

***“A Laboratory of Change”:***

***A Critical Study of the Durban Medical  
School and its Community Health  
Experiment, 1930-1960.***

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Supervisor: Dr. Catherine Burns

Submitted in partial fulfilment of the requirements for the  
Master of Arts Degree in the Department of History,  
University of Natal, Durban.

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## Acknowledgements

Any thesis cannot begin without the acknowledgement of many people whose ideas, assistance and support helped to bring this project to fruition. I am most grateful to a number of generous, courageous and outstanding people whose “words of wisdom” shaped my dissertation in profound ways. I am indebted to Professors Soromini Kallichurum and Fatima Mayet for making time for me to interview them in their busy schedules. Their special memories and views about their past student days at the Durban Medical School nearly 40 years ago added a rich flavour to my writing about this institution. I am also very appreciative of Bongiwe Bolani - an amazing woman who I have had the great honour to know for the past year and a half - who too cleared a space in her busy daily life to be interviewed by me. As a nurse at King Edward VIII Hospital at the time of the Medical School’s establishment and first years of existence, her memories also provided fascinating insights for my dissertation. A big thank you must also go to Professor Mervyn Susser and Dr. Zena Stein - colleagues of Sidney and Emily Kark - who whilst on a short visit to Durban, provided a short interview session at the Campbell Collections (amongst their many other pressing itinerary demands). Their thoughts and opinions greatly clarified my thinking especially with regard to what motivated innovative community health doctors such as the Karks.

Whilst searching through the archives, I also incurred many debts of gratitude. The assistance of archivists and librarians especially at the Campbell Collections, but also the Durban Medical School, University of Natal Archives, Natal Provincial Archives in Pietermaritzburg and National State Archives in Pretoria was and is most appreciated. So too is the assistance I received from community health doctors such as Steve Reid - who showed a sustained and continued interest in this project. Dr. C.C. Jinabhai as Head of the Department of Community Health at the Durban Medical School was very helpful as he provided me with a copy of the transcripts of his and Dr. Nkosazana Zuma’s interview session with the Karks in 1992. As a historian fascinated in the interesting sidelights, contradictions, but also enormous historical achievements doctors have made, and continue to make, in this community health field, it is reassuring to see that the Karks recognition of the importance of cross-disciplinary work is still

prevalent today where much can be learnt from such an interactive experience between different disciplinary paradigms.

My enormous gratitude goes to my supervisor Dr. Catherine Burns who I have been most privileged to study and work with over the past five years. Catherine's ideas, knowledge, keen intellect, but also her compassion and enthusiasm for life, have left an indelible impression on me. She helped me and my work to grow, but always in her own unique and gentle manner. Catherine has been my guide, my mentor and my friend who walked beside me on this exciting and fascinating but also challenging academic journey. I hope that as the years pass, she will see her reward in her past generations of students - such as myself - who will carry what she taught us to further generations of students - for such is the legacy of a true teacher.

I also wish to record my appreciation to the History Department at the University of Natal Durban, which has for many years continually been a warm, friendly and welcoming place. It has been my second home for many years and I thank every person who has contributed to its wonderful atmosphere and academic working environment. The support and encouragement given to all its students has been an essential form of nourishment for my continued interest in History. I am also greatly indebted to one of my colleagues in the History Department - Daniela Scrazzolo - for all her assistance with regard to the scanning and layout of my illustration pages. I could not have done it without her help. Her insightful ideas with regard to the title of this dissertation is also much appreciated.

I have also had the great honour of being part of the KwaZulu-Natal Women's Narrative Group which was initiated and motivated by Catherine Burns a year and a half ago. I thank all the women in the WNG who have provided an encouraging, stimulating and supportive environment to discuss research and writing works around common threads of women, health and healing in this region. However, special thanks must go to Dr. Janet Giddy, and her partner Dr. Steve Reid (an honorary WNG member!) for all their help with regard to my many "medical" questions. Having both started off their careers as community health doctors at Bethesda Hospital in rural Northern KwaZulu-Natal, many of their comments and suggestions with regard to social and community health medicine were extremely useful and insightful to my

work. Thanks must also go to June Webber for her inspirational ideas and for the use of her thesis and to Julie Parle for continuously finding important sources of information for me. And finally, a big thanks must go to my best friend Janet Twine – also a past member of the WNG – who is now journeying overseas on a working-holiday. I now realise the importance of academic networking and give many thanks to all these women for coming through for me and providing me with enormous support and encouragement.

And finally, to my Mom and sister, thank you for your support and patience and for giving me the space to focus on my writing of this dissertation, especially over the past few months. It hasn't been an easy journey for any of us. But my mother has been my biggest supporter in all that I've achieved and it is for this mostly hidden, unassuming, and unconditional support that I dedicate this thesis to her.



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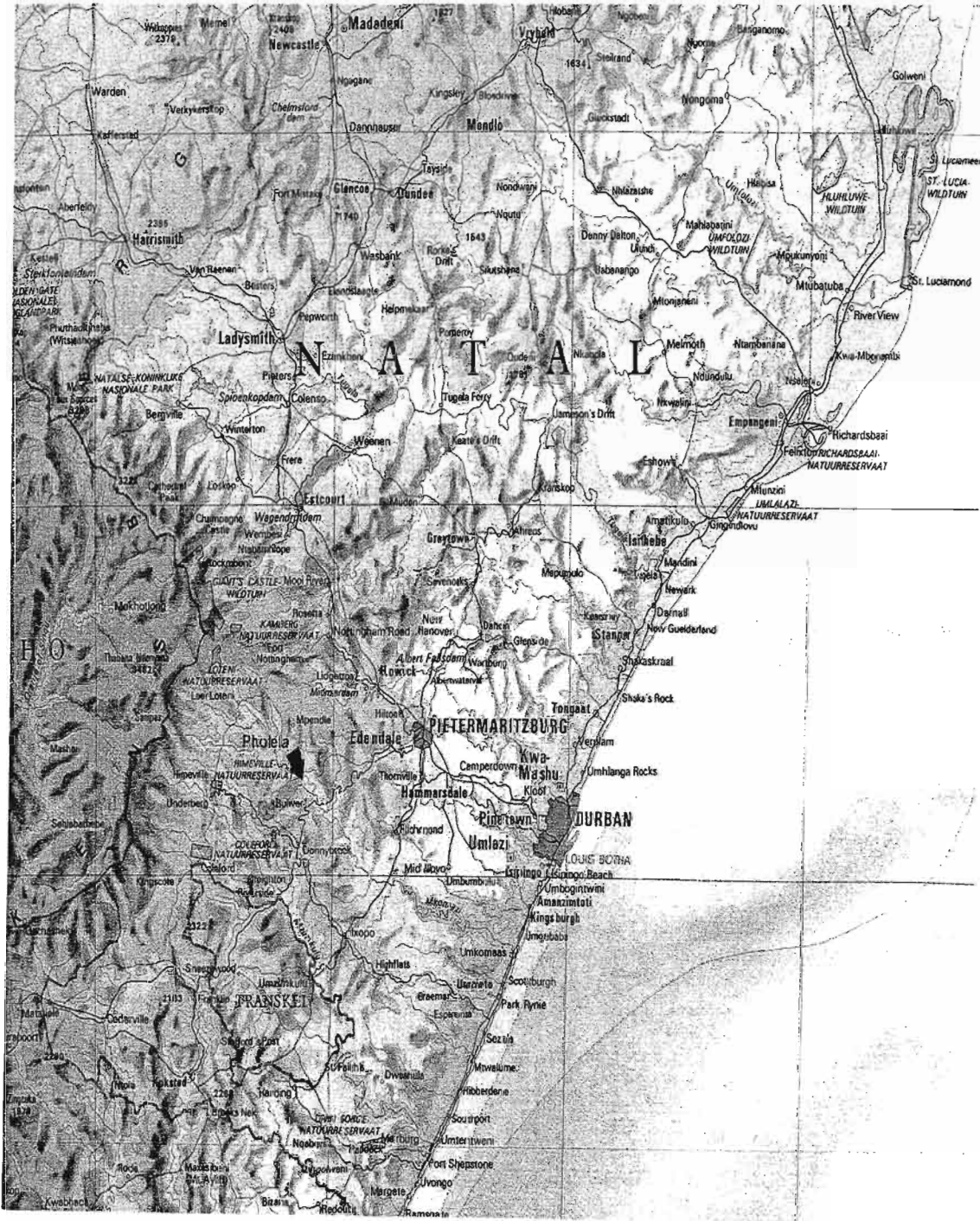
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## Map Illustrating Location of Pholela in Natal



## Pholela Health Centre Staff



Dr. Sidney L. Kark  
1911 - 1998



Dr. Emily Kark



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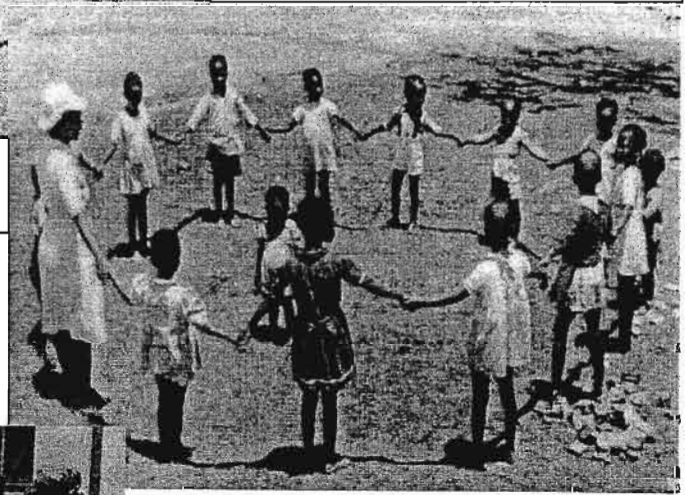
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## Pholela Health Centre Activities



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II. Preschool play group at the Pholela Health Centre with Community Health educator Margaret Shembe



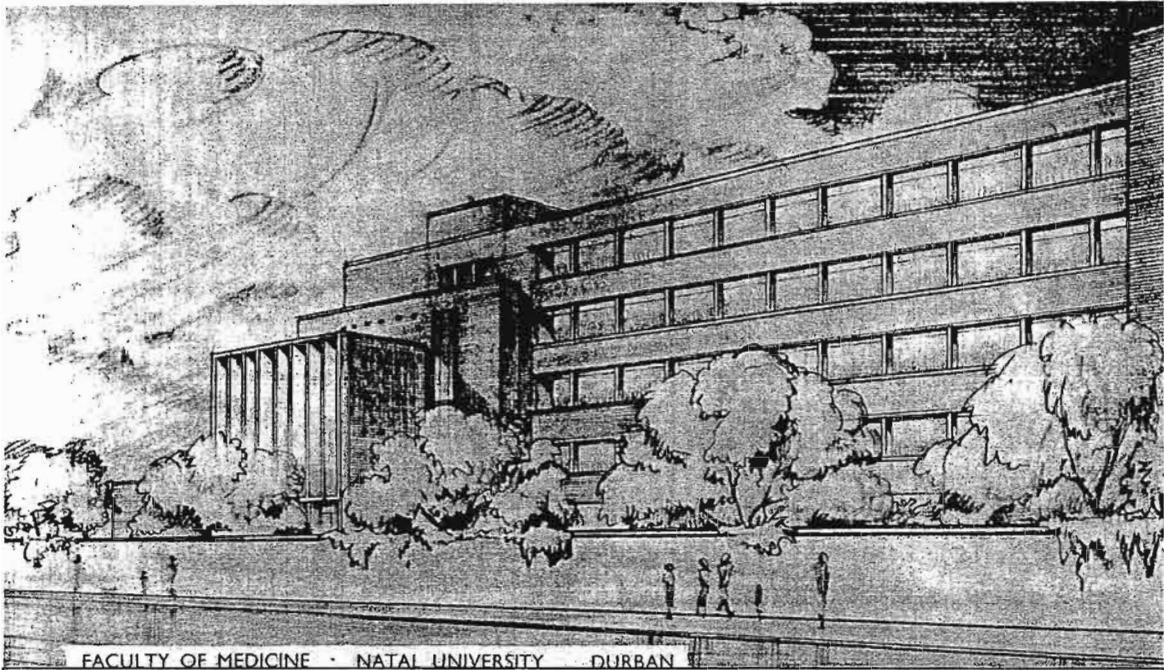
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## Durban Medical School

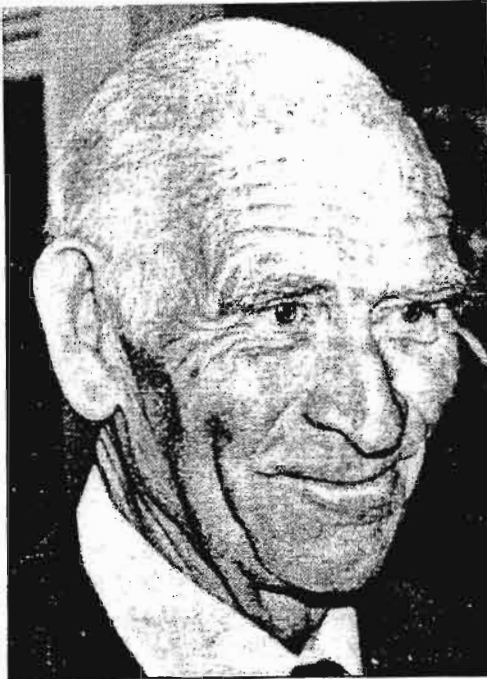


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E.G. Malherbe



I. Dr. E. G. Malherbe  
1895 - 1982



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(A £300,000 NON-EUROPEAN MEDICAL SCHOOL IS TO BE BUILT IN DURBAN AS A FACULTY OF THE UNIVERSITY OF NATAL — NEWS ITEM)

III. Sunday Post. 19.09.1948

**Pioneer Doctors who participated in the Establishment and Education of  
Blacks Students at the Durban Medical School.**



I. Dr. Alan Taylor



II. Dr. Henry Gluckman



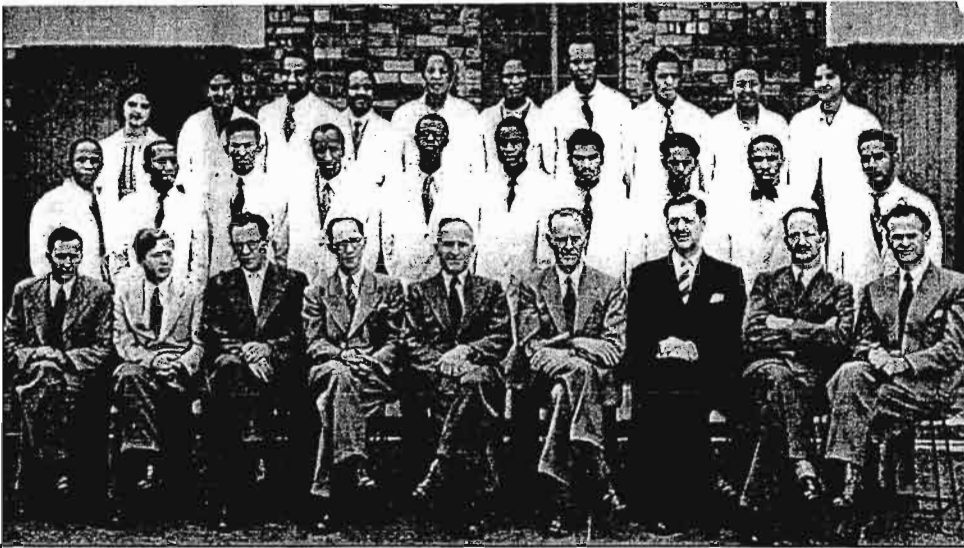
III. Dr. George W. Gale



IV. Dr. Isidor Gordon



## Durban Medical School Pioneer Class of Students



University of Natal Durban Medical School. Staff and Second Year Students, 1953.  
Back row: F. Mayet, C.H. Davidson, I.M.P. Yeni, M.S. Mbambo, J.W. Ntsepe, M.B. Zondi, H.M. Mogadime, L. Piliso, S. Kallichurum.  
Middle Row: A.M.S. Makunyane, D.M. Mahomo, N.E.G. Foster, B.C. Nkolombe, C.D. Marivate, D.K. Konoso, V.K.G. Pillay, B.T. Naidoo, P.S. Ngakane, A. Thambiran.  
Front Row: P.A.S. Canham, Dr. S. Ripley, Dr. E. Rosenberg, Professor T. Gillman, Dr. G.W. Gale, Professor J.A. Keen, Dr. J.D. Raftery, Dr. A. Belles, Dr. C.J. Kaplan.



Pre-Examination Final Year Dinner 1957.  
Back row: (Staff) Alan Taylor, Sidney Kark, I. Gordon, E.N. Keen, D. Crichton, Alan Kark, E.B. Adams, T. Gillman.  
Middle row: N.E.G. Foster, B.T. Naidoo, A.M.S. Makunyane, H.M. Mogadime, P.S. Ngakane, M.B. Zondi, C.H. Davidson, A. Thambiran, C.D. Marivate.  
Front row: M.S. Mbambo, K. Naidoo, F.G.H. Mayet, S. Kallichurum.

**Recent Photographs of two of the Women Graduates of the pioneering Class  
of the Durban Medical School**

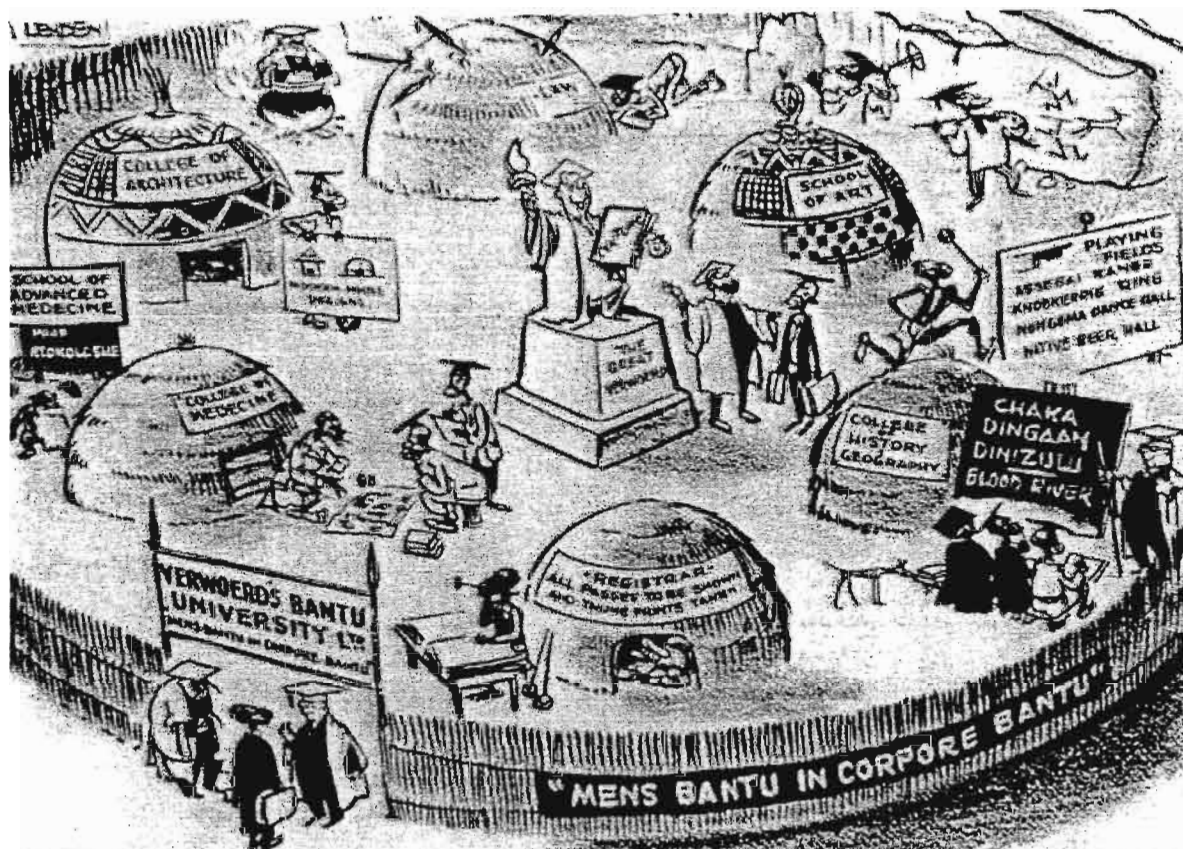


I. Prof. Soromini Kallichurum



II. Prof. Fatima Mayet

## Protests against the Apartheid Government's Introduction of the Separate Universities Education Bill.

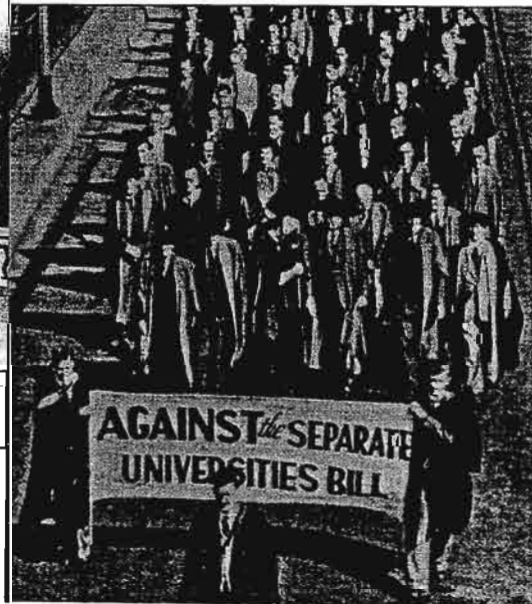


I. "The shape of things to come" – by J. Leyden. At the time Dr. Verwoerd wanted to preclude all Black students from attending the existing White Universities and to compel them to go to a Black University to be built in a tribal environment. This would have meant the end of the Medical School in Durban.



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## Introduction

When I try to remember what influenced my decision to embark on a detailed institutional history - a critical analysis of the extraordinary institution of the black Medical School affiliated to the University of Natal (UN) in Durban - I think a whole host of factors over the past few years lay the groundwork and ultimately swayed my interest to embark on a research dissertation in this direction. In 1996 I began my historical research by writing the life history of a remarkable woman in Durban. Killie Campbell, an Africana specialist, was a collector of other people's life histories who during her life time amassed a vast assortment of historical sources, but especially personal documents of the life histories of great, but also ordinary South African people. Few realised until her death in 1965 the marvellous gift Killie Campbell left to this country, and the world, for people who are interested in the history of Natal and South Africa more broadly.<sup>1</sup> What this project taught me, which greatly influenced my later work, was the importance of using life histories - biographies and autobiographies - as essential historical sources to help establish a fuller understanding of past events. Her life taught me about the importance of collecting material and preserving it in archives - despite all archival weaknesses, gaps and issues of power and silences that dominate this realm - so that researchers like myself can, many years afterwards, explore the intricacies and complexities of the past. But, an analysis of her life's work also showed me that the content of the record was of as much importance as its form and thus exposed me to amazing discoveries and the unique strength of "unconsidered trifles" such as private letters, unpublished manuscripts, diaries, unassuming booklets and pamphlets (used together with conventional historical sources) to build a rich tapestry of past times. She bequeathed her enormous and rich collection to the UN before her death, so that generations of researchers, like myself, would experience its benefits, and I have continued to do so throughout my archival research expeditions.

A year later, my Honours dissertation built on many of these themes, such as using personal narratives or autobiographies as historical sources, especially to uncover the hidden voices of women from different social and cultural backgrounds in South Africa. I thoroughly enjoyed this wonderful journey of tracing the individual life histories - of Mabel Palmer, Killie

## Introduction

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Campbell, Sibusisiwe Makanya, Dr Goonam and Phyllis Naidoo - and trying to recapture historically, something of their unique, but also collective contributions that impacted directly on their societies in and around Durban during the 20th century.<sup>2</sup> I have always been particularly interested in the enormous struggles and difficulties women in South Africa, but especially black women have had to face over the last century, and the fact that many still managed to achieve remarkable lives despite being discriminated against with regard to their class, race and gender. It was so empowering to me, as a woman, to see that these women, under the most difficult and restricting circumstances at the beginning and middle of the 20th century, were not afraid to walk alone down unconventional career paths to achieve career success in largely male-dominated professional and public spheres.<sup>3</sup> My Masters dissertation was influenced by the fact that each of these women had a strong belief in the importance of education and their life's work was in educating others to uplift themselves, as well as to create a space for others to follow. Here, the particular contributions of Mabel Palmer were key - as founder and organiser of the "Non-European Section" of the UN in 1936 - to provide higher education for black people, including that of medical education. In both projects, the UN was the institutional setting which linked the lives of the protagonists' in my work and it was this ambiguous and contradictory institution and its contributions to the history of the region, and any possible institutions which branched off from it, that led to my interest in studying its unique black Medical School. And it was through the UN's Killie Campbell Africana Library that I was able to discover much of my primary research material that facilitated my exploration of some of the complexities and contributions of black medical education in South Africa.<sup>4</sup>

For my Masters dissertation, I felt that medical history would be an interesting aspect to examine, because up until recent years it has not been a major focus in South African history.

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<sup>1</sup> See Vanessa Noble. "An Archive of Life Histories": Killie Campbell's Gift to KwaZulu-Natal. University of Natal Durban: Third Year Research Project in History, 1996 and Norman Herd. *Killie's Africa: The Achievements of Dr Killie Campbell*. (Pietermaritzburg: Blue Crane Books, 1982).

<sup>2</sup> See Vanessa Noble. "Ruffled Feathers": The Lives of Five Difficult Women in Durban in the 20th Century. A Study of the Lives and Contributions of Mabel Palmer, Killie Campbell, Sibusisiwe Makanya, Dr Goonam and Phyllis Naidoo. University of Natal Durban: Honours Dissertation in History, 1997.

<sup>3</sup> Mabel Palmer was an academic, Killie Campbell was an Africana archivist, Sibusisiwe Makanya was the first Zulu woman social worker, Dr Goonam was the first woman Indian doctor in Durban, and Phyllis Naidoo was an Indian woman lawyer who fought for people's human rights. They "ruffled feathers" in their communities as they challenged an array of conservative, traditional, sexist and racist forces blocking their paths to career success.

<sup>4</sup> Recently the Killie Campbell Africana Library, together with her house and her brother William's Museum, which contains artefacts, paintings, furniture etc., became known as the Campbell Collections.



Colleagues in History suggested that I should not restrict myself to analysing individual life stories of particular people only, but possibly expand my work and write a critical institutional history in which various individuals would feature. Only a few people have worked on the history of institutions in South Africa, and the problem with many of these works is their uncritical hagiographical nature.<sup>5</sup> Having read an engaging Ph.D dissertation on the institutional history of a black women's maternity hospital in Johannesburg - the Bridgeman Memorial Hospital - by Catherine Burns I was fascinated and intrigued by how such an institutional analysis could reveal interesting nuances and aspects of medical institutional history.<sup>6</sup> I began thinking about these themes and scouring the archives to determine if this would interest me. It was soon clear that no other major historical works had been done on the black Durban Medical School, and would provide me with a unique opportunity to analyse critically its medical education and training contributions to the region and South Africa more widely, and thus contribute to some of the gaps of research in this medical field.<sup>7</sup> In terms of accessibility, the School was also just down the road from the UN's main Howard College campus, and would thus easily facilitate an in-depth scouring and continued exploration of its archival materials, as

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<sup>5</sup> For largely hagiographic institutional studies see Edgar Brookes. *A History of the University of Natal*. (Pietermaritzburg: University of Natal Press, 1966), J.H. Louw. *In the Shadow of Table Mountain. A History of the University of Cape Town Medical School*. (Cape Town: Struik, 1969), Dr James B. McCord. *My Patients were Zulus*. (New York and Toronto: Rinehart and Co., Inc, 1951). However, other academics have written superb critical and engaging pieces on the complexities and contradictions of medical institutions including: Bruce K. Murray. *Wits the Early Years: A History of the University of the Witwatersrand Johannesburg and its Precursors, 1896-1939*. (Johannesburg: Witwatersrand University Press, 1982) and his later work, *Wits the 'Open' Years: A History of the University of the Witwatersrand, Johannesburg, 1939-1959*. (Johannesburg: Witwatersrand University Press, 1997), June Webber. "Fragmented, Frustrated and Trapped: Nurses in Post-Apartheid Transition at King Edward VIII Hospital, Durban". (University of Natal Durban: Soon to be completed Ph.D. Dissertation in Social Sciences), Howard Phillips. *The University of Cape Town, 1918-1948: The Formative Years*. (Cape Town: University of Cape Town, 1993).

<sup>6</sup> See Catherine Burns. "Reproductive Labours: The Politics of Women's Health in South Africa, 1900 to 1960". (Northwestern University, Evanston, Illinois: Unpublished Ph.D. Dissertation in History, 1995).

<sup>7</sup> No comprehensive accounts of this fascinating and extraordinary institution exist, other than a few pamphlets and booklets primarily marking anniversaries which usually celebrate the evolution of the institution, medical conference material, staff publications, statistical analyses, a few autobiographies and short articles in medical journals. See UN Archives, Pmb. H6/1. "UN Medical School Reconciliation Ceremony Address by Professor B.M. Gourley", 1995, H.L. Watts. "Black Doctors. An Investigation into Aspects of the Training and Career of Students and Graduates from the Medical School of the University of Natal". (University of Natal Durban: Institute for Social Research, 1975), "The Durban Medical School: A Response to the Challenge of Africa". (Durban: University of Natal Development Foundation, 1957), "1951-1976: 25 Years of the Faculty of Medicine at the University of Natal", "The Medical Faculty Silver Jubilee, 1951-1976".



often as need be. I found a rich wealth of fascinating primary material at both our local Natal archives and national State archives, which promoted my enormous excitement in the project.<sup>8</sup>

After much archival research, I decided to write an institutional history of the Durban Medical School - from its earliest times to the present - but I soon realised that my over-enthusiasm, stimulated by the massive quantity of source material I found, was far more than I could successfully chew upon. I have thus concentrated on the vital early years leading up to its establishment in 1951, but also the difficult “teething” problems it experienced during the first decade of its existence. Whilst searching through these archival collections I also constantly came across what sounded like a fascinating major department of the Durban Medical School that was connected to an earlier social and community health centre movement in a rural African community in Pholela near Bulwer in Natal. However, instead of being catalogued amongst the files and primary archival materials of the Durban Medical School, this Department of Social, Preventive and Family Medicine was catalogued and housed in its own separate folders, occupying its own space on the archival shelves and boxes. When I embarked on this institutional project, I never considered examining any particular department within the institution, but rather the institution as a whole. However, this unique department constantly drew my attention and I decided to analyse its contributions as part of the larger institutional historical project. When I glanced through this department’s folder contents, I very quickly realised how unconventional and important its particular contributions had been to the Durban Medical School, and South African medical education more widely. It was this department and its unique social, preventive and community health approach, which, if adopted nationally, would have placed Durban and South Africa in the vanguard of developments in this medical field worldwide. When I think back now, it is sad to reflect on the fact that while this department’s existence and focus on social and community health care was accorded the respect

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<sup>8</sup> Killie Campbell’s manuscript collection (particularly the E.G. Malherbe Collection, the Gordon Papers and Mabel Palmer collection) produced some fascinating insights. Other local archives including the UN archives and Provincial archives in Pietermaritzburg and the Medical School’s own archives, and the National State Archives produced more enlightening primary material in the form of minutes of meetings, memoranda, letters, reports, speeches and health-related material. However, what concerns me is that the extraordinary primary materials at the Durban Medical School have not been properly housed and catalogued, whether due to a lack of human and/or financial resources. There is very interesting material including letters, official UN and Medical School reports and memos, photographs etc. Instead they are contained in a dishevelled manner, with no systematic or organised cataloguing in the head librarian’s filing cabinet that is not very accessible to the public and interested researchers such as myself. There are also enormous gaps in the material which have been lost or misplaced over the years.

it deserved on the shelves of South Africa's archives, it was not appreciated in reality as an innovative health care alternative which could alleviate the country's desperate health needs. It was instead undermined by numerous parties and attacked from a variety of internal and external forces. Thus, my sojourn through the extensive archives in Natal and in Pretoria has provided me with extraordinary material on which to embark on my dissertation. However, I am also aware of the biases, weaknesses and gaps involved in using "official" archival material, and will return to this theme when I discuss my theoretical position later on in this chapter.

My aim is thus to examine the history of black medical education in South Africa, through the eyes of a particular Medical School in Durban, which, for more than twenty years before Medunsa was established in 1976, was the only tertiary institution whose main concern was providing medical training for black students. Its contributions have been praised by many for its high standards, attracting international recognition for its excellence in research and training, and for having trained more black doctors than any other University in South Africa. However, the means used to reach this desired end by many of the people involved over its nearly five decades of history, were from the start complicated, ambiguous, contradictory and in many instances unjust. Its pioneers, who recognised the urgent need for black medical training, were continually forced to struggle and fight an upward battle against a variety of forces determined to see them fail.

Before I can embark on any empirical analysis of the institution's history, it is essential that I place this dissertation amidst the theoretical debates and historiographical traditions that have influenced the form of my historical investigation. My aim is to write a history of the Durban Medical School as an interdisciplinary study within the wider debates and insights from international and local studies. Here I am particularly interested in questions around the nature of power, but especially apartheid power and its impact in the health sphere. Many historians and scholars have been interested in questions of power, especially State power, and many theories have been proposed regarding how the State gained hegemony in South Africa and how the apartheid State's power worked which enabled it to last for so long. It is from many of these scholastic works that I will begin my dissertation. I intend to show how complex interconnections of class and race - both socio-political and economic forces - directly influenced health provision and medical training in South Africa. These forces created massive inequalities

in all spheres but especially shaped the health sphere where my research is located. Of particular interest to my research is to analyse whether the racist apartheid State, which came into power in South Africa in 1948, was all-powerful and monolithic in all spheres, or whether in theory and practice was compromised and negotiated. What distinguishes my work here from many of the works I will consider, is that this thesis will reassess State power through the lens of health sector - a highly contested space - which prevented the State being able to simply impose, and carry out in practice all its racist apartheid ideas. I will show that these contradictions and ambiguities in State power both enabled innovative South African health professionals to negotiate unique spaces for themselves and even introduce a progressive health care system and black Medical School in Durban which ran counter to its intended racist and segregationist socio-political policies, but also pointed to how a system like apartheid actually worked. This central, inherent ambiguity was in fact apartheid's strength, and enabled it to survive for so long, because these many compromises and complex spaces actually fed the apartheid ideology, and gave the State time to adapt and reassess its original policies and even learn from its internal enemies. But this approach will also give due respect to, and not underestimate, individual people's complex daily lives and consider how in practice a system like apartheid could never be monolithic or all-encompassing. This study will thus be both a social and institutional history and will address some of the complex and intricate theoretical debates around medicine, power and knowledge, where issues of discrimination surrounding race, class and gender centrally impinged on people's lives.

### ***The Revisionist Tradition.***

While Marxist theory dominated the South African historiography for many years, from the 1970s onwards their often mechanistic, static and all-encompassing focus on economic class and State structural power relations were increasingly criticised for ignoring individual agency in the making of their own history.<sup>9</sup> These critics - who became known as the revisionists - while still recognising the significance of structural materialist issues in influencing people's lives, also argued for the importance of other factors such as race, gender, intellectual and popular ideas and

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<sup>9</sup> It is important to see that historiographical traditions are not fixed, especially in a subject as dynamic as history. Historiography (the thoughts and interpretative traditions) like history is constantly changing and shifting in relation to the demands and intellectual trends of particular historical moments.

culture, all of which influenced social change. Of particular importance in South Africa were the twinned issues of race and class, as John Cell argues:

Marxists went too far. By identifying class as real and structural while insisting that race is fictitious, mystifying and superstructural, they have oversimplified a complex problem. The consciousness, consolidation, power and hegemony of class are always developed and exercised in the context of specific historical circumstances. Throughout much of the world, race is an important part of that context.<sup>10</sup>

For Cell and other revisionists like him, both class and race are historical phenomena which powerfully influence societies in which they are situated, “in modern, capitalist, competitive societies that become or remain racially stratified, the two phenomena of race and class intersect in particularly confusing, complex ways. There is no simple horizontal class, only horizontal classes within races”.<sup>11</sup> This is especially true of the health sphere and it is from this central tenet that I will begin analysing the history of medical education in South Africa.

Many scholars, from within the Afrikaner nationalist tradition and its critics, have argued that because apartheid was based on the foundations laid by the previous segregationist regime, this facilitated the establishment of apartheid as a single, systematic grand plan which dominated every facet of life to preserve white minority rule in South Africa. As a socialist, Brian Bunting argued:

there has been nothing haphazard or laissez-faire about the Nationalist’s rule, in striking contrast to previous regimes. Operating on the basis of a preconceived ideology which has undergone very little change in the last 15 years, [they] have planned their strategy with care and worked step by step towards their goal. Nothing has been left to chance.<sup>12</sup>

<sup>10</sup> John W. Cell. *The Highest Stage of White Supremacy: The Origins of Segregation in South Africa and the American South*. (Cambridge: Cambridge University Press, 1982), p.16. The revisionists, which emerged in the 1970s, were influenced by the backdrop of renewed militancy in the struggle against apartheid and racial oppression in South Africa. They were vital in their historical context as while this tradition has become part of the establishment now, making it difficult to see how radical their “revisions” were, they importantly revised the historiography.

<sup>11</sup> Cell. *The Highest Stage of White Supremacy*, p.17. While this revisionist historiographical tradition has had slight variations within the body of its scholarship, they introduced complex “racial capitalism” theories to explain the nature of State power in South African society.

<sup>12</sup> Deborah Posel. *The Making of Apartheid, 1948-61: Conflict and Compromise*. (Oxford: Clarendon Press, 1991), p.2. Also see Dan O’Meara. *Volkskapitalisme: Class, Capital and Ideology in the Development of Afrikaner Nationalism, 1934-1948*. (Cambridge: Cambridge University Press, 1991). He also shows how much of the literature written from an Afrikaner nationalist perspective aimed to portray Afrikaners as sharing a common ideology, enemy and language and that their unity against these threats was their strength. In a later historiographical tradition, the liberal analysis of apartheid power was explained on the basis of the racist Afrikaner nationalists who hindered the logical outcome of capitalism and claimed that true unfettered capitalist development would lead to equitable racial

The revisionist tradition however was developed based on criticisms of these assumptions, and numerous scholars have shown how apartheid power was anything but monolithic. During the 1980s, both John Cell and Saul Dubow argued for the essential structural and ideological ambiguities embedded in segregation and later apartheid, which facilitated its success:

it was a many-faceted policy made up of varying components which could be and were subtly shifted in response to circumstances and to the needs of different interests of the dominant white group in South Africa. Indeed its great strength as an ideology was its very elasticity, its ability to serve the needs of very many different interests and to absorb 'elements stemming from the way of life of classes and fractions other than the dominant class or fraction.'<sup>13</sup>

John Cell maintains that segregation was not a crude or rigid system but triumphed for the very reason that it was flexible and sophisticated. He maintained that as a system which was:

mystifying, rationalising and legitimising a particular configuration of caste and class, it enabled white supremacy to survive in an increasingly threatening world ... For far from being the crude, irrational prejudice of ignorant 'rednecks', segregation must be recognised as one of the most successful political ideologies of the past century. It was, indeed, the highest stage of white supremacy.<sup>14</sup>

Dubow's later work concurred with Cell, as he asserted that its longevity can be explained by "this flexibility and ambiguity which facilitated a range of political alternatives, segregation, rather than being a simple rationalisation of white domination and capitalist exploitation, was an umbrella ideology which included a wide range of different interests in its consensual orbit".<sup>15</sup> This structural ambivalence extended to the emerging black bourgeoisie oppressed classes. While still confined within the boundaries of race, a small minority were given the opportunity of overcoming the barriers of class and thus had a stake in the system instituting a basis for collaboration, acquiescence and accommodation.<sup>16</sup>

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relations. The Liberals, like the Afrikaner nationalists explained apartheid origins and functions in terms of political and ideological factors to ensure white minority rule in South Africa.

<sup>13</sup> Saul Dubow. *Racial Segregation and the Origins of Apartheid in South Africa, 1919-36*. (Oxford: Macmillan, 1989).

<sup>14</sup> Cell. *The Highest Stage of White Supremacy*, p.18.

<sup>15</sup> Dubow. *Racial Segregation and the Origins of Apartheid in South Africa*, p.180.

<sup>16</sup> Cell. *The Highest Stage of White Supremacy*, p.19.

In 1991, Deborah Posel published a fascinating book entitled, *The Making of Apartheid* where she criticises assertions that apartheid power was monolithic, and instead argues for its contradictory and ambiguous nature. Posel shows how during the early “phase” of apartheid rule (1948-53), when the Afrikaner nationalists had a tenuous hold on political power, many of their apartheid policies and practices were not pre-determined or influenced by a single “grand plan” but were rather negotiated and compromised in both theory and practice. It took time for the Afrikaner Nationalists to impose their will. The process was fraught with inconsistencies, struggles and class conflict, which greatly influenced the implementation of its policies. Many facets of apartheid’s original policies also had to be revised and altered. It was only with a stronger Parliamentary majority during the later 1950s and 1960s that National Party ideology and practices became more entrenched. Posel showed how arguments for a ready-made “blueprint”, “misrepresented the political process whereby apartheid was built” by greatly exaggerating the extent of continuity, control and long-term planning involved, and thus undermine the extent to which its policies were forged through struggles within and beyond the State, which forced apartheid architects to adapt and revise many of their original strategies.<sup>17</sup> As Posel argues:

it is more important to explore more deeply within the workings of the State, to understand processes whereby various apartheid policies were made, implemented and contested. The single grand plan notion does not show the uncertainties, deviations, conflicts and failures of the internal workings of the State departments, which though less obvious than many of the continuities and triumphs of apartheid were vital to its development.<sup>18</sup>

For Posel the issue is not one of characterising apartheid in stark terms as an instrument of capitalist interests, but rather explaining how and why discrepancies between policy and practice arose because of different parties contesting it, and this importantly in turn “opens the space for a matrix of factors hitherto largely excluded or marginalised to enter the explanatory arena”.<sup>19</sup> The differences between its purposes and unintended consequences of apartheid policies recasts the explanatory framework and shows that many parties at different levels of society influenced how apartheid policy took shape.

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<sup>17</sup> Posel. *The Making of Apartheid*, p.5. She analyses the N.P.’s 1948 Sauer Report and shows that it did not have a single hegemonic conception of apartheid. It was rather an internally contradictory and ambiguous document.

<sup>18</sup> Posel. *The Making of Apartheid*, p.5.

<sup>19</sup> Posel. *The Making of Apartheid*, p.18.

This lack of a pre-determined policy by the National Party (N.P.) is also made evident by the fact that many historians have disagreed about the main functions and purposes of apartheid policy. Apartheid policy was not a single grand plan as it suffered from divided loyalties and conflicting interests within the N.P.'s own ranks which influenced its design. Historians have debated the relationship between apartheid and capitalism, and many agree - to varying degrees - that apartheid was designed both to preserve white racist minority rule and to provide the political conditions necessary for the expansion of all capitalist interests to promote white economic prosperity.<sup>20</sup> However, what is important to note, is that this debate showed that there was great controversy in Afrikaner circles centred around disagreement over how to attain and maintain white supremacy while still ensuring economic prosperity, which directly affected apartheid policy. Harold Wolpe's work has shown how apartheid segregation policies were greatly influenced by the needs of capital to ensure a cheap African labour force for industry, the mines and on farms and was thus designed to control the movement of labour between urban and rural areas.<sup>21</sup> Dan O'Meara's book, *Volkskapitalisme*, builds on this argument as well, and he shows how Afrikaner capitalists relied on its policies to survive. O'Meara reveals how Afrikaner nationalists and their racist policies were not unified but highly fractured and had deep divisions and conflicts as a capitalist class. These struggles directly influenced the way apartheid was built and whose interests it represented, as during the turbulent economic pressures of the 1940s, conflicting economic interests between industrial, mining and agricultural capitalists "required

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<sup>20</sup> While revisionist historians agreed to the dual influence of racial capitalism on apartheid policies, many disagreed over whether apartheid acted as an instrument or obstacle to capitalist interests. Also see Saul Dubow. *Illicit Union: Scientific Racism in Modern South Africa*. (Cambridge: Cambridge University Press, 1995). Dubow adds an interesting dimension to the debate and shows how pseudo-scientific doctrines of social Darwinism and eugenics exerted a further important influence on South Africa during the 1930s and even 1940s. It was these theories which lay behind the concern to preserve "racial purity", based on the common speculation about the innate intelligence of different races, an unquestioning acceptance of the 'evils' of miscegenation, and a highly charged fear about the 'degeneration' of both black and white races in the industrial context.

<sup>21</sup> Harold Wolpe. "Capitalism and Cheap Labour Power in South Africa: from Segregation to Apartheid", in *Economy and Society*, (1971: 1/1). For Wolpe, the successful growth of the economy took place on the basis of cheap migrant labour and that segregation functioned to subsidise industry's labour costs by ensuring that the burden of the social reproduction of the black labour force was mostly met by the pre-capitalist economies of the reserve, which enabled wages to be pegged a very low levels. However, the combined effects of greater mechanisation in industry under war-time expansion as well as a breakdown of production in the reserves saw the influx of thousands of rural Africans into the urban labour market in open defiance of influx control (and represented a threat to skilled and semi-skilled white labour). Wolpe argued that apartheid was thus implemented as a specific system introduced at a specific time, to secure the cheap reservoir of African labour, under conditions in which African reproductive capacities in the rural reserves were being eroded.

differing forms of State intervention to secure and restructure conditions of accumulation”.<sup>22</sup> Towards the 1948 election, the N.P. obtained its support by negotiating a fragile alliance - a “new economic order”- by promising to secure cheap labour for all three Afrikaner capitalist sectors.<sup>23</sup> However, during the election and thereafter, the Afrikaner capitalist class remained divided over competing interests and thus the very nature of apartheid to protect white supremacy interests and its economic policy was questioned.<sup>24</sup> Afrikaner nationalism and its apartheid policies must thus be analysed and studied in the historically specific context of the contradictions and struggles in the development of capitalism in South Africa.

Posel argued that apartheid design was influenced by many other factors besides serving capitalist interests. Of particular importance is historical contingency and that much of its programme was adopted in reaction to immediate pressures and priorities of the historical moment. Of particular importance in this regard, was the growing militancy and protests of the urban African proletariat during the war years who opposed the exploitative system of racial capitalism with its worsening conditions of poverty, overcrowding and ill-health.<sup>25</sup> This collective and individual resistance left an indelible mark on its design, legislative promulgation and administration. Resistance included squatter movements, mass demonstrations against pass laws, transport fares, food shortages and liquor raids. The white racist “State was threatened by the prospect of a united cohesive African working class, where ‘tribal’ differences were fast eroding” and thus had to act against these unexpected perceived threats to policies.<sup>26</sup> It could never be a single grand plan as apartheid architects never knew to what extent or form black resistance would take and were forced to continually refine their policies as the system developed. While collective, organised resistance was slowly eliminated through legislative

<sup>22</sup> O’Meara. *Volkskapitalisme*, p.232. With better wages being offered to Africans in secondary industry, the massive influx into the urban areas greatly drained white agricultural farmers of their labour and increasingly the State had to intervene on their behalf during the 1940s to secure cheap labour to work their farms.

<sup>23</sup> O’Meara. *Volkskapitalisme*, p.234. While the war managed to enable the weakened United Party (U.P.) Smuts Government to continue, because of the profits generated in all sectors of the economy, after the war, the U.P. was not able to simultaneously represent all interests and maintain a coherent policy.

<sup>24</sup> See O’Meara. *Volkskapitalisme*, p.243. However, unlike O’Meara who argued that economic interests united the Afrikaners in policy of total segregation under the term apartheid in a “single political movement”, Posel maintains that conflicting interests continued with regard to the degree of apartheid policy. See Posel. *The Making of Apartheid*, pgs. 51-54. The N.P. was divided over whether to embark on “total segregation” which the extreme racial supremacists called for, or “practical apartheid” which the industrialists wanted to allow for a relaxation of influx control measures to enable them to continue benefiting from an abundant supply of cheap migrant labour.

<sup>25</sup> Posel. *The Making of Apartheid*, p.27-34.

<sup>26</sup> Posel. *The Making of Apartheid*, p.38, 264.



measures and had limited success, Posel shows how unorganised and informal resistance was more successful.<sup>27</sup> The apartheid State thus, not only suffered divisions in its own ranks, but also suffered external complications as well.

### *New Historiographical Influences in the Revisionist Tradition.*

While I firmly place my dissertation within the explanatory framework of the “racial capitalism” of the revisionist tradition, my work has also been influenced by more recent trends in South African historiography. In South Africa, the mainstream revisionist historiographical tradition has become increasingly influenced by particularist histories, especially radical social history and women’s history together with its feminist theoretical arguments. These traditions have resulted in an increasingly subjective approach towards the writing of history and have stressed the distinctiveness of the historian’s position as opposed to the central, “objective” mainstream historical approaches. For the first time the inclusion of previously marginalised historical perspectives contributed to new methods of interpreting and writing about history.<sup>28</sup> But both traditions have opened up exciting new theoretical and methodological approaches.

Because the nature of apartheid has been debated by revisionists by way of its relationship to racial capitalism and dominant interests and tacitly downgraded the importance of “struggles from below”, recent historians have rejected the distorted large-scale, mainstream revisionist metanarrative history to examine the intricacies and complexities of social life - the inner dynamic which drives history.<sup>29</sup> Aware of the gaps in the broad themes of the revisionist scope, these social historians have promoted a shift in the historiography and argued for a closer

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<sup>27</sup> Posel. *The Making of Apartheid*, p.264-266. This included evading laws, continued influx into the cities as illegals to live and work. Also see Paul Maylam and Iain Edwards (eds). *The People's City: African Life in Twentieth-Century Durban*. (Pietermaritzburg: University of Natal Press, 1996) for an account of how African men and women in the city of Durban, managed to carve social, political and economic spaces for themselves, despite apparently rigid apartheid laws and policies.

<sup>28</sup> Peter Novick. *That Noble Dream: The “Objectivity Question” and the American Historical Profession*. (Cambridge: Cambridge University Press, 1988). Although in South Africa this trend happened many years later, Novick shows how these new fields of radical social history and women’s history during the 1960s in America resulted in a crisis in historical “objectivity” - an unobtainable ideal - because these emerging historians wrote from within their own particularist positions and attacked the values of the mainstream approaches to history. History seemed in danger of losing its ability to establish the “truth”, as historians were no longer “non-historical observers” but rather wrote from within a specific historical position with a specific agenda in mind.

<sup>29</sup> However, this criticism can only come because that leg-work research has already been done and absorbed. They are in fact new revisionists, in whose efforts to find new ground for examination occasionally fall into the trap of denying their historical heritage.

examination of the role that issues of gender, culture, ideas, psychology, identity and consciousness have played in shaping history.<sup>30</sup> They have provided a definitive critique of exclusively “top-down” explanations and made an enormous contribution to South African historiography, by abandoning the overdeterminism of structure and focused on the “lived experience” and agency of marginalised and oppressed people at the “bottom” of society.<sup>31</sup> Their work thus brought the subordinate classes to the foreground as actors, who were also engaged in multi-faceted processes of struggle against the weight of the State and capital bearing down upon them.

What is important is that because they had a very specific political agenda of exposing the contributions of the underclasses to history and because the conventional or “official” records have been silent about people at the “bottom” of society, these social historians also developed a new methodological approach. Other historians, such as Ralph Trouillot have provided thought-provoking analyses of history and the power of archives to silence historical narratives.<sup>32</sup> While arguing that history has a power of its own beyond the present interpretations of it, Trouillot still recognises the uneven exercise of power in the creation, cataloguing and use of historical sources that people must be aware of when writing about history:

this book is about history and power. It deals with the many ways in which the production of historical narratives involves the uneven contribution of competing groups and individuals who have unequal access to the means for such production

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<sup>30</sup> For South African examples see Charles van Onselen. *The Seed is Mine: The Life of Kas Maine A South African Sharecropper, 1894-1985*. (Cape Town: David Philip, 1996) and Belinda Bozzoli. *Women of Phokeng: Consciousness, Life Strategy, and Migrancy in South Africa, 1900-1983*. (Johannesburg: Ravan Press, 1991). For international perspective see Gert Brieger. “The Historiography of Medicine” in W.F. Bynum and Roy Porter (eds). *Companion Encyclopedia of the History of Medicine*. (London and New York: Routledge, 1993), p.24-30. Brieger has shown how the writing of medical history, like history generally, has also had changing historiographical traditions in the international arena. Whereas much of the medical history up until 25-30 years ago were mainly hagiographies of triumphant progress and technical advance written by doctors in the interests of the medical profession, and analysed diseases in narrowly biological or technical levels of understanding, this has shifted largely under the influence of the social history tradition of the 1960s. He shows how over the last few years a more mature social history of medicine has emerged which has included analyses of doctors and their patients, the changing nature of women’s health and women’s role in the profession, as well as the wider influences of social, political and economic conditions on disease. The work is also more problem oriented and interdisciplinary than earlier work.

<sup>31</sup> Edward Thompson. *The Making of the English Working Class*. (Harmondsworth: Penguin, 1963). The social historical tradition began under the influence of a radical Social Marxist historian, Edward Thompson, during the 1960s who was influenced by political activism and the thrust of deinstitutionalisation. He was critical of Marx’s metanarratives of structure and class to the exclusion of agency and history “writ small”. He argued that people are active in the making of their own histories, and that their lives are not merely socially and historically conditioned. Many South African social historians were influenced by this international tradition.

<sup>32</sup> Ralph Trouillot. *Silencing the Past: Power and the Production of History*. (Boston: Beacon Press, 1995).

... I also want to reject both the naive proposition that we are prisoners of our pasts and the pernicious suggestion that history is whatever we make of it. History is the fruit of power, but power itself is never so transparent that its analysis becomes superfluous. The ultimate mark of power may be its invisibility, the ultimate challenge, the exposition of its roots.<sup>33</sup>

Together with this awareness of the archival power's ability to silence and exclude the voices of the oppressed from history, social historians have promoted oral history (the use of the remembered past) as the essential tool for historians writing about the pasts of oppressed, illiterate and marginalised communities and provide a more balanced historical perspective. Isabel Hofmeyr's book, *We Spend our Years as a Tale that is Told*, has been particularly useful in this regard.<sup>34</sup> In reconstructing "oral historical narratives", Hofmeyr conducted numerous interviews with local men and women in an attempt not only to capture the individual person's remembered personal pasts but also to recapture the oral traditions of the people from Valtyn in the Transvaal and has provided invaluable information with regard to this particular African community which would otherwise have remained silenced. Charles van Onselen's book, *The Seed is Mine*, has also done vital historical work using oral sources, but instead of using it to supplement the existing written historical record, he shows how oral history in itself is an essential historical practice which can stand on its own. This he demonstrates in the life history of a black sharecropper, Kas Maine. His protagonist in his book, is the "biography of a man who, if one went by the official record alone, never was".<sup>35</sup> Kas only appeared once in the archival record. Thus the reconstruction of Kas's life through oral history methods demonstrates the

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<sup>33</sup> Trouillot. *Silencing the Past*, p.xix. Trouillot shows how power and silences enter the process of historical production at four crucial moments: fact creation, fact-assembly, fact-retrieval and historical interpretation. Archives are a representation of a collection of facts, which the dominant culture at that point in time deemed relevant to history. However, unlike the many post-modernists and post-structuralists who have criticised and undermined the very discipline of history, as something that does not exist outside the present interpretation of it, Trouillot - and I would agree - argues for the essential existence of a historical past, and that the only way to try to uncover and analyse this authentic, autonomous historical past is by recognising the numerous mostly hidden powers that silence, and which thus shape the writing of the historical narratives.

<sup>34</sup> Isabel Hofmeyr. *We Spend our Years as a Tale that is Told: Oral Historical Narratives in a South African Chiefdom*. (Johannesburg: Witwatersrand University Press, 1993). Oral historians have to be constantly aware of problems with regard to the "remembered" past such as loss of memory, hagiographic renditions of people's individual involvement in past events, deliberate falsifying of the truth etc. However written sources are also plagued by bias and "silencing" problems and its thus important to verify the historical past one's dealing with by using as many varied sources as possible to substantiate the information. The problem of subjectivity is also present when reconstructing sources through oral history, and the researcher needs to be constantly aware of the limitations of their own involvement in the process of the construction of historical knowledge.

<sup>35</sup> van Onselen. *The Seed is Mine*, p.3.

power of oral historical traditions to reclaim the life of a black man, who in his individual and small way, made a unique contribution to the history of South Africa.

Along with social historians, feminist scholarship - aimed at uncovering the hidden voices of women in all spheres in society - has also fundamentally transformed disciplinary paradigms in South Africa, especially history. As Joan Wallach Scott has argued, because it has been one of the major “silences” in an androcentric historical tradition, the study of women could not simply be added to it as a new subject matter, but required a critical re-examination of the very premises and standards of existing scholarly work, “it implies not only a new history of women, but also a new history”.<sup>36</sup> However, more importantly, it helped to forge a new historical tradition in a number of settings as well as in South Africa, bringing individual women’s voices to the fore by using the theoretical and methodological approaches of social history. Drawing on the strengths of autobiographical and biographical history has brought a whole host of individual life histories and experiences of women, especially black women’s silenced and marginalised voices to the fore, and vitally contributed to the racist and gender biased conventional South African historiography.<sup>37</sup> Much of South Africa’s influential women’s history has been interested in analysing how the inequalities of power have been organised along three axes - race, class and gender - where black women have experienced the most oppression. Feminist historians have employed a variety of theoretical approaches to analysing inequalities in women’s history and thus importantly, helped to inform strategies for change.<sup>38</sup>

An important body of literature which described and analyses women’s realities emerged during the 1980s and stemmed largely from radical Marxist and social historians. Belinda Bozzoli’s 1983 Marxist-feminist analysis issued a call to extend the historiographical analysis into the domains of patriarchal and class relations within households and between the domestic

<sup>36</sup> Joan Wallach Scott (ed). “Gender: A Useful Category of Historical Analysis” in *Gender and the Politics of History*. (New York: Columbia University Press, 1988), p.29.

<sup>37</sup> See Bozzoli. *Women of Phokeng*, Margaret McCord. *The Calling of Katie Makanya*. (Cape Town and Johannesburg: David Philip Publishers, 1995), Shula Marks. *Not Either an Experimental Doll: The Separate Worlds of Three South African Women*. (Pietermaritzburg: University of Natal Press, 1987), Ellen Kuzwayo. *Call Me Woman*. (Johannesburg: Ravan Press, 1996), Emma Mashinini. *Strikes have Followed Me all my Life: A South African Autobiography*. (London: The Women’s Press Ltd, 1989), Phyllis Ntantala. *A Life’s Mosaic*. (Berkeley: University of California Press, 1993).

<sup>38</sup> Scott. “Gender: A Useful Category of Historical Analysis”, p.33.

and productive spheres.<sup>39</sup> Scholars, such as Bozzoli, have engaged in critical debates that have resulted in the expansion of theoretical approaches to understand the nature of class, race and gender relations within many sites of oppression, exploitation and resistance.<sup>40</sup> Of particular importance has been growing numbers of works concentrating on analysing opposing and contradictory forces located in the “public” sphere.<sup>41</sup> In a radically transforming society, as the neat divide between private and public dissolves under careful scrutiny, many scholars have showed how women laboured, together and alone, for decades of this century, to fight for a space in and broaden the definition of, a predominantly white male public sphere. These works have prepared the foundation for exploring complex intersections within these categories, elaborated in day-to-day experiences of women, and have used novel means of approaching the silences in the historical record.<sup>42</sup>

Since the 1990s, many historical works, especially those within the feminist tradition, have increasingly incorporated more in the way of post-structural theoretical analyses to understand the nature of power relations in society.<sup>43</sup> Michel Foucault’s work has been seminal in this regard. Instead of focusing on powerful individuals or oppressive structures (such as the central power of the State), Foucault has analysed the more pervasive, insidious, relational and negotiated mechanisms of power and how it filters down into society to demonstrate the

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<sup>39</sup> Belinda Bozzoli. “Marxism, Feminism and South African Studies”. *Journal of South African Studies*, Vol. 9, No. 2, April 1983. African women have experienced many forms of subjugation in society in the form of unequal gender relations, economic exploitation and racial oppression. Of these, patriarchy has resulted in women’s subordination generally but also within the parameters of segregationist ideologies in what Bozzoli calls “patchwork of patriarchies”.

<sup>40</sup> See Shula Marks. *Divided Sisterhood. Race, Class and Gender in the South African Nursing Profession*. (London: Macmillan Press Ltd, 1994). This work has also provided a critical enquiry into the nursing profession of South Africa and applied an analytical framework of race, class and gender in weaving the complexities and contradictions of hierarchy and domination into the history of nursing.

<sup>41</sup> See C. Walker (ed). *Women and Gender in Southern Africa to 1945*. (Cape Town: David Philip, 1990). Much work has been done on the “sex-gender” system and sexual division of labour in both domestic and paid work. This book attempts to understand women’s experiences under the impact of patriarchal, colonial and capitalist forces. It shows that gender inequalities cut across races, with an uncompromising persistence in constructing women’s social role in domestic terms - that of nurturers, care-gives, and reproducers - compared to men who were seen as decision-makers and providers. But it also show’s sites of women’s resistance to and their own compliance in their oppression. Also see C. Walker. *Women and Resistance in South Africa*. (London: Onyx Press, 1982). Her work on women and resistance largely centred around productive work enlarged the image of African women, not as passive victimised and oppressed, but make visible their strategies and leadership in resisting racial and class oppression.

<sup>42</sup> See Bozzoli. *Women of Phokeng*.

<sup>43</sup> Post-modernism and post-structuralism as new scholarly trends have challenged many binary oppositions, overarching rules, social and linguistic forms of construction, structuralist formulations in human relations and opposed essentialist notions of the certainty of meaning within many academic traditions.

multiplicity of subject positions people hold in relation to this.<sup>44</sup> He also shows how people actively engage in activities that reproduce dominant relations of power and it is this, which enables power to thrive. His work was particularly useful for feminists who employed his conceptual devices to explain the social organisation of production and reproduction of women's unequal subject positions and relations according to their gender.<sup>45</sup> For Foucault, the basis of power is in minute, "capillary-like" relations of domination:

that is dispersed, heteromorphous, localised procedures of power are adapted, reinforced and transformed by these global strategies, all this being accomplished by numerous phenomena of inertia, displacement and resistance; hence one should not assume a massive and primal condition of domination, a binary structure with 'dominators' on the one side and 'dominated' on the other, but rather a multiform production of relations of dominations which are partially susceptible of integration into overall strategies.<sup>46</sup>

However, many historians have criticised him for overrating the density of power's saturation of society, which leaves little room for individual agency and resistance, or critiques of the larger structures of authority and power.<sup>47</sup> Thus, while it is very useful to conceptualise aspects of apartheid power with regard to the health sphere as more fluid and contradictory, with multiple locations of power, Foucault's conceptual tools for exploring issues of resistance which facilitate individual human agency and recognise the resistance of power at many levels are inadequate. I will show that at certain historical moments and places, individuals did escape the apartheid State's power, especially if they were aware of it and could thus resist it. As Ania Loomba has argued, power relations involve "complex reciprocity" where the oppressed do act to "negotiate the cracks of dominant discourses in a variety of ways."<sup>48</sup>

<sup>44</sup> Colin Gordon (ed). *Power/Knowledge: Selected Interviews and other Writings, 1972-1977 by Michel Foucault*. (New York: Pantheon Books, 1980), p.236.

<sup>45</sup> Colin Jones and Roy Porter (eds). *Reassessing Foucault: Power, Medicine and the Body*. (London and New York: Routledge, 1994), p.11.

<sup>46</sup> Gordon. *Power/Knowledge*, p.142.

<sup>47</sup> See Jones and Porter. *Reassessing Foucault*, p.10 and Gordon. *Power/Knowledge*, p.255-256. These scholars have argued, that this approach could end up serving reactionary ends through their masking of the historical exercise of power. And also, because his theoretical arguments are not located on the side of resistance, people are trapped in an inescapable form of domination, because the multiplicity and fluidity of power-relations imply their imperviousness to resistance.

<sup>48</sup> Ania Loomba. "Can the Subaltern Speak? Postcolonialism, Postmodernism and Writing Subaltern History". Unpublished paper delivered to the History and African Studies Seminar Series (no. 9) University of Natal, Durban, 1998, p.2. Loomba's paper shows how human agency may not take the traditional form of "oppositional consciousness", but can take any form of resistance, engagement or negotiation; but, importantly, these more hidden forms of opposition need to be identified to decentre notions of the oppressed as silenced.

Thus the writing of much of this work has only been possible in the light of my own thinking with regard to social history and feminism in particular - with influences from more classical Marxist theory and the work of such scholars as Foucault.

In this thesis I will thus draw eclectically on theoretical ideas from a variety of traditions to show the complexities and nuances of relations of power in the medical sphere in South Africa. As a final note on theoretical influences on my work, I must also assert that this work was greatly assisted because of having been written in the context of post-apartheid South Africa. Of particular importance in this regard is that it has been facilitated by pragmatic access to people who were prepared to be interviewed by a white researcher like myself, and discuss difficult issues concerning race and oppression with me. I think its fitting that I have had the privileged of researching and writing this project now, in this South African post-apartheid moment, as we near the end of the millennium as well as the 50 year anniversary celebrations of the Durban Medical School, as it is an important time of self-reflexivity for many people and institutions and facilitates my reassessment of apartheid and health with fresh eyes. As a young historian, especially fascinated by the often unexpected and interesting sidelights, contradictions and ambiguities of history - at a juncture in time when the disciplines foundations are being undermined - I hope to show that history, as a discipline studied and written in conjunction with other disciplines, has fascinating and rewarding lessons to teach South Africans. As a cross-disciplinary exercise in writing about “the history” of an institution in the “medical” sphere, I have learnt much from my encounter with the medical paradigm. I hope that my historical disciplinary skills will make a contribution to a better understanding of the complex history which surrounded the establishment of black medical education in South Africa, and possibly provide some lessons for future medical education policy makers.

### ***Political Economy of Health in South Africa.***

Thus having discussed the theoretical debates and historiographical traditions which have informed my historical investigation generally, it is important - before moving onto the next section which provides empirical discussions of factors which influenced the establishment of black medical education in South Africa - to demonstrate how these particular debates and

traditions regarding the nature of State power impacted more specifically in the health sphere. Two decades after the revisionists began their “revision” of South African history; its main tenets are so accepted that few would deny the validity of the racial capitalism thesis. It is from within this explanatory framework that I write and place my theoretical interpretation of medical history in South Africa. This thesis will demonstrate - by employing the twinned and historically specific metanarratives of race and class to understand the nature of State apartheid power in society - that racist segregationist ideology had a powerful influence on the provision of unequal health care facilities and educational training for blacks in this country.<sup>49</sup> A wide range of ideological forces, political considerations and deep economic structural inequalities always mediated and shaped competing claims to supposedly egalitarian health service in South Africa.<sup>50</sup> However, while unequal health services were overwhelmingly influenced and regulated by the discriminatory State, it will also be shown how doctors and their organisations aided in the provision of inadequate health services.<sup>51</sup> Doctors advocated purely curative medical responses to solve ill health while the social preventive policies necessary for improvement were

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<sup>49</sup> While gender analysis has largely been of less importance in this historiographical tradition, this thesis provides a tacit recognition that gender inequalities and discriminations have always made the lives of women, especially black women in the health sphere, far worse than men. The use of oral interviews and autobiographical and biographical works will provide important insights into their particular experiences.

<sup>50</sup> Steven Feierman and John M. Janzen (eds). *The Social Basis of Health and Healing in Africa*. (Berkeley, Los Angeles and Oxford: University of California Press, 1992). Also see Guenter B. Risse. “Medical Care” in *Companion Encyclopedia of the History of Medicine*, p.45-46. He provides an interesting argument that State power in the medical/health sphere was always compromised by the “universality” of its impact in all human societies. History reveals that in every society, people have suffered physical and emotional distress and illness and sought assistance from people devoted to healing. However, while disease is universal and has no respect for boundaries (its racially, culturally and gender-blind), the different societal cultural frameworks have determined acceptable definitions, explanations and treatments for health problems. The provision and nature of the healing practice has also been a contested area and continues to be.

<sup>51</sup> See Shula Marks and Neil Andersson. “Typhus and Social Control: South Africa: 1917-1950” in Roy MacLeod and Milton Lewis (eds). *Disease, Medicine and Empire. Perspectives on Western Medicine and the Experience of European Expansion*. (London and New York: Routledge, 1988), Randall M. Packard. *White Plague, Black Labour. Tuberculosis and the Political Economy of Health and Disease in South Africa*. (Pietermaritzburg: University of Natal Press and James Currey Publishers, 1989), Randall M. Packard. “Industrialisation, Rural Poverty and Tuberculosis in South Africa, 1850-1950” in Steven Feierman and John M. Janzen (eds). *The Social Basis of Health and Healing in Africa*. (Berkeley, Los Angeles and Oxford: University of California Press, 1992), Elaine Katz. *The White Death: Silicosis on the Witwatersrand Gold Mines*. (Johannesburg: University of the Witwatersrand Press, 1994). The above works all to varying degrees (and focusing on different diseases) show how the provision of unequal health care was directly influenced by racist capitalist policies and segregationist ideology. However, they also show how public health doctors were at the forefront of demands for urban segregation to help prevent the spread of infectious diseases, which they saw black communities carried. This “sanitation syndrome” as Maynard Swanson coined, showed how medical and “scientific” thought directly influenced racist ideas in society. It was never simply a one-way process where racist State ideas permeated the medical profession. These medical ideas provided a compelling rationale for major forms of social control by the State which rationalised their early segregationist moves on the basis of the prevention of disease.



left unimplemented. While they recognised that disease and general ill-health in black communities was a direct consequence of the structural contradictions in the development of racial capitalism in South Africa, where the exclusion of blacks from incorporation into the capitalist economy except as a cheap, exploitable migrant labour force resulted in ill-health, impoverishment and underdevelopment in the reserves, they did nothing to address these underlying socio-political causes of disease. Thus, in this thesis the central political battles are centred on health and health reform as a vital shaping influence on the political economy of South Africa. Instead of taking the view that health is merely a “backseat” provision in the State’s policies of the day, I will show how struggles for health took central stage.

### ***State Sponsored Curative, Hospital-Based Medicine - The Other Problem?***

Another major problem promoting inequality in health care provision in South Africa, as with many Western countries, is that while disease is a universal phenomenon, the provision and nature of the dominant healing/therapeutic tradition has always been contested. In South Africa, State power, through legal and financial intervention on the side of curative, hospital-based scientific biomedical systems of healing have dominated and undermined other indigenous traditions.<sup>52</sup> The problem is that expensive and high-tech hospital-based medicine is only available to a small section of the population, while the majority seek assistance from indigenous healers.<sup>53</sup> Many African patients have also avoided hospital-based medicine because of its

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<sup>52</sup> Steven Feierman and John M. Janzen (eds). “Therapeutic Traditions of Africa: A Historical Perspective”. *The Social Basis of Health and Healing in Africa*. (Berkeley, Los Angeles and Oxford: University of California Press, 1992), p.164-165. Many people have written about the State’s power as a central shaping influence in promoting particular medical traditions that are not beneficial but detrimental to health care. Others have shown the pervasiveness of the political dimension in healing. See Paul Rabinow (ed). *The Foucault Reader: An Introduction to Foucault’s Thought*. (London: Penguin Books, 1984), Gordon. *Power/Knowledge*, Jones and Porter. *Reassessing Foucault*, Michel Foucault. *The Birth of the Clinic. An Archaeology of Medical Perception*. (New York: Vintage Books, 1994). Foucault shows how health (under the newly emerging scientific biomedical “clinical” tradition) during the 18th century, becomes a matter of social, political and economic concern, where the State and wider society sanctioned the employment of medical knowledge claims and practices as apparatuses to regulate, manage and control the sick. But he also shows how power became localised within particular institutions, such as hospitals at the same time, which created new scientific medical knowledges and technologies and experts (doctors which reproduce the unequal power relations with their patients). Within these institutional setting he shows the capacity of medical power (“the gaze”) while apparently positive and benign, to be oppressive, where technologies of power (based on experiments, systems of observation, notation and record making) create powerless subjects (patients). Disease thus becomes an object of certain forms of knowledge and a target of certain institutional practices to manage both individual and collective health.

<sup>53</sup> Risse. “Medical Care”, p.57. Western biomedical tradition has up till recently been characterised by its largely white male university trained professional cadre of physicians who fought to establish their position at the top of the hierarchy of other healers with their dominant individualist, empirical and scientific-based worldview and value-

detached impersonality of a positivist and reductionist “scientific-value” orientation as a dehumanising experience, and rather seek out their own indigenous healers who have a wider understanding of their patients within their societies and communities and provide emotional support.<sup>54</sup> However, the State - which endorses and supports this biomedical tradition to the exclusion of all others - legislatively closed down other healing spaces. By examining this process one can again see the devastating effects racist State influence can have over the provision of health services for South Africa’s black communities. However, these alternative health traditions have never been completely dislodged from their communities and I will show that the actual patterns of health care thus emerge from the midst of these paradoxes.<sup>55</sup>

### ***Ambiguous State Power with Regard to Health.***

The impact of this tradition on my research has also been the recognition on the part of revisionists that State apartheid power was never as monolithic as it may have appeared. The arguments made by various historians such as Cell, Dubow and Posel will be incorporated throughout this thesis, to show how apartheid power was negotiated, ambiguous and compromised in theory and practice. The difference in my dissertation to the above-mentioned work is that I will reassess the negotiated nature of State power through the lens of the health sphere. I will show that State power was uncertain and precarious at all levels in the health arena, from its central Department of Public Health in Pretoria down to its smallest locale of power in the form of an individual health centre in a rural community in South Africa. It was a highly contested space, which never allowed apartheid power to be a monolithic entity in reality, but was compromised and involved in constant struggles and conflicting interests. While I will mainly focus on the positive consequences for health provisions and training that emerge from this ambiguity, it is also important to point to the even bigger contradiction: that this central, inherent ambiguity in the system was ironically also apartheid’s strength, which enabled it to survive for so long. I will show how the many compromises and negotiated spaces that emerged

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system to the exclusion of all others. Scientific and technical advances have over the years been linked to doctors’ professional status as healing was reorganised around particular specialties who have struggled for control of the market.

<sup>54</sup> Risse. “Medical Care”, p.67.

<sup>55</sup> Feierman and Janzen (eds). *The Social Basis of Health and Healing in Africa*, p.16. Also see Catherine Burns. “Louisa Mvemve: A Woman’s Advice to the Public on the Cure of Various Diseases”. *Kronos: Journal of Cape History*. No. 23, November 1996

from conflicting positions actually fed into the apartheid ideology, gave the State time to adapt and reassess its original policies and thus even learn from its internal enemies to enable it to impose better thought-out and more inflexible policies at a later stage.

The main arguments and body of this thesis will attempt to demonstrate the positive consequences for health and medical training that emerged from these contradictory State policies. The unique negotiated spaces created in these battles at many levels against the State provided many opportunities for innovative health professionals - interested in alleviating the massive burden of ill-health in the majority of black communities - to introduce a unique experiment designed to completely reorient the way modern medicine delivered health care to impoverished communities through preventive, social and community medicine, as well as bring their dreams of a full medical education for black students to fruition. I will analyse throughout this dissertation how it was possible that precisely during South Africa's particular racist and segregationist socio-political circumstances that the country was able to lay the foundation for some of the most progressive developments in health services and medical education the world has ever seen, while still maintaining the hegemonic racial ideology of white South Africa. This approach thus undermines any "grand-plan" notions of apartheid power, as it will give due respect to individual contributions in their daily lives and shows that apartheid policies were forged through struggles within and beyond the State.

### ***Structure of Dissertation.***

This dissertation is divided into five chapters. This chapter has tried to raise many of the major issues and themes discussed in much greater detail in the remainder of the chapters. My aim to show the reader as clearly as possible what each of the individual chapters analyse and how they relate to one another in the overall scheme of things. This thesis is essentially a narrative history, designed to show the complexities of a series of unfolding events and the diversity of responses to these events, over a thirty-year period from approximately 1930 to 1960. This will not be merely an uncritical chronicle or rending of facts of the growth and successes of an extraordinary black medical training institution, but also a critical analysis of its failings and weaknesses. While the narrative of events and debates will be dealt with as chronologically as possible within individual chapters, at times the reader will encounter separate

chapters which appear to be re-examining events already mentioned or discussed. This is an unavoidable occurrence and is a telling commentary on historical form: as particular events or factors influence one particular aspect of society or history in one way, they may simultaneously have a very different effect on another. This is especially evident with regard to many of the parallel debates and factors which both facilitated the emergence of the progressive social and community health centre movement and the establishment of the Medical School for black students in Durban.

Chapter One - "The Emergence of Durban in the Political and Social Fabric of Health in South Africa" is concerned with the wider segregationist political, social, economic and medical contexts during the late 1920s and 1930s from which debates for progressive social and community medicine and ideas for the training of black medical students would arise. It traces and analyses the developments and debates which led to the growing awareness of the State, medical and other concerned lay people, of the importance of preventive medicine as the only possible way forward to address the disastrous state of public health in South Africa generally, but especially for its oppressed and marginalised black majority labouring under the burden of ill-health. This chapter focuses on the State's small, cautious, and under-funded Department of Public Health (D.P.H.) and its vastly inadequate and divided provision of health services according to race. It provides a broad-based analysis of the desperate plight of health in South Africa, and how these concerns were debated at a national level, before moving onto an analysis of the more specific, localised context of a unique social and community health experiment in rural Natal, which would later be in dialogue with, and even radically transform this weak Department of Public Health at a national level.

Chapter Two is entitled, "The Pholela Health Centre and the Development of a National Health Service". Running parallel to these D.P.H. national debates to find better options for inadequate public health policies, I will analyse in this chapter, the small but significant beginnings of a progressive, but at first non-mainstream and peripheral preventive social and community health centre experiment in a black rural reserve area of Pholela in Natal which came to provide vital answers to the D.P.H.'s searching health questions. Much of this chapter will analyse the innovative contributions of individual pioneer doctors at both a local "grass-roots" level, and a national level (those in influential legislative and decision-making capacities) who

initiated, facilitated and championed the continued development of this movement during the 1940s. While particular doctor's roles will be examined, this will be done with a tacit recognition that much of their individual work would never have begun without important developments in the broader social, political and intellectual contexts of the day which made it more conducive to change. I will also show how during the mid-1940s (while having developed largely separate from it) many of these social and community health ideas became incorporated in the D.P.H. (for a variety of reasons not least being the cost) which for the first time became State-directed, funded and rooted in its new National Health Services programme. It is a complex and ironic commentary of South African segregationist history, which while becoming increasingly racist, still facilitated the production of health practitioners - and allowed for the implementation of their work at a national level - whose labours made the region a world leader in an experiment designed to completely reorient the way modern medicine developed health care to impoverished communities.

Chapter Three, which is called "The Birth of South Africa's First Black Medical School and its Unique Orientation in Social, Preventive and Community Medicine", analyses the establishment of the Durban Medical School in 1951. Placed within the wider socio-political context of segregationist and later apartheid Durban society, this chapter is concerned with tracing the intricacies and difficult circumstances which led to the development of a full black medical education in South Africa through the history of this institution which was conceived during segregation, born under apartheid and gestated by racial ambiguities and contradictions. It will be shown how, from the start, every aspect of the establishment of black medical education of the highest standard and concomitantly the creation of a black medical profession was directly affected by the dominant political racial battles of the day, where the preservation and dominance of white political power determined how the profession was "created" and how the resources of the community would be distributed. Important analysis will also be made of the fact that the very existence of this institution facilitated the continuance of the social and community health ideas. From 1948 I will demonstrate how under the control of a more racist apartheid Government, these progressive community health ideas at a national level were increasingly undermined and removed from national status as too radical for conservative N.P. ideologues. This chapter will explain how, fortunately, they became incorporated into the

fledgling Durban Medical School and were able to continue the progressive work for another five years despite mounting State hostility. This chapter also lays the foundation - by showing how the Institute of Family and Community Health and Medical School merged with the financial assistance of an international philanthropic agency (the Rockefeller Foundation) - for a greater analysis in the following chapter of the important work this new Department of Social, Preventive and Family Medicine would undertake and the influence it would have on this black Medical School.

Chapter Four - "Student Memories and Experiences of their Medical Education at the Durban Medical School" - is concerned with analysing the often "behind-the-scenes" struggles and internal politics, to establish a sound medical training for black doctors of the highest standards during the first decade of its existence. This chapter is based primarily on oral interviews and the experiential, day-to-day memories and records of some of the students and other interested people connected to the School and intends to help balance the one-side archival perspective, as well as bring in the voices of black communities and women whose lives bore the brunt of policy changes but had little input in their formulation. Many of the issues build closely onto my previous arguments about the very ambiguous and contradictory nature of the School during the first years of its existence. Forced to develop in an increasingly hostile racist apartheid city in the 1950s, it will be shown how this School was caught up in and influenced by racist ideas and often perpetuated them, causing much hurt in an apparently "noble" medical profession. However, the racist nature of this institution was never uncomplicated, as it was also a protective academic "haven" for an elite group of aspiring black doctors. Still able to manoeuvre in the chinks of the apartheid armour in the early years, many far-sighted aims and policies could be implemented. It was in this regard that the School's pioneering steps were made in introducing a radical and unique medical curriculum founded on the highest standards of western biomedicine but also adapted specifically to meet the health needs of South Africa black societies. It is for these academic contributions, that I believe the School should be remembered in its early years, which placed it in the vanguard of other medical schools both in South Africa and abroad.

Chapter Five which is entitled "A 'Bitter-Sweet' Victory for Black Medical Education" discusses the demise of the social and community health centre movement in South Africa as

well as the apartheid State's failed attempts to remove the Durban Medical School from its control by the white UN and bring it into line with its policies of establishing fully segregated higher education institutions. It analyses the Medical School's "bitter-sweet" victory against the apartheid State, as while continually plagued by relentless State attempts to control every aspect of its black medical training, it was able to manoeuvre in small gaps and negotiate in practice much of the State's intended policy. However, the Durban Medical School simultaneously lost its fight to protect and perpetuate its Department of Social, Preventive and Family Medicine which came to its demise in 1960, after it was left devoid of funding and support. But while it lost its fight for its progressive social and community health department, at least as a black institution providing a high degree of medical education in various fields, it survived the apartheid State's attack, and was able to continue training aspiring black doctors. The situation could have been far worse had the standard of the Medical School's education been lowered whilst under direct and racist Government control. However, by undercutting the cheapest and only alternative health care option to address the disastrous state of health in South African black communities, the racist State ensured health care underdevelopment instead of promoting South Africa as a leader in this social and preventive field of medicine. In the complex and ambiguous medical education sphere, State power over black education and training was far less assured and came up against just as determined academic opposition. All policies required negotiations and compromises in theory and practice.

The Conclusion will round off major themes and theoretical issues raised. This thesis aims to critically trace the early development of black medical education in South Africa through the extraordinary and complex history of one particular institution – the Durban Medical School – which was initiated during segregation, came to fruition under apartheid and was shaped by racial ambiguities and contradictions. The history of this black Medical School will attempt to show how ideologies of race postponed its creation, endangered its attempts to provide the highest academic standards and threatened its existence while in the full time of success. Constant racist apartheid State meddling in medicine's apparently "noble" profession was highly discriminatory and left scars of deep personal hurt and anger. Moreover, analysis will also be made of the largely ambivalent act of massive emigration of community health doctors from South Africa, which left the country's black communities destitute and without health services.

Despite the many ambiguities and contradictions raised, one can not help but be in awe of the immense amount of dedication and human effort (within and outside the medical sphere). Many people fought for this institution and overcame many hurdles to ensure the continued training of the Medical School's black students. I aim to undertake further deeper theoretical analysis of medical education in South Africa, focusing on this extraordinary institution's later years when I embark on my Ph.D research.



## Chapter One

### The Emergence of Durban in the Political and Social Fabric of Health in South Africa

In 1942 a Government Committee - known as the “Smit Committee” - appointed to enquire into the economic, health and social conditions of Africans living in urban areas throughout the Union and the “training of Natives in medicine”, heard and collected what it considered alarming evidence concerning the health conditions in Durban.<sup>1</sup> This Committee recognised the essential problem of health care provision in South Africa and reported:

it is customary to boast of our cloudless skies and our glorious sunshine, and yet our country is ridden with disease which will sap the energy of a large section of the population and threaten economic disaster. When one thinks of the state of health of our poor whites and our non-European population ... and the problem of malnutrition among these groups, it at once becomes clear that the problem of health in South Africa is far greater than the problem of training doctors for the treatment of disease. ... Doctors should be trained rather as preserver[s] of health than as mender[s] of diseased bodies.<sup>2</sup>

This statement poignantly displayed how from the 1920s, and extending over the next twenty years to about the mid-1940s, the central Government of the day opened its eyes to the importance of preventive medicine. Practiced in conjunction with curative medicine this was seen as the only possible way forward to address the disastrous state of public health in South Africa generally, but particularly for its oppressed and marginalised black majority. The training of doctors to be “preservers of health rather than menders of diseased bodies” was one of the founding principles behind the formation of the Durban Medical School in 1951. This chapter will trace and analyse the development of the black Medical School and its unique training in preventive and community medicine, within its wider political, medical and intellectual contexts. Here, I will examine the small but significant beginnings of a progressive, but at first peripheral

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<sup>1</sup> SAIRR, A843, B9.5. “Alarming Evidence before Commission: Terrible Conditions in Durban”, 15/11/1941. D.L. Smit (Secretary for Native Affairs) was Chairman, while the following were members: Dr Peter Allan (Secretary for Public Health), Mr F.D. Hugo (Secretary for Education), Professor R.A. Dart (Dean of the Medical School at Wits), Dr. C.J. Albertyn (Vice President of the Medical Association of South Africa) and Dr G.W. Gale (Assistant Health Officer of the Department of Public Health). Increasingly during the 1940s the Government, strongly influenced by the views of the Medical Profession, began reconsidering the merits of “second rate” Medical Aid Scheme and started pushing towards the training and employment of blacks as fully qualified and registered medical practitioners.

<sup>2</sup> SAB. GES, Vol. 2957, Ref. PN 5, Native Medical Aids. Report of the Committee of Enquiry on the Medical Training of Natives to the Minister of Public Health, 15/6/1942, p.8.

community health movement which drew a group of innovative doctors to Durban in the 1940s, who specifically practiced a particular community-based form of preventive medicine. This largely revolutionary movement and these fundamental early years had an enormous impact on bolstering and gaining acceptance for the idea of the establishment of a black Medical School in Durban ten years later. What is essential to note is that South Africa managed to produce health practitioners whose radical social and community health work made the country a world leader in its attempt to reorient health care delivery away from the expensive and inappropriate but dominant curative hospital-based tradition. As a new medical approach, social and community health medicine was also in direct opposition to the increasingly segregationist social, political and economic policies during this time. This chapter will also hint at an argument running throughout the dissertation that if this social and community health movement had been allowed to develop fully, it would have made South Africa a leader in this medical field internationally.

This chapter will also place the doctors of this innovative theoretical and applied medical field in historical context. I am particularly interested in analysing how these individuals and their promotive work would win for the Province of Natal the (at first sole) right to embark on innovative health-related work in the pilot community health centre of Pholela and how this would eventually lead to greater acceptance for Durban as the centre for the full medical training of black doctors. It would ultimately be at this black Medical School that a number of innovative health professionals from various parts of the country would come to teach a largely unique social and community oriented medical curriculum for the first time. However, unlike several studies which have focused attention on the extraordinary work of particular pioneer figures or “great people” and failed to analyse, except in the most general terms, the wider historical context, this study will constantly place these individual doctors within their broader context in which they first developed their ideas. An accompanying problem is that key institutions have not been studied in detail. Many of the studies which have been done up to date, have been hagiographies, providing largely uncritical facts about the institution whilst not providing in-depth analyses of their weaknesses and failures.<sup>3</sup> Besides these overviews and scattered critical texts there is another vast set of themes on non-biomedical health systems as yet largely untapped by any historians. The work, practices, knowledge-base and shifting dynamics of

healers, diviners and herbalists is only recently receiving sustained attention in the writings of anthropologists and historians such as Comaroff and Burns.<sup>4</sup> Just as it is key to understand the history of key biomedical institutions and the role of the training, practices and discourses emerging from these in order to understand the community medicine movement and the emergency of the University of Natal (UN) Medical School, it is just as vital to point to the rich and complex world of healing practices that took place around and outside of these groups. In Natal, but particularly in Durban as this chapter will show, the role of *izinyanga* and indigenous healers was often seen as inimical to biomedical advances, but to gain any new ground in rural communities and to draw in new cadres of young doctors, the pioneers at the UN Medical School had to challenge themselves and their training in order to broach the idea of healers as intermediaries. This approach had been initiated by Durban-based medical missionaries in a more systematic way by the 1920s - and James McCord was a key person here.<sup>5</sup> Thus Durban as a centre was a key site by the late-1930s of various layers of debate and practice drawing magnet-like to its rural hinterland, urban conurbation and subtropical shores a range of committed health activists. However, the broader ideological, political and social milieu of South Africa at the time needs to be fleshed out in greater detail in order to assess the extent of the Durban experiment's unique approach by 1951. The history of segregation discourse and practice is therefore a useful starting point.

### ***The Political, Medical and Intellectual Context of Segregationist South Africa of the 1920s to 1940s and its Impact on Health.***

Paul Rich and Saul Dubow have written complex intellectual histories of ideas about “race” and segregation, ideas which, as will be shown throughout this thesis, had a huge impact on medical debates. The development of a progressive community health movement and the parallel drive to establish a black Medical School in Durban were rooted in these debates.<sup>6</sup>

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<sup>3</sup> Fortunately, in recent years various historians have embarked on works to critically analyse the histories of institutions. See introduction for references.

<sup>4</sup> See Catherine Burns. “Reproductive Labours: The Politics of Women’s Health in South Africa, 1900 to 1960”. (Northwestern University, Evanston, Illinois: Unpublished Ph.D. Dissertation in History, 1995) and Jean and John Comaroff. *Of Revelation and Revolution: Christianity, Colonialism and Consciousness*. (Chicago: University of Chicago Press, 1991).

<sup>5</sup> See Dr James B. McCord. *My Patients were Zulus*. (New York and Toronto: Rinehart and Co., Inc, 1951) and Margaret McCord. *The Calling of Katie Makanya*. (Cape Town and Johannesburg: David Philip Publishers, 1995).

<sup>6</sup> See both of Paul Rich’s books, *White Power and the Liberal Conscience: Racial Segregation and South African Liberalism, 1921-60*. (Manchester: Manchester University Press, 1984) and *Hope and Despair: English-Speaking*

Rather than focusing on the internal dynamics of Afrikaner political mobilisation and the rise of white Afrikaner nationalism, both these scholars (to different degrees), examine the origins of racial segregation and the instrumental role played by the English-speaking South African liberals therein, which underpinned later racist Afrikaner national “apartheid” ideology. Rich traces the development of the English intelligentsia (many of whom lived in Natal) who were not always “liberal” in any wider understanding of that term, but formed a deeply conservative strand helping to sustain the ideology and political framework of racial segregation in the course of the 20th century. However, despite the racial segregation policies which flourished in the Province, and in Durban, the contradictory nature of this liberalist ideology was especially evident in this city because particular individuals in the city displayed a “philanthropic spirit”, especially the missionary group and new emerging “progressives” who claimed autonomy or distinctiveness from South Africa-wide State rule. Their influence would be key as it was their efforts which would facilitate the advancement of community health initiatives, as well as promote the later establishment of the black Medical School in Durban.

Physicians of all racial groups - in a profession that repeatedly declared itself “apolitical” and disinterested in politics - formed part of a range of figures in the liberal establishment, whose political position reflected the uncertainties of South African liberalism. For white liberals, much of their ideology was based on their roles as Christian, cultural intermediaries to help “remodel” African societies in their “own” rural areas away from the socially divisive effects of rapid industrialisation; while their benevolent pattern of “trusteeship” stressed the need for “consultation” and co-operation between the races.<sup>7</sup> Within this paradigm, the notion of “gradualism” offered the only token of political and social rights for Africans who tried to work through existing structures of the State, and counseled Africans against militant action which would inflame white public opinion.<sup>8</sup> This strand of ideology was unashamedly paternalistic towards Africans and gave unquestioning commitment to the maintenance of white supremacy. However, many black leaders, emerging as intellectual figures in the 1930s, took up political

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*Intellectuals and South African Politics, 1896-1976*. (London and New York: British Academic Press, 1993), and both of Saul Dubow’s books, *Racial Segregation and the Origins of Apartheid in South Africa, 1919-36*. (London: MacMillan Press, 1989), and *Illicit Union: Scientific Racism in Modern South Africa*. (Cambridge: Cambridge University Press, 1995).

<sup>7</sup> Dubow. *Racial Segregation and the Origins of Apartheid*, p.8, 44.

<sup>8</sup> Rich, *Hope and Despair*, p.95.

positions which also reflected the uncertainties and ambiguities of South African liberalism.<sup>9</sup> Politicians such as Z.K. Matthews and Dr. A.B. Xuma (who received his medical training in the U.S.A.) were essentially conservative, elitist and “accommodationist”, as they shied away from antagonising their white allies by mobilisation of the masses, wanted to be included in “Western civilisation” and compromised with the racist State to ensure their own interests. It was argued that “they worked within the framework of the existing order and although they protested against white discrimination ... they protested from a class rather than a national or racial position”.<sup>10</sup> Many of these liberals supported the United Party (U.P.) under Jan Smuts who too evinced the contradictions of liberal segregationism. As a convinced segregationist who promoted political and territorial segregation, Smuts also tended towards a more moderate, gradual incorporation of the emerging black elite into the structures of white power. Segregation was seen as a moderate compromise between the polar opposites of “assimilation” and “repression” of the politics of Afrikaner leaders such as Hertzog which was narrowly exclusionist and explicitly racist in character, where the unified sense of white identity was engendered through political, social and economic exclusion of blacks from society.<sup>11</sup>

The only counter-discourse was a small but well-organised socialist movement located in several cities, where non-racialism had taken root and which drew on a small group of intellectuals and workers from miners to journalists. Socialists and communists worked with broader leftist and anti-racist groups in the course of the 1930s and during World War II and formed part of anti-fascist campaigns which drew in wider support. The voice and ideology of this perspective gained ground through the medium of several excellent socialist newspapers and through several strategic campaigns in World War II, and it strengthened the more left wing versions of liberalism and challenged - albeit with not much success - the racial framework and

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<sup>9</sup> Rich. *White Power and the Liberal Conscience*, p.20, 77, 87. Z.K. Matthews, while an Anthropology Professor at the black University College of Fort Hare, was a member of the first generation of ANC leaders whose conservatism and elitism frustrated much of their efforts for black liberation. He was also a member of the liberal, ineffective and weak N.R.C.

<sup>10</sup> Paul Maylam. “The Changing Political Economy of the Region, 1920-1950” in Robert Morell (ed). *Political Economies and Identities in KwaZulu-Natal: Historical and Social Perspectives*. (Durban: Indicator Press, 1996), p.113.

<sup>11</sup> Dubow. *Racial Segregation and the Origins of Apartheid*, p.9 and *Illicit Union*, p.252. Smuts argued that total segregation was “utterly impracticable”, for rural to urban migration could not be stopped with the rapidly expanding labour needs of an industrial economy. Hertzog was determined to impose greater restrictions on African migration.

the class divisions of South African political and social movements across the spectrum. It was these groupings, from the 1930s particularly, which influenced the secular group of doctors - many Jewish by birth - who threw themselves into reorganising medical care and education in South Africa. However, this impact on national consciousness was very short lived and when the South African Communist Party was banned in the late-1950s memories of Smuts taking up membership of organisations like the South African Friends of the Soviet Union and sharing platforms with socialists were quickly packed away.<sup>12</sup>

During the war and until 1943, with the Smuts-Hofmeyr Government relatively secure in power, it attained what was for a time a “liberal” political policy and the socio-political circumstances it created had a substantial influence on health policy. However, following the Afrikaner National Party (N.P.) gains in the 1943 election, the Smuts Government was unwilling to take on the political fight and seemed paralysed and unable to act against the myriad of problems, including massively inadequate health provisions for the black majority, confronting it.<sup>13</sup> Despite this weakening of power, the years leading up to the 1948 N.P. election victory were influenced by the UP liberal segregationists who laid the ground for some progressive developments in health service initiatives while also influencing the emerging hegemonic racial ideology of white South Africa. It is on these contradictory years leading up to the N.P. election victory in 1948 which this chapter will focus. The political position of many of the new community health doctors, who are the subject of this thesis, must always be qualified as somewhat “progressive” in relation to the varying ideas of the liberal establishment of which many of them were apart, “radical” in terms of the Afrikaner nationalist perspective, while at the same time they often came up against an African nationalist point of view which regarded them as too timid in their stand against racist politics.

It is ironic that it was in Natal - the Province where these ideas about racial segregation found resonance in the particularly racially segregated city of Durban - that the progressive community health care initiative began and where later, the black Medical School was

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<sup>12</sup> See Pauline Podbrey. *White Girl in Search of the Party*. (Pietermaritzburg: Hadeda Books, 1993), E. Roux, *Time Longer than Rope*. (Madison: University of Wisconsin Press, 1964).

<sup>13</sup> A. Jeeves. “Public Health and Rural Poverty in South Africa: ‘Social Medicine’ in the 1940s and 1950s”. Seminar Paper presented at the University of the Witwatersrand Institute for Advanced Social Research, 30 March 1998, p.9.

established. From earliest of times, the city developed into a distinctly racist, but also class-based society. This resulted in a complex web of repression and control, wherein increasing racial polarisation of the city through segregation and banishment of the black underclasses to the periphery promoted unequal and circumscribed access to social, political and economic resources, as well as residential space in the interests of the city's white minority.<sup>14</sup> Natal, the most British of South African colonies at the beginning of the 20th Century played an influential role in the establishment of racial segregation. Stemming from the "reserve" politics of Theophilus Shepstone in the colonial period, to the evolution of the "Durban System" in the first decade of the century, Durban and its municipality had been at the forefront of moves to impose racial restrictions and the exercise of tighter control over the black subordinate groups in the city.<sup>15</sup> With hindsight, Durban could be seen as an "early urban apartheid laboratory", whose "native" administrative system became the model for subsequent urban management and control at a national level.<sup>16</sup> Its policy makers also devised a town-planning model in the early-1940s based on racial segregation on exclusive lines that prefigured Afrikaner nationalist Group Areas legislation. It is an ironic and a telling commentary on the complexity of South African history, that while very racist and segregationist in character, it was also in Durban that progressive social medicine ideas took hold and had a profound influence on the form that the innovative new community public health system and Durban Medical School took.

### ***The Politics of Medicine in South Africa before 1948.***

In the period before the establishment of the Durban Medical School in 1951, the wide range of social, political and economic differences across South African society influenced the vast disproportion of health care provision and medical training facilities. The desperate needs in most black communities helped stimulate a response in the form of a progressive community

<sup>14</sup> Paul Maylam and Iain Edwards (eds). *The People's City: African Life in Twentieth-Century Durban*. (Pietermaritzburg: University of Natal Press, 1987).

<sup>15</sup> William Beinart and Saul Dubow (eds). *Segregation and Apartheid in Twentieth-Century South Africa*. (London and New York: Routledge, 1995), p.6. The politics of Theophilus Shepstone included attempts made by colonial authorities to gain access to cheap African labour and to control powerful African kingdoms in rural "reserve" areas. See Maylam and Edwards, *The People's City*, for an account of the evolution of the "Durban System", where municipal control and management of the city's African population was based on the funds raised by the monopoly manufacture and sale of beer to Africans.

<sup>16</sup> Maylem. *Political Economies and Identities in KwaZulu-Natal*, p.104. Also see Bill Freund. *Insiders and Outsiders: The Indian Working Class of Durban, 1910-1990*. (Pietermaritzburg: University of Natal Press, 1990), p.58.

health care initiative to alleviate the burden of the marginalised black majority. Medicine, which set itself up as a profession immune from interference by those with vested interests in the economic and political order or “a profession ... apart from, and above politics”, was almost wholly controlled by the South African State as well as local political interests.<sup>17</sup> Health services were overwhelmingly influenced and regulated by a discriminatory State, which did not ensure the minimum right of health care for all its people. It is important to realise that while the project of medicine and scientific knowledge, and ethical practice, has been disguised in the language of “rational” or “objective” ends -- both colour and gender-blind -- the nature of medical practice in South Africa has demonstrated that ideological forces, political considerations and deep structural inequalities always mediated and shaped competing claims to egalitarian health service. In Durban itself, long discussions over a black medical profession became embroiled in the dominant racial political battles of the day, where the preservation and dominance of white political power determined how the profession was “created” and how resources for the community were distributed. This was not a rational response to South Africa’s health needs but it showed that medical knowledge and practice was (and still is) always in tension between the Enlightenment ideals pinned to the Hippocratic Oath and the lived, contradictory experience of both the most principled but especially the least ethical medical professionals.

Many revisionist historians, such as Shula Marks and Neil Andersson, have explained South Africa’s specific disease patterns - and thus black ill-health - as a consequence “racial-capitalism”. Here, South Africa’s specific form of urban industrialisation and capitalist development, and exclusion of blacks from incorporation into the capitalist economy - other than as a cheap, exploitable, migrant labour force for the mines and industry - resulted in the direct consequence of disease, impoverishment and underdevelopment in the reserves.<sup>18</sup> But, while scholars have largely written about how unequal health care provision was directly influenced by racist segregationist ideology, others have also shown how in the early part of the 20th Century, public health officials were in the forefront of demands for urban residential segregation to help prevent the spread of infectious diseases. Here analysis has been made to demonstrate how

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<sup>17</sup> Arnold H. Tonkin. “A State Medical Service for Natives”. *South African Medical Journal*, 9 August 1941, p.290.

<sup>18</sup> See Shula Marks and Neil Andersson. “Industrialisation, Rural Health and the 1944 National Health Services Commission in South Africa”, in Steven Feierman and John M. Janzen (eds). *The Social Basis of Health and Healing in Africa*. (California: University of California Press, 1992), p.131-161.



industrialisation and black urbanisation which accompanied the mineral revolution, developed concurrently with racist segregationist public health official consciousness and desires to control the spread of epidemic diseases such as typhus.<sup>19</sup> Marks and Andersson also show how at the turn of the century, it became increasingly evident with the large presence of blacks working in the towns, that disease “knew no colour bar”. This threat of the spread of disease to white settlers and desire to control it, as well as the possibility of interference with the reproduction of the labour force lay behind much of public health legislation and development of State policies of urban residential segregation.<sup>20</sup> The equation of urbanised black underclasses with the spread of infectious diseases provided a compelling rationale for major forms of separation such as placing blacks in rural “reserve” areas or on the periphery of towns in municipal locations. Maynard Swanson’s work on the “sanitation syndrome” was vital in this regard, as he argued, that the equation of:

black urban settlement, labour and living conditions with the threat to public health and security - became fixed in the official mind, buttressed by the desire to achieve positive social controls and confirmed or rationalised white race prejudice with the popular image of medical menace.<sup>21</sup>

The black experience of public health policies was thus largely authoritarian and repressive. It would take many more years before it was recognised, as Marks and Andersson argue, that “epidemics highlight the nature of power relations in society [which] ... sharpen existing behaviour patterns which belie deeply rooted and continuing social imbalances”.<sup>22</sup>

Other historians such as Packard and Katz have also analysed the ambiguities of doctors who failed to understand or deal with, “the structural contradictions in the development of racial capitalism in South Africa”.<sup>23</sup> Both scholars - Packard focusing on the persistence of Tuberculosis (T.B.) and Burns focusing on the training of male nurses in South Africa - have

<sup>19</sup> Shula Marks and Neil Andersson. “Typhus and Social Control: South Africa: 1917-1950” in Roy MacLeod and Milton Lewis (eds). *Disease, Medicine and Empire. Perspectives on Western Medicine and the Experience of European Expansion*. (London and New York: Routledge, 1988), p.263.

<sup>20</sup> Marks and Andersson. “Typhus and Social Control”, p.259.

<sup>21</sup> Marks and Andersson. “Typhus and Social Control”, p.263.

<sup>22</sup> Marks and Andersson. “Typhus and Social Control”, p.265.

<sup>23</sup> Randall M. Packard. *White Plague, Black Labour. Tuberculosis and the Political Economy of Health and Disease in South Africa*. (Pietermaritzburg: University of Natal Press and James Currey Publishers, 1989), p.215. Also see Packard, Randall M. “Industrialisation, Rural Poverty, and Tuberculosis in South Africa, 1850-1950” in Steven

analysed the very conservative and often reactionary character of South African doctors. In this book, *White Plague, Black Labour*, Packard argued that T.B. continued because the State, mining officials and doctors were not willing to address the foundations of black poverty and malnutrition upon which the disease was based.<sup>24</sup> While doctors were not unaware of the socio-political underlying causes of ill-health and means to prevent or cure it, they continued to advocate purely curative medical responses to solve health problems while the social preventive policies necessary for improvement were left unimplemented. In her article on male nursing in South Africa, Burns draws on the interesting work done by Katz. Burns uses Katz's arguments about Miners' Silicosis (lung diseases caused by mining dust) but show how in the early-1900s health officials employed by the mining industry provided little health care for workers (especially black miners) which resulted in high morbidity and mortality rates. Katz argued that:

mine owners provided their black workers with minimal services of poor quality, and many incapacitated Africans returned home either to be cared for by their kin or to be buried. Even after 1902, when rudimentary health structures were introduced on the mines as a result of Government pressure, the position did not alter radically. Despite doctors' denials to the contrary, there was a large measure of truth in the public allegation that management daily 'shunted' trainloads of sick and dying black workers to their rural homes.<sup>25</sup>

Like Packard, Katz's study provides evidence of the way in which doctors, as paid employees of the mining industry, enjoyed little independence and their professional commitment to safeguarding health was severely compromised as a result. It was only after the World War I that mining concern for the health and maintenance of their labour force was stimulated and slow improvements began to be made, which was reinforced by growing health concerns in the central Government.<sup>26</sup>

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Feierman and John M. Janzen (eds). *The Social Basis of Health and Healing in Africa*. (California: University of California Press, 1992), p.104-130.

<sup>24</sup> Packard. *White Plague, Black Labour*, p. xvi.

<sup>25</sup> See Elaine Katz. *The White Death: Silicosis on the Witwatersrand Gold Mines*. (Johannesburg: University of the Witwatersrand Press, 1994), p.54. For another interesting discussion of the inadequacies of Government provision of health services for Africans during war time and in mining settings see Catherine Burns. "A Man is a Clumsy Thing who does not know how to handle a Sick Person': Aspects of the History of Masculinity and Race in the Shaping of Male Nursing in South Africa, 1900-1950", in *Journal of Southern African Studies*, Vol. 24, No. 4, December 1998.

<sup>26</sup> Also see Karin A. Shapiro. "Doctors or Medical Aids - The Debate over the Training of Black Medical Personnel for the Rural Black Population in South Africa in the 1920s and 1930s". *Journal of Southern African Studies*, Vol. 13, No. 2, January 1987.

In a more general sense, health services in South Africa in the 1920s and 1930s were in a chaotic state. The focus was on curing established disease rather than on promoting and safeguarding good health.<sup>27</sup> However, the mere “doctoring” of the community and providing increased curative facilities was no solution to the problem of meeting the country’s health needs efficiently.<sup>28</sup> The public health system was not organised on a national basis, financial and administrative responsibilities were divided in a confused manner among local, provincial and national authorities, while a disorganised army of people who lacked central direction had duties promiscuously distributed between several departments.<sup>29</sup> Health services lacked co-operation, co-ordination, were ineffective, disjointed, haphazard, parochial and overlapped, and as late as the 1940s the *South African Medical Journal* lamented in an editorial, that “it is all patchwork, a patch here and a patch there and no planning”.<sup>30</sup> Voluntary organisations supplemented the services provided by the State while thousands of white private practitioners conducted their practices on an individual fee-paying basis.<sup>31</sup> South African whites bore the immediate monetary brunt of costs through taxations for health services while blacks contributed little to health expenses incurred by local authorities that completely failed to meet the health needs of rural black communities.<sup>32</sup> White doctors, many of whom were not prepared to carry out their services in rural areas where the poor could not afford to pay, left health services for blacks to a small cadre of missionary doctors scattered throughout remote rural areas.<sup>33</sup> An unequal distribution of services was provided not according to people’s needs, but according to their ability to pay, where the poor (who needed them most) were the most poorly supplied.

<sup>27</sup> Henry Gluckman. *Abiding Values: Speeches and Addresses*. (Johannesburg: Caxton, 1970), p.444.

<sup>28</sup> SAB, GES, Vol. 2957, Ref. PN 2. Native Medical Services, 20/6.1955, p.9.

<sup>29</sup> SAB, GES, Vol. 2957, Ref. PN 5, Native Medical Aids. Report of the Committee of Enquiry on the Medical Training of Natives to the Minister of Public Health, 15/6/1942, p.7. The provinces controlled general hospitals while the central Government controlled special services such as mental, leper and TB hospitals and extra-institutional personal curative services through district surgeons, who provided free medical attention to the sick poor in black rural areas and services to whites in the area on a fee-paying basis.

<sup>30</sup> “The National Health Service”. *South African Medical Journal*. Vol. xix, No. 2, 27 January 1945, p.19.

<sup>31</sup> GP, F14, KCM 25797 UNMS. IFCH Report of the Medical Officer-in-Charge. Year ending June 30th, 1950, p.ii.

<sup>32</sup> SAB, GES, Vol. 2957, Ref. PN 2. Native Medical Services, 20/6.1955, p.1.

<sup>33</sup> See M. Gelfand. *Christian Doctor and Nurse: The History of Medical Missions in South Africa*. (Sandton, RSA: Mariannhill Mission Press, 1984) for a discussion of the work of medical missionaries. Faith drove them to isolated places cut off from the outside world where few others would venture. These doctors had little in the way of monetary reward, but were driven by a strong set of moral purposes, and sacrificed themselves to break new ground where no other health services were available. However, their operations were not co-ordinated, but scattered and could only meet a fraction of the black community’s health needs. It was only after W.W.II that the State gained greater control through subsidies as increased expenditure went beyond the capacity of mission church resources.

In South Africa the provision of adequate health care became increasingly a focus of political agendas at a time of increased industrialisation, urbanisation, proletarianisation and class conflict which proceeded rapidly under the impact of the two world wars. In the early-1940s it became clear that there was a corresponding acute shortage of doctors to meet the high mortality rate, overcrowding and impoverishment from which African societies - particularly in the disintegrating rural reserve areas - suffered. There were great difficulties in providing medical care as a high proportion of blacks lived in remote rural areas while others were undergoing rapid industrialisation and concomitant urbanisation. Included with the materials of the State Information Office concerning "Health Services for the Bantu in South Africa", it was estimated that in a general population of 12,400,000 (in the incomplete 1946 census) blacks made up three-quarters or 8,400,000 people.<sup>34</sup> At the end of 1947, it was estimated that there was one white doctor for every one thousand white patients compared to one for every twenty two thousand blacks in both rural and urban areas.<sup>35</sup> There was a lack of trained staff and inadequate funds for a complete public health service, which was aggravated by the need to provide a segregated service by race.<sup>36</sup> Officials were concerned with the threat of infectious diseases in what they saw as the burgeoning reserves spilling into white urban areas. There was also an increased concern with the problem of African health in towns and rural areas as the country's cheap labour policy (based on migrant labour and rural impoverishment) took its toll, with the escalation of T.B. and sexually transmitted disease (STD's) rates, malnutrition, soil erosion and social maladjustment.<sup>37</sup> The high morbidity and mortality rates were a burden on the South African economy at a time when secondary industry became the most important sector of the economy, while the mining industry became concerned about the physical reproduction of the labour force it had done so much to debilitate.<sup>38</sup> It was only when arguments were made for

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<sup>34</sup> SAB, GES, Vol. 2704, Ref. 2/62 and 1/62B. Native Health and Medical Services Polela Unit. General Matters. How South Africa Fights Disease among her Native Population, 1940-52, p.1. This item was included with materials of the State Information Office, Department of Interior, entitled "Health Services for the Bantu in South Africa".

<sup>35</sup> SAB, UOD, Vol. 1546, U3/40/4. Letter from Dr. E.G. Malherbe, Principal of NUC, to Dr. H. Gluckman, Minister of Health, 5 May 1947. It is interesting to note that Britain had a ratio of 1 doctor to every 800 or 900 people.

<sup>36</sup> SAB, GES, Vol. 2704, Ref. 2/62 and 1/62B. Native Health and Medical Services Polela Unit. General Matters. How South Africa Fights Disease among her Native Population, 1940-52, p.1.

<sup>37</sup> See Sidney Kark. "A Health Service Among the Rural Bantu". *South African Medical Journal*, Vol. XVI, No. 10, 23 May 1942, p.197 and Sidney L. Kark. "Migrant Labour and Family Health" in *A Practice of Social Medicine. A South African Teams Experiences in Different African Communities*. (Edinburgh and London: E. and S. Livingstone Ltd, 1962), p.199.

<sup>38</sup> Shula Marks. "South Africa's Early Experiment in Social Medicine: Its Pioneers and Politics". *American Journal of Public Health*. Vol. 87, No. 3, March 1997, p.453.

health to be viewed as a right, an economic and social asset for all people, and for sickness to be viewed as a disability for individuals but also costly for the group, that changes began to occur.<sup>39</sup> Increasing numbers of Africans in urban hospitals were, as Shula Marks argues, “the visible tip of the iceberg” which increasingly worried provincial authorities responsible for hospital services who were reluctant to pay the high medical costs.<sup>40</sup> However, in the 1930s State medical and welfare planners increasingly recognised that it would be impossible to build up and maintain the health of the population without profound changes to the broader socio-economic system as it impinged on health provision. In 1939 the Secretary for Public Health, Eustace Cluver wrote to the Deputy Chief Health Officer in Cape Town:

Government is definitely opposed to any increase in Native hospital beds. All increased demand for treatment of illness among Natives must be met by cheap clinics. Such clinics must be set up in rural areas where the bulk of patients could be treated on outpatient lines.<sup>41</sup>

Thus, the Government at the time did not consider an increase in expenditure for hospital services for “Natives” as a feasible option by the cash-strapped Government at the time. For the first time, small steps began to be taken by the Government to provide a cheaper rural health service based on preventive lines. And as Shula Marks has asserted:

It’s somewhat ironic that the health centres that were to become South Africa’s showpiece in the field of preventive medicine in the 1940s and keystone of National Health Services Commission took their origin in a drive by the Government for a cheap formula for African health needs in the context of segregation.<sup>42</sup>

It is important to note that during 1928, a major piece of public health legislation - the Medical, Dental and Pharmacy Act - was passed in South Africa, which facilitated stricter controls and policies with regard to practice and training in the medical sphere. However, while this was a piece of strong legislation, before this and even after the passing of this Act, the Department of Public Health (D.P.H.), was often dismissed as unimportant when it came to State

<sup>39</sup> Sidney L. Kark. *Epidemiology and Community Medicine*. (New York: Appleton-Century-Crofts, a Publishing Division of Prentice Hall, Inc, 1974), p.323.

<sup>40</sup> Marks. “South Africa’s Early Experiment in Social Medicine”, p.454.

<sup>41</sup> Marks and Andersson. “Industrialisation, Rural Health and the 1944 National Health Services Commission in South Africa”, p.150.

allocations. This was because the D.P.H. was an essentially weak and overlooked department in the Government (it was established with the passing of the 1919 Public Health Act). It also operated with a heavy “top-down” approach, and did not consult communities most affected by its policies. And it is this traditional and largely static public health approach, with its massive failings in the delivery of health to the country’s black majority, that would be challenged from a peripheral, at first small-scale, but radical social and community health centre movement in the late-1930s.

### ***Competing Medical Traditions: The Role of Healers, Izinyanga and Medical Missionaries.***

However, before analysing these innovative social and community health developments, it is also important to discuss the fact that the delivery of health care was further complicated by the existence of competing medical traditions and systems.<sup>43</sup> Black communities also made provision for their own health needs through itinerant or resident traditional healers whose claims to expertise and whose healing arts had long-standing roots in these societies. In *The Journal of Cape History*, Catherine Burns has written a fascinating paper entitled, “Louisa Mvemve: A Woman’s Advice to the Public on the Cure of Various Diseases” which precisely addresses this complicated issue.<sup>44</sup> Focusing on the personal life story of one ambiguous woman (though possibly representative of many) who traversed many boundaries as “a midwife, healer, herbalist, diagnostician and innovator of cures”, Burns shows how Mvemve continuously threatened the boundaries of Union segregation legislation and the “western” medical profession’s acts and statutes during the period 1914 to the 1930s. However, Mvemve was unique in that she wanted to create a niche for herself, as Burns argues:

not as a nurse or western doctor, nor as a diviner, traditional healer, or as a mere hawker of goods: she wanted to carve for herself no less than the role of a new kind of medical broker.<sup>45</sup>

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<sup>42</sup> Marks and Andersson. “Industrialisation, Rural Health and the 1944 National Health Services Commission in South Africa”, p.150.

<sup>43</sup> SAB, GES, Vol. 2704, Ref. 1/62B and 2/62. Native Health and Medical Services Polela Unit. General Matters. Social Medicine among the Kraals of Natal. Modern Methods of Health Propaganda oust the Old-Time Witchdoctors of Polela by Alastair Matheson, 1940-52, p.2.

<sup>44</sup> Catherine Burns. “Louisa Mvemve: A Woman’s Advice to the Public on the Cure of Various Diseases”. *Kronos: Journal of Cape History*. No. 23, November 1996, p.108.

<sup>45</sup> Burns. “Louisa Mvemve”, p.112.

The paper focuses on the politics and power of medical knowledge, authority and practice and Mvemve's battle to gain recognition as a woman with valuable healing power, skill and talents in a specialised male-dominated medical arena. Mvemve, and others like her, also provided a vital contribution to the history of healing and medical care in South Africa. However, her attempt to establish a new "craft" from traditional skills and techniques of western biomedicine occurred at a time when the medical profession in South Africa began closing its ranks, centralising its authority, and undermining the independent expertise of traditional practitioners. She was also forced to face a losing battle as a black woman herbalist providing treatment for all races in racially segregated, "white" urban milieu during the early-1930s. As Burns argues:

the politics of medical practice and segregation intertwined and were inseparable in the experience of Louisa and her patients. Her forced departure from the Rand marks a significant moment, and provides a pungent example of the mingling of struggles over medical authority, attempts to control women and the elaboration of racial segregation in South Africa at the beginning of the 1930s.<sup>46</sup>

Medical practitioners, especially those in Government positions have played a large role in influencing medical and public health legislation and by extension popular discourse in South Africa. Burns's article demonstrates that during the 1920s a renewed interest in debates around opposing and contradictory discourses and bodies of knowledge and practice: western biomedicine and traditional healing cosmology, took shape in a number of medical, religious, philanthropic and Government circles.<sup>47</sup> In the early years, medical missionaries were the only people to offer western biomedical care to the majority of black South Africans, especially in remote rural areas, and were at the forefront of training black nurses, assistants and eventually doctors.<sup>48</sup> They viewed medicine and Christianity as a team effort to protect themselves against the ubiquitous superstition of the "native mind" and to facilitate religious conversions. From the early years of Union, medical officials and guilds lobbied to curtail the activities of "native medicine men and women", to criminalise certain healing practices, define and outlaw "witchcraft" and prohibit the selling of "dangerous concoctions".<sup>49</sup> But in the early years, the

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<sup>46</sup> Burns. "Louisa Mvemve", p.112.

<sup>47</sup> Burns. "Louisa Mvemve", p.120.

<sup>48</sup> See Gelfand. *Christian Doctor and Nurse*.

<sup>49</sup> Burns. "Louisa Mvemve", p.121.

central State was not prepared to combine these measures with a comprehensive health plan for blacks. Health facilities remained widely scattered or non-existent. While in Natal, a Native Ordinance of 1895 which protected existing traditional healers and provided for their licensing by Magistrates in the absence of other medical facilities, by the turn of the century, most of the other Provinces repealed similar codes and only recognised certified and western trained medical practitioners. Many loopholes in the medical legislation were exploited (such as the Mvemve story demonstrates) until the authority of biomedical knowledge and right to heal were bolstered in the 1928 Medical, Dental and Pharmacy Act which legislated against providing Africans with licenses to practice traditional health methods. From then onwards, many traditional healers were unable to withstand the attacks of either segregation law makers nor the onslaught of the increasingly professional medical academy. Only the “Natal Exception” allowed *izinyanga* who were licensed, to continue practicing and could have their licenses renewed. Despite voluminous correspondence, petitioning and legal action, no medical men or women outside Natal received licenses after the passage of the 1928 Act except with ministerial permission. The Act was massively criticised as while restricting traditional healing practices, provided nothing to take its place.<sup>50</sup>

An important influence on this debate is embodied in the life-long work of medical missionary Dr. James McCord, who was influential throughout South Africa, but whose role in making Durban a pivotal focus for black medical training and service was central. His personal interventions, though premature in the early 20th Century, prompted many reconsiderations in the medical field in later years. His concept of training so that black doctors could “serve their own people” was at one and the same time a tacit acknowledgement of the possibility that black people had the potential to become skilled medical professionals and yet maintained at its core the separateness of white-controlled medical knowledge and practice as the norm or standard, while blacks continued to remain an “other”. In 1909, this American missionary, opened the first Zulu Hospital in Durban, and was later joined by Dr. Alan Taylor at the end of World War I. In 1921 McCord raised the idea of a medical school for black doctors for the first time. In his autobiography, *My Patients were Zulus*, he argued that the main reason for Taylor coming to South Africa in 1921 was to assist him in establishing a private medical school for training “Zulu

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<sup>50</sup> SAB GES, Vol. 2271, Ref. 61/38B. Native Medical School. Training of Native Doctors: Native Medical Aids, 10



men” in medicine to “serve their own people”.<sup>51</sup> He realised that the rapidly growing black population in and around Durban would require health services. They started a small private school in Durban but the medical authorities responsible for registering medical practitioners refused to recognise any inferior qualification for blacks to those ordinarily required for registration for whites, and forced them to abandon their efforts within a year. Thus, thirty years prior to the establishment of the Durban Medical School, medical authorities refused to accept an inferior or lower medical qualification for black students, which would discredit the high standards maintained by the white medical profession, effectively scuppering McCord’s early plans. However, McCord had succeeded in drawing attention to this need and challenged the complacency of the State, in the face of mounting evidence from its own reports concerning serious lacks in health provisioning for the black majority.

***Government Debates: The Creation of a Unified versus Separate State Medical Service for Blacks and the Issue of the Standard of their Professional Training.***

The 1920s to 1940s saw a growing recognition and priority given - despite a lack of political will from many South African doctors - to the desperate health needs of the black majority. This new recognition was influenced by a general expansion of a humanitarian outlook, the fear that the untreated sick poor were a danger to the rest of society through the spread of infectious diseases, and the worry that the diseased proletariat were detrimental to the economic well-being of the State by hindering economic and industrial progress.<sup>52</sup> It was argued in various debates from as early as the 1920s that “without a form of *State Medical Service* there was no hope of providing an effective medical service for the bulk of the population”.<sup>53</sup> Intertwined with the issues raised in the State investigations concerning medical service and training was also the central, but complex and ambiguous question of the *standard of professional medical training* and health care opportunities for blacks in South Africa. From the beginning, the question of black physicians struck at the core of the racially cast and elitist notions embedded in the public and private medical organisations of the day. While white doctors had a long history of treating

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March 1936, p.4.

<sup>51</sup> McCord. *My Patients were Zulus*, p.221-229. McCord Zulu Hospital was also the first school for the training of African nurses and midwives.

<sup>52</sup> “Medical Services in Native Area”. *Journal of the Medical Association of S.A. (B.M.A.)*, 24 January 1931, p.35.

<sup>53</sup> SAB, GES, Vol. 2957, Ref. PN 5, Native Medical Aids. Report of the Committee of Enquiry on the Medical Training of Natives to the Minister of Public Health, 15/6/1942, p.9. My italics.

black patients both for economic gain, and in the case of missionary and other humanitarian doctors who saw it as their ethical duty under oath to render medical services wherever and whenever needed, in South Africa's racially segregated society, black doctors were forbidden from treating white patients.<sup>54</sup> The issue of professional competition was especially strong, where white doctors felt they could remove the threat of black doctors - who undermined their client bases - by denying them access to the training needed for entry into the profession.<sup>55</sup> However this was highly problematic within a profession that recognised the massively inadequate supply of doctors for the black population.

It is important to note that during these years, there were only a few qualified black doctors in South Africa. The first black doctor to fully qualify within South Africa only achieved this after a great struggle at the end of 1945.<sup>56</sup> In the years following this achievement, newly qualified black doctors out of a total group never exceeded six per annum.<sup>57</sup> It was recognised by many Government medical officials, but also doctors outside this sphere, that black doctors alone would not have any appreciable effect upon the existing medical services. There were too few doctors to have an impact upon the enormous health needs and no guarantee that this small number would devote their entire practices to serve the rural areas. Even before these doctors began partly qualifying in South Africa however, there was a long, upward battle to gain admission into the existing "white" medical schools at the Universities of the Witwatersrand (Wits) in Johannesburg and in Cape Town (UCT). While universities may regard themselves as leaders of society, they generally reflect the dominant features of the society around them and even mirror the worst prejudices of the dominant group. This is evident with South African universities and their attempt to address the problem of providing higher education in a

<sup>54</sup> E.G. Malherbe. File 463/7/3. KCM 56990 (74). "Medical Apartheid" by E.G. Malherbe, *Daily News*, 7 June 1972. p.3. This was not based on legal means, but an irrational social taboo that went against the Hippocratic Oath.

<sup>55</sup> Bruce K. Murray. *Wits the Early Years: A History of the University of the Witwatersrand Johannesburg and its Precursors, 1896-1939*. (Johannesburg: Witwatersrand University Press, 1982), p.302-303.

<sup>56</sup> See "50 Years Ago in the Leader: First 'Crop' of Locally Qualified Medics Lauded". *The Leader*, 8 December 1995, p.12. Thank you to Riashnee Pather for this insightful article. In 1945 the first group of black doctors graduated from Wits. This was the first time that black doctors were fully qualified in South Africa and did not have to go overseas to complete the clinical part of their qualifications.

<sup>57</sup> SAB, GES, Vol. 2957, Ref. PN 5, Native Medical Aids. Report of the Committee of Enquiry on the Medical Training of Natives to the Minister of Public Health, 15/6/1942, p.18. During the early part of the century, when Wits and UCT were just fledgling universities without well-established medical schools, courses were given to aspiring white doctors in the pre-clinical subjects during the 1920s who were then required to venture overseas for further clinical training. Towards the end of the 1920s full medical degrees were established in South Africa for

politically dominant and racist white society opposed to the admission of blacks into “white” universities.<sup>58</sup> An important problem that compounded the shortage of doctors in South Africa was the inadequate and limited provision of medical training facilities, where the needs of one-fifth of the white population, as enumerated at the time, was met by three medical schools, while four-fifths of the rest of society had no such facilities.<sup>59</sup> Bruce Murray’s book, *Wits the Open Years*, demonstrates how Wits reflected the racial prejudices of the white-controlled organs of segregated society avoiding challenges to white public opinion and only very hesitantly opened partial access to all races towards the end of the 1930s. Prior to this, blacks were denied admission to the medical faculties as there were no segregated clinical facilities.<sup>60</sup> “Mixed or open” universities were an anathema to many whites who feared miscegenation, were against black students “observing” and treating white patients, “fraternising” among medical students which would “level very drastically the social scale between the two races”, and professional competition from blacks who gained access to equal training.<sup>61</sup> Aspirant black doctors were faced with enormous competition when they applied to already overcrowded medical facilities, whose limited space did not cater for their growing demand for medical training. The admissions increased slowly due to the growth of a more liberal, democratic spirit during and after the war, and because the war years made it impossible for Africans to train overseas. Thus black admissions to “open” universities were riddled with reservations and student numbers were always negligible making up no more than 5% of the student population.<sup>62</sup>

Another debate underlying the furore over black admissions to universities was the issue of educational and qualification standards and professional parity. An analysis of the many deputations, delays and early efforts, as gleaned from the minutes and reports of those concerned with the provision of a black medical service and the professional standards of the training of

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white medical students. However, for aspiring black doctors who until the late-1930s were barred from “white” universities, they were forced to receive their full medical training degrees overseas.

<sup>58</sup> *Cape Times*, 21/22/48 “College worthy of New Status”.

<sup>59</sup> G.W. Gale. “Medical Schools in Africa: A Short Historical and Contemporary Survey”. *Journal of Medical Education*, Vol. 34, No. 8, August 1959, p.716. With a population of approximately 14 million at the end of the 1940s, the three medical schools of UCT, Wits and Pretoria catered for whites, with Pretoria exclusively so, while UCT and Wits only accepted black admissions of 5%. The exclusively black University College of Fort Hare did not offer medical training.

<sup>60</sup> Bruce K. Murray. *Wits the ‘Open’ Years*. (Johannesburg: Witwatersrand University Press, 1997), p.27.

<sup>61</sup> See Murray. *Wits the Early Years*, pgs 35-36 and 300-302. Blacks were not even allowed to perform or witness post-mortems on white bodies.

such a service, reveals that opinion was split over the issue that progressive medics proposed: “unless and until a full university training in medicine was provided for non-Europeans they could not become medical practitioners”.<sup>63</sup> There were strong arguments for an inferior, or what was seen as a “partial” or “second best” medical training by its proponents for black doctors or “medics” in the early years of the century. This proposal had an enormous impact on the emerging progressive public health centres movement, but as the later chapter on the establishment of the Durban Medical School will show, these views lost ground during and after the second World War, to the growing arguments from those determined to maintain the highest standards of training exactly comparable to white doctors. The latter view developed into a position which argued that while an equal standard of training had to be provided for an elite group of select black doctors, this training would have to occur through separate institutions and facilities that would train black doctors to serve “their own people”. The debate was explosive, aided by an increase in discriminatory segregation legislation during the inter-war period.

The debate for full medical qualifications versus “second rate” Medical Aids took place within the wider debates of the State commissions concerning the provision of a “Native State Medical Service”, where there was a great division of opinion regarding the nature of such a scheme. Arguments made for an inferior medical degree for blacks included people holding a variety of political positions. It is worth tracing these debates and formal Commissions from the 1920s to the mid-1940s to understand the complex nature of the debate. Sincere but paternalistic medical professionals - especially missionaries - were driven by the recognition of the greatly inadequate facilities to treat an increased black population in desperate need of medical care. As early as 1926 Edward Thornton (Union Assistant Health Officer and later Secretary of Public Health), pre-empted the findings of the Loram Committee and proposed a health service similar to that which already existed in French West Africa, where black medical “auxiliaries” worked under the control of white medical officers. He pushed for an inferior training based on the fact that it would be cheaper, required a shorter training period, and would ensure that blacks would not compete with white doctors on an equal basis.<sup>64</sup> Many black intellectuals, such as Dr. A.B.

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<sup>62</sup> Murray. *Wits the 'Open' Years*, p.xi. At Wits, a policy of “academic non-segregation and social segregation” existed where the social colour bar limited mixing to purely academic, but not social activities.

<sup>63</sup> Prof. I. Gordon. *Report on the Government's Intended Action to Remove the Faculty of Medicine from the University of Natal*. (Durban: Hayne and Gibson Ltd, 1957), p.5.

<sup>64</sup> Murray. *Wits the Early Years*, p.302-303.

Xuma were adamantly against this scheme. Xuma voiced his opinion many times insisting that the medical training should be based on a universal and sound education for all races. He argued that the inferior qualification proposed by Thornton was racist and represented a “false economy” which was placed above ethics or professionalism, which was thus “morally wrong, untenable and unjust”.<sup>65</sup> Casting aside all racial prejudice and sentiment, Xuma poignantly argued that:

the best protection for both our white and black public would be to have the best quality of practitioner only. ... [as] disease knows no barriers or colour bars.<sup>66</sup>

A few years before Xuma expressed these views, mounting fear about the spread of infectious diseases to whites and concern about an adequate labour supply to the mines, prompted a national debate. In 1928 the “Loram” Committee, headed by C.T. Loram, reported on the “Training of Natives in Medicine and Public Health” to address the massive shortage of doctors.<sup>67</sup> Fearing white public opinion regarding the admittance of blacks into existing “white” medical schools, and recognising that the establishment of a new medical school would be costly, the Committee recommended that the Johannesburg medical school for “natives” be segregated from the existing Wits medical school but under its control.<sup>68</sup> The segregation *status quo* would be maintained as they argued that blacks would be trained separately to whites. However, an important new outcome was the insistence that there be no dual standard of medical qualification in the Union and no inferior medical degree for blacks, because the maintenance of good health and curing of disease required the same skilled treatment. An important new interest however, was placed on the preventive aspect of medicine and the committee devoted much time to its future relation in the medical curriculum. This Committee and its later report, made it increasingly obvious that the country was “ridden with disease” and an urgent problem and massive threat to the state of health of South Africa’s black and white population. The Committee minutes stated that:

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<sup>65</sup> A.B. Xuma. “The Training of Natives in Medicine: Notes on a Native Medical Service in Rural Areas”. *The Journal of the Medical Association of S.A. (B.M.A.)*, 24 January 1931, p.41.

<sup>66</sup> Xuma. “The Training of Natives in Medicine”, p.41.

<sup>67</sup> See the Report of Committee appointed to Inquire into the Training of Natives in Medicine and Public Health, U.G. 35, of 1928, and Shapiro. “Doctors or Medical Aids”, p.235. C.T. Loram was a former inspector of education in Natal, founder member of the Joint Councils and long-standing member of the Native Affairs Commission.

<sup>68</sup> Gordon. *Report on the Government’s Intended Action*, p.5.

the problem of health in South Africa is far greater than the problem of training doctors for the treatment of disease. ... doctors should be trained rather as preserver[s] of health than an mender[s] of diseased bodies.<sup>69</sup>

The Committee members agreed that the best way to combat disease in South Africa's "native territories" was to establish a Government medical service that employed three categories of medical personnel - doctors, nurses and importantly health assistants (skilled in preventive work and hygiene) - in teams integrating curative and preventive medicine.<sup>70</sup>

It is important to note again here that as the Department of Public Health was only established in 1919 and was an attempt to control and co-ordinate all health activities in the Union through on central health administration, it was still an essentially weak and overlooked Department in the Government and required many amendments for improvement. Its fundamental principal was "decentralisation" where local and provincial authorities took responsibility for different duties. Varying levels of responsibility were thus placed on three levels of authority.<sup>71</sup> In the same year as the Loram Committee, the passage of the 1928 Medical, Dental and Pharmacy Act was the first substantial piece of centralised medical legislation since the 1919 Public Health Act. For the first time medical officials were given the kinds of legal tools to prosecute and enforce codes of legal entitlement to practice and to close down practices and institutions which did not conform. It largely retained and entrenched gender and racial discriminations.<sup>72</sup> It is clear though that until the end of the 1930s, the D.P.H. remained weak and cautious. This was evident by the fact that nothing came of the Loram Commission's recommendations and would only do so in later years. The kinds of "liberal" opinions of the day garnered in this Commission failed to gain legal or practical expression in health or other sections, and most of its suggestions lay dormant for another ten years.

<sup>69</sup> SAB, GES, Vol. 2957, Ref. PN 5, Native Medical Aids. Report of the Committee of Enquiry on the Medical Training of Natives to the Minister of Public Health, 15/6/1942, p.8.

<sup>70</sup> SAB, GES, Vol. 2957, Ref. PN 5, Native Medical Aids. Report of the Committee of Enquiry on the Medical Training of Natives to the Minister of Public Health, 15/6/1942, p.9.

<sup>71</sup> J. Gilliland. "Health Legislation - A Historical Review". *South African Medical Journal*, 21 March 1979, p.480. This arrangement governed public health action until 1977, with unsuccessful attempts to change this structure throughout the years.

<sup>72</sup> Burns. "A Man is a Clumsy Thing", p.707.

The issue of black medical training and an emphasis in preventive medicine gained new urgency in the first few years of the 1930s but continued to be clouded by circular debates about the level of medical training for blacks. An important factor confounding progress was the lack of clarity and uniformity regarding the form such a health service should take.<sup>73</sup> In 1933, under the Chairmanship of Edward Thornton, Secretary of Public Health, a new course was recommended by the Interdepartmental Committee of Native Medical Education, which advised the establishment of a five-year “Medical Aid” course of an inferior medical training based on the French West Africa scheme. The aim was to provide immediate relief to rural black communities labouring under the burden of disease.<sup>74</sup> Started in 1936, the training of black medical aids was proposed by the State to facilitate the Department of Public Health’s establishment of a completely separate “Native Health and Medical Service” in 1938, that would be limited to segregated and defined areas and administered jointly by itself and the Department of Native Administration.<sup>75</sup>

In 1938, further central Government interest in medical training and health-related issues was stimulated by debates in the once again State-appointed “Botha” Committee, to investigate medical training in South Africa.<sup>76</sup> This Committee went further in recognising and bringing to the public’s attention the shortage of black doctors and the desperate need for a basic medical service for what they still saw as the country’s “disease-ridden” black population. It highlighted how inadequate the existing medical schools were in dealing with this problem due to their overcrowded facilities and policies of limited admissions. Although the Committee did not recommend the immediate establishment of a medical school for blacks, it did argue that “the establishment of a separate medical school for non-Europeans in the future be envisaged; for this

<sup>73</sup> D. Harrison. “The National Health Services Commission, 1942-1944 - Its Origins and Outcome”. *South African Medical Journal*. Vol. 83, September 1993, p.680.

<sup>74</sup> SAB, GES, Vol. 2957, Ref. PN 5, Native Medical Aids. Report of the Committee of Enquiry on the Medical Training of Natives to the Minister of Public Health, 15/6/1942, p.2. Also see Shapiro’s article, “Doctors or Medical Aids” for a detailed discussion of the development of this “Medical Aid” scheme.

<sup>75</sup> H.S. Gear. “The South African Native Health and Medical Service”. *South African Medical Journal*, Vol. xvii, No. 11, 12 June 1943, p.168.

<sup>76</sup> Gordon. *Report on the Government’s Intended Action*, p.5. Members of the Committee included amongst others: Prof. M.C. Botha (Secretary for Education), Edward Thornton (Secretary for Health), Dr. S.M. de Kock (President of SAMDC), and Secretary of Committee was Dr. E.G. Malherbe (who became Principal of Natal University College in 1945).



purpose we think Durban be the most suitable centre”.<sup>77</sup> Under pressure from the Afrikaner community to establish an Afrikaans-medium medical school, it decided to cater for them and established the third medical school in Pretoria. The idea of ethnic language-groupings as the basis for separate institutions was thus introduced into medicine, to be later replaced by race-grouping arguments.

To address black medical needs, greater attempts were made to train black “Medical Aids”. This course was sponsored by the State and endowed by the Chamber of Mines with a grant of £75,000. It involved a four-year medical training at the black University College of Fort Hare and adjacent Victoria Hospital at Lovedale near Alice in the Eastern Cape, followed by a final year’s “internship” at McCords Hospital in Durban.<sup>78</sup> The course provided a special training along curative lines for a new category of health personnel who would work for the State under an increased District Surgeoncy system.<sup>79</sup> It was cheaper, required a shorter training period, was professionally inferior and thus ensured that Medical Aids would not compete with white doctors on an equal basis.<sup>80</sup> However, the scheme floundered as this “near-medical” training was mistaken by students as a course leading to an ordinary medical qualification. Many graduates performed technically illegal acts “pertaining to the calling of registered medical practitioners” which violated the Medical, Dental and Pharmacy Act. The impossibility of maintaining a system where a “Medical Aid” could diagnose and treat a very limited range of conditions in the context of rural areas remote from fully trained doctors undermined the entire point of the scheme. This was further confirmed when the South African medical authorities, always wary of maintaining their position of professional equality with international bodies, again refused to recognise any inferior qualification.<sup>81</sup> This “second rate” course was unpopular with the students, as the training produced personnel not required for promotive or preventive work but only an incompetent curative training and the absence of a State Medical Service framework within

<sup>77</sup> Gordon. *Report on the Government’s Intended Action*, p.5. It was argued, that the small numbers of black students who matriculated did not warrant the cost of providing a completely new medical school.

<sup>78</sup> UN Archives Pmb. H6/1/1. George Gale. “The Story of the Durban Medical School”, 25/1/76, p.2. Also see Shapiro. “Doctors or Medical Aids”.

<sup>79</sup> SAB, GES, Vol. 2957, Ref. PN5, Native Medical Aids. Report of the Committee of Enquiry on the Medical Training of Natives to the Minister of Public Health, 15/6/1942, p.4.

<sup>80</sup> Shapiro. “Doctors or Medical Aids”, p.248.

<sup>81</sup> SAB, GES, Vol. 2957, Ref. PN 5, Native Medical Aids. Letter from G.W. Gale Dean of the Medical School to Dr. le Roux, Secretary for Health, 19 May, 1952, p.2. SAB, GES, Vol. 2957, Ref. PN5, Native Medical Aids. Report to

which Medical Aids could be absorbed, resulted in them being given unattractive duties as hospital orderlies or side room technicians far below their level of training with little chance of advancement.<sup>82</sup> Many other recommendations for a black medical service were delayed by the outbreak of World War II. The course was abandoned in the mid-1940s but not before the training of blacks at UCT and Wits commenced, where many Medical Aids resigned from the service and retraced their steps back to the first year of full training at the medical schools.<sup>83</sup>

Thus by 1940, a flawed but “embryo Native Health and Medical Service” had been created. While it became increasingly clear that a full medical training for black students would have to be provided in the future, this scheme, many argued, would have to suffice for now. It had limited advantages for it provided some form of health personnel in remote rural reserve areas where white vested interests in the area were small and thus created a favourable field to carry out an experiment in State medicine.<sup>84</sup> It also provided scope for African health workers by drawing them into areas they would have avoided if given free economic choice, and thus exposing some rural communities to western biomedical treatments for the very first time.<sup>85</sup>

Towards the end of the 1930s, State medical and welfare planners increasingly pushed for a new health services approach. It is ironic that in a decade when social, political and economic segregation in South Africa was to strengthen and harden, the same society produced health practitioners whose labours made the region a world leader in the experiment designed to completely reorient the way modern medicine delivered health care to impoverished rural and urban communities.<sup>86</sup> An important factor which paved the way for the greater acceptance of

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the Governing Council, South African Native College, Fort Hare from Prof. W. Norman Taylor, Dept of Hygiene Concerning Course of Instruction for B.Sc. (Hygiene), with suggestions for Future Development, March 1952, p.1.

<sup>82</sup> See SAB, GES, Vol. 2957, Ref. PN5, Native Medical Aids. Report of the Committee of Enquiry on the Medical Training of Natives to the Minister of Public Health, 15/6/1942, p.9 and Report to the Governing Council, South African Native College, Fort Hare from Prof. W. Norman Taylor, Dept of Hygiene Concerning the Course of Instruction for the B.Sc. (Hygiene), with suggestions for Future Development, March 1952, p.2.

<sup>83</sup> SAB, GES, Vol. 2957, Ref. PN5, Native Medical Aids. Report of Committee of Enquiry on Medical Training of Natives to Minister of Public Health, 15/6/1942, p.5 and SAB, GES, Vol. 2957, Ref. PN5, Native Medical Aids. Report to Governing Council, SA Native College, Fort Hare from Prof. W. Norman Taylor, Dept of Hygiene Concerning the Course of Instruction for B.Sc. (Hygiene), with suggestions for Future Development, March 1952, p.1. Only 35 students were trained as Medical Aids by the time the scheme ended.

<sup>84</sup> SAB, GES, Vol. 2704, Ref. 2/62 and 1/62B. Medical and Health Services for Natives. A State Health Plan for the Reserves, Edgar H. Brookes, 1940-52.

<sup>85</sup> SAB, GES, Vol. 2704, Ref. 2/62 and 1/62B. Medical and Health Services for Natives. A State Health Plan for the Reserves, Edgar H. Brookes, 1940-52.

<sup>86</sup> Jeeves. “Public Health and Rural Poverty in South Africa”, p.2.

radical changes in health services was the role of a small group of progressive, pioneer doctors, some within the State's Department of Public Health and for a short time close to decision-making, who re-evaluated traditional public health practice, were interested in social medicine, and who initiated and facilitated (although only for a short time) through legislation the establishment of a revolutionary new health care system.<sup>87</sup> These themes will be addressed in detail in later chapters.

It is important to note at this time - and these progressive health planners recognised this fact - that medical practice in South Africa as a whole was almost totally separated between curative (clinical/hospital practice that is disease-oriented aimed at treating and curing the sick individual who first turns to the doctor for care when sick) and preventive (public health medicine aimed at thwarting emerging disease instead of striving to cure it once established) medicine.<sup>88</sup> Advances of medical knowledge in the late 19th and early 20th centuries had modified the practice and study of medicine and resulted in a worldwide trend in the over-growth of specialisation, which divided the complex human body into narrowly focused parts.<sup>89</sup> Insufficient consideration was given to the high cost of medical advances in the field of bacteriology, where the focus on new therapeutic discoveries, the development of surgical techniques and skills to the exclusion of humanistic sciences with its sound medical and social philosophy and focus on the patient in the hospital ward in isolation distracted attention from the broader social causes without which noxious bacteria would not have developed.<sup>90</sup> At this time only the field of public health was organised on a regional or national level, focused on population groups as the unit of measurement to promote health, aimed at preventing disease, promoting health and ensuring the distribution of material resources.<sup>91</sup> However, social, political and economic exigencies and large institutions and their decision-making authorities were not in direct contact with the community in which the service was extended, which undermined many

<sup>87</sup> "J.K. de Kock. "Doctors in Parliament". *South African Medical Journal*, 11 April 1964, p.237.

<sup>88</sup> See SAB, GES, Vol. 2957, Ref. PN5, Native Medical Aids. Report of the Committee of Enquiry on the Medical Training of Natives to the Minister of Public Health, 15/6/1942, p.8, and Kark. *Epidemiology and Community Medicine*, p.317-318 and S.L. Kark. *The Practice of Community-Oriented Primary Health Care*. (New York: Appleton-Century-Crofts, 1981), p.2.

<sup>89</sup> "The Family Doctor". *South African Medical Journal*, 25 August 1951, p.605.

<sup>90</sup> J.A. Ryle. "The History and Modern Concept of Social Medicine". *South African Medical Journal*, 10 July 1948, p.436.

public health projects. This separation from the community allowed little scope for community participation and a lack of decision making by those most affected by the service.<sup>92</sup>

When a small group of innovative public health professionals took control of policy-making in the small, cautious and under-funded D.P.H. during the late-1930s and 1940s, they together began to move health policy in radical new directions.<sup>93</sup> As the next chapter will show, these doctors were influenced by a more sophisticated and holistic understanding of the social and biomedical causes and roots of disease and emphasised co-operation and co-ordination between medical and allied health workers in the promotion of good health.<sup>94</sup> Increasingly, it came to be seen that doctors were to become preservers of health rather than merely menders of diseased bodies.

In concluding this chapter, it is necessary to pause and reflect on the significance of this change in central State thinking regarding the medical sphere. This chapter is an ironic and telling commentary on the complexity of South African history - that the central State while becoming increasingly racist and segregationist in character in most spheres - allowed its relatively weak D.P.H. to embark on such radical medical changes. A multiplicity of factors in the broader socio-political, economic and intellectual context of South Africa influenced these radical changes. But it was in the D.P.H. that progressive social medicine ideas were able to take hold during the 1940s which had a profound influence on the form that the innovative new community health movement and later Durban Medical School took. It was these same ideas that could have made South Africa a leader in the medical field of community health.

The State's central but weak D.P.H. underwent a remarkable transformation, especially in its public health policy thinking, in the first three decades of the 20th century. This chapter has shown that the predicament in the South African health services debate reached a national level of interest during these years, with an increasingly urgent need to alleviate desperate health conditions, especially for its black underclasses. I have hinted at, and will elaborate on in the

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<sup>91</sup> See Kark. *The Practice of Community-Oriented Primary Health Care*, p.4 and Kark. *Epidemiology and Community Medicine*, p.319. Such as sanitation, water supplies, nutrition, immunisation, health education, maternal and child health.

<sup>92</sup> Kark. *The Practice of Community-Oriented Primary Health Care*, p.6.

<sup>93</sup> Gilliland. "Health Legislation - A Historical Review", p.480.

following chapter, the importance of a progressive new social and community health strand which began to emerge in this initially cautious D.P.H. which saw pioneering medical professionals take South African Government public health policy in new directions, if only for a short time. It gradually evinced the enormous potentialities of community-based health services as a State-funded and directed initiative and attracted worldwide attention. The following chapter will demonstrate how this movement was initiated, taken up and became rooted in the State's National Health Services programme. The State's D.P.H. was thus revolutionised with these radical new community health ideas which infiltrated it in numerous ways. For a short moment in South Africa, public health medicine merged with radical social and community health ideas at a national level and became the central D.P.H. ideas during the mid-1940s. By feeding into each other, the D.P.H.'s focus shifted and produced something never seen before. While I will analyse the innovative and unique achievements of particular pioneering doctors in this movement, such as Sidney and Emily Kark, Henry Gluckman and George Gale to mention but a few, this will be done with a tacit recognition that much of their individual work would never have begun without important developments in the broader social, political and intellectual contexts of the day which made it more conducive to change. The role of Durban as a centre drawing this energy, these people, and these ideas together in one place cannot be overestimated. With a rural hinterland far more evident than either Cape Town or Johannesburg, with licensed non-western healers in the midst of city and rural life, with a lively and active missionary medical community, and with a bid for a new Medical School gaining central State acceptance, Durban was set to become the scene of experiments in broad-based preventive medical research, training, and practice over the next decades. The centrality of Durban is a theme taken up again at the centre of Chapter Three, where the late-1940s and early-1950s are the key focus of analysis.

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<sup>94</sup> Derek Yach and Steve M. Tollman. "Public Health Initiatives in South Africa in the 1940s and 1950s: Lessons for a Post-Apartheid Era". *American Journal of Public Health*, Vol. 83, No. 7, 1993, p.1044.

## Chapter Two

# The Pholela Health Centre and the Development of a National Health Service for South Africa

Towards the end of the 1930s, the South African State's weak and cautious Department of Public Health (D.P.H.) came to play a central role in initiating debates and instituting commissions in an attempt to address some of the desperate health problems and massive public health failings of its inadequate approach. This was especially so for its black constituency, many of who lived in largely remote rural areas with scattered missionary-based services or non-existent health facilities. At the same time as the D.P.H.-led debates raged at the national level, searching for alternative public health policies, a small health experiment in a black rural reserve area of Pholela in Natal was beginning to find its feet and would, in the early-1940s, provide vital answers to the D.P.H.'s searching health questions.

The first half of this chapter will be concerned with analysing this new, non-mainstream and even radical experiment in social and community health medicine - based on the "health centre" approach - in rural Pholela.<sup>1</sup> I will show that in its early years, this approach was initially small-scale and largely outside the D.P.H.'s area of concern, and instead developed around a few farsighted pioneering doctors. It is important to emphasise from the beginning that before the 1940s there was a clear distinction between the central State Department of Public Health policy and the new radical social and community health movement - stimulated by individual doctors - which while initiated by the State, developed largely outside from its national public health policies. This chapter will thus be an analysis of how a social and community health movement operating outside of the mainstream came to influence and be accepted as central to national health policy in South Africa, and how and why community health doctors began working with the D.P.H. toward this end. This chapter will begin by analysing how this particular field of community health medicine first established itself and the particular form this movement took under the specific influence of certain key individuals. While this section will focus on key innovations and unique achievements of a small handful of pioneering doctors in this radical

community health movement, this line of inquiry is undertaken with the implicit recognition that much of these individuals' work would never have begun, nor gained this national status, without important developments in the broader social, political and intellectual contexts of the day. In a later chapter I will also demonstrate how these broader factors ultimately limited the achievements that these innovators - working together either as individual men and women or in teams - could attain. This first section will also examine in some detail the degree of community resistance to the health centre team's attempts to establish itself in the rural black community. I will briefly analyse the extraordinary position of black cultural "brokers" or intermediaries in their newly created roles as "health assistants or educators". Because many of these "health educators" were increasingly drawn from the local community in which the health centre was established, as trained members of the health centre team they were placed in a unique position to help bridge the wide gap of distrust and suspicion between the cultural divides and established better working relationships between both parties.

The second half of the chapter will be concerned with demonstrating how the ideas of this initially peripheral, small-scale community health movement were taken up and incorporated into the central Government D.P.H.'s 1944 "National Health Service" policy. I will show that in just four decades since its inception at the turn of the century, the D.P.H. underwent a remarkable transformation. For a short moment in South African medical history, public health medicine merged with radical social and community health ideas at a national level, where they fed into each other and revolutionised public health policy. This change evinced the enormous potentialities of community-based health service as a State-funded and State-directed initiative. Indeed this approach attracted worldwide attention during the 1940s. An important factor paving the way for greater acceptance of radical changes within State health services was the role played by a small group of public health professionals, some of who were employed in the D.P.H. by the late-1930s. For a short time the opportunity to be close to decision-making enabled this group to move public health policy in radical new directions. They re-evaluated traditional public health policy and practice and facilitated new legislation through the establishment of the framework of a revolutionary new health care system. The key to the new "social medicine"

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<sup>1</sup> The term "Pholela" or "Polela" has been spelt differently by various people in their written texts over the years. They both refer to the same place, but I will use "Pholela" throughout to refer to the rural community in Natal where South Africa's pilot health centre was established.

approach urged upon the D.P.H. by this group was a more sophisticated and holistic understanding of social and biomedical root causes of disease. The emphasis in social medicine involved co-operation and co-ordination between medical and allied health and social workers in the promotion of good health.<sup>2</sup> The false divide between preventive and curative medicine was exposed and instead the preventive approaches were stressed. In this vision doctors were repositioned as preservers of health rather than as menders of diseased bodies. They also changed a long-tradition of “top-down” public health policies and decision-making away from community contact to a community-involved, “bottom-up” approach with participation of people who were most affected by the service.<sup>3</sup> In a later chapter I will demonstrate how these progressive ideas would have a profound influence on the establishment of the Durban Medical School. This chapter ends with the energies of social and community health as public health policy at their peak. However, the resonance and power of this approach to public health in South Africa as a whole lasted only a short time before a variety of forces undermined it. In the next chapter I will show how after 1948 these progressive health ideas became a provincial matter, rooted in a fledgling institution in Durban in the 1950s, whose marginalisation from national affairs would also contribute to its vulnerability and seriously undermine its project by the 1960s.

### ***International Precursors to the New Health Centres Approach.***

Before analysing the experimental and, what some have argued, revolutionary community health centres approach that developed in South Africa during the late-1930s and 1940s, it is important to state from the outset that this health centre movement was not entirely unique and had a number of predecessors with a slightly different focus and form. The idea of a “health centre” - the collaboration of practice and service aspects of both a protective and remedial kind - was not new, but over the years it had developed different functional interpretations in various countries. The term “health centre” was first used in England in 1920 when the Dawson Report on the “Future Provision of Medical and Allied Services” introduced a version of a national system of health centres and recommended that preventive and curative

<sup>2</sup> Derek Yach and Steve M. Tollman. “Public Health Initiatives in South Africa in the 1940s and 1950s: Lessons for a Post-Apartheid Era”. *American Journal of Public Health*, Vol. 83, No. 7, 1993, p.1044.

<sup>3</sup> Sidney L. Kark. *The Practice of Community-Oriented Primary Health Care*. (New York: Appleton-Century-Crofts, a Publishing Division of Prentice-Hall, Inc, 1981), p.6.



medicine not be separated in any medical service scheme.<sup>4</sup> In China, a less developed country at the time, the pioneer experiment in health centre work and training was undertaken by Dr. John Grant in 1921, when he was appointed by the Department of Hygiene of Peking Union Medical College in China - which had been taken over by the Rockefeller Foundation - to establish a “demonstration health station”.<sup>5</sup> Here an attempt was made to bring health maintenance, prevention, and curative medicine together and was used in the teaching of medical undergraduates and public health nurses. However, the problem with these early forms of health centres, in both developed and developing countries, was that they were not comprehensive and did not successfully co-ordinate and integrate preventive and curative services into a unified system of health care. Sick patients were largely separated from “health” services, while the centres tended to confine themselves to out-patient curative medical practice, and did not combine “individual and community medicine into community-oriented primary health care”.<sup>6</sup> Another problem was that the trained staff to implement this new service did not exist at any level either. It was only twenty years later when the British National Health Service Act of 1946 improved the quality of family service with a team of doctors in collaboration with related ancillary services, that they were given an opportunity to practice a better quality of co-ordinated curative and preventive individual and community medicine.<sup>7</sup> But this was only after South Africa introduced legislation outlining its own form of health centre service which revolutionised medical thought both locally and internationally.

### ***Historiographical Interlude.***

Alan Jeeves argues that ironically in the same decade when social, political and economic segregation in South Africa was to strengthen and become entrenched in later apartheid legislation:

... the same society produced health practitioners whose labours made the region a world leader in the experiment designed to completely reorient the way modern medicine delivered health care to impoverished rural and urban communities

<sup>4</sup> Kark. *The Practice of Community-Oriented Primary Health Care*, p.10. A well known example was the pre-war Peckham Health Centre.

<sup>5</sup> UN Archives Pmb. H/6/1/1. George Gale. “The Story of the Durban Medical School”, 25/1/76, p.6.

<sup>6</sup> See Kark. *The Practice of Community-Oriented Primary Health Care*, p.10, and SAB, GES, Vol. 2958, Ref. PN5, Vol. 1 and 2. A Report on the Health Centres Service of the Union Department of Health, by Dr. John A. Ryle (Prof. of Social Medicine in the University of Oxford), n/d, p.1.

<sup>7</sup> Ryle, A Report on the Health Centres Service, p.2.

through social medicine.<sup>8</sup>

Recently published works of revisionist South African scholarship have argued that the laws and practices associated with segregation and later apartheid ideology which systematised, rationalised and entrenched white supremacy and power, had at their centre no grand plan or predetermined approach, but were continually negotiated in theory and practice.<sup>9</sup> Dubow maintains that segregationist discourse was “ambiguous” and its ability to adapt to changing situations enabled white supremacy to survive.<sup>10</sup> As John Cell argues, “segregation triumphed for the very reason that it was flexible and sophisticated”.<sup>11</sup> Deborah Posel has argued that close examination of cabinet minutes and other State records in the 1950s reveals that even much Apartheid planning was *ad hoc* and formulated after internal debates at least until the late-1950s. It is the complex and ambiguous nature of segregation and apartheid which has fascinated many historians, including myself, and which, I will argue, allowed a small number of progressive community health doctors to embark on a less travelled path in the forest of complexities and ironies within segregationist history. I hope to explain why it was precisely during these particular socio-political segregationist circumstances, that the groundwork was laid down for some of the most progressive developments in health services the world has ever seen, while the hegemonic racial ideology of white South Africa was still maintained - even in health provision. It is an ironic and telling commentary on the complexity of South African history that it was in racially segregated South Africa that ideas promoting social medicine took hold.

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<sup>8</sup> A. Jeeves. “Public Health and Rural Poverty in South Africa: “Social Medicine” in the 1940s and 1950s. Seminar Paper presented at the University of the Witwatersrand Institute for Advanced Social Research, 30 March 1998, p.2.

<sup>9</sup> See H. Wolpe, “Capitalism and Cheap Labour-Power in South Africa: From Segregation to Apartheid”, in *Economy and Society*, I, 4, 1972, S. Marks. *The Ambiguities of Dependence in South Africa. Class, Nationalism and the State in Twentieth-Century Natal*. (Baltimore and Johannesburg: Johns Hopkins University Press, 1986), J.W. Cell. *The Highest Stage of White Supremacy: The Origins of Segregation in South Africa and the American South*. (Cambridge: Cambridge University Press, 1982), P.B. Rich. *White Power and the Liberal Conscience. Racial Segregation and South African Liberalism, 1921-60*. (Johannesburg and Manchester: Manchester University Press, 1984), Deborah Posel. *The Making of Apartheid, 1948-61: Conflict and Compromise*. (Oxford: Clarendon Press, 1991).

<sup>10</sup> Saul Dubow. *Racial Segregation and the Origins of Apartheid in South Africa, 1919-36*. (Oxford: Macmillan, 1989), p.180. Rather than simply an ideological legitimisation of white domination and capitalist exploitation, segregation was an “umbrella” ideology including diverse interests.

<sup>11</sup> Cell. *The Highest Stage of White Supremacy*, p.18.

### ***Progressive Public Health Doctors in the United Party Government.***

As important as most of the studies on health and disease in South Africa are - studies dominated by analyses of large curative structures and technologically sophisticated institutions of a capitalist society in a racial order maintained by white prosperity and black poverty, and which produced the associated disease outcomes of each - they illuminate only one part of the complicated history of medicine in South Africa. The other, more silent history, is that of the progressive social and community health movement, where South Africa became a world leader in experiments designed to reorient the way modern medicine delivered health care to impoverished rural and urban communities. Many contributing factors have been presented as facilitating these progressive preventive, social, and community health centre movements, which were centred around individual and farsighted doctors. Some scholars have approached an analysis of these developments using only “great men theories” - invoking detailed analyses of one or two pioneer figures - to the exclusion of many other influential broader intellectual, political and social contexts at the time. While I will focus on the numerous broader factors that resulted in the development of this movement, this chapter will also largely be an analysis of some of these individual doctors and their outstanding work contributions in this field, so as not to detract from their remarkable achievements. People such as Emily and Sidney Kark and their cadre of community health doctors, who were seen as non-mainstream and made rapid progress often hidden from the public view and situated initially away from the attention of the central State’s D.P.H. Restoring the work of these kinds of people into 1940s and 1950s South African history is a salutary reminder that only the broad brush strokes of South Africa’s early apartheid history have been completed, and that it was possible for this society - whose socio-political situation can seem monolithic viewed from the outside - to be actually internally contested and made up of parallel often contradictory strands, especially within the health sphere.

However, it must be stated from the beginning, that much of this work would never have begun - even at the small-scale, peripheral and grass roots level - without the support of key doctors within all levels of the D.P.H. For a short time, a small group of innovative public health professionals, who were close to State decision-making, took control of policy-making in the small, cautious and underfunded D.P.H. and together moved policy in radical new directions. They re-evaluated, initiated and facilitated through legislation public health policy and practice,

which helped establish South Africa's unique health system.<sup>12</sup> Edward Thornton (Secretary for Public Health 1932 to 1938) who gained experience in French West Africa, first proposed a system of health centres for black areas in the 1927 Hospital Report. While his concept was vague, ill-conceived and failed to provide the motivation for a comprehensive primary care service, it provided the framework on which South African health centre concepts were built.<sup>13</sup> His ideas for a health centre based "Native Medical Service" were publicly supported by the Loram Committee set up to review black health services in 1928, but it failed to articulate the precise function and scope of the health centre practice. Dr. Harry S. Gear also influenced the service, when he became Assistant Health Officer of the Union in 1935. Having just returned from China and having been influenced by health services developed for rural people by the Dutch in Java, India and China, he committed the D.P.H. to a system of "health units" intended to form the basis of the "Native Medical Service" and provide a comprehensive health service to rural black populations.<sup>14</sup> Pholela would form one of these health units.

### ***Broader Context of the Emergence of Progressive Medical Activists and Thinkers in the 1930s.***

An interesting corresponding element to the emergence of progressive medical thinkers and activists in the 1930s was the particular social and cultural background of many of these medical innovators. Like the key role played by Christian medical doctors in the establishment of medical services (an involvement well documented in secondary literature) this cadre of community health doctors were also marked out by religious designation: an overwhelming proportion were women and men of Jewish background. While many were secular by lifestyle and practice their Jewish roots provided them with some aspects of a shared past and present experience of the world. In the context of world events much of the 1930s were dominated by anti-fascist movements. In a series of mass migrations with their roots in the late 19th century, many European Jews fled their countries for lack of employment or to escape the oppression and racial persecution to which they were subjected throughout Eastern Europe. For many refugees, America was the land of opportunity and freedom, but when this American haven was closed to

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<sup>12</sup> "J.K. de Kock. "Doctors in Parliament". *South African Medical Journal*, 11 April 1964, p.237.

<sup>13</sup> D. Harrison. "The National Health Services Commission, 1942-1944 - Its Origins and Outcome". *South African Medical Journal*. Vol. 83, September 1993, p.682.

<sup>14</sup> Harrison, "The National Health Services Commission", p.682.

these oppressed people, would-be emigrants looked about for other destinations and many chose sunny South Africa, “the country where streets were paved with gold”.<sup>15</sup> While many studies have analysed these years, focusing on the growing fascist tendencies of the Afrikaner Nationalists, another area having had less analysis, was the growing response to this of radical and progressive socialists. Many South Africans, but particularly Jews, who were attracted to virtues of socialism and motivated by the dream of a better future and the end of oppression and dehumanisation, supported progressive socialist ideas.<sup>16</sup> The Jewish community came to play a vital role in bringing about change in South Africa, in all spheres including political, social, economic and importantly, the medical sphere. Suttner argues in his book, *Cutting through the Mountain*, how ironic it was, that in South Africa, where Jews were not the primary objects of oppression and racism, there was no sense of collective outrage based on their own experience or memories of persecution but were silent spectators to the systematic oppression and exploitation of the black majority and generally, like other whites, enjoyed the fruits of an apartheid society.<sup>17</sup> But despite the silence of Jews as a whole community, a number of Jews connected to one another in small groupings chose to involve themselves fully in South Africa’s affairs. Through this resistance and commitment these men and women faced a difficult future but played a vital part in transforming South Africa into a more just society. There were two streams of activism - those who fought from “within the system” such as jurists, members of Parliament, the media, or in civil society, and those who entered “illegal” organisations which were socialist, communist or mass-based in character.<sup>18</sup> Suttner argues that:

a whole set of atavistic cultural memories shaped and motivated their unique contributions. In many cases, the heritage of Eastern European marginalisation,

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<sup>15</sup> Pauline Podbrey. *White Girl in Search of the Party*. (Pietermaritzburg: Haded Books, 1993), p.2. This autobiographical book is about the life and experiences of Pauline Podbrey, an immigrant Jew who came to South Africa from Lithuania and became involved in the communist party, black trade unions and the struggle against racial discrimination. It is a memorable account of a young woman dedicated to the cause of social justice in a discriminatory and oppressive country.

<sup>16</sup> Immanuel Suttner (ed). *Cutting through the Mountain: Interviews with South African Jewish Activists*. (London: Viking Penguin Group, 1997), p.601. A big thank you to Maya Scholtz for pointing out this fascinating book to me. Maya is also doing interesting research for her Honour’s Dissertation on the contributions of Jewish doctors in the medical sphere in South Africa.

<sup>17</sup> Suttner. *Cutting through the Mountain*, p.1-2.

<sup>18</sup> Suttner. *Cutting through the Mountain*, p.2. I was disappointed to find that of all the interviews included in his book, Suttner does not include interviews of, nor does he analyse the roles played by many Jewish doctors in the struggle against segregation and apartheid.

landlessness and proletarian militancy created an openness to radical positions and a capacity for imaginative empathy with those most directly oppressed.<sup>19</sup>

He thus makes the assertion that Jewishness played a significant role in making activists, because their status in the broader white community as “outsiders” helped to make them more sensitive to the huge flaws in South African status quo.<sup>20</sup> This tradition of Jewish non-conformists exemplified solidarity with the underdog and uncompromisingly continued a tradition of social concern and criticism. Adherents to this tradition devoted their services to a fight against injustices and journeyed to find a common humanity. As Suttner argued:

if there is an original sin, it is allowing our fears to blind us to the humanity of those who appear different from us, because we see the noises in our heads rather than the people in front of us.<sup>21</sup>

A large number of social and community medicine’s pioneering doctors were Jewish. This is particularly significant since Sidney and Emily Kark’s – both important community health doctors – central pioneering approach was directly influenced by this Jewish philosophy. In their recently published book, *Promoting Community Health*, the Karks asserted the following:

our personal development and our awakening consciousness to the evils of racial segregation and apartheid. There were are least two processes involved in this personal change. The first occurred while studying at the University of the Witwatersrand and was stimulated by a leading group of faculty members. The second was related to our own Jewish family origins. The European anti-Semitic movement was reaching its height of racism and this affected us personally as the number of whites in South Africa who were inspired by Hitler grew along with the rise of Nazism over Europe and beyond. No doubt the growing awareness of this horrendous movement increased our receptiveness to liberal-social democratic values.<sup>22</sup>

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<sup>19</sup> Suttner. *Cutting through the Mountain*, p.2. This book documents the oral testimonies of a number of well-known individual Jews who were active on the left, or in the fight against apartheid’s political and cultural hegemony, or in both. Its a celebration of Jewish leftist achievements, many of whom had previously been written out of histories celebrating collective Jewish achievements.

<sup>20</sup> See Suttner’s arguments in *Cutting through the Mountain*, p.3, 625-626.

<sup>21</sup> See Suttner. *Cutting through the Mountain*, p.624.

<sup>22</sup> Sidney and Emily Kark. *Promoting Community Health: From Pholela to Jerusalem*. (Johannesburg: Witwatersrand University Press, 1999), p.xvi-xvii.

At a short interview section with Mervyn Susser and Zein Stein (colleagues and close friends of the Karks), I asked them whether they thought their Jewish background would have influenced and even motivated the Karks. Susser replied:

Oh, that undoubtedly influenced him. You know, I think that's sort of a continuing historical threat, so long and so deep that it influences practically anybody who's reared, issues from a Jewish background. Consciously or unconsciously, willingly or unwillingly it's there ...<sup>23</sup>

Another important influence on the Kark's philosophy was the medical education they received at Wits during the 1930s. While they experienced a largely "blinkered" education at Wits medical school - an education strictly for whites based on the British medical curriculum of medical matters that dominant white minorities shared with their British counter-parts and blind to the wider health concerns of South Africa's segregated black majority - they more importantly received valuable guidance from a few remarkable Faculty members who did not neglect the broader issues of a multi-layered society.<sup>24</sup> Joseph Gillman's pioneer nutrition studies greatly influenced Sidney Kark and Emily Jaspen (they were married after graduation and became life-long collaborators) whom as students in the mid-1930s before graduating, founded the "Society for the Study of Medical Conditions among the Bantu".<sup>25</sup> As Sidney Kark argued:

we went out to meet different people, [this] was an important thing. We had no African students then at Wits, not that many anyway, certainly not in the medical school, ... so we had to almost create our own community health society.<sup>26</sup>

Wits, at the time, while not a radical institution was led by a liberal cohort - including Dean Raymond Dart head of the Medical School. Dart encouraged a more liberal engagement with African health issues, and ensured that Wits became the first school to admit limited numbers of black students for training in South Africa. Many progressive doctors lectured there, such as Henry Gluckman and Eustace Cluver, before moving into politics, which they saw as the best

<sup>23</sup> Interview with Mervyn Susser and Zein Stein by Vanessa Noble and Maya Scoltz, at the Campbell Collections Durban, 4 June 1999. Both Sidney and Emily Kark's families had emigrated from Lithuania, Europe in the 1880s. See Karks. *Promoting Community Health*, p.5.

<sup>24</sup> Mervyn Susser. "A South African Odyssey in Community Health: A Memoir of the Impact of the Teachings of Sidney Kark". *American Journal of Public Health*, Vol. 83, No. 7, July 1993, p.1039.

<sup>25</sup> Susser. "A South African Odyssey in Community Health", p.1039.

<sup>26</sup> Interview of Emily and Sidney Kark by Prof. C.C. Jinabhai and Dr. Nkosazana Zuma, Durban, 1992, p.2.

way to improve South Africa's health policies.<sup>27</sup> Gluckman was also Jewish and he helped revolutionise health policy in South Africa. While his role will be discussed at greater length at a later stage, suffice to say that his Parliamentary career was meteoric as he rose within eight years (1938-46) to become the only Jew to attain Cabinet rank in South Africa up until that point.<sup>28</sup> Being drawn early in this medical career to social and preventive aspects of medicine, after serving as Chairman of the National Health Services Commission (1942-44) he was appointed as Minister of Health in 1946, where under his leadership, plans were laid for a comprehensive health service based on a network of countrywide health centres available to all sections of the population. This plan, if implemented, would have made South Africa a world leader in the field of community health.<sup>29</sup> Without these influential, socially-conscientised leading medical figures, many of whom were involved at a governmental level, even the limited successes particular individuals achieved would have been impossible.<sup>30</sup> The Karks thus emerged from training in the late-1930s with a broad view of health in society and were determined to provide health services for the black oppressed. With the help of progressive doctors in Government, the Karks were determined to make primary health care the instrument in and for public health. Susser has argued:

Sidney Kark is among the most single-minded, persistent, and dedicated person I have known. Ever since he was a medical student, he had been thinking about, developing, elaborating, putting into practice, and enlarging his ideas on Social Medicine.<sup>31</sup>

A brief window period of opportunity that coincided with the desperate crisis in black health and lent the health centre idea wider support, was the parallel crisis in white health caused by land loss and transformation in the first decades of the 20th century, where large

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<sup>27</sup> Bruce K. Murray. *Wits the Early Years. A History of the University of the Witwatersrand, 1896-1939*. (Johannesburg: Witwatersrand University Press, 1982), p.179. Also see Karks. *Promoting Community Health*, p.6-10 for a detailed analysis of the influence of individual Faculty members on the Karks. One of the names they mention is Eustace H. Cluver, their public health professor who had a great interest in social and preventive medicine and joined the D.P.H. as Assistant Health Officer and in 1938 became Secretary of Health and Chief Health Officer of the Union and was in this important position when the NHSC was initiated.

<sup>28</sup> "Henry Gluckman". *South African Medical Journal*, Vol. 72, 15 August 1987, p.302.

<sup>29</sup> S.M. Tollman. "The Pholela Health Centre - the Origins of Community-Oriented Primary Health Care: An Appreciation of the Work of Sidney and Emily Kark". *South African Medical Journal*, Vol. 84, No. 10, October 1994, p.653.

<sup>30</sup> Shula Marks. "South Africa's Early Experiment in Social Medicine: Its Pioneers and Politics". *American Journal of Public Health*. Vol. 87, No. 3, March 1997, p.453.

<sup>31</sup> Susser. "A South African Odyssey in Community Health", p.1042.



numbers of Afrikaners formed a large unskilled urban work-force.<sup>32</sup> In the early-1930s, one in five Afrikaners were classified as “poor white” and suffered much preventable disease as many could not afford and thus had little access to health care. Some even turned to “alternative” forms of medicine.<sup>33</sup> The State was inspired into action because of the clamour against high medical costs, while resolution would be achieved more cheaply for white taxpayers and provincial authorities through health centres than through hospitalisation. Thus progressive public health doctors were aided by the growing bi-partisan political consensus on the urgent need to address the health needs of both blacks and poor white communities which helped facilitate the development of a farsighted policy of social medicine.

### *First Tentative Steps.*

An important stimulant for health changes in South Africa was the growing world-wide trend and recognition of the fact that disease causation was too intimately associated with social and economic problems, the burden of poverty, and widespread apathy of past clinical medicine, for these to be ignored when developing modern health programmes.<sup>34</sup> It was realised, in South Africa, that the multiplication of hospitals and part-time District Surgeons in remote black reserve areas would do little to raise the standards of community health. In 1938-39 the D.P.H. commissioned its first comprehensive “National Bantu School Children Nutrition Survey”, under the direction of the newly qualified Dr. Sidney Kark as Medical Officer-in-Charge of the field team. The survey provided proof of the rampant disease and premature death from malnutrition, STDs, malaria and T.B. which were crippling the population especially in rural areas, and the “outstanding fact is that all is preventable”.<sup>35</sup> Situated within the wider Government concerns for health provision of the 1930s, this Nutrition Commission culminated in 1939 in the proposed establishment of three experimental State health centres or “Native Health Units”, each to serve a defined area - especially in black rural “betterment areas” simultaneously being planned by the agricultural section of Department of Native Affairs. Kark was given the opportunity as Medical

<sup>32</sup> Marks. “South Africa’s Early Experiment in Social Medicine”, p.454.

<sup>33</sup> Marks. “South Africa’s Early Experiment in Social Medicine”, p.454.

<sup>34</sup> H.S. Gear. “The South African Native Health and Medical Service”. *South African Medical Journal*, Vol. XVII, No. 11, 12 June 1943, p.168-169. Before the D.P.H. established its “Native Health and Medical Service” in 1938, a number of preventive health services were surveyed in developed countries such as the Life Extension Institute in the USA and Institute of Social Medicine in Oxford but especially rural health services in developing countries such as India, Dutch East India, China, tropical Africa and Europe to provide guidance for South Africa.

<sup>35</sup> UN Archives, Pmb, H6/1/1. George Gale. “The Story of the Durban Medical School”, 25/11/76, p.4.

Officer, or leader of a team of nurses and health assistants, to develop a service of curative, but more importantly, promotive, preventive and extra-hospital medicine as a comprehensive service.<sup>36</sup> While there was a genuine concern for the rising tide of disease among the black majority which lay behind support for the establishment of health centres, Cluver cleverly crouched his argument in terms calculated to appeal to the Treasury:

in order to control the expenditure on Native hospitalisation and to reduce demand in a manner which would ultimately result in considerable saving ... a scheme has been evolved to establish inexpensive clinics for the treatment of disease among Natives.<sup>37</sup>

However, the outbreak of World War II hampered the Department of Health's operations. Of the three proposed pilot health units to be established in Natal, the Transvaal and Transkei before the war, only one was initially established at Pholela in Natal in 1939/40.<sup>38</sup>

### ***Window of Reform: World War II and the Radicalisation of Medicine.***

South Africa's new health care initiative was greatly influenced by the triumph over Nazi fascism in Europe which stimulated principles and ideals of universal human rights in a democratic post-war world. These progressive ideals coincided after the war with the anti-colonial struggle in Africa and Asia as well as the civil-rights movement in the US.<sup>39</sup> The great social, political and economic ferment stimulated by the needs of wartime production, industrial expansion, and the accompanying urbanisation and proletarianisation had an enormous impact on South African society. Black South African opposition politics which had vacillated before the war - hindered by conservative and elitist leadership, continual financial weaknesses and factional disputes - now became more revolutionary and mass based. Economic pressures were accompanied by shifts at a political level and a new generation of radical activists and worker trade union organisations emerged to direct growing radicalism and militancy of workers (initially ignored by elitist politicians) who now felt the greater pressure of white racism and competition for jobs and space in the cities.<sup>40</sup> The massive influx of black subordinate

<sup>36</sup> UN Archives, Pmb, H6/1/1. Gale. "The Story of the Durban Medical School", p.3-4.

<sup>37</sup> Marks. "South Africa's Early Experiment in Social Medicine", p.454.

<sup>38</sup> Harrison. "The National Health Services Commission", p.682.

<sup>39</sup> Dubow. *Racial Segregation and the Origins of Apartheid*, p.177-180.

<sup>40</sup> Robert Morell (ed). *Political Economies and Identities in KwaZulu-Natal: Historical and Social Perspectives*. (Durban: Indicator Press, 1996), p.102, 113. In the 1921 census, 12% of Natal's population was urbanised, by 1951

communities into urban areas, together with their growing solidarity and dissatisfaction with available facilities and services, especially health, precipitated a crisis for the racist State to control the threat to white power and to address desperately inadequate health needs which might otherwise have been delayed until later years.

The “ideals” of the medical profession in South Africa, apparently universal in scope, were in reality largely circumscribed and shaped by British metropolitan ideas about class, race and gender. This is especially evident at UCT and Wits, institutions which were always forced to deal with colonial versus metropolitan “inferiority” complexes and were in the early years very cautious about movement beyond these structures and curricula. But World War II brought a challenge to this and provided a new progressive thrust in the western medical academy. In South Africa this took a particular form, where the definition of ethical medicine widened substantially. It was within this liberal climate that many changes occurred. Progressive doctors made use of the rare window period of opportunity stimulated by the war to initiate and develop a farsighted policy of social and medical reform. A great deal of the radicalism in South African medical discourse was influenced by development in international metropolitan trends in medical training and practice and the growing movement for social medicine.<sup>41</sup> In Britain, two years after South Africa’s NHSC Report, the Goodenough Report of 1944 stressed the importance of social medical training in all medical schools:

a concept that regarded the promotion of health as the primary duty of the doctor, that pays heed to man’s social environment and heredity as they affect health, and recognise that personal problems of health and sickness may be communal as well as individual aspects.<sup>42</sup>

Social medicine inspired younger, more radical members of the South African medical community, who found themselves surrounded by the disease consequences of industrialisation and rural impoverishment. The medical profession as a whole, which was renowned for its large

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this had risen to 32%. The percentage growth for the Indian population was striking with only 21% urbanised in 1921, against 74% in 1951. Africans were only 5% urbanised in 1921, which increased to 16% in 1951. Also see Bill Freund. *Insiders and Outsiders: The Indian Working Class of Durban, 1910-1990*. (Pietermaritzburg: University of Natal Press, 1990), p.50 where he shows how Indians became the most militant workers in South Africa in the 1940s.

<sup>41</sup> Marks. “South Africa’s Early Experiment in Social Medicine”, p.454.

<sup>42</sup> Gordon Papers (GP). File 17, KCM 25841. UN Medical School. Minutes of the Meeting of the Curriculum Sub-Committee held on 20th June, 1952. “The Curriculum and the Organisation of Teaching for the Degree of M.B., Ch.B. of the UN”, p.1.

constituency of conservative and reactionary members, was either silenced during the war years or also caught up in the euphoria and optimism of social reform. It is important to note that many of these conservative, even racist white doctors left unimplemented social policies they saw as necessary for health improvement and instead advocated purely medical responses to black health needs. At the same time a smaller number of influential public health doctors advocated complex ideas and practices of social medicine, which removed the profit incentive from disease and replaced it with a higher ethical ideal of service.<sup>43</sup> While small in number, their contributions were to produce the most notable developments in social medicine worldwide as their ideas formed models for social and community health.<sup>44</sup> Despite the undoubted contradiction in their thought and practice living in and with the realities of a race and class segregated South Africa, the leading figures explicitly identified both the socio-political causes of ill-health and the means to prevent or cure it, even if they were ultimately powerless to implement broader policies they believed necessary.

### ***Pholela: South Africa's Pioneer Health Centre in Natal.***

In 1940 the State's D.P.H. was provided with an opportunity to stop preventable diseases by exploiting a cheaper, more experimental approach.<sup>45</sup> While both the 1928 and 1938 Government Committees on health service provision had recommended the establishment of "Native rural Health Units", the "pilot plant" (upon which others would be modeled) was only established in April 1940 when the first team was placed in the field, and would take another four years before the State's D.P.H. fully appreciated the health service contributions it had to make.<sup>46</sup> It was during these early years - when this approach was initially small-scale and largely outside the D.P.H.'s central area of focus - that it developed around a few doctors. This next section will thus analyse how this particular field of community health medicine first established itself and the particular form this new movement (initially radical and very different to the D.P.H.'s traditional public health policies) took under the specific influence of certain key individuals, before later moving into an analysis of how and why this non-mainstream movement came to influence and be accepted as South Africa's mainstream public health service at a

<sup>43</sup> Arnold H. Tonkin. "A State Medical Service for Natives". *South African Medical Journal*, 9 August 1941, p.290.

<sup>44</sup> Marks. "South Africa's Early Experiment in Social Medicine", p.453.

<sup>45</sup> Jeeves. "Public Health and Rural Poverty in South Africa", p.3.

national level. This “pilot plant” was known as Pholela or “*Kwa Mpoli ya Bantu*” - the place where people are given life.<sup>47</sup> As Kark asserted, “it was the first ... health centre in the country. Certainly in the rural areas it was the first. I think it is true to say even in urban areas, and among blacks without question”.<sup>48</sup>

In an interview with S. Cameron-Dow, Kark was asked to explain what Pholela was like. Kark responded:

I must say this for Pholela - it is one of the most beautiful areas of this country, it's situated in the foothills of the Drakensberg Mountains in the South West corner of Natal [near Bulwer], it ranges from ... about 4 and half thousand feet above sea level rising to it's highest mountain top in Polela itself, it was about 7 thousand feet above sea level so there were parts of Polela itself that were exposed to snow every winter, our Health centre site ... [here] we were living in snow bound country.<sup>49</sup>

Kark claimed that it had a population of about 30,000 Zulu-speaking African peasants.<sup>50</sup> According to the State Information Office, Department of Interior, the site was chosen because of the high incidence of disease and poverty, but also because it was situated in a “betterment area” conducted by the Native Administration Department (NAD), where agricultural and stock improvement and afforestation had commenced to correlate with health centre work.<sup>51</sup> The headquarters were situated in the “heart of the location”, which according to Kark was ideal for demonstration purposes<sup>52</sup>, while the area serviced varied with local conditions forming a radius of between fifteen and twenty miles.<sup>53</sup> According to John Cassel's report, health conditions were extremely poor:

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<sup>46</sup> SAB, GES, Vol. 2957, Ref. PN5, Native Medical Aids. Report of the Committee of Enquiry on the Medical Training of Natives to the Minister of Public Health, 15/6/1942, p.12.

<sup>47</sup> SAB, GES, Vol. 2704, Ref. 1/62B and 2/62. Native Health and Medical Services Polela Unit. General Matters. “Social Medicine among the Kraals of Natal. Modern Methods of Health Propaganda oust the Old-Time Witchdoctors of Polela” by Alastair Matheson, 1940-52, p.3.

<sup>48</sup> Interview of Emily and Sidney Kark, p.4.

<sup>49</sup> UN Archives, Pmb. H6/1/1. Interview with Professor S. Kark and Professor Gordon on the Facts and Aspects of our Medical School which are not Recorded, by S. Cameron-Dow, December 1980, p.9.

<sup>50</sup> Sidney Kark. “A Health Service Among the Rural Bantu”. *South African Medical Journal*, Vol. XVI, No. 10, 23 May 1942, p.197.

<sup>51</sup> SAB, GES, Vol. 2704, Ref. 1/62B and 2/62. Native Health and Medical Services Polela Unit. General Matters. Social Medicine in South Africa, March 1951, p.1.

<sup>52</sup> Kark. “A Health Service Among the Rural Bantu”, p.198.

<sup>53</sup> H.S. Gear. “The South African Native Health and Medical Service”. *South African Medical Journal*, Vol. XVII, No. 11, 12 June 1943, p.171.

the infant mortality rate was 276 per 1,000 live births, the crude mortality rate was 38 per 1,000 ... Inadequacy of the diet was evident in the fact that more than 80 per cent of the people exhibited marked stigmata of nutritional failure and that malnutrition in the form of pellagra and kwashiorkor was rife. Frequent epidemics of typhoid, typhus fever, and smallpox contributed to the high death rate; tuberculosis, venereal disease, and dysentery were major problems.<sup>54</sup>

Sidney Kark, assisted by his life-long partner and also a medical graduate from Wits (at first in an honorary capacity and later in a paid post) together founded Pholela from its inception in 1940 until the end of 1945 when they were transferred to Durban.<sup>55</sup> As Kark argued: “When we came to Pholela we came from a honeymoon which we spent in Durban”.<sup>56</sup> As young doctors, the Karks had some preparation for this work. They both had several years of training as interns and residents in hospital medicine, paediatrics and surgery. Sidney had subsequent experience in the national nutrition survey and in T.B. and STDs.<sup>57</sup> Emily had casualty and ER medicine experience in several African hospitals, and according to Kark, was well prepared for her new work:

she had her whole housemanship in the ... Non-European General Hospital in Johannesburg ... and the kind of jobs she did ... there was gynaecology and obstetrics, medicine, and then she became a doctor in charge of the emergency service in that Non-European hospital and this little woman would do emergency surgery on all the kinds of people who came in from the violence of those days.<sup>58</sup>

She also did casualty work at McCord’s Zulu Hospital in Durban. As Medical Officer-in-Charge, Kark was team leader and his duties included clinical, but also training and supervision, administrative and policy directed work, but was also required to produce enthusiasm and encourage people to remain in the preventive service. He was given great scope to work out new

<sup>54</sup> John Cassel. “A Comprehensive Health Program among South African Zulus” in Benjamin D. Paul (ed). *Health, Culture and Community: Case Studies of Public Relations to Health Programs*. New York: Russell Sage Foundation, 1955, p.15-16.

<sup>55</sup> UN Archives, Pmb. H6/2/3. Correspondence concerning Establishment of the Department of Family Practice. Health Services in S. Africa. Blight Falls on a Courageous Experiment in *Manchester Guardian*, September 1953

<sup>56</sup> Interview of Emily and Sidney Kark, p.4.

<sup>57</sup> Kark. *The Practice of Community-Oriented Primary Health Care*, p.197.

<sup>58</sup> Interview of Emily and Sidney Kark, p.4.

methods to approach rural health problems.<sup>59</sup> Kark had much to say about the free-reign afforded to him by his “boss”, Harry Gear:

Harry Gear was the kind of boss, he was a meticulous administrator but he was also very tolerant when he said ‘I’m going to give you a general view of the place, the people, you must go out there and see it, and you develop this as you think best, but give it a preventive orientation ... remember, in peoples like those that we’re going to serve, prevention is a thousand times more important than any cures you or anybody else is going to be able to do. ... We got a free hand to develop it as we wanted.’<sup>60</sup>

During the 1930s, medicine seemed to many, such as Mervyn Susser (a community health doctor who worked at Alexandra health centre in the mid-1950s), a “bourgeois suburban activity for upwardly mobile people”. After the war, “we were swept up by the euphoria and optimism about social reform in the world at large [and brought] to see that medicine might be a social service to people and community”.<sup>61</sup> He maintained that many of these pioneer doctors such as Kark, were motivated to embark on health centre work “to resist the consequences of increasing State callousness and repression. The change and force of circumstances impel us into the activist role”.<sup>62</sup> Jack Geiger concurred with Susser and in his article on these community health doctors wrote that part of their work was derived from political action or resistance to segregation, apartheid, and social inequity. As Geiger wrote:

health centres were idealistically conceived by their originators as instruments of social change, a means of intervention in social, biological, physical and even political environments that so greatly determined the health status of the oppressed and disadvantaged in the first place. ... A change in the social order was seen as essential for lasting improvement in the health of the poor.<sup>63</sup>

When I asked Mervyn Susser what he thought motivated the Karks to embark on community health work, and whether they were political activists in their own right he maintained:

I think he was, [but] he wasn’t once he got into medicine - a political activist. ... while he was in the Government service ... he had to toe the line a lot. It was either survival

<sup>59</sup> SAB, GES, Vol. 2957, Ref. PN5, Native Medical Aids. Report of the Committee of Enquiry on the Medical Training of Natives to the Minister of Public Health, 15/6/1942, p.12 and Gear. “The South African Native Health and Medical Service”, p.170-171.

<sup>60</sup> Interview of Emily and Sidney Kark, p.4.

<sup>61</sup> Yach and Tollman. “Public Health Initiatives in South Africa”, p.1047.

<sup>62</sup> Yach and Tollman. “Public Health Initiatives in South Africa”, p.1047.

<sup>63</sup> H. Jack Geiger. “Community-Oriented Primary Care: The Legacy of Sidney Kark”. *American Journal of Public Health*. Vol. 83, No. 7, July 1993, p.947.

in a system in which he could do what he wanted to do or [not]. ... while Gluckman ... and Gale [were] there he was safe but I think he chose ... political action [by] confin[ing] himself to working directly for health. But he was socially motivated, oh very much. ... but what I'm saying is that the actual political action angle, he abandoned and did it as a social thing ... a socially committed thing you'll find in the health sphere.<sup>64</sup>

In their new book, Emily and the recently deceased Sidney Kark have written something about how they viewed their activist role:

we were never political party activists, but rather activists for the promotion of community health through developing a new form of primary care practice in which family practice and community health care are combined.<sup>65</sup>

It is no accident that many of these initiatives had their roots in the soil of anti-fascist movements of the 1930s and mid-1940s.

The Karks embarked on their new health venture with another married couple, Edward and Amelia Jali. As Kark argued, "the two of them ... as a young married couple, and the two of us, as a young married couple were the ... founders of the Pholela Health Unit ... the four of us each had our own expertise, and developed further."<sup>66</sup> While one might be amazed at how they managed to achieve so much being so young and inexperienced in an area with such a lack of trust in Government services, Kark maintained, that this was their strength:

we were two white doctors, Emily and myself, one Zulu Medical Aid ... [to help] introduce us to the Zulu culture ... [and his] wife a nurse ... you can only do it in the way we did with the degree of complete innocence that we had. With the kind of knowledge we'd have today, we'd tread much more warily and perhaps not as successfully, perhaps innocence had its uses.<sup>67</sup>

The Karks were introduced to the Jali's through their personal and professional contacts with Alan Taylor at McCord's Zulu Hospital. Sidney Kark asserted "our links with McCord were well set right from the time ... with Alan Taylor as its chief and he remained a very good friend of

<sup>64</sup> Interview with Mervyn Susser and Zena Stein by Vanessa Noble and Maya Scoltz at the Campbell Collections, Durban, 4 June 1999. Susser told me that Sidney was the Wits delegate to NUSAS in the 1930s and leader of the Socialist Party. His commitment to the socialist philosophy was thus set from the beginning of his medical career.

<sup>65</sup> Karks. *Promoting Community Health*, p.5.

<sup>66</sup> Interview of Emily and Sidney Kark, p.5. See Karks. *Promoting Community Health*. The Karks first two children - Carol and Jeremy - were born during their 6 year stay at Pholela, while their third son was born whilst they were in Durban in 1946.

<sup>67</sup> UN Archives, Pmb. H6/1/1. Interview with Professor S. Kark and Professor Gordon, p.10-11.



ours from day one until the end of his time”.<sup>68</sup> Once again, the Christian missionary effort in this movement was strong, especially with support provided for the social and community health movement. It is interesting to note the ease with which progressive secular socialist-inspired Jewish doctors connected with Christian missionary counterparts on many key issues of the day.

From the outset, the Karks recognised that curative and preventive medicine could not be separated from one another and instead envisaged an integrated promotive (health education), preventive and curative service for the improvement of health. Through necessity - to alleviate rampant disease and to have preventive services successfully established - it had to be related to the confidence engendered by curative services.<sup>69</sup> But treatment of disease was a function of the health centre and did not monopolise the energies of the staff. Edward Jali was involved mainly in preventive work in the health centre. The health centre scheme was the salvation for many Medical Aids, like Jali, as it provided them with opportunities commensurate with their university training as senior health educators and demonstrators, laboratory technicians and tutors to health assistants. One of his most important roles though, was the study of local beliefs and practices, and he came to be seen as an additional leader by the people and health team, especially in matters relating to the traditional mores of the community.<sup>70</sup> Amelia Jali, as a family nurse who was available for all their nursing needs, helped raise the standard of community health by providing integrated preventive, curative and promotive health care.<sup>71</sup> Kark had an enormous respect for the work of Edward and Amelia Jali:

<sup>68</sup> UN Archives Pmb. H6/1/1. Interview with Professor S. Kark and Professor Gordon, p.10.

<sup>69</sup> G.W. Gale. “Health Centre Practice, Promotive Health Services and the Development of the Health Centres Scheme”. *South African Medical Journal*, Vol. 20, 2 June 1946, p.328 and SAB, GES, Vol. 2703, Ref. 1/62A. Native Health Units and Medical Missions, G.W. Gale, Assistant Health Officer, 30/6/1941, p.3.

<sup>70</sup> See SAB, GES, Vol. 2704, Ref. 1/62B and 2/62. Native Health and Medical Services Polela Unit. General Matters. Social Medicine in South Africa, March 1951, p.4, SAB, GES, Vol. 2957, Ref. PN5, Native Medical Aids. Letter from G.W. Gale, Dean of the Medical School, to Dr. le Roux, Secretary for Health, 19 May, 1952, p.4, and Kark. *The Practice of Community-Oriented Primary Health Care*, p.203.

<sup>71</sup> Helen D. Cohn. “Family and Community Nursing” in *A Practice of Social Medicine. A South African Teams Experiences in Different African Communities*. (Edinburgh and London: E. and S. Livingstone Ltd, 1962), p.41-43. Also see Karks. *Promoting Community Health*, p.27. Amelia Jali was the first black nurse of the health centre service in the country. In their book, the Karks speak about how, as newly married couples together with the Jali’s, “we shared many experiences together in our daily living and work situations”. Amelia and Emily had their first babies around same time and - Sibongile and Carol attended the same health centre nursery school. However, as the Karks argue, her death was an enormous loss, “unfortunately tragedy befell all of us when Amelia died in hospital during childbirth with her second daughter. This was a very sad personal loss to Edward Jali, ourselves and the entire Pholela staff and community. Apart from being a skilled and capable nurse, she was a pioneer of black nursing sisters”.

he became very important in our lives, became one of our close friends. ... he had worked with McCord for many years as a medical assistant ... and when the Fort Hare University opened the Medical Aid course ... [it] qualified him to be a Medical Aid; it didn't qualify him to be the fine person he was. ... Amelia Jali was a qualified nurse from McCord, and a manageress of the four of us really. And a very skilful one. ... I think she organised us. ... he became really, very knowledgeable in the local customs and beliefs about health and disease. And he specialised in this. And he was really our traditional practice advisor/consultant. ... Together the four of us took various projects with these groups of health assistants... They were the first group of people we actioned as general community health workers, not curative workers.<sup>72</sup>

Thus, an interesting and possibly even influencing factor which ensured the growth, continuance and ultimate success of this isolated health centre work was the fact that many, if not most of the health professionals (including the doctors, nurses and health assistants) were married, and both partners were thus involved with particular aspects of the health centre work. Emily and Sidney Kark led this cadre of community health professionals by example and showed the importance of “team work” in every conceivable way - including teamwork in their personal and professional lives - for the health centre movement to be a success. As Kark argued:

My wife, Dr. Emily Kark, has been closely identified and professionally involved in whatever principles and practices of community oriented primary health care we have developed over the past 40 years.<sup>73</sup>

Their orientation was based on a “family” and community oriented approach to health care. These close-knit partnerships and their sense of mission may have ensured the motivation of the movement, especially considering that many of the health centres were established in isolated and remote rural areas. When I interviewed Mervyn Susser and Zena Stein, I asked them whether they agreed with my views regarding this “family-oriented approach” to health being given by married couples. Zena Stein agreed with my assessment and she told me about another couple - Drs. Bert Gampel and Julie Chesler - who married when they embarked on their community health work: “about Julie [when she first came] I said well do you think she will stick to it and we said well it depends who she marries and then she married Bert and she did”.<sup>74</sup> Another married couple - Drs. Eva Salber and Harry Phillips - were also prominent in community health centre work during the 1950s, and Salber in her autobiography recalls the importance of

<sup>72</sup> Interview of Emily and Sidney Kark, p.5.

<sup>73</sup> Kark. *The Practice of Community-Oriented Primary Health Care*, p.ix.

<sup>74</sup> Interview with Mervyn Susser and Zena Stein.

“working couples” (doctor- doctor, doctor-nurse, doctor-dentist relationships) carrying out their duties in these health centres.<sup>75</sup> Unlike the rose-tinted picture of the successes and achievements of the health centre movement, in her book Salber presents another more complex perspective of the difficulties that health centre work presented to the doctors’ personal lives - especially women doctors with other family responsibilities to consider:

we were a closely-knit group akin, I often thought, to secular missionaries. Many of the senior staff, particularly Sidney, were deadly serious and single-minded in their mission. They lived and breathed health centre ideology, leaving little room for the ‘selfishness’ of a private life. There was no way I could let Sidney and the Institute down, but I desperately wanted to be with my children. ... Most of us were working couples ... with heavy responsibilities, but patients’ problems, not staff difficulties, were discussed at the Institute. In looking back, however, I know that many of us had personal problems that needed strong collegial support. “Missionaries” however, are not encouraged to share their own dilemmas at work, and we were expected to be role models for new trainees.<sup>76</sup>

### ***The Karkian Philosophy.***

Individual doctors, such as Kark and his colleagues were pioneers, because they re-evaluated South Africa’s traditional inadequate public health practice and initiated ideas for the establishment of a revolutionary new health care system, which was later facilitated through legislation.<sup>77</sup> However, while Kark’s basic conceptual ideas which were stimulated and established in South Africa during the 1940s and 1950s and formed the essential foundation of his social and community health centre based approach, the practice of what became known as “Community-Oriented Primary Health Care” only occurred in his later years in Israel, after years of adaptation and change and developed by years of experience in different countries. An analysis of the work of Kark and his community health colleagues in the early years at Pholela will thus be carried out with a tacit recognition that while outstanding and revolutionary in its own right, this was a theory or philosophy still in progress, or in the process of development, which would take many more years, and a far greater amount of experience and research work before it was firmly established and entrenched.

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<sup>75</sup> See Eva J. Salber. *The Mind is Not the Heart: Recollections of a Woman Physician*. (Durham and London: Duke University Press, 1989), p.82-106. Salber and Phillips were trained after the war, and then opened up and ran the urban African health centre at Lamontville during the 1950s.

<sup>76</sup> Salber. *The Mind is Not the Heart*, p.103.

The driving force for the Karks was the establishment of a progressive health service for the community. Kark et al worked within the framework of “social medicine” - a more sophisticated understanding of biomedical but also socio-economic-political root causes and treatment of disease which saw a renewed world-wide interest during the first three decades of the century - as they believed it was impossible to separate disease from these other factors. As Kark argued, “it represented a return to a holistic interpretation of community disease ... as a unified and total process”.<sup>78</sup> In an article in the *South African Medical Journal* in 1943, Gear’s views concerning how material deprivations interacted to produce disease concurred with Kark’s view that disease causation was too intimately associated with social and economic problems, lack of social facilities, “widespread ignorance and the burden of poverty” for them to be ignored when developing modern health programmes.<sup>79</sup> Reviewing Kark’s work throughout the years, Alan Jeeves argues that one of Kark’s greatest contributions was his recognition of the complex chain of causality, where disease and death were directly linked to political disenfranchisement and economic insecurity. He recommended a series of important social, economic and political changes, such as active political participation and economic stability through increased employment, better wages, agricultural co-operatives, and a progressive tax structure to address root causes of disease. It is important to note that social medicine came increasingly to service the disenfranchised black community, whose health profiles and incomes were below average and whose health beliefs and practices were different to the groups in power. Kark’s philosophy challenged orthodox medical practice as his clinical methods de-emphasised the individual doctor-patient relationship in favour of the wider community interests, he opposed special medical clinics to treat particular diseases (thus “dividing the indivisible”), aimed to shift funds away from expensive, high-tech hospitals, promote the integration of medical and social welfare services and emphasised the social investment in disease prevention.<sup>80</sup>

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<sup>77</sup> There were numerous community health doctors who worked with the Karks to establish health centres in South Africa. They included: Guy W. Steuart, Bert Gampel, Julie Chesler, John Cassel, J.H. Abramson, Eva Salber, Harry Phillips etc.

<sup>78</sup> Sidney L. Kark. *Epidemiology and Community Medicine*. (New York: Appleton-Century-Crofts, a Publishing Division of Prentice Hall, Inc, 1974), p.4.

<sup>79</sup> Gear. “The South African Native Health and Medical Service”, p.168-169.

<sup>80</sup> Jeeves. “Public Health and Rural Poverty in South Africa”, p.2.

Community medicine formed an important element of Kark's view of social medicine. It importantly, united features of clinical and public health practices through the integration of personal/individual primary health care services with the health of the community as a whole.<sup>81</sup> Kark's approach recognised the overlap of individuals as members of families, and families within the wider community, where health care was necessary at each of these levels to prevent disease. He thus saw community health as an approach that integrated direct personal curative and preventive care and health education, and in addition, widened the medical horizon to include the potential for community organisation and broader socio-economic planning.<sup>82</sup> This approach extended care away from necessary but largely static and expensive hospital environments alone, to different situations and groups within the community. Kark's objective was to focus on preventive rather than curative medicine to modify the environment through direct community involvement.<sup>83</sup> This approach required a modification and extension of medical practice to include screening procedures for conditions other than that for which the patient turned to doctors for help. It also required a change in direction of public health practice where the doctor rather than patient took the active initiative to explore health conditions, while the findings were used for the good of the individual patient and for the health of the general public at large.<sup>84</sup>

### ***“Social Epidemiology” - A New Research Methodology for Community Health?***

In South Africa, the concern with delivery of health care to rural communities after the 1930s resulted in the development of new research methods that combined social science techniques such as anthropological theories and methods with medicine.<sup>85</sup> A further innovation in Kark's health centre approach, was that he developed a “socially-oriented” epidemiology to

<sup>81</sup> Kark. *The Practice of Community-Oriented Primary Health Care*, p.10-11.

<sup>82</sup> See Kark. *Epidemiology and Community Medicine*, p.5 and 325.

<sup>83</sup> Kark. *Epidemiology and Community Medicine*, p.317.

<sup>84</sup> Kark. *Epidemiology and Community Medicine*, p.324-330.

<sup>85</sup> James Trostle. “Anthropology and Epidemiology in the Twentieth Century: A Selective History of Collaborative Projects and Theoretical Affinities, 1920-1970” in Craig R. Janes et al (eds.), *Anthropology and Epidemiology*. (D. Reidel Publishing Company, 1986), p.72-80. The collaboration between anthropology and epidemiology saw the combined study of behavioural and cultural factors in disease causation, they shared research hypotheses and techniques, and embarked on cross-cultural field projects.

identify the underlying social causes of disease and to provide social solutions.<sup>86</sup> Social epidemiology was important not because it led to the discovery of the connection between social relations and health (a well-established fact) but because “it had been possible to evolve a technique which included such concepts as an integrated part of its daily practice” and formed the foundation science of community health.<sup>87</sup> Epidemiology differed from other medical sciences as it was concerned with the study of disease - not of individuals but of “groups” or “populations” - as a mass phenomena.<sup>88</sup> As Kark argued, “epidemiology is the study of the distribution of disease or conditions in the population and of factors that influenced this distribution”.<sup>89</sup> Thus, it was more than just a descriptive science concerned with health or disease distribution, but was also analytical and gave an “interpretation of the distribution in terms of possible causal factors”. Sidney Kark’s approach aimed to protect the community against disease through the study of well-being in groups, sought to gain a better understanding of the nature, sources and spread of disease and ultimately control its spread through the promotion and preservation of good health.<sup>90</sup> Thus the health status of the community was assessed using social science and epidemiologic methods to develop a multi-disciplinary approach to understand the extent of the community’s health problems, direct the focus on curative and preventive measures, and to evaluate progress to improve health.<sup>91</sup> It demanded training in a new kind of knowledge of epidemiology, community diagnosis, health action and evaluation of change.<sup>92</sup> Kark argued about the important distinction they made between community-oriented and community-based approaches, and while stressing community-oriented approach, recognised that both were necessary:

you can’t do this without epidemiology, if you do this without epidemiology, you’re never really community-oriented, you may be community-based because you live there ... but not having anything to do with the community. ... Community-oriented health

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<sup>86</sup> Trostle. “Anthropology and Epidemiology in the Twentieth Century”, p.78. The original definition of epidemiology was adapted to include new categories of research into the distribution and causes of chronic non-infectious and socially-caused illnesses, not only epidemics of infectious diseases.

<sup>87</sup> See Kark. *Epidemiology and Community Medicine*, preface, p.vi and Trostle. “Anthropology and Epidemiology in the Twentieth Century”, p.61.

<sup>88</sup> Kark. *Epidemiology and Community Medicine*, p.1.

<sup>89</sup> Kark. *Epidemiology and Community Medicine*, p.3.

<sup>90</sup> Kark. *Epidemiology and Community Medicine*, p.9.

<sup>91</sup> Trostle. “Anthropology and Epidemiology in the Twentieth Century”, p.61.

<sup>92</sup> Kark. *Epidemiology and Community Medicine*, p.326.

care demands a skill in epidemiology. ... Community-based demands that you be living in the area and that the community is participating in your service. Both are necessary.<sup>93</sup>

In Susser's view, for many of the Kark's students, to see and treat patients and their communities in the light of this knowledge, was a medical revolution.<sup>94</sup>

Kark saw the vital role of empirical evidence, gained through social-epidemiologic methods, as the basis for understanding the extent of health problems, helping to decide about relevant policies and practices in the evolution of health services, and as key to evaluating their effectiveness.<sup>95</sup> Continued community surveys of personal health services, environmental conditions, community organisation, health education, material resources were seen by Kark et al as the foundation of community diagnosis which they saw as essential to understanding local culture and conceptions of health and disease and ensuring the successful development of innovative public health action programmes to promote, prevent and treat disease.<sup>96</sup> Kark argued:

only by a system of recording the facts, no matter how small and how slow, could knowledge be accumulated for planning our future distribution of work. In this way we hoped to lay the foundation for accurate epidemiology studies, for measuring movements of the population, and for assessing the influence of various environmental factors on people.<sup>97</sup>

During the start-up phase of the Pholela health centre, Kark et al's survey of the existing medical services in the area revealed an appalling situation.<sup>98</sup> There was only one part-time, bio-medically trained District Surgeon for the entire Pholela district (who was well known with a large practice of both black and white patients built up over the previous twenty years) who was responsible for the maintenance of public health and prevention of infectious diseases.<sup>99</sup> The nearest modern hospitals and clinics were situated forty five miles away in Pietermaritzburg or

<sup>93</sup> Interview of Emily and Sidney Kark, p.45.

<sup>94</sup> Susser. "A South African Odyssey in Community Health", p.1041.

<sup>95</sup> Trostle. "Anthropology and Epidemiology in the Twentieth Century", p.66.

<sup>96</sup> Kark. *Epidemiology and Community Medicine*, p.332. In an Interview with Emily and Sidney Kark by C.C. Jinabhai and Nkosazana Zuma in Durban in 1992, p. 31, Kark argued that like individual diagnoses, community health doctors did community health diagnoses (an epidemiological study) of the major health problems to allow doctors to take action through treatment and promotion of health.

<sup>97</sup> Yach and Tollman. "Public Health Initiatives in South Africa", p.1045.

<sup>98</sup> See Karks. *Promoting Community Health*, pgs. 44-67 for a detailed discussion of the common community diseases and disorders prevalent in the Pholela district e.g. malnutrition, infectious diseases and psycho-social disorders.

<sup>99</sup> Jeeves. "Public Health and Rural Poverty in South Africa", p.4. He provided free medical care to the black indigent as well as a fee-paying health service for whites in the area.

one hundred miles away in Durban. Kark's early reports showed rapid progress in getting the health centre programme into action. Their initial activities involved the introduction and explanation of the purpose of their work to local community leaders, teachers, magistrates, missionaries and families, and the establishment of a general clinic and control of infectious disease outbreaks through immunisation programmes.<sup>100</sup> Information of health relevance was sought in magisterial and government office records as well as from various officials and individual from the community.<sup>101</sup> They faced an enormous problem in planning their health service in Pholela due to the distinct absence of data - incomplete census of demographics of the area, no organised preventive service, no sources concerning its state of health other than reports of epidemics and a limited number of cases with notifiable diseases such as leprosy and T.B.<sup>102</sup> Maps of the area did not show homes, as there was no system of addresses and thus even this limited information available on illness could not be linked to any particular family or home.

### *Programme of Action.*

Kark and his team aimed to change the long-tradition of "top-down" public health policies and decision-making to a community-involved, "bottom-up" approach with participation of those community members most affected by the service.<sup>103</sup> Kark argued that their approach to learning about health conditions had to change if they were to understand the network of relations in African society:

we began a new approach in which we decided that we needed to know the people we were dealing with ... medically, health-wise and personally. This meant that we needed to meet them in various situations, not only in clinic, we had to visit homes, we had to meet them in the fields, we had to go to their schools and we had to function with them in a variety of ways so that at least we would become familiar, we had to go to their weddings, their funerals, [know] their miseries, their happinesses. This gave us insight into their living ... it also made the people realise that we were different kinds of creatures from the doctors they'd met before and this was very important because the very people who were very suspicious of us became our closest colleagues and friends and began working in a voluntary way for the health centre - because it was for them.<sup>104</sup>

<sup>100</sup> S.M. Tollman. "The Pholela Health Centre - the Origins of Community-Oriented Primary Health Care: An Appreciation of the Work of Sidney and Emily Kark". *South African Medical Journal*, Vol. 84, No. 10, October 1994, p.654.

<sup>101</sup> Kark. *The Practice of Community-Oriented Primary Health Care*, p.197.

<sup>102</sup> Kark. "A Health Service Among the Rural Bantu", p.197-198.

<sup>103</sup> Kark. *The Practice of Community-Oriented Primary Health Care*, p.6.

<sup>104</sup> UN Archives Pmb. H6/1/1. Interview with Professor S. Kark and Professor Gordon, p.11.



The health centre's central epidemiological project was to initiate and expand a house-to-house survey - through a system of home visits - in an intensive "Family Welfare Service" area.<sup>105</sup> The objective was to ascertain among a defined area and stable group of households - by using epidemiological studies and systematically gathering and recording all health-related data - the social and environmental factors on the health of the community. Emily Kark argued that this defined, limited area approach was the best way of obtaining health centre preventive goals to prevent being swamped by the mass of curative demands. She describes this as:

the technique of ... looking at areas, taking small bites of the thing. ... the idea of starting in a smaller way ... you take small bites, cause in order to get your methodology right you must just go in and define a community.<sup>106</sup>

They mapped homesteads in the defined area, gathered demographic data, conducted surveys of health-relevant behaviour, environmental material resources, cultural practices, economic activities and education standards.<sup>107</sup> This collection of statistics was more comprehensive than any census done in other black areas. Emily continued about the benefit of using defined areas:

we were able to compare them in a kind of a secular way, a time-controlled being, and see the difference. [our] area completely free of immunisable diseases. And it's a very satisfying way to finding it ... you see a doctor can only get satisfaction in seeing that their patient is getting better; now your patient is your community.<sup>108</sup>

Health assistant visits were set for once a month or every six weeks, where they did survey and health promotive work, disseminated propaganda on health and hygiene and encouraged regular visits to the health centre for examinations.<sup>109</sup> As Kark argued:

it was not right to sit back and wait for patients to come as happens in most clinics and hospitals. We learnt very soon that if we were going to bring about a change in the state of health of people ... and to give emphasis to prevention ... we couldn't wait until sick

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<sup>105</sup> Trostle. "Anthropology and Epidemiology in the Twentieth Century", p.63. It also was confined to a small, defined area because of its limited budget and staff. The service at first covered 130 families comprising 1000 people and later 1000 homes within a 12 mile radius comprising 9,000 people.

<sup>106</sup> Interview of Emily and Sidney Kark, p.34, 54.

<sup>107</sup> Kark. *The Practice of Community-Oriented Primary Health Care*, p.198-199.

<sup>108</sup> Interview of Emily and Sidney Kark, p.55.

<sup>109</sup> SAB, GES, Vol. 2704, Ref. 1/62B and 2/62. Native Health and Medical Services Polela Unit. General Matters. Social Medicine in South Africa, March 1951, p.3.

people came, we had to think of a fresh approach, to get the people to a position where they wanted to change towards a better state of health.<sup>110</sup>

Survey work required continued monitoring to identify targets for intervention, provided the staff with knowledge about the community, to help them change harmful community habits through health education and ensured continued progress.<sup>111</sup> It was recognised that there was little value in advising the community about various problems at clinics unless, at the same time, they showed them practical methods to solve them in their own homes.

Regular clinics and examination sessions were held to establish health care programmes including immunisation, gave weekly instruction on health, hygiene and nutrition for pregnant women, mothers and school children.<sup>112</sup> The health centre thus consisted of a general clinical service as well as a more defined family health care programme. The health promotive work included: advise on proper housing, hygiene, water supplies, sanitation, food production and preparation, general soil conservation and agricultural methods.<sup>113</sup> The entire unit was in fact situated and designed for demonstration purposes (model huts, compost heaps, pit latrines). As an experimental area aimed at improving health services, it induced others to follow its lead.<sup>114</sup> Health education by means of home visits, group discussions, and practical demonstrations, aimed to stimulate people to modify harmful habits which would lead to better standards of health. It aimed to reduce the high incidence of preventive diseases, improve the state of nutrition through improved diet, appreciate the value of periodic health examinations and the early treatment of disease.<sup>115</sup>

### ***Health Assistants - A Pioneering Addition to Community Health Team.***

An important factor, which made the overall programme that emerged at the Pholela experiment an original and uniquely South African achievement, was Kark's promotion of,

<sup>110</sup> UN Archives, Pmb. H6/1/1. Interview with Professor S. Kark and Professor Gordon, p.11.

<sup>111</sup> G.W. Gale. "Government Health Centres in the Union of South Africa". *South African Medical Journal*, 23 July 1949, p.633 and Interview of Emily and Sidney Kark, p.32-34.

<sup>112</sup> SAB, GES, Vol. 2704, Ref. 1/62B and 2/62. Native Health and Medical Services Polela Unit. General Matters. *Social Medicine in South Africa*, March 1951, p.4-5.

<sup>113</sup> SAB, GES, Vol. 2704, Ref. 1/62B and 2/62. Native Health and Medical Services Polela Unit. General Matters. *Social Medicine in South Africa*, March 1951, p.5.

<sup>114</sup> Gear. "The South African Native Health and Medical Service", p.172.

<sup>115</sup> S.L. Kark and J. Cassel. "The Pholela Health Centre. A Progress Report". *South African Medical Journal*, 9 February 1952, p.101-102.

training, and use of “health assistants” to undertake the majority of promotive health centre work. It was only several months after the Karks arrived at Pholela, with persistent requests for staff to be trained for this service, that the D.P.H. sent five black men (four had been trained and previously employed as male malaria assistants) to be retrained as pioneering additions to the health centre staff.<sup>116</sup> Despite these malaria assistant precedents, Kark’s health centre, with their focus on low-cost preventive medicine and use of multi-racial teams of health assistants, developed along lines unlike anything established in South Africa up till then.<sup>117</sup> Kark aimed to establish a comprehensive, completely integrated primary and community health service, using the health centres as the foundation.<sup>118</sup> These pioneer community health doctors recognised the need to reunite the unnecessary divide between preventive and curative medicine, and importantly promoted the preventive approach, and viewed doctors as preservers of health rather than menders of diseased bodies. Like Sidney Kark, Emily Kark also recognised the vital importance of health assistants:

they’re a terribly important element of the team but they’ve got to have special training, more as promoters of health and health educators. ... Yes, the health team, doctor, nurse and the two must learn to work together ... [but] we found in one of our evaluations, it was really the health educator who contributed to the success of the programme, because they were the ones out on horseback in Pholela going round homes to homes, helping people protect their springs, and digging the latrines and helping with the gardens and giving the health education.<sup>119</sup>

Because no adequate training facilities existed in South Africa for this particular type of health service, health assistants were given an “in-service” general training at Pholela in matters relating to family and community health and the elimination of conditions adverse to health such as elements of physiology, first aid, an intensive practical course in rural hygiene, sanitation, nutrition, epidemiology and methods of survey work. Three types of worker were evolved: health educators, who were required to visit and observe people’s homes, their environment and other social factors working against health and advise families about hygiene and nutrition;

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<sup>116</sup> Tollman. “The Pholela Health Centre”, p.653.

<sup>117</sup> Jeeves. “Public Health and Rural Poverty in South Africa”, p.4.

<sup>118</sup> Kark. *The Practice of Community-Oriented Primary Health Care*, p.201.

<sup>119</sup> Interview of Emily and Sidney Kark, p.56.

laboratory technicians; and health recorders who compiled, analysed and interpreted records.<sup>120</sup>

However, Kark modestly maintained that it was all a question of learning together:

the Union Health Department appointed to our staff five health assistants ... [as] a new type of sub-professional group. ... We began training those five health assistants to suit them to community health work and although I say we began training, it was a question of learning together, we did our field work together, we visited homes together, we began to work out an approach to health care in a rural area like Pholela in which we ourselves learned that the training we'd been given was quite unsuited to the needs of the people in that area.<sup>121</sup>

This new approach thus provided scope for African health workers and exposed some remote rural communities to western biomedical treatments, with a progressive preventive orientation, for the first time.

### ***Resistance to Kark Health Centre by the Pholela Community.***

In the beginning, Kark argued that the health centre team faced enormous suspicion and resentment from the local community who objected to what they perceived as further Government interference, especially the appointment of “outsiders” as health assistants and their intrusive home visits “like spies” rather than allowing people the choice to use the clinics when they pleased.<sup>122</sup> But by respecting community beliefs, having regular visits with chiefs, community leaders, working through established structures of authority, and training local community health assistants, the team slowly broke down the local people’s suspicions.<sup>123</sup> In a recent interview with the Karks, Sidney gave an example of how they had to be persistent in fighting to overcome community distrust:

the training of health assistants “was very, very successful, even after the terrible antagonism of the people to us, remember we came from the Government, we were white, we were talking non-traditional medicine, we were doing everything that

<sup>120</sup> Kark. “A Health Service Among the Rural Bantu”, p.197.

<sup>121</sup> UN Archives Pmb. H6/1/1. Interview with Professor S. Kark and Professor Gordon, p.11. See Karks. *Promoting Community Health*, p.23. The first 5 health assistants were J. Mngoma, A. Ngcobo, C. Shembe, E. Dzanibe and J. Mbele (Sibanyoni) all Zulu men.

<sup>122</sup> See Kark. “A Health Service Among the Rural Bantu”, p.197 and SAB, GES, Vol 2704, Ref. 2/62 and 1/62B. Native Health and Medical Services Pholela Unit. General Matters, 1940-52. “Pholela Centre Provides ‘Pilot Plan’ for Native Health Schemes”. *The Natal Daily News*, 27/2/1952. See Karks. *Promoting Community Health*, p.24-25. A large amount of suspicion and resistance to health centre work was caused by the introduction of male community health workers who would visit people’s homes while most of the men were working in the towns.

<sup>123</sup> Kark. “A Health Service Among the Rural Bantu”, p.197.

the people would distrust.<sup>124</sup>

Kark told the interviewer that their presence in the Pholela area created a central rift in an important and powerful family in the area - the Nzimandes. The oldest brother, Joseph Nzimande, and an elder in the Church, preached against Kark and his team and attacked them for doing preventive rather than curative medical work. They were also accused of not knowing what *forfunyana* was – a common disease afflicting many in the local community. According to the Karks he explained to Sidney that:

the Government not only sends you here, a young doctor, but you know nothing about the main disease that's killing us. ... When I was a little boy there was no *forfunyana* in this area, and now there's an epidemic. And you come here to learn from us instead of being able to treat it.<sup>125</sup>

Fortunately for them, as Sidney Kark maintains:

the other Nzimande family ... was with us, [this] was Margaret Nzimande's family. She succeeded her father as headmistress of the Inkumba school and we became good friends with her. And the arguments she had with Joseph, the enemy of the centre, were fantastic. I literally think that ... she did more to change Joseph than anybody else. Because changing Joseph was very important, because, later on, a couple of years later, Joseph blessed us in his church.<sup>126</sup>

### ***Community Participation.***

From the start Kark and his team worked to stimulate community participation in their own health.<sup>127</sup> The aim was to empower families by showing them through regular home visits, that good health was to be achieved by taking responsibility for their own health.<sup>128</sup> Community leaders and groups were made directly involved in health centre activities to help the staff learn about local health beliefs/practices through expert advice, as well as to disseminate new ideas, while health assistants through routine home visits and small group discussions, became part of the community by participating in its daily life.<sup>129</sup> It was soon discovered, as Guy Steuart argued, writing about community health education, that the best learning situation is where the

<sup>124</sup> Interview of Emily and Sidney Kark, p.6.

<sup>125</sup> Interview of Emily and Sidney Kark, p.6. *Forfunyana* was a form of hysteria or insanity.

<sup>126</sup> Interview of Emily and Sidney Kark, p.6.

<sup>127</sup> SAB, GES, Vol. 2704, Ref. 2/62 and 1/62B. 1940-52. Native Health and Medical Services Polela Unit, p.6.

<sup>128</sup> Jeeves. "Public Health and Rural Poverty in South Africa", p.2.

<sup>129</sup> Trostle. "Anthropology and Epidemiology in the Twentieth Century", p.62.

community “feels the need to learn and gives an active participation in this experience” rather than plays the role of passive listener.<sup>130</sup> He continued, that success is achieved only where “felt” community needs are harnessed, and the job of health assistants is to make “unfelt” needs “felt” to motivate people to make changes in their way of life.<sup>131</sup> Margaret Nzimande’s influence on the community’s participation in centre activities was enormous, as Sidney Kark argues:

we got very friendly with her and eventually together with her we decided we must employ local people and extend this health assistant programme to the local people. Margaret was the first woman appointed. ... Once we were appointing local people there was a difference about the attitude of the people to the Centre.<sup>132</sup>

It is important to note that the health centre chose both men and women from the local community to become health educators. Like their male counterparts, women community health workers were thus also taught preventive and health promotive work directed towards individuals, the family and wider community as a whole.<sup>133</sup> “Ma Nzimande” as she became known was the first woman health educator to be appointed to the health centre staff, as Kark asserted:

we were able to appoint all our subsequent health assistants from among the people of Pholela itself ... these were people born and brought up in Pholela, some of them very senior, like the headmistress of a school there, who moved from being a headmistress of a school to being the first woman health educator that we trained in this country, she died about a year ago in Pholela having worked there all the years at that Pholela Health centre from the time she was trained in the 1940s until last year.<sup>134</sup>

“Ma Nzimande” was particularly important as she pioneered a system of “pre-school child centres” - which were play groups (for children under five) but also served as nutrition educational and feeding centres. Produce from local vegetable gardens provided food for the children. These “child centres” were staffed by women volunteers from all over the district who were trained in the specifics of child health and nutrition.<sup>135</sup> Kark recalled that the volunteer mothers used to rotate the supervision of the children and their activities. Kark argues that what

<sup>130</sup> Guy W. Steuart. “Health Education in South Africa”. *South African Medical Journal*, 2 February 1957, p.96.

<sup>131</sup> Guy W. Steuart. “Community Health Education” in *A Practice of Social Medicine. A South African Teams Experiences in Different African Communities*. (Edinburgh and London: E. and S. Livingstone Ltd, 1962), p.65.

<sup>132</sup> Interview of Emily and Sidney Kark, p.6.

<sup>133</sup> SAB, GES, Vol. 2703, Ref. 1/62A. Medical and Health Services for Natives. “The Functions and Training of Non-European Women Health Assistants”, n/d.

<sup>134</sup> UN Archives Pmb. H6/1/1. Interview with Professor S. Kark and Professor Gordon, p.11-12.

was important in this regard was the promotion of greater community participation - especially between different generations of women: “voluntary women [who were] recruited for this ... had to learn to trust one another because no other mother could do this full-time”.<sup>136</sup> As far as Kark was concerned community interest and involvement in the activities of the health centre was the only way to promote its success. Another interesting occurrence regarding the establishment of community women’s health work around these “child centres” was a growing recognition of the organisational value of African women outside the home in a male-dominated and patriarchal community. Kark remembered a specific incident that highlighted this point:

it was about fifteen years after the start of the centre that the chief of that area at a 15th celebration, got up and said “I think you should appoint a women’s committee to advise this health centre and I will use that same women’s committee to advise me and my tribal council”. Now, anybody who knows that particular tribe and that particular culture will know what a radical transformation that was to have a women’s advisory committee to a tribal council and to a health centre.<sup>137</sup>

Health educators - of both genders - were thus increasingly drawn from the local area to do propaganda work in people’s homes and wider community.<sup>138</sup> This action proved to be very successful and was a major factor in promoting better co-operation and community participation with health centre staff and activities. However, while they helped bridge the gap between traditional Zulu health beliefs/practices and those of western biomedical systems, these incoming health assistants were oriented and trained in scientific-based methods and functioned as agents of health change, which distinguished them from the health/disease concepts and practices of the local people.<sup>139</sup> Thus while, the programme progress was slow and uneven, after the first year, the health team managed to shift attention from the treatment of disease to address health education and disease prevention.<sup>140</sup>

<sup>135</sup> UN Archives Pmb. H6/1/1. Interview with Professor S. Kark and Professor Gordon, p.12.

<sup>136</sup> UN Archives Pmb. H6/1/1. Interview with Professor S. Kark and Professor Gordon, p.12.

<sup>137</sup> UN Archives Pmb. H6/1/1. Interview with Professor S. Kark and Professor Gordon, p.13.

<sup>138</sup> SAB, GES, Vol. 2704, Ref. 1/62B and 2/62. Native Health and Medical Services Polela Unit. General Matters. Social Medicine in South Africa, March 1951, p.2. Also see Karks. *Promoting Community Health*, p.24-25. Within 2 years most of the health workers were recruited from the local community and included two women (Margaret Shembe and Audrey Bennie) and four men (Raphael Zaca, Benjamin Nzimande, Edward Bennie and Fred Madlala).

<sup>139</sup> See Kark. *The Practice of Community-Oriented Primary Health Care*, p.81-82 and Trostle. “Anthropology and Epidemiology in the Twentieth Century”, p.62.

<sup>140</sup> Jeeves. “Public Health and Rural Poverty in South Africa”, p.6.

### ***Health Centre Activities and the Influence of Indigenous Healers.***

The health centre team experienced resistance to the acceptance of western biomedical ideas and were forced to confront the “lingering superstition” or work of traditional healers who had practiced their “medicine” unchallenged for centuries.<sup>141</sup> Most of Pholela’s health care was provided by a large number of mainly female *isangoma* (or diviners) and male *izinyanga* (or herbalists) who were either itinerant or resident in the area. Kark argued that indigenous healers were an integral part of the community, whose practices - steeped in local culture especially the medical system - were consistent with the local community’s belief system about the nature, causes, prevention and treatment of disease.<sup>142</sup> Diviners addressed the social and magical causes of illness/misfortune and sometimes referred the afflicted to herbalists for treatment by using a wide variety of plant or herbal remedies. While viewing them as a conservative force, Kark recognised the influential power of these healers when devising his health centre programme:

you get a preliminary impression from practitioners there, and don’t leave the traditional practitioners out. That’s a big mistake. Whether you believe in their magical or mystical beliefs or not, it doesn’t matter, people do. ... you have two parallel things ... let me call the one modern ... scientific based, and the traditional, [with an] empiric basis but not scientific. In other words it’s the result of generations of observation, but non-scientific, not put to the test.<sup>143</sup>

Kark recognised that understanding their orientation and management of disease would give health centres insight into community beliefs and practices which would increase their knowledge about how to approach individual, family and community change. Although the conceptual framework of the health centre was based on western biomedical systems, from the start, Pholela adopted a holistic approach through the development of social medicine - toward understanding social, cultural and psychological processes in the epidemiology of health and disease - which resembled the indigenous healer’s concerns more than western biomedical practitioner. Health centres thus uniquely formed a bridge between the biological and social/cultural orientations of medicine.<sup>144</sup> Kark even went as far as recommending that

<sup>141</sup> SAB, GES, Vol. 2704, Ref. 1/62B and 2/62. Native Health and Medical Services Polela Unit. General Matters. Social Medicine among the Kraals of Natal. Modern Methods of Health Propaganda oust the Old-Time Witchdoctors of Polela by Alastair Matheson, 1940-52, p.2.

<sup>142</sup> Kark. *The Practice of Community-Oriented Primary Health Care*, p.81.

<sup>143</sup> Interview of Emily and Sidney Kark, p.29.

<sup>144</sup> Kark. *The Practice of Community-Oriented Primary Health Care*, p.81-82.



traditional healers be appointed as consultants and functionaries of their staff to help include the community in the service. He asserted that:

we are missing so many diagnoses of importance, unless you have these experts, who are our traditional practitioners who can help you work out what kinds of illnesses people have and separate out the Bantu disease from the so-called white man's disease. ... but we were not allowed legally to function with them and [we] were aware of the fact that we were having enough trouble surviving in the midst of a different kind of medicine ... for the powers that be to decide this was really mad ... we adapted and worked with most of them and tried to further them.<sup>145</sup>

It is important to note that it was only in later years that Kark et al recognised that health education was a two-sided process - to teach, the health educator must learn - and that seemingly capricious patterns of acceptance and resistance to health change became intelligible from within.<sup>146</sup> As Steuart argued in Israel many years later, "we need to begin to see the world through the eyes of the people we claim to be trying to help and not through the lens of our own".<sup>147</sup> It is upon this duality of cultural understanding that later health education programmes were built. Kark and his team recognised that community behaviour must be understood in culturally-defined circumstances. Kark argued that customs which regulate health were deeply rooted in a community's cultural belief patterns, "that culture is learned and shared by the community, it provides the rules that define the roles that make the relationships that constitute the group".<sup>148</sup> Thus, together with studying material resources and the environment, Kark et al also studied the social interaction patterns, shared experiences, cultural practices and beliefs which was vital to help health workers understand the community and to successfully plan and administer their health programme.<sup>149</sup> However, while recognising that African communities had their own concepts about health integrated as part of their total culture and well-established ways of maintaining health, preventing disease and treating the sick, during the early years many of

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<sup>145</sup> UN Archives Pmb. H6/1/1. Interview with Professor S. Kark and Professor Gordon, p.13.

<sup>146</sup> Benjamin D. Paul (ed). *Health, Culture and Community: Case Studies of Public Relations to Health Programs*. New York: Russell Sage Foundation, 1955, p.5. "Felt" needs were issues such as the high infant mortality rate. "Unfelt" needs included inadequate diet, poor state of hygiene and sanitation etc.

<sup>147</sup> "Community Health Development: An Anthology of the Works of Guy W. Steuart". Supplement 1. *Health Education Quarterly*. (New York: Wiley Publishers, 1993), p.140.

<sup>148</sup> Kark. *Epidemiology and Community Medicine*, p.148-149.

<sup>149</sup> Kark. *Epidemiology and Community Medicine*, p.130-133.

the doctors and health workers did not understand the degree to which their own behaviour was culturally-determined and thus culturally biased in their assessment of the behaviour of others.<sup>150</sup>

While many of their medical concerns were based on valid health problems, insights into Kark and his colleagues' biased attitudes to cultures different from their own, can be gleaned from their early scientific reports about the area when they first arrived, and helps one to understand the anthropological perspective from which they wrote and out of which they could not escape. Even Kark viewed the community as "backward" educationally, agriculturally and religiously.<sup>151</sup> In a 1942 article of the *South African Medical Journal*, Kark wrote:

their cultural level, like that of their economic status is low. They are a conservative people steeped in superstition, which even in the case of the Christianised people is usually grafted onto the new religion. Their poverty, lack of education and their animistic explanations of natural phenomena all combine to render them suspicious of any innovation which might modify their present mode of living. Ignorance of elementary physiological and biological facts has to be overcome before the people will introduce national health measures.<sup>152</sup>

Many of John Cassel's comments were also culturally biased. This is evident in his view that the population "is not so backward or superstition-ridden to require years of preliminary work" to secure the community's confidence and cooperation.<sup>153</sup> Cassel and the Karks also viewed many African activities as inadequate, "of these, the disruption of family life caused by the migrant labour system and the inadequacy of the old codes and mores in a changing world have perhaps the most important health implications".<sup>154</sup> While Cassel recognised that people in different communities had their own culturally-conditioned ideas, understanding and modes of behaviour, he did not view them as valuable in their own right, but pushed for the "re-education of the community" and "reshaping" of the novel element to make it reasonably congruent with the existing framework of understanding.<sup>155</sup> While many of these progressive community health doctors approached their tasks with the best of intentions, located at different points in social

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<sup>150</sup> See John Cassel. "Cultural Factors in the Interpretation of Illness" in *A Practice of Social Medicine. A South African Teams Experiences in Different African Communities*. (Edinburgh and London: E. and S. Livingstone Ltd, 1962), p243-244 and Kark. *Epidemiology and Community Medicine*, p.11.

<sup>151</sup> UN Archives, Pmb. H6/1/1. Interview with Professor S. Kark and Professor Gordon, p.10.

<sup>152</sup> Kark. "A Health Service among the Rural Bantu", p.197.

<sup>153</sup> Cassel. "A Comprehensive Health Program among South African Zulus", p.16.

<sup>154</sup> Cassel. "A Comprehensive Health Program among South African Zulus", p.17. and Gear. "The South African Native Health and Medical Service", p.172.

<sup>155</sup> Cassel. "A Comprehensive Health Program among South African Zulus", p.4.

space and time to the African community they served, one is constantly able to see through their speech and reports that their perceptions of the world were still directly influenced by their particular community, class, or occupation.

Many of the team's programmes of action were hindered by resistant cultural attitudes to health change. Both Kark and Cassel show in their work, how, while some attitudes were central, resulting in violent responses to questioning and attempts to undermine their values and practices, others were peripheral and not so deeply rooted to conceive of modification of attitudes over time if proved harmful to health. However, they also demonstrated that there were no rules to be learned in advance to determine which health beliefs/behaviour would yield readily under pressure and which would offer tenacious resistance.<sup>156</sup> In an article in a book, *A Practice of Social Medicine*, Cassel argues, "when potent emotional factors are involved, the rate of change is slow, if at all".<sup>157</sup> When analysing Kark et al's "progressive" promotive programmes, one has to be constantly aware of the problematic issues of the "ethics" of anthropological interventions into Zulu societal and cultural ways, which were viewed as "better" and more advanced than its predecessor's approaches, and would "save" the society from its "harmful" ways. This was especially evident in health centre attempts to change, or "re-educate", the community's attitude towards the production and consumption of foods such as vegetables and milk, and their treatment of pulmonary T.B. or attempts to combat soil erosion, which were all met by higher levels of resistance.<sup>158</sup>

Health centre activities in these "preventive", not purely curative medical spheres of interest, must be viewed in the light of the health centre programme's attempt to contribute to a broadly-based community development plan in the black rural reserves. This required a close functioning of the health centre with other services concerned with general health and welfare of the community. As Kark argued "clinical services must be brought within the sphere of a broader social health scheme before they can make a full contribution to national health".<sup>159</sup> Kark recognised that while the health centre could achieve much through individual health education,

<sup>156</sup> See Kark. *Epidemiology and Community Medicine*, p.153 and Cassel. "A Comprehensive Health Program among South African Zulus", p.15. Such as the practice of diet in relation to nutrition, sanitation and food hygiene.

<sup>157</sup> Cassel. "Cultural Factors in the Interpretation of Illness", p.243.

<sup>158</sup> Trostle. "Anthropology and Epidemiology in the Twentieth Century", p.67.

<sup>159</sup> Kark. "A Health Service Among the Rural Bantu", p.197.

he knew that broader and more long-lasting progress was largely dependent on their successful collaboration and co-ordination with other social health agencies (labour, housing, social welfare) for the prevention of disease and enhancement of the individual and community.<sup>160</sup> He pushed for a co-operative form of research into local conditions to give precise data and important direction to central State departments' action concerned with promotive services such as nutrition, health education, agricultural development, environmental hygiene and general economic problems.<sup>161</sup>

The Pholela health centre created an innovative garden programme which the community readily accepted to supplement their poor diets once the proper incentive had been found. The centre provided the community with seeds, taught them how to grow vegetables in their own gardens which could be sold at the community market or to supplement school meals, and how to prepare nutritious meals (though in conformity with local preferences). But, as Cassel shows, habits pertaining to the consumption of milk were difficult to change because they had a strong emotional tone associated with deep-seated and powerful customs, surrounding the subject of cattle, the veneration of ancestors, and proper human conduct, and no amount of demonstration of the nutritional value of milk would convince the people that they should increase its use.<sup>162</sup> It turned out to be "unexpectedly easy" and with "a little ingenuity", the health centre team were able to introduce milk through the "back door" in the form of powdered milk. As Kark argued:

when we decided on our programme ... the people here are pretty poor, we didn't have many resources, other than our heads, we decided on a garden campaign. We also decided to persuade the Government that dried milk powder was a medicine, because they were prepared to supply medicines but not food. So we persuaded them ... and so was vitaminised oil, and we got bags of it, so we were able to give the people dried skim milk and vitaminised oil and we were able to develop a garden at the Health centre, so that everybody on the staff became a skilled gardener, all of us. ... We knew how to make compost. ... We then took that out into the schools, to establish gardens in the school, we created a school meal service, from their own gardens. ... we realised, this isn't a research project, this is the way we must practice.<sup>163</sup>

However, far more difficult to alter were conceptions about T.B., because the symptoms of the disease were seen to be the effects of social evil through witchcraft - an entire subject surcharged

<sup>160</sup> Gear. "The South African Native Health and Medical Service", p.169-170.

<sup>161</sup> SAB, GES, Vol. 2704, Ref. 2/62 and 1/62B. 1940-52. Native Health and Medical Services Polela Unit, p.4.

<sup>162</sup> Cassel. "A Comprehensive Health Program among South African Zulus", p.16-29.

with powerful feelings - which many in the local community felt that only the indigenous healer could adequately treat. As Cassel argues, the most difficult tasks involved “trying to change those cultural features which stood as symbols of fundamental moral codes governing interpersonal relationships”.<sup>164</sup> The most difficult problem was their attempt to control soil erosion - the condition basic to many of the other health problems - by improving agricultural practices and reducing the size of cattle herds to prevent overstocking and overgrazing.<sup>165</sup> It resulted in an impasse with massive hostility and resistance from the community. Thus “progress” for the health centre staff was slow, where tedious and prolonged health education on certain issues, only saw a slight decrease in resistance with time. It is important to view these health centre attempts to improve health conditions, not in isolation, but rather by understanding the total context including cultural, political, economic and social considerations.<sup>166</sup>

### ***Pholela’s Contributions to Community Health.***

Pholela’s contribution to the delivery of health services was ambiguous, producing both positive and negative results. Whereas previously much intensive research had been carried out among black urbanised communities, this was the first of its kind to do so in a rural area, and was designed to deliver an efficient health service to rural South African communities. At first, because the scheme was so new, it functioned independently of any existing State health service and thus enjoyed considerable freedom by not having to conform to any district or regional health authority. It proved effective as it captured the confidence of the community and served as a model for the development of others to follow. It provided a fully integrated extra-institutional promotive, preventive and curative service, and was responsible for the total health care of both individuals and communities.<sup>167</sup> As Gale argued, “it provided through members of the same team, under unified control, every kind of medical care outside of hospitals”.<sup>168</sup> Trostle maintained that “its innovative research methods, high quality of investigation and training, and spread of its ideas made it the ‘birthplace’ of the most important collective research effort of

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<sup>163</sup> Interview of Emily and Sidney Kark, p.8.

<sup>164</sup> Cassel. “A Comprehensive Health Program among South African Zulus”, p.15

<sup>165</sup> Cassel. “A Comprehensive Health Program among South African Zulus”, p.35-36.

<sup>166</sup> “Community Health Development: An Anthology of the Works of Guy W. Stuart”, p.S9.

<sup>167</sup> Marks. “South Africa’s Early Experiment in Social Medicine”, p.453.

<sup>168</sup> Gale. “Government Health Centres in Union of South Africa”, p. 630.

social epidemiology”.<sup>169</sup> However, while Kark recognised that much of Pholela’s burden of disease had socio-political-economic origins, that curative services would not modify the basic causes of disease, and thus gave equal weight to the social and biomedical dimensions, Kark and his team were ultimately powerless to implement broader policies they believed necessary for change. This is evident by the health centre team’s immediate success when they first entered the unserved area, where by using simple preventive measures and health education, quickly produced a dramatic reduction in morbidity and mortality and improved their quality of life.<sup>170</sup> However, once the improvements had been made and dramatic reduction in infant mortality and other diseases had been achieved, the team came up against the basic structural constraints producing worsening poverty, family instability and decline of agricultural production. The introduction of syphilis and T.B. into the rural Pholela community made long-term treatment a problem.<sup>171</sup> Kark even recognised that in the South Africa situation with its enormous health problems, social medicine essentially only alleviated the symptoms in Pholela not the underlying causes rooted in the wider political economy, which would later lead to its downfall.<sup>172</sup>

This section thus assessed the philosophy of particular pioneer doctors, their specific programmes of action and the achievements of their new, non-mainstream and even radical experiment in social and community health medicine in rural Pholela. The following section will focus on how it came to influence and be taken up as South Africa’s national public health service in 1944. In this section I will show that for a short time, public health medicine merged with radical social and community health ideas at a national level, where they fed into each other and revolutionised public health policy. This movement showed the enormous potentialities of community-based health services as a Government-funded and directed initiative which attracted

<sup>169</sup> Trostle. “Anthropology and Epidemiology in the Twentieth Century”, p.61.

<sup>170</sup> Jeeves. “Public Health and Rural Poverty in South Africa”, p.8.

<sup>171</sup> See Kark. “A Health Service Among the Rural Bantu”, p.197, Sidney L. Kark. “Migrant Labour and Family Health” in *A Practice of Social Medicine. A South African Teams Experiences in Different African Communities*. (Edinburgh and London: E. and S. Livingstone Ltd, 1962), p.200, and Trostle. “Anthropology and Epidemiology in the Twentieth Century”, p.68. The health centre programme was restricted by many conditions beyond its control, which limited its achievements. Oscillating male migration created by South Africa’s labour regulations associated with industrialisation continually reintroduced T.B. and STD’s into the rural areas. There was also extreme poverty, high unemployment, population pressure, a skewed gender distribution in rural and urban areas, combined with monotonous, deficient traditional food preferences and poor, outdated land use and agricultural patterns helped make soil erosion a serious problem and malnutrition common.

<sup>172</sup> Kark. “A Health Service Among the Rural Bantu”, p.197.

international attention during the 1940s. If allowed to continue it would have made South Africa a world leader in the field of preventive, social and community medicine.

### ***Health Reform: A National Health Service for South Africa.***

Out of the chaos, destruction and suffering of World War II, a few politically powerful and farsighted people in Government positions of power, began to plan for a better post-war world, secure and free from future wars and to guarantee basic human rights.<sup>173</sup> As the United Nations Charter stated, the hope was to “reaffirm faith in fundamental human rights, in the dignity and worth of the human person, to promote social progress and a better standard of life”.<sup>174</sup> One of the basic human rights which came to the fore was the right of all people to basic health care, as it was realised that without health, there could be no happiness - “it was a prerequisite to our economic prosperity, to our social happiness and to our political stability”.<sup>175</sup> In South Africa, it was recognised that while the war was fought for the betterment of all, the white ruling class had neglected the rights and needs of their black communities. As “disease knows no colour bar” and the “welfare of each depends on the welfare of all”, the promotion of health meant that it had to be done for all races.<sup>176</sup> All over the world, people awaited the establishment of comprehensive health services to ensure the prevention of disease and promotion of good health.<sup>177</sup> This new national interest in the provision of better health care for all, focused considerable attention on Kark’s highly experimental but farsighted health service achievements in the small rural black community in Natal, which would provide the model for the rest of South Africa and the world.

As the war was reaching its climax, Henry Gluckman under great war-time difficulties (particularly the diversion of people and materials to defense requirements) planned for post-war

<sup>173</sup> Henry Gluckman. *Abiding Values: Speeches and Addresses*. (Johannesburg: Caxton, 1970), p.413.

<sup>174</sup> SAB, GES, Vol. 2377, Ref. 209/38A. National War Memorial Fund, n/d, p.1.

<sup>175</sup> Gluckman. *Abiding Values: Speeches and Addresses*, p.158.

<sup>176</sup> See SAB, GES, Vol. 2377, Ref. 209/38A. National War Memorial Fund, n/d, p.1-2, SAB, GES, Vol. 2378, Ref. 209/38B. National War Memorial Health Foundation. Annual General Meeting of Members, 16 May 1949, p.4-6 and Gluckman. *Abiding Values: Speeches and Addresses*, p.78. The National War Memorial Health Foundation Fund - a “living memorial to South Africans who had given their lives during the war” (including many blacks)- was established after the war to make a substantial contribution towards improving the health of “non-European” races in South Africa through prevention of disease and healing of the sick. Much of its work was carried out in conjunction with the NHS, and provided funds for nutrition programmes, bursaries for blacks interested in health related careers in the NHS, and other promotive health and social welfare projects.

<sup>177</sup> Gluckman. *Abiding Values: Speeches and Addresses*, p.133.

betterment. In 1942, he was appointed by the State as Chairman of the National Health Services Commission (NHSC) to make a nation-wide survey of existing health services and produce a plan for a National Health Service (NHS) designed to promote and preserve health for all sections of the population in accordance with modern standards of health. As Gluckman argued in Parliament some years later, “history teaches us that periods of great national and international upheaval and strife are followed by the demand for and establishment of far-reaching social reforms”.<sup>178</sup> During this time South Africa was also politically divided on the question of participation in the war on the side of Britain, because a large part of the white population fostered strong anti-British sentiments. Post-war reform, with the promise of benefits to all sections of the population, was thus also seen by the pro-war Smuts party as a strategy with potential unifying effects.<sup>179</sup> Gluckman was an inspirational and farsighted doctor who saw the enormous contribution medicine had to make to the reconstruction of the war-torn world. For him, it was the “most international of human activities [which unified people] by only one bond and inspired by one aim, namely service to the sick”.<sup>180</sup> After two years of extensive investigation, they presented a radical report showing how the Union was wastefully spending millions of pounds on ill-health services which were haphazard, provided by a multiplicity of overlapping authorities and directed towards curing established disease.<sup>181</sup> Instead it recommended a total reorganisation of South Africa’s health system and aimed to bring all health services under unified control.<sup>182</sup> However, the uniqueness of the report was not in the depressing picture it painted with regard to curative medical services, but in the brilliance of a single new idea: the promotion of health. Despite massive medical technological advances made during the war, it was also realised that passive diagnosis and isolated “doctoring” of the community was not enough to solve the massive flood of health problems affecting communities and swamping hospitals.<sup>183</sup> The NHSC instead called for the establishment of an integrated

<sup>178</sup> Gluckman. *Abiding Values: Speeches and Addresses*, p.133.

<sup>179</sup> Harry T. Phillips. “The 1945 Gluckman Report and the Establishment of South Africa’s Health Centres”. *American Journal of Public Health*, Vol. 83, No. 7, July 1993, p.1037.

<sup>180</sup> Gluckman. *Abiding Values: Speeches and Addresses*, p.105.

<sup>181</sup> Gluckman. *Abiding Values: Speeches and Addresses*, p.10.

<sup>182</sup> See Gluckman. *Abiding Values: Speeches and Addresses*, p.433 and SAB, GES, Vol. 2958, Ref. PN6, Vol. 1 and 2. National Health Services, G.W. Gale, Sec. for Health, 2/2/1949, p.2. Gluckman hoped that the service would be paid by a new graduated, universal health tax of up to 4% of income and an increase in the poll tax on Africans.

<sup>183</sup> Gluckman. *Abiding Values: Speeches and Addresses*, p.134, 501.



extra-hospital service to escape the high-cost of private practice and static urban hospital system which had failed the majority of the people.<sup>184</sup>

In the proposed new NHS, hospitals would only be of secondary importance to a more adequate foundation of establishing community-based and oriented health centres on a national basis. In 1943, the NHSC members made an historic visit to Pholela to evaluate the effectiveness of the integration of this curative and preventive approach to the health needs of the rural African community and to experience the new types of auxiliary workers trained to supply health needs to the community.<sup>185</sup> The Karks pioneering work greatly fortified the NHSC thinking, as Gluckman argued, the Karks were pioneers and enthusiasts of rare quality:

among the backward and superstitious Native peoples, two graduates of ... [Wits] Medical School, man and wife, working with the determination of pioneers and with a missionary zeal, assisted by their own trained health assistants, have set themselves the task of grappling with the root causes of ill-health, ignorance, malnutrition and poverty.<sup>186</sup>

Because the NHSC members were so impressed with Pholela health centre, in 1944, they recommended the establishment of a network of integrated promotive, preventive and curative health centres (linked with a national hospital system) throughout South Africa, to be organised and administered according to the Pholela model.<sup>187</sup> Health centres were not an end in themselves, but were intended to form part of a wider vision: to be the foundation of a truly comprehensive and integrated NHS, to nationalise all personal health services, to reduce the huge cost of illness and expensive institutions for treatment, and to effect a more rational and efficient distribution of doctors and other health personnel who would work together as teams in the promotion of good health.<sup>188</sup> This was the beginning of an exciting experiment in the delivery of health care at a national level as distinguished from medical care. As Gluckman and others

<sup>184</sup> Marks. "South Africa's Early Experiment in Social Medicine", p.452.

<sup>185</sup> Gluckman. *Abiding Values: Speeches and Addresses*, p.504.

<sup>186</sup> Gluckman. *Abiding Values: Speeches and Addresses*, p.104.

<sup>187</sup> Harrison. "The National Health Services Commission", p.682.

<sup>188</sup> See Gluckman. *Abiding Values: Speeches and Addresses*, p.159 and Marks. "South Africa's Early Experiment in Social Medicine", p.455. In 1945, it was agreed that provinces would develop general hospitals and provide free hospitalisation as far as possible, while the central Government would develop extra-hospital services, mainly through health centres to reduce the volume of ill-health requiring expensive hospital care. The Government, however, would financially assist the provinces in working towards free hospitalisation. In that same year, there was an increased provision in the budget for health centres as an to show the State's earnest intention to carry out its part of the overall national health programme.

recognised, “to raise the standard of living of any man anywhere in the world is to raise the standard of living by some degree of every man everywhere in the world”.<sup>189</sup>

In February 1945 Gluckman urged Parliament to adopt the NHSC report and to create a separate Ministry of Health for its implementation, as “health services are not a luxury [as] without health there can be no true happiness, no true security, not true wealth”.<sup>190</sup> In November Gluckman became Minister of Health in the newly established Department of Health (DH). Kark had the highest regard for Gluckman in his role as Minister of Health:

it had to be because it was a national policy, you know it’s a rare thing in the history of any country to have a minister of health like Gluckman with a degree of sophistication that he developed as the chairman of the health commission going through a country and seeing its needs and having to balance different approaches, it’s a very rare thing for such a man to be a minister of health and one mustn’t depend too much on chance.<sup>191</sup>

Gluckman’s appointment, but also that of Dr George W. Gale as Secretary of Health and Chief Health Officer of the Union in 1946, injected tremendous enthusiasm into the health centre project. Gale played a vital role in promoting and gaining support for health centre policies and practices at a national level. Gale qualified in public health in Edinburgh in 1927, and on his return to South Africa became centrally involved in the public health sphere. Before his appointment to the Ministry of Health - a position where his progressive ideas about “native” health on a wider scale could be implemented - Gale gained first-hand experience and knowledge of the health conditions among both rural and urban black communities. Gale spent his early career as a mission doctor in the Msinga District (an African reserve in rural Natal) and later gained experience in city conditions before being invited to join the D.P.H. as Chief Health Officer of the Union.<sup>192</sup> During the 1930s and 1940s, Gale was directly involved in, or gave evidence for many Government debates and commissions, and although not a member of the NHSC, as Gluckman’s adviser, he had an enormous influence on the outcome of the NHS report. More importantly, it was through Gale that Kark and Gluckman met, and it was Gale who saw

<sup>189</sup> Gluckman. *Abiding Values: Speeches and Addresses*, p.297.

<sup>190</sup> Gluckman. *Abiding Values: Speeches and Addresses*, p.11.

<sup>191</sup> UN Archives Pmb. H6/1/1. Interview with Professor S. Kark and Professor Gordon, p.23.

<sup>192</sup> See both the *Durban Medical School University of Natal: A Response to the Challenge of Africa*. (Durban: Hayne and Gibson, 1954), p.33 and UN Archives Pmb. H6/1/1. Dr George William Gale and the Medical School of the University of Natal. A Short Tribute by Audrey Gale, n/d, p.1. Gale held this position as Chief Health Officer for the Union for 7 years, which gave him enormous administrative experience.

health centres as a “model not simply for native territories, but also for the whole country”. He also brought the work of the Karks at Pholela to the attention of the NHSC.<sup>193</sup> As Kark argued:

George Gale ... was really very important [as he] persuaded Gluckman to bring his Commission out to Pholela. George Gale was an ex-missionary doctor, he was the founder of the Tugela Ferry Mission Hospital, his father was the missionary there, and he decided to go to Scotland and train as a missionary doctor. He became a life-long friend of Emily's and mine. And a very close one.<sup>194</sup>

In another interview, Kark recognised the importance of the NHSC coming to Pholela:

that visit changed our life history, if it hadn't been for that visit we might still have been at Pholela ... [they] expanded the horizons of Pholela because they saw in that the potential for a foundation network service in the country.<sup>195</sup>

Gluckman and Gale were the political and executive heads of the health centre approach and were enormously persuasive. They won many people over by their broad “South Africanism” and national concern and influenced many opinions as they defended and intervened on behalf of the health centres movement in Government circles.<sup>196</sup> They envisaged a chain of health centres stretching across South Africa to take health care into the myriad of rural and urban communities.<sup>197</sup>

Looking back over these momentous years, Kark felt that David Landau, who was a far less recognised national figure than Gale – who was Health Officer of a Local Health Commission in Natal during the mid-1940s – had a pivotal role to play in promoting health centre practice and advancing and gaining recognition for Durban, as the site of radical health service changes. Kark maintained that during the 1940s:

as Health Officer of the Commission it was his responsibility to attempt to establish health services in all the peri-urban areas of Natal ... Now, it was over his Edendale work that we became very close because he used to come out to Pholela and see what we were doing and we used to go to Edendale to see what he was doing. ... Eventually we ran similar services.<sup>198</sup>

<sup>193</sup> Marks. “South Africa’s Early Experiment in Social Medicine”, p.454.

<sup>194</sup> Interview of Emily and Sidney Kark, p.9.

<sup>195</sup> UN Archives, Pmb. H6/1/1. Interview with Professor S. Kark and Professor Gordon, p.15.

<sup>196</sup> UN Archives, Pmb. H6/1/1. Dr G.W. Gale and the Medical School of the UN. A Short Tribute by Audrey Gale, p.2 and Gluckman. *Abiding Values*. p.115.

<sup>197</sup> “Henry Gluckman”. *South African Medical Journal*, Vol. 72, 15 August 1987, p.302.

<sup>198</sup> UN Archives Pmb. H6/1/1. Interview with Professor S. Kark and Professor Gordon, p.15.

According to Kark, Landau's early reports of his Edendale programme, while dealing with a different community, were very similar and even paralleled Pholela in its training of health assistants both recognised the importance of doctors and nurses fulfilling different roles. When Kark was overseas receiving additional social medicine training during 1947/48, Landau actually took his place as Head of the Institute of Family and Community Health (IFCH), ran the training programme and made his profound influence in this field felt.<sup>199</sup> Just before his untimely death in August 1948, Landau had been appointed Chief of the Division of Social Medicine (a new division in the Ministry of Health created by Gale as Secretary for Health). One month after the Karks return from England, Landau died before he could take up his full-time post in Pretoria. Kark felt that his death was a tremendous loss as:

he would have spread this very far. David got so interested in this in the end that he actually joined us and he would have been my boss if he had lived long enough. I think David had a lot to do with influencing the Gluckman Commission together with George Gale because he and George were very close.<sup>200</sup>

Kark maintained, that even though he died so unexpectedly and had only a few years to influence people, he "had a most incisive and penetrating mind, I think possibly the most incisive mind I've met in my life, and I've met a fair number".<sup>201</sup>

It is also essential to contemplate and ascertain the NHSC's achievements more broadly, because while this largely experimental health centred approach only survived at a national level for a short time, its impact on health provision and medical education in South Africa, and the world at large, was enormous. It is important to discuss something of these contributions to later appreciate why its forced demise was such a tragedy to South African health services and medical education. This new 1942-44 NHSC was an innovative achievement in South African health history, for in a country preoccupied by war demands, it produced a plan for a NHS far superior to those being produced in developed countries.<sup>202</sup> What was unique, too, was that a radical, non-mainstream social and community health movement was taken up and directly determined South Africa's NHS from 1946. Gluckman produced a radical report and within

<sup>199</sup> UN Archives Pmb. H6/1/1. Interview with Professor S. Kark and Professor Gordon, p.18.

<sup>200</sup> UN Archives Pmb. H6/1/1. Interview with Professor S. Kark and Professor Gordon, p.15.

<sup>201</sup> UN Archives Pmb. H6/1/1. Interview with Professor S. Kark and Professor Gordon, p.15.

<sup>202</sup> Gluckman. *Abiding Values: Speeches and Addresses*, p.498.

twelve months of the NHSC Report's appearance, was appointed Minister of Health in charge of the Department directly concerned with the implementation of his own report.<sup>203</sup> During 1944-45, the Government made £50,000 available from the Treasury to establish health centres and from June 1946 to May 1948, the service increased rapidly to over forty health centres by the time of the UP defeat two years later.<sup>204</sup> While its policies were only partly implemented, the NHSC was a landmark in the history of medical thought and practice and challenged many conventions, such as: urging the promotion and preservation of good health through community health centres, providing a holistic understanding of health, pushing a commitment to a unitary health care system, and created a mechanism for the democratic control of health services which represented a giant leap beyond the thinking of most of the medical profession. It is also important to note, that this elaborate medical plan for the reconstruction of the country's entire health system challenged conventional assumptions about separate health services for blacks and would have helped to deracialise South Africa's health system if allowed to continue.<sup>205</sup> In Shula Marks' view, the NHSC Report put in place the framework of a revolutionary new health system which if properly implemented, would have completely reoriented the way modern medicine delivered health care to impoverished rural and urban communities.<sup>206</sup> It served as a blueprint for the development of South Africa's national health system, put the country in the forefront of social medicine in the 1940s, and attracted international attention on a scale without peer anywhere in the world. During the mid-1940s, Britain's Minister of Health, Malcolm MacDonald was quoted as exclaiming, "here is a report that shows us what we should be doing!"<sup>207</sup>

However, the scheme was also economically cost-effective and while it was recognised that the need for hospital care remained, health centres services were cheaper, and helped to alleviate the overcrowded hospital facilities burdened with treating patients with advanced stages

<sup>203</sup> Gluckman. *Abiding Values: Speeches and Addresses*, p.499.

<sup>204</sup> "The Health Commission's Report". *South African Medical Journal*. Vol. XIX, No. 2, 27 January 1945, p.17.

<sup>205</sup> Harrison. "The National Health Services Commission", p.683-684.

<sup>206</sup> Marks. "South Africa's Early Experiment in Social Medicine", p.452.

<sup>207</sup> "Henry Gluckman". *South African Medical Journal*, Vol. 72, 15 August 1987, p.303. Shula Marks in her article, "South Africa's Early Experiment in Social Medicine", p.452, argues that the NHSC report was ahead of the progressive Beveridge Report which established the NHS in Britain. The British NHS was brought into being at the same time, and while it subscribed in theory to this view, in many practical respects found imperfect expression. Their health centres were far removed in concept from those established in South Africa, where preventive and curative medicine remained functionally separate and only later achieved full integration.

of disease.<sup>208</sup> When the comprehensive service was properly developed, it cost about £1 per head of the population per year. Studies in relationship to increased hospital costs in South Africa showed that the health centre costs were reasonable and an important contribution in the curative field.<sup>209</sup> Another saving more difficult to translate into actual monetary value was the early recognition of disease, and its effective treatment before costly and advanced illness developed. Health education carried out in the clinics or homes of the people in the community also helped to stimulate improved habits related to health and hygiene which resulted in decreased disease.<sup>210</sup> Increased interest and active co-operation of the people resulted in reduced gross nutritional failure and the absence of epidemics despite outbreaks in surrounding areas.<sup>211</sup>

However, as a later chapter will show, the farsighted national health service ideas and policies were too radical to be accepted by the white voting public in the latter 1940s and 1950s, and many of its policies for restructuring health care provision were shelved. This small number of innovative public health professionals in State policy roles worked closely with health centre doctors operating in the communities and transformed public health policy in radical new directions, but only for a short while. It was the very nature of its radical orientation, that would undermine attempts to establish the necessary framework for a revolutionary new health care system, and would rob South Africa of taking its lead as an innovator in the social and preventive medicine sphere. I will show that health centres came to operate against a very different administrative and financial background from that which had been envisaged by the NHSC, and the NHS became increasingly compromised as health centres were added to the still divided

<sup>208</sup> SAB, GES, Vol. 2704, Ref. 2/62 and 1/62B. 1940-52. Native Health and Medical Services Polela Unit, p.3. See UN Archives Pmb. H6/2/3. Correspondence concerning Establishment of the Department of Family Practice, 1953-55. Arguments Against Closure of the Institute of Family and Community Health. Gale argues that King Edward Hospital showed far fewer admissions from the areas served by the health centres than others, which were not. See SAB, GES, Vol. 2704, Ref. 1/62B and 2/62. Native Health and Medical Services Polela Unit. General Matters. Social Medicine in South Africa, March 1951, p.6. At Pholela there was a steady decrease in the death-rate from 28.15 per 1000 in 1945 to 13.65 in 1950, and a drop in infant mortality rates from 275 deaths per 1000 births in 1942 to 115 in 1950.

<sup>209</sup> SAB, GES, Vol. 2704, Ref. 2/62 and 1/62B. 1940-52. Native Health and Medical Services Polela Unit, p.2. The cost of treating a patient by the health centre was considered lower than the share the central Government had to contribute to hospitalisation. The cost it had to contribute to health centre care ranged from about a quarter to half the hospital costs and thus drastically reduced the Government's expenditure. The Government provided funds through a general subsidy to meet half the cost of provincial health services.

<sup>210</sup> SAB, GES, Vol. 2704, Ref. 2/62 and 1/62B. 1940-52. Native Health and Medical Services Polela Unit, p.3. "Home at the health centre" for pregnant women and a limited number of sick saved the staff time and allowed for intensified family education, where relatives joined the patients, prepared their own food and assisted the nurses.

<sup>211</sup> Kark and Cassel. "The Pholela Health Centre. A Progress Report Continued". *South African Medical Journal*, 16 February 1952, p.136.

public health service rather than becoming its foundation.<sup>212</sup> And the clouds of doom loomed ever larger for this progressive health service as the years progressed.

### ***Establishment of the Institute of Family and Community Health.***

There was one very important outcome that emerged from investigations into possible training facilities for health personnel in a new South African NHS. In 1944, one of the most important findings of the national NHSC was that there were in existence, “measures not adequate to provide, by any mere process of expansion, a NHS of the range and quality demanded by our terms of reference”.<sup>213</sup> As already argued, initially Pholela provided an “in-service” social and community training for its health assistants and doctors, but the requirements for a nation-wide network of health centres outgrew Pholela’s limited resources, while it was recognised that its rural African nature would provide an inappropriate training for the diverse racial and socio-economic groups and conditions in South Africa. The State DH was confronted with training teams of personnel for health centres.<sup>214</sup> Because no other facilities existed in South Africa for giving health centre experience, the DH decided to establish a large training scheme to remain under its control (rather than the Department of Education) until such time as the full content and methods had been determined in the light of experience as they developed.<sup>215</sup> Gluckman was determined to establish an “Institute” for the dual function of training doctors and various health auxiliaries, to work as members of health centre teams, as well as to provide

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<sup>212</sup> Harrison. “The National Health Services Commission”, p.683.

<sup>213</sup> See GP, File 14, KCM 25797 UNMS. IFCH Report of the Medical Officer-in-Charge. Year ending June 30th, 1950, p.ii and SAB, GES, Vol. 2377, Ref. 209/38A. University of Witwatersrand, Johannesburg, Faculty of Medicine, Memorandum on the Need for the Establishment of an Institute of Hygiene and Social Medicine, 16/8/1945, p.1-4. The other medical schools in South Africa lacked facilities for teaching, training and research in hygiene and tropical medicine. After World War II’s influence on the development of social medicine, there were urgent attempts to provide facilities to meet these new developments in the field of State and social medicine. However, postgraduate diplomas in public health, tropical medicine and hygiene were hampered by a lack of a museum of hygiene and medicine in relation to African conditions, no teaching or lab accommodation and small clinical facilities. There was massive competition between Johannesburg and Durban for the site of the new “Institute of Hygiene” to train health centre staff in promotive and preventive medicine, but Durban was favoured in the most suitable site.

<sup>214</sup> GP, F14, KCM 25797 UNMS. IFCH Report of the Medical Officer-in-Charge. Year ending June 30th, 1950, p.iii. The State had proposed the establishment of 50 health centres over the next two years (1946-48) with more to follow.

<sup>215</sup> SAB, GES, Vol. 1831, Ref. 68/30. Medical and Dental Training for Natives, Gale (Secretary for Health), 7/11/1951, p.3.

opportunities to carry out research into and allow for the assessment of the value of various new techniques required for this new kind of practice.<sup>216</sup>

### ***Clairwood, Durban - The Perfect Site.***

The “Institute” was first established, at the former military hospital at Springfield, Durban, together with eight health centres in 1946.<sup>217</sup> Gale played an influential role in persuading the pioneering Karks to come to Durban to establish this training scheme towards the end of 1945. In an interview in 1980, the Karks argued that they were both plagued by doubts about leaving Pholela and agreed to come only on condition that it remained the rural teaching health centre so as not to be completely separate from it.<sup>218</sup> Pholela thus formed the prototype for all health centres to be built in South Africa. While accommodation was cramped and only temporary in Springfield, this site formed the first training base at a city level. Health centres were established which dealt with Indian, African and Coloured communities, whilst home visits and health examinations were regularly undertaken. In 1948, it was felt that a permanent institution was necessary, and the premises of the Institute were transferred to their permanent headquarters at Clairwood in Durban.<sup>219</sup> However, negotiations for this site required all of Gluckman’s skill, tact and persuasion, and he even came in person to Durban to negotiate with the Natal Provincial Administration (NPA) and Durban City Council (DCC) to secure, in his view, the best land and buildings for health centre purposes. He argued that by so doing, Durban would be facilitating the advancement of health services not only locally and provincially, but also nationally.<sup>220</sup> As a result, the central Government bought Clairwood from the DCC - the land on which had been erected the Clairwood Military Hospital and its auxiliary buildings which were thirty six acres in extent - at only half the open market value, on condition that it be used to establish an “Institute of Family and Community Health” (IFCH) at which research

<sup>216</sup> Gluckman. *Abiding Values: Speeches and Addresses*, p.505-6.

<sup>217</sup> G.W. Gale. “Health Centre Practice, Promotive Health Services and the Development of the Health Centres Scheme”. *South African Medical Journal*, Vol. 20, 2 June 1946, p.328. There was a Medical Officer-in-Charge, 4 Medical Officers of Family Welfare, Epidemiology, Environmental Hygiene and Clinical Pathology, a Dental Officer, Nutritionist, Psychologist, tutor health visitor, inspector, demonstration Medical Aid and Health Assistants.

<sup>218</sup> UN Archives, Pmb. H6/1/1. Interview with Professor S. Kark and Professor Gordon, p.16.

<sup>219</sup> See SAB, GES, Vol. 1831, Ref. 68/30. Medical and Dental Training for Natives, Gale (Secretary for Health), 7/11/1951, p.4 and UN Archives, Pmb. H6/2/3. Correspondence concerning Establishment of the Department of Family Practice. History and Future of the IFCH, Clairwood, Durban by G.W. Gale, 1/6/1954, p.2.



techniques of health centre practice and the training of health personnel would be carried out.<sup>221</sup> The land was valuable and could have been used to develop a municipal housing scheme to lie between Woodlands and Lamontville or sold for industrial purposes to the Mobeni industrial area.<sup>222</sup> According to Gale, no better site could have been found anywhere in the Union, as there was a rapid and easy access for health service, research and training purposes to a wide range of communities representative of the various cultural and racial groups in South Africa, who were living under differing conditions ranging from urban, semi-urban to rural areas immediately beyond the municipal boundaries.<sup>223</sup>

Thus, with Gale's influence, Sidney Kark was made Director and team leader of the IFCH from 1945.<sup>224</sup> The IFCH staff were all public servants employed by the DH which also subsidised the IFCH's running costs, equipment and accommodation. The IFCH had a complex structure made up of several divisions concerned with the development and training of health centre personnel, where they worked as members of a close-knit team to allow for the effective development of group practice outside the hospital.<sup>225</sup> The IFCH included experts in: Family and Home Health, Nutrition, Dental Hygiene, Physiology, Clinical Pathology, Environmental Hygiene, Control of Infectious Diseases, Biometrics and Epidemiology and Health Education.<sup>226</sup> Through a co-ordinated effort, the IFCH was able to develop a programme of research and investigation on the one hand, with demonstration or teaching and field service to the communities on the other, and thus provided steadily increasing practical and theoretical training for prospective health centre personnel. It used seven practicing health centres situated in Durban

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<sup>220</sup> See Gluckman. *Abiding Values: Speeches and Addresses*, p.506 and UN Archives, Pmb. H/6/1/1. Gale. "The Story of the Durban Medical School", p.5. The name IFCH was preferred to that of Institute of Hygiene, although it fulfilled the same functions recommended by the NHSC for such an institute.

<sup>221</sup> UN Archives, Pmb. H6/2/3. Correspondence concerning the Establishment of Department of Family Practice. Faculty of Medicine UN and the IFCH. Fruitful Planning of Health Services, Dr G.W. Gale, 16/3/1954. The site was transferred for only £17,500 and its intended educational and research uses were written into the title deed. See also the Interview of Emily and Sidney Kark, p.12 for Kark's comments on the naming of the Institute. Kark suggested "Institute of Social Medicine" but Gluckman argued that "social medicine [was] like a red rag to a bull" of the newly elected racist NP Government. So they settled on an alternative name the "Institute of Family and Community Health".

<sup>222</sup> SAB, GES, Vol. 2958, Ref. PN6, Vol. 1 and 2. NHS, G.W. Gale, p.10

<sup>223</sup> SAB, GES, Vol. 2958, Ref. PN6, Vol. 1 and 2. NHS, G.W. Gale, p.10

<sup>224</sup> UN Archives, Pmb. H6/2/3. Correspondence concerning Establishment of Department of Family Practice. Letter from Prof. I. Gordon, Dean of the Medical School to Dr. William A. McIntosh, Rockefeller Foundation, 2/6/55, p.1. Pholela health centre was placed under the direction of Dr John Cassel.

<sup>225</sup> UN Archives, Pmb. H6/2/3. Correspondence concerning Establishment of the Department of Family Practice. History and Future of the IFCH, Clairwood, Durban by G.W. Gale, 1/6/1954, p.3.

<sup>226</sup> Gale. "Government Health Centres in Union of South Africa", p.635.

and its surrounding areas and served a population of about 65,000 to 70,000 people, including 1740 whites, 5,200 Coloureds, 13,350 Indians and 47,000 Africans, and provided them with an intensive family preventive and curative service.<sup>227</sup> As Kark argued:

Pholela Health Centre was to be its rural training branch ... in Durban itself we wanted a group of health centres immediately around which ever the future home of the training scheme was to be.<sup>228</sup>

### *A Progressive Training in “Pre-Hospital” Promotive and Preventive Health.*

Training of various types of health personnel constituted a significant part of the IFCH work. Fully qualified doctors and registered nurses were admitted for a six months training course at the IFCH before taking up their appointments in health centres around the country. As Kark argued:

we had to do two things at the same time, one train our staff, because they were all new, and two train the doctors who were passing through. ... We had to do exactly the same with nurses. They came to us with general nursing and midwifery. We appointed an ex-mission nurse Helen Cohn from Lady Selborne Pretoria as our Chief Nurse. On George Gale’s advice, he introduced us to her, she was really a brilliant woman.<sup>229</sup>

Forty to fifty health assistants were admitted for training in an at first, shortened six month training course, to meet the immediate health needs and it was hoped would later develop into a longer, formal training course.<sup>230</sup> These community-recruited and trained health assistants

<sup>227</sup> “The Institute of Family and Community Health: Summary of the Report of the Medical Officer-in-Charge for the year ending 30 June 1950”. *South African Medical Journal*, 24 November 1951, p.870. Also see GP, F14, KCM 25797 UNMS. IFCH Report of the Medical Officer-in-Charge. Year ending June 30th, 1950, p.v. and UN Archives, Pmb. H6/1/1. Interview with Professor S. Kark and Professor Gordon, p.17 for a more detailed discussion of the seven practising health centres used. Four were accommodated at Clairwood (which included Woodlands for whites, Lamontville for Africans, Merebank for Indians and Mobeni as a black industrial area), two were situated in Durban (Springfield and Newlands) and the seventh was at rural Pholela about 100 miles away. Gale argues, in SAB, GES, Vol. 1831, Ref. 68/30. Medical and Dental Training for Natives, 7/11/1951, p.2, that each of the “divisions” within the Institute were placed under a medical officer primarily responsible for teaching and research, while each health centre was also placed under a medical officer to facilitate the organisation of field teaching, who were responsible to the Medical Officer-in-Charge of the Institute, instead of, as with all other health centres, directly to the Secretary of Health.

<sup>228</sup> Interview of Emily and Sidney Kark, p.12.

<sup>229</sup> Interview of Emily and Sidney Kark, p.13.

<sup>230</sup> SAB, GES, Vol. 2957, Ref. PN5, Native Medical Aids. Report of the Committee of Enquiry on the Medical Training of Natives to the Minister of Public Health, 15/6/1942, p.14. In 1944 when the State-sponsored “medical aid” scheme floundered, that State converted it into a 3-year course for the B.Sc. (Hygiene) Degree from UNISA taken at Fort Hare and after further training in Durban, employed as “Hygiene Officers” or “Health Assistants” in the State health services in activities which did not infringe upon the law. But the course was too long and could not provide health personnel immediately for the desperate shortage of medical personnel, especially in rural areas. It’s

formed key members of the health team practice engaged in mainly promotive and preventive work in the communities.<sup>231</sup> The course grew by trial and error, and while the nature of the health services varied for different communities providing a rich inter-cultural experience, they resembled each other in basic conceptual framework.<sup>232</sup> The IFCH tried as far as possible to train people in the teams that were going out to begin new health centres together.<sup>233</sup> All previous training based on clinical techniques learnt in hospital environments, were omitted in exchange for a reoriented focus on “pre-hospital” preventive and promotive medicine in a team practice based on health centres.<sup>234</sup> Increasingly, as the years continued, the theoretical and practical aspects of health assistant training came to be focused at the IFCH.<sup>235</sup> Health assistant training was based on an integrated biological and social theoretical training developed alongside controlled field service experience.<sup>236</sup> It was simple, based on promotive health education, gave a basic knowledge of physiology, nutrition, parasitology (to help with the prevention of the spread of infectious diseases), environmental hygiene, psychology and sociology in relation to understanding different customs affecting health.<sup>237</sup> Their task, was to prevent disease at its main source by modifying “unhealthy” family habits, cure more diseases in their earlier stages to reduce costs, and to alleviate the huge pressure on hospitals.<sup>238</sup> When working at health centres, health assistants continued to undergo a vigorous in-service training at regular weekly sessions, where the team discussed new programmes and problems and evaluated progress.<sup>239</sup> As developed at Pholela, the main feature of the service was periodic home visits to appreciate the social conditions in which disease originated and regular health examinations to assess the state of health. Through health promotive/educational work, the community was also able to

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important to note, that in 1951, this replacement scheme was abandoned when the Durban Medical School training of fully qualified black doctors got underway.

<sup>231</sup> Susser. “A South African Odyssey in Community Health”, p.1040.

<sup>232</sup> Sidney and Emily Kark. “A Practice of Social Medicine” in *A Practice of Social Medicine. A South African Teams Experiences in Different African Communities*. (Edinburgh and London: E. and S. Livingstone Ltd, 1962), p.6.

<sup>233</sup> UN Archives, Pmb. H6/1/1. Interview with Professor S. Kark and Professor Gordon, p.17.

<sup>234</sup> SAB, GES, Vol. 1831, Ref. 68/30. Medical and Dental Training for Natives, Gale (S. for H), 7/11/1951, p.5.

<sup>235</sup> UN Archives, Pmb. H/6/1/1. Gale. “The Story of the Durban Medical School”, p.2.

<sup>236</sup> Guy W. Steuart. “Community Health Education” in *A Practice of Social Medicine. A South African Teams Experiences in Different African Communities*. (Edinburgh and London: E. and S. Livingstone Ltd, 1962), p.89.

<sup>237</sup> UN Archives, Pmb. H6/2/3. Correspondence concerning Establishment of the Department of Family Practice. Letter from G.W. Gale to Department of Health, 5/11/1952, p.4.

<sup>238</sup> SAB, GES, Vol. 2957, Ref. PN5, Native Medical Aids. Report of the Committee of Enquiry on the Medical Training of Natives to the Minister of Public Health, 15/6/1942, p.25.

<sup>239</sup> Steuart. “Community Health Education”, p.89.

consciously and actively participate in the improvement of its own health.<sup>240</sup> They continued to use their innovative socially-oriented research methodology that was comprehensive, multi-disciplinary and drew extensively on anthropological methods and understandings of social and cultural factors in health status, to develop the practice of Community Oriented Primary Health Care (COPC).<sup>241</sup>

However, with the shift in Government power in 1948 to the racist Afrikaner National Party, many of the progressive NHS policies were undermined, whilst innovative public health professionals in the State's DH together with those operating at the ground level in helping to alleviate the desperate health burden of disadvantaged black communities, came under threat. For a short time, the U.P. State's D.P.H., desperate to improve health conditions for the country's majority, and influenced by the impressive, persuasive arguments of public health doctors in positions of power, incorporated and even elaborated social and community health ideas as the foundation of a national public health service. The health centre experiment in the small, black rural reserve area of Pholela was heralded as the answer to the D.P.H.'s searching questions. Thus, a vital transformation occurred in the State's D.P.H. in the first four decades of the 20th century which revolutionised public health thinking. What began as a peripheral, non-mainstream social and community health movement, stimulated by the work of unique, individual doctors whose particular philosophies and personalities drove this radical movement during the late-1930s and early-1940s, was taken up and promoted as South Africa's mainstream public health service at a national level from mid- to latter-1940s. For a brief moment, traditional public health policy thus merged with radical social and community health ideas at a national level and revolutionised public health policy. This move attracted world-wide attention as it showed the enormous potentialities of community-based health services as a nationally-directed initiative. However, this national initiative only lasted a short time and the next chapter will demonstrate how, increasingly, the State's DH slowly relinquished its central hold on the health centre movement as it became viewed as too progressive and radical for a conservative and racist apartheid State. I will show that these progressive and radical social and community health ideas increasingly became a provincial responsibility, rooted in a fledgling institution in Durban - the

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<sup>240</sup> SAB, GES, K20, Vol. 14 Tomlinson verslag Korrespondensie en Werkstukke. Department of Health. Institute of Family and Community Health Report of the Medical Officer-in-Charge year ending June 30th, 1950.

<sup>241</sup> Trostle. "Anthropology and Epidemiology in the Twentieth Century", p.61.

black Medical School which was established in 1951 - whose parochial nature and marginalisation from national affairs would eventually lead to its demise during the late-1950s and early-1960s. But it will also be an analysis of the incredible work, undertaken by one Department in a medical school which took up the role of promoting and continuing the social and community health work in an academic institution, which lead the way and promoted international recognition for and interest in this newly established black medical institution. The Durban Medical School's direct affiliation with the IFCH placed it in the vanguard of other medical schools in South Africa and even ahead of those in Europe and America.

## Chapter Three

### **The Birth of South Africa's First Black Medical School in Durban and its Unique Orientation in Social, Preventive and Community Health**

... A strong department of Social Medicine within a Medical School would be one of the best ways of ensuring that doctors who qualify in that school are imbued with the right outlook on their job - viz. that they should deal as much with the promotion of health as with the cure of disease.<sup>1</sup>

In 1947 one of the most energetic and wealthy philanthropic bodies in the world - the Rockefeller Foundation - committed itself to funding a radical experiment in social and community health in South Africa - with a new Medical School in Durban as its key site. The last years of World War II had provided a window of opportunity for State support for this approach and thus for a brief moment in South African public health history, traditional public health policy merged with innovative social and community health medicine ideas at a national level, which revolutionised how the South African State provided health services for the majority of its population. What is important about this move was that it attracted worldwide attention, as it showed the enormous potentialities of community-based health services at a national, State-directed level. Unfortunately for South African health - as I will show in the next chapter - this national social and community health initiative only lasted for a few short years.

This chapter will analyse how the State's Department of Health (DH), under the influence of a more conservative and racist apartheid National Party (N.P.) Government in the late-1940s and 1950s, slowly began to relinquish its national hold on the health centre movement as it became viewed as too progressive and radical. It will be shown how, increasingly, throughout these years these radical medical ideas became a provincial responsibility, rooted in the fledgling institution of the Durban Medical School. However, before an analysis can be made of how and why this radical social and community health movement came to play a pivotal role in alleviating the burden of ill-health, rooted in the institutional setting, it's imperative that I also

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<sup>1</sup> SAB, UOD, Vol. 1546, U3/40/4. NU College Establishment of Medical School for Natives. Letter from E.G. Malherbe to Dr Gluckman, Minister of Health re: Medical School for Non-Europeans: Durban, 5/5/1947, p.2.

examine the often parallel debates and factors that influenced the establishment of this black Medical School, and why it was situated in Durban. Thus, while I am interested in determining how and why this controversial and progressive social and community health movement managed to continue its work in South Africa for another decade with increasing State hostility to its central philosophy, this chapter is also concerned with examining what influenced the establishment of this black Medical School in Durban in 1951, whose existence eventually facilitated the continuance of the Institute of Family and Community Health (IFCH). But it will also be shown how in fact, this prior IFCH movement, played a vital role in bolstering support for the establishment of the new black Medical School, and influenced why it was situated in Durban, and not some other province. I will thus demonstrate how these progressive ideas, increasingly expelled from the central State's DH, became incorporated into one Department - of Social, Preventive and Family Medicine - in one black Medical School. Once firmly established in this university setting, and not limited by the restrictions of the State's DH, this new social and community health approach revolutionised the School's newly established medical curriculum and promoted phenomenal international recognition for its preventive and social medicine approach which placed the Durban Medical School in the vanguard of medical schools the world over. In the process, this attention facilitated the movement's continuance through an overseas financial donor, who saw the worth of the School's work and helped sustain its development for a longer period, despite growing attacks by the racist apartheid State determined to undermine its progress. However, its isolation from wider national health services and its cut in funding made it vulnerable to attack, which would eventually lead to its demise during the late-1950s and 1960s.

### ***Early International Interest in Possible IFCH Links with an Academic Institution.***

Before analysing, in detail, the intricacies and complexities in the establishment of the Durban Medical School, to which the IFCH would later be affiliated, it's important to show how the incorporation of revolutionary social and community health ideas at a national level - which demonstrated the enormous potentialities of community-based health services - attracted world-wide interest and attention during the mid-1940s, and would play a vital role in promoting the affiliation and close association between the IFCH and soon to be established Durban Medical

School. As early as 1946, an American philanthropic organisation, known as the Rockefeller Foundation, who appreciated the social and environmental aspects of health, immediately recognised the important potential of Durban and its IFCH.<sup>2</sup> The Foundation expressed admiration for the work being carried out at the IFCH and its associated health centres, not only for its intrinsic worth - providing an integrated programme of theory and practice in preventive and curative medicine, the multi-racial team work of staff and training of a new category of black “health assistants” skilled in promotive work to serve their own communities - but also for its potential for the training of medical students in the kind of general, preventive practice which they regarded as well adapted to the needs of the “non-Europeans”.<sup>3</sup>

Between 1946 and 1948, many representatives visited Durban to ascertain whether there was any way in which the Foundation could assist in this very significant project. While the University of Natal (UN) was not originally in a position to assist in the establishment of the IFCH, during the late-1948s and early-1950s, on account of it sponsoring the soon-to-be-established Durban Medical School, the Rockefeller Foundation became concerned with the uncertain future of the IFCH and was determined to find ways to associate this Institution with a University to bring it into line with other research and education institutions. Dr Grant of the Rockefeller Foundation supported the UN’s fear of continued State control undermining the high standards of research and service, and was most emphatic from his wide experienced that:

an Institute of Social Medicine which was not integrated with a University Medical School would become a second rate institution and was doomed to fail in the end. Divorced from an institution of higher learning it would tend to be actuated by a spirit of narrow occupationalism and would become intellectually isolated. ... A strong department of Social Medicine within a Medical School would be one of the best ways of ensuring that doctors who qualify in that school are imbued with the right outlook on their job - viz. that they should deal as much with the promotion

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<sup>2</sup> See UN Archives, Pmb. H6/2/1. Correspondence of Prof. I. Gordon Faculty of Medicine, 1954-57. Letter from Dr. G.W. Gale to Dr Gordon, 21/ 5/1955, p.2 and UN Archives, Pmb. H6/2/3. Correspondence concerning Establishment of the Department of Family Practice. The Rockefeller Foundation, 1953-55. While not itself engaged in research or experimental efforts, it was a U.S.A. philanthropic organisation which sought to identify and address the sources of human suffering chiefly through research grants to universities and other institutions, which assisted many countries to develop advanced medical education and thus acquired a vast experience in this field. The Rockefeller Foundation helped discover new medicines, built modern health institutes and improved the quality of medical research and education.

<sup>3</sup> UN Archives, Pmb. H6/2/3. Correspondence concerning Establishment of the Department of Family Practice. Letter from Dr. G.W. Gale to E.G. Malherbe, 12/7/1954, p.3.



of health as with the cure of disease.<sup>4</sup>

In anticipation of the eventual participation of the staff of the IFCH in teaching at the planned Durban Medical School, the Rockefeller Foundation provided one year overseas fellowships for three of its members to undertake courses of study in epidemiology and social sciences to enhance their experience and value as teachers.<sup>5</sup> These fellowships were an early indication of the significance of what was being done at the IFCH for the proposed Medical School, and increasingly pioneering doctors in the IFCH began working toward uniting their community health initiatives with the training of black doctors.<sup>6</sup>

However, while the value of the association of the IFCH and proposed Durban Medical School was recognised for its intrinsic worth in the medical sphere, this affiliation was also promoted to ensure the perpetuation and continuance of the progressive work done by the IFCH in an increasingly hostile society. While the earlier chapter dealt with the IFCH as a complex institution within the wider socio-political context of the segregationist era, this chapter is interested in the IFCH's increasingly difficult attempts and manoeuvres to survive (mainly through association with the proposed Durban Medical School's establishment), despite political attacks of a powerful racist Afrikaner National Government which came to power in 1948 based on the platform of "apartheid", involving fuller segregation of the races through more dogmatic, repressive legislative means. For the IFCH, these racist, central State ideas had postponed its creation, endangered its attempts to alleviate communities burdened under ill-health, and threatened its existence while in the full tide of its success. It was increasingly recognised that ways had to be found to associate the IFCH with a university institution, because the only way to

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<sup>4</sup> SAB, UOD, Vol. 1546, U3/40/4. NU College Establishment of Medical School for Natives. Letter from E.G. Malherbe to Dr Gluckman, Minister of Health re: Medical School for Non-Europeans: Durban, 5/5/1947, p.2.

<sup>5</sup> See UN Archives, Pmb. H6/2/3. Correspondence concerning Establishment of the Department of Family Practice. Letter from Dr. G.W. Gale to E.G. Malherbe, 12/7/1954, p.4, and Trostle. "Anthropology and Epidemiology in the Twentieth Century", p.64. In 1947, Kark was given overseas experience at the Institute of Social Medicine and Social Anthropology at Oxford with a Nuffield Fellowship, and in 1948 was given a Rockefeller Foundation Travelling Fellowship to visit U.S. health centres and to study their teaching methods in the social aspects of health and disease. Others, including John Cassel (Director of Pholela when Kark left), G.W. Steuart (Psychology) and Helen Cohn (Chief Public Health Nurse), were given fellowships in 1952 and 1953. Leave of absence was attained from the DH and granted with full awareness of the ultimate objective as explained by Secretary for Health, Dr George W. Gale.

<sup>6</sup> UN Archives Pmb. H6/2/3. Correspondence concerning the Establishment of Department of Family Practice. Memorandum by the Principal of the University to the Minister of Health the Hon. Dr. T. Naude, 13/4/1955, p.1.

protect the Institute from Government attack was by associating it with a tertiary academic institution, whose traditional autonomous status would protect freedom for research and training.

### ***Ideas for the Establishment of a Black Medical School in Durban.***

To gain a greater understanding of how and why the progressive social and community health movement managed to continue and even develop its innovative work in South Africa for another decade, despite increasing apartheid State hostility to its central philosophy from 1948 onwards, it's necessary that analysis be made of the early, but often parallel debates and institutional history of the establishment of the Durban Medical School, whose existence eventually facilitated and even promoted the continuance of the IFCH's work in a provincial, academic setting, and revolutionised the School's curriculum, placing it in the vanguard of other medical schools in South Africa and even the world.

The University of Natal's Medical School opened in Durban in 1951, and for more than two decades (until Medunsa was opened in 1976), was the only tertiary institution whose main concern was providing medical training for black students.<sup>7</sup> It has been praised by many for its high standards, attracting international recognition for its excellence in research and training, and for having trained more black doctors than any other university in South Africa. However the means used to reach this desired end by many of the people involved over its nearly five decades of history were, from the start, complicated, ambiguous, contradictory, and in many instances, unjust. Placed in the wider socio-political context of segregationist and later apartheid South African society in which it developed, the complex and ambiguous history which led to the Medical School's establishment will be discussed. From the beginning the Medical School has been shaped by the wider political struggles, and as Edgar Brookes argued, "this has been its misfortune, not its fault" to find itself continually in the vortex of apartheid politics.<sup>8</sup> Forced to develop in an increasingly hostile racist city in the 1950s, it will be shown how the Durban Medical School was both a protective haven for an elite group of aspiring black doctors, but was also caught up in and was influenced by racist ideas and often perpetuated them. The aim of the chapter is to trace the early development of black medical education in South Africa through the

<sup>7</sup> *University of Natal Medical School Reconciliation Graduation Booklet*. (Durban: Indicator Press, 1995), p.4.

<sup>8</sup> E.H. Brookes. *A History of the University of Natal Medical School*. (Pietermaritzburg: University of Natal Press,

history of an institution, conceived during segregation, born under apartheid and gestated by racial ambiguities and contradictions. This will not be merely an uncritical chronicle of the growth of the School, but also a critical analysis of the failings, weaknesses but also successes of an extraordinary institution. The School's establishment was only made possible after thirty frustrating years of discussions, deputations, delays, often under extremely difficult circumstances. It took courage and creativity from many of its pioneering founders, nearly fifty years ago, to bring the dream to fruition. For those pioneering doctors and other interested parties who recognised the urgent and vital need for a black medical school in Durban, it was always a struggle, an upward battle against a variety of different but powerful forces, often determined to see it fail.

This chapter is largely based on written archival material with all its accompanying challenges. These archives are based on the writings of white male authors with all the ambiguities of their power over what to say and what to silence, and factors which have influenced the production of many historical narratives to date.<sup>9</sup> Much of this chapter is based on "official" documents such as Government and UN letters, memos, minutes of meetings, speeches, newspaper reports and secondary sources. An analysis of the public history of this medical institution and the public figures who were involved has allowed me to get an important grip on some of the more complex, diffuse and overlapping discourses surrounding medical history and black education in South Africa. This forms the gravitational centre around which interesting personal histories, nuances and experiential day-to-day memories and records of past students and others connected to the Medical School will be used in the next chapter, to balance this chapter's largely one-sided archival perspective. Oral interviews of past students and other interested parties, will hopefully bring in the voices of black communities and women, whose lives bore the brunt of policy changes but who had little input into the formulation of these policies.<sup>10</sup>

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1966).

<sup>9</sup> Ralph Trouillot. *Silencing the Past: Power and the Production of History*. (Boston: Beacon Press, 1995), p.3. Also see Peter Novick. *That Noble Dream: The "Objectivity Question" and the American Historical Profession*. (Cambridge: Cambridge University Press, 1988), for arguments about the mirage of "objective" history, but rather that history is influenced by people's various points of view serving specific interests and purposes.

<sup>10</sup> See Isabel Hofmeyr. *We Spend our Years as a Tale that is Told: Oral Historical Narrative in a South African Chieftdom*. (Johannesburg: Witwatersrand Press, 1993) and Charles van Onselen. *The Seed is Mine: The Life of Kas Maine a South African Sharecropper, 1894-1985*. (Cape Town: David Philip Publishers, 1996).

## ***Growing Arguments for a Full Medical Qualification for Aspiring Black Doctors.***

Having analysed something of the broader context - political, medical and intellectual health debates and developments in State and medical circles - at a national level to try address the massive shortage of doctors and health personnel to alleviate the desperate burden of disease under which the majority of the segregated black population in South Africa laboured, this chapter will trace developments with regard to the provision of medical provisions and the training of black medical doctors in the more specific context of one institution - the establishment of the first black Medical School in the city of Durban, in the Province of Natal. As already shown, medical history demonstrates that ideological forces, political considerations and deep structural inequalities always mediated and shaped competing claims to egalitarian health service and from the start in Durban, the long discussions over a black medical profession became embroiled in the dominant political battles of the day, where the preservation and dominance of white political power determined how the resources of the community were distributed. Together with these issues, a key struggle shaping the establishment of the Durban Medical School were its founders' positions in relation to the long-standing debate over the training black doctors and health professionals at all, and if so, the acceptable qualifications and standards of professional training. From the start the question of black physicians struck at the core of the racially cast and elitist notions embedded in public and private medical organisations of the day. Opinion was split over the issue that progressive medics proposed: "unless and until a full university training in medicine was provided for non-Europeans they could not become medical practitioners".<sup>11</sup>

Throughout this chapter it will be shown how strong arguments for an inferior medical training degree in the early part of the century lost ground to the growing arguments from those determined to maintain the highest standards of professional training exactly comparable to white doctors. This is evident as far back as 1928, when the Loram Committee, when reporting on the "Training of Natives in Medicine and Public Health", insisted that there should be no dual standard of medical qualification in the Union, and more importantly no inferior medical degrees

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<sup>11</sup> I. Gordon. *Report on the Government's Intended Action to Remove the Faculty of Medicine from the University of Natal*. (Durban: Hayne and Gibson Ltd, 1957), p.5.

for blacks because the maintenance of good health required the same skilled treatment.<sup>12</sup> While nothing came of its recommendations, this view was bolstered when ten years later, the “Botha Committee”, appointed to investigate medical training in South Africa and recognising the inadequate provisions of existing medical schools, came to the conclusion that the “establishment of a separate medical school for non-Europeans in the future be envisaged; for this purpose we think Durban would be the most suitable centre”.<sup>13</sup> Unfortunately, its recommendations regarding Durban were delayed by the outbreak of World War II. As the years passed, it became clearly evident that a full medical training for blacks students would have to be provided in the future, and that anything other than a full training was not an option, as health care among all races required the same skilled treatment, while any lowering of medical qualifications would discredit South Africa’s internationally recognised medical qualifications. But, while the white male medical academy thus began to concur that an equal standard of training had to be provided for an elite group of black doctors, this training would have to occur through separate institutions that would train black doctors to serve “their own people”.

### ***“Liberals” in Natal and the Non-European Section of Natal University.***

Having already argued in a previous chapter that the existence of a variety of polarised views of South African politics and society were centred around the city of Durban, this milieu still managed to produce socially-conscientised individuals, especially doctors who reoriented the way modern medicine delivered health care to impoverished rural and urban communities through social medicine. One can view the Natal University College’s ambiguous and contradictory actions in its establishment of the separate but apparently equal “Non-European Section” during the 1930s in the same light. It is necessary to give a brief analysis of this separate “Non-European Section” of the Natal University (NU), as in years to come, this arrangement facilitated the establishment of the proposed Durban Medical School as a separate black medical faculty within a white university. It’s a telling commentary on the complexity of South African history, that while very racist and segregationist in character, it was still in Natal,

<sup>12</sup> Report of Committee appointed to Inquire into Training of Natives in Medicine and Public Health, U.G. 35, 1928.

<sup>13</sup> Gordon. *Report on the Government’s Intended Action*, p.5. However, the committee did not recommend the immediate establishment of a medical school for blacks as it was felt that the cost of providing a completely new medical school was not warranted by the small numbers of black students who matriculated. It instead catered for a new medical school in Pretoria. To address black medical needs, an abortive attempt was made to train black medical aids at Fort Hare, but the course floundered when the medical authorities of South Africa refused to

that “progressive” ideas took hold. As a negotiated theory and practice, segregation politics enabled white supremacy to survive and adapt in situations of uncertainty and change.<sup>14</sup> These racist and segregationist ideas in the years leading up to the establishment of the Durban Medical School had a huge impact on the form that it took. Paul Rich has done extensive research on the English-speaking intelligentsia during the 20th century, who played an instrumental role in the education sphere. He argues that many of them, far from being “liberal” in any wider understanding of the term, formed a deeply conservative strand, whose ideas helped to establish and sustain the ideology and political framework of racial segregation in the course of the 20th century.<sup>15</sup> It will be shown how these ideas found resonance in the particularly racist city of Durban, where increasing racial polarisation of the city through segregation and banishment of the black underclasses to the periphery, promoted unequal and circumscribed access to social, political and economic resources in the interests of the city’s white ruling minority.<sup>16</sup> But it’s also within the gaps and ambiguities in the very character of segregation ideology that white “liberal” educationalists in Natal were allowed to introduce changes and reforms in the tertiary education sphere, while still maintaining the hegemonic racial ideology of white South Africa.

It’s important to show the early university educational segregation developments in Natal to understand how they would facilitate greater acceptance of a black Medical School in Durban (and its affiliation with the IFCH) in years to come. When the N.P. came to power in 1948, with their aim to establish “proper relations” between the races, an important pull factor to establish a black Medical School in Durban, was the path already laid by the segregation formula which had been applied at the Natal University since 1936 (with its separate facilities for the higher education of blacks and whites).<sup>17</sup> This situation of segregated higher education in Natal was achieved mainly through the efforts of Dr. Mabel Palmer. Originally a Fabian by political

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recognise any inferior degree.

<sup>14</sup> See Saul Dubow. *Racial Segregation and the Origins of Apartheid in South Africa, 1919-36*. (London: MacMillan Press, 1989), p.180, and John W. Cell. *The Highest Stage of White Supremacy: The Origins of Segregation in South Africa and the American South*. (Cambridge: Cambridge University Press, 1982), p.18.

<sup>15</sup> See both of Paul Rich’s books, *White Power and the Liberal Conscience: Racial Segregation and South African Liberalism, 1921-60*. (Manchester: Manchester University Press, 1984) and *Hope and Despair: English-Speaking Intellectuals and South African Politics, 1896-1976*. (London and New York: British Academic Press, 1993). In his view, it was the limitations of white liberalism that sustained segregationist ideology for so many years, and which underpinned later racist Afrikaner nationalist “apartheid” ideology.

<sup>16</sup> Paul Maylam and Iain Edwards (eds). *The People’s City: African Life in Twentieth-Century Durban*. (Pietermaritzburg: University of Natal Press, 1987).

<sup>17</sup> See *Cape Times*, 21/2/48. “New University Applauded: Apartheid Formula in Natal”.

persuasion, Palmer was often to the left of liberal opinion in the city she made home for the majority of her life. Recognising the thirsty demand for tertiary education, and because the NU refused to allow mixed classes to be held on university premises, Palmer organised and set up a “Non-European Section” where lectures were first held at her own home and later at Sastri Indian College, where lecturers ran dual classes. Her reputation was widespread as “Africans and Indians, many of them from remote country areas, came by trains and slept in doorways ... to attend these classes”.<sup>18</sup> While Palmer had less to do with the founding of the Medical School, the very existence in Durban of segregated classes in other subjects must have been a determining factor in the Government’s decision to establish the first black Medical School in Durban.

Another key person who had a leading role to play in the establishment of the fourth Medical School in Durban was Dr. E.G. Malherbe, one of the country’s leading educationalists.<sup>19</sup> In 1945, Dr. E.G. Malherbe accepted the post of Principal and Vice-Chancellor of the Natal University College (NUC), where over a period of twenty years of great ferment in the South African academic world, he brought the NUC to independent status as a University, which expanded five-fold becoming the three campuses of Durban, Pietermaritzburg, and the “Non-European Section”. As Principal he presided over the founding of the Durban Medical School for “non-Europeans” in the face of much Government opposition. Malherbe appropriated and extended Palmer’s “formula” which resulted in him being congratulated by the N.P. for his “realistic” approach to race relations in Natal.<sup>20</sup> A careful reading of State and local archives reveals that the proposal for the establishment of the Durban Medical School was made more acceptable to the Nationalists when they came into power in 1948 because an Afrikaans-speaking man was elected as Principal.<sup>21</sup> At the Fifth Annual Meeting of the Convocation of the

<sup>18</sup> See “How non-European Classes began at Natal University”, *Daily News*, 15/3/57, and Mabel Palmer. File 35. KCM 18231. Letter from Mabel Palmer to Editor, *The Daily News*, 12 March 1957. Also see Vanessa Noble. “Ruffled Feathers”: The Lives of Five Difficult Women from Durban in the 20th Century. (University of Natal Durban: Honours Dissertation in History, 1997). Born in 1876 Victorian England, Mabel Palmer’s outlook on life was progressive for her time, as she was a member of the suffragette movement, but was also a Fabian Socialist. Influenced by G.B. Shaw and Sidney and Beatrice Webb, she was dedicated to gradual reform and improving society by non-revolutionary means. Here education had a vital role to play.

<sup>19</sup> Brookes. *A History of the University of Natal*, pgs 58-62.

<sup>20</sup> E.G. Malherbe Collection. Vol. 1 (Index). “A Short Biographical and Photographic Sketch”. Student enrolment increased dramatically when he became Principal from an initial 836 in 1945 to over 4500 when he retired in 1965.

<sup>21</sup> See “Man behind the Broederbond File”, *Daily News*, 3 October 1976, and “Malherbe’s latest book exposes the great laager” 5 May 1977, both in BIO P 3/2/5. SP 6/12/5 Cuttings E.G. Malherbe 3/10/76 - 13/5/81, Rich, *Hope and Despair*, p.51 and *Cape Times*, 21/2/48. “New University Applauded: Apartheid Formula in Natal”. Malherbe was the son of an Afrikaner Free State dominee and was sympathetic to the Afrikaner’s assertions and protection of

University of Natal it was argued in that we “cannot forget that the University of Natal went and chose an Afrikaner for it’s Principal”, in an English-speaking university and English-speaking province of Natal, where many English-speakers perceived a threat by the Afrikaner. As the Convocation speaker continued: “It is true that he is not a Nationalist ... [but] we did a very odd thing when we chose the present Principal. If anything we needed to proclaim us a South African university, this did so”.<sup>22</sup> When the University Act was read in Senate in 1948, Senator Dr. W.J. O’Brien, Chairman of the NUC Council argued that they were “most fortunate” to have obtained the services of Dr. Malherbe who had “done excellent work and it is mainly through his efforts that the College is now in a position to seek University status”.<sup>23</sup>

It’s important when analysing the NU “Non-European Section” and the development of the Durban Medical School as part of this segregated institution in a white university, to do so in the context of providing higher education facilities in a racist “multi-cultural” society. For while universities might regard themselves as leaders of society, they usually reflect the dominant features of societies around them, and often mirrors the worst prejudices of the dominant group. There were three higher education systems in operation in South Africa, two of which were unacceptable to Natal society at the time. The first represented completely separate universities such as the black University College of Fort Hare. As far as Malherbe was concerned, this system of providing training exclusively for black students resulted in problems of having to deal with stigmas of inferiority being attached to them as separate facilities of training and degrees.<sup>24</sup> The second option was that of the “mixed or open” universities of UCT and Wits which provided equal academic opportunities to a restricted number of black students.<sup>25</sup> However, this choice was an anathema to many whites in South Africa, who feared miscegenation and professional

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cultural identity. The years preceding the 1948 Afrikaner nationalist victory, were marked by as much anti-imperialist feeling as racism, and the struggle against British imperial domination gripped Afrikaners politically and intellectually. The Afrikaner language was made the main language of Government, but it was not strong enough to dominate the rest of the Union, where English remained dominant in business and commerce, and the English-language remained strong in white communities in Provinces such as Natal. Malherbe was a great promoter of Afrikaans-English bilingualism.

<sup>22</sup> Mabel Palmer. File 35, KCM 18254. Minutes of 5th Annual Meeting of the Convocation of UN held at City Building Durban 23 May 1953. “The Freedom of our Universities”.

<sup>23</sup> Brookes, *A History of the University of Natal*, p.69.

<sup>24</sup> E.G. Malherbe Collection, File 464/2, KCM 56990 (130). “Higher Education of Non-Europeans in South Africa”. *The South African Outlook*. Vol. 86, No. 1023, 2 July, 1956, p.103.

<sup>25</sup> Bruce K. Murray. *Wits the ‘Open’ Years: A History of the University of the Witwatersrand, Johannesburg, 1939-1959*. (Johannesburg: Witwatersrand University Press, 1997). The admission criteria of an ‘open’ university was supposedly purely academic, applied without regard to considerations of race, colour or creed, and that students of



competition from blacks gaining access to equal training.<sup>26</sup> The facilities were also overcrowded, while a policy of “academic non-segregation and social segregation” existed, where social colour bars limited “mixing” to purely academic not social activities.<sup>27</sup>

### *Malherbe’s “Natal Experiment”.*

Malherbe’s “Natal Experiment” represented a compromise of partial separation, by providing higher education to black students through the NU, with the same degrees, staff and exams, but on separate or parallel lines. As far as Malherbe was concerned, the policy adopted was entirely a practical one, dictated by the unique circumstances in Natal, and the desire to give black students the best possible facilities to obtain a higher education rather than a desire to discriminate against them.<sup>28</sup> Malherbe felt that Natal was in a unique position because it had the largest contrasting ratio of blacks to whites in any Province and differed from UCT and Wits, by catering for the largest group of black students as part of its student body, which within a few years would outnumber the white students.<sup>29</sup> He argued that the Natal case was also warranted because black students came to the university with considerable educational disadvantages, and it was necessary to provide for the raising of the level of education through smaller classes, and the maintenance of a slower pace, without slowing down, or lowering the standards of the rest of the University’s classes.<sup>30</sup> Malherbe also had to cater for a politically dominant white society that was largely opposed to the admission of blacks into their “white” universities.<sup>31</sup> He was forced to take into account the complexity of the racial and social situation and to separate classes to prevent educational facilities being jeopardised by the lowering of standards, loss of public faith,

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all races were taught in the same classes.

<sup>26</sup> Bruce K. Murray. *Wits the Early Years: A History of the University of the Witwatersrand Johannesburg and its Precursors, 1896-1939*. (Johannesburg: Witwatersrand University Press, 1982), p.300-302. This had helped to maintain the exclusivity of the white medical profession.

<sup>27</sup> Murray. *Wits the ‘Open’ Years*, p.xi.

<sup>28</sup> E.G. Malherbe File 465/3, KCM 56990 (170). Letter from E.G. Malherbe to The Editor, the *Times Educational Supplement* 12 May 1948. “Commission of Enquiry into Separate university facilities for non-Europeans 1953-54”.

<sup>29</sup> *Help your People: The Natal University Non-European Section: Appeal for Funds*. (Durban: Hayne and Gibson, 1953), p. 10. Also see E.G. Malherbe File 463/4/1. KCM 56990 (16)c. *Natal Witness*, Jan-Feb 1948. “Malherbe says non-European students will predominate at Durban”. The threat perceived by many whites of being “swamped” by blacks in Natal was based on the demography of the region. Within a 200 mile radius of Durban there were +/- 3 million blacks (90% African), representing a disproportion of 10 to 1.

<sup>30</sup> E.G. Malherbe. File 464/2, KCM 56990 (30). “Higher Education of Non-Europeans in South Africa”. *The South African Outlook*, Vol. 86, No. 1023, 2 July 1956, p.104. For Malherbe, this was not a reflection of inferior black intelligence but a recognition of poor educational opportunities and their home and other environmental factors.

<sup>31</sup> *Cape Times*, 21/22/48 “College worthy of New Status”.

loss of financial support and a loss of the best students who would not attend an “inferior” facility.<sup>32</sup>

When evaluating Malherbe’s choices and policies, it’s important to place him within the context of the society in which he lived. He was not a simple-minded racist. He was an ambiguous figure who had a rich experience and progressive ideas about education for his time, which helped to put the UN firmly on the academic map. But he also evinced a powerfully paternalist attitude towards blacks, especially with regard to providing higher education. He never once challenged the idea of separate development for all races and soothed his conscience by instead attempting the impossible: to ensure that separate remained equal. He believed it was the moral duty of upstanding white South Africans to lend a guiding hand in these kinds of institutions and gave an unquestioning commitment to the maintenance of white supremacy. Malherbe formed part of a range of figures in the liberal establishment whose political positions reflected the uncertainties of South African liberalism. But his political position must always be qualified as somewhat “progressive” in relation to the varying ideas in the “liberal” establishment of which they were a part, but also as “radical” in terms of Afrikaner NP perspectives, while at the same time “conservative” in relation to African nationalist views for not taking a stronger stand. Under his “liberal” influence and his university’s separate facilities for the races, the proposed establishment of the Durban Medical School would in time be easily facilitated within this complicated and ambiguous segregationist arrangement.

### ***World War II: A Climate of Health Reform and Black Radicalism.***

As previously discussed, World War II and the euphoria and optimism in the world at large, provided a window period of opportunity for social reform in South Africa, especially in the health sphere. A progressive thrust in the white, male-dominated medical academy saw a shift away from a focus on curative medicine of individuals in hospitals to “ethical” health, and raising the standards of community health through preventive, promotive and social medicine. It is within this liberal and progressive medical climate that the growing support for a black Medical School took shape. Increasing and strengthening black opposition politics during the war years, promoted a greater urgency and demand for the training of black doctors to address

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<sup>32</sup> *Help your People*, p. 11. Also, see E.G. Malherbe. File 464/2. KCM 56990 (123). Higher Education for Non-

the desperate health conditions for the majority of black South Africans. The influence of war-time industrialisation, urbanisation and proletarianisation pushed larger numbers of people who were suffering under the burden of poverty, disease and racist apartheid policies into closer proximity in urban areas, while the development of new State policies to control the threat to white power, promoted more radical resistance and protest. Increasingly, “old-guard”, conservative, elitist and accommodationist black leaders gave way to new black nationalist opposition politics and trade union activity which was revolutionary and mass-based, and who were determined to have their grievances heard. The wider decolonisation process in Africa and India also influenced this militancy. Many conservative and accommodationist leaders, such as A.B. Xuma in the African National Congress (ANC) at this time began to recognise the inadequacy of working with white liberals - as he argued:

no European is going to save the African people from disaster. They may help but one need not go to Parliament to serve the cause of better race relations. There are many Europeans - unsung heroes - who are doing their bit quietly. [But] the salvation of the African people from disaster is [through] the African himself through his organisations.<sup>33</sup> By the early-1950s, while the ANC and National Indian Congress were nationally

organising against new apartheid laws, in Durban, ambiguous educationalists such as Malherbe felt that the only way forward was through a gradual process of “acculturation”, where education would in time solve most of the racial problems.<sup>34</sup> While he recognised the weaknesses of his policy to “temper one’s idealism with ... realism”, for him this was the only “practical” way forward in a multi-cultural society.<sup>35</sup> Both Malherbe and Palmer, one from a liberal Afrikaner perspective and one from a Fabian Socialist background, were criticised by many people for keeping the races apart and preventing social interactions between the races. They were criticised

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Europeans in South Africa. “Seventh Congress of the Universities of the Commonwealth, 1954”, p.39.

<sup>33</sup> Rich. *White Power and the Liberal Conscience*, p.81. In 1927 Xuma returned to South Africa from the US after his studies. He was one of the few elite black South Africans who studied overseas and managed to get access to all the facilities denied to blacks in South Africa. He was a qualified medical practitioner by profession. See Bill Freund. *Insiders and Outsiders: The Indian Working Class of Durban, 1910-1990*. (Pietermaritzburg: University of Natal Press, 1995), for Indian politics and how it too became more militant during the 1940s under the pressure of white racism and African competition for urban jobs and space in the city. During the 1940s they launched a Passive Resistance campaign against the Asiatic and Land Tenure and Representation Act (Ghetto Act) and were influenced by the triumphs of the nationalist movement in India which culminated in its independence in 1947. This broadened the base of Indian political activism and was the largest political mobilisation of Indian people in South Africa.

<sup>34</sup> E.G. Malherbe. File 464/1. KCM 56990 (122). “Talk by Dr Malherbe on the Topic of Higher Education for Non-European Students in South Africa”, p. 11-13. Malherbe stressed the importance of education as a prerequisite for a change of attitudes in South Africa., and that it would be a gradual process.

<sup>35</sup> E.G. Malherbe. File 464/1. KCM 56990 (101). “Higher education for the Non-Europeans in South Africa: Natal University Plan to Meet a Growing Need”. *African World*, 19 November 1947, p.10-11.

for their “disservice” to black aspirations by what they saw as the limitations of white liberalism, and for “not step[ping] outside the assumptions of segregationism in this period ... intending to resolve the contradictions of segregation rather than challenge its premises”.<sup>36</sup> People such as Prof. Z.K. Matthews felt that the “non-Europeans section” was a mere capitulation to the existing social order and that Malherbe was pandering to the prejudices of whites. For Matthews, “tempering idealism with realism” was a tragic weakness of South African liberalism.<sup>37</sup> Others argued that separate facilities were not equal but instead boosted white superiority, while the discriminatory and segregated system of education was designed to support the political doctrine of white hegemony.

### ***The National Health Services Commission and Gluckman’s Support of a Black Medical School in Durban.***

Many of World War II’s progressive health reform ideals were captured in the 1944 National Health Services Commission (NHSC) report to ensure basic medical and health services to all members of the community.<sup>38</sup> When planning for the provision of an organised NHS, Gluckman played a vital role in promoting Durban as the site for a black medical school, and even after hearing strong claims for why the school should be located in Johannesburg under the aegis of Wits, he came to the conclusion that the “balance of evidence was in favour of Durban as the site of a medical school *primarily for non-Europeans, but also for those whose object is to serve non-Europeans*”.<sup>39</sup> It was his influence as Minister of Health, not his Minister of Finance and Education, J.H. Hofmeyr, who persuaded Smuts to favour Durban as the site. Dr Gale argued

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<sup>36</sup> Sylvia Vietzen. “Mabel Palmer and Black Higher Education in Natal, 1936-1942”, *Journal of Natal and Zulu History*, Vol. VI, 1983, p.107. For Palmer, the principal of “second best” was better than none, for what was in her view an impenetrable white racial prejudice. Following her experiences of the admission of women at British universities, she hoped that the staff would tire of repeating lectures and push for admission of blacks into ordinary classes. See Shula Marks. *Not Either an Experimental Doll: The Separate Worlds of Three South African Women*. (Pmb: University of Natal Press, 1987).

<sup>37</sup> “Segregation in Education? Four Views on Dr E.G. Malherbe’s Higher Education Experiment at N.U.C.” in *The Forum*. Vol. 10, No. 31, 1 November, 1947, p.25.

<sup>38</sup> Gluckman. *Abiding Values*, p.72, 359-361.

<sup>39</sup> See Gluckman. *Abiding Values*. p.116. and “Non-European Medical School”, *Natal Witness*, 16/11/45. For a number of years prior to the NHSC, there was increased competition between Johannesburg and Durban for the site of the Medical School for black students. As former Principal and Chancellor of Wits, Hofmeyr (in his position of Minister of Finance and Education) favoured Johannesburg and the link to Wits, as the better centre to ensure the highest standards. However, Hofmeyr was a person with a “combination of opposite roles”, as many of his “liberal” education policies were tainted by the need for economy. In this situation, he felt that the high cost of setting up a new, separate medical school did not warrant the small number of black students interested. It took great persuasive power on Gluckman’s part to change his mind.

that, this was a “notable example of his broad South Africanism”, and for all his past associations with Wits, he was still an advocate of “regionalism” because he recognised that two medical schools already existed in the Transvaal, and that the fourth should go to another province to promote a balance:

for undoubtedly the very presence of a medical school raises standards of medical care over the whole region of which it is the centre; he stressed also that coastal Natal being near-tropical, there were many diseases there which could be studied more fully than elsewhere in the Union; and stressed also its proximity to great African tribal areas as well as to the major portion of the Indian population.<sup>40</sup>

However, before the decision could be implemented, the Government changed parties in 1948. Gale argued that it was here that Gluckman’s influence mattered as the incoming N.P. found arguments as stated by Henry Gluckman in his official memoranda on the subject:

so compelling that, after some struggling with their preconceptions, they endorsed the decision. I don’t think there is anyone today, even in Johannesburg, who would question the wisdom of the decision - but it is not generally known, even in Durban, how important ... and how decisive a part was played by Henry Gluckman.<sup>41</sup>

### ***“The Medical School Committee”: Local Support for Durban.***

While it’s important to recognise the role played by State DH public health professionals at a national level, to promote Durban’s case, it’s also essential to recognise the city of Durban’s particular role in promoting their own interests in this medical school debate. The School was put into practice by a host of people within and outside the medical sphere, including: the medical profession, NU and NPA.<sup>42</sup> Early steps were taken by interested parties in Durban to ensure that the city would not be overlooked as the centre for black medical training. In 1944, the Council of the Natal University College gave its official support to the proposal to establish the Medical School under its control.<sup>43</sup> Local support for Durban was strong, and the public committed itself to raising £100,000. In 1945 a strong committee was formed, called the “Medical School

<sup>40</sup> Henry Gluckman. *Abiding Values: Speeches and Addresses*. (Johannesburg: Caxton, 1970), p.115. See B.T. Naidoo. “A History of the Durban Medical School”. *South African Medical Journal*. Vol. 50, No. 41, 25/9/1976, p.1625 for a discussion of why the Council for Scientific and Industrial Research (CSIR) supported Durban. It was largely on similar grounds to those given in the Gluckman Report.

<sup>41</sup> Gluckman. *Abiding Values: Speeches and Addresses*, p.116.

<sup>42</sup> “The Natal Medical School - 25 Years”. *South African Medical Journal*. Vol. 50, No. 41, 25/9/1976, p.1573.

<sup>43</sup> Gordon. *Report on the Government’s Intended Action*, p.5. The University of Natal only became known as such after it gained independent status in 1949. Before this, it was known as the Natal University College.

Committee” which played a huge role in sending deputations to the central State and persuading various ministers concerned.<sup>44</sup> Within the context of white hegemony and privilege, Malherbe and Palmer supported and played an active role in the establishment of a Medical School for black students in Durban and were determined to see the young NU succeed as it directly reflected on their achievements, especially Malherbe’s as Principal. For while the NU had grown rapidly, there was a lack of any outstanding feature to the NU in comparison to other universities in South Africa, and a black medical school had the chance of growing into an institution that would give the UN, under Malherbe’s leadership, a special character amongst the universities of the world.<sup>45</sup> As Palmer argued in 1947:

if Durban took advantage of this opportunity, it would become the university centre for the general and medical training of non-Europeans in the Union and the whole of East Africa.<sup>46</sup>

In opposition to Hofmeyr’s arguments in 1947, Malherbe as principal of NU, produced evidence in favour of Durban showing sufficient numbers of qualified black matriculants to guarantee an annual intake of forty students. Malherbe argued, “the medical profession did not share Hofmeyr’s view as the existing medical schools were incapable of catering for the expanding health needs of the country which were greatly overcrowded”.<sup>47</sup> What is interesting though, is that the medical profession in Natal, but also South Africa more widely, supported the scheme for a black medical school. Between 1945 and 1947, Durban received the backing of the Federal Council of the Medical Association of South Africa, which passed numerous resolutions supporting its establishment in Durban.<sup>48</sup> This show of support was in sharp contrast to events twenty five years before, where most members of the medical profession were against McCord and Taylor’s pioneering ideas to establish a black medical school in Durban, as well as the profession’s criticism and non-involvement in the progressive social and community health movement leading up to and including this period. The medical missionary endeavour in

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<sup>44</sup> Gordon. *Report on the Government’s Intended Action*, p.6. This Committee consisted of representatives of the NUC, Natal Coastal Branch of the Medical Association, the Union Health Department, and Natal Provincial Hospital Services. People such as Alan Taylor, E.G. Malherbe, Mabel Palmer, S.F. Bush and F.A. MacFadyen played an influential role on this Committee and the later establishment of the Acting Board.

<sup>45</sup> E.G. Malherbe. File 463/4/1, KCM 56990 (17)c. Medical School History and Establishment. *Witness*, 7th July 1955.

<sup>46</sup> “Commission of Natives: Medical School Discussed”. *Mercury*, 27/11/47.

<sup>47</sup> Letter from Malherbe to Gluckman, Minister of Health, 5th May 1947, SAB, UOD, Vol. 1546, U3/40/4, p.3.

<sup>48</sup> Medical School Archives. Letter from E.G. Malherbe to Dr Gluckman (Minister of Health), 5 May 1947,

promoting this black medical school was always strong. From as early as the first two decades of the 20th century, Dr James McCord and Dr Alan Taylor had an enormous influence in pioneering the idea and formulating proposals for the founding of a black medical school in Durban. When Taylor was appointed part-time Acting Dean of the new Medical Faculty in 1951, it was a fitting fulfillment of a worthy idea conceived through the missionary endeavour thirty years ago.<sup>49</sup>

### ***Further Delays: A Change in Government in 1948.***

After considerable pressure from local business and the medical profession, as well as broader interests of the Government's NHSC recommendations, the United Party (U.P.) Government under General Smuts approved in principle, in 1947, the establishment of the Medical School in Durban, under the aegis of the NU, "primarily for non-Europeans" but also for whites intending to practice amongst the black population. Smuts realised that it would be unfair to expect a young university institution, like Natal, to bear the responsibility for the establishment and maintenance of a Medical School primarily for non-Europeans, as it was not a "charitable institution ... this Medical School is a national institution and merits national support".<sup>50</sup> However, before the policy was implemented Hofmeyr died in 1948, and in the same year in the general election, Smuts's U.P. fell and the "apartheid" N.P. came into power under D.F. Malan. There were further delays in obtaining the necessary financial provisions from Treasury, and it was well over a year before the new N.P. Government confirmed the decision of its predecessors to establish a Faculty of Medicine in the newly constituted University of Natal in 1949. Thus, more than twelve years after the matter was taken up by the State and thirty years since the first attempts were made by individual pioneer doctors, the Medical School dream became a reality.

It will be argued that from the beginning, this School was shaped by wider political struggles. Forced to develop in an increasingly hostile racist city in the 1950s, the Medical School was an ambiguous and complex institution. While providing a progressive education to a small black elite, it was also caught up in and was influenced by racist ideas and even

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concerning "Medical School for non-Europeans: Durban", p.3.

<sup>49</sup> UN Archives H6/1/1. George Gale. "The Story of the Durban Medical School", 25/1/76, p.1.

perpetuated them. The School's growth under "progressive" and democratic post-war influences but under an racist apartheid regime made South Africa a pariah State. In 1944, Major L. Byron declared:

it is a tragedy that our local efforts to tackle any human problem are usually balked by racial intolerance in some form or another. Sometimes I wonder if we, in post-war South Africa will be able to rise to the World Freedom which we are fighting for; or ... are doomed to perish in the midst of petty racial prejudices while the rest of the Human Family marches on to progress.<sup>51</sup>

### ***Financial Strings: Greater State Involvement in University Education.***

While the new Afrikaner N.P. State was racist in character and intent on segregation of races in all spheres, they still, importantly, recognised the need for full medical training for black doctors to meet the desperate shortage in both rural and urban areas. The earlier policies of higher education based on "language-grouping" were replaced with separate "race-grouping" training, and while intrinsically irrelevant to combating disease, became the overriding policy of the State. Malherbe criticised this situation as blatantly against a doctor's Hippocratic Oath to render medical service where needed, and asserted that:

patient-doctor quotas [thought of] in terms of compartmentalised racial groupings ... makes South Africa not only unique, but also ridiculous in the eyes of the medical world.<sup>52</sup>

However, a firm commitment to the implementation of "apartheid" did not mean that the N.P. had a systematic "grand-plan" for the future.<sup>53</sup> In fact, its hold on power in the first few years was precarious, and racist Afrikaner politicians were still sensitive to international criticism and portrayed apartheid as a "positive" policy designed to minimise racial conflict by allowing blacks to develop fully their own cultures in their own areas.<sup>54</sup> It was only with a greater

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<sup>50</sup> Gordon. *Report on the Government's Intended Action*, p.7.

<sup>51</sup> Letter from Major L. Byron to the Administrator of Natal on 10th July 1944, "Re: Proposed School of Medicine: Natal University College". SAB, UOD, Vol. 1546, U3/40/4.

<sup>52</sup> E.G Malherbe. File 463/7/3, KCM 56990 (74). "Medical Apartheid" by Malherbe, *Daily News* 7 June 1972. p.5.

<sup>53</sup> Dubow. *Illicit Union*, p.275. See Deborah Posel. "The Meaning of Apartheid before 1948: Conflicting Interests and forces within the Afrikaner Nationalist Alliance", in Beinart and Dubow. *Segregation and Apartheid in Twentieth-Century South Africa*. (London and New York: Routledge, 1995). Posel argues that apartheid was not a unitary ideology embodying a preconceived "grand plan", but represented conflicting interests in the Afrikaner nationalist movement and its hold was more fragile than apparent. See Chapter Two.

<sup>54</sup> Dubow. *Illicit Union*, p.276. Afrikaner nationalists were careful not to use explicit racist formulations in the first



electoral victory in 1953, that the N.P. tightened its hold on power and extended its control to more areas. This lack of any “blueprint” had an enormous influence in the higher education sphere, and bought the “open” or “mixed” universities - which were an anathema to the N.P. - time to continue their policies as a hesitant and uncertain State experienced much resistance from South African universities to State interference.

The new debate concerning educational and medical considerations became increasingly subordinate to political concerns. What was different in Malan’s campaign (in comparison to Smuts’) was that the N.P. stressed that the establishment of a School in Durban would be *primarily for non-Europeans*. This racial exclusivity in medical education showed the Government’s increasing interest in controlling higher education facilities during the 1950s. Its interest through greater financial contributions and support tied it much more intimately to the affairs of the Durban Medical School. However, from the beginning, the UN placed itself in an ambiguous relationship with the State, as the UN only agreed to establish and run the School on the agreement that the State would be financially responsible for the costs of the building, equipment and annual running expenses. A special subsidy was applied to finance the Medical School separately to the UN, whereby the State would meet a major part of the capital expenditure and total cost of the UN’s running expenditure.<sup>55</sup> However, this was only granted on condition that no white students be admitted to the black Medical School. A lengthy exchange of correspondence ensued between the UN and Department of Education, which have been reproduced in the Gordon Reports, showing how an ambiguous compromise was reached. On 12 September 1950, J.H. Viljoen, Minister of Education wrote to the UN and argued that:

university education should not be and is not State education. It is justly only subsidised education. Nevertheless, in the case of the Medical School for non-Europeans in Natal, the Government has departed from its normal subsidy basis and assumed what is virtually full financial responsibility for the initial stages, as it fully realised that the young and

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few years and withdrew from pro-Fascist sentiment that was evident during the war.

<sup>55</sup> UN Archives, Pmb. H6/2/2. Medical School. Advisory Committee. Estimates and Expenditure 1955. “University of Natal Subsidy for a Trifocal University”, 2 April, 1955, p.1. At the time of the Medical School establishment, the UN was already extended beyond its limit by running the dual campuses of Pietermaritzburg and Durban, as well as the additional costs of running the “non-European section” which was physically separated from the “white” Howard College campus. Thus UN was a three-centred and biracial institution, but only funded as single institution. A special grant had to be allocated as it was impossible to finance the School as part of the UN on the basis of the existing formula based largely on fee income, which the majority of black students could not afford.

growing University could not tackle this major task on a normal subsidy basis ... the Government went out of its way to grant most liberal financial aid.<sup>56</sup>

As far as the State was concerned, this financial grant entitled it to “introduce safeguards” to ensure that public funds made available for black education was applied to this purpose only.

### ***UN Opposition to Government Interference in University Autonomy.***

While these State “financial strings” had a direct impact on determining the admissions criteria and the internal politics of the School, it will be argued that this was never an uncomplicated process. In response, the UN Council fought the State’s “unqualified acceptance” that no white students be allowed to enrol, but constantly from its ambiguous racial position. It argued that it was its policy to provide separate teaching facilities for different racial groups and that “the Council d[id] not intend to depart from its general policy in this matter”.<sup>57</sup> It also argued that it was not the intention of the UN to compete with the three existing white medical schools, but that the School was designed “primarily” for black students. However, the UN felt strongly that in “exceptional cases” - where white students wished to work amongst black communities - whites should be allowed to enrol. They maintained that the Medical School would also offer excellent postgraduate research opportunities into African tropical diseases, which would be a cheaper option than going overseas and would enhance the status of the School by offering superior research possibilities. The most important point of contention was what the UN viewed as State interference with their autonomy - it “abrogat[ed] the right entrenched in the University Act, which alone had the power to decide who shall be admitted to the University”.<sup>58</sup> However, while the UN continued to fight against the threat of growing State interference, it was forced to accept the State conditions, or else all the delays and hard work to secure the Medical School would have been to no avail. It thus accepted the face-saving condition in respect of undergraduate students with the proviso that, “subject to agreement by the Minister of Education, postgraduate European students might be admitted”.<sup>59</sup> The UN had lost its ambiguous fight against State control, during this round. It would fight harder on other issues.

<sup>56</sup> Gordon. *Report on the Government's Intended Action*, p.29. Letter from the Secretary for Education, Arts and Science to the Principal of the UN on 12 September 1950 concerning the “non-European Medical School”.

<sup>57</sup> Gordon. *Report on the Government's Intended Action*, p.29 Appendix 1. Letter from E.G. Malherbe to the Secretary for Education, Arts and Science on 26 August 1950 concerning the “Non-European Medical School: UN”.

<sup>58</sup> Gordon. *Report on the Government's Intended Action*, p.29.

<sup>59</sup> Gordon. *Report on the Government's Intended Action*, p.31. Letter from E.G Malherbe to the Secretary for

### *Other Financial Contributions.*

By the end of 1957 total capital expenditure for the School in respect of buildings and equipment amounted to £503,600. Of this sum the State provided £407,000 for the building and fixed equipment and a further sum of £56,000 for movable equipment.<sup>60</sup> A shortfall of £40,000 was obtained from funds raised by the Natal University Development Foundation who had gained donations from the general public.<sup>61</sup> It's important to realise that other organisations and private bodies also recognised the importance of having a black medical school in Durban and financially contributed to its establishment. The Natal Provincial Administration (NPA) made a huge contribution to the establishment of the School in Durban. It provided three acres of land immediately adjacent to King Edward VIII Hospital, for the building of the School. King Edward, which fell under the NPA, became its teaching hospital - the largest "non-European" hospital in the Union, whose site linked central Durban to the industrial area at the head of the Durban Bay, and to the extensive African and Indian residential areas to the South and West of the city.<sup>62</sup> A white magazine described the Hospital as a "national" institution providing medical care for black communities from all over the Union:

a motley crowd of people are daily admitted to the outpatients and casualty wards. Their clothing varies from colourful Zulu tribal dress, brightly coloured Indian saris, beads and skin drapery, to the plain Western dress of the business and professional men.<sup>63</sup>

As a teaching hospital it provided a sound training for undergraduates. It was staffed by leading physicians and surgeons, equipped to meet the needs of modern medical science and had vast quantities and varieties of clinical material for practice and research. The urgency for starting

Education, Arts and Science on 25th November 1950. Although the UN persisted in opposing such limitations to their admissions policy, no white student, either under- or postgraduate were admitted to any course of the Medical School during this period.

<sup>60</sup> Medical Association of South Africa. 41st South African Medical Congress, Durban, 16-20 September, 1957, p.107

<sup>61</sup> *The Durban Medical School of the University of Natal: A Challenge to the Response of Africa*. (Durban: Hayne and Gibson Ltd., 1954), p.27. This represented a shortfall from the original promise of £100,000 to be raised by the general public. This money was to supplement State finances to provide extra bursaries and research facilities. Funds were also raised from overseas bodies such as the Rockefeller Foundation, the Nuffield Foundation, Chamber of Mines and other commercial and industrial businesses.

<sup>62</sup> *A Challenge to the Response of Africa*, p.27.

<sup>63</sup> "Hospital Serves Non-Whites", *South African Panorama*, February, 1962, p.17. King Edward Hospital had +/- 600,000 outpatients and 70,000 other patients treated p.a. It also had the largest maternity hospital ward in South Africa.

clinical training for the first group of students in 1955, forced the UN and the NPA to confront the difficulty of grafting the new School onto the established hospital. After protracted negotiations an agreement was reached where certain joint posts would be shared between the hospital and the medical faculty, as well as shared services, accommodation, equipment, facilities and costs.<sup>64</sup> The NPA thus made great financial contributions towards the maintenance and development of the Medical School both directly and indirectly.

While State support was necessary for the School's establishment, it was also recognised that finances had to be raised from other sources to supplement this. In 1951 Taylor appealed to the Durban public and private institutions to support the new School, as it would not come as an outright gift, "its citizens would have to want the School sufficiently to contribute towards its erection".<sup>65</sup> Arguments were made on humanitarian and utilitarian basis. Appeals were based on welfare arguments to improve the burden of poverty and disease that disadvantaged black communities were forced to suffer under. It was also argued that it was the responsibility of employers in industry and commerce - who relied on a strong and healthy black labour force for economic development - to contribute towards the establishment of a service providing better health care which would result in greater efficiency and productivity. Large donations were received from the Chamber of Mines, Commerce and other industries to promote a healthier labour pool in all spheres.<sup>66</sup>

Financial support for the School was also obtained from the black community, whose health would directly benefit from its existence. In October 1954, £2,200 was collected by Zulu Chiefs in response to appeals by King Cyprian Bhekuzulu, and in an elaborate ceremony, was handed to the School by the Zulu king.<sup>67</sup> According to Brookes, the Chiefs were received by the staff in full academic dress and by the black students in white overall coats. Speeches were made

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<sup>64</sup> Gordon. *Report on the Government's Intended Action*, pgs 8-9 and 35-37. A Committee of Inquiry to "Investigate and Report on the Medical Staffing Conditions of the Provincial Hospitals in Durban" was set up. The teaching duties and clinical care of patients were to be shared. See Gordon Papers. File 23, KCM 25927. UN Medical School. Miscellaneous. "Recognition of Hospitals by the SAMDC" by Dr. Gale, 5/1/55. Dr Gale stressed the importance of teaching hospitals to maintain the highest standards because "upon the standards of teaching hospitals depends the standards of the practice of medicine in the future".

<sup>65</sup> *Natal Mercury*, 5/1/48. "Natal must Contribute Liberally: Government View on Medical School".

<sup>66</sup> SAB, UOD, Vol. 1546, U3/40/4. Non-European Medical School. Minutes of the Meeting in the Mayor's Parlour, City Hall, Durban, on the 13th November, 1945, p.3. The Chamber of Mines donated £50,000, which was originally part of the subvention for the "Medical Aid" training scheme at Fort Hare, which collapsed. The money was transferred to Durban.

by the King and by Dr. G.C. Scully, Chairman of the Natal University Development Foundation (NUDF). This event showed the goodwill of the community, as money was gathered in small amounts from many Zulu people. Contributions were made from the lowest and poorest to the more wealthy.<sup>68</sup> This ceremony represented a joint effort between the State and the public, the NPA and UN and between white and black. Brookes argued, it showed a willingness and co-operation of both races to share in the responsibility of providing health and education services. The meaning of the School for ordinary Zulu people is unknown, but one could suppose that their participation in the ceremony was an affirmation of their faith in the endeavour, and an acceptance of the School as their own.

The provision of Indian medical training in Natal was in the beginning hindered by opposition from the Native Affairs Department (NAD), Chamber of Mines and Sugar Industry to contributing to a School to which Indians would be admitted.<sup>69</sup> The arguments to fund the School based on utilitarian reasons held no sway with these industries that did not depend on Indian labour for their prosperity. In 1945 Malherbe argued that such a School “should be *predominantly but not exclusively* for non-Europeans ... there should be no racial discrimination e.g. against admitting Indians”.<sup>70</sup> His arguments persuaded many business, medical and lay people at a meeting in November 1945 where a motion was passed that immediate steps be taken towards the establishment of a medical school in Durban, to “be designed primarily for the medical education of the Bantu, *with this proviso, that no person be excluded from attending on the grounds of race or colour*”.<sup>71</sup> He argued that a School *exclusively* for “Bantu” would be a mistake, as many Indians were wealthy and could contribute to the School, but could also benefit from medical training that was “practically on their doorstep”.<sup>72</sup> Instituting a general scheme of bursaries for Africans would ensure their predominant numbers. Indian leaders from the Natal

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<sup>67</sup> Brookes, *A History of the University of Natal*, p.84.

<sup>68</sup> E.G. Malherbe Medical School History and Establishment. File 463/4/1 KCM 56990 (13). “Address at Medical School Opening July 1955”. p.3. Small donations were gathered from many people, e.g. a 10/- note donated by a washerwoman mother of a student of Alexandra Township, and parents of another Johannesburg African student donated £2.2.0. It’s important to note that £2,000 was also raised in the Transkei Bunga. Again this shows the importance of the Durban Medical School as a national institution catering for the needs of South African black communities more widely. The Xhosa elite also felt that the School was a worthy cause and thus helped raise funds.

<sup>69</sup> SAB, UOD, Vol. 1546, U3/40/4. Letter from the Chairman of the Medical Association of South Africa (British Medical Association) Natal Coastal Branch to Minister of Finance and Education, Mr. Hofmeyr, 21st April 1945.

<sup>70</sup> SAB, UOD, Vol. 1546, U3/40/4, p.1. Letter from Malherbe to Hofmeyr, 13th July 1945.

<sup>71</sup> *A Response to the Challenge of Africa*, p.7.

<sup>72</sup> SAB, UOD, Vol. 1546, U3/40/4, p.2. Letter from Malherbe to Hofmeyr, 13th July 1945.

Indian Congress (NIC) attacked Malherbe's segregation policy for worsening race relations. They argued that he could not expect Indians to contribute to an institution "which has closed its doors on them", and warned people not to naively "swallow ... his sugar-coated pill".<sup>73</sup> Still others argued that segregated facilities were better than none. Despite initial opposition from within their own Indian communities to having Indians in the Medical School, many undertook a drive to collect money for the School. The Indian community in Durban raised £6,000. Thus, in matters of health care and disease control, it is interesting to note that instead of promoting strong "indigenous" African and Indian Ayurvedic traditional medical systems as a counter-point to white racial hegemony, black leaders in the intensifying atmosphere of apartheid South Africa emphasised a different route. Western, modern biomedical traditions spread across the world at large after World War II. In South Africa this medical tradition, one of whose more progressive principles was the right of all people to basic medical care, won favour amongst black communities, and helps to explain the support the King Edward Hospital and the black Medical School garnered.<sup>74</sup>

### ***Durban: An Advantageous Site?***

Before analysing the contradictory and ambiguous internal racist policies and practices, but also progressive curriculum developments that together influenced the initial development of the Medical School, it's essential to explore the factors, which determined why it was in Durban that, the Medical School was established and developed. Here analysis will be made of Durban proponents' own arguments of its apparent lack of competition with other established medical faculties in South Africa, as well as its long-established medical profession and facilities, its amazing geographical and climatic situation for enormous research potential, and perhaps most importantly, its already well-established IFCH, to which the medical training of black students could be promoted in the desired field of general and preventive medicine to alleviate the huge burden of disease in their own communities. This affiliation was essential as it ultimately facilitated the continuance and even expansion of the progressive social and community health care movement in an academic institutional setting, away from the limiting influence of the State's DH. I will show how during the 1950s, located in just one Department in an institution in

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<sup>73</sup> "N.U.C. Chief's Medical School Plan Attacked". *Mercury*, 10/7/47.

<sup>74</sup> Refer to Chapter One.

the Province of Natal, the IFCH and its philosophy revolutionised this medical curriculum, and led the Medical School for a short time to international distinction as a progressive social, preventive and community health training facility, despite increasing attacks by the conservative and racist central Nationalist-dominated State's DH which aimed to undermine its radical work.

Many proponents who pushed for the establishment of a black medical school in Durban, argued for the strength of Natal's long-established body of several hundred medical practitioners, whose experience and advice of local conditions could be drawn upon by the fledgling Medical School from the beginning.<sup>75</sup> There were also a number of long-established hospitals and municipal clinics already established to serve the needs and provide sufficient material for the requirements of this medical training. It was also maintained by these advocates, that because the NU, as an academic institution, was prepared to accept control and responsibility for the School's functioning, it would guarantee the highest standards of teaching, as the wider sub-structure of the general sciences and humanities faculties would provide successful professional training and advanced research to supplement the biomedical focus.

### ***Geographical and Climatic Suitability.***

The claims for Durban were also strengthened by what medical researchers saw as its wealth of local clinical material unrivalled anywhere in South Africa.<sup>76</sup> Proponents argued that the School, if placed in Durban, would provide research in a heterogeneous area where a western educated population with a highly developed infrastructure existed side-by-side with a vast number of black communities of African and Indian origin. It was favourably situated as it provided within a small geographical area, abundant material for study and demonstration in almost every variety of racial, social and economic background in both densely populated urban and adjacent rural environments.<sup>77</sup> Added to this, Durban was the major seaport and airport on the East African seaboard of the Indian Ocean, which would provide rich and diverse sanitary service experience in public health work.<sup>78</sup> Climatically, the city was situated in a sub-tropical

<sup>75</sup> *A Response to the Challenge of Africa*, p.23.

<sup>76</sup> SAB, UOD, Vol. 1546, U3/40/4. NU College for Establishment of Medical School for Natives, 1945-48. Fourth Medical School in Durban, p.8.

<sup>77</sup> SAB. UOD, Vol. 1546, U3/40/4, 1945-48. NU College Establishment of Medical School for Natives. Summary of Representations for the Establishment of a Fourth Medical School (primarily for Non-Europeans) at Durban, p.3.

<sup>78</sup> SAB. UOD, Vol. 1546, U3/40/4, 1945-48. NU College Establishment of Medical School for Natives. Summary of Representations for the Establishment of a Fourth Medical School (primarily for Non-Europeans) at Durban, p.3.

environment productive of diseases of both temperate and tropical climates where unique research work into Natal's major regional health problems such as malnutrition, T.B., malaria, bilharzia, hookworm, dysentery and others could be carried out without rival anywhere in the world.<sup>79</sup> It would thus attract students from other African countries interested in research and training in tropical diseases but who lacked the training facilities and large hospitals to make such a training possible. It also offered facilities for the study of industrial medicine and hygiene in a great variety of industries.<sup>80</sup> Durban also provided a unique opportunity to analyse social and economic, as well as trans-cultural differences in the incidence and management of disease.<sup>81</sup> As far as Prof. S.F. Oosthuizen, President of the South African Medical and Dental Council was concerned, it would raise the standard of medical practice and research in Natal:

not only is the Durban School in an enviable position with regard to making contributions towards medical science and the health of mankind by virtue of its unparalleled opportunity for research, but also because its students will have to go into the front line of the fight against disease among such a large percentage of population of this country.<sup>82</sup>

***A Vital Precedent to the Medical School - A New School with a New Focus to Address Different Health Needs.***

Possibly one of the strongest arguments used in bolstering support for locating the new black Medical School in Durban, was that the city had already been chosen for the IFCH (located at Clairwood six kilometres away) which formed the training institute for the State's national health centre-based service, into which it was envisaged that later fully trained black doctors would also be absorbed.<sup>83</sup> The IFCH had a well-organised system of health centres, which provided a basic training to health auxiliaries, doctors and nurses, and a service in preventive family and social and community medicine to black communities in desperate need of health

<sup>79</sup> SAB, GES, Vol. 2957, Ref. PN5. Native Medical Aids. The Durban Medical School. 15/5/1952, p.4.

<sup>80</sup> SAB. UOD, Vol. 1546, U3/40/4, 1945-48. NU College Establishment of Medical School for Natives. Summary of Representations for the Establishment of a Fourth Medical School (primarily for Non-Europeans) at Durban, p.4. These industrial problems included heavy work in a climate with a high humidity, analysis of migrant labour systems, high absenteeism and industrial accidents.

<sup>81</sup> A Response to the Challenge of Africa, p. 23. Also see Memo on the Question of a Fourth Medical School, p.2.

<sup>82</sup> A Response to the Challenge of Africa, p.16.

<sup>83</sup> See UN Archives, Pmb. H6/2/3. Correspondence concerning Establishment of the Department of Family Practice, 1953-1955. Arguments Against Closure of the Institute of Family and Community Health, p.2 and SAB. UOD, Vol. 1546, U3/40/4, 1945-48. NU College Establishment of Medical School for Natives. Summary of Representations for the Establishment of a Fourth Medical School (primarily for Non-Europeans) at Durban, p.3.



care, which would also provide abundant material for the requirements of medical training.<sup>84</sup> It was felt by those in the State's DH, that this fourth Medical School, if established in Durban, would then come under the influence of this IFCH and thus develop along new lines in the history of medical education, whereas an additional school at Wits or UCT would merely be a replica of the existing schools.<sup>85</sup> And, more importantly for white supremacists in the State, this new medical orientation would ensure that there would be no competition with established "white" medical schools in terms of provision of student numbers, staff and clinical material, as well as provide no competition on racial grounds, but rather fill the health care void by providing fully trained black doctors who would service their own areas.<sup>86</sup>

Thus, as the years progressed, ways were increasingly sought by the pioneering doctors in the IFCH and progressive public health professionals in the State - who were close to decision-making and aware of the growing conservative shifts in politics - to affiliate this essential social and community health research and training facility in its legitimate sphere of an academic institution, where it would be free to develop and advance under the influence of the academic researchers and teachers, not the Government. As early as 1944, Gluckman, in developing South Africa's national health services system, foresaw that the IFCH would provide facilities and contribute in concept and practice to the development of the first black Medical School training in health centre practice. He thus promoted Durban as the ideal site for full medical training, as it was envisaged that the majority of black doctors would be attracted to enter a general, health centre type service to be established among their own health-needy communities and away from expensive hospitals.<sup>87</sup> Although his tenure as Minister of Health was short-lived by a change in Government, Gluckman together with his Secretary of Health, Dr George Gale, ensured that the health centres service was so well established when they left the

<sup>84</sup> See SAB, UOD, Vol. 1546, U3/40/4, 1945-48. NU College Establishment of Medical School for Natives. Summary of Representations for the Establishment of a Fourth Medical School (primarily for Non-Europeans) at Durban, p.4, SAB, UOD, Vol. 1546, U3/40/4. NU College for Establishment of Medical School for Natives. Memo on the Question of a Fourth Medical School, 1/10/1947, p.3 and SAB, GES, Vol. 2957, Ref. PN5. Native Medical Aids. The Durban Medical School. 15/5/1952, p.3.

<sup>85</sup> SAB, UOD, Vol. 1546, U3/40/4. NU College for Establishment of Medical School for Natives. Memo on the Question of a Fourth Medical School, 1/10/1947, p.3.

<sup>86</sup> Gordon. *Report on the Government Intended Action*, p.7.

<sup>87</sup> See Gluckman. *Abiding Values: Speeches and Addresses*, p.508, SAB, GES, Vol. 1831, Ref. 68/30. Medical and Dental Training for Natives, Gale (S. for H), 7/11/1951, p.1 and UN Archives, Pmb. H6/2/3. Correspondence concerning Establishment of the Department of Family Practice. Memorandum on the Establishment of a Department of Family Practice by Dr. G.W. Gale, 10/8/1953, p.5. Gluckman hoped that the great increase in personnel to carry

public health service, that the movement continued to develop almost under its own momentum for years thereafter.<sup>88</sup>

Gale's role in a ministerial position but also later as Dean of the Durban Medical School, played a pivotal role in every stage of health centre development and planning from its early days at Pholela and in uniting the fledgling Medical School with the IFCH.<sup>89</sup> Whereas initially, the UN was not in a position to assist in the establishment of the IFCH while the Medical School was still in its formative period of development, during the early-1950s, on account of the Durban Medical School which it was now sponsoring, the UN became very interested in the future of the IFCH and aimed to bring it into line with other independent research and educational institutions to continue its work.<sup>90</sup> In 1952, Gale relinquished his post as Secretary for Health to become full-time Dean until 1955, to address to the enormous problems attendant upon the development of an entirely new Medical School for black students. As Chief Health Officer for the Union and Secretary for Health, Gale was at the forefront of health planning and played an influential role at a national State level to provide better health services for black communities, promoted full medical training for blacks, and welcomed the chance to become the first full-time Dean of a black medical school to watch over its planning and building. Like Gluckman, Gale was also a very persuasive politician, he won many people over to his beliefs by his broad "South Africanism" and national concern.<sup>91</sup> When referring to Gale's arguments for a Medical School in Durban at the NHSC, his life long partner, Audrey Gale argued, "George fought a hard and successful battle to have it established in Natal ... [and] had agonising discussions with the authorities, Chiefs, Hofmeyr to have it placed in Durban and not Joburg,

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out preventive services would ultimately result in a decreased need for doctors to practice curative medicine.

<sup>88</sup> Gluckman. *Abiding Values: Speeches and Addresses*, p.510.

<sup>89</sup> UN Archives, Pmb. H6/2/3. Correspondence concerning Establishment of the Department of Family Practice. Letter from G.W. Gale to Department of Health, 5/11/1952, p.1.

<sup>90</sup> See UN Archives, Pmb. H6/2/3. Correspondence concerning the Establishment of Department of Family Practice. Letter from W.A. McIntosh to Dr Gale. Tentative Docket Item Durban Medical School, University of Natal Union of South Africa, 17/5/1954, p.4 and UN Archives, Pmb. H6/2/3. Correspondence concerning Establishment of the Department of Family Practice. History and Future of the IFCH, Clairwood, Durban by G.W. Gale, 1/6/1954, p.1.

<sup>91</sup> Gluckman. *Abiding Values*. p.115. Because there were already two medical schools in the Transvaal and one in the Cape, Gale argued that the fourth should go to another Province to help raise the health care provision and standards of Natal. Gale was directly involved in, or gave evidence before many of the Government Commissions during the 1930s and 1940s concerning whether "non-Europeans" should be trained as doctors, and the standard of their training.

which the Wits people wanted”.<sup>92</sup> Gale’s views are evident in the case he presented at the NHSC, as he argued:

for the suitability of Durban as the site for the fourth medical school, which is non-racial in character, open to Natives, Coloureds, Indians and Europeans particularly those who would devote themselves to work among the non-European population.<sup>93</sup>

According to Sidney Kark, Gale contributed to some of the most notable developments in social medicine in the world, as he was important at a time when their social and community health ideas were by no means accepted by the majority of medical practitioners or even by all members of the DH, and his constant vigilance and reasoned defense of health centres was decisive.<sup>94</sup> When he accepted the invitation to become Dean he thus had extensive experience in the organised public health services and had acquired first hand knowledge of the conditions under which the majority of graduates of the Durban Medical School would practice, and was one of the best people to help develop a sound and effective black medical education.<sup>95</sup> As Dean, he also importantly ensured, that the IFCH was consolidated as part of the Department of Social, Preventive and Family Medicine in the Faculty of Medicine at the UN.<sup>96</sup>

### ***Three Way Negotiations to Affiliate the IFCH to the Durban Medical School.***

Together with Gale’s individual role, this section will be concerned with understanding how the new Medical School in Durban, with the financial aid of an international philanthropic agency - the Rockefeller Foundation - became affiliated to the IFCH, with its emphasis on integrated family and community preventive and curative medicine - as an integral teaching health centre to the newly founded School’s Department of Social, Preventive and Family Medicine - an association that existed in no other South African medical school at that time.<sup>97</sup>

<sup>92</sup> E.G. Malherbe. File 463/4/2, KCM 56990 (38) Letter from Audrey Gale to E.G. Malherbe 3/4/76. He won support from Dr Stals, (new Minister of Health), the Federal Council of the Medical Association of South Africa and the CSIR.

<sup>93</sup> UN Archives Pmb. H6/1/1. Gale, “The Story of the Durban Medical School”, p.4.

<sup>94</sup> Shula Marks. Public Health Then and Now. South Africa’s Early Experiment in Social Medicine: Its Pioneers and Politics. *American Journal of Public Health*, March 1997, Vol. 87, No. 3, p.453.

<sup>95</sup> *A Response to the Challenge of Africa*, p.33.

<sup>96</sup> Marks. “Public Health Then and Now”,

<sup>97</sup> See SAB, GES, Vol. 1831, Ref. 68/30. Medical and Dental Training for Natives, Gale (Secretary for Health), 7/11/1951, p.2, “The IFCH: Summary of the Report of the Medical Officer-in-Charge for the year ending 30 June 1950”. *South African Medical Journal*, 24 November 1951, p.871, and UN Archives, Pmb. H6/2/3. Correspondence concerning Establishment of the Department of Family Practice. Memorandum on the Establishment of a Department of Family Practice by Dr. G.W. Gale, 10/8/1953, p.5. At this time, while there were moves being made

Once again, this progressive movement became spearheaded by a small group of innovative individual doctors, as the IFCH and its central philosophy moved away from the restrictive influence of the State's DH. From the early-1950s, it became increasingly evident to pioneer doctors in the Durban Medical School, that the State's Department of Education would not provide the School with additional financial assistance to enable it to establish special facilities for training in the social and preventive sphere, because a training in this sphere did not exist to any marked degree in any of the three established medical schools in South Africa.<sup>98</sup> Thus to develop both research and teaching facilities in social medicine at an academic level, the School had to obtain financial assistance from another source. Until 1956, evidence of many years of discussions and negotiations are scattered throughout the School's official archival material and correspondence, involving the Medical School, the State's DH, the Natal Provincial Administration (NPA) and Rockefeller Foundation, which finally led to the IFCH's affiliation with the Medical School's newly established Department of Social, Preventive and Family Medicine. While an analysis will be made of the intricacies involved in facilitating this affiliation, the details of the Medical School's progressive and largely unique social and preventive emphasis in its medical curriculum for black students will be discussed at great depth later in the chapter.

Both Malherbe, as Principal of the UN and Gale, as Dean of its Medical School, pushed for an early association between these two institutions. As Malherbe argued:

I am strongly impressed by the need for greater emphasis on the preventive and promotive functions of our medical service. I have also gained first-hand knowledge of the excellent work that is being done for the non-European by the Health Centre at Pholela, under your Department. Thus far only the fringe of the vast field has been touched. These health centres have to be multiplied, particularly in native areas. But they need doctors as well as health assistants.<sup>99</sup>

He felt that training in this sphere would probably constitute the most distinctive and important part of a black medical education at the School, and thus make it a "pioneer of an important

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by Wits and other South African medical schools to teach preventive and social medicine, they mainly paid lip service to it. Unless it was made the specific responsibility of a Department in the medical faculty, such teaching was neglected.

<sup>98</sup> UN Archives, Pmb. H6/2/3. Correspondence concerning Establishment of the Department of Family Practice, 1953-55. Durban Medical School: Project for a Department of Family Practice, p.2-3.

<sup>99</sup> SAB, UOD, Vol. 1546, U3/40/4. NU College Establishment of Medical School for Natives. Letter from E.G.

advance in medical education”.<sup>100</sup> Gale felt that the most valuable contribution of the IFCH facilities to health needs would be in the medical training of black doctors inside, but more importantly, outside hospitals in “family practice” in the homes and communities where the majority of black doctors would practice. In 1952, the Curriculum Committee of the Interim Medical Faculty, led by the Acting Dean Alan Taylor, recognised this and indicated its desire to co-operate with the IFCH to make use of DH practical facilities for medical training, as “the Board of the Faculty is of the opinion that the King Edward VIII Hospital cannot offer adequate facilities for giving the kind of experience which is particularly desirable that non-Europeans should have”.<sup>101</sup>

In 1951, Dr Bremer, Minister of Health agreed in principal to co-operation between the IFCH and Durban Medical School in training undergraduates in family and community medicine, but it would take a number of years of protracted negotiations to get the arrangements finalised.<sup>102</sup> This did however, provide the School with an opening for the initiation of discussions with the aim of the UN taking over from the DH the extra-hospital, teaching functions undertaken at the Institute, which was jointly responsible for the co-ordinated teaching-service aspects of the health centre training programme.<sup>103</sup> Gale argued, that “since the vast majority of these trainees are non-Europeans, it’s appropriate to suggest that the non-European Medical Faculty of the UN undertake this responsibility which lies in the sphere of undergraduate teaching”.<sup>104</sup> Just as medical schools required access to the wards of teaching

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Malherbe to Dr Gluckman, Minister of Health re: Medical School for Non-Europeans: Durban, 5/5/1947, p.1.

<sup>100</sup> See SAB, UOD, Vol. 56, Ref. U3/26/4/5. UN Building Grants and Loans for Medical School of Non-Europeans, Durban. Letter from E.G. Malherbe to The Secretary for Education, Arts and Science Re: Durban Medical School: Establishment of a Department of Family Practice, 7/10/1953 and E.G.M. F 463/5/2. UNMS. *Natal Mercury*, 11/11/54.

<sup>101</sup> UN Archives, Pmb. H6/2/3. Correspondence concerning Establishment of the Department of Family Practice. Letter from E.G. Malherbe and G.W. Gale to Dr Bremer, Minister of Health, 14/8/1952, p.1-2.

<sup>102</sup> See UN Archives, Pmb. H6/2/3. Correspondence concerning Establishment of the Department of Family Practice. Memorandum on the Establishment of a Department of Family Practice by Dr. G.W. Gale, 10/8/1953, p.3.

<sup>103</sup> See SAB, GES, Vol. 1831, Ref. 68/30. Medical and Dental Training for Natives, Gale (S. for H), 7/11/1951, p.8 and UN Archives, Pmb. H6/2/3. Correspondence concerning the Establishment of Department of Family Practice. Letter from Dr Gale to W.A. McIntosh, 26/5/1954, p.4. This included the IFCH’s postgraduate training of doctors and nurses in the organisation and techniques of extra-hospital practice, which Gale was confident the Medical School could provide in accordance with the accepted racially segregated policy of the UN. The aim was to extend and include training of general nurses, midwives, medical and welfare social workers, health educators and statisticians in preventive and social medicine.

<sup>104</sup> SAB, GES, Vol. 1831, Ref. 68/30. Medical and Dental Training for Natives, Gale (S. for H), 7/11/1951, p.6.

hospitals, so access had to be acquired to organised health centre services at the IFCH to provide instruction in “pre-hospital” medicine.

While the Medical School proponents for affiliation did so for the intrinsic medical value of an association with the IFCH, negotiations also intensified towards the mid-1950s, to ensure the continuance of the service and research aspects of this progressive social and community health institution, which came under increasing threat, from a conservative and hostile apartheid State determined to undermine its work. The State, including its DH under new ministers during the early-1950s, became once again very cautious and highly conservative under increasing pressure from a racist State to end all progressive and social medicine movements that attempted to ease the lot of black communities labouring under the burden of poverty and disease. Although U.P. Minister of Health Gluckman’s (who was forced to resign in 1948 with the change in Government) successors - Dr Stals and Bremer - were skeptical of the basic tenets of the programme, they allowed its development to continue during their terms of office despite opposition.<sup>105</sup> However, their untimely deaths during the early-1950s, together with an increasingly hostile N.P. voting public strongly opposed to the health centre’s liberal and social welfare and medical services, resulted in increasing State pressure and threats (through withdrawal of financial support and policies of retrenchment) to end all that had been achieved at a national level.<sup>106</sup> The DH refused to provide funds to enable its participation in the innovative medical education nor joint appointments of teaching personnel between the IFCH and Medical School. It was prepared to allow students access to the IFCH but the standards would drop as students would be taught by doctors in whose appointment the UN had no voice.<sup>107</sup> Its end would be a huge tragedy for black rural communities in desperate need of its preventive medicine approach. It was recognised that if the work and achievements of the IFCH was to continue, the Institute had to be quickly incorporated into a university medical curriculum. As Gale argued:

we are very anxious that the teaching of social medicine - or, to use terminology ... which they favour, teaching in health centre practice as developed at the IFCH - should be incorporated in the medical curriculum from the very outset. Otherwise, so quickly do

<sup>105</sup> UN Archives, Pmb. H/6/1/1. Gale, “The Story of the Durban Medical School”, p.13.

<sup>106</sup> UN Archives, Pmb. H/6/1/1. Gale, “The Story of the Durban Medical School”, p.16.

<sup>107</sup> UN Archives, Pmb. H6/2/3. Correspondence concerning Establishment of the Department of Family Practice, 1953-55. Durban Medical School: Project for a Department of Family Practice, p.5.

conservative influences become dominant in institutions, it is probable it will never be introduced at all.<sup>108</sup>

In 1952, having just left the DH to become Dean of the Medical School, Gale was shocked at the DH's new policies towards reducing health centre services provisions through a cut in staff and facilities.<sup>109</sup> He felt that the State was being irrational as the service reduced disease and thus expensive hospitalisation, and was thus an economic wisdom to increase rather than decrease their services.<sup>110</sup> Gale had strong opinions with regard to the DH's shortening of the three-year training programme of health assistants to a Junior Certificate minimum plus one year. Gale felt that an inferior training was a waste of time and energy, which would produce inexperienced and inefficient personnel, that would be destructive to health centre work established thus far and reduce health centres "to the lowest common denominator of health services".<sup>111</sup> As he argued:

I was appalled at the misconceptions and ignorance of the Department of Health ... I do not think such persons can make any significant contribution to the preventive and health educational side of health services [and] will never be able to accomplish what health assistants have accomplished in field work.<sup>112</sup>

Gale was even more appalled that the DH blatantly disregarded the advice of the ablest men in the DH who "devoted years of their lives to building up this new type of service, and in evolving this new type of health personnel, in accordance as they thought with the progressive policy of the Department of Health".<sup>113</sup> He was embarrassed for having been a member of the DH and was concerned for the country's medical reputation:

<sup>108</sup> UN Archives Pmb. H6/2/3. Correspondence concerning Establishment of the Department of Family Practice, 1953-55. Durban Medical School Project for a Department of Family Medicine, p.6.

<sup>109</sup> See UN Archives, Pmb. H6/2/3. Correspondence concerning Establishment of Department of Family Practice. Letter from Dr. G.W. Gale Dean of the Durban Medical School to Dr. le Roux, Secretary for Health, 26/10/54, and UN Archives, Pmb. H6/2/3. Correspondence concerning Establishment of Department of Family Practice. Letter from G.W. Gale to Dr. le Roux, Secretary for Health, 10/11/1954. The DH wanted to reduce Medical Officers to seven in total, to provide a service for 40,000 people, which would make it a purely curative service as preventive medicine took a backseat to the desperate needs to provide curative treatment.

<sup>110</sup> UN Archives, Pmb. H6/2/3. Correspondence concerning Establishment of the Department of Family Practice, 1953-1955. Arguments Against Closure of the Institute of Family and Community Health, p.1. It cost less than half the cost of domiciliary treatment of people sick in bed rather than in hospitals. In terms of economics, this should have been persuasive, as the State subsidy met half the cost of provincial hospital services at the time.

<sup>111</sup> UN Archives, Pmb. H6/2/3. Correspondence concerning Establishment of the Department of Family Practice. Letter from G.W. Gale to Department of Health, 5/11/1952, p.4.

<sup>112</sup> UN Archives, Pmb. H6/2/3. Correspondence concerning Establishment of the Department of Family Practice. Letter from G.W. Gale to Department of Health, 5/11/1952, p.1-2.

<sup>113</sup> UN Archives, Pmb. H6/2/3. Correspondence concerning Establishment of the Department of Family Practice. Letter from G.W. Gale to Department of Health, 5/11/1952, p.4.

it is very humiliating to me, vis-à-vis my colleagues in the University of Natal, who now include representatives of the NPA, that I have failed to persuade my old Department to act as generously as the Province has acted towards the Medical School. Finally, my remarks are the expression of my very deep and sincere feelings, as a former Chief Health Officer for the Union and as still a citizen jealous for the reputation of my country abroad.<sup>114</sup>

In a letter to the DH in 1952, Gale wrote:

when the health experts in many countries who appreciate the significance of what has been accomplished in health centres in South Africa hear that the service is being emasculated, on the recommendation of the senior health officers of the country, they will doubtless feel that reaction and repression have now invaded the health field too.<sup>115</sup>

### ***Financial Assistance: Negotiations with the Rockefeller Foundation.***

Since 1946, the Division of Medicine and Public Health of the Rockefeller Foundation, an American philanthropic organisation, immediately recognised - with the persuasive influence of Gale and Kark - the important potential of Durban with its experimental programme in social and community medicine at the IFCH, and expressed its desire to assist in affiliating the IFCH with the newly established Durban Medical School.<sup>116</sup> Because of the growing conservative threat to undermine the work at the IFCH by the racist Government, and its refusal to provide additional finances for special facilities for this training in social and preventive medicine that did not exist to any marked degree in any of the established medical schools, progressive doctors at the School looked elsewhere for support.<sup>117</sup> Gale felt that it was unlikely that the State would cover the cost of an entirely new Department for which there were no precedents in the existing medical schools. When Gale was awarded a Rockefeller travelling grant to the US in 1950, he gained permission from Dr Stals to find alternative funding sources and:

to open negotiations with the Rockefeller Foundation in New York, unofficially, for a subsidy for a pioneer venture in putting into practice new ideas that were being much talked about but rarely implemented in the field of medical education ... This prepared the way for a favourable response to the official negotiations later put in

<sup>114</sup> UN Archives, Pmb. H6/2/3. Correspondence concerning Establishment of Department of Family Practice. Letter from G.W. Gale to Dr. le Roux, Secretary for Health, 10/11/1954, p.2.

<sup>115</sup> UN Archives, Pmb. H6/2/3. Correspondence concerning Establishment of the Department of Family Practice. Letter from G.W. Gale to Department of Health, 5/11/1952, p.5.

<sup>116</sup> UN Archives, Pmb. H6/2/1. Correspondence of Prof. I. Gordon Faculty of Medicine, 1954-57. Letter from Dr. G.W. Gale to Dr Gordon, 21/ 5/1955, p.2.

<sup>117</sup> UN Archives Pmb. H6/2/3. Correspondence concerning Establishment of the Department of Family Practice, 1953-55. Durban Medical School Project for a Department of Family Medicine, p.3.



hand by the University.<sup>118</sup>

In 1948, with the change in Government, Gale used all his persuasive powers with successive Ministers to ensure the continuance of the IFCH service, a pioneer service subject to increasing criticism from conservative elements in the profession and an intensification of racial and political prejudice.<sup>119</sup> When writing to Gordon in 1955, he felt that his involvement in affiliating the IFCH to the Durban Medical School was one of his greatest contributions:

the most important contribution which I have made to the Medical School, next to securing its establishment at all, is the preservation of the IFCH from extinction before the time was ripe to knit it to the School.<sup>120</sup>

There were many delays with regard to the Foundation's provision of a financial grant to the UN due to concern for the State's racist attitudes and non-involvement (as the controlling influence on the IFCH) in participating in the proposed affiliation. In a letter in April 1954, Dr W.A. McIntosh wrote to Gale with his concerns,

from my conference in Cape Town with Dr le Roux, I learned that he does not favour, if I understood him correctly, the development of similar relationships between your Department of Family Practice and the IFCH. ... Furthermore, I gained the impression that the future of the Institute itself may be in balance. Under these circumstances, I am unable to see my way clear to take up with the Foundation, the question of support towards your Department of Family Practice [and it's a pity] as my feeling is that this Institute could present an exceptional opportunity for co-operation with your Medical School in providing training in the field of preventive medicine.<sup>121</sup>

Gale gave many assurances in his letters that the Institute and its associated health centres would continue their work, even if classified under a different name or controlling influence. He made it clear that this was increasingly the way the central State was going, by slowly relinquishing its hold on the service. But in Gale's view, the best provision of the service would be to affiliate it to a Department in a university medical school:

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<sup>118</sup> UN Archives, Pmb. H/6/1/1. Gale. "The Story of the Durban Medical School", p.13.

<sup>119</sup> UN Archives, Pmb. H6/2/1. Correspondence of Prof. I. Gordon Faculty of Medicine, 1954-57. Letter from Dr. G.W. Gale to Dr Gordon, 21/ 5/1955, p.3.

<sup>120</sup> UN Archives, Pmb. H6/2/1. Correspondence of Prof. I. Gordon Faculty of Medicine, 1954-57. Letter from Dr. G.W. Gale to Dr Gordon, 21/ 5/1955, p.3.

<sup>121</sup> UN Archives Pmb. H6/2/3. Correspondence concerning Establishment of the Department of Family Practice. Letter from Regional Director of the Rockefeller Foundation, Africa W.A. McIntosh to Dr. G.W. Gale, 6 April 1954.

I am confident that the health centre services would not cease to exist. The communities for whom they have provided for seven years now, cannot suddenly be left without medical care. Both the Provincial Administration and local authority (DCC) have power to establish or take over health centre services ... Indeed, Dr le Roux has indicated that it is his policy to persuade local authorities to exercise their powers and take over health centres established by the Government. My main point ... is that we can be sure that health centres will be available - whether conducted by the State, or Provinces or City Council - for teaching purposes. By taking the key personnel of the Institute into the Department of Family Practice we would make it practicable for the new Department to continue - or revive - the teaching and research functions which have been developed by the Institute.<sup>122</sup>

There was much correspondence and assurances from Gale with regard to the importance of the scheme. He emphasised how the Government had incurred heavy expenditures for the construction of the new School and was not prepared to recognise any innovations in the field. Gale made them see that it required an international foundation like Rockefeller, experienced in this innovative field of social and community medicine, to persuade the conservative South African State to see the logic and value of the proposed affiliation. In a letter to Gale in May 1954, McIntosh's arguments showed a change of emphasis concerning the Foundation's duties to facilitating the association, and saw their role as a "rescuing mission":

the basic importance ... of establishing the Department of Family Practice and effecting field teaching affiliations with the IFCH requires demonstration to the Union's Department of Education. [He recognised that] there is a tendency for the Department of Education to look upon field relationships between its Department of Family Practice and the IFCH as in the nature of an innovation. The step, however, is timely, for the Medical School is now in its formative period, and the Union Government otherwise may discontinue support to this Institute. The latter is due to a change in policy about administering educational services directly. Hence, the rescuing of this Institute by the placement of its educational and research activities under even more advantageous circumstances than in the past, is an urgent consideration.<sup>123</sup>

In a letter to Gale in July 1954, McIntosh made it clear that the Foundation would go ahead with the provision of the grant. However, three conditions had to be met. The first was that the pertinent IFCH staff, including Dr Kark, Guy W. Steuart and Nancy Cohn had to remain in South Africa and accept the positions; the second concerned the need for written Department of

<sup>122</sup> UN Archives Pmb. H6/2/3. Correspondence concerning Establishment of Department of Family Practice. Letter from G. W. Gale to the Regional Director of the Rockefeller Foundation, Africa W.A. McIntosh, 26 May 1954, p.1.

<sup>123</sup> UN Archives Pmb. H6/2/3. Correspondence concerning Establishment of Department of Family Practice. Letter from the Regional Director of the Rockefeller Foundation, Africa W.A. McIntosh to Dr. G. W. Gale, 17 May 1954.

Health support in the development of this association with the UN; and the third was the need for clarification with regard to whether black students from other areas of Africa could be admitted to the School.<sup>124</sup> Between July and September 1954, largely through consistent pressure and persuasion on the part of Dr Gale and others, all three conditions were met. Even the State DH gave its assurance of full co-operation essential for the success of the project.<sup>125</sup> With these assurances, the grant was given and the UN was notified on the 24th September 1954 that the Rockefeller Foundation was prepared to provide it with a grant of up to £42,400, for the development of a Department of Family Practice in its Medical School.<sup>126</sup> This fund was for use during a five-year period beginning on January 1, 1955, where payments were made on a semi-annual basis upon receipt at the beginning of each year of a budget for the project and annual statements of receipts and expenditures.<sup>127</sup>

### *A Joint Arrangement of Mutual Benefit.*

In October 1954, after many years of negotiations, a meeting was held in the Secretary of Health le Roux's office to finalise discussions for the necessary provisions for an association between the Union DH, and UN Medical School.<sup>128</sup> After further months of negotiations, the Minister of

<sup>124</sup> UN Archives Pmb. H6/2/3. Correspondence concerning Establishment of the Department of Family Practice, 1953-55. Letter from G.W. Gale to Dr Andrew J. Warren, Director - Division of Medicine and Public Health Rockefeller Foundation, 2 August 1954.

<sup>125</sup> UN Archives, Pmb. H6/2/3. Correspondence concerning Establishment of the Department of Family Practice. Letter from Dr. A.J.R. van Rhijn Minister of Health to Dr A.J. Warren Director: Division of Medicine and Public Health, Rockefeller Foundation, 28/7/1954.

<sup>126</sup> UN Archives Pmb. H6/2/3. Correspondence concerning Establishment of the Department of Family Practice, 1953-55. Letter from Flora M. Rhind, Secretary Rockefeller Foundation to Dr Malherbe. Also see UN Archives, Pmb. H6/2/3. Correspondence concerning Establishment of Department of Family Practice. Letter from G.W. Gale to Dr. le Roux, Secretary for Health, 8/11/1954, p.5-7. McIntosh was informed that the basis accepted by the NPA was that they paid 50% of salaries at university scales. His "Schedule of Itemised Estimates" was as follows: a five year grant of £42,400 calculated: salaries for five years at £7,050 p.a. (£35,250), running costs £1,071 p.a. (£5,355), initial equipment (non-recurrent) £1,787. The total reached was £42,392. The breakdown of staff salaries were as follows: Professor and Head of Department (£2,500), Senior Lecturer in Family Practice (£1,800), Two lecturers in Family practice (£3,000), lecturer in health education (£1,500), lecturer in public health nursing (£1,000), tutor in health educational methods (£900), tutor in casework (£900). In his estimates, Dr McIntosh assumed that the Department of Health would contribute 50% of salaries, to a total of £7,050 p.a. including proportionate contributions to c.o.l.a. and pension contributions.

<sup>127</sup> See UN Archives Pmb. H6/2/3. Correspondence concerning the Establishment of the Department of Family Practice, 1953-55. Letter from Prof. I. Gordon to W.A McIntosh, 2 June 1955 and Gordon. *Report on the Government's Intended Action*, p.17. In 1955, Gordon wrote to the Foundation requesting commencement of the grant from January 1956 to December 1960 to allow for finalisation of negotiations between the NPA and Union DH. Kark and his community health colleagues would also then be given time to prepare themselves for their new course. The Foundation complied.

<sup>128</sup> UN Archives Pmb. H6/2/3. Correspondence concerning the Establishment of Department of Family Practice. Memorandum by the Principal of the University to the Minister of Health The Hon. Dr. T. Naude, 13/4/1955, p.2.

Health agreed that his DH would co-operate both in the provision of facilities at the IFCH and in the provision of staff to carry out the “dual functions” of providing a service and teaching to which may be added the concomitant of research.<sup>129</sup> This was based on the similar pattern of joint teaching and service already established with the King Edward teaching hospital, through co-operation with the NPA hospital authority and UN. As Gale argued:

this Institute will be used as a laboratory for training in family practice, and the teaching staff of the University Department will be active participants in the services, which this Institute renders to the non-European community.<sup>130</sup>

In this joint arrangement, the State DH, would be financially and administratively responsible for the extra-hospital services, but grant the UN students free access to the IFCH and health centres for training purposes under the control of Medical Officers, in whose appointment they had a say and to whose salaries they contributed. The teaching staff thus had duties and responsibilities both to the UN and State DH.<sup>131</sup> Salaries of the teaching staff were shared between the UN and DH.<sup>132</sup> Other non-medical staff required for the health service continued as public servants in the employment of the DH, while the DH continued to meet the cost of service to the community by the IFCH and cost of training auxiliary personnel.<sup>133</sup> This joint arrangement promoted mutual benefits for both parties. Training at the IFCH ensured that black medical students were trained in general practice outside hospitals, thus producing specially trained black medical graduates that the DH could draw upon for cheaper, pre-hospital health services throughout the Union to prevent excessive and expensive hospitalisation.<sup>134</sup> It also raised the standards of clinical practice and levels of research and training, where the UN medical staff would be kept in daily contact

<sup>129</sup> E.G.M. F 463/5/2. UNMS. *Natal Mercury*, 11/11/54.

<sup>130</sup> SAB, GES, Vol. 1831, Ref. 68/30. Medical and Dental Training for Natives, Gale, 7/11/1951, p.7.

<sup>131</sup> SAB, GES, Vol. 1831, Ref. 68/30. Medical and Dental Training for Natives, Gale, 7/11/1951, p.7.

<sup>132</sup> UN Archives, Pmb. H6/2/3. Correspondence concerning the Establishment of Department of Family Practice. Letter from Dr Gale to W.A. McIntosh, 26/5/1954, p.4.

<sup>133</sup> See UN Archives Pmb. H6/2/3. Correspondence concerning the Establishment of Department of Family Practice. Memorandum by the Principal of the University to the Minister of Health The Hon. Dr. T. Naude, 13/4/1955, p.2 and UN Archives, Pmb. H6/2/3. Correspondence concerning Establishment of Department of Family Practice. Draft. 4th April 1955, p.1. The State Treasury made available, by way of an annual grant to the UN, the financial provision needed for a determined number of posts, while all running costs (other than salaries) of the health service were met by the DH. The UN appointed a larger number of Medical Officer units than normally required to provide the health service at the IFCH. Their salaries were met by private funding, but all Medical Officers participated in both health and teaching services. The Medical Officers were UN employees, subject to UN conditions of service. The UN met all running costs of the teaching service.

<sup>134</sup> SAB, GES, Vol. 1831, Ref. 68/30. Medical and Dental Training for Natives, Gale, 7/11/1951, p.7. This was facilitated by a State bursary/loan system, which guaranteed the DH 15 bursars who were required to give seven

with the actual problems of the public health service, while still retaining their academic freedom and independence to an extent not possible if they were members of the public service.<sup>135</sup> This system also alleviated the anxiety of students not being fitted by training to fit into any organised medical service. Students were being trained for a specific form of medical practice that would be State-directed and controlled, rather than entering competitive private practice with, as Gale argued, the evils of exploitation of the poverty-stricken masses.<sup>136</sup>

Thus, the new Department of Social, Preventive and Family Medicine commenced teaching in 1955, under the direction of Sidney Kark. Pending settlement of the arrangement, as well as delays in the transfer of property of the IFCH from the central DH to the NPA, in February Gale requested an interim arrangement to be made for carrying out teaching functions in the new Department at the same time as the other clinical subjects commenced.<sup>137</sup> Kark and his colleagues at the IFCH were given permission to begin their work at the new Department.<sup>138</sup> In 1956, the NPA assumed control of the IFCH when it was finally affiliated to the Medical School. Thus, the NPA hospital authority became responsible for both the IFCH and teaching hospital of the School. In this way, the necessary elements of this new Department assured the continuance of the IFCH service work, and through additional funds from the Rockefeller Foundation also provided an academic teaching service, despite determined opposition from the National Party Government and gradual demise of the health centre movement in South Africa.<sup>139</sup>

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years service, in exchange for their financial support through training, to the State Medical Service after qualifying.  
<sup>135</sup> See UN Archives, Pmb. H6/2/3. Correspondence concerning Establishment of the Department of Family Practice. Letter from E.G. Malherbe and G.W. Gale to Dr Bremer, Minister of Health, 14/8/1952, p.1-2, and UN Archives, Pmb. H6/2/3. Correspondence concerning Establishment of the Department of Family Practice, 1953-55. Durban Medical School: Project for a Department of Family Practice, p.7.

<sup>136</sup> UN Archives, Pmb. H6/2/3. Correspondence concerning Establishment of the Department of Family Practice. Memorandum on the Establishment of a Department of Family Practice by Dr. G.W. Gale, 10/8/1953, p.5.

<sup>137</sup> See UN Archives, Pmb. H6/2/3. Correspondence concerning Establishment of Department of Family Practice. Letter from Dr. G.W. Gale Dean of the Durban Medical School to Dr. le Roux, Secretary for Health, 26/10/54, p.8 and UN Archives Pmb. H6/2/3. Correspondence concerning Establishment of the Department of Family Practice, 1953-55. Letter from J.F. Naude Minister of Health to Dr Malherbe, 2 June 1955.

<sup>138</sup> G.P. File 23. KCM 25915. UN Medical School. Report by the Dean of the Durban Medical School for Advisory Committee to Council on Non-European Affairs, 13/4/1955. See UN Archives, Pmb. H6/2/3. Correspondence concerning Establishment of Department of Family Practice. Letter from Prof. I. Gordon, Dean of the Medical School to Dr. William A. McIntosh, Rockefeller Foundation, 2/6/55, p.1. The UN invited various individuals to function in honorary capacities pending finality in other negotiations (Prof. and Head of Dept, Dr. S.L. Kark, Clinical tutors, Drs J. Abramson, J. Chester, B. Gampel and Emily Kark, senior lecturer in health education, Mr. G.W. Steuart, Lecturer in Case work and home care, Nancy D. Cohn, lecturer in Health education, Mrs N.T. Ward).

<sup>139</sup> S.M. Tollman. "The Pholela Health Centre - the Origins of Community-Oriented Primary Health Care: An

While this chapter has been focused on the interesting but largely “public” and external influences - of both the State and international philanthropic bodies - on the formation of this complex and ambiguous medical institution, the next chapter will focus on the internal dynamics and complex student relations and student/staff interactions. For this thesis is not merely focused on an analysis of the outside factors and people who promoted and helped facilitate the development of this extraordinary institution in Durban, but also involves an investigation of the more hidden people - especially the pioneer class of aspiring black doctors - who received their training within the School. Based largely on oral interviews with past students, as well as other people interested in the School’s formation and existence, the next chapter will thus be an in-depth analysis of the no less exciting and very complex “behind-the-scenes” dynamics, sets of events and social relationships which led to the School’s particular internal formation.

## Chapter Four

### “Student Memories and Experiences of their Medical Education at the Durban Medical School”

... he gave us the first talk because he was first Dean here, and he said you have to be better than the white Medical Schools, he said we're going to be extremely hard ... because, you know the whole establishment depends on its students ...<sup>1</sup>

Recalling one of her first experiences of being a medical student at the inauguration class of 1951, and one of the many motivating “prep” talks given to them by Dr Alan Taylor, Soromini Kallichurum emphasises at one and the same time the pride and deep tension rooted in the University of Natal (UN) black Medical School experiment. For someone like Kallichurum, the pressure to succeed must have been immense as local, but also, international public attention was focused on this small pioneering class of 35 aspiring black medical students - their training and progress - through the long and gruelling seven year training course. While focusing on the “success” stories of the students who succeeded despite the enormous pressure, one cannot continue without also analysing the failures, compromises and disappointments of the early years - for a large number of students who failed - because of the inadequacies, prejudices and disjunctures within the very heart of the Medical School project. Racism, paternalism, class, gender, and ethnic divisions between the staff and students in the 1950s cannot be wished away in the context of the overall programme aims and successes of that era. If social history teaches us anything it is that small and seemingly insignificant failures and cul-de-sacs are just as important to an overall critical assessment of any institution as its successes.

Having analysed how and why Kark and his team’s progressive social and community health approach managed to continue and even develop its innovative work in South Africa for a few more years thanks to the academic institutional support of the Durban Medical School, the

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<sup>1</sup> Interview with Professor Soromini Kallichurum, by Vanessa Noble, Durban, 29 May 1999. I am very grateful and appreciative of Professor Kallichurum giving of her time so freely to be interviewed by me. She had, and still continues to live an extraordinary life. Having been trained at the Durban Medical School, she specialised in anatomical pathology. In 1983 Kallichurum became the first woman dean of the Medical School. Later she was the first woman to serve on the Medical Research Council and recently has added another first to her resume - that of president of the South African Interim Medical and Dental Council (now the Health Professions Council of South Africa). Also see the article in the *Natal Mercury*, 13/11/95 entitled, “No stopping this Doc of a ‘Different’ Gender”.

Natal Provincial Administration (NPA) and Rockefeller Foundation (associated with the UN), this chapter is interested in how this movement, once firmly rooted in this university setting and not restricted by the State's Department of Health (DH), revolutionised the School's newly established medical curriculum and promoted enormous international recognition for its preventive and social medicine approach. However, the means used to reach this desired academic end by many of the people involved over its nearly five decades of history, were from the start complicated, ambiguous, contradictory and in many instances unjust. This chapter will investigate the often "behind-the-scenes" struggles and internal politics, to establish a sound medical training for black doctors of the highest standards during the first decade of its existence. Many of the issues build closely onto my previous arguments about the very ambiguous and contradictory nature of the Medical School during the first years of its existence. Forced to develop in an increasingly hostile racist apartheid city in the 1950s, it will be shown how this School was caught up in and influenced by racist ideas and often perpetuated them, causing much hurt in an apparently "noble" medical profession. However, the racist nature of the Medical School was never uncomplicated, as it was also a protective academic "haven" for an elite group of aspiring black doctors. Still able to manoeuvre in the chinks of the apartheid armour in the early years, many farsighted aims and policies could be implemented. It was in this regard that the School's pioneering steps were made in introducing a radical and unique medical curriculum founded on the highest standards of western biomedicine but also adapted specifically to meet the health needs of South Africa black societies. It is also for these academic contributions, that I believe the School should be remembered in its early years, which placed it in the vanguard of other medical schools both in South Africa and abroad.

While use of archival materials and secondary sources is a prerequisite for any sound piece of historical work - and analysis will be made of "official" Government and University documents - to move beyond the "public" and more accessible narratives of the history of this medical institution, it is also essential to use other sources to come to grips with some of the more complex, diffuse and overlapping discourses surrounding black medical history and education in South Africa. Here use will be made of interesting personal histories, and experiential day-to-day memories and records of students and other people connected to the Medical School in the belief that these oral and personal narratives of its history will balance the



often uni-dimensional archival perspectives and provide interesting sidelights into the “official” and “public” view. Oral interviews of past students and other interested parties will bring in the voices of black communities and women, whose lives bore the brunt of policy changes and initiatives at this School and many other South African institutions, but who had little input into the formulation of these.<sup>2</sup>

### ***Student Views of Drs. Alan Taylor and George Gale as Dean of the School.***

As previously discussed, despite the furore and debates about if and where it should be established, and the long, drawn-out delays, the first State Treasury approval for the development of the Durban Medical School occurred in 1950, and the Acting Board of the Faculty of Medicine was established. Dr Alan Taylor was appointed part-time Acting Dean in 1951. He was very influential in his one year at the School, and his missionary spirit and endeavour despite massive hardships came across strongly to the first cohort of students, who would have experienced great pressure as the pioneering class. Soromini Kallichurum, one of the pioneer students argued:

I know the whole thing was led by Dr Taylor from McCord's, and you see the beginnings of this Medical School, the establishment of this Medical School lay with the missionaries, not the academic or profession. And I think working at McCord's, he saw the neglect, you know, of black patients, and so he just fought for a Medical School in Natal that would take black students, students of colour. And there was a lot of talk if its all black will it be inferior ... but he gave us the first talk because he was first Dean here, and he said you have to be better than the white Medical Schools, he said we're going to be extremely hard ... because, you know the whole establishment depends on its students, that's what he told us. ... Alan Taylor wanted to motivate us, and you know, he spoke to us, he was a bit different in that respect.<sup>3</sup>

In 1952 Taylor was succeeded by Dr G.W. Gale who would be forced in this role to address the enormous problems attendant upon the development of an entirely new Medical School for black students. Gale became Dean at a time of great mistrust and criticism from both whites and blacks regarding the principle that a segregated institution would be an inferior one. During the early

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<sup>2</sup> See Isabel Hofmeyr. *We Spend our Years as a Tale that is Told: Oral Historical Narrative in a South African Chiefdom*. (Johannesburg: Witwatersrand Press, 1993) and Charles van Onselen. *The Seed is Mine: The Life of Kas Maine a South African Sharecropper, 1894-1985*. (Cape Town: David Philip Publishers, 1996).

<sup>3</sup> Interview with Professor Kallichurum.

1950s, the National Party (N.P.) apartheid ideologues passed laws that legislated for separate and inferior provisions for blacks in all spheres. As Gale himself argued:

I have been told by many non-Europeans that the appointment as Dean of a person with my record and known views regarding non-European problems in general helped to allay this initial suspicion and to establish confidence at least in the *bona-fides* of the project.<sup>4</sup>

But he was also a complex and contradictory figure, who was very much a person of his time, caught up and influenced by the socio-political historical context of segregationist and later apartheid South Africa. As Fatima Mayet, also a former student in the first cohort of students at the Medical School maintained:

we didn't have much contact with him, but as far as I'm concerned he was a racist. ... it was actually the sort of statements he used to make, gave one the impression that he was always conscious of colour, and he was sort of coming down to your level.<sup>5</sup>

For while his ideas and policies for a high standard black medical profession and training in South Africa were quite radical for his time and in relation to the Government for which he worked, he never worked to overthrow the structures of racial segregation by aligning with black nationalists fighting for liberation from racial oppression. Instead, like Malherbe and other liberals, he worked within the structure of racial segregation in higher education established by the apartheid ideologues and continually tempered his arguments and had to justify his actions to them. Like Kark, he also identified the socio-political causes and ways of preventing and curing ill-health, but was ultimately powerless to implement the broader policies he believed necessary for change in the medical sphere.

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<sup>4</sup> UN Archives Pmb H6/2/1. Letter from Dr. Gale to Prof. Gordon, 21 May 1953, p. 3.

<sup>5</sup> Interview with Professor Mayet by Vanessa Noble, Durban, 4 June 1999. A big thank you to Professor Mayet for also giving of her time and agreeing to be interviewed. After graduating and doing her internship in 1958, Mayet specialised, lectured and did research work in the Department of Medicine at the Medical School. In 1970 she became Principal Physician/Senior Lecturer and Head of the Department of Medicine at the R.K. Khan Hospital and in 1980 she returned to academic medicine and became Associate Professor in the Department of Medicine until her retirement during the 1990s. She is now Chairperson of the South African National Foundation of Cheshire Homes (for the physically disabled).

***“An Inferior Education?”: Medical Training under Apartheid.***

With the new State’s increased interest in racially controlling higher educational facilities in South Africa, many fears were expressed concerning its intimate ties to the affairs of the Durban Medical School through enormous financial contributions. These fears revolved around the issue of providing an inferior medical education to an exclusively black student body who would ultimately practice in black communities. It will be shown how political ideologies of race impacted on the internal policies of the School, but in an apartheid situation where there was no initial blueprint to follow and where pioneers in black higher education were determined to maintain the highest standards, they were still able to manoeuvre in the gaps that the still uncertain NP had not closed. Initially the new State sensitive to international criticism as a pariah State, was forced (while trying to make the establishment of the Medical School as economical as possible) to argue that it was a “positive” example of apartheid, and that everything would be of the highest standard comparable with any “white” university. As J.H. Viljoen, Minister of Education argued, “the public has the assurance that the course offered is of high standard and in no way inferior to that at other schools”.<sup>6</sup> Dr Stals, Minister of Health also maintained:

it was created for the training of non-Europeans to meet the health needs of their own people ... [but] made available under circumstances and conditions which are not liable to create prejudice, to injustice self-respect or disturb the friendly relations among various sections of the community.<sup>7</sup>

The high standards that the UN had to maintain would also be assured by the external medical body of the South African Medical and Dental Council (SAMDC), who had to approve of the degrees before doctors could be placed on the medical register.<sup>8</sup> Fatima Mayet at first intended on doing a medical degree at Wits but when the N.P. Government came into power in 1948, they increasingly made it difficult for black students to attend white “open” universities, because it was argued that there was now a black Medical School in Durban. However a question of the School’s standards was always evident:

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<sup>6</sup> I. Gordon. *Report on the Government’s Intended Action to Remove the Faculty of Medicine from the University of Natal*. (Durban: Hayne and Gibson, Ltd., 4 March 1957), p.7.

<sup>7</sup> Gordon. *Report on the Government’s Intended Action*, p.8.

<sup>8</sup> *The Durban Medical School of the University of Natal: A Response to the Challenge of Africa*. (Durban: Hayne and Gibson, 1954), p.14.

I was told by the Government that there is a university, a Medical School in my own province, and they refused to give me a permit. ... Because I used to be on a six monthly permit and each time I went, and each time I returned from Johannesburg, I had to report at a police station to say that I am now in the Province. Every six months they renewed my permit. But once the Medical School opened I had no choice but to come here. ... [but] I was very reluctant to come to this Medical School because the perception was that its going to be a “tribal” Medical School and we would be sort of second grade, with our qualifications not gaining any recognition. ... I was per force made to come to this university as they refused to give me a permit.

Thus from the beginning, the establishment of this black Medical School was complicated and the development of black medical education was fraught with many racial ambiguities and contradictions. Some of the students sitting in the first class were reluctant to be there, while others were delighted with this new institution.

Until his forced resignation in 1955, Gale in his position as Dean, did everything in his power to ensure the highest medical standards for the School. By doing this, he came into direct conflict with the State in relation to the standards of the building plan for the new Medical School itself, postgraduate training of all races, and his determination to raise the salaries of his staff. In 1954 he was criticised by the UN and the State for his “legend of extravagance and irresponsibility” in the capital expenditure on the new Medical School building.<sup>9</sup> In defending his actions, Gale argued that the implementation of unauthorised revisions and expenses was done to prevent jeopardising completion of the building before teaching of the first medical students commenced in 1954, while the initial design was open to criticisms as inferior and not up-to-date. Gale felt that the extra cost was in the best interest of the School and reputation of the UN, as it would remain in the public eye both locally and overseas, as an example of “positive” apartheid and thus must maintain the highest standards.<sup>10</sup> During this same period, Gale came into conflict with the State over their lack of interest in providing postgraduate facilities for all races. As Gale argued in 1956:

I would certainly not have resigned the post of Secretary for Health in order to become Dean of a Medical School restricted to undergraduate training. I believed, on the strength

<sup>9</sup> Gordon Papers. File 13, KCM 25771. Letter from G.W. Gale to Dr. E.G. Malherbe, 20th April 1954. p.1.

<sup>10</sup> UN Archives Pmb. H6/1/1. George Gale. “The Story of the Durban Medical School”, 25/1/76, p.12. Gale assumed that the UNDF would contribute to the additional costs, and when this alternative failed, he used his persuasive powers to convince former colleagues in the Government as well as other interested bodies to cover the additional costs.

of my discussions with two Ministers specifically [Drs Stals and Bremer] and of my faith in the good sense and reasonableness of their successors, that postgraduate training of Europeans would not only be permitted but encouraged - in the public interest.<sup>11</sup>

Gale argued that restricting white doctors access to the best facilities for advanced training in “non-European” health problems would diminish the return the country would obtain by way of increased numbers of personnel prepared to work in the black medical service in desperate need of doctors, and would result in no advanced research conducted at all, because it would take years before black doctors were available for postgraduate studies. Although Gale won his arguments for the existence of postgraduate studies at the School, these would only be for black students, as during his tenure, although he continually fought the State’s racial policies with regard to admissions, no white students were admitted to under- or post-graduate studies. Closely related to this debate, Gale also attempted to raise the low salaries of the staff at the Medical School, to attract the best staff, not the leavings of other medical schools. Gale argued that, as a pioneer Medical School, the staff would have to create standards and precedents through their own research work, and could not merely follow the lead of others, who had no experience in preparing black students to practice medicine against a background very different to the “white” experience.<sup>12</sup> Thus, through his persuasive arguments for the maintenance of the highest standards, Gale managed to secure external financial support to supplement salaries and offered staff terms not less favourable than at other schools. This external funding also provided research opportunities, which attracted many staff, members to the School.

When I asked Kallichurum what her thoughts were on the white Durban Medical School staff who taught her, she had only good things to say:

I think the training we had here at King Edward was superior, and it was also because I must say most of our, all of our professors and lecturers were white, but they were highly dedicated and motivated people you know. It was because of them that we as students felt we belonged here. ... role models are essential in medicine. ... I didn’t find, I must say, anyone of them racist you know, they accepted us as their students and we accepted them as our teachers. And on the whole the relationship was excellent. ... You know the term ‘a doctor means the teacher’. Every medical person is obliged to teach in

<sup>11</sup> Gordon. *Report on the Government’s Intended Action*, p.34. Letter to Dean of Faculty of Medicine by Dr. Gale.  
<sup>12</sup> Gordon Papers. File 13. KCM 25748. “UN Memorandum on the Financial Needs of the Medical School” Submitted to the UNDF on 15 April 1952 by Dr. Gale. p.1. Even if the salaries were equated, Natal was still at a disadvantage, as doctors with homes and careers already established in other cities were not likely to move elsewhere unless the prospects were better.

my book. ... They were of excellent quality ... You know, looking at, working in the Medical School and being the Dean here and looking at staff, I always said you know, we were very lucky, they were excellent people, you know, people who are hard to replace.<sup>13</sup>

Mayet also argued that many of the Professors were supportive and keen on working hard to produce results, “if you showed interest and took the initiative, they went out of their way to assist you and took an interest in you, a personal interest”.<sup>14</sup> In interviewing Mayet and Kallichurum I was interested in establishing what motivated these physicians to accept their positions at the segregated black Medical School, where they were subjected to social, academic and political stigmatisation as it was said “that they were carrying out the policy of the Government”.<sup>15</sup> When I asked Kallichurum what she thought motivated these doctors, and whether they were influenced by a social conscience and desire to train black doctors, she asserted:

Yes, and also an environment to achieve that in, you see. I think, if you think of Adams and Wilmot and Powell they’d have done very well in private practice. But they didn’t go for that too. ... Ja, its like Alan Taylor, why does he leave the States and come to run McCord hospital with so many problems. There are such people you know, they have this missionary spirit in them I think. ... I think it appeals to them to be in that environment, you know, to do something other than making money.<sup>16</sup>

In her view, they could have earned far more money in private practice:

it must be that they were dedicated to this establishment and its success, because they could have earned 20 times more outside. ... it was research and teaching that they were placing above. ... [They were] very good role models in a way, I can tell you that.<sup>17</sup>

During the interview with her, Kallichurum gave me a lengthy example of the sort of people some of the white Medical School staff were like and is worthy of being quoted at length:

It was a unique relationship, I don’t think that relationship was found in any other medical school. You know I was sick, and I was married and I was living in a flat and it was final year and it was July 1957 ... I had the flu and Professor Wilmot who was

<sup>13</sup> Interview with Professor Kallichurum.

<sup>14</sup> Interview with Professor Mayet.

<sup>15</sup> “Medical School Posts ‘Would be Declined’: Doctors Discuss New Bill”. *Cape Times*, 14/3/1957. Also see “Taking-over of Medical School by Government: Principal Warned Minister of Disastrous Results”. *Natal Mercury*, 11/5/1957.

<sup>16</sup> Interview with Professor Kallichurum.

<sup>17</sup> Interview with Professor Kallichurum.

the Professor of Medicine said “well where is she”. If you didn’t go to something they missed you, they knew you were not there, there were so few of us. ... And then one of the students said “I’m sick” and then he says, “well has she seen a doctor” and they said “well maybe and all”. He found that flat of mine and he came, home, and I saw him through the window and I thought “oh my God, he’s going to come in now and tell me why I’m not at [the School]” and he said “I have come to examine you because you should be better by now if it was the flu”. And then he told my husband he would take me to hospital, arranging a ward in the teaching ward, you know a little isolated room, ... because I had violent pneumonia, and my entire lung was involved. ... So he brought me and I was in hospital for over a month and the final exams were starting ... and Professor Adams said you write in June/July next year. I said not on your life, I’m going to write, because I had some books there and he took them away, you know, and then ... I got another set of books! [and passed everything]. Now which university would do that?<sup>18</sup>

She also felt that their white Professors should be respected and that reflecting on them may have something to teach present doctors in South Africa:

You know, that white staff spent more time with its students, much, much more time with students, than the staff presently do. ... I don’t think any student today has ... anywhere near the hours of contact we had with these people. It was a different era. You know, now days its limited by private practice, people are not here all the time. ... its very sad, because now, you know, the business enterprise becomes more important then the human endeavour of medicine.<sup>19</sup>

In an interview with an ex-Matron from McCord’s Zulu Hospital - who was a nurse at the King Edward VIII Hospital when the first class of black medical students were training there - Bongiwe Bolani promoted a largely different perspective of the white doctors working in the Medical School. Her particular view is useful as an “outsiders” perspective in direct comparison to the views of the black medical students quoted thus far. She questioned the white doctors’ motives for working in the School:

with the Medical School it was clear that white medical doctors could not train together with blacks. But this message was nothing new. Perhaps they felt us inferior ... But we passed the same standards even with those poor backgrounds. White people were good at deception and deceived us but we were quite clear that we were not intellectually inferior. There is something about white people always pushing for the highest standards. I get the feeling sometimes about the wonderful things they did and produced. What motivated them - was it to uplift and serve the interests of

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<sup>18</sup> Interview with Professor Kallichurum.

<sup>19</sup> Interview with Professor Kallichurum.

black medical students or to uphold and maintain their own standards and reputations. It was the glory of it all, but for whose benefit?<sup>20</sup>

### ***An Apartheid Anomaly: A Black Medical School in a White University.***

From the beginning, the Durban Medical School was also fraught with apartheid racial ambiguities in terms of its admissions requirements and candidate selection procedures. The Medical School was originally built to accommodate forty students in each year, but there were always many more qualified applications for admission than places available. This is evident when in 1951, the School selected thirty five students from approximately one hundred and seventy black applicants (of both sexes) to enter the pre-medical course.<sup>21</sup> The selection procedures of medical students in South Africa and even internationally, remains one of the most contentious aspects of medical education. This was also so for the Medical School's selection committee, who during these early years struggled to establish adequate selection procedures to assess student academic and personality characteristics to help them select the most promising students from the large number of qualified applicants who fulfilled the basic minimum requirements. Student selection was based on many factors including matriculation records, school principal reports, past university records, oral interviews and later, experimented with forms of intelligence tests to determine these students' intelligence, industry, interests, and personality.<sup>22</sup> Because of the School's high failure rate, an educational psychologist at the UN, W.R.C. Branford - during from the late-1950s to early-1960s - was employed to run a series of written and oral based "tests" on the first year medical students to determine whether their educational and family backgrounds and personality characteristics were "suited" to medical

<sup>20</sup> Interview with Bongiwe Bolani by Vanessa Noble, Durban, 1 May 1999. A very big thank you to Bongiwe Bolani for her very interesting and insightful comments with regard to her memories of the Durban Medical School.

<sup>21</sup> Medical School Archives. "Information for students seeking admission to the Faculty of Medicine of the UN", p.4. The course was open to all matriculated black students who had in addition, passed mathematics and English. Students who held approved degrees at any other recognised university who had obtained credits in Botany, Chemistry, Physics and Zoology, such as those holding the B.Sc. (Hygiene) degree from Fort Hare, were permitted to enter direct work in the second year. Also see Gordon Papers. File 18. KCM 25863. Letter from H.S. van der Walt, Secretary for Education, Arts and Science to the High Commissioner of Southern Rhodesia on 5/11/53. Limited admissions were opened to African students north of the Union on condition that accommodation was available at the School, and that no Union blacks were denied opportunities.

<sup>22</sup> Gordon Papers. File 21, KCM 25878. "Report of Screening Committee appointed to consider Application for Admission in 1956" and Gordon. *Report on the Government's Intended Action*, p.13. See Saul Dubow. *Illicit Union: Scientific Racism in Modern South Africa*. (Cambridge: Cambridge University Press, 1995), p.244-245. Dubow argues how this "objective" intelligence testing gave people in authority (race defined the privileged position of the tester) the power to calculate and delimit the intelligence of their subjects, legitimising the right of whites to make decisions for and on behalf of blacks. It was only in 1964 that the selection committee discontinued these



training. In his 1961 Ph.D. dissertation, as the title “Some Problems in the Selection and Preliminary Training of Non-European Medical Schools” suggests, Branford investigated some of the difficulties involved in the selection and later successful completion of aspiring black medical students at the School.<sup>23</sup> Intelligence testing had a long tradition in South Africa as a long-standing feature of racial science, supposedly based on “objective” and “scientific” criteria for measuring racial differences and educability. While methodologically flawed and unreliable, it continued to be used to understand the “native mind” until the mid-1960s, showing the pervasiveness of racist ideas about black mental inferiority and educability. As Dubow argued:

mental testing ... objectified those whom it observed, sustaining the notion of the existence of essential differences between ‘us’ and ‘them’. ... Power was conferred upon those specialists ... with the authority to calculate and delimit the intelligence of others. In general terms, it legitimised the right of whites to make decisions for and on behalf of Africans.<sup>24</sup>

Branford’s investigations, as well as a number of articles during the 1970s in the *South African Medical Journal*, demonstrates how the debate over relevant selection procedures was still very much on the medical agenda (of all medical schools in South Africa and abroad) and this continued through the 1980s and into the present.<sup>25</sup> All investigations recognise the weaknesses and criticise them for being biased, emotive, having an overemphasis on test-demonstrated intelligence, which showed a poor correlation with general ability, later academic, work and performance.<sup>26</sup> Personality tests and interviews were also viewed as inadequate and showed the conceit of selectors who assumed that they could get an accurate reflection of students in a few minutes.<sup>27</sup> Branford also argued that the many years at medical school had a profound influence on students and could remarkably change them. He argued that a single set of

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tests/interviews.

<sup>23</sup> See W.R.G. Branford. “Some Problems in the Selection and Training of non-European Medical Students”. (University of Natal Durban: Unpublished Ph.D. dissertation, 1961).

<sup>24</sup> Dubow. *Illicit Union*, p.244-245.

<sup>25</sup> See “The Selection of Medical Students”, *SAMJ*, 23 March 1957 and M.A. Simpson. “Selection of Medical Students - A Review”. *SAMJ*, 25 November, 1978. Also see J.V.O. Reid and A.J. Wilcot (eds). *Medical Education in South Africa. Proceedings of the Conference on Medical Education held at the University of Natal, Durban in July 1964*. (Pietermaritzburg: University of Natal Press, 1965). A number of chapters in this volume debate the problems of medical school selection procedures around South Africa.

<sup>26</sup> See Simpson. “Selection of Medical Students - A Review”, p.929-930 and “The Selection of Medical Students”. *SAMJ*, 23 March 1957, p.292.

<sup>27</sup> “The Selection of Medical Students”. *SAMJ*, 23 March 1957, p.292. Branford also did extensive research into the problems of applying categories of age, health, marital status, financial position, environmental background and sex as ways of correctly selecting the most promising medical students.

standards should not be laid down, and that medicine and health services have a wide scope for many different types of people.<sup>28</sup>

For the Durban Medical School, such test-demonstrated intelligence selection criteria were in place until the mid-1960s, but were also evident in other Schools where qualified candidate applications always outnumbered the number of places available. Further racial ambiguities can be seen in the proportion of Indian, African and Coloured students selected for admission. It's important to note that while issues of intelligence and personality characteristics were vital for selection, other external issues such as socio-economic factors and need for doctors to address specific racial group shortages also influenced the number of applications and selection board decisions.<sup>29</sup> The shortage of African students with the necessary qualifications (because of their poor school education) also influenced who was able to take advantage of the medical training facilities. The selection committee had to make difficult decisions concerning choosing Indian applicants with a better chance of graduating or African applicants whose communities were seen to need them more. This was extremely problematic since Durban was the only city at the time with an approximately equal one-third proportion of Indians, Africans and whites. From 1951-1955 the racist trend of the selection committee is evident. One hundred and ninety one students enrolled, with one hundred and eight African, seventy four Indian and nine Coloured.<sup>30</sup> The racial distribution of students included: 55% African, 30% Indian, 7% Coloured, thus favouring African. Foreign-born students made up the rest. The statistics make interesting reading, showing how the Medical School authorities were essentially racist in their selection of black students, denying Indians equal opportunity to the School. Between 1951-53 there were approximately as many candidates as places available, compared to 1960 where there were three times as many students, making selection procedures even more difficult. During this same period, while higher proportions of Indians succeeded in qualifying for admission, fewer places were awarded to them than to Africans. There was no corresponding increase in qualified

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<sup>28</sup> "The Selection of Medical Students". *SAMJ*, 23 March 1957, p.292.

<sup>29</sup> E.G. Malherbe. File 465/4/2. KCM 56990 (184). Comments on Recommendations of the Interdepartmental Committee on the Establishment of Separate University Colleges for Non-Europeans. Government White Paper, 1957, p.2-3.

<sup>30</sup> E.G. Malherbe. File 463/5/2 KCM 56990 (59) f. Interim Report on Applicants of Admission to Pre-Medical Courses at UN 1951-60 by W.R.G. Branford, pgs. 4-5.

African applicants even though by 1959 all other schools were closed to blacks.<sup>31</sup> These tests and admission quotas, thus perpetuated racial inequalities and complex power politics in the School.

### *Academic and Residential Zoning.*

One of the most distinctive aspects of South African history has been the extent and range of its discriminatory legislation, where most facilities and services between people of different races, were progressively restricted and divided on a racial basis.<sup>32</sup> As a black medical faculty in a white university and society where ideas about racial segregation and apartheid were entrenched, the Durban Medical School was fraught with ambiguities as it tried academically to escape these racial restrictions, while socially and residentially, it perpetuated racial apartheid ideology to perfection. The siting of the Medical School on Umbilo Road, was filled with great controversy. Strong initial opposition from the Durban City Council (from whom it had to get permission to build) around the issue of providing black medical student residences on the premises, almost prevented its erection. Many Council members spoke strongly against the proposed building and even told Malherbe “to promise to build a 10 ft wall on the pavement of Umbilo Road to shut off the Medical School should it be built there”. Only after persistent “lobbying” from Malherbe and Taylor did they secure approval.<sup>33</sup> However, while the School won the right to be built in a central position in Durban, adjacent to the black King Edward VIII Hospital, which serviced Natal and even the Union, the Durban City Council would not agree to allow black medical students to have their residences anywhere near King Edward, because of its proximity to white residential and shopping areas. One of Gale’s first duties as Dean was to assure the Council that:

<sup>31</sup> E.G.M. File 463/5/2. KCM 56990 (59)f. Branford. Interim Report on Applicants of Admission, pgs. 4-5. In this situation one would have expected an increase in numbers of African students applying to Durban Medical School who were turned away from applying at other “white” universities. From 1951-1955, of the 191 students enrolled, 161 were men (83%) and 30 were women (17%). The percentage losses were 30% African, 30% Indian, 11% Coloured; 30% men and 23% women. It is interesting to point out with regard to the student body in Durban, that about 5% are women, which differs markedly from African student bodies in other medical schools in Africa (south of the Sahara) in which women student were rare. Among the 14 pioneer graduates in 1957, there were 3 women.

<sup>32</sup> William Beinart and Saul Dubow (eds). *Segregation and Apartheid in Twentieth-Century South Africa*. (London and New York: Routledge, 1995), p.4.

<sup>33</sup> E.G. Malherbe. *Never a Dull Moment*. (South Africa: Timmins Publishers, 1981), p.297. Much opposition came from the Mayor Percy Osborne at the time.

students would not be allowed to use the natural main entrance, from Umbilo Road, into the School and that no hostel for medical students would ever be built for medical students anywhere in Congella.<sup>34</sup>

Racial zoning and residential segregation of the city by Group Areas legislation made it impossible to obtain land with security of tenure in a close position to the School.<sup>35</sup> Eventually the World War II military building site at Wentworth, eleven kilometres away from the School, was negotiated and converted into hostels, but also lecture rooms and labs for the full-time premedical training of the “preliminary” and first year students. This “arrangement”, according to Malherbe, “favoured the perspective of town planning”, as it provided a useful “buffer” between black and white residential areas extending south and north respectively.<sup>36</sup>

Black medical students were subject to a host of legal restrictions and prohibitions in white urban and residential areas. There were many disadvantages of having the hostel at Wentworth. The students experienced huge transport problems living in a hostel eleven kilometres miles away from the Medical School and fifteen kilometres from the CBD, where there was no direct municipal transport. The great distances insisted upon by apartheid residential zoning resulted in great additional expenses to the students and UN, which had to assist with daily transport for students and staff between Wentworth and the Medical School.<sup>37</sup> As Kallichurum argued:

I think that second year was the hardest for us. It was hard for two reasons, because we had to live in residence at Wentworth, and travel here for classes and we did the anatomy dissections here in the morning, and we had to get back to do physiology laboratory work at Wentworth. ... and transport wasn't very good those days.<sup>38</sup>

Indians who were greatly affected by Group Areas residential relocations and segregation, experienced great hardships as medical students if they lived at home and were forced to spend far more time commuting. As Mayet maintained:

<sup>34</sup> UN Archives Pmb. H6/1/1. Gale. “The Story of the Durban Medical School”, p.18. It’s ironic that while the Durban City Council would not allow any hostel to be built for black medical students anywhere in Congella, black nurses were housed on land immediately adjacent to the hospital area of King Edward.

<sup>35</sup> Gordon Papers. File 23, KCM 25915. “Premedical Courses in Arts and Sciences and Non-European Hostel” p.3.

<sup>36</sup> Letter from E.G. Malherbe to the Secretary for Public Works, Department of Public Works, 14th August 1947. SAB, UOD, Vol. 56, Ref. U3/26/4/5, p.2.

<sup>37</sup> Gordon Papers. File 23, KCM 25915. “Premedical Courses in Arts and Sciences and Non-European Hostel”. p.1. Often students had to walk long distances to reduce the cost of the fare, and spent many wasted hours commuting.

<sup>38</sup> Interview with Professor Kallichurum.

no, I didn't live in. We started off at Wentworth, and had to catch a bus all the way in ... it was restrictive, because by the time we got home, and the time at which you had to leave to go to Wentworth wasn't easy and if you finished work, finished from university or left Wentworth late, the buses were full already when we had to go home ... so we had to stand in queues in order to catch our buses and by the time we go home it was dark.<sup>39</sup>

When pushed on this issue, Mayet felt that there were many difficulties in those early days around transport issues, but also because the Medical School building had not yet been erected when they started with their premedical subjects. This added more pressure to their load:

There was a lot of pressure and then when we were in second year, we had to move into the Medical School in Umbilo Road because the Anatomy Act was not satisfied by the dissection room that we had [at Wentworth] ... so we had to go to Umbilo Road where they were still building. The builders were there, the construction site and so on. ... we used to have to travel. Anatomy was here in Umbilo Road, Physiology and everything else was over there. ... we had to go by bus, and we had to jump over things and so on. ... The noise was there and then for tea, we used to get the builders to give us their water, boiled water, which was full of smoke because there were no other facilities, they were still at ground level so they just had to finish the Anatomy Department so that we could be accommodated.<sup>40</sup>

As part of the set of interviews I conducted I was also interested in exploring this first group of students' relations with one another as the first pioneering group of black medical students. Both Mayet and Kallichurum felt that as a group, they had excellent relationships with one another and were a very close-knit group. They studied and socialised together. Kallichurum felt that their relations with one another, were so good because:

it was such a small group of students, you know. ... 35 students isolated at Wentworth is not a big group, you know. And we knew each other well, and we spent a lot of time together, and I must say the male students were very protective towards the female students, living out there in isolation. ... and when we went out or anything, they were very protective, made sure that somebody came with us to the shop or something like that.<sup>41</sup>

When I asked her about whether there were any difficulties with regard to the racially mixed or heterogeneous group, she maintained that there were no problems,

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<sup>39</sup> Interview with Professor Mayet.

<sup>40</sup> Interview with Professor Mayet.

<sup>41</sup> Interview with Professor Kallichurum.

There was never any difficulty with that. You know, the black cultural group, a lot of Indian students understood because ... we were closer to them than to whites. We didn't understand the white cultural group, we understood the black, African cultural group and coloured groups, it was great, we all just got on well, we were great friends.

However, living in a racist apartheid city, many African students directly experienced the effects of racial zoning and curfew restrictions (11p.m.-4a.m.) more harshly than their peers. They were particularly affected by the 1952 Native Laws Amendment Act, which aimed to establish greater State control over the movements of Africans in urban areas. While the municipality gave the UN permission to give written "certificates" to full-time African students, they were not a guarantee against arrest.<sup>42</sup> This introduced an atmosphere of insecurity. Dr. B.T. Naidoo, also one of the first class to graduate argued:

we endured the holding of courses in humanities at a black campus 25 kilometres away, after hours, and with no organised transport facilities. This resulted in students being held in police cells for transgressing curfew regulations.<sup>43</sup>

Professor Kallichurum argued that it was essential for their group of medical students to remain so close so that they could help each other out if they experienced any problems. There were many problems with regard to students violating curfew restrictions, as Kallichurum claimed:

you know, when you isolate a group of people, there's more than just your studies in medicine that brings them together, its your whole lifestyle in this country. So you know, they often said this student body is very political, that isolation made us political. ... We spent time with each other, got to know each other, we got to know each other's problems you know, and there was a sharing of knowledge and ideas and activities. ... because very often you'd get a phone call from a black student who was picked up because he didn't have his pass on him, and the students had to go on a collection drive and bale him out because he was part of that group. I don't think big groups could ever be as close as we were, I doubt it. ... and we only had ourselves really, there was nobody else, our families were not around.<sup>44</sup>

Students were also cut off from contact between staff, other students on the main UN campus and from their families. The site was dangerous to their health because their nearest neighbour was the Standard Vacuum Oil Refinery, which emitted foul smells and fumes, and intermittent

<sup>42</sup> Gordon Papers. File 6, KCM 25708. Appendix CC. "Some Comments by the Organiser on Pass and Curfew Laws that Affect our African students. 24 April 1956.

<sup>43</sup> *The University of Natal Medical School Reconciliation Graduation Booklet, 1995*. (Durban: Indicator Press, 1995), p.17.

<sup>44</sup> Interview with Professor Kallichurum.

noises, which disturbed both lectures and sleep. A doctor argued, that it was quite possible “that exposure to some of these fumes, however dilute and intermittent, over a period of 7 years may produce toxic states of liver, bone-marrow, blood etc., especially in adolescents and young adults”.<sup>45</sup> The fumes induced asthma, headaches and nausea. It even interfered with laboratory apparatus by causing rubber and fabrics to rot. B.T. Naidoo also argued that the residential facilities were overcrowded, of poor quality, had meagre recreational facilities, rigid meal times and strict regulations. Because it was a converted military barracks that the UN was able to purchase, the student accommodation and facilities were very sparse and uncomfortable.

Kallichurum argues:

it was really army type barracks. Our rooms and all, were just absolutely sparse, you know. ... separate, females had a separate building and the males had a separate building. But it was very, how could I describe it. You know, when you look at the movies with these army things - the beds there, and there’s one wardrobe there and there was one table you know, and two people had to share the room. So it wasn’t a very comfortable place. ... you had to make do.<sup>46</sup>

Thus, residential zoning made life very difficult for these black medical students. When I asked them whether they thought their early years studying medicine managed to shield them from broader politics, both Mayet and Kallichurum argued that their lives, and that of the rest of the black students were always political. Kallichurum argued:

there’s one thing this University must understand. I was a student here and I know. I said my everyday life is politically determined, I study where I study for political reasons, I worked where I worked for political reasons, I drive through certain streets to reach home for political reasons and I stay where I stay for political reasons. My whole life is determined by politics, you know.... So I said ... we must understand that every move they make is political. ... life is political for us ... but it was a fact of life, which I felt, the University never understood.<sup>47</sup>

Mayet maintained that you had to be determined and committed to qualify. As medical students they had to overcome the challenges thrown at them in a very political environment, and while she recognised all the contradictions with regard to training and treatment by race, she felt that in all professions black South Africans chose to enter, politics would always be a determining factor:

<sup>45</sup> Gordon Papers. File 23, KCM 25915. “Premedical Courses in Arts and Sciences and Non-European Hostel”. p.2.

<sup>46</sup> Interview with Professor Kallichurum.

if you're a black in South Africa, your life is politics, you can't get away from it. ... But you couldn't do anything in life, without it being racial. I joined the medical profession to assist with the upliftment of the community, in which you were practicing. We had no choice. ... So we were with politics all the time.

Thus, by 1955 the racial restrictions the School perpetuated socially and politically resulted in the development of a highly complex and ambiguous institution. The nature of medical practice in South Africa demonstrated that ideological forces, political considerations and deep structural inequalities shaped and mediated the "creation" of a black medical profession. It was embroiled in the dominant political battles of the day, where the preservation and dominance of white political power determined how resources in the black community were distributed. The School's racial ambiguity was even carried as far as the restricted work that the future graduates of the School would undertake. From the beginning, the Medical School facilitated the creation of a racially "skewed" black medical profession. Because many African students could not afford to attend the School, a bursary scheme was an inseparable counterpart to a Medical School to train black doctors for the desperately underserved reserve areas. Recognising this, the State offered fifteen bursary/loans in each year of study on condition that African student bursars would confine their medical practices' to their "own race" and/or only in areas approved by the State, where they would be "in the service of the Government for a period ... of at least one year for every 200 pounds allocated to the candidate".<sup>48</sup> The racially based nature of the award was also evident by the fact that it was confined to African students alone. Only one award could be made to an Indian and/or Coloured student if there was a lack of suitable African students.<sup>49</sup> While Mayet and Kallichurum felt that this racial allocation of bursaries was not fair, they knew that the School had been established to train mainly African

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<sup>47</sup> Interview with Professor Kallichurum.

<sup>48</sup> Gordon Papers. File 21. KCM 25878. "Summary of Conditions of the Award of a Bursary/Loan offered by the Government of the Union of South Africa at the UN", p.1. The award amounted to £150 p.a. for the first 2 years and £200 p.a. for each of the subsequent 5 years, resulting in a total of £1,300. In terms of the agreement, bursars had to repay half the sum advanced to them (together with 4% in instalments repayable beginning in the year of their compulsory internship. Also see Gale. "Medical Schools in Africa", p.716. When the Medical School opened in 1951, the State cancelled its bursaries for black students at Wits, and offered them at Durban only. The State's intention was to make it illegal in the future for "open" universities to admit black students, and this represented a way of channelling black students into their own exclusive institutions and help created a State-sponsored black medical profession whose practice was restricted to certain areas.

<sup>49</sup> Gordon Papers. File 8. KCM 22571. Minutes of Meeting of Acting Board of Faculty of Medicine held on 1 September, 1954 at the City Building. For most Indian and Coloured students, financial worries were always high on the agenda, and had to rely on private funds, gained largely from family members or other bodies.



students, whose communities, especially in rural areas, were in desperate need of medical services. Both of these Indian students had to finance their own studies, and as Mayet argued, “it was a great sacrifice” to her parents. Kallichurum argued that:

it was Government-funded, but the Indian students were fee-paying students, because the Medical School was established mainly for African students, and because there were places left, that the Indian students came in, they were fee-paying, they were not on any Government grant. ... it was very clear, and you had to go and work in the homeland or area that gave you the bursary. It ... came from the ... Government to their students and also you had to give back so much, so many years in service anyway, you see, so I think a lot of the Indian students didn't apply for that.<sup>50</sup>

Thus, the contradictions regarding this bursary were evident at the time, but many African students had no choice but to apply for, and accept this bursary to enable them to study medicine. And from 1959, the State was in the position to recruit approximately fifteen doctors annually to serve in the whole-time public health department medical service in black areas. These bursaries thus tied the students to the State for a number of years and helped to create a *black State Medical Service*.

### ***“Unique Curriculum” for Black Medical Education in South Africa: The Durban Medical School as a Haven for Aspiring Black Professionals.***

Thus, while I have argued that the Medical School was inherently racist, perpetuating many of the white society's ideas within the School, this chapter is also concerned with analysing how academically, the Medical School was a protective “haven” for a small elite group of aspiring black doctors. In 1951 when the School first opened, there were scarcely the beginnings of an African medical profession. Many anxieties prevailed around what kind of profession it would be and the medical training it would provide. However, it was maintained from the start that the aim of the Durban Medical School was the creation of a black medical profession of the highest standards. In an increasingly racist society, this Medical School pioneered a number of “progressive” and farsighted advances in medical training and curriculum. This section is concerned with analysing developments of innovative and progressive social and community health ideas, which were taken up by one Department, in one black Medical School in Durban. Rather than being another inferior institution in a racist white

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<sup>50</sup> Interview with Professor Kallichurum.

society for black students, this Medical School, through its Department of Social, Preventive and Family Medicine, revolutionised the medical curriculum and concurrently, thinking in medical education nationally and internationally. I will argue that once established in this academic institution in the syllabus of the medical training of aspiring black doctors, and thus more protected from fluctuating Governmental support, ideas concerning social and community preventive medicine were promoted to new heights, as the Department led the Medical School to international recognition, placing it at the forefront of all other medical schools interested in this field. Durban, because of its interest in social and community health, thus became viewed as a community health laboratory, but one providing the highest academic standards whilst entrenched under the control of a free-thinking academic university institution.

### ***Wider Trends in Social Medicine Internationally.***

While I will argue that the Durban Medical School's orientation and curriculum was largely unique in comparison to other medical schools in South Africa and even the world, it is important to recognise that it was not formed in a vacuum, but influenced by wider medical education trends and debates.<sup>51</sup> What is interesting though, is that as a fledgling Medical School attempting to find its way during the early-1950s, instead of following the trend in most medical schools of increasing fragmented specialisation, it committed itself to a curriculum that moved away from this trend to a more liberal and general education.<sup>52</sup> The Medical School Curriculum committee felt that teaching in general practice and social medicine should be carefully integrated and co-ordinated at every level. It was directly influenced by the recommendations of the world renowned 1944 British Goodenough Report, which argued that the present deficient system of medical education which neglected the promotion of health required a radical reorientation, and that:

training must fit the student to enter practice as a general practitioner who should possess a scientific foundation for professional work and a proper outlook on social aspects of medicine and the promotion of mental and bodily healing.<sup>53</sup>

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<sup>51</sup> Gordon. *Report on the Government's Intended Action*, p.11.

<sup>52</sup> G.P. File 1. KCM 25662. UN Medical School. UN: Report of the Sub-Committee appointed by the Acting Board of the Faculty of Medicine to draft a Proposed Curriculum for the Training of African Medical Students, 1/9/50, p.1.

<sup>53</sup> Gordon Papers. File 1. KCM 25662. Report of Sub-Committee appointed by Acting Board of Faculty of Medicine to Draft a Proposed Curriculum for Training African Medical Students, 1 Sept. 1950. Also see Reid and Wilcot (eds). *Medical Education in South Africa*. It was felt that black student doctors should be given a sound foundation

Many counter-arguments had to be made that this orientation was a positive attribute not to be acquainted with the stigma of inferior standards associated with an exclusively black Medical School. As Dr Alan Taylor strongly asserted:

although it is recognised that as a new school we can more easily break new ground than can a long-established school, it is felt that ... other things must be added on to basic things, not used to replace them. ... It will probably be much more difficult to make significant changes after a given curriculum has been followed even for only a few years, than to introduce them from the outset. We should not allow the fear of misrepresentation by agitators to deter us from innovations which are in the ultimate interests both of the students and of the people whom they will service; and in any case full reasons for innovation should be given to all concerned: even agitators will do the School good if they compel it to explain and defend what it is doing.<sup>54</sup>

It's important to note that while the Durban Medical School had a different orientation, it still offered a full medical qualification that followed the requirements laid down by the South African Medical and Dental Council which only allowed doctors to register as medical practitioners based on one standard and on the same professional basis as other qualified "white" doctors with full status.<sup>55</sup> When I asked Kallichurum about her views regarding how it came to be that in this very racist city of Durban, progressive social and community health ideas took hold, she argued:

you know when you said Durban was the most racist city, I wouldn't agree with you. I found the cities in the Transvaal, Johannesburg and Pretoria very racist, even the Cape. I thought Durban was more progressive health wise, it was the very first Province that took black nurses into white hospitals, that allowed black doctors eventually to go into white hospitals. There was no other place that did that. So Durban wasn't that racist as the other Provinces. ... otherwise we wouldn't have this Medical School in a white area, you know ... the people in Durban were prepared to listen. I don't think they'd have

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to help students acquire a competent grasp of what was essential from the mass of new knowledge and scientific discoveries, and help in the conditioning of the student towards adapting their professional practice to the ever-changing pattern of medical practice.

<sup>54</sup> G.P. File 17. KCM 25841. UN Medical School. Minutes of the Meeting of the Curriculum Sub-Committee, Durban, by G.W. Gale, 20/6/1952, p.1.

<sup>55</sup> UN Archives, Pmb. H6/1/10. "Memorandum prepared by Prof. I. Gordon for Informal meeting between Prof. F.E. Stock and Prof. Gordon and Adams and Dr Cochran", 19 May 1970, p.6. See G.P. File 17. KCM 25841. UN Medical School. Minutes of the Meeting of the Curriculum Sub-Committee, Durban, by G.W. Gale, 20/6/1952, p.1. Here continued training in curative medicine would persist. However, it would promote more of a preventive approach. At the outset of its rules for the "Minimum Medical Curriculum" the SAMDC states: (1) The main task of medical schools is to train general practitioners. (2) Emphasis must be laid on the preventive aspects of medicine throughout the whole period of study.

got the same reception in Pretoria, or Cape Town or Johannesburg or Bloemfontein, definitely not. ... I think it was easier to get something established in Natal, than anywhere else. ... Durban was definitely different. ... It was easier to get something started in Natal, if it had political connotations than anywhere else. They wouldn't even give you an ear, they wouldn't even listen in the other provinces.<sup>56</sup>

The aim of the new Durban Medical School curriculum was to pay more than merely lip service to the foregoing principles in planning and carrying out the curriculum for undergraduate training, as it was envisaged that the vast majority of black doctors would become and remain general practitioners among “non-Europeans”, as it is “among non-Europeans that the concepts of preventive and of social medicine applied in general practice and not merely in a public health service separately conducted, can do so much - as has been demonstrated in Health Centres in the Union - to raise the standards of health of the community as a whole”.<sup>57</sup> Much thought was given to the design of the curriculum by many interested bodies, which ensured that the curriculum was founded on the highest and most “modern” standards of western biomedicine, while also specifically adapted to meet the desperate health needs of the majority of black communities.<sup>58</sup>

### *A Seven Year Course.*

The establishment of the Medical School curriculum was also largely influenced by the problem of laying the foundations for a black medical profession of the highest standards, for students with a weaker secondary education and not equipped with the necessary scientific skills for the course. To ensure that the training would be in no way inferior, the course was lengthened to seven years, leading to the doctor's general qualification of M.B., Ch.B. (Bachelor of Medicine and Surgery taken concurrently), conforming to the requirements laid down by the

<sup>56</sup> Interview with Professor Kallichurum.

<sup>57</sup> G.P. File 17. KCM 25841. UN Medical School. Minutes of the Meeting of the Curriculum Sub-Committee, Durban, by G.W. Gale, 20/6/1952, p.1.

<sup>58</sup> G.P. File 1. KCM 25662. UN Medical School. UN: Report of the Sub-Committee appointed by the Acting Board of the Faculty of Medicine to draft a Proposed Curriculum for the Training of African Medical Students, 1/9/50, p.1. See E.G. Malherbe Collection, File 459/2. KCM 56977 (657). Anthropological and Medical Research at the UN. African and Non-European Research in South Africa. A Report to the Chairman of the Nuffield Foundation South African Liaison Committee, 6/6/1953, p.52. Gale argued that in the beginning the staff was to be all European and methods of instruction and standards of medical practice also those of European medical schools. He importantly recognised the contradictions in this situation where people who had no knowledge of the attitudes and beliefs about disease and medical practice of the communities they'd be eventually serving was training black doctors. For Gale, obtaining information about this and teaching it would provide a valuable background for the teaching of the

SAMDC.<sup>59</sup> The first to sixth years corresponded to the six years of medical training given at other medical schools in the Union, which dealt with the basic sciences in the early years and concluded in the last three years with clinical subjects.<sup>60</sup> However, in Durban, a “Preliminary” year was added to that given elsewhere, extending the pre-medical course to two years. During this year, additional subjects in the human and social sciences had to be taken together with biological and physical sciences.<sup>61</sup> Students were also required to take a credit course in Psychology during the “Second” and “Third” years to encourage greater understanding of human behaviour and culture in later family medicine and sensitive awareness of the effect of the social environment on health and disease.<sup>62</sup> Kark argued that it was very difficult to bring social and medical subjects together:

to try and bring these together wasn't that simple, it was hard to bring the social sciences together, to do something they'd never done before. ... Yes, we wanted them to integrate it for the medical students. ... when George [Gale] became Dean, it took form. It never really reached the full form we'd have liked though, it could have reached.<sup>63</sup>

As Head of Department of the newly established Medical School Department of Social, Preventive and Family Medicine, Kark experience opposition from both the conventional departments and staff, and the medical students, who at first, questioned the value of this sort of social medicine work and did not appreciate its importance for medical practice. There were objections from the staff also, largely because as an extra course, it was cutting into their time. One day a week the medical students did not even come to the Medical School but spent it out at the Institute of Family and Community Health (IFCH). As Kallichurum argued:

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practice of medicine. To do this he realised social anthropologists and doctors had to work together.

<sup>59</sup> E.G. Malherbe. File 464/2. KCM 56990 (130). *The South African Outlook*, p. 158.

<sup>60</sup> Gordon. *Report on the Government's Intended Action*, p.10. In March 1957 the syllabus was as follows: Preliminary year - English I (or Afrikaans I), History I, Botany I, Introduction to Physics and Chemistry. First year - Chemistry I, Physics I, Zoology I and Sociology I. Second Year - Anatomy, Physiology and Psychology. Third Year - Psychology (continued), Pathology and Pharmacology. Fourth, Fifth, and Sixth years - Medicine, Surgery, Obstetrics and Gynaecology, Social, Preventive and Family Medicine, Special subjects.

<sup>61</sup> See G.W. Gale. “Medical Schools in Africa: A Short Historical and Contemporary Survey”. *Journal of Medical Education*, Vol. 34, No. 8, August 1959, p.717 and *A Response to the Challenge of Africa*, p.32. The preliminary subjects included a language (English or Afrikaans), sociology and history accompanied by an introduction to the four pre-medical sciences (physics, botany, chemistry and zoology).

<sup>62</sup> Gordon. *Report on the Government's Intended Action*, p.14.

<sup>63</sup> UN Archives Pmb. H6/1/1. Interview with Professor S. Kark and Professor Gordon on some Facts and Aspects of our Medical School which are not Recorded, by S. Cameron-Dow, December 1980, p.20.

you know in the beginning we as students were a bit worried about this because now instead of writing four major subjects you were going to write five, it was a major subject. ... It was an orientation that wasn't present in the other disciplines at say King Edward. ... And it was just the orientation that came from a single department. ... didn't matter so much that it was a single Medical School. What mattered was that we found that it wasn't even fully accepted by the staff of this Medical School. ... And we also wondered whether it was racially oriented to have this, you know, to have this right at the very beginning, being the only Medical School with it, but then gradually we found out that it had nothing to do with all that, and towards the end we found that it was an exceptionally memorable course.<sup>64</sup>

Kark had to be very persuasive to influence his fellow medical colleagues on the Medical Faculty Board about his Department's worth. He eventually did get the co-operation of the other Professors in the clinical years. Kark felt that Gordon played an enormously influential role in this regard, because he supported Kark the whole way:

you may be embarrassed at this but this thing could not really have developed as an academic discipline without you as Dean ... a Dean who was supportive in the face of students real serious questioning of why they've got to do all this stuff when leading schools don't have to do it. If we hadn't have known that we had support from the Dean's office, it couldn't have happened and this has been one of the major problems in many schools in the world today where they introduced community Medicine and a new Dean's appointed and the Faculty and Community Medicine doesn't have the support of the Faculty Board itself and the thing gets undermined from both ends, the students who want to do with less than they've got to do if you add another subject and the Faculty Board ... who are not interested. ... the importance of a Dean in a School is tremendous, and without that support I don't think this thing could have gone on, even to the extent that it did go on.<sup>65</sup>

This curriculum structure in the early years of study provided an effective background for training in later years when students were required to undertake clinical subjects in King Edward VIII Hospital but also the homes of families in communities served by the affiliated IFCH in Durban.<sup>66</sup> Malherbe argued that the pre-medical course was lengthened to cater for black students with poor science backgrounds and language difficulties who would have otherwise failed the course.<sup>67</sup> Rather than failing students outright, he felt that spreading the teaching load deliberately over two years would allow the students necessary absorption time and thus prevent

<sup>64</sup> Interview with Professor Kallichurum.

<sup>65</sup> UN Archives Pmb. H6/1/1. Interview with Professor S. Kark and Professor Gordon, p.21-22.

<sup>66</sup> Gordon. *Report on the Government's Intended Action*, p.11.

<sup>67</sup> E.G. Malherbe. File 463/4/1, KCM 56990 (15) b. *The South African Outlook*, p.158. Also see Gordon Papers. File 17. KCM 25826. "Notes on Proposed Curriculum", 13/9/54.

failures in subsequent years. Gale also argued that it would “provide the student with a broader basis of general education before proceeding to [their] more specialised professional training” and promote an understanding of “western cultural values and institutions” which influenced the western biomedical tradition.<sup>68</sup> Taylor also felt that a curriculum oriented towards the social sciences would broaden the education:

the course could provide a stimulating introduction to modern medicine considered as a part of the cultural heritage of civilised mankind, and would enable non-European students in particular to see the health problems of the societies of which they are a part against a much wider background than the political, racial and even purely economic which at present occupies so much of their horizon.<sup>69</sup>

### ***Unique Influence of the Department of Social, Preventive and Family Medicine.***

The Medical School’s Department of Social, Preventive and Family Medicine, with its radical reorientation from existing orthodox medical training based on individual, disease-oriented curative, hospital-based medicine, was the School’s major contribution in the first decade of its existence.<sup>70</sup> As Malherbe contended, “it made a genuine contribution by supplementing training given at other schools rather than merely duplicating it”.<sup>71</sup> The progressive practical, clinical and research work of Sidney Kark and his colleagues in the IFCH - which became affiliated to the School in 1955 - for a short while made a historic attempt to reorient medicine to the prevention and promotion of good health in the community, where students came to appreciate the social and family conditions in which disease originates. Kark and his colleagues’ method was still designed around delivering health care to diverse communities by combining biomedical with sociological and psychological sciences, to understand wider socio-political and cultural influences on health. He continued the practice of multi-racial teams of doctors and health workers and a multi-disciplinary curriculum built on the sophisticated anthropological base of “social epidemiology” to develop a dynamic and

<sup>68</sup> Gale. “Medical Schools in Africa”, p.717.

<sup>69</sup> G.P. File 17. KCM 25841. UN Medical School. Minutes of the Meeting of the Curriculum Sub-Committee, Durban, by G.W. Gale, 20/6/1952, p.4.

<sup>70</sup> UN Archives, Pmb. H6/2/3. Correspondence concerning Establishment of the Department of Family Practice. Memorandum on the Establishment of a Department of Family Practice by Dr. G.W. Gale, 10/8/1953, p.5. Many medical schools in Europe and the US were establishing similar departments, very often with title of Department of Social Medicine - but this was a term the Medical School Faculty Board avoided because the content and purpose of social medicine had become a matter of controversy and even confused with “socialised” medicine. Thus, these progressive doctors in continuing their radical approach, even had to take care with regarding to its naming.

continually evolving training, practice and service, modified in the light of experience and put to the most searching tests.<sup>72</sup> Durban was thus in the vanguard of medical schools, and no way inferior, as it provided the unique testing ground for an affiliation between two very different institutions which united social and community teaching, service and research in an academic setting. Instead of merely bringing the two institutions in line with other research and education institutions, their achievements far surpassed anything anyone could ever have imagined. As Head of Department, Sidney Kark was directly responsible for developing the particular type of social and community medical training that emerged. At this point, the work of individual pioneer doctors and their unique personalities, once again resurfaced as the State DH relinquished its power over their philosophies. Mervyn Susser has argued:

the content had been developed and honed since the years at Pholela. Kark, inveterate pedagogue, was ideally suited to the work. In all this Kark was direct or indirect mentor to many.<sup>73</sup>

Sheltered within an academic institution, Kark et al built on and even extended the innovative foundation of social and community health work laid down at Pholela and the IFCH. The IFCH, its integrated health centres, and its community services provided the practicing and clinical base for the Department of Social, Preventive and Family Medicine in much the same way as do various units in teaching hospitals associated with medical schools.<sup>74</sup> These doctors developed a “family practice”, and in Kark’s book, *A Practice of Social Medicine*, when reflecting back on his work in Natal during the 1960s, he argued that:

the whole practice of health centre development is one, which reflected an increased understanding of individuals in terms of their family situations, of families in terms of their life situation within the local community and finally the way of life of the community itself in relation to the social structure of South Africa.<sup>75</sup>

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<sup>71</sup> Letter from Dr Malherbe to Acting Secretary for Education, 8 January 1948. SAB, UOD, Vol. 1546, U3/40/4.

<sup>72</sup> Gordon Papers, File 14, KCM 25797. IFCH Report of the Medical Officer-in-Charge. Year ending June 30th, 1950, p.v. Kark et al recognised that it was impossible to design one standardised health care programme, as they were dealing with vastly different communities, with different health needs and problems.

<sup>73</sup> Mervyn Susser. “A South African Odyssey in Community Health: A Memoir of the Impact of the Teachings of Sidney Kark”. *American Journal of Public Health*, Vol. 83, No. 7, July 1993, p.1040.

<sup>74</sup> Sidney and Emily Kark. “A Practice of Social Medicine” in *A Practice of Social Medicine. A South African Teams Experiences in Different African Communities*. (Edinburgh and London: E. and S. Livingstone Ltd, 1962), p.35.

<sup>75</sup> James Trostle. “Anthropology and Epidemiology in the Twentieth Century: A Selective History of Collaborative Projects and Theoretical Affinities, 1920-1970” in Craig R. Janes et al (eds.), *Anthropology and Epidemiology*. D. Reidel Publishing Company, 1986, p.61.



As a practical training and service, a “family diagnosis” - or recognition of “the family”, of their personal and community health problems - had both individual and wider epidemiological implications for the study of the health at various levels, and formed one of the most important determinants of individual and public health.<sup>76</sup>

This “family practice” training extended over the three years of clinical studies and constituted the central core of the medical students’ experience in preventive social and community medicine. The training in this subject was provided by practical experience, including the weekly clinical clerking of families/communities and various demonstrations in the practicing health centres, supplemented by systematic lectures, case discussions and seminars.<sup>77</sup> Syllabus subjects included studies in family and neighbourhood health, family care, epidemiology and public health administration and health education.<sup>78</sup> Steuart argued that staff responsible for both the basic training and service aspects gave an everyday reality to training by continually integrating training and service experiences.<sup>79</sup> Students were given at least one long-term family study to provide a continuous relationship with individual patients and their families, as well as a number of short-term allotments which provided varied experience of common health problems which were common in family and community practice at the IFCH.<sup>80</sup> Mayet maintained that this was a very useful form of experience, which she enjoyed very much. In both studies, investigations had a double objective of diagnosing, understanding and eventually treating individual and family, but students had the opportunity to consider the implications of family practice in the care of the community, the interdependence of family health aspects, social participation of families in common community group activities and by extension comparison with the experiences of other communities in South Africa.<sup>81</sup> Student home visits, early diagnosis of disease and development of programmes, together with

<sup>76</sup> Sidney and Emily Kark. “A Practice of Social Medicine”, p.7.

<sup>77</sup> Sidney L. Kark. “Family and Community Practice in the Medical Curriculum. A Clinical Teaching Program in Social Medicine”. *Journal of Medical Education*, Vol. 34, No. 9, September 1959, p.906.

<sup>78</sup> Gordon. *Report on the Government’s Intended Action*, p.17. For a more detailed analysis of this curriculum, see Medical School Archives. Report on the Faculty of Medicine for Inclusion in Principal’s Annual Report, 1956 and Sidney and Emily Kark. “A Practice of Social Medicine”, p.34.

<sup>79</sup> Guy W. Steuart. “Community Health Education” in *A Practice of Social Medicine. A South African Teams Experiences in Different African Communities*. Edinburgh and London: E. and S. Livingstone Ltd, 1962, p.89.

<sup>80</sup> Sidney and Emily Kark. “A Practice of Social Medicine”, p.36-37.

<sup>81</sup> Sidney L. Kark. “Family and Community Practice in the Medical Curriculum”, p.908. Sidney and Emily Kark. “A Practice of Social Medicine”, p.38.

modification of family habits producing ill-health aimed to reduce largely unnecessary and costly hospital admissions.<sup>82</sup>

When I interviewed Kallichurum and Mayet regarding Kark's work in the Department of Social, Preventive and Family Medicine, they both argued that he radically changed their perceptions about clinical practice:

the special thing about it was it taught us that it was just not the sick patient, you know, it was the family, it was the community, it was much broader than just having a patient and treating it and discard. There were other problems associated with it, within the family, within the community. ... we had to do home visits. ... We were not just concentrating on one sick person, we were concentrating firstly on the family and the community.<sup>83</sup>

She continued that this had a remarkable affect on her outlook whilst dealing with patients in King Edward VIII Hospital:

it had an impact on us because when we returned to King Edward we were thinking what's this person's family like and asking about these things, and we were not just seeing one person only in the bed. ... And you know, then when we were discharging patients we'd ask them where are you going, what's the family like, you know, where do you work? We would never have done that. Previously we just signed the discharge. But now we were asking our patients. ... he instilled in us, that it was just not the patient, the patient within a family, within a community, that's what he was teaching us, so he instilled that in us.<sup>84</sup>

Mayet concurred with Kallichurum's assessment of Kark's remarkable work:

we were particularly fortunate because we had Sidney Kark. Sidney Kark gave us that orientation, and that has helped me considerably. We did a Social, Preventive and Family medicine as a major, so it was on an equal footing with medicine, surgery, obstetrics and gynaecology and paediatrics and the three years that we spent there I think gave us a very good background into the social orientation. At first we resisted because it didn't exist at any other medical school, and we wondered whether this was an attempt to turn us into health educators ... But because of his competence, it gave us a very good orientation, and had a band of doctors who assisted him ... we always looked forward to his lectures ... I realised its value and I think it has had a very positive effect on my attitude towards medicine and caring and so on. ... a very much worthwhile experience. It shifted my orientation completely with this kind of clinical practice.<sup>85</sup>

<sup>82</sup> Sidney and Emily Kark. "A Practice of Social Medicine", p.39.

<sup>83</sup> Interview with Professor Kallichurum.

<sup>84</sup> Interview with Professor Kallichurum.

<sup>85</sup> Interview with Professor Mayet.

In 1959, a study was made of the first group of medical students' receptivity and attitudes to their social and preventive aspects of their training.<sup>86</sup> The findings indicated a considerable student awareness of the important of social and preventive health aspects, with a progressive increase during the three clinical years, which was influenced by students being repeatedly confronted with preventable diseases, which had obvious social and cultural determinants.<sup>87</sup> Because the majority of the students were members of black communities who personally experienced the social, political, economic and cultural problems of oppressed and underprivileged groups, its no wonder that there was high receptivity of ideas that poverty, poor diet, unsanitary conditions and poor housing were the most important factors in the production of disease.<sup>88</sup> However, while the specialised training of the Department of Social, Preventive and Family Medicine was appreciated and valued, the School experienced much resistance from students who resented wasting time and money on "extra" subjects in an "extra" preliminary year that differed to "white" medical school requirements.<sup>89</sup> Despite negative feedback from students, other influential outside observers were also impressed by the integrated nature of the curriculum which promoted a social medicine orientation throughout the course. In a letter to Professor Gordon, G.A. Elliot, Professor of Medicine at Wits gave a positive assessment of the Medical School's pioneer group of students. He argued that its students were given a better grounding than those at Wits, whose black students were always forced to "catch up" and were placed in direct competition with white students who had better opportunities. In his opinion:

these 14 students showed a standard of knowledge and understanding of the subject of medicine equal to any group of medical students I have been accustomed to examine over the past years in UCT, Pretoria and Wits.<sup>90</sup>

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<sup>86</sup> J.H. Abramson. "Natal Medical Students' Attitudes to the Social and Preventive Aspects of Medicine". *South African Medical Journal*, Vol. 35, 25 March 1961, p.250. The method used to gather data was based on voluntary, self-administered questionnaires which were anonymous.

<sup>87</sup> Abramson. "Natal Medical Students' Attitudes", p.253.

<sup>88</sup> Abramson. "Natal Medical Students' Attitudes", p.252-253. More than 90% regarded these factors as the most important factors causing disease in the preliminary and preclinical years. In the clinical years, while recognising the problems caused by these factors, they were also aware of the importance to the clinician of the patient's nutrition, knowledge and attitudes, and the value of patient education of making contact with relatives.

<sup>89</sup> UN Archives Pmb, H6/1/1. Interview with Prof. S. Kark and Prof. Gordon, p.21.

<sup>90</sup> Medical School Archive. Letter from G.A. Elliot, Professor of Medicine, Wits to Gordon. Report on the Examination in Medicine of the 14 final year Students of Durban Medical School", 25 November, 1957, p.1.

He was particularly impressed by what he called the students' "individual personalities", as they displayed no feelings of "difference" to their fellow students and could stand on their own feet to fight their own battles. In his view, the Durban model was a success story from the start.

Realising that Mayet and Kallichurum and their fellow students thus spent a great deal of time with Sidney Kark, I was interested to learn about their particular thoughts with regard to him as a person and doctor. Kallichurum highly respected Kark for going the extra mile and taking a particular interest in his students:

Kark was more a caring sort of person, you know, who taught us the caring attitude towards patients. ... he did go the extra mile. ... [he spent] a lot of time, and that's where there was a difference because ... even while I was a student, the Karks became my friend. ... I think it was unique, it was a relationship that was unique, being a student.... they took an interest in all students but then we became sort of friends. ... They were tremendous people you know, they were, I'd say they were, both the husband and wife were, and a lot of people who worked with them, were sort of very caring people you know. And Kark was exceptionally bright, he was, he was an exceptionally intelligent man and a very good listener and he was very good, quite unique.<sup>91</sup>

Mayet respected him because of his community concern and his strong determination in what he believed in:

I enjoyed working with him, [he was] very approachable and concerned, and genuinely concerned about the community and its problems. And really believed in what he was doing, in starting that Pholela centre, community centre.<sup>92</sup>

When I asked them what they thought motivated the Karks to become community health doctors, this is what Kallichurum had to say:

I think what could have motivated them is the suffering that was surrounding them, you know, the neglect of people in this country. I think those things must have motivated them, that here I can do something, you know, and see the rewards for it in people whom I'm helping. ... Whereas if you are a doctor say in private practice, you're like any other doctor, if they get tired of seeing you, they'll go to another doctor, you know. But this is different where these people sort of become dependent on you and you feel that you are responsible for them. ... and you can't just leave them, if you start feeling responsible for people.<sup>93</sup>

<sup>91</sup> Interview with Professor Kallichurum.

<sup>92</sup> Interview with Professor Mayet.

<sup>93</sup> Interview with Professor Kallichurum.

Mayet maintained that it had to do with their social commitment to the community:

I think it's just their commitment and dedication to the community, that community-orientation and identified the problems. ... all staff was Jewish, all medical staff was Jewish. ... It was also their mission [to alleviate] all this suffering and deprivation, and that maybe we should concentrate on it.<sup>94</sup>

Thus, the inclusion of the teaching of social and community medicine and health education as part of a major subject for qualification alongside medicine, surgery and obstetrics and gynaecology was a very progressive step for the Durban Medical School, and an important area of student experience not evident in any of the other medical schools. In 1954, an editorial in the *Natal Mercury* argued that,

the Durban Medical School will be first to make provision, through a Department established for the purpose, for training in clinical practice in the consulting room and the home, and among perhaps only a dozen in the world which do so, although such a step is in accordance with recommendations which medical educationalists have been making for many years. The School will thus be one of the pioneers of an important advance in medical education.<sup>95</sup>

### ***Themba Bolani - A Story of Crushed Medical Hopes and Thwarted Dreams.***

In 1957, the first group of these pioneer medical students graduated. While this thesis is mainly concerned with analysing the “success” stories of the School - of its staff and students – it's also important to reflect on the effect it would have had for aspiring black doctors who never managed to complete the course. In an original class of thirty five in 1951, only twelve graduated - there were four African men (no women), three Indian men and three Indian women and two Coloured men. The pioneering class thus totalled nine men and three women.<sup>96</sup> During the early years, but also throughout the medical course, the failure rate was high. While many students managed to repeat years and get through that way (but involving far more expense and time), others never returned. The effect on those students who did not succeed, and the pressure, which they must have felt as elite groups of aspiring black doctors, must have been enormous. Many failed for a variety of reasons, such as being insufficiently prepared with their weaker

<sup>94</sup> Interview with Professor Mayet.

<sup>95</sup> E.G. Malherbe. File 463/5/2. University of Natal Medical School. *Natal Mercury*, 11/11/54.

<sup>96</sup> B.T. Naidoo. “A History of the Durban Medical School”. *SAMJ*, 25 September 1976, p.1627.

educational backgrounds to undertake the gruelling course, heavy family responsibilities, and insufficient finances to support themselves. The maintenance of the highest standards comparable to other Medical Schools was also always the School's main objective, which made it difficult to pass, as Kallichurum argued:

I think because this medical faculty being black set a standard, as I told you, Dr Gale told us the standards will be extremely high because of the colour of this institution, because it'll never be a third rate degree, the standards were high, there's no doubt about it. I think that if those students were around now, they'd have passed. ... The staff at this Faculty had to prove that the end product would be good, that's it, better than anywhere else, you know. ... There was no leeway.<sup>97</sup>

After several years of establishing trust with the ex-Matron from McCord - Bongiwe Bolani - mentioned earlier in the dissertation, I asked her if I could interview her about her late husband's painful experiences at the UN Medical School when he failed to continue his studies. She had referred to this in passing as part of another oral based project.<sup>98</sup> I shall demonstrate that Themba Bolani's failed attempt to complete his medical degree had an enormous influence on his and his

<sup>97</sup> Interview with Professor Kallichurum.

<sup>98</sup> See Janet Twine. "I'm Just an Ordinary Nurse": A Life History of Matron Bongiwe Bolani. (University of Natal Durban: Honours Dissertation in History, 1997). Its important to note, as Shula Marks does in her book, *Divided Sisterhood: Race, Class and Gender in the South African Nursing Profession*. (Johannesburg: Witwatersrand University Press, 1994), that during the early-1980s very little had been written about women's health or women as the providers of health services in South Africa. Thus many scholars embarked on projects throughout the 1980s and 1990s on women and health. Much of this work has been focused on the nursing profession which has importantly uncovered the hidden voices of these health providers by appropriating categories of class, race and gender to elicit many of the contradictions involved in nursing. Unlike physicians, nursing has mostly tended to be viewed as a women's occupation (an extension of their domestic, caring and healing duties in the home) and thus do not compete with the male-dominated medical profession. Thus the emergence of women into the medical profession was a huge accomplishment, but simultaneously resulted in a division of labour which consisted of the doctors (men) in charge being "served" by the nurses (women) beneath them. See T.G. Mashaba. *Rising to the Challenge of Change: A History of Black Nursing in South Africa*. (South Africa: Juta and Co., Ltd, 1995), C. Searle. *The History of the Development of Nursing in South Africa, 1652-1960*. (Pretoria: The South African Nursing Association, 1965), Catherine Burns. "'A Man is a Clumsy Thing who does not know how to Handle a Sick Person': Aspects of the History of Masculinity and Race in the Shaping of Male Nursing in South Africa, 1900-1950". *Journal of Southern African Studies*, Vol. 24, No. 4, December 1998, June Webber. "Fragmented, Frustrated and Trapped: Nurses in Post-Apartheid Transition at King Edward VIII Hospital, Durban". (University of Natal Durban: Soon to be completed Ph.D. Dissertation in Social Sciences, 1998). Catherine Burns has done further work on the importance of African women midwives and indigenous healers, see Catherine Burns. "Reproductive Labours: The Politics of Women's Health in South Africa, 1900-1960". (Northwestern University, Evanston, Illinois: Unpublished Ph.D. Dissertation in History, 1995) and "Louisa Mvemve: A Woman's Advice to the Public on the Cure of Various Diseases" in *Kronos, Journal of Cape History*, No. 23, November 1996, p.108-134. Other works on raising women's health issues have also been important, such as Margaretha Goosen and Barbara Klugman (eds). *The South African Women's Health Book*. (Cape Town: Oxford University Press, 1996), Claire Dyer. "Gender and the Political Economy of Health and Health Care of Women". (University of Natal Durban: Masters Dissertation in Women's Studies, 1990) and Marcia Wright, Zena Stein and Jean Scandlyn (eds). *Women's Health and Apartheid: The Health of Women and Children and the Future of Progressive Primary Health Care in Southern Africa*. (New York:

family's lives. Thus while social history can be used to highlight the achievements and successes of the underclasses in history, it can also be used to analyse the small and seemingly insignificant failures and cul-de-sacs which are as important to an overall critical analysis of any institution.

While starting a B.Sc. degree at Fort Hare in 1953, Themba Bolani abandoned this degree the following year to embark on a full medical training course at the newly opened Durban Medical School. When I questioned Bongiwe Bolani if she could remember whether her husband ever considered becoming a "Medical Aid", she strongly asserted, "there was no question at that time of becoming a Medical Aid. It was not an issue at all. Medicine was the only option. That's all he had in mind".<sup>99</sup> Unfortunately, he failed Physiology in 1956, and although he received the opportunity to repeat the year, he failed the subject again in 1957. Bongiwe and Themba were married while he was doing his medical studies. Bongiwe had just qualified to be a nurse and was working at King Edward VIII Hospital at the time. I was interested to know whether family responsibilities had provided too much pressure, which led to his eventual failure. When I asked Bongiwe why she thought he failed, she replied:

it was very difficult for me to say. He often left me and our family in Mayville to study with other medical students for examinations. I didn't like remaining alone. His mother said this marriage disturbed him and his studies. I don't know. I managed to work and still look after my family. It was important for him to make something of his life. He had a very important goal to attain. How it didn't happen I just don't know.<sup>100</sup>

She did tell how me though, how enormously bitter and devastated he was because of his failure, and how he blamed the white professors for his failure. This provides an interesting new perspective on the relationships that some of the black students may have had with an all white medical teaching staff:

he was very bitter about it. He didn't believe he should have failed. It was very important for his family and people back home in Johannesburg for him to come back a doctor. He had a family to look after but I was working anyway. He blamed the professors at the Medical School. It had nothing to do with the Government. The Government had nothing directly to do with failing him, only the School. He used to say the professors failed him. ... he thought he was capable of doing it, he shouldn't have failed and did not take the blame himself. The medical students used to talk

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Columbia University, 1988).

<sup>99</sup> Interview with Bongiwe Bolani.

<sup>100</sup> Interview with Bongiwe Bolani.

angrily about it when they got together. Many others failed. Some of them went and took up teaching and Themba was reluctant to take it up. Some went and I thought he would too, but he always thought something better would come along, but nothing did.<sup>101</sup>

Bongiwe also brought up views, which contradicted other medical school students' views of their relationships with one another. She maintained that racism was rife amongst the students during her husband's years at the School, but recognised that his views were possibly expressed through anger rather than truth:

racism between blacks was an important issue in those days. African students seemed to think it was mostly black people who failed. I knew black students who did not feel good about Indians. Africans thought Indians were favoured somehow, when Indians passed so well and Africans failed. They were angry and bitter and felt that some mischief was going on. [The issue] of Indian bribery always surfaced - that Indians were bribing the professors in order to pass. My husband was so bitter but I think he was also trying to rationalise his failure to himself.<sup>102</sup>

Because he had been awarded a Government bursary/loan, he was forced to pay it back over the years, which made life for him and his family very difficult. Themba found it very difficult to find a job after leaving the Medical School and in the end he did clerical work at a school in Durban and then worked as an inspector for the Durban Municipality. It took him many months to find a job after his failure, and Bongiwe had to largely support their growing family during that year - as she argued, "I supported the family during that year while I was at King Edward. I was responsible for everything".<sup>103</sup> However, she argues that their relationship suffered a great deal because of his failure from the medical course.<sup>104</sup> He was constantly bitter and angry about life:

we used to quarrel when he would go for an interview and he would be very angry and they told him he had a chip on his shoulder. This happened twice with two different people ... maybe it was the things he said to them, maybe it was this bitterness and anger that made him talk out to authority.<sup>105</sup>

<sup>101</sup> Interview with Bongiwe Bolani.

<sup>102</sup> Interview with Bongiwe Bolani.

<sup>103</sup> Interview with Bongiwe Bolani.

<sup>104</sup> See Twine. "I'm Just An Ordinary Nurse", p.113. She argues that this may have been a contributing factor to their eventual divorce in 1987. In an interview with Twine, Bongiwe confided in her that: "We lived together and then we parted again because he really was difficult to live with. And he lost his job. He was angry with the Government, he was so angry, you don't know how angry he was. ... In the end I had to divorce him".

<sup>105</sup> Interview with Bongiwe Bolani.



She maintained that it affected him all his life because medicine was his life long dream:

I think he got over it in the end. But it did affect him. The sense of failing was great - failing the thing he desired so much ... it affected him a lot. But he was a good father and his family meant a lot to him and if we were not there he probably would have crumbled and been destroyed in the end.<sup>106</sup>

Thus, it's important to appreciate the enormous pressure that was placed on these pioneer doctors to succeed, and psychological, emotional and financial effect it would have had on them if they had failed. And too many failed to exclude a discussion of their lives. Their voices were hidden by the success stories, and I hope that this one life story of Themba Bolani, has helped to fill in the record of the students who did not succeed. This is a story which is representative of many. It is fitting to conclude this section with a poignant remark from Bongiwe Bolani who recognised the importance of the quest and maintenance of the highest medical standards, which ironically, and in the process, largely undermined the success of aspiring black doctors:

It was the good training they were given at the Durban Medical School which showed a great pride in the work they were doing. They were saying to the Government you see you didn't think we would do it and we did. You need to understand that there were such vigorous standards set and why it was that so many failed. It showed the Government up. It was a lesson to the whole of South Africa. One can feel sympathy for them – they were driven by the quest for standards many couldn't attain.<sup>107</sup>

### ***Black Doctors as Interns.***

For the handful of black doctors who successfully passed their final year in 1957, the road ahead was no less difficult. They had to constantly fight for their place in the white medical world in a social and political situation dominated by apartheid. In 1958, they embarked on their internship year which conformed with the requirements laid down by the SAMDC, to give these newly qualified doctors a year's practical experience in hospital work, after which they were entitled to register as medical practitioners in terms of the Medical, Dental and Pharmacy Act.<sup>108</sup> As a "bridging" year between study and actual practice, the internship provided a vital year of

<sup>106</sup> Interview with Bongiwe Bolani.

<sup>107</sup> Interview with Bongiwe Bolani.

<sup>108</sup> Gordon. *Report on the Government's Intended Action to Remove the Faculty of Medicine from the University of Natal*. (Durban: Hayne and Gibson Ltd, 4 March 1957), p.11. See T.B. McMurray. "Medical Education and Internships". *SAMJ*, 13 April 1957 for more on internship training. From 1949, a period of one year's compulsory internship was introduced following graduation. The Medical Council, however, did not make it clear whether they regarded this year as primarily an educational one or for the intern to form part of the labour force.

experience for these black medical students and was a period of consolidation of theoretical knowledge acquired during undergraduate years put to practical use. It was a vital year for these student doctors when they had to assume responsibility for patients for the first time.

Kallichurum argued that it was the unique experience of working with patients at King Edward VIII Hospital, which promoted her enjoyment of medicine because they needed her:

I think it was the patients at King Edward, you felt needed at King Edward you know. There's no doubt, I always said after my internship I'm going to stop being a doctor, but it was King Edward where you felt you were needed ... You never felt redundant at King Edward ... when you work with patients and it's your responsibility, after that I enjoyed it [medicine] extremely I must say, that's why I just stayed on in medicine otherwise I'd have stopped work.<sup>109</sup>

However, in the work place of the hospital too, these inexperienced doctors were not protected from the effects of racism and segregation, within their work situation and were blatantly exposed to apartheid's effects by the numerous disadvantaged and poverty-stricken patients which lined King Edward Hospital's corridors. As Mayet concurred, "the facilities were very terrible, with patients all over the floor, under the beds, in the corridors all over".<sup>110</sup> In their interviews with me, both Mayet and Kallichurum distinctly remembered the discriminatory standards of practice, which in a profession which was meant to be above politics, really hurt. One of their fellow students, Dr. B.T. Naidoo argued, "we were prevented from using the changing rooms in theatre. The segregation at graduation and in the seating arrangements of parents disgusted us. Discriminatory scales for doctors hurt".<sup>111</sup> Kallichurum concurred with his view, and maintained that racial discrimination hurt, but she never allowed it to dictate her life and toughened herself against it:

definitely it did hurt, it did hurt. I'm sure it hurt but you know you develop an attitude, a don't care attitude, you know, if you don't want me, I don't want you too, type of attitude, and it hurts you know. It never bothered me that segregation ... for theatre duties but the others didn't want to ... but it truly didn't bother me. I know it was hurtful, the principle of the whole thing but personally, I couldn't care less you know.<sup>112</sup>

Mayet also remembered the hurtful nature of discriminatory policies in hospitals,

<sup>109</sup> Interview with Professor Kallichurum.

<sup>110</sup> Interview with Professor Mayet.

<sup>111</sup> UN Medical School Reconciliation Graduation Booklet, p.17.

<sup>112</sup> Interview with Professor Kallichurum.

we had a problem when we went to theatre. We had to have separate toilet facilities ... [for] blacks. And then in theatre we were not allowed, we were initially using the same facilities, change room facilities and toilets and so on. And one of the interns complained. ... A white intern complained to the Maritzburg Department of Health to say that black doctors are using the same facilities, toilet facilities and change-room facilities in theatre. So they were separate, males had their own room, and females had to use the nurses' change room. [It hurt] of course it did, but then having been brought up in South Africa one expects that sort of thing.<sup>113</sup>

When I questioned them about whether they thought the treatment of disease was colour blind, Mayet argued that it was most definitely not:

when they started introducing black doctors in hospitals, in white hospitals, patients were asked. They were informed that it's a black doctor and is it alright if he attends to you. If they said no, then there'd be a white doctor who'd come and attend to the patients ... if they requested it.<sup>114</sup>

Being in a black teaching hospital, they were only allowed to work on black patients:

we only worked at King Edward, we were not allowed to work at any other hospitals ... At Wits and Cape Town which were non-racial, if there was a ... white body coming in, all the black students had to leave, you know they were not allowed to appraise the white bodies, that were being demonstrated on.<sup>115</sup>

Mayet had a lot to say about the huge amount of racism that they as the first class of pioneer black doctors experienced, both in their earlier clinical years when they began doing ward rounds at King Edward, and then later during their internship years. The quotes will be included at length as they very aptly demonstrate the racist attitudes of many of the nursing staff to these new black doctors. Mayet explained:

Let me tell you a story. We were the first lot of black doctors at King Edward. When we were in final year, well first of all before we got into final year, when we got into fourth year and clinical medicine had to be done, we were restricted to one ward, and we had all white sisters at the hospitals, you know, no blacks were in charge of wards, and the sisters were asked and informed that black students would be coming here, in this ward, do you want to remain or would you like to move on. So she says she'd like to remain, but they must use the back entrance. We were not told this at the time, I learnt this subsequently. But of course we were not aware of it and we went through

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<sup>113</sup> Interview with Professor Mayet.

<sup>114</sup> Interview with Professor Mayet.

<sup>115</sup> Interview with Professor Mayet.

the front entrance. Then after a couple of weeks, I understand she told the head of Department that they're not so bad after all. So they realised that blacks are human. So that was a very interesting thing. It was educational for the white staff.<sup>116</sup>

When I asked Mayet about whether these racist attitudes changed during their internship year, she maintained that they got even worse:

that again is another story because as I said, all sisters were whites. So the whole hospital was informed that there would be black doctors employed at King Edward, and they had a choice. They either remain there, in which case they would have got some financial bonus, or they could ask for promotion and become matrons, or be transferred to another hospital. The majority of them did not remain in the ward. ... [they] transferred or became matrons. We were restricted to a few wards only, as teaching wards, not the whole hospital, so we worked only in a few wards and they were happy with us. And the ward I was working in for my internship was a professorial ward. It fell directly under the Department of Medicine and the staff, senior staff there. And there were two interns per ward. It was Dr Ngakane and myself allocated to D Ward. I went in there in the first year and I there was a white person, and Dr Ngakane was on leave for the first month, he joined us in February. On the 1st of February there was chaos in the ward because the black sisters realised that ... the in charge sister wasn't there, and the keys were lying on the desk. Because the prospects of having a black doctor giving her orders I suppose was too much. And she became a matron and she left the ward. These were the things that were going on, you know. To take instructions from a black doctor was unacceptable.<sup>117</sup>

When I asked them what their views were regarding the help their professors gave them whilst they were interns, Kallichurum felt that they were excellent:

the relationship between staff and students were different. Now I could as intern ... if I didn't find a registrar, ring the Professor directly and say I've got trouble and I can't handle this patient, even if its midnight, they'd come. They don't do that now. Senior staff never come ... to see the patients in the hospitals. We would get them out in the middle of the night, they'd come. Not anymore. So the whole scene has changed. The role models have gone. And we are worried that the doctor of today is, you know, as Florence Nightingale who said, who would recognise the nurses, I don't know who ever it is, won't recognise our doctors.<sup>118</sup>

During my interview with the ex-Matron of McCord's, Bongiwe Bolani, I asked her what her

<sup>116</sup> Interview with Professor Mayet.

<sup>117</sup> Interview with Professor Mayet. Also see Twine. "I'm Just an Ordinary Nurse", p.111. As a nurse at King Edward at the time, Bongiwe Bolani concurred with Mayet's view about the mass resignations of white nurses who refused to work with black doctors. She argues that these resignations ultimately facilitated greater promotion opportunities for black nurses, as she argued: "that is why I also got a promotion quite early because of the doctors and the sisters who left ... so it helped us".

<sup>118</sup> Interview with Professor Kallichurum.

thoughts were with regard to these new black doctors at King Edward. She was a nurse at King Edward during the late-1950s, and I thought she could provide interesting insight as a black nurse in the field. Bongiwe felt that as doctors, they were very well trained and made good doctors:

they were well-trained and good doctors and they got beyond the initial resistance. But it was also a novelty and people were worried about whether they would be good or have problems. But there were no major disasters and the whites who were threatened and worried ended up staying. Dr Mayet was a very good doctor. In fact all these doctors were good. They were well trained, and Durban Medical School had done a good job and they had enough practice. You could get just about anything at King Edward.<sup>119</sup>

What's also interesting is that when I asked her about whether she could remember any tensions in the hospital between the white and black staff she maintained, placing a whole new angle on the issue, "there was some friction between black nurses and black women doctors and perhaps a bit of jealousy and rivalry to win the hearts of these special young men [doctors]."<sup>120</sup> She also importantly felt that these newly trained black doctors formed important role models for other black doctors to follow:

I think they were good role models. People were proud of them. They were watched very keenly by the communities – how they carried themselves, what they did. Their families were also watched in the communities. People took an interest in their personal lives. The doctors became celebrities and I believe young people who saw them wanted to be like them, they were role models. .... In the community they made a big thing of them and they were given special recognition.<sup>121</sup>

### ***Women Doctors.***

As mentioned earlier, out of a class of twelve pioneer medical students, three were women doctors who graduated in 1957. This was an important achievement, because from the time when this black Medical School was established in 1951, black women have qualified and been admitted into the medical course, and competed equally to their male counterparts.<sup>122</sup> When

<sup>119</sup> Interview with Bongiwe Bolani.

<sup>120</sup> Interview with Bongiwe Bolani.

<sup>121</sup> Interview with Bongiwe Bolani.

<sup>122</sup> In South Africa, a number of white women, but increasingly black women doctors during the post-apartheid era have written their autobiographies and recollections of their experiences of being women doctors in this country. Jean Walker. *"Skin Deep": The Autobiography of a Woman Doctor.* (Cape Town: Dr. J.F. Midgley J.P., 1977), Eva J. Salber. *The Mind is Not the Heart: Recollections of a Woman Physician.* (Durham and London: Duke University Press, 1989), Mamphela Ramphela. *Across Boundaries: The Journey of a South African Woman Leader.* (New

I questioned the two pioneering women graduates who qualified with their class in 1957, I was eager to ascertain whether they experienced any gender discrimination upon entering the training and education sphere of a largely white, male dominated profession.<sup>123</sup> What is especially interesting is that in their views, women were treated equally during their training at Medical School, unlike their female counterparts in Europe and America who experienced enormous gender discrimination during their medical education years.<sup>124</sup> When I asked Mayet about whether she could remember having experienced any gender discrimination, she argued:

I think in the medical profession, gender wise, there was very little gender discrimination, if any. We were generally accepted. ... I think that the profession was very open-minded as far as gender is concerned. ... in my experience is that there wasn't any discrimination.<sup>125</sup>

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York: Feminist Press, 1995), Mamphela Ramphele. *A Life*. (Cape Town and Johannesburg: David Philip Publishers, 1995), Pauline Klenerman. *Reminiscences of a Lady Doctor*. (Johannesburg: Pauline Klenerman, 1993).

<sup>123</sup> Dr Goonam. *Coolie Doctor: An Autobiography*. (Durban: Madiba Press, 1991). Also see Vanessa Noble. "Ruffled Feathers": The Lives of Five Difficult Women in Durban in the 20th Century. (University of Natal Durban: Honours Dissertation in History, 1997). I was fortunate enough to interview Dr Goonam in 1997. She was the first Indian woman doctor in Durban and because she was a generation ahead of Mayet and Kallichurum, she was forced to go overseas to Britain to undertake her medical degree because it was not offered in South Africa. What is interesting is that she experienced far greater gender discrimination and the constraints of conservative and traditional beliefs - when she returned to South Africa to begin her practice in 1936 - than the pioneer women doctors at the Medical School experienced during the 1950s. As Goonam argues in an article in *The Asian* on 23/9/97, "the struggles we had to fight were numerous. As a young woman doctor, I had two battles to fight - racism and sexism [and] the prejudice existed on three counts: I was female, Indian and unmarried ... I was the first female Indian doctor in this country".

<sup>124</sup> During the 18th and 19th centuries, the emergence of the professional, scientific medical community was done on exclusionary lines which debarred women from access, mainly through denying their admission to universities. But women have always been healers outside the "professional" ranks as midwives, indigenous and community healers in the homes of people. What stood in their way was an array of strongly held sexist views that a woman's place was in the home, that women earning professional fees would demean the place of the male breadwinner, that professional work would make female bodies unfit for child bearing, that medical knowledge would defile their natural purity, and that intellectual work would end in neurosis. Opinion changed exceedingly slowly and only under pressure from women's movements. During the 19th century separate medical facilities for women doctors were established for their training and only in the latter part of the 19th and 20th centuries did established male-dominated medical schools open to women. For discussions of these topics see Johanna Geyer-Kordesch. "Women and Medicine" in W.F. Bynum and Roy Porter (eds). *Companion Encyclopedia of the History of Medicine*. (London and New York: Routledge, 1993), Ornella Moscucci. "Introduction" in *The Science of Women: Gynaecology and Gender in England, 1800-1929*. (Cambridge: Cambridge University Press, 1990), Carol MacCormack and Marilyn Strathern (eds). *Nature, Culture and Gender*. (Cambridge: Cambridge University Press, 1980), Isobel Allen. *Any Room at the Top? A Study of Doctors and their Careers*. (London: Policy Studies Institute Publications, 1988), Paul Starr. *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry*. (New York: Basic Books Inc., 1982), Judith Lorber. *Women Physicians: Careers, Status and Power*. (New York and London: Tavistock Publications, 1984), Elianne Riska and Katarina Weger (eds). *Gender, Work and Medicine: Women and the Medical Division of Labour*. (London: Sage Publications Ltd, 1993), Anne Witz. *Professions and Patriarchy*. (London and New York: Routledge, 1992), J. Leeson and J.Gray. *Women and Medicine*. (London: Tavistock, 1978).

<sup>125</sup> Interview with Professor Mayet.

What is important though was that they both felt that racial discrimination far outweighed any other form of discrimination, including gender. However, while gender discrimination faded into the background, it was an ever-present undercurrent, which influenced these black women doctors' lives. Their fight was not with their male students, but with the racist apartheid Government which overshadowed any gender issues. When I asked them how they managed to balance their family and training responsibilities, both maintained that it merely required good time management.<sup>126</sup> As Kallichurum maintained, that time management was the key as well as making quality time to spend with your family. She argued that her husband was very understanding of her work and the enormous demands it made on her and that he helped immensely with family responsibilities.<sup>127</sup> Mayet had this to say about her conflicting role demands:

well if you have a conscience, if you provide a medical service, you provide a service, you're at the beck and call of your patients as far as I'm concerned. A lot of demands get made ... but my husband has been very considerate and supportive too, that made a lot of difference in that I was able to work full time. At night too as a registrar I had to go out to do calls and the children were small we used to put them in the car and they used to come with me to go to hospital and do my calls. ... I had a lot of commitment, but I adapted and organised my schedule such that I spent quite a lot of time with the children. ... no gender didn't make a difference.<sup>128</sup>

Role models were very important in a difficult profession like medicine, especially when the odds were so greatly against black doctors embarking on medicine as a career. When I asked Mayet whether she regarded herself as a role model for other aspiring women doctors she modestly maintained:

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<sup>126</sup> Professor Mayet was married during her internship year, while Professor Kallichurum was married during her medical school studies. Although they claimed that it was merely a matter of good time management to balance work and family responsibilities, there is an extensive literature on the difficulties many women doctors experienced with conflicting role demands which placed them under enormous pressure. Often career choices were restricted because of family responsibilities. Women who did manage to successfully balance both roles were viewed as unique "superwomen", as Allen in her book *Any Room at the Top?*, argues, "lots of women have unrealistic expectations. Women who are successful are superwomen! Either they are single and behave like men, or they're superwomen and have combined family and career!". Also see Nophasika Maforah. "Black, Married, Professional and a Woman: Role Conflicts?" in *Agenda*. Vol. 18, 1993, p.5-7, Lorber. *Women Physicians*, Riska and Weger (eds). *Gender, Work and Medicine*, Leeson and Gray. *Women and Medicine*.

<sup>127</sup> Interview with Professor Kallichurum.

<sup>128</sup> Interview with Professor Mayet.

some of them did say that they were using me as their role model. ... went onto medicine, but they have now all gone, subsequently all went, into private practice. But they said that they were using me as their role model. ... it was good to know that.<sup>129</sup>

Whilst Kallichurum argues that she did not experience any gender discrimination during her training at Medical School, she still attributed her success as a woman doctor to the fact that she always worked harder than her medical colleagues to keep one step ahead of everyone else:

I've had no difficulty. I had no difficulty because I made sure they don't cause me difficulty. Really, that is very important.... And you had to be one step ahead of them at all times, you know, you just, because you have to also prove you know, that as a person of colour, as a female you could do things just as well as they could. ... No, no but then you must remember I grew up with that attitude, I schooled myself into this attitude, because of the politics of this country, maybe if the politics of this country were not there, I'd be a different person today. ... No, no you know, I always said if anybody's does the trampling it's going to be me. Ja, you have to be otherwise you don't succeed. And another thing as a female you know with males, you have to be better informed than them. That is exceptionally important, that at all times you have be better informed than them. ... You have to, you know, to survive you have to.<sup>130</sup>

The School was thus an important pioneer, but it took many years of hard work and even many hurdles of failure before it succeeded. This chapter has attempted to show the immense amount of human effort and dedication that many people - within, but also outside the health sphere, at both a national, provincial and local level - displayed in their attempt to establish a black medical school in Durban. They fought so hard and for so long - some for thirty years before their pioneering ideas were heard and realised - because they believed that theirs was a worthy effort, an effort involving courage and commitment against threats of attack for being too farsighted and progressive, to attempt to address the massive shortage of black doctors and to alleviate the desperate burden of disease under which the majority of black South Africans were labouring. It's also the amazing story of how one Department in a fledgling Medical School, under the influence of a few unique doctors such as Sidney Kark, facilitated the continuance and even stimulated the advancement of social and community health work, even if only for a few extra years, whilst under direct attack by increasing State hostility for what it regarded as a radical socialist philosophy. However, only a handful of students benefited from this work and training because, as the next chapter will demonstrate, the apartheid clouds of doom that had

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<sup>129</sup> Interview with Professor Mayet.

<sup>130</sup> Interview with Professor Kallichurum.



been constantly evident in this chapter from the late-1940s, towards the late-1950s became a full-blown storm, which attacked the very foundation of the IFCH's safety-net of an autonomous academic institution, that would no longer remain free from Government attack. The IFCH's isolation from wider national health services and massive cuts in funding made it vulnerable to attack and would eventually lead to its demise by 1960. Removed of its "life-blood" of funding and stimulation by pioneering doctors who later emigrated, South African health services were left in a desperately underdeveloped state, and for many years thereafter, devoid of vitality and the necessary foundations to provide adequate health care for all.

## Chapter Five

### A “Bitter-Sweet” Victory for Black Medical Education in South Africa

It took enormous courage and determination from many of its pioneering founders - at both a national, provincial and local level - over nearly half a century to bring the dream of full medical education to black doctors in a university institution to fruition, and as this chapter will show, it took even more to keep it there. For individuals and interested parties who recognised the urgent and vital need for a black medical school in Durban, it was always a struggle, an upward battle against a variety of different but powerful forces, determined to see it fail. Previous chapters have examined how the broader socio-political context and State apartheid policies had a direct affect on the unequal distribution and inadequate provision of health services in South Africa. The State’s power over black medical education and training was far less secure and assured during the early-1950s as it came up against the interests of largely autonomous university institutions, independent medical bodies, and other private organisations which hindered the straightforward imposition of its apartheid policies. This is evident in the argument made by the Secretary for Health to the Superintendent of the McCord Zulu Hospital in 1952 in reference to apartheid education plans:

the implementation of this policy in the medical field is, however, hampered by factors over which the Government has no direct control and it is therefore necessary to wait for these difficulties to solve themselves.<sup>1</sup>

As earlier chapters have argued, segregation and apartheid ideology that was mobilised to systematise, rationalise, and entrench white supremacy and power at every level, was not based on a predetermined approach, but was continually negotiated in theory and practice. And this is why many progressive doctors, situated in the ambiguous and complex medical sphere, were able to exploit many gaps in the apartheid Government’s theories and practices, and promote progressive and farsighted approaches to black medical education and services, while still maintaining the wider hegemonic racial ideology of white South Africa.

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<sup>1</sup> SAB, GES, Vol. 1861, Ref. 115/30. Letter from Private Secretary G. de Villiers on behalf of the Secretary for Health to the Medical Superintendent, McCord Zulu Hospital, 7 May 1952.

This chapter will demonstrate that while the apartheid Government's policies strengthened and expanded during the late-1950s to incorporate almost every sphere of South African social, political and economic life, its attempts to impose its policies on the academic sphere - the sphere in which medical training, education and research had for years been successfully associated - came up against massive opposition and resistance from various universities as well as medical and other professional sectors. I will examine the widespread protests and opposition in South Africa to the imposition of apartheid onto universities, and why it was that their protests largely failed. I will also analyse, within this broader debate, the particular protests by the University of Natal (UN) and its Medical School, and more importantly, why this small, fledgling black Medical School was able to escape the apartheid Government attempts to remove it from the ambit of a white university. However, it will be shown that this was a bitter-sweet victory for the Durban Medical School, because while it successfully resisted State attempts to control it as a State-run institution, it simultaneously lost its fight to protect and perpetuate its progressive Department of Social, Preventive and Family Medicine affiliated to the Institute of Family and Community Health (IFCH). I will analyse how this Department fell out of national favour first with the apartheid Government in the 1950s; how it then became incorporated under one particular structure through the funding provided by the Rockefeller Foundation to the Durban Medical School; and how finally the social and community health care movement as a whole became increasingly exposed to conservative and racist State hostility towards a movement perceived as radical and socialist, and was thus undermined. While attracting international attention for its unique achievements in an academic setting, this same progressive approach to medical work was viewed by the State as a threat to its policies. During the late-1950s, this initial Government hostility became a raging storm, which attacked the very foundation of the movement's "safety-net" - its position in an autonomous academic institution. It was clear that even this sector would no longer remain free from apartheid control. The IFCH's isolation and marginalisation from wider national health services and massive cuts in funding made it vulnerable to attack, and when the Department's international funding came to an end in 1960, the Government refused to co-operate. Deprived of its funding, and its protection from progressive doctors in high places looking out for its interests and fending off attacks, as well as the emigration of doctors overseas, the social and community health movement was left unshielded from assault which eventually led to its demise. In many

ways, this Government move undercut its own policies, because it was the cheapest, and really the only possible way forward to address the disastrous state of public health in South Africa's black communities labouring under the strain of poverty and disease. South African health services remained underdeveloped and where the country could have taken the lead and been an innovator in this field of medical education and service, instead South Africa's State disengaged itself from all association with this health philosophy and work, and undercut the health centre foundation which aimed to provide adequate health care for all.

### ***An Autonomous University Tradition.***

Before analysing the factors that led to the demise of South Africa's social and community health centres movement it is important to determine why it was that this progressive social and community health approach was able to survive and achieve further results, even if only for a few more years whilst rooted in this academic institution. It is essential to note from the beginning of this chapter, that the furore that surrounded Government attempts to impose apartheid ideology on South Africa's universities was based on the Government's attempts to undermine a long-established tradition. This tradition was seen to be based on university education's independence and autonomy, which produced an environment that promoted freedom of thought and a high quality of unfettered research.<sup>2</sup> Whether or not universities in South Africa had indeed by the 1950s acted independently and in an unfettered manner is of course open to public debate and needs careful scrutiny. That is not my purpose here. What is clear is that liberals and progressives in the universities believed they owed their reputations, their vitality and their success particularly in the medical sphere, to this apparent autonomy.<sup>3</sup> When universities were obviously targeted by political, religious and State forces (evidently aiming to use them as "tools" in their political agendas), then the project of a well-rounded education and the highest quality of academic research was at risk.<sup>4</sup> For almost a decade before the Government implemented university apartheid legislation which affected most of the

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<sup>2</sup> I. Gordon. *Third Report on the Government's Intention to Remove the Faculty of Medicine from the University of Natal*. (Durban: Process Printers, 25 February 1958). Appendix JJ. Summary of Evidence by the UN to be presented to the Commission on the Separate University Education Bill, p.1.

<sup>3</sup> I. Gordon. *Report on the Government's Intended Action to Remove the Faculty of Medicine from the University of Natal*. (Durban: Hayne and Gibson Ltd, 4 March 1957), p.25. There is no parallel for them growing up around teaching hospitals like in Britain.

<sup>4</sup> Gordon. *Report on the Government's Intended Action*. Record of Statement and Comments of Full-Time Academic Staff of the Faculty of Medicine of the UN as printed in the Natal Mercury, 18 February 1957, p.43.

universities and their medical schools in South Africa, the Durban Medical School and its unique Department of Social, Preventive and Family Medicine were able to survive and develop because of the ability to exploit a more open and flourishing academic environment for “progressive” views for which the still legally autonomous University of Natal provided space.

### ***Reasons for the Demise of the Social and Community Health Approach.***

There are a number of complex reasons why the social and community health approach was rejected at a national policy level - which forced it to become rooted in the academic institution of the Durban Medical School where it survived and continued its work for a few extra years - but which ultimately resulted in its marginalisation and later demise in the late-1950s. It is important to note too, that there was no single, or all-encompassing reason for its collapse, but was rather a gradual process, involving numerous forces which undermined its influence as they were determined to see it fail. Historians such as Shula Marks have argued, and I would agree, that contrary to conventional wisdom - although its hostility and apartheid policies contributed at a later stage to its demise - the failure of the health centres approach and wider national health plans cannot merely be blamed on the new National Party (N.P.) Government in 1948 - but it preceded it.<sup>5</sup> An important reason for this failure was the earlier rejection of key elements of the National Health Services (NHS) Commission Report and the non-implementation of major administrative and financial elements, which meant that the health centres operated against a very different background from that envisaged in the Report. Key proposals for a unified NHS were not implemented, whilst radical changes in extra-hospital services were to be achieved only by a “series of measures” and not by full scale replanning.<sup>6</sup> Marks argues that this failure resulted from a lack of white consensus. The white electorate refused to support a drastic restructuring of the social order that would affect them, and their strong vested interests in provincial health authorities ensured that they could maintain the status

<sup>5</sup> Shula Marks. “South Africa’s Early Experiment in Social Medicine: Its Pioneers and Politics”. *American Journal of Public Health*. Vol. 87, No. 3, March 1997.

<sup>6</sup> Henry Gluckman. *Abiding Values: Speeches and Addresses*. (Johannesburg: Caxton, 1970), p.502. Also see SAB, GES, Vol. 2958, Ref. PN6, Vol. 1 and 2. National Health Services, G.W. Gale, Secretary for Health, 2/2/1949, p.2-3. Most local authorities retained executive control and were 25% responsible for the financing of personal (clinical) health services in their own areas. Gluckman regarded an increase in Government subsidy as an interim measure to afford relief to local authorities for a service, which would become a Government responsibility.

quo.<sup>7</sup> Efficiency was increasingly compromised as health centres were added to the public health service instead of forming its foundation and as the NHS only introduced “piecemeal” restructuring (determined primarily by political considerations) which resulted in little improvement of health care for all. As Marks maintained, “the failure to bring all publicly funded health services under unified administrative control resulted in incoordination, overlay and unbalanced development of the service”.<sup>8</sup> Marks also shows how Gale, too, was aware of the problem, arguing: “health centres, which were intended to be only the first step in the establishment of the National Health Service ... proved also to be its last”.

Another constraining influence on the success of the social and community health centres approach was the influence of the wider racist and segregationist socio-political and economic contexts in which these centres operated. And many of these factors were beyond the health centres’ control, which set restrictions on health improvements.<sup>9</sup> When the health centre teams first entered unserved areas where poverty and ill-health flourished, they were able to quickly produce dramatic reductions in morbidity and mortality, and improve the health quality of the community’s life with simple preventive and health educative methods which produced immediate results.<sup>10</sup> However, once these improvements were made, the team came up against the basic structural constraints of unemployment, poverty, soil erosion and the oscillating system of rural to urban migration - associated with industrialisation created by South Africa’s labour regulations - which intertwined to ensure prevention of long-term gains with continued high levels of malnutrition, family instability and continued introduction of TB and STD infections into the rural community.<sup>11</sup> While Kark and his team gave equal weight to the social and

<sup>7</sup> Marks. “South Africa’s Early Experiment in Social Medicine”, pgs.452, 455, 457. Key recommendations left unimplemented included that all health services be administered by the same central authority, as provincial control over hospitals continued, while a national health tax was never implemented because of the difficulty of imposing it on a heterogeneous population. Thus increased spending on curative hospital services, instead of preventive services, resulted in an ever growing number of desperately sick patients who required expensive hospitalisation.

<sup>8</sup> Marks. “South Africa’s Early Experiment in Social Medicine”, p.455. During 1944/45 the Govt voted £50,000 out of the publicly funded State health budget of £1,300,000 for health centres. In 1948 this increased to £140,000 but was still less than 3% of the total vote for Health and Mental Hospital expenditure.

<sup>9</sup> John Cassel. “A Comprehensive Health Program among South African Zulus” in Benjamin D. Paul (ed). *Health, Culture and Community: Case Studies of Public Relations to Health Programs*. (New York: Russell Sage Foundation, 1955), p.39.

<sup>10</sup> A. Jeeves. “Public Health and Rural Poverty in South Africa: ‘Social Medicine’ in the 1940s and 1950s”. Seminar Paper presented at the University of the Witwatersrand Institute for Advanced Social Research, 30 March 1998, p.8.

<sup>11</sup> See S.L. Kark and J. Cassel. “The Pholela Health Centre. A Progress Report”. *SAMJ*, 16 February 1952, p.136, Sidney L. Kark. “Migrant Labour and Family Health” in *A Practice of Social Medicine. A South African Teams*

biomedical dimensions of disease, and appreciated the means to prevent and cure ill-health in the communities, they were ultimately powerless to implement the broader policies they saw as necessary to address the underlying root causes in the wider socio-political economy. By only being able to successfully treat many of the symptoms, many of the staff were disillusioned and frustrated for attempting to tackle the end results of conditions they had little power to alter.

### ***Conceptual and Administrative Weaknesses in the “Social Medicine” Project: A Critique.***

Further community health centre problems can be traced to their weak conceptual and administrative approaches. In an article commenting on the training scheme for health personnel in Durban, Harry Gear felt that the weakness lay in the vague ideological conceptions around the meaning and forms of practice, and much “loose thinking” and the lack of any clear definition of social medicine, which meant that doctors were “dabbling in the work more properly undertaken by social agencies and local authorities”.<sup>12</sup> In 1947/48, John Ryle, a Professor of Social Medicine at Oxford came to South Africa for a two month visit to review the operation of the health centre system. While very critical of the scheme, he did commend the Karks for their enthusiasm, which enabled the scheme to progress despite lack of financial and structural support:

they had courage to set themselves a difficult task, have already achieved much and have amply demonstrated the very serious need for a system of health and sickness service of the kind not as yet tested elsewhere and in the long run likely to prove of real value to the peoples of South Africa.<sup>13</sup>

However, he severely criticised the Department of Health (DH) for expanding the NHS too quickly during this period (1946-48), which resulted in insufficiently recruited and inefficiently trained staff (especially health assistants), as the immediate need for a large number of health personnel to service the many health centres scattered around the Union, stretched the IFCH to

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*Experiences in Different African Communities*. Edinburgh and London: E. and S. Livingstone Ltd, 1962, p.196-99 and Sidney Kark. “A Health Service Among the Rural Bantu”. *SAMJ*, Vol. XVI, No. 10, 23 May 1942, p.197.

<sup>12</sup> SAB, GES, Vol. 2958, Ref. PN6, Vol. 1 and 2. National Health Service. Comments upon the Training Scheme for Health Personnel: Durban, by Dr. H.S. Gear, n/d, p.1.

<sup>13</sup> SAB, GES, Vol. 2958, Ref. PN5, Vol. 1 and 2. A Report on the Health Centres Service of the Union Department of Health, by Dr. John A. Ryle (Prof. of Social Medicine in the University of Oxford), n/d, p.14.

beyond its limit.<sup>14</sup> Unfortunately, his hasty visit and hurried inaccurate interpretation of very complex social, political and economic problems affecting health provision in South Africa, and his medical critique of the scheme, armed hostile politicians with “objective scientific” evidence to stifle the new orientation in preventive health centre work from its earliest years.

However, while Ryle made often hasty and unsupported claims, many of his arguments were not groundless as evidenced by reports on the part of several other people who fully supported this health centre approach and wanted to see it succeed, who were not blinded by idealism but recognised massive administrative shortcoming in the service. In 1947, David Landau - a social medicine doctor who was an enthusiastic champion of the health centre scheme - when visiting all the health centres in operation at the time, “found a most depressing tour” of Medical Officers who doubted the ability of the service to function properly. In his view, only Pholela and Springfield health centres “did work of a good quality”.<sup>15</sup> His visit brought out into the open, that many of the health centre staff were demoralised and “without exception unhappy”, as many of the inexperienced Medical Officers felt isolated and overwhelmed in a State public health service who ignored their requests for guidance and registration of complaints, in a service where the staff remained inadequate and untrained. Their conditions of service also remained uncertain, based on contract-work with inadequate salaries and no security of tenure.<sup>16</sup> Gluckman wrote:

so serious is the position, vis-à-vis opinion among medical men that few, if any application would be received were it not for the persistent efforts ... made by

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<sup>14</sup> See SAB, GES, Vol. 2958, Ref. PN5, Vol. 1 and 2. Ryle. A Report on the Health Centres Service, and SAB, GES, Vol. 1831, Ref. 68/30. Medical and Dental Training for Natives, Gale, 7/11/1951, p.3. Ryles was critical of the intensive family-area survey work which he saw as discriminating against the larger community, together with its “excessively unrealistic”, time consuming and hierarchical system of documentation collection and analysis of health-related data. He criticised the fact that South Africa’s NHS made no apparent attempt to draw on the practical experience of social medicine in other countries. He was especially concerned with the quick, non-university-based six months training course, that was too condensed with theory and placed heavy responsibilities on inexperienced and newly trained health assistants. Ryle argued that this sort of training had to be done in a university setting, because a public health service could not provide a detached, critical and academic atmosphere essential for progress.

<sup>15</sup> Jeeves. “Public Health and Rural Poverty in South Africa”, p.10. Landau was appointed as Chief of the Division of Social Medicine of the Department of Health whilst Gale was in the position of Secretary of Health.

<sup>16</sup> See D. Harrison. “The National Health Services Commission, 1942-1944 - Its Origins and Outcome”. *South African Medical Journal*. Vol. 83, September 1993, p.683, Marks. “South Africa’s Early Experiment in Social Medicine”, p.457, and Jeeves. “Public Health and Rural Poverty in South Africa”, p.10.



men of the Advisory Committee and of the Department, who are apolitical and explain away delays, which to applicants appear indefensible.<sup>17</sup>

Because of these inadequate conditions, many highly qualified community health doctors left the service in the hands of people who were ill-trained, and who did not necessarily understand the driving principles of social medicine. Both Landau and Ryle questioned the wisdom of establishing many, understaffed and ill-equipped health centres, and argued that:

rather our major effort should be bent towards establishing and equipping with suitable personnel a few good health centres by which we may not be ashamed to be judged, rather than setting up a number of health centre institutions of indifferent character, giving a service, little if at all better than that obtained in the crowded rooms of an overburdened polyclinic or outpatient department.<sup>18</sup>

Thus, as Marks poignantly asserts, it's important to see health centres not only in the "rose-tinted" light of the cadre of community health doctors who were successful in their work, but that rather to establish a more balanced understanding of the movement's achievements – it's essential to bring to the fore the fact that:

the successes of health centres is far fewer than the literature leads one to believe as they were written after all by a handful of successful doctors who were inspired by the experiment rather than by the many who did not succeed.<sup>19</sup>

### ***The National Party Election Victory and Attacks on the "Radical" Movement.***

While recognising the important preceding factors that weakened the health centres approach from the start, it took a massive conservative and right-wing shift at a national level before its opposition could implement more stinging attacks on the health centre service. When the National Party came to power in 1948, there existed a massive disjuncture between the NHS's social philosophy of commitment to health equity and a "comprehensive and progressive public health policy" based on the community-developed objectives of Community Oriented Primary Health Care (COPC), and the new apartheid Government's commitment to white

<sup>17</sup> Jeeves. "Public Health and Rural Poverty in South Africa", p.10.

<sup>18</sup> Marks. "South Africa's Early Experiment in Social Medicine", p.457. Also see SAB, GES, Vol. 2958, Ref. PN5, Vol. 1 and 2. Ryle. A Report on the Health Centres Service, p.19.

<sup>19</sup> Marks. "South Africa's Early Experiment in Social Medicine", p.456.

supremacy and hostility to any form of socialist movement.<sup>20</sup> Increasingly during these years, because of the State's growing conservative and anti-Communist ideology (strengthened during the Cold War years) which further heightened its hostility to notions of social medicine - with its connotations of "socialised medicine", universal equal health services and multi-racial health teams - the IFCH came under greater pressure and scrutiny by a Government deeply suspicious of their work and motives.<sup>21</sup> Secretary of Health, Gale was forced explicitly to separate the operation of health centres from the concept of social medicine:

in view of the ambiguity, misunderstanding and controversy which have arisen from the use of the term social medicine, it has been decided, by the present Minister of Health himself, to discontinue its use in connection with Government health centres. Henceforth the term used is simply 'health centre practice'.<sup>22</sup>

The Nationalist paranoia became so intense that Kark was even investigated by the Department of Health, to which he had given devoted service since 1938, for "communist activities", which included the free distribution of food supplies to rural black communities surrounding the health centres under his direction. Kark and his colleagues were viewed as politically unreliable which resulted in their increasing isolation, while the Government ideologues tried to find ways to undermine their work.<sup>23</sup> Susser felt that South Africa's politicians, by attacking doctors who were working to alleviate the country's burden of diseases in black communities were narrow-minded and even ridiculous, and he was reported arguing, "South African politics more than most, have been charged with the paradox and irony and one might even say comedy, were the issues not so grave".<sup>24</sup>

What's also important to realise, was that during the late-1940s, the balance of political forces in the State also removed the influence of the small number of progressive public health professionals in decision-making position, who took along with them the impetus behind the

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<sup>20</sup> Derek Yach and Steve M. Tollman. "Public Health Initiatives in South Africa in the 1940s and 1950s: Lessons for a Post-Apartheid Era". *American Journal of Public Health*, Vol. 83, No. 7, p.1047-8.

<sup>21</sup> See G.W. Gale. "Government Health Centres in Union of South Africa". *SAMJ*, 23 July 1949, p.633.

<sup>22</sup> James Trostle. "Anthropology and Epidemiology in the Twentieth Century: A Selective History of Collaborative Projects and Theoretical Affinities, 1920-1970" in Craig R. Janes et al (eds.), *Anthropology and Epidemiology*. D. Reidel Publishing Company, 1986, p.64.

<sup>23</sup> Jeeves. "Public Health and Rural Poverty in South Africa", p.9.

<sup>24</sup> Mervyn Susser. "A South African Odyssey in Community Health: A Memoir of the Impact of the Teachings of Sidney Kark". *American Journal of Public Health*, Vol. 83, No. 7, July 1993, p.1042.

social and community health movement which came from within the DH. Without Gluckman (from 1948), and then Gale's (from 1952) supportive presence and powers of persuasion in the DH, work became increasingly difficult for the community health doctors interested in social equality and in social medicine as apartheid became increasingly applied to policies in the realm of public health. As Gale argued, "health centres were ultimately undermined by political action: having been introduced by one Government, they looked at askance by the Government, which displaced it".<sup>25</sup> Alan Jeeves indicates, writing on public health and rural poverty in South Africa during the 1940s and 1950s, that there is a sad correspondence in the DH files where Kark and Gale tried to explain to the Minister of Health how segregated their system really was. Jeeves argues that they were civil servants who felt obliged at least not openly to oppose established State policies, but they did so with great misgiving and increasing reluctance as the years progressed, as Gale wrote:

we have done our best, under difficult circumstances and against persistent campaigns of what I call 'smearing', to carry out fully and loyally the policy of the Government with regard to non-Europeans.<sup>26</sup>

As Secretary of Health, Gale did everything in his power to ensure the continuance of the IFCH and its health centre approach, "even so, I could not save it from considerable mutilation". Despite this, he had enormous respect for the community health doctors who continued with their work despite continued and increasing Government attacks:

let me add to this, with my gratitude and admiration that not all my efforts in Pretoria could have saved the IFCH from collapse had it not been for the courage and tenacity of Sidney Kark and his colleagues on the staff of the IFCH, who did not relinquish their posts despite endless malice, misrepresentation, disappointment and frustration.<sup>27</sup>

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<sup>25</sup> Marks. "South Africa's Early Experiment in Social Medicine", p.455.

<sup>26</sup> Jeeves. "Public Health and Rural Poverty in South Africa", p.9.

<sup>27</sup> UN Archives, Pmb. H6/2/1. Letter from Dr. G.W. Gale to Dr Gordon, 21/ 5/1955, p.3. Also see UN Archives, Pmb. H6/2/3. Letter from G.W. Gale to Dr le Roux, Secretary for Health, 6/8/1953, H6/2/3. Letter from G.W. Gale to Dr Cloete, Public Service Inspector, 9/10/1953 and Marks. "South Africa's Early Experiment in Social Medicine", p.457 for a discussion of internal State DH attacks on the health centre movement. Dr. H.F. Annecke, who was appointed Acting Chief Medical Officer in Gale's absence overseas, used the opportunity to appoint a critical committee of enquiry which produced a Report in 1951 which attacked the IFCH and the entire health centre service as unsound in principle, unsuited to South African needs, extravagant, preoccupied with matters other than a medical service. It was based on limited and incomplete facts and deliberate misrepresentation of evidence, which produced inaccurate and erroneous opinions, which questioned the professional conduct, and integrity of S.A. doctors. Copies were recalled by Dr Bremer who was Minister of Health, as it was viewed as offensive for doctors to undermine the professional integrity of their fellow colleagues.

Without the persistent and persevering staff support, Gale felt that their important work would not have continued for as long as it did. But, as the 1950s advanced, the work of Kark and his colleagues and the health centre movement were increasingly isolated from State political and financial support, as N.P. officials and the white voting public (under Malan, Strijdom and Verwoerd) became strongly critical and hostile to a service viewed as liberal and opposed to authoritarian methods in promoting a welfare and elaborate medical system for black communities.<sup>28</sup> During my interview session with Kallichurum and Mayet, I asked them both why they thought the N.P. State was so threatened by the social and community health movement. In Mayet's opinion, Government opposition was stimulated because Kark's philosophy went contrary to Government policy and was providing a health care service and spending money on black communities. Kallichurum concurred with Mayet's views:

For one thing they were bringing to the surface the lot of black people, you know, even if it was in one isolated community it could happen anywhere in South Africa. ... and I think they felt that they would have a reactionary influence on students and maybe even the patients, the communities. ... you see, you must remember also, that no other Medical School ... had this subject and here is a black Medical School, that has this now special subject about social and community [medicine] and they could have seen it as a threat. You know that they were training reactionaries here, you know activists and things like that. It is quite possible that they saw it as such a threat, because they thought well why didn't Stellenbosch or Pretoria get this ... because they are better than this Medical School.<sup>29</sup>

Kallichurum also asserted that another important reason for the State's relentless action and what often appeared a "blundering" and largely blind attack on this community health movement was their ignorance of this orientation in medicine:

I always believed more than anything else they just didn't know what this whole subject was about. ... And they just thought it's a threat, but I don't think they knew what it was. ... the Government of that day never tried to find out anything, I can tell you that. ... They didn't care. ... They always felt the conclusions they came to were right. They never found out. Consultation was not in their books, you know.<sup>30</sup>

<sup>28</sup> UN Archives, Pmb. H/6/1/1. George Gale. "The Story of the Durban Medical School", 25/1/76, p.16. The IFCH training of health workers was completely dismantled in the mid-1950s when the Department of Education assumed responsibility for their training.

<sup>29</sup> Interview with Professor Kallichurum by Vanessa Noble, Durban, 29 May 1999.

<sup>30</sup> Interview with Professor Kallichurum.

The creation of a mechanism for the democratic control of a progressive, national and unified South African health service (including the incorporation of separate black health services) directly challenged accepted conventional assumptions and apartheid practices.<sup>31</sup> Early N.P. interest in health service reform, while once driven by concern for ill-health amongst poor whites, was waning by the 1948 election. After wartime expansion of the economy and economic and political protection of poor whites in the marketplace, together with provision of free hospital services, the urgency for reform was removed. Whites were not prepared to sustain the costs involved in the NHSC once poor whites and their associated burden of disease among the rural white community largely disappeared. The service increasingly reverted to “inexpensive clinics for the early treatment of disease among Natives”.<sup>32</sup>

### ***Conservative and Reactionary Forces Within South Africa’s Medical Profession.***

It is also important at this point, to demonstrate how the medical profession in South Africa generally, and their very conservative and reactionary opinions and attitudes with regard to innovative changes in the medical profession never supported, but rather played a large role in undermining this progressive social and community health approach. As Kark argued:

if you’re going to emphasise community health care of the kind we developed, you couldn’t expect an outcry from the medical profession, the medical profession has never been in the forefront of this development anywhere, individual medical men have been but the profession as a whole has not been interested because the profession’s own history of education is one of increasing education within the portals of the hospitals.<sup>33</sup>

The creation of a mechanism for the democratic control of a progressive and holistic South African health service represented a giant leap beyond the health thinking of most medical professionals. From the start of the health centre approach in the 1940s, the scheme lacked the support of the medical profession, and while support for notions of social medicine was stronger during the idealism of the war years, its progressive ideas “proved remarkably ephemeral” as by

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<sup>31</sup> Harrison. “The National Health Services Commission”, p.684.

<sup>32</sup> Marks. “South Africa’s Early Experiment in Social Medicine”, p.457. After 1948 the N.P. state relied increasingly on influx control, Group Areas legislation and rigorous police enforcement to prevent the increased poverty and disease in black areas impacting negatively on white communities.

1952 it was dismissed as “a drastic and revolutionary NHS based on the NHSC’s Report (as) impractical and undesirable”.<sup>34</sup> When I asked Kallichurum whether she felt the medical profession - Medical Association of South Africa (MASA) did anything to help the Durban Medical School or its Department of Social, Preventive and Family Medicine during trying times, she adamantly argued that it did not:

They didn’t know what it was all about. It was lack of knowledge, it was just ignorance about this course that caused the problems I think. ... I felt as a profession in the whole apartheid era, this MASA did sweet blow all ... for this Medical School at trying times, so I felt I could never be a member of that body ... they were too conservative.... I don’t know why they wouldn’t support issues ... why didn’t they fight? ... the professional bodies did nothing. ... You know you don’t expect statutory bodies to do much, but ordinary people, the associations and societies you belong to, you feel that the objections must come from there, that level you know and it didn’t. ... they find it very difficult to transform - doctors. ... they don’t like change, even if it’s for the better.<sup>35</sup>

Many of these mainly white, male doctors of the profession, were imbued with the values of individualised, curative, and hospital-based medicine, and were thus hostile to Kark’s basic philosophy - repudiating many of their core beliefs and traditions - which ultimately helped to undermine his health centre movement at a national level. The profession felt threatened by Kark’s hostility to orthodox medical practice and its clinical methods, and to the growing trend of specialisation to treat specific diseases. Kark and his team de-emphasised the individual doctor-patient relationship in favour of the whole family, made a social investment in disease prevention, removed the incentive of profit in disease, and replaced it with a higher ethical ideal of service, and tried to shift public funds from expensive, high-tech hospitals and equipment to cheaper community health centres where patients could be treated early and shown through health education the value of prevention of disease.<sup>36</sup> The profession felt that his approach was centred on the wrong kind of research, as it was applied and social, rather than basic and medical, was “amateurish” with its use of teams of doctors and other health workers and was oriented towards family welfare rather than the biomedical causation of disease. Jeeves argues that many felt contempt for Kark’s “distracted” interest in addressing social and economic

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<sup>33</sup> UN Archives Pmb. H6/1/1. Interview with Professor S. Kark and Professor Gordon, on some Facts and Aspects of our Medical School which are not Recorded, by S. Cameron-Dow, December 1980, p.23.

<sup>34</sup> See Marks. “South Africa’s Early Experiment in Social Medicine”, p.456 and Harrison. “The National Health Services Commission”, p.682.

<sup>35</sup> Interview with Professor Kallichurum.

<sup>36</sup> See Jeeves. “Public Health and Rural Poverty in South Africa”, p.9-10 and Arnold H. Tonkin. “A State Medical Service for Natives”. *South African Medical Journal*, 9 August 1941, p.290.

origins of illness instead of treating the biomedical causes of disease which formed part of the respected tradition of the medical profession as:

he was a trained doctor who preferred busying himself with vegetable gardens, pit latrines, sewing circles and day nurseries rather than focusing on the actual practice of medicine.<sup>37</sup>

The profession was thus threatened by his attempt to involve them in a radically different kind of public health service, which would restrict their lucrative practices. Gale and Gluckman made great efforts to minimise opposition and to reassure private practitioners (especially District Surgeons who carried out public health functions in rural black areas) that health centres would “not encroach on the legitimate rights of private practitioners”.<sup>38</sup> In 1949, Gale argued that health centres were aimed at supplementing existing duties and would only be located in “areas where local authorities are either non-existent or too poor to provide personal health services”.<sup>39</sup> Thus personal curative services remained largely in the hands of private doctors, except as in the past for the indigent poor. Contrary to their original intention of a non-racial vision - due to the conservative influence of the medical profession - health centres became confined to the poor and marginalised black communities. This greatly undermined the service as it resulted in an increased vulnerability of the scheme, and without powerful allies, it was easier to starve the health centres of the necessary funds. Thus, while in 1947/48 the “poor” still included whites, by 1952 it was resolved that because health centres provided the cheapest option of providing medical care for black communities, “all personal health services for non-Europeans now conducted by local authorities would be reorganised on a health centre basis”.<sup>40</sup> And as a consequence of health centre underfunding from the start and the marginalisation of health centres as a low-cost option for the black poor as apartheid policy became entrenched, they became targets for extinction through crippling budget cuts. This racist State was not prepared to

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<sup>37</sup> Jeeves. “Public Health and Rural Poverty in South Africa”, p.10.

<sup>38</sup> Trostle. “Anthropology and Epidemiology in the Twentieth Century”, p.64.

<sup>39</sup> See Gale. “Government Health Centres in Union of South Africa”, p.634.

<sup>40</sup> Marks. “South Africa’s Early Experiment in Social Medicine”, p.456. Key recommendations left unimplemented included that all health services be administered by the same central authority, as provincial control over hospitals continued, while a national health tax was never implemented because of the difficulty of imposing it on a heterogeneous population. Thus increased spending on curative hospital services, instead of preventive services, resulted in an every growing number of desperately sick patients who required expensive hospitalisation.

finance a health service which focused on various deprivations which interacted at a social, political and economic level to produce disease, as well as providing a service to black communities who were economically disadvantaged and politically disenfranchised.

### ***End of Rockefeller Foundation Funding - the Final Straw.***

Thus, over a period of twelve years, from 1948 to 1960, the activities of the social and community health centres approach was slowly attenuated and finally dissolved. In an interview in 1980, when recalling the Government's attempts to undermine the IFCH's work, Kark argued that its demise did not occur in one monumental sweep, but gradually and deliberately over many years:

let me indicate how the Government ensured that we would close down. I'm not saying this with malice, this is the way politicians' function. Any post on the institute staff that became vacant, I was not allowed to fill ... we had three groups of forty [health educators] going for three year training, the new class was frozen so we could finish off the training in the three years but we couldn't admit new ones. That's when we realised that this was the end, the beginning of the end. ... it would be two or three years before ... new doctors were not sent to us for training, they were appointed direct to health centres and then some health centres were beginning to be converted into small hospitals ... so in one way and another the notice was served that this was not going to be the policy of the Government.<sup>41</sup>

Denied of any funding from 1960 onwards - when the Rockefeller Foundation grant came to an end - the Government refused to take financial responsibility to continue the progressive work that had justified the hopes of its original sponsors, and the movement came to an end. Gale maintained that this was the very opportunity for which the politically-minded enemies of the Medical School, supported, though for different reasons by conservative-minded members of the medical profession had been waiting for:

what they wanted was not the perpetuation of the IFCH but its destruction. Their influence was now decisive, and the Government showed its unwillingness to perpetuate an activity that in any case it regarded with suspicion and doubly so as having been sponsored by an agency outside the country known for its liberalism.<sup>42</sup>

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<sup>41</sup> UN Archives Pmb. H6/1/1. Interview with Professor S. Kark and Professor Gordon, p.18.

<sup>42</sup> UN Archives Pmb. H6/1/1. Gale. "The Story of the Durban Medical School", p.16.



Gale wrote to the Foundation and pleaded with them to renew their grant as he felt assured that by 1965 the present opponents in the Government would be replaced by others who realised the importance of the community health work. However, this was not to be as it was felt that the money would be wasted under a Government directly opposed to the concept of community health. As Gale argued:

1960 was the year of Sharpeville, and the Rockefeller Foundation, recalling with bitterness that the many millions of dollars it had contributed to development of the Union Medical College in Peking early in the century had not helped in any way to prevent the Communist take-over of China, and fearing that South Africa too was now set on a course towards totalitarianism, albeit of a right-wing variety, it was not prepared to risk a repetition of its experience with China.<sup>43</sup>

The Department of Social, Preventive and Family Medicine was thus abolished. Some vestiges of its activities were incorporated into the teaching programmes of the traditional clinical departments. By 1960 most of the peripheral health centres had been forced to close and were handed over to the provincial administrations for conversion into detached out-patient clinics. A few Medical Officers in outlying black areas persisted for a few years, but by the mid-1960s most health centres had been closed. Sadly, in January 1961, the IFCH was also converted into an out-patient department practicing curative medicine only.<sup>44</sup> Mayet argued that a small attempt was made to keep it going, but - in her view - because Kark's Department had always been regarded with suspicion by the other Departments within the Medical School itself, it never really stood a chance of continuing:

it's a pity that it was stopped. There was an attempt at keeping it going, a half-hearted measure, and then it was stopped. [In the School] .... there hasn't been community involvement. ... but that [there] was just his Department, no one else. There was no community involvement. ... I don't know how much support the Medical School gave to that Department to start off with, its lack of support you know when the Karks left, there was no interest in continuing, except for a small group of people. So it being lost was a natural death.<sup>45</sup>

<sup>43</sup> UN Archives Pmb. H6/1/1. Gale. "The Story of the Durban Medical School", p.17.

<sup>44</sup> Harrison. "The National Health Services Commission", p.682. Because the Provinces had no constitutional power to undertake preventive work, they thus only provided curative services. Black health assistants were either retrenched or used as hospital orderlies.

<sup>45</sup> Interview with Professor Mayet by Vanessa Noble, Durban, 4 June 1999.

Kallichurum strongly asserted that in her opinion, the UN never fought hard enough to help the Medical School keep its Community Health Department; it had never really provided the support the black fledgling Medical School deserved:

the University and Medical School didn't really go on an all out fight to keep this man and find funding for that Department [which] was very sad in my opinion. ... And when they left there was nothing ... A great loss, and to the country, it was a great loss, and to the Medical Profession. ... I think the School felt it more than anybody else you know. I don't think the University felt it because we always, I still believe, if the University was sympathetic and knew what type of work was being done, they would definitely have gone out and found a donor for this thing. ... No, I don't think they worked at all. The Medical School was, you know, just involved in this whole thing, but not the University. And to get donors, a black faculty, it was not easy in those days but the University could have done it.<sup>46</sup>

As a result, many of the senior staff left South Africa, while the remaining staff were transferred to existing curative services in local hospitals or clinics. Not able to withstand the major racist shift in Government policy, which ran counter to the health centre's social philosophy and community development objectives, the movement was forced to an end, and rural health services in South Africa remained underdeveloped. As Farrer-Brown, Secretary of the Nuffield Foundation and a member of the Goodenough Committee argued:

what a pity to break down so promising a service: we have nothing in Britain which embodies so many of the ideals in everyday medical practice that we advocated in our Report.<sup>47</sup>

Thus, by 1960, most vestiges of the teaching aspects of the Department of Social, Preventive and Family Medicine had been lost to the Durban Medical School, while many of Natal's practicing health centres were also closed down, together with a nation-wide shut-down or conversion of other health centres into curative out-patient clinics. The State's determination and hostility against the movement's radical, and what it perceived as a socialist threat, had succeeded. The movement's doctors, and the School's long and hard fight had been lost, largely due to the movement's isolation and marginalisation from wider political and financial support, leaving South African black communities once again without desperately needed preventive

<sup>46</sup> Interview with Professor Kallichurum.

<sup>47</sup> UN Archives, Pmb. H6/2/3. Letter from G.W. Gale to Department of Health, 5/11/1952, p.5.

health services. But the State did not stop there. During the late-1950s, initial State hostility to higher education for blacks in white universities became a raging storm as it attacked the universities' foundation of autonomy, which ensured their high academic standards. Having had a long history of freedom and independence from State interference, this sphere remained no longer free from attack as this obdurate N.P. apartheid Government left no stone unturned in its quest to protect and promote white supremacy and power at every level.

This section will demonstrate that when the university Apartheid Bills were introduced, the battle was waged on two fronts. This included the fight against the general issue of academic segregation and promotion of academic freedom - a fight which the South African universities lost (including the "non-European Section" of the UN which was also forced to close), and the very specific issue of the black medical school and its continued existence as part of a white university on which the UN won.<sup>48</sup> While emphasis in the two phases was slightly different, the ultimate issues were the same. Thus, the State was successful in undermining general university autonomy and freedom, as well as the Durban Medical School's progressive social and community health department housed within its ranks. But I am also interested in determining why the State retreated on the medical front when it tried to remove this institution from UN control and place in under a State Department. I will argue that the strength in meeting the threat to the Medical School was produced by a united stand by various bodies, but particularly the School's own white academic staff which obstructed the Government's proposed intention, with blatant non-cooperation and their threat to resign *en masse*. It will be argued that, once again in the medical education sphere, the Government encountered many obstacles. And it was these complexities which eventually undermined many of its racist and segregationist political intentions.

### ***Apartheid Antecedents to Full-Blown University Attack.***

The 1948 the Nationalist apartheid victory was based on promotion of fuller segregation of the races and greater repressive control. The transition from the compromises of the previous "segregationist" era to the new vigour of the apartheid era was particularly marked in the field of education - but especially higher university education - which was subjected to direct attack

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<sup>48</sup> E.H. Brookes. *A History of the University of Natal*. (Pietermaritzburg: University of Natal Press, 1966), p.90.

through a series of legislative measures which ultimately established a new apartheid order in both schools and an end to the N.P. anathema of racial “mixing” in the “open” universities. Because medical schools had for years been associated within the intellectual and academic milieu of the university sphere, attacks on university autonomy and freedom thus also meant attacks on them. Malherbe made a poignant assessment that legislation dealing with segregating higher education, while apparently a “relatively silent area of involvement”, was in its ultimate consequences possibly more harmful than the more visible and tangible applications of policies to restrict civil rights such as job reservation, influx control and forced removal of families, because in this sphere, the State was now interfering with intellectual pursuits, people’s freedom of thought, right to criticise and academic standards of learning.<sup>49</sup> It was a State assertion of ideological control over the black elite to ensure the maintenance of white supremacy, even in the intellectual sphere, where the majority of leaders of the black community would be born.

Government apartheid policy-making on racial-control of university education in South Africa went through two distinct phases of development, largely because apartheid, like segregation before it, had no predetermined plan, but was continually negotiated in theory and practice. During the first phase under D.F. Malan, some scholars have argued that the N.P. legislation seemingly “progressed as a pre-programmed juggernaut that pushed ahead relentlessly, trampling over everything that stood in its path”.<sup>50</sup> This aspect of apartheid policy is evident in the fact that, although in vague terms, the N.P. manifesto for the 1948 election included racially segregated universities in their negotiated apartheid policy for South Africa. As early as 1951, the N.P.’s Eiselen Commission into “Native education” recommended the creation of a new, national scheme for African education “to meet the needs of Africans as an independent race [which included] the founding of an independent Bantu University”.<sup>51</sup> Its first major attempt to control black education was through the passing of the Bantu Education Act in 1953, which set up an entirely separate schooling system for Africans under the central control of H.F. Verwoerd’s Native Affairs Department (NAD). Legislative control of higher education was thus perceived by some as the natural and general development of apartheid policy, where the

<sup>49</sup> E.G. Malherbe. File 464/2. KCM 56990 (128). “Higher Education for Non-Whites”. *Progress* (Magazine of the Progressive Federal Party), February 1970.

<sup>50</sup> Bruce K. Murray. *Wits The ‘Open’ Years: A History of the University of the Witwatersrand, Johannesburg, 1939-1959*. (Johannesburg: Witwatersrand University Press, 1997), p.113.

<sup>51</sup> Murray. *Wits The ‘Open’ Years*, p.115.

new proposed racially segregated university institutions - which would supply black intellectual leaders for the separate “homelands” - would provide blacks with an inferior education to “fit them for their subordinate roles and thus complete the divided educational structure already developed for blacks in primary and secondary schools.<sup>52</sup> Verwoerd argued in 1953:

when I have control of Native education I will reform it so that Natives will be taught from childhood to realise that equality with Europeans is not for them ... People who believe in equality are not desirable teachers for Natives. ... When my Department controls Native education it will know for what class of higher education a Native is fitted, and whether he will have a chance in life to use his knowledge.<sup>53</sup>

However, while recognising the vigorous nature of the apartheid State policies, other scholars such as Deborah Posel, have emphasised the fluidity in Nat policy-making.<sup>54</sup> This is especially evident with regard to the realm of higher education, where N.P. policy ran into a series of obstacles before the passing of the infamous *Extension of University Education Act* was clearly mapped out in 1959. Between 1948 and 1953, there was a strong sense both within and outside Nationalist ranks, that their tenuous hold of the parliamentary majority gained in 1948, made their hold on power precarious and checked the influence of extremists. The N.P. also had no clear “blueprint” for developing an apartheid system of higher education. While “intermingling” of races at the “open” universities served as the main target for attack, there was hesitation within the State as to whether it could legitimately legislate against universities. In 1951, J.H. Viljoen, Minister of Education left the impression that the Government would not legislate university apartheid as universities were autonomous bodies and it would “constitute a revolutionary step to interfere with them”.<sup>55</sup> In the same year, the Eiselen Commission into “Native Education”, when contemplating the creation of a national scheme for African education, advised that this would “depend on a well-thought out plan for Bantu development” and would require “thorough study”. In 1952, the State publicly accepted its responsibility of

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<sup>52</sup> E.G. Malherbe. File 465/5/1. KCM 56990 (194). “University Apartheid in South Africa”. Reprinted from *Nature*, Vol. 180, 30 November 1957, p.2-4. This system put an end to the system of “liberal” mission schools supported by African taxation under the direction of provincial education departments.

<sup>53</sup> E.G. Malherbe. File 465/5/1. KCM 56990 (196) d. Memorandum on Higher Education for Non-Whites in South Africa consequent upon the Enactment of the Extension of University Education and Fort Hare University College Transfer Legislation by the National Union of South African Students, Cape Town, January 17-20, 1961, p.29.

<sup>54</sup> See Deborah Posel. *The Making of Apartheid, 1948-1961*. (Oxford: Oxford University Press, 1991).

<sup>55</sup> Murray. *Wits The 'Open' Years*, p.115.

providing proper academic training for blacks, but Malan suggested this might be done by means of separate university institutions or simply require Wits and UCT to establish separate divisions within their universities for their black students like the UN's "Non-European Section". Initially there was no grand, or all-encompassing strategy of N.P. attack.

While the N.P.'s early policies were in many ways exploratory (to determine the white public's voting consensus) and hesitant, even before university apartheid legislation could be passed, the N.P. found devious ways to undermine what they viewed as the anathema of "social intermingling" at "open" universities. In 1948, the Government announced its plan to terminate State scholarships for African students at Wits, which were phased out over three years. In another move, students from outside the Union and Indians from Natal, were refused international and inter-provincial permits to enable them to study at Wits. This Nationalist harassment of "open" universities had long-term implications for university autonomy, and these initial forays prepared the way for a total ban of black students at the "open" universities. As Phillip Tobias of Wits forewarned in his presidential address to the National Union of South African Students (NUSAS) conference in 1950, what was going on was a "softening up process as a prelude to legislating apartheid for Universities".<sup>56</sup> Bullying also extended to veiled warnings over the future of State subsidies to universities who did not toe the party line.

### ***The 1953 Holloway Commission.***

This first apartheid phase culminated in the State's appointment of the Holloway Commission (consisting of J.E. Holloway, Chairman and Secretary for Finance, E.G. Malherbe and R.W. Wilcocks, Rector of the University of Stellenbosch) in 1953 to "investigate the financial implications of providing separate university facilities for non-European students".<sup>57</sup> The scope of the inquiry and their terms of reference were limited to dealing only with the financial and practical implications of providing separate training facilities for blacks, and not whether segregation was desirable.<sup>58</sup> In March 1954, H.R. Raikes, the Principal of Wits, questioned Malherbe's motives:

<sup>56</sup> Murray. *Wits The 'Open' Years*, p.114.

<sup>57</sup> E.G. Malherbe. File 465/3. KCM 56990 (175) b. "Report of the Government Commission on Separate University Facilities for Non-Europeans". *University of Natal Gazette*, Vol. II, No. 1, June 1955, p.1.

<sup>58</sup> E.G. Malherbe. File 463/5/2. KCM 56990 (54) d. "Commission on Separate University Facilities for Non-Europeans". *University of Natal Gazette*, Vol. I, No. 2, June 1954, p.28.

you are the only active Principal with a seat on the Commission and you are thereby given some countenance to the Government's effort to tell the Universities what they must do. Other directions will follow in due course and I feel that you may find yourself in an invidious position vis-à-vis your colleagues if you have participated in the first destruction of University autonomy.<sup>59</sup>

Malherbe replied that the UN felt as strongly about the issue of protecting university autonomy as Wits did, and felt his presence on the Commission was possibly the only way of preventing interference with university autonomy.<sup>60</sup> The Commission Report had grave misgivings as to the policy of introducing segregation into the university sphere and unanimously rejected the proposals by the Secretary for Native Affairs to establish ethnically determined new State run university institutions. The Commissioners objected to State interference and curtailment of traditionally autonomous university rights and refused to consider the creation of separate facilities, which were inferior as "such as a step would mean material retrogression in regard to the university training of non-Europeans".<sup>61</sup> Although bound by their terms of reference to assume the desirability of segregation, they were realists and saw the NAD's fanciful ideas to establish new separate universities or separate facilities at Wits and UCT as too expensive to be practicable, and preferred to build on existing foundations. They recommended that should segregation in higher education be desired, the most feasible scheme would be to concentrate African and Indian students at Fort Hare and Durban where segregation was already practiced, and to allow Coloured students to continue non-segregated studies at the Universities prepared to admit them.

### ***The Second Phase: Introduction of University Apartheid.***

However, the Holloway Report was rejected as entirely unsatisfactory by the N.P. Government, following their reelection victory at the end of 1953, now under J.G. Strijdom, and following the intervention in Cabinet of H.F. Verwoerd as the doctrinaire Minister of Native

<sup>59</sup> E.G. Malherbe. File 465/3. KCM 56990 (172). Commission of Enquiry into Separate University Facilities for Non-Europeans 1953-54. (The "Holloway Commission"). Letter from Dr. H.R. Raikes, Principal of Wits to Dr. E.G. Malherbe, 20 March 1954.

<sup>60</sup> E.G. Malherbe. File 465/3. KCM 56990 (172). Commission of Enquiry into Separate University Facilities for Non-Europeans. Letter from Malherbe to Raikes, 20 March 1954.

<sup>61</sup> E.G. Malherbe. File 465/3. KCM 56990 (175) b. "Report of the Government Commission on Separate University Facilities for Non-Europeans". *University of Natal Gazette*, Vol. II, No. 1, June 1955, p.1-5.

Affairs. When Strijdom took over the reigns of power with an increased majority, Nationalist Government policy shifted into a more driven ideological and assertive second phase. Hardliners in the Cabinet were emboldened, providing a clearer ideological direction and the N.P. made its first legislative moves to eliminate the “open” universities which ran contrary to the policy of apartheid, as well as constructing separate ethnically based universities for blacks.<sup>62</sup> Because the Holloway Commission Report was viewed as too liberal and inadequate for the more extremist N.P. ideologues, a determined N.P. announced in May 1955 that further investigation would be necessary for the policy of apartheid in universities to be implemented. In November, Viljoen announced the establishment of a purely internal investigation, in the form of an Inter-departmental Committee to enable the Government to “determine the financial implications of providing separate university educational facilities for non-Europeans in order to enable it to decide whether, from a financial point of view, it would be practical without incurring an excessive drain on the State’s finances”.<sup>63</sup> Its terms of reference also prevented an inquiry into the desirability of segregation in the field of university education and it never consulted the “open” universities during its deliberations. It was instructed, and managed to work out an elaborate scheme for establishing separate university facilities for five different race groups, namely: the three major “Bantu ethnic”, Indian and Coloured groups. The Committee estimated the total capital costs, spread over ten years to be only £3 million (R6 million).<sup>64</sup>

### ***Early State Policies with Regard to the UN - the 1954 Wilcocks-du Toit Report.***

While recognising that these early N.P. Commissions of inquiry and exploratory policies to devise ways to control university education in South Africa had an impact on all university institutions concerned with providing black students with a higher education, I am more interested in the impact these apartheid policies had on the UN, and more specifically, its Medical School. As argued in the previous chapter, the Government agreed to financially subsidise the Durban Medical School if it were housed separately and provided “exclusively for

<sup>62</sup> Murray. *Wits The 'Open' Years*, p.115.

<sup>63</sup> UN Archives Pmb. H6/2/2. Medical School Advisory Committee. Estimates and Expenditures. Letter from Principal of the UN to H.S. van der Walt, Secretary for Education, Arts and Science, 12 January 1955 and E.G. Malherbe. File 465/4/5. KCM 57009 (41). Short Summary of the Interdepartmental Fact-Finding Committee’s Findings on the Financial Implications in Connection with the Establishment of Separate University Colleges for Non-Europeans, 1956, p.3.

<sup>64</sup> Murray. *Wits The 'Open' Years*, p.291.



non-Europeans". While regarded as an interference of its autonomy, the UN accepted it on condition that the State gave its assurance that the course offered would be of the highest standard and no way inferior to other medical schools. When the School was opened in 1951, no white student was admitted, and the School continued this policy conscientiously. However, in the early-1950s, the UN faced an increasingly desperate financial situation, with its duplication and even triplication of staff, subjects and equipment in a university that had developed as a trifocal structure. Because the Holloway Commission did nothing really to remedy the situation, the State increasingly came to interfere in UN academic matters justified on the basis of its financial concern for the institution.<sup>65</sup> In November 1954 the Department of Education, through the Medical School Sub-Committee of the University Advisory Committee, visited the School to devise a way to overcome these problems, but the Committee did not consider any of the UN proposals for extending the special State subsidy formula, but concentrated their investigation on what cuts could be made in the UN's expenditure in order to enable it to balance its budget in 1955. It rigorously examined its financial situation:

with a view to devising a basis of subsidy which will not cause the University to be continually faced with a series of financial crises which ... are most frustrating and disturbing in the conduct of proper University work.<sup>66</sup>

It questioned the standard of UN administrative and financial control of the School, made no provision for essential equipment or normal increments in salaries and gave no further subsidy to pay off the UN accumulated deficit.<sup>67</sup> Instead, it recommended the abolition of what it saw as an unnecessary full-time Deanship and a "phased-out" abolition of the additional "preliminary year".<sup>68</sup> In a letter from H.S. van der Walt, Secretary for Education, in February 1955, the UN was advised that the State supported the views of the Wilcocks-du Toit Report that the post of full-time Dean be abolished at the end of 1957 and the "preliminary year" be abolished at the end

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<sup>65</sup> See UN Archives Pmb. H6/2/2. Medical School Advisory Committee. Estimates and Expenditure, 1955. A Brief History of Attempts by the University of Natal to solve its Problems, 5th April 1955, p.3. Its recommended additional subsidy of £12,000 would not cover the costs of the UN with a trifocal structure.

<sup>66</sup> UN Archives Pmb. H6/2/2. A Brief History of Attempts by the UN to solve its Problems, p.3.

<sup>67</sup> See Gordon. *Report on the Government's Intended Action*, p.10 and UN Archives Pmb. H6/2/2. A Brief History of Attempts by the University of Natal to solve its Problems, 5th April 1955, p.4.

<sup>68</sup> UN Archives Pmb. H6/2/2. Medical School Advisory Committee. Estimates and Expenditures. Letter from Dean G.W. Gale to Principal of the UN, E.G. Malherbe concerning the Wilcocks-du Toit Report, 20 April 1955.

of 1956.<sup>69</sup> It also recommended a reduction in the number of technicians and other staff posts. It was not prepared to recognise the Department of Social, Preventive and Family Medicine for subsidy purposes when the Rockefeller Foundation grant ended. The Government relentlessly aimed to cut UN spending by £8,500 per annum, even if it meant undermining the high academic standards.

### *A Sad End to the Gale Era.*

In April 1955 Gale resigned as Dean and in May accepted an invitation to become Professor of Preventive Medicine at Makerere Medical School in Kampala, Uganda. But as Gale argued, it was not a voluntary decision but the final blow in a continual battle against slow but persistent Government attempts to undermine the high standards he was determined to maintain at the black Medical School. In March 1955, Gale wrote how he and his colleagues resented State interference in the financial running of the School:

I, and I am sure my successor, would resent very much the advent of a medical commission charged with the duty of still further pruning estimates which, we have declared repeatedly, are the minimum compatible with maintenance of standards of teaching equivalent to those elsewhere. It would look as though the Department doubted our competence, or our honesty, or both.<sup>70</sup>

Gale defended all his actions and the expenses raised, as being in the best interests of maintaining the highest standards for the School:

if a cut of £8,500 is really put into operation I have no hesitation in saying that the School will be maintained at such a low level that it will be essential to prevent any visitors from overseas from seeing inside the Medical School, for if they reported back what they saw it would damn South Africa in the eyes of the rest of the world for running a Medical School for non-Europeans only in which conditions were hopelessly inferior to conditions in the other Medical Schools in South Africa.<sup>71</sup>

In April, Gale wrote to the UN Principal, E.G. Malherbe to explain why he had resigned and was being forced to hand in his resignation prematurely:

<sup>69</sup> UN Archives Pmb. H6/2/2. Medical School Advisory Committee. Estimates and Expenditure, 1955. Letter from H.S. v.d. Walt Secretary for Education, Arts and Science to the Registrar UN, 8 February 1955.

<sup>70</sup> See UN Archives Pmb. H6/2/2. Medical School Advisory Committee. Estimates and Expenditure, 1955. Letter from G.W. Gale to Principal of the UN, 1 March 1955.

the Wilcocks-du Toit Report makes clear that a policy of ruthless and unimaginative economy is henceforth to dominate the relations between the State and the Durban Medical School and, therefore, the ‘somewhat extravagant luxury’ which I am described as being has no choice but to accept an alternative post as soon as it offers, rather than remain - an embarrassment to the University vis-à-vis the Government - until such time (1957 at the latest) as Government sees fit to pronounce sentence of death.<sup>72</sup>

While Gale’s dismissal was supposedly based on financial stringency, others have argued that it was because his ideas and policies were too liberal for the Government of the day. Malherbe complained to the Secretary for Education about Gale’s forced resignation for, “it places me in a very difficult position ... it is very difficult for me to see how I can carry on the administration of the Medical School ... [and] I shall probably have to expect the resignation of other valuable people in this UN”.<sup>73</sup> Gale was assured by Malherbe of the UN’s determination to persuade the Government to reverse its decision, but Gale knew that it would not budge and felt that he had no other choice (he was not able to afford to retire and unable to reenter private practice for being out of it for twenty years) but to accept an alternative post.<sup>74</sup> While disappointed at being forced to leave the Medical School sooner than anticipated, he was appeased by the fact that it would be left in capable hands:

my sorrow at having to leave my native land and School in the establishment of which I had so much to do over so many years was greatly assuaged by the appointment of “Okkie” Gordon, the Professor of Pathology, as my successor as Dean, for I knew he shared my ideas and ideals for medical education.<sup>75</sup>

In a letter to the new Dean in 1955, a disheartened Gale wrote how disappointed he was at being forced to resign from a position he had hoped to hold until retirement, “I need not deny to you, that it is a very bitter thing to have to leave one’s country and, at the same time, a lifetime’s

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<sup>71</sup> See UN Archives Pmb. H6/2/2. Medical School Advisory Committee. Estimates and Expenditure, 1955. Letter from G.W. Gale to Principal of the UN, 1 March 1955 and Letter from Dean of the Medical School, G.W. Gale to Principal of the UN, E.G. Malherbe concerning the Wilcocks-du Toit Report, 20 April 1955.

<sup>72</sup> UN Archives Pmb. H6/2/2. Letter from Dean of the Medical School, G.W. Gale to Principal of the UN, E.G. Malherbe concerning the Wilcocks-du Toit Report, 20 April 1955.

<sup>73</sup> UN Archives Pmb. H6/2/2. Medical School Advisory Committee. Estimates and Expenditures. Letter from Principal of the UN to H.S. van der Walt, Secretary for Education, Arts and Science, 12 January 1955.

<sup>74</sup> UN Archives Pmb. H6/2/1. Correspondence. Letter from Gale to Gordon, 21 May 1953, p.6. Malherbe was anxious about Gale resigning for fear that other prominent doctors that supported him would have resigned too, leaving the school with inferior staff.

<sup>75</sup> See UN Archives Pmb. H6/1/1. Gale. The Story of the Durban Medical School, p.15.

ambition unfulfilled".<sup>76</sup> Whilst in Makerere in 1976, Gale wrote a brief autobiographical account of his life and work in Durban, and about how difficult and sad it was for him and his family to give up their home in Durban, together with all their friends, as he argued, "now that I am no longer in South Africa, and knowing how easily things are forgotten, I would like the story to be on record among my friends - many of them friends for a lifetime".<sup>77</sup> He was slightly appeased though by his contributions to the School's establishment:

thus disappointed as I am at having been compelled to leave the School so much sooner than I had anticipated when I joined it, I am glad that I was able to stay long enough to see the fabric of the building completed, the equipment assured, and above all, the seven major departments headed by men in whose hands the future of the School is bright with promise. It has been my privilege to be the obstetrician of the Durban Medical School, and I am proud of the full-weight and healthy baby that has been born. I had hoped to be its paediatrician too, but that was not to be.<sup>78</sup>

### ***The Beginning of a New Era: The Medical School under Dean Isidor Gordon.***

In May 1955, Professor Isidor Gordon took over from Gale as Dean of the Medical School, a position he held for the following fourteen years.<sup>79</sup> As an interesting aside and continuing theme that seems to emerge in the history of this medical institution, was that Gordon was also Jewish, and once again a doctor of influential standing, devoting his life and work to the progress and development of black medical education. Gordon joined the ranks of the work of other Jewish doctors in the Medical School including: Sidney Kark and his band of colleagues in the Department of Social, Preventive and Family Medicine, A. Kark as the first Professor of Surgery and Teddy Gillman as the first Professor of Physiology, who fought against social injustices by training black doctors to provide a medical service to desperately health-burdened and disadvantaged black communities. The progress and international recognition gained by the School over these years owed much to Gordon's leadership and tenacity. Like Gale, Gordon also entered the Medical School in 1953, after having a distinguished career in the Union Department of Health as Senior Government Pathologist and Officer-in-Charge of the State Pathology Labs

<sup>76</sup> UN Archives Pmb. H6/2/1. Letter from G.W. Gale to Prof. Gordon, 2 May 1955.

<sup>77</sup> UN Archives Pmb. H6/2/1. Correspondence. Letter from G.W. Gale to I. Gordon, 21 May 1955, p.1.

<sup>78</sup> UN Archives Pmb. H6/2/1. Correspondence. 21 May 1953, p.6.

<sup>79</sup> B.T. Naidoo. "A History of the Durban Medical School". *SAMJ*, 25 September 1976, p.1626.

in Durban.<sup>80</sup> It was in his position as Dean, that Gordon would play a vital role in leading the medical profession in a strong stand against salary discrimination on racial grounds, and was at the forefront of the eventually successful struggle against the State's attempt to remove the School from UN control.

### ***University Opposition to the Government's Blunder into University Apartheid.***

In March 1956, Dean Gordon heard unofficially that the State had decided to transfer control of the Medical School from the UN. In 1957, the universities in South Africa were subjected to direct attack through a series of legislative measures, which ultimately established a new apartheid order in higher education. Many attempts were then made by the UN to obtain information about this reported Government intention.<sup>81</sup> The first official news that Principal Malherbe of the UN received from the Department of Education of its change in policy was on 24 January, when he received written notice by the Secretary of Education of a special meeting of the Council of the University of South Africa (UNISA) to discuss the removal of all black classes from UN control – which included that:

the Medical School for non-Europeans will no longer fall under the control of your University. It is intended that the University of South Africa should become the examining body for the Medical School ... I express the hope that your Council will see its way clear to cooperate with the Department in the transfer of the Medical School when the proposed legislation has been accepted.<sup>82</sup>

And this was to occur even before the pioneer group of medical students had graduated. The year 1957 was marked by the Government's first step on 11 March to introduce into the House of Assembly, the *Separate University Education Bill*.<sup>83</sup> The Bill was concerned with implementing the policy of separate university institutions for "non-Europeans", which was an assertion of

<sup>80</sup> UN Archives Pmb. Bio-S-506/1/1. Gordon, Isidor Prof. "Admission of Emeritus Professor I. Gordon as an Honorary Fellow of Forensic Pathology in the Faculty of Forensic Medicine of The College of Medicine of South Africa at a Special Admission Ceremony in Durban on 4 July 1984". *Transactions of The College of South Africa*, Vol. 28, No. 2, July-December 1984, p.60.

<sup>81</sup> Gordon. *Report on the Government's Intended Action*, p.19. Indirect representations were also made to the Minister and the University authorities learned unofficially that he regarded the whole situation relating to black higher education as being *sub judice* pending the receipt by him of the report from the Interdepartmental Committee.

<sup>82</sup> E.G. Malherbe. File 465/4/5. KCM 57009 (41). Short Summary of the Interdepartmental Fact-Finding Committee's Findings on the Financial Implications in Connection with the Establishment of Separate University Colleges for Non-Europeans, 1956, p.3.

<sup>83</sup> UN Archives Pmb. H6/1/10. Medical School. Memorandum prepared by Professor I. Gordon for Informal Meeting between Professor F.E. Stock and Professors Gordon and Adams and Dr. Cochran, 19th May 1970, p.5.

ideological control over the black elite to ensure the maintenance of white supremacy including the intellectual sphere. It never consulted the universities or experts in university education about the effects it would have, as Chancellor of UCT, A. van de Sandt Centlivres argued:

it casts a vivid light on the methods adopted by a Government which closes its mind to any representations made to it by people who are entitled to be regarded as experts in their own field.<sup>84</sup>

It gave the Minister of Native Affairs the power over the education for “Bantu persons” and for the Minister of Education to cater for other “non-whites”; and made provisions for the transfer of Fort Hare and the UN Medical School to Government control. It was argued that it was intended that these institutions would be constituent colleges of the University of South Africa (UNISA) - which would serve as the examining body for these separate colleges to ensure their standards - and would eventually develop into separate universities.<sup>85</sup> The Bill gave the Minister extensive control over these new colleges, empowered him to appoint and discharge the Senate, Principal and academic staff, as well as accept or deny student admissions.<sup>86</sup> It thus entailed a racially segregated and State-dominated and controlled higher education for blacks. From that moment on, a massive struggle began between the universities and the Government, which lasted for two years, and greatly hindered the Government’s intended actions.

While I will examine the widespread protests and opposition in South Africa to the imposition of apartheid onto universities, and why it was that their protests largely failed, I will also analyse, within this broader debate, the particular protests by the UN and its Medical School, more importantly, and why this small, fledgling black Medical School was able to escape the apartheid State’s intentions. It will be shown that, in the field of higher education, the State’s power over education was far more uncertain and tentative in the beginning as it came up against the interests of powerful autonomous university institutions, medical bodies, local and international opposition, including lack of support from members within the N.P.’s own ranks.

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<sup>84</sup> van de Sandt Centlivres. “Blundering in University Apartheid”, p.1 and Gordon. *Report on the Government’s Intended Action*, p.19. In his report, Gordon shows how the UN made repeated efforts to have their side, and their evidence heard, but the Government Committees never consulted the universities.

<sup>85</sup> Murray. *Wits The ‘Open’ Years*, p.291. University Colleges for Africans were financed from the Bantu Education Account and other “non-Europeans” out of the Consolidated Revenue Fund.

<sup>86</sup> E.G.M. File 465/4/2. KCM 56990 (183). *The UN and the Separate University Legislation, 1957*, p.3, 13. This bill gave complete power to the Minister who could prescribe the duties, functions and responsibilities of the University

### *Defending the Open Universities.*

During the late-1950s the racially “open” universities, who were an anathema to the N.P. as they subverted the principles of apartheid, were targeted for attack. However, there was an enormous response within, and outside of Wits, to avert this threat of university apartheid. The passing of legislation through Parliament was carried out in the face of major campaigns of protest mounted by Wits, UCT and NUSAS, who co-ordinated their student protests both domestically and internationally, and showed a high degree of solidarity between the universities in developing a united front on their campuses and in co-ordinating action between them. Throughout the two years from the tabling of the first Bill in 1957, the “open” universities protests (of varying intensity) against university apartheid legislation, was done to ensure that an important set of principles - university independence and autonomy - was defended and not simply allowed to go by default. At Wits and UCT the student protests involved all their constituencies including the Council, Senate, Convocation, lecturers and students. As Murray demonstrates, Wits staged two important protests. The first in the University’s history involved a march through the streets of Johannesburg to the City Hall in May 1957, and it was commented in the *Witwatersrand Student* on the eve of the march, “Wits is today a completely united front against apartheid”.<sup>87</sup> The second would occur just before the final University apartheid act was passed through Parliament in 1959. Various “liberal” organisations such as the Black Sash and SAIRR and other concerned public bodies joined in the campaign to arouse public opposition to the Government’s proposals for university apartheid. Murray asserted in his book, *Wits the ‘Open’ Years*:

apart from the removal of the Coloured voters of the Cape Province from the common roll, no other single measure of the 1950s gave rise to so great and prolonged a public furore, and as a consequence of international links that NUSAS and the universities themselves brought into play, repercussions were international.<sup>88</sup>

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Councils. It thus removed the traditional right of each South African university to decide upon the nature and constitution of its student body in accordance with University Council’s view in the best interests of the institution.

<sup>87</sup> Murray. *Wits The ‘Open’ Years*, p.289, 295. However, in the beginning Wits was hindered from strong protest action because of fundamental divisions between Principal and University Council on the one side and SRC on the other. It was only when this battle was resolved in 1955 that the staff and students joined forces.

<sup>88</sup> Murray. *Wits The ‘Open’ Years*, p.289.

### ***University of Natal: Opposition from an Ambiguous Position.***

When the 1957 Bill declared the sweeping away of total integration as well as partial segregation, the 1936 Natal University College's parallel but separate "non-European Section" arrangement came under the Government spotlight. From the beginning the UN was forced to resist academic segregation from a position of ambiguity and internal conflict, having years before already bowed to the racial pressure of separate facilities. However, the State's intention to close its "non-European Section" down, and aim to change the status of its black Medical School, was a reversal of the original policy approved by the Government, and resulted in the UN and its Medical School embarking on the mobilisation of opposition:

it is clear, also, that any concession made by a University to meet the wishes of the Government must in future be regarded as fruitless, for the compromise accepted by the University of Natal on the question of admission of students is now brushed aside as if it had never been made.<sup>89</sup>

When the Bill was passed, the UN's Council, Faculties, academic staff and students had emergency meetings during February 1957 to decide how to handle the devastating State assault on the UN's autonomy and academic freedom. Although the UN authorities were outraged and sent numerous deputations to try and negotiate with the Government, the Government refused to budge, and the UN always ambiguously counseled an approach which had regard primarily to the academic and professional consequences of the proposed change in status, and did not fight for the particular freedom interests of its black students.<sup>90</sup> In 1957, the senior members of the academic staff of the UN issued the following statement:

we fully support our colleagues of the Medical Faculty in the stand they have taken against the removal of our Medical School to a Government Department. Without consultation, they are to be transferred to a service, which they did not voluntarily enter and which constitutes a degradation of their academic status. Their idealism, ability and devotion have, in a few years, created a Medical School which is widely recognised for its high academic standards and pioneering work in medical education, and we sympathise deeply with them in their well-grounded fears for destruction of this creative achievement. Of deep concern, too, is the fate of our students who entered our Medical School with full assurance that they would receive an education of the highest academic

<sup>89</sup> "Amputation in Natal". *The Cape Argus*, 11/3/1957.

<sup>90</sup> Gordon. *Report on the Government's Intended Action*. Emergency Meeting of the Council of the UN, 12 February 1957, p.39. Also see p.23 where strong support was also received from its Convocation, and "Threat of Medical Staff Boycott". *The Natal Mercury*, 15/3/1957 for student protests and meetings.



quality. We, the undersigned heads of department of the UN, stand together with our medical colleagues in opposition to the invasion of University independence, degradation of academic status and breach of faith to both staff and students.<sup>91</sup>

However, the UN did not wish the matter to become a major political issue - the universities were part and parcel of their surrounding communities and thus relied on their financial and other support, and did not want to ostracise this wider support because of its stand on racial issues - and instead implored the Government not to change the status of its “non-European Section” and black Medical School because of the enormous academic progress made at these sections, which if removed would threaten academic standards for black education. As Principal, Malherbe argued that the State interference in university affairs and their aim to remove black students from the UN and put them in separate institutions was a flagrant violation of this last strong-hold of academic freedom - an ideal which they had pledged to uphold at the inauguration of the UN as an independent university in 1949, as he argued:

they have been left as oases of freedom from State regimentation. But now the desert sands threaten to engulf these little, bubbling springs of freedom which are the very life-blood of a nation. We are all very disturbed about this because we do not know what the future has in store for us.<sup>92</sup>

His ambiguous role is evident in that while he saw the necessity to maintain certain forms of apartheid in other spheres in South African society, he did not believe that this should extend into the university sphere which would violate the autonomous and high standards of the universities and undermine South African universities in the eyes of the outside world:

it is reasonable to believe that there is sufficient pride and patriotism amongst our South African people not to allow South Africa to be made to look ridiculous in the eyes of the outside world by debasing its University currency through the introduction of such a piece of bad University legislation.<sup>93</sup>

University apartheid legislation was opposed for a number of complex reasons. While most people argued against the legislation on academic grounds - that having racially segregated and State-controlled institutions would lower the high standards - universities also opposed the

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<sup>91</sup> Gordon. *Report on the Government's Intended Action*. Statement by Senior Members of the Academic Staff of the UN, 1 February 1957, p.42.

<sup>92</sup> “Malherbe says Age-Old Rights are Taken Away”. *Natal Mercury*, 5 March 1957.

<sup>93</sup> E.G. Malherbe. File 465/4/2. KCM 56990 (187). Critical Comments on the “Extension of University Education Bill”, 2 April 1959, p.7 and p.3.

fact that the Bill gave the State sole power of nominating University Councils and Senates.<sup>94</sup> This move was justified by the State on the grounds that it financially subsidised these institutions and thus had a right to interfere with university's autonomous decision-making bodies.<sup>95</sup> Gordon took umbrage to the State's use of its financial provisions to justify assuming control over these institutions, as well as the lack of any consultation with any university academic staff:

its important to recognise that any Government in making budgetary contributions towards a vitally important service such as provision of higher education for people, merely acts as trustee of the public's funds. The argument that the State Department, because of its financial subventions, can assume complete control of a University college or faculty of a University, gravely endangers the autonomy of all universities. If on the basis of this argument, transfer of a faculty from a University can be justified at one time, transfer of other faculties from other universities may well be justified at other times by the same or by successive and different Governments.<sup>96</sup>

The academic staff also took strong exception to the provision of the Bill that gave the State sole power to appoint, dismiss and punish staff for misconduct, which would undermine the confidence of the staff to perform their academic duties properly and debase their academic posts. The Bill made it clear that the Principal and academic staff became civil servants and thus instruments of policy-makers because they had to subordinate their own judgements to that of the Government, while their conduct was subject to the State sanctions inconsistent with university freedom.<sup>97</sup> This very prohibitive and severe aspect of the Bill must be remembered when considering the brave protest actions of many of the university staff around the country, who were in fear of being punished or dismissed each time they openly opposed the State. But many

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<sup>94</sup> Gordon. *Third Report on the Government's Intention*. Appendix JJ. Summary of Evidence by the UN to be presented to the Commission on the Separate University Education Bill, p.2. Also see E.G. Malherbe. File 465/4/2. KCM 56990 (183). The University of Natal and the Separate University Legislation, 1957, p.16-17. This State power would rob the University Councils of their power as ruling academic bodies which determined university policy from within. The Council is composed of responsible representatives not only of the community which the university services, but also former students, donors, staff and the Government.

<sup>95</sup> E.G.M. File 465/5/1. KCM 56990 (206). "Malherbe Attacks State's Use of 'Power of the Purse'". *Daily News*, 3/10/1957.

<sup>96</sup> "Medical School can be Removed 'At Any Time'". *Natal Daily News*, 10/5/1957.

<sup>97</sup> E.G.M. File 465/5/1. KCM 56990 (202) "University Apartheid". *The Lancet*, 30/3/1957, p.676 and Gordon. *Further Report on the Government's Intention*, p.15. The Bill stated that staff were guilty of misconduct and dismissal if the "publicly comment adversely upon administration of any Department of Government" or if associated with propaganda calculated "to cause or promote antagonism among any section of the population" or "to impede, obstruct, or undermine the activities of any Government Department". It also gave the State power to institute disciplinary proceedings against staff in respect of alleged misconduct before the date of its implementation.

continued doing so. Gordon argued that the academic staff resented being placed at the mercy of any official who might interpret their statements as being calculated to cause antagonism:

a feeling of frustration and of being regarded as political agitators had become common among responsible South Africans who had found themselves in disagreement with the Government. This sense of frustration is a tragic consequence of recent developments in the country which indicate that decisions are made without consultation and despite arguments against carrying out of predetermined policies.<sup>98</sup>

Further university offence was taken with regard to the Minister (not the University Councils) having sole power to decide upon the nature and constitution of the student body, which was not done in the best interests of the universities, but in the best interests of political apartheid considerations.<sup>99</sup> Many objections were lodged against the provisions that individual students would now be liable to conviction, imprisonment or fine if they contravened any section of the ethnic exclusionary provisions. In an address to the Convocation of Wits in 1959, Gordon strongly asserted:

the fact that the present Bill not only incorporates the principle of exclusion, but also provides for penal sanctions to prevent admission of students ... is one of the most infamous clauses ever written into the University Charter or Statute in the history of Western Civilisation.<sup>100</sup>

Together with the affront on university freedom and autonomy, as well as the State's use of undemocratic methods of execution in this manoeuvre, the apartheid legislation was opposed for further complex reasons. Malherbe criticised the Government's attempts to provide new separate "non-European" universities because of the enormous expense it would entail. He too resented the fact that the State was prepared to spend unnecessarily, millions of rand on new "universities in the Bundu", whilst legitimate existing university financial requests were dismissed by the State, who told existing institutions that "we must tighten our belts and carry on as best we can".<sup>101</sup> A further reason for concern was that the creation of isolated, ethnically

<sup>98</sup> "Medical School Issue put to Medical Council". *Natal Daily News*, 11/3/1957.

<sup>99</sup> E.G. Malherbe. File 465/4/2. KCM 56990 (183). *The UN and the Separate University Legislation, 1957*, p.13.

<sup>100</sup> E.G. Malherbe. File 463/7/2 (B). KCM 57009 (17). Address to be Delivered by Professor I. Gordon at the Invitation of the Convocation of Wits on Thursday, April 2, 1959 in the Great Hall, p.3. Previously the individual universities were subject to punishment or fine if they admitted students against the will of the State.

<sup>101</sup> E.G. Malherbe. File 465/4/2. KCM 56990 (187). *Critical Comments on the "Extension of University Education Bill"*, 2 April 1959, p.1-3. The Interdepartmental Committee on the Separate University Bill reported that the cost of providing even mediocre services at new institutions would be more than three to four times as high for the State as the cost at present of providing black higher education at the UN "non-European Section". Much evidence was

exclusive institutions in isolated “Native territories” would become danger spots where agitators were bred, as they would become centres of political disaffection, discontent and result in the development of strong anti-white feelings. As Malherbe, a staunch segregationist, ironically argued:

people learn to understand one another only when there is some field in which they can meet on an equal footing, and where they can exchange ideas frankly and with respect. Opportunities for such exchanges are to be totally and compulsorily extinguished by the present legislation. ... the pattern that is now being laid down will do much to intensify growing mistrust between European and non-European leaders. Where such attitudes and prejudices prevail, it will indeed be difficult to achieve a common endeavour to strengthen and develop Western civilisation in South Africa.<sup>102</sup>

Malherbe also voiced anxiety over the fact that while university institutions in the past evolved and developed slowly as part and parcels of their surrounding communities (which demanded their existence), these new State-developed and imposed colleges would have no roots or long-established connections with the surrounding communities, and nor did they reflect the ethos of each ethnic group. To continue with his metaphor of universities being like small “springs of freedom”, he argued:

each of these new universities will in fact be a small oasis, with springs bubbling with the blessings of Western learning, in a desert of crude and largely illiterate tribalism. What comes from these academic springs will, however, be carefully siphoned and sterilised under strict governmental surveillance.<sup>103</sup>

### ***The Durban Medical School’s Grounds for Opposition.***

It is ironic that the first target of the original *Separate University Education Bill* that the State passed in 1957, was the completely racially segregated black Medical School at the UN. In an article in the *Natal Daily News* at the time, it was argued:

what is of import at the moment is the aggression by the Government on the UN. It is not the much-hated Cape Town or Witwatersrand universities with their mixed classes which are to be the first victims of Dr. Verwoerd’s passion for taking all non-white

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produced of the violence and “agitation” experienced at the black University College of Fort Hare. These opponents of State policy did not see the “open” Universities as danger spots (like the restricted, isolated segregated institutions) but felt pent up disaffection would be more successfully dissipated through contact with other races in mixed institutions.

<sup>102</sup> E.G. Malherbe. File 465/4/2. KCM 56990 (183). The UN and the Separate University Legislation, 1957, p.20.

<sup>103</sup> E.G. Malherbe. File 465/4/2. KCM 56990 (187). Critical Comments, p.6-7.

education out of anything resembling European partnership or control, but that the first blow is to be struck at the autonomy of the UN, which practices academic segregation.<sup>104</sup>

The UN had established this exclusively black Medical School - with its imposition of total apartheid despite the fact that it infringed on their autonomy - and with the full concurrence and financial support of the racist N.P. Government.<sup>105</sup> As Malherbe argued in a letter to the Secretary for Education, Arts and Science to try to dissuade the Government of its action: "I based my hopes also on the fact that, with the University of Natal in control, the Medical School had proved to be an unparalleled success as an 'apartheid' institution in conformance with the Government's wishes".<sup>106</sup> In an article in the *Natal Daily News*, it was reasoned that the Government's first move against the Medical School was done because:

the Government, anxious to act against 'mixed classes' at the University of Cape Town and the Witwatersrand, is finding opposition there a little too strong. Now, to make a demonstration, it had recourse to the easier way of attacking the fledgling non-European Medical School of the UN.<sup>107</sup>

What the Government was not prepared for was the massive opposition that would result from this unprovoked attack.

On 13 February 1957, a resolution was passed by the Heads of Department of the Medical School which expressed strong protest against the Government's intended move, as:

without consultation either with the UN or members of its academic staff, the Government has decided to change the status of the Faculty. This disregard of the UN constitutes, in our view, a serious challenge to University education in general, and an affront on our University of Natal in particular.<sup>108</sup>

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<sup>104</sup> Gordon. *Report on the Government's Intended Action*. "University in the Bundu". Editorial Comment. *The Natal Daily News*, 11 February 1957, p.44.

<sup>105</sup> E.G. Malherbe. File 463/7/3. KCM 56990 (79). "Nature and Significance of the Attack on University Autonomy". *University of Natal Gazette*, Vol. IV, No. 1, June 1957, p.1.

<sup>106</sup> E.G. Malherbe. File 463/7/2. KCM 57009 (12). Letter from E.G. Malherbe to Mr Op't Hof Secretary for Education, Arts and Science re Transfer of Medical School, 8 April 1958, p.1.

<sup>107</sup> Gordon. *Report on the Government's Intended Action*. "Everything as Usual". *Natal Daily News*, 15/2/57, p.46.

<sup>108</sup> Gordon. *Report on the Government's Intended Action*. Statement by Heads of Departments of the Faculty of Medicine of the UN, 13 February 1957, p.40. Signatories: I. Gordon (Dean and Prof. of Pathology), E.B. Adams (Prof. of Medicine), Derk Crichton (Prof. of Obstetrics and Gynaecology), Theodore Gillman (Professor of Physiology), A.E. Kark (Professor of Surgery), Sidney L. Kark (Professor of Social, Preventive and Family Medicine), J.A. Keen (Professor of Anatomy). Also see p.43 for the Record of Statement and Comments of the Full-Time Academic Staff of the Faculty of Medicine of the UN as printed in the *Natal Mercury*, 18 February 1957. As they argued, "the proposals of the Government, in our opinion, endangered the very foundation of University life

The staff was supported by its pioneering medical student body who asserted:

we strongly deprecate the unethical and immoral action of the Government to transfer the Medical School from the UN to the UNISA. They consider this move as yet another method to subject the non-European people of South Africa to perpetual servitude and to be in line with the intentions of the Bantu Education Act. Students wish to appeal to the Minister of Education to halt this malicious inroad into the freedom of universities for the good and harmony of race relations in South Africa.<sup>109</sup>

From the beginning, the academic staff of both the UN and Medical School questioned and undermined the Government's arguments of the advantages to be gained, by removing an already separate, and very successful black faculty which had been carrying out its functions on an apartheid basis from the very competent control of its "white" UN and placing it under the control of another.<sup>110</sup> What concerned these academics was that the State could not produce evidence of incompetent administration or any advantage to be gained by taking medical training away from the UN. As Malherbe argued, "you merely reiterated that this was a matter of Government policy. In other words, that this was a purely arbitrary act on the part of the Government for which it did not feel itself obliged to give any reason to the University of Natal".<sup>111</sup> They thus cleverly reversed the State's apartheid arguments and used them against it:

the School has become the Government's best showpiece. Now that which has been built up with so much care, dedication and idealism by the University, and which gained the confidence and trust of the non-Europeans, is to be uprooted and dislocated by taking it away from the University. Such a step is beyond the comprehension of every reasonable man who knows something of Universities. If the Government goes ahead with this intention, it will be a vital blow for the most successful experiment in University apartheid.<sup>112</sup>

Malherbe questioned the necessity of prohibition and compulsion, for if the State was confident of the academic merits of these "Bantu colleges", they would attract students, just as the UN Durban Medical School had, without legislation and as a separate institution alongside "open"

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and thought, and will constitute a breach of faith with the staff of our faculty, students, and with all who have contributed to the establishment and growth of this section of the UN".

<sup>109</sup> Gordon. *Report on the Government's Intended Action*, p.22.

<sup>110</sup> E.G. Malherbe. File 465/4/2. KCM 56990 (183). *The UN and the Separate University Legislation*, 1957, p.9.

<sup>111</sup> Gordon. *Further Report on the Government's Intention*. Appendix B. Letter dated 11 March 1957 addressed to the Minister of Education by the Principal of the UN, p.20.

<sup>112</sup> "Drop Medical School Plan: Request Made to Minister". *Natal Daily News*, 20/2/1957.

universities and in free competition with them.<sup>113</sup> Gordon was also concerned with the State's legislative compulsion, which prohibited the admission of black students to the "open" Universities, as he maintained:

the fact that medical students are not forced to enrol in a particular Medical School is a matter of fundamental importance because it ensures that the merits of a particular school become the criteria of selection by intending students. Enforced enrolment in a particular Medical School is one of the factors, which must inevitably lead to a fall in standards at the Medical School.<sup>114</sup>

Gordon had hoped that the Durban Medical School would have been in the forefront of African medical education, and when the Government decided otherwise, at every opportunity given to him, he proclaimed its threat to general university, but especially medical education.<sup>115</sup>

### ***A Strong All-Round Medical Profession Offensive.***

The pressure to maintain the existing situation of the Durban Medical School was thus sustained during the two years before the Bill was enacted with massive protests by outraged members of the UN Council, its Senate, academic staff, students, as well as from tremendous votes of confidence and support from other universities in South Africa. But the Medical School also importantly had the united support of the South African Medical and Dental Council (SAMDC) and its professional medical associations across the country, which came out in strong opposition to the Government's declared intention to remove the Faculty from the UN. Much of their opposition was based on what they perceived as a State attack on medical education and thus ultimately their professional standards in South Africa. Many medics felt that the UNISA was in no way suitable as a supervising body for the Medical School - as traditionally a correspondence college, it could not help in the way of academic fellowship as given by their colleagues in all Faculties at the UN - and thus reduce the School from its university status to the level of a State Department and destroy its claim to equality with other Medical Schools, "UNISA is only to assume functions of an examining body and to award degrees. The taking

<sup>113</sup> E.G. Malherbe. File 465/4/2. KCM 56990 (183). The UN and the Separate University Legislation, 1957, p.3. In 1957 180 matriculated candidates applied for admission to 40 vacancies in the first year course.

<sup>114</sup> Medical School Archives. Address to be delivered by Professor I. Gordon to an Extraordinary General Meeting of Medical Students of the University of the Witwatersrand, 22 August 1958, p.6.

<sup>115</sup> "Medical School Issue put to Medical Council". *Natal Daily News*, 11/3/1957.

over of examinations and of awarding degrees is quite farcical".<sup>116</sup> Gordon continually highlighted the threat of Government proposed action to medical education generally which inspired many of his medical colleagues in other professional bodies around him to become involved in the protest. In March 1957, Gordon attacked the State's apartheid move:

we are not primarily concerned with the political aspect of the crisis, but are deeply worried about the grave threat to University education in general, and to medical education in particular, which will result from the Government's drastic action.<sup>117</sup>

He felt that by separating the faculty from the UN there would inevitably be a fall in standards, as it was reported in the *Cape Times*, concerning Gordon's appeal to the SAMDC for their support:

non-European practitioners must be trained to the same standard as their white colleagues. There must be no differentiation. Half-baked medical practitioners and medical aids prey on their own people. This Council must stand on the fundamental issue that it is concerned that medical practitioners are required to achieve the same standards.<sup>118</sup>

Largely as a result of Gordon's moving arguments, on 11 March 1957, Professor Oosthuizen, who was President of the SAMDC, submitted the Council's unanimous resolution:

the SAMDC is *inter alia* concerned with the entire pattern of medical education and particularly as far as acceptance of minimum standards is concerned. It has been brought to the notice of the Council that a new method of control of education is envisaged for the Durban Medical School and that there is a possibility that this may lead to a new pattern which may not be acceptable to the Council for purposes of training of medical practitioners.<sup>119</sup>

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<sup>116</sup> "Natal Medical School Head Warns on State Control". *The Cape Argus*, 14/3/1957. Also see E.G. Malherbe. File 465/4/2. KCM 56990 (183). The UN and the Separate University Legislation, p.14. The anomaly of why UNISA teachers were left immune from restrictions and penalties laid down for staff dealing with blacks was also seen as irrational. The UN wanted to know why the State felt greater confidence in this white institution.

<sup>117</sup> "Natal Medical School Issue: Professor Attacks Government Move". *Natal Mercury*, 12/3/1957.

<sup>118</sup> "Medical School Posts 'Would be Declined': Doctors Discuss New Bill". *Cape Times*, 14/3/1957.

<sup>119</sup> See "The Proposed Transfer of the Durban Medical School". *SAMJ*, 23 March 1957, p.289. See Gordon. *Further Report on the Government's Intention*, p.6. As a statutory body, the SAMDC had responsibilities with regard to medical education and existed to protect the profession against a lowering of standards. Its scope of duties as defined in Section 93 of the Medical, Dental and Pharmacy Act indicates clearly its concern with "all matters relating to medical practitioners ... interns [and] medical students. The Council may be required by the Minister to advise the Government on any matter within its sphere, and shall communicate to the Minister information acquired by it in the course of its duties on matters of public import". In the course of the debate, what many in the Council initially viewed as an "educational" problem and purely political matter (and thus not of Council's concern) became a medical issue when the politics of the day intruded into the academic sphere of the teaching of its Hippocratic



Many deputations were also sent by the SAMDC to the Minister of Education to reconsider their actions. The significance of the Council's unanimity with which the resolution was adopted cannot be over-emphasised. It meant that, whatever personal political prejudices of the Council members, these were set aside in consideration of the possible threat to the standards of medical education and practice. In an editorial published in the South African journal, *Medical Proceedings* in March 1957, it was stated:

the gravest issue ever raised in the SAMC was the plan of the Government to remove the Durban Medical School from the University of Natal, which gave it birth, and to place the School under the control of a Department of State. ... By its action in recognising its plain and forthright duty to deal with an embarrassingly delicate colour issue, the Medical Council has demonstrated not only to South Africa but also the rest of the world that it is a worthy and honourable custodian of our most cherished professional standards.<sup>120</sup>

The UN and its Medical School protests were also immediately supported by various provincial branches of the Medical Association of South Africa. Particularly strong support was received from the Natal Coastal Branch when in February 1957, it sent a strongly worded telegram to the Minister of Education, J.H. Viljoen which stated that:

the Natal Coastal Branch of the Medical Association of South Africa, which was instrumental in the establishment of the Durban Medical School, [had] decided to protest most vigorously at your intention to remove the School from the aegis of the UN. Having due regard to the implications of the altered status proposed by the Government, this branch will find it impossible to cooperate in any way with any authority other than the UN in staffing the Medical School.<sup>121</sup>

It argued that the Government move was one of piracy against the medical profession as a whole, and threatened that if the proposal was carried out, the MASA was confident that it would gain the support of the majority of doctors and academic medical staff in the country, and thus prevent the Government from finding staff to implement ludicrous proposal. In their view it was impossible to divorce medical education from other forms of university education, as:

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traditions and scientific principles. It then became a matter which the Council felt its duty to intervene in order to protect.

<sup>120</sup> Gordon. *Further Report on the Government's Intention*. Appendix D. Editorial published in the South African Journal "Medical Proceedings" on 30 March 1957, p.23.

if the School is to be administered directly or indirectly by the State then its stature in the eyes of medical men in this country will be worthless ... Medical education must be outside politics and must be integrated with other education. It cannot be isolated.<sup>122</sup>

While determined to maintain amiable relations with the Government of the day, in March 1957, the Federal Council of the MASA also passed a unanimous resolution in support of the Medical School's protests. It was angered by the fact that the Government had not consulted it and it expressed to the Minister of Education its grave concern at the proposed severance of the Medical School from the UN as its controlling body and appealed to the State to reconsider its decision.<sup>123</sup>

It's interesting at this point to briefly reflect on the particular character of the medical profession in South Africa, but particularly in Durban over this last half century. Its opinions and actions in support or opposition to various medical educational and practical changes and innovations have largely been ephemeral. In this case where the Government threatened to undermine their professional training and standards by controlling their educational facilities, MASA came out in full opposition to the State's attacking scheme, even though its members had different political affiliations. Protection of the larger medical "profession's" standards was perceived as far more important, especially in the wider international medical world, than their individual racial opinions. But this massive support for the black Medical School in Durban by the MASA, and its largely radical stand against the actions of a racist apartheid Government at this particular juncture in time, had not always been so, and it is a telling commentary on the ironies of medical history in South Africa. For just a few decades before, this same medical profession had vehemently protested against Drs McCord and Taylor establishing a hospital for Africans in Durban, as well as their original ideas of having a black medical school in Durban. Added to this hostility a few years later, was its reactionary and conservation opposition to the progressive social and community health centres movement in Durban, which if continued would have revolutionised medical training and service and provide the foundation for a health care

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<sup>121</sup> Gordon. *Report on the Government's Intended Action*. Record of Meeting of the Natal Coastal Branch of the Medical Association as printed in the Natal Mercury, 15 February 1957, p.41. Also see p.22 for the Cape Western Branch of the MASA's resolution which was also passed in February supporting Natal's decision.

<sup>122</sup> Gordon. *Report on the Government's Intended Action*. Record of Meeting of the Natal Coastal Branch of the Medical Association as printed in the Natal Mercury, 15 February 1957, p.41.

system that could have substantially alleviated the health burden plaguing the majority of black South Africans. Instead, the profession, before trying to understand the basis of the movement and how it could have contributed enormously to health provision, narrow-mindedly attacked it as too radical, impractical and unsound. Many of the medical profession felt hostility to Kark and other community health doctors' "distracted" interest in addressing the socio-political and economic origins of disease instead of curatively treating the biomedical causes which formed part of the respected tradition of the medical profession. The creation of a mechanism for the democratic control of a progressive and holistic South African health service represented a giant leap beyond the health thinking of most medical professionals. Their lack of support largely helped to undermine the preventive, social and community health movement in South Africa. Thus, while a force to be reckoned with, the medical profession often worked against progressive and radical changes, and was only prepared to help a black medical profession, not because it had racially progressive ideas, but because an attack on black medical educational standards, meant an attack on all medical standards in a country that only recognised one, standardised and equal qualification.

Further opposition came from the Natal Provincial Administration (NPA) during these two years as well. The Administrator of Natal, D.G. Shepstone, in a public address to the Natal Provincial Council in March 1957, objected to the way the NPA had been disregarded and not consulted by the Government regarding its policies which directly affected it. In the same month he advised the Minister of Education that they took offence to the State's action as the NPA had been very closely associated with the Medical School since its inception, and had become involved in substantial capital and maintenance expenditure in terms of its joint teaching and service agreement with the UN. He expressed the opinion that serious repercussions would follow if the School was removed from UN control and requested that the NPA be given the opportunity to submit its views to the Government before laws were introduced. When the Government went ahead with its plans to remove the Medical School from UN control, a decision was taken by the NPA that as a matter of fundamental policy, the NPA would not enter into an agreement for the joint maintenance of the Medical School with any educational authority other than the UN. The NPA decision to "freeze" all joint appointments at the Medical School

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<sup>123</sup> "The Non-European Medical School. Editorial". *SAMJ*, 27 April 1957, p.400.

pending clarification of the situation by the Government, was an enormous threat to the State, as it would have led to a complete breakdown of teaching in the hospital, whilst black hospitalisation services in the Province would have been prejudicially affected.<sup>124</sup>

Many articles in the newspapers of the time provide valuable evidence for this largely unexpected, but effective outcry by the body politic in Natal, which hindered the Government's scheme. On 11 February 1957, the *Natal Daily News*, produced an editorial which chastised the Government for its discourteous behaviour with regard to the NPA:

if the Government behaved with discourtesy towards the University, it acted with even more to one of the constituent parts of the Government, the NPA. After much delicate negotiation, an agreement was worked out between the UN and Province (whose hospital provides cases for the Medical School) for the day-to-day control and administration of the teaching school. The Province has been generous in its finance and in its arrangement of new hospitalisation so that it should be suited for a teaching University. Now all this is to be replaced at one swoop with control from a non-teaching University in Pretoria. The Province has deserved better than this.<sup>125</sup>

In another article three days later, but in the *Natal Mercury* this time, further opposition to the Government's "disastrous" apartheid university policy was raised, and will be quoted at length for its poignantly balanced argument which recognised the threat of university apartheid to education and Provincial rights:

it is the first shot in an attack, which is about to be launched this Parliamentary session on University autonomy and scholastic freedom in those levels of learning which play so important a part in shaping the character of the nation. ... In this respect the decision taken by the UN Council ... do[es] not sufficiently mirror the real anger and resentment felt in this Province at the thoroughly discourteous and despotic manner in which the Government had handled a delicate matter of immense complexity. This decision not only strikes a blow at Provincial rights, but ... is also demonstrably short-sighted and ill-considered. ... Inexorably Dr Verwoerd is extending his dominion over black South Africa [and] step by step he is building a State within a State. Moreover it is a racial empire which pays scant regard to Provincial boundaries or Provincial authority. If this sinister process is to be checked, if social and economic chaos into which this Government is driving us is to be avoided, there must be more than qualified protests

<sup>124</sup> See Gordon. *Further Report on the Government's Intention*, p.11 and E.G. Malherbe. *Never a Dull Moment*. (South Africa: Timmins Publishers, 1981), p.311-312.

<sup>125</sup> Gordon. *Report on the Government's Intended Action*. "University in the Bundu". Editorial Comment. *The Natal Daily News*, 11 February 1957, p.44.

and piecemeal resistance from a bewildered and confused public. By means of full and informed publicity those who hold the reins of leadership in Natal must contrive with greater energy to bring home to people [what will happen] if the N.P. are allowed to win the next stage in the educational battle. This is that segregated non-European universities will increasingly tend to become breeding grounds for an aggressive anti-European nationalism. The writing is already on the wall for those with eyes to see.<sup>126</sup>

### ***Ambiguous Internal Divisions within N.P. Circles.***

This apartheid Bill was opposed by many academics outside N.P. circles because it was perceived as another example of the stubborn and senseless attempt by “blundering” apartheid bureaucrats, who had no experience of the internal workings of universities, and who designed measures which were so clumsy and inept that they found it difficult to see how the State’s ethnically-based universities could operate under them.<sup>127</sup> As it was argued in the *Cape Times* in February 1957:

the decision to change the status of the Medical School of the UN is another incomprehensible move by an incomprehensible Government. The Natal Medical School is a totally-segregated faculty according to strictest specifications of race-crazy politicians who control this country’s destinies. Nobody quite seems to know what has happened now, except that politicians have interfered ... there has been no adequate consultation, least of all with those most intimately concerned ... The upshot seems to be the usual mess - indignation, emotion, suspicion, distrust, withdrawal of cooperation by Durban doctors, protest meetings, flying visits to make representations. We wonder whether the Government is happy each time a new blow is delivered at inter-racial cooperation.<sup>128</sup>

However, while recognising the vigorous opposition from outside forces to an incomprehensible policy, an important factor that impeded the N.P. Government’s legislative efforts, was opposition from within its own ranks, from people (mainly academics from the Afrikaans universities) who had enormous misgivings about the imposition of apartheid’s “blundering” policy in the sphere of higher education in South Africa. As already mentioned, early calls to establish segregation at universities - in the form of its Government inquires into university finances and separate facilities in 1953 and 1954 - was hindered by commission skepticism and emphasis on avoiding interference in university autonomy, which did not translate into organised forms of action. As Malherbe argued:

<sup>126</sup> Gordon. *Report on the Government’s Intended Action*. “A Disastrous Policy”. *The Natal Mercury*, 14/2/57, p.44.

<sup>127</sup> E.G. Malherbe. File 465/4/2. KCM 56990 (187). *Critical Comments*, p.4.

no one seriously believed that the Cabinet, the members of which had been nurtured upon academic freedom, would go to the length of emasculating the ultimate source of strength of the nation in order to implement apartheid which clearly created costly and disruptive cleavages.<sup>129</sup>

However, as the years progressed, plans for implementing apartheid policy in higher education became more rigidified. While N.P. extremists showed a contemptuous and blatant disregard for the reasoned opinions and representations of leading experts, when these expert oppositions came from within their own ranks, and included their own leading university academics, much opposition was generated, which impeded the extremist's progress. For as Malherbe asserted, in their view, "to place such a Bill on our Statute Books is to make South Africa look ridiculous in the eyes of the academic world, not only overseas but also in South Africa itself".<sup>130</sup>

### ***United Party Opposition Arguments in Parliament.***

When the Separate University Education Bill was introduced in 1957, the U.P. opposition also put up a dogged resistance in Parliament to the proposed legislation, which constantly questioned and undermined the N.P. legislative policies. The opposition parties in the Assembly combined to fight the Bill from the moment it was introduced. The United, Labour and Liberal Parties all took steps to oppose the Bill as a dangerous interference of academic freedom. At different times, the Opposition argued that the bill endangered university autonomy and traditional academic freedom, introduced inferior State-controlled institutions for blacks and was just another blatant attempt to recast society in the rigid ideological mould. As United Party M.P. D.L. Smit argued:

the Bill is part of the Government's policy of indoctrinated teaching, which sought to impose a form of national ideology on the country's intellectual life, sought to introduce a system of Government control which would confine non-Europeans to a state of permanent inferiority and would further aggravate estrangement and prejudice already existing between the races.<sup>131</sup>

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<sup>128</sup> Gordon. *Report on the Government's Intended Action*. "University Blunder". *The Cape Times*, 15/257, p.46-47

<sup>129</sup> E.G. Malherbe. File 463/7/3. KCM 56990 (79). "Nature and Significance of the Attack on University Autonomy". *University of Natal Gazette*, Vol. IV, No. 1, June 1957, p.2.

<sup>130</sup> E.G. Malherbe. File 465/4/2. KCM 56990 (187). Critical Comments, p.4.

<sup>131</sup> "Opposition Makes Attack on Separate University Education Bill", *Natal Daily News*, 28/5/1957.

The Opposition also challenged the Government on the basis of its aim to “nationalise the truth”, as it was argued:

how can we imagine that there will be freedom of professors to teach and students to learn the truth about race in South Africa ... when part of the truth will be blacked out ... or are banned as subversive literature in South Africa? Can the Minister of Native Affairs imagine the fearless search after truth when the only permissible truth in South Africa on many questions is the truth allowed by the Department of Native Affairs as contained within the walls of the doctrine of Apartheid, while the opposition view is regarded almost as treason?<sup>132</sup>

The liberal, Native Representative Margaret Ballinger argued that the Bill ran counter to traditional and well-tried patterns of development of higher education, and “constituted a form of rigid planning or a straitjacket into which to put the country’s academic life” and would stunt the development black communities, as well as be against the freedoms of everyone in South Africa more generally. It was argued that this move to isolate black students, would also importantly isolate whites “from those who ought to be their companions in the building up of Western civilisation. University apartheid would be a handicap to those who were supposed to be the torchbearers of Western Civilisation”.<sup>133</sup>

### ***International Opposition.***

Government determination to impose racial segregation at the university level and State control of ethnically-defined black “colleges” caused great concern and indignation in university circles around the world. In March 1957, the heads of departments of a number of Medical Schools in Great Britain came together and issued the following statement to voice their support for local protest actions:

we, the undersigned, your colleagues in British Medical Schools, are seriously alarmed at the decision to remove the Durban Medical School from the University of Natal and to place it under a Government Department. Such an act must inevitably result in the destruction of the School as a University institution and is therefore a matter of grave concern for all who care for academic liberty and freedom of thought wherever they may

<sup>132</sup> See “United Front on Apartheid: Introduction of Bill is Opposed”. *Cape Times*, 13/2/1957 and “Terror and Darkness If Truth is Nationalised, Says Lovell”. *Natal Mercury*, 12/3/1957.

<sup>133</sup> “Opposition Makes Attack on Separate University Education Bill”, *Natal Daily News*, 28/5/1957.

happen to live and work. We applaud your vigorous opposition to this step and we offer you our sympathy in your efforts to preserve the School in the University of Natal.<sup>134</sup>

Later in the year, more of this concern found expression in the well-attended conference in London in November 1957, under the sponsorship of the International Committee on Science and Freedom. By an overwhelming majority, a resolution was passed which stated:

we would emphasise once again the concern that is felt in University circles throughout the world at proposed legislation for compulsory race segregation in South Africa. We trust that an alternative policy will be found that will respect the fundamental principles of genuine University education - open to all, regardless of race or creed - which, together with academic freedom and autonomy, form an essential part of the tradition of University education in non-Communist countries.<sup>135</sup>

They expressed admiration and support for those South African universities, which were resisting their Government's policy and called upon the apartheid Government to heed the cruel and disastrous consequences of its policy and to abstain from its further pursuit.<sup>136</sup> In an article in *The Lancet* in 1957, international support for the SAMDC's stand against apartheid in medicine was evident:

the SAMDC which has not so far been prepared to admit dual educational standards for doctors, will, it is hoped, stand firm on this point. The South African Government is clearly determined to impress its policy of racial segregation on every corner of the Union ... but the SAMDC will be widely supported in South Africa and in many other countries, if it continues to insist on the maintenance of high teaching standards. Those in positions of influence in the medical profession in South Africa will, we hope, realise how much they stand to gain in the esteem of their colleagues all over the world if they speak out boldly against this attack on the freedom of the University and doctor.<sup>137</sup>

This international support and recognition was vitally important to sustain local opposition to proposals to establish apartheid at a university level. However, the obstinate N.P. Government was determined to impose its policies. As Malherbe argued:

<sup>134</sup> Gordon. *Further Report on the Government's Intention*. Appendix M. Statement of Heads of Departments in Medical Schools of Great Britain, March 1957, p.33.

<sup>135</sup> E.G. Malherbe. File 465/5/1. KCM 56990 (198) b. Committee on Science and Freedom sponsored by the Congress for Cultural Freedom. Statement on Apartheid in the South African Universities presented to the Government of South Africa April 1959.

<sup>136</sup> E.G. Malherbe. File 465/5/1. KCM 56990 (194). "University Apartheid in South Africa". Reprinted from *Nature*, Vol. 180, 30 November 1957, p.1.

<sup>137</sup> E.G. Malherbe. File 465/5/1. KCM 56990 (202) "University Apartheid". *The Lancet*, 30/3/1957, p.676.



we are moving through a period of tragedy in our academic lives because we have had to concede that all that had been done had been of no avail. ... It had not helped to lay bare the sense of outrage which the present Government's educational philosophy evoked - it had not helped that leading South African academics, including those who supported the present Government's 'apartheid' policy, had spoken against regimentation of University colleges as State institutions, and it had not helped to record protests of University societies and communities from all parts of the world. ... this effort was received by a spirit of derision.<sup>138</sup>

Despite massive opposition from many quarters, the State was determined on its policies and it would take something more, something extra, to radically hinder the Government in its path.

### ***The Durban Medical School Trump Card.***

The Government, after passing its original Bill in January 1957, was not able simply to impose its apartheid ideas and policies on South Africa's system of higher education in universities. However, while pressure was maintained by protests in various sectors - by outraged members of the UN Council, Senate, Faculty of Medicine, students, other UN academic staff and students, academics and students in other Universities in South Africa and abroad, by the MASA and other medical organisations and NPA, in editorial commentaries in medical journals (locally and internationally), in South African newspapers, as well as by the informed general public in various parts of the country - and whose opposition helped to hinder the Government's action - it took another more vigorous form of protest action to stop Government's intentions relating to the Durban Medical School.<sup>139</sup> On 18 March 1957, the Medical School staff, after a secret ballot, adopted a resolution by twenty nine votes to two to resign in mass if the Government continued with its declared intention, "we, the full-time members of the academic staff of the Faculty of Medicine of the UN, intend resigning if the Separate University Bill of 1957 is implemented".<sup>140</sup> This was supported the following day when the part-time visiting staff at the King Edward Hospital voted in favour of adopting this resolution and not participating in the teaching of medical students if the Government's intentions were carried through. In an editorial in the *Medical Proceedings* journal, it was argued:

<sup>138</sup> E.G. Malherbe. File 465/4/2. KCM 56990 (187). Critical Comments on the "Extension of University Education Bill", 2 April 1959, p.4.

<sup>139</sup> E.G. Malherbe. File 465/4/5. KCM 57009 (41). Short Summary of the Interdepartmental Fact-Finding Committee's Findings, p.3.

<sup>140</sup> Gordon. *Further Report on the Government's Intention*, p.13.

they have given some of the best years of their professional lives to the establishment of what undoubtedly is an outstanding teaching and research centre. Now they find themselves amputated from their *Alma Mater* and faced with the prospect of complete academic annihilation.<sup>141</sup>

During my interview sessions with Kallichurum and Mayet, I asked them both what reasons they felt hindered the Government's actions. Kallichurum concurred with the above factors, that it was the unique protest actions taken by the Medical School staff:

Because I think they'd lose the entire Medical School, because they couldn't run it without the Professors here and they knew that they didn't have the manpower to bring in here ... and I think internationally they were a bit worried too that it would have impact. ... That there could be.<sup>142</sup>

I also asked Kallichurum about student protest actions. She responded:

There were so many, always you know. ... Oh, we'd just stay away from classes and walk around the streets, making a noise ... but it was always in front of the institutions ... other than that it would be a letter-writing exercise between the Dean and the students.<sup>143</sup>

When I asked her about her views regarding the white Professors' threats to resign *en masse* she argued that the black medical students supported their actions and would have given up their medical studies too. This was because there was in her opinion a strong unity between staff and students, and if the staff resigned, then:

students would just go too, you know, the students said well it doesn't matter if we're in our final year, we'll just give it up. ... because the principle was always more important than what was happening you know ... the studying part. ... Students were prepared to give it up you know, there is no doubt they just thought, it's not worth it.<sup>144</sup>

When presented with these intentions, the Government had just two alternatives: it could leave the Medical School to carry on undisturbed as it had done so efficiently in the past under the control of the UN in conformance with the Government's apartheid policy; or persist in removing it from UN control and placing it under a Government controlled "puppet body" which would result in staff resignations, interruption of courses and possibility the collapse of the

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<sup>141</sup> Gordon. *Third Report on the Government's Intention*. Appendix RR. Editorial published in the South African Journal *Medical Proceedings* on 22 February 1958. "The Fate of the Durban Medical School", p.2.

<sup>142</sup> Interview with Professor Kallichurum.

<sup>143</sup> Interview with Professor Kallichurum.

<sup>144</sup> Interview with Professor Kallichurum.

Medical School which they had funded. This resolute intention by the Medical School staff, showed evidence of enormous bravery, because their actions blatantly contravened the staff “misconduct” provisions of the Bill and were thus liable to punishment by fine or imprisonment, for actions, “calculated to cause or promote antagonism among any section of the population [as well as trying] to impede, obstruct, or undermine the activities of any Government Department”.<sup>145</sup> When Gordon made these intentions known to the Government, the Minister of Education appealed to him as Dean to prevent his staff from carrying out these threats on the basis that the staff had responsibilities to the country, and that it was their “duty” to remain. He told Gordon, and its most notable for its irony, “that they have to deal with reasonable men who would act with justice, in all circumstances”.<sup>146</sup> However, the Medical School staff threat remained unless the Government’s intention to remove the Faculty was rescinded. In the *Natal Mercury*, it was argued:

if the Government is wise, it will reverse a decision into which it seems to have been stampeded by its extremists. If this does not happen there is a real danger that the School may be closed down, for many of the staff who justifiably regard their services to the School as a vocation are unlikely to permit themselves to be turned into mere pawns on the racial chessboard of Dr H.F. Verwoerd, Minister of Native Affairs.<sup>147</sup>

The massive struggle between the Medical School within the UN and the Government, as well as the vigorous protest actions from many people around the country resulted in the Government being thwarted in its grandiose scheme. The Government was also hindered because the opposition had plans to invoke the parliamentary rule whereby the progress of the Bill was a “hybrid bill” affecting private rights of individuals and groups could be obstructed.<sup>148</sup> The Government thus withdrew the Bill, and bowed before this storm, and although it reintroduced it on 8 April 1957 - as the *Revised Separate University Education Bill* - chapters relating to the Durban Medical School and black University College of Fort Hare were excluded. These

<sup>145</sup> Gordon. *Further Report on the Government's Intention*, p.15.

<sup>146</sup> Gordon. *Further Report on the Government's Intention*, p.16.

<sup>147</sup> Gordon. *Report on the Government's Intended Action*. “Resolute Protests”. *The Natal Mercury*, 15/2/57, p.46.

<sup>148</sup> See E.G. Malherbe. File 465/5/1. KCM 56990 (196) a. *Contact*. (A monthly newsletter of the Liberal Party of South Africa, edited by P.M. Brown and printed by *Natal Witness*), April 1957 and Medical School Archives. Address to be delivered by Gordon, to an Extraordinary General Meeting of Medical Students of Wits, p.8. A hybrid bill is one which while introduced as a measure of public policy, adversely affects the private rights of particular individuals, groups of individuals or localities as distinct from the public at large. It is Parliamentary practice in such cases that the persons whose rights are affected have to be given the same opportunities to defend them and lead evidence in opposition to the Bill as are afforded to persons whose rights and interests are invaded by a private Bill.

institutions could not therefore be dealt with by Parliament unless certain preliminary steps had been taken.<sup>149</sup> The delay thus saved the black Medical School, for the impossibility of rushing legislation at once through Parliament facilitated the mobilisation of further opposition and protest for the School. However, the “reprieve” for the Durban Medical School, did not leave it, or its proponents complacent. This caution was influenced by the fact that on the very next day, in reply to a question by a R.R. Butcher a Durban M.P., the Minister stated that legislation would be introduced to separate the Medical School from the UN. However, the important issue to note was that this would only be done after negotiation and further consideration: “as soon as the Government’s legislative programme and circumstances permit”.<sup>150</sup> Some have even argued that it even left the Medical School “in a complete state of chaos; by excluding the School from the original Bill it has not improved the position one whit, because neither staff nor students know when the blow may fall and the School come under UNISA”.<sup>151</sup> Thus, believing that the Government “retreat” was merely a tactical manoeuvre to deceive the Medical School and attack at a more opportune moment, in May 1957 the Medical School released a unanimous resolution reaffirming its previously expressed objections and unwillingness to cooperate should the new pattern for black higher education be applied to the School.<sup>152</sup> The decision was taken because the academic staff believed that they would not be able to carry out their professional work or fulfil their responsibilities to their students if the Bill was passed. In a letter from Malherbe to the Minister in 1958, it was written:

the Dean and I repeatedly warned you and the late Minister that in this particular case you have to deal with a group of independent professional men who will not submit to threats of arbitrary governmental State institutions.<sup>153</sup>

As a professor at the Medical School maintained, “resignation can most certainly be expected once this Bill becomes enacted. There are among us those who cannot stomach the sort of situation this Bill seeks to bring about”. He argued that there would be a considerable sacrifice in jobs, but that the staff would remain until the Act was passes as an obligation to their students.

<sup>149</sup> E.G. Malherbe. File 463/7/3. KCM 56990 (79). “Nature and Significance of the Attack”, p.4.

<sup>150</sup> See Hansard, 8-11 April, 1957, Column 4240.

<sup>151</sup> E.G.M. File 465/5/1. KCM 56990 (203). “Viljoen’s Pass to University”. *The Natal Daily News*, 11/4/1957.

<sup>152</sup> E.G. Malherbe. File 463/7/3. KCM 56990 (79). “Nature and Significance of the Attack”, p.5. See Hansard 27-29 May 1957, Columns 6767-6768 for the progress of debates in the House of Assembly relating to the second reading of the revised bill. It was always Government intention to gain control over the UN Medical School.

As he continued, “we are just one of the heads to fall in this ideological concept which the Government is pushing”.<sup>154</sup> Opposition in Natal and around South Africa continued with desperate attempts to protect the universities from Government control and interference. But for the “open” universities, the Government remained intent on its actions, while further plans were devised for established separate, ethnically-based university institutions in the “homelands”.

Towards the end of 1957, the Government advised the UN that it would be sending a Committee to the Medical School to investigate how it could successfully take it over, which it maintained had always been its intention. It was requested that the UN give its full cooperation and that this might make the relevant legislation “more elastic” and adaptable than previously intended. Malherbe, who was shocked by the request, replied that he was concerned about this move, as he had after much difficulty, managed to persuade most of the Medical School staff to remain on the grounds that the legislation was postponed and that:

if such a Committee were now to appear ... and create the impression that taking over is now being proceeded with, I fear that it will precipitate the same sort of crisis all over again. The result will be that the staff will not only believe that I misled them but they will, by refusing to cooperate voluntarily with this Committee, decline to be party to the carrying out of a death sentence on our Medical School, where they have so devotedly braved the difficulties and problems of the pioneering years.<sup>155</sup>

In response to further Government requests for assistance, Gordon issued a caustic statement of non-cooperation on 4 February 1958, and is worth quoting it in length:

in spite of all representations ... the Minister of Education has stated that the Government intends to proceed with its plan to convert the Medical School into a Government institution. Having made up its mind, the Government now wishes to send a Committee to the Medical School to find means whereby this disastrous decision can be implemented. In other words, we are going to be asked to participate in what we felt would be the ‘digging of our own graves’. We see no reason why our School should be removed from the UN ... As resolved as the Government may be to convert our Medical School into a Government institution, so determined are we to remain in the UN. In the space of a few years, the Durban Medical School has made great contributions in the field of medical education, medical research and medical services to non-white peoples. The Durban Medical School is an institution worth fighting for and if the

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<sup>153</sup> E.G Malherbe. File 463/7/2. KCM 57009 (12). Letter from E.G. Malherbe to Mr Op’t Hof Secretary for Education, Arts and Science re Transfer of Medical School, 8 April 1958, p.3.

<sup>154</sup> “Threat of Medical Staff Boycott”. *The Natal Mercury*, 15/3/1957.

<sup>155</sup> Gordon. *Third Report on the Government's Intention*, p.10.

Government wishes to rob the UN of its School, then it must carry out this assault without any assistance from us. We hope that the UN teachers, medical profession and general public in all parts of the country will continue to help us to resist the Government plan, and will support us in the bitter struggle, which must now inevitably ensure.<sup>156</sup>

In April 1958 Malherbe wrote to the Minister and pleaded with him to reconsider their stated intentions:

the Medical School is an organic growth which owes its success to a delicately balanced set of relationships generated and fructified over the years by the unstinting devotion of professional men to the ideal of ministering against disease and of promoting health, particularly amongst our non-European peoples. To build up this fine set of relationships has required the most patient negotiations and cooperation with medical profession and Provincial Administration, as well as with the Union Government which has been mainly responsible for the cost of establishing and maintaining the Medical School. This cooperation was made possible under sponsorship and control of the UN which, through intimate inter-Faculty relationships, has succeeded in building up standards of excellence acclaimed by distinguished medical authorities from overseas - despite its being an 'apartheid' institution. ... I must therefore plead with you ... again to stay your hands and not to break up this delicately balanced and efficiently operating set of relationships by taking a step, which seems as senseless as it is unnecessary.<sup>157</sup>

Eventually the Government was forced to give up on its intentions. Protest action surrounding its proposals to control the black Medical School in Natal produced too great an opposition from too many parties against the Government's scheme. The disqualification and thus delay in policies affecting the Durban Medical School in 1957 allowed the Medical School to rally more vigorous support.

However, the "hybrid" bill disqualification delay did not save the general principles of university freedom from Government interference, or ultimately Fort Hare, where its policy remained unchanged. But opposition did hamper its smooth operations over the two years. The Government remained obdurate, and reiterated that "it was Government policy" to move blacks to separate institutions and went ahead with the revised bill.<sup>158</sup> In 1958, the Government postponed the passage of the Bill until after the general election. Instead, during the recess, a Commission under the Chairman M.D.C. de Wet Nel (Deputy Minister of Native Affairs) was

<sup>156</sup> Gordon. *Third Report on the Government's Intention*, p.12.

<sup>157</sup> E.G Malherbe. File 463/7/2. KCM 57009 (12). Letter from E.G. Malherbe to Mr Op't Hof Secretary for Education, Arts and Science re Transfer of Medical School, 8 April 1958, p.3.

<sup>158</sup> Medical School Archives. Address to be delivered by Gordon, to an Extraordinary General Meeting at Wits, p.8.

appointed to “investigate and report on the details of the Separate University Education Bill, having regard to the principles contained therein”, and to hear evidence on the “purely administrative” aspects of the measure. Again there was no inquiry into the desirability of applying the principle of apartheid in higher education. Thus for a second time, the passage of the Bill was obstructed, and the Government had to retreat. Both Malherbe and Gordon have argued that they thought this “stalling” of the passage of the Bill through Parliament occurred because the Government was hesitant, as serious misgivings had arisen in the minds of many thinking N.P., especially in the minds of representatives of Afrikaner universities. Malherbe argued that, though they did not come out into the open, the fact that they on no occasion supported the Government proved to be a deterrent.<sup>159</sup> In an editorial comment on Gordon’s views in *The Natal Daily News*, on 5 February 1958, once again this N.P. hesitancy is evident:

in what Dr Gordon calls ‘this bitter struggle’ the authorities have every right to expect support not only of the people of Natal, but also of those N.P. in academic life who are opposed to the principle of State control of the Universities. Evidence before the Nel Commission on University apartheid showed abundantly the extent and depth of Nat opposition to the idea of the State exercising complete authority over higher educational institutions. It is to be hoped, therefore, that Government once again meet with opposition in its own ranks, as it did when it first put forward its preposterous proposals for the control and administration of the separate non-white University institutions it proposed to establish. It has been shown before that Strijdom Government is not immune to public pressure exercised consistently and sincerely; unrelenting opposition now might still save the Medical School from a fate which some of its warmest supports would regard as worse than extinction.<sup>160</sup>

However, this was the first Commission that was officially prepared to hear the UN’s evidence on University apartheid. The Commission presented “Majority” and “Minority” Reports devised on party lines, where the minority report was based on expert evidence, which was led, while the majority report ignored the expert recommendations. The principles of the measure of the Majority report were accepted by a seventy two to forty two vote.<sup>161</sup> Both reports, however, agreed that provisions relating to the Durban Medical School be withdrawn

<sup>159</sup> E.G. Malherbe. File 465/4/2. KCM 56990 (183). The UN and the Separate University Legislation, 1957, p.3.

<sup>160</sup> Gordon. *Third Report on the Government’s Intention*. Appendix QQ. Editorial Comments on Statement made by the Acting Minister of Education, Arts and Science in the House of Assembly on 4 February 1958. “Worse than Extinction”, *The Natal Daily News*, 5 February 1958.

<sup>161</sup> van de Sandt Centlivres. “Blundering in University Apartheid”, p.5-6. The evidence the Commission presented was also used to serve as a build-up to the election in 1958. Dr Malherbe, Professor J.D. Krige and Professor Gordon represented the UN and provided evidence on its behalf.

from the operation of the Bill. But University apartheid was assuredly on its way for other existing higher education institutions, with its final shape being increasingly determined by the Department of Native Affairs. After the 1958 elections, which gave the N.P. a commanding majority in Parliament, the State introduced the curiously renamed *Extension of University Education Bill* in the House of Assembly in August, which conformed to the recommendations of the Majority report. It encompassed Verwoerd's vision for the development of self-governing "Bantustans" and urged that trained personnel and leaders to develop "Bantu areas ... for and by the Bantu" necessitated the founding of separate "Bantu University colleges". But the "development" Verwoerd envisaged was to provide limited educational opportunities for a "sufficient number of deserving Bantu for posts in the service of their community that are essential to fill".<sup>162</sup>

On 5 March 1959, just before notorious *Extension of University Education Act* was passed, Bruce Murray argues that students staged what was then the biggest student demonstration in the history of Wits. Hundreds of students lined the traffic island in Jan Smuts Avenue holding a "300 yard long iron chain to symbolise the chaining of University freedom" while others carried banners and posters.<sup>163</sup> As the *Rand Daily Mail* reported on 9 March 1959, "few of the Union Government's apartheid measures have created a worse atmosphere for this country overseas than the University Apartheid Bill".<sup>164</sup> On 6 March, crowds of about a thousand banner-waving and slogan-shouting students marched through the streets of central London to protest against university apartheid.<sup>165</sup> After the second reading debate of the *Extension of University Education Bill* in the House of Assembly in April 1959 resulted in the Government imposition of a guillotine on all further discussion, students and the Black Sash gathered outside the gates of Parliament in Cape Town and maintained a constant vigil in the pouring rain to record the University's "solemn protest" against the new legislation.<sup>166</sup> The Minister of Education, Viljoen was also presented with a petition signed by two hundred prominent citizens

<sup>162</sup> Murray. *Wits The 'Open' Years*, p.293. The number of subjects offered was distinctly limited to a small number of subjects and would do little more than train teachers and bureaucrats. A major structural change from the original Bill was the creation of parallel non-European "advisory" councils and senates at each of the University colleges, so as to perfect apartheid within them and train "non-Europeans to manage their own affairs successfully and to take over full responsibility from Europeans.

<sup>163</sup> Murray. *Wits The 'Open' Years*, p.318.

<sup>164</sup> Murray. *Wits The 'Open' Years*, p.289.

<sup>165</sup> Murray. *Wits The 'Open' Years*, p.319.

<sup>166</sup> Murray. *Wits The 'Open' Years*, p.320.



of Cape Town against Government interference in university autonomy (ministers, lawyers, doctors, business people, artists), as it was stated:

we are opposed to academic segregation on racial grounds and express our strong disapproval of the Government's proposal to enforce academic segregation at the Universities of Cape Town and the Witwatersrand, against clearly expressed wishes of Councils, Senates, lecturers, students and convocations of these Universities.<sup>167</sup>

Despite these massive protest efforts both locally and internationally, the erosion of traditional autonomy and academic freedom of South African universities was formally achieved by the enactment of the *Extension of University Education Act* in 1959, and under the third Prime Minister H.F. Verwoerd. After a prolonged second reading debate in April, the Government imposed a guillotine on the remaining stages of the Bill in the House of Assembly and curtailed further debate in the Senate. It was argued that while the Bill provides that certain universities will be closed to non-Europeans, “provision is made for considerable extension of University facilities for non-Europeans - an extension that will far exceed the limitation”.<sup>168</sup> Thus the provisions of this apartheid legislation affected all existing universities in South Africa, but especially the universities who provided for black students. In 1959 a separate enactment came into force - the *University College of Fort Hare Transfer Act* - which provided for the transfer and control of Fort Hare’s governing Council to the Minister of Bantu Education.<sup>169</sup> These conditions imposed on South African universities gravely affected their freedom, as it established racially segregated universities for each of South Africa’s “ethnic groups”, and made it illegal for black student to be admitted to white universities without ministerial consent.<sup>170</sup> The Government predicted that the number of black students at white universities would gradually decline until numbers were negligible. In 1959, UCT Chancellor van de Sandt Centlivres argued

<sup>167</sup> “200 Sign Protest Letter to Viljoen”. *Cape Times*, 30/5/1957.

<sup>168</sup> van de Sandt Centlivres. “Blundering in University Apartheid”, p.9 and UN Archives Pmb. H6/1/10. Medical School. Memorandum prepared by Professor I. Gordon for Informal Meeting between Professor F.E. Stock and Professors Gordon and Adams and Dr. Cochran, 19th May 1970, p.6. In terms of its provisions the establishment of following colleges were notified: University College of North at Turfloop (under Govt Notice no. 1195 of 31st July 1959), University College of Zululand at Ngoye (under Govt Notice no. 1196 of 31st July 1959, University College of Western Cape at Bellville (under Govt Notice no. 1776 of 30th October 1959) and the University College for Indians at Durban (under Govt Notice no. 2129 of 30th December 1960).

<sup>169</sup> UN Archives Pmb. H6/1/10. Memorandum prepared by Professor I. Gordon for Informal Meeting, p.6.

that the open universities did not object to provisions being made for further facilities but rather the arbitrary threat to compel them to close their doors to black students and to herd them into institutions which do not have the characteristics of a true university:

I think that it is clear, from the manner in which the Government has approached this matter, that they are blundering blindly into University apartheid without at any stage having submitted the question of principle to inquiry and report by an independent commission.<sup>171</sup>

Students at Wits erected a huge banner on the columns of the Central Block showing Wits's affirmation and commitment to the idea of open universities and photos of this were published around the world. On 17 April 1961, the Chancellor Richard Feetham unveiled a plaque at the entrance of the Great Hall to record the Affirmation and Dedication pledged by the Wits two years before:

we affirm in the name of the University of the Wits that it is our duty to uphold the principle that a University is a place where men and women, without regard to race and colour, are welcome to join in the acquisition and advancement of knowledge; and to continue faithfully to defend the ideal against all those who have sought by legislative enactment to curtail the autonomy of the University. Now, therefore, we dedicate ourselves to the maintenance of this ideal and to the restoration of the autonomy of our University.<sup>172</sup>

When one considers how the white "liberal" universities fared in their lost protests against university apartheid, in the liberal analysis, the whole movement of student protest from 1948 onwards gained for the "open" universities an eleven year reprieve, enabling hundreds of black students to receive full university education. However, critical observers have argued that the formal protests staged by Wits and UCT were little more than symbolic. As Murray argues in his book, *Wits the "Open" Years*, ANC President Albert Luthuli, made the following comment:

it was some small comfort to see the way in which world universities, and South Africa's formerly 'open' universities, demonstrated against the Act. But they were too late. This Act's foundations were laid much earlier, when the Act applying to

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<sup>170</sup> E.G. Malherbe. File 464/2. KCM 56990 (128). "Higher Education for Non-Whites". *Progress*, and Gale. "Medical Schools in Africa", p.716. Both Universities and black students were liable to be persecuted if they disobeyed the law.

<sup>171</sup> van de Sandt Centlivres. "Blundering in University Apartheid", p.10.

<sup>172</sup> Murray. *Wits The 'Open' Years*, p.322.

school education was passed. The Nationalists were not deterred.<sup>173</sup>

From the standpoint of the left, Wits, and the other traditional “white” university, should have made an active alliance with the black majority to mount any truly effective resistance to the N.P. plans for university apartheid. The English-medium universities largely perceived themselves as powerless against the all-powerful apartheid State. As a lecturer at Wits recalled:

a few lecturers on the Left met to discuss the situation. Were we to stay and help the segregated institutions function, or should we resign demonstratively? We knew we could expect no support from other members of staff and did not believe any students would follow us. If they did, their student days would be over, just as our jobs would be forfeit. Eventually we decided that if we did resign we might make headlines, only to be forgotten the day after.<sup>174</sup>

Many historians of South African liberalism criticised the “English” universities for their narrow focus on the particular interests of the universities. As Murray argues, in order to defend itself as far as possible, the:

official Council standpoint gave more weight to defending the narrow principle of University autonomy - a principle that enabled it to protest against enforced University segregation while still maintaining its practices of racial discrimination - than to that of academic freedom.<sup>175</sup>

This emphasis placed on the rights of the universities was derided by F.S. McNeilly a Wits lecturer in Philosophy:

once more the liberal forces of South Africa are on the march. Once more they have raised the wrong flag, and grappled furiously with imaginary enemies. ... They deserve to be attacked frontally for their superstitious policies, and not merely to be deafened by the clamour of irrelevant bleatings. ‘Non-Europeans’ of our Universities have been badly done by also. We shall miss them if they go, and they will miss us. But it is their rights that should have been defended, and not the imaginary rights of the Universities.<sup>176</sup>

When the legislation was passed, the “white” universities, who were each heavily dependent on State financial support, complied with the Government’s apartheid legislation, and while students were allowed to complete their degrees, no new students could be admitted to these universities without ministerial permission.

<sup>173</sup> Murray. *Wits The ‘Open’ Years*, p.290.

<sup>174</sup> Murray. *Wits The ‘Open’ Years*, p.320.

<sup>175</sup> Murray. *Wits The ‘Open’ Years*, p.321.

<sup>176</sup> Murray. *Wits The ‘Open’ Years*, p.321.

Thus, like the other “white” universities who were forced to close their doors on their black students, the UN’s “Non-European Section” also fell under Government attack. According to past students such as Kallichurum who lived through the ordeal, the University of Natal (just like the other “white” Universities) did not fight hard enough for its black students - both in the Medical School but especially it’s “Non-European Section”:

it was ... disappointing because the University’s attitude towards the Medical School was never healthy while we were students. ... They didn’t want a black faculty, lets face it.... Well, there were some people who had to agree to it, you see, after a lot of pressure.... from Taylor and his group because I don’t think the Principal Dr Malherbe was very enamoured with this place, in the beginning, eventually when he agreed to it, there was still a lot of sort of non-acceptance, for a long time. ... I don’t think the universities fought hard enough in my opinion. ... The Medical School did because it wasn’t the University. ... You know coming from this Medical School and knowing how we fought, and then seeing the University performances, it didn’t impress us, you know. Let’s be frank about it, they didn’t fight hard enough. ... You know so, when people ask me what academic or professional support you had - nil.<sup>177</sup>

The UN’s Medical School also lost its control and perpetuation of its progressive social and community health centre movement as well, which could have massively alleviated much of the burden of disease under which the majority of black South African’s were suffering under. The promotion and continuance of this medical approach in the Medical School could have also put South Africa in the lead internationally in this progressive sphere. But it lost its fight here. As some have argued, Government victory in passing legislation concerned with university apartheid occurred because the universities focused their attention on fighting for university (or institutional) independence and autonomy, rather than on their black student’s rights or on the critique of oppression in society at large. For many black nationalists they never fought hard enough. However, in this two-pronged UN attack against Government interference and control in the running of their university, the UN won its fight - what Edgar Brookes called a “stubborn fight” - to keep its black Medical School as provision was made that the restricting provisions in the Act, “shall not apply to non-white persons in respect of their registration and attendance as students at the Medical School”.<sup>178</sup> This occurred because there were exceptionally strong protests by both medical, academic and the lay public to the Government’s incomprehensible and

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<sup>177</sup> Interview with Professor Kallichurum.

illogical action. Another reason why the Government was forced to abandon its fight, was also the fact that the UN, by practicing a form of internal segregation, and having done so voluntarily over two decades before this Act was passed, provided the key weakness in the Government's case for its black Medical School. The UN thus exploited the initial State regulations governing black medical student access to its white university and continued to admit certain categories of "non-European students without ministerial consent.

I would argue that one of the most important reasons for the maintenance of the Medical School status quo as a UN run institution, was the determined opposition by the Medical School's own white staff, who recognising the great worth of the School and its contributions to black medical services in South Africa and refused to surrender their fight. They fought for their black students every step of the way. When the resignation threat was presented to the Minister of Education on 22 March 1957, although the Minister tried to rationalise with Gordon to dissuade his staff from its purpose, the announcement shocked the Government. Although no formal retraction was made by the Government, this was the turning point at which the proposal for the Medical School transfer was unhinged, as Brookes argued:

any University would in similar circumstances have resisted such a Bill, but what made the resistance of the University of Natal effective was its vigour, promptitude and perseverance. ... In deciding to resign their academic posts and emoluments which went therewith, the Professors of the Faculty acted with great courage and selflessness for the sake of principle and in defense of medical education at its best: their resignation was the decisive argument.<sup>179</sup>

However, while the Medical School was saved for the UN the Government persisted in its threat to deprive the University of their fundamental right to decide on the admission of students. From 1959 onwards, no white students were allowed into the School, a condition that lasted until the 1990s.

This black Medical School has thus had an ambiguous and contradictory history. This chapter has tried to demonstrate this fact that, while continually plagued and hounded by

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<sup>178</sup> See UN Archives Pmb. H6/1/10. Memorandum prepared by Professor I. Gordon for Informal Meeting between Professor F.E. Stock and Professors Gordon and Adams and Dr. Cochran, 19th May 1970, p.5 and Brookes. *A History of the University of Natal*, p.91.

<sup>179</sup> Brookes. *A History of the University of Natal*, p.91-92.

relentless apartheid Government attempts to control every aspect of its black medical education, the UN's Medical School was able to manoeuvre in small gaps and negotiate Government theory and practice in many ways. While the Medical School lost its fight for its progressive social and community health department, at least as a black institution providing a high degree of medical education in various fields, it survived the attack, and was able to continue training black aspiring doctors. The situation could have been far worse had the whole Medical School collapsed under Government-control. Their determined fight, and Government abandonment of this intention, assured the School's continuing work for years to come. Thus, in the complex and ambiguous medical education sphere, State power over black education and training was far less assured and came up against, just as determined academic opposition.

## Conclusion

The University of Natal (UN) Medical School opened in Durban in 1951 and since then has made a unique contribution to medical education in South Africa. For more than two decades, it was the only tertiary institution whose main concern was providing medical training for black students.<sup>1</sup> Many people have praised the School for its high standards attracting international recognition for its excellence in research and education, and for having trained more black doctors than any other university in South Africa. However, the means used to reach this desired end by many of the people involved over its nearly five decades of history, were from the start complicated, ambiguous, contradictory and in many instances unjust. In 1995 a “Reconciliation Graduation Ceremony” was held by the University of Natal to help in the process of reconciliation and the healing of wounds inflicted on the institution and its students and staff during the apartheid era. But as the present Vice Chancellor of the University of Natal argued, citing Milan Kundera, this can only be done when there’s a “victory of memory over forgetting”.<sup>2</sup> It was argued that the University of Natal, in a new democratic era, had to face its past mistakes, to recognise and apologise for them and more importantly, to learn from them to ensure that they never happened again in the Medical School or any other branch of the University. An analysis of the establishment and development of this black Medical School was attempted in the hope of providing a small glimpse and appreciation of the magnitude of the injustices, moral and political failures, but also the enormity of effort and human agency which was involved in the contributions embodied in the School.

It has been shown that from the beginning, the Medical School has been shaped by the wider political struggles, and as Edgar Brookes argued, “this has been its misfortune, not its fault” to find itself continually in the vortex of apartheid politics.<sup>3</sup> I have attempted to trace how ideologies of race postponed its creation, endangered its attempts to provide the highest academic standards, and even threatened its existence while in the full tide of success. Forced to

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<sup>1</sup> *University of Natal Medical School Reconciliation Graduation Booklet*. (Indicator Press: University of Natal, 1995), p.4. Since its inception, over 40 years later, +/- 2500 students have graduated from the School - a record unmatched by any other South African University. Importantly, the majority of black doctors in South Africa have been trained in Natal.

<sup>2</sup> UN Archives, Pmb. H6/1. “UN Medical School Reconciliation Ceremony Address by Professor B.M. Gourley”, 1995, p.1.

<sup>3</sup> E.H. Brookes. *A History of the University of Natal Medical School*. (Pietermaritzburg: University of Natal Press, 1966).

develop in an increasingly hostile racist city in the 1950s, I have analysed how the Durban Medical School was both a protective haven for an elite group of aspiring black doctors, but was also caught up in and was influenced by racist ideas and often perpetuated them. The search for access to an apparently “noble” profession was always clouded by racial discrimination, which left deep scars of personal hurt and anger.

This thesis has tried to grapple with a complex and ambiguous institution, and even more ambiguous racist and segregationist apartheid socio-political situation in which it was positioned and forced to evolve. It opened having experienced a tumultuous thirty years leading up to its establishment, but an analysis of its first decade of existence shows that this was by no means mitigated after the School was opened. Every feat proved racially, politically, socially and economically complex and challenging. Kallichurum maintained that despite these problems it must always be remembered that: “it was a shining example of survival inspite of apartheid, the Medical School, that’s how I saw it. It was a shining example of survival inspite of the politicians”.<sup>4</sup> The victories the pioneering doctors won in the field of medical education for black doctors, were never easy, but hard earned after dedicated and determined fights for what they believed was a worthy effort - to address the massive shortage of black doctors to help alleviate the desperate burden of disease under which the majority of black South Africans laboured.

However, while I have traced the development of a black medical institution in Durban, I have also analysed an important achievement that this Medical School alone promoted a unique orientation and training in preventive, social and community-based medicine. As a progressive and farsighted health care movement in opposition to the expensive, dominant traditional curative and hospital-based medical approach, which only a handful of people (mainly white) could afford, this approach catered especially for impoverished black communities who were in desperate need of community-based preventive health care. This thesis has thus also attempted to trace the small but significant beginnings of this at first non-mainstream and peripheral health care movement and how its central philosophy (together with its group of innovative doctors) for a brief moment in history, became the foundation of public health policy at a national level, which set the framework for a unique experiment world-wide, in State-directed and sponsored community health. However, due to various complex reasons, but importantly a change to a



more racist Government, this movement was halted at a national level and became incorporated into Durban's black Medical School. Within this institutional academic setting, once again social and community health orientation left its mark, this time by revolutionising the School's medical curriculum, which led the School for a short time to international distinction, as a progressive social, preventive and community health education facility. And it is for these particular academic contributions, that I believe the School should be remembered in its early years, which placed it in the vanguard of other medical schools both in South Africa and abroad. As Dr Gale wrote with foresight in 1954:

the University of Natal is presented with an opportunity to introduce, under circumstances probably more stimulating and more favourable than in any other medical teaching centre in the world, an advance in medical education, which is particularly desirable in this particular School and which, will attract worldwide attention in the field of medical education. It would bring medical educationalists from many countries to study its details, and give to Durban and Natal a special place in international medicine.<sup>5</sup>

Unfortunately for South Africa, as the last chapter demonstrated, due to loss of funding and conservative and racist State attacks, this largely radical movement came to an untimely end. And this occurred despite South Africa's health centre service having attracted international attention as a largely unique experiment in social medicine on a scale without precedent or peer in the world.<sup>6</sup> As Susser argues in a recent journal article, "Pholela became world famous and was considered by Dr Grant of the Rockefeller Foundation to be more advanced in concept than anything in world".<sup>7</sup> The vitally important ambiguities and chinks in the apartheid armour, which

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<sup>4</sup> Interview with Professor Kallichurum by Vanessa Noble, Durban, 29 May 1999.

<sup>5</sup> UN Archives, Pmb. H6/2/3. Correspondence concerning Establishment of the Department of Family Practice. History and Future of the IFCH, Clairwood, Durban by G.W. Gale, 1/6/1954, p.4.

<sup>6</sup> See Henry Gluckman. *Abiding Values: Speeches and Addresses*. (Johannesburg: Caxton, 1970), p.511 and G.W. Gale. "Government Health Centres in Union of South Africa". *South African Medical Journal*, 23 July 1949, p.636. While the British National Health Services was brought into being at the same time, but in many respects failed to bring about an integration of preventive with curative medicine in general practice, which remained functionally separate for a long time. It only later achieved functional integration. As far as Gale and Gluckman were concerned, South Africa's short-lived community health services had no counterpart in any other country, and the concepts which underlay it and found expression elsewhere was nowhere so clearly expressed or persuasive as in South Africa.

<sup>7</sup> Mervyn Susser. "A South African Odyssey in Community Health: A Memoir of the Impact of the Teachings of Sidney Kark". *American Journal of Public Health*, Vol. 83, No. 7, July 1993, p.1042. Also see Harry T. Phillips. "The 1945 Gluckman Report and the Establishment of South Africa's Health Centres". *American Journal of Public Health*, Vol. 83, No. 7, July 1993, and Gluckman. *Abiding Values*. These works show how South Africa's National Health Services recommendations influenced Dr Grant's commission appointed in India to plan a National Health Service for its vast population. Its 1947 Bhore Report made recommendations regarding health centres very similar

had facilitated negotiated spaces for these farsighted doctors to achieve amazing health reforms over a twenty year period starting from 1940, were closed from 1960 onwards, when the apartheid State reached the height of its power.

While the loss of its funding was essential to undermining the movement, a more important factor was its loss of stimulation from many of its innovative cadre of community health doctors who emigrated from South Africa throughout the 1950s, but reaching a crescendo in 1958/59. Instead of becoming a leader in this medical field internationally, South African health services were left in a desperately underdeveloped state and for many years thereafter devoid of important foundations to provide an adequate health care for all. In 1958 Sidney and Emily Kark also left South Africa and their important work here. Sidney's comment that:

in 1958 after 20 years of application, but scarcely four years after starting what I believe was the most far-reaching program in family and community health anywhere then or now ...

is borne out by this thesis.<sup>8</sup> In a recent interview with the Karks, Sidney gave a detailed response to the interviewer for why he and Emily left South Africa:

we knew that our innings wouldn't last, we were very surprised to find they'd lasted 10 years of the Nationalist Government, how we did it I still don't know. ... Now, what happened to us personally ... I'm going to tell it to you in a purely non-political atmosphere because that's the only way I want to express it, as a visitor to a country that is going through its own revolution. We were, I would say, compelled to recognise that our time was limited in South Africa if we wanted to do the things that we wanted to do in our lives. And what we wanted to do was what we now call Community Oriented Primary Health Care, COPC, that's its name today in the world, not only where we've named it in Israel. We knew that we couldn't survive with that kind of medical and health philosophy in an atmosphere where the whole finance depended upon recognition of this field by a Government that wasn't thinking that way. It just wasn't there. George Gale knew this too, he realised it before we did, that's why he left before we did, he went to

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to those in South Africa. In a leading article in the *British Medical Journal* of 21 February 1948 entitled "Social Medicine in the Curriculum", Dr Grant also made approving reference to South Africa concepts and practices of Social Medicine. It received massive international publicity and many doctors from other countries visited South Africa and when they returned home, applied to local problems methods seen in successful operation in South Africa.

<sup>8</sup> Susser. "A South African Odyssey in Community Health", p.1042.

Makarere some years before we left. To put it in nutshell I would say that we were strangled slowly so that there should be no fuss about this thing, and there was no public fuss. It was done very successfully. The whole thing, I would say is an illustration that under certain circumstances success can also mean failure.<sup>9</sup>

While George Gale emigrated three years before the Karks did, his views with regard to the apartheid Government's blatant hostility and slow strangling of their work is also evident, which created much anger in him, especially since he too had given devoted service to the State Department of Health for so many years:

I am appalled because the Senior Officers of the Department of Health, my colleagues for so long, should have so little knowledge of, or insight into what has been happening in their own Department that they can be parties to the murder of its finest effort (carried out with real devotion, under a perpetual cloud of insecurity and malevolence) without being aware that a murder is being committed.<sup>10</sup>

Kark felt that many people emigrated because they had no alternative, "many of the senior IFCH medical staff had no alternative but to leave for posts in other parts of the country, while others left the country to take up academic and research appointments abroad".<sup>11</sup> Harassed by the State and finding themselves in an increasingly hostile political climate, many of the leading advocates of the social medicine movement scattered around the world, but mostly to the US and Israel. However, the ideas and methods initiated at Pholela, the IFCH and Durban Medical School spread throughout the world and helped to spawn similar projects in other areas.<sup>12</sup> In 1962,

<sup>9</sup> Interview of Emily and Sidney Kark by Prof. C.C. Jinabhai and Dr. Nkosazana Zuma, Durban, 1992, p.16-17.

<sup>10</sup> UN Archives, Pmb. H6/2/3. Correspondence concerning Establishment of the Department of Family Practice. Letter from G.W. Gale to Department of Health, 5/11/1952, p.6. Also see UN Archives Pmb. H6/1/1. George Gale. "The Story of the Durban Medical School", 25/1/76. After Gale's resignation from the Durban Medical School, he accepted an appointment as Chair of Preventive Medicine at Makerere University in Uganda. After his retirement there in 1960, he went to Thailand to help develop departments of preventive medicine in two large medical schools in Bangkok and helped establish a new medical school in Chiangmai, 500 miles north of Bangkok. In 1965 he spent another four years in Malaysia to help develop the teaching of social and preventive medicine in the first medical school in that country, at Kuala Lumpur.

<sup>11</sup> Sidney and Emily Kark. *Promoting Community Health: From Pholela to Jerusalem*. (Johannesburg: Witwatersrand University Press, 1999), p.194. See Derek Yach and Steve M. Tollman. "Public Health Initiatives in South African in the 1940s and 1950s: Lessons for a Post-Apartheid Era". *American Journal of Public Health*, Vol. 83, No. 7, July 1993, James Trostle. "Anthropology and Epidemiology in the Twentieth Century: A Selective History of Collaborative Projects and Theoretical Affinities, 1920 to 1970", in Craig R. Janes et al (eds). *Anthropology and Epidemiology*. (D. Reidel Publishing Company, 1986), *In Memory of Sidney Kark. 1911-1998. A Summary of his Professional Life and Scientific Contributions*, (Hadassah Medical Organisation. Hebrew University-Hadassah Braun School of Public Health and Community Medicine, 21st January 1999).

<sup>12</sup> Trostle. "Anthropology and Epidemiology in the Twentieth Century", p.65. These experienced community health doctors helped to revolutionise health care in the USA, Israel, Canada, several countries in Africa such as Uganda, Asia, Latin America and more recently in Spain and the UK. The Karks emigrated to the US in 1958 and later to

Sidney Kark and Guy Steuart co-edited a book entitled, *A Practice of Social Medicine: A South African Team's Experiences in Different African Communities*. Steuart argues:

we began the book in South Africa. The decision to do the book was one we made as a result of having to leave South Africa. Sort of last chance. Sort of a dedication to that experience. Saying good-bye to it.<sup>13</sup>

But what had been learned at Pholela and the IFCH was disseminated through an international teaching programme and published works. Indirectly too, Kark's protégés, students and followers in several countries shared that task. Not only Israel but the world at large gained by the relocation of the Karks. His resulting accessibility to nearly all countries around the world as teacher and writer helped him and those influenced by him to survey the sophisticated central ideas of health based on COPC.

For both Sidney and Emily Kark, their emigration was a response to growing frustration caused by an increasingly hostile and racist apartheid Government that took drastic action without any consultation and in the face of international opposition. In their view the State's move was:

a retrogressive step in South African medical history, and a great loss to the thousands of people in need of the community oriented primary health care service. It was with a sense of increasing frustration and sadness that we had witnessed the gradual attrition and eventual termination of the extended primary care service that had been developed for the communities, which were an integral part of the IFCH.<sup>14</sup>

The loss to South African of this highly trained and motivated cadre of health professionals was tragic. Another community health doctor, Eva Salber, in her book, *The Mind is Not the Heart*, also deals with the issue of her and her family reluctantly abandoning their homeland of South Africa in the face of an increasingly harsh apartheid system. But the prospect of raising her children in an environment of growing cruelty and oppression tipped the balance against her heartfelt dedication to her black patients. When she moved to Boston in the USA, in 1956, she wrote:

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Israel in 1959 and were joined there by other IFCH staff who had been invited to serve in the expanded program at Hebrew University - Hadassah Medical School in Jerusalem.

<sup>13</sup> "Community Health Development: An Anthology of the Works of Guy W. Steuart". Supplement 1. *Health Education Quarterly*. (New York: John Wiley and Sons, Inc., 1993), p.S4.

<sup>14</sup> Sidney and Emily Kark. *Promoting Community Health*, p.195.

I note with pride, and some self-shame, that young, vigorous students continue to demonstrate their concerns over inequalities and inequities in South African society. But many young people left South Africa - as we did - unable any longer to lead the kind of schizophrenic existence of white, privileged people living in a political system where skin colour determines position in society. The country's loss is keen and accelerating.<sup>15</sup>

Throughout this life history of her work in the US, she was constantly plagued by her ambivalence, as I am sure many of the other community health doctors felt about whether their emigration had been the right step and whether their having left was the ultimate betrayal:

Harry, in contrast to me, was so anxious to pull out of South Africa that he was excited rather than sad at going, but I left reluctantly, with more sorrow and guilt. If all socially conscious doctors left South Africa, who would do our kind of work?<sup>16</sup>

With the mass emigration of community health doctors around the world, Sidney Kark's central philosophy which became known as Community Oriented Primary Health Care development and spread too, influencing the lives of countless numbers of doctors and their patients. One wonders whether if they had chosen to stay and been forced to abandon the social and community health effort altogether due to State hostility, their driving philosophy would have disappeared completely and robbed the world, not only South Africa, of the important lessons it had, and still continues to teach. Unfortunately for South Africa, but fortunately for the rest of the world, Sidney Kark's work - and that promoted by his team of doctors who relocated all around the world - became seminal in this medical field and after Kark's death in April 1998, an enormous void has been left with his loss. In memory of his work and contributions, a compilation of journal article quotes, as well as letters from his past students, colleagues and friends were produced in a booklet in January 1999. To show the great influence - personal as well as professional - Sidney Kark had on various people around the world, I think it is useful to quote a few now. Professor Leon Epstein wrote the following about Kark:

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<sup>15</sup> Eva J. Salber. *The Mind is Not the Heart: Recollections of a Woman Physician*. (Durham and London: Duke University Press, 1989), p.122.

<sup>16</sup> Salber. *The Mind is Not the Heart*, p. 123, 127-128.

he left an indelible impression on those who were privileged to study and work with him. The ideas and principles that were developed over the years by Sidney and Emily Kark and known to us as COPC or Community Oriented Primary Health Care have become the basis for thinking and planning of health services [and have spread] to the four corners of the globe. Few have succeeded in their lifetime to impact in so significant a manner on the health of so many.<sup>17</sup>

A number of Kark's students also had enlightening words to say about Kark - the man - and his work, for example:

he led us by example, equitable principles and systematic methods, in endless search for better primary health care. Dr Sidney Kark's work changed my life and the way I approach my mission in it. His books gave me the knowledge and skills to orient my life to service and the world community.<sup>18</sup>

Rebecca Bergman, one of his colleagues in Jerusalem wrote:

Sidney was one of the greatest pioneers in health care internationally, and certainly in Israel and South Africa. ... He was always a teacher for me - not by his intent - but as a role model. He made you grow, to think in broad concepts; he was ready to fight for what he believed, but always gently and with wisdom. Sidney will always be a guide to me.<sup>19</sup>

As a doctor, but more importantly, a teacher, his work will live on in his many students who were touched by his work, as Violet Cherry claimed:

as I review my career now, thirty years already in the U.S. and a senior health administrator in New Jersey, I think of all I learned from Sidney Kark and the health centre team who trained us way back in 1949 ... I think those of us who trained in the health centre movement in Durban stand out in many ways because of wonderful heritage that Sidney shared with us about Public Health, and we have carried that concept along wherever we have worked. It has given me a sense of values that I have never lost. Sidney's passing is a loss to all of us but know that his many achievements will go on, and be long remembered by those of us who were touched by him.<sup>20</sup>

And Gerry Shaper concurred with this assessment:

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<sup>17</sup> *In Memory of Sidney Kark*, p.1. Leon Epstein is Chairman of the Department of Social Medicine in the Hadassah Medical School of the University of Jerusalem.

<sup>18</sup> *In Memory of Sidney Kark*, p.6. Dr Elvira Beracochea, Uruguayan graduate of 1987 International Master of Public Health Programme in Jerusalem.

<sup>19</sup> *In Memory of Sidney Kark*, p.6. Rebecca Bergman, formerly head of Community Health Nursing in Department of Social Medicine at the Hebrew University - Hadassah, Jerusalem worked with Sidney for five years.

<sup>20</sup> *In Memory of Sidney Kark*, p.6. Violet was one of the first Indian women health educators at the health centre training Institute in Durban.

work in South Africa had a considerable impact on my thinking and choice of direction ... His impact, indeed the impact of your joint contribution to family medicine throughout the world is readily recognisable and will always represent what is best in Social Medicine. We will always remember him with admiration, respect and love and we will be comforted by knowledge that his contribution will continue through the generations, for such is the legacy of a true teacher.<sup>21</sup>

Besides the international people who were colleagues or friends of Sidney Kark, the black undergraduates (or the next generation of doctors) who he trained during the 1950s - such as Soromini Kallichurum and Fatima Mayet - were also powerfully influenced by his legacy. This dissertation has not only concentrated on the amazing achievements of white community health doctors such as the Karks and their team. It also demonstrated the often hidden bravery and courage of the first cadre of young black doctors who stayed on in South Africa and used their ambiguous positions to provide health services and medical education as part of a tiny and often besieged group of black medical professionals. For this next generation of UN black doctors in the 1960s and 1970s the choices they faced became increasingly complicated and resulted in a split in their ranks - between those who were forced overseas and into exile and there fought for the liberation struggle and those who struggled on here (often at their own personal risk) and formed powerful groups of black doctors in Durban who worked against the interests of apartheid and for the betterment of the health of their communities. Unlike the Karks and their colleagues who refused to compromise their principles in an increasingly repressive and racist country and thus chose to emigrate overseas, many black aspiring, but also fully trained doctors, who were unable to remain in South Africa because of political persecution were forced to leave. During the 1970s the UN's Medical School became a fulcrum of student activism in South Africa where Indian and African students radicalised in the process of becoming politically conscientised which still leaves its residues today in the 1990s. People such as Nkosazana Dlamini Zuma who started her medical education at the Medical School was forced to go underground and into exile (in England where she completed her degree) due to constant apartheid State police harassment for her radical student activism. Other black ex-medical students such as Steve Biko paid the ultimate price for their activities with their lives. During the 1990s many of these exiled doctors returned to South Africa such as Zuma. Zuma and many of her medical colleagues from the Medical School have since taken up important

portfolios in the post-apartheid Government. In 1994 Dr Zuma became Minister of Health. Many of her policies have been important too because they have taken up elements of COPC at the centre of South Africa's health programme. However, while the important initiative for taking up community health ideas exists, the long gap between the National Health Services Commission's plan in 1944 and all the years of apartheid misrule of health will mean that gaining acceptance for and implementing these policies will be no easy walk to create a non-racial, equitable and excellent health service.

### ***Lessons for South Africa Today as the Wheel of Community Health Turns Full Circle.***

While the value, impact and relevance of Kark's early social and community health centre work was carried out to the rest of the world, failure to build upon these early models cost South African dearly, not only in financial terms, but also and more importantly, in terms of preventable disease, disability and death. In the post-apartheid era, South Africa now has to contend with a health system seriously compromised by decades of racial discrimination and incapable in the present form of serving the health needs of its people. As Kallichurum argues with regard to the loss of doctors such as the Karks:

you know it is very sad to have lost people of that calibre, at that time, from this country. ... I think they could have made a big difference, through the students that they were training, and all, you know, lots of things could have happened a little earlier I think. ... because I think a lot of people do things and think a certain way because of ignorance and once they see the whole picture and know what the truth is, they change. ... [South Africa lost this] it is very sad. We always felt that it was exceptionally sad. We were angered and frustrated about this whole affair of this subject being dropped out.<sup>22</sup>

As a past student of theirs, Mayet also felt that if the Karks and their team had remained in South Africa, health provisions could have been very different today, and even if still racially skewed, the Karks would have assisted the process of transformation:

I think they left a very big gap. ... there is now transformation into that approach with our Medical School [but] our graduates, are not sufficiently qualified in that respect, to adopt that sort of attitude and approach. So all the sort of ivory-tower

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<sup>21</sup> *In Memory of Sidney Kark*, p.8. Gerry Shaper is Prof. Emeritus, in the Department of Clinical Epidemiology, University of London.

<sup>22</sup> Interview with Professor Kallichurum.



medicine approach is [only] slowly changing. ... I think it was a very retrogressive step to have withdrawn it. If they could have got it going even as a small Department it would have been very beneficial to the Medical School, and the graduates. You know at that time we never anticipated this ... democracy, but that would have given a good background in the transformation process, because now they are starting health centres and health programmes and so on and trying to emulate that sort of approach. ... [it was] a great loss, it was tragic that it was given up completely.<sup>23</sup>

From being at the forefront of community and public health developments in the 1940s South African health services now have to catch up with many other countries.<sup>24</sup> And what is more sad, Alan Jeeves argues, is that the importance of the social medicine movement, with the specific lessons to be learned at Pholela are not well remembered in the South African medical community today.<sup>25</sup> In an interview with Sidney Kark in 1980, Kark voiced his chagrin with regard to the great unawareness in South African medical circles - because of the lack of training and skills caused by the twenty year gap in thinking - about past community health ideas:

really the birth in South Africa of modern family and community medicine which pre-dated ... so many other places and one could cry at the fact that from a position of being in the forefront of development of what has become a modern trend, South Africa today is just discovering, ... it's just beginning to be thought about and functioning and reintroduced.<sup>26</sup>

Kark also had many words of wisdom for South Africa's present health policy makers:

the major thing to avoid is over-centralisation. ... No matter who gets power, when you over-centralise, too much power remains with one person, whatever his political opinions may be, there's the danger of ... interference by powers that be. ... The more decentralisation you've got, the less dependent you are on the central political power.<sup>27</sup>

Further advice rested upon the nature of health funding, and the importance of obtaining independent sources - such as that gained from the Rockefeller Foundation during the 1950s - to finance any "experiments" and thus prevent conservative political powers undermining it:

<sup>23</sup> Interview with Professor Mayet by Vanessa Noble, Durban, 4 June 1999.

<sup>24</sup> Yach and Tollman. "Public Health Initiatives in South Africa in the 1940s and 1950s", p.1048.

<sup>25</sup> A. Jeeves. "Public Health and Rural Poverty in South Africa: "Social Medicine" in the 1940s and 1950s. Seminar Paper presented at the University of the Witwatersrand Institute for Advanced Social Research, 30 March 1998, p.11.

<sup>26</sup> UN Archives Pmb. H6/1/1. Interview with Professor S. Kark and Professor Gordon on some Facts and Aspects of our Medical School which are not Recorded, by S. Cameron-Dow, December 1980, p.19.

<sup>27</sup> Interview of Emily and Sidney Kark, p.25.

if you want to develop an experiment in medical education, if you can get it, short term or long term funding to support you, you prolong your life, you also prolong your time. ... look, it kept us alive for 5 years longer than we should have been kept alive.<sup>28</sup>

However, despite all the problems, at least the initial step in South Africa has finally been seriously taken of recognising the work of pioneer social and community health doctors fifty years ago, and possibly learning from their important lessons. In an article in the *South African Medical Journal*, it has been asserted:

the Pholela health centre was [a] ... spectacular attempt at health care innovation that surfaced in the early 1940s, well ahead of their time. ... Today's policy-makers need look no further for a model on which to base a sensible and effective health care network.<sup>29</sup>

In an article entitled, "A South African Odyssey in Community Health", Mervyn Susser shows the importance of the whole movement coming "full-circle" in South Africa, in a health situation in desperate need of past miracles:

not only Israel but the world at large gained by the relocation of the Karks. Sidney Kark's resulting accessibility to nearly all nations as a teacher and writer has helped him and those influenced by him to purvey the sophisticated central ideas of health based on community-oriented primary care. The ideas have followed the natural epidemic curve, except that, having reached a climactic point at *Alma-Ata*, they have not as yet shown the expected signs of a downturn. They have instead become part of the everyday discourse of practitioners as well as the *cognoscenti* in the field. And, once more, these ideas are beginning to guide thinking about health care in the homeland to which they have returned and which may soon complete its liberation.<sup>30</sup>

What is interesting for Durban's sake, is that Kark argued that its Medical School should be the place that it re-emerges, since it was here that the whole movement began:

I'm saying at this School in particular because it began here ... it stopped here and now men are very interested in it and they're re-discovering the wheel because each generation is still educating itself ... my own feeling is that this is the School that should still aim to do it, and I think what Guy Steuart said many years ago when we were having a discussion in Durban 'health is much too important a subject to be left to doctors', and I really believe that this should almost become a motto of this

<sup>28</sup> Interview of Emily and Sidney Kark, p.26.

<sup>29</sup> *In Memory of Sidney Kark*, p.4. See Daniel Ncayiyana, "The Pholela PHC Model: No Need to Rediscover the Wheel". Editorial comment. *South African Medical Journal* 1994; 84:9.

<sup>30</sup> Susser. "A South African Odyssey in Community Health", p.1042.

School, that community health care urgently needs other professional groups and I don't know if there are many places outside of this School that are going to be able to do it.<sup>31</sup>

Thus, in conclusion, I would argue that in-depth analyses of medical history provides a wealth of fascinating insights and deep ironies and complexities, of no less interest or value than in other well-researched South African history fields. Analysis of the health sphere provides an interesting contrast to that of the socio-political or economic spheres, because it was largely a hidden, but no less contested space, where the State experienced many difficulties imposing its apartheid will. In an interview in 1980, the interviewer Shelagh Cameron-Dow had an important dialogue with Sidney Kark regarding a history student embarking on research to do with medical education in South Africa:

Interviewer: you see, the idea is that we're hoping to persuade an honours or masters student ... in the department of History [to] do this as a major thesis and ... will really get down to the beginnings and the roots of this Medical School going right back to 1921.

Kark: I think a very important area either for that student or somebody doing parallel [work] with [them] is to try and look at the development of medical education through the eyes of a school like this and through the eyes of its history and in so doing to see the attempt that had been made to move towards an orientation in community health care and the difficulties that have been involved in doing this.<sup>32</sup>

When I learnt about this I was thrilled to discover that Sidney Kark had also recognised the importance of writing an in-depth historical analysis of the difficulties, hardships but also successes of medical education in South Africa, through the eyes of an extraordinary medical institution like the Durban Medical School. An analysis of the establishment of one particular Medical School has allowed me to get an important grip on some of the more complex, diffuse and overlapping discourses surrounding medical history and education in South Africa. It has also formed the gravitational centre around which many interesting and nuanced personal memories and experiences have emerged which do not exist in any of the conventional historical narratives. Thinking back over the past year and having done extensive research on this topic, it has been my privilege to have embarked on this amazing journey into the fascinating and contradictory world of health and politics in South Africa during the early and middle years of

<sup>31</sup> UN Archives Pmb. H6/1/1. Interview with Professor S. Kark and Professor Gordon, p.24-25.

<sup>32</sup> UN Archives Pmb. H6/1/1. Interview with Professor S. Kark and Professor Gordon, p.23.

the 20th century. Much can be learnt about South African history and the powers that be through the health lens. I have come to learn that the nature of State power (including that of the apartheid ideologues), especially in the health sphere, while very influential, is far less comprehensive than imagined but in reality was formed through enormous amounts of compromise, contradiction, conflict and negotiation. This is particularly evident with the Durban Medical School's determined fight to resist relentless apartheid attempts to control every aspect of black medical education. With the State's retreat and the UN's victory on the medical front - this round - the Durban Medical School was able to continue its high quality of academic research and training for years to come.

Further research projects will have to take up in greater detail a theme only touched upon in this thesis, namely the failures, compromises and disappointments of the early years because of inadequacies, blindnesses, prejudices and disjunctures at the very heart of the Medical School and Kark et al's project. Racism, paternalism and the class and ethnic divisions between the staff and students in the 1950s cannot be wished away in the context of the overall programme aims and successes of that era. If social history teaches us anything it is that small and seemingly insignificant failures and cul-de-sacs are as important to an overall critical assessment and analysis of any institution or social movement. In this thesis besides an analysis of the tensions and challenges of the "pioneer class" - many of whom succeeded in qualifying - I have also spent some time on the experiences of such people as Themba Bolani whose bitterness towards the Medical School is also part of the legacy and a warning of the dangers of hagiographic and romanticised historical accounts.

In the light of the odds faced by the Medical School and its students in the 1960-1990 period, the 1950s struggles seem less intense and all encompassing as the State's relentless attempts to undermine and control black medical education in South Africa during this period would continue and only later become more powerful. In this decade though, State power over black education and training was far less assured and came up against, just as determined academic opposition. Apartheid took such hold for the very reason that it was flexible during the 1950s and only rigidified after 1960. But it also allowed a small number of innovative South African doctors to travel down unconventional paths in the chinks, complexities and ironies of its

history. For a brief time, despite growing social, political and economic racist apartheid ideology in South Africa during the 1950s, South Africa was still able to lay the ground for some of the most progressive developments in health services and medical education the world has ever seen. While the hegemonic racial ideology of white South Africa was not undermined by the work and struggles of people referred to in this dissertation, their legacy left a powerful imprint on South African medical thinking and practice. This thesis has highlighted the fact that extraordinary individuals, while located in the repressive context of South Africa, were yet able to achieve medical marvels. While explicitly focusing on health education and community service this thesis has also contributed, I hope, to an analysis of how the system of apartheid functioned by working in small steps and increments incorporating some aspects of radical thinking while undermining the overall aims of any non-racial or progressive intellectual or social forces. Because this system took time to emerge, and because it grew from the soil of a segregated society anyway, it was only when compromises of principle became extreme that people such as the Karks and Gale and others had to leave or face a very long and complex liberation struggle over many decades in a system where apartheid functioned. I think its fitting to end this thesis with the poignant words of one of the Durban Medical School's past students who had much to say with regard to this very compromised nature of the apartheid State's power:

you know one thing we believed as students ... some of us, that whenever a threat came, we always said it would take them [the Government] about two or three years to implement whatever they had. And that was something, that sort of kept us going, that it could not be implemented with immediate effect. ... It buys you time. That, we understood, you know, always, that whatever the threat, the implementation would take time. ... and that was something that was an important thing to know.<sup>33</sup>

When I asked Kallichurum about how she could continue studying and practicing in the medical field so plagued by apartheid ambiguities and contradictions she responded:

You know, I must say it was disheartening, but I always believed it wouldn't last, although it lasted a long time, but I kept believing that it must change, it has to change. ... Really, I never gave up the belief that it would remain as is, I always felt it will change. ... It lasted so long, but the hope that I will see the change before I die was so great in me, that it just kept me going. I never gave up that hope that it'll change. ... I think that propelled me and motivated me to continue.<sup>34</sup>

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<sup>33</sup> Interview with Professor Kallichurum.

<sup>34</sup> Interview with Professor Kallichurum.

This thesis has aimed to give due respect to individual voices (at many levels) whose struggles within and beyond the State's boundaries of power and their complex daily lives have caused an enormous monstrosity like the apartheid State and its architects to falter in its steps, to pause, reflect, adapt and revise many of their original policies and intentions. Power is never simply a one-way or top-down process. It involves negotiation, compromise and conflict at every level. I hope that this particular journey of South Africa history - carried out through the eyes of the Durban Medical School and the wider health lens - has shown how much more complex and ambiguous power has, and continues to be.

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See Files H6/1

H6/1/1

H6/2/1 - H6/2/3

H6/1/10

BIO P 3/2/5. SP 6/12/5. E.G. Malherbe.

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#### *The Mabel Palmer Collection.*

See File 35 for materials on Mabel Palmer and the Durban Medical School's Establishment.

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