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Saving Missionary Skins Saves Patients' Lives

The Role of the Political and Legal Environment on Medical Outcomes

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Abstract

When the first American medical missionary to China established the first western-style hospital in Guangzhou in 1834 the political and legal environment was hostile to foreigners and to missionaries in particular but, in some respects, it was conducive to safe medical practice. Given that the early nineteenth-century hospital in the West was a very dangerous place it was important to limit risk in the hospital if the evangelical mission was to survive. An analysis of Peter Parker's (1804–1888) reports and case studies reveals not only his superior skill and patient outcomes but also the medical and administrative strategies he employed to minimize risk. The study places Parker's medical work in a comparative frame; moving away from a mission-centric focus to draw China medical missions into a larger narrative of the history of modern medicine.

Résumé

Lorsque les premiers missionnaires-médecins américains en Chine ouvrirent le premier hôpital de style occidental à Guangzhou en 1834, le contexte politique et légal était hostile aux étrangers et aux missionnaires en particulier. Cette situation favorisait néanmoins par certains aspects une pratique médicale sûre alors même qu'en Occident, au début du 19^{ème} siècle, les hôpitaux étaient des endroits très dangereux. La mission évangélique devait en effet absolument limiter les risques au sein de l'hôpital si elle voulait assurer sa survie. L'analyse des rapports établis par Peter Parker (1804–1888) et des études de cas montrent non seulement les talents remarquables de ce missionnaire et les résultats qu'il a obtenus, mais aussi les stratégies médicales et administratives qu'il employa afin de minimiser les risques. La présente étude place le travail médical de Parker dans un cadre comparatif, en s'éloignant des approches centrées sur la mission pour replacer les missions médicales dans le cadre plus large de l'histoire de la médecine moderne.

Keywords

China – missions – medicine – 19th century – informed consent

Mots-clés

Chine – missions – médecine – 19ème siècle – consentement éclairé

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It is not enough for the physician to do what is necessary, but the patient and the attendant must do their part as well and the *circumstances* (my emphasis) must be favourable.

HIPPOCRATES' First Aphorism¹

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When the first American medical missionary to China arrived in Canton late in 1834 the odds were stacked against him. The political and legal environment was hostile to foreigners in general and missionaries in particular. The American Board of Commissioners for Foreign Missions (A.B.C.F.M.) had chosen an inexperienced, but zealous, thirty-one year old graduate in medicine and theology from Yale, Peter Parker (1804–1888), to spearhead their entry into China.² The idea was for him to use his medical training as a device to gain access to potential Chinese converts. This stratagem meant, besides being restricted as a foreigner and a missionary he would be subject to Chinese law that prescribed heavy penalties for a doctor whose patient died. Should Parker fall foul of the law he risked being barred from medical practice and having to abandon the missionary enterprise altogether. In this paper I will argue that, because medical missionaries, such as Parker, were missionaries first and medical practitioners second they adopted strategies to avoid official sanction and to stay on the right side of the law. The effect was to save patients' lives.

1 J. Chadwick, W.N. Mann and G.E.R. Lloyd, *Hippocratic Writings* (London: Penquin Classics, 1983), p. 206.

2 For a summary of Peter Parker's background, see Gerald H. Anderson, "Peter Parker and the Introduction of Western Medicine in China", *Mission Studies*, Vol. 23 (2) 2006, pp. 203–238.

Political Restrictions on Foreigners

In 1760, the Qing government established the “Canton System” to regulate trade with the West. Foreigners could reside only part of the year in China and were confined to the ‘factory’ area of Canton.³ Furthermore, any Chinese discovered teaching a foreigner the language could be “denounced and punished as a traitor to his country.”⁴ So far as missionary activity was concerned, a 1721 imperial edict banning Westerners from proselytizing and distributing Christian tracts in China was still in force.⁵ The prospect of any effective missionary activity among the Chinese was thus very slight. An American missionary, Elijah Coleman Bridgman D.D. (1801–1861), who had arrived in Canton in 1833, suggested to the A.B.C.F.M. that western medicine might be a way missionaries could get a foot in the door. He asked them to recruit “a first rate oculist ... who understood all cutaneous diseases.”⁶ Peter Parker was that oculist.

Foreign Missionaries and Chinese Law

For his first ten years in China between 1834 and 1844 Parker would be subject to Chinese law: specifically a section of the Qing Penal Code which stated that “all foreigners who come to commit themselves to the government of the empire, shall, when guilty of offences, be tried and sentenced according to the established laws.”⁷ Most foreigners, restricted as they were by the Canton

3 For details of the Canton System, see Dun J. Li, *China in Transition, 1517–1911* (New York: Van Nostrand Reinhold Company, 1969), pp. 29–34.

4 See “Promulgation of the Gospel in China”, *Chinese Repository*, Vol. 3 (9) 1835, p. 432.

5 Translation of the edict and its context, see Dun J. Li, *China in Transition*, pp. 20–22.

6 Michael C. Lazich, “Seeking Souls through the Eyes of the Blind: The Birth of the Medical Missionary Society in Nineteenth-Century China”, in D. Hardiman (ed.) *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa* (Amsterdam: Rodopi, 2006), p. 64.

7 “Penal Laws of China: Review of Ta Tsing Leuh-le; being the fundamental laws, and a selection from the supplementary statutes of the Penal Code of China ... translated from the Chinese by Sir George Thomas Staunton, London 1810”, *Chinese Repository*, Vol. 2 1833, pp. 10–19, 61–73, 97–111. It should be noted that in practise the Qing government restricted exercising its jurisdiction only to aliens thought to have committed homicide against Chinese subjects. For full treatment of foreigners and the Penal Code, see R. Randle Edwards, “Ch’ing Legal Jurisdiction over Foreigners”, in J.A. Cohen (ed.) *Essays on China’s Legal Tradition* (Princeton: Princeton University Press, 1980), pp. 222–269.

System, could avoid transgressing Chinese law but a missionary – preaching *and* conducting a medical practice – would be much more exposed. Since the seventeenth century, Chinese intellectual attitudes towards Christianity and its missionaries had run deep, from “callous indifference to impassioned hatred.”⁸ In 1826 a clause was added to the Penal Code within the section dealing with “wizards, witches, and superstitious practices” which referred specifically to Christians. If it was proved “by authentic testimony [that] people of the western ocean ... propagate, clandestinely print books, or collect congregations to be preached to” their leader should be sentenced “immediately to death by strangulation.”⁹ A sub-statute of the Code, which specified strangulation for “sorcerers or taoists who use heterodox arts ... (or) uncanonical old books” to treat illnesses, was a further potential hazard for a Christian practicing western medicine.¹⁰

Doctors and Chinese Law

If the fear of civil litigation makes the practise of medicine in America a legal minefield today, consider the situation in nineteenth-century China. Whilst Chinese doctors did not require a license to practise they were subject to the section of the Qing Legal Code dealing with homicide. The consequences for a doctor whose patient died hung on the doctor's intention. If he intentionally mixed medicine “not in accord with the original prescription with the result someone dies” it was classified as *ku sha*, (deliberate killing), punishable by decapitation.¹¹ If the doctor was merely unskilled and “administers drugs, or performs operations with the puncturing needle, contrary to the established rules and practice, without any design to injure, kills the patient (*wu sha*, accidental killing) [he] shall be allowed to redeem himself from the punishment

8 Paul A. Cohen, *China and Christianity: The Missionary Movement and the Growth of Chinese Antiforeignism, 1860–1870* (Cambridge Ma.: Harvard University Press, 1963), p. 265.

9 Editor, “Christian Missions in China: Edict published in 1836; Extracts from the Penal Code; with remarks respecting the disposition and policy of this government towards Christianity, by the late Dr Morrison”, *Chinese Repository*, Vol. 6 (2) 1837, pp. 53–54.

10 Derk Bodde and Clarence Morris, *Law in Imperial China Exemplified by 190 Ch'ing Dynasty Cases with Historical, Social, and Judicial Commentaries* (Cambridge, Mass.: Harvard University Press, 1967), pp. 356–357.

11 *Ibid.*, p. 354. For a full discussion of the Qing Code in relation to homicide see, Geoffrey MacCormack, *Traditional Chinese Penal Law* (Edinburgh: Edinburgh University Press, 1990), pp. 183–189.

of homicide but *shall be obliged to quit his profession for ever* (my emphasis).¹² A law being on the books does not guarantee that it would be upheld but, as Bodde illustrates in his examination of the application of Qing Law, cases had been brought against Chinese charged with medical malpractice.¹³ In 1834 *The Chinese Repository* (the Canton-based periodical edited by Bridgman) and the *Canton Register* warned foreigners of the dangers of breaking the law: the “law says that foreigners in China killing each other, may be punished according to foreign law; but does not willingly concede this to a foreigner killing a Chinese ... their pride urges them to require the life of a foreigner, whenever the death of a native has been caused (no matter how) by his agency or instrumentality.”¹⁴ Parker knew that a patient’s death could force him to quit his medical practice, effectively ending his evangelical mission.

The Court of Public Opinion

Parker and his American colleagues would gain immunity from Chinese law in 1844 when the Treaty of Wangxia granted the United States the right to exercise extraterritorial jurisdiction in both civil and criminal cases involving American citizens.¹⁵ But this change would not shield them from adverse official or public reaction to a patient’s death. Western surgery, new to China, was a deep well for rumours. Rumour-mongering was so pervasive that some had even made their way into the law: the same clause of the Penal Code relating to Christians went on to state: “in the case of the mad practice of picking out the eyeballs of dying persons being had recourse to; let the crime be deliberated on at the time of occurrence, and be punished according to its enormity.”¹⁶ In an attempt to check such rumours Parker and others advocated consulting and operating in full view of other patients and their relatives.¹⁷ But even the

12 “Penal Laws of China”, p. 104.

13 Bodde and Morris, *Law in Imperial China*, pp. 354–357.

14 “Homicides in China”, *Chinese Repository*, Vol. 3 (1) 1834, pp. 38–39. See also Roger Houghton, “A Peoples’ History 1793–1844 from the Newspapers: Dr Peter Parker has had a Brush with the Law”, 2011, online at <http://www.houghton.idv.hk/> (accessed August 18, 2013).

15 See, Ping Chia Kuo, “Caleb Cushing and the Treaty of Wanghia, 1844”, *Journal of Modern History*, Vol. 5 (1) 1933, pp. 34–54. The Treaty of Nanking, granting extraterritoriality to Britain, had been signed in 1842.

16 Editor, “Christian Missions in China”, p. 54.

17 Michelle Renshaw, *Accommodating the Chinese: The American Hospital in China, 1880–1920*

false rumour of a hospital death could feed the anti-foreigner anti-missionary sentiment widespread in China and give city officials cause to take action. As a colleague of Parker, Benjamin Hobson (1816–1873), was to remark in his hospital report of 1855, “using the knife among a people so suspicious and fault-finding requires unusual caution.”¹⁸ Robert Coltman (1862–1931), who was to be appointed Professor of Surgery at the Imperial University at Peking in 1898, echoed this sentiment when he summed up the situation of medical missions, “an unsuccessful or fatal operation in a new field would have a very detrimental effect on not only the medical work, but all branches of the missions’ work.”¹⁹

The State of Western Hospital-Based Medicine

To understand the risks Parker and his fellow medical missionaries were taking we need to keep in mind the state of medicine in America at the time. Far from being a showcase for the efficacy of western science, the hospital was a dangerous place; a “tidal wave of infection and suppuration of wounds” had become evident in the eighteenth century and was to reach “alarming heights in the third quarter of the nineteenth century.”²⁰ The set of ‘hospital acquired’ infections²¹ – hospital gangrene, pyaemia, and erysipelas – was so common in the 1840s that “the very making of an incision was fraught by mortality so prohibitive operations were restricted to those most urgently indicated.”²² Stephen Smith, who started work at the Bellevue Hospital in New York in the early 1850s, provides a first-hand account of the surgical wards:

(New York: Routledge, 2005), p. 146. For an alternative view see Tian Xiaoli’s PhD dissertation, which identifies ‘secret spaces’ as the source of rumours, Tian Xiaoli, *Relocating Science: Medical Missions and Western Medicine in 19th-Century China*, PhD, University of Chicago, 2011.

18 Quoted in William Lockhart, *The Medical Missionary in China: A Narrative of Twenty Years Experience* (London: Hurst and Blackett, 1861), p. 188.

19 Robert Coltman, *The Chinese, Their Present and Future: Medical, Political and Social* (Philadelphia: F.A. Davis, 1891), p. 174.

20 E.D. Churchill, “The Pandemic of Wound Infection in Hospitals: Studies in the History of Wound Healing”, *Journal of the History of Medicine and Allied Sciences*, Vol. 20 (October) 1965, p. 390.

21 See James Y. Simpson, *Hospitalism: Its Effects on the Results of Surgical Operations. Part 1, Country Amputation Statistics* (Edinburgh: Oliver and Boyd, 1869).

22 Churchill, “Pandemic of Wound Infection”, p. 390.

amputation wounds rarely, if ever, recovered ... except after long suppuration ... if the wound were large, on the second or third day the fever formally began ... The fever generally ran high, with consequent exhaustion and depression of the patient ... Few indeed survived this fever.²³

Choosing to open a hospital, then, in the first half of the nineteenth century in the hope of inducing the Chinese to convert to Christianity might be considered foolhardy. If medicine was to succeed as an effective missionary tool it would have to be a lot safer than it was at home; the benefits would need to outweigh the dangers.

The medical marketplace Parker sought to enter was already crowded. A contemporary observer of Canton estimated there were “not less than two thousand” members of what he called the ‘medical community’ serving a city of an estimated one million.²⁴ This ‘medical community’, like the one in contemporary America, was far from uniform. At the top of the heap were a small minority of ‘scholar physicians’ who were outnumbered by “a plethora of different practitioners, wielding different techniques and forms of healing knowledge.”²⁵ Taoist or Buddhist priests, shamans, and mediums practised various forms of religious, demonological, and magical healing. Fortune-tellers, geomancers and soothsayers set up on the streets of Canton alongside “pavement doctors” – ocularists, aurists, dentists, cuppers, acupuncturists, bone-setters and barbers – who provided more practical services.²⁶ If Parker was to stand out in the marketplace, he had to be able to supply an alternative to what was on offer. And there *was* a niche: the Chinese were prone to eye diseases and contemporary Western ophthalmological surgical techniques were far superior to those in use in China.²⁷ Parker could provide an effective treatment for eye disease.

23 Stephen Smith, “The Comparative Results of Operations in Bellevue Hospital”, *The Medical Record*, October 17, 1885, p. 429.

24 “Description of the City of Canton”, *Chinese Repository*, Vol. 2 (7) 1833, pp. 289–308: p. 306.

25 Yi-li Wu, “The Bamboo Grove Monastery and Popular Gynecology in Qing China”, *Late Imperial China*, Vol. 21 (1) 2000, p. 59.

26 “Lectures on China No. V”, *Christian Advocate and Journal*, Vol. 21 (11) 1847, p. 43. Wu, “Bamboo Grove”, p. 43.

27 See Anderson, “Peter Parker”, p. 21, for a discussion of the state of cataract surgery in China.

Parker's Practice

Ophthalmology was a particularly apt choice of specialization for Parker: his dissertation at Yale had addressed the question of "Purulent Ophthalmia" and his *only* practical medical experience had been one week spent at the Eye Infirmary in New York.²⁸ Most importantly, given the legal and political environment, eye surgery was relatively safe. It was also quick so that large numbers of patients could be dealt with in a short time and the majority would not need to be admitted as in-patients; all important factors when the principal purpose was evangelical. The benefits of treatment would be obvious to all, thus enhancing Parker's 'reputation,' an important quality for a doctor in China. To that end he opened the forty-bed Canton Ophthalmic Hospital in November 1834. His case notes show Parker used silver nitrate or copper sulphate to treat acute and chronic ophthalmia, (inflammation of the eye); he "couched" for cataract; and operated on inverted eyelids (entropia).²⁹ All could give immediate, often dramatic, relief. Causing the 'blind to see' was a most fitting demonstration of Christian benevolence and, incidentally, the efficacy of Western 'scientific' medicine. But he never succeeded in confining himself solely to treating eye diseases. For the first two and a half years, ophthalmology accounted for more than eighty percent of his patients but by the end of the 1830s the balance had started to shift and from 1848–1849 it comprised less than half.³⁰

Beyond ophthalmology, Parker had a further advantage; western doctors performed general surgery whereas practitioners of Chinese medicine did not. Daniel Drake, describing the medical profession in America in 1832, wrote, "all our physicians are surgeons." The surgery they performed was limited to "the reduction of dislocation and fractures, the management of ulcers, trephining, amputating, dressing wounds." Parker's case mix certainly included his fair share of such surgery. What, according to Drake, distinguished a physician from a 'proper' surgeon was that he would decline "the greater operations – such as those for hernia, lithotomy, aneurysm, deep-seated tumors, cataract, and a few

28 Edward Vose Gulick, *Peter Parker and the Opening of China* (Cambridge, Ma.: Harvard University Press, 1973), p. 19.

29 See data included in Peter Parker, *Reports of the Ophthalmic Hospital at Canton* (Chinese Repository, 1835–1852).

30 Parker counted each patient, not each visit. He registered a total of 43,762 patients between November 1835 and December 1851. All references to Parker's caseload from now on are taken from an analysis of the data contained in these hospital reports.

others.”³¹ In this respect, Parker stood out from his physician contemporaries at home; he performed all of Drake’s “greater operations.”

Parker did not consider operating for cataract a ‘great’ operation, it was his bread and butter and relatively safe so long as cleanliness was observed and care taken.³² Performing mastectomies, extirpating deep seated tumours, and the lateral perineal operation for bladder stones, was more problematic. Joseph Lister’s biographer describes what it was like to operate for breast cancer before antiseptics:

only small and incomplete – and hence almost useless – amputations had been performed for cancer of the breast because death almost always invariably followed the infection of the tremendous wound.³³

Parker started excising tumours, including breast cancers, from the very beginning and was rightly famous for his success. In the hospital’s first three months he removed a ‘sarcomatous’ tumour weighing a pound-and-three-quarters from the temple of Akae, a girl of thirteen, with no adverse effects.³⁴ Following Akae, 980 patients presented with tumour; on average, six patients per month for every month the hospital was open until Parker’s final report to December 1851.³⁵

Although tumour cases accounted for only just over two per cent of his patients, the potential danger they posed to his practice was out of all proportion to their number. Swift amputation, especially prior to the introduction of anaesthetics, was imperative and in this, Parker’s surgical skills were impressive. Of the twenty-one cases where he reported how long the operation took,

31 The American physician and writer, Daniel Drake (1785–1852) was a founder of the medical school in Cincinnati, Ohio. Daniel Drake, *Practical Essays on Medical Education and the Medical Profession in the United States* (Baltimore: Johns Hopkins Press, 1972 [originally published, 1832]), p. 21.

32 1,800 patients treated, 1836–1851.

33 Rhoda Traux, *Joseph Lister: Father of Modern Surgery* (London: George G. Harrap & Co. Ltd, 1947), p. 128. See also, E.H. Barker, “St. Bartholemews Hospital. Removal of Scirrous Glands Near the Breast: Death from Pleurisy”, *British Medical Journal*, Vol. 31 (31 October) 1857, p. 903 on the risk of pyaemia in operations of the breast.

34 Peter Parker, “Ophthalmic Hospital at Canton: First Quarterly Report, from the 4th of November 1835 to the 4th of February 1836.”, *Chinese Repository*, Vol. 4 (10) 1836, pp. 467–469.

35 Peter Parker, *Minutes of Two Annual Meetings of the Medical Missionary Society in China including the Sixteenth Report of its Ophthalmic Hospital at Canton, for the Years 1850 and 1851* (Canton: Medical Missionary Society in China, 1852).

eleven referred to extirpating tumours. On average, a tumour was removed in 5.1 minutes with the six mastectomies taking an average of 5.6 minutes each. Towards the end of 1836 he removed twenty-three year old Po Ashing's diseased arm at the shoulder: "the first Chinese, as far as I know, who has ever voluntarily submitted to the amputation of a limb". It took just "one minute from the application of the scalpel till the arm, resembling a large ham of bacon and weighing twenty-one and a half pounds, was laid on the floor".³⁶ After the excision of tumours, which afforded the most visible illustration of his surgical prowess, Parker is perhaps best known for introducing the art of lithotomy – 'cutting for stone' – to China. In 1835, Jean Civiale had published the first "true comparative series" of cases he had collected from all over Europe; the mortality rate was "a staggering 1 in 5."³⁷ Thomas King, who in 1832 strongly urged his fellow surgeons to eschew the 'dangerous' operation of lithotomy, concluded one in seven or eight patients submitting to the 'lateral' operation would die.³⁸

Parker did not turn patients with bladder stones away but he *was* cautious. He removed his first stone by lithotripsy – using forceps to crush the stone so that the debris could be passed naturally – when the hospital had been running for just over six months. Not until he returned from an extended sojourn in the United States and Europe during which he observed the operation at Guy's Hospital (London) did he perform his first lithotomy, in July 1844. His patient was a thirty-five year old resident of Canton. The operation, the "first instance ..., either in ancient or modern times, which has been performed upon a Chinese" was a success – "not an unfavorable symptom followed." It heralded "a new era" in the life of the hospital.³⁹

Parker's 'new era', preceded the discovery of the anaesthetic properties of sulphuric ether by almost three years. He used opium to calm patients before major surgery and wine or brandy during the operation. Parker started using

36 Case 2152, Peter Parker, "Ophthalmic Hospital in Canton: The Fourth Quarterly Report, for the term ending on the 4th (sic) of November, 1836", *Chinese Repository*, Vol. 5 (7) 1836, pp. 329–331.

37 Jan P. Vandenbroucke, "Commentary: Treatment of Bladder Stones and Probabilistic Reasoning in Medicine: an 1835 Account and its Lessons for the Present", *International Epidemiological Association*, Vol. 30 2001, p. 1256.

38 Thomas King, *Lithotripsy and Lithotomy Compared: Being an Analytical Examination of the Present Methods of Treating Stone in the Bladder. Remarks on the General Treatment of Gravel and Stone* (London: Longman, Rees, Orme, Brown and Green, 1832), p. 104.

39 Peter Parker, "The Thirteenth Report of the Ophthalmic Hospital, Canton, including the period from 1st January 1844, to 1st July, 1845.", *Chinese Repository*, Vol. 19 (10) 1845, pp. 452–455.

ether in mid-1847, a mere nine months after it had been first demonstrated at the Massachusetts General Hospital in October, 1846. Along with most of his fellow practitioners, he switched to using chloroform soon after James Simpson described it in late 1847. Once he had mastered the art of administering anaesthetics, the rate at which he treated patients suffering from bladder stones increased dramatically.

Parkers Patients' Outcomes

Parker registered over 53,000 patients in 19 years at Canton⁴⁰ and, despite performing some of the most dangerous operations of the day, was never ordered to cease practising. He published detailed accounts of 248 patients 75.3 per cent of whom he described as leaving hospital 'cured', 'healed', 'healing' or 'well', in other words the outcome, as far as Parker knew, was positive.⁴¹ Nineteen died, a remarkably low death rate of 7.7 per cent which was more comparable to the data Simpson collected from country surgeons operating in one-roomed miners' cottages than that from crowded hospitals.⁴² It is important to note that Parker's establishment, like all mission hospitals, was always crowded.⁴³ Moreover, since the 248 patients suffered disproportionately from the more serious diseases (with the majority requiring surgery) this was not a representative sample. For instance, Parker was thirteen times more likely to expand upon the details of tumours he treated than would have been the case had he reported them in proportion to his patients as a whole.⁴⁴ He detailed thirty-two cases of lithotomy, that is, 12.9 per cent of the 248 cases, but patients with bladder stones comprised less than half of one percent of the total hospital population.⁴⁵

Approaching a medical missionary and submitting to surgery was the last resort for many patients. According to Parker's records, nearly one in four had had their complaint for more than ten years. On average, patients had suffered with tumours or bladder stone for between seven and eight years but could have had the disease for up to twenty-three years in the case of bladder stones

40 J.D. Key, J.A. Callahan and W. Walters, "Hog Lane Surgery (Ophthalmic Hospital, Canton, China)", *Minnesota Medicine*, Vol. 69, 1986, p. 283.

41 Of the 248 cases, details of results were present in 237.

42 See data in Simpson, *Hospitalism*.

43 See Renshaw, *Accommodating the Chinese*, pp. 59–62.

44 Tumours (981) accounted for 2.24% of the 43,762 patients registered between November 1835 and December 1851 but 29.4% of those detailed in reports.

45 172 of the 43,762 patients.

and up to thirty years in the case of tumours.⁴⁶ Parker's detailed cases refer disproportionately to these long-term diseases, making his low death rate even more remarkable.

Parker's low reported death rate might seem to be an instance of him wanting to give his readers at home good news. But the evidence suggests otherwise: his reports, aimed at both lay and professional readers, did not avoid reporting deaths but reported them more rather than less often. He was keen to demonstrate to his supporters that the Chinese authorities sanctioned his hospital and used deaths to draw attention to the lack of difficulty encountered from officials when they occurred. For example, in early 1836 Parker reported that a 44 year old man, suffering from "asthma and opium-mania" had become the first person to die in the hospital and the "corpse was removed and no difficulty ensued."⁴⁷ Three years later in February 1839, another patient, a woman suffering from "dropsy and disease of the heart and liver" had journeyed a long distance by boat to the hospital by herself. When she died there was no family to arrange a burial. In a letter to the *Canton Register* Parker described how Magistrate Nanhai Lew had been called by the *hong* members to carry out the first inquest at the hospital. Fortunately Lew and members of his family and office were among Parker's ex-patients⁴⁸ Lew did however conduct a "lengthy enquiry into Parker's qualifications and treatment ... before he was satisfied."⁴⁹ He ordered the burial with "not a single word of disapprobation" much to Parker's relief; the inquest had brought the foreign hospital "distinctly before the government"; and "if no edict follows, such silence (would) be a tacit recognition of the institution."⁵⁰

Of the nineteen people Parker reports as having died under his care only seven died during or following surgery; three of the seventy-three patients with tumours or cancer; two of the thirty-one lithotomy patients and one of the nineteen amputees. His results for lithotomy compare very favourably with

46 Parker, *Reports of the Ophthalmic Hospital at Canton*.

47 Case Number 931, Peter Parker, "Ophthalmic Hospital at Canton: Second Quarterly Report, from the 4th of February to the 4th of May, 1836", *Chinese Repository*, Vol. 5 (1) 1836, p. 36.

48 He had sought medical assistance for the child of a relative within the first six months of the hospital's operation. See, *Ibid.*, p. 33.

49 Roger Houghton, "A Peoples' History 1793–1844 from the Newspapers: Dr Peter Parker has had a Brush with the Law", online at <http://www.houghton.idv.hk/> (accessed August 18, 2013).

50 Peter Parker, "Medical Missionary Society's Hospitals: ... inquest held on the body of a deceased patient in that at Canton", *Chinese Repository*, Vol. 12 (10) 1839, p. 552.

Jean Civiale's one in five or even the one in eight reported by the Norfolk and Norwich Hospital between 1772 and 1862.⁵¹ At University College Hospital, London, the mortality rate following 174 cases of amputation performed during the 1840s was almost twenty-four percent.⁵² Parker's death-rate of 4.9 percent associated with major surgery is impressive: the more so for having been carried out in a converted warehouse, with no running – let alone hot – water, no water closets, no electricity, wooden beds, and no nursing staff. But gross surgical mortality rates are only one way to assess the quality of hospital treatment.

Post-Operative Complications

A better measure of the success of a hospital is the rate at which complications arise following surgery. The British statistician, William Farr (1807–1883) observed that it was rare for patients to die “on the table”; they died from diseases such as erysipelas and pyaemia, for which the hospital – not the surgeon – was responsible.⁵³ As Florence Nightingale said in *Notes on Hospitals*, “careful observers are now generally convinced that ... the appearance and spread of hospital gangrene, erysipelas, and pyaemia generally, are much better tests of the defective sanitary state of a hospital than its mortality returns.”⁵⁴ When a young American, Jonathon Mason Warren, was training in Paris in the early 1830s he wrote to his father (also a surgeon) explaining “they are very cautious how they amputate here as more than two thirds of their patients die after it.” Warren attributed the high loss of life to the manner of dressing surgical wounds and consequent post-operative infections.⁵⁵ Post-operative complications were as rare in Parker's practice as were deaths.

Only ten of one hundred and forty-eight patients on whom Parker performed major operations suffered *any* post-operative complications. The most

51 Vandenbroucke, “Treatment of Bladder Stones”, p. 125.

52 Peter Stanley, *For Fear of Pain, British Surgery, 1790–1850*, The Wellcome Series in the History of Medicine (Amsterdam; New York: Rodopi, 2003), p. 153.

53 William Farr (1807–1883), was appointed as the first “compiler of abstracts” (chief statistician) in the Office of the Registrar-General when it was established in 1838.

54 Florence Nightingale, *Notes on Hospitals*, 3d ed. (London: Longman, Green, Longman, Roberts, and Green, 1863), p. 16.

55 Letter to his father dated January 9, 1833. Jonathan Mason Warren, John Collins Warren and Russell Moseley Jones, *The Parisian Education of an American Surgeon: Letters of Jonathan Mason Warren, 1832–1835* (Philadelphia: American Philosophical Society, 1978), p. 95.

severe was a lone case of gangrene following Parker ligaturing the external femoral artery to treat Wang Kiang, a thirty-two year old fruiterer, for “popliteal aneurism of the leg.”⁵⁶ In response, Parker amputated the limb at the thigh with no adverse consequences and Wang recovered completely.⁵⁷ Not a single case of pyaemia or erysipelas, the curse of hospitals in the West, supervened on an operation in the Canton Hospital.

If Parker’s patients had been sickening and dying from post-operative infections we would have not only have seen him reacting like his counterparts in America – “wards would be closed, aired, scrubbed, fumigated and white-washed in an attempt to be rid of the scourge”⁵⁸ – we would have seen officials acting to close down his hospital. Parker certainly closed the hospital from time to time because of politics, war or for repairs, but *never* on account of infection or official edict.

A detailed analysis of Parker’s cases makes clear that the clinical medicine he practised was not extraordinary by the standards of his time: as Roland concluded from an assessment of Parker’s *materia medica* and procedures: “there seems no doubt his general standard of practice – medical and surgical – conformed closely to that recommended by the experts of the day.”⁵⁹ And, according to Zhao, missionary doctors were not “bringing technology or clinical skills superior to those already available in China.”⁶⁰ What *was* different were his circumstances: he was a *missionary* running a hospital in China.

Parker’s Circumstances

In nineteenth-century America, hospitals were still relatively rare and the last resort of the poor, the homeless, the friendless, or the desperate. Anyone who could afford it was treated in their own home by their personal doctor. The most persuasive argument for establishing a public hospital was as a site for training medical students and for doctors conducting research. In the early 20th century

56 Using the “Hunterian technique” named for “Father of Surgery”, John Hunter (1728–1793), the pioneer of using ligature to treat popliteal aneurysm, 1785.

57 Case 39434, Parker, *Sixteenth Report*, p. 31.

58 Stanley, *For Fear of Pain*, p. 15.

59 Charles Roland and Jack D. Key, “Was Peter Parker a Competent Physician?”, *Mayo Clinic Proceedings*, Vol. 53 (2) 1978, p. 127.

60 Zhao Hongjun, “*Jindai Zhongxiyi lunzheng shi* (History of the Modern Controversies over Chinese vs. Western Medicine)”, *Chinese Science*, Vol. 10 1991, p. 22.

some western doctors in China would use this aspect of hospitals to encourage others to join them. China was, they said, the

finest place in the world to find clinical material ... the field is enormous, the patients are unlimited; it is quite as easy to get a thousand eye patients or skin patients or general surgical patients as it is to get a thousand mixed patients.⁶¹

But Parker and his contemporaries did not view *their* patients as 'clinical material'. For them, medicine was still subservient to evangelism – they were saving lives in order to save souls. In America the death of someone routinely referred to as 'clinical material' might have been regretted but did not put the doctor in mortal danger or force the hospital to close. The legal and political situation of the medical missionary in Qing China demanded doctors limit their risk.

Managing Risk

First, Parker tried to restrict his exposure by turning away those he doubted he could help: any who had, as he put it, "a cough, a fever, or any other disease that requires the physician rather than the surgeon." He found refusing to admit "those who are within reach of remedial powers ... very unpleasant" and feared it could harm his larger venture.⁶² It didn't. His records show that he treated only a very tiny number of patients for "intermittent fever" (especially in the early years) but the hospital was never short of patients.⁶³ Operating before the germ theory of disease was formulated, his purpose in restricting patient intake was not necessarily to limit cross-infection rates, but the absence of people in the hospital with an infectious disease would surely have gone some way to lower it.⁶⁴

61 W. Hamilton Jefferys and James L. Maxwell, *The Diseases of China* (Philadelphia: P. Blakiston's Son & Co., 1910), p. 3.

62 Peter Parker, "Ophthalmic Hospital at Canton: the Sixth Quarterly Report, for the term ending on the 4th of May, 1837", *Chinese Repository*, Vol. 6 (1) 1837, p. 35.

63 See lists of diseases treated included in Reports of the Ophthalmic Hospital at Canton, 1835–1851.

64 It was not uncommon for general hospitals in America to restrict their patient population, see Renshaw, *Accommodating the Chinese*, p. 132.

Second, Parker selected his patients carefully. However potentially 'interesting' a case might be, it was not unusual for him to explain to a patient or their family that he considered their case "incurable" or that the patient was unlikely to withstand an operation. He advised the parents of a three-year-old child whose nostrils were blocked as a consequence of smallpox to "wait a few years, when the operation for restoring the passages can be better performed and more easily endured by the child."⁶⁵ He told another father an operation could not save his three-year-old daughter whose face had been attacked by gangrene three days previously following an episode of measles. The father accepted the advice and "preferred to take her home to die."⁶⁶ Parker observed that a one-year old child with a "congenital tumor" about the size of a hen's egg was "wary of it being handled." As the boy's health "seemed not to be compromised," he advised the parents "not to interfere."⁶⁷

Once selected, Parker's patients were well cared for both before and after surgery. Preparation for an operation regularly involved a course of purgatives as well as a prescribed diet, moderate exercise and abstinence from alcohol, meat, tobacco or opium.⁶⁸ He often mentioned delaying surgery until a "more suitable time". He was not adopting the Chinese practise of consulting the almanac for propitious dates but, rather, awaiting suitable weather.⁶⁹ As far as post-operative care was concerned, my analysis of Parker's case notes suggests his treatment of wounds compared favourably with that outlined by the Professor of Clinical Surgery at London University, Robert Liston (1794–1847).⁷⁰ Parker operated in a relatively antiseptic environment. He does not specifically mention washing in relation to his own hands or instruments but he frequently reports cleaning wounds with (antiseptic) chemicals such as 'chloride of lime',

65 Peter Parker, "Twelfth Report of the Ophthalmic Hospital at Canton: from 21st November, 1842, to December 31st, 1843", *Chinese Repository*, Vol. 13 (6) 1844, p. 307.

66 *Ibid.*, p. 309.

67 *Ibid.*, p. 310.

68 See G.D. Pollock, "Hospital Practice: St. George's Hospital", *British Medical Journal*, Vol. 6 (February 7) 1857, p. 101 on the danger of the "morbid condition in persons excessively reduced by previous disease ... [latent pyæmia]."

69 For example see Case No. 446, "while the heat of midsummer not a little increased the hazard of such a measure (removal of a tumour which 'grew rapidly and was fast tending to suppuration') ... it was resolved to embrace the first favorable day for the operation". Peter Parker, "Ophthalmic Hospital at Canton: Third Quarterly Report, for the term ending on the 4th of August, 1836", *Chinese Repository*, Vol. 5 (4) 1836, p. 188.

70 Robert Liston, "The Dressing and Healing of Wounds", *Lancet*, Vol. 24 (609) 1835, pp. 135–138.

poultices and soap. The astringents he used, including silver nitrate and copper sulphate, would have had the added benefit of acting as antiseptic agents – as would the caustics. He never refers to pus favourably, let alone as ‘laudable.’⁷¹

Parker’s and his colleague’s success in terms of low infection rates did not go unnoticed. Wu Lien-teh described it as no more than “fortunate” that “wound infections, which made the contemporaneous surgical wards in Europe such haunts of horror, were practically unknown in China.”⁷² Parker’s biographer, Edward Gulick, describes the lack of infection as a “puzzle [which] remains.”⁷³ A British missionary, George Tradescant Lay, thought *he* had an explanation. As he wrote in the *Lancet*, “the success which has almost uniformly attended every case” of Parker’s 6,300 patients to date, was not a “miracle” but had “two or three natural causes”, which have “abetted” Parker’s “professional skill in a remarkable manner.” The causes were to be found in the Chinese “constitution,” which was particularly responsive to “every dose of physic”; the Chinese “happy temper,” whereby “inflammation seldom rises to a higher degree than is necessary to set up the healing process”; and Chinese “patience ... and acquiesce” so that the “restorative functions are seldom impeded by fretful or laborious thinking.”⁷⁴ I think the evidence suggests it was neither merely ‘fortunate’ nor a ‘puzzle.’ I have found nothing to support the thesis that the Chinese, by nature, are immune to infection. Beyond medical precautions Parker rigorously employed an administrative approach which served to limit his risk: he involved patients, their relatives and friends in the decision whether to operate or not.

Informed Consent

Students of medicine today are taught, and will argue, that obtaining ‘consent’ before treatment acknowledges a patient’s autonomy. But the doctor’s fear of litigation is more often his motivation.⁷⁵ This fear can cause a doctor to

71 Quoting an 1865 report, “the wound discharging healthy pus and granulating finely’ ... in a word it was an era of laudable pus”. Stewart Marshall Brooks, *Civil War Medicine* (Springfield: C.C. Thomas, 1966), p. 8.

72 Best known for pioneering work in the introduction of modern measures of public health into China following the outbreak of pneumonic plague in Manchuria from 1910–1911. Wu Lien-teh, “Past and Present Trends in the Medical History of China”, *The Chinese Medical Journal*, Vol. 53 (4) 1938, p. 319.

73 Gulick, *Peter Parker*, p. 163.

74 G.T. Lay, “Hospitals at Canton and Macau”, *Lancet*, Vol. 34 (887) 1840, p. 814.

75 For an example of explicit advice to doctors in Hong Kong, see T.J. Hegan, “‘You Never Told

become overly timid. As we have seen, Parker was anything but timid but he did institute a policy of obtaining the patient's 'informed consent' to surgery. This is a routine expectation in America today but in the mid-nineteenth century it was a novelty. The first American case against a doctor who performed an operation without the patient's consent was not brought until 1905⁷⁶ and the landmark case was settled nine years later, in 1914.⁷⁷

According to historians of the subject, to qualify for definition as *informed consent*, *historical evidence* should be tested against the following "(1) a patient ... must agree to an intervention based on an *understanding* of ... relevant *information* (2) consent must *not be controlled* by influences that would engineer the outcome, and (3) the consent must involve the intentional giving of *permission* for an intervention."⁷⁸ Parker's record shows his process more closely met these requirements than a typical nineteenth-century surgeon who had "*advised* amputation of an infected leg and the patient had *agreed* or *consented*."⁷⁹ Parker used a variety of terms besides "consent": for example "permission," "desire" and "indemnity," but his objective was the same in each case: self-protection. Three cases taken from Parker's first hospital report exemplify his policy.

In the case of Akae, mentioned earlier, Parker describes laying out the potential dangers of surgery and "procuring a written instrument signed by both parents ... that the operation was undertaken at their desire."⁸⁰ A young woman named Pang-she had suffered from severe "abdominal dropsy" – retention of fluid – for three years when she and her husband sought Parker's help. Although he "had no particular cause for apprehension ... the possible fatal consequences were stated to the husband ... I told him I would do my best, and he must be content with the result". Her husband was "dissatisfied with the prospect of danger, and urged that I 'secure' success." Parker explained he could not guarantee suc-

Me That Could Happen!" Consent and Litigation: How to Avoid it", *Hong Kong Medical Journal*, Vol. 8 (1) 2002, pp. 63–64.

76 *Mohr v. Williams*, *Supreme Court of Minnesota 1905*, 95 *Minn.* 261, 104 *N.W.* 12., online at http://www.audiocasefiles.com/acf_cases/8656-mohr-v-williams (accessed August 18, 2013).

77 *Basic Right to Consent to Medical Care – Mary E. Schoendorff, Appellant, v. The Society of the New York Hospital, Respondent*, Court of Appeals of New York 1914, 211 *N.Y.* 125; 105 *N.E.* 92, online at <http://biotech.law.lsu.edu/cases/consent/Schoendorff.htm> (accessed August 18, 2013).

78 Ruth R. Faden, Tom L. Beauchamp and Nancy M.P. King, *A History and Theory of Informed Consent* (Cary, NC: Oxford University Press, 1986), p. 54.

79 *Ibid.*, p. 54.

80 Parker, "Ophthalmic Hospital at Canton: First Quarterly Report", pp. 467–469.

cess and would not have operated, as he put it, “but for the resolution of the patient herself.” After an “embarrassing delay” her husband referred the decision to his wife, “which she settled in an instant.”⁸¹

The third case is of a thirteen year old girl brought to the hospital, suffering from “ascites with anasarca” – fluid retention and generalized swelling – of the lower extremities. We don’t know how much information Parker gave her friends but he reports telling them that “they must either take her away, or be satisfied if, after the best I could do, she should die in the hospital.” They were “urgent that she should remain, promising to make no difficulty.”⁸²

That Parker went further than mere formality when seeking ‘consent’ is apparent in the case of a four-year old boy with a tumor in his eye, so advanced the “protruded eye, which came down upon the cheek as low as the mouth, was six or seven inches in diameter.” The child’s fate was obvious if left untreated. Parker warned the father that an operation could be fatal and the father responded “it was better for his child to die than live in such a condition.” Parker went on to explain there was a possibility of the tumor returning “should the operation not prove successful.” The father, armed with this information, “still desired it to be performed.”⁸³

As an example of a number of his patients who “have submitted to operations after the fullest declaration that there was imminent risk, but that death was *inevitable* unless they accepted the *possible* relief” Parker described the case of Leang Ashing, a twenty-seven year old artificial flower maker. Leang had an “enormous tumor upon the right side of his face” which had been developing for ten years. He came to the hospital in August and it was decided he could safely wait for cooler weather before submitting to an operation. When he returned two months later his condition had deteriorated; the tumor was “exceedingly fetid ... and a healthy countenance had given place to the sallow and cadaverous expression of one fast verging to the grave.” Parker advised his patient of the “certainty of a speedy death if left alone, the possible unfortunate termination if extirpated, and the encouraging prospect that he might live for years if he submitted to the operation.” Leang and his brother certified in writing that “they requested the removal of the tumor, and if successful would rejoice; but if otherwise ... it was ‘the will of heaven,’ or fate and no blame would be incurred by the operator.”⁸⁴

81 Ibid., p. 470.

82 Parker, “Second Quarterly Report”, pp. 34–35.

83 Parker, “Third Quarterly Report”, p. 187.

84 Case 1625. Parker, “Fourth Quarterly Report”, p. 325.

Parker, it seems, was giving his patients relevant information and they were giving their express consent, but was he engineering the situation? It would appear not. Not all patients, given the opportunity to choose, consented to an operation. Parker, for example, had no doubt “of the feasibility and desirableness” of removing an encysted tumor from 26 year old Yu Foo’s neck. The patient’s wife, however, was not convinced and it seemed to Parker her unwillingness had caused the thought of the operation to be “more formidable to the man himself.” Parker noted philosophically “whether it shall be attempted or not, depends upon the man and his relations to determine.”⁸⁵

Parker also did more than get *general* consent to surgery – the scope of the consent could be limited; for example, in the case of a thirty-seven year old woman who presented in August 1844 with a tumour. It had been developing for ten years and occupied “the whole extent of her right thigh, and even displaced the patella.” Parker told her and her husband that operating might reveal the tumor to be of an ‘anuerismal character’ in which case the only recourse would be amputation. If, however, it turned out to be merely an ‘encysted tumor’ it could be extirpated with a fair chance of success. The couple made it clear they objected to amputation under any circumstance “as she preferred to die than return to her parents mutilated.” They both “desired the tumor to be removed, and though it should prove to be of a complex character and the bleeding could not be controlled, and she should not survive the operation, still they desired to take this chance of life.” As it happened, she died of exhaustion on the operating table, observed by her husband and her sister. The corpse was removed quietly the next day and there were no “untoward effects.”⁸⁶ Her death was, Parker noted, the “first instance of the kind [on the operating table] that has occurred since the founding of the hospital” almost nine years previously.

Even today when gaining a patient’s consent is *de riguer*, under certain conditions of extreme urgency a doctor may act without it. Parker contemplated such a situation when planning to amputate Po Ashing’s arm.⁸⁷ Po’s father was not present so Parker decided to wait until the next day to operate “unless subsequent symptoms forbade.” The next day the situation had deteriorated causing Parker to worry, “there could be no safe delay, [and] the operation would have been performed immediately but for the absence of the patient’s friends.”

85 Case 2261. Peter Parker, “Ophthalmic Hospital in Canton: the Fifth Quarterly Report, for the term ending on the 4th of February, 1837”, *Chinese Repository*, Vol. 5 (10) 1837, p. 458.

86 Case Number 11,700, Parker, “Twelfth Report”, pp. 310–312.

87 Parker, “Fourth Quarterly Report”, pp. 329–331.

He waited a while longer until “the father and friends of the patient had come, and given the agreement usual in cases liable to fatal termination.”⁸⁸

Parker’s process of gaining consent had been formalized by 1848. Before performing a lithotomy on Chung Ping in July 1848 he received a written indemnity described as a “specimen” of those given “before serious cases and which are said to be valid in Chinese law.” The full text was reproduced in the hospital report of May 1850:

Agreement. I, Chung Ping, thirty-three years of age, ... being afflicted with stone, have several times sought medical aid, yet without avail. Now, fortunately I am under obligation to Dr Parker of America, for employing his knife, and extracting it, and when cured, not merely I, one person, will be bedewed with his favor, but a united family will be grateful for his kindness. Should the mountain from its height, and the water from its depth, be impassable (i.e. should the result be fatal), it shall not concern the Doctor; all will acquiesce in the will of heaven. Lest oral evidence be invalid, I make this written agreement, and deliver it to the Doctor to hold as evidence.

Taukwang, 28th year, 6th moon, 5th day (5th July 1848) (signed) Chung Ping.⁸⁹

The discussions Parker held with his patients and their families would not only have gone some way to protecting him from legal and political consequences but, by limiting surgery to those who agreed after hearing of the attendant risks, his surgical list was restricted to those with more assurance of success. Parker set the standard for those who followed such as Benjamin Hobson (1816–1873) who counselled in 1855, “(r)egard must be had to the wishes of the patient’s friends. One unsuccessful case, without the full consent of the patient and his relatives, would endanger the reputation of the hospital, and give ground for the unjust and injurious remark, ‘the doctor killed the patient.’” He found it “necessary to divide the responsibility in undertaking operations that involve danger to life, and ... wise to only perform those that hold out a very favourable hope of recovery.”⁹⁰

88 Ibid., p. 330.

89 Peter Parker, “Fifteenth Report of the Medical Missionary Society’s Ophthalmic Hospital at Canton, for the years 1848 and 1849”, *Chinese Repository*, Vol. 19 (5) 1850, p. 260.

90 Quoted in Lockhart, *Medical Missionary in China*, p. 188.

Favourable Circumstances

There was only so much Parker and his colleagues could do medically or administratively to limit their exposure to the law or to adverse public opinion. However some of the legal circumstances in China proved to be ‘favourable’ for medical missionaries. For example, dissection of human bodies and post-mortem examination were banned and not legalised until the early Republican period.⁹¹ Dissection was no more legal in America than in China – the Bill legalizing the study of anatomy and the dissection of dead bodies would not be passed in New York State until 1854 – but that hadn’t stopped the New York Medical College advertising, “Obstetrical cases and subjects for dissection are abundantly furnished for the students” in the same issue of the *New York Medical Times* in which the New York Academy of Medicine called for legislation.⁹²

Being concerned with “changes of state, dynamic and psychic factors, function rather than substance”⁹³ Chinese medicine had no need for anatomical knowledge in the way western medicine did. Or as a Sichuan practitioner, Tang Zonghai (1846–1897), put it: “Westerners know only the shape and structure of the body, and not the functional activity of the vital spirit *qi*.”⁹⁴ If there was no need for anatomy teaching there was no need for dissection and if the disease that caused someone’s death was not to be found within an organ there was no need for autopsy. In other words, there had been no imperative for Chinese doctors to find ways around the law. A more popular justification for the failure to study comparative anatomy using dissection by the Chinese is found in the notion of Confucian filial duty: “the human body was considered a gift from the ancestors that should be preserved intact; mutilation or dissection of a corpse

91 Post-mortems had been performed on rare occasions earlier in the century but were legalised in November 1913 and the use of dead bodies for teaching purposes, in April 1914. K.C. Wong and Wu Lien-teh, *History of Chinese Medicine: Being a Chronicle of Medical Happenings in China from Ancient Times to the Present Period*, 2nd. ed. (Shanghai: National Quarantine Service, 1936), pp. 597–599.

92 “Proceedings of Societies: New York Academy of Medicine”, *New York Medical Times*, Vol. 3 (2) 1853, p. 69.

93 Manfred Porkert and Christian Ullman, *Chinese Medicine as a Scientific System: Its History, Philosophy, and Practice, and how it fits with the Medicine of the West* (New York: Henry Holt and Company, 1982), p. 30.

94 Ma Kanwen, “East-West Medical Exchange and their Mutual Influence”, in R. Hayhoe (ed.) *Knowledge Across Cultures-Universities East and West* (Hubei: OISE Press, 1993), pp. 154–181. From, Tang Zonghai, *Zhongxi huitong yijing jinyi* (Essence of Medical Classics in the Confluence of Chinese and Western Medicine).

was perceived as disrespectful to the whole lineage."⁹⁵ Thus Chinese law and popular belief acted in concert and in China the law was obeyed.

As "a service to the living," in 1838, Parker did offer a family \$50 to be allowed to take a tumor for examination from a man who had refused an operation and subsequently died at home. His request was refused and he doubted \$500 would have been enough to "overcome their superstition."⁹⁶ Whilst Parker regretted the opportunity to undertake autopsies, other missionaries were scathing in their denunciation of the Chinese attitude to dissection:

so long as it is considered unfilial and wicked to make a breach or wound upon the dead, there is not much hope that this obstacle to improvement will be removed. ... All study of animated nature is neglected and despised; error is preferred to truth, and the ignorant sayings of their ancient literati, before the splendid discoveries of modern experimental science.⁹⁷

That they observed the prohibition on autopsy and dissection proved to be fortuitous. This would become obvious after Semmelweiss (1818–1865) demonstrated (in 1847) that a major source of puerperal fever was the "cadaver of any age, of either sex, without regard to the antecedent disease."⁹⁸ Doctors and students carried, what he called, "decomposed animal organic material" from diseased bodies to a parturient woman or newly-operated-upon patient. It was not until after Joseph Lister had fought his battle against the entrenched attitudes of surgeons, who could not admit they were responsible for the death of so many of their patients, that surgery would become relatively safe in the 1880s. The situation described by Liston where

Sponges were indiscriminately used for the washing of all and sundry sores and sloughings, for the post-mortem examinations, and for the operations upon the living body⁹⁹

95 Frank Dikotter, *The Discourse of Race in Modern China* (Stanford, CA: Stanford University Press, 1992), p. 41.

96 Peter Parker, "Ophthalmic Hospital at Canton: the Eighth Report including the period from January 1st to June 30th, 1838", *Chinese Repository*, Vol. 7 (2) 1838, p. 105.

97 Benjamin Hobson, "Report to the Committee of the Medical Missionary Society, Hong-kong", *Chinese Repository*, Vol. 17 (5) 1848, p. 256.

98 Extract of "The Concept of Child Bed Fever" by Ignaz Phillip Semmelweiss in Logan Clendening, *Sourcebook of Medical History*, 2nd ed. (Mineola, NY: Dover, 1960), p. 607.

99 Liston, "The Dressing and Healing of Wounds", p. 137.

simply could not happen in a Chinese mission hospital. There was no dissecting room. Not only were dissection and autopsy absent from Chinese hospitals, dead bodies were not kept there for any length of time.¹⁰⁰ Parker's concern to avoid giving the authorities cause to close his hospital meant family and friends were responsible for the timely removal of bodies. As Parker records in his very first Report, "even the burial of the corpse was a subject of forethought and agreement."¹⁰¹

Conclusion

By 1905 there were 164 mission hospitals in China and by 1919 this number had almost doubled to over 310.¹⁰² Medical missionaries had gained legitimacy in their own right and were no longer viewed merely as a means to an evangelical end.¹⁰³ I have argued that because the political climate in China was hostile, missionaries used medicine – especially surgery – to gain access to the people they hoped to convert. Given the legal and political situation in China and the state of Western medicine in the mid-nineteenth century this was a potentially dangerous strategy. Fearful of losing the right to practise medicine and thus their mission, they took measures to minimise their risk. The precautions they took ranged from selecting patients with a favourable prognosis, preparing them to withstand the rigours of surgery and caring for their wounds post-operatively. As we have seen, Parker's record of success, particularly in avoiding post-operative infection, is testament to his skill and care. As missionaries they were more focussed on saving the patient to save his soul than they were in using him as 'clinical-material' for research or teaching.

Autopsies were not conducted and student training did not include dissection. Running a hospital in nineteenth-century China was quite unlike doing the same in the British colonies Mark Harrison describes where "[i]nvestigative autopsies were conducted as a matter of routine."¹⁰⁴ In Britain, according

100 See "Death and Dying" in Renshaw, *Accommodating the Chinese*, pp. 191–194.

101 Parker, "Ophthalmic Hospital at Canton: First Quarterly Report", pp. 467–469.

102 Henry Fowler, "Medical Mission Policy", *China Medical Journal*, Vol. 37 (2–3) 1923, p. 251.

103 See W.J. Sheils (Ed.), *The Church and Healing* (Oxford: Basil Blackwell, 1982); Theron Kue-Hing Young, "The William Osler Medal Essay: A Conflict of Professions: The Medical Missionary in China, 1835–1890", *Bulletin of the History of Medicine*, Vol. 47 (3) 1973, pp. 250–272.

104 Mark Harrison, *Medicine in an Age of Commerce and Empire: Britain and its Tropical Colonies, 1660–1830* (Oxford: Oxford University Press, 2010), p. 289.

to Harrison, the “supply of bodies for dissection was still severely restricted” but not so in the colonies where “cadavers were plentiful.”¹⁰⁵ In contrast, Western Hospitals in China were characterized by the *absence* of the dead; to avoid antagonising the family it suited the missionary to comply with the Chinese desire for patients to die at home or, at least, for their bodies to be quickly removed from the hospital.

Parker protected himself and his mission by only operating once he had obtained the informed consent of his patient and the family. In doing the latter, Parker pioneered a new concept. In America and Britain the notion of patients' rights in terms of consent was still half a century away.¹⁰⁶ Whether Parker's use of informed consent in China influenced practice in the West is not knowable but his reports *were* widely disseminated. Not only did he distribute them in the form of individual pamphlets, his reports were reproduced in their entirety in the *Chinese Repository*. Knowledge of Parker's surgical endeavours would have reached a wider audience through the *Lancet*: at least three articles, published in 1837 and 1840, included references to his requiring and obtaining consent or respecting the patient's decision not to consent.¹⁰⁷

Ironically, it appears that, because, in a hostile political and legal environment saving the *mission* was the top priority, many Chinese lives were saved and patients' autonomy was advanced. Hippocrates' was right, circumstances matter.

105 Ibid., p. 4.

106 It was not unknown but, equally, it was not common and often coerced. See Stanley, *For Fear of Pain, British Surgery, 1790–1850*, p. 191.

107 See A. Currie, “Ophthalmic Hospital, Canton”, *Lancet*, Vol. 28 (724) 1837, p. 608.; G.T. Lay, “Diseases Among the Chinese: Tumours”, *Lancet*, Vol. 34 (888) 1840, pp. 851–853; Lay, “Hospitals at Canton and Macau”, Vol. 34 (887), 1840, pp. 814–815.