A REVIEW OF MEDICINE IN NATAL*

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EARLY DAYS OF NATAL MEDICINE

In 1823, a naval officer on half pay, Francis George Farewell, and an adventurous Cape Town merchant, John Robert Thompson, crossed the Port Natal bar in the ship *Salisbury*. This was largely involuntary, since a sudden gale had arisen and the *Salisbury* was forced to make for the harbour. One could almost say that Port Natal (or Durban, as it was called later by Captain Allen Gardiner) was founded by a south-east wind. This was the beginning of Port Natal as a settlement, although Farewell and Thompson, whose main object was to trade in ivory or any other exportable product, had no intention of settling here.

Dr. Edington

Until the coming of the White man the only medicine that was practised was that of the witch doctor or medicine man. These gentry were a real force for evil in early Zululand and they flourished mightily. There are good descriptions of them written by Nathanial Isaacs in 1830, and it is interesting to note that Dr. Sam Campbell presented a paper on Zulu witch doctors and experiences among the Zulus at a meeting of the Medico-Chirurgical Society of Glasgow in 1888.

Probably the most interesting early medical consultation is that recorded in the diary of Henry Francis Fynn, when Chaka asked him to cure him, and threatened him with death if he failed. He asked Chaka what his complaints were and Chaka said that Fynn must tell him. Fynn then asked Chaka to stand up and he did this reluctantly. On noticing that Chaka's loins were scarified, Fynn correctly told the royal gathering that Chaka had pains in his loins. Chaka held his hand up to his mouth in astonishment and Fynn's wisdom was applauded by all present. Seven days later Chaka was stabbed in the chest and Fynn again attended him successfully.

* Valedictory address, Durban, 14 February 1963.

Much of the early traders' success was probably related to the good relations established by Fynn and Farewell. This depended originally on 'Fynn's modicum of medical and surgical knowledge, which he gained as a scholar at Christ's Hospital'. And so the successful beginning of Port Natal can be attributed partly to a primitive African's faith in the early White man's somewhat primitive medical knowledge.

The first two properly qualified medical men to settle in Natal were the American missionaries, Newton Adams and Alexander Erwin Wilson. Dr. and Mrs. Adams came to Port Natal in 1835, 12 years after Farewell's arrival.

If one orientates the time in history, 1832 was an eventful year in Britain. The British Medical Association was founded by Charles Hastings. There was a cholera epidemic in Britain, while the country was recovering from the economic depression following the long wars with France and her allies. The first passenger railway of any practical value was opened from Liverpool to Manchester, and the first successful trials of steam vessels were being carried out on the Thames.

A medical register was not established in Britain until 1858, though the Apothecaries Act of 1815 had made it illegal for anyone not licensed by the Society to call himself an apothecary.

Medicine in 1835 was still hardly a science. The stethoscope had been invented in 1819 by Laennec, but the few doctors who used it were forced to defend its use. Pasteur was not to conduct his notable experiments until the 1860s. Lister and antisepsis were something of the distant future. The public was still recovering from the Burke and Hare trial in 1828 when, in that great city of learning, Edinburgh, 16 patrons of a certain cheap boarding house had been murdered so that their bodies could be sold for dissection to Robert Knox, an anatomist.

And now to get back to Dr. Adams, who had arrived in Port Natal at the age of 29, after he had been in practice in New York State for about two years. Dr. and Mrs. Adams first established a station at Umlaas River. This survived plundering by Dingaan's warriors in 1838. In 1844 he moved his mission to the Amanzimtoti Reserve, to the site of the present Adams College which was named after him. Dr. Adams encouraged development and concentrated on education and religious work. He was a man of many parts and most industrious. He was regarded as an exceedingly skilful physician and surgeon by colonists and Boers, who often travelled long distances to see him; in fact it has been recorded that at times the wagons were so numerous on the hill above his station that it appeared like a 'nagmaal' congregation.

His Zulu name was 'the teacher with three coats', which arose from his donning a different garb for different tasks.

One of his coats was a white one which he put on after breakfast each day to receive his patients. In 1845 his congregations varied from 500 to 800 in winter and from 600 to 1,000 in summer. His day school provided instruction for 100 pupils. He died in 1851, aged only 45 years, deeply esteemed by Black and White alike. All the military officers and the majority of Durban's residents rode out to attend the funeral.

Dr. Wilson arrived in Natal in June 1837 and settled in Zululand as a missionary. All went well until Dingaan murdered Retief and Dingaan's *indunas* set fire to the American missions. Dr. Wilson and his compatriots had to flee for their lives. After this he first returned to the States, and some years later died from dysentery in West Africa.

Edmund Burrows, in *A History of Medicine in South Africa,* stated that the growth of medical practice and medical institutions in Natal followed a pattern that occurred in other parts of South Africa. First there were the missionaries, 'carrying the vanguard of civilization to the indigenous tribes; then the trekboers seeking fresh pastures, opening the country and making it fit for the White man; and on their heels the British to consolidate, to develop and to build towns'.

It is very unlikely that the Voortrekker parties were accompanied by doctors. They relied on home remedies carried in a chest on the wagon, and sometimes one of the women was skilled in doctoring.

The first qualified civil doctor to practise among the Boers in Natal was a Hollander, Dr. Bernardus Poortman. He arrived in Port Natal in 1839, settled in Pietermaritzburg in 1840, and started practice. He married the daughter of a leading trekker Natalian, and participated in the affairs of the infant trekker Republic.

Later, when British rule spread after the Boers abandoned Congella, he applied to the Government in Cape Town to be made a diplomatic agent in the Natal territory, since 'owing to the unusual salubrity of the climate and the aversion of people in general to medical aid, their poverty, and a combination of the other circumstances' he had been unable to make a living.

Dr. Poortman was the first qualified physician other than a missionary to practice in either Natal or the Orange Free State.

Another early doctor was Wilhelm Julius Heinrich Schultz, who came to Port Natal from the Cape in 1840 and settled among the trekkers in their small village at Congella. He was doctor to the Boers at the siege of Durban, which began on 23 May 1842 and lasted 34 days. Dr. Schultz's fee for his services, rendered at the request of the Commandant-General, was 135 rixdalers for services and 25 for medicines and instruments. The rixdaler was worth about 17c. However, the impecunious Volksraad not only disallowed the 135 rixdalers, but also demanded a detailed statement of the rest of the accounts.

When Natal became part of the Cape Colony and the British regularized medical matters, Dr. Schultz applied for permission to practise as a physician, surgeon and accoucheur. He could produce no diploma. He informed the Government that he had studied at Berlin University for four years and had actually passed his final examination, but evidence of this had been lost. Finally, he had to write a quaint examination which took place at Pietermaritzburg on 8 March 1847. It consisted of a paper comprising 23 questions, intended to cover the whole field of medical knowledge. While the questions were set in English, Dr. Schultz's answers were written in a mixture of Dutch and German, with Latin medical terms. He evidently satisfied the examiners, Drs. Stanger and Menzies (Dr. Poortman had excused himself), and was licensed to practice provisionally for 12 months.

The doctor who attended the British at the siege of Durban in 1842 was James Alexander Frazer, M.D. The following is a description given by one of the relief party of the scene after the siege:

'The main entrenchment across the camp appeared to have been converted into a hospital. I found men with their legs and arms off and some suffering from dysentery. The only shelter they had from the sun by day and the cold by night were the hides of the horses they had killed for food; the stench of these hides was most offensive. Great credit is due to Dr. Frazer; although in want of almost everything that was requisite, every amputation he undertook succeeded.'

One wonders what was requisite in those days, with no sterility, no anaesthetics, no antibiotics. Probably purgatives, derivatives of opium, alcohol, and some surgical instruments.

In the succeeding years the population of Natal increased by immigration from Britain, and a number of settlers came from the Cape, among them several medical men. It is surprising to note how many of these early medical doctors became civil servants. This was probably on account of the difficulty in making a living through the practice of medicine.

There was Benjamin Blaine, who was the first 'Surgeon of the District of Natal'. He had voyaged to the Cape from England for health reasons, and was licensed to practise in the Cape Colony in March 1843. He then decided to settle in Natal and made the journey through Pondoland by ox-wagon, arriving at Durban in November 1843. Dr. Blaine first settled at Marianhill, where he farmed with Bombay-grown cotton seed and also performed medical duties. In 1847 he sailed for England, where his samples of cotton were pronounced by experts to be better than the Indian-grown product. This gave great publicity to Natal as a cotton country.

Later Blaine forsook both medicine and agriculture and entered the Natal Colonial Service. He was at first an Assistant Magistrate and later did duties as a Magistrate at Verulam, and then at Maritzburg.

There was also William Stanger, who came to Natal in 1845. He had already visited Australia and had survived a disastrous expedition to West Africa as geologist-cum-doctor. He had been one of the few to emerge alive from the West African jungle. In 1845 he applied for and was appointed to the post of Surveyor-General of Natal. He set out to fix the exact boundaries of Natal, and also laid out Durban and Pietermaritzburg, several smaller villages, and the main roads. He was also a member of the Executive Council, Natal's 'cabinet'. He died at the age of 42, and was succeeded in his post as Surveyor-General of Natal by another doctor, Peter Cormack Sutherland.

Burrows wrote of Dr. Sutherland that 'the span of his life was so long and the range of his interests so wide that his biography is virtually the history of Natal'.

Before coming to Natal he had travelled extensively. He had been to Canada, West Africa and the Arctic, where a polar island was named after him. He had written a book, *Penny's Voyage in Search of Franklin,* and had lectured to the Royal Society on the geology of Greenland. When appointed to his new post as Surveyor-General of Natal, he at once set out to complete the tasks Dr. Stanger had begun — charting Natal, laying out villages and districts, planning roads, bridges and irrigation schemes, and guiding the fate of Grey's Hospital. He was on the Legislative Council, and though it is unlikely that he ever practised as a doctor, he was the first surgeon to the Military Volunteer Corps, which later became the Natal Carbineers, the country's senior regiment. He was chairman of the Natal Medical Committee throughout the 40 years of its existence (1856 - 1896). It afterwards became the Natal Medical Council. Dr. Sutherland was a man of very wide interests, which ranged from temperance to agriculture, and from natural history to education, and 'he played a vigorous part in the intellectual atmosphere of the Colonial capital'.

Robert James Mann was another doctor who became a civil servant. He arrived in Natal in 1858 and was licensed to practise as a physician, surgeon, and apothecary in the same year. Eight months later he was appointed Inspector of Education throughout the Colony. He was also a man of wide interests and became the 'recognized authority on all scientific matters'. He served on the Natal Medical Committee and on Grey's Hospital Committee. He resigned from his post and returned to England in 1870.

Gradual changes occurred and improvements were made in the Colony. Thanks to the development of sugar-cane farming, the Colony's economy started to improve in 1860. Cottage hospitals were erected, and later larger hospitals; of particular note was the erection of Grey's Hospital in 1857, Addington Hospital at its present site in 1878, and a lunatic asylum at Town Hill, Pietermaritzburg, in 1880.

The number of doctors increased, many of them fine personalities, doing much to stimulate development in the

Colony. What these men lacked in medical knowledge, they made up for in personality.

There was the Addison family: William Henry Addison arrived in 1849, and it was he who advised the Governor on the suitability of applicants to practise in Natal, before the Natal Medical Committee was created. When he settled in Durban he was advised against renting a small cottage behind the gaol since 'Mrs. Addison would be terrified by the elephants who used the verandah posts as rubbing places and were continually knocking them down'. Dr. Addison experimented with sugar cane with great success. He gave '40 years of devoted service to the profession in the Colony'. His son, William Henry Addison jnr., was also a fine individual who succeeded his father in the Durban practice that he had built up. Addison junior participated successfully in the diamond rush to Kimberley in 1869 before going to England to study medicine. He was at one time house-surgeon to Mr. Joseph Lister. He did a tremendous amount of surgical work at Addington Hospital and built up an enormous surgical and general practice and 'an enviable reputation as a fine doctor, a fine friend, a sportsman and a very splendid colleague'. His grand-daughter, Mrs. Pam Gie, lives in Durban, and her husband, Dr. Alan Gie, is a member of our Branch.

The last of the early doctors whom I wish to mention is Dr. Nembula, who was the first African doctor to qualify. He was the son of Ira Nembula, whom Dr. and Mrs. Adams had brought up at the Amanzimtoti Mission. He was taken to the USA by a missionary to assist type-setters with the transcription of the Zulu Bible. He remained there to study medicine, paying his way at Chicago University by doing clerical work and utilizing the gift he possessed of copper-plate handwriting to write personal visiting cards and other scripts for sale. He returned to South Africa in 1888, where he executed his duties satisfactorily. He was first a district surgeon at Pomeroy, and died at Mapumulo at the age of 36 from tuberculosis.

THE MEDICAL ASSOCIATION

The first South African Medical Association was founded in Cape Town in 1883. This Association disappeared from the scene when the Cape of Good Hope Branch of the British Medical Association (now the Cape Western) was formed in 1889. A Natal Branch was founded in 1896.

At the time of the formation of this Natal Branch the medical profession in Natal was not organized to any great extent. A Medical Society had been established in Durban about 1870, and one had existed in Pietermaritzburg for some years.

When it was proposed that a Natal Branch of the British Medical Association be formed, it was decided to approach all practitioners in Natal and to call a meeting in Durban of the combined societies. Even in those days, as today, all was not unanimity, as was shown by the reply received from Dr. Orsmond of Newcastle. He said:

'I fail to see the good of joining our own society of practitioners out here. The local one in Pietermaritzburg is of no earthly good to country members, and judging from reports of the Provincial men in Durban, their contributions were not equal to that of a student fraternity. It almost makes one blush to belong to a profession where so much twaddle is talked and so much fuss made about inanities. We are not fit to contribute much to medical science. Later I shall see if I can raise the necessary funds, meanwhile it takes one month to pick up a spare half-guinea.'

The new Branch received official recognition in 1896. It consisted of 44 foundation members, with Dr. James Hyslop, one of the country's pioneer specialists in mental diseases, as the first President.

In the same year as the Natal Branch of the British Medical Association was formed, there was a second attempt to form a South African Medical Association. This was at the fourth South African Medical Congress, held in Johannesburg in 1896 under the distinguished presidency of Dr. W. G. Atherstone, who was in his 82nd year.

Dr. Atherstone was one of South Africa's most celebrated medical men. He was a skilled doctor and the first man to use ether as an anaesthetic in South Africa. He was a well-known geologist and is particularly famous for having identified a small shiny pebble sent to him as a 21-carat diamond. He stated at the time that wherever that came from there must be lots more. Since this was the Hopetown diamond, the first to be found in this country, he was certainly correct.

He was a botanist as well as being a musician and astronomer. He gave great service in public and political life. Had it not been for him it is unlikely that I would be here tonight, since it was at his instigation that the Colonial Bacteriological Institute was established at Grahamstown in 1891, and my grandfather, who had been Lecturer in Bacteriology at Edinburgh University and the Professor of Comparative Pathology at the new Veterinary College, was asked to come out to be the Colonial Bacteriologist.

At this fourth South African Medical Congress, a motion to form a South African Medical Association was proposed, seconded and carried unanimously. The fact that the British Medical Association was eight weeks of travel away from South Africa and in no position to undertake practical work in this country was stressed as one of the reasons for having a South African Medical Association.

In the early days of the Natal Branch of the British Medical Association the ordinary general meetings of the Branch and the annual general meetings were held alternately in Durban and Pietermaritzburg. Matters which occupied the attention of members very soon were the institution of a uniform death certificate, the establishment of an inebriates' home, and the institution of locked wards in the general hospitals, with the more active combating of venereal disease.

The first lady member of the Branch was Dr. Lilian Jenkins, afterwards Robinson, who in 1900 complained that she had not been admitted to the meetings. This anomaly was adjusted.

In 1904, the first steps were taken to form two divisions of the Natal Branch. These divisions were raised to the status of Branches in 1908. Like any history of development in which human relations played a large part, there have been stormy periods when harsh words were not spared and even fisticuffs threatened.

On one occasion no less than four members took off their coats with the intention of coming to blows. On another occasion, a certain complainant remarked that this was 'the Natal Coastal Branch of the British Medical Association and not Dr. Campbell's private Branch'. Dr. Campbell was President of the Branch that year.

However, though there were big differences there were some outstanding personalities in the Branch, such as Archie Mackenzie, Sam Campbell, Maurice Pearson, Alma Dumas, Stanley Copley and Herbert Mundy. Many of these had sons who carried on the traditions their fathers had begun.

In 1926, thanks to the good work of Dr. Alfred Cox of the BMA, the Medical Association of South Africa (BMA) was formed, under the Presidency of General A. J. Orenstein, and some years later we separated completely from the BMA.

With regard to the present status of our Branch of the Association, I consider our position satisfactory in many respects. We are a large, active, friendly Branch with many hard workers for the Association and its principles and interests.

Unfortunately, our clinical meetings are not well attended, and I have remarked on this at several excellent clinical meetings during the past year. On the other hand, our annual dinner is well supported and has been a very successful function during recent years.

The resignations and relatively poor percentage membership among full-time colleagues are distressing. We hope the new sliding scale of subscriptions will encourage recently qualified doctors and full-time doctors to join the Association.

We are anxious to see our full-time non-European colleagues receive equal recognition with their European colleagues for the good work they do in the Provincial Service.

In recent years we have had a very active Women's Auxiliary, who have done excellent work raising money for our Benevolent Fund. Not only do they help the Benevolent Fund, but their functions bring the profession together.

One of the problems we have had to deal with during the past year is that of medical publicity. I feel it is time that the medical profession modernized its views on publicity, as was recently urged by Sir William Haley, Editor of *The Times*, when he spoke to the Winchester Branch of the British Medical Association.

Firstly, I feel we should make medical news available to the Press, and do our best to educate the public. Secondly,

I feel we should not be so sensitive about our colleagues receiving indirect publicity, provided the information given is for the benefit of the community. For instance, if a professor of paediatrics is requested to give a statement on kwashiorkor, I feel it should be in order for him to do so and that he should not have to remain anonymous.

I have been conscious many times during the past year that the Association is taken for granted. One is told that the Association is not worth belonging to since it costs too much and all one gets is the *Journal*. However, demands are made for certificates at short notice, and numerous complaints, some of them very minor, are received and are expected to be investigated immediately. I may say that the criticisms often come from those who contribute least.

I am not going to review all that the Association does for us, but I wish to make the following remarks in this connection.

Firstly, our predecessors found it necessary to have medical societies and Branches of the British Medical Association, for the protection of their interests, to control ethics and to lay down medical fees. Also, the branches and societies instigated health legislation and encouraged the development of medical services and the broadening and exchange of medical and scientific knowledge.

Secondly, the Association is regarded as the mouthpiece of the profession. It is looked on by the Provincial authorities and the Government as the body that represents the profession. I feel every doctor should make a contribution by being a member of our professional body, the Medical Association, and every doctor should do his best to see that our Association is a strong and united one to meet the difficulties and dangers that confront the profession.

The effectiveness of the Association depends on the support it receives. It is most important to have a strong Association to look after our own interests and also to stimulate health legislation where necessary.

THE NATAL MEDICAL SCHOOL

No review of medicine in Natal would be complete without mentioning the Medical School in Durban. There is little doubt that the establishment of the Faculty of Medicine within the University of Natal has been one of the most significant events in medicine in South Africa, and we are proud of the part played in this by our Branch. To date 105 doctors have qualified from this Medical School.

There is no doubt that the Medical School has been a boon to medicine in Natal, and particularly to Durban. We are proud of the high standard that is maintained by an able and dedicated staff. There are numerous ways in which it has helped medicine in Natal other than by the provision of African and Indian doctors, which of course is its primary service.

For us practitioners the Medical School is always a further court of appeal. Numerous interesting meetings are organized by the Medical School staff. For those on the part-time staff, there is the considerable stimulation of association with full-time colleagues and trainee specialists, and all the advantages resulting from being on the staff of a teaching hospital.

There has been effective liaison with Addington Hospital, with definite advantages to the doctors of Durban and the public. This has occurred particularly in the departments of pathology, paediatrics, anaesthetics and medicine. Lastly, as a result of the presence of this Medical School, there is a constant stream of visitors from overseas who help to stimulate us and keep us in contact with medical thought elsewhere.

Our Branch is anxious to have a Medical School at Addington Hospital for many good reasons, one of which is that European students from Natal could train in their own Province. But until this idea receives more support from the Government it cannot be proceeded with. However, it is important to keep the project in view.

NATAL MEDICAL PLAN

During the past year we have seen the development of the Natal Medical Plan on the lines of the pilot scheme, the Medical Services Plan, which was started in Johannesburg under the leadership of Dr. Maurice Shapiro. The basic idea behind the Plan was to develop a comprehensive medical scheme that would benefit the patient and be a fair and satisfactory one for the doctor. It was intended that the scheme should allow the patient to budget in advance, knowing that all his medical expenses could be covered as far as possible, and at the same time remove any third party from the contract. Also, by means of a committee of doctors there would be scrutiny of accounts, and both the patient and the doctor would be disciplined, when necessary.

Since the start of the Plan we have had the report of the Snyman Commission, which includes the investigation into medical aid schemes by Dr. N. Reinach. This report has filled most of the profession with considerable apprehension. However, this matter will be fully dealt with during the coming months, and I shall not enlarge on it now. The Plan as a project of development has been launched successfully, and we are proud of the united effort that has been made by members of this Branch. A great deal of hard work was done by many members, and I cannot speak too highly of the Executive Committee, ably led by Drs. N. G. Steere and N. R. Pooler. I sincerely hope that the Plan, with support from the Chamber of Commerce, will go from strength to strength.

MEDICAL PRACTICE

In the year 1963 the doctor is in the satisfactory position of having very effective weapons against disease. His position differs vastly from that of the doctor of 100 years ago, when Oliver Wendel Holmes wrote: 'I firmly believe if the whole of *Materia Medica,* as now used, could be sunk to the bottom of the sea, it would be all the better for mankind, and all the worse for the fishes!'

The last 50 years have been aptly named the golden era of therapeutics. We take it for granted that there are effective remedies or adequate prophylactic measures for the dreaded diseases of the past. I mention, in particular, tuberculosis, typhoid, pneumonia, syphilis, rickettsial diseases, pyogenic infections, gonorrhoea, malaria, and poliomyelitis.

However, the position has in some ways been over-compensated. An American writer in 1957 estimated that there were 140,000 medicaments, of which some 90% did not exist 25 years previously.

This tremendous advance in therapeutics has made the practice of medicine far more satisfactory for the doctor and certainly for the patient. The doctor is bewildered at times by the number of drugs available, by the number of drugs produced from the same organic nucleus, and by the multitude of sales representatives. A new hazard with which the medico has to contend is, of course, the side-effects of these new drugs, some of which can be lethal.

At this stage I should like to survey briefly the state of medicine in our Province.

If any one of us were asked what is the standard of medicine in Natal, could he give a thought-out answer? Most of us are conscious of our own standard of medicine, or we should be.

I have discussed this subject with doctors from all parts of Natal during the past three months, and wish to make the following observations.

I should like first to consider the indigent patient, and here I wish to quote Prof. J. F. Brock's brilliant and widely-embracing address on 'Man and Medicine', delivered as the Public Lecture at the 43rd South African Medical Congress in Cape Town in 1961:

'There is no doubt that our much-maligned country is providing more and better medical and social services to our indigent sick than has been provided at any time in the history of the African continent. This statement is true whether we consider the services of the colonial governments to their territories or those of the emergent African states. On the other hand, our services are totally inadequate for the needs they seek to serve. The squalor and misery of sickness among rural under-developed peop'e is no less clamant and piteous than that of the slums of an industrial community. The heart-rending misery of our urban clinics and hospital outpatient departments demands a far greater effort than we have so far made. This effort must include not only curative services on a far more generous scale, but also an entirely new approach to the

problem of raising living standards and providing the simple necessities of nutrition, housing and hygiene. In this latter respect our profession must be the conscience of the nation, since we see the facts and the issues every day in their stark and ugly reality.'

And here I should like to congratulate the members of the Paediatric Department of the University of Natal, who have done a great deal to publicize kwashiorkor and the conditions that produce it. As a result of their efforts and of others, this is now a notifiable disease.

In Natal the bulk of our population is African. I feel that once the African patient gets to a hospital (whether it be a Provincial hospital or a mission hospital) the attention he receives is on the whole satisfactory. This, of course, depends on the staffing of the hospital concerned, since at present some hospitals are badly understaffed. Hospital beds for the non-European are, as yet, far from adequate in number, though the authorities are making efforts to improve the situation.

What of the position of the African before he gets to hospital? There is no doubt that there are doctors with large African practices, particularly in rural areas, who are doing very fine work. These doctors have to compete with ignorance, superstition and quacks.

Here I should like to mention a visit I paid to Dr. M. V. Gumede at Mapumulo. He is a district surgeon, and the only doctor listed in the Mapumulo district, where 35,000 people live, although there are doctors on the outskirts. I was impressed by his standard of medicine and the way he runs his practice.

We have to admit, however, that many Africans in the country do not get adequate attention, and there is no doubt that, at times, the African is exploited. It is difficult to see how this can be controlled.

I was interested to hear from Dr. W. G. McNeil, Superintendent of Grey's Hospital, who has recently been to Kenya. He felt the hospital facilities there did not compare with ours, but he was much impressed by the country clinics in Kenya, where the African receives excellent attention.

The European in the country districts is usually a private patient and he receives adequate skilled attention.

There is also the problem of the distribution of doctors to the rural areas. Many large areas are very inadequately provided with medical practitioners. It has been pointed out by Dr. H. A. Shapiro that this is related to economic factors: 'Doctors are no different from any other citizens. They will settle where they can maintain their professional associations and interests and be near civilized amenities. The inevitable result in our present society is a tendency for a concentration of practitioners in the larger urban areas.' This can only be altered 'if employment at a sufficiently attractive level of remuneration under sufficiently attractive conditions is offered for practice in such areas. To cope with this problem is a major social undertaking in which the State would have to take the initiative.'

In the urban areas and the towns, the standard of medical treatment for both Europeans and non-Europeans varies with the practitioner, but on the whole it is good. Many of the non-Europeans attend hospital outpatient departments where the attention they get is usually satisfactory, though sometimes the services are strained by the numbers that attend, and they may then receive perfunctory treatment.

Except for a few blatant exceptions, mainly in non-European practice, there is not excessive commercialism. There are a few doctors who are excessively surgically inclined, and an occasional doctor who is prepared to undertake operative procedures for which he has neither the training nor the experience. One country doctor told me that he would never send any patient of his to a certain town for investigation. The patient would inevitably return, not only investigated, but also minus some non-essential organ.

In the towns the European is well served with hospitals where he receives good attention.

Inevitably, when discussing the standard of medicine, the question of the relationship between the general practitioner and the specialist arises. This is a problem that is being continually reviewed.

Here I should again like to quote Professor Brock, when he stated that we should 'never lose sight of the fact that public confidence in the efficiency and integrity of the medical profession will always be determined by the quality of service given by the individual doctor to the individual patient and his close family'.

I would say of my own experience of medicine, since coming here about ten years ago, that the relationship between the general practitioner and specialist is far healthier than previously. If the general practitioner is what he ought to be, that is, a person with close contact with the patient and the family, he does not lose his place to the specialist.

Lastly, there is no doubt that the College of General Practitioners in Britain is doing a great deal to improve the status of the general practitioner, and this, I am sure, will be the case here when the College becomes well established in South Africa.