SOME RECOLLECTIONS OF THE EARLY DAYS OF THE MEDICAL SCHOOL, CAPE TOWN

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I am afraid that what I have to say about the early days of medical training at the University of Cape Town must necessarily be restricted to the period of the completion of the curriculum by the addition of the clinical chairs, which followed some years after the establishment of the pre-clinical medical training.

Furthermore, since I kept no diary or records of those early days, my account must necessarily be based on personal experiences and recollections, rather than on statistical data, and, therefore, perhaps may lose considerable value, if not interest, while probably appearing to be very egotistical.

On the other hand, a teaching unit, for good or ill, is always a reflection of the personality of the teacher, and, in so far as this is true, it is difficult or impossible to avoid some apparent egotistical references. In this case, too, seeing that I am dealing, not with teaching in general, but with its inception at the University of Cape Town Medical School, it would appear to be even more difficult to keep such egotism out of the picture.

I arrived in Cape Town on 1 March 1920, the last of the 3 'clinical' professors appointed to complete the medical curriculum, the others having arrived a week earlier.

I was met by Prof. T. J. Mackie, Professor of Bacteriology, acting as deputy for the principal, Sir J. C. Beattie. He was a bright, cheerful person, energetic and competent, and he at once infused a happy optimism into a venture

utterly different from anything to date in my own experience. However, any lighthearted approach was soon adjusted in my interview with the principal, who emphasized the pioneering nature of the post, with all the attendant difficult problems and hard work involved. On leaving the principal, I met another pre-clinical colleague, who was anything but enthusiastic and offered the remark that we would find this a place of aborted schemes and not infrequent suicides. I am however glad to say that the depression he caused was very temporary.

Professor Saint

My 'clinical' colleagues were Profs. A. W. Falconer and E. C. Crichton, and our selection, whether by intent or chance, was very representative of the British Isles. Professor Falconer was a Scotsman from Aberdeen, with either a family strain of Irish or at least a leaning that way; Professor Crichton was an Irishman with an old family strain of Scots and German in him; while I was an Englishman — 3 parts Scottish and one part English with a Huguenot strain. There can be little doubt that all the elements conducive to full and complete discussion were present.

I was exceedingly fortunate in my surgical colleagues at the hospital and from the start we always worked together in the most amicable way, so that the association was and remained helpful and happy throughout the whole period of our cooperation.

Accommodation

The accommodation offered to me for the Surgical Department was somewhat primitive, and comprised 2 bedrooms and a small cupboard on the first floor of a building opposite the Hiddingh Hall, occupied chiefly by the Department of Physical Chemistry. The smaller bedroom, about 10ft. 6 in. square, served as an office and general work room, the larger bedroom providing accommodation for 15 - 20 students on long schoolroom benches and forms, and serving as a lecture room. The small cupboard, the ownership of which was for a very short time disputed by the professor downstairs, was finally transformed into a dark-room.

At the New Somerset Hospital I had been allocated about 30 - 40 beds in all for White and Coloured male and female adults, and a few children's beds. There were no rooms apart from the wards where teaching could take place, and the outpatient department consisted really of two small dressing rooms, where patients injured in accidents could also be seen. To start with, the second of these dressing rooms became the outpatient examination room, the first remaining for dressings.

However, this inadequacy was overcome by the University putting up a wooden building in the grounds which was arranged as an outpatient department, together with a clinical lecture theatre, and this lasted for several years until we were able to move to the Groote Schuur Hospital at Observatory.

Establishment of the Curriculum

The Faculty of Medicine was a very limited body at that time and, in view of all the developments that were envisaged, the principal was usually present, especially for inter-departmental discussions, which were always downright and not infrequently acrimonious.

Of the 3 departments, Medicine, Surgery, and Obstetrics and Gynaecology, the former two because of their wider scope and more comprehensive nature, were inclined to be regarded as major ones and equal in importance. As a result, they were regarded in a way as complementary, requiring an even distribution of hours and times allocated to them. As both professors favoured morning work, and the professor of obstetrics and gynaecology was not opposed to afternoon work, the other two departments concentrated on the mornings, and so the bulk of their hospital work was done then.

This produced an upheaval at the hospital, where the honoraries were accustomed to working in the afternoons. As a result it was especially difficult for the Department of Surgery since the regular anaesthetists, for example, were occupied in private practice in the mornings and so could not attend. However, this difficulty was finally overcome by my second house surgeon, Dr. H. Berelowitz, deciding to specialize in anaesthetics. He became my anaesthetist, and retained this post as long as I remained on the hospital staff. He also acted as my anaesthetist in my private work till I retired. No one could have had more obliging, pleasant and efficient service throughout that whole period.

I have said that, in the working out of the details of the curriculum, discussions were always downright, and sometimes acrimonious, almost entirely between my medical colleague and myself; chiefly, I think, because we both held very strong views and were not prepared to give in to each other. In fact, we both much preferred to get than to give, but the principal expressed gratification at this state of affairs, since he was satisfied that he got the best possible understanding of any situation in this way. As an example of how strongly we both felt, there was one famous occasion when we were at loggerheads and each very determined to get his way. We both turned up with our resignations in our pockets, unknown to each other, but the worst was avoided by a compromise which was produced by Professor Mackie, and which we could both accept — and so the Medical School was able to continue.

A very pleasant memory of those early days was my great good fortune in having Sir John Bland Sutton, one of my sponsors, present at my inaugural address. Having found out that he was on his way to South Africa for a trip, I cabled him in mid-Atlantic and asked him to be present. He was gracious enough to put back his trip up-country for several days to be able to comply, and he congratulated me on having had the temerity to interrupt his holiday. We were great friends.

Teaching

I was always convinced that our main task in establishing and developing the first medical school in the country was to turn out efficient medical practitioners, and that it was therefore necessary to give priority to teaching, as opposed to research. I am quite sure my colleagues agreed with this view. It in no way belittles our appreciation of the importance and necessity of research.

With reference to the teaching of surgery, my opinion was, and always has been, that it is best carried out by a two-fold

approach, viz. (1) the teaching of principles, and (2) the application of the principles in practice, which may be divided into two sub-sections, (a) clinical teaching and (b) surgical pathology.

The teaching of principles, which is partially an abstract proposition, is best achieved in a series of systematic lectures. Naturally, if the teacher has no principles to teach, the need for systematic lectures falls away, and, under these circumstances, I would not press for them.

The application of the principles in practice comprises, in the first place, the whole of what is usually called 'clinical' surgery, but this includes much more than simple bedside teaching, as the word implies. In other words, the term, in present-day usage, covers the complete handling of the patient, whether a bed or ambulant patient, from start to finish, including all investigations. Essentially, it stands for the endeavour to make a complete diagnosis of the underlying pathology from the various manifestations presented, so that reasonable treatment may be instituted, with a hoped-for cure.

Surgical pathology reverses the programme of clinical surgery and provides us with an approach that enables us to elucidate and formulate the symptoms and signs that the patient would have presented, by carefully considering the pathological specimen offered. Such a procedure, as in the case of clinical surgery, can only be carried out thoroughly by an application of the principles which have been learned.

The whole object of such a programme of teaching is to establish a rational approach to the subject, by which it can be learned on a cast-iron foundation of understanding — perhaps a little difficult to acquire at first, but becoming progressively easier with experience. This is infinitely superior to the scheme of memorizing isolated and disjointed items of knowledge in a parrot-like fashion — 'psittacism', as I have called it. Indeed, while the former method may be learned by anyone if he is prepared to apply himself, to concentrate and do some work, the latter is really limited to those who possess good memories. In the former it is a question of rational and logical thinking, in the latter it is purely a question of memorizing without any analytical thinking at all.

We were fortunate in having only 2 students in surgery the first year, and this gave us an excellent opportunity of developing the scheme, very humble at first, which gradually evolved into the permanent set-up. Naturally the 2 students were fortunate in that they got 100% individual teaching, which, practically, amounted to private coaching.

The systematic lectures were at first given, as I have mentioned, in a small room in a building chiefly occupied by physical chemistry, opposite the Hiddingh Hall; the clinical work was done at the New Somerset Hospital, some 20 minutes to half an hour away; and the surgical pathology was taught in association with the pathology department.

The wooden hut which was put up in the hospital grounds chiefly as an outpatient block, tided us over the initial years, until we moved out to Groote Schuur.

Clinical material was at first very sparse, but it was amazing how quickly the outpatient department developed and extended, and how the patients admitted improved in number and quality, i.e. for teaching purposes.

In the beginning there were no specialists except ENT and ophthalmic surgeons, and the general wards took all sorts of patients, even quite a number of gynaecological cases; and so the surgeons were truly 'general'.

With the era of specialization rapidly developing, this was gradually changed, our gynaecological, urological and orthopaedic activities being progressively curtailed, in this sequence. As an example, we did a great deal of bone surgery at the beginning, and patients with fractures were admitted to all surgical wards. In fact, I myself held a fracture clinic for years, usually in the physiotherapy department.

With our move to the Medical School at Observatory, while we were infinitely better housed and had our own surgical pathology department — rapidly becoming an excellent unit, our difficulties were increased by much time being wasted on transport to and from the hospital. This was only finally solved when we were able to occupy the Groote Schuur Hospital, and so things settled down to a reasonably concentrated and equipped medical school.

Private Practice in Relation to Teaching

Perhaps a short note on this subject would not be out of place, since in certain quarters in those early days it ranked high in importance as a very contentious topic.

In terms of our appointment, we were all allowed private consulting practice, with the consent of the University Council, contingent on its not interfering with our university duties. This was in keeping with university custom that professors were permitted consulting practice in their own spheres, so that there was no special privilege about it.

Unfortunately, and perhaps naturally, the local practitioners, some of whom were to be our colleagues on the hospital and university staffs, were not in favour of it; a few were indeed very much against it.

All of us had had consultant status in the United Kingdom. We asked for similar conditions here, and the essential feature was agreed — that we were to be true consultants, as opposed to the ordinary specialists, in our subjects. Patients, therefore, had to be referred to us by doctors and could not just come on their own.

From the University point of view, at no time was there ever any suggestion that our University duties suffered in any way from our private practice, the existence of which, as I have said, depended absolutely on our carrying out at all times the complete fulfilment of those duties.

For example, again in my own case, for years I did most of my set private operations at 7 a.m., so that I could be free before 9 a.m. for university work.

Research

As mentioned above, research as such did not come up prominently for consideration, but I commenced with some experimental removals of pineal bodies in ostriches, old and young, placed at my disposal by Mr. Alec Hooper of Oudtshoorn. However, as I could get no grant from the University and had to pay all my expenses myself, including travelling, etc., I had to give it up, since my private practice did not develop at a sufficiently quick speed to pay for it. Incidentally, the removal of the pineal in the adults did no harm to them at all, i.e. those which survived the anaesthetic, and in the chicks it interfered in no way with their subsequent development. It will be remembered that the gland, as in the lizard, lies immediately under the cranium.

As the school gradually settled down to its present conditions, the question of research came more into prominence and, fortunately, through the good offices of an old house surgeon of mine, Dr. D. H. Pfeiffer, his uncle had left to the surgical department a small residue in his estate, which, by the time it came to us, had increased to about £22,000.

This was a great help, and a postgraduate scholarship in Surgical Research was created, under the control of the professor of surgery. In 1937 Dr. R. H. Goetz was appointed. He did excellent work on peripheral vascular problems, and later was given the status of Associate Professor in Surgical Research in the Department of Surgery. In addition to his own work, he was able to help very materially those postgraduate students who were expected to do research in connection with their theses for the degree of Ch.M. They worked in his department.

The importance of this section of the Department of Surgery steadily increased, especially under Prof. Chris Barnard, the present occupant of the chair. Wonderful scope for training is therefore offered to postgraduate students of surgery, particularly in the sphere of cardiovascular condtions.