MEDICAL EXAMINER

In Medicine We Trust

Should we worry that so many of the doctors treating Ebola in Africa are missionaries?

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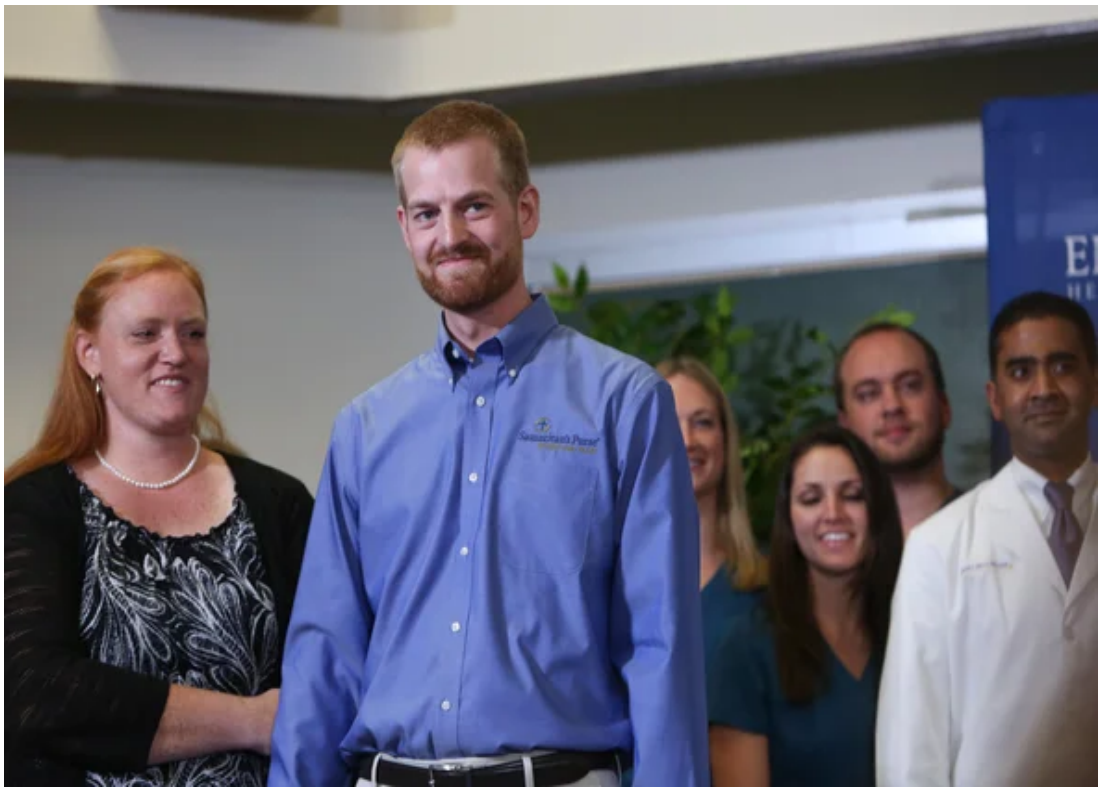
OCT 02, 2014 • 9:49 AM



Dr. Kent Brantly during his release from Emory Hospital after treatment for the Ebola he contracted in Liberia.

Photo by Jessica McGowan/Getty Images

I recently sat in on a course for infectious disease specialists in Austria. Around 40 young doctors and academics were discussing infection control in hospitals and communities in the developing world, and the talk inevitably turned to Ebola. Controlling the spread of the disease continues to challenge the medical world, but there is consensus on one issue. "MSF is the only group on the ground," said one doctor, using the French acronym for Doctors Without Borders. "They are the only ones making any difference." The congregation nodded in agreement.

The statement was probably intended as a jibe at the World Health Organization and the U.S. Centers for Disease Control and Prevention, but it slighted another group by omission: missionaries. Missionary doctors and nurses are stationed throughout Africa, in rural outposts and urban slums. Rather than parachuting in during crises, like some international medicine specialists, a large number of them have undertaken long-term commitments to address the health problems of poor Africans.

And yet, for secular Americans—or religious Americans who prefer their medicine to be focused more on science than faith—it may be difficult to shake a bit of discomfort with the situation. Our historic ambivalence toward missionary medicine has crystallized into suspicion over the past several decades. It's great that these people are doing God's work, but do they have to talk about Him so much?

Missionaries have been dealing with this kind of criticism for a very, very long time. More than a century ago, the undercurrent of discontent with missionary work had already become so widespread that experienced missionary James Levi Barton penned a book-length defense of his career. Many of his

points are, even to my modern ears, reasonably persuasive. No one complains when the West crams its commercial values down the throats of Africans, Indians, and Chinese, he pointed out in 1908. We insist that these unfortunate, uncivilized people buy our wheat flour and bicycles, even though rice and rickshaws are probably just as good. How is that different from what missionaries do? They simply offer Christianity rather than consumerism.

There's one other big difference between missionaries and Western merchants: The missionaries don't profit personally from their work. They are compensated very poorly, if at all. Many risk their lives. How many people would risk death to spread the gospel of Western consumer goods gratis?

The Ebola crisis, and the role missionaries are playing in it, has brought dislike of missionary work out into the open. When an infected American missionary was flown back to the United States for treatment, Donald Trump griped that do-gooders trying to save Africa should be prepared to "suffer the consequences." Ann Coulter called the doctor "idiotic," and asked of his mission to Africa, "What was the point?"

Obviously, Trump and Coulter don't speak for the majority of Americans. Trump is a publicity-obsessed birther who says he "couldn't care less" what doctors say about vaccines. Coulter somehow manages to be more offensive than Trump, calling the president childish names and insisting that God wants us to "rape" the earth.

Still, a fair number of Americans were thinking a much milder, less offensive form of what those two shock merchants wrote. I'll hold my own hand up. I still don't feel good about missionary medicine, even though I can't fully articulate why.

There are a few legitimate reasons to question the missionary model, starting with the troubling lack of data in missionary medicine. When I write about medical issues, I usually spend hours scouring PubMed, a research publications database from the National Institutes of Health, for data to support my story. You can't do that with missionary work, because few organizations produce the kind of rigorous, peer-reviewed data that is required in the age of evidence-based medicine. A few years ago in the *Lancet*, Samuel Loewenberg wrote that there is "no way to calculate the number of missionaries currently operating in Tanzania," the country he was reporting on. How can we know if they're effective, or how to improve the health care systems they participate in, if we don't even know how many missionary doctors there are?

There are serious questions about the quality of care provided by religious organizations in Africa. A 2008 report by the African Religious Heath Assets Programme concluded that faith-based facilities were "often severely understaffed and many health workers were under-qualified." Drug shortages and the inability to transport patients who needed more intensive care also hampered the system.

There is also a troubling lack of oversight. Large religious health care facilities tend to be consistent in their care, but the hundreds, if not thousands, of smaller clinics in Africa are a mystery. We don't know whether missionary doctors are following international standards of care. (I've heard murmurs among career international health specialists that missionaries may be less likely to wear appropriate protective equipment, which is especially troubling in the context of the Ebola outbreak.) We don't know what happens to the patients who rely on missionary doctors if and when the caregivers return to their home countries. There are extremely weak medical malpractice laws (and even weaker court systems to enforce them) in much of sub-Saharan Africa, so we have no sense whatsoever of how many mistakes missionary doctors are making. We don't know how many missionaries are helping to train new doctors and nurses in the countries where they work—the current emphasis of international health delivery.

And yet, truth be told, these valid critiques don't fully explain my discomfort with missionary medicine. If we had thousands of secular doctors doing exactly the same work, I would probably excuse most of these flaws. "They're doing work no one else will," I would say. "You can't expect perfection."

I'm not altogether proud of this bias—I'm just trying to be honest. In his *Lancet* article, Lowenberg quotes a missionary who insists he does not proselytize, even though he tells his patients, "I'm treating you because of what God has given me and his love for me." That statement—which strikes me as obvious proselytizing— suggests that some missionaries are incapable of separating their religious work from their medical work. Whether implicitly or explicitly, some missionaries pressure their patients, at moments of maximum vulnerability and desperation, to convert. That troubles me. I suspect that many others have the same visceral discomfort with the mingling of religion and health care.

Like it or not, though, we are deeply reliant on missionary doctors and nurses. The 2008 ARHAP report found that in some sub-Saharan African countries 30 percent of health care facilities are run by religious entities. That system is crumbling due to declining funding, possibly motivated in part by growing Western suspicion of missionary medicine. We have a choice: Swallow our objections and support these

facilities, spend vast sums of money to build up Africa's secular health care capacity immediately, or watch the continent drown in Ebola, HIV, and countless other disease outbreaks.

As an atheist, I try to make choices based on evidence and reason. So until we're finally ready to invest heavily in secular medicine for Africa, I suggest we stand aside and let God do His work.

Read more of Slate's coverage of Ebola.

Religion Ebola

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