

AGENTS OF EMPIRE: THE MEDICAL PROFESSION IN THE CAPE COLONY, 1880–1910

by

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British imperial control and the civilizing mission of the empire were imposed by a variety of means in the nineteenth century. The role of the missionary in this process has been well studied. By contrast, the contribution of the doctor has been curiously neglected. H. A. C. Cairns, in *Prelude to imperialism* for instance, has referred extensively to David Livingstone and to Robert Laws, one of the founders of the Livingstonia Mission in Nyasaland (Malawi). Livingstone, he contends, was “ultimately unclassifiable in terms of vocational criteria” and he never mentions that both were doctors.¹ In the eyes of historians, the imperial role of the medical profession has been much less visible than that of the missionaries, yet it could be argued that they contributed significant elements to empire.² Except as missionaries, doctors were rarely pioneers in the imposition of imperial control. Their role came later, when a government infrastructure began to develop. In South Africa, medical men contributed as administrators and technocrats to the creation of the efficient, paternalist administrations so prized by the imperial pro-consuls of the Cromer school. In attempting to introduce sanitary concepts and to reform public health, doctors tended to reinforce and legitimize the values of the white ruling groups. Their influence was pervasive in a hybrid colony like that of the Cape, part colony of white settlement, part colony of conquest. As they were often amongst the few educated men in small rural communities, and the only ones who were scientifically trained, they were the means by which sanitary concepts, so central to Victorian middle-class views of civilized society, were transmitted to the remoter corners of the colony.³ As “agents of empire” at the Cape, the medical profession played a complex role as healers, educators, and rulers.

This article attempts to examine the impact of the developing medical profession on the Cape Colony from 1880, just after diamonds were discovered, until 1910, when the

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¹ H. A. C. Cairns, *Prelude to imperialism. British reactions to Central African society 1840–1890*, London, Routledge & Kegan Paul, 1965, p. 7.

² Amongst the few exceptions are T. J. Johnson and M. Caygill, ‘The British Medical Association and its overseas branches: a short history’, *J. Imp. Commonw. Hist.*, 1972–3, 1: 303–29; K. J. McCracken, ‘Scottish medical missionaries in central Africa’, *Med. Hist.*, 1973, 17: 188–191; R. MacLeod and M. Lewis, (editors), *Disease, medicine and empire*, London, Routledge, 1988; David Arnold (ed.), *Imperial medicine and indigenous societies*, Manchester University Press, 1988.

³ B. Haley, *The healthy body and Victorian culture*, Cambridge, Mass., Harvard University Press, 1978.

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colony entered the Union of South Africa. It argues that doctors were able to exert a substantial influence on colonial reform only after the profession had become effectively organized and the elements of a public health system had begun to develop. As individuals, however, they possessed a personal influence in local communities when they became absorbed into the local hierarchies. Medical missionaries stood somewhat apart from the rest of the profession since they placed a greater emphasis on the moral function of medicine, yet, in the last resort, this difference was one of degree rather than kind.

By 1880, the boundaries of the Cape Colony in practice embraced the diamond fields of Griqualand West, centred on Kimberley, and the African territories of the Transkei. The population was not large and was thinly scattered, the only sizeable towns being the capital, Cape Town, Kimberley, and Port Elizabeth. The colony received responsible government in 1872 but remained essentially impoverished and dependent on wine and wool for its economic survival. The discovery of gold in the Transvaal in 1886 changed the picture radically, both demographically and economically.

POPULATION CHANGE ACCORDING TO THE CAPE CENSUSES

	White	Coloured ⁴	African ⁵	Total
1875	236,783	98,561	385,640	720,984
1891	376,987	312,101	838,136	1,527,224
1904	579,741	405,726	1,424,787	2,409,804

Despite the new-found affluence of the colony, prosperity was uncertain. It was generated in the north, and the Cape economy became parasitic. Booms and slumps distinguished its history, with the peak years in the 1890s and depression after 1904. The influx of population led to rapid urbanization in a colony in which agricultural interests had always predominated. Even so, towns were small, Cape Town reaching 77,662 in 1904. Most new residents were British immigrants who remained in the urban areas. Cities like Cape Town were predominantly English by the turn of the century. The Dutch were ousted from economic, political, and cultural control, and the British filled the ranks of the civil service as well.⁶ A significant minority of new residents were Jewish refugees from Eastern Europe. Unlike the situation in the colony of Natal, there were not many Indian immigrants, although there were enough small traders to encourage the Cape to restrict their entrance into the colony in 1902. The development of medicine at the Cape needs to be seen in this context of rapid demographic change and growing resources in the 1890s.

British immigrant doctors came to the Cape primarily because of the possibilities offered by the expansion of imperial control. While they were not specifically recruited for the purpose, the majority appear to have shared assumptions about the superiority of British civilization. Their understanding of this civilization was shaped by the urban experience of industrializing Britain. Civilization was equated less with political

⁴ The definition of this category varies wildly in the different censuses.

⁵ The great increase arises from the incorporation of the Transkei into the Cape Colony.

⁶ J. V. Bickford-Smith, 'Commerce, class and ethnicity in Cape Town, 1875 to 1902', Ph.D. thesis, University of Cambridge, 1988, pp. 96-8.

freedom than with a clean water supply and a society educated in sanitary principles. In many respects, the character of the Cape medical profession was probably not strikingly different from that in Britain or other parts of the Empire. Its most notable feature was the overwhelming predominance of British-born and British-trained doctors.⁷ This was anomalous in the Cape, where English-speaking colonists were a minority.⁸ Between 1880 and 1910, the number of doctors on the Cape register trebled. Many may have been driven out of Britain by excessive competition.⁹ The second Anglo-Boer War (1899–1902) put the country on the map, medically speaking, and these years saw a flood of names added to the Cape register. Many of these doctors first entered the country as medical officers attached to the British army. As military doctors, they made a considerable contribution to the care of wounds but their long-term influence on the Cape was limited compared with the Transvaal and the Orange Free State, where an anglicized administration was created from scratch.¹⁰ A significant proportion left the country when severe depression struck in 1904, so their impact was brief.

NUMBERS ON THE CAPE REGISTER¹¹

1880	1885	1893 ¹²	1895	1900	1905	1909
306	422	512	522	720	868	961

An analysis of 1,593 doctors on the Cape register between 1880 and 1910 provides a more detailed picture. As might be expected, the great majority of Cape doctors were general practitioners. Few possessed the most prestigious British qualifications, such as the FRCP or English university degrees, although by the 1890s London and Cambridge MDs were becoming more common. Only one London FRCP placed his name on the Cape register. The English FRCS appeared occasionally—three in 1880 and 29 altogether between 1880 and 1910. The Scottish universities, on the other hand, were popular. The single most usual qualification in 1880 was the English MRCS, held

⁷ The same appears to be true of Australia. B. Egan, ‘“Nobler than missionaries”’: Australian medical culture c.1880–c.1930’, Ph.D. thesis, Monash University, 1988, pp. 42–3. Permission to cite this reference was given by Dr Egan, who kindly provided this information.

⁸ Exact figures cannot be ascertained since the Cape censuses made no distinction between Dutch- and English-speaking Whites.

⁹ The scale of the influx suggests that the situation in Britain had not changed very much since the first half of the century, when the excessive number of general practitioners, struggling to make a living, worked “in deadly competition” with one another. I. Loudon, ‘Two thousand medical men in 1847’, *Bull. Soc. soc. Hist. Med.*, 1984, 33: 8.

¹⁰ See E. Lee, *To the bitter end. A photographic history of the Boer War 1899–1902*, Harmondsworth, Viking, 1985, pp. 66–84, 109–13, 179–90; J. C. de Villiers, ‘The medical aspect of the Anglo-Boer War 1899–1902’, *Milit. Hist. J.*, Dec. 1983, 2: 63–70; June 1984, 3: 102–8.

¹¹ Since the early registers were very inaccurate, these figures are not exact.

¹² This was the first register to be published after the passing of the 1891 Act. At this time many names were removed from the register, although even so the figures are misleading since increasing numbers of doctors practising in other colonies and states in southern Africa registered in the Cape. The *South African Medical Record* calculated that the 1903 register was the first to be reasonably accurate. Of 844 names on the register it estimated that 141 were dead, resident elsewhere, or out of practice. This left 740–50 medical men in practice in the colony at that date. *S. Afr. med. Rec.*, Dec. 1903, 1(10): 163.

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by 128 doctors of 306 on the register, but it was not usually combined with the LSA as had occurred in mid-Victorian England.¹³

GENERAL DISTRIBUTION OF QUALIFICATIONS ON THE CAPE REGISTER

	Eng.lic.	Eng.deg.	Sc.lic.	Sc.deg.	Irish lic.	Irish deg.
1880	197	5	73	128	29	23
Total, 1880–1909	876	148	583	1080	157	158

TEN MOST COMMON QUALIFICATIONS IN 1880

MRCs (Eng.)	128	LRCS (Edin.)	20
LSA (Lond.)	53	CM (Aberd.)	19
LRCP (Edin.)	44	CM (Edin.)	18
MD (Germany)	42	MB (Edin.)	17
MD (Edin.)	22	MB (Aberd.)	15

This picture conforms fairly closely to that drawn by historians of the emergent general practitioners of mid-Victorian Britain.¹⁴ The one exception was the prevalence of German doctors. Dutch South Africa had close ties with Germany. Perhaps half of all Afrikaners were, and are, of German descent and this link was reflected in the medical profession, although it is not clear why the Dutch medical influence was so weak during the period.

In 1910, the pattern was very similar except that Scottish qualifications were even more popular:¹⁵ 360 had qualified in Edinburgh, 63 elsewhere in Scotland, 115 in England or Ireland, and 37 in other countries. Although it is difficult to identify doctors born in the Colony, Edinburgh qualifications predominated among the 263 so identified on the Cape registers between 1880 and 1909.¹⁶

This educational pattern was determined both by conditions in the colony and by legislative requirements for registration. By 1890, doctors were exceptional in belonging to the one major profession which still required qualification in Europe.¹⁷ The situation was a reflection of the backwardness of tertiary education at the Cape

¹³ Loudon, *op. cit.*, note 9 above, p. 4.

¹⁴ The literature on the emergent general practitioner in Britain is extensive. See, for instance, N. and J. Parry, *The rise of the medical profession. A study of collective social mobility*, London, Croom Helm, 1976; W. J. Reader, *Professional men. The rise of the professional classes in nineteenth-century England*, London, Weidenfeld and Nicolson, 1966; J. Woodward and D. Richards (eds.), *Health care and popular medicine in nineteenth-century England. Essays in the social history of medicine*, New York, Holmes & Meier, 1977; J. Peterson, *The medical profession in mid-Victorian London*, Berkeley, University of California Press, 1978; Loudon, *op. cit.*, note 9 above, pp. 4–8.

¹⁵ E. H. Burrows, *A history of medicine in South Africa up to the end of the nineteenth century*, Cape Town, Balkema, 1958, p. 347. Egan, *op. cit.*, note 7 above, pp. 42–3, notes that by 1911 Scottish first qualifications had come to outnumber first diplomas from England and Ireland together in Australia too.

¹⁶ A crude estimate has been reached by counting those doctors who are known to have been colonial-born or those who appear to have Cape names. Such a method does give a considerable bias towards Dutch-speaking colonists. An additional complication occurs because many students had multiple diplomas, the “triple licence”—LRCS (Edin.), LRCP (Edin.), LFPS (Glas.). Usually these students had studied at Edinburgh and taken the Glasgow licence as an addition.

¹⁷ The other professions were the Church and the Law. Lawyers had of necessity to qualify locally since Cape law was a blend of pre-Napoleonic Dutch law and English law (only Ceylon possessed anything similar).

rather than that of the medical profession. The University of the Cape of Good Hope was constituted in 1873, but it was only an examining body for additional courses taught at some high schools. At the major school, the South African College, science departments regularly disappeared when their incumbents left. Despite the unique flora of the Cape and a rich scholarly botanical heritage, botany was absent from the curriculum for years, only returning in the 1880s. Apart from P. D. Hahn, Professor of Chemistry, the College lacked a tradition of research and there was no substitute in other research institutions, except for the Royal Observatory. Although there were some distinguished men at the Cape, including doctors like Emil Holub, the Czech ethnographer, explorer, and naturalist, they did not impinge much on the educational life of the colony.¹⁸

More significant, perhaps, was the Cape Dutch doctor, D. R. Kannemeyer. It seems likely that his intellectual interests were stimulated in Edinburgh where he studied medicine in the 1870s. He chose to practise in the remote village of Burgersdorp on the north-east frontier of the Cape Colony, an area which was rich in fossils. Kannemeyer's scientific pursuits were maintained mainly by correspondence, but he was also an important local figure, encouraging education and cultural activities. One can only surmise about the extent of Kannemeyer's influence. Whatever its value for the development of palaeontology, it seems to have been limited by his relative isolation and the lack of institutions through which his knowledge could be disseminated. The public lecture appears to have been almost his only forum, although his collections were deposited in the South African Museum in Cape Town.¹⁹

This situation began to change only in the 1890s. In 1893, the Colonial Bacteriological Institute was established in Grahamstown to conduct research into animal diseases, and after the second Anglo-Boer war new chairs were instituted at the College.²⁰ Although the establishment of a medical school was occasionally considered, at least one colonist thought that education overseas was desirable. Only by the broadening of its intellectual horizons could the medical profession avoid "the narrow aims and contracted provincialism of doctors who have never left the Colony".²¹ In the event, penury prevented any substantial moves in this direction before 1911.

The Colonial Medical Council, the certifying body at the Cape, did recognize the *Staats Examen* of Holland and Germany. For some students, especially those of Dutch extraction, the attractions of a continental training were considerable, particularly since it was reputed to be fairly cheap. One student explained. "I have £65 a year at my disposal, with which sum, as far as I can find out, it is impossible to study medicine in England."²² Unfortunately, although he could obtain the MD from the University of Berlin, he could not present himself for the *Staats Examen* without first passing the *Abiturienten Examen*; in other words, he had to attend a German

¹⁸ *Dictionary of South African Biography (DSAB)*, vol. 1, pp. 390–2.

¹⁹ *Ibid.*, vol. 2, pp. 356–8.

²⁰ A. C. Brown (ed.), *A history of scientific endeavour in South Africa*, Cape Town, Royal Society of South Africa, 1977, pp. 66–7.

²¹ *Cape Monthly Magazine*, Jan. 1871, 2: 35; Feb. 1871, 3: 109.

²² Medical Committee, Cape Archives (MC), 17, R. J. Reinecke to the Secretary of the Colonial Medical Committee, 4 Nov. 1883.

gymnasium. It would seem, therefore, that there were severe impediments to acquiring a continental qualification. Of the 306 doctors on the 1880 register, 42 had German diplomas and 12 had Dutch. Only two men registered Dutch qualifications thereafter, while there were a total of 116 German degrees in the period from 1880 to 1909.²³

The 1830 and 1891 licensing regulations ensured that colonial doctors would qualify in Britain. They also ensured that colonial doctors came from reasonably affluent homes, that they were, by definition, middle class or aspirant middle class. The need for access to wealth and education excluded virtually all Blacks. Throughout this period only three colonial-born black men managed to become doctors. One, William Anderson Soga, was the son of Tiyo Soga, the first black ordained minister of the United Presbyterian Church of Scotland, and a Scottish mother. Soga, a Xhosa missionary, had his son educated in Scotland to avoid the limitations his colour imposed on him at the Cape. W. A. Soga became a medical missionary, founding the Miller Mission at Elliotdale in the Transkei.²⁴ The other two, Mohammed Omer Dollie and Abdullah Abdurahman, were both Muslims, so-called “Malays”, the descendants of slaves who had been urbanized for many decades and some of whom had accumulated wealth since emancipation. Dollie was the son of a Cape Town fish merchant who had retired from business to settle in England, where he educated his son. Dollie returned to Cape Town in 1906, after acquiring the London LSA, to work mainly amongst “his own people”.²⁵

Abdullah Abdurahman is well known because of his leadership of the African Political [People’s] Organisation (APO), one of the earliest black political organizations, founded in 1902. Abdurahman was the grandson of slaves and was, uniquely for a Muslim, educated at the South African College. He qualified in Edinburgh and returned to Cape Town in 1895. While much has been written about him as a politician,²⁶ little has been said of his medical career. He was the first black member of the Cape Town municipal council on which, at least in his earlier years, he espoused the “dirty party” cause of the small property owners who objected to expensive water schemes. As a Muslim doctor, he seems to have done much to reconcile Muslims to “white” medicine. The Muslims had a rich medical tradition of their own, combined with a legacy of bitter resistance to vaccination and such sanitary measures as the closure of cemeteries.²⁷ In 1901, when a plague epidemic struck Cape Town, Abdurahman seems to have been an important intermediary between the Muslim community and the Cape government when rapid and arbitrary measures were introduced to control the disease.²⁸ The one point which is clear is that it was his status as a Scottish-trained doctor which gave him standing in the white ruling establishment.

²³ Many of these were held by German or Dutch immigrants.

²⁴ D. Williams, *Umfundisi. A biography of Tiyo Soga, 1829–1871*, Lovedale, Lovedale Press, 1978, pp. 87–8, 118.

²⁵ Obituary, *S. Afr. med. Rec.*, 25 Nov. 1922, 20(22): 443.

²⁶ *DSAB*, vol. 1, pp. 1–4; G. Lewis, *Between the wire and the wall: a history of South African ‘coloured’ politics*, Cape Town, David Philip, 1987, pp. 27 ff.; R. E. van der Ross, *The rise and decline of apartheid: a study of political movements among the coloured people of South Africa, 1880–1985*, Cape Town, Tafelberg, 1986, pp. 28 ff.

²⁷ A. Davids, “The revolt of the Malays”—a study of the reactions of the Cape Muslims to the smallpox epidemics of nineteenth-century Cape Town’, *Studies in the History of Cape Town*, 1983, 5: 46–79.

²⁸ E. B. van Heyningen, ‘Cape Town and the plague of 1901’, *ibid.*, 1981, 4: 100–1.

Two black immigrant doctors completed the tally. Umedram Lalbhai Desai was an Indian with the triple diploma from Edinburgh and Glasgow but, although he retained his name on the Cape register, he appears never to have lived in the colony. Andrew Christopher Jackson, who was probably a West Indian, had Edinburgh (LRCP) and London (MRCS) qualifications. He had trained at Guy's Hospital and emigrated to Cape Town in 1866, immediately after qualifying. In his younger days he identified himself with the "coloured" community, occasionally taking a public stand against racism.²⁹ Perhaps hoping for freer conditions, he moved to the Transvaal in the 1890s but soon returned to Cape Town, driven out by the rampant prejudice of the South African Republic. His obituary in the *South African Medical Record* suggests that he was accepted into the Cape medical community but he probably played a less prominent part than he was capable of.³⁰

Women doctors were almost as rare. In all, ten women placed their names on the Cape register between 1880 and 1910. By far the most prominent was Jane Waterston, who will be discussed below. There was one other medical missionary, Edith Pellatt, who established an Anglican mission to the Cape Town Muslims in 1896. Her career was cut short by blindness and she returned to England in 1903. Four doctors came to the colony as married women and it is not known whether they practised. Others remained at the Cape only for a few years. As far as is known, the only colonial-born women doctor was Edith Gertrude Pycroft, the daughter of a Cape Town pharmacist. She started her practice only in 1906, having obtained Edinburgh degrees. The majority of women doctors had Scottish qualifications apart from Jane Waterston, who had trained too early to be eligible; Edith Pellatt and Emmy Rose Neukirch, who had the London LSA; and Hester Sophia Davies who, like her husband, had an American degree, although she had also acquired the London LSA. The qualifications were usually of a comparable standard to men, although a few of those mentioned above were relatively underqualified. Others, notably Jane Waterston, made special efforts to improve their standards. In 1879 the only licence she could take was that of the King and Queen's College of Physicians of Ireland. In 1888 she returned to Europe to take Edinburgh LRCS and Brussels MD, since she still could not obtain a British degree. She admitted proudly that the latter was awarded with "great distinction". She had, she explained, wanted "to perfect myself a little more in medicine".³¹

The Cape medical profession was overwhelmingly male, white, middle class, British-born, and educated in Edinburgh. The preference of colonial doctors for Edinburgh may be explained partly by the influence of Scots educators in the colony. The example of Hans Sauer is a case in point. Sauer was educated at Burgersdorp Public School, where he came under considerable Scots influence. Not only was Mr Elliott, his headmaster, a Scot—"a very learned and excellent teacher who had been Professor of Literature at Glasgow"—but he boarded with the local Dutch Reformed minister, who was also a Scot. Immediately after finishing his schooling in South

²⁹ Bickford-Smith, op. cit., note 7 above, p. 86.

³⁰ *S. Afr. med. Rec.*, April 1905, 3(4): 86.

³¹ L. Bean and E. B. van Heyningen, *The letters of Jane Elizabeth Waterston 1866–1905*, Cape Town, Van Riebeeck Society, 1983, pp. 197, 212.

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Africa, Sauer went to Britain, first to London, where he matriculated, and then to Edinburgh, “then the foremost medical school in the world”, he claimed.³²

These young men were familiar with the Scottish Calvinism preached by the Scots ministers imported earlier in the century by the British government. In addition, Scots influence pervaded the entire educational system of the Cape, from the first superintendent-general of education, James Rose Innes, through such mission colleges as Lovedale, to country schools like Bedford Public School, presided over by the remarkable Robert Templeton. The South African College was staffed largely by Scots. One of the most successful teachers was Roderick Noble, who hailed from Inverness and obtained part of his education at Edinburgh University. From 1859 to 1875 he was professor both of English and of Physical Science and was also the editor of the *Cape Monthly Magazine*. Colonial students studying abroad, then, were likely to have been familiar with the Scottish intellectual milieu and may well have been directed to Scots educational institutions by their teachers, doctors, and ministers. In turn they may have encouraged fellow students to emigrate to South Africa.

Taken in conjunction with the large number of immigrant doctors who were Scots or Scots-educated, the influence of the Scottish medical schools on the Cape profession must have been considerable. The precise quality of this influence is difficult to determine. It may have contributed to a sense of social purpose amongst Cape doctors. Edinburgh’s influence in social reform in the early nineteenth century may have lingered on into the later period, especially in a colony so permeated with Scottish traditions.³³ It may even have been reinforced by the Scottish missionary presence. One example was that of John Ross, the son of a Scottish missionary, who published a little book on public health in 1887. In this practical little work dedicated to Dr James Stewart of Lovedale Institution, “my old teacher, who first gave me a liking for scientific study”, he wrote,

Hygiene is a study of all the conditions and influences which affect mankind for good or evil. These influences may be mental, moral or physical, and they must be studied not only as they affect individuals or families, but also as they have an influence on communities and nations. . . . Attention to the laws of health is a public as well as a private duty. . . . People must be taught that attention to public health is a moral duty, that cleanliness, avoidance of excess, and health preservation go hand in hand with mental and moral training, and that morality consists as much in a hearty submission to the precepts of health as to the observation of creed.³⁴

Although he was writing forty years after Chadwick and the early public health reformers, John Ross still faithfully propagated their ethos in the colonial context.

The practice of medicine was first regulated shortly after the British occupation of the Cape. In April 1807, a proclamation was issued at the instigation of British army medical men who were shocked at the extent of quackery in the colony. It established a Supreme Medical Committee with the authority to license practitioners and to

³² H. Sauer, *Ex Africa*, London, Bles, 1937, pp. 7, 20, 27, 33.

³³ A number of writers have commented on this sense of social purpose amongst doctors. See Haley, *op. cit.*, note 3 above; A. S. Wohl, *Endangered lives. Public health in Victorian Britain*, London, Methuen, 1983, pp. 6–7, 175–7.

³⁴ J. Ross, *A few chapters on public health, adapted for South Africa*, King William’s Town, Hay, 1887, p. 1.

exercise some control over the vending of drugs.³⁵ The Committee retained the European distinction between physicians, surgeons, and apothecaries, but it applied solely to Cape Town. A separate category was introduced of less qualified practitioners who might work only in the country. Only 31 were licensed.³⁶

The Supreme Medical Committee existed with some interruptions from 1807 to 1830. In that year, an ordinance replaced it with the Colonial Medical Committee, which performed a similar function.³⁷ Its stated purpose was to “superintend the civil medical concerns” of the colony and to license physicians, surgeons, accoucheurs, surgeon-apothecaries, chemists and druggists. The committee consisted entirely of nominated medical men. Although, theoretically, pharmacists were included, in fact they were represented only for a few years.³⁸ This ordinance remained the means by which the medical profession was regulated for most of the nineteenth century.

Up to a point, the Colonial Medical Committee performed a useful purpose. It made some attempt to keep up with advances in medical training abroad by introducing more stringent terms for licensing. In the early years, almost any medical qualification was accepted. By the 1880s, however, continental diplomas were in theory recognized only if the applicants had passed the relevant *Staats Examen* and were licensed to practise in the country of training. Swiss and French qualifications were not recognized since those states did not grant reciprocity to British doctors, but the doctors of the Swiss-French Protestant missions were registered. American certificates, often spurious, were treated with growing suspicion. From about 1868 the Colonial Medical Committee also published a list of registered practitioners twice a year. The list was intended to give the public and profession some protection against quacks but it had no standing in law. Nor did the Committee have the power to strike off the register any practitioner who had been convicted of a misdemeanour or felony, although in fact it did so.³⁹

Over the years anomalies began to creep in and the 1830 ordinance became more and more inadequate. The government itself was a sore offender in employing unlicensed men in medical posts. Thomas O’Hare, for instance, had a medical training but had not obtained any certificate. He had been appointed district surgeon of Oudtshoorn in 1857. Another was the Hollander, H. W. Dieperinck, who did not have the Dutch *Staats Examen* but still held a variety of official positions.⁴⁰ Common sense often forced the Colonial Medical Committee to close its eyes to the situation. It pointed out to an over-zealous licensed dentist, “There are very few qualified dentists here (only twelve have availed themselves of registration) and if the public had to rely solely on

³⁵ *Cape Town Gazette*, 24 April 1807, 2: 67.

³⁶ Burrows, *op. cit.*, note 15 above, pp. 72, 74–5.

³⁷ Ordinance No. 82–1830. It was repealed by Ordinance No. 12–1836 but, when the latter was not confirmed by the British government, the 1830 ordinance was revived.

³⁸ M. G. Ryan, ‘Aspects of the history of organized pharmacy in South Africa, 1885–1946’, M.A. thesis, University of Cape Town, 1983, pp. 21–2.

³⁹ Select Committee Reports of the House of Assembly of the Cape of Good Hope (SC), 25–1883, *Report of the select committee on medical law reform*, pp. 1–2; MC 30, Secretary of the Colonial Medical Committee to the State Attorney, Orange Free State, 6 Mar. 1890; MC 13, Under Colonial Secretary to the President, Colonial Medical Committee, 13 Feb. 1890.

⁴⁰ SC 6–1890, *Report of the select committee on the Medical Practitioner’s Bill*, pp. 5–9, 12, 56–8. Neither of these men was incompetent and both were licensed to practise after 1891 under the terms of a special clause.

their services throughout the colony the victims of toothache would be in a sorry plight".⁴¹ Nevertheless it was not happy. By 1888 it was reprimanding the government for continuing to appoint men with chemists' qualifications as district surgeons. "They feel strongly on this matter and respectfully suggest that the Government will be able to give qualified medical practitioners who have complied with the government regulations, that protection which they are obviously led to expect."⁴²

A major source of confusion lay in the lack of definition of the "general practitioner". As in New South Wales, frontier conditions made European distinctions between physician, surgeon, and apothecary inappropriate. The Cape also needed general practitioners who could cope with any medical situation.⁴³ The ordinance itself was not explicit, and the Colonial Medical Committee had never differentiated between surgeons and physicians, accepting either qualification as adequate for practice in all branches of medicine in the colony. It was taken aback, therefore, when the Griqualand West appeal court ruled that Frederick Rutherford Harris was not entitled to seek payment for medical advice since he was only licensed as a surgeon and accoucheur (he held the Edinburgh LRCS and midwifery diploma).⁴⁴ The Committee's response to the government was that, after a fixed date, all applicants for licence should be required to produce proof of the double qualification. In the meantime a notice in the *Government Gazette* should authorize all doctors to practise in both branches of the profession.⁴⁵

Such *ad hoc* arrangements were manifestly unsatisfactory as the numbers of doctors in the colony increased and society became more complex. The list of registered practitioners was unreliable, full of errors and often containing the names of doctors who were dead or no longer practising.⁴⁶ There was pressure for reform from other directions as well. The pharmacists in particular were dissatisfied with their subjection to the doctors and wanted greater autonomy.⁴⁷ By the late 1880s, even parliament was beginning to express its disapprobation. "This was a most effete and useless body", declared the Cape parliamentarian, James Rose Innes, in 1889.

What had the Medical Committee done? It consisted of four or five gentlemen . . . who examined certificates and lunatics, and during the last year they visited Robben Island once, and went down to the beach to examine the seaweed which had been washed up . . . instead of a useless body we should have a useful body. There should be a Department of Public Health . . .⁴⁸

⁴¹ MC 30, Secretary of the Colonial Medical Committee to the Colonial Secretary, 10 Feb. 1882.

⁴² *Ibid.*, 11 May 1888.

⁴³ *Ibid.*, to F. Rutherford Harris, 16 May 1884; M. Lewis and R. MacLeod, 'Medical politics and the professionalisation of medicine in New South Wales, 1850–1901', in MacLeod and Lewis, *op. cit.*, note 2 above. This information was kindly provided by the authors when the book was in proof.

⁴⁴ MC 17, Ruling of the Griqualand West Court of Appeal, 8 May 1884, and attached correspondence.

⁴⁵ MC 30, Secretary of the Colonial Medical Committee to the Colonial Secretary, 16 May 1884, 5 Sept. 1884. It is not clear whether the government followed this recommendation, but the Colonial Medical Committee usually seems to have demanded this double qualification from this point.

⁴⁶ SC 25–1882, p. 21; MC 12, Acting Under Colonial Secretary to the Secretary of the Colonial Medical Committee, 18 Mar. 1880; MC 30, Secretary of the Colonial Medical Committee to the Colonial Secretary, 23 Sept. 1881.

⁴⁷ Ryan, *op. cit.*, note 38 above, discusses in detail the position of the pharmacists.

⁴⁸ House of Assembly, *Debates*, 1889, p. 203. Rose Innes later became Chief Justice of South Africa.

Parliamentary criticism revealed more of the lay public's ignorance of the needs of the medical profession than it did of the deficiencies of the Colonial Medical Committee. In the absence of an effective public health system, the Committee seemed to be responsible for the general health of the colony, yet that had never been its function. Complacent and unenterprising it may have been, but the Committee had been created purely as an advisory body and it was never intended to be a substitute for a proper public health department.

The rising tide of criticism provoked the appointment of two commissions of inquiry, in 1883 and 1890. The delay in passing a new bill arose mainly from dilatoriness in parliament. The profession was not well represented in the House of Assembly before the 1890s. In 1890 the colony was only just emerging from a depression which had blighted many reform initiatives. A greater impediment was the lack of a medical bureaucracy. In 1891 the only medical officer of health in the colony was employed by the municipality of Cape Town. The Cape Colonial Office,⁴⁹ which was responsible for health and local government, had no medically-qualified personnel at all and it was for this reason that the Colonial Medical Committee had taken on inappropriate functions. The one exception was the institution of the district surgeon, dating back to Dutch rule in the eighteenth century. Every magisterial district had one or two state-appointed district surgeons who were responsible for vaccination, for caring for local state employees, and who implemented the occasional central government directives. Their work was part-time and often poorly remunerated. Their one strength was that, as a body, they alone had the ear of the Colonial Secretary, but until 1902 they had no organization of their own through which they could articulate their views.⁵⁰ In the circumstances, reform could only be initiated by the ill-organized general practitioners.

Unlike New South Wales, where there was substantial resistance to medical professionalization, the Cape Colony saw little active opposition to the improved registration of doctors. Pharmacists were equally anxious for a change in the law. "Alternative" medicine was widespread but it was practised domestically and had virtually no public voice because it was associated with African, Muslim, or Dutch superstition. Some resisted the pretensions of scientific medicine, but this mainly took the form of local authority objections to the implementation of sanitary regulations rather than to the institutionalization of the profession. Finally, in 1891, a new Act was passed without undue difficulty.⁵¹ In some respects it was a curious hotch-potch, a response to the 1890 select committee's criticism of the first bill. The affairs of the pharmacists and doctors were separated with the creation of a Colonial Medical Council for the latter. This was to consist of four members elected by the profession and four (including a dentist) nominated by the government. The functions of the Council were not stated but they would seem to have been confined to the regulation

⁴⁹ The Colonial Office was the Cape equivalent of a Ministry of the Interior, or Home Office. Its parliamentary head was the Colonial Secretary and its permanent head, the Under Colonial Secretary.

⁵⁰ *S. Afr. med. Rec.*, June 1903, 1(4): 64–5.

⁵¹ Act No. 34–1891, Medical and Pharmacy Act.

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of the profession and to the certification of nurses and midwives. Certainly its old advisory powers were not mentioned. A medical practitioner was defined as anyone licensed as a physician, surgeon, or accoucheur before the passing of the Act, or, afterwards, as “every person duly qualified by licence and registration under the Act to practise as a physician and surgeon in the Colony”. This automatically included the right to work as an accoucheur. In a colony not noted for its advanced feminist views, clause 33 explicitly stated that no person should be disqualified merely because she was female.⁵² Although laymen were not prevented from practising medicine, they could not recover charges in a court of law, hold any official appointments, or sign medical certificates.

Much has been made of the novel features of the 1891 Act, particularly of the registration of nurses and midwives.⁵³ For our purposes, however, its importance lay in the fact that by its passing the Cape medical profession came of age. It had acquired all the attributes of full professionalism—the right to regulate itself, the legal authority to enforce its decisions, recognition by the state, and the ability to protect the practice of medicine from lay encroachment.

Despite this advance, disunity was difficult to overcome. A root cause was overcompetition. According to census figures, by the end of the century the local medical profession was becoming more overcrowded than it had been in Britain.

	No. of doctors ⁵⁴	Total population	Ratio	Total white population	Ratio
1875	145	720,984	1:4,972	236,783	1:1,633
1891	336	1,527,224	1:4,545	376,987	1:1,122
1904	629	2,409,804	1:3,831	579,741	1: 922

Since very few Blacks consulted white doctors, even in the urban areas where the poor often resorted to the cheaper, unlicensed practitioners, most of their patients were white.⁵⁵ Even these were drawn from a limited portion of the population. Particularly in the rural areas, the Dutch had a long tradition of folk medicine and were resistant to the expensive encroachment of science. At best they made use of patent medicines.⁵⁶ The result was a heavy concentration of medical practitioners in the towns. According to the 1891 census, only 42 of the 336 doctors lived in the rural areas.

⁵² This clause was presumably inserted to protect Dr Jane Waterston, who was a firmly established member of the profession by 1891.

⁵³ C. Searle, *The history of the development of nursing in South Africa 1652–1960*, Cape Town, Struik, 1965, pp. 102–3; Burrows, op. cit., note 15 above, pp. 332–3.

⁵⁴ G42–1876, G6–1892, G19–1905. These figures, taken from the census reports, are lower than the numbers on the medical registers. One reason may be that doctors in full-time government employment appeared under a different heading. The numbers taken from the medical registers would give an even more unfavourable ratio.

⁵⁵ SC 25–1883, pp. 6, 23; *S. Afr. med. Rec.*, Dec. 1904, 2(12): 231.

⁵⁶ One enterprising pharmacist climbed on this bandwagon by making up a “*Huis Apotheek*” comprising a number of these “Dutch medicines” in a tin box retailing for about 20s. Ryan, op. cit., note 38 above, pp. 2–3.

Competition was a recurrent theme in the complaints of the doctors. Fees were forced down and bickering doctors presented a disunited front. Competition also diminished the incomes of district surgeons who looked back wistfully to the golden years of the mid-century. Salaries, they claimed, were inadequate, "fixed many years ago when there was very little competition amongst medical men, and those who were here had every chance of making a fortune, and when expenses were very low".⁵⁷ The volume of official work had since increased, while the income from private practice had declined. The result, Dr Darley Hartley, the editor of the *South African Medical Record*, complained, was that politicians held medical practitioners in low regard, as one explained to him.

What can one do for you people? You always stand in your own light. If the lawyers want a thing they ask it with a single voice, whatever dissensions they may have had in private. But each one of you is always striving to make us believe that some of you is a scoundrel. That goes dangerously near to making us believe you are all scoundrels.⁵⁸

Only in the 1890s did the Cape medical profession begin to organize itself more efficiently. Numbers had increased sufficiently to make a medical organization and a regular journal financially viable. As medicine became more sophisticated, the need to keep up-to-date was more urgent. In addition, with the growth of the urban population, particularly that of Cape Town, the nature of the medical problems confronting the profession intensified. Colonial health care had remained rudimentary, while that of Europe advanced enormously. Not only had the provision of public health become vastly more sophisticated; in addition, the formulation of the germ theory and the development of antiseptics were altering the very basis of medicine. For the young doctors now entering the colony, coming from a Britain where health care had made huge advances and imbued with all the enthusiasm which exciting discoveries generate, the Cape must have seemed extraordinarily backward. Yet if they were to bring any effective changes, they needed to speak with a single voice, and they needed to be heard.

In 1883 the South African Medical Association was founded in Cape Town, largely at the instigation of two young men, Drs C. L. Herman and J. H. Meiring Beck. Despite its title, and the formation of several country branches, the Association remained local. The associations established in Kimberley, Grahamstown, and elsewhere soon exhibited fissiparous tendencies and the membership of the South African Medical Association failed to grow. In 1889 it was ousted by the formation of a local branch of the British Medical Association.⁵⁹

The establishment of a branch of the BMA was not without significance, as T. J. Johnson and M. Caygill have pointed out.⁶⁰ At the Cape, as elsewhere, military doctors, who felt professionally isolated in their regiments and lacked the authority and status accorded to line officers, played a prominent role in founding an

⁵⁷ *S. Afr. med. Rec.*, 15 May 1904, 1: 86–8.

⁵⁸ *Ibid.*, June 1905, 3: 119–20.

⁵⁹ Burrows, *op. cit.*, note 15 above, pp. 350–2; C. Blumberg, 'The provision of medical literature and information in the Cape, 1827–1973', M.Bibl. thesis, University of South Africa, 1974, p. 30.

⁶⁰ Johnson and Caygill, *op. cit.*, note 2 above, pp. 308–29.

organization which they hoped would further their interests. The Cape of Good Hope branch was established largely at the instigation of Surgeon-General J. G. Faught, the Principal Army Medical Officer. The BMA itself actively encouraged such expansion. It prided itself on being an imperial institution which linked members of the profession in one body, animated by a common purpose—"the advancement of scientific medicine and the social well being and dignity of its associates".⁶¹ At the Cape, membership consisted mainly of the more active and imperially-minded British doctors although the presence of such Dutch colonials as Dr J. H. Meiring Beck testified to its larger worth.

The BMA in Cape Town did much to improve professional standards. In the early 1890s it established a library, but its use was hampered by the lack of an adequate home until it finally found a place in the new university buildings in 1907.⁶² At times the BMA acted as a pressure group. When the 1891 bill was before parliament, several deputations from the Association discussed the clauses in detail with the Colonial Secretary.⁶³ Regular meetings provided opportunities for discussion and the interchange of ideas.

The BMA also had its limitations. Despite the proliferation of branches in the British colonies, its imperial character prevented it from achieving wider South African acceptance.⁶⁴ Doctors felt the need to overcome divisions between English and Dutch. In 1892 the first South African medical congress was held in Kimberley in conjunction with the Kimberley Exhibition. In an attempt to overcome the problems of a disunited profession, two motions were put forward—to form a South African medical association and to publish a South African medical journal, the latter to be the medium through which obscure medical and surgical information of colonial interest might be placed on record and made available to others. The move to create a larger association was abandoned "as being liable to interfere with the working of the various branches of the British and other medical associations".⁶⁵ The *South African Medical Journal*, however, was launched a few months later, in May 1893, with Dr Alexander Edington, the Cape government bacteriologist in Grahamstown, as editor. He was succeeded later by Dr George Eyre of Cape Town. The *South African Medical Journal* was published until the second Anglo-Boer war brought about its demise. Its obvious success and the clear need for such an organ encouraged Dr Darley Hartley to found the *South African Medical Record* in 1903 as a business venture, and this continued until 1926.⁶⁶ The existence of forums such as the BMA and the medical journals enabled colonial doctors to articulate their belief that the profession had a special function to perform in colonial society. As early as 1871, an

⁶¹ *Ibid.*, p. 303.

⁶² Blumberg, *op. cit.*, note 59 above, pp. 33–8, 68.

⁶³ BMA (Western Cape branch). Unpublished annual reports, 1890–1891.

⁶⁴ The first branch was established in Griqualand West in 1888, followed by those in the Cape of Good Hope (1889), Grahamstown and Eastern Province (1893), Natal (1896), Border (1907), Transvaal (1907), Rhodesia (1912), Orange Free State (1913). Johnson and Caygill, *op. cit.*, note 2 above, p. 314.

⁶⁵ *S. Afr. med. J.*, May 1893, 1(1): 1. A South African Medical Association was founded in 1897, but it had little influence in Cape Town. Burrows, *op. cit.*, note 15 above, p. 360.

⁶⁶ Darley Hartley had previously published a *South African Medical Journal* (1884–9) in Port Elizabeth, but this had failed.

anonymous contributor to the *Cape Monthly Magazine* had defined the unique role of the profession. The doctor, he declared, was a social necessity, rendered indispensable by the progress of civilization which brought in its wake vices, frailties, and the natural fruits of evil courses. Using the familiar metaphor of the priest, he observed that since the “medical confessional” had its origin in human passion and weakness, it was the duty of society to ensure that the doctor possessed both knowledge and integrity. “Regarded in the abstract”, he continued, “there is no profession more noble than that of medicine. By the study of it, we mean not only the dry study of strictly professional detail, but the subjection of the brain and heart, to such culture and discipline as shall develop the intellect, elevate the judgment, and stimulate the moral sense”. Unfortunately, he believed, the young colonial practitioner lacked these qualities. He exerted no vital influence.⁶⁷

The medical profession itself expressed these views in slightly less elevated phrases. In his presidential address to the first South African medical congress in 1892, Dr Alfred Hillier commented on the unique conditions of practice in South Africa, conditions which did not prevail in older and more civilized communities. He considered that they broadened the demands on medical practitioners. “Throughout this country, in town and village, we are continually seeing the doctor speaking out or ‘rubbing it in’ in the cause of civilisation; and I feel most strongly that here, where the number of men of liberal education is small, the function of medical men is often wider than in the older countries of Europe.”⁶⁸ Hillier, who became a member of the Transvaal Reform Committee which instigated the Jameson Raid in 1896 a few years later, was expressing Britain’s imperial mission in medical terms.

But less imperialistically-minded men also thought that the work of the profession should be performed on a larger stage. J. H. Meiring Beck, one of the most distinguished of the Dutch-speaking doctors, and for many years an Afrikaner Bond member of the Cape House of Assembly, called upon medical practitioners to play a wider role in society. In a rousing presidential address to the Cape Western branch of the British Medical Association, he remarked on the extent to which everything was being “democratised”. This threw a responsibility on all.

All that being so, it is impossible, undesirable, and wrong for an educated and intelligent profession like that of medicine to keep aloof from doing its share of public work. Whilst we should never lose sight of the necessity for equipping ourselves as well as our abilities and energies permit for our special medical work . . . we should also bear in mind that, in the shaping of the destinies of a new country like this we ought to bear no inconsiderable share. . . . We must see to it, gentlemen, that this medical influence as the years roll on is not lessened. In an age when public health legislation is rapidly and recognisably pushing its way as a first essential in good government, it would be disgraceful for us as a profession not to assist in shaping the laws. . . .⁶⁹

The editor of the *South African Medical Record*, Dr Darley Hartley, was an ardent imperialist and founder of the South African League, Sir Alfred Milner’s agency for

⁶⁷ *Cape Monthly Magazine*, Feb. 1871, 2: 108.

⁶⁸ *S. Afr. med. J.*, May 1893, 1(1): 2.

⁶⁹ *Ibid.*, Oct. 1894, 2(6): 147–8.

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imperial expansion. In the journal, Hartley explicitly championed the political cause of the medical profession. He drew attention regularly to the activities of those doctors who were engaged in politics, and continually emphasized the need for the profession to be represented in parliament.⁷⁰ The prospect of union in 1910, in particular, provoked discussion on their future in the new South Africa.

We are to-day on the eve of entering upon a new era in South African life, and it should go without saying that, as men, women and children are the greatest assets of a state, legislation for their physical and mental welfare should be intelligently directed, for administration, however capable, is well nigh useless unless the legislation creating that administration is on sound lines. Therefore, it is above all things necessary that as many medical men as possible should find places in the ranks of our future legislators, and thus be in a position to secure for medical matters more than that perfunctory attention which has hitherto been all they have received.⁷¹

Meiring Beck and Darley Hartley saw their medical mission in political terms, but the influence of Cape doctors on colonial society was exerted more subtly. In the rural areas, doctors who assumed positions of local leadership helped to erode traditional indifference to scientific medicine and as educated men they contributed to the maintenance and extension of civilized values. This seems to be the case particularly with immigrants who were assimilated into Dutch rural communities.

A typical example was Joseph William Castles, an Irish immigrant who went into private practice in Montagu. There he married a Dutch woman, became a municipal councillor and later mayor. In addition he was the “manager” of the public library and a member of the local school committee.⁷² John Stephen Gibbons, a Lincolnshire man, was district surgeon of Prieska for thirty years. “He had identified himself with the village in which he resided so long, and was regarded as the ‘Father’ of it, being the head and fount of every movement for the benefit of the people . . .”.⁷³ Edward Roger Rowland made his mark in Dordrecht, starting his practice there in 1878.

He did one of the largest practices in South Africa, sometimes with assistance, sometimes without, and he occupied an extraordinarily unassailable position to which we have known few parallels in the past, and which practically no one can hope to reach now. It may literally be said that his word was law with his patients.

Rowland was also mayor of Dordrecht for nine years and chairman of the school board.⁷⁴ Walter Henry Lawrence Welchman, an American, similarly rooted himself in Graaff Reinet; while Andrew Whyte did the same in Swellendam, even standing as an Afrikaner Bond candidate. Indeed, several doctors who had made names for themselves in local politics went on to represent their districts nationally.⁷⁵ The most eminent was Sir William Bisset Berry, who was the first mayor of Queenstown in the Eastern Cape, an English-speaking district. In 1894 he was

⁷⁰ *S. Afr. med. Rec.*, Jan. 1908, 6(2): 24; Feb. 1908, 6(4): 62; April 1908, 6(7): 106.

⁷¹ *Ibid.*, March 1910, 8(5): 49.

⁷² *Ibid.*, March 1904, 2(3): 56.

⁷³ *Ibid.*, Nov. 1906, 4(11): 335.

⁷⁴ *Ibid.*, Oct. 1920, 18(19): 376.

⁷⁵ *Ibid.*, Oct. 1905, 3(10): 212; Jan. 1905, 23(1): 6.

elected to the Cape Legislative Assembly, became Speaker of the House of Assembly in 1898, and continued to represent Queenstown almost without a break until 1919.⁷⁶

The obituaries from which these details are taken imply that doctors were significant agents in transmitting imperial values. They were probably most effective when they were absorbed into the Dutch communities, when they did not challenge Dutch values too seriously. Above all, this would mean a tacit acceptance of white superiority as a political priority.

In the middle of the nineteenth century the governor of the Cape, Sir George Grey, had seen medicine as a means of incorporating the frontier tribes into the empire. Grey Hospital in King William's Town was established explicitly for this purpose.

It was believed that the plan could not be carried out so as to benefit the Native Tribes and destroy the influence of the Witch Doctors except by educating Native Surgeons, and employing them afterwards as District Surgeons, with liberty to practise among their own people . . . In this way the Witch Doctor would be chased out of the field.⁷⁷

Africans were also likely to encounter this policy amongst missionary doctors. Although the Cape had no mission hospitals, missionaries prized medical qualifications. This was particularly true of the Scots, many of whom were attached to the stations of the Free Church of Scotland, of which the most important was the prestigious Lovedale Institution in the Eastern Cape.⁷⁸ One reason for the emphasis on a medical education can probably be found in the character of the Free Church, a wonderfully characteristic Victorian institution. The Free Church appealed particularly to the emergent industrial middle class of Scotland for it emphasized hard work, thrift, and self-help.⁷⁹ Medicine had been a means of social mobility to the Scots, providing access to the middle classes, and at the same time providing an outlet for reformist ideals. A notable product of this ethos was Dr David Livingstone, whose influence on Scottish missionaries was extraordinarily potent.

As a young man, James Stewart had accompanied Livingstone on one of his expeditions into central Africa and this contact almost certainly persuaded him to qualify as a doctor and to become a missionary. Although Stewart, principal of Lovedale Institution from 1867 to his death in 1905, and founder of the Livingstonia Mission in Nyasaland, had a greater impact as an administrator than as a doctor, medicine was at the heart of his missionary vision. Not only would a medical training enable him to relieve human misery, but it would also combat the influence of African medicine, "one of the mightiest and most malignant influences in Africa". Stewart believed that European medicine could be used as an ally of the gospel by eradicating

⁷⁶ *DSAB*, vol. 2, pp. 55–6.

⁷⁷ Burrows, *op. cit.*, note 15 above, pp. 180–1.

⁷⁸ McCracken, *op. cit.*, note 2 above, is one of the few to examine the contribution of Scottish medical missionaries. Surprisingly, a recent work by John Iliffe denies their importance in the nineteenth century. *The African poor: a history*, Cambridge University Press, 1987, p. 113.

⁷⁹ A. L. Drummond and T. Bulloch, *The church in Victorian Scotland*, Edinburgh, St. Andrew Press, 1975, ch. 1.

African superstition since “the union of medical and spiritual work seems reasonable to the African, as his doctor is also his priest”.⁸⁰

While Stewart saw medicine as a means of combating African superstition, he was not primarily interested in practising his skill. The case was different with his protégée and friend, Jane Waterston, South Africa’s first woman doctor.⁸¹ Like Stewart, Waterston believed that medicine had an evangelical and moral purpose. A Scot from Inverness, the daughter of a bank manager, she had been recruited by Stewart in 1866 to start a girls’ school at Lovedale. Although an extremely effective teacher, Waterston was determined to work as a medical missionary in the north. In letters to Stewart, she explained her views. An African mission, she considered, “should be a *civilizing*, and an *energizing*, as well as a Christianizing Agent”. Her main goal was to help “these poor wretches of women up country”. She felt she had a special understanding of their plight. “I am a woman myself and it haunts me more than I can tell you, the thought of these poor wretches whose present life is misery, and their hereafter.”⁸²

In 1874 Jane Waterston returned to Britain, where she was one of the first students at the London School of Medicine for Women. After qualifying in 1879, she went to Livingstonia Mission but she found the experience bitterly disillusioning and left after six months. Eventually she moved to Cape Town, where she practised as a doctor to the end of her long life in 1932. In Cape Town the same sense of mission motivated her. She expected to find a niche as a women’s doctor but she soon acquired a larger practice, including black patients. “They feel, I think, that I treat them like human beings and not *niggers* as the term is here”.⁸³ Her patients included African dock labourers, female prisoners, lepers and lunatics on Robben Island, and the women of the slums. In 1888 she founded the Ladies’ Branch of the Free Dispensary to improve maternity care.

In many respects Jane Waterston epitomizes the doctor as “agent of empire”. As a committed imperialist and ardent supporter of Milner’s expansionist policies, she would have been proud to bear that title.⁸⁴ Her concept of the imperial mission was multi-faceted, embracing political expansion and the imposition of Western values which were defined variously by education, hard work, the wearing of European dress, and the proper relation of men to women. Waterston was undoubtedly paternalist and class-bound but she rejected racialism which saw black people as inherently inferior. She believed them capable of salvation. In the last resort evangelical religion governed her thinking and she was scathing about modern evolutionary theories. “I am sick of Tyndale [*sic*] and Darwin, the ape-faced man”, she declared when a student in London.⁸⁵

Although Waterston was a woman, uniquely she was also a member of the ruling

⁸⁰ J. Wells, *Stewart of Lovedale: the life of James Stewart, D.D., M.D.*. London, Hodder and Stoughton, 1908, pp. 94–6. For a recent study of Stewart see S. M. Brock, ‘James Stewart and Lovedale: a reappraisal of missionary attitudes and African response in the Eastern Cape, South Africa, 1870–1895’, Ph.D. thesis, University of Edinburgh, 1974.

⁸¹ This honour is usually given to James Barry, an important medical figure at the Cape in the 1810s and 1820s. As Barry’s sex was uncertain and s/he practised as, was believed to be, and may have been a man, the claim seems irrelevant.

⁸² Bean and van Heyningen, op. cit., note 31 above, pp. 21, 22.

⁸³ *Ibid.*, p. 196.

⁸⁴ For Jane Waterston’s relationships with Edmund Garrett, editor of the *Cape Times*, and Sir Alfred Milner, see G. Shaw (ed.), *The Garrett papers*, Cape Town, Van Riebeeck Society, 1984.

⁸⁵ Bean and van Heyningen, op. cit., note 31 above, p. 79.

establishment in Cape Town. She was accepted by the local medical profession, and from 1905 to 1906 she was president of the Western Cape branch of the BMA. She was never in full-time government employment but she was official inspector to several institutions and frequently acted in an advisory capacity. Probably as a result of Milner's influence, she was also the only South African member of the Committee of Ladies, led by Millicent Garrett Fawcett, which was set up by Britain to inquire into concentration camp conditions during the second Anglo-Boer War. In these, and a variety of other activities, she promoted the liberal imperial vision which she espoused.

Waterston's position in Cape Town society and her capability of asserting such values were inseparable from her role as a doctor, and she took care that she was professionally well-informed. Stewart thought well of her medical ability—"she is a good doctor—quite the modern school or style—no depleting—and very enthusiastic".⁸⁶ Her own comments, scattered through her letters to Stewart, confirm this impression. In 1886 she remarked,

What a wonderful difference the antiseptic method makes in a confinement. My patients are delighted with the sweetness of their rooms and the absence of fever, even milk fever. To do it perfectly takes any amount of carbolic wool and gauze, Iodoform pessaries, Quinine and Condy. But the purity and sweetness of the patient, bed and room are worth it all.⁸⁷

Medical missionaries like James Stewart and Jane Waterston performed a double function. The skills which they offered enabled them to attract followers to their missions more easily and, secondly, made the penetration of Western influence more rapid and more effective. The impact of European medicine on black communities has barely been explored.⁸⁸ When care was sensitive and helpful it was probably welcomed. In the twentieth century, nursing became an important means of upward mobility for black women. Too often, however, scientific medicine was associated with coercive measures which were resented. Compulsory vaccination, the enforced isolation of lepers, and the incarceration of syphilitics all provoked resistance at times. Missionary work was most effective when the Church, rather than the doctor, was associated with healing. The continuing vigour of traditional medicine implies limits to the acceptance of Western medicine.

As "agents of empire", members of the medical profession were increasingly engaged in Cape government by the end of the nineteenth century. Until the 1890s, the Cape had virtually no health service at all. The effects of the absence of any bureaucracy, already noted, were compounded by a lack of legislation as well. The scope of the only public health acts, the Contagious Diseases Act of 1856 and the Public Health Act of 1883, was limited to the control of epidemics; at that, they were ineffective. The health regulations of local authorities were equally rudimentary. A number of factors contributed to a public health revolution in the 1890s. Statistically-minded doctors, especially the district surgeons, conscious of mounting mortality

⁸⁶ *Ibid.*, p. 176.

⁸⁷ *Ibid.*, p. 197.

⁸⁸ A brief but valuable comment is that of T. Ranger, 'Healing in the history of colonial South/Central Africa', *Bull. Soc. soc. Hist. Med.*, Dec. 1978, 23: 9–10.

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rates, had pressed for the registration of births and deaths for several decades to no avail. The census of 1891, the first imperial census in which the Cape participated, was significant for two reasons. Firstly, it confirmed suspicions that mortality rates were abnormally high.⁸⁹ Secondly, it brought Dr A. J. Gregory into colonial employment, initially as the first officially-appointed medical adviser to the Cape government. A born technocrat, efficient and impatient of fools, Gregory was probably the most influential medical figure at the Cape until Union in 1910.⁹⁰ Although he was formally appointed colonial medical officer of health only in 1901, Gregory created a medical department in the Colonial Office almost single-handedly.⁹¹ He complained that his authority was vitiated by lay interference, but the archival records testify to his energy. Virtually no local-authority regulations passed through the department unscathed by his pungent comments. He was the prime instigator of the Public Health Act No. 23 of 1897, which gave South Africa its first modern health legislation, based on acts in Britain and the Australian colony of Victoria. Gregory had envisaged a centralized administration of Chadwickian proportions, but the original bill was weakened by indignant parliamentarians who cherished local independence. Nevertheless, the Act gave the government far greater powers than before, at least in times of epidemic.

Gregory's importance also lay in his clear vision of the desirable state of Cape society. In an age when most Britons accepted the inherent superiority of their own culture, he operated on assumptions about the way in which less cleanly groups should be treated, at least until they had been educated into sanitary habits. He actively supported exclusionist and segregationist legislation on the grounds of public health. Two examples give some idea of his policies. Like Britain itself and the other colonies, at the beginning of the twentieth century the Cape decided to exclude "undesirable aliens" with the hasty passing of the Immigration Restriction Act No. 47 of 1902 based on the "Natal formula".⁹² The purpose of the Act was primarily to exclude Indian contract labourers, and "undesirability" was legally defined in cultural terms, predicated upon the ability to write in a known European language. The debates on undesirability in parliament and the press had been couched in sanitary terms, however, and the administration of the Act was placed in Gregory's hands. His report on the working of the Act, issued in 1904, confirmed the prejudices which had led to its passing in the first place. Russian Jewish immigrants, for instance, were "unsatisfactory in most important respects; ill-provided, indifferently educated, unable to speak or understand any language but Yiddish, of inferior physique; often dirty in their habits, persons or clothing and most unreliable in their statements."⁹³

The Health Department would probably not have acquired the unsuitable task of administering the Aliens Immigration Act had it not been for the central role which it

⁸⁹ C. Simkins and E. B. van Heyningen, 'Fertility, mortality and migration in the Cape Colony, 1891–1904', *Int. J. Afr. Hist. Stud.*, 1989, 22(1), Appendix I.

⁹⁰ *DSAB*, vol. 5, p. 301.

⁹¹ Simkins and van Heyningen, *op. cit.*, note 89 above.

⁹² Australia and New Zealand also passed restrictive legislation based on the "Natal formula" at the turn of the century. R. H. Huttenback, *Racism and empire. White settlers and colored immigrants in the British self-governing colonies 1830–1910*, Ithaca, Cornell University Press, 1976, pp. 166, 281.

⁹³ G63–1904, *Report on the working of "The Immigration Act, 1902"*, p. 15.

had played in the previous year, when plague struck Cape Town. The epidemic is now well-established in South African historiography as the occasion for one of the most critical episodes in the creation of a segregated society because Africans resident in the city were forcibly rounded up and removed to a location on the outskirts on the ground that they were a danger to public health.⁹⁴ For the first time, Africans lost the right to live on equal terms with their fellow citizens; the removal clearly contradicted the spirit of the Cape constitution, with its franchise open to all races, and the concept of equality before law. The action was performed under the aegis of the 1897 Public Health Act and with the active encouragement of the Cape medical profession, led by Gregory.

It would be ahistorical to suggest that the Cape doctors, in pressing for segregation, were aberrant. On the contrary, they shared the prejudices of most British people of the period. Moreover segregation, one of the most ancient means of combating epidemics, had already been attempted at the beginning of the twentieth century by British doctors in India, with little success.⁹⁵ The Indian experience was significant for the Cape since the main adviser to the colonial government, Professor W. J. Simpson, the British plague authority, had gained his knowledge in India. He brought to the job prejudices which were a good deal more rampant than any expressed by local doctors. "Next to Bombay, Cape Town is one of the most suitable towns I know for a plague epidemic", he declared; there was an extraordinary proportion of ancient and filthy slums, occupied by a heterogeneous population; the Africans were unfit for town life; the poorer coloured people were even dirtier in their habits, while the Malays and Indians possessed the habits of the Asiatic, and the poorer class Portuguese, Italians, Levantines, and Jews were almost as filthy as the others. "Living in the same insanitary areas, often living in the same houses, the different races and nationalities are inextricably mixed up, so that whatever disease affects the one is sure to affect the other".⁹⁶

The tiny colonial health department, somewhat grudgingly aided by the local medical profession, dealt extremely efficiently with an epidemic which had threatened to be catastrophic. In the end perhaps 389 people died in the Peninsula, out of a total of 807 cases in a population of about 140,000. Although the disease gradually spread to other parts of South Africa, almost certainly through the negligence of the British army, and ultimately became endemic in the country, it did not return to Cape Town. This was a tribute mainly to Gregory. The point about the episode, however, is not the quality of the health care, which was high given the limited resources of the colony, but the way in which the medical profession confirmed and legitimized existing notions about the desirable social order. This is hardly surprising. It has been observed before that the Victorian medical profession was too concerned about its

⁹⁴ W. Maynard Swanson, 'The sanitation syndrome: bubonic plague and urban native policy in the Cape Colony, 1900–1909', *J. Afr. Hist.*, 1977, 18(3): 387–410; C. Saunders, 'The creation of Ndabeni: urban segregation and African resistance in Cape Town', *Studies in the History of Cape Town*, 1979, 1: 165–93; van Heyningen, *op. cit.*, note 28 above.

⁹⁵ See, for instance, the case of Poona where plague measures gave rise to considerable unrest. B. R. Nanda, *Gokhale. The Indian moderates and the British Raj*, Princeton University Press, 1977, pp. 103–15.

⁹⁶ W. J. Simpson, *Lecture on plague*, Cape Town, Cape Times, 1901, 8–9.

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status in society to challenge conventional thinking.⁹⁷ In the South African context it reinforced existing tendencies towards paternalism and authoritarianism, which became in the process ever more deeply entrenched.⁹⁸

It has been argued that the Cape medical profession was a means by which British imperial control was extended and reinforced in the late nineteenth century. As the Cape had responsible government, the process was indirect. Doctors contributed to the development of an administration which drew much of its inspiration from the British example, and explicitly set out to create a society similar to that of Britain and loyal to her. They attempted to transmit British cultural values to the variety of residents of the colony. They were only partially successful in their efforts. The Dutch and Blacks alike often resented attempts at reform and at anglicization. The implementation of public health reform had reduced white mortality rates but it had little impact on Blacks. By 1904, Whites had a life expectancy of fifteen years more than Blacks, while black infant mortality was double that of Whites. Towns had become graveyards for black people and would remain so for decades.⁹⁹ On the other hand, the equation of sanitation and cleanly living with civilized standards had been thoroughly absorbed by the ruling establishment, which modified these concepts to serve its needs as it understood them in the Cape context. The medical legacy of the empire in South Africa was ambiguous and contradictory.

⁹⁷ P. T. Cominos, 'Late Victorian sexual responsibility and the social system', *Int. Rev. soc. Hist.*, 1963, 8: 18–48, 216–50.

⁹⁸ S. Marks and N. Andersson, 'Issues in the political economy of health in Southern Africa', *J. S. Afr. Stud.*, Jan. 1987, 13(2): 177–86.

⁹⁹ Simkins and van Heyningen, *op. cit.*, note 89 above.