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A Mission Doctor in Africa

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In June this year my wife and six children and I returned from Southern Rhodesia where we spent three years. I worked for Bishop A. Haene in his diocese of Gwelo, at a large tuberculosis sanatorium and general hospital.

During my internship I first began thinking seriously of dedicating a few years as a doctor in the foreign missions. Later, when in the Army in 1959, my wife and I decided that we would at least explore the feasibility of such an undertaking. This proved to be considerably more difficult than first anticipated. We wrote to several organizations to obtain information. One was the Lay Mission-Helpers group of the Archdiocese of Los Angeles. It seemed to be the answer to our prayers.

Monsignor Anthony J. Brouwers, the founder of the Lay Mission-Helpers, also Director of the Society for the Propagation of the Faith of the Los Angeles Archdiocese, had just inaugurated the "Mission Doctors Association." Past experiences with members of the medical profession, which he had incorporated into his Lay Mission-Helpers, showed that Mission Doctors needed their own professional organization with a strong home base of apostolic-minded Catholic doctors to manage the selection, placement, and support of the volunteer doctors in the mission field.

Thus, from the Catholic Physicians' Guild of Los Angeles evolved the Mission Doctors Association. We felt that this was the type of organization that would give us the support and security needed for such an undertaking. We were its first family to be sent abroad. In May 1961 we sailed from New York to Africa.

Southern Rhodesia was one of the last countries of sub-Saharan Africa to be penetrated by missionaries. Consequently, the Church here is relatively young when compared with the rest of Africa.

A systematic evangelization of the Rhodesias began only after white settlers arrived here in the last decade of the 19th century. Driefontein, founded in 1906, was one of the first mission stations. But due to lack of priests, brothers, and sisters, the Church made little impact on the African population until twenty years ago when new missionary societies came to the help of the English Jesuit Fathers. The country was then divided into several ecclesiastical districts. One diocese, in 1947, was entrusted to the members of the Bethlehem Missionary Society of Switzerland.

In addition to Ruth and me at Driefontein Hospital, there were eight Lay Mission-Helpers on the staff. They were a hospital administrator, a dentist-anesthetist, and six nurses. Our new home was situated 70 miles east of Gwelo and about 150 miles south of Salisbury, the capital. The climate is healthy and pleasant. We lived almost a mile above sea level, on the high plateau-land that comprises most of the Rhodesias and Nyasaland.

A mission station is something of a self-contained unit with its own sources of food, water, and electricity. You live within a stone's throw of the Church, which makes daily Mass an easy privilege. The hospital, too, is but a few yards away from the comfortable bungalow which we and our children called home.

Ruth taught the two elder children with the aid of a local correspondence course. We found this adequate and on return home the children were placed in the grade we had anticipated without difficulty. We had a few luxuries not found in the average station—a 24-hour supply of electricity from the giant Kariba hydroelectric system on the Zambesi River, and workable telephones which were definite luxuries for Africa.

Life at a mission station becomes dull and monotonous at times. Those who search outside themselves for diversion and entertainment will not last long in the missions.

HOSPITAL AND STAFF

Our Catholic hospital at Driefontein boasted a 300-bed TB sanatorium and a 100-bed general hospital, only recently opened. The sanatorium had excellent X-ray facilities, a laboratory, pharmacy, and operating room. These serve the general hospital patients as well.

I was the only doctor there. Besides caring for the 400 beds at Driefontein and daily outpatients, I spent one day a week at an out-station where the sisters operate a clinic. There is enough work for one doctor in all the rural mission clinics in the diocese. We badly needed a second doctor at Driefontein. I was replaced by Dr. James Carey of MDA but this still does not solve the basic problem of need for two, maybe three doctors at Driefontein.

The staff at our two hospitals was made up of the American Lay Mission-Helpers mentioned above and three Swiss Lay missionaries, three German Dominican sisters, and three African nursing sisters. You would be deeply impressed by the genuine catholicity of our staff. Bishop Haene has tried to internationalize our missionary personnel. I personally believe that this admixture of nationalities does much to unify our life and work and impress the Africans with our Faith at work and at play.

The African sisters in the hospitals greatly inspired us all. Though the Gwelo diocese has yet to ordain its first African priest, we had more than 50 African sisters. This flourishing community demonstrates God's special blessings on the missionary labors of Gwelo diocese, if one realizes with what sacrifices and courage an African girl becomes a nun.

Our sanatorium was built in 1960 to treat the high percentage of TB victims. This disease is Southern Rhodesia's chief health problem. The H-shaped building is the result of a joint effort by the Bethlehem Missionaries and the Government Health Service. Bishop Haene carries the major part of the construction costs. The Government assumes the burden of the day-to-day operating expenses. It is the largest TB sanatorium in the country, with its 300 beds continually occupied.

The African patients in the sanatorium come from distances of a hundred to two hundred miles around. They are sent to us by Government and mission hospitals and often arrive in a debilitated condition. Most patients come from rural districts where the African people still live in "reserves." These are large tracts of land set aside for them by Government. However, with each passing year the trek of natives to the towns and cities increases. Living in urban slums, eating out of the same pots and pans, and close physical contact constitutes a fertile breeding ground for TB infection.

THE AFRICAN PATIENT

Our most difficult problem with the patients is that they have an insatiable urge to leave as soon as they feel

a little better. It is hard to make them realize that although they are improving, their TB has only been arrested. Further drug therapy is necessary because outpatient treatment does not work in rural areas. If they leave before properly discharged, they are soon back to begin treatment all over again. However, we have constantly on hand a number of patients who have run off before finishing treatment and now are worse off than before. One can point to them as examples of what will happen if the long convalescence is not maintained.

A second difficulty arises from the pagan notion that diseases are caused by spirits of the deceased. If the sick person is to regain his health, the evil spirit causing the sickness must be placated. Obviously, this fear complicates the organic trouble. The sick African will first try by ritual to appease the offended evil spirit. If he does not know which spirit has been offended, he will resort to the native doctor, or *nganga*. The *nganga* will instruct him what to do to quell the spirit and he may prescribe some of his own herbalistic concoctions. Some *nganga* do not resort to medications, but bravely confront the evil genii with mystic gadgets. Others deal only in medicines; a few do a good business with both their occult charms and whatever juices they can squeeze from roots, plants and leaves.

While the *nganga* treatment goes on for days or weeks, valuable time is lost before the patient reaches the clinic or hospital. Often he never reaches such a center before death strikes. Witch doctor brews usually do further damage to the already sick man. When such a victim of witchcraft comes to us we have first to diagnose the principal malady and the effects of the witch doctor's poisoning. In children this is particularly tragic. Most of our patients take native medicines before they come to e hospital. Many even have them bro ht into the hospital without our nowledge, only complicating our t ment and procedures.

The native docto as always played a major role in pre-c onial Africa, and among our people still does. The African's belief ar dependence on native medicines a ancient. From them he derived g t security. This central fact has to e appreciated to understand the comp x problem of the African herbalist an he psychological makeup of the Afri n patient.

DOCTOR AND SSIONARY

Sickness, medica treatment, and death are for the A ricans events of the spiritual order, ot mere physiological processes. A octor for whom the African is merel a "medical problem" fails to meet s patient's spiritual needs. The ide Catholic doctor must impress his tients with the Christlike meaning d value of pain and suffering. To d less is to minimize the missionary character of his medical labors.

A doctor's religio conviction, however, can never be a ubstitute for professional excellence. The former is rather a fulfillment of the latter.

After having bee associated with MDA for four years, three years of which were in the missions, I want to make the following observations:

There are several other efforts which are endeavoring to supply the great need for doctors in the developing countries of the world. Many of them are well known and successful in varying degrees in their own manner. The MDA does not see itself in competition with these but simply that its approach is different.

It is my considered opinion that an effort that works within the framework of the Church has several advantages for the individual and for the Church. For the individual, it assures that he is properly indoctrinated in his role in the total mission effort and in a deeper spiritual life. Next, he is assured that he will be assigned to a location that needs him and where his family will find life bearable. Finally, he is supported by a home base while in the missions and is helped to resettle on his return home. This relieves many worries and problems entailed in such an undertaking, especially if the doctor has a family.

There are advantages to the Church also. The social work of the Church is furthered. Specifically here I am speaking of curing of ills. To realize that this type work is close to the ideal of Christ, one has only to read the Gospels, especially that of St. Luke. A majority of the miracles performed by Christ were concerned with physical maladies.

The local bishop has many problems to face and he must use his resources in the manner that seems wisest to him. He would like some assurance that any effort he makes to help his flock can be continued and he is reluctant to undertake the cost involved in building a hospital. An organization such as MDA is trying to eradicate the uncertainty of supply of doctors to the missions. We all realize that the demand will probably always exceed the supply. Thus, MDA endeavors to seek out the more suitable locations from various aspects in which to work and hopes to slowly expand. Without such an assurance of continuity, medical work in the missions is an irresponsible adventure and not a worthwhile service to the Church and the people.

Much is spoken and written in this time about the growing role of the layman, about the renewal in the Church, about liberalism and conservatism, both on the national political scene and within the ecclesiastical framework. One fact stands out and it is that the age of the layman has really arrived and it is only by cooperating with God's grace and asserting himself that the layman will assume his proper role within the Church. It certainly will not be handed to him on a silver platter. Members of the medical profession can do this in several ways, but for those of us who are still young, what better way to get started than spending a few years in the mission field. Waiting for our government to do it is obviously not the answer, and manifestly the various orders and congregations of priests and sisters cannot do it. Rather, we must work together with them in the promotion of God's kingdom on earth.

I hope these observations will enlighten and perhaps encourage Catholic doctors to give a few years of their lives as medical missionaries. My wife and I know that we are most privileged to share the labors of the Missionary Church. We shall be forever grateful that God gave us the grace to go to Africa as medical missionaries.

Brother Juniper

"He says he caught cold from the wheat germ."