time for the morning worship at the opening of the dispensary. She became

an interested listener and soon asked to be taught to read so that she might read the Bible for herself.

She made diligent use of pencil and slate each morning, copying the lesson set. When she told her husband he raised objections, but later gave an unwilling consent, and was quite proud of her when in six months time she could read. She had begun to love Jesus, but her husband would not consent to her baptism.

Though she was a caste woman, she asked to be allowed to help in the dispensary in dressing wounds. The doctor told her it was unpleasant work and involved touching the so-called 'untouchables', but she replied, 'This is service for Jesus and I want to do it'.

Some time later her husband consented to her baptism. She lived in her home for a time, but when they found she would not take part in Hindu worship, they turned her out. So her husband brought her to the doctor. There was nothing offered for her support, so she was given the work of ward *ayah.* She was never very well, and after a short life, rich in blessing to others, she died. The relatives came to see the Christian burial and stood by reverently. The doctor adds, 'she being dead, yet speaketh'.

The following two incidents further illustrate the social difficulties met with.

> A young Brahman woman came to us from a remote village in the north of the district. She had been ill a long time and she was very weak. A few days after her admission I found her reading with interest a Kanarese New Testament she had found in the ward. She studied it for some time and finally she told me one day with a beaming face, 'This is what I have been looking for, for such a long time, and I could not find it in our *shastras*'. She was speaking of the redeeming power of Christ. She made a quick recovery and soon the time came for her to go home. She purchased a Bible and she left us full of joy, as one who had found the pearl of great price. For a long time we did not hear from her. Then one day she came to us in the dispensary, with her father who was keeping a close watch on her, not allowing her to speak freely with us. All joy had gone from her face and there was no light in her eyes. She complained that her sight was failing and that she could no longer read. On examining we could find no special reason for this. After that we could not get in touch with her nor help her except by praying for her.
>
> Another Brahman patient was brought to us in an appalling state of weakness and wasting. She was suffering from hysteria and was refusing to take food. For two months she had been forcibly fed by her people. Owing to the loving attention she received here, she very quickly began to improve and to eat

again. Soon she was well enough to listen to what the Bible-woman had to tell her of Jesus Christ. We have seldom witnessed such a tranformation in a patient's condition. The family noticed it too and understood the reason of it. So they began to be anxious and one day they came to us with a tale that the patient's mother had died and that it was absolutely necessary for her to attend the funeral ceremonies. She was at that time barely able to sit up, still less to walk. We tried to explain to the relatives that her nervous system was still unbalanced and that it would be most harmful for her to attend such ceremonies. All that we could say was in vain, they had decided that it was unsafe to keep her any longer under our influence.

It is not often that a devotee of the devil responds as this patient did.

One evening a man was brought and laid in the porch of the clinic building. He was moaning and groaning and suffering considerable pain. No one seemed particularly interested; those who brought him left him to our mercy. We found him covered with gory rags. Evidently the wounds from which he was suffering were the result of a fight. Later we learnt that he was a devil devotee. He had been beaten by some infuriated ryots who owed him money and whom he had intimidated by his *mantrams* and incantations. The wounds were dressed by our nursing staff and he was asked to come into hospital. This he refused to do as he did not wish to part with his money and the hospital was Christian. Some one took him to the neighbouring hospital run by Government.

We had almost forgotten the incident when one morning, soon after, his wife came and pleaded with the writer to admit him to our hospital. After considerable parleying back and forth the man was brought in. The upper jaw was bashed in from the beating he had received, and his arms and body considerably bruised and cut up. High fever was raging from the infection of his wounds. After several weeks the broken jaw was restored to its original place by plastic surgery. This healed by first intention.

During convalescence the man became very interested in our work. He attended the morning worship, came to church services and became a very cheerful patient. He was a source of encouragement to other patients.

The day came for his departure. We asked him how he felt and if he was happy to go. He said he was very glad to tell us that he was a changed man, that he had no desire to return to his old life of incanting for the devil. He was going to make it right with those whom he had been so

hard on. The way of Christ, he said, had made a great change in his life.

This is a story of a recovery, reconciliation and reintegration:

> Just two weeks ago we had a bit of news which has strengthened our faith that, 'In due season you shall reap if you faint not'. The news was in answer to prayers and effort which began about four years ago. At that time a young, attractive, unmarried, prospective mother came to us for care. She had finished an elementary teacher's course shortly before coming to us. After her baby came, her mother told her that she could come home if she would give the baby away. Her mother-love rebelled and believing that such a love can be a refining and purifying force we offered her a temporary home until she could get a suitable teaching position. She accepted the home and made herself a helpful force in it. She taught some of the illiterate patients and members of the servants' families. She became an acceptable and faithful helper of one of our own number. After some time in our big Christian family she became a Christian too, and soon was a real help in the little Church near the hospital. A few weeks ago she began teaching in one of our small Christian schools. The good news that we recently received was that the father of her little son, for whom she has been praying and who has been seriously thinking for some time, had taken the definite step, been baptized and had been taken into the Church. Along with our prayers of thanksgiving we must add our prayers that the girl's mother, who has become sufficiently reconciled to live with her and take care of the child during school hours, may also have a complete change of heart.

A doctor describes a hopeless case, but in such a case there is comfort to be given:

> Raj was a young Hindu girl with recurring tuberculous disease. . . . First a hand was amputated, then a foot, then the arm and the shoulder, then a rib—a pathetic maimed figure—and the only message from her religion was that all this suffering was the result of errors in a former life. 'As doctors, how little we have to offer to such a one—as Christian men and women, how much!'

There are places hallowed by the prayer of those who have passed into the beyond.

A doctor writes of a Christian widow who gave a plot of land and a house for the church in her village for the opening of a dispensary. Years ago, on the very spot where the dispensary now stands, there was a mud house falling into ruins. A little girl of a

goldsmith family, who was attending the Christian school, used to slip into this old house to pray. Her people at home were not in sympathy with what she told them of the things she learned at school. The little girl died in childhood without receiving baptism; but who can tell how God valued her prayers? On this spot now is the dispensary, and some twenty families in the village are asking for baptism.

Thus it behoves us to heed the injunction, 'in the morning sow thy seed and in the evening withhold not thine hand: for thou knowest not whether shall prosper, either this or that, or whether they both shall be alike good' (Ecc. 11: 6).

CHAPTER VII

THE CHURCH AND THE HOSPITAL

'Then they that gladly received the word were baptised. . . . And they continued steadfastly in the apostles' doctrine and fellowship, and in the breaking of bread, and in prayers.'—ACTS 2: 41, 42.

THE need of fellowship in prayer at the beginning of the day, is recognized by the staff of all our hospitals. Sometimes the meeting takes place in a room that is used for other purposes, such as the out-patients waiting room; sometimes there is a prayer room in the hospital, or a little chapel for hospital use.

A separate room or chapel is increasingly recognized as necessary to a hospital, not only for the use of the staff as a group, but for the use of nurses or doctors off duty who want a quiet place for prayer, and for friends of patients who wish to pray for the sick, and for the evangelist who may wish to bring someone for a quiet talk or prayer.

At Azamgarh, U.P., the doctor describes a chapel which 'has been built in the centre of the hospital compound and will place our worship and inspiration at the centre of all our work. The worship will be truly Indian in form as we still sit on mats on the floor. At one end there is a raised platform on which is a communion table, and in front a communion rail, made of beautifully polished wood. The door is left open, so that patients and their friends may go in and sit quietly in meditation or prayer.'

There is a lovely story to tell about the chapel of the Holdsworth Memorial Hospital, Mysore:

> Many months ago a poor unkempt woman came to us. She was suffering indescribable pain, and was so uncouth and hard that we wondered if we should ever find a point of contact. She refused to bathe or comb her hair, and gave us all a very bad time whenever her dressings were done. Sometimes, indeed, she seemed almost devil-possessed; for she would rush and seize one by the throat, making some absurd demand. After such a demonstration there was always a period of languor and remorse.
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> One morning I noticed that she had followed me into our little chapel, and watched me polish the Communion table. We only smiled at one another as I passed out, leaving her crouched in the corner near the door. After that she crept in each day, and when I offered her a duster to help me with the cleaning, her face lit up. Long after I left, she stayed in the chapel polishing the windows and floors.

Once when we were working there together, she pointed to the black marble cross let in the floor, and asked what it was. Could anyone have wished for a better opportunity than was given me that morning? There, in the quietness of that little Bethel, Rangi heard that the marble cross was an emblem with a meaning for her, and that it spelt release from the bondage of sin. Her dull intellect could grasp very little, but after that first day's talk she realized that the chapel was hers and that the cross was there for her. This was not the end of the storms of temper, but they became much less frequent, and we know that the devil received many defeats as Rangi sought refuge in the little sanctuary at all hours of the day or night.

Without being asked to do so, she took over the responsibility of keeping the floor of the chapel clean. For her it is a holy place. She bathes each morning before entering it at six o'clock, and then she washes the floor, in readiness for our morning worship at half-past six. She repeats this office before we assemble for the evening service.

A short time ago it was suggested that her scrubbing work should be changed. Never shall I forget the fear that was written on her face, as she came to explain to me that if this happened she could not clean the chapel. After imploring to be allowed to continue this work, she said, 'You see, Sister, Jesus saves me there; I go and look at that cross and know that I am safe. I will never leave that work. It's made me hate my bad life.' Needless to say there has never been another word spoken about Rangi changing her work.

Christian hospitals have been established in India chiefly by Missions from abroad, but it is being recognized that they should develop a more rapid and more intimate relationship to the indigenous Church. In a few denominations the medical work is directed by the Church councils or conferences. But in most cases it is still under the Mission, with perhaps provision for consultation with Indian members of the medical staff. It is felt that as soon as possible the management should be in the hands of a board or a committee in India, composed of the hospital staff and members of the Christian Church, who are able to understand and help in the conduct of the hospital.

The director of the two well-established hospitals of the American Board in Ceylon writes of their relationship to the Church. The men's hospital, Green Hospital at Manipay, was begun almost a hundred years ago; the women's, McLeod Hospital at Inivil, is not yet fifty years old. Each has one hundred and twenty-five beds, each is staffed entirely by nationals, except for the director who serves both, and each is financially self-supporting. This is the statement:

In thinking over the past year of our medical work I would like to describe, first of all, the connection between our medical institutions and the Church. As has been so well pointed out by the C.M.A.I., co-operation between these two bodies should be very real and close in order that the most efficient kind of medical work should be done. When I arrived in Ceylon I felt very strongly the lack of this co-operation and in fact there was a feeling almost of antagonism in some parts of the indigenous Church, due mainly to the fact that the medical institutions had in the past been placed on a firm financial basis and therefore had, relatively speaking, no problems of this kind. The Church, however, some years ago had been cut off from all American support and was, and is, finding it difficult to make both ends meet. The staffs of the hospitals, on the other hand, held the Church almost in suspicion, feeling that many outstanding men of the Church group would give away anything to take control of the hospitals and thereby strengthen the financial structure of the Church.

This uneasy relationship has been tackled in two or three ways. First of all, a percentage of the yearly allowance for salaries was handed over to the Church Council. This amounted to about Rs. 450 a year. It was a form of financial aid which the hospitals could well afford and of course it was a great help in strengthening the financial condition of the Church Council.

Secondly, the co-operation of the Church was sincerely asked for by the director of the medical work. At Green Hospital, Manipay, we were fortunate in having the pastor of the parish living on the compound. This being the case there is an easy and valuable opportunity for the pastor to make daily visits and calls on the sick people of the hospital. The director provided this pastor with a copy of the book called *The Art of Ministering to the Sick*, written by a well-known doctor and minister of Boston. This I feel gave a good incentive to the minister for carrying on the medical side of the pastoral work. The lack of a hospital evangelist was felt so that during the past year the trained evangelist of a nearby community has been employed on a part-time basis at Green Hospital where he spends two to three hours each day in the wards and rooms of the sick, visiting both Christians and Hindus.

At McLeod Hospital the situation was not so favourable. There have been two Bible-women on the salary roll of the McLeod Hospital for many years but the only ministerial help the hospital has had has been given by the occasional calls of the pastor of the large Udivil Church which is two miles away. Two years ago agitation was begun by the director in hope that the Church Council would see its way clear to put in an extra

Church worker for McLeod Hospital. By his continued efforts and the co-operation of the Jaffna Council of the South India United Church, a happy solution was brought about and during the past year here we have seen installed as chaplain of the hospital a fully qualified young minister with the degree of Bachelor of Divinity. In order to do this the Udivil Church had to increase its subscriptions and the hospital has added another thirty rupees to its already large monthly subscriptions to the Church. The chaplain has now direct control over the Bible-women, works out the programme and arranges all the chapel services and, most important of all, gives intelligent spiritual aid to those inmates of the hospital who could never have been approached by the Bible-women. I feel what I have described is a real step forward in the co-operation of the medical and Church work.

Another doctor writes of the help given by the hospital to the Church:

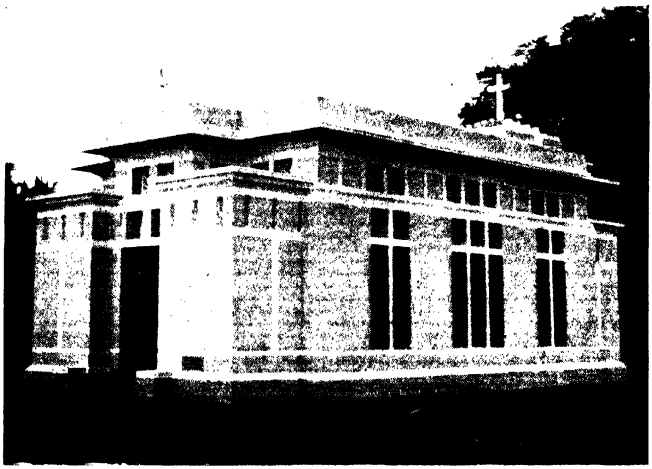
From the standpoint of the work of the Church the medical work has been a great blessing in the community. Three Indian Churches have been raised up as a result of contacts made at the hospital and the healing work done by Christ. Nurses and compounders can take Christian truth to the homes of the people and they are doing it.

At Udipi the Church and hospital are mutually helpful:

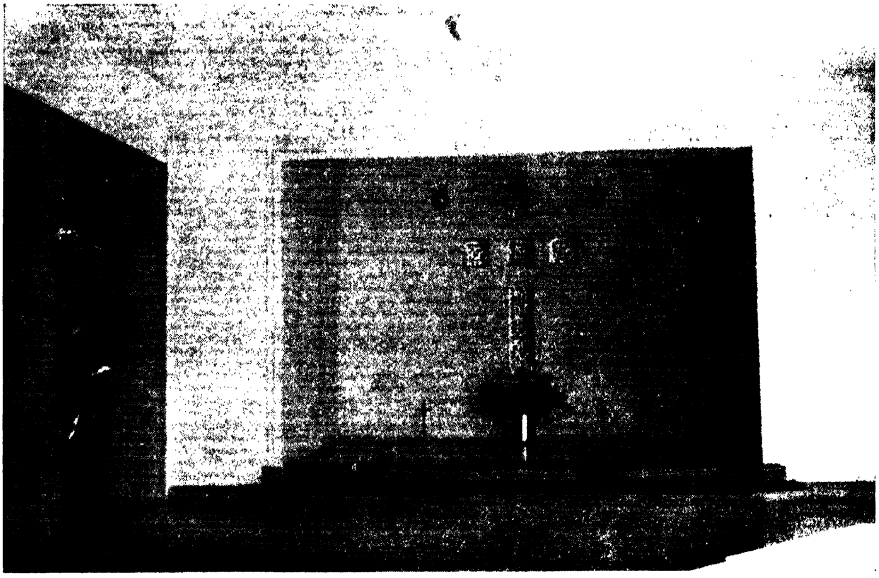
The hospital is trying to help the Church, not only in attending to the sick, but also in fitting young girls for service in the congregations. The observance of Hospital Sunday in all the Churches of the district for the last six or seven years has done much to awaken interest in the Mission hospital. Besides the collections gathered at the services on that day, many gifts in kind gathered from the congregations near the central station are brought to the hospital. The pastors and evangelists pray for the work, not only on that day, but throughout the year. Thus there is a growing sense of responsibility on behalf of the medical mission, and the bonds of co-operation between the hospital and Church are becoming closer year by year.

At Puttur in Jaffna, Ceylon there is carried on under the British Methodist Board a training school for deaconesses. A regular part of the training is given at the health clinic, where the students are given training in how to prevent disease and promote health, and how to give simple remedies. They visit the homes and do health propaganda.

These are illustrations of how the Church helps the hospital:

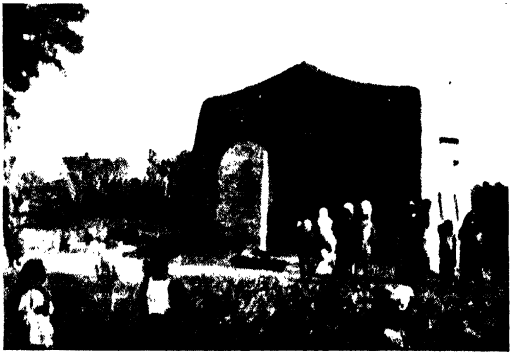


The Chapel at the Kalyani Hospital, Madras

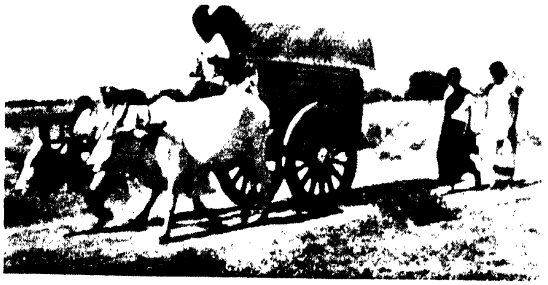


Interior of the Women's Hospital Chapel at Madura

A village Church built by the people, near Ambala, Punjab



IN RURAL PLACES



The hospital bandy and two nurses, Karimnagar, Nizam's Dominions (*pp. 61-62*)

Trailer Dispensary of Philadelphia Hospital, Ambala Punjab (*p. 93*)

The Doctors Abraham (second and third from the left) and staff of the rural hospital, Vadala Mission (*pp. 97-98*)

The doctor at Azamgarh, U.P. reports encouraging co-operation on the part of the Christian community in promoting health measures by regular health examinations, and by inoculations against cholera and plague. The Church has engaged in regular and sincere prayer for the sick and members have co-operated in the building work. The need of a health visitor or almoner is felt here, as elsewhere.

In Jagadhri, Punjab, the Church members have found an avenue of service through the hospital.

Two years ago, on a Hospital Sunday, our medical superintendant spoke to the local congregation of the hospital work, not as a separate Mission institutional activity, but as an avenue of service through which every Christian could give his or her witness. Since then we have received the Hospital Sunday collection as a special gift; old bottles and jars (most useful indeed) have been handed in; the Sunday school children at times make and bring small posies of flowers to each patient, and sing in the different wards; our Anjuman (the women's society) meets every month to do sewing and mending for hospital, and once a month a group of our Church folk take the Hospital Sunday service. So not only for us whose special work is medical, but for every Christian a mission hospital is a golden gate of opportunity.

In Palwal Hospital visitors are appointed by the Church, of whom one is the pastor's wife. Sewing parties and sales of work have helped financially, and a Christmas offering is made. From the Salamatpur School on Monday evenings the senior scholars come to sing. Among these are some who were once in the hospital as 'unwanted babies'. Now, as Christians, they come to give the message of God's love to others.

The large hospital at Ongole, of the American Baptist Mission, plans to have a managing committee soon. The Church and hospital are in cordial relation. The Church helps financially and also by sending laymen to address and visitors to visit the patients on Sunday afternoons.

Regarding the large medical work at Neyyoor the doctor writes:

The Indian Church at some future date ought to take over the medical mission as part of the Christian witness, and responsibility should be gradually laid upon it to an increasing extent.

At the present time the Church in Travancore is not quite ready to do this. The reason for this is largely financial. A medical mission is a far more costly type of institution than any other variety of mission enterprise and the free treatment of poor patients which is necessary as part of their work can only be kept up by attracting to our hospitals the wealthier class of

patients who at the present time around Neyyoor are more ready to come for European aid than to trust themselves to their Indian brothers. The doctors on our staff can safely perform operations which many English surgeons would be unable to manage. In the next ten-year period the work in this direction must develop with the definite end of wholly Indian management in view; every European missionary must have the grace to echo the word of John, 'He must increase but I must decrease', and the prayers of our friends at home are especially asked for the Indian staff, that they may develop a real sense of responsibility, and an increasing efficiency, combined with personal dedication of all their faculties to the service of God.

The Baitalpur Church, C.P. takes an active interest in the medical work.

> The local pastor has almost become a member of our staff. The poor of the Church are treated free upon his recommendation. As far as finances are available the Church helps the poor with food while they are in hospital, and also sometimes with the payment for medicines. The women from the Women's Society of the Church come and visit the patients and entertain them with songs and delight them with flowers. Young men (still unfortunately very few) come of an evening to have discussions on religious subjects with the patients and their relatives.

Here is what the chaplain says of a member in the Church of Madura:

> In our Church there is an old lady who had not the benefit of modern education. She was poor and brought up in the country; the greater part of her life was spent in a village. She now resides near the hospital. She quietly comes in at the visiting hours, she goes from patient to patient, asking about their health, speaking words of encouragement and instructing them to put all their trust in God. Sometimes she brings oranges or biscuits with her and gives them to the needy suffering. The patients derive a great deal of comfort from her. After two years illness during which time she was not able to visit the hospital, she recently returned, her face full of thanksgiving and love.

The chaplain adds that Hindus like prayer and often wait for him to help them in that way.

The Syrian Christian Church in Travancore and the Anglican Diocese there, afford us illustrations of indigenous churches undertaking medical work. The wife of a missionary, herself a doctor, writes:

> The Anglican Diocese of Travancore is self-governing and is running some medical work which it hopes to develop as finances permit. It has floating dispensaries staffed by com-

pounders. These tour the backwaters and bring medical help where there is no other, staying ten days in each place before moving on. The two existing dispensaries are not nearly enough, as each place may receive a visit only once in two years. The Diocese is planning to organise maternity welfare and public health propaganda in connection with these dispensaries. It has also a small dispensary at Bethel Asram, the training centre for women workers in the Church. It has a small hospital in the Molkavu Hills, a very isolated and inaccessible district. This was originally intended for a maternity centre, but the Medical Board of the Diocese is considering developing it on more general lines as a central hospital with a well-qualified doctor and a ring of out-lying dispensaries in charge of compounders who can be trained by the doctor in charge.

The Church is also encouraging elementary training for its pastors and the doctor has been lecturing to these students. The emphasis is on elementary hygiene and preventive medicine and the students are not encouraged to consider themselves doctors.

Alwaye, in Travancore, is well known because of the Christian College there carried on by a fellowship of Christian men drawn from the Syrian Church and the C.M.S. In connection with the College, but independently, there arose a small medical fellowship, which began the Rural Medical Fellowship of the Union Christian College. Those who belong to it had a vision of the need and consecrated themselves to the service of the sick. There is a compounder, a young man who had completed two years of college work, now serving for love of the work and not for the bare maintenance he receives. Another is in Madras taking his medical course and will come back to serve. The wife of the C.M.S. missionary on the college staff is the third devoted member of the trio. From a hut, the work has grown to a small hospital and out-patient department. Gifts still come from abroad, but much also comes from friends in India.

Across the river at the Girls' School is another fellowship, a social service league. It is a still younger and more tender plant. In the Women's Christian College, Madras, the students used to go out weekly for welfare work to the poorer parts of the city. A student who did this is now one of the teachers at the Girls' School. In order to be able to develop Christian social service in the school she gave a year to learning something of nursing in a large mission hospital in Madras. She longed that the senior girls in the school should learn to take an interest in the poor folk in the villages near the school. So the Social Service League was begun. On Sundays five groups of girls, with teachers, go out and give health teaching and tell Bible stories. They soon began to feel the need of more help.

> They used to try and do little dressings and gave minor medicines themselves but this was not very satisfactory, so they began to ask about nurses, and they heard about an English lady, a trained and certified nurse and midwife who from other sources could obtain enough money to live upon, and they asked her to come and help them. Five years ago she came and together they started work in a shed with the school teachers taking it in turn to translate and the children gathering money for the medicines. This was not altogether satisfactory, so she started telling her friends and relations about this work and some of them gave occasional presents so that gradually a trained staff was built up, and the teachers and the school children work hard to keep going a steady, though small, medicine fund for the poor people.

Though the work of this dispensary is small and its funds limited it is very valuable because it is teaching the senior girls to care for the people round about them.

The following shows the fruit of the medical work in the beginning of a Christian Church, not without persecution.

The Syrian Christian doctor of Cheriazheekal, says that the Women's Auxiliary Evangelistic Association of the Mar Thoma branch of the Syrian Church help to support the hospital there. The hospital is on a sort of island—the sea on one side and the backwater on the other—and the people are insular in their outlook. After some years, he says:

> A family of these people accepted Christianity openly and were baptized. This happened on the day when the Travancore Government published the temple entry proclamation for all Hindus. The local people, all Hindus, did not like this one family leaving them and accepting Christianity. With the support of their Hindu brethren outside this place, they asked this family to leave and go anywhere they liked. As they objected to this order the poor convert was caught and handled very roughly. The angry crowd then turned against the doctor also and he too got his share. But, by the grace of God, both escaped with their lives and are alive to this day. The persecutions could not stop the progress of Christianity. Within a month's time three more were baptised and all are doing very active Christian work. Now the local people have no objection to these Christians staying among them.

Thus we see the hospital growing out of the heart of the Church as an expression of the compassion which is of the very essence of our fellowship with God and our love of our fellowmen and as such is a vital part of Church life.

CHAPTER VIII

AMONG THE VILLAGES

'And when he saw the multitudes, he was moved with compassion on them.'—MATTHEW 9 : 36.

FEW Mission hospitals are found in the larger cities. There are none in Calcutta, Bombay or Lahore. In Madras, Delhi, Poona, Lucknow, Cawnpore, Madura and a few other large cities there are hospitals established for women which were pioneers in their day, and have grown in usefulness with the years. Most hospitals are in places of moderate size and minister to a considerable proportion of village people. It is a recognized policy to maintain a well-equipped central hospital and to establish branch hospitals or dispensaries in the smaller towns and villages. This is illustrated by Neyyoor, Nagercoil, Miraj and Amritsar. There are causes operating to place increased emphasis on rural work. Some of these are that private practitioners are now found in the larger towns, and the villages are therefore the more needy places; the development of group movements toward Christianity, has given a new opportunity and responsibility to provide them with a health service. For fifteen years there has been also a much greater emphasis on rural work in general. The conferences held by Dr. Butterfield in 1930 after the Jerusalem Conference were a great stimulus. The work of Mr. Brayne in rural uplift has been widely studied. Schools and colleges have become more rural-minded.

This chapter is chiefly concerned with work undertaken primarily for the villages, and maintaining in the interests of the village some connection with a larger medical centre to which, when necessary, patients can be referred.

The first account of such work is written by an American woman doctor who was for several years in a mission hospital, but who for more than ten years has devoted herself whole-heartedly to village work. Her ideas, though not her convictions, have undergone some modification. It was some years before she decided to settle permanently in Wandiwash, North Arcot district. She lives in what was described as part tent and part South Sea Islander's hut. It is a combined hut and tent on a concrete floor, and with a thatched roof on pillars. She lives alone there on the Church compound, and has not yet found a permanent Indian trained nurse or doctor as associate.

> When I first started medical work among villages, it was my desire to do preventive work rather than the treatment of disease

which is everywhere so prevalent that one can never hope to cope with it adequately. I had visions of making a village a more sanitary and healthful place for the people to live in and for children to grow up in. There were many things that could be done to reconstruct an Indian village that would, from our point of view, add to the happiness of the people and give the children a better chance of a healthy body and mind. If it meant only dealing with things, much could be done. But one must first of all deal with people who live in the village. They are the real problem. It means changing customs established through many generations, habits of living which do not trouble the villagers, no matter how obnoxious and unhealthy. It means changing of characters whose standards have often been low. It means changing the centre of attention from the individual and his family to the broader vision of the good of all—the general welfare of the whole village. It means changing the mind from a bondage to fear and fatalism to the freedom of the mind that comes with faith and trust in the love of God in Christ.

Ten years have passed since I ventured forth on this unknown work of what was popularly called village uplift. During these ten years I have learned many things, and have come to certain conclusions. First, to try to do preventive work without treating those who are ill will not go far in the villages. If we can show them that our way of taking care of maternity cases is superior to their own, it is more likely that they will listen and heed teaching about prenatal and child care in the prevention of infant sickness and mortality as well as that of the mother.

Second, village work is most effective when done, not as mass efforts, but in patient, personal work. All efforts for the masses need not be excluded but influencing individuals as occasion presents is a far more effective way.

Third, thinking of methods of changing the character of a village usually ends in going round and round in the same vicious and hopeless circle. I believe more than ever that if one would really change a village one must get the children. That means that the influence of the village must be counteracted. Therefore the children must be gotten early. Habits developed before boarding school age are so firmly rooted that they survive many years of boarding school life, and when sent back to the village the individual slips almost without noticing it back into the ways of village life. For that reason I believe that nursery schools and child welfare centres where the very young children may be cared for while the mother is away at work for the day, promise much. I have not tried this method, but it has been in my

mind for a long time if I could find suitable workers to start this scheme. Children must develop habits of cleanliness if the village is to become cleaner. Children must learn to like being clean, for until they do there is not much hope that any change will be permanent. Mothers are either too busy or too unconcerned to bother about habits of cleanliness. The pity of it is that this is not limited to ignorant village people, nor to the outcastes.

We are trying to do something for children of school and pre-school age in a small way. The children come one afternoon a week. We have two groups—one in our own village, the other in a village not far away which we visit once a week. We also try to gather groups of children together on our roadside work when a Bible-woman takes charge of them. At least once a week the children are washed and combed. This will not likely produce the results we would like to see but it is a beginning.

In the many little villages, far from the main travelled roads, there is often little influence from the outside world and life and thought are as they were many, many generations ago. Caste spirit is usually very strong. One of the results of work among the villagers has been the introduction of new points of view, new ways of thinking and acting. I was very much surprised to see that as an actual fact in one of our roadside centres. The caste people present were from a very conservative village. A little outcaste girl had an abscess that had to be opened, and she was frightened and fought against the treatment. The father tried feebly to hold her, but he had probably always let the child have her own way, so his efforts were very ineffective. An older woman tried to help but she was herself not very well and could not cope with the fear and anger of the little fighting patient. We were working outdoors under the trees. The group from the caste village stood at a safe distance watching. Suddenly from that group a young man came forward and took the child in his hands and held her while the necessary work was done. He was commended for the help he had given. His fellow caste people said nothing, Whether they said anything afterwards I do not know. But for once the young man had won a victory over the pride and prejudice of his training.

The woman who had tried to help was a poor leper who had nothing in the world. She used to come every week, at first with uncombed hair and not too clean. After I asked her one day to come clean and with her hair combed she always appeared neat and clean. Besides getting her weekly treatment she enjoyed sitting at the feet of our Bible-woman listening to her teaching and stories of Jesus. She would always stay until we

were ready to go. Somehow she seemed to have grasped something of the love of God in Christ and she had a simple faith. After returning from a summer holiday I missed her. I inquired about her and was told that she was very bad and could not walk. When for several weeks she did not come, I walked out to the little village where I was told she was. When I reached the place I asked for her and was at once led to a tumble-down shed where she was lying. She was all alone. Beside her was a rusty tin into which some neighbour had poured a little gruel for her to eat. I could hardly recognize her. She was very glad to see me. I sent someone to another village for a little milk which was not available where she lived. Before I left her I prayed with her. The next week I walked out to see her again. She was then very weak and could scarcely lift her hand. She asked if I had brought her some sweets for which she had asked the week before. I had, and she was happy to have them. When I told her I had to go, she said, 'Aren't you going to pray today?' Of course her request was gladly granted and I could only pray that her release might soon come. She was satisfied and I left. Just two days later, on a Sunday morning early, she passed away. Her faith was a simple one, but I am sure it sustained her to the end.

More and more I believe that individual work for individuals is the most effective way of dealing with our village problems. It may not be spectacular but it counts in the end. Not a few times have we seen the attitude of a whole village change because of help given at a time of need.

We are only touching the fringe of things in our efforts for the villages. Our greatest need is for workers who will be willing to serve in the difficult and lonely places. The need is tremendous in these dark places, and the physical need is perhaps not even the greatest, although it is the physical need that forces itself into our consciousness all the time. Only a few days ago a little child of about three years was brought to our dispensary. She had sore eyes. The eyes were not visible. The lids were so swollen that they looked like two large tumours protruding from the sockets. For ten days they had 'gone round the temple' twice a day because someone told them that would cure the sore eyes. When they were thoroughly frightened they came for medical treatment. On the third day of treatment the eyes were opened and the parents greatly relieved.

A few days ago, at one of our roadside leper treatment centres, one of the patients without notice got up to speak to the group of lepers. He told his own story, how he had been crippled, unable to walk, unable to bring his hand to his mouth to eat. After several years of treatment, he was now as they

saw him, able to walk, able to work, his 'spots' had all disappeared. He told them that the reason he had received such definite help was that he had faith and he had come regularly for treatment. He urged them all to have such faith and to follow his example. There was a real hush over that crowd when he stopped speaking. He is perhaps one in a thousand, but he is at least one that has gained more than the restoration of his physical health.

At another leper centre, a patient who was formerly a teacher, read the handbill which we distribute to all who can read. The others of the group listened with much interest. After finishing the reading he proceeded to comment on the subject matter. His witness was a real Christian witness. Before treatment he could not hold a pen in his hands to write. After five years he is now able to write about as well as before although he will never have complete use of his fingers. He is quite a reader and he has a Bible. He has read a great deal in it and can speak intelligently about it. I do not know how far his faith has carried him, but we hope that some day he may come to the full light of the Christian way.

So in many places there is a gleam of light because we have begun to do village work. I sometimes wish that all missionaries could go out to do pioneer work in the villages, leaving the institutions of the towns in other hands.

The second account of work is by a Scottish nursing sister, for many years Superintendent of Nursing in the Rainy Hospital, Madras. She had a desire to do village work for a long time before she was released for it. Like the doctor she is a pioneer in her field. As often happens, an incident in a village had awakened her interest. She saw a child wearing a neat, clean bandage and discovered that there was a trained nurse employed by the municipality. But she also discovered that the trained nurse was allowed only to serve the caste people. When her opportunity at last came she began work in a Christian village. Recognition of the value of the service was given on the occasion of the celebration of the jubilee of the Women's Missionary Society of the Church of Scotland. The money collected by the Churches was given for the opening of a new village welfare centre.

She writes:

Village welfare work must of necessity embrace much more than midwifery and ordinary care of the sick, which is the nurse's principal work in hospitals. During my years in hospital in Madras, I came more and more to feel that there was a large piece of health work hardly touched by what we were doing there—curing patients who then went home to very bad living conditions and who got no help nor instruction unless

they got ill again and came back to the hospital. Health visitors, ante-natal clinics and child-welfare centres are, to some extent, supplying that need in cities and small towns. There is still the great need of the villages. We all know of the teeming populations for whom there will be no kind of medical or nursing help except the native doctor and the barber. The ideal would be to have centres in as many villages as possible, where trained nurses would live amongst the people and do what district nurses would do in western countries, combined with health teaching and Christian religious instruction. A large part of the latter can best be done by example and the loving care of all who come for help, also by teaching about the true cause of disease, in contrast to the present superstitious ideas in connection with malevolent spirits, and in directing them towards a God of Love, who cares for them.

Our welfare work in the Chingleput District was begun at the end of 1930 with one centre with a fully trained Indian Christian nurse living in the village. I do not believe it is possible yet in our villages to run centres purely on 'welfare' lines i.e. instruction in health, including advice regarding the care of children, isolation from infection, etc. I have found that it is *through* our successful treatment of the sick that advice regarding health matters has been listened to. So often we hear, 'but that is our custom'. Nothing will change that except an object lesson, worked out in the midst of the people, showing that to go against their established custom does not bring devastating consequences, but rather more happiness, health and comfort.

The buildings for our centres are of the simplest. An ordinary village house of mud and thatch but with walls of a good height, whitewashed *inside* as well as out, and with windows, enables the people to realise what can be done with the things which are familiar to them. As much of our work as possible is done out of doors. So many people, especially children, are very much afraid of being taken inside an unknown place. There are things which of necessity must be done in private and for that we have a room in the centre. Others see what we are doing, so we are teaching as well as working. One of the governing principles of our centre is to cast out fear and in its place to establish confidence and trust. Children are encouraged to drink their own medicine, instead of having it forced upon them by an adult. Sweets reward their successful efforts. This may seem a trifle, but in practice it is one of our greatest influences and makes for success. The people see that we love the children and that wins them also. It often takes time and patience, but it is worth while.

Hot water for baths is an essential part of our equipment. It is obtained by means of a copper boiler, which has a pipe for fuel down the centre and a tap for the water to be drawn easily. Our children collect twigs and leaves for fuel, so that our hot water does not cost us anything. Anyone in the village can have hot water for baths at any time, if they collect the fuel and fill the boiler. It heats up in a very short time. Our aim is that every child in the village where we have a centre should come daily for a scrub. Most of them do. All children coming for treatment for itch are also bathed, and as many others as possible. One of the village women supervises this part of the work and we encourage mothers and big sisters—and brothers too—to do the work themselves for the children. Soap is provided.

At 8 a.m. daily we stop our work for about ten minutes and have a simple Bible lesson, usually using a picture, then prayer. We find this more satisfactory for the patients than at the very beginning of the morning's work.

We ask everyone who receives treatment to pay at least one-quarter anna. Those who can afford it pay the actual cost of their medicine and give something over and above that for the work of the centre. Maternity patients give a contribution according to their means. It may be As. 4 or sometimes up to Rs. 5. The expenses—excluding the missionary's salary—are the nurse's salary and Rs. 3 or 4 for the woman who helps. The centre could be run for Rs. 50–60 per mensem. More money would allow for more stock. This does not include the cost of motor car for supervision of the work. Included in the budget are salary of the nurse, Rs. 25–30; helper, Rs. 4; equipment, Rs. 4; drugs and dressings, Rs. 15; contingencies, Rs. 2.

This work was not begun without opposition and reaction to the idea of a nurse living by herself, or having her own household, out in a village. It is due to the fine example and work of the nurse who built up the first centre that our work has prospered and that public opinion in our area is now very much in favour of this very valuable form of service. It is better to leave a village centre closed for a time, rather than to put in a nurse who is not specially fitted for this kind of service.

Such village work also affords an opportunity for Church members to take some active part in it. Our 'Sisters' Association' helps by a donation from its funds and by members visiting with the nurse in the homes or helping with the evangelistic work. The Sunday schools and other organizations of the Church also help by contributions. As the work develops we hope that it will more and more become possible for it to become part of the activity of the Indian Church.

A Rural Extension Medical Work is being carried on in the district round Fategarh, U.P. where the American Presbyterian Mission has a general hospital in the midst of a large Christian population. Many of the Christians came originally from the Depressed Classes. The doctor-in-charge of the extension work is a qualified medical woman, wife of a district missionary.

She says:

> We have been trying to find the Christian children who are untouchable to caste vaccinators. In many places their mohullas remain an endemic centre for smallpox, whence it is spread by their mothers, who do village sanitary work. All this because caste prevents the Government vaccination officers from giving them vaccination. Many families send me word of new babies who have come since I last vaccinated the group and want protection for them also. And some, of course, still remain unconvinced of the value of vaccination. On them we still continue to use our best persuasion and tact.
>
> Every Fly and Villain mosquito has been well portrayed in our feltographs (made by Mrs. E. D. Lucas, of Lahore) and we find the scenarios very much appreciated. Flannel-backed pictures, attached at a touch to a flannel background make it dramatic to construct a village in an instant. The people are then brought in, and buy fly-contaminated sweets; or drink water from a filth-draining well; or are bitten by a malaria-laden mosquito, before our eyes. The dire end of cholera, the slow wasting of tuberculosis, the hope of recovery for those who eat quinine, are instantly perceptible by these means.
>
> Beekam is a Christian, dug from the nethermost social pit, an outcaste, a sweeper. But his home is a centre of Christian faith in a poor, dark village. His caste neighbours respect his judgment, and ask his advice. He has brought and sent many patients to our Christian dispensary held weekly at the Home Mission house, seven miles from his village. He brings us word of who have come and of how they fare after treatment. He brings us word of the needy ones, whose coming we urge through him. He is a man of real, vital Christian faith. He has his Bible-reading and prayers, before the day's work. *The Naya Dihati*, a monthly paper in village Hindi, enjoins cleanliness and gives directions for various simple home remedies. Beekam says he read in it how to cure cholera by giving the patient many glasses full of dilute potassium permanganate solution, and by so doing saved a man's life. He has saved many eyes from blindness, and hands and feet from lameness, by using the simple medicines he understands to combat infection, where otherwise incantations and offerings to idols are the classical treatments.

The doctor at Amballa, Punjab, describes the out-station work visited by a travelling dispensary:

> The last few years have seen two new types of work begun. As a result of Dr. Farra's efforts we opened a little two-bed hospital in a village eighteen miles away. Everyone was afraid to live there at first, and our girls thought it was dangerous. It was the same way when we first put nurses in private rooms or homes for special duty. It is true it is dangerous, and if a girl has a weak character she may fall. The staff nurse out there goes regularly to give health teaching and advice at both boys' and girls' schools.
>
> Now a well-equipped trailer caravan makes a weekly trip to the out-station for consultation and supervision. All the nurses are anxious to spend a month there now. It is like a country home. The roadside travelling dispensary carries a doctor, two nurses, supplies, and sleeping space. It is used as an ambulance, too. The patients and relatives are entertained and instructed by victrola records in the vernacular, prepared by Government, on subjects of health, economics and common village problems. The trailer stops at appointed places on regular days along the side of the road. If petrol and money for other expenses were available, this work would continue to grow.

The roadside dispensaries are a well-developed feature of the hospital at Vellore, and through them nurses and medical students become acquainted with the needs of the villages. Their work is thus described:

> In 1907 this work was opened, on a road leading to a large town twenty-five miles to the west. Notices were sent out to all the villages along that road, that on the following Wednesday a motor car would come, bringing medicines to any who were sick, and all who needed help could come to the side of the road and hold up a bottle and the car would stop, It was with a sense of wondering what was before us that we started out, but we were amazed at our reception, for the road seemed lined with people holding out bottles in silent appeal for help.
>
> The loss of time, from frequent stopping for two or three, made it necessary to appoint certain halting places for the following week. Great over-hanging trees, which would provide shade for those who were waiting, were selected near nine villages. But the car still stops at intermediate places if one sees a bed by the roadside, a group of waiting people, or a signal raised.
>
> The work grew steadily, and during the past year a new strategic centre has been established by the building of a small

hospital with fourteen beds. One of the Vellore graduates with two nurses, a compounder and Bible-woman carry on the work. Usually every bed is full, and a dispensary varying from 130 to 180 patients daily is held. Lepers are attending in increasing numbers, and twice a week between fifty and sixty assemble to have their hypodermic injections. These lepers have built a very good shed for themselves, providing all the material and labour.

The doctor usually sits on the front seat, and patients come there to pay their half anna or more, are examined, and the diagnosis and treatment written on a slip. The patient then goes to the back of the ambulance where a nurse and a medical student have all things ready on the step for treatments. . . . A Bible-woman gathers groups a short distance away and tells them the story of Christ. Children often bring flowers and receive a picture postcard with Bible verses printed on the back, which they learn and recite the following week.

If time permits, the doctor or the medical student gives a short lecture on hygiene and how the villager can help to prevent disease.

Any very sick persons are urged to remain under the tree until the ambulance returns at night, when they are picked up and taken to the hospital.

We give below an account of a few hospitals established especially to meet the needs of the villages.

In the Eastern part of Bengal are two stations where the New Zealand Baptist Mission is carrying on its work, Chandpur and Agartala. The small hospital at Chandpur is giving a nurses' training to girls, which they feel is worth while, though the hospital is too small to be registered. In the districts round Chandpur, three thousand died from cholera. Eight thousand lives were lost in a cyclonic storm in Barisal, not far away. We think of lives lost in war, but here are thousands lost in other ways. The hospital is for women, but it is realized that a man evangelist is needed to approach the men relatives.

In Tripura State there are about 3,500 Christians, chiefly of the aborigines. With the idea of providing medical aid and health measures for the Christians specially and others as well, a woman doctor has begun work under the N.Z. Baptist Mission.

Needing a place for in-patients, she had a bamboo shed erected where a man has had his little daughter. He became an enquirer, one of the evidences of his faith being his refusal to allow the usual sacrifice to be offered for her recovery. The doctor tells of a high caste patient suffering from tuberculosis who was a happy Christian. His people did not approve of his new faith, and neg-

lected him, but he said he was never alone for 'Another' was always beside him.

The roads are mere tracks and many places are difficult to reach, so stocks of common medicines are left in the hands of the Christian school teachers. The aim is to have a trained male nurse or compounder in each, but it is difficult to find and keep them. The local Christians help by bringing rice and also by paying something for their medicines. They built a house for a compounder, but when he came and realized he would have no shopping centre near, he refused to stay.

The doctor of the American Evangelical Mission at Baitalpur, C.P., is in charge of a leprosarium which is doing special work for a wide area. He writes of how circumstances compelled him to open beside the Leper Home, a treatment centre for general cases which has gradually grown into a hospital. He says:

> Finally the need of the villagers in our vicinity forced our hand. Beginning with such accommodation as was available, in 1938 a long shack with mud floors, mud walls going up about six feet high, and low partitions, was erected. This also soon filled up, and so last year 416 patients received treatment as in-patients. There is a hope that plans for a small well-equipped hospital will be granted by the Mission.
>
> Ten years ago the mention of injection to the ordinary villager meant a surgical procedure of major magnitude. Today the same villager feels that he is not getting adequate treatment unless he gets an injection. Rarely were we allowed to give saline or glucose transfusions in former years. Now we do not hesitate. The word 'operation' is not now associated with certain death or regarded as a last resort. People accept our judgment.
>
> And through all of this what a wonderful opportunity to tell folk that all this is done because there are men and women who love the Lord Jesus Christ!

Of the greatest obstacles to work he writes:

> Our great obstacles to good work, aside from our own selves, are, to my mind, antiquated religious rules and economic distress. Religious rules often prevent us from prescribing correct diets for diseased conditions. So much of Hinduism is concerned with rules of eating and drinking, and these are definite obstacles in hospital work. But in these things as well as the reluctance of women to be treated by men physicians we are seeing a very perceptible change. These rules have recently been repeatedly set aside for medical reasons. Patients say that for health's sake many rules may be evaded. But the almost insurmountable obstacle is the economic distress in which most

villagers find themselves. During the past year we have had to deal with an increasing number of cases suffering from the effects of malnutrition.

Seven years ago the C.M.S. began medical work at Pachwad, Hyderabad, to meet the needs of the Christians in a mass movement area. They have now a small hospital.

A notable feature of the hospital has been the help and co-operation which it has received ever since its inauguration from the Church of Scotland Mission Hospital at Jalna, over forty miles away, the missionary doctor and sister from there having come over for consultations and surgery every week until this was rendered impossible by petrol rationing. Now they are ready to come out on receipt of a wire, if help is needed in surgery, and this means that the hospital is able to deal with patients who would otherwise have to be refused. Some are willing to submit to an operation in Pachwad, but are not willing to go the extra distance to Jalna, which is for most of them an unknown area.

Indigenous *dais* are still active in the neighbourhood and are loath to let any cases slip out of their hands, nor have we as yet been able to persuade any of them so much as to come and see the hospital! However, we hope that a day will come when we may be able to get them for training and so save much suffering. A recent instance in Pachwad was that a woman had twins who happened to be born whilst all the neighbours were out in the fields. The *dai* came and delivered the first child, but when there was a delay in the birth of the second she became frightened, quietly shut the door on the suffering woman and went out leaving her undelivered. When the husband returned from his field he found his wife and two babies all lying dead in the empty house. And this was within five minutes walk of the hospital. One might add that no action was taken to bring the *dai* to book.

In the near future we are hoping to extend the scope of the work by making Pachwad a base hospital for a chain of district dispensaries.

A daughter of India, educated at the Missionary Medical College for Women, Vellore, and now of the Methodist Mission in Sironcha, C.P., says 'an out-door dispensary, a ten-bed hospital and village medical service constitute our work under the name of Clason Memorial Hospital'. The mode of travel is by slow-moving oxcarts.

Our jungle road goes through beautiful forests of bamboo, teak and various other trees winding round and over the hills, crossing the streams, big and small, on its way to the villages. Here we find people poorly nourished, clothed in ignorance,

superstition and sin. To take the love of God and His healing power with the means and measures provided one must go with Christ through these jungle roads.

Four teachers or Bible-women carry on simple treatments. Two of these are widows who have received training in midwifery. A fascinating story is told of a contact made in one part of India, and renewed in an entirely new place.

> Many years ago, away in the tea gardens of Assam, a missionary of Sironcha met a group of Telugu-speaking labourers recruited from her own area. Among these was a woman named Bachamma with whom she became friends. Years afterwards she met Bachamma again in her native village, a few miles from Sironcha, and she had not forgotten the old friendship, and gladly accepted help for her sick child. Later on both children became ill and Bachamma brought them to a village near Sironcha and walked two miles daily to have them treated. Her caste prejudice was too strong to allow her to have them admitted as in-patients. But the need for good food and treatment for her children, and her own observation of what was going on in the hospital, at last overcame her objections. Not only did the children recover but the six weeks stay in the hospital induced in her a grateful heart and a knowledge of Christ and His power to heal.

From the same place the doctor writes:

> Yaws is a prevalent disease in this part of the country. At first it was discovered amongst the aboriginal hill tribes but now it is found among all classes of people. The local government is taking pains and putting a special doctor on duty and providing drugs towards its eradication. So we are fortunate in getting a free supply of preparations available from their stock, together with a small grant to feed those patients coming in from a distance for treatment. Both the Mission and the Government hospitals co-operate in this weekly clinic, selecting Monday as a convenient day because it is the bazaar day for all. This weekly clinic is attended by all classes of people from far and near within a radius of thirty miles.

'Vadala Mission' gives its name to a post office of its own. An Indian doctor and his wife, who is also a doctor, began medical work there in 1937. The hospital has had a rapid growth in four years from eight to forty beds. The management is entirely Indian, but the Mission co-operates heartily. About 75 per cent of the money comes from local sources. The local workers contributed a month's salary toward the building fund. The doctor says:

We started this hospital in the year 1937 with practically no assistant staff or nurse to cope with our work. But as the work increased God helped us wonderfully.

One of our problems is accommodation of the patients of high castes and low castes in the same ward. The orthodox Hindus in the villages are very strict about their castes. One day a Christian was operated on and put into the male ward, which elicited a protest from all the Hindu patients and they went the length of changing their beds to the verandah. But we insisted in keeping the Christian in the ward and within a few days the other patients got used to it and continued staying with the Christian in the ward. Still some friction between the patients regarding this goes on, but we shut our eyes to such complaints. I believe it is the hospital which can remove the caste prejudice and we, as Christian doctors, have the opportunity to preach for the removal of caste prejudice in India and show it in practice.

In writing of Vikarabad, the Indian doctor in charge says that the 'hospital is the direct response of God to the earnest prayers of the pioneer missionaries' and quotes from Bishop B. T. Badley's *Visions and Victories*:

For years the need of medical aid was keenly felt. There were times when we sat by loved ones, expecting that every breath might be the last. We sent to Hyderabad to try to get a doctor but no one could come. Then we cried unto the Lord in our trouble. He heard our prayer and in 1910 laid it on the heart of Mrs. J. L. Crawford who had given us the school to give us the hospital as well.

A succession of doctors have done creative work. Hyderabad State has epidemics of plague and cholera. Some twenty-five years ago Dr. Taylor trained students in his hospital and sent them to the villages to help. Some of these men are still practising; two of them are in charge of small dispensaries. Then came Dr. Linn, who, to facilitate the distribution of simple remedies, began a Tablet Industry, now at Bowringpet.

In 1928 came the present superintendent of the district, an earnest educationalist. In his effort to fight against illiteracy in the villages under his jurisdiction, he discovered the two great products of illiteracy—first, superstition and, second, disease.

In his thinking he was led to the establishment of village centres combining the preacher, teacher and healer in one unit. This is in line with the plan set forth so well in the Rural Reconstruction Unit advocated in 1930 by Dr. Butterfield, who visited India following the Jerusalem Conference as a specialist in rural work. There are now three centres open and two more ready when workers are

available. Each centre has a preacher, teacher and nurse, and two have compounders as well—all married persons. All can be visited and supervised from Vikarabad. One of these centres served a hundred villages within ten miles. They do preventive work against small-pox, cholera and plague. Their effort is to get the people to understand what to do and to form public opinion to fight disease, for they are ignorant and superstitious. A man suffering from yaws told the doctor that it had come upon him because he had omitted the ceremony of worship of an idol the previous year.

Under the influence of the Mission hospital at Hadya in Mysore, a change is taking place in the outlook of the people. Caste prejudice, ignorance and superstition are breaking down. The nurse who does welfare work and visits in the homes is finding that the women are responding in the care they give their children and in the cleanliness of their homes. The doctor tells of a young man of a respected family who came with his wife and newly born infant to get treatment for venereal disease. They had to remain for some time. One day he heard the story of the man sick of the palsy brought to Jesus, and of the forgiving of his sins to which his disease was related. He was touched, repented and accepted God's forgiveness and came into an experience of happiness.

The doctor at Dharapuram who began the medical work in 1927 in a district in which there are many village Christians, writes of the contrast between then and now. She describes how she began work in a little dark room with no equipment and no medicine except two tins of Calow's pills, one bright green and the other pink. There was a growing mass movement in an area over a fifty miles radius. Infinite need, infinite suffering, infinite fear. All the first cases were brought as a last hope in a dying condition. For many months patients tended to mistake fountain pens for knives, and to flee screaming at the sight of a stethoscope. The majority of those admitted ran away after a few days, unless a dramatic cure could be obtained. The scavenger went on strike, because she would not clean up after 'these outcastes'. All midwifery cases were abnormal, and of a kind seldom described in text-books.

Very much land remains to be possessed but now, in 1941, there is a forty-bed hospital, moderately well equipped, and capable of expansion to sixty beds as funds permit. The doctor still has much to learn, but she can talk the local dialect, and is discovering how to relate the astonishing statements she hears to the more conventional text-book descriptions of symptoms. There is a European sister, three trained staff nurses, and probationers learning to work in rural conditions before going to a larger hospital to study for their Government midwifery examination. There are beds, and electric light, and the beginnings of a drainage system, and the sweeper is a friend and a colleague. The odd job man who serves

the men's meals is a member of the very despised community, but when he goes into the kitchen or hands out the plates no one murmurs. Patients come trusting and friendly, and clamour to be examined at once. Some still run away, but the majority stay to finish their treatment. Last year there were over fifty maternity cases, more than half of which were normal, and two-thirds of the babies were born alive. Maternal death is increasingly rare.

What next? The doctor says:

> There is a grand opportunity for village work in the hundreds of villages where there are Christians. We are learning to cure many of the diseases which afflict our friends, but we are doing only too little in the way of preventive work. Investigation of local problems, the right presentation of health teaching, and the carrying of the message of Jesus to the whole life of man—these call for time, work and study, and we have hardly touched any of it so far.

CHAPTER IX

'THE LEPERS ARE CLEANSED'

IT is an interesting and significant fact that in the fragments of a Gospel manuscript discovered a few years ago, of earlier date than any other yet found, an account is given by the leper who came to Christ for healing of how he contracted the disease. 'Master Jesus, journeying with lepers and eating with them in the inn, I myself became a leper.' For him the inn was a place of bitter hurt. But the places of rest and refreshment which have been established in India in Christ's name for some of her neediest lepers have become true inns of healing.

At first they were inns of helping rather that of healing. It was 'at the Sign of the Good Samaritan' that refuges for these victims of life's highway were opened. They grew out of a compassionate response to the needs and pleadings of men and women in whom the whole six of the grievous situations described in the parable of the Last Judgment met. An hungered for food, thirsty for sympathy, strangers in their own land, naked in their need, sick in their bodies, in prison and bound by their inescapable fate, such were the lepers who constrained men and women to be hosts to them for Christ's sake. No wonder they were known in the Middle Ages as 'God's Afflicted'.

It was the compassion of Christ which made William Carey at the beginning of the 19th century plead in the pages of the *Friend of India* for the establishment of probably India's first leper asylum at Calcutta, after the burning alive of a leper had wrung his heart. It was compassion which quickened Ensign Henry Ramsay around the year 1840 to set about erecting at his own expense a few simple huts for the mendicant lepers of Almora, out of which grew the Home there today. It was compassion which moved the heart of Wellesley Bailey to leave his school classroom at Ambala to give of his spare time to bring joy to a little company of lepers at Ambala in an asylum established by the kindness of military officers; and out of that visiting of the sick there sprang the Mission to Lepers, with its wide, and widening, range of activities today. So one might continue to tell of others — Haripant Kelkar, Rosalie Harvey, Isabel Hatch, Henry Uffmann, K. Nottrott, P. A. Penner — all men and women who saw and answered Christ's challenge in the leper's need; and in compassion and faith and courage, became Hosts on His behalf.

Little did these ministers of mercy conceive to what consequences their hospitality would lead. For now Christian leper work occupies

a unique place in the activities of Medical Missions. Out of a total of nearly 14,000 leprosy patients for whom residential accommodation is provided in India, over 10,000 of them are in Mission Homes and Hospitals; and a number of the remaining institutions are superintended by missionaries. This means that whereas in general hospital work secular institutions greatly preponderate, the position is reversed in leper work, where Christian institutions are in a big majority. Out-patient work for many thousands of sufferers from the disease in a less advanced stage has also sprung up. It is difficult to assess the service thus rendered to India by these hospitals which began by extending simple hospitality. From a public health point of view a very great deal is being achieved. But something more vital than that is being accomplished. That something is a clear demonstration of a neighbourliness and fellowship which is strengthened and not weakened by need, and of the unfailing power of Christ to bring, even amid suffering, a more abundant life.

> And here, in dust and dirt, oh here,
> The lilies of His love appear.

'. . . an hungered, and ye gave me meat'

We can but give glimpses of these Homes and Hospitals as they are today to illustrate some of the distinctive characteristics of their work and witness. Through those six grievous situations of human need to which we have referred, and through the way in which they have been faced, this comprehensive ministry of hospitality may be portrayed.

The first need of the average sufferer from leprosy in India is a good meal. Poverty is leprosy's big ally. Inadequate food lowers resistance; and then, when the disease flares up and the village has no further use for the sufferer, the pangs of hunger become more urgent. It was in sharing his meal with two beggar lepers who approached him for alms that P. A. Penner began the great work at the Champa Leper Home in the Central Provinces, with now over five hundred guests. The tragedy is that still so many have to be turned away.

> 'I wish that for one week you could be here and with me go to the Leper Home and see the pitiful cases I am compelled to send away. The sights would haunt you for weeks,' wrote the Superintendent. And then, when the alms of Christ's people, given through the agency of the Mission to Lepers, made it possible even in war-time for sanction to be given for twenty more cases to be admitted, this report came: 'This morning we called the applicants who have been waiting in front of the south gate for admission. *There were seventy-six who appeared.* Our maximum had been 527. Now we have taken up to 547.'

It would not be the best service, however, if the feeding of so many were not matched with an effort to give patients, their own hunger satisfied and strength in a measure renewed, opportunity for joining in the task of providing some of the common food. The blessedness of receiving turns bitter if no scope is provided for winning the sweeter blessedness of giving.

Cultivation work is the occupational therapy *par excellence* for sufferers from leprosy, and many Homes have thriving farms and dairies run by the patients' own labours. The Homes at Dichpali, Chandkhuri, Naini, and Saldoha are particularly advanced in their farm work, and many others follow close behind. 'During the year our twenty cows gave us 1,21,458 lbs. of milk,' writes the Superintendent of the Chandkhuri Home in the Central Provinces. 'All the milk is used by our children and patients to supplement their diet.' '641 maunds, 22 seers (52, 606 lbs.) of rice was grown by our patients. There were also record vegetable and dal crops,' comes the report from Purulia Home in Bihar. In one year the Dichpali Hospital in Hyderabad State produced, with the labour of the patients, 79,089 lbs of fruit and vegetables and the work on the farm is carried through under such expert supervision that it is used by Government as a Demonstration Farm.

So do those who arrive an hungered, and are given meat, come to share in the task of its provision. They come, too, to share in the joy of providing food for others in need. Here is a fine example from the Kothara (Ellichpur) Home in Berar:

> The inmates certainly never lag behind in generosity whenever a case of need presents itself. On the contrary, they are sometimes eager to go beyond their means and have to be held back. Quite recently an appeal was made to help the famine-stricken Bhils in Indore District. In a consultation meeting together, from which the missionary was absent, it was decided that most of the 300 lepers would go without meat and sugar for a month; the money thus saved, supplemented by a donation from their Church funds, amounted to Rs. 130, and this was at once sent to relieve the suffering Bhils. Never yet has an appeal been made to the lepers of Kothara to help someone suffering more than themselves, which has not met with a quick and generous response.

Another example comes from the Vadathorasalur Home in the Madras Presidency:

> While for all who were discharged others were taken in, there still remain some at the gate, and we have to tell them 'No room, you must wait!' In April, when the sun was scorching, several patients asked to be taken in, and we had no room. Fifteen of them. I made a calculation. We could make

room, but what about food? While I was giving out the rations one day I said to the patients, 'Will you be willing to cut a little of your diets—it will mean a cut in everything, and then we will be able to admit those waiting? Please put up your hands, those in favour.' And up went all the hands!

Then, a month later, came the good news from England that we might admit an additional ten patients, and so the first ten of these fifteen felt themselves more safe; but the rest we have also not sent away, and they share in the food of others.

'. . . thirsty, and ye gave me drink'

Not only are Christian Missions met with the challenge of the lepers' physical hunger and want. They come parched and dry spiritually. And in the Homes many have come to find in Christ Jesus the Water of Life.

A few testimonies are typical. This is what an English-speaking patient at the Manamadura Home in South India wrote:

> I find that the Lord's blessing is hidden in the apparent curse of my disease; that in the act of bearing the cross of suffering I increase my faith and strength, a true vitality renewing my soul; that my ruined life has been restored and that my loving Saviour has hidden me under His healing wings and has driven the foul things from my soul by His powerful medicines and His wonderful bread and water of life. My heart is at rest enjoying the gift of peace which passeth all understanding.

'Jesus is my best friend,' one patient painted over the door of his room at the Raniganj Home in Bengal; and another at the same Home, who had sunk far in the slough of despair and sin when he was admitted, and who had become an opium-eating victim as the way out for his suffering, came to experience a new life:

> Today he always has a cheery smile for all and responds laughingly to his nickname of George, and is one of the best mannered of our patients. He was formerly employed by a Calcutta broker, and has travelled largely in the Himalayan tea tracts. His employer lost his money, and Rakhal apparently lost his, too, and eventually found his way to Asansol where he began to beg. He tells us that his leprosy came after that, but his story is not altogether clear. In any case he tells us that leprosy was sent to him as a punishment from God, and that through it he has learnt his lesson. If he but hears another patieht complain of suffering or sorrow, Rakhal reminds him of his own experience and says, 'Cheer up, brother, for suffering is God's good gift'.

THE MISSION TO LEPERS

from Despair to Victory

'IS THERE *NO* ROOM FOR ME?'
A patient awaiting admission to a Leper Home

TREATMENT

PHYSICAL DRILL

HEALED—AND HELPING

These two young men, once contagious cases of leprosy, became healthy after treatment, and trained as compounders.

THE MISSION TO LEPERS

Life in the Homes

WORSHIP

WORK

PLAY

STUDY

It is a cheering and challenging experience to join in worship in one of the churches built by the Mission to Lepers in its many Homes. These buildings are rightly made the central feature of its institutions. In one or two cases an attempt has been made to incorporate traditional features of Indian architecture and bring them into the service of Christ. The church building at the Vadathorasalur Leper Home in South Arcot (illustration facing this page) is regarded as one of the most successful of such efforts. But it is in the Church itself among lepers that there is seen, welling up in its refreshing grace, the Water of Life.

This is what happened at the Meerut Home in the United Provinces:

> It is a real joy to be able to report that the spiritual side of the work is one of the brightest, if not the brightest of the whole of the district work here. These poor souls are now keenly interested and were so pleased when they were asked to pray definitely for this village, that they have now adopted the village and regularly pray for it. They were so struck when they were told that the Church membership of this village was about 900, and yet was little more than a 'valley of dry bones'; and now they call themselves the Qudrat Khana (Power House) instead of Korhi Khana (Leper House).

And this is what the Salur (Madras) patients did:

> To make other people as happy as themselves they collect some funds to support their own Mission station, paying for the teacher and building a chapel there.
>
> Every Sunday they bring their little offerings and sometimes also vegetables out of their own garden. After Church is an auction in which mostly a high price is paid for their own produce. Besides this they have a special collection for the Bible Society.

'. . . a stranger, and ye took me in'

A romance could be written about the way in which the widely scattered Christian Leper Homes in India came to be built, so that the stranger might be taken in. The village schoolmaster of Poladpur, Haripant Kelkar, putting up rough huts for needy lepers, and becoming beggar on their behalf; Rosalie Harvey beset by starving lepers in the plague-ridden city of Nasik and going off to Bombay to confront Indian business men with their needs, and returning with enough money to buy corrugated iron sheets to provide a roof against the approaching monsoon; these illustrate beginnings in this great adventure of hospitality.

And the gifts of Christian people in far-scattered countries throughout the world have about them something of the quality of the Good Samaritan's 'two pence' which he left with the inn-keeper,

for the care of his neighbour in need, because he himself must be about his own business.

What better illustration could there be than that of a London postman, going his common rounds, with a great purpose in his heart, so that building after building might be erected at the Home in Manamadura, South India, for the needy stranger there:

> 'I had to put by nearly £2 a week out of my wages of £3.10, but I was able to do so by living very simply and I had only myself to keep,' he once wrote.

One who knew him set down this record of Francis Cardinal's austere regimen:

> 'No luxuries adorned his table; onions, some rice, eggs, tea and margarine formed the major part of his menu. Pasted on the inside of a cupboard was a bill of fare which he religiously adhered to, such was his passion to save for the lepers.'

And there is a charming story about the donors of the New Nursery Building at Chandkhuri:

> When I met Mrs. B. a few years ago, after welcoming me at the door of her home, she said: 'Come in and meet our children. There are fourteen.' After seven had been introduced she said, 'And the other seven are in India. For every child God gives us here, we adopt one in the Homes of the Mission to Lepers in India. Here are their pictures.'

Little strangers, for Christ's sake, brought right into the family, with a house provided for them, and assurance given that 'Whatsoever thou spendest' for them will be met till they grow into strong men and women. This particular Home, from the care rendered to save children of indigent lepers, has been able to send out over fifty school teachers!

When those who have been strangers have themselves found a welcome, and have recovered something of their strength, they are often eager to join in the task of building houses for others. At the great Home and Hospital at Purulia, Bihar, it is good to see the patients; often crippled and fingerless, engaging in all the labour (under skilled direction) for the erection of the many additional buildings put up in the last few years. And the patients at Raniganj went one better. In the erection of the operating theatre the work from scale-plan and making of bricks to the last coat of paint was done by the patients. Only the fitting of heavy plate glass was done by an outsider.

Here is an instance where both funds and labour were provided by patients. It came from the Chevayur Leper Home, near Calicut;

> We must first make mention of a munificent gift of Rs. 500 by our patients towards the construction of an isolation ward.

> Several times when there has been an outbreak of small-pox in the Home, we have keenly felt the need of such a ward. The work was done by the patients themselves, and well done too.

And there was a touching act where one patient became 'a stranger' again to let his brother in. The story comes from the Belgaum Home:

> A younger brother of one of the inmates of this Home arrived asking for admission. As we have a waiting list, I had to refuse. The two brothers are about 18 and 15 years of age. The elder brother spent most of the day weeping, but I felt out of justice to an earlier applicant I could not take his younger brother—we are full up. Next day the elder requested me to take his younger brother, who he said was too young to fend for himself, and he would go. It was a really noble gesture, and I agreed, though most reluctant to let the elder boy go.
>
> There is a happy ending to that story, for an Australian friend reading of this came forward with the support of the elder brother and he was again taken in.

The statistics showing the number of those now provided for in Christian Leper Homes and Hospitals in India are set down in 'A Note on the Statistical Survey' given at the end of this book.

'. . . naked and ye clothed me'

It is the tragedy of so many who suffer from leprosy that, little by little, they see themselves divested of all that goes to clothe life and make it more than a bare existence. Theirs is a stripped life. And to clothe such lives again, with friendship and with reinstatement in a community which has a place for them, is one of the primary tasks of the worker.

An instance comes from the Vadathorasalur Leper Home, where a patient was brought in great agony:

> His face was so swollen that his eyes could not be seen and he suffered terrible pain. The Home was full, but as he was suffering so much some of the other patients said, 'He can have one room; we will manage!' The next morning he was much better, following fomentations. In the afternoon a crowd of men came into the compound. They asked for Ramaswamy's belongings. At last I came to know that they had brought him the previous day in order that he could commit suicide in the Home! At first they would not believe he was still alive. We asked Ramaswamy about the statement of his relatives. 'Yes,' he said, 'if I'd committed suicide in my own village no one would touch my body or burn it, but I knew that if I did it here

you would bury me. That is why I came. But now I am not going to do it!'

Ramaswamy improved, and soon was beginning to come to the Church services. In time he entered the Christian fellowship. Now he is better, and back in his own village telling his people, I am sure, what wonderful things God has done for him.

This re-clothing of lives stripped bare is one of the most important functions of Leper Homes. Schools are established, panchayat systems are adopted to enable patients to feel they have civic duties, competitions are introduced for the tidiest houses, sports are organized.

'They are a wonderfully happy crowd,' wrote the Bishop of Lahore of the patients at the Palampur Home. 'Their houses are a miracle of cleanliness. I never saw anything like them. They have a cook-house competition for which is the best block and the decision must be very difficult to come by. The competition not only keeps the houses occupied and interested; it is their equivalent of a cross-word puzzle.'

Officers of Government are quick to perceive that one of the strongest features of Mission institutions for sufferers from leprosy is that they deal not only with the patient's physical, but also his mental condition. The Inspector-General of Civil Hospitals for Bihar, writing of the work at the Purulia Leper Home and Hospital, commented on this fact:

No one can visit this famous Leper Home without a feeling of appreciation of the magnificent work that has been done and is being carried on in the cause of leprosy treatment and relief. Above all, the leper patients are not treated merely for their physical disease, but this is supplemented by all the up-to-date methods of combating such an infection as leprosy, viz. good food, occupational therapy, cleanliness, the eradication of concomitant infections. And what is more important, the patients are brought to learn that they are not here regarded as outcastes of society but merely as victims of an infectious disease which they have acquired through no fault of their own. Such physical and mental treatment produces the best possible results, as can readily be seen in the personal cleanliness and mental outlook of the persons unfortunately afflicted with this infection, but fortunate enough to gain admission here.

It is one of the fine and heartening things for any superintendent to see his patients, so hopeless on arrival, coming to 'turn their adversity'. A chemistry school teacher who entered the Naini Leper Home came in time not only to take charge of the laboratory, but to train technicians, and to do many tests for the Jumna Dispensaries, and Mission hospitals without laboratory facilities. His disease has

now advanced far, and he is not able to continue this service. He was signally honoured a few years ago by being awarded the Kaisar-i-Hind silver medal.

Other patients become weavers, teachers, nurses, injectors, masons, carpenters, record-keepers. The majority find their community life again in the work of gardens or fields. Field games are played with more zeal than skill; there are awkward squads for drill; at some Homes leper Guides and Scouts try to honour the law of their fellowships; the aid of the drama is called in by patients to portray many a religious story; the Manamadura Home has a well-organized Y.M.C.A., run by the patients, with its adult school, dramatic society, Bible discussion class, library.

In all these activities there is to be seen the reclothing of life, until in the end the naked deformities and distresses of leprosy are almost lost sight of amid the smiling, contented, useful living which marks the progressive Leper Home. 'These were the dust under our feet, and you have turned them into gold,' said a gracious Raja to the Superintendent of the Purulia Home, when he saw with surprise the lives of the patients invested with a new significance.

'. . . sick, and ye visited me'

In the early days of Christian work for sufferers from leprosy it was ordinarily the most advanced and crippled cases—and therefore the most necessitous—who were ministered to. The task of caring for these still remains, and much of the labour of those engaged in leper work is in bringing medical relief to those who cannot hope for complete cure, because of the mutilations already inflicted by the disease. The dressing of ulcers is the equivalent of the binding up of the wounds of the victim who confronted the Good Samaritan. At the Purulia Home alone there were over forty thousand dressings performed in 1941, with careful attention given to the best measures to afford relief to each particular ulcer. Today this is a routine service; but when the Christian care of lepers began in India it was regarded almost as an heroic act to touch the leper and personally minister to him, so that there was an almost sacramental significance in the first medical efforts of the pioneers. One reads with interest an early letter of the Rev. K. Nottrott, who had begun caring for famine lepers at Chankhuri, C.P., in 1897, appealing for help from the Mission to Lepers. After describing a poor woman, fingerless, toeless, with large wounds alive with worms he continued,

> I clean her wounds carefully every day, and she is able to walk again, and is glad to be cured thus far.

What a contrast with the Home there today, with its hospital wards, its laboratory and operating theatre, its treatment centre and dressing stations, its X-ray equipment, its American and Indian

doctors and nurses, its compounders and injectors. Here is not only sick-visiting and the lightening of the burden of suffering, but also the restoration of the health of many. More and more early cases now come to this and other Homes. Of 10,181 in-patients who received treatment in Mission Homes in India (and Burma) in 1940 and of whom records are available, 1,092 cases became 'arrested without deformity', and 596 cases more were arrested in whom, however, marks of deformity remain.

Mission Leprosy Hospitals are often used as training centres for government or local board doctors. For instance, the Dichpali Leprosy Hospital of the Methodist Mission has regular courses of training, as has the Government Leprosy Sanatorium at Chingleput managed by the Church of Scotland Mission. At the Leprosy Hospital near Fyzabad, the resident medical officer recently gave a series of lectures and demonstrations to 180 rural development organizers; for lay-workers also have their part to play in the anti-leprosy campaign.

It is significant that in the recently prepared Report on the subject of leprosy and its control in India approved by the Central Advisory Board of Health, particular tribute is paid to the leading part Missions have played in the medical care of Indian lepers:

> The Mission to Lepers, as has been explained, is the biggest single agency in anti-leprosy work in India, and has in many ways given a lead in such work. . . . Not only are such institutions well run, but they act as centres of training of workers, of out-patient diagnosis with treatment and of anti-leprosy work in general and sometimes of research.

A very encouraging feature is that, whereas pioneer work was largely engaged in by non-nationals (and laymen at that), the great majority of the medical care of leprosy patients today in Mission institutions is being undertaken by a devoted band of Christian Indian medical men upon whom, also, an increasing measure of administrative responsibility is being placed. And under them patients have been trained so that ward work, routine dressings, and injections, all are engaged in by those who themselves are receiving treatment.

It is not always given at once to see beyond the immediate physical distress which is being ministered to; and perhaps that is as God would have it—'*Lord*, when saw we thee sick?'—but to those who have given themselves to this service there does come in time a vision of much more than tortured bodies. Here is what one medical missionary wrote from Naini, Allahabad, only a week or so before he died suddenly at his post, his beloved sick about him:

> I had been warned that close association with lepers and their suffering might make me callous to their condition, but I

think I may truthfully claim the very opposite. This involves a confession: when I first saw the mutilated features of some of our advanced cases, it was difficult to escape a feeling of physical revulsion, but now I no longer see the tortured physiognomy; I see only the noble, stoical spirit behind the scarred face; I see a soul that has been refined by much suffering and the whole personality assumes a semblance of spiritual beauty.

Mention should also be made of the rapidly developing work for children with leprosy, certain Homes such as Chandkhuri, Chingleput, Dichpali, Purulia and Vadathorasalur giving special attention to these boys and girls for whom the whole course of their lives is being changed because of early treatment. And out-patient clinics for the multitudes of sufferers who cannot find (and often do not need) the hospitality of a Home, have also in recent years been developed by Missions.

One piece of out-patient work of quite unusual character is that at Kagal, in the Bombay Presidency. Here, quite literally, is an Inn or *dharamsala*. Adjoining the dispensary and treatment rooms are others designed especially to enable patients, who are compelled to travel long distances, to rest, cook their meals and stay the night if necessary. The rooms are adorned with brightly coloured Sunday School Union pictures; and though the buildings are of the simplest character, they have all modern conveniences—running water and up-to-date sanitation. There is always room in this inn. And the clinic is very popular because of the care of individual cases. It is a moving experience to join with this company of life's wayfarers, of many creeds, at the beginning of the day's clinic, and unite with them in offering the Lord's Prayer, which they have eagerly learnt to say, while they have waited their turn on previous visits.

Perhaps the most notable of the clinics are the two at Calcutta, known as the Premananda dispensaries, supervised by a committee representative of various missionary societies. During the last year under report 40,975 injections were given and 5,638 general treatments, while 3,681 minor operations or dressings were performed. In 111 patients the disease was arrested during the year.

Surely we see in all this a following and even a fruition of our Lord's command to 'Cleanse the lepers'.

'. . . in prison, and ye came to me'

Only for some, however, does liberty from the bonds of physical disease appear. For others, a new and fuller freedom is enjoyed as

they witness the rescue of their children from their own bonds. And for others still, release is found in that state where, even amid the most galling physical limitations, the liberty of victorious living is experienced. In whatever form, it is always the privilege of the Christian visitor to those 'in prison' not only to cheer, but, on Christ's behalf, to 'proclaim release to the captives'.

A remarkable contrast between bondage and regained liberty through an Inn of Healing is provided by the Medical Superintendent of the Dichpali Leprosy Hospital:

> Here is an extract from a letter of application for admission I recently received: 'I passed my matriculation and came to J. . . . to continue my college course. I have passed my first year exams, but cannot continue further as I am not healthy. You will understand what I mean from the fact that I am writing to you. To write and to think about it gives me a shock almost to death. I feel the agony of death facing me. It seems to have already laid its cold hands on me and I am in its clutches. I feel doomed to death and feel inclined to commit suicide. You can perhaps understand my agony, for I can't put it into words. I cannot mix with healthy society and there is no place for me even in my home.'
>
> When we contrast this dismal picture with that of a young man of very similar position who, after two years of treatment in the hospital, went home with his disease arrested, secured employment and married, and is now a very respected member of society in the area in which he lives, we realise something of the service we can render to those poor lepers. It is a real joy to think that we can change a 'living death' and make it a useful life; that we can see despair becoming joy and, most of all, that we can see not only cleansed bodies, but souls which have been freed from the bondage of sin.

And what liberty has been won for those children of sufferers from leprosy who, because of the care which they have received, are able to go out into the world as healthy and useful citizens!

The Superintendent of the Tarn Taran Leper Home, in the Punjab writes:

> It does one good to see the old boys who are still in training in the army, looking smart and fit in their uniforms. They are serving in different capacities, as tank drivers, fitters, carpenters, nursing sepoy, sapper and miner, labour corps, cook, etc. One is in the Navy as a sailor. I wish their supporters could see them and realize what a grand thing they have done in bettering the world by helping the Mission to Lepers in saving these children, who probably would otherwise have been rotting in the dread disease of their parents.

Perhaps one of the most striking illustrations of what may be done for the children is provided in the case of a leper mother who years ago brought her two sons with her to a Mission Home. The elder son had the disease already; the younger bore no signs of it and was brought up in the separate Home for healthy children. Today the younger brother is a qualified medical practitioner, at work for the Mission which was the means of rescuing him from bonds, and is giving treatment to his own elder brother.

Greatest of all is the liberty which so many thousands have come to experience even amid the bondage of their disease.

From the Leper Home at Cuttack, Orissa, comes an example of this liberty amid bondage:

> We have marvelled at the bravery with which patients have borne their pain and weakness, and the triumphant joy with which they entered into the Valley of the Shadow, knowing that the Saviour whom they love awaits them on the other side. One of these dear women was an exceptionally fine convert. She had entirely lost the use of her legs, and had no fingers or teeth. Yet she was always smiling, and whenever people went to see her clapped her poor stumps with joy and said, 'Praise the Lord for all His love and goodness'. Once she was asked how she managed to feed herself, having no fingers. She laughed heartily and replied, 'I eat like you do, Memsahib, with a spoon. I can manage quite well without teeth or fingers. Praise the Lord Jesus who has saved me.'

So does this ministry of hospitality, beginning with total want, go on until at any rate the earnests of total victory begin to appear. The story of the Incarnation began at an Inn, too full to receive a weary Mother. And in the last chapter of the final Gospel we see the Risen Christ, still the Perfect Host, gathering fuel and cooking a meal for chilled and dispirited fishermen. The Gospel story forever makes of hospitality a most blessed sacrament. And in India, Inns of Healing for some of her most needy lepers and their children, that sacrament is being daily observed.

'Lord, when saw we thee an hungered and fed thee?
'Or athirst, and gave thee drink?
'And when saw we thee a stranger, and took thee in?
'Or naked, and clothed thee?
'And when saw we thee sick, or in prison, and came unto thee?'

You may find the answer of the King in the lives of thousands of those who are accounted 'even these least', and for whom the service of the Inn of the Good Samaritan has meant both succour and salvation.

CHAPTER X

CHRISTIAN MISSIONS AND TUBERCULOSIS IN INDIA

'ACCORDING to your faith be it unto you,' were the opening words of a speech made by the President of the Union Mission Tuberculosis Sanatorium, Arogyavaram, Madanapalle, at the celebration of its Silver Jubilee in 1940. These words equally well suit the opening of a chapter which looks at the work of Missions against tuberculosis throughout India.

The last decade of the nineteenth century had seen the waning of the brilliant hopes of a rapid cure for tuberculosis raised by the discovery of the cause of the disease. The twentieth century opened with an increased emphasis on the ability of the body itself to overcome it, given suitable conditions typified by life in a sanatorium. On the continent of Europe first experiments were being made with the surgical treatment of pulmonary tuberculosis. In a number of countries in the West the first national campaigns against the disease were just beginning.

It was at this stage in the history of the fight against tuberculosis that organized effort in India also was first made. Mission hospitals had of course treated cases of tuberculosis coming to them in the course of general medical work, but the length of treatment required and the usual hopeless prognosis in the majority of Indian patients were discouraging. Outside Mission hospitals there was probably even less eagerness to accept tuberculous patients. Wealthy patients had a slightly better hope when they could be sent to Europe, but for the poor hardly anything was done.

About 1906 Dr. T. V. Campbell of the London Mission, Mysore State, himself fell a victim to the disease and was invalided back to England; but God saved him for a greater work. He recovered and returned to India determined that in India, too, institutions must be started where tuberculous patients would not only be welcome, but where the best methods of treatment might also be employed. Largely through the efforts of Dr. Campbell and a few other missionaries whom he inspired with his vision, developments began in South India.

In 1908 the South India Missionary Association, a body whose work was later taken over by the Representative Christian Councils in South India under the National Christian Council, stressed the need of combating the increasing menace of tuberculosis, specially in Mission boarding schools. In 1909 the American Arcot Mission

founded the first sanatorium at Punganur, but it was soon after moved to Madanapalle where better medical supervision was possible under Dr. Louisa Hart. In 1912 the Union Mission Tuberculosis Sanatorium Committee was formed at a meeting in Kodaikanal, with Dr. L. R. Scudder as president. This committee was at first made up of representatives of seven missions in South India; in the course of a number of years eight more missions joined, including one in Calcutta. This committee took over the small institution in Madanapalle and at the same time a site was selected four miles away for the building of a larger sanatorium. The spirit moving that committee was shown by their kneeling down in the scrub jungle of the proposed site, praying that if this place was God's choice, it might become available. There Arogyavaram—a name meaning 'God's gift of health'—began under the leadership of Dr. C. Frimodt-Möller of the Danish Missionary Society. Since its opening in 1915, the institution has grown until it has now 253 beds, and is still the largest institution of its kind in India. The treatment has developed from a simple sanatorium regime of rest and graded exercise, good food and fresh air, to include advanced major surgery of the chest; and a hope of cure has been extended from the early cases for whom sanatoria were first intended to most advanced cases who in former days were refused admission as being beyond help.

A similar growth is being witnessed in other Mission sanatoria in India. Among these may be mentioned the Sir William Wanless Tuberculosis Sanatorium at Miraj in Bombay Presidency. Dr. (later Sir) William Wanless began this work as an adjunct to his main work in Miraj, with its hospital and medical school. The fame of Miraj as a centre for surgery was widespread, even beyond Western India, and it was natural then that in this sanatorium emphasis should be laid on the surgical treatment of pulmonary tuberculosis. In the last twelve years the institution has grown till it has now 210 beds.

In the Pendra Road Sanatorium in the Central Provinces a rapid development has also been seen in recent years. After being begun by the Disciples of Christ Mission, it was re-organized as a Union Mission institution. With Dr. T. J. Joseph, an Indian doctor, as Medical Superintendent, it has expanded in the last five years so that it has now 150 beds. In 1941 Dr. Joseph was invited to be the first Medical Superintendent of the Lady Linlithgow Sanatorium at Kasauli, started by the Tuberculosis Association of India, and he has been succeeded at Pendra Road by Dr Verghese, who has had some years of experience at Arogyavaram.

Other Mission sanatoria are Jubar and Almora in the Himalayas, Madar in Rajputana, Vengurla in Bombay Presidency, and Visranthipuram near Rajahmundry in South India. This last sanatorium is of special interest as it is the first sanatorium founded by the Indian Church as distinct from Missions. It was begun in 1926 by the

Christian community living in and round Rajahmundry; beginning with 25 beds, it has now accommodation for over 100 patients.

In the last few years another development has been seen in the tuberculosis work of Missions. The comparatively few beds available in special tuberculosis institutions were only able to take a small fraction of the sufferers from that disease. Even patients who were accepted for admission to these sanatoria had often to wait months before they could be taken in. It was realized that with the development of the modern treatment of tuberculosis much could be done for such patients in ordinary hospitals, both for those who were waiting to go to sanatoria and for those who could not go. Many Mission hospitals have therefore opened tuberculosis wards. For example, the Emery Hospital, Anand, has an annex of thirty beds, and the W.F. Pierce Hospital, Madura, has a ward of twenty-five beds, the Women's Hospital at Ludhiana, the Mure Hospital at Nagpur, the Wadia Hospital, Poona and many others have special wards. A further development of this has been seen in the C.E.Z.M. Hospital at Bangalore, which, from having a tuberculosis ward, became almost wholly a town tuberculosis hospital and specializes in the treatment of tuberculosis in pregnant women.

The treating of patients suffering from tuberculosis, numbering in all several thousands, is but a small part of the contribution of Christian Missions in India to the fight against the disease. The training of doctors in the diagnosis and treatment of tuberculosis has greatly added to the workers in the campaign all over India. The sanatorium at Arogyavaram has been specially prominent in its teaching, and this has recently been recognized by the Madras Government instituting a Diploma for Tuberculous Diseases, the first in India, for which six out of nine months' training is at this sanatorium. Over 70 doctors have now been trained at Arogyavaram and fill posts of responsibility throughout India; these doctors have been both Christian and non-Christian, and have included several women. A number of the Christian doctors have been trained for Mission sanatoria, but several are in charge of Government and local sanatoria and clinics, and in this way the contribution of the Indian Christian community to the country is widening.

In connection with training, the contribution of the Vellore Medical College for Women may be mentioned. They have sent all their students to Arogyavaram for two weeks' intensive training in the diagnosis and treatment of tuberculosis. In this way Vellore has not only shown that it recognized the importance of tuberculosis, but it has also conveyed this to its students, who on completion of their course have gone out to use this knowledge in many a town and village.

The development of the laboratory work at Arogyavaram made possible another contribution, namely, the training of laboratory techni-

Laboratory at the Union Mission Tuberculosis Sanatorium. Here technicians are trained (*p. 118*)

Her Excellency the Lady Linlithgow visits the Colony Store at the Union Mission Tuberculosis Sanatorium accompanied by Rev. R. M. Barton and Dr. P. V. Benjamin (*p. 117*)

Wards at Vishrantipuram Sanatorium (*p. 115*)

DR. C. FRIMODT-MÖLLER

Lately Superintendent of the Union Mission Tuberculosis Sanatorium, Arogyavaram and Commissioner for the Tuberculosis Association of India.

DR. DAVID

Superintendent of the Government Tuberculosi Clinic, Nagpur

DR. T. J. JOSEPH

Superintendent of the Lady Linlithgow Sanatorium, Kasauli

DR. P. V. BENJAMIN

Superintendent, of the Tuberculosis Sanatorium, Arogyavaram

DR. JOTI RAJ

Superintendent of the Vishrantipuram Sanatorium, Rajahmundry

DR. C. FRIMODT-MÖLLER

and a group of doctors trained at the Union Mission Tuberculosis Sanatorium, Arogyavaram and now in charge of Sanatoria or Clinics

DR. M. C. VERGHESE

Superintendent of the Pendra Road Sanatorium, C.P.

cians; and in classes held since 1927 about 100 men and women have been sent out as laboratory technicians, mostly to general hospitals, and several doctors have been trained specially in tuberculosis laboratory technique.

The knowledge gained by years of experience has been made available to a wider sphere by the publication of papers in medical journals. In the last fifteen years about sixty such papers have been written by members of the staff at Arogyavaram, and in the last few years papers on various aspects of tuberculosis have been coming from other Christian institutions also.

The first, and so far the only, ex-patients' colony in India was begun at Arogyavaram in 1920, and now employs about 20 ex-patients—men who, if they had returned home, would have broken down, but who under the conditions of life and employment in the colony can remain well, earn a living for themselves and their families, and make an important contribution to the life of the institution. The Pendra Road Sanatorium has secured land and money for the beginning of a colony, in which effort they have been greatly helped by Her Excellency the Marchioness of Linlithgow. The ever-increasing number of patients, in spite of the increasing success of the treatment, has only emphasized that the problem of tuberculosis cannot be solved by the treatment of the sick alone, but must go further back to prevention. Here much study is required; and surveys have been made from Arogyavaram which have shown the high incidence of infection, and even active disease, in village and town, proving the vastness of the problem to be faced.

In ways such as these just described, the total contribution of Christian Medical Missions to the pioneer efforts in the fight against tuberculosis has been of the greatest value. Until 1939, about half the number of beds set aside for the treatment of tuberculous patients, in the whole of India, were to be found in Mission institutions; and it was the work in some of these institutions which was largely responsible for raising the whole standard of treatment of tuberculosis throughout India, so that despair and apathy began to give place to hope and a call for action.

This call for action came from Her Excellency the Marchioness of Linlithgow, on her arrival in India, after being associated with tuberculosis work in Great Britain. Through her initiative and drive there came into existence the Tuberculosis Association of India in 1939, following an appeal for funds to begin a campaign. It was but natural that she found at Arogyavaram in Dr. C. Frimodt-Möller the person most fitted to be the first Medical Commissioner to the new Association. The fruits of nearly twenty-five years' experience at Arogyavaram were thus made of far wider use for the all-India campaign. Under his guidance in two and a half years' great advances have been made in British India and in the Indian States,

so that already the number of institutions for the treatment of tuberculous patients has almost doubled, and general practitioners throughout the country are realizing the importance of tuberculosis and what can and should be done. When ill-health made it impossible for Dr. Frimodt-Möller to continue his work, the tuberculosis Association looked again to Arogyavaram, this time to Dr. P. V. Benjamin, an Indian doctor who had succeeded Dr. Frimodt-Möller as Medical Superintendent. The sanatorium was able to lend him to the Association for some months to be acting Medical Commissioner.

This chapter has up till now dealt with the contribution of Medical Missions to the tuberculosis campaign in India; but there is another contribution which they make and which is the ground for their existence as Mission institutions—the proclamation of the Gospel. There is no doubt that the standard of their work has in itself helped to create a respect for Christians and Christian activities, and has therefore indirectly witnessed to the faith for which they stand. But as Christian institutions their work goes deeper than that. The very nature of the disease, the difficulty and length of treatment was and is a challenge to Christians as Christians, calling for an expression of the love of God in service, together with the patience and perseverance which belong to that love. The length of the treatment has often meant an intimate contact between patients and staff, leading to a knowledge of each other not often possible in diseases of short duration, and so patients have learned of the faith of those who treat them shown in life and word. A first understanding of the power and love of Christ has often come when a patient begins to ask: 'Why do you show me all this love? At home all my friends ran away and left me when they heard I had tuberculosis because they were afraid. But you show no fear, but spend your time helping me. Why do you do it?' And a knowledge of the love of Christ has often led to a confession of faith in Him.

A member of the staff of a sanatorium in Western India writes:

> A patient (Mohammedan) came to this institution from North India. He was well connected and belonged to a rich zamindar's family. He seemed to have come in contact with Christianity while undergoing a course of treatment with major and serious operations and the like. Slowly he began to love Jesus and His wonderful teachings. He got well and before he left the sanatorium confessed his faith and love for Christ and was baptized in the sanatorium church. He went home rejoicing in the mighty deed which was wrought in him.

The following comes from a sanatorium in South India:

> To illustrate the influence of a Christian patient, the following is an example from our sanatorium. A very sick Telugu Christian man was a patient in a general ward for

a time before he was finally sent home as he was too sick to get better. A sweeper, who had not had a good record because he used to drink, quarrel, and had had several 'wives', was by his bedside to call help if help was needed. The patient gradually taught the sweeper to read, using as a textbook the New Testament, and soon the man was able to read fairly well. Then he, too, was found to be suffering from tuberculosis and came under treatment. He continued to read the Bible and came to have a remarkable understanding of even the more difficult books like the Epistle to the Romans. His life was completely changed, and then he determined to try to help all the other sweepers to become Christians. When he was a little better he gave witness before them all. 'I want to tell you of the love of God. He might have let me fall sick in a place where I could get no help, but in His love He let me fall sick in a place where I could get all kindness and help shown, and therefore I must believe in Him. . . . I do not want to become a Christian in order to wear a black coat or sit in a chair, but because of the love of Jesus.' Largely because of this the sweepers as a group asked for instruction, and members of the sanatorium staff gave regular teaching for one and a half years, and at the end of this time nearly eighty of the sweepers and their families asked for baptism. Such was the power given by God to two very sick patients, both of whom shortly afterwards He called to Himself.

CHAPTER XI

HEALTH AND PREVENTIVE WORK

'I have come that they might have life, and that they might have it more abundantly.'—JOHN 10: 10.

ONE who has travelled up and down India for many years in the service of the Christian Medical Association judges that the palm for progress in preventive work must be awarded to the Methodist (Episcopal) Mission in North India. The work began as a very natural outgrowth from the Tuberculosis Sanatorium at Tilaunia, Rajputana. After the privations endured in the great famine of 1899–1901, the children rescued and received into schools and orphanages showed a high incidence of tuberculous infection. To isolate and treat these young people, the Methodist Mission, with help and encouragement from the Scottish Mission, founded a sanatorium.

After the sanatorium had been been working a number of years the Superintendent came to the conclusion that if they were to root out this disease from their schools they ought to have regular, thorough examination of the children and teachers, so that the disease might be detected early, thus avoiding infection of others and giving more hope of recovery. The Superintendent and her aides, two American nurses specially trained in health work, undertook to do this, and work was begun in 1926.

The purposes defined were:

1. To reduce the incidence of tuberculosis in the Mission schools.
2. To raise the health standard of the Christian community.

The programme included regular health examinations for pupils and teachers, children and adults, mothers and babies. The physical examination embraced the whole condition of the children, and where necessary was accompanied by appropriate advice and treatment. A careful record was kept of every child, and children were regularly weighed. Health instruction was also carried out in schools and in conferences. The diets of forty schools were studied and improved. Health literature, posters, stories, songs and dramas have been provided. In the fifteen years of this work the health level has steadily risen where the programme has been carried out. The plan is now to carry the programme from the school into the college.

As a result of this programme postures are improved, heads cleaned of nits, itch eliminated, ears released of plugs of hardened wax, eyes tested, and teeth treated. Striking improvement has sometimes

followed removal of tonsils, as in a teacher whose heart condition cleared up and who also made a rapid gain in weight. In one school where thirty-eight children were operated on for infected tonsils there was improved health and less frequent colds and sore throats. Formerly in a series of schools 76 per cent had enlarged spleens; now there are few such cases. Infestation with intestinal parasites is very high, amounting in some places to 90 per cent, and these are all dealt with.

Here are two letters written in English by children after the health examination:

> 'My eyes were weak and my teeth are very dirty. But I go to hospital because my mercurochrome put my eyes and I clean my teeth with fine charcoal and fine salt. Now I have cleaned all the nits out of my head, now my head is very clean. You examined us effectiouly.'
>
> 'When you went, Miss West gives us codliver oil calcium, milk, vegetable, fruit and eggs. She give me rest any work. I sleep a hour in a day. They take our weights after two weeks, and I gained five! My teeth is clean than the other day. I am trying to stand in straight. We gave you thank for your kindness. Because you told us what thing we need. We use these things.'

The regular health examination of school children is now widely practised by Missions, and to a large extent also by the Government. A doctor whose village work has been referred to in a previous chapter wrote when she was in the midst of the school examinations: 'This I feel is really a piece of work where preventive work is possible and as far as I am concerned it is at present the only place where such work is possible. The village people do not see the use of new and other arrangements than they have always had. They will come to better ways sometime in the not very near future, although I try to take advantage of every little opportunity to drive home a better idea.' Her conviction is that persuasion must be backed up by authority if indifference, inertia, ignorance and slavery to custom are to give way to better conditions.

From Sialkot, Punjab, a doctor whose husband is on the staff of the Christian College, writes of the health examinations and of a nursery school:

> Our College is one unit in a School Children's Health League which the Medical Officer of the city has had running for a number of years. Every schoolboy in the city pays one anna a month, and for this they receive two medical examinations yearly, daily attendance of a doctor in each institution for a short period, free medicines, simple treatments, eye examinations and dental treatment. There are thousands of children

in the scheme. For a year or two girls' schools and our college girls have also taken advantage of the scheme. This is quite apart from Mission work. The three Mission schools have their own medical examinations.

In Sialkot Cantonment a Child Welfare Centre of an unusual type has been opened. It is almost entirely for Christian children who are washed, fed and treated. This autumn a nursery school has been opened in the same building where children from three to six are being kept while their mothers are out at work. They, too, are washed and fed, play games, learn to sing, have a sleep, and begin kindergarten work. The next step should be a crèche. This is an attempt to solve the problem of uplift and both secular and spiritual education in a *basti* where both father and mother are quite uneducated, have both long hours of work, and are miserably poor.

We hope that children who spend three years there may have so much desire to attend ordinary school that they may get over the hindrances.

Malnutrition prevails to a wide extent in India, due either to too little food or to defects in the diet even if the food is sufficient in quantity. In consequence such conditions as rickets, beri-beri, pellagra, certain skin diseases, night blindness, dryness and irritation of the eyes, frequent colds and lack of resistance to disease are common; osteomalacia in pregnant women has been mentioned elsewhere. The great incidence of gastric and duodenal ulcer in South India is attributed to poor diet, often only rice water or tapioca. Dr. Somervell of Neyyoor says that duodenal ulcer is 600 times as common in Travancore as it is in the Punjab where a well-balanced diet is eaten. In many parts of India people get only one meal a day, and sometimes not even one good meal.

Where the diet is defective, the chief defects are lack of animal proteins, vitamins and fats. There may be also lack of balance, too much grain food or too much of one kind, for example, rice at all meals, instead of rice at one meal and wheat, ragi or millet at others. Considerable research is being carried on in India with regard to diets. Emphasis on eating unpolished rice, and on the addition of fresh fruit and vegetables to the diet, is gradually producing results; the wild gooseberry, sold dried in all bazaars, is said to have as much vitamin C as the orange, a vitamin often too low in Indian diets. Some years ago when food prices were lower, Dr. Aykroyd of the Nutrition Research Laboratories, Coonoor, stated that an expenditure of Rs. 3 a month on food should be the minimum for a child. The difficulty of the problem may be seen when it is understood that there are very many parents who cannot afford to spend that much on their children's food.

The diets of a great many Mission and Church schools are being checked against the results of research, with a considerable improvement in the health of the children, and not only that, but through the practical teaching in the schools improvements are being effected in the homes. An example of a well-balanced school dietary is the following used in some schools:

Daily Ration

Ata	4 chataks	Vegetable Oil ...	3/16 chatak
Rice	2½ „	Gram	1/2 „
Dal	6/7 „	Meat	1/2 „
Vegetable ...	5 „	Milk	1 „
Ghee	3/16 „	Gur and Fruit ...	1 „

A chatak equals about two ounces

> Once a week each girl gets one-half pint of milk and one-half pint of butter-milk.
>
> Once a week meat must be liver. Do I hear some of you saying, 'That is too expensive a diet for our budget?' In answer, I can only say, 'Would it not be better to educate fewer and do a better job in the care of their physical well-being?'

Another effort is to get people to cultivate ther own vegetables. A missionary told the writer that he had offered free seeds to all the village preachers of his district, but no one took advantage of the offer. The reason given was that they could not keep out that energetic and destructive creature, the village goat. The goat is to be blamed for much of the barrenness of the lands where it is allowed to roam.

A doctor of South India writes:

> Malnutrition is rife in this area, and tomato seedlings have been distributed amongst the village Christians and others, in an effort to combat it. This is our first effort, and alas, the survival rate of the seedlings is very low! It is a case of try, try again. 'A drumstick tree to every home' is our slogan.

At a hospital in Central India a grateful patient offered a gift of fifty Nagpur orange trees. These have been planted near the hospital and serve as an object lesson in cultivation of fruits for food.

While it is true that in some measure health propaganda is done in and through the hospitals, most hospitals realize that much more could be done.

From Nuzvid the doctor writes:

> Throughout the district berberi and other malnutritional diseases are very manifest. We publish literature at the hospital giving the signs and symptoms and treatment of these diseases.

> This is spreading the gospel of health. Now as we tour around we find that many are using foods that help them to stay well. Wealthy ryots are being influenced to help take care of their families and servants in this matter of diet. Conditions are still deplorable, but many are becoming diet conscious as a result of the quiet, simple propaganda conducted through the spoken word and written pamphlet.

The Mission from which the above report came, publishes a health magazine in English which has a wide circulation in India. The Christian Literature societies have health publications in the chief languages of India, and a new impetus has been given to the production of health literature by the adult literacy campaign. Health dramas, songs, lantern slides, pictures, puppet shows and health exhibits have all been used. Another Mission, the Methodist Mission, puts on community health programs where desired, when making their examinations.

The use made of trained health visitors in Christian hospitals is very limited. From previous chapters it can be seen that there is very little follow-up work done, though it needs to be done and would reward effort. Two reasons for this may be that a trained health visitor's salary is higher than that of a nurse, and the financial stringency of Missions during the last decade has prevented their employment. A second reason is that, from the nature of the work, it requires a person of mature years and character to do such work successfully. Such women are not numerous.

> The need for home visiting, is well illustrated in the case of a 12 year-old boy. He was admitted to the hospital every third or fourth day suffering from a very bad asthma attack. He would go home, get a bad attack, come back to the hospital, recover, be dismissed and again return. After a time a staff nurse and senior student were sent into the home. They found the family of six living in two rooms. There was a cow-dung and clayfloor. This was brushed up often with but little water. As soon as any dust was stirred up the boy began to have an attack.

The Methodist Mission Hospital at Kolar, as well as a group in Mid-India, have been considering giving some instruction and training in public health nursing as part of the regular course in nursing. There has also been a move toward 'domiciliary midwifery' training, in which nurses are taught not only to deliver a case with all the facilities available at a hospital, but to make use of a much simpler outfit in the home of the patients. In the latter case, there is more opportunity for impressing the patient and the family with the need of hygienic methods.

A conviction shared by many medical workers is that preventive work alone, apart from curative, is not effective. In his recent book *In the Service of Suffering* Dr. Chesterman writes:

> If Missions get too badly bitten by the public health bug they may become blighted. The satisfying of *felt needs* in curative work is the sure and historically true way to create public opinion and demand for services which entail limitation of the personal freedom of the individual. Except in the case of the killing diseases and fatal epidemics this order should not be reversed, or medical missions will be considered as part of a persecution and missionaries as inquisitors instead of good Samaritans.

A doctor provides an illustration of the value of curative work for teaching the need of proper ante-natal care.

> Early one morning we were called to a girl who was expecting her first child and was having fits, in fact she had been having fits for some time before we arrived. The condition of the patient was very serious, and this was explained to the crowd of relatives who gathered round. We prayed in the home, as we often do before we start treatment. God has often wonderfully answered our prayers as He did in this case. The patient lived, and this fact together with a demonstration of albumin in the urine, and an explanation of how it might be found and treated, did what any amount of preaching on the topic had failed to do.

The lack of proper disposal of night-soil in small towns and villages is a cause of an incalculable amount of ill-health. The usual practice in rural areas is to resort for calls of nature to the fields or to the banks of streams before sunrise in the morning. Unfortunately the precautions enjoined by Moses on the Children of Israel in the wilderness are not known or practised (Deuteronomy 23: 12–14). The soil becomes polluted. When the rains come, water flowing over the surface finds its way to the rivers and wells, carrying infection which results in outbreaks of dysentery, diarrhoea and cholera. Hookworm infection acquired by walking with bare feet on polluted soil is widespread, as also is round worm infection, sometimes as many as 90 per cent. of children in schools being infected. Systematic examination of the stools in several schools shows that the incidence of hookworm infection in rural schools is much higher than that in schools in towns.

Mr. Gandhi, who has concerned himself with the welfare of the village, has impressed upon his followers the need of setting an example by cleaning up the village streets themselves. He desires not only that the filth should be removed but that it should be used in fertilizing the land. Mr. Brayne, recently employed in Rural Reconstruction work in the Punjab, has called the manure and refuse pit, 'The farmer's treasure house' and has shown how to construct retiring places suitable for villages.

As before stated, Christians have a special responsibility toward their own community. The writer was asked to serve on a committee to investigate and advise on the opening of a village health centre. We visited a large village where there were about 200 Christian homes, with 600 Christians. The houses compared well with others, but we found very inadequate provision for light and air, and none at all for the disposal of night soil. It was thirty years since the Christian movement began there.

Many Missions have enlisted the help of preachers and teachers in the villages where there is no medical aid. The following is an account of how a doctor has helped to enlist the help of the divinity students.

> My husband's job is training students for the ministry. My first year in India (1939–40) I gave his students a short course of lectures in preventive medicine—how diseases are spread, simple sanitation, etc. One result of this was seen when one of these students was put in charge of his first parish. There was an outbreak of dysentery and he got together the health authorities and various workers and organised a house-to-house teaching campaign which stopped the outbreak. The Hindus in the area were greatly impressed because this was obviously done for their welfare and not for the sake of making converts. Another of these students applied to me for quinine when a number of his parishioners returned with malaria from a tea estate.
>
> As a result of this year's experience it became very evident that there are great possibilities for co-operation between pastors and doctors in rural work, and that some elementary training in public health, simple health measures and preventive medicine should be available for the Indian pastor.
>
> One of the big problems among the poor is malnutrition. I used to feed a series of babies on our verandah. These babies were sometimes fed on polished rice from the age of three months, and it was astonishing what rapid improvement followed the addition of even one teaspoonful of tinned milk powder to their daily diet. Marmite sometimes worked wonders.
>
> In my opinion great strides could be made in the health of the rural population if propaganda on the following lines were carried on officially by the Church, its pastors and workers:
>
> 1. Sanitation and cleanliness. Boiling all drinking water and milk. By these measures worm infections and bowel diseases could be eliminated.
> 2. Nutrition. How to procure a better balanced diet for the same outlay.
> 3. Clean and scientific midwifery, ante-natal and child welfare work.

> The Church, like its Founder, should be concerned with the health of man's body as well as his soul, and I believe that measures on these lines would do more than innumerable hospitals to relieve the sufferings of the poor.

Mission Hospitals in Hyderabad State have done good work by giving preventive inoculations and vaccinations for such diseases as plague, cholera and small-pox. They have saved thousands of lives. There are large numbers of Christians in that State who are ready to accept advice and take precautions. Certain parts of the State, held by privileged landowners, do not come under the State Health Department. Such are a menace to the adjoining districts, and are often the source of epidemics. Another danger to health comes from the thousands of pilgrims passing through the State to a popular shrine. Cholera is particularly apt to follow in the wake of such a migration.

The following note shows how effective was preventive treatment at Medak.

> There was a plague epidemic in Medak town in the early months of the year which led to a general exodus, and reduced our out-patient work for a time; but on the in-patient side, the hospital work has been overflowing. There have been no cases of plague inside the Mission compound of 1000 people as a result of the precautions taken and inoculations given by the hospital staff.

It would be strange if the work of Mission Hospital did not effect some improvement in the health of the Christian community.

The figures of the Public Health Commissioner for British India for 1934 showed the death-rate per thousand by communities to be:

Hindus ...	... 28	Christians	... 16·2
Mohammedans	... 24·2	Others ...	... 25·6

The average infant mortality for seven provinces worked out at:

Hindus ...	... 195	Mohammedans	... 183
	Christians	... 118	

The death-rate statistics for 1940 for one Province are:

Madras		*For Infants*	
Mohammedans	... 23·8	Mohammedans	... 172·3
Hindus ...	... 25·1	Hindus ...	... 178·9
Christians	... 22·2	Christians	... 128
Others ...	... 24·1	Others ...	... 181·9

For Infants in United Provinces

Mohammedans	143·4	Christians	... 103
Hindus ...	... 134	Others ...	... 105

While the inaccuracy of statistics is proverbial, yet, as in all reports the Christian community has the lowest rates, it may be concluded that there really is some improvement. Yet there is still a long way to go.

The ante-natal and child welfare work, which now forms a part of the work of many Christian hospitals, is not here touched upon as it has been referred to in previous chapters.

We close with a quotation from the Report (Section IX B) of the International Missionary Conference at Madras:

> There is a clear call to give greater attention to preventive medicine. This will mean active sharing in all forms of health welfare work, and health teaching in schools. Such work need not be costly. Emphasis should not be on the mere dispensing of medicines, but, rather on tracing each disease to its source with a view to its elimination. Each Christian hospital should be a centre of health, that educates the community it serves. Its purpose cannnot be considered fulfilled unless its influence permeates the community as a whole and is manifest in clean streets, a pure water-supply, better sanitation, and cleanly habits.

CHAPTER XII

PRAYER AND HEALING

'I cry unto the Lord with my voice, and He answereth me.'—PSALM 3: 4.
'The prayer of faith shall save him that is sick.'—JAMES 5: 15.

'IT is not really absurd to suggest that drugs and no prayer may be almost as foolish as prayer and no drugs,' said Sir Oliver Lodge. One of the great contributions which medical missions are making to the healing of the sick is their emphasis on the place of prayer in healing. The prayer of faith of the early Church was succeeded by a vast conglomeration of superstition, quackery and trickery, and although the belief in prayer in time of sickness was never altogether lost, it receded into the background. The early crude efforts of medical and surgical treatment which often made anything better than falling into the hands of a doctor, were succeeded by modern scientific medicine, but the brilliant achievements of this have tended to a materialistic outlook on disease.

But even modern medicine has had its many failures and these failures are helping men to realize that man is not merely a body, but mind and spirit as well, and that mind and spirit have their influence on the body for the worse and also for the better in functional and nervous diseases and also in organic disease.

Men and women who have come out as medical missionaries have brought with them not only their medical knowledge but also the prayer of faith, although sometimes a real belief in healing prayer has been weakened by the outlook fostered by their medical training. There is, however, both among missionary doctors and nurses and among men and women of this country associated with them a growing witness to the power of prayer. Stories are coming from various hospitals of healing where medical aid had seemed impossible, of changes wrought in patients beyond what could be expected by medical and surgical treatment alone, and of a power of spirit over body in which prayer seems to have made available healing powers of God witnessing to His glory.

The following story comes from a village in the Nilgiri Hills in South India.

> A few years ago we were making one of our regular visits to a Badaga village where we were always welcomed. Following our usual procedure we sat on the verandah entrance to one of the houses at the invitation of the women who gathered to listen to the good news of God's love. One of the women who

had always shown an unusually keen and intelligent interest in the Gospel message, told our doctor of increasing pain from a complaint for which we had been treating her for some time. At the conclusion of the preaching the doctor examined her and found that the condition—rectal fissure—was not yielding to treatment, and suggested that she should undergo an operation as soon as possible. To this the husband would not consent and voiced his opinion that his wife was making a fuss over nothing; no amount of argument would convince him of the seriousness of the patient's condition. With sad hearts we left the village, but not before we had spoken a word of comfort to the brave little woman, telling her that we would pray for her and that she, too, must pray to 'Yesu Swami' for healing. That night we had special prayer for her.

Some days later we again visited the village and were met by our friend, her face radiant with joy. 'Come and sit down,' she said, 'I have good news to tell you. I remembered the word you spoke last time you came when you told us that your God will hear our prayers, and if we believe He will forgive our sins and heal us. I prayed to Him and I am quite healed; I have no more pain.' She told us how the same evening of our previous visit when she had lain down to sleep, she prayed to Yesu Swami to heal her complaint. 'I think I must have slept,' she said, 'for the next thing I remember was a very beautiful Person standing looking at me. I did not ask His name for I knew it was Yesu Swami. He said to me, "What do you want?" I replied, "I want to be healed of my pain and of this disease." He said, "Do you believe that I can heal you?" I said, "Yes, oh yes, I believe, I know that You can heal me. Have I not prayed as they have told me!" Then He said, "You will have no more pain, you are healed". Oh, it was so wonderful, and His face, it was so beautiful, I shall never forget. I am healed, quite healed.' She then invited the doctor to examine her and the doctor was able to confirm her witness that complete healing had indeed taken place.

It was a very wonderful experience to us, but what must it have been to her? We realized a little of what it had meant to her by her radiant face and eager witness, for she came with us all round the village telling again and again what God had done for her. She was able to tell from personal experience that faith in Christ Jesus had brought peace of heart and healing for body and soul.

A doctor working in the Telugu country sends the following:

A woman was brought into the hospital suffering with a terrible heart condition. She could not lie down and was

gasping for breath. My assistant saw her first and said to me, 'She cannot live more than a few hours; there is no use in admitting her to the hospital.' When I saw her and examined her I felt very much as my assistant did about the poor woman; her recovery seemed to be an impossibility. However we do not like to turn a patient away just because death seems imminent, so we started treatment at once and wrote careful orders for her medicine through the night. Then we gathered at her bedside and lifted our hearts to God for her. We prayed that if it were the Lord's will the treatment might be blessed and she might recover. Humanly speaking her case seemed hopeless; but we believe that God can do things that seem impossible to men. I expected to be called in the night with the message that she was dying. But no message came and next morning she was a little bit easier. Slowly, but steadily, she grew better until after five or six weeks' treatment she went home cured and happy.

From another hospital a doctor writes of the father of one of their doctors who developed gangrene of the foot. 'When gangrene developed, and it was a moist spreading gangrene, I called Dr. R. and we felt that only amputation would save him—he is an old man and his condition very poor, and we told him frankly and let him decide.' And this is what the old man himself has written:

When pain became compelling proper attention was paid. Being baffled at all attempts to bring it under control the doctor gave up hopes and said I shall have to bear it all through life. Other doctors tried but failed. A stage was reached when for fear of developing gangrene, amputation had to be faced. A fully equipped hospital with efficient hands had to be chosen at a distance. Human efforts, however efficient, have to be blessed by God for the desired cure. Requests for special concentrated prayer were made to familiar churches and friends—prayer that God might be glorified through life or death. Doctors in the hospital referred to left no stoned unturned. With all that the dreaded gangrene manifested itself. At this critical moment I had to decide whether an operation should be performed. I placed the matter before God for His guidance. The answer came, 'Leave it alone; don't be afraid'. This was in the middle of the day. The next morning the gangrene instead of spreading showed signs of shrinking, to the agreeable surprise of all concerned. This shrinking continued steadily and in a few days the affected phalanx dropped off. There ended the ulcer. For this miracle I thanked God. I am sure those who prayed for me and those who hear of this will glorify God. After a few days I have been thinking of returning to

my place. When suddenly an unusual and inexplicable fever started. In spite of treatment it continued for thirteen days without intermission. Fearing that remaining in the same place might make me too weak for the journey I made ready to start the next day. In the evening of the thirteenth the doctor gave me a final injection against the day of departure. The next morning I had no fever and no fever thereafter. I believe in *Believing Prayer.* I also believe in *medicine and medical treatment subject always to the will and blessing of God.*

Another story comes from Neyyoor:

He was a schoolmaster and had developed tubercular disease of the tibia, the larger of the two bones of the lower leg, to which had apparently been added a secondary infection. The leg got worse and worse. Complete rest, careful dressing and everything we could do seemed to be of no avail. The leg got worse, and the patient himself, too, was going downhill in general condition. Amputation was advised several times, but the man had got it into his head that the leg could be cured, and refused to have it amputated. Finally, as the condition of both leg and patient was getting worse, I sent the X-ray picture of his leg to a very good surgeon in another part of India, and his opinion confirmed mine that the leg was incurable and amputation offered the only chance of life. The patient consented to this, with a condition: 'Will you let me keep my leg for three weeks? I don't believe it is God's will for it to be lost, and I am going to pray about it. If it is not better in three weeks, you can take it off.' He went home, feverish, flushed and ill, and three weeks later, true to his promise, he came back here again to see me. He certainly was looking much better, and was actually putting the foot on the ground, with the aid of a stick. X-rays showed that the bone was remarkably improved, though not yet free from the disease, and his general condition was amazingly good. He told me that he was sure it was against God's will that His servants should suffer in this way. He collected his family and some of his friends and asked them to pray for the leg. 'I have a life before me of service to God if I can keep my leg,' he said, They organized a week of continuous prayer in this household of faith and—to make a long story short—the patient within a few months was walking about and playing games, and witnessing to the power of God to heal and to save.[1]

[1] Quoted from *Knife and Life in India* by T. Howard Somervell.

Dr. Somervell writes:

An interesting thing that we always notice here is that non-Christian patients very often ask a Christian member of the staff, or our evangelist, to pray with them; and we have a House of Prayer here where anyone of any religion can, if they choose, go and pray for their patients. This is sometimes used, though not so often as I should like to see; I am told that in the early morning people quite often go into it, and I certainly have seen Hindus *fairly* often praying for their relatives there.

I am against the idea of having a list of patients for special prayer at a hospital. The very fact that the patient's name comes on that list makes them frightened, and brings them to think of the fact that they are specially dangerously ill; and I am sure that prayer for patients in a hospital should always be done without such a list—that is to say, without a list that is posted up or made public.

Very often patients or their relatives ask us to pray for them in the weekly prayer meeting. The question of prayer about disease is a very vexed one. I know a devout Christian couple whose son suffered from the very serious condition called polio-encephalitis. He was unconscious for several days. During this time his parents definitely prayed that he might be recovered from the disease. They told me that they did not believe in saying 'Thy will be done' in prayer. Their faith was so great that they believed that they should *force* God into healing the boy. This they proceeded to do, and their prayers were answered. The boy recovered (to everyone's surprise, as by all the rules of medical science he ought to have died), but he recovered to a life of a mentally defective cripple. This is a striking instance of the way prayers should *not* be used in my opinion. I am sure that we must always put in the condition of God's will in praying about disease and injury. Personally I seldom pray for the *recovery* of a patient from disease, but that the disease may be used to lead him to God through Christ.

I do a good deal of work in connection with Bishop Pakenham-Walsh. His use of prayer is very intelligent, as you know, and if he feels that any patients in his list should have an operation, he sends them here, if their home is anywhere within 200 miles or so from this place. It is only when we have done all that is possible by medicine or surgery that he is prepared to trust to prayer without medical aid. That is in my opinion the *right* use of prayer. God has given us knowledge, and we must use that backed up by prayer. When our knowledge and skill has done all that it can, then prayer and only prayer remains: and if only we had a true apostolic faith, how much could be done that is at present left undone!

The ministry of prayer in healing is sometimes associated with the laying on of hands or by anointing with oil. Some years ago a servant of God was visiting a patient in hospital in a South Indian town; the man was suffering from abscess of the liver and was in great agony and was expected to die. The minister had prayed with the patient several times and he had temporarily seemed a little better. Then one day as he was again cycling to the hospital to see the patient, he seemed to hear the words, 'Fast, pray, anoint,' in a way he had never before or since experienced. When he entered the ward the patient said to him, 'I want you to fast and pray for me'. 'Why did you say this?' he asked. The patient said, 'Christ revealed it to me'. So after due preparation while the group present, consisting of an Indian pastor, a doctor, some nurses and some friends, continued in prayer the minister anointed the patient. After the service the sick man said that the pain had gone; in three days he was sitting up and said that if only his faith had been great enough, he could have got up and walked immediately after the service.

The laying on of hands is sometimes done by a group of people and the following story from North India shows also what may be a hindrance to the prayer of healing.

A doctor and her nurses used to meet regularly to pray for their patients and to pray with their patients. One of this group of nurses fell ill, her condition became very serious and she had intense and long pain followed by long periods of coma. She had all the symptoms of stone, the same as she had had on a previous occasion when she had been operated on and no stone had been found. Again stone was suggested, the diagnosis being agreed to by another experienced doctor also. Hysteria or other neurosis was excluded. An operation was done and again no stone was found, and the patient's condition became very low and it seemed as if she could not live long. Then the doctor suggested to the group of nurses that they should offer their hands to the Lord in case He desired to heal through any one of them. After prayer they came to her; one by one the doctor and the nurses laid their hands on her when she was in intense pain. When it came to the turn of a certain nurse to lay on her hands, the patient had relief and sleep, but not healing. The doctor wrote to a minister from whom she had learned much and asked what he thought was the hindrance, and he replied 'probably unrepented sin either in the patient or in one of the praying group'. But before the reply came, it transpired that two of the praying group were living immoral lives, and they had to be dismissed. As soon as they had gone and the nurse who had the gift of healing laid on her hands, a *very rapid* recovery took place.

Recovery or improvement does not however always follow on prayer even when prayer is made by men and women of God for saintly Christians and there seems to be no human hindrance. God

may have other plans for such as these, but even if recovery does not take place often prayer leads to a glorifying of God in other ways.

A man of God in Calcutta was suffering from arthritis and was sent to hospital in great pain and in an extremely serious condition. He asked for anointing. He was full of faith and was willing, if God so willed, to die, and if it was God's will that he should get better he believed like a child it would be so. The last six months everyone was aware of an amazing spiritual power in him. Finally, he saw he must resign the important post he held, called for his papers and files, put them all into proper order for his successor, and then as a last act signed his resignation, and died that night. Though he did not regain his health through the prayer of anointing, the prayer was answered, for all in the hospital felt that the whole of his sickness had been under the control of God.

A doctor sends this story:

> When I was a young doctor, I had to treat a missionary, who was suffering from acute pain in the shoulder. I gave her the treatment for rheumatism and used local applications to relieve the pain, but she was suffering greatly. I was much distressed. She had charge of a girls' school and there had been a time of spiritual refreshment in the school. I said to one of the teachers on the evening of a day when the patient had suffered much, 'I wish you would pray for relief for her, and ask the others to pray too'. I slept in the verandah near the patient's door, and about two in the morning I heard her singing in Hindi the hymn, 'Let us with a gladsome mind, Praise the Lord for He is kind'. Thinking she was awake I went in. My entrance roused her and she awoke. 'How is the pain?' I asked. 'It is still there but I have been lifted above it.' She did not realize she had been singing in her sleep. In the morning I learned that relays of her girls had watched in prayer throughout the night.
>
> While she was still unable to use her arm, the girls came up in procession to the Church singing as they usually did. I remarked that I liked the tune but wished they had better words to sing to it. Could she not write a better hymn? So she called a teacher to do the writing and between them they wrote out the words of a hymn that has since been used in Hindi and Urdu and has been translated into English. It is a hymn which paraphrases Scripture passages about the Cross of Christ and the verse forming the refrain is 'God forbid that I should glory save in the Cross of Christ my Lord'.

For the Christian prayer is not in conflict with medical and surgical treatment. All the illustrations given in this chapter have come from either doctors or nurses or those who have a belief that it is God

who has given medical knowledge and that therefore He can be served and glorified through the use of medical and surgical methods. How a patient came to realize this can be seen from this story:

> I have a friend who was a missionary who had conceived the idea that it was more honouring to God to be healed without medicine. She asked me to pray for the removal of a tumour she had. I wrote to her and said that I would pray, but that I thought she limited God if she restricted His operations to cure without means. I admitted that God could heal through the spirit, through the mind, and through medicine and surgery, and it was for us to seek His guidance to know what He would have us do. She wrote to me later to say the tumour had disappeared but that she had had a new experience of how God could heal. She had fever and she called her friends to pray beside her. During the prayer time she had a strong impression that she should take the medicine that had been suggested for her recovery. She had thought that to take medicine would make her feel less in touch with God but she found to her surprise and pleasure that He was just as near when she used the means suggested.

Other doctors write of the help of God that has been given through prayer in guiding them in the use of medical and surgical treatment:

> There came to the village dispensary old Martin, a Christian, poor as poor, dressed in a tattered old loincloth, and thin as a rake, who had earlier had one eye operated on unsuccessfully for cataract. He was pitifully anxious that his remaining eye should be 'made'. He was taken back to hospital in the hospital car—such a business to get him fitted in! In due time he was prepared for his operation. According to custom we prayed for him and slowly, for he repeated the prayer phrase by phrase after us, then lay calm and collected. It was a difficult business, because, owing to long-standing previous disease, iris and lens were adherent one to the other. Twice in the course of the work we laid aside the instruments and said quietly to the old man, 'Martin, we are in trouble. Let us remember that God is here with us now, giving us courage and showing us what to do. Let us keep silence and ask His help.' The tension in all of us slackened —Martin's lips moved silently. At last the bandages were fixed and he was carried back to bed. When the bandages were opened some days later, he cried out, 'I see, I see. Thanks be to God.' And now every few weeks he comes to the village dispensary. He does not want anything but just to show himself and say how happy he is. He is better clothed than of yore;

he walks erect; he is fatter—they feed him now at home since he can watch the cattle and is useful to them. Little is said when he comes. Patient and doctor grasp hands and murmur to each other *Jesu sahae*, which is, being interpreted, 'May Jesus be your support'. So old Martin goes back to his cattle.

Another doctor sends these stories:

I had been ill for about two weeks and was not making progress. I suggested to my nurse, who was also my friend, that we should make special prayer unto God for His guidance. After prayer we both felt that a woman surgeon from a city a few hours distant by train, should be asked to do an operation we felt was needed. We were in the Mission House with the local doctor in attendance. Next morning, without any hint from either of us, the doctor in charge came in and made the suggestion that this surgeon should be called. This was done and recovery took place.

I am a doctor. On one occasion I was treating a man's eyes and was also treating him for a disease for which an iodide was prescribed. For some reason the eyes did not respond to treatment. In the middle of the night I woke up and it flashed into my mind that iodides should not be given as they were secreted in the tears and formed an irritating mixture with the medicine dropped in the eyes. It always seemed to me that God had flashed the thought into my mind when the mind was free to receive it.

Another worker tells how in the middle of a service in Church there came to him a formula for some blood studies which has now been in use for ten years in a number of institutions and has proved of great service.

Someone writes, 'It is my belief that sometimes God waits to be asked before we get the guidance and I have felt as if He said to me when I have come to Him after trying this and that without benefit—'Why did you not ask me before?' Sometimes His answer has been like that He gave to Paul, 'My grace is sufficient for thee', and I can say that He does make all things work together for good to those who love Him and seek His guidance'.

More things are wrought by prayer
Than this world dreams of. Wherefore let thy voice,
Rise like a fountain for me night and day,
For what are men better than sheep or goats,
That nourish a blind life within the brain,
If, knowing God, they lift not hands of prayer
Both for themselves and those who call them friend,
For so the whole round world is every way,
Bound by gold chains about the feet of God.

TENNYSON.

CHAPTER XIII

TRAINING FOR CHRISTIAN MEDICAL SERVICE

'*Thou shalt love thy neighbour as thyself. . . .*
And who is my neighbour?—LUKE 10: 27, 29.
'*Inasmuch as ye have done it unto one of the least of these my brethren, ye have done it unto me.*'—MATT. 25: 40.

IN his book *Jesus of Galilee*, F. Warburton Lewis writes,[1]

> Is there anywhere a more vivid picture than this: 'A man was going down from Jerusalem to Jericho, and fell among robbers who both stripped him and beat him and departed, leaving him half dead.' The story goes on to tell how a priest came down that way, looked at him, and passed on. I should have done that myself, I expect. It was not a nice sight to look at, and called for all a man had of courage too for there was danger in the business. . . .
>
> We can look at it now, and it is high time that someone looked inquiringly at this wounded man. We often talk of the Good Samaritan . . . but that man in the ditch bleeding to death—what about him? . . . And I am sure that I know his name. His name was Jesus and that is why we must look at him.

Whether it was an incident out of Jesus' own experience as the author believes, or not, the thought that Jesus may have been the victim rescued by the Good Samaritan emphasizes the words. He said that whoever served one of the least of His brethren, in reality, served the Son of Man Himself. The two spiritual qualities needed to make medical service truly Christlike are compassionate love for our fellowman, and something of Christ's sense of the supreme value of an individual in serving whom we are serving God.

That this is not the attitude of the modern doctor and nurse is the opinion of a medical man writing in the January, 1942 issue of *The Coracle*[2] under the title 'Integration in Medicine'. He affirms that the doctor and nurse have become too impersonal in their relation to their patients, whom they regard as subjects rather than objects; that their work has become more and more a trade for which intellectual qualities and not qualities of the heart are needed; that instead of servants they have become rulers and bosses and the patient in hospital feels himself in jail.

[1] p. 147.

[2] *The Coracle* being the 8th publication of the Iona Community, January, 1942.

The cause assigned for this condition is the rupture between religion and science. 'To realize again the human being as well as the human body would create a perfectly new understanding of the diseases.' He suggests that the faith of the physician, the charity of the nurse, and the hope of the patient may again become the foundation of a new medicine.

The medical missions carried on in the world were born and cradled in religion. It was as natural for the medical missionaries to begin training others as helpers in their work as it was for the Master to choose His twelve disciples that 'they might be with him' and that He might send them forth 'to preach the Kingdom of God, and to heal the sick', and today they hold strongly in India that Christian Medical Education of the highest grade is needed. As has been said:

> If we are right in desiring that the Christian witness in India should include the work of healing it is not necessary only to secure technical qualifications; what is needed is the development of a Christian medical profession which has thought out its Christianity in relation to science, and its science in relation to Christianity and for which the skill of the professional technician has been fused with the spirit of Christian love and compassion. It is no ungenerous criticism of existing institutions, nor a merely narrow sectarianism, which holds that there are no grounds for expecting that now or in the future Government medical colleges will produce the men needed.[1]

The first Christian medical school for women began in Ludhiana in 1894. In later years it has been known as the Women's Christian Medical College, with which is incorporated the Punjab Medical School for Women. It is over twenty years since the Government recognized this as its school for women, and throughout that time an increasing number of students from other religious communities, including Sikhs, Mohammedans and Hindus have been admitted till they now number about fifty per cent of the student body. A *per capita* grant is given by Government for every student from the Punjab. The majority of the Christian students are from the other Provinces, some of them provided with scholarships by their missions or by the college. The college prepared students for the licentiate examination. Having obtained the consent of the Punjab University it began to teach students for the M.B. course, but owing to its being unable to fulfil university requirements as to staff, it could not continue this course, and is now conducting classes for the L.M.S., higher than the first qualification, but less than the M.B. The graduates number more than 400 and the enrolment in 1940-41

[1] A statement and appeal prepared at the request of the C.M.A.I. Executive by Rev. W. Paton, Secretary of the International Missionary Council, vide *Journal of the Christian Medical Association*, May, 1929.

was 150 students. In March, 1939, it was stated that about 150 graduates were in Government service, about 120 in mission hospitals about 50 in private practice and the rest have died or retired or are not working after marriage.

Ludhiana has always had its Governing Body in India with Auxiliary Committees in various countries, chiefly in London, England. An effort is now being made to have it put on a union basis, with support from various missions served by it. Its friends in North India as well as in the supporting countries wish to see it continued and raised to the full M.B. standard. Dame Edith M. Brown, one of the group that founded the institution, has been the one and only Principal and still continues in office after fifty-one years of service in India.[1]

The Miraj Medical School was founded by the late Sir William Wanless in 1897 under the American Presbyterian Mission as a school for medical evangelists. The founder regarded the school as the most important part of the service he had been able to give to India—of much more value than all his great surgical work. His successor, Dr. Vail, also affirmed that he regarded this work as supremely important. The school is constantly being graded up to meet the Government requirements and it is predicted that by 1947 all schools in the Province will have to come up to the University College grade of the M.B. degree.

The present Dean of the School, Dr. L. B. Carruthers writes:

> When one recalls that in 1937 the total number of medical students graduated in India, with its 400 million population, was only 1,559 and of these only 594 came from the highest grade medical colleges, 965 from licentiate schools such as the one at Miraj, and when one compares these figures with those of the United States where are approximately 5,000 graduates in medicine each year in a country with only one-third the population of India, one can readily realize the importance of maintaining the work of the medical school at Miraj and of its meeting all the increased demands for higher teaching standards, no matter how severe they may be. Great faith, prayer and much hard work will be required.
>
> Last April, eighteen students completed the course, bringing our total number of graduates to 308. In June, a new class of twenty-four was admitted. The present student body numbers 118, of whom 73 are Christians. We continue to hear great stories of our graduates and we know of several who are now serving in the armed forces. Only the other day we heard of one of our graduates who, ten years ago or more, went into a

[1] In October, 1942, Dr. Aileen M. Pollock was appointed Principal and Dame Brown becomes Principal Emeritus.

DAME EDITH M. BROWN

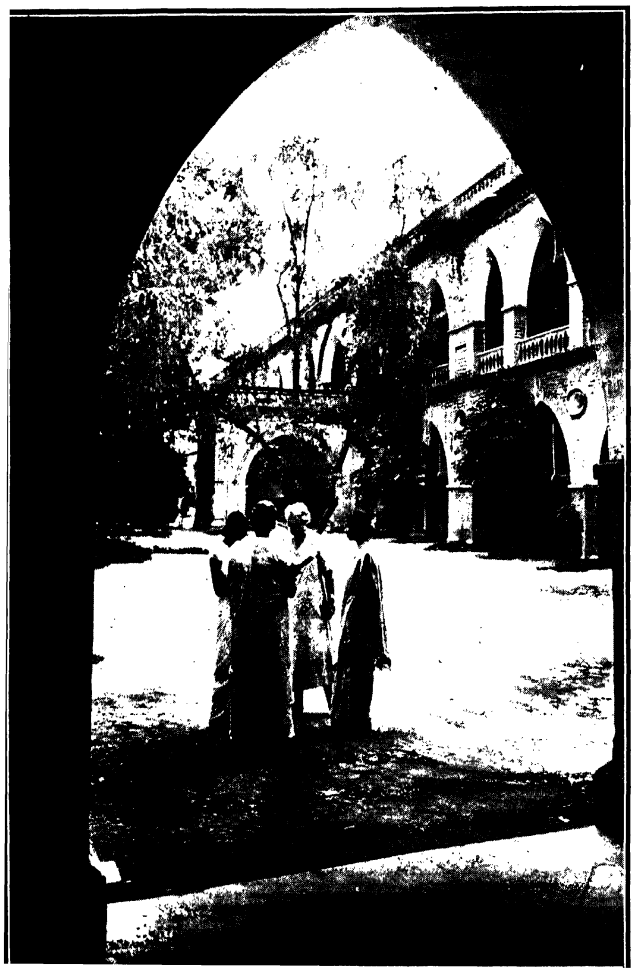
Principal since the beginning of the Women's Christian Medical College, Ludhiana, begun in 1894 (*p. 139*)

DR. L. B. CARRUTHERS

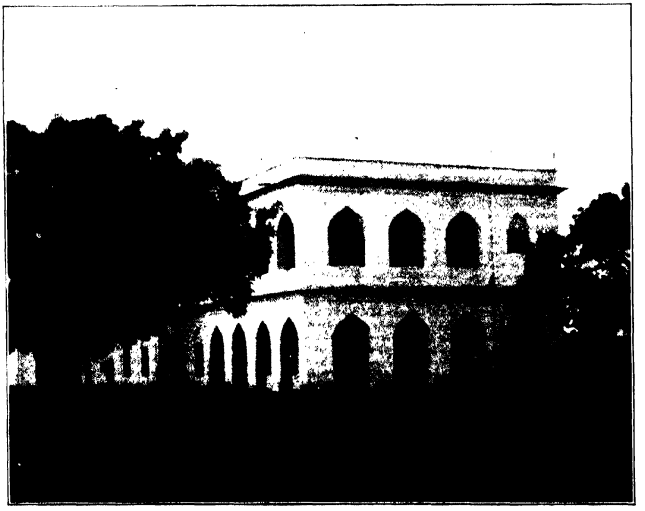
Principal of the Miraj Medical School, in succession to Dr. Charles E. Vail. The school was founded in 1897 by Sir William Wanless who was its first Principal (*p. 140*)

DR. IDA S. SCUDDER

Principal since the beginning of the Missionary Medical College for Women, Vellore in 1918 (*p. 141*)



On the campus of the Women's Christian Medical College, Ludhiana. Dame Brown is in the centre (*p. 139*)



The Nurses' Home at the Scudder Memorial Hospital, Ranipet, S. India. (*p. 145*)

district on the Malabar coast, and was allowed to settle there only because he was a doctor. When the first convert in this area was baptized the doctor and the convert were both stoned. Now this place has become the centre of a mass movement into Christianity. Stories like these make us feel that, no matter what the difficulties, the work must go on.

Besides all the departments required in a medical school, Miraj has a department of Bible and Church History.

The Miraj School has a Board of Directors in India. The Mission Board gives the salaries and services of the missionaries on the staff, and for the rest the college and hospital are self-supporting on an annual budget of about two hundred and fifty thousand rupees.

The Missionary Medical College for Women, Vellore, was opened in July 1918. A group of doctors in South India felt more and more strongly the need of having Indian Christian doctors to meet the needs of India. While Ludhiana grew up by itself, and Miraj was backed by the American Presbyterian Mission, Vellore was begun when co-operation among missions was being introduced and eleven missions, seven of them American, the rest European, united in the work at Vellore. Dr. Ida S. Scuddor of the Arcot Mission was chosen Principal, and the hospital of the Arcot Mission at Vellore was give for the use of the school. The majority of the Christians of India live in the South and there has never been any lack of students from the Christian community.

In January, 1920, a two-year campaign was begun in America to raise three million dollars for seven Women's Christian Colleges in the Orient, one of these being the Medical College at Vellore. So the buildings needed for the school and hospital were erected. In the city itself there is a hospital of 300-bed capacity, with residences for staff; and at the Hill Site, amid beautiful surroundings, are the grey stone buildings of the college, students' hostels and residences. Each group of buildings has a beautiful chapel at the centre.

About 250 students have graduated in medicine, the majority of whom are serving in Christian hospitals, but many in Government hospitals and some in private practice.

Though the Vellore College is the youngest of the three, circumstances have compelled its immediate advance from the licentiate to the degree course. The lower grade has been abolished in the Madras Presidency and it is only a matter of time till other provinces take the same action.

A University Commission of eminent medical educationalists from all India, visited the college, and recommended to the University of Madras that on the fulfilment of certain conditions laid down the college should be affiliated to the University for the first two years of the M.B. course. This course was begun in July, 1942. In 1944

the University will review the situation to see whether the college can be granted affiliation for the final years of the course.

The Christian Medical Association of India, the Central Board of Christian Higher Education and the National Christian Council of India, Burma and Ceylon have all endorsed the action taken to raise the standard at Vellore to the M.B. grade. The war prevented the visit of Dr. Ida S. Scudder to Britain in the summer of 1939. In 1940–41 she went about in India presenting the needs of the college and raised more money than was expected. In 1941 she proceeded to America where she is touring in the United States and Canada.

Vellore is governed by a joint Body with one section in New York and the other in London. Some of the eleven Mission Boards are increasing their grants, even at the expense of other medical work.

The question arises, What about higher Christian medical education for men? This subject has been of major importance to the Christian Medical Association since 1929. In the evolution of their plans, in consultation with the National Christian Council, they have at last come to the conclusion that, provided Vellore is willing, the best plan would be to have there a United College for men and women. A Joint Statement drawn up in June, 1942, by a group composed of four members of the Vellore Council in India and an equal number representing the C.M.A.I., states briefly convictions that have since been accepted by both the above mentioned bodies.

In this statement it is recorded that 'it is our conviction that at the present time there should be only one Christian Medical College of the higher grade'. The reasons in support of this conviction are three. The greatest is the difficulty of finding staff with the high qualifications and teaching experience required for professorships from among Christian forces in India. Already non-Christians have had to be taken on in some cases in the medical schools. As it is the desire that the Christian College should be distinctive as a character-building institution — character built on a Christian foundation — it is felt that we ought not to attempt more than one college at present. The second difficulty is that of maintenance. It takes much more to run a medical than an arts college. The apparatus is expensive and in addition there has to be a large hospital maintained to provide the clinical cases needed for the teaching of the students. And the third reason is that it is felt that the Christian College, if it is to be recognized by future Governments and Medical Councils in India, must be so strong and so distinctive that its value cannot be questioned. It is not enough to come up to minimum requirements only. The distinctive lines for such a college have been suggested: to give a lead in lines that need emphasis such as research, service in rural areas, the moral and spiritual basis of healthful living and also

in the development of a quality of character and an attitude to the sick and suffering which would be unmistakably Christlike.

And so at present the proposal is that this one special college should be developed at Vellore where for the last twenty-four years the Women's College has been carried on.

In addition the C.M.A.I. has reaffirmed:

> We state emphatically that we regard Christian Higher Medical Education as the most urgent and important project for medical missions in India, so important that if it cannot be attained otherwise, some of the medical work in India should be sacrificed even though the loss would be great.

It seems as if the Spirit of God is moving men to action in this important matter. The India Committee of the North American Conference of Missions and the corresponding committee of the British Conference of Missions have recently given evidence of their active interest in the development of practical plans for beginning to build up the men's side of higher Christian medical education.

Throughout the years spiritual encouragement has been given by the great missionary statesman, Dr. John R. Mott. It was a question he put to a group of doctors at our Conference in 1929, 'What are your problems?' that precipitated the thinking of the group on the need of higher Christian medical education. He has assured us in more recent years that if we are in the line of God's will, we can get the funds needed. He has told us how plans must be prepared to the smallest detail, and facts ascertained beyond controversy. If this is God's will, it is the task of the major boards on both sides of the Atlantic. We must pass over the sacrificial path; some must drop other work and take the torch. At a time when some thought of the scheme as too vast to be undertaken, one of us heard Dr. Mott say, that there were donors who did not like to give in fractional amounts, but liked to give largely to a great cause. And so we must, he says, have a plan for large donors, and a plan, if this fails, to spread the net more widely for smaller gifts.

If the proposal for a united college at Vellore is refused other plans, which have been under consideration will be carried forward to provide men's education. But of this there is no doubt, that the men and women who throughout the years have given most thought to the future of medical missions in India, are convinced that Christian medical education is the most important undertaking.

The medical schools have provided many Christian doctors of the licentiate grade.. Through training and experience many of these have become superintendents of mission hospitals or colleagues of missionary doctors. Comparatively few M.B. grade doctors have been in Mission service, and one reason is that there has been no Christian College of that grade. In the coming years this is bound to

change. We do not expect all graduates to find posts in Mission hospitals. As now in the schools, some will find Government posts, or engage in private practice. But we trust they will have learned something of supreme value—the spirit of compassion and the vision of Christ in their fellowmen.

II

'In spite of the difficulties under which the European nurses have had to work, and their having to begin to build up the nursing profession with uneducated girls, as a result of their work the whole Indian outlook on nursing has changed'.[1]

A few statements from actual experience will illustrate the progress that has been made. The first is from a hospital in Bengal:

> Another marked change is in the nursing staff. Over twenty years ago it was impossible to find women with elementary education. The best we could do was to teach them Bengali, Roman and English numbers from one to twenty. All medicines for the eye, ear and throat had to be in bottles of varying sizes, shapes and colours, while another set of bottles larger but still of assorted sizes and colours was used for lotions. That is all changed. Staff nurses, registered with the medical faculty for general nursing and midwifery, have replaced the old type. Today we aim at seventh class Middle English pass for our probationers. Many of our nurses with full certificates have taken posts in other hospitals, while there are others with full training but not able to pass the state examinations, working in various mission hospitals.
>
> There are still difficulties; one of the greatest is, and I expect will always be, character training. Education alone, be it fourth class or even matriculation pass, does not in itself deepen the spiritual life. It is often with many prayers and many tears that these girls are seen to develop, but looking back Sister and I feel it is well worth while when we see the real change and a nurse not only qualified but able and willing to pass on what she has found in Christ to junior nurses and patients.

From a hospital in Central India a nursing sister writes:

> Then the Nursing Superintendent had to spend a large portion of her time scrubbing floors, cleaning equipment, emptying and cleaning bedpans, etc., to demonstrate to students and patients that when necessary no labour is too lowly to be performed in the cure and prevention of disease or for the

[1] Dr. P. V. Benjamin in a pamphlet in the series prepared for study before the meeting of the International Missionary Council at Madras.

comfort and happiness of the patient. Now these lowly services are taken as a matter of course by both. Then with difficulty patients were persuaded to take medicine from our hands; now they take medicine, water and often food.

Then the higher caste patients were very conscious of their high class, so much so that they very frequently made it very unpleasant for the low caste patients in the ward. Now high and low meet and mingle in the same ward very freely. Then the nursing superintendent had to get up night after night to attend to patients and care for emergencies. Now Indian nurses efficiently care for most of these emergencies and she is rarely called.

Another nursing sister, writing of a beginning about fifty years ago, says:

The nurses were widows or married women, not necessarily Christians, of little education and often very trying. In 1896 the first ward of the hospital was built and training of nurses begun. The first students were of a low educational standard and the training was frequently interrupted and often unfinished. By 1915 seven nurses had been prepared for Mission Board Examinations.

By 1941 the hospital had increased to 130 beds and 30 cots, 38 student nurses were taking lectures and all teaching given in English in preparation for the C.P. Medical Board's examinations in medical and surgical nursing and in senior midwifery. Eleven trained Indian nurses on the staff are capable of running their own wards on day and on night duty and to help in teaching. A comfortable nurses' home with facilities for recreation and a prayer room have been built.

All this appears hard cold statistics, but how much lies behind it all—the patience and hope of missionary doctors and nurses carrying on, in spite of many disappointments and seeming failures, because of their vision of what the hospital could become. Surely God's rich blessing has been on their labours that in this short space of time, this great work of Christianity is living and witnessing to thousands of sick and weary women and children.

In her pamphlet on nursing in India, issued for study before the Madras Conference, Miss W. Noordyk, R.N., Ranipet, traces the history of nursing in India. She points out that the social system of the Hindus which sets up caste barriers prevents women of good social position or education from undertaking nursing. The less rigid social system of the Mohammedans might have been expected to be more helpful. But the *purdah* system obtaining among the better class, and the lack of education among women prevented girls from

undertaking nursing service. One must add to these two barriers also the custom of early marriage.

Miss Noordyk writes:

> Who then became the first nurses in India? Christian converts or the children of converts. Some were widows, some orphans and girls who were intellectually not fitted for the teaching profession. All who came were looked upon as a sort of glorified menial servants by their relatives and friends, to be pitied rather than emulated. Even today there is opposition from Christian parents when their daughters voice a desire to enter a nurses' training school.
>
> It was a long, hard struggle to teach the left-overs from the teaching profession, nursing. Patient drilling in the classroom and constant supervision on the wards has been rewarded by seeing them become devoted, consecrated and unselfish workers. One recalls some of the older workers.
>
> One must not forget the Anglo-Indian girls, who entered the Government training schools as well as a few Mission schools. They have played a prominent part in the development of modern nursing in India. Many of them have occupied, and are occupying, positions of responsibility in large institutions. They and the Indian Christian girls are demonstrating what real nursing is, and are helping to create a desire for skilled nursing service among the better class of Indians. I quote from an editorial in the *Madras Mail* of recent date the following:
>
> > Anglo-Indians and Indian Christians have deserved well of the country. When others turned their back on nursing, they entered the profession, brought relief and comfort to the sick and the suffering, and as our own Premier recently said, brought many back to health for whom the ministrations of doctors alone were insufficient.

There has been a progressive, changing attitude towards nursing during the last ten years. Today there are many applicants for training, both young men and women, with a good educational background, some of them having completed their S.S.L.C. We do not have to seek our candidates and beg them to come. There are more applicants than we can take each year and we can select from among them those who seem best qualified. Occasionally non-Christians apply, but not many Mission training schools admit them. They usually go to Government institutions. Even there the majority of the students have been Indian Christians and Anglo-Indians.

In both North and South India there are several training schools for male nurses. These young men work in men's hospitals where it is practically impossible to have young

women care for men patients. At present some of these men are employed in Government hospitals for work in the venereal wards and clinics. In Mental hospitals also they would prove a valuable asset. And as there will be fewer foreign nursing superintendents as time goes on, these male nurses should be able to take the posts of nursing superintendents in men's hospitals. One or two of them have been acting in that capacity.

What is the future of nursing in India? It would seem to be entering upon a new era. The new Government is aware of the needs of the rural population and is determined that medical aid should be made available for more villages. Also in the matter of Public Health there is strong sentiment that more must be done than in the past. The nurses coming out of training schools now should have many opportunities to assist in these schemes of medical aid and public health, when they are put into operation.

Indian medical men and women are more and more aware of the value of good nurse-assistants. Both in institutions and in private practice they will need nurses. Government and Mission institutions as well as private hospitals will need an increasingly larger and better trained nursing staff. In the institutions which have nurses' training schools attached to them nurse-instructors are necessary. In all of them nursing superintendents, ward sisters, operating room supervisors, head nurses, nurse-anæsthetists, nurse-laboratory technicians are needed. What large opportunities for the well-trained men and women with a good education as a foundation for posts of responsibility!

Public Health is another large field for the nurses. School nurses, health visitors, industrial nurses—what an amount of sickness could be prevented and how much health teaching done by properly qualified people along these lines! This field has hardly been touched by the Indian nurse. One can only hope and pray that the many nurses graduating from our schools annually all do their bit to spread the Gospel of Good Health wherever they are.

The training of midwives was begun even before the training of nurses, and it is still carried on as a separate department by a few hospitals. But the usual procedure now is that at the end of her three years' course in general nursing, the student takes a course in midwifery and passes her examination for registration.

The Trained Nurses Association of India owes its existence largely to missionary and Indian Christian nurses. It was organized by a group of nursing superintendents and today it has more than 1,600 members, the majority of whom are Indian Christians. It has

a paid secretary and a monthly journal. Its officers watch carefully over the interests of nursing in India.

> In 1930 the long-felt desire for some organisation to work parallel to the Christian Medical Association, to gather up the work done by nurses' committees and to have an official standing, issued in the discussion of organising a Nurses' Auxiliary. This was completed in 1931. A bi-monthly, *Nursing News*, is issued in English and in six vernaculars. The Nurses' Auxiliary is finding its special field of service among nurses trained in the vernacular and is doing a good work.

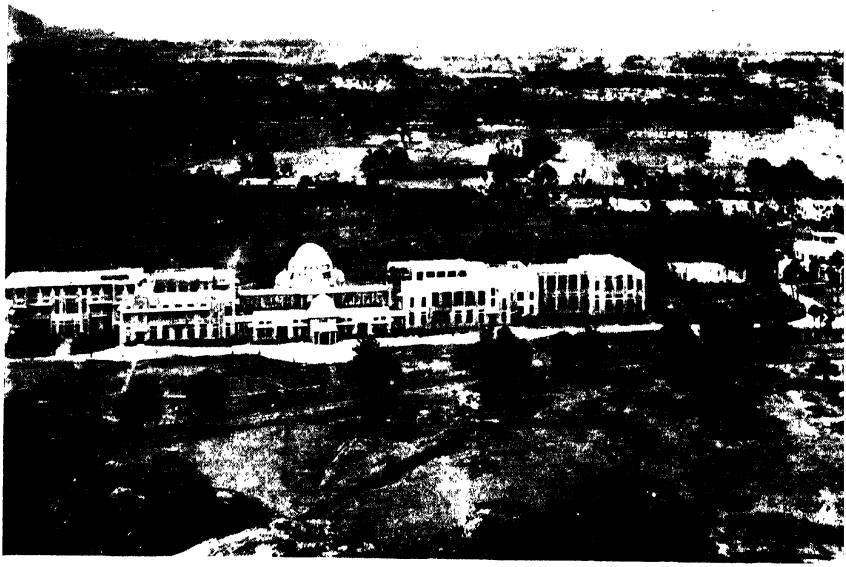
When there was still no Government registration of nurses, the Missions co-operated in organizing examining boards and preparation of text books in the leading languages. Some of these boards were discontinued on the introduction of registration, but two of them continue to the present and are recognized by the Provincial Governments as examining bodies for nurses trained in the vernacular. Quite a number of Mission hospitals in South India, and a few elsewhere, have raised the standard for entrance to matriculation. With the raising of the standard and also with the Government regulations regarding registration of the degrees of foreign nurses, the Mission training schools have tended to decrease in numbers and increase in efficiency. There are still a few Mission hospitals not recognized as training schools carrying on very useful training for nurses, either as nurse-midwives, who can be registered in midwifery, or as fully trained nurses, designed for service among Christians in the villages. Of the former there is the C.M.S. Hospital at Multan and of the latter the hospital of the Basel Mission at Gadag-Betgiri.

In a few hospitals, such as the Rainy Hospital of the Church of Scotland Mission in Madras, and the Vellore College Hospital, there are special post-graduate courses for nurses to prepare them for tutorial and administrative posts. From such hospitals nurses have gone to posts of great responsibility, such as superintendents of the Health School at Delhi and Calcutta, or to be sisters in large hospitals or supervisors of wards.

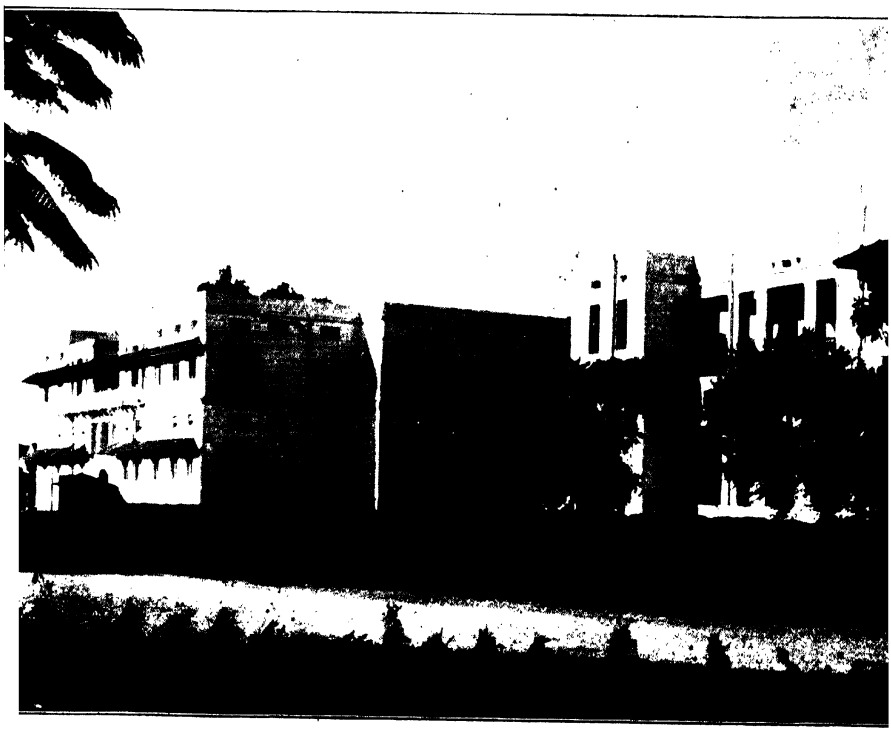
The war is hastening a movement which was on the way for the establishment of a school of post-graduate nursing with Government recognition. The Vellore Training School has been asked to become the centre for such training in the Madras Presidency.

Many women have been trained in women's hospitals only, and so it has not been easy for them to volunteer for army nursing. But the prejudice against women nursing men is lessening, and as a number of women's hospitals have opened wards for men it will be easier for women to get used to the idea of nursing men.

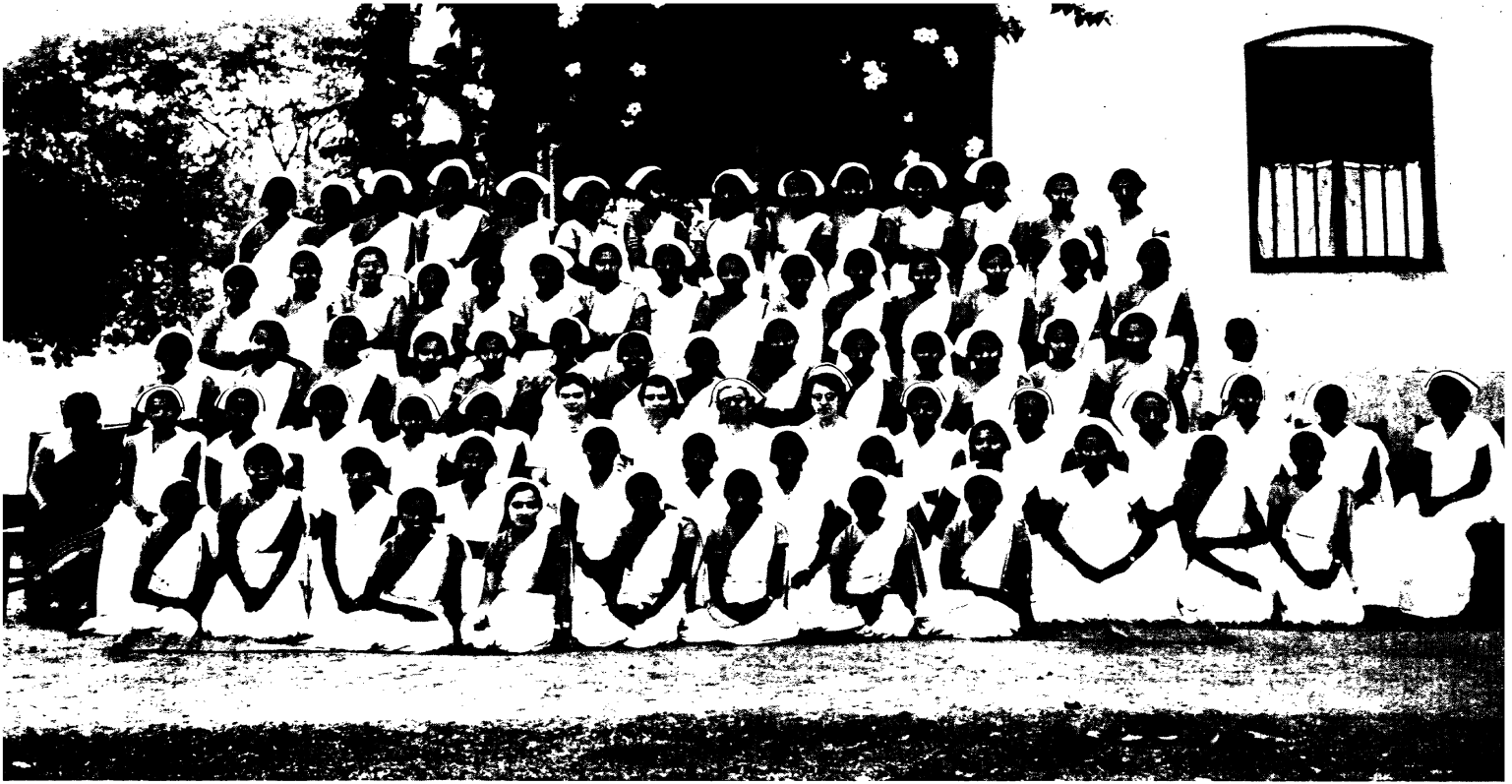
A few years ago it was estimated that about ninety per cent of the nurses in India were Christians and eighty per cent were trained in



The Missionary Medical College for Women at Hill Site, Vellore. The larger domed building is the Chapel (p. 141)



The Hospital of the Missionary Medical College for Women, Vellore (p. 141)



Nursing staff and nurses in training at the Hospital of the Missionary Medical College for Women, Vellore.

Graduate nurses have a black band on the cap

(*p. 148*)

Mission hospitals. Those percentages have been decreasing. Parsee women have not had the caste prejudice of Hindus, and are taking part in the nursing, especially in the large Bombay hospitals. Hindu widows began training some years ago and, as we have seen in Kashmir, Mohammedan women are also taking to the nursing profession. But it will always be to the credit of the Christians in India that they were the pioneers in this Christlike service.

It is customary for many Mission hospital training schools to have a religious ceremony in connection with the graduation. A candle-lighting ceremony has become popular. The following is an account of a graduation at Ludhiana.

> The front seats were occupied by the nurses in training, sisters and staff nurses, the very front row being reserved for the graduating and first year nurses.
>
> The Nursing Superintendent led a procession consisting of the Principal, the Vice-Principal and Medical Superintendent, the Pastor of the local Church, the Nursing Superintendent of the Lady Hardinge Medical College Hospital, Delhi, and the graduating and first year nurses.
>
> When everyone had taken her seat, the nurses sang their special hospital hymn, 'Lord, touch my hands'.
>
> Lord, touch my hands with healing power,
> That day by day, and hour by hour
> Thy healing balm through them may flow
> To weary sufferers in their woe.
>
> After prayer, the Rev. Khansan Singh addressed the graduating nurses. He spoke of his interest in the profession, due to his wife and sister both being trained nurses. He reminded them of the high ideals of service the profession fostered. He spoke of the example our Lord set when He washed the disciples' feet. He asked them to remember that they were Christ's representatives on earth, that they could say, 'Christ has no hands but my hands . . . no feet but my feet'.
>
> After this the Principal presented the diplomas and also three prizes for nurses who had gained honours and first class in the Preliminary State Anatomy examination. This was followed by each nurse having the Hospital Badge pinned on her by their Superintendent. Each graduating nurse then signed a copy of the Nightingale Pledge which was given to her.
>
> After a brief address by the Superintendent of the Lady Hardinge College Hospital the Nursing Superintendent came to the front of the platform with a lighted Florence Nightingale lamp. The graduating nurses filed past her on a lower platform, each one lighting a candle from her lamp. They then turned to face the audience, and in their turn passed

on the light to the first year nurses, who stood on the floor of the hall—a symbol of the light which Florence Nightingale lit so many years ago, and which is still being passed on from generation to generation of nurses.

Then, while the audience stood, these nurses repeated the Nightingale Pledge so distinctly that every word was heard. The Benediction was pronounced, followed by the procession out of the hall, the nurses still holding their lighted candles.

III

There remain two other departments of training to be described. The older of the two is the training in the compounding and dispensing of medicines. It will be seen from the statistics that there are hospitals where this is still carried on. Several of the English Missions have in charge women who have qualifications in pharmacy. The students in some cases take the Government examinations and in some cases a Mission examination as well. Male nurses often combine the two professions of nursing and compounding.

The latest development has been the opening of classes for training laboratory technicians. When the Survey of Medical Missions was undertaken by the C.M.A.I. in 1925–27 it became evident that laboratory work in most hospitals was largely neglected, and the chief cause was that the doctors often did not have time to do even the simpler laboratory tests. It was suggested that a great improvement could be made in this respect if trained laboratory technicians were available. As a result the Rev. R. M. Barton, who had done laboratory work during the first World War and who had helped in the laboratory at the Sanatorium at Arogyavaram while a patient there, was invited to undertake the training of technicians for Mission hospitals at Arogyavaram. Training began in 1927 and since then about 100 men and women have been trained, chiefly those sent by Mission hospitals to which they have returned for service.

Since this beginning was made training has been undertaken at five other centres. Mr. Barton has now proposed that the C.M.A.I. set a standard for all these centres, have one curriculum, one examination and issue a diploma. There is no such recognized standardized course elsewhere in India, and in most cases the laboratory work in Government institutions is done by fully qualified doctors. Thus once again there comes to us an opportunity for pioneer work in a needy field.

It is hardly necessary to say that the laboratory work has greatly improved since these training classes were begun.

Thus in various ways men and women are being trained for a life of service to the sick.

CHAPTER XIV

OUR ASSOCIATION

'Not forsaking the assembling of yourselves together.'
—HEB. 10: 25.
'We become selves only in relation to other selves; only by receiving from and giving to other persons.'

'Now I think that this Association is just the organization that is needed to hold together all medical men and women, whose primary object is the establishment of the Kingdom of God, in whatever capacity they may come out to India. I also hold that the time has come to include much more largely in our membership the Indian doctors who have this same object.'

These words were spoken by Dr. Ernest Muir, our President, at the Fourth General Meeting of the Association in Calcutta in December, 1924. That meeting is regarded as one in which the springs of creative thought were unusually strong and issued in the deepening of the stream of usefulness of the Association.

Out of it came the impetus for the change of constitution which transformed the Medical Missionary Association into the Christian Medical Association, now admitting to its membership Christian men and women, duly qualified, who are in sympathy with the objects of the Association. The primary object is thus stated:

> The prevention and relief of human suffering and the pursuit of measures for the promotion of health in the spirit of Christ in the extending of the Kingdom of God.

There is now a large number of Indian doctors in the membership with a sprinkling of doctors in Government or other services, as well as medical missionaries. In 1940 the Association elected as President Dr. P. V. Benjamin, a member of the Syrian Church in India, a Christian doctor of distinction, Superintendent of the Union Mission Tuberculosis Sanatorium in South India.

At that same memorable meeting Rev. W. Paton, Secretary of the National Christian Council, informed the Association that the National Christian Council had decided to accept it as their Medical Committee[1]. The National Christian Council in 1926 endorsed the action of its Executive, welcomed the Christian Medical Association as fulfilling the functions of its Medical Committee, pledged its co-operation, and promised representation of the C.M.A.I. on the Council. They recommended to Provincial Councils that

[1] See Res. XVIII of the N.C.C. Executive, Nov., 1923.

they enter into similar relationship with the C.M.A.I. Provincial Associations.

When the C.M.A.I. decided to have a full-time paid secretary, the N.C.C. at its meeting at the end of 1932, passed a resolution agreeing that this secretary 'when appointed become the honorary secretary for medical work of the National Christian Council'. The Secretary has since resided in Nagpur, has an office with the N.C.C. and is an ex-officio member of the N.C.C. Executive. Thus there has developed a close relationship with the N.C.C.

A third action of this important meeting, was to make the *Journal of the Association* a bi-monthly periodical instead of a quarterly. Always a useful journal, it has become increasingly valuable, and has a circulation not only in India, Burma and Ceylon, but in other lands where there are medical missionaries, and among mission organizations in Britain and America. It is unique in combining scientific medical articles with articles on religion, and accounts of the practical working of medical missions.

A fourth action was to make the General Meeting a biennial occurrence, and since then eight biennials have been held.

A fifth, and highly important action, for which the time was ripe, was the organization of a Committee of Survey, Efficiency and Co-operation. The member who presented at the conference a paper on the need of a survey of medical missions, had been stimulated by an account of an address by Rev. J. H. Oldham in which he was reported to have said that missions ought 'to examine and examine again their fields and ruthlessly to amend or eliminate their inefficient work and to plan not for today or tomorrow but in view of the needs of ten years hence'. No medical mission survey had ever been carried out in India, and except in a rare case, there was no clearly-stated *raison d'être* or definite policy for medical missions.

The Survey Committee was guided and encouraged in its work by the Secretaries of the National Christian Council. At the first meeting, after a sharing of thoughts and convictions by all present, there was crystalized out a statement, which was given the name of The Basic Statement, and this statement was afterwards accepted by the Biennial Conference of the Association. It is as follows:

> It is our conviction that the ministry of healing is an essential part of the work of the Christian Church, whose mission it is to represent God as revealed in Jesus Christ. We observe that Christ's own testimony concerning His mission was that He came to do the will of the One who sent Him and to finish His work. We must believe that the ministry of healing for the body is an expression of the attitude and mind of God toward man and has its source in the compassion and love of God. It is our conviction that the Christian should concern himself with the care of the sick apart from whether others are

carrying on the work or not. From this conviction it becomes our duty to develop Christian Medical work as part of the essential work of the Church in India, and to consider how this may best be done.

The recognition of the ministry of healing as an essential part of the work of God through the Church involves the thought that the service thus rendered is a natural and vital expression of the Spirit of Christ and can best be engaged in by men and women imbued with the Spirit of Christ Who served men for love of them and Who, as evidence of His identity, drew attention to the work He was doing, 'The blind receive their sight, the lame walk, the lepers are cleansed, the deaf hear, the dead are raised up and the poor have the gospel preached unto them'.

It is impossible to estimate fully the influence this statement, and articles written on the theme, have had in clarifying the vision of many persons, including Christian doctors and nurses. Many had thought of the ministry of healing in medical missions as a pioneer or evangelistic agency and not as an integral part of the Gospel and of the work of the Church. To apprehend it now in its rightful place was a deeply joyous experience.

Primarily it follows that we seek to integrate the healing ministry in the indigenous Church, and welcome every spontaneous development from within the Church. Secondly, it follows that the work initiated by Missions, so far as it is worthy of being continued, should gradually devolve upon Indian Christians, and be related to the Church. For the worthy fulfilment of these aims, the training of men and women for Christian medical service in the spirit of Christ is essential.

The report of the Survey was published in 1928, and is substantially reincorporated in a Handbook called *The Ministry of Healing in India*, printed in 1932.

When the delegates were chosen for the International Missionary Conference at Jerusalem in 1928 two medical missionaries from India were invited, both of whom had served on the Survey Committee. A request had been made that medical missions should have a place on the programme, but the request was not granted. It may be recalled that the subject was omitted from the programme of the World Missionary Conference at Edinburgh in 1910. But the India medical delegates were encouraged to hope that on arrival they might find it possible to confer with other medical delegates. There was just one other, a Chinese doctor, but there were two conference doctors, so the five held a meeting, and felt that they had a message to give. Introduced by our friend Mr. Paton, the little group had lunch with Dr. Mott, who was himself interested, and provided a group of board secretaries and others to discuss and bring in findings,

and he also made it possible for an address to be given at a full meeting of the Conference setting forth the place of medical missions in the task of the Christian Church. Thus it happened that there was an interesting discussion on medical missions and important findings in the records—which was only possible because of the preparation of thought done in connection with the Survey.

Ten years later at the International Missionary Council Meeting at Tambaram, medical work was given a place, and there were medical delegates from China, Java, Africa, Arabia, America and India. The findings are widely considered and quoted and they are being used as a guide and stimulus in the work.

With the idea of winning the interest of the indigenous Church in the healing ministry, the observance of the Second Sunday in February as Hospital Sunday was initiated in 1927. Each year the Association distributes widely a pamphlet with suggestions to pastors and subjects for prayer. Emphasis is laid on the healing ministry as related to the Church, and offerings in aid of medical work, in coin or in kind, are received.

It has been noted elsewhere, and is only recalled as being in the list of the Association activities, that classes for laboratory technicians were begun some years ago, and the course is now likely to be standardized; that a Nurses' Auxiliary parallel to the Medical Association was begun in 1931, which has been specially helpful by its conferences, and its *Nursing News*, published in six vernaculars; that much thinking and planning has gone into the project for higher Christian Medical Education.

Other activities are the carrying out of local surveys at the request of missions; the holding of regional medical conferences in the Provinces and at the hill stations; the maintenance of lists of posts vacant and posts wanted by doctors and nurses; correspondence on behalf of the Association when needed with Government and with the internationally organized bodies in Britain, America and China.

A series of conferences for hospital evangelists was arranged in 1940–41. For many years it has been felt that the evangelistic work was not on a par with the medical in personnel and in effectiveness. Moreover, for the most part, the evangelistic staff were not aware of the way in which their ministry was related to the health of the patients. In these conferences there has been an effort to help the evangelists to understand the background of the patients, religious and social, and to help them to know how to present their message. There has also been an attempt to show the unity of the body and mind, and to suggest how the evangelist may help the doctor in the healing of the patient.

In 1937 the Association set up in Bombay a purchasing agency of its own called The Hospital Supply Agency, to ensure a supply of reliable medicines and equipment at fair prices. Some of the leading wholesale houses give a substantial reduction to mission hospitals. The Agency's telegraphic address is 'Succour, Bombay', and it, together with Dr. Linn's All-India Missions Tablet Industry, have been 'succourers of many'.

The need of a secretary for preventive work was stated and restated at successive Biennial Conferences. In the Conference at Allahabad in 1929, Miss H. J. Fernstrom, R.N., B.Sc., by her informed and enthusiastic presentation of the subject of health work made an indelible impression on the delegates. Meantime she has been engaged in that effective piece of health service under the Methodist Mission in North India referred to in a previous chapter, and has also given inspiration to groups at regional conferences. She received a hearty welcome at the last Biennial Conference, which by a unanimous vote, agreed to a resolution asking that she be lent for a period of three years for service in connection with our Association. We are deeply grateful to the Women's Division of Christian Service of the American Methodist Church that they have agreed to our request. Miss Fernstrom is in America on furlough, but we are looking forward to her return, if God wills, in 1943. Through her work a new and needed emphasis will be given to health and preventive work in general and particularly to health work in Christian schools and in rural communities, work in which teachers and parents will also be included.

A department of medical work that has hitherto received practically no attention from Christian missions, is the treatment of nervous diseases, especially border-line cases. The need of a hospital for nervous diseases has been felt for a long time, and for some years a committee of the Madras Christian Council, now joined by the medical committee of the Andhra Christian Council, has been working toward the provision of a treatment centre. Their recent proposal, which is likely to be acceptable, is that a department for the treatment of nervous diseases should be opened near Vellore, and be related to the hospital of the Missionary Medical College for Women at that centre. This is a kind of service requiring qualities of patience, hope and faith and should make a very special appeal to Christian compassion. It is good to think that a beginning is to be made. There should be at least one hospital of this kind in each language area.

The regulations governing the registration of foreign degrees is a concern of the Association. Registration of medical qualifications in India is being put upon a strictly reciprocal basis. Special

recognition is given to medical missionaries in two of the Provinces, and in other Provinces unregistered doctors have no better status before the law than quacks. For this reason it is highly desirable that in future all intending medical missionaries should acquire a qualification, for instance a British qualification, which is registerable in this land. These restrictions constitute an additional argument for pressing on with the higher Christian Medical Education to ensure a supply of missionary-minded Indian Christian doctors for carrying on the work.

The conferences of the Association which call together men and women loyal to the one Master to confer in regard to their work, to plan for projects in co-operation and to work together in committees, provide an opportunity for the beginning and continuance of enriching fellowships which are of the real substance of life. 'We want to meet great personalities,' said a doctor of the assistant grade, disappointed by the attendance at a regional conference specially arranged as a refresher course. It is the meeting with those who have gone farther in experience than ourselves that is specially inspiring. Even more helpful is the confidence in one another and the solid friendship that is built up in working together on the committees. Valuable as the work is in itself, perhaps its special value is the 'fellowship of kindred minds' for 'All real life is meeting'.

SHORT BIOGRAPHICAL NOTES

Some of the Indian Christians in Posts of High Responsibility

1. KRUPA ABRAHAM, L.M.P. (Vellore)

Dr. Abraham graduated from Vellore Medical College in 1922. She is one of Dr. Ida S. Scudder's first batch of students. She went to Khammamett in January, 1923, and has been there ever since.

2. T. I. ABRAHAM, L.C.P. & S, and
MARY ABRAHAM, L.S.M.F.

Dr. and Mrs. Abraham have been in charge of the Fairbank-James Friendship Memorial Hospital, Vadala Mission, near Ahmednagar, since its beginning in 1937.

Dr. Mary Abraham graduated from Ludhiana in the year 1933, worked at Manamadura 1934, Satara Mission Hospital in 1936, Jubbulpur Panagar Mission 1936–37; at Vadala since 1937.

Dr. T. I. Abraham graduated from Miraj in 1934, worked as house-surgeon in Miraj in 1934, as assistant surgeon in Wai Mission Hospital, 1934–36, and in Vadala Hospital as medical officer in charge from 1937.

3. SAMUEL D. ARAWATTIGI, L.C.P.S. (Bombay)

Dr. Samuel D. Arawattigi graduated from Miraj Medical School in 1929, remained as an intern for two years and as a resident for two more years. These eight years of medical preparation enabled him to take up much of the surgery that Dr. C. E. Vail was doing until his death in 1936. Dr. Arawattigi's name is now known far and wide as a general surgeon at Miraj Mission Hospital.

4. LUCY S. AUGUSTINE, L.M.P.

Dr. Augustine was one of the first class to graduate from Vellore, and worked for one year as intern in the hospital. For six and a half years, previous to her marriage in 1929, she worked at the Methodist Mission Hospital at Ikkadu. In 1931 she joined the staff of the Mure Memorial Hospital of the Church of Scotland at Nagpur, where she has the full work and status of a colleague with the missionary doctors.

5. SUNDAR GAIKWAD, L.S.M.F.

Daughter of a doctor in Government service. Attended high school in Ahmednagar; graduated from Ludhiana in 1924; served as intern and on the staff of the American Marathi Mission Hospital at Wai; joined the staff of the United Church of Canada Hospital at Banswara, S. Rajputana in 1930; in 1936 had post-graduate study in Canada; in 1937 she took full charge of the U.C.C. General Hospital at Mandleshwar, C.I. She is a member of the Medical Commission of the United Church of Canada India Mission and was a delegate to the International Missionary Conference at Tambaram.

6. S. GURUBATHAM, L.M.P. (Tanjore)

Passed out of Government Medical School, Tanjore, in July, 1917; Served in the military department for two and a half years; 1920–28 worked in the Swedish Mission Hospital, Tirupatur, Ramnad District. When a wealthy Indian Christian offered to start an eye hospital at Coimbatore he took charge of the hospital and during a period of thirteen years built it up into a hospital of forty beds. In 1935 the Mission sent him to Europe on deputation work and he visited all the important eye clinics in England and on the Continent. In 1940 he settled in a village trying to combine medical work with rural uplift. In 1941 he was called to Vellore to build up the eye department for the Missionary Medical College for Women.

7. MISS ANNA JACOB, Regd. Nurse

Syrian Christian. Passed S.S.L.C., 1932. Admitted to the Missionary Medical College Hospital for Women, Vellore, as a student nurse, July, 1932; passed all examinations the third year with distinction; Government Midwifery Examination, 1936; post graduate course given in Vellore, 1935–36; served as a staff nurse in all departments from 1937–40. In 1940 did six months' post graduate course at the Lady Hardinge Medical College Hospital, New Delhi, in administration and teaching. Returned to Vellore as an assistant to Sisters in the Vellore College Hospital for one year. In August, 1941, was appointed Sister-in-charge of the Midwifery Department, taking a full share in the Christian training of the nurses as well as training them in their professional duties.

8. GRACE JONES, L.S.M.F. (Punjab)

Dr. Grace Jones, a third generation Christian, in fellowship with the American Friends at Chattarpur. She took a course in compounding and served in that capacity for a few years and then became a student at the Women's Christian Medical College at Ludhiana, from which she graduated in 1933. For several years she worked with Dr. Ruth Hull at the Friends Hospital at Chattarpur, C.I., of which she is now in charge.

9. TARA MARTIN, L.C.P. & S.

Graduating from Ludhiana in 1908 she began work at the Church of Scotland Mission Hospital at Nasirabad, Rajputana. Passed also the L.C.P. & S. (Bombay) 1914, and Grade Examination of Assistant Surgeons set by the Mission 1915, putting her in the Assistant Surgeon's grade. Has been in full charge at Nasirabad since 1915 and has done extensive welfare work for the community.

10. JAYA LUKE, L.M.P.

Whose father was a pastor of the Methodist Episcopal Mission, graduated at Vellore in 1925. Served as assistant to Dr. Stella Dodd in Sironcha 1925-30; in 1931-32 in charge at Berhampur; in 1932-34 in change at Jagdalpur, C.P.; after a six months refresher course in Madras, she was placed in full charge of the hospital and rural extension work at Sironcha, C.P.

11. L. I. ROBERTS, M.R.C.S. (Eng.), L.R.C.P. (London). Qualified in 1920.

Appointments held: House Physician, Brompton Hospital for Diseases of the Chest, London; Casualty House Surgeon, Royal Infirmary, Hull;

Dr. Jaya Luke

Dr. Tara Martin

Dr. Krupa Abraham

Dr. G. Samuel

Dr. Sundar Gaekwad

Dr. Maria Selvanayagam

Dr R and Dr Grace Vedabodakam

Dr S Gurubatham

Dr Grace Jones

Dr Lucy S Augustini

Miss Anna Jacob

Dr Samuel D Arawattigi

Dr Obed and Dr Elizabeth Shantappa

Resident Medical Officer, General Hospital, Southend; Senior Resident Officer, North Lonsdale Hospital, Barrow-in-Furness. From 1927 he has been engaged in Medical mission work for the Society for the Propagation of the Gospel at Nandyal in the Diocese of Dornakal.

12. MARIA SELVANAYAGAM, L.M.P.

Daughter of Rev. and Mrs. R. C. Selvanayagam of Uttamapalayam, Madura District. Midwifery training and Health Visitors' training in Madras and Delhi, respectively, 1920–22; served as a Health Visitor in Coimbatore and Mysore 1923–26; medical training in Vellore from 1926–30; internship 1930–31 in the American Mission Hospital for Women and Children; served as an assistant in the Kugler Hospital, 1931–32. At present working in E.T.C.M. Hospital, Kolar from 1932, of which she is Medical Superintendent.

13. ELIZABETH SHANTAPPA, L.F.M.S. and
OBED SHANTAPPA, L.C.P.S.

Dr. O. Shantappa graduated from Miraj Medical School in 1921, worked in the London Mission at Jammalamadugu and Chikkaballapur from 1921–1925. In 1926 he was in Kolar and from 1927 in charge at Bidar. Post graduate work in New York.

Dr. E. Shantappa graduated from Ludhiana in 1921, worked in Kolar for a few years, then one year in Chikkaballapur. Since 1927 she has been in charge of the women's work at Bidar.

14. R. VEDABODAKAM, L.M.P. and
GRACE RUBY VEDABODAKAM (Apothecary)

Dr. R. Vedabodakam graduated from Madras Medical School, 1916. Assistant at St. Luke's, Nazareth for one year 1916–17, and in charge from 1917.

Mrs. Grace Ruby Vedabodakam, Apothecary Grade (L.M.P.), in charge of the Women's Section, St. Luke's Hospital, 1920. Qualified at the Madras Medical College, 1915–20.

15. G. SAMUEL, M.B., B.S.

The Sir William Wanless Sanatorium, Miraj. After taking his L.C.P. & S. and serving for some years, specializing in Tuberculosis, Dr. Samuel took his M.B. at Madras and returned to serve with Dr. Jones at the Wanless Sanatorium. Since Dr. Jones left for America, over two years ago, Dr. Samuel has been in charge of the sanatorium.

EPILOGUE

AND so, for the present, we reach the end of the 'Tales from the Inns of Healing'; for who can doubt that those who have read these tales will soon be asking to hear more of these living experiences from frontier and city, from hill country and plain, from one end to the other of this vast country of India. In these tales we see work of varied character—some very humble and even primitive, some of a very high scientific order contributing to the medical knowledge of the world, some with imperfections which those who are engaged in it would often be the first to admit; yet in the centre of it all is the dominating idea of service controlled by the love of God. In these tales we see His power and His love working through the hearts and hands of Christian men and women, whose lives and whose work are, as a recent writer has said, 'making the love of God credible'. How much we need this in a world in which there is so much which makes it hard to believe in a God whose character is love.

Does this not show the true place of Christian medical work in the proclaiming of the Gospel? The ministry of Him who was in the midst as one that serveth is still being carried on through men and women, Indian and non-Indian, who are giving their lives in His name to the service of the sick. Without such a ministry, the work of the Church would be incomplete. We have a long way to go before we in India fully recognize this. The leadership in medical work is still largely in the hands of missionaries, and there has been less devolution in this sphere than in other parts of the Church's work. This cannot be otherwise unless there are Indian doctors of ability and of Christian vision and character. The efforts being made to establish a Christian Medical College for men as well as for women are a recognition of the need for the training of Indian leaders in this branch of the Christian ministry, so that it may take its proper place as an integral part of the work of the indigenous Church. The same is true of the higher training for nurses, which is being started, for example, in Vellore; up till now there have been very few Indian nursing superintendents.

One of the most important contributions the Christian Medical Association of India has been making is their emphasis on this place of the ministry of healing.

I should like to pay a tribute to the work of Dr. B. Choné Oliver, who, save during furloughs, has been the Secretary of the Medical Association since 1929. A great part of what the Association has been able to accomplish, as described in the previous chapter, has been due to her vision, enthusiasm and organizing ability

and finally these Tales, too—the collecting of material, the editing and compiling of the book, owe much to her.

As this book goes out, it is my hope that those who read it may be encouraged, may be brought to thank God for what He has done through the ministry of healing in India, and that more and more the Church in this land may be led to follow the Great Physician, Healer of body and soul, and to live out the love of God.

Arogyavaram
November, 1942

P. V. BENJAMIN
President of THE CHRISTIAN MEDICAL ASSOCIATION OF INDIA BURMA AND CEYLON

STATISTICAL SUMMARY OF CHRISTIAN MEDICAL SERVICE IN INDIA BURMA AND CEYLON

We take leave to quote a poem written especially for the *Interpretative Statistical Survey of the World Mission of the Christian Church*:

To whom a talent by the Lord is lent
Makes it his constant care, with labour fine,
To hold it as a trust. His life is spent
In striving to interpret the divine.
He will create, of sound or hue or line,
A thing of beauty; for his high intent
Is of his skill to make a sacrament
The glory of his Master to enshrine.

No less, to the discerning, to the wise,
These figures—rank on rank, austere yet fair,
Assembled patiently with ordered care—
These too assume a sacramental guise;
And human lives behind the figures show
The Master moving in His Church below.

—M.M.U.

Though our figures cannot claim to be absolutely accurate (as what statistics can be?) it is certain that they have been 'assembled patiently with ordered care'. A fuller report, with the names of all the hospitals, sanatoria, leprosy homes and most of the dispensaries is being published in the *Journal of the Association* and reprints will be available. No institution with less than ten beds is classed as a hospital.

Statistics for the Year 1941

CHRISTIAN HOSPITALS		
Central	244	
Branch	44	
	——	288
DISPENSARIES		
Separate	165	
Branches	33	
Outlying from Hospitals ...	160	
Out-patient Departments of Hospitals	283	
	——	641
SANATORIA	...	10[1]
LEPER HOMES AND HOSPITALS ...	...	62

[1] This includes the Tuberculosis Department of the Ludhiana Hospital but not those of Madura, Anand, etc.

BEDS			
In Hospitals	15,970		
In Sanatoria	979		
In Leper Hospitals	1,113[1]		
In connection with Dispensaries	60		
			18,122
ACCOMMODATION IN LEPER HOMES ...			11,044
IN-PATIENTS			
In Hospitals	270,513		
In Sanatoria	1,881		
In Leper Homes and Hospitals ...	11,044		
In Dispensaries	517		
			283,955
OUT-PATIENTS			
Individuals treated at Dispensaries and Out-patient Departments			2,237,911
Total Treatments ...			6,643,436
OPERATIONS			
Major	32,897		
Ophthalmic	19,479		
Minor	155,062		
Unclassified	10,957		
			218,395
MIDWIFERY CASES			
Normal	25,026		
Abnormal	8,796		
Unclassified	3,030		
			36,852
FINANCIAL			
Received in India from fees, donations and grants-in-aid, approximately ...		Rs.	4,269,368
Received from abroad approximately ...			2,249,121[2]
Total amount expended ...			6,571,380[2]

Staff

FOREIGN					
Doctors	*Men*, 120;	*Women*,	148 —		268
Nurses	...	...	...		308
Qualified Pharmacists	...	...	...		12
Qualified Technicians	...	...	...		10
Evangelists ...	...	...	...		39[3]
Others—Business Managers, Voluntary or Part time Helpers ...	...	...	...		61
NATIONAL					
Doctors	*Men*, 246;	*Women*,	199 —		445[4]
Nurses	„ 231	„	807 —		1,038
Midwives	...	...	...		208

[1] The accommodation for leprosy patients in the homes is about 12,000. The above figures refer to beds in the hospitals.

[2] This is an under-estimate because salaries of missionaries were not always included and a number of institutions did not report.

[3] Some part time.

[4] Fifty-nine are of the M.B. grade.

Staff. NATIONAL *(Contd.)*					
Unqualified Nurses ...	*Men*		*Women*,	604 —	918
Qualified Dispensers ...	,,		,,	132 —	430
Qualified Laboratory Technicians ...	,,	92	,,	35 —	127
Full Time Evangelists	,,	76	,,	151 —	227
Others—Business Managers, Part Time and Voluntary Evangelists ...				...	372

Training Classes

Medical Students ...	*Men*, 102;		*Women*,	203 —	305
Post-graduate Students in Tuberculosis ...	...		...	...	14
Nurses in Training ...	*Men*, 308;		*Women*,	1,656 —	1,964
Dispensers in Training	,,	73	,,	78 —	151
Midwives in Training	...		...	...	383
Technicians in Training	...		...	...	41

PUBLICATIONS

The Journal of the Christian Medical Association of India, Burma and Ceylon (Bi-monthly). Subscription Rs. 5 a year ($2 or 7*s.* 6*d.*)

The Nursing News of the Nurses Auxiliary (Bi-monthly). Re. 1-8-0. Also in five vernaculars.

The Ministry of Healing in India. Handbook of the Association, 1932. Free, plus postage, 4½ annas.

Efficiency in the Task of Medical Msssions. By DR. R. E. HOFFMAN. 2 annas, plus postage.

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