CHAPTER TWO

Crossing the divide: medical missionaries and government service in Uganda, 1897–1940

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One of the distinctive features of Western medical practice in early colonial Uganda was the high level of collaboration between mission doctors and the Colonial Medical Service.¹ In the period before 1940, a number of Church Missionary Society (CMS) doctors negotiated dual roles as missionaries and colonial medical officers. An even greater number participated in and managed government health campaigns, or were engaged unofficially by the administration in an advisory capacity. The reasons for collaboration were diverse: some wished to extend the reach of missionary work, some to advance professionally, while others were determined to boost what they felt to be meagre missionary stipends. By undertaking this work, the mission doctors went beyond filling a gap in state provision: they contributed specialist knowledge, language skills, equipment and personnel that shaped the practice of the Colonial Medical Service in Uganda as much as they supplemented it. However, the relationship was never clearly defined. Stemming in part from the inability to draw an absolute line between ‘missionary’ and ‘government’ medical work, missionaries and colonial administrators reacted to local circumstances, formulating guidelines in a largely *ad hoc* manner.

Historians of medicine have explored the numerous ways in which missionaries and government officials came together in Uganda.² While these historians have not always focused on the relationship between medical missionaries and the Colonial Medical Service *per se*, their work has indicated that the boundary between the two was often fluid. Carol Summers, for example, has shown how the establishment of the Maternity Training School in Uganda represented ‘a joint venture between the state and its missionary subcontractor, two groups with different agendas but overlapping interests’.³ John Iliffe has set out the ways in which medical education schemes in East Africa, and Uganda in particular, developed directly from the early efforts

of medical missionaries to train tribal dressers and African medical assistants.⁴ Anna Greenwood has noted how the divide between missionaries and government officials in East Africa was not always clear cut.⁵ Some joined the Colonial Medical Service having been rejected by a missionary society, whereas others felt a calling to join the Church in their retirement. And more recently Kathleen Vongsathorn, looking specifically at the theme of cooperation, has argued that missionaries and government officials put aside their differences to engineer model leprosy settlements for the relief of suffering.⁶

In Uganda, the contribution of missionaries to the development of government medical services has not been downplayed or marginalised to the extent it has been elsewhere in colonial Africa.⁷ This is due in part to early historians of medicine in Uganda, admittedly some themselves missionaries, who have stressed the debt of the colonial administration to the pioneer medical work and research started by Albert Ruskin Cook.⁸ It also stems from the extensive collection of records deposited by the CMS in archives at the University of Birmingham (UK), the Wellcome Library (UK), Uganda Christian University (Mukono, Uganda), and the Albert Cook Library (Makerere University, Uganda). This has resulted in a bias in the historical literature towards CMS activities, and specifically those initiated by Albert Cook. Roman Catholic missionaries were also engaged in a number of medical projects, including leprosy and maternal health, but the difficulties historians have experienced in accessing archival material has resulted in little critical analysis of their work.⁹ It is beyond the remit of this chapter to redress this bias, but the interest of historians of missionary medicine – Catholic or Protestant – in medical ‘projects’, such as the training of doctors, maternal health, venereal diseases, or leprosy, has led to a related skew in the historical literature, the focus of which is the starting point for this piece. CMS medical missionaries collaborated with the colonial government on a number of campaigns, but this does not necessarily mean that they came together only when their interests converged. What has yet to be explored in a medical context in Uganda is the multiple ways that missionaries and government officials came together on a more mundane, day-to-day basis, assisting and offering advice even when it was not necessarily in the mission’s or government’s best interests. These activities brought together mission and government doctors as professional colleagues and ‘experts’, and in turn shaped what both ‘missionary medicine’ and ‘colonial medicine’ could offer to patients.

This chapter examines the practicalities of the relationship between medical missionaries and colonial administrators in the period before 1940, focusing primarily on CMS mission doctors. It starts by

considering the everyday dealings between mission doctors and the colonial government at the CMS Mengo Hospital, founded by Albert Cook in 1897.¹⁰ It then turns to CMS hospitals elsewhere in Uganda, looking at how the Colonial Medical Service sought in the 1920s to formalise their relationship with individual mission doctors. This is followed by a section that investigates how increased government funding for individual projects, campaigns, and hospitals eventually shifted the nature of colonial medicine in Uganda, and with it the relationship between missionaries and the colonial government. The chapter ends by briefly considering the patients themselves. Indeed, it is important to remember that while the sharing of specialist knowledge, equipment, and personnel assisted in extending the reach of Western medicine, both mission and government doctors remained on the periphery of a much broader therapeutic landscape in Uganda.

Mengo Hospital, 1897–1920

In the early years of colonial rule, the relationship between mission and government doctors was determined largely by practical circumstances. Government medical provision, as Robert Moffat, Principal Medical Officer (PMO), complained in 1903, was almost non-existent: there were no native hospitals that could 'be dignified by the name', and those that did consisted 'generally of small temporary sheds or huts in which a sick man can be sheltered'.¹¹ For Moffat, the lack of facilities not only affected staff morale, but had serious implications for the scientific study of disease:

In hospital cases can be carefully watched and studied and in this way far more information can be obtained in regard to diseases which may be prevalent or peculiar to the country than can be got in an out patient consulting room. For this reason the returns and records of the work done by Government Medical Officers are for the most part valueless. The work done by the Mission Doctors at their hospital in Namirembe is in contrast and they are often enabled to record the presence or prevalence of diseases even the names of which never find a place in my reports.¹²

The importance of Mengo Hospital, Namirembe, in identifying disease had already been demonstrated. In 1901, brothers and fellow mission doctors Albert and Jack Cook had notified the colonial government and the medical community in Britain of concerns over the growing number of sleeping sickness cases arriving at their hospital, sparking international interest in a disease that was to devastate local communities on the shores of Lake Victoria.¹³ The role assumed by mission doctors at Mengo Hospital, and the manner in which they informed

and advised the Colonial Medical Service, was to shape government medical practice in Uganda for the next thirty years.

The ability of mission doctors to communicate with patients in a number of local languages, combined with their attention to record keeping, meant that the doctors at Mengo Hospital were looked upon as having exceptional insight into local health and disease conditions. Of particular interest were Mengo Hospital's records on sleeping sickness, plague, blackwater fever, venereal diseases, and enteric fever, which were repeatedly searched for information on the frequency, etiological signs, and geographical distribution of disease.¹⁴ In August 1916, C.J. Baker, Medical Sanitary Officer, even went so far as to apologise for his repeated requests for information from the mission hospital, but stressed the effect they could have on government policy – if any local cases of enteric fever could be found in Mengo Hospital's collection of patient case notes, it 'would strengthen a plea for a piped water supply for the town'.¹⁵

Stemming in part from their location on the outskirts of Kampala Township and their extended presence in the region, the mission doctors at Mengo Hospital were considered to have 'strong ideas' on government policy affecting Kampala, and were frequently consulted by senior officials on an unofficial basis.¹⁶ Advice was sought on aspects of medical practice, hygiene, sanitation, and town planning, demonstrating both the influence of mission doctors within government circles and how the reach of missionary medicine extended beyond their own curative services. Such was the volume of correspondence, Albert Cook noted in 1919, coming from 'all over both Protectorates, sometimes entailing 20 letters a day, all the Administrative work of a large Hospital, keeping in touch with Govt Officials, looking after Affiliated Dispensaries, needful Indents, as well as the purely Professional side of the work', that he felt exhausted and in desperate need of a secretary.¹⁷

Certainly, in addition to their own patients, the doctors at Mengo Hospital advised on difficult cases by post and accepted patients referred by colonial medical officers from across Uganda. While these patients were predominantly European, a number of African and Indian cases were also sent for operations and specialist treatment.¹⁸ Between 1912 and 1938, Mengo Hospital housed the only X-ray equipment in Uganda, and patients requiring X-rays were sent to the hospital by government officials from around the country.¹⁹ In 1915, Jack Cook also received two convicted murderers – one for a broken arm and the other for observations on his mental state.²⁰ In this instance, as in other cases, no restrictions were placed on the spiritual side of the mission doctors' work. While additional fees may have come from the

colonial government, patients were admitted on the same basis as other patients, and were obliged to attend daily prayers and ward services.

Over time, this professional relationship was strengthened by the formation of an intellectual community in Kampala. From its establishment in 1913, mission and government doctors met regularly at meetings of the Uganda branch of the British Medical Association (BMA) and while on furlough in London.²¹ In addition to being a powerful lobbying voice for the Colonial Medical Service, the local branch of the BMA also provided a forum through which doctors could come together as medical colleagues and professional experts. At the first Presidential Address, for example, held at Mengo Hospital in December 1913, Albert Cook presented a paper on obstetrics in Uganda, to which both colonial medical officers and other mission doctors offered their opinions on clinical cases and patient fees.²² Mission and government doctors also corresponded privately on interesting cases and particular aspects of research, offering feedback on papers for submission to scientific journals.²³

Mission and government hospitals both suffered from a lack of specialist facilities and staff, necessitating cooperation on the level of general medical practice and research. Of course, much of this assistance was rooted in financial concerns, but it was also reflective of a more general collaboration between mission and government doctors that was not regarded as exceptional. Indeed, before the 1920s, the close working relationship between the doctors at Mengo Hospital and the Colonial Medical Service caused little controversy; while the anti-venereal, motherhood, and education campaigns were accompanied by negotiations on the boundaries between mission and government responsibilities and the place of religion, there were no clear guidelines on the appropriateness of their other professional activities. In their published writings, the mission doctors also presented a number of aspects of their day-to-day collaboration with the Colonial Medical Service as examples of the mission's importance, both for Britain and for the Empire as a whole. This was most overt during the First World War, when Mengo Hospital was used as a government base hospital for the war in East Africa. Commenting on the policy of the CMS with regard to war service, J.H. Cook noted in *Mercy and Truth*, the medical journal of the CMS, how 'on the one hand, missionary duties have not prevented our missionaries and doctors from offering their services to their country in connexion with the war; and, on the other hand, war service has not curtailed, but has greatly increased, the scope and opportunities of their missionary labours'.²⁴

Much of the discretion held by the mission doctors in their daily activities stemmed from the fact that the 'missionary' element of

medical mission work was never well defined. On the one hand, medical missions were presented as a way of reaching potential converts – natives would be ‘dazzled’ by Western medicine and become more receptive to the Christian message as a result.²⁵ On the other, even more ‘secular’ medical activities, such as research, could benefit the mission by enabling the hospital to offer the latest therapeutic techniques and so cater for an increasingly demanding patient population.²⁶ In their general medical practice, at least, the doctors at Mengo Hospital found it impossible to draw a line between the two; requests for advice and consultations were unexceptional, and even to be expected, given their long presence in the region. By tacitly fulfilling these roles, however, the mission doctors were shaping the activities of the Colonial Medical Service, and involving themselves in both policy and practice.

Half-time workers

If the everyday relationship between medical missionaries and the Colonial Medical Service had been relatively unproblematic, it was to emerge as an area requiring definition and regulation in the early 1920s. Faced with the need to increase the size and scope of government medical provision at minimal cost, administrators started to attempt to harness missionary manpower through formal arrangements.²⁷ In Western Province, encompassing Ankole, Toro, and Kigezi Districts, this involved the creation of a new type of post, that of the ‘half-time’ District Medical Officer (DMO). Between 1921 and 1928, at least four CMS medical missionaries posted to Toro and Kigezi – Alfred Schofield, Ernest Cook, Algie Stanley Smith, and Leonard Sharp – took on dual roles as missionaries and colonial medical officers.²⁸ For the mission doctors, this arrangement allowed them access to additional facilities and equipment, as well as providing them with the opportunity to gain extra money for the mission. For the government, the formal co-opting of mission doctors into the Colonial Medical Service allowed for the façade that government medical provision was expanding at an impressively cost-effective rate.

The first mission doctor to be approached in this way was Ashton Bond, founder and head of the CMS Kabarole Hospital, Fort Portal. Bond had been the sole Western medical practitioner in Toro District since 1903, and had long undertaken work for the colonial government on an unofficial basis.²⁹ As early as 1911, Bond had expanded his ordinary hospital work to include visits to native and government prisons, provided colonial administrators with statistics, toured the sub-counties, and provided district and provincial administrators with

advice.³⁰ By 1920, Bond also had sole responsibility for the treatment of European government officials and the official medical management of epidemics, which in 1919–20 involved a serious outbreak of cerebro-spinal meningitis.³¹ While the work did not go unappreciated by the Colonial Medical Service, it was not paid, and no formal arrangement had been made. Indeed, Bond had long seen this work as part of his 'daily routine': it neither interfered with his CMS work, nor could be easily separated from it.³²

Early in 1920, Bond approached the PMO, independently of the CMS, and asked to receive part of the fees paid by the government for his medical work. Recognising the Uganda government's inability to send a colonial medical officer to Toro, while feeling increasingly obliged to expand government medical services, the PMO agreed.³³ The CMS authorities in London balked at the proposed arrangement: missionaries were not to make personal agreements with the government, and they were certainly not to receive any payment in addition to their missionary stipend. In a letter to Bond in May 1920, George Manley, CMS Secretary with primary responsibility for East Africa, noted that: 'We think you would act quite rightly if you were to point out to the government that you are already fully employed with your CMS work, that you had gone out on the understanding that you would give your whole time to that [and] that you must therefore decline to undertake any work on behalf of the government'.³⁴ Manley was well aware that the distinction between missionary and strictly secular medical work could be blurred, but the prospect of a formal agreement and personal remuneration for Bond had forced him to set out the limits.³⁵

It was these concerns about mission authority and money, rather than the nature of the work, which were repeated when the issue of Bond's appointment resurfaced in October 1920. Keenly aware that the Colonial Medical Service still had no presence in Toro District, the PMO offered Bond an allowance as a half-time medical officer. Without consulting the CMS, Bond accepted. Enraged at what he saw as the hypocrisy of the CMS when it came to receiving money from the government, Bond pointed out that CMS missionaries who took Sunday services for government officials received fees and a small travel allowance: 'There is nothing I consider (and the government agree) different in principle to the clergy receiving an allowance for taking a service for government officials, and others, on a Sunday, and my receiving an allowance for medical and official work which I do for them on weekdays'.³⁶ In Bond's opinion, the extra payment would not only be fair, but necessary in a country like Uganda, where the cost of living was so high.³⁷ Unsurprisingly, the CMS again ordered Bond to decline any formal agreement. Pointing out that Bond was not 'at

Liberty' to negotiate with the government, the local Secretary of the Uganda Mission, based at Namirembe, stressed that if Bond felt 'that he would be happier under Government', he could give six months' notice of his intention to resign.³⁸

The situation was somewhat different when Sharp was appointed as half-time DMO for Kigezi, with the sanction of the CMS in London and Namirembe, in the following year. Mission medical work in Kigezi had been approved only on the basis that the bulk of the costs for the first four years would be from extra-mission sources.³⁹ Permission had been granted to seek a large government grant for the mission, but while no large grant was forthcoming, the colonial administration was willing to subsidise work in the form of making Sharp a half-time Medical Officer. This suited both parties: the CMS would have a small income for its mission as well as immediate use of hospital buildings at Kabale, and government medical work would officially be extended into Kigezi.⁴⁰

Clearly unaware of the purpose of the funds in the Kigezi case, Bond took issue with the new agreement. Highlighting what he saw as inconsistency between CMS rules and practice, he asked how other extra-mission activities – including private medical practice and land-ownership – were not proscribed.⁴¹ Adding to this the low stipends granted to missionaries in the field, Bond stressed how he could not 'accept ... [the] ... view that a missionary has sold himself body + soul to the society, + that they may not accept any remuneration except what they receive from the society'.⁴² This tension between Bond and his superiors mirrors wider debates that occurred within the Colonial Medical Service over whether government medical officers should be allowed to engage in private practice.⁴³ Government service was associated with loyalty not just to colleagues, but also to the British government. Thus, while the CMS allowed its doctors to participate in private practice, it was particularly sensitive about arrangements with the government that might lessen its control over mission workers.

Sharp was unable to ignore his commitment to missionary work while attached to the Colonial Medical Service in Kigezi. Some areas of work could be clearly delineated financially, of course: the administration of government dispensaries, for example, comprised a major part of Sharp's duties as DMO.⁴⁴ But much was also left to Sharp's discretion, including the investigation of outbreaks of disease, permission to delegate duties to his missionary colleague, Stanley Smith, and his evangelical work.⁴⁵ Having been reported to have compelled patients at the government-owned Kabale Hospital buildings to attend religious services, for example, Sharp noted that: 'I am using these buildings as though they were Missions premises and ... regular services have been

started for the patients ... In this connection I must mention that it is one of the first rules of C.M.S. Mission Hospitals that all patients should attend the service.⁴⁶ Sharp had earlier criticised medical practice at Mengo Hospital for 'becoming more + more philanthropic in contradistinction to missionary in character', and did not intend his own work to follow the same pattern.⁴⁷ As the Provincial Commissioner (PC), Western Province, conceded in 1922:

It would not appear possible for Dr. Sharp to draw any dividing line between his Government and Missionary work and as long as the Government employs a half time District Medical Officer, I think it must allow him full discretion over his work and leave to you any steps you may think fit to lay down as regards the supervision of his work on tour. I would therefore recommend the withdrawal of the words 'when travelling solely on Government duty' and substitute 'while carrying out Government work'. In this way the present difficulty raised by the District Commissioner will be avoided, and it will be left to Dr. Sharp to carry out his Government duties on tour along with his Missionary work.⁴⁸

A similar amount of discretion was granted to the CMS mission doctors who were employed as part-time DMOs in Toro District. Following Bond's abortive attempt to seek payment for his unofficial government work, Ernest Cook and Schofield were granted permission to make formal arrangements with the Colonial Medical Service, with money going to the mission.⁴⁹ Recalling the reasons behind the arrangement ten years later, Schofield noted how, despite the feeling that government service would be 'a hindrance to my missionary work', the extra money it allowed the mission was irresistible. He attributed similar financial concerns to the colonial administration:

Every Government Doctor cost the Government £1,600 to £1,750 per year, apart altogether from the cost of the work he did. This figure was simply what it cost to keep a Doctor, for instance, at Toro – his house allowance, and all other allowances, part of a wife's passage, his own passage and cost of relief during holiday, in other words, the same sort of figures we have to work on in the Mission are £600 (average). But in addition to this sum there had also to be taken into account the material, drugs, maintenance of buildings, wages of his assistants and everything else and that estimate came to between £4,000 and £5,000 per Doctor per year. Of course that meant a lot of medical work and a lot of people seen and a lot of people treated, but (and this was the argument used to me by the P.M.O. at the time) that if they gave us a *quarter* of that amount of money we would be able to do the same amount of work.⁵⁰

Despite mutual financial advantages, however, the part-time nature of the work was increasingly deemed to be inadequate. Not only were

the mission doctors prohibited from evangelising while undertaking duties for the government, however ill-defined, but medical work on both sides was suffering.⁵¹ In March 1923 it was noted that patients in Kigezi were shuttled between the government and CMS hospital, with the Sub-Assistant Surgeon, under Sharp, dealing 'with the local native sick, police, porters etc. and ... [keeping] ... the hospital records and care of stores; cases requiring special treatment being sent to the C.M.S. Hospital'.⁵² In Toro, too, the PC, Western Province, noted in March 1925 that the 'District Medical Officer must of necessity expend nearly all his time at his Hospital at Kabarole and has consequently little chance of supervising the work of the County Dispensaries'.⁵³ 'Likewise', he continued, the DMO 'cannot do any touring should any infectious disease break out, he is practically tied to his Headquarters'.⁵⁴ Adding that this was not a criticism of the work done by the mission hospital, the PC finally stressed that:

From the Mission point of view I doubt either whether the present arrangement can be considered entirely suitable as the Government duties to be performed must to a considerable extent prevent the Mission Doctor from carrying out the full Mission duties which he would otherwise perform, nor would the £300 received by the Mission be in this respect commensurate.⁵⁵

Ultimately, the arrangement was criticised primarily for resulting in the underdevelopment of government medical provision in Western Province. With the existence of mission hospitals at Kabale and Fort Portal, coupled with a policy that privileged development in Buganda and Eastern Province, Western Province had been ignored.⁵⁶ By 1925, the only permanent government hospital building in Western Province was at Mbarara, Ankole District. A small temporary building was in use at Kabale, while at Toro the government relied completely on the CMS hospital.⁵⁷ These facts were an increasing embarrassment for the Colonial Medical Service, and in 1925 a full-time DMO was appointed to Toro District. The half-time arrangements held at Kigezi for longer, in part because the District was much smaller, but in 1929 that arrangement, too, was terminated.⁵⁸

Mengo Hospital, 1921–40

The presence of colonial medical officers at Kampala and Entebbe meant that the doctors at Mengo Hospital were not called on as 'half-time' workers in the way they were elsewhere in Uganda. But attempts to extend government medical work did not go unnoticed by those working at Namirembe, who recognised the threat this

posed to their own activities. At a meeting in 1923, medical and non-medical missionaries noted that while the government appeared anxious to work with the CMS, experience had shown that 'where Government Centres were established [*sic*] the C.M.S. work would be extinguished'.⁵⁹ The efforts of the doctors at Mengo Hospital to train African medical assistants were a particularly sore example of this, with government funding having recently been redirected to its own Medical School at Mulago Hospital.⁶⁰ The mission doctors who trained them had intended African medical assistants to take on basic clinical duties and to go out into 'untouched' regions to fight 'heathenism' and the traditional 'medicine-man'.⁶¹ In practice, the relationship between African doctors and Western medicine was more ambiguous, and they would struggle with the CMS and the Colonial Medical Service over their status, duties, and right to private practice for the next thirty years.⁶²

The desire to maintain missionary influence in colonial medical practice was a key reason for increased collaboration between mission and government doctors at Mengo Hospital, most notably through projects and campaigns, but also through individual arrangements. Following the failure of the CMS to secure government funding for a hygiene and education campaign, the Colonial Medical Service requested the 'loan or transfer' of Ernest Cook for medical education work at Mulago Medical School from 1925. Keen to have someone on the inside of the new school, and aware that internal disagreements between staff at Mengo Hospital meant there was no obvious place for Ernest Cook in its established medical mission work, the CMS agreed. But discussions over his secondment, and Ernest Cook's eventual decision to remain in the Colonial Medical Service permanently, raised similar issues over understandings of the 'missionary' element of medical missionary practice in Uganda as it had done elsewhere.

Writing to Ernest Cook in 1928, shortly before he decided to leave the CMS, Albert Cook noted that:

You have been brought up to the cross roads once more & must decide one way or the other which road to take, & the choice this time seems to be final. On the one hand there is continuing in Govt service, receiving as you told me £800 a year at present, and an increasing scale of pay. You are doing there really useful work, valued by them & by the Baganda alike, and are showing a really fine Christian witness. On the other hand you do not feel the atmosphere from a missionary point of view is congenial. You ... have no freedom to preach Christ to the patients in the Hospital, your Christian work, apart from the very powerful effect of example, must be out of hours & indirect.⁶³

At the heart of it, while Albert Cook maintained that medical work could serve a Christian purpose anywhere, it was the attachment to a society that made a missionary: 'I sincerely believe that the Return of our Lord is very imminent, & may take place at any moment. Would you not like Him to find you in C.M.S. ranks? Even though you can do, very real work for Him at Mulago?'⁶⁴ Taking a rather different view of the role of the missionary, Ernest Cook defended his position, telling his uncle that:

Apparently you are taking it for granted that the will of God for us lies necessarily in the C.M.S. and that we are seeking our own way if we do not go back.... I try to work as in His sight always, and our location here is not of our seeking – why should I be ashamed of it when He comes?⁶⁵

When Ernest Cook finally decided to remain in the Colonial Medical Service, he did so primarily for financial reasons, and in so doing joined a number of other medical practitioners who both engaged with Christian ideals and sought a higher-paying alternative to missionary life.⁶⁶

Among the doctors at Mengo Hospital, the financial pressures arising from the post-war reduction in missionary subscriptions, coupled with increased competition from government hospitals, meant that even those remaining in missionary service felt it necessary to focus on the more 'secular' aspects of medical work.⁶⁷ This they did with increasing autonomy, using the hospital's status as self-supporting to disregard the authority of the local missionary governing board at Namirembe.⁶⁸ Most prominent among these activities were medical consultations, which had multiplied with the opening of new government hospitals in the early 1920s. Mengo Hospital continued to house the only X-ray equipment in Uganda until 1938, and at least one of its doctors, Robert Stones, was a noted ophthalmologist.⁶⁹

The professional collaboration between mission and government doctors was not one way. Indeed, the doctors at Mengo Hospital were reliant on the laboratory at Mulago Hospital for Wasserman reaction tests, the CMS being unable to afford the equipment or the time to conduct its own tests for syphilis.⁷⁰ There was also an increasing presence of colonial medical officers in the Uganda branch of the BMA, which held its first meeting at Mulago Hospital, as opposed to Mengo Hospital, in 1921. By 1927, the Uganda branch of the BMA had started to hold regular scientific meetings, and mission doctors maintained an active presence until the 1940s at least.⁷¹ A report on the inter-territorial meeting of the East African Branches of the BMA, held in Kampala in May 1936, described how mission and government doctors came together to discuss topics as diverse as the mental adjustment

of Africans, urban and rural plague, and the frequency of trachoma in natives.⁷² While these discussions could lead to extended debates between individual mission and government doctors, these activities nevertheless underscored an implicit *esprit de corps* as medical colleagues and 'experts'.

The doctors at Mengo Hospital remained influential in official government circles until the 1930s, but requests for advice on sanitation, hygiene, and town planning appear to have come more out of respect for Albert Cook than out of any feeling that Mengo Hospital still retained exceptional insight into local health and disease conditions. Indeed, as Cook withdrew from medical practice at Mengo Hospital in 1934, so did the regular requests for advice and assistance. By the mid-1930s, the influence that Mengo Hospital had previously enjoyed was on the wane, and changes in government legislation on patient fees and charges prompted the first of several financial crises.⁷³ In 1934, Robert Stones, the new head doctor of Mengo Hospital, finalised an arrangement for a government grant to support medical work at the hospital. While the mission doctors were to remain free to continue ward services, the grant came with other conditions, including a note to the effect that Schofield would ideally not play any leading role in the hospital. Having co-opted him as a half-time DMO in Toro during the 1920s and found him 'difficult', the government was anxious not to deal with him again.⁷⁴

Finally, in 1939, the Colonial Medical Service set out its views on the future of Mengo Hospital. With the addition of 300 new beds at Mulago Hospital planned for 1940, it was anticipated that 'the need for Mengo Hospital as a general hospital would then pass away'.⁷⁵ Mengo Hospital, as Jack Cook and Stones reported back to the CMS, might then serve one of three purposes:

- a. That the Hospital should function as a hostel for the enlarged Mulago and the University that is to be.
- b. That it should be a training school, recognised by Government, for the training of nurses during their first years.
- c. That it should undertake certain specialized activities which Government never intends to take up, such as Orthopaedic work, Tuberculosis work, Leprosy etc.⁷⁶

The emphasis of the Colonial Medical Service on curative as well as preventive medicine had shifted the relationship between mission and government doctors to the point where missionary input was no longer required. With it, the high level of collaboration that had characterised Western medical practice in early colonial Uganda ceased almost entirely.

Conclusion

Michael Jennings has argued that historians of medical missions have tended 'to define "missionary medicine" as something peculiar to the Christian mission', stressing its evangelical and Christian theological underpinnings rather than the ways mission doctors responded to wider trends in medicine.⁷⁷ These mission doctors, as Jennings has pointed out, 'had the same training that all doctors underwent, read articles in medical journals, were kept informed of latest developments, and participated in research trials of new drugs'.⁷⁸ CMS doctors in Uganda, too, were not isolated from wider intellectual communities, and played an active role in education and research both in Uganda and further afield. These activities brought together mission and government doctors as professional colleagues and experts, and in turn shaped what both 'missionary medicine' and 'colonial medicine' could offer to their patients.

The complexity of the relationship between mission and government doctors in early colonial Uganda means that neither missionary nor colonial medicine should be considered in isolation. In this period, mission doctors and colonial medical officers were granted a considerable degree of autonomy in their everyday medical practice. As a result, the sharing of specialist knowledge, language skills, technical equipment, and personnel was surprisingly non-contentious. What was deemed to be appropriate 'missionary' as opposed to 'government' medical work was rarely, if ever, well defined, as mission and government doctors alike consulted and collaborated on individual patients and matters of policy. Indeed, missionary and colonial medicine were defined as much in relation to each other as they were within the broader context of general medical provision in Uganda.

Any history of missionary medicine inevitably touches on questions of power. Missionaries have frequently been accused of promoting 'cultural imperialism'; acting as vanguards for colonial overrule and as agents for imperial expansion.⁷⁹ Certainly, for much of the colonial period, the Colonial Medical Service in Uganda relied on missionaries to share their knowledge of local health and disease conditions and to implement medical services in areas it was unable or unwilling to administer. Yet, while mission doctors wielded a considerable amount of power, they were hardly unproblematic 'agents of Empire', nor were they ignorant of the implications of their collaboration. These missionaries, as Jeffrey Cox has argued for the Indian context, 'struggled with the conflict between universalist Christian religious values and the imperial context of those values'.⁸⁰ Missionaries who engaged in government service in Uganda expressed tension, anxiety, and confusion over discrepancies between the rules set out by the CMS and the

practical realities of practising medicine in colonial Africa. Money, facilities, and intellectual communities were as important to the medical work of mission doctors as was their belief in God.

In many ways this chapter has presented a one-sided history. By focusing on the relationship between missionary and government doctors in their everyday practice, it has missed out one group of historical actors: patients and their families. These are an essential part of any history of Western medicine, not least because, for most, mission and government hospitals were peripheral agents of health-care. Families continued to care for their sick in their own ways, and to make decisions about treatment that were unrelated to either government or mission policy. This was due in part to the limited reach of Western medicine – Singo County, for example, had by 1935 only one government-run dispensary to serve an estimated population of 70,000, spread over 2,734 square miles.⁸¹ But it was also because those families who did engage with Western medicine did so largely on their own terms, and with their own expectations and priorities in mind. As John Orley, anthropologist and psychiatrist, noted on patient choices in Uganda, ‘Africans, being pragmatists, looked for a system that worked, and if one traditional remedy failed then another could be tried and so on until eventually Western medical treatment could also be given its chance’.⁸²

This vast, and as yet inadequately explored, area of history is well beyond the scope of this chapter.⁸³ However, a few examples from the patient case notes of Mengo Hospital are instructive. Nakoli M. was admitted to Mengo Hospital in 1929, having been found walking around Kampala by the police. Although he had been originally sent to Mulago Hospital, the doctors there had been unwilling to deal with him, and had passed him over to Mengo Hospital, where Alma Downes-Shaw, along with medical student Y.K. Tabamwenda, diagnosed Nakoli with acute mania. They prescribed multiple doses of potassium bromide on a daily basis, a drug used widely in asylums in the United Kingdom and India to sedate patients. After a month there was still no improvement in his condition and he was ‘[t]aken away against wish of the Doctor’. Nakoli maintained that he had been ‘given poison mixed in water by a native’, and it was perhaps a remedy for this poison that his relatives wished to find elsewhere.⁸⁴ More detail is evident in the case notes for Erina W., who was admitted to Mengo Hospital by R.Y. Stones in 1935, following a history of violence, hysteria, insomnia, and ‘talking nonsense’. Towards the end of her twenty-day stay at the hospital, Erina took a dislike to her husband and the head hospital girl. Shortly after, and perhaps suspecting that the hospital staff were turning Erina against him, her husband removed her from the hospital.⁸⁵ In these

cases, as in many others, families remained unconvinced about the ability of either mission or government doctors to relieve the suffering of their relatives. Indeed, it was partly the belief that Western medicine would be successful only when it was practised by African medical practitioners that fuelled attempts to train African medical practitioners, which both mission and government doctors sought to control.⁸⁶

In Uganda in the early twentieth-first century the words 'history of medicine' remain synonymous with Albert Cook and Mengo Hospital. All medical students passing through Makerere University study in the Albert Cook Memorial Library at Mulago Hospital, which still houses Mengo Hospital's earliest patient case notes. The history that is woven into the educational lives of each generation of doctors sees missionaries as pioneers in Western medicine, setting up the foundations from which the government eventually took over. Yet it also perhaps acts as a statement of independence – as a reminder of the extent to which African medical practitioners have moved away from the colonial past, and have transformed their own profession.

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Notes

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- 2 This literature includes: Ann Beck, *A History of the British Medical Administration of East Africa: 1900–1950*, Cambridge, MA, Harvard University Press, 1970; W.D. Foster, 'Doctor Albert Cook and the Early Days of the Church Missionary Society's Medical Mission to Uganda', *Medical History*, 12, 4, 1968, pp. 325–43; W.D. Foster, *The Early History of Scientific Medicine in Uganda*, Nairobi, East African Literature Bureau, 1970; Kirk Arden Hoppe, *Lords of the Fly: Sleeping Sickness Control in British East Africa, 1900–1960*, Westport, CT, Praeger, 2003; Kuhanen, *Poverty, Health and Reproduction*; Carol Summers, 'Intimate Colonialism: The Imperial Production of Reproduction in Uganda, 1907–1925', *Signs*, 16, 4, 1991, pp. 787–807; Michael William Tuck, 'Syphilis, Sexuality, and Social Control: A History of Venereal Disease in Colonial Uganda', unpublished PhD thesis, Northwestern University, 1997; Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness*, Cambridge, Polity Press, 1991; Kathleen Vongsathorn, '"First and Foremost the Evangelist"? Mission and Government Priorities for the Treatment of Leprosy in Uganda, 1927–48', *Journal of Eastern African Studies*, 6, 3, 2012, pp. 544–60; Diane L. Zeller, 'The Establishment of Western Medicine in Buganda', unpublished PhD thesis, Columbia University, 1971
- 3 Summers, 'Intimate Colonialism', p. 803

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- 4 John Iliffe, *East African Doctors: A History of the Modern Profession*, Kampala, Fountain Publishers, 2002
- 5 Anna Crozier, *Practising Colonial Medicine: The Colonial Medical Service in British East Africa*, New York, I.B. Tauris & Co. Ltd, 2007, pp. 60–1
- 6 Vongsathorn, “‘First and Foremost the Evangelist’?”
- 7 For an excellent review of the ways in which the historiography of medical missions has been plagued by generalisations and misconceptions, see especially Michael Jennings, “‘A Matter of Vital Importance’: The Place of the Medical Mission in Maternal and Child Healthcare in Tanganyika, 1919–39”, in David Hardiman (ed.), *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa*, Amsterdam and New York, Rodopi, 2006; Michael Jennings, “‘This Mysterious and Intangible Enemy’: Health and Disease Amongst the Early UMCA Missionaries, 1860–1918”, *Social History of Medicine*, 15, 1, 2002, pp. 65–87
- 8 These have included W.R. Billington, ‘Albert Cook: A Biographical Note’, *East African Medical Journal*, 10, 28, 1951, pp. 397–422; Foster, *The Early History of Scientific Medicine*; H.C. Trowell, ‘The Medical Pioneers and Explorers of East Africa’, *East African Medical Journal*, 34, 8, 1957, pp. 417–30
- 9 There is certainly room for a history of Catholic medical missions in Uganda, and in particular the history of Rubaga Hospital. Summers, ‘Intimate Colonialism’, p. 799; Vongsathorn, “‘First and Foremost the Evangelist’?”.
- 10 On the early history of Mengo Hospital, see especially W.D. Foster, *The Church Missionary Society and Modern Medicine in Uganda the Life of Sir Albert Cook, K.C.M.G., 1870–1951*, Newhaven, CT, Newhaven Press, 1978; Foster, ‘Doctor Albert Cook’
- 11 Rhodes House Library, Oxford (RHL) Micr.Afr.609(4) Papers of J.N.P. Davies, Medical Report for the Year Ending March 31, 1903
- 12 RHL Micr.Afr.609(4) Papers of J.N.P. Davies, Medical Report for the Year Ending March 31, 1903
- 13 Albert Ruskin Cook, *Uganda Memories, 1897–1940*, Kampala, Uganda Society, 1945, p. 1; J.H. Cook, ‘Notes on Cases of “Sleeping Sickness” Occurring in the Uganda Protectorate’, *Journal of Tropical Medicine*, 1901, p. 237; Douglas M. Haynes, ‘Framing Tropical Disease in London: Patrick Manson, *Filaria Perstans*, and the Uganda Sleeping Sickness Epidemic, 1891–1902’, *Social History of Medicine*, 13, 3, 2000, pp. 467–93, pp. 485–7
- 14 See, for example, Albert Cook Memorial Library, Makerere University, Uganda (ACMM) Sir Albert Cook Records, Mengo Hospital Correspondence, 1897–1963 (MHC) letter from C.A. Wiggins to Dr Cook, 23 December 1914; ACMH MHC letter from J.M. Collyns to Dr Cook, 22 July 1915; ACMH MHC letter from G.O. Stratham to Dr Cook, 14 February 1916
- 15 ACMH MHC letter from C.J. Baker, Medical Sanitary Officer, to Albert Cook, 31 August 1916
- 16 ACMH MHC letter from L. Allworth to A. Cook, 2 March 1914
- 17 University of Birmingham Special Collections (UoBSC) G3 A7/O 1919 Uganda Mission Outgoing Correspondence 1919, fo.35, letter from Albert Cook to Dr Lankester, 18 February 1919
- 18 See, for example, ACMM MHC, letter from R. van Someren to Dr Cook, 8 May 1915. Such was the popularity of Albert Cook in particular, that on his retirement in 1934 mission authorities feared that his withdrawal into private practice would necessitate the closure of Mengo Hospital altogether. UoBSC G3 A7/O 1934, Uganda Mission Outgoing Correspondence 1934, fo.40, letter from Bishop of Uganda to Rev. H.D. Hooper, London, 13 March 1934
- 19 UoBSC Acc. 514, Papers of Winifred Annie Milnes-Walker, Report of the CMS Mengo Hospital, Uganda, 1897–1937; E.N. Cook, ‘The Adventures of an X-Ray’, *Mercy and Truth*, 276, 1920, pp. 277–81
- 20 J.H. Cook, ‘A Year’s Hospital Work in Central Africa’, *Church Missionary Review*, 66, 796, 1915, pp. 482–6, p. 485
- 21 On the Uganda branch of the BMA, see Crozier, *Practising Colonial Medicine*,

- pp. 96–7; J.N.P. Davies, 'The History of the Uganda Branch of the British Medical Association, 1913 to 1932', *East African Medical Journal*, 31, 3, 1954, pp. 93–9
- 22 Davies, 'The History of the Uganda Branch', p. 94
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- 24 J.H. Cook, 'Missionaries and War Service', *Mercy and Truth*, 226, 1915, pp. 326–8, p. 328
- 25 T. Beidelman, *Colonial Evangelism: A Socio-Historical Study of an East African Mission at the Grassroots*, Bloomington, IN, Indiana University Press, 1982, p. 76; David Hardiman, 'Introduction', in David Hardiman (ed.), *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa*, Amsterdam and New York, Rodopi, 2006, p. 25
- 26 Hardiman, 'Introduction', pp. 18–20
- 27 On the expansion of government medical services, see especially: The National Archives, UK (TNA) CO 536/140 History of Ugda Medical Reforms; TNA CO 536/129 Medical Department. Coordination of Services and General Reorganisation; Beck, *A History of the British Medical Administration*; Crozier, *Practising Colonial Medicine*
- 28 The districts and years served were: L.E.S. Sharp (Kigezi, 1921–29); E.N. Cook (Toro, 1923–24); A.T. Schofield (Toro, 1924–25); A.C. Stanley Smith (Kigezi, temporarily, 1925)
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- 30 J.H. Cook, *9th Annual Report*, 1911
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- 32 UoBSC G3 A7/O 1920 111–end Uganda Mission Outgoing Correspondence 1920, fo.197, letter from Ashton Bond to George Manley, 12 October 1920
- 33 UoBSC G3 A7/O 1920 1–110 Uganda Mission Outgoing Correspondence 1920, fo.69, letter from F. Rowling to George Manley, 17 February 1920; UoBSC G3 A7/O 1920 111–end, fo.197, letter from Ashton Bond to George Manley, 12 October 1920
- 34 UoBSC G3 A7/O 1921 Uganda Mission Outgoing Correspondence 1921, fo.68, letter from Ashton Bond to George Manley, 3 May 1921
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- 39 UoBSC G3 A7/O 1920 1–110, fo.28, 'Minute of Medical Committee, January 27, 1920'
- 40 UoBSC G3 A7/L4 1919–1926 Uganda Mission Letterbook 1919–26, pp. 106–7, letter from George Manley to Mr Ladbury, 9 June 1921; UoBSC G3 A7/O 1921, fo.63, letter from C.A. Wiggins to Dr Sharp, 21 March 1921; UoBSC G3 A7/O 1921, fo.83, letter from A.C. Stanley Smith to 'My dear Ruanda friend', 7 May 1921
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- 42 UoBSC G3 A7/O 1921, fo.68, letter from Ashton Bond to George Manley, 3 May 1921
- 43 See Crozier, *Practising Colonial Medicine*, p. 91; Ryan Johnson, "'An All-white

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 - 46 KDA Medical General 1921–5, letter from Sharp to DC Kabale, 28 April 1921
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 - 51 UoBSC G3 A7/O 1923, Uganda Mission Outgoing Correspondence 1923, fo.108, Medical Sub-Conference Minutes, 6 November 1923; UoBSC G3 A7/O 1934, fo.106, letter from A.T. Schofield to Rev. Hooper, 3 October 1934
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 - 59 UoBSC G3 A7/O 1923, fo.109, Medical Sub-Conference Minutes, 6 November 1923
 - 60 On medical work in Uganda, see especially Iliffe, *East African Doctors*; Audrey W. Williams, 'The History of Mulago Hospital and the Makerere College Medical School', *East African Medical Journal*, 29, 7, 1952, pp. 253–63
 - 61 E.N. Cook, 'A Medical Mission in War Time', *Mercy and Truth*, 216, 1914, pp. 392–4, p. 394
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