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Résumé de l'article

Ces missions furent, jusqu'à la domination communiste en 1949, les seules sources de soins médicaux modernes en Chine. Bien qu'il existe actuellement une littérature peu importante — mais croissante — sur les missionnaires-médecins en Chine, les études en ce domaine ont traité de la médecine missionnaire en tant que service de santé homogène. Cette opinion sur la médecine missionnaire est simpliste du fait même que le travail médical conduit par les missions chrétiennes a pris des formes diverses dans la société chinoise. L'objectif de l'article qui suit est de présenter une typologie de la médecine missionnaire qui puisse fournir un cadre pour de futures recherches. Les activités médicales des missions comprenaient trois catégories principales, allant du travail à l'hôpital et au dispensaire, ou travail médical « primaire, » à l'enseignement médical et de santé publique, ou travail médical « secondaire. » Alors que le travail médical primaire constituait l'activité sine qua non de chaque mission, l'importance des ressources médicales allouées au travail secondaire variait considérablement selon les missions. L'utilisation des concepts « local » et « cosmopolite » permet de distinguer deux types de médecine missionnaire en fonction de l'importance du travail médical secondaire fourni par la mission. Les missions médicales locales investissaient la plus grande part de leurs ressources dans le travail primaire, délaissant le travail secondaire. Par contre, les missions médicales cosmopolites allouaient d'importantes ressources au travail médical secondaire tout en maintenant le travail primaire. Afin d'illustrer cette typologie local/cosmopolite nous faisons mention du travail médical conduit par trois missions canadiennes en Chine du début du siècle à 1937. Nous discutons aussi de l'utilité et des implications de cette typologie pour la conduite d'études sur les services de santé en Chine.

Toward a Typology of Missionary Medicine: a Comparison of Three Canadian Medical Missions in China before 1937

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Until the Communist domination in 1949, medical missionaries had been the chief source of modern health care in China. While there is now a small but growing body of literature on medical missionaries and their work in China, studies in this area have treated missionary medicine as a homogeneous type of health care. This is a simplistic view of missionary medicine, as medical work organized by Christian missions has exhibited a variety of forms in Chinese society.

The purpose of this paper is to offer a typology of missionary medicine, which will provide a useful framework for further research in this area. Medical missionary activities fell into three main dimensions, ranging from hospital and dispensary services, or "primary" medical work, to medical education and public health, or "secondary" medical work. While primary medical work was the sine qua non of every mission, the amount of medical resources allocated to secondary medical work varied tremendously among the missions. By using the concepts of "local" and "cosmopolitan," two types of missionary medicine can be distinguished on the basis of the amount of secondary medical work carried out by a mission. Local medical missions devoted most resources to primary work, making few secondary efforts, whereas cosmopolitan medical missions allocated substantial resources to secondary work apart from maintaining primary work.

The medical work of three Canadian missions in China from the turn of the twentieth century to 1937 will be used to illustrate the local-cosmopolitan typology. Also, the utility and implications of the typology for the study of health care in China will be discussed.

Ces missions furent, jusqu'à la domination communiste en 1949, les seules sources de soins médicaux modernes en Chine. Bien qu'il existe actuellement une littérature peu importante — mais croissante — sur les missionnaires-médecins en Chine, les études en ce domaine ont traité de la médecine missionnaire en tant que service de santé homogène. Cette opinion sur la médecine missionnaire est simpliste du fait même que le travail médical conduit par les missions chrétiennes a pris des formes diverses dans la société chinoise.

L'objectif de l'article qui suit est de présenter une typologie de la médecine missionnaire qui puisse fournir un cadre pour de futures recherches. Les activités médicales des missions comprenaient trois catégories principales, allant du travail à l'hôpital et au dispensaire, ou travail médical « primaire, » à l'enseignement médical et de santé publique, ou travail médical « secondaire. » Alors que le travail médical primaire constituait l'activité sine qua non de chaque mission, l'importance des ressources médicales allouées au travail secondaire variait considérablement selon les missions. L'utilisation des concepts « local » et « cosmopolite » permet de distinguer deux types de médecine missionnaire en fonction de l'importance du travail médical secondaire fourni par la mission. Les missions médicales locales investissaient la plus grande part de leurs ressources dans le travail primaire, délaissant le

travail secondaire. Par contre, les missions médicales cosmopolites allouaient d'importances ressources au travail médical secondaire tout en maintenant le travail primaire.

Afin d'illustrer cette typologie local/cosmopolite nous faisons mention du travail médical conduit par trois missions canadiennes en Chine du début du siècle à 1937. Nous discutons aussi de l'utilité et des implications de cette typologie pour la conduite d'études sur les services de santé en Chine.

Introduction

In the past century, missionaries have been very important Western agents of modern health care in many developing countries[1]. Very often, medical missionaries were not only the first ones to introduce modern medicine[2], but they still provide a significant portion of medical services in these countries today (McGilvray, 1968; Dayton, 1969; Hartwig, 1979). Since the late nineteenth century, when Christian missionary movements were sweeping through the West, medical work has been an integral part of foreign mission work. Medical work serves to alleviate physical sufferings and break down the prejudices of the native people against missionaries (Robinson, 1915:28), thereby performing the "instrumental function" of facilitating evangelical work (Cheung and New, 1981, 1982). Mission-sponsored medicine, or missionary medicine, is an important starting point for any studies of Western health care in developing countries.

Medical missionary work also had a long history in China, from the 1830's to a few years after the 1949 Communist Revolution. Medical missionaries were the pioneers among scientists who transplanted Western sciences into China (Buck, 1980), and they also carried the main burden of modern health care until 1949[3].

While there is now a growing body of literature on medical missionaries and their work in China and other developing countries, studies in this area have treated missionary medicine as a homogeneous form of health care. This is a simplistic view of missionary medicine. It is our contention that medical work organized by Christian missions has exhibited a variety of forms. The purpose of this paper is to formulate a typology of missionary medicine, which will provide a useful framework for further research in this area. A clear distinction of different organizational forms of missionary medicine will not only allow us to identify different impacts of these forms on the recipient society with respect to health care at the local level and medical policies at the national level, but it also allows us to make more accurate comparisons between missionary medicine and other sources of Western medicine and health care. Based on the data of three Canadian medical missions in China from the turn of the twentieth century to 1937, we will develop a typology of missionary medicine[4]. In this paper, we are concerned basically with the structural aspect of missionary medicine[5].

Dimensions of Medical Missionary Work in China

The late nineteenth century witnessed a change in the approach to medical missionary work in China. The early "individual work" approach adopted by pioneer medical missionaries such as Peter Parker (Gulick, 1973) and William Lockhart (Lockhart, 1861) in the 1830's, when there were only a handful of such missionaries in a few ports of China, gave way to the institutionalization of medical missions in the last two decades of the nineteenth century, when mushrooming numbers of medical missionaries were sent to China after it was forced by Western powers to open its interior to foreigners. The institutionalization of medical missions resulted in a clear definition of the scope of medical missionary work than before.

Three areas of medical work were formally advocated by the China Medical Missionary Association, the official association of the medical missionaries in China formed in 1887 (Hyatt, 1966).

HOSPITAL AND DISPENSARY SERVICES

In the early days, when there were few missionary doctors and meagre resources allocated to medical work, few missions had the money and manpower to open hospitals. Medical work of a typical mission in the nineteenth century was in the form of a small dispensary or clinic manned by a medical missionary, with perhaps a few Chinese assistants as well. The medical missionary would also journey to nearby places to dispense medicine, or attend housecalls made by patients. These routines were considered adequate, as medical missions were seen as an "entering wedge" for evangelical work.

With the expansion and diversification of medical missionary work, the small and ill-equipped dispensaries gave way to mission operated hospitals. Croizier (1968:38) estimated that there were sixty-one missionary hospitals and clinics in China by the end of the nineteenth century. In the late 1910's, the number of missionary hospitals alone had already reached

289 (Lennox, 1933:454). Not all missions had hospitals, since some financially struggling missions continued their operations in dispensaries. These missions would take ten or more years to accumulate enough funds and manpower to transform their dispensaries into hospitals. Nevertheless, in the early 1900's, the general pattern of many missions' medical work was the erection of a small hospital in the mission compound, coupled with a few dispensaries in surrounding towns or villages where the missionary doctors attended a few times a week.

The institutionalization of medical missionary work at the turn of the twentieth century markedly increased the importance of the missionary hospital as a centre of medical activities of the mission. The hospital was an indispensable unit in any serious practice of modern medicine. Since medical missions were "outposts" of modern medicine, the missionary hospital became the sine qua non of medical missionary work. In the hospital, order and cleanliness merged with religious atmosphere to give the best example of the harmonious joining of the body and soul. Apart from being a place for healing, the missionary hospital was an ideal place for evangelical work (Maxwell, 1912), and it also became a training centre for Chinese medical workers. The number of missionary hospitals in China increased from 170 in 1910 to 326 in 1927, dropping to about 235 in 1933 (Lennox, 1933).

MEDICAL EDUCATION

The training of Chinese medical assistants dated back to the earliest stage of medical missionary work. Dr. Peter Parker, for example, had already trained a small band of "young men of good promise" by the apprentice approach when he was superintendent of the Canton Hospital which he helped open in 1835 (Gulick, 1973:149-151). This method was soon found inadequate, and more formal medical education was instituted. By 1915, there were sixteen medical schools under the missionary auspices, whereas the numbers of government and private medical schools were eight and five, respectively (Chinese Recorder, 1915:655).

The new emphasis on formal education embraced a broader perspective in contrast to the earlier limited focus of training medical assistants to serve the more immediate needs of the medical missionaries. To meet the medical needs of China's four hundred million people in early twentieth century, the numbers of medical missionaries and hospitals were woefully inadequate. The solution was to systematically train Chinese men and women who could take over Christian medical work in the future.

The establishment of medical schools required large amounts of money and manpower. This made it impractical, if not impossible, for any one mission to undertake a proper medical school. The China Medical Missionary Association therefore advocated a "union" scheme in medical education, proposing that missions should pool resources and strengthen a few existing schools which were relatively well staffed and equipped. The schools selected for upgrading were located in Mukden, Peking, Tsinan, Chengtu, Hankow, Foochow, and Canton, all large cities (Hume, 1915:294).

PUBLIC HEALTH

Like medical education, public health was another line of medical missionary work advocated in the 1915 China Medical Missionary Association Conference (Balme, 1915). It was understandable that early medical missionaries would be absorbed in curative aspects of medical work. But gradually some missionary doctors began to understand the importance of preventive medicine. Public health work would not only benefit the people the missionaries served, but would also reduce the medical missionaries' workload as a result of improvement of the health of the people.

Public health education started "at home"—the missionary hospitals. Mission bodies were urged to "put [their] own house in order" (Balme, 1915:181), as orderly and clean missionary hospitals were "practical illustrations of the value of personal cleanliness," and there the Chinese could learn the "rules of hygiene" (Boone, 1901:25). A more significant and organized push was the formation of the Joint Council on Public Health in 1915. This Council, supported by the China Medical Missionary Association, the Y.M.C.A., and the National Medical Association[6], was directed by Dr. W.W. Peter, who had been very active in public health campaigns launched by the Y.M.C.A.[7]. Aspects of the work of the Council included demonstrated health lectures, public health exhibits, national health lantern slide exchanges, and health education literature.

In sum, hospital and dispensary services, medical education, and public health were the key dimensions of medical missionary strategy. Hospital and dispensary services may be designated as primary medical work, because it was the "basic necessity"[8]. Medical education and public health may be called secondary dimensions of medical missionary work, as they were extensions in medical work.

Local and Cosmopolitan Missions

Although the three areas of medical missionary work discussed above were formally espoused in missionary circles, this ideal was rarely attained by the average mission. All missions carried out the most essential hospital and dispensary work, but medical education and public health were often neglected. If their commitments to the secondary dimensions were used as a criterion, we could designate the ones with low commitments as local missions, and those with substantial involvements as cosmopolitan missions. Before we proceed to scrutinize the differences between these two groups of missions, let us briefly review the concepts of "local" and "cosmpolitan."

In a study of interpersonal influence in a small town, Merton (1957:387-420) first used the terms local and cosmopolitan to describe two types of influential people in the community. The basic difference between the two lies in their orientation towards the community. The local influentials largely confined their interests to the local community, and were preoccupied with local problems, to the exclusion of national and international affairs. The cosmopolitan influentials had a different orientation. While maintaining a minimum of interests and relations with the local community, they were significantly oriented to the outside world, and regarded themselves as an integral part of it (1957:393).

While Merton's use of the terms local and cosmopolitan refers to roles within communities, Gouldner (1957, 1958) employed them to study social identities and roles in connection with formal organizations. He first distinguishes between "manifest" and "latent" social identities. Manifest social identities are those consensually regarded by group members as relevant to them in a given setting, whereas latent identities are those which group members define as being irrelevant, inappropriate to consider, or illegitimate to take into account. Manifest social roles are expectations which are associated with the manifest social identities, and latent social roles are expectations oriented toward the latent identities (1957:284-285).

In a formal organization, manifest social identities and expectations are prescribed and directed toward occupants of organizational roles. Gouldner warns that organizational analyses have focused too much on the relatively visible, manifest organizational identities and roles, to the neglect of latent identities and expectations. He contends that latent identities and roles have significant bearings on organizational behaviour, because they entail value commitments and reference groups that conflict with those normatively prescribed by the organization. He uses the terms local and cosmopolitan to classify two latent organizational identities. Local identities are "those high on loyalty to the employing organization, low on commitment to specialized role skills, and likely to use an inner reference group orientation," whereas cosmopolitan identities are "those low on loyalty to the employing organization, high on commitment to specialized role skills and likely to use an outer reference group orientation" (1957:290).

We can borrow the local-cosmopolitan scheme for classifying missions in connection with their medical work. The unit of analysis in Merton's and Gouldner's studies is the individual in either a community or an organization. In the present study, our unit of analysis is a collectivity—the mission. We can use the local-cosmopolitan scheme to analyze different social identities of individual missionaries in a certain mission. However, we are here concerned with the mission as a collectivity rather than with individual roles in the mission. The criterion we use to distinguish between local and cosmopolitan missions is: the amount of secondary medical missionary work (i.e., medical education and public health). Primary medical work (i.e., hospital and dispensary services) had the most direct bearing on the mission's goal of healing body and soul, and therefore was ubiquitous among missions. Secondary medical work did not, however, bring immediate, clearly visible benefits to the mission. The mandate to train a generation of Christian Chinese physicians, nurses, and assistants, emphatically advocated by the China Medical Missionary Association, pointed to a long term goal which would take many years to achieve. Moreover, it was a lofty ideal that had its meaning anchored at the level of the Christian enterprise in China as a whole, not at the level of individual missions. Likewise, public health had only indirect relevance to the mission's work, as the Chinese would be grateful for relief from present illnesses but they would not easily comprehend and appreciate the positive value of prevention. In short, primary medical work involved an inner orientation toward the specific mission, whereas secondary medical work demanded an outer orientation toward the larger missionary enterprise in China. Thus, we can say that local missions were inner-oriented missions, which devoted most of their medical resources to primary medical work, making few attempts in secondary work, and

cosmopolitan missions were outer-oriented ones which devoted substantial amounts of resources to secondary medical work apart from maintaining primary medical services.

Having reviewed the different dimensions of medical missionary work and identified two kinds of missions in connection with medical work, we will next examine the organization of medicine by the three Canadian Protestant missions under study[9].

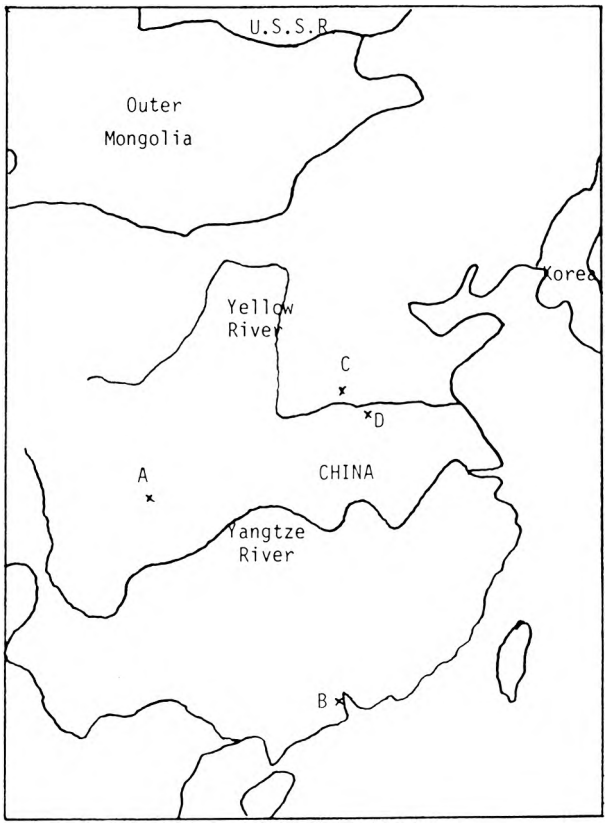
Three Canadian Missions in China

In this study, three Canadian Protestant missions are chosen for analysis: the South China Mission (hereafter, SCM), established in 1902 by the Canadian Presbyterian Church; the North Honan Mission (NHM), established in 1888, also by the Canadian Presbyterian Church; and the West China Mission (WCM), started by the Canadian Methodist Church in 1892. In 1925, these three missions were operated by the United Church of Canada when the Canadian Methodist, Presbyterian, and Congregational Churches became amalgamated. The three missions terminated their work in China a few years after the Communist Revolution in 1949 (see Map One for locations of these missions).

SCM grew out of a request from the Chinese Christians in Canada for a foreign mission in their homeland in China. Most of the Chinese in Canada in the late nineteenth century came from regions around the Pearl River Delta in Kuangtung Province, South China[10]. The request of the Chinese Christians in Canada was ratified by the Canadian Presbyterian Church, which then appointed Reverend and Mrs. W.R. McKay the first missionaries of SCM. The couple arrived in Macao in October, 1902, to be joined by other missionaries later. In 1908, the Mission moved its headquarters to Kongmoon. SCM covered three adjoining countries with a total population of more than one million (see Appendix One for map of SCM). The Mission had only a small staff, as compared with NHM and WCM. Forty-one missionaries had served in the Mission, of whom seven were medical missionaries.

NHM was born of the vision of the students and alumni of Knox College, Toronto, and Queen's University, Kingston, during the 1880's. In early 1887, student and alumni representatives of Knox and Queen's met with the Foreign Mission Committee of the Canadian Presbyterian Church, which promised to support a few men of the two colleges to set up a mission in North Honan

Map One
Locations of the Canadian Missions



A = West China Mission
B = South China Mission
C = North Honan Mission

(MacKenzie, n.d.). In 1888, a group of seven, including Reverend D. MacGillivray and Miss H. Sutherland, reached the coastal Province of Shangtung, 1,200 miles away from their destination. After overcoming much opposition from both the Chinese and missionaries from other countries who were already in North Honan, the Canadians finally set up their permanent headquarters in Changte in 1894 (New and Cheung, 1982a). In 1900, there were twenty-six missionaries working in the Mission. The number increased to fifty-eight in 1910, and to eighty-five in 1920, and dropped slightly to seventy-two in 1930 (Grant, 1948). Since the late 1920's, there were an average of five or six doctors in a year. The Mission had main stations in six districts and many outstations in nearby towns and villages of these cities. The total population in the Mission's territory was about five million (see Appendix Two for map of NHM).

Similar to the case of NHM, WCM was proposed by two Queen's graduates to the Canadian Methodist Church which received the proposal

favourably (Beaton, 1941). In May, 1892, the first missionary group, consisting of Dr. and Mrs. V.C. Hart and their daughter, Dr. and Mrs. O.L. Kilborn, Mr. and Mrs. G. Hartwell, and Dr. and Mrs. D.W. Stevenson, arrived in Chengtu, the capital of Szechwan Province in West China. In one or two decades, the Mission was able to set up ten central stations in ten cities, and eighty-one outstations in other towns and villages. The Mission's territory covered twenty-four counties, stretching some 20,000 square miles (see Appendix Three for map of WCM). It was responsible for evangelizing twelve million people (Kilborn, 1920:73). Compared with SCM and NHM, WCM had the biggest staff. In the mid-1920's, there were 218 missionaries serving in the Mission, making this the largest missionary group in the Province (Foster, 1977: 331). Forty-six medical missionaries had served in the Mission between 1892 and 1937.

Hospital and Dispensary Services of the Missions

All missions shared quite similar beginnings in medical work. Soon after the arrival of the first missionary, or missionaries, some form of medical work would immediately begin. In the first two years, the medical missionaries would be busy studying the Chinese language and medical work was limited. When the doctors were ready for full-fledged work, the first step was to set up a dispensary. It was common that, due to the Chinese opposition to foreigners' purchase of land and buildings, the doctor and other mission staff would encounter great difficulties in renting a small place to be used as dispensary. The place might be a small, shabby quarter or might even be an ancestral hall or Chinese temple. After the mission was successful in buying land and erecting its own compound, which usually took two or three years to accomplish, a new dispensary or a hospital would be built inside the mission compound. From then on, regular medical work of the mission could be said to really begin[11].

The three Canadian missions followed the above pattern in opening hospital and dispensary services. SCM opened its hospital in 1912, which had thirty-three beds. A nursing school was also started in connection with the hospital. Since the opening of the hospital, the number of patients had steadily increased. There were usually two missionary doctors in the hospital whose workloads were extremely heavy. When one of them was home on furlough, the burden of medical work fell on the shoulder of the other one. Appeals to the home church in Canada for more doctors were made every year. However, reinforcement of medical manpower was very infrequent.

In 1924, a new hospital building was completed, doubling the previous number of beds. A few more doctors joined the Mission before 1937. Since the 1930's, big strides were made in medical work because of the construction of motor roads and the beginning of bus services in the city and the country-side. More patients could now come to the Mission's hospital by modern transportation. The Mission also purchased a second-hand car to be used as an ambulance, bringing emergency cases swiftly to the hospital. With these modern conveniences, the doctors were more mobile than before, and they could set up several dispensaries and clinics in more remote areas.

Since SCM was a small mission with a tiny budget and a small medical force, it could open only one hospital and several dispensaries. The hospital had an average of roughly 800 patients and 4,000 out-patients a year. The dispensaries, opened twice a week, treated about 150 patients daily. A few Chinese doctors and nurses were employed to assist the missionary doctors and nurses. Medical work was always hindered by social and political instability. In times of serious social disorder such as anti-missionary movements in the mid-1920's, medical work and other missionary activities would come to a halt for a year or more because the missionaries had to leave their stations for safe places near the coast, or might even have to return to Canada.

NHM was much larger than SCM in terms of health manpower and financial resources. In 1909, for instance, two young medical missionaries were already requesting the home church in Canada for better hospital facilities than there were available then. Mr. and Mrs. Yuile from Montreal donated $10,000 specifically to build a hospital in Wuan. Eventually three large hospitals were built, in Weihwei, Haiking, and Changte, by the 1920's. In the five years, 1920-1925, a number of "modern" hospitals were built, and the Mission took great pride in the Weihwei Hospital which opened its doors in 1923, with private patient wards for twenty-nine patients as well as additional public wards. It had the first X-ray facilities in that part of the Country, and a nursing school attached to the hospital was established as well. The Mission had about five or six medical missionaries at the height of medical work in the 1930's. However, shortage of medical manpower was a serious problem throughout the whole period of operation.

Like SCM, NHM's medical work in outlying clinics progressed rather quickly in the 1930's when

modern transportation became available. But unlike SCM, NHM was subjected to the pressure to build modern hospitals with the latest equipment partly because of the opening of the Peking Union Medical College and its hospital, a Rockefeller Foundation effort (Bullock, 1980). There was a fair amount of comparison of the NHM effort with that of P.U.M.C. Thus, every opportunity was made of introducing new technology, such as the X-ray, or new therapy treatments such as radium.

The biggest mission among the three, WCM had the largest hospital and dispensary capacity. It had two hospitals which had 150 beds, two with sixty beds, and six smaller ones, each with less than thirty beds. The number of dispensary patients increased from 38,504 in 1913 to 118,891 in 1916. The numbers of hospital in-patients in 1913 and 1916 were 1,151 and 4,652, respectively.

WCM provided a larger variety of medical services than did SCM and NHM. In 1907, the Mission set up a dental unit, a rarity in medical missionary work. The Mission also had its own trained pharmacists who were charged with the dispensing and purchase of drugs.

At the height of the medical force, the Mission had twenty-four medical missionaries in 1924. Due to the large scope of its medical work, WCM also suffered from persistent shortages of medical manpower. Compared with SCM and NHM, WCM employed more Chinese doctors and other medical workers in the hospitals and dispensaries.

In sum, all three missions carried out substantial amounts of hospital and dispensary services, relative to their sizes. While the extent of primary medical work varied with the size of the mission, the three missions shared some common difficulties. For example, inadequate health manpower had remained as a serious and unresolved problem. Medical work was hampered by serious anti-missionary movements and socio-political unrests in the Chinese society.

As mentioned earlier, primary medical work was the basic necessity for all missions. However, secondary dimensions of medical work varied a great deal among missions. The degree of commitment to secondary medical work of a mission reflects its degree of localness or cosmopolitanism. Let us now examine the secondary medical work of the three missions.

Medical Education of the Missions

The medical union movement, started in the first decade of the twentieth century, resulted in the decision to strengthen six missionary medical schools in large urban centres through union efforts. SCM was geographically very close to Canton, one of the focal points for a union medical school. In 1911, like other missions in South China, SCM was asked to participate in the union medical scheme in Canton, which involved the upgrading in every respect of the existing medical school of the Canton Christian College (later renamed Lingnan University). SCM's contribution would be to spare one missionary doctor to work full-time in the new medical school of the College. This request did not meet with the approval from the Toronto Foreign Mission Board, because SCM was having only two doctors who were already overworked and, without reinforcement in the near future, it could not afford to set apart a doctor for the union medical school. Thus, SCM did not join other missions in the South China area in union medical education.

In addition to its lack of participation in union medical education in Canton, SCM did not lend support to the Chinese in Canton in medical education either, when an opportunity arose in the mid-1910's. In 1914, the Chinese sponsored Kung Yee Medical School solicited contributions and support from missionary bodies. However, the Foreign Mission Board in Toronto also rejected any cooperation. While manpower shortages of SCM was again the chief reason used by the Toronto office, the office was not willing to contribute because the Chinese medical school lacked "Christian character."

NHM was much more active in union medical efforts. In 1908, the Church of England in Canada approached NHM to see if it would be interested in a union effort in education. After much negotiation, NHM decided not to go forward with any union work with the Church of England. In 1914, NHM also considered the possibility of joining with the China Medical Board of the Rockefeller Foundation to begin medical education in Peking. However, NHM missionaries felt that the medical school should give its instruction in Chinese, and CMB was committed to teaching in English (see New and Cheung, 1982b). The Shangtung Christian College in Tsinan, Shangtung Province, was already in operation (Lutz, 1971:109). In 1916, President of that College, Dr. Harold Balme, had also approached NHM to join with its effort to create a stronger medical faculty. Since Shangtung Christian College gave its instruction in Chinese, NHM missionaries were much more sympathetic in a union effort with them. In 1916, when Dr. William McClure was on furlough in Canada, Dr. Balme made a formal request to the Presbyterian Board of Foreign Missions for his services and this

was agreed upon. From that time on, Dr. McClure became part of the faculty in Tsinan. In 1920, Dr. E.B. Struthers also joined the faculty. In addition to paying the salaries of the two medical missionaries teaching there, the Presbyterian Church committed a yearly sum to maintaining medical education. A few years later, Miss C. Brodie, R.N., was added to the School of Nursing, Tsinan.

While NHM made substantial manpower and financial contributions to the union medical school in Tsinan, WCM's engagement in medical education was even greater in that it assumed the leadership role in the establishment of the union medical school in Chengtu. This medical school was part of the West China Union University, opened in 1910. The Canadian Methodists were the first to have a vision of a university in Szechwan Province. They were joined by four American and British missions in opening the University. The Medical School of the University was opened in 1914. Because of WCM's progress in dental service and pharmaceutical work, dentistry and pharmacy departments were set up in 1918 and 1932, respectively. WCM contributed over half of the staff and teaching time of the Medical School. In fact, the Canadian mission was the mainstay of the union medical scheme in the Province.

In sum, the three missions differed considerably in the involvement in union medical education. SCM did not lend support to any of such schemes. NHM participated in union medical education in Tsinan, contributing not an insignificant share in manpower and finance of the Shangtung Christian College. WCM was not only an active participant in the union medical school in Chengtu. It was the chief engineer of the West China Union University and its medical programs. Its contributions to the medical school outweighed the other four participating missions. Thus, WCM's involvement in union medical education was greater than NHM's.

Public Health Promotion of the Missions

Another dimension of secondary medical missionary work was public health. Here, the three missions also displayed marked differences in performance. During the whole period of time under study, public health was not important for SCM. The missionaries recorded only three public health related incidents. In January, 1929, SCM was contacted by government health officials for the first time. The local Board of Health asked the Mission to help carry out vaccinations against small pox. Vaccine was supplied by the Board, and the doctors and nurses of the Mission's hospital vaccinated everyone who came.

In December, 1929, Dr. Wallace McClure of the Mission was invited by government officials to attend a large public health exhibition in a nearby city. Dr. McClure spoke to the assembly before the parade began. In the evening of the same day, he spoke to an audience of 1,000 in the city's Y.M.C.A. on some elementary principles of public health and preventive medicine.

SCM also hosted an exhibition of its own, an "Agricultural and Health Exhibition." Ancestral halls or public places were rented to hold the exhibition in four places. The Canton Hospital furnished hundreds of charts of family hygiene and treatment of common diseases such as hookworm.

Apart from these instances, SCM did not carry out any significant public health work or public health education. But public health was a greater part of medical work in NHM than SCM. When Dr. Robert McClure, the son of Dr. William McClure, joined NHM in 1922, taking the place of Reverend J. Menzies, M.D., who was killed by the Chinese rebels, he worked at first in one of the hospitals. Gradually, however, Dr. McClure's medical work began to branch out into neighbouring villages. Visiting nurses would make home visits, and Dr. McClure also began to train medical assistants and stationed them in outlying rural areas (Scott, 1977).

In the early 1930's, four Chinese physicians, graduates of the Shangtung Christian University Medical College, staffed two hospitals of NHM. Dr. Lin even gave a series of lectures on public health to summer theological students. However, even earlier than that, in 1916, Dr. P.C. Leslie wrote a textbook on *Hygiene and Public Health*, in Chinese, and this was circulated among medical students and practitioners.

In the 1930's, the Chinese Government had become conscious of the need of public health and preventive medicine in rural areas. This effort was led by John B. Grant, M.D., through the P.U.M.C. "health experiment" in Ting Hsien, near Peking (New and Cheung, 1983). This same spirit spread to NHM as well as to other missions. NHM collaborated with the Government in a number of public health projects, such as vaccinations, public health programs in secondary schools, child welfare programs, and the like. Throughout this period, until 1937, Dr. Robert McClure was the leading figure in many of the public health efforts. The Sino-Japanese War of 1937 ended many of these beginning efforts abruptly.

As in medical education, WCM was also the most active among the three Canadian missions in public health work. In the late 1920's, WCM became involved in sizeable organized endeavours in public health. In 1929, the West China Council on Health Education was formed and supported by nine societies, including WCM. After his return from furlough in 1929, Dr. Wallace Crawford was appointed Director of the Council. The work of the Council included the preparation of health tracts and charts, the preparation of textbooks on hygiene, the organization of baby clinics, the conducting of physical examinations in government and missionary schools, and the organization of public health campaigns. The most notable aspect of the Council's work was, however, the dissemination of public health knowledge of hygiene, health habits, physical fitness, care of babies, etc. In 1930, 267,000 tracts were sold, and the figure reached 819,000 in 1932. In addition to tracts, the Council also printed thousands of hand bills containing health messages, to be pasted up in conspicuous places such as streets, lanes and tea houses.

The distribution and sale of tracts extended to the people living in towns and villages as well. In a rural district, missionary workers would go to selected towns on market days, when thousands of people from surrounding country areas would gather to buy and sell. When the workers arrived in a village, they would call on the village leader to request permission to distribute tracts. They would also ask for a suitable platform to address the people on the causes and cures for common diseases, the menace of flies, malarial mosquitoes, and unsanitary conditions, etc. The method of tract distribution allowed the missionaries to reach out to rural areas to disseminate public health and other knowledge to farmers.

Toward the middle of the 1930's, the Central Government embarked on a national rural reconstruction campaign and mustered support from missionaries. As mentioned earlier, NHM collaborated with the Government in a number of public health ventures. In Szechwan, WCM's involvement in government public health projects was even greater than NHM in its areas. His expertise in public health education naturally brought Dr. Wallace Crawford into close collaboration with government officials in planning and implementing public health projects.

Thus, comparing the public health work of the three missions, we can conclude that WCM's efforts were the most notable, followed by those of NHM. SCM's involvement in this dimension of secondary medical work was only minimal.

Discussion

After describing the primary and secondary medical work of the three Canadian missions, we can now classify them according to the local-cosmopolitan typology developed earlier. In the case of SCM, most of its medical resources was devoted to primary medical work. It did not join any union medical education scheme. Although public health efforts did take place, they were trivial and scanty. Secondary medical work was, therefore, minimal. Because of such performance, SCM may be classified as a local mission.

Both NHM and WCM can be classified as cosmopolitan missions because of their substantial involvements in secondary medical work. NHM sent two doctors to teach in the Medical School of the Shangtung Christian University, and made considerable financial contributions to the University. In public health, Dr. Robert McClure's Haiking rural medical experiment was an innovative effort to bring medical care and health knowledge to rural areas. However, WCM had an even higher degree of cosmopolitanism than NHM. In secondary medical work, WCM was not only an active participant, but it was the leading mission among various missions in Szechwan in medical education and public health promotion. Among the five cooperating missions of the West China Union University, WCM contributed over half of the financial and manpower resources for medical education. In public health, WCM was also the most active mission in initiating and coordinating various public health educational campaigns, and in cooperating with government officials in public health ventures. It thus had exhibited an extremely high degree of cosmopolitanism.

Why were there differences among the three missions in the degree of cosmopolitanism in medical work? There are several possible explanations. The first factor was resources. With a very tiny budget and staff, SCM could not spare much resources for secondary medical work even if it wanted to. NHM was about four times larger than SCM in size, and was therefore able to engage in more medical education and public health efforts. WCM had about twice the amount of resources of NHM, and thus was more well equipped than NHM in promoting secondary medical work.

Geographical location was another possible factor. SCM was committed to working in a few counties near the metropolitan city of Canton. This

left little room for any expansion in medical work of the Mission in medical education or public health. NHM had a larger territory, but, like SCM, it was relatively close to the coast, where missionary activities were much more well established than those in the interior. Severe competition among missions in medical and other areas of missionary work might make it difficult for certain missions to expand their work. The situation with WCM was quite different. Although the Canadian Methodist missionaries were not the first group to start work in Szechwan, missionary work in this inland province was much less developed than coastal regions. Therefore, it was a vast "land of opportunity." With a prodigious amount of resources, the Mission was able to expand quickly in its first twenty years, and became a spearhead mission in that province.

The most important factor was perhaps the difference in theological position between the Canadian Methodists and Presbyterians. WCM placed over-riding emphasis on secular education as an integral part of its missionary endeavours. This was due to the strong social gospel influence on the Canadian Methodists at the turn of the twentieth century (Lawrie, 1979:114-127). The impact of this movement resulted in active participation of various churches in social reforms in Canada (Allen, 1973). Translated into foreign mission work, the social gospel approach emphasized the role of social reconstruction of "heathen" societies in evangelism. To WCM, education was the key means by which social transformation of the Chinese society could be achieved. As Allen noted, the Canadian Presbyterians also "made their entry into the passionate world of social gospel" (1973:6). However, the numerical predominance of the Methodists in the social gospel had overshadowed the contributions of other denominations (1973:16). It was no wonder, then, that the Canadian Methodists' mission in West China was more involved in medical education and social reform in China than were the Canadian Presbyterians' NHM and SCM.

In this paper, we have developed a typology of missionary medicine, and illustrated it with the medical work of three Canadian Protestant missions in China from 1888, 1892, and 1902 to 1937. The significance of the local-cosmopolitan typology lies in the fact that local and cosmopolitan missions had dissimilar impacts on the recipient society. Medical missionaries of cosmopolitan missions were likely to be more effective "change agents" (Cheung, 1982) than those of local ones, because of the former's greater engagements in secondary medical work. This means that, at the national level, the more cosmopolitan missions, the greater the contributions of missionary medicine to the recipient society. This typology, then, provides a way to assess missionary medicine in developing countries. Moreover, the distinction between two types of medical missions facilitates more accurate comparisons between missionary medicine and medicine promoted by government and private sources. More research should be done to determine more accurately factors influencing the local-cosmopolitan orientation of missions, and to discern the different adjustment patterns of local and cosmopolitan missions in the environment of the recipient society.

NOTES

1. This paper was presented at the Annual Meetings of the Canadian Ethnology Society, Vancouver, May 7-11, 1982. The analytical framework and the data of two of the three missions were taken from the senior author's Ph.D. dissertation ("The Social Organization of Missionary Medicine: A Study of Two Canadian Protestant Missions in China Before 1937," Department of Sociology, University of Toronto, 1982). Data on the remaining mission were collected by the coauthor. All the data were collected in the United Church of Canada Archives, Toronto. The authors thank the staff of the Archives for their cooperation and assistance.

2. Other Western agents who had a heavy share in shaping the medical systems of many developing countries were colonial governments and large Western "philanthropic" organizations such as the Rockefeller Foundation. For discussions on the impact of these agents, see, for example, Fanon (1965), Navarro (1976), Donaldson (1976), Ehrenreich (1978), and Brown (1979).

3. For a brief review of the contributions of missionary medicine in China, see Cheung (1982: 214-220).

4. The Sino-Japanese War was formally started in 1937. This war ended in 1945, and was followed by civil wars between the Nationalist and the Communist troops. The latter won and took over China in 1949. During these wars, missionary work was seriously interrupted. Thus, the analysis in this paper ends with the year 1937.

5. In medical missionary work, medical missionaries were involved in certain relations and interactions with the local people, including patients, with the social and political environment in which they worked, and with their home church in the West. A discussion of the social relational aspect of missionary medicine can be found in Cheung (1982).

6. The National Medical Association, formed in 1915, was the first medical association established by Western trained Chinese physicians.

7. For a brief description of Dr. W.W. Peter's health campaign strategies, see Yip (1982).

8. This should not be confused with "primary health care," which is a policy advocated in the first International Conference on Primary Health Care, jointly sponsored by the World Health Organization and UNICEF in September, 1978 at Alma-Ata, Soviet Union. This policy emphasizes low-cost, low technology care and preventive measures in health care delivery to the people. See Bennet (1979) for discussions.

9. Data for this paper are taken mainly from the following sources: SCM and WCM, from Cheung (1982); NHM, from Margaret N. Brown, History of the Honan (North China) Mission of the United Church of Canada, Originally Mission of the Presbyterian Church in Canada, 1887-1952, Vol. 1-4. Data for the original study in Cheung (1982) and the Brown volumes were collected in the United Church of Canada Archives, Toronto.

10. For discussions on the history of the Chinese in Canada, see, for example, Morton (1974), Lai (1975), and Li (1979). For discussions on aspects of the contemporary Chinese community in Canada, see, for example, Sedgwick and Willmott (1974), Thompson (1979), and Cheung (1979, 1981).

11. It should be mentioned that, apart from treating Chinese patients, missionary doctors were also busy taking care of the health of their colleagues in the mission. Some missionaries suffered from diseases they contracted in the new environment. Some were unable to adjust to the living and working environment, and suffered from mental imbalance. These physical and mental health problems of missionaries were not uncommon, especially in the early years of the mission's operation (New and Cheung, 1982a).

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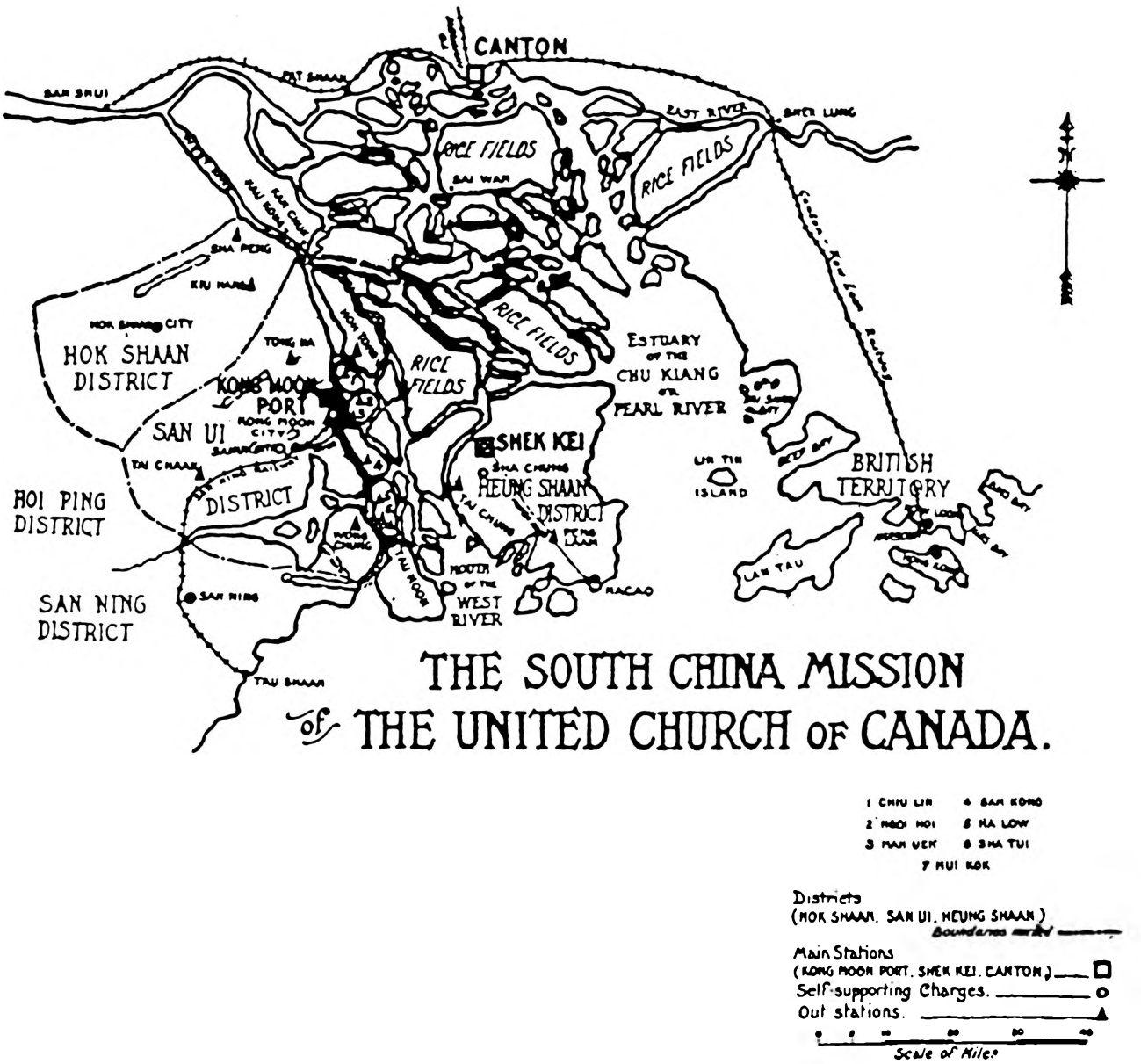
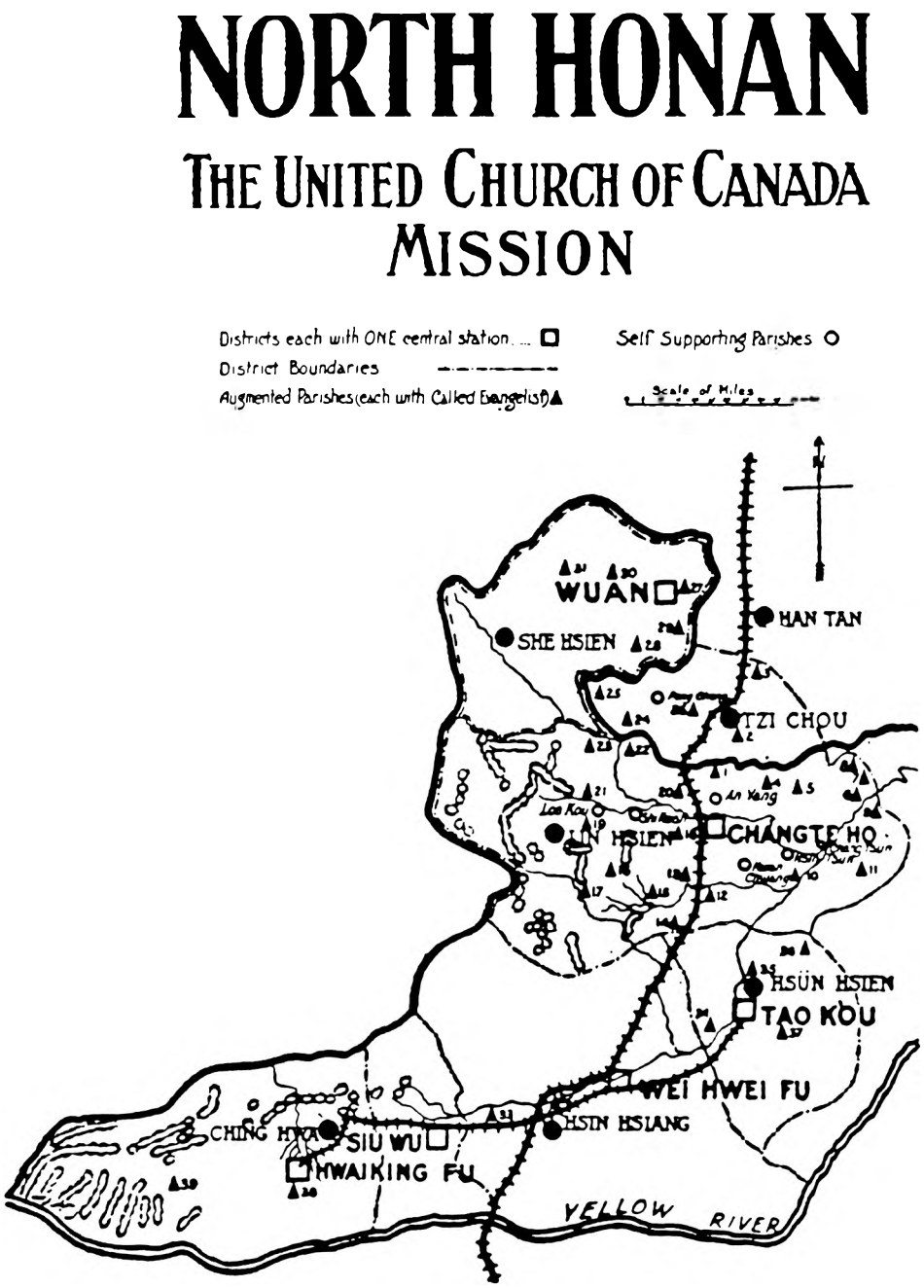
Appendix One
Map of South China Mission



Source: *Forward With China: The Story of the Missions of the United Church of Canada in China*, Toronto: Ryerson Press, 1928, p. 162.

Appendix Two
Map of North Honan Mission



Source: *Forward With China: The Story of the Missions of the United Church of Canada in China*, Toronto: Ryerson Press, 1928, p. 76.

Appendix Three
Map of West China Mission

Source: *Forward With China: The Story of the Missions of the United Church of Canada in China*, Toronto: Ryerson Press, 1928, p. 222.