

TRAINING OF MEDICAL AIDS.

The following notes represent the purely personal views of one individual only, albeit of one who has followed keenly the development of this question and who has been in close touch with most of those who have had to do with its development, from Dr. Loram onwards.

The "Loram Commission" reported in 1928. This Commission consisted of Dr. Loram, at that time a member of the Native Affairs Commission, Chairman; four distinguished members of the medical profession in South Africa, and Mr. W.G.R. Murray of Capetown University, who was a member as well as Secretary. The Commission took evidence from some forty medical people (including eight professors) and twentyfive missionaries and experienced officials of the Native Affairs Dept. It visited Lovedale, Kingwilliamstown, East London, Capetown, Bloemfontein, Durban, and Johannesburg.

Although eight years have elapsed, I do not think the fundamental problems, as stated in Chapters I & II of the Commission's Report, have materially altered, except that the Universities of Capetown and Jo'burg are now turning out medical graduates in larger numbers than the Commission anticipated.

The Commission reported in favour of training male Natives (1) to the full M.B. standard of the University of the Witwatersrand, which was willing to offer facilities for "parallel classes"; (2) as Native Health Assistants, Std. VI entrance and three years thereafter.

The Report was discussed at the South African Medical Congress in July 1928 at Durban. The main proposal was turned down, and the second seems to have attracted no attention at all. Government apparently was unwilling to act on the recommendation of its own Commission, against the opposition not of the experts and leaders of the medical profession who had been consulted by the Commission, but of the rank and file of the profession - who, to be fair, had, or thought they had, more likelihood of being affected by the "competition" of Native medical men than had the leaders and professors. A Government that enforced Colour Bars in industry could hardly have aided the training of Natives to acquire full status in the medical profession.

Soon followed the world wide economic depression: the State could hardly save the farmers, and Native health needs were left to look after themselves.

In 1930 there began a severe epidemic of malaria in Natal, which carried off many Europeans, decimated some Native areas, and threatened the economic organisation of the sugar industry, qua labour supplies. To meet this situation, Dr. Park Ross (the Senior Health Officer for Natal) gathered together groups of Natives, selected rather on grounds of personality and character than on academic qualification, and gave them short intensive courses on malaria prevention and cure. It has been represented that by the time these

men were in the field the epidemic was already waning as all epidemics do. That is true, but - and I write as one who saw at first hand the work of these Native Malaria Assistants in a typical Native Reserve - it does not alter the fact that these men were remarkably successful in conveying to masses of illiterate and superstitious Natives the truth concerning the somewhat bizarre life-cycle of the malarial parasite, and in persuading them to preventive work (e.g. spraying of huts, voluntarily and at their own expense) based upon that knowledge. In short, in a very few months a small band of Natives of very imperfect general education, but highly expert in one subject and trained to be propagandists, succeeded in conveying to tens of thousands of raw Natives beliefs and practice which two or three generations of European practitioners had not even begun to get across even to the more educated Natives. I think the significance of the work of the Native Malaria Assistants cannot be over-emphasised, and should be closely studied in planning for the training of Natives for rural health work.

Whether or not this work was responsible for a revival of Government interest in Native health needs, whether it was the fear on the Rand of diminishing labour supplies, or whether it was just a touch of conscience, I do not know. But in 1934 an Interdepartmental Committee (Public Health, Education, and Native Affairs, with the P.M.O. of the Chamber of Mines thrown in) reported to the Minister for Public Health, who acted upon their report.

Before coming to this, I should like to mention another experiment in education of Native Health Workers, smaller but no less significant than that of Dr. Park Ross. Dr. Anning, the M.O.H. for Maritzburg, gave a six months training in hygiene etc. to a small group of Native men, some of whom had Matric. These men were afterwards used in the municipal Native location, mainly as propagandists and follow-up workers in V.D., T.B., infantile enteritis, etc. and as inspectors of nuisances - thus not displacing, but supplementing, the work of nurses. They proved very successful. One of them is now training as a Medical Aid. There is definitely a demand for this type of Native health worker in urban locations, although of course the Medical Aid training is intended for rural workers.

The Interdepartmental Committee took a middle course between the two proposals of the Loram Commission, as regards standard of training. It recommended a five years course from J.C. entrance, running parallel to but at a lower level than the full M.B. course, and with greater emphasis on hygiene and preventive medicine than is usually given even in a full M.B. course. This proposal was submitted to the Federal Council of the S. Af. Medical Association, which referred it to the branches: it was never discussed at a Congress, and did not arouse strong opposition except in a few quarters. It was accepted by the Federal Council, on behalf of the Association, on the understanding and pledge that it was not to be used as the thin end of the wedge for introducing full medical training for Natives; and of course the fact that the starting point was two years below the standard of entrance into a full medical course, was in itself a guarantee against any such policy.

The Committee also differed from the Loram Commission in regarding the South African Native College, Fort Hare, as a suitable centre for the training of medical men: Para 44 of the Loram Report is entitled "Inadvisability of Attempting more than the First Year Course at the South African Native College" - meaning the first year in the preliminary sciences, Chemistry etc. But (1) the Committee had in view only an inferior type of medical training, starting at J.C. level, so that it may have thought that the facilities at Fort Hare were adequate for the purpose they had in view. Further, the Committee suggested a probationary period of service, after five years at Fort Hare, at one or other of the larger Native Hospitals in other parts of the Union, which would supplement the clinical side of the training. And (2) the Committee may have supposed, although I do not know that they actually did so (and if they did, their supposition was incorrect, as I shall show later), that since 1926 the facilities for clinical training at the Lovedale Hospital had so increased that they would be adequate.

A consideration which I know definitely, from one of its members, did influence the Committee was that at Fort Hare the students would not be exposed to the temptations of life in a large town such as Durban or Johannesburg.

At this stage the Chamber of Mines offered £75,000 to the Government to be used for the promotion of Native Welfare. The financial part of the Committee's recommendations adumbrated the ultimate expenditure by Government of £70,000 per annum on the Native Medical Service of Native Medical Aids in the field; and the capital expenditure of £5,000 p.a. for the next 20 years, on houses and dispensaries for the Aids. The Govt has publicly accepted these proposals.

Government then proposed that the gift of £75,000 be handed over to Fort Hare in order to enable that College to equip itself to train the Medical Aids. The only contribution which the Government itself is making towards the training of the personnel for so considerable a public service as that adumbrated above, is, as far as my knowledge goes, £1500 p.a. of which only proportionate fractions are being paid pending the full development of the course.

I do not know what steps, if any, were taken by the authorities of the South African Native College to determine whether the College would be able at Fort Hare to provide a really adequate training, and whether £75,000 plus an annual grant of £1500 in addition to the extra income which would accrue through increased grants, (by reason of increased fees resulting from the establishment of medical classes) from the Union Department of Education - would be sufficient to finance the course. With regard to the facilities, as this is a confidential document, I think it is only fair to himself, as the one whom most would regard as facile princeps among those who would be consulted at Fort Hare itself, to state, although the responsibility for making the statement through the medium of the written word is entirely mine, - that Dr. Neil Macvicar was in 1934 quite definite and open in his view that the facilities for clinical teaching at Fort Hare were not adequate and could not by any practicable measures

be rendered adequate. It is to be noted at this point that it was at the suggestion of the College authorities that the fifth year of the course is to be given at the McCord Zulu Hospital in Durban. This is not the same as the suggestion of the Interdepartmental Committee, of a kind of "postgraduate" year at one or other of several hospitals. I thought it had been made in recognition of the inadequacy of the local hospital for full clinical training, but the Principal told me that it not that, but rather in the nature of a recognition on the part of the College of Dr. McCord's pioneer venture over a decade ago in the training of Native medical men. In any case, clinical work (First Aid) is down in the Medical Aid curriculum to begin in the Second Year, i.e. three years before the students go to Durban.

The South African Native College, however, was not willing to accept the course as proposed by the Committee. Although in its earlier years the College had been occupied mainly with pre-Matriculation work (from J.C. entrance), it had always done post-Matric. work as well, and its policy was eventually to do away with pre-Matriculation classes altogether. It was within measurable distance of achieving this when there came the suggestion of the Committee for a course in medicine starting at J.C. level. The Committee had not realised that the S.A.N.C. was working towards full University-College status. The College pressed its point - this was in 1934 - which was accepted, somewhat unwillingly, by the Govt. representatives, - that the Matric. should be the starting point.

In October 1934 there was a conference at Fort Hare between Dr. Cluver, representing the Union Health Dept, and the the Medical SubCommittee of the Council of the South African Native College. The personnel of this "Medical" SubCommittee was as follows: five non-medicals with no training in, knowledge or experience of the practical problems of medical education - in fact, not even training in science, all holding arts degrees; and four medicals - Dr. Macvicar, Dr. McCord, and two others who, without any disrespect to either, would probably not have been invited to serve on such a Committee but for the accident of their availability. The two doctors named were the only members of the Committee who had any real experience of Native practice, that is, of the nature of the task which would confront the Medical Aids when they had finished the training which the Committee was to organise. Dr. Macvicar had already made his protest that Fort Hare had inadequate facilities, but by this time understood that the Govt. had insisted that Fort Hare should be the place. Dr. McCord, who was the only member of the Committee who did not come from Fort Hare or Lovedale, could hardly have been expected to make any protest, in view of the fact that Durban was the only likely alternative. As Dr. McCord is now in America, I need hardly say that this is merely my own conjecture as to his views at that time.

I have, through the courtesy of Dr. Kerr, read the verbatim report of the conference. Many topics were touched upon, finality was reached in scarcely any. This SubCommittee did not meet again for exactly two years.

At the outset, Dr. Cluver asked whether, if the standard of entrance were raised to Matric, there would be sufficient students forthcoming to guarantee the numbers of finished Medical Aids which the Govt. had in view. He was assured by Dr. Kerr and Dr. Wilkie that there would be no lack.

The conference therefore proceeded on the understanding that the Matric was to be the starting point. It seems to me strange that the conference did not realise the logical consequences of this initial decision. I shall now point them out.

The Interdepartmental Committee had in view a training which started at a point two years below the standard of entrance into the university. Such a course could be in no way comparable with a university course in medicine. It would indeed only be something rather superior to a nursing course: some would dispute even that, since many nurses start at J.C. level, spend four years in general training, and six months in midwifery, working steadily throughout this period in hospitals daily (Sats. and Suns. included, and one month's holiday a year, not two or three.).

But a course of five years' duration, starting at the level of entrance into the university, is a very different thing. Experience at Fort Hare has proved that there is a marked difference between the student who has just passed J.C. and the student who has just passed Matric. Fort Hare ~~claims~~, and has proved in instance after instance, that matriculated ~~students~~ Bantu students have as great an intellectual capacity as European. The one thing that the non-medical members of the conference could have stressed was that by thus raising the starting point the course was coming perilously near a full medical degree course, in length if not in content. As a matter of fact, I think they did realise it, but were pleased rather than apprehensive, because it fitted in with their general aim of running courses of study of university standard. What they did not realise, apparently, for if they had surely they would have faced up to it, was that by thus raising the level of the whole course they were proposing something which the Loram Commission had said was not practicable, viz. the location of a full medical course at Fort Hare. Before citing the Loram Report, I wish to elaborate proof of the attitude of Fort Hare. In the conference referred to above, the Principal stressed the desire of Fort Hare to give these medical students as much medical knowledge as they could absorb, and as he himself believes and has proved that they can absorb as much as European students, who in Britain can obtain a full medical degree five years from matriculation (and more than one Bantu student overseas has done so), - it is clear that he visualised the subjects of the medical curriculum being taught at Fort Hare up to, or very nearly up to, full standard for the M.B. Further, he hoped within a very short while to establish classes in Anatomy and Physiology at Fort Hare which would secure recognition overseas as qualifying for the Second Professional examination. And, later, possibly Pathology and Materia Medica as well. This was part of his general conception of the training scheme for Medical Aids. The group admitted for training, at Matric level, was to be shaved off at both ends: those not up to the required standard of character and ability were to be rejected at the end of the first year; and those who showed special ability and promise were, if possible, at the end of the first year (which is already equivalent to the First Medical Professional) or even at the end of the second year (when the College second year course had been worked up to full standard), to be sent overseas for the complete medical course, aided by bursaries within the gift of the College. Thus the Medical Aid Course was to be used as a kind of recruiting ground for the Native full medical profession, and the best of the prospective Medical Aids were to be withdrawn from the student body.

I need hardly say that I am as keen as anyone that Natives should receive as full a medical training as possible, and that they should be given a chance for full medical qualification, overseas if they cannot get it in South Africa. BUT, the policy sketched out on the preceding page simply cannot be reconciled with the pledge given by the Government to the Medical Association that the Medical Aid Course was not the thin end of the wedge to introduce full medical training for Natives. I am a member of the medical profession who disagrees with the shutting of the front door; but I believe one day that door will be opened, and meantime I refuse to push Bantu students in through the back door.

Last year I was in close touch with the leading group of Medical Aid students. Without fomenting any sense of grievance among them (as it has been suggested by some that I did), I gained their confidence and an insight into their views. I was very impressed with the acuity of their own insight, sharpened no doubt by the unhappy suspicions which recent events in the political world have brought about. In pursuance of the policy referred to above, one of the number who began the year with them was in July sent over to Edinburgh, where, if he is steady, he will gain his full qualification in medicine at the same time as those who started with him gain their Medical Aid diplomas. He will be entitled to practise anywhere in the Empire, and to earn the maximum income to which his ability will entitle him; he will have the full status and privileges of a medical man, and be a university graduate. Those who started with him will have no degree, will for ever be subordinate to fully qualified men (almost invariably Europeans, many of them only too anxious to "keep the Native Aid in his place," vide recent correspondence in the S.A. Med. Journal), and will never be able to earn more than £300 a year. Incidentally, it is no good telling them, as I did most earnestly, that on a fixed salary basis they may be as well off as many medicos - with the example of men like Molema, Moroka, etc. they simply do not believe it. And after all, how many fully qualified men would join the Service in order to secure a fixed salary? Well, the students pressed me to tell them why, if they were to get a definitely inferior qualification, their course was to be so long. One simply could not put them off with any explanation in which one did not believe oneself. Having consulted the Principal, I told them that in my own opinion it not necessary to give them more than four years - having in view the type of work for which the Public Health authorities intend to use them, and the danger of training to too high a standard men who in perpetuity are to be subordinate to fully qualified Europeans. From the point of view of the medical teaching staff, I should like to put it quite plainly, that if we are to spend five years over the course and NOT train our students to a higher standard than is wise, we shall have to waste a good deal of both their time and ours, and that would not be good for their future - to keep them working at less than their maximum capacity.

Another important consequence - however wrong we may think their attitude to be (personally I have every sympathy with it) - is that the students are in a state of dissatisfaction, and this is reflected backwards, so that there is danger of a boycott of the course on the grounds that it comes so near to and yet is so far from the cherished ambition of most of the students, to become fully qualified. The Native medical men, practitioners, in the Union are against this thing, and their influence is very

strong. Even those students who do enter the Medical Aid Course are doing so with the end in view that, after they have saved enough money they will go overseas and take a full course, and in this they are encouraged by the present Fort Hare policy, and they are of course very anxious that the course shall be identical with the full M.B. course as far as possible. Now these ideas are definitely contrary to those of the Public Health Dept., who look forward to a permanent service, not to one which will be made use of simply as an avenue to something else. Public money is being spent, and why should the Service lose its ablest men just as they are beginning to acquire real experience?

Personally, I think it is a very great pity that the Medical Aid training has been introduced at and by Fort Hare in such a way as to make it appear a deliberately inferior substitute for the full professional course, or as a half way house to it. My own view, which I shall not elaborate here, is that the Medical Aid should not be regarded as in any sense an inferior kind of doctor, i.e. clinician, but a Health Worker, a propagandist, a teacher: for what is at present, and for many years to come, required among the rural Natives is not simply the provision of more hospitals and doctors, but some means whereby the Natives may be won from their own superstitious beliefs and love for the witchdoctor and herbalist - to an understanding of and confidence in European methods of treating and preventing disease. More than 50 per cent of the disease in the locations is preventable: why build more hospitals? - why not send out men to the people who will go in and out of their kraals and on the spot point out to them how they may avoid many of their ills? This is my conception of the work of the Medical Aids. To prepare them for it we do not need five years, and we do not need to make them near-doctors: but the kind of training which we need to give them CANNOT be given at Fort Hare.

There are at the moment only seven students in the leading group at Fort Hare, i.e. only seven who will qualify in 1939, assuming there that there are no casualties during the next three years. We shall be lucky if we get as many in the 1940 group. And yet Public Health is looking for double that number, and more.

One thing we could have done at Fort Hare to attract students was to have quickly decided that four years was sufficient length for the course, and advertised that fact before the opening of next session. This could have been done, but was deliberately held up in order to satisfy the aims which, however commendable in themselves, are actually opposed to the understanding between Govt. and the Medical Association. I am prepared fully to prove this statement. Medical Aids are needed among the people, but their production is being hindered in order to satisfy educational policy and ambition. The course at present stands officially as a five year course.

Yet another point is that the salary scale (£180 - £15 - £300) was originally equated to that of teachers, who in five years from J.C. could get both the B.A. degree and the Fort Hare Diploma in Education, and get on to that salary scale. With the raising of the entrance qualification to Matric, there at once arises a serious discrepancy, noticed by students and serving still further to turn them against the course. It is true that medical students will all get bursaries, but then so do nearly all the students at Fort Hare; and with the other handicaps already imposed upon the Medical Aid Course, it means that only those students who are not good enough

to secure "open" scholarships will turn to the Medical Aid Course as their only hope of post-Matric education, i.e. we shall get the inferior students. Great emphasis has been laid upon the provision of £500 houses for the Medical Aids (N.B. this figure also includes dispensary and its equipment, so it is not really a £500 "house"); but this again is offset by the fact that the hours will be irregular and probably longer (night work, Saturdays, Sundays, public holidays), expose them to greater climatic risks, and the holidays will be only three weeks a year instead of well over two months - as compared with teachers, who nearly all do ploughing etc in the summer holidays, just the time when the Medical Aids in most districts will be busiest.

Fort Hare has proposed that the salaries be raised in order to meet this discrepancy, rather than that the course should be shortened, as I think it could without any sacrifice whatever of its efficacy. In the long run, as public funds are limited, this will mean fewer Medical Aids in the field, that is, medical needs of the people all over the country are to be sacrificed to the educational policy of Fort Hare.

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To return now to the question of the location of the course. Allowing that it might be possible to make adequate provision for the lower-grade J.C. course visualised by the Interdepartmental Committee at Fort Hare (although personally I am sure that it would not be possible), no one fully acquainted with local details could suppose for very long that it is possible to provide for a course of definitely University grade although not actually leading to a full medical degree. .... The Interdepartmental Committee (at anyrate its medical members) did not visit Fort Hare. The College Subcommittee, which tacitly assumed that the resources were adequate, was composed of less than 50 per cent medicals, and being almost entirely local in its personnel could not help being a little biased in favour of Fort Hare (no offence is intended in saying this) - see p.4b. of this memorandum. Neither of these bodies had the weight, as an impartial medical committee judging a matter of medical education, of the Loran Commission, which included four very distinguished medical men as well as an expert in education, and which had closely questioned many medical witnesses and had visited Fort Hare and Lovedale. I shall quote from the Report of the Commission.

Para. 42. - "The unity of the South African Native College is an attractive ideal, and one which deserves to be kept steadily in view. It seems certain however that it will not be possible to concentrate certain branches of professional and technical study at the college for the reason that Fort Hare lacks the facilities for practical teaching."

Para. 44. - headed, Inadvisability of Attempting more than the First Year Course at the South African Native College. "Your Committee considered whether or not instruction in the subjects usually taught in the second year of the medical course, namely, anatomy and physiology, should be given at the South African Native College; but in view of the special difficulties of obtaining and conserving the necessary material, and of the necessity of associating these subjects with general clinical teaching, the Committee came to the conclusion that it would not be wise for the college to attempt more than the first year's course."

The italics above are my own. During the last few months I, who have been appointed lecturer in anatomy

and physiology at the College, and who might be supposed therefore to know something about the teaching of these subjects as well as the local situation, have been fighting a Committee composed mainly of non-medicals, on this very point. The Committee has been compelled to recognise that the clinical teaching must go to Durban if it is to be done properly, and is now trying to insist, in the teeth of such a report by the most competent and best informed body which has yet sat on the question (not to mention my own little views, which I am proud to say have the support of Dr. Macvicar), - that at least the anatomy and physiology should be kept at Fort Hare, i.e. the course to be dismembered in order to satisfy the educational aspirations of Fort Hare to have as many different courses as possible given within its four walls. I have pled in vain for the unity of the course, for the necessity for team work between the three or four lecturers who are to be responsible for the entire range of the course.

Para. 45. - "Suitability of other Centres for a Medical School." - The third proposal considered by the Committee was the development of a non-European medical school elsewhere than at Fort Hare but organised as a faculty of the South African Native College.

Several localities were mentioned by witnesses as suitable for such a school, such as East London, Port Elizabeth, Umtata, Durban, and Johannesburg. The comparative proximity of some of these centres to Fort Hare might, perhaps, be urged in their favour, but on every other ground it seems to your Committee that a case could only be made out for Durban or Johannesburg."

Para. 43 of the Report presents an analysis of the inpatient admissions to the Victoria Hospital, Lovedale, for 1926. There were 751, of which even at that time tuberculosis formed by far the largest single group. Surgery and midwifery have never formed a very high proportion of the work at Lovedale. The admissions have now risen to about 1000 annually, the increase being due almost entirely to tuberculosis cases. There are now 160 beds, but of these 80 are devoted to cases of spinal T.B. (average stay in hospital 2-3 years) and another 40 to other types of T.B., leaving only 40 for all other types of sickness. Outpatient attendances number from 5000 to 8000 per annum - about 20 a day on the average - the vast majority of which are medical cases. Medical students, from their second year onwards, depend upon the outpatient practice of hospitals for practice in dressings, first aid etc. At Lovedale there are already many nurses in training, so that there will be absolutely no material left over for 30 or 40 Medical Aid students: this is Dr. Macvicar's opinion, ~~not mine~~, as well as mine.

So that the conclusion of the Loram Committee still holds good - "It is patent that this institution does not offer the clinical material necessary for modern training of medical students."

One would not linger on this point but for the fatuous suggestions that are now being made by the authorities (educational, not medical: the medical staff at the Victoria Hospital agrees entirely with me) ~~to~~ with a view to augmenting the local resources. They quote the advent of the new Govt. T.B. Hospital (75 beds), which of course makes not the slightest difference to the case given above. Then they

express vague hopes that the local hospital will "grow" in other departments in consequence of the enlargement of the T.B. section. Apart from the fact there is a natural limit to the growth of any hospital set in the midst of a rural area, it is more likely that large numbers of chronic and hopelessly sick people in the hospital will repel other types of patient - for the T.B. hospital is to be in the very grounds of the Victoria Hospital, and part of it. Further, like any hospital for Natives in a rural area, the Victoria Hospital has been built up in the confidence of Natives all over the Ciskei, on the reputation and experience of Dr. Macvicar, who has been there for over thirty years. Within a short while he will be retiring, and whoever succeeds him cannot at once acquire the reputation which is his, and so the hospital may decline - the more so as there are other hospitals and clinics in the vicinity which did not exist until recently - e.g. Mt. Coke, a clinic at Healdtown in charge of a fully trained nurse, a young Bantu doctor with a rising reputation in practice at Middledrift.

Another suggestion is that the students should be taken round the adjacent villages in order to hold clinics: apart from the cost of travelling, and the impossibility of getting to many of the villages at all in the rainy season when sickness is most prevalent, this would waste hours of time in mere travelling - the same time spent at the outpatient dept. of a large town hospital would provide infinitely more material at no travelling cost at all - and of course there would be no guarantee that there would always be sick people at the villages chosen for visitation. Students would have to be accompanied by their medical tutors, for they could not while still in training be let loose upon the countryside, and how would the tutors get time for lecturing and lab. work. Further, even assuming the villagers took kindly to all this, would they pay for it, and if they did not, what would the local private practitioners say to this constant touting for clinical material? It really seems absurd to be answering this suggestion, but it has been made in all seriousness as a possible solution of the difficulty stated so explicitly by the Loram Committee, which of course did not stop to consider such a proposal - if it was made at that time.

My own views are (1) the course should be a post-Matriculation course - first year (preliminary sciences) at Fort Hare, as recommended by the Loram Committee. (2) - three, not four, medical years at Durban. I need not stay to detail reasons for preferring Durban to Johannesburg, but there are several which I think are cogent. (3) We should get right away from any idea that this is an inferior medical course. The transfer from Fort Hare to Durban would - though this of course is not my reason for suggesting the transfer - help us in making a break with that idea, which, as I have tried to show, is doing harm. The course should be presented to Bantu students, not as a short cut to, still less as a kind of substitute for, the full medical status to which some of them may still legitimately aspire, - but as an entirely new profession in which even the ablest man may well find a splendid life's work. The Medical Aid is not to be a man who can only go so far and no further, under pain of dread penalties, in the ordinary work of a doctor: he is to be a man who, by virtue of a special type of training as well as by virtue of his racial sympathies and understanding of his less fortunate kinsmen, will be able to do what very very few European doctors

have been able to do even when they have wished and tried to do it, namely, to persuade ignorant and superstitious illiterates to take advantage of the medical facilities within their reach. I insist that, as far as rural areas are concerned - and every medical missionary in the country will bear me out, it is going to be far easier to provide hospitals and outstation clinics than it is to persuade the people to make use of them. No one who has not lived and practised in the country can realise the strength of superstition and the hold of the withdoctor. Now the Medical Aids - because of their sex more mobile than nurses, and more likely to grow old in a service where experience will count in the development of efficiency - should perform that vital function of linking the daily needs of the people with hospital and clinic. They will require clinical skill in certain directions, otherwise they will not gain the confidence of the people: they will need to know how to give advice about common ailments, to spot at sight the infectious diseases, to render first aid or expectant treatment in the emergencies likely to be met with in country practice (which differ from those of town practice): and above all, to preach the gospel of personal and community hygiene. Obviously, they will differ from ordinary doctors. Their training can omit much of what is included in the ordinary medical curriculum, and include much which is omitted.

DURBAN - in contradistinction to Fort Hare as a centre for a Medical School - and all this applies equally whether we are considering a full medical course or a Medical Aid course with objectives suggested above - possesses the following advantages:- A large, growing Native population which will supply every possible variety of clinical material; several large hospitals where this material, outpatients and inpatients, is ready concentrated for teaching purposes, e.g. the McCord Hospital (2800 admissions annually, cf. Lovedale 1000) with 250 beds equally divided between all classes of work, the new non-European Hospital of 500 beds and a vast outpatient work mainly surgical, the T.B. Hospital with at least 100 non-European beds, the Leper clearing station for all Natal and Zululand, an Infectious Diseases hospital, a Govt. pathological lab. receiving from all Natal & Zululand - more material in a day than you will see in a year at Lovedale - full time pathologist and several assistants, an elaborate municipal health organisation with full personnel affording possibilities of demonstrations on all branches of public health work, another organisation (Union Health Dept.) with experts in malaria etc., a large Native population within 20 miles of Durban - living under rural conditions - but accessible by much better roads than those around Fort Hare, a large and increasing group of experienced and sympathetic medical men in the town (which has over 200 practitioners) from among whom could be brought together a really useful & consultative body to guide this new departure in medical education and who would even assist in lecturing on special subjects, etc.

Is all this to be thrown away in order to preserve unto Fort Hare a monopoly of higher education for Natives?

See p.2 - A medical school in Durban might very well also undertake the training of Natives for municipal health work, for which there is already a big demand. Could, up to a point, be combined with training of rural health workers (Medical Aids). Impossible at Fort Hare.

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G. W. Gale.

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