

## Chapter 2: The historical context

In South Africa race and gender discrimination have intersected. A Medical Association of South Africa [MASA] submission to the Truth and Reconciliation Commission [TRC] in 1997 examining its past history, described the organisation as 'white, male, elitist, educated, professional'.<sup>1</sup> These words, while none of them derogatory in themselves, in combination sum up some of the issues which this historical background to discrimination at UCT Medical School has attempted to explore. What is at issue is not only the nature of the medical profession but also the kind of medicine inculcated at the Medical School.

This study has attempted to go beyond a simple catalogue of events. The first section makes the point that segregation was entrenched in South Africa, even in the relatively liberal Cape, well before Union. The medical profession at the Cape played its part in this process, calling for segregation on sanitary grounds. The second part of this study explores the intellectual context of racism in medicine, noting the role of anatomy in contributing to notions of scientific racism. It argues that, up to the Second World War, doctors were functioning in a world in which racial differences were taken for granted and such views were part of their mindset, rarely examined and questioned. The cohesiveness of the medical profession in itself tended to reinforce such perspectives.

The following two sections, dealing with the periods before and after the Second World War, provide a brief political and social background. In the section dealing with the interwar period, the ongoing question of black admissions into the Medical School is the main focus. The changes which occurred are noted, as well as UCT's own admissions policy. The part dealing with the apartheid years opens with a brief consideration of the emergence of social medicine in South Africa - a development which arose because of declining health of black people and the urgent need to provide more effective care for Africans in the rural areas especially. UCT's response to this trend is explored. The remaining part of the section examines the tightening grip of apartheid and the Medical School's changing response to repression.

There is less consideration of gender issues in this study, mainly because relatively little historical writing has focused on overt discrimination suffered by white women in their undergraduate training. Legal discrimination facing women arose more explicitly once they started work. Although most legal disabilities were removed fairly quickly once the South African Society of Medical Women started a campaign to remedy these deficiencies, postgraduate training for women remained a very difficult experience for women well into the 1990's<sup>2</sup>. The situation was very different for black women whose position is touched on briefly.

One point should be made. A work such as this tends to highlight the inequities, the injustices and the sheer apathy of an institution and its members. This is hardly a fair picture. Although I have tried to indicate, at least in the apartheid period, where opposition to discrimination occurred, the picture is unbalanced. It should be said at the outset, therefore, that I am aware that this is a study of usually dedicated and humane people, shaped by the context of the time, responding to a complex and difficult world.

### ***South Africa before Union***

In attempting to place discrimination in the UCT Medical School into an historical context, it is useful to go back as far as the end of the nineteenth century when segregation was more firmly and more formally entrenched in the British colonies. The Boer republics made no bones about the fact that racial segregation was one of the keystones of their societies. Blacks had few legal rights and Indians were excluded entirely from the Orange Free State (and remained so until about 1994). But the situation was more ambiguous in the British colonies, particularly in the Cape where there was a race-free franchise. Although black rights under the franchise had been eroded since it had been introduced in 1872, all black men with the requisite financial or educational qualifications had the vote. In some constituencies in the Eastern Cape the black vote was a real force and even in Cape Town politicians could not ignore it.

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<sup>1</sup> South Africa. *Truth and Reconciliation Report*, (Pretoria, 1998), vol.4, 146.

<sup>2</sup> Saloojee H, Rothberg AD. (1996). 'Is registrarship a different experience for women?' *S Afr Med J*. 1996 Mar;86(3):253-7

This did not mean, however, that blacks were not increasingly subjected to discrimination. By 1900 the public schools were largely closed to blacks who were usually confined to mission schools with inferior education. The exceptions were the handful of mission colleges in the Eastern Cape, such as Lovedale and Healdtown, where the standard of education was comparable with many white schools. The quality of education was important since it was an additional obstacle to the acquisition of medical training for blacks, of whom there were four or five on the Cape medical register before 1910.<sup>3</sup>

Other institutions, particularly medical institutions, were also becoming segregated by 1900. This was true of most hospitals, although in overcrowded and underfunded institutions like the Old Somerset Hospital for the chronic sick poor this discrimination was often ignored. The newly-built Valkenburg Hospital, on the other hand, was intended entirely for whites, confining black 'lunatics' to Robben Island. The trend, in other words, was towards increasing segregation and the medical profession concurred in this process.

In fact, doctors did more. Medical officials in colonial and local government were active in promoting segregation. In his seminal article on 'The sanitation syndrome' Maynard Swanson has drawn attention to the way in which the colonial medical authorities seized the opportunity of the outbreak of plague in 1901 to establish locations and remove Africans, identified as the source of infection because of their living conditions, from the cities in Cape Town, Port Elizabeth and East London.<sup>4</sup> Other historians have developed this point further.<sup>5</sup> In acting in this way colonial practitioners had the support of the best imperial authorities. A man like Sir William Simpson, Professor of Hygiene at King's College, London, whose plague experience had been gained in India, would gladly have seen segregation carried to far greater lengths if it had been economically practicable.<sup>6</sup>

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<sup>3</sup> E. van Heyningen, (1989). 'Agents of empire: the medical profession in the Cape Colony, 1880-1910', *Medical History*, 33 (1989), 450-71.

<sup>4</sup> M.W. Swanson, 'The sanitation syndrome: bubonic plague and urban native policy in the Cape Colony, 1900-1909', *Journal of African History*, 18(3), (1977), 387-410.

<sup>5</sup> C. Saunders, 'The creation of Ndabeni. Urban segregation and African resistance in Cape Town', *Studies in the History of Cape Town*, 1, (1984) 165-93; E. van Heyningen, 'Public health and society in Cape Town, 1880-1901', (unpublished Ph.D. thesis, University of Cape Town), 1989, 286-349.

<sup>6</sup> M. Sutphen, 'Striving to be separate? Civilian and military doctors in Cape Town during the Anglo-Boer War', in R. Cooter et al, *War, Medicine and Modernity* (Stroud, Sutton Publishing, 1998), 50.

Political rights then, did little to save blacks from a discrimination which was sanctioned by apparent scientific advance. Segregation and the forces of modernism went hand in hand.

The situation in Natal was far less liberal. Although, in theory, Natal also had a race-free franchise, colonial settlers were almost completely successful in excluding blacks from the vote. Given this attitude, blacks were even more likely to be stigmatised as a source of infection, a threat to the health of white settlers. Segregation was nearly as intractable as it was in the Boer republics - the main difference was that it was sometimes a matter for debate.

When South Africa entered Union in 1910 the position of blacks was further weakened. Although black men retained the franchise in the Cape, Africans were soon confined to voting for 'native representatives' rather than participating in the common vote. When white women were enfranchised in 1930 it was partly because their vote helped to outweigh the influence of the coloured vote in the Cape. Politically the Cape continued to differ from the other provinces in that coloured people and Indians could, and did, sit on municipal councils. The redoubtable Dr Abdurahman was an outstanding figure in Cape Town local politics - a status which he acquired partly by virtue of his medical qualifications<sup>7</sup>.

### ***A world of unstated assumptions: racism and medical science***

In seeking to understand why humane doctors were so slow to resist apartheid practice in medicine, one needs to look beyond the march of events; to explore the *mentalité* of the profession.

Discrimination is an infinitely more subtle process than the crude practice of apartheid. Discrimination and racism have often operated within a context of what Philip Curtin has called the 'world of unstated assumptions', ideas which have become so culturally embedded that they are rarely discussed or critically examined. Writing of the racism of

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<sup>7</sup> Dr Abdurahman was the founder of the African People's Organisation (APO) in 1902, one of the first black political organisations in South Africa. He was also the first black city councillor in Cape Town and remained on the council for several decades. He obtained his medical qualifications in Glasgow. See: G. Lewis, *Between the Wire and the Wall. A History of South African 'Coloured' Politics*, (Cape Town, David Philip, 1987).

British colonial officials he notes that: 'The more cohesive the society, the less need to bring these unstated assumptions into the open'.<sup>8</sup>

South Africa in the twentieth century was one such world. Medical practitioners, as products of their society, often shared racial assumptions. More than this, their medical culture reinforced such premises, giving them scientific credibility.

By the twentieth century the South African medical world was, in many respects as cohesive as that of the British ruling establishment. This was even more true of the Cape. Before colonial doctors could train locally the great majority, as is well known, trained in Scotland, notably in Edinburgh. Moreover, since overseas training was financially unattainable for many colonials, most doctors were British-born, with Scottish doctors predominating.<sup>9</sup> When the UCT Medical School was established, the teaching staff was largely recruited from Scotland, particularly in the early years, and the model of the curriculum was also Scottish.<sup>10</sup> The result, at least up to about 1939, was 'an unanticipated coherence which was reflected in the general approach to the medicine of its graduates. Typically, he or she became a safe, Scottish-style general practitioner, able to perform satisfactorily in all branches of medicine.'<sup>11</sup> Nor was this influence confined to Cape Town. The Wits Medical School was similarly endowed at first.<sup>12</sup> The schools shared a Scottish tradition of comparative anatomy, a heritage that helped to stimulate ongoing interest in the subject.<sup>13</sup>

In other respects, too, the South African medical profession was relatively cohesive. By 1940 there was an infrastructure of medical organisations and institutions which set standards and promoted the interests of practitioners. These included the Medical Association of South Africa [MASA], the South African Medical and Dental Council

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<sup>8</sup> P. Curtin, *Images of Africa. British Ideas and Action, 1780-1850* (Madison, University of Wisconsin Press, 1964), vii.

<sup>9</sup> H. Phillips et al, *The Cape Doctor. The Cape Medical Profession in the Nineteenth Century* (Amsterdam, Radopi, 2003-4 *In press*).

<sup>10</sup> H. Phillips, *The University of Cape Town 1818-1948. The Formative Years* (Cape Town, University of Cape Town Press, 1993), 85.

<sup>11</sup> *Ibid.*, 102.

<sup>12</sup> B.K. Murray, *The Early Years. The University of Witwatersrand Johannesburg and its Precursors, 1896-1939* (Johannesburg, Witwatersrand University Press, 1982), 177; S. Dubow, *Scientific Racism*, 23.

<sup>13</sup> Dubow, *Scientific Racism in Modern South Africa* (Cambridge, Cambridge University Press, 1995), 39.

[SAMDC] and a variety of journals, amongst them the *South African Medical Journal* [*SAMJ*], dating back to the nineteenth century in various forms. The process of professionalisation itself reinforced the cohesiveness of medical practitioners. There is a considerable sociological literature on professionalisation which emphasises, for instance, the ways in which a profession excludes, and how it accumulates and mystifies knowledge to ensure the continued need for professionalisation. Liz Walker has argued that medical professionalisation has also been a gendered process, entrenching institutionalised male power.<sup>14</sup> The point is that medical professionalisation was a powerful and conservative process which not only excluded competitors but reinforced bonds within the profession, leaving limited space for opposition and conflict.

This coherence was partially dissolved when medical schools were established at the Afrikaans-speaking universities. The effect was to train doctors who were exposed mainly to the values of emergent Afrikaner nationalism. By 1948, when Malan's Afrikaner Nationalist government took power, Afrikaner doctors had a dominating place in many of the regulatory medical institutions. The result was that MASA, especially, had become politically conservative, unwilling to challenge the injustices of apartheid, even when they ran counter to ethical medical practice. But English-speaking doctors were often equally reluctant to question government actions. There were a number of reasons for this, some of which will be explored later, but a sense of solidarity with their fellow doctors, a reluctance to cause controversy within their professional institutions, and racist thinking itself, undoubtedly played a part.

It was against this background that Curtin's 'world of unstated assumptions' functioned. The role of scientific racism in shaping apartheid has been admirably explored by Philip Curtin, Saul Dubow and Leonard Thompson, amongst others.<sup>15</sup> There is no place here to examine the influence of scientific racism on medicine in any detail, but several points can be made.

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<sup>14</sup> E. Walker, 'The South African Society of Medical Women, 1951-1992: its origins, nature and impact on white women doctors' (unpublished Ph.D. thesis, University of the Witwatersrand, 1999), 7-9, 26-33; See also F.R. Ames, *Mothering in an Apartheid Society*, 2d ed. (Cape Town, The Author, 2002)

<sup>15</sup> Curtin, *Images of Africa*; Dubow, *Scientific Racism*, L. Thompson, *The Political Mythology of Apartheid* (New Haven and London, Yale University Press, 1986).

The emergence of modern medicine was closely linked to the emergence of modern scientific thinking. Systems of classification, the use of statistics, and the critical study of the human body were all elements of modern science by the nineteenth century. But these developments took a racial turn fairly early. Anatomists, particularly, began to classify human 'types' and to establish a hierarchy in which Europeans were regarded as the most advanced and Africans, especially 'Hottentots' and 'Bushmen' were at the bottom of what was to become an evolutionary scale. Such ideas soon went well beyond the scientific and educated world, to become part of popular discourse. The notorious Edinburgh anatomist, Robert Knox<sup>16</sup>, played a particularly significant role in promoting early physical anthropology and in popularising it. Curtin describes him as 'the first real founder of British racism and one of the key figures in the general Western movement towards a dogmatic pseudo-scientific racism'<sup>17</sup>

The relationship between trained scientific thought and popular notions is not a simple case of dissemination downward, distorted or otherwise. Scientists themselves imbibe cultural norms which may serve in turn to shape their training and research. An obvious example in the nineteenth century is the way in which the beliefs that women were naturally passive creatures, prone to hysteria, unfitted for a public role, were confirmed, reinforced and promoted by the medical profession of the day.<sup>18</sup> Ideas about race were equally vulnerable to cultural misconceptions.<sup>19</sup> They proved, moreover, extraordinarily flexible in the face of fresh scientific thought. Emerging forty years before Darwin's *The Origin of Species* in 1859, scientific racism took evolutionary theory on board readily,

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<sup>16</sup> Dr Knox was an Edinburgh surgeon in the early 1800's who employed the dubious services of a pair of grave robbers, William Burke and William Hare, to find corpses for his anatomy classes. Burke and Hare began to murder victims for money in order to supply Knox with cadavers for dissection. After being caught, Hare turned state witness, and William Burke was found guilty, sentenced to hang and his body to be publicly dissected. Dr Knox was never charged with a crime but the Edinburgh citizens were angry at his involvement and there was a riot outside his house shortly after the trial. He eventually left Edinburgh due to dwindling uptake of his classes and his general unpopularity, and moved to Glasgow and later London where he eventually died in 1862.

Accessed at <http://www.edinburgh.gov.uk/libraries/historysphere/burkeandhare/burkeandhare.html>

<sup>17</sup> Curtin, *Images of Africa*, 377.

<sup>18</sup> E. and E. Showalter, 'Victorian women and menstruation', 38-44, J. Conway, 'Stereotypes of femininity in a theory of sexual evolution', 140-54, and P.T. Cominos, 'Innocent femina sensualis in unconscious conflict', 155-72 all in M. Vicinus (ed.), *Suffer and Be Still. Women in the Victorian Age* (London, Methuen, 1972).

<sup>19</sup> Dubow, *Scientific Racism*, 6-7.

giving rise by 1900 to eugenics - the belief that races were engaged in a struggle for survival and that the unfit should be eliminated lest the race become degraded, unfit also in the political struggle for survival between nations.

It was not surprising that teachers in South African medical schools, like their peers abroad, should hold views on the superiority or inferiority of races. At Wits H.B. Fantham, professor of zoology, for instance 'interested himself in questions of human heredity and "race admixture" and warned against mixing the races in South Africa'.<sup>20</sup> Better known was Raymond Dart, professor of anatomy, who was also, for many years, external examiner in anatomy at UCT. A controversial figure in his day, Dart remains contentious now. Dubow has drawn attention to the racism which infused his views on physical anthropology. Dart's story, he suggests, must be told with reference 'to the wider assumptions about the nature of race, within which he operated and did so much to sustain'.<sup>21</sup> Assumptions of intrinsic racial difference and notions of superiority and inferiority were so embedded in Dart's lifework, he suggests, that it is impossible to assess his contribution to anthropological knowledge in isolation from this fact.<sup>22</sup>

The professor of anatomy at UCT, Matthew Drennan, another Edinburgh graduate, shared similar views. Drennan was a successful and influential teacher, whom Christiaan Barnard described as his ideal.<sup>23</sup> Much of Drennan's research was devoted to the investigation of the 'Boskop man' which hypothesised that modern 'Hottentots' and 'Bushmen' were degenerate lineal descendents of an earlier physical type. He was, Dubow suggests, contemptuous of modern 'Bushmen' whom he regarded as the human equivalent of the dodo. He 'reinforced the racist conception that they were not fully human. His dismissive references to them as "morphological Peter Pans" encouraged the view that they were "the race that never grew up"'.<sup>24</sup>

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<sup>20</sup> Murray, *The Early Years*, 157.

<sup>21</sup> S. Dubow, 'Human origins, racial typology and the other Raymond Dart' in A.F. Alexander et al, *Africa Today. A Multi-Disciplinary Snapshot of the Continent in 1995* (Canberra, Australian National University, 1996), 255.

<sup>22</sup> *Ibid.*, 257.

<sup>23</sup> C. Barnard and C.B. Curtis, *One Life* (Cape Town, Howard Timmins, 1969), 60.

<sup>24</sup> Dubow, *Scientific Racism*, 51; D.J. Coetzee, *Living with the Dead. Impressions of Some Years with Professor M.R. Drennan in the Anatomy Department, Medical School, Mowbray, Cape* (Observatory, The Author, 1954), 49.

South African physical anthropologists did not exist in an ivory tower. Dart, particularly, was a vigorous populariser of his own views and they had a wide influence beyond academe. Scientific thinking of this kind infused the speeches of intellectual South African politicians like Smuts and J.H. Hofmeyr. Thus Smuts, giving the keynote address to the South African Association for the Advancement of Science in 1932 could say:

'We see in the one the leading race of the world, while the other, though still living, has become a mere human fossil, verging on distinction. We see the one crowned with all intellectual and spiritual glory of the race, while the other still occupies the lowest scale in human existence. If race has not made the difference, what has?'<sup>25</sup>

Moreover, in South Africa science was closely identified with rational progress. Dubow has pointed out that as racial segregation came to dominate the political agenda from the early 1920s, intellectuals and social reformers embodied scientific findings in their rationalisation of segregation. The intellectual politician, J.H. Hofmeyr, declared in 1929 that the challenge of science in Africa was to help determine 'the lines along which white and coloured races can best live together in harmony and to their common advantage'.<sup>26</sup>

It was influences such as these that led Leonard Thompson to conclude that before 1948 'there were no fundamental, generic differences' between the racial assumptions of Afrikaners and of other white South Africans. Such differences as existed, he suggests, 'were more a matter of occupation, class and regional milieu than of ethnicity'. Most simply assumed that they were members of a race that was superior to that of other races in Africa.<sup>27</sup>

After the Second World War racist physical anthropology became discredited. The terrible racist logic of the Nazi Holocaust did much to turn minds against such ideologies. The development of genetics also gave new directions to scientific thinking

'Strongly informed by the 1952 UNESCO statements on race, the new discourse embraced keywords such as gene "pools", "clusters", "flows" and "breeding populations". This vocabulary indicated a departure from the static associations of typological analysis, and a new emphasis on the dynamic plasticity of human

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<sup>25</sup> Dubow, *Scientific Racism*, 42, 51.

<sup>26</sup> *Ibid.*, 14-17.

<sup>27</sup> Thompson, *Political Mythology*, 100.

populations. The “races of man” paradigm was openly disavowed and replaced by “populations” and “ethnic groups”. These were said to “grade into one another to such an extent that races or sub-species as normally defined in zoology”, were “meaningless when applied to anthropology”.<sup>28</sup>

Men like Drennan, Dubow suggests, struggled to adjust to these trends, still clinging to notions of racial diversity, where genetics now emphasised unity. And these ideas about racial typology and consequent racial hierarchy lingered on into the 1960s. Colleagues were often slow to disavow the work of their eminent mentors. Dubow has pointed to the ambiguity in Phillip Tobias's statements about Dart.<sup>29</sup> At UCT, J.H. Louw's history of the UCT Medical School gives no hint that Drennan's researches had become discredited.<sup>30</sup>

The above discussion is not to suggest that racist physical anthropology formed part of the undergraduate medical curriculum. Indeed, one student noted that when he was examined by Dart in anatomy, he knew nothing of the Taung skull and the 'missing link problem'.<sup>31</sup> Medical students were educated at home, in school and at university in a context in which differences between the races was taken for granted and the inherent superiority of 'Europeans' assumed. The road to change was long and slow.

### ***Between the wars***

The first half of the twentieth century saw the rapid consolidation of mining as the predominant force in the economy of the country, predicated on the super-exploitation of black labour. While racial discrimination was the official policy of successive governments, , the implementation of racial discrimination was widespread and systemic under apartheid. Political resistance to racial oppression was manifested mainly in non-violent appeals to the white ruling authorities, premised on liberal notions of fairness and justice for the indigenous population that had formed part of the rhetoric of justification for British colonial expansion. Not surprisingly, such efforts were ineffective in halting

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<sup>28</sup> Dubow, *Scientific Racism*, 65.

<sup>29</sup> Dubow, 'Human origins', 262, 273-274.

<sup>30</sup> J.H. Louw, *In the Shadow of Table Mountain. A History of the University of Cape Town Medical School and its Associated Teaching Hospitals up to 1950, with Glimpses into the Future* (Cape Town, Struik, 1969), 261.

<sup>31</sup> R.E. Kirsch and C. Knox, *UCT Medical School at 75* (Cape Town, Department of Medicine, University of Cape Town, 1987), 207.

the growth of white exclusionary politics that was manifested in the subsequent ascent to power of the National Party in 1948, and its apartheid policies.

Initially Union in 1910 did little for the advance of medicine. The early Union governments, dominated by ex-Republicans who had placed relatively little store by a well-developed medical bureaucracy, failed to establish medical practice on a national footing before the First World War. Only after the scandalous mortality of the 1918 Spanish influenza epidemic revealed how poor the health status of the Union was, did the government establish a national Department of Health.<sup>32</sup> The gradual realisation that the migrant labour system, combined with viciously unhealthy conditions on the mines, was undermining the economic security of the country, led to the establishment of research institutions to investigate industrial health. Even so, tuberculosis especially, took an increasing toll of South Africa's workers, not only on the mines but more and more in the rural areas as well as a result of desperate conditions under which the rural population were increasingly forced to live.<sup>33</sup>

Tuberculosis was not the only reason for the poor health of South African blacks. During the interwar years a symbiotic process occurred in which poor whites were empowered while blacks lost most of the little access they had to wealth and power. The 1913 Land Act was crucial in removing Africans from land outside the designated reserves and forcing them into the overcrowded black territories. The right to work in the towns was circumscribed by the Urban Areas legislation which was based on the premise that Africans should only be allowed into the towns to provide labour for white industry and business. The pass system has an ancient history in South Africa, but it was more strictly enforced now and Africans were largely confined to designated townships. It is true that some inner city areas like Sophiatown survived but, as segregation tightened its grip, this became less common. Africans remained in the towns largely because state structures were not yet sufficiently well funded to enforce the law rigorously.

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<sup>32</sup> H. Phillips, ' "Black October": the impact of the Spanish influenza epidemic of 1918 on South Africa', *Archives Year Book for South African History*, I, (1990).

<sup>33</sup> R.M. Packard, 'Industrialization, rural poverty and tuberculosis in South Africa, 1850-1950', 104-30 and S. Marks and N. Andersson, 'Industrialization, rural health, and the 1944 National Health Services Commission in South Africa', 131-162, both in S. Feierman and J.M. Janzen (eds), *The Social Basis of Healing in Africa* (Berkeley, University of California Press, 1992), 104-130.

Coloured people and Indians were particularly affected by government programmes to uplift poor whites during the interwar years. Sub-economic housing was usually built for whites while coloured people were left to the increasingly depressed inner-city slums, especially in areas like District Six in Cape Town. More serious was the institution of job reservation. Young coloured boys found it almost impossible to get apprenticeships; white women replaced coloured in the factories. The result was unemployment and impoverishment which was reaching crisis proportions by 1939. During the 1930s, in the wake of the Great Depression, which had hit South Africa particularly hard, both social services (mainly for whites) and social science as a discipline had evolved. At the Universities of Cape Town and Stellenbosch departments of sociology were established (that at Stellenbosch under the young academic, Dr Verwoerd). At UCT Professor Edward Batson instituted a social survey of Cape Town which was published during the Second World War and which revealed starkly the terrible poverty which now existed amongst Cape Town's coloured population. Even those in employment usually earned pitiful incomes, while young men had little hope of finding jobs. Their plight contributed to growing social problems in Cape Town, long before the apartheid removals tore communities apart.

It was against this background that the UCT Medical School was established, first in the opening of the anatomical and physiological laboratories at UCT in 1912<sup>34</sup> and later in the formal founding of the Medical School in 1920. There is no need here to trace its origins.<sup>35</sup> Other aspects of the Medical School will be discussed later. The academic life of the School was dissociated from the broader political developments occurring in South Africa. Reading the Faculty Board minutes, for instance, there is little to indicate that the diseases of poverty were the primary health concerns of the country; that tuberculosis was rife in Cape Town and that infant mortality rates were unacceptably high. To put it bluntly, the doctors being trained at UCT were better fitted for general practice in Europe than South Africa.<sup>36</sup> This is not to say that the Medical School was ignorant of the

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<sup>34</sup> Ncayiyana D. (1999). Medical education challenges in South Africa. *Medical Education* 33:713-715

<sup>35</sup> Louw, *In the Shadow of Table Mountain*; Phillips, *The University of Cape Town*, 84-6.

<sup>36</sup> See the section dealing with medical training. UCT medical students expected to work amongst whites in the towns, not amongst blacks in the rural areas.

poverty and deprivation that existed in Cape Town. Of course it was not - staff and students encountered these problems daily in the city's hospitals - but medical training was not, in the first instance, directed to coping with them.

There was one political issue which was, however, beginning to impinge on the consciousness of the Medical School. This was the growth of Afrikaner nationalism. Afrikaner nationalists were particularly sensitive to the fact that, although South Africans could now obtain their medical training in South Africa, they received it in English, despite the fact that, by 1938, 20% of students at WITS and 33% of students at UCT were Afrikaners<sup>37</sup>.

Demands for medical schools at the Universities of Pretoria and later Stellenbosch, had as much to do with the feeling that, in a modern South Africa, Afrikaners had the right to an Afrikaans medical education, as it had to do with the need to increase the number of practitioners in the country. The Botha Commission of 1939 argued that the State had a constitutional duty to provide an Afrikaans medical education.

'For broadly national (in the sense of doing justice to both sections of the people in the matter of language), cultural and educational reasons, therefore, it is the duty of the State through its medical schools to provide Afrikaans medium medical training. If this premise is accepted - and we cannot imagine anybody questioning it - then it becomes a question of how this provision is to be made.'<sup>38</sup>

Both the Federal Council of MASA and the *SAMJ* agreed that the University of Pretoria was the suitable institution for an Afrikaans medical school<sup>39</sup> UCT made a bid to preserve its turf by offering first-year classes in Afrikaans. At first, despite their numbers, Afrikaans medical students were slow to opt for first-year classes in Afrikaans since it was felt to be a hindrance when the rest of the training was in English.<sup>40</sup> Nevertheless, even after the Pretoria medical school was established in 1938, the number of Afrikaans

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<sup>37</sup> UG 25-1939, *Report of the Committee on Medical Training in South Africa*, 49.

<sup>38</sup> *Ibid.*, 31.

<sup>39</sup> Murray, *The Early Years*, 324-5.

<sup>40</sup> UCT Administration Archives [AA], Medical Faculty Board minutes, 15 March 1933.

medical students increased during the war years and by 1948 first-year parallel-medium classes had become more popular.<sup>41</sup>

Quite apart from the political issue, by the 1930s it was obvious that UCT and Wits could not produce enough graduates to satisfy South Africa's needs. The issue was spelt out in two commissions in the interwar years, the Loram Commission of 1928 which investigated black medical training, and the Botha Commission of 1939, inquiring into all medical education.<sup>42</sup> The situation was, in fact, not very different from that which existed at the end of the twentieth century.

The 1939 Botha Commission estimated that there was a doctor-patient ratio of about 1:5000 for the whole population and 1:1000 for whites only. However, since doctors were largely confined to the towns, the situation in the rural areas, particularly in the African territories, was very different. Here it was calculated that the doctor-patient ratio stood at about 1:60-70,000 people. Both humanity and self-interest were involved. Many Africans died without treatment. 'They are left in the hands of the Native herbalist who too often combines with his rude art the practices of the Witch doctor.' As a result the mortality rate was unacceptably high. 'Indeed, it was stated by the magistrate in one district that the general death rate had actually overtaken the birth rate.'<sup>43</sup>

Both Commissions concluded that the only remedy was a state-sponsored medical scheme for blacks.

'In considering the availability of medical practitioners to the population we must again point to the economic factor which in the last resort determines these ratios. We have no reason to believe that the doctors are influenced in their opinion by selfish and commercial motives. The medical profession is no longer the Eldorado which it was once upon a time. Medical training is an expensive business and the doctor must live. There is a comparatively small number of doctors who work above their capacity and earn thousands of pounds every year, but the income of the great majority is not such as can be considered attractive to people with money-making intentions. Unless, therefore, the State can initiate a scheme by which medical men can obtain full-time government

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<sup>41</sup> Phillips, *The University of Cape Town*, 323.

<sup>42</sup> UG 35-1928, *Report of the Committee Appointed to Inquire into the Training of Natives in Medicine and Public Health*; UG 25-1939.

<sup>43</sup> UG 35-1928, 5.

employment, we must reluctantly conclude that the country cannot under present conditions absorb a material increase in the number of medical practitioners.<sup>44</sup>

What was really at issue was the training and employment of black health care workers. Some of the racial questions had already been confronted by the nursing profession. Was it appropriate for white nurses to tend black patients? Natal particularly had been strongly opposed to this practice but in the early 1900s it was too expensive to keep hospitals completely segregated and the nurses themselves did not usually object to black charges.<sup>45</sup> The attitude of the nurses was very different when it came to black doctors, however. When Dr Silas Molema admitted white patients into the Victoria Hospital in Mafeking in 1927, the entire nursing body, including the matron, resigned. They refused either to be ordered by a black doctor or to assist him in treating white patients - the patients themselves did not apparently object.<sup>46</sup> This episode became the benchmark against which the issue of black doctors in white wards was measured. Provincial Administrations seized the opportunity to introduce legislation which gave hospital boards the authority to refuse admission to doctors who were not on the hospital staff. This proved to be a convenient tool to keep out black medical students as well as black doctors.<sup>47</sup>

In the Cape the matter became further politicised since Afrikaner nationalists dominated in the provincial bodies which governed hospitals. In 1938 the Provincial Council instructed the Cape hospitals to use black servants where there were no black nurses to tend black patients. Both the Trained Nurses' Association and the medical profession were outraged. Louis Leipoldt, then editor of the *SAMJ*, declared it 'a monstrous suggestion that decency and humanity must disappear when confronted with colour. One stands aghast at a mentality apparently unable to regard non-Europeans in human terms and that projects its own obsessions on members of an honourable profession.'<sup>48</sup> To some, the obvious solution was to train black nurses, but for years the various authorities jibbed

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<sup>44</sup> UG 25-1939, 5.

<sup>45</sup> S. Marks, *Divided Sisterhood: the Nursing Profession and the Making of Apartheid in South Africa* (London, Macmillan, 1994), 49-56.

<sup>46</sup> *Ibid.*, 59-60.

<sup>47</sup> Murray, *The Early Years*, 302.

<sup>48</sup> Marks, *Divided Sisterhood*, 60-61.

at the financial investment involved. Ironically it was Afrikaners rather than blacks who were recruited into the nursing profession in the interwar years. As with black doctors, black nurses only began to be trained on a substantial scale after the Second World War.

The Botha Commission, the members of whom were all medical men, is a study in moderate, 'rational' racism. The language is judicious, steering its way carefully between extremes of right and left. The classification of Europeans as negrophiles or negrophobes vitiated serious discussion and stifled action, the Commission believed.<sup>49</sup> But South African racism was not to be challenged. 'This social colour bar is as stubborn a fact as any that can be imagined and must simply be accepted without argument', the Commissioners considered. All the discussion which followed was based on this premise. Not surprisingly, it led to contradictions in their thinking on black medical training. On the one hand they recognised the need to train black medical students, who, at the time, could only obtain their qualifications abroad, an undesirable situation on a number of counts, the Commissioners felt. It was expensive and black students were exposed to influences which fitted them ill for life in racist South Africa. 'Without going into the question of the sociological dangers which may be attached to a five or six years sojourn in a country which does not know and cannot appreciate social segregation on the ground of colour and all that it implies, it would be safe to say that for medical reasons it would be better if non-Europeans could be trained in South Africa.'<sup>50</sup> Overseas medical students would not encounter the diseases of poverty which were so rife in South Africa. Moreover it was difficult to find places in European medical schools and the Commissioners recognised that they had not right to expect concessions from European schools which they were not willing to make themselves.

The harsh reality, however, was that the poor black schooling system ensured that only a handful of blacks ever obtained matriculation, let alone gained the marks they needed to enter Wits or UCT. In 1928 the Loram Commission anticipated that there would be no more than five students a year available for the next five years.<sup>51</sup> The situation had improved little in the 1930s. Between 1933 and 1937 a total of 465 blacks matriculated -

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<sup>49</sup> UG 25-1939, 38.

<sup>50</sup> Ibid.

213 Africans, 156 coloured students and 96 Indians.<sup>52</sup> The numbers were too small to make a black medical school viable. UCT and Wits both expressed a willingness to train black students provided that they were taught in separate classes (funded by the state). Unfortunately there was another obstacle in that the provincial administrations, mindful of the Mafeking debacle, refused to allow black students to have anything to do with white patients. Until the hospitals were willing to make facilities available, clinical training was impossible. Given their view that colour prejudice must simply be accepted, neither the Commission members nor the universities were willing to press the matter further.

The result was that the members of both Commissions were forced to rationalise other options. There was no point in training doctors to treat blacks since the great majority of Africans did not use Western Medicine, they claimed. Africans still believed in their diviners and herbalists and were not willing to submit to scientific medical treatment, the Botha Commission argued. Moreover, most could not afford medical treatment. It was up to the State, the Commission concluded, to educate Africans into the meaning of health and to provide health services for them. As with the nurses, much of the debate centred on the training of health care assistants rather than fully-qualified doctors. Their role would be to teach Africans clean and healthy living, the Botha Commission argued; to prepare them to accept Western medical care. Underlying the discussion, however, was the feeling that Africans, suitably acculturated into accepting Western medicine, would provide useful livings for white practitioners. To the Loram Commission such work was 'honourable to the European and advantageous to the Native.'<sup>53</sup> The Botha Commission was more direct:

'The contention that non-Europeans are more capable or serving their own people in any capacity than are Europeans, is disputed by many who are not only friendly disposed towards, but also have intimate experience of them. It has been contended, on the contrary, that the christianised Native is less acceptable to the mass of his people than the European, and that he often has less sympathy with their primitive habits and customs. For essentially the difference between the tribal Native and the European is not so much

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<sup>51</sup> UG 35-1928, 9.

<sup>52</sup> UG 25-1939, 39.

one of race, language and colour, but rather of what we vaguely call civilisation or culture. The point we wish to make here is that the medical interests of non-Europeans need not be neglected on the ground of the lack of medical practitioners of their own race.<sup>54</sup>

Conversely, although this was not mentioned in the Commission reports, there was a very real fear that white practitioners might lose white patients to black doctors.<sup>55</sup> The logical conclusion was that it was better to create an Afrikaans medical school in Pretoria than to train black doctors.

UCT's stance in the debate was ambiguous. The University had been advised that its constitution did not give it the right to exclude students on grounds of race. From 1921 the policy was, rather, to persuade black applicants that the University could not offer them appropriate facilities to complete their training. In 1921 an Indian applicant was turned away, as were Africans consistently for years, even after coloured and Indian students were admitted. At a special meeting in 1927 the UCT Medical Faculty had recommended that 'it was not desirable that natives be admitted to the existing medical classes at the University'. The Medical School preferred, in fact, that a separate medical school be established for black students and that the standard should be the same as that at existing medical schools.<sup>56</sup> It was essentially these resolutions which were incorporated into the report of the Loram Commission. The Commission noted that UCT had formally resolved that Africans should be trained in South Africa rather than overseas, to the same standards as whites, but that an African medical school was inadvisable since it could not offer the facilities of the existing schools. UCT was willing to offer parallel classes for the pre-clinical years but it had no suggestions to get round the problem of clinical teaching. The Loram Commission, however, thought that blacks were more appropriately located at Wits, where more clinical material was available and which was closer to the black reserves.<sup>57</sup> In the event UCT continued to refuse admission to black medical students in the 1930s. In 1931 A. Minikulu, for instance, was advised that, although his

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<sup>53</sup> UG 35-1928, 16.

<sup>54</sup> UG 25-1939, 38.

<sup>55</sup> Murray, *The Early Years*, 301.

<sup>56</sup> AA, Medical Faculty Board minutes, 12 May 1927.

<sup>57</sup> UG 35-1928, 15-16.

son, who had completed his first year, could be admitted for the second and third years, there was no point since he could not complete his clinical training at UCT because of the shortage of clinical beds.<sup>58</sup>

It is probable that the Medical School had not given the matter very serious attention before the 1930s, for it was only after a series of applications from black students in the early 1930s that the question was raised about the willingness of the hospital authorities to allow black students into the wards. Prior to that the excuse had always been that there was insufficient clinical material. This was true enough but it was not given as an excuse in the 1940s when black students were admitted and the problem of enough clinical beds was once again acute. In the event, when UCT did inquire in the 1930s, the Cape Hospital Board refused admission to black students, a situation which UCT accepted without protest.<sup>59</sup> Murray suggests that, prior to the war, UCT, rather than Wits, had led the way in taking in black students although Wits accepted its first coloured medical student in 1926. In 1937 there were forty black students at UCT, mainly coloured, and only ten at Wits, five coloured and five Indian.<sup>60</sup> This 'openness' was very limited, however. In the first place no African was admitted to either medical school. Secondly, black students were still not allowed to undertake their clinical training in the Cape hospitals.

J.H. Louw's treatment of admissions policy is indicative of the denial which still existed in the Medical School of the 1960s. By this time the University had taken a stand as an 'open' university, and Louw treats the whole question as though UCT had had an open admissions policy since the 1920s. 'Since 1921 many non-White students have been admitted to all faculties of the university, including the medical faculty', he claims. Later on he wrote, 'It should be noted that since its inception the University of Cape Town admitted non-White as well as White students and subscribed in the strongest terms to the system of university autonomy, under which it is free to choose its own staff, to decide the nature of its curricula and to select its own students from among those who are

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<sup>58</sup> AA, Medical Faculty Board minutes, 11 March 1931.

<sup>59</sup> Ibid., 7 October 1931, 5 April 1932, 9 May 1932, 5 October 1932, 15 March 1932.

<sup>60</sup> Murray, *The Early Years*, 298-9, 302, 316-7.

academically qualified, irrespective of race, colour and creed.<sup>61</sup> This was far from the case.

By 1939 little had changed. Before the Second World War a handful of black medical students entered UCT Medical School. In 1939 six coloured and six Indian students were admitted although at the time they still had to complete their clinical training abroad.<sup>62</sup> Other medical institutions varied in their response to the question. Leipoldt, as editor of the *SAMJ*, was consistently liberal in his attitude to black education, even questioning the need for separate classes but MASA itself was much more reactionary, supporting a second-grade black medical education.<sup>63</sup>

Murray notes that the Second World War transformed the situation for black medical students. During the war it was impossible for them to obtain their training abroad. Both UCT and Wits were forced, to some extent, to revise their policies. Black students themselves no longer took the prohibition lying down. By the 1940s they were becoming more militant, with a Non-European Medical Students Vigilance Committee, led by B.M. Kies, to campaign actively for students to be admitted to the clinical years.<sup>64</sup>

Things changed when the new hospital was opened at Groote Schuur. From 1943 Coloured and Indian students were allowed into the 'non-European' hospital wards, on condition that they had no contact in any way with white patients, even post mortem.<sup>65</sup> Given the large number of Afrikaans students at the Medical School in the 1940s, this proviso was easily and closely monitored and the Medical School went to 'grotesque lengths', Phillips notes, to ensure that the rule was kept. Even staff members of markedly left-wing views complied unquestioningly. There was reason for being careful. In 1944 there was a public outcry, with letters in *Die Burger* and a question in parliament, regarding the presence of black students during an operation on a white child. The furore

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<sup>61</sup> Louw, *In the Shadow of Table Mountain*, 300.

<sup>62</sup> *Ibid.*, 145.

<sup>63</sup> Murray, *The Early Years*, 307.

<sup>64</sup> AA, Principal's Office, Admission of students, F2/1, B.M. Kies to the Registrar, 2 February 1943.

<sup>65</sup> AA, Medical Faculty Board minutes, 8 October 1942, 9 March 1943

died down when the students concerned explained that they had not realised the child was white, but it was a warning of which the University took heed.<sup>66</sup>

In 1947 the Medical School had believed that this arrangement would be temporary but segregated teaching continued through to the 1960s.<sup>67</sup> The students admitted in 1939 were able, however, to complete their training at UCT. By 1944 there were ninety-four black students registered at UCT, of whom twenty-four were in the Medical Faculty. In December 1945 M. Samy-Padiachy, RAAR. Lawrence and C.H. Saib were the first to obtain the M.B., Ch.B.<sup>68</sup>

### ***The apartheid years***

The Second World War had a significant impact on the political environment in South Africa, temporarily suspending the increasingly powerful moves towards the institutionalisation of racial discrimination. National patriotism in the effort against the Nazis briefly united the country with the result that the political groupings such as the Communist Party, fighting for the rights of black people, were accepted into the dominant political discourse of the time. As we have seen, the changed political and economic environment meant that some opportunities previously denied on the basis of race were opened for black South Africans as a result of the exigencies of the war economy.

However, the brief period of the loosening of racial discrimination came to a rapid end with the ascendancy to power of the National Party government in 1948, and the introduction of a host of racially discriminatory laws in the decades to follow. The ushering in of the apartheid state was to have the most profound impact on the training of health professionals, both black and white, for the coming decades.

The Population Registration Act of 1950 formed the bedrock of the apartheid state in providing for the classification of every South African into one of four racial categories. Access to societal resources (housing, education, health care, etc.) was then defined by

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<sup>66</sup> AA, Medical Faculty Board minutes, 29 February 1944, 13 March 1943.

<sup>67</sup> AA, Principal's Office, Admission of students F2/1, Registrar to Town Clerk, East London, 16 April 1947; Phillips, *The University of Cape Town*, 323.

race group. In terms of the 1950 Group Areas Act the entire country was demarcated into zones for exclusive occupation by designated racial groups. Implemented from 1954, the result was mass population transfers involving the uprooting mainly of black citizens and the resulting destruction of communities.<sup>69</sup> For medical students, this Act further restricted opportunities for training through limiting where and how students could live, make use of public transport or gain access to health facilities. Other legislation included the 1950 Immorality Amendment Act; the 1949 Prohibition of Mixed Marriages Act; the 1953 Separate Amenities Act; and the 1953 Bantu Education Act<sup>70</sup>.

Perhaps the most noteworthy apartheid legislation which affected students in this period was the 1959 Extension of University Education Act which denied black students the right to attend their university of choice. It therefore became illegal for white universities to admit black students except with ministerial permission.<sup>71</sup>

During this period, resistant to apartheid rule shifted from the strategies of negotiation and reasoning to that of mass mobilisation and protest politics. In 1943 the ANC's Youth League was formed and by 1949 they had adopted a programme of action relying on the strategy of mass mobilisation.<sup>72</sup> In 1952 a defiance campaign was launched led by Nelson Mandela and others. This was followed by major school boycotts in 1955 and an anti-pass campaign in 1959. These civil disobedience actions resulted in an increase in support of the ANC and the Youth League. In 1955 there were many bannings and the Congress of the People was held, where the ANC aligned itself with representatives from all the race groups and the Freedom Charter was adopted.<sup>73</sup>

The war years had done more than open the medical schools to black students. They had also seen great changes in the attitude to social welfare. In an age of total war, when the entire population is committed to the war effort, it has been common for governments to promote war as a means of change. The old inequalities will be swept away and better things will follow. The Second World War was no exception and in Britain, particularly,

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<sup>68</sup> Louw, *In the Shadow of Table Mountain*, 300.

<sup>69</sup> TRC, *Report*, Vol.1, chap. 2.

<sup>70</sup> Ibid.

<sup>71</sup> Ibid.

<sup>72</sup> Marx, 1992.

plans for the welfare state were publicised. Most famous was the Beveridge Report which promised 'cradle to the grave' welfare, including a national health system. South Africa was by no means immune to these influences. After the German invasion of Russia in 1941 and the alliance with Soviet Russia, South African communists were free to promote their ideas more publicly. All this hastened the slow shifts in thought which had been occurring in some quarters long before, particularly in relation to socialised medicine. Both the Loram and Botha Commissions had accepted that only a state health system could remedy the deficiencies in medical care for blacks. At UCT men like Batson were also promoting the idea of some form of social security. But it was on the Rand that new ideas about the management of health in South Africa came. Amongst the pioneers were Sidney and Emily Kark who had established the first health centre at Pholela in Natal just before the war. In the Department of Health men like Eustace Cluver, Secretary of Health, 1938-1940, Harry Gear, Deputy Chief Medical Officer from 1939, and George Gale, Chief Medical Officer and Secretary for Health in 1946, were all key figures. Smuts's Minister for Health, Dr Henry Gluckman, described by Shula Marks as South Africa's only progressive Minister of Health before 1994, was another crucial figure.<sup>74</sup> Yet another factor was the visit of Henry Sigerist in 1937-1938, as a guest of the South African Students' Visiting Lecturers' Trust Fund. Described by the *Cape Argus* as the 'foremost apostle of socialised medicine', he did much to inspire younger doctors at UCT and Wits. Social medicine, Marks suggests, 'had within it a liberatory potential which inspired and excited the younger, more radical members of the medical community, surrounded as they were by the disease consequences of rapid industrialisation and rural impoverishment'.<sup>75</sup>

Marks argues that, in the field of social medicine, 'for just over a decade in the mid-century, South Africa was widely acknowledged as being in the forefront of international progressive thought, its distinctive social conditions and developed medical practice

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<sup>73</sup> Ibid.

<sup>74</sup> S. Marks, 'Doctors and the state: George Gale and South Africa's experiment in social medicine' in S. Dubow (ed.), *Science and Society in Southern Africa* (Manchester, Manchester University Press, 2000), 189.

<sup>75</sup> Marks, 'Doctors and the state', 198.

making possible an experiment in social medicine with far-reaching implications'.<sup>76</sup> It was in the context of the rising tide of African ill health that a health clinic was established at Pholela by the Karks as an experiment in social medicine. The health clinics were initially promoted by Cluver and Gale as an inexpensive way of treating Africans, rather than hospitalising them.<sup>77</sup>

The war years also saw some radicalisation of the medical profession. The Federal Council of MASA set up a planning committee to consider a future national health policy for the Union, the *SAMJ* ran a series of articles on the same subject, MASA published a pamphlet advocating a national health service controlled by the medical practitioners. Then, in 1942 the government set up the 'National Health Services Commission on the Provision of an Organized National Health Service for all Sections of the People of the Union of South Africa' under the chairmanship of Dr Henry Gluckman.<sup>78</sup> The report of the Gluckman Commission offered a vision of health care based on about 400 health centres throughout South Africa - in effect a system of primary health care very different from the hospital-based system which then existed.

The vision of the Commission was never implemented although about fifty health clinics were established in the post-war years, including one at Grassy Park in Cape Town. In Durban the Karks set up an Institute of Family and Community Health, intended to establish a comprehensive system of health care for the entire Durban community, and to train health workers.<sup>79</sup> But Smuts was never wholly behind the report and he allowed the conservative provinces to retain control of the hospital services.<sup>80</sup> The Nationalist government which came into power in 1948 had little interest in social medicine and the clinics were slowly closed down or absorbed into the existing system.

This brief experiment in social medicine had one other outcome. In 1951 the long-discussed medical school for blacks was established at the University of Natal. The Brebner Commission of 1948, which inquired into the conduct of teaching hospitals and

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<sup>76</sup> *Ibid.*, 188.

<sup>77</sup> *Ibid.*, 196.

<sup>78</sup> UG 30-1944.

<sup>79</sup> Marks, '1944 Health Commission' 157.

<sup>80</sup> Marks, 'Doctors and the state', 201-2; Marks, '1944 Health Commission', 156.

medical schools, had stressed the inclusion of preventive and social medicine in the curriculum. Students were encouraged to establish and maintain health centres like SHAWCO.<sup>81</sup> The Natal Medical School was to follow these guidelines; it was not to be a 'feeble replica' of the existing schools. Instead it was to move away from the curative, hospital-based approach to promote social medicine, 'the medicine of the future'.<sup>82</sup> George Gale became the new Dean and it was his vision which permeated the school in its early days. But Gale did not last long in Natal, his tenure foundering on financial rocks. The establishment of the Durban Medical School did, however, let UCT off the hook as far as African students were concerned. It was no longer necessary to make embarrassed refusals to Africans wishing to study medicine at UCT. The first African medical student was only admitted to UCT in 1985.<sup>83</sup>

UCT Medical School did not escape these winds of change in medicine entirely although they left remarkably little mark on the teaching curriculum. During the war years blacks had migrated into Cape Town in unprecedented numbers in response to the wartime demand for labour. Many had settled on the Cape Flats, in the Kensington-Windemere area, where a large mixed population of squatters built their shanties. Badly flooded in winter, living conditions were dire and Cape Town Municipality was forced to absorb the area into the municipality in order to provide some basic services. UCT medical students also responded to the crisis, setting up a medical clinic in Kensington-Windemere in 1943. The clinic expanded rapidly although neither the UCT Principal nor the Dean of the Medical Faculty was prepared, at first, to acknowledge it as a legitimate activity of the medical students. Subsequently social work students also became involved, the organisation eventually expanding into the Students' Health and Welfare Centres Organisation [SHAWCO].<sup>84</sup>

One other change at UCT Medical School had some limited impact. This was the appointment of J.R. Brock as Professor of Medicine in 1938. Brock had been an assistant

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<sup>81</sup> Louw, *In the Shadow of Table Mountain*, 302.

<sup>82</sup> Marks, 'Doctors and the state', 204.

<sup>83</sup> L. London et al, *Truth and Reconciliation, a Process of Transformation at UCT Health Sciences Faculty* (Cape Town, University of Cape Town, 2003), 19.

<sup>84</sup> E. van Heyningen, *The History of SHAWCO 1943-1975* (Cape Town, SHAWCO, 1975).

of John Ryle in Cambridge, the latter holding the first chair in social medicine in Oxford. Ironically, an influence on Ryle's thinking, as with a number of other contemporary social reformers, was Smuts's philosophy of holism.<sup>85</sup> For a brief moment it was hoped that the Rockefeller Foundation, which funded the Durban Medical School, might subsidise a social medicine unit at UCT, but the proposal was abandoned because of the relatively small number of Africans in Cape Town.<sup>86</sup> Nor was UCT generous in research funding. However, Brock was able to embark on a major project on nutrition with funding from the Union Department of Public Health.<sup>87</sup> In 1949 he headed a Clinical Nutrition Research Unit and in 1950 he was commissioned by the WHO to investigate kwashiorkor in Africa. Despite its remoteness from the rest of Africa, Brock considered Cape Town well placed for such work. Scurvy was rife in the town and Cape Town was 'one of the meeting places of old and new cultures' which displayed 'differences of dietary habit and nutrient availability'.<sup>88</sup>

For years Brock urged UCT to make social medicine a more prominent part of the medical curriculum. In 1948 he put forward a strong memo on the teaching of social medicine at UCT. 'One of our basic proposals is that throughout undergraduate and postgraduate education, emphasis must be placed on the acquisition of a sound knowledge of all measures that may make and preserve a healthy nation; that these measures must be regarded as part of the concept of Medicine, and that they should be the subject of wide and intensive research', he urged. Mindful of financial constraints (and perhaps the views of his colleagues), Brock did not advocate the establishment of a new Department. More important, he considered, was a new philosophy which should permeate the teaching of medicine. At this stage he envisaged a 'People's Centre' in Goodwood, to be funded by the National War Memorial Health Foundation, along the lines of the Pholela Clinic. The People's Centre would be 'a pilot centre to demonstrate how disease prevention and health promotion can be forwarded by voluntary survey and

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<sup>85</sup> Marks, 'Doctors and the state', 189, 204.

<sup>86</sup> *Ibid.*, 204.

<sup>87</sup> Phillips, 324.

<sup>88</sup> *Ibid.*, 335-6.

service, guided by technical experts'. Although the Faculty approved the proposal, little came of Brock's proposals or the Goodwood Centre.<sup>89</sup>

A few years later Brock turned to the SHAWCO clinic as a suitable health centre to play a much larger role in University teaching.<sup>90</sup> A medical officer was appointed with the special duty of developing social medicine work and teaching.<sup>91</sup> At SHAWCO Dr H.T. Phillips took up the baton for a number of years. Although a UCT graduate, Phillips had worked in Durban with the family health centre movement, whose principles he promoted at SHAWCO. In 1955, for instance, he planned to initiate a scheme which would familiarise more students with social medicine.<sup>92</sup> Like so many health centre advocates, he emigrated in the 1950s and, after his departure the scheme was gradually abandoned. The Grassy Park Health Clinic, one of the Pholela-type health clinics, attracted almost no attention from UCT despite its innovatory services. Batson took a few students there but the Medical School seem never to have taken any interest in its existence.<sup>93</sup>

By the late 1950s none of these schemes had attained any prominence in the medical curriculum and even the teaching of public health was struggling to survive. In the anti-socialist atmosphere of the 1960s the term 'social medicine' fell away, to be replaced by 'comprehensive medicine'. The change in name did little to alter the situation and comprehensive medicine also had limited support.<sup>94</sup> UCT's reluctance to embrace social medicine may, perhaps, be summed up in an early Faculty Board resolution to the effect that 'all departments were emphasising the importance of the preventive aspects of their subjects'.<sup>95</sup> This was enough. UCT's focus in teaching remained firmly curative, based on the hospital. Although standards were high and UCT work was internationally recognised, it was not yet grappling with the major health issues of South Africa.

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<sup>89</sup> AA, Medical Faculty Board minutes, 3 May 1948, 3 June 1948.

<sup>90</sup> Ibid., 24 October 1952, Recommendations . . . arising out of the report of the committee appointed to consider the teaching of public health, preventive and social medicine.

<sup>91</sup> Ibid., 18 December 1952, 27 April 1954.

<sup>92</sup> E.J.Salber, *The Mind is Not the Heart. Recollections of a Woman Physician* (Durham and London, Duke University Press, 1989), 82-121; AA, Medical Faculty Board minutes, 28 October 1954.

<sup>93</sup> H. Phillips, 'The Grassy Park Health Centre: a peri-urban Pholela' (unpublished paper, 2003). I should like to thank Professor Phillips for making this paper available to me.

<sup>94</sup> AA, Medical Faculty Board minutes, 7 March 1967.

Admittedly, this was becoming increasingly difficult. As the homelands policy got under way, and power was devolved to the corrupt and incompetent governments of the Bantustans, health care in South Africa was fragmented more and more. Census data and vital statistics for much of South Africa's population was lean at best, entirely absent for large areas since 1910 or before. The management of a disease such as tuberculosis was rendered almost impossible by this fragmentation.

The 1950s were quiet years when the status quo in the Medical School went virtually unchallenged. The small number of black students admitted into the Medical School could be accommodated without difficulty. Such students were accepted in the face of stiff competition, when about half UCT's applicants for first year were turned away, the Medical School explained to J.G. Meiring, head of the newly-established University College of the Western Cape in 1964.<sup>96</sup> But numbers were increasing. By 1962 there were 157 black students enrolled in the Medical Faculty, at least three times as many as in any other faculty.<sup>97</sup> As a result new problems regarding admission were arising as black graduates sought to specialise. UCT medical staff were usually sympathetic to these requests but their approaches were couched in the discourse of apartheid, still assuming that separate facilities were right and proper. Thus, when one graduate wanted to specialise in psychiatry, the professor of the day explained:

'There is a great deal of mental illness amongst Coloureds - in fact tens of thousands of cases are dealt with annually in Cape Town alone, and there are many more, including alcoholics, who exist in the community without specialist psychiatric attention. However, there is not one trained Coloured psychiatrist in the entire country, and there is an urgent need to recruit and train Coloured medical practitioners for this speciality, especially as there is an acute shortage of psychiatrists in South Africa (there being less than 70 to cope with the needs of the whole country.)<sup>98</sup>

In 1968 UCT pointed out to yet another commission on medical education that there was an urgent need for facilities for black post-graduate training. The problem was a shortage

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<sup>95</sup> Ibid., 9 September 1924.

<sup>96</sup> Ibid., 25 August 1964.

<sup>97</sup> AA, Principal's Office, Admission of students F2/1, Vol 2, Registrar to Adv. A.H. Broeksma, 4 December 1962.

of clinical beds. The establishment of a medical school at Stellenbosch had already created difficulties; the possibility of a third medical school in the Western Cape filled the Medical School with dismay.<sup>99</sup> Above all the Medical School urged, black and white medical education should be considered together.

'The University of Cape Town has for many years trained Coloured and Asiatic medical students and is convinced the training offered these medical graduates is second to none. In spite of the difficulties encountered in conducting a medical curriculum attended by mixed racial groups the University is convinced that the results justify the inconveniences and would urge the Committee give very careful consideration to the full implications of the establishment of yet another Medical School in the Western Cape.'

There would appear to have been another consideration at work, however - the fear that standards might be lowered. Coloured students entering UCT Medical School did so in competition with whites, who benefited from a far better educational system. That this resulted in only a handful entering the School was not considered an issue. Between 1959 and 1964 about twenty-five coloured students were admitted each year, with only about six graduating (ten in 1963). 'The university regards it as desirable, in order that standards should be maintained, that these relatively well-qualified applicants should continue to face the stiff competition of UCT First Medical Year.'<sup>100</sup>

Exact figures of the numbers of black medical students at UCT are difficult to find. The proportion of black university students in South Africa as a whole, although greater than it had been in the 1940s, was in reality diminishing in comparison with whites. The number of black doctors was still very small and that of black medical students remained a tiny percentage of the whole.<sup>101</sup> In 1959, of 7789 medical practitioners in South Africa, only 67 were African and 93 Indian and coloured. Of 1371 medical students, 108 were African.<sup>102</sup>

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<sup>98</sup> AA, Medical Faculty Board minutes, 3 August 1965. 8; 22 April 1968, Memo of UCT Committee on the Commission on Medical Education.

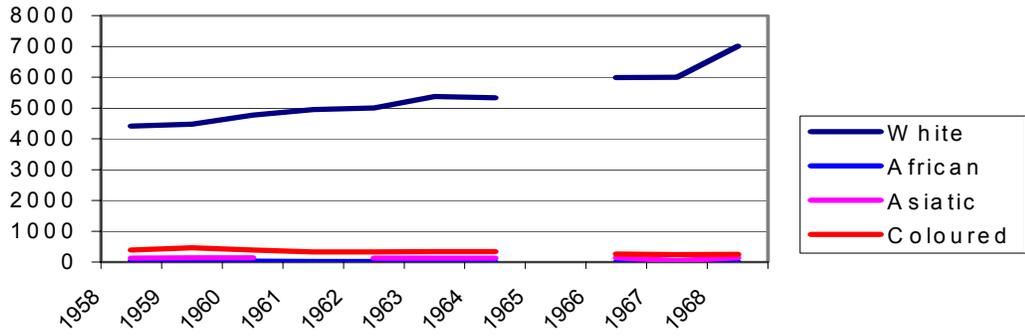
<sup>99</sup> Ibid., 22 April 1968.

<sup>100</sup> Ibid., 25 August 1964, draft reply to J.G. Meiring, Rector, University College of the Western Cape.

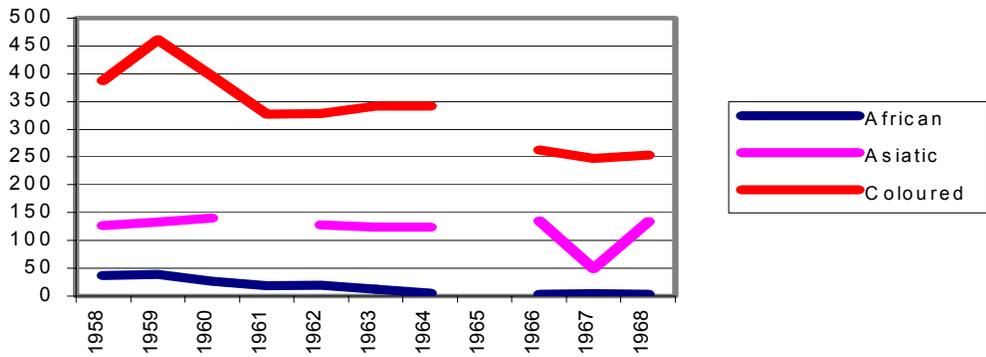
<sup>101</sup> AA, Principal's Office, Admission of students, F2, NUSAS Memo on the enrolment at South African Universities and University Colleges, 12 April 1969. These figures are problematic since the numbers of black enrolments seems very small indeed.

<sup>102</sup> Ibid., Association leaflet.

### Enrolment at South African Universities and University Colleges, 1958-1968



### Black enrolments 1958-1968



The issue of black post-graduate training remained unresolved until 1971, when Stuart Saunders invited Bryan Kies to be the registrar in neurology at Groote Schuur Hospital. Discrimination still existed, however, because Kies was not entitled to eat or sleep with his white colleagues. As more black students undertook their postgraduate training they began, nonetheless, to use such facilities as the doctors' bungalow. When the housekeeper objected, she was told she could resign and from this point most facilities were open to all. A crucial figure in desegregation at Groote Schuur was the medical superintendent, Dr J.G. Burger. Appointed as a Nationalist, he, nevertheless, supported Saunders and others in their efforts to end discrimination.<sup>103</sup>

By the end of the 1950s most of the key apartheid legislation had been put in place - the Population Registration Act (1950), Group Areas zoning (1950), the Reservation of Separate Amenities Act (1953), the Bantu Education Act (1953) which destroyed the mission schools. In 1951 Africans lost their remnants of parliamentary registration, as did Indians. From 1952 coloureds were also disenfranchised. The communist party was banned in 1950. The 1955 Natives (Urban Areas) Amendment Act restricted even further the right of Africans to remain in the cities. The result was an upsurge in popular protest and state repression. The ANC and the PAC were both banned, driving resistance underground and abroad. Many of the leaders who remained in the country were arrested and imprisoned on Robben Island. During this period, also, a number of segregated black universities opened, removing most black students from the white institutions. The opening of the University College of the Western Cape [UWC] affected UCT most directly. Many of the new institutions were plagued with student unrest; some were closed down for varying periods of time.

This era also saw the mushrooming of today's Historically Black Universities: Fort Hare (in Xhosa territory) had been in existence since the early years of the century; now followed Turfloop (for the Sotho, Tswana), Zululand (for the Zulu), Durban-Westville (for the Indians), Western Cape (for the Coloureds).

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<sup>103</sup> S. Saunders, *Vice-Chancellor on a Tighrope. A Personal Account of Climatic Years in South Africa* (Cape Town, David Philip, 2000), 66, 95.

At the end of the 1950s the 'liberal' universities were confronted directly by apartheid planning when the Extension of the University Education Act of 1958 was passed, prohibiting black students from admission into white universities and providing for racially-based black institutions.<sup>104</sup> For the first time, the University really confronted the implications of its claim to be an 'open' university. Led by the principal, T.B. Davie, UCT put up a sustained protest against the Act. Representatives of UCT and Wits met in Cape Town to discuss the Bill, the proceedings of which were recorded in *The Open Universities of South Africa*. In this document was presented carefully reasoned arguments in defence of the four essential freedoms formulated by the late Dr T.B. Davie: 'Freedom (of a university) to determine for itself on academic grounds who may teach, what may be taught, how it shall be taught and who may be admitted to study.'

In another act of demonstrated opposition to the Bill, on 7 June 1953 UCT marched through the streets of Cape Town, after the Bill was read a second time in Parliament in the same month. The procession of about 3 000 graduates, undergraduates, members of the staff and of Council moved up Adderley Street into Wale Street and Government Avenue to Hiddingh Hall. At its head marched the Chancellor, the Vice-Chancellor and Acting Principal, and the Chairman of the University Council. Subsequently other forms to protest against the Bill were held. Despite such resistance, the Bill was enacted.

Medical students were often at the forefront of these protests, Ralph Kirsch remembering that 'Many of our class took our turn at holding these [banners outside parliament] while others attended the debate wearing black arm bands mourning the death of academic freedom. I remember my anger at being asked to leave the Gallery and not return until I had removed the band from my jacket sleeve.'<sup>105</sup>

However, an upshot of the Separate University Education Bill was that, two years later, on 29 July 1959, the University of Cape Town formally dedicated itself to academic freedom. The dedication was signed by the Chancellor, the Chairman of Council, the

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<sup>104</sup> London, *Truth and Reconciliation*, 22.

<sup>105</sup> R.E. Kirsch (ed), *The Forman Years* (Cape Town, University of Cape Town Department of Medicine, 1984), 226.

Vice-Chancellor and the President of Convocation. This dedication, which was amended in 1973, is affirmed annually at the T.B. Davie Memorial Lecture.

But the university authorities apparently felt that they had gone far enough in resisting apartheid by encouraging an open academic environment. After T.B. Davie's death they were extremely reluctant to challenge social conventions. The Principal explained to the President of the SRC in 1958, 'Council has declared that it considers that in all non-academic or social affairs the University should abide by the customs and conventions of the community in which it exists.' The student leaders, however, were unwilling to accept this ruling. The following year the SRC expressed its dismay and refused to police student gatherings as the authorities considered that it should.

Since its inception the University of Cape Town has on no previous occasion resolved to treat students differentially on racial grounds in matters which have been within its jurisdiction and we find this acceptance of the "customs and conventions of this community" strangely in contrast with the spirit of a university and contrary to the policy and tradition which we have considered to have been accepted by the University of Cape Town. During the short history of this University, changes in the relationship between students have come about by a natural evolutionary process, and it is this same evolutionary process, neither impeded nor enforced by external agencies, which we wish to see continued in the University of Cape Town.<sup>106</sup>

How far was this ban to go, the students demanded. To Chess Club meetings? To meals in the Union cafés? To student committees? Nevertheless, black graduates had been prohibited from attending the Graduation Ball in 1959 and in the following year the Principal disallowed a mixed final-year Medical Students' Dinner. As a result an increasingly radical SRC passed a resolution protesting that the banning of the Medical Dinner was 'a seriously retrogressive step in student social relations' which was 'contrary to the principles for which the University claims it has been fighting.'<sup>107</sup> But the ban still held in 1962 when the students were again warned that mixing in sport as well as social functions was forbidden.<sup>108</sup>

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<sup>106</sup> AA, Principal's Office, Admission of students, F2/1, vol. 2, D. Clain, President, SRC to the Principal, 9 March 1960.

<sup>107</sup> Ibid., Memo on social practice, 6 July 1960.

<sup>108</sup> Ibid., H. van Huyssteen, Acting Secretary of Council to Mr Callie, President, SRC, 22 June 1962.

The 1960s were dominated by increasing political and economic repression for the majority of South Africans. Heightened political campaigns were met with severe responses by the apartheid state. During this period the campaign against the passes which Africans were required to carry gained widespread support and resulted in the rally in Sharpeville on 21 March 1960, where 69 unarmed men, women and children were killed by the police. The international response to these killings was met with the banning of the ANC and PAC by the Nationalist government. The Rivonia Trial which followed the arrest of the leadership of the ANC's armed wing in 1963, effectively led to the jailing of much of the resistance movement's leadership and shifted the focus of political resistance into exile. It also marked the phase of urban sabotage organised by the ANC, begun from 1964.

By the late 1960s the economic climate in the country had improved. In the 1970s several leaders of the liberation movement were in exile or imprisoned and opposition in South Africa was halted by brutal police force and by the forced removals of individuals from urban areas to separate homelands.<sup>109</sup> The result was substantial fear and little active resistance. However, underneath the surface of what appeared to be a silencing of the opposition, discussions for future resistance were taking place, particularly amongst the black students in the segregated universities.<sup>110</sup> The overcrowded schools and growing universities created opportunities for students to discuss the discrimination they suffered. Black Consciousness Organisations were formed and student organisations such as the National Union of South Africa Students (NUSAS) began to be radicalised in a decade marked by significant political events, including the independence of Portuguese colonies, Angola and Mozambique, after protracted liberation wars, an outburst of labour strikes in response, and the subsequent growth of the independent trade union movement. On June 16, 1976, the Soweto uprising took place which was a protest against the imposition of Afrikaans as a medium of instruction. The harsh response of the police to the protest resulted in 25 students being killed. Six days after the initial uprising, 130 people were officially listed as having been killed.<sup>111</sup>

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<sup>109</sup> Marx, 1992.

<sup>110</sup> Ibid.

<sup>111</sup> Ibid.

In recent years some of those writing about the UCT Medical School have noted the lack of political protest from leading members of the Faculty. Given the cautiousness of the University environment when J.P. Duminy was Principal, this is not difficult to understand but individual responses also played their part. Professor Frank Forman was a case in point. A loved and respected teacher, clearly a humane man, whose wife, Golda Selzer, had played a prominent role in the founding of SHAWCO, Forman almost never expressed public opposition to apartheid.<sup>112</sup>

One must also ask why some members of the Medical School adopted a stronger stance than this against apartheid. Neither political allegiance nor personality is always adequate explanations; certainly abhorrence of apartheid is not. A younger generation was probably more militant. In some cases, a personal experience changed perspective. Stuart Saunders admits that it was the arrest of his wife in the late 1960s, while she was dispensing soup in the townships, that led him to part company from more conservative members of the Medical School staff. 'I made a firm resolve then and there never to allow any consideration of my reputation, or the way in which people might see me, to interfere with the response that I would give publicly to matters of public concern. Principle and values should rule, not expediency.'<sup>113</sup>

If the Medical School could ignore protest at home, staff travelling abroad encountered opposition and outright hostility to an extent which they had not done before.

Medical staff on leave were forced to examine their own political views. Most probably regarded such issues as irrelevant to medical practice but a few considered it sufficiently important to comment in their leave reports. Some were defensive, others anxious to explain the good things which were nevertheless being achieved, while a few commented critically on government policy. The Professor of Obstetrics and Gynaecology admitted that he found it difficult to defend South Africa's policies. 'What a pity it is that so fair a country in all its many natural aspects is so seemingly unfair in its basic human concepts,' he wrote.<sup>114</sup> Another seized the opportunity to correct 'wrong impressions' about South

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<sup>112</sup> Kirsch, *The Forman Years*, 194-8, 203.

<sup>113</sup> Saunders, *Vice-Chancellor on a Tightrope*, 46-7.

<sup>114</sup> AA, Medical Faculty Board minutes, 17 August 1960, Professor James Louw's leave report.

Africa which could, if not watched, 'do considerable harm to this country'.<sup>115</sup> Hoffenberg, soon to be banned, reacted somewhat differently, responding optimistically to the civil rights movement, then at its height in the United States. 'It is apparent', he noted, 'that the integrationists have gained in respectability and I found Deans of Medical Schools, factory-owners, and people from many walks of life who have accepted integration now not only as a necessary, but as a desirable aspect of their lives'.<sup>116</sup>

Perhaps the most sustained discussion came from the Professor of Orthopaedic Surgery, commenting on a report on 'Rehabilitation in Africa'. His remarks are at once conservative and enlightened - typical, perhaps of the confused thinking of humane and liberally-minded white South Africans who had not yet come to terms with the implications of racism. He was clearly irritated by the attitudes of some anti-apartheid activists.

I find it of interest that many countries who in the past have had dealings with Africa and some who have been enriched by their association with Africa, should suddenly at this period in history become aware of the need of uplift of the African. This is the more interesting if it is assumed that such countries did not take steps to uplift the African in the past at times when they were so associated with him'.

He wrote of Africans as alien people - the other - but with sympathy and some insight. There was a tendency to write of all dark-skinned Africans as if they were the same, he complained, but tribes differed materially.

Very important in any consideration of assistance that may be given to the African are the host of curious beliefs, African folk-lore and ways of life. One must be prepared to accept that the African may not welcome assistance; he may prove very disappointing from some points of view; he may, in fact, even be hostile. There are many matters about which it is very hard for the so-called civilised European mind to comprehend in the viewpoint of the black people of Africa . . . From my own meagre knowledge of the African I cannot help but feel that, by and large, they are a wonderful people. Their way of looking at life is different from ours and may, in fact, never come into line with ours. It is my impression that they may be as correct in what we call a primitive outlook as we are in our so-called educated and civilised outlook.'

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<sup>115</sup> Ibid., 14 August 1961, leave report of Professor C.W. Lewer Allen.

<sup>116</sup> Ibid., Dean's Circular No 10, 25 April 1966, 5.

By the late 1960s the Medical School could no longer avoid confrontation with the forces of apartheid. In July 1967 Dr R. Hoffenberg was banned, ostensibly because of his involvement in the Defense and Aid Fund. The event tested the moral fibre of the Medical School staff. Brock led the protest against the banning, drafting a protest letter to the South African Medical Journal that was never published<sup>117</sup>, and the Medical School passed a resolution deploring it.<sup>118</sup> Other University staff and students joined the protest, as did UCT's Chancellor and the Vice-Chancellors of Wits and Rhodes. Leadership from the UCT Principal, still Duminy, was weak, however, and by no means all senior medical staff supported the movement, some suggesting that there was no smoke without fire. The Cape Western branch of MASA, dominated by government supporters, took no action. The difficulty was the form that protest should take. Petitions and protest marches were all very well, but had little effect. The suggestion that all Medical School and hospital staff should resign was turned down by Brock since patients' lives would be put at risk. Saunders commented of their dilemma: 'It raises the crucial issue of what the appropriate form of protest should be against a thoroughly evil regime. We said a lot but did very little. Should we have done more on this and other occasions when we protested against apartheid? We probably should have done so, and I regret what could have been shortcomings. We could have put ourselves at greater risk, but I could not have resorted to violence.'<sup>119</sup> Unable to practise, Hoffenberg was forced into exile.

In the international medical world Hoffenberg's banning produced a very negative response. Taken with growing protests from black health care workers about the inequity of differential salaries for the same work, there was a strengthening of the academic boycott against South Africa. 'The system of differential remuneration to medical and academic staff at South African Institutions according to race and colour has become better known overseas and is doing a tremendous amount of unnecessary harm and damage to South Africa's image in overseas academic circles', one academic noted.<sup>120</sup>

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<sup>117</sup> F Ames. (1991). Biko revisited. *S Afr Med J* 80: 107-108.

<sup>118</sup> *Ibid.*, 8 August 1967.

<sup>119</sup> Saunders, *Vice-Chancellor on a Tightrope*, 39-42; Kirsch, *Forman Years*, 246.

<sup>120</sup> AA Medical Faculty Board minutes, Dean's Circular No 24, 22 February 1968, Dr H. de V. Heese's leave report, 2.

Dating perhaps from the attack on university freedom and the banning of Hoffenberg, but particularly from the 1970s, there was a palpable change in the Medical School in its response to apartheid. Less and less were health care professionals willing to collaborate in the existing system. This was not, of course, true of everyone, but objections, protest and resistance became a regular pattern in the next two decades. An important factor in this change was the quality of leadership in the Medical School and in the University as a whole. Duminy retired in 1967, to be replaced by Sir Richard Luyt, providing a much more congenial context for protest - conservative though he seemed to some. At the Medical School itself stronger leadership emerged when men like Stuart Saunders, who had succeeded Brock as Professor of Medicine, took a more determined stand. Saunders' later appointment as principal of UCT also strengthened leadership in the University's opposition to apartheid. In the Medical School a Professional Standards Committee [PSC] provided a forum in which staff and students could debate political issues as they related to the practice of medicine.

One issue on which the UCT took a more explicit stand was that of separate training institutions for the different race groups. When UCT made a submission to the Commission of Inquiry Relating to the Coloured Population Group, the Medical School made its views explicit. If the different population groups had to rely on their own practitioners, trained in their own institutions, the position of coloured people, let alone Africans, was unacceptable. Only 32 (7%) of students at Natal Medical School were coloured; Wits trained only a handful. By contrast an average of 90 coloured students a year had been registered at UCT over the past 12 years. A medical school for coloureds would do little to relieve the situation. It made no sense to debar them from UCT.

'Quite apart from the above practical considerations, there is the fundamental principle that a university, including a medical school, should have the right to admit anybody who is academically qualified for the course and should not be forced to select students with any relationship to their ethnic origin. The young Coloured man should be able to compete on equal grounds with people of other race groups to try to go to the Medical school which he thinks is the best for him and should not be forced, for ethnic reasons, to accept what he thinks is second-best. . . .'<sup>121</sup>

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<sup>121</sup> Faculty of Health Sciences [FHS], Medical Faculty, Dean's Circular, No 61, 10 September 1973.

If UCT had made progress in its understanding of the implications of racial discrimination, there was little advance in gender sensitivity.

The issue of differential salary scales became the major problem confronting the Medical School in the 1970s. This was a form of discrimination which could not be justified as unchangeable convention. As the Anti-Apartheid Movement gained strength, the problem raised its head repeatedly during international visits. Professor Stuart Saunders was vigorously attacked at a workshop of the CIBA Foundation in London in 1974. Even more daunting was the confrontation with Professor M.D. Bowie in Bristol in 1978. 'I have little doubt that there is an organised campaign in Great Britain against academic medicine in South Africa', Saunders concluded, 'and can only hope that such issues as the inequality of pay will be corrected in the very near future because whenever one discusses the many positive contributions to health care in the country existing gross professional inequalities cut the ground from under one's feet and are in themselves basically wrong and indefensible.'<sup>122</sup>

The Medical School could do little itself to rectify the disparities as, in terms of the Joint Agreement with Province, the staff were paid by the Province but they protested repeatedly all through the 1970s. It was prodded to do so in the first instance by the Medical Graduates Association and by the Junior Hospital Staff Association at Groote Schuur Hospital.<sup>123</sup> The matter was raised in Faculty in 1977 and again in 1978 when it was acknowledged that the gap was widening. Finally in 1979 the inequalities began to be addressed.

Differential salaries were not the only issue which affected the hospitals. The practice of excluding black students from access to white patients was also gradually eroded, again, largely in response to dissatisfaction from students, who found the lack of progress in repealing this colour bar unacceptable.<sup>124</sup> . There were also practical considerations. The cost of separate ICUs led to the first integration of black and white patients but segregation in the wards remained official policy into the 1980s. By that time student

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<sup>122</sup> FHS, Medical Faculty, Dean's Circular No 64, 11 January 1974; Medical Faculty Board minutes, 18 July 1878.

<sup>123</sup> *Ibid.*, 1 October 1968

interns were playing an active role in pressing for change. Both a UCT Declaration and the Geneva Declaration, which formed the basis of the oaths taken by the student interns, were flouted in the wards where students were sometimes prevented from treating the victims of political violence, and where they felt that black patients still received inferior treatment.<sup>125</sup> Fearing a government backlash, the Professional Standards Committee [PSC] of the Medical School responded more cautiously to student demands than the students liked, agreeing that the UCT Declaration should be rewritten to accommodate the students' concerns. To the discontent of the students little else changed in the next year and members of the PSC were aware that more urgent action was needed, resolving 'to recommend and obtain the removal of all prejudicial racial considerations in our patient management at the UCT's teaching hospitals forthwith'.<sup>126</sup> It is probably fair to say that these events hastened moves to integrate the old hospital. From this point black patients were allowed to overflow into white wards, while some departments integrated their wards more actively.<sup>127</sup>

When a new hospital was planned at Groote Schuur, the Medical School was determined that these gains should not be lost. As a result the University was led into outright confrontation with the Provincial authorities and was forced to abandon its policy of quiet desegregation. Dr Niklaas Louw, the Director of Hospital Services, had made it clear that the new Groote Schuur Hospital was to be segregated but the Planning and Commissioning Unit at UCT had ignored this intention in planning the new wards. However, when Louw stated his position in the press, UCT was forced to declare its determination to provide medical care free from all discrimination. Students were informed of this at a Faculty Assembly on 7 May 1987<sup>128</sup> and a letter to the *SAMJ* reaffirmed this stance.

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<sup>124</sup> 'One of Many' (anonymous), 1977. Letter to Pulse 3(1):8

<sup>125</sup> FHS, Professional Standards Committee [PSC], Memo submitted to the PSC by the Intern Committee of GSH on 'Racial discrimination in the medical management of patients in the Univeristy's teaching hospitals, 8 August 1984.

<sup>126</sup> Ibid., November 1985. For student views see also PSC, MSC student poster, 17 April 1987.

<sup>127</sup> FHS, PSC, Chronological recapitulation of events leading towards the integration of patients of different colour in Groote Schuur Hospital, Faculty Assembly, 7 May 1987.

<sup>128</sup> Ibid.

'Tradition and international ethical codes of medical practice make it clear that there is no place for discrimination on racial, social or other such irrelevant grounds in the care of patients. Health care professionals throughout the world agree that no-one may direct them to practise otherwise.

In our society, where racial discrimination has been imposed by statute, medical practitioners, nurses and the other professions allied to medicine have endeavoured despite these unacceptable restrictions to provide the best possible care in state-controlled medical institutions. Over recent years the segregation of facilities has progressively been reduced in a number of private and public hospitals, on the basis of convictions that are explicitly enjoined by our professional codes.

Considerable progress has been achieved at Groote Schuur Hospital, to the point that integration has occurred at many (although not all) levels. This has reflected a determination of the staff to practise according to the professional principles to which they are committed, and to make optimum use of limited resources.

It has recently officially been stated that the new Groote Schuur Hospital, into which we are about to move, will be segregated according to race. We reject this proposal on ethical grounds and we must therefore oppose it with determination, in order to protect the professional, clinical and teaching standards in which we firmly believe and to preserve the dignity of our patients. We cannot agree to the imposition of racially segregated facilities in the old Groote Schuur Hospital or in the new hospital.<sup>129</sup>

Louw argued that patients were segregated in accordance with the spirit of the International Code of Medical Ethics, whereby all patients had the right to decide where they should be treated: 'This does not imply that patients must be confronted with the question as to whether or not they would be prepared to be hospitalised in a mixed ward. Thus, to avoid any embarrassment to patients they should be accommodated with their own population group from the outset.' He was incensed that patients continued to be mixed 'and this despite the official and announced policy on the hospitalisation of in-patients at the new hospital and particularly after I had arranged a compromise at the highest possible level and had conveyed the later to you'.<sup>130</sup> He threatened the Medical School with disciplinary steps but the University had by now discovered that hospital segregation had no standing in law. Since it had inherited *de facto* segregation in

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<sup>129</sup> FHS, Medical Faculty, Board minutes, 5 May 1987

<sup>130</sup> FHS, PSC, Dr N.S. Louw to Dr J.D.L. Kane-Berman, 30 June 1987.

hospitals from the beginning of the century, the government had failed to put the necessary legislation in place.<sup>131</sup> Thus, by the mid-1980s Groote Schuur could claim that it was the only hospital in South Africa which was not segregated by race, although this was far from the case at its peripheral draining hospitals.

However, the role of the Faculty as driving desegregation was not uniformly accepted by many stakeholders. Students, in particular, felt that the Faculty too easily resorted to 'sitting on the fence'<sup>132</sup>. Indeed, correspondence between the Dean and students in 1988 indicated his view that 'immediate racial desegregation [of peripheral hospitals in the teaching complex was] not feasible and [was] not practically attainable'<sup>133</sup> and he cautioned one protesting student "against ... precipitate action which might result in curious consequences ... harmful to your medical career."<sup>134</sup> Thus, while recognising the need to address the harmful consequences of race segregation, the Faculty was also limited in the kinds of measures it was prepared to take, and the support it gave its students in their protests.

Nonetheless, in the Professional Standards Committee it was recognised that the issues related to segregation in medicine went far beyond that of separation of the races in the wards. Moreover, the introduction of a new constitution which created 'own' and 'general' affairs, in which health became an 'own' affair, to be administered by three different racial administrations, threatened to fragment health care even further. The effect would be intolerable.

'We are very concerned that under the new Constitution hospitals and health services may be divided and become fragmented and urge that the deleterious consequences of such a move be very seriously considered. We believe that only a unitary health service can meet the needs of the Republic of South Africa and that a division of health services into own affairs and general affairs cannot achieve this. The health of all South Africa is at stake and we urge that this fragmentation should not occur.'<sup>135</sup>

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<sup>131</sup> FHS. PSC, Prof P. Folb to Prof. G. Dall, 3 February 1986.

<sup>132</sup> Anonymous, 1987. Apartheid: Sitting on the fence. Pulse (undated).

<sup>133</sup> Correspondence cited in Mindel, 2003: 164.

<sup>134</sup> Ibid, 164.

<sup>135</sup> FHS, Medical Faculty, Professional Standards Committee, 7 December 1987.

Backed by UCT the College of Medicine also issued a credo, stating its opposition to discrimination and to violence.<sup>136</sup>

The desegregation of Groote Schuur took place against a background of deepening disaffection both on and off the campus. By this time the entire pass law system and Urban Areas legislation was breaking down as increasing numbers of Africans poured from the desperately impoverished black 'homelands' into the almost as impoverished squatter settlements on the outskirts of Cape Town. The government, however, had not yet accepted the change and persisted in demolishing the squatter camps - Modderdam and Werkgenot in 1977, Unibel in 1978.

The changing social context persuaded the Medical School, in theory if not entirely in practice, that the practice of medicine itself needed to be approached differently. As early as 1977 they spelt this out in a letter to the *SAMJ*.

We have firmly turned our backs on treating diseases only and emphasize instead diagnosis and therapy for the patient as a whole. Students are taught to pay attention to the total background of the patient - his home circumstances, economic considerations and cultural and hereditary factors. We teach that tuberculosis is rife when there is malnutrition and overcrowding; the rheumatic fever is common in those who live below the breadline; that typhoid is associated with poor sanitation and inadequate water supplies; that kwashiorkor and infantile gastro enteritis flourish as unemployment rises; that alcoholism, prostitution and venereal disease are promoted in societies where there is no stable family life and that failure to recognize this comprehensive approach results in inadequate health care and human misery. Comprehensive medicine is taught in every medical school in the Republic of South Africa, and community care, with its emphasis on preventive medicine, is highlighted. Surely it is time for members of the medical profession to use their influence collectively to promote a healthier community life throughout South Africa.

Our responsibility for human welfare insists that we draw attention to the dangers of social disorganisation, inadequate housing and disruption of the family unit. The matter is urgent and deserves our immediate attention.<sup>137</sup>

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<sup>136</sup> FHC, PSC, 5 August 1986.

<sup>137</sup> FHS, PSC file, *SAMJ*, 15 October 1977.

This shift in thought contributed to the greater standing of the SHAWCO clinics, many of which were, moreover, located in the squatter camps. This often took staff and students into the most disaffected areas. When SHAWCO took the decision to offer its services to the rapidly-expanding illegal black squatter settlements the Medical School encountered the demoralising effects of apartheid policy more directly. When Unibel was threatened some members of the Medical School went beyond delegations and petitions, to monitor events on the ground and to report on the medical aspects of the demolition. Later in the year, when Crossroads erupted in internal conflict, both SHAWCO and some medical staff were on hand to treat those who had been assaulted. The Dean, however, was unhappy at this turn of events and some members of the Faculty were openly hostile.<sup>138</sup>

Then, in 1976, the Soweto uprisings marked the spread of political unrest to Cape Town and onto the UCT campus. Even in the hospitals the medical staff was confronted by the effects of civil unrest, treating gunshot wound victims from the townships. When the police demanded the names of the victims, the staff refused, with the result that police were placed in the wards. Rising indignation led to objections from the Medical School, with the result that one of the leaders of these protests, Dr Louis van der Poel, was arrested and his contract terminated by the Province. Only after the Somerset Hospital staff, where van der Poel was training as a registrar, threatened to go on strike in conjunction with hospitals in Port Elizabeth and Durban, and members of the Medical School staff met L.A.P.A. Munnik, then Minister of Health, was he released and reinstated.<sup>139</sup>

For the medical profession in South Africa the real turning point was the death of Steve Biko in detention in 1977. The two state district surgeons who attended to Biko prior to his death were shown to have colluded in his torture by allowing the security police to dictate their management of the brain-injured detainee<sup>140</sup>. National and international outrage urged that disciplinary action be taken against the two doctors, Lang and Tucker, for their failure to maintain ethical standards. The Biko case was an acid test for the

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<sup>138</sup> Ibid., 56-8.

<sup>139</sup> Saunders, *Vice-Chancellor on a Tightrope*, 68-9.

<sup>140</sup> Baldwin-Ragaven L, de Gruchy J, London L. (1999). An ambulance of the wrong colour. Health professionals, human rights and ethics in South Africa. UCT Press, Cape Town, 91-100.

profession's ability to adhere to ethical standards and to accord respect to, and recognise the dignity of a black person.

For UCT the issues were particularly acute since the district surgeons responsible for Biko had been UCT graduates. The ethical considerations related to Biko's death have been widely discussed<sup>141</sup>. An extended submission was made to the TRC on the circumstances of Biko's death<sup>142</sup> and Saunders has related at some length the actions of himself and other staff at UCT and Wits University in this regard<sup>143</sup>. On the one hand, Saunders, then Vice-Chancellor designate at UCT, offered outstanding leadership. Together with a number of other doctors, he resigned publicly from the MASA because of disquiet at the way in which the medical institutions had handled the matter. MASA 'had behaved intolerably in its response to Biko's death, Saunders declared. Similarly, Frances Ames, a consultant neurologist at UCT was one of a handful of committed health professionals who mounted a legal challenge to the South African Medical and Dental Council's failure to discipline the 'Biko' doctors. Their actions, at considerable risk to their own security, were successful in the Supreme Court, and forced the SAMDC to take action in 1985, when it reversed its initial finding that Drs Tucker and Lang had not been guilty of misconduct. The Biko case, and its treatment by the MASA and the SAMDC prompted significant organization amongst medical students at UCT, and served as seminal years for the development of a student leadership committed to social justice<sup>144</sup>.

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<sup>141</sup> See, for example, McLean GR, Jenkins T. (2003). *Developing World Bioeth. The Steve Biko affair: a case study in medical ethics* 3(1):77-95; Berat L. (1989). *Doctors, detainees and torture: medical ethics v. the law in South Africa. Stanford J Int Law* 25(2):499-542; Kandela P. (1985). *South Africa: medical care of detainees. Lancet* 2(8462): 1000-1; EM Barker. (1983). *The Steve Biko case. S Afr Med J.* 1983 May 21;63(21):796; Hoffenberg R. (1984). *The Biko case: an appeal. Lancet* 2(8412):1158; Johnson E. (1984). *The continuing South African controversy. Can Med Assoc J.* 130: 1623-4.; Rayner M. (1987). *Turning a blind eye? Medical accountability and the prevention of torture in South Africa. Washington DC: American Association for the Advancement of Science.*

<sup>142</sup> Submission to the Truth and Reconciliation Commission regarding medical involvement in torture and death of Stephen Bantu Biko: Sept/Oct 1977. Professor Peter Folb, TRC Health Sector Hearing, June 17-18<sup>th</sup> 1997.

<sup>143</sup> Saunders, *Vice-Chancellor on a Tightrope*, pp 85-91.

<sup>144</sup> Anonymous. *Biko: The case continues. Pulse Magazine*, September 1984: 14-15. See also Mindel M. (2003). *The construction of medical education in an unequal society: A study of the University of Cape Town Medical School, 1904-1907. Thesis submitted for the degree of Doctor of Philosophy (PhD), University of London: 151-153.*

However, Ames' actions, now recognized for their courage and principle<sup>145</sup> did not at the time enjoy the wholehearted support of her colleagues who feared retribution from government should UCT be seen to speak out. She found to her 'dismay and surprise that senior colleagues could ... refuse to pursue the fight because of reluctance to crucify their colleagues and their feeling that they should close ranks.'<sup>146</sup> Student petitions calling for action on the Biko doctors found only a minority of senior staff willing to sign up and few professors were willing to follow Saunderson's example of resigning publicly from MASA<sup>147</sup>.

Nonetheless, in the years that followed Biko's death, the UCT Medical School began to take a firmer stand in defying the security forces. Dr Neil Aggett's death in detention in 1982 prompted a Faculty protest assembly<sup>148</sup> and a letter to the Medical Journal urging the profession to support the protection of the rights of detainees<sup>149</sup>. The Professional Standards Committee, set up in the Faculty in response to the Biko case, publicized six ethical criteria that should govern the delivery of health care to detainees, and called for strict adherence to the Tokyo Declaration and the protection of rights of detainees<sup>150</sup>. UCT staff (including Frances Ames) helped diagnose thallium intoxication in an Eastern Cape youth who was poisoned with the heavy metal during his detention<sup>151</sup>. Later, in 1985, the Dean called for medical panels to provide better care of detainees and for support for district surgeons when the police ignored their instructions<sup>152</sup> and the Faculty publicly congratulated Wendy Orr for the stand which she had taken against police maltreatment of detainees.<sup>153</sup> In the late 1980s and 1990s, UCT staff were increasingly engaged in the activities of anti-apartheid health groups providing services to victims of

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<sup>145</sup> See Ncayiyana, 1997

<sup>146</sup> F Ames. Verbal submission to the TRC Health Sector Hearings, Cape Town, 17 June 1997. See also Mindel, 2003: 146 for a description of Faculty ambivalence regarding openly speaking out.

<sup>147</sup> Mindel, 2003: 145.

<sup>148</sup> Folb P. See Statement on Aggett. Pulse April 1982: 13; Saunders, Vice-Chancellor on a Tightrope, 126-127.

<sup>149</sup> Benatar SR. (1982). *The death of Neil Aggett*. S Afr Med J 82: 300.

<sup>150</sup> McKenzie D. (1982). *Medical treatment of prisoners and detainees*. S Afr Med J 72: 688.

<sup>151</sup> Majoos FL, Marais AD, Ames FR. (1983). Thallium poisoning. A case report. S Afr Med J 64: 328-30

<sup>152</sup> SAMJ, 68, 3 August 1985, 133, in PSC file.

<sup>153</sup> FHS, Medical Faculty, Board minutes, 1 October 1985.

political repression<sup>154</sup>, and in engaging in public debates on the ethical issues involved<sup>155</sup>. Like colleagues elsewhere in the country, UCT clinicians were having to grapple with the ethics of managing hunger strikers in detention or who were campaigning for the release of political prisoners, and developing appropriate ethical guidelines<sup>156</sup>.

With regard to civil unrest, the Faculty adopted a public position in 1985 that its staff would be governed by the principles of medical ethics alone in treating the victims of civil conflict: 'Members of the medical profession who are called upon to supply their services in armed conflicts, including civil unrest, should refuse to give their assistance to measures of reprisal against persons in their care or under their protection and should attempt to oppose acts of reprisal by all means at their disposal', the Faculty stated.<sup>157</sup> Indeed, it would appear that staff members working at Groote Schuur and UCT-linked hospitals were relatively successful in preventing police from routinely arresting injured patients under their care, in contrast to other local hospitals<sup>158</sup>. As a result, security forces appeared more likely to route detainees in need of health care away from hospitals which were seen to be resistant to their control<sup>159</sup>. In the following year, amid an environment of escalating repression, staff at UCT also issued public statements against the effects of political violence and detention on mental health<sup>160</sup> and on the consequences of detention for the health of children<sup>161</sup>. These actions on the part of some of the medical fraternity at UCT helped to prevent the government from sweeping the effects of its repressive actions under the carpet.

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<sup>154</sup> Baldwin-Ragaven et al, 1999: 185-207.

<sup>155</sup> Benatar SR. (1988). Ethical responsibilities of health professionals in caring for detainees and prisoners. S Afr Med J 74: 453-456; L London. (1991). Ethical Issues in the Management of Civil Unrest Injuries. SA Family Practice 12: 277-283

<sup>156</sup> Keeton GR. (1993). Hunger strikers--ethical and management problems. S Afr Med J 83: 380-1.

<sup>157</sup> SAMJ, 68, 3 August 1985, 133, in PSC file.

<sup>158</sup> Information contained in NAMDA W Cape Newsletter, October 1985.

<sup>159</sup> Baldwin-Ragaven et al, 1999: 58.

<sup>160</sup> Ben-Arie et al. (1986). *Disaster, detention and mental health*. S Afr Med J 70: 370.

<sup>161</sup> Beighton et al, (1986). *Children in detention*. S Afr Med J 70: 235.

Yet at the same time as Faculty members spoke out on human rights abuses, medical students at UCT were warned against public protest and/or threatened with sanction by senior Faculty and University leadership when protesting apartheid<sup>162</sup>. One black alumnus recounted how, when he approached the Dean as an undergraduate student for assistance with dealing with the accommodation difficulties posed by the Group Areas Act, the Dean “shrugged his shoulders and said it was not UCT's problem, and they had to abide by the Group Areas Act.”<sup>163</sup> Similarly, despite strident protests by the University against proposed legislation to restrict the intake of black students, UCT's actual admissions of black students were woefully limited<sup>164</sup>.

This ambivalence also appears in the Faculty's increasing criticisms of the apartheid government's race-based policies in health during this period. For example, at the 1984 Graduation Ceremony, the Dean was reported as voicing the University's opposition to racial discrimination, on the basis that race separation under apartheid led to ‘dissimilar standards of medical treatment for different population groups.’<sup>165</sup> By the end of the 1980's, other faculty staff were raising concerns in the Medical Journal about the impact of apartheid separation on health care for black people<sup>166</sup>. Yet, students who pressured the Faculty to more active in ending hospital apartheid, found the Faculty reluctant to take concrete action, and to make overt mention of racism in its public statements<sup>167</sup>. For example, one student response to the failure of the Faculty to follow through on a Mass Meeting's resolution on desegregating the teaching hospital bemoaned the lack of progress: “... one of the few incidents whereby this medical school establishment have recognised their role in this strange, unequal society in which we live, has just disappeared – gone into the wastepaper bin. ... Is it possible that the powers that be are actually inhibiting the recognition and action that that Mass Meeting's position called

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<sup>162</sup> See Mindel (2003): 146, 151, 153.

<sup>163</sup> Personal communication, Dr Maart, February 2<sup>nd</sup> 2004.

<sup>164</sup> Mindel (2003): 153-155.

<sup>165</sup> Staff reporter. Stand on Medical Ethics. Cape Times 13<sup>th</sup> Dec 1984.

<sup>166</sup> Benatar SR. (1989). Apartheid and medical care. S Afr Med J 75: 559-560; Klein M. (1989). Effects of apartheid on health care. S Afr Med J 76: 172.

<sup>167</sup> Mindel (2003): 160.

for?”<sup>168</sup> Indeed, much of the criticism of apartheid health care emanating from UCT staff was fed by and, in return, fed into growing discontent amongst students with race segregation in the health services, discontent that finally drove the de facto desegregation of health facilities at UCT some years prior to the official dismantling of apartheid.

However, it should also be noted that the strongest voices campaigning against apartheid inequalities and the effects of political repression on health in South Africa did so much earlier than did the University and from institutional bases outside the University, such as non-governmental organizations or progressive professional organizations<sup>169</sup>. In that sense, while individual UCT staff members were active in making public stands against apartheid, they were also instrumental in leading the Faculty on a path that was evolving for the health sector as a whole in South Africa during the period of political transition.

By the 1990s, then, both the structures of the medical profession and the character of the student body at the Medical School had altered considerably. If transformation had not been fully achieved, especially in the ethnic makeup of the teaching staff, the School was significantly more Africa-centred than it had been twenty years before.

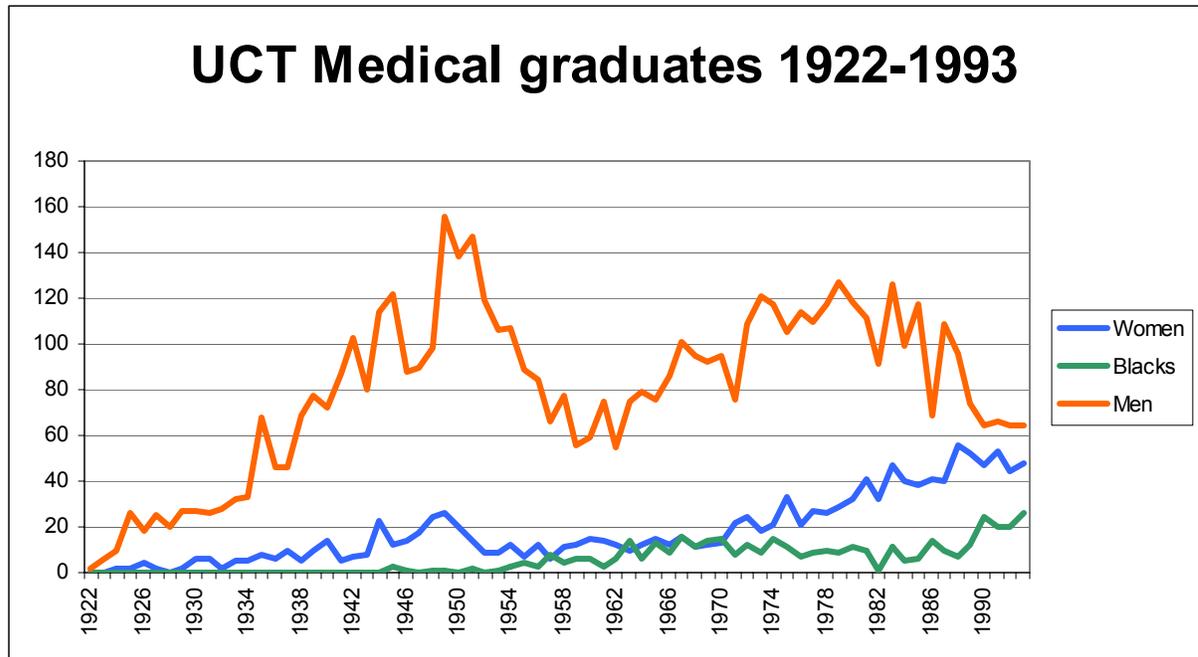
The graph below gives some indication of the changes occurring in the student body of the Medical School. It should be noted, however, that UCT seems not to have kept an analysis of the students.<sup>170</sup> Women and black students have been identified by name. This means that the number black students is undercounted. Black and white women have not been distinguished and black women are included in both categories.

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<sup>168</sup> Edwards B. (1982). Letter to Pulse, p4.

<sup>169</sup> Submission to the Truth and Reconciliation Commission on behalf of the Progressive Doctors's Group (PDG) in respect of the National Medical and Dental Association (NAMDA), May 1997, TRC, Cape Town; Baldwin-Ragaven et al, 1999, 185-207; see also Mindel (2003): 156.

<sup>170</sup> Walker seems to have encountered the same difficulty. See her graph at the end.



### *Women in the Medical School*

The literature on the history of gender discrimination in South Africa is far more slender than that on racism. In particular, the position of white women has attracted little interest, partly because they may have been seen as collaborators in racism, achieving the vote at the expense, in different ways, both of black men and black women. The doctoral thesis of Liz Walker, examined the experiences of early white women doctors at UCT<sup>171</sup>, while Mindel (2003) analysed a set of documentary interviews with female graduates of the Faculty from the second half of the 20<sup>th</sup> century.

Bruce Murray, in his history of Wits, has argued that women students were not discriminated against in the Medical School, although women staff were. 'They were paid less, retired earlier, and were liable to have their service terminated when they married.'<sup>172</sup> However, in terms of women's experiences at the University of Cape Town, the data on whether white women encountered overt discrimination as medical students is equivocal. Eva Salber comments on the 'ease and casualness' with which she entered

<sup>171</sup> Walker, 'The South African Society of Medical Women'.

Medical School, a situation she believed to be very different from the situation in America.<sup>173</sup> Indeed, the University of Cape Town and its medical school had never excluded women and two women, Edith Paterson and Norah McCullough, graduated from the Medical School within two years of the first two men, in 1924. However, although there was always a sprinkling of women in every year, as a percentage of the class they increased very slowly. In 1982 women still formed only 18.5% of the class, the same as they had done 50 years before, although as a proportion of the graduates their numbers were increasing by then.<sup>174</sup>

Nonetheless, the extent of discrimination or harassment encountered by female medical students in Medical School emerges in later narratives. Although the Medical Faculty Board minutes never suggest that this was an issue at all, the Dean of the Faculty, in correspondence regarding need for UCT to make a submission for the TRC Health Sector Hearings in 1997, acknowledged that ‘Women were very much in the minority for much of the existence of the Medical Faculty and they frequently talk of being disadvantaged as medical students and subsequently in their careers.’<sup>175</sup> For example, anatomy classes were segregated, not only by race, but also by gender, a situation that was apparently accepted without question. Walker notes that separate anatomy classes continued into the 1960s<sup>176</sup> confirmed by accounts of female graduates from that period<sup>177</sup>.

The strongest evidence of hostile and patronising attitudes towards women emerges in relation to accounts of treatment of female patients, particularly black women. For example, numerous accounts from the early 50s through to the 1980s<sup>178</sup> emerge of female

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<sup>172</sup> Murray, *The Early Years*, 327.

<sup>173</sup> Salber, *The Mind is Not the Heart*, 4. It should be noted, however, that the USA opened its doors to women doctors far earlier than Britain.

<sup>174</sup> Kirsch, *UCT Medical School*, 85.

<sup>175</sup> Van Niekerk JP. Correspondence with Dr Wendy Orr, 28 May 1997, TRC, Cape Town.

<sup>176</sup> Phillips, *The University of Cape Town*, 91; Louw, *In the Shadow of Table Mountain*, opp. p.138; Kirsch, *UCT Medical School*; Salber, *The Mind is Not the Heart*, 7; Walker, 'The South African Society of Women Doctors' 91.

<sup>177</sup> Mindel, 133-138.

<sup>178</sup> *Ibid*, 134, 140, 170-177.

patients, particularly in obstetrics and gynaecology, being treated with lack of respect - being examined without being covered by large numbers of students, being called by patronising terms (e.g. 'meisie' or 'girlie')<sup>179</sup>, it being assumed that women always lie about their pregnancy, and patients generally being there to be practiced upon. Most notoriously, the concept of 'the black pelvis' taught to students represented a particular confluence of racial stereotyping with misogynous science<sup>180</sup>.

Some evidence also highlights offensive treatment of women by both staff and male colleagues. For example, one female student recalled being addressed by a registrar in sexist and patronising terms – “come, come my girlie. Be a good girlie<sup>181</sup>.” Walker notes the subtle ways in which women were excluded or patronised.<sup>182</sup> Entry into the medical school, she suggests, did not guarantee acceptance into the profoundly male culture of the profession.<sup>183</sup> Most women seem to have ignored such attitudes. Some, Walker argues, responded by adopting a masculine stance. 'In a masculine discourse of science, to be feminised is to be trivialised . . . Maintaining femininity renders women doctors, at worst irrelevant, and at best marginal.'<sup>184</sup> Given that research decades later into institutional culture in the Medical Faculty suggested that, well into the 1990s, sexist and misogynist comments from lecturers and gender-biased assumptions in teaching materials and method were common, and widely accepted as the norm<sup>185</sup>, it confirms that the experience of women undergraduates in the Faculty through earlier decades was significantly gendered. Thus, while access as an undergraduate was not barred to women, the experience was probably one which was highly discriminatory

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<sup>179</sup> “Concerned”, letter to the editor, *Pulse*, March 1981.

<sup>180</sup> Mindel, 2003: 137.

<sup>181</sup> *Ibid.*, 138.

<sup>182</sup> See also Salber's comments on Creighton's lectures. *The Mind is Not the Heart*, 9-10.

<sup>183</sup> Walker, 'The South African Society of Women Doctors', 88-93.

<sup>184</sup> *Ibid.*, 93.

<sup>185</sup> Rose P. Report on Institutional Culture. A Review of experiences of the Institutional Culture of the Medical Faculty, University of Cape Town. Students' Representative Council, UCT, 1995.

The situation with regard to access to career development after women qualified was more explicit in its discrimination. Until, perhaps, the 1960s, the norm was that the work of women who qualified as doctors would take second place to that of their husbands, a view accepted by most women graduates themselves. Eva Salber notes that her daughter, as an undergraduate, was the first to speak of her mother's job as a 'career'.

'In my time and country a women who chose to follow a profession did so knowing that her husband's career came before her own, that she would have to go with him when and wherever his work necessitated, and that the care of children would remain primarily her obligation whether she worked or not.'<sup>186</sup>

This may be one reason why the career paths of women doctors tended to be different from that of men - they looked for work which could accommodate the demands of marriage and children. However, the institutions of medicine discouraged career progress of women into specialities other than those few in which women's roles as mother and wife could be accommodated<sup>187</sup>. For example, a 1918 advertisement for a lecturer post at UCT Medical School stated quite clearly "Women eligible, men preferred."<sup>188</sup> In the period prior to the Second World War, because women found it difficult to get work when their training was completed, they tended to enter public health services, one of the least valued areas of medicine. Certainly relatively few found employment in the Medical School although, by the 1930s some were working as temporary or part-time assistants<sup>189</sup>. In 1932 the position of laboratory assistant was created for women B.Sc. graduates.<sup>190</sup> Those women who remained in employment for any length of time rarely obtained positions beyond that of lecturer.<sup>191</sup> This situation was not for lack of ability. Women

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<sup>186</sup> Salber, *The Mind is Not the Heart*, x.

<sup>187</sup> Typically, these would be general practice or specialties such as radiology or dermatology, which could provide a work schedule approximating closer to 'office hours.'

<sup>188</sup> Phillips, 139.

<sup>189</sup> The few exceptions included the botanist, Edith Stephen, who was a senior lecturer long before most women achieved such a position and Dr Deborah Morrison, who was appointed senior lecturer in physiology as early as 1921 – see Louw, *In the Shadow of Table Mountain*: 157 and AA, Medical Faculty Board minutes, 14 June 1921. Bacteriology attracted a number of women who carried the burden of their department in the face of the drinking problem of their head – see Phillips, *The University of Cape Town*, 329. Almost all these appointments were in the pre-clinical years or for non-medical posts, however.

<sup>190</sup> Louw, *In the Shadow of Table Mountain*, 233.

<sup>191</sup> Phillips, *The University of Cape Town*, 329. There were exceptions, however. Botanist, Edith Stephen, was a senior lecturer long before most women achieved such a position. Another was Dr Deborah

regularly won prizes and distinctions in the School <sup>192</sup> but this did not translate into increasing number of women staff in the Faculty. It was true, however, that few women who were appointed remained in their posts for many years and the University complained that women rarely stayed the full five years of the laboratory assistants' course or left shortly after to marry. However, many reasons other than marriage may have been responsible, particularly the institutional culture and the fact that salaries were too low to be attractive.<sup>193</sup>

Other, more subtle, explanations may also be found. Frances Ames traced the obstacles which confronted her when she was offered the opportunity to specialise. She was pregnant at the time but she could not work part time since the SAMDC did not accept part-time work for registration as a specialist. With so few women doctors in the hospitals, there was no provision for maternity leave or crèche facilities.

'The thought of women demanding such help never occurred to us. It would have entailed contesting male authority. The threat of being considered unfeminine and thus sexually undesirable was far too great. The hierarchical structure of the medical school and hospital was also never questioned.'<sup>194</sup>

After she was appointed to the Medical School staff, she was limited by her unfamiliarity with male structures of advancement. It never occurred to her to ask for a contract at work or to look actively for promotion. 'I waited humbly for things to be bestowed upon me'.<sup>195</sup>

The South African Society of Medical Women was formed in 1951 to lobby for the abolition of inequities in the employment of women doctors. The two issues which most concerned them was the age of retirement and the bar against permanent employment

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Morrison, who was appointed senior lecturer in physiology as early as 1921 – see Louw, 157; AA, Medical Faculty Board minutes, 14 June 1921

<sup>192</sup> For example AA, Medical Faculty Board minutes, 14 December 1922, 13 December 1923, 7 December 1926.

<sup>193</sup> AA, Medical Faculty Board minutes, 29 May 1956, Draft reply to questionnaire on medical auxiliaries.

<sup>194</sup> F.R. Ames, *Mothering in an Apartheid Society*, 2d ed. (Cape Town, The Author, 2002), 54. See also Eva Salber' comment on the view of professional women as unfeminine. Salber, *The Mind is Not the Heart*, 5.

<sup>195</sup> Ames, *Mothering in an Apartheid Society*, 55.

after marriage. As with women in other occupations, the Second World War had provided spaces for women in medicine in the public sector. Although some were forced to move out after the war, others noted that the positions they gained then were retained.<sup>196</sup> This meant that the discrimination existing in the public service was now more irksome. In 1950 women in the public sector retired at 55 rather than 60 and their pension payments were commensurately higher, while married women were employed only in a temporary capacity. The Society developed a low-key campaign of letters, petitions and deputations. Its struggles, Walker notes, were 'genteel, polite, and lady-like'.<sup>197</sup> They were able to take advantage of their status as educated, white, middle-class women to gain access to senior public officials. The result was that their goals were achieved fairly rapidly and without much difficulty. 'What was conceived as a large stumbling block to women's position was in effect handed to them on a plate.'<sup>198</sup> At UCT, however, a ceiling existed and it was not for years before a women was appointed as full professor. Frances Ames seems to have been the first, appointed as Professor of Neurology in 1976.

It is evident that the gender discrimination suffered by black women in the Medical School was compounded by hurdles of race in ways that accentuated hierarchies both in access and in career opportunities. Using names as a very unsatisfactory guide, it would appear that the first black women only graduated with M.B. Ch.B. in 1961, with about 7 women qualifying in the 1960s and about 12 in the 1970s. Ironically, the first African graduate of the faculty in 1990 was female. But opportunities for black graduates for post-graduate training, already limited by race bars, were further compounded by gender prejudice. One black female doctor recalled being actively discouraged by a white male Head of Department from specializing in a particular field because her family and personal life should come first.<sup>199</sup>

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<sup>196</sup> Walker, 'The South African Society of Medical Women', 103-4.

<sup>197</sup> *Ibid.*, 108.

<sup>198</sup> *Ibid.*, 121.

<sup>199</sup> Mindel, 2003: 175.

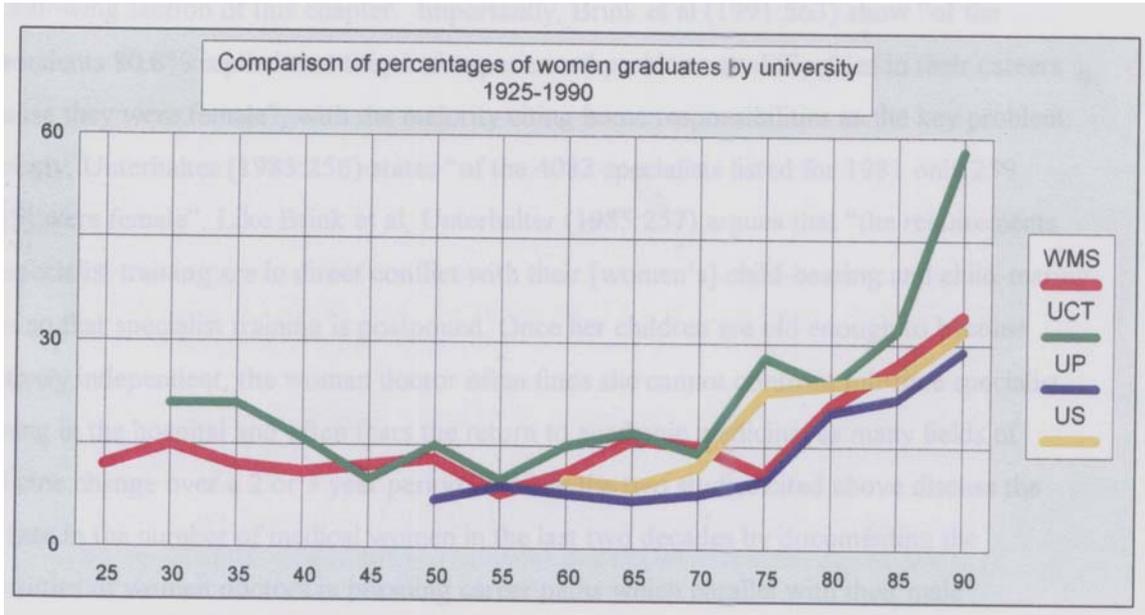
## Conclusion

In reading the memoirs of male and female doctors, one is left with the sense that the practise of medicine sometimes had different meanings for the two genders. Eva Salber commented on how detached she felt during her medical training. Disease did not interest her deeply. 'I could appreciate the hard work and often brilliance that went into the diagnosis of disease . . . but this predominantly intellectual task didn't excite me.' The teaching at UCT was good but it stressed 'the biological and bacteriological causes of disease and the acquisition of diagnostic and prognostic skills'; therapy was little emphasised. Still less were students shown the importance of social, economic and political factors in disease.

'Later, when I got away from the academic setting with its emphasis on individual patients, I began to think in terms of groups of people and the relationship between their living conditions and their illnesses. Only then did it dawn on me that I'd chosen a profession in which I could express my values through my work.'<sup>200</sup>

Frances Ames chose a different career path, but her extraordinary memoir, *Mothering in Apartheid Society*, describes a life which was very different from her male counterparts. It is a journey of discovery of her relationship with a black domestic worker, Rosalina, who gave her the support she needed to carry on her career after the death of her husband, while her sons were still young. It is also a study in the process of understanding, over many years, a mother from a very different culture. Through this work she explores the meaning of feminism for herself, as a woman doctor. For her the male hierarchy of the medical profession and the male routes to power appear to go hand in hand with the authoritarian practice of medicine, which characterised the South African profession. She has little to say, explicitly, about her own well-recognised and well-respected stand against apartheid but the reasons are implicit throughout. Ames's personal experience as a woman doctor and mother, and her actions in opposing apartheid were indivisible. This is not to suggest that women doctors were uniquely humane and sensitive to apartheid.

However, the experience of women doctors may have encouraged them to practice a form of medicine with a larger social commitment than that which had traditionally been taught in the Scottish-based medical schools which had characterised the first eighty years of South African medical education.



<sup>200</sup> Salber, *The Mind is Not the Heart*, 7.