The Adler Museum of Medicine was founded in 1962 and was situated in the grounds of the South African Institute for Medical Research, Johannesburg. It is now housed at the University of the Witwatersrand’s Medical School Campus in Parktown, Johannesburg.

In June 1974 the Museum’s co-founders, Drs Cyril and Esther Adler, presented the Museum to the University of the Witwatersrand which named it the Adler Museum as a token of the esteem in which the founders were held by the University. In addition, the University bestowed the degree of Doctor of Laws (honoris causa) upon Dr Adler and the degree of Doctor of Philosophy (honoris causa) upon Mrs Esther Adler. Until Esther Adler’s death in 1982 she was the Museum’s Honorary Curator while Cyril Adler acted as Honorary Director of the Museum. From 1982 Dr Cyril Adler was appointed by the University as Director/Curator of the Adler Museum, a post he held until his death in 1988.

1975 saw the inception of the Adler Museum Bulletin, the brainchild of Mrs Rose Meltzer. Mrs Meltzer produced the first edition single-handedly and she continued to edit it until her retirement in 1991 and was editorial consultant until her death in 1992.

The Museum contains interesting and invaluable collections depicting the history of medicine, dentistry, optometry and pharmacy through the ages. Items of medical historical interest on display include microscopes and other scientific instruments, early bleeding and cupping equipment with an exquisitely crafted incision knife, ceramic pharmacy jars dating back to the 17th century, a collection of bone china and ceramic feeding cups, some dating from the 18th and 19th centuries, an early 19th century wooden handled amputation set in a wooden case, diagnostic and surgical instruments, treatment apparatus such as one advertised as ‘Patent magnetic electrical machine for nervous diseases’ used by Queen Victoria to ease her rheumatism (19th century) and the first electrocardiograph machine (1917) used in the Johannesburg General Hospital, the original artificial kidney machine used in South Africa, early anaesthetic apparatus, ear trumpets and brass ear syringes (early 20th century), hospital and nursing equipment and medical ephemera.

There are reconstructions of an African herb shop, a patient consulting a sangoma (traditional healer), and a 20th century Johannesburg pharmacy, a doctor’s consulting room, a dental surgery, an operating theatre and an optometry display of the same period. A history of scientific medicine is augmented with displays of several alternative modalities. Other attractions range from a reconstruction of a patient being treated by the famous Persian physician Avicenna to an exhibition of early electro-medical equipment, and a collection of rare iron lungs.

A showcase containing new acquisitions to the collection is constantly changed as donations are received. The objects displayed provide an insight into the range and diversity of the collection.

In the foyer outside the Museum are panels relating to the history of the Cradle of Humankind (Sterkfontein and environs) and a display of replicas from the site give visitors a fascinating glimpse into this world heritage site.

The Museum has a rare book collection and a significant history of health sciences reference library. An archive arranged by subject matter is housed in the library. Biographical information relating to thousands of medical and allied health professionals is available for research purposes which includes photographs, notebooks, academic certificates, records, personal papers and memorabilia of prominent health professionals and academics.

The Museum arranges public lectures, tours, temporary exhibitions and provides excellent facilities for health sciences historical teaching and research.
The Board of the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, has appointed the following members to serve on the Board of Control:

Vice Dean: Faculty of Health Sciences __________________ Professor Merryll Vorster
Department of Anatomical Sciences ___________________ Professor P V Tobias
Mr Brendon Billings

Health Graduates’ Association _________________________ Dr P Davis
Pharmaceutical Society of South Africa _________________ Mr B Sachs
Medical Students’ Council _____________________________ Mr Christopher Mathews
Other members ______________________________________ Professor JCA Davies
Mr Ali Khangela Hlongwane
Dr Sekibakiba Peter Lekgoathi
Ms Alba Letts
Professor Yosuf Veriava
Dr A Wanless

Curator ______________________________________________ Mrs Rochelle Keene
Professional Officer _________________________________ Ms Cheryl-Anne Cromie
Professional Officer (Collections) _____________________ Mr David Sekgwele
Museum Attendant _________________________________ Mr Gilbert Singo

ADLER MUSEUM BULLETIN

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Medical professionalism in a changing society

Professor Yosuf Veriava
School of Clinical Medicine, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg

Guest Editorial

Doctors in South Africa face many challenges, challenges that we have come to know all too well; the burden of disease made all the more onerous today by the emergence of new viruses and the pressures of climate change, as well the problems wrought by the dysfunctionalities within our health care system. But there is also the ever-present challenge of sustaining medical professionalism, a challenge that we should face every day as a profession and as individual health practitioners. It is this challenge that I want to talk about tonight.

Recently, many public sector doctors went on strike in response to the delay by the Department of Health in implementing the occupation specific dispensation. This was an important moment in our profession, not only for how it came to highlight issues around the remuneration of doctors working in the public sector, but perhaps even more importantly, and we should add urgently, for the ethical questions it posed for the profession as a whole. Whilst the community appeared sympathetic to the plight of doctors, it also expressed real concerns over the consequences of such actions on patient care, particularly for the indigent, and all those who rely solely on the public sector for health services.

We, in the past, never contemplated strike action even when, as black public sector doctors, we received lower salaries than our white colleagues and were subject to humiliating and often arbitrary discriminatory practices. But we were not docile either. Many of us would in fact come to recognise our struggle, not as a separate one, but as part of the wider struggle of our communities, a struggle against the injustices of apartheid and the extension of those policies into the health care system. And if we came to see the enemy as apartheid, we could not accept that the very communities from which we came should be victims of how we chose to fight against it.

Today we live in a democracy, but one in which we are still faced by the legacy of the past, a legacy that continues to be felt in the dysfunctionality of the heath sector and the poverty and disease that ravage our communities. Our responsibility, indeed our struggle, today must be to direct our efforts at reconstructing our health services and not to destroy them.

In his Critique of Violence, the early 20th century Marxist theorist and critic, Walter Benjamin, would find cause to reflect on the doctors’ strike that crippled a number of
German cities, likening it to a blockade that, in his words: “showed a repellently unscrupulous use of violence - positively depraved on the part of a professional class that ... without the least attempt at resistance, ‘secured death its prey’, only to abandon life of its own volition at the first ... opportunity.”

These German doctors, like our own, perhaps forgot the most basic principle of our profession - ‘Do no harm’. This is the motto of my talk tonight on medical professionalism.

In South Africa, the injustices of our not so distant past have meant that, as doctors, we have had no shortage of occasions for reflecting on the ethics of the medical profession. And in the 42 years that I have enjoyed the very real privilege of serving the South African community as a medical doctor, I have also been fortunate enough to have been able to make a contribution to this profession, albeit a modest one. So today, as I go reluctantly, some (my children especially) might even say kicking and screaming, into retirement, one of the things I am most proud of is having had the opportunity to participate in different ways in three important cases that cut to the heart of the ethical responsibility and the challenges that face our profession.

Steve Biko, a well known and popular political activist in the 1960s and 1970s, died in detention in September 1977 of severe head injuries following assaults by the security police. Whilst still alive, but badly injured, Biko was under the medical care of two district surgeons. These doctors failed in their professional responsibility, putting the interests of the security police before those of their patient, Steve Biko. The case received extensive publicity, both locally and internationally, casting a negative light on the profession. But the case of Steve Biko also demonstrated the profession’s capacity for self-regulation and its ability to meet the ethical challenges presented by apartheid. And it was because of the intervention made by six doctors, five of whom were from Wits, that the South African Medical and Dental Council (now the Health Professions Council of South Africa) was forced to convene a disciplinary hearing. The doctors who failed Biko and their profession were eventually found guilty of unprofessional and disgraceful conduct. This was a minor victory in the wider struggle against apartheid, but it was an important one for our profession.

Another important case arising out of the apartheid era was the involvement of South African Defence Force medical practitioners in biological warfare. In 1981, there was a project called ‘Project Coast’, which involved chemical and biological warfare research. My understanding of this project is that it was not of a defensive nature as its mission was to test, design and manufacture toxic and biologically active weapons which would be directed at populations and which had disabling and, in some cases, lethal effects. The HPCSA in its disciplinary hearing will have to determine whether the doctor in charge, by failing to distinguish between his duties as a physician and his duties as a soldier, violated numerous and long established ethical norms as he applied his medical knowledge.

However, if the Biko and biological warfare cases illustrate the ethical responsibility of doctors in maintaining their professional autonomy from a repressive state, in more recent times new ethical challenges have emerged as the very fabric that makes and sustains life comes to be traded on the international market as any other commodity.

Recently, a number of medical practitioners in KwaZulu-Natal were investigated on allegations of human organ trafficking. It was...
believed that these practitioners played an active role in an international kidney trade syndicate which recruited financially disadvantaged individuals (mainly Brazilians) as donors of organs to be implanted into wealthy (mainly Israeli) citizens. Such transplants were in fact carried out in hospitals in Johannesburg, Cape Town and Durban. Over 109 of these took place in Durban between 2001 and 2003. As a consequence of this case, South Africa is now listed as one of the countries involved in organ trafficking. According to our local and international code of ethics, trading in human organs is one of the most serious crimes that can be committed by the medical profession.

Questions of medical ethics are, however, not only the stuff of high profile cases like these, or simply a historical record of our exceptional past, but is the very stuff of everyday practice ... dare I say, the stuff that makes a good doctor.

There are in fact few professions where day to day practice calls for nothing less than a commitment to:

- **Integrity,**
- **Compassion,**
- **Altruism,**
- **Continuous improvement,**
- **Working in partnership with members of a wider community,** and
- **Excellence.**

And if these values and traits imply a greater responsibility than those expected of lawyers, journalists and politicians, it is also matched by the tremendous public trust and regard given to doctors.

There are, however, more and more reports of dissatisfaction with the medical profession. Many of these stem from misrepresentations in the media, motivated by the sensational impact of medical errors and misdiagnoses. These overshadow routine good medical practice.

But there are also other factors which convey a negative image of the profession that, unfortunately, are often of our own making. For instance, the perception that many of us who practice in the private sector are only in it for the money, where the relation between a doctor and patient becomes a simple matter of economic exchange along the model of willing buyer-willing seller. Regrettably such an ethos does exist among many doctors. While it is not unprofessional for a doctor in practice to charge a patient for professional services rendered, overcharging or over servicing is unprofessional. This applies also to the practices of doctors receiving financial and other forms of 'kickbacks' from pathology laboratories or pharmaceutical companies. Instances of medical aid fraud by doctors are undoubtedly disgraceful and unfortunately far too common.

Even in the public sector there is much that raises concern. Central to the patient-doctor relationship is patient experience. Public sector doctors are often perceived by the community to be unfriendly, uncooperative and lacking in compassion. Doctors within the public sector have in some instances also failed to keep up with changing societal expectations.

Fortunately for public sector health services, the majority of doctors possess a strong dedication to patient care despite adverse working conditions, and a professional ethic that for many has been the reason for forgoing personal wealth in favour of life of public services and the different, but no less rich, reward that comes from it.

A medical career, however, extends over a period of 30 – 40 years during which a doctor
might experience a weakening commitment to professionalism, and need to find ways of sustaining it. As Dhai and McQuoid-Mason suggest, reflection and reappraisal is thus a primary and ongoing aspect of our professional life. And it is crucial that - even as we trade in life and death - we remember our own humanity. We are not gods (even if we sometimes would like to believe otherwise). We are as unique and fragile as the patients we care for and our individual fulfillment is the key to internalising, sustaining and communicating a professional ethic. “To produce happy patients we need happy doctors” (RCP).

As medical professionalism comes under constant and new threats, its strengthening and protection becomes ever more important. This is a combined responsibility: a responsibility of both individual doctors and professional organisations such as the HPCSA, SAMA, medical schools and the Department of Health. Each has a role to play.

For statutory bodies, such as the HPCSA, this role is perhaps best summed up by the Supreme Court judgement that compelled the former’s apartheid era counterpart to conduct a disciplinary hearing against the doctors involved in the torture of Steve Biko:

They are the custodians of the honour and rectitude of the profession. It is left to them to say what standards of honour the members of the profession should conform to. The Council is truly a statutory custos morum of the medical profession, the guardian of the prestige, status and dignity of the profession and the public interest in so far as the members of the public are affected by the conduct of the members of the profession.

The Department of Health, on the other hand, as the major provider of health services, has a specific role in creating an enabling work environment for doctors to perform their responsibilities according to the dictates of professional ethical codes. Attention to additional considerations, such as adequate salaries and benefits, future security, pleasant working conditions, adequate time to attend to professional development and a promising career path, will go a long way to creating a ‘happy doctor’ population in the public sector.

Medical schools also have a critical role to play in developing the future generations of truly professional doctors. They need to consider selection criteria which would identify students with developed, or the potential to develop, qualities that I have spoken about tonight. Furthermore, the values of professionalism must be integrated into and inculcated throughout a student’s entire medical curriculum. Our Faculty of Health Sciences has for this very reason introduced professional values early into the undergraduate curriculum and attempted to promote a culture of medical professionalism through the creation of institutions like the Steve Biko Centre for Bioethics.

The ethical foundations of our profession are ancient. And, indeed, our profession has come to embody the highest values; a commitment to the well-being of others, mastery of a body of knowledge, of a set of skills and self governance; values that are very close to how the ancients understood ethics itself, that is as the care of the self and others.

A working party of the Royal College of Physicians in the United Kingdom recently defined medical professionalism as:

[A] set of values, behaviours and relationships that underpins the trust the public has in doctors.
This trust, which is the very life blood of our profession – and what our patients’ faithfulness to the prescriptions we set rests upon – depends on nothing less than an ethical comportment that, in the words of the Royal College of Physicians, requires “a partnership between patient and doctor ... based on mutual respect, individual responsibility and appropriate accountability.”

I would like to end my talk tonight, and what have perhaps been somewhat scattered thoughts on professionalism, with two possible scenarios that John Williams, in a recent publication, lays out for the future of our profession.

In the first, the forces of commercialism, consumerism and bureaucratisation prove overwhelming and health care is largely taken over by corporations and run on business principles. Efficiency becomes the primary value, insofar as it constitutes profits, eclipsing patient well-being. Indeed, in this scenario the patient is nothing more than a customer and physicians serve either as employees, managers or owners of a business whose commodity is health. The ethical centre of the profession has now become the enterprise as the primary object of professional loyalty.

The second scenario is one I prefer and which I believe is worth striving towards:

Medicine will continue to be a healing profession dedicated to serving humanity. Its cornerstone will contribute to the relationship of trust between the patient and the physician. It will uphold with integrity the values of respect for persons, compassion, beneficence and justice. It will strive for excellence and incorporate progress in its art and science. It will maintain high standards of ethics, clinical practice and research in order to serve patients. It will encourage the development of healthy communities and of practices and policies that promote the well being of the patient. It will demonstrate its capacity for societal responsibility through self regulation and accountability. It will actively participate in decision making policy regarding health and health care policy. It will guard against forces and events that may compromise its primary commitment to the well being of patients.

This is the vision and challenge I will have to leave to you to realise. The future of our profession and the health of our communities depend on you rising to meet it. But I have every faith that you will not fail us and the profession that you now have the privilege of belonging to.

Hopefully you were well taught.

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4. Veriava and others v President SAMDC and others: The South African law reports. May 1985 (2).
Yosuf "Joe" Veriava is perhaps best known within the academic community for the ‘Steve Biko court case’ in which he participated against the South African Medical and Dental Council in 1985. Joined by other renowned Wits academics, including Phillip Tobias and Trefor Jenkins, the group succeeded in restoring some faith and confidence in the medical profession by having the errant ‘Biko doctors’ struck off the medical roll. The official case reference [Veriava and others v President, South African Medical and Dental Council, and others, November 1985] defines Professor Veriava as a person who lays the ethical and moral foundations on which others may build. He is a person who is able to stir the conscience and mobilise the support of giants like Tobias and Jenkins; someone who has the courage to challenge and rock the very foundations of his own profession. The Biko case, while noteworthy and triumphant in its own right, was but one of many moral and ethical victories in a campaign that started at least a decade earlier, with Veriava, a junior medical consultant at Coronation Hospital and a member of the Wits academic staff, regularly confronting the Director of the formidable, arbitrary and vindictive Transvaal Provincial Hospital Administration.

Himself a victim of differentiated salary and other conditions of service that were applied to ‘non-whites’, Joe established groupings such as the Doctors’ Support Committee, but it was mostly in his personal capacity that he confronted the authorities, invariably risking his own position, and on several occasions compromising opportunities for promotion. Whether campaigning for equal conditions of service for equally-qualified professionals, equal opportunities for undergraduate and postgraduate students, desegregated facilities for patients, or the right to publish revealing facts on disparate hospital conditions, he was always at the forefront. As such, he has served the Faculty, the University and the country in the pursuit of dignity and justice for more than 30 years, and there can be few people in our midst who have done as much to move this institution and its various medical campuses forward in the quest for equity and transformation.

Behind the academic scenes Joe was also politically active in positions such as Secretary for Health of the Azanian Peoples Organisation, and he played a vital role in providing health services...
to disadvantaged and disempowered local and remote communities, from Kliptown and Alexandra to Brandfort and Potgietersrust. These activities gained him recognition by the populist Sowetan newspaper and Drum magazine, while simultaneously putting the hospital administration on alert for any infringements that would give them cause for his dismissal. However, Joe always ensured that his patients had been treated, his students taught, his clinical duties fulfilled.

His profile as a highly-regarded clinician and an activist undaunted by apartheid officialdom and its menacing organs resulted in Joe being called on repeatedly by lawyers in the late seventies and early eighties to examine detainees and provide evidence of abuse and torture. This he did with unwavering honesty and objectivity, again ignoring the risk to his own freedom and professional career. His involvement with detainees led to the establishment of the Parents’ Support Group and a medical panel that gave further voice and some opposition to the plight of detainees and the circumstances under which they were held. As a consequence of these and other activities that involved parents, notably the protection of children engaged in the schools boycott in 1980, Joe was detained for five months during which he was assaulted and subjected to prolonged solitary confinement, while also having to deal with the news of his father’s unexpected death.

At Faculty level Professor Veriava has been a driving force behind the establishment of standing committees such as the Equal Opportunities, Racial and Sexual Harassment Advisory, and Professional and Ethical Standards committees. More important, however, were his roles in the Faculty’s submission to the national Truth and Reconciliation Commission in 1997, and the Faculty’s subsequent Internal Reconciliation Commission. These initiatives speak to another aspect of Joe’s make-up, his commitment not only to rights and justice, but also to peace and reconciliation. A consistent and renowned characteristic of this man of profound integrity remains to always engage and respect colleagues (even through times when they were undoubtedly less than worthy of that respect) and not to bear grudges or harbour resentment. In return he enjoys the respect of those who work with and for him, and it is clearly apparent that when he speaks out in an assembly such as the Senate on matters of principle, ethics and equity, colleagues listen and are usually persuaded by his rational and balanced arguments.

Joe’s contributions to the rights of patients, doctors and students, and his victories over the injustices of academic and hospital apartheid, between 1970 through even into the nineties, are identified in Advocate Jules Browde’s Report on the Faculty’s Internal Reconciliation Commission. These include leading roles in:

- the development of an ethical policy for the management of hunger strikers (essentially preventing the police from removing striking prisoners from the hospital)
- the formal establishment of the Coronation and J G Strijdom hospitals as a multiracial hospital complex following the disastrous transfer of the latter hospital to the white ‘Own Affairs’ department in an attempt to exclude other races, and
- support for a group of Baragwanath doctors in their case against the Province after they had been denied jobs for refusing to apologise to the Director of Hospital Services for a critical letter published in the South African Medical Journal.

These and other achievements have won Joe an Indicator Human Rights Award, an award from the South African Medical and Dental Practitioners group, the Benjamin Pogrund Medal from Wits, the Alligarh Gold Medal, and importantly, in eventual recognition for his contributions to the Gauteng Province and its health system, he recently received the MEC’s Award for Service Excellence. The University recognised his clinical abilities and superb leadership skills by appointing him as Academic Head of the internationally-renowned Department of Internal Medicine. However at this time we would be failing in our duty were we not to also recognise his unwavering commitment and dedication to the human, moral, ethical and transformational aspirations of Wits and the communities it serves. Honoris causa is translated as ‘by reason of honour’ – Joe Veriava has honoured Wits by his contributions over thirty years, it is appropriate for us to now honour him.
Enquiries into health and safety in South African mines in the 20th century: what did they have to say about occupational lung disease?

JCA Davies
Professor Emeritus, University of the Witwatersrand, Johannesburg

Editors’ note: A short version of this paper was presented at the International Congress on Occupational Health held in Cape Town in March 2009

‘Upon this gifted age, in its dark hour,
Rains from the sky a meteoric shower
Of facts ... they lie unquestioned,
uncombined.

Wisdom enough to leech us of our ill
Is daily spun; but there exists no loom
To weave it into fabric; ...

Fragment from a poem by Edna St Vincent Millay, taken from her book ‘Huntsman What Quarry’ and originally quoted by Neil Postman in his essay entitled: ‘The Information Age: A Blessing or a Curse?’

‘Capitalism did not survive in the United States or in the other industrial countries because of a rigid adherence to individualist precept ... . It survived because of a continuing and generally successful effort to soften its harsh edges – to minimize the suffering and discontent of those who fail in the face of competition, economic power, ethnic disadvantage or moral, mental or physical incapacity.’

Fragment from a graduation address by John Kenneth Galbraith to graduands at Berkley entitled: ‘Two Pleas for Our Time’ which is published in a collection of his essays: ‘A View from the Stands’.

These two fragments were written before the advent of the disaster we now know as ‘globalisation’, when it was still fashionable to be a romantic and still permissible to question the conventional wisdom. They are set out here to provide me with an opportunity to say that the future of the working man or woman is more bleak and uncertain than it ever was. In the hands of the captains of industry, the rich and powerful, dust levels and the prevalence of work-related disease and injury do not decline without tough state intervention. The proposed amendments to the South African Mine Health and Safety Act are evidence of a new and hopefully much tougher stance in respect of health and safety in the South African mining industry.

THE WAKE UP CALL

The Second South African (Anglo-Boer) War ended officially on 31 May 1902. During that war mining activity on the Rand virtually ceased, but the reported death rate among machine men employed before the war led to the appointment in December 1902 of the Miners’ Phthisis (Milner) Commission – pretty prompt action considering the circumstances. This commission was seen by the scientists and the doctors working in South Africa at the time, and in the period up to 1930, as the wake-up call. Personally I don’t think anyone was sleeping, but that they simply did not realise the full extent of the increase in toxicity of the mine dust, mainly if not entirely due to the smaller particle size, brought about by the technology change from hand drilling to pneumatic drilling. We know from the lung ash studied by Dr John McCrae1 in 1913 that 70% of
the particles retained in the lungs of miners exposed on the Witwatersrand were less than 1 micrometer in diameter. If an international comparison can be made the Enquiry into the Health of Cornish Miners began at almost the same time, and for exactly the same reason, and their report records the interchange of information between the two commissions. So those responsible in South Africa were up with the leaders in 1902, not sleeping, as they themselves implied! The terms of reference were:-

a) To enquire into the extent to which Miners’ Phthisis prevails.
b) To ascertain the cause of the disease.
c) To make recommendations as to the preventive and curative measures which should be adopted either by legislation or otherwise.

There were ten members of the commission, including the chairman. Four were doctors, and one of these was the Medical Officer of Health of Johannesburg. The first meeting was held on 4 December 1902, and the completed report is dated 29 May 1903.

DISEASE AMONG ROCK DRILLERS

The conclusion on the extent of miners’ phthisis was based on a cross-sectional survey of “4,403 miners officially declared to be working underground in the gold mines of the Witwatersrand”. The response rate was only 27.5% (1,210) and of these 15.4% (187) were “certified by the examining doctor to be affected by the disease”. The disease was suspected in a further 7.3% (88). In modern statistical parlance the confidence intervals are narrow, but inappropriate as the 1,210 responders were not a sample and the biases inherent in the responder group are unknown. The Commission reported the major limitation of their study as “the difficulty in making a diagnosis in cases which present no distinctive features [without chest X-rays] so that the above percentage[s] cannot be considered absolutely reliable, in so far as those examined may not be representative of the whole body of miners.”

The report continues: “Viewed as a whole, however, the number of miners known to be, and believed to be, suffering from the illness under investigation is sufficiently large to confirm the impression already made that the extent to which Miners’ Phthisis prevails at the present time is so great that preventive measures are an urgent necessity, and that such a large number of sufferers in our midst is a matter of keen regret, especially when it is found that their average age is only 35.5 years.”

Lest we forget, the figure for 1902 is less than the prevalence of silicosis among working miners retrenched in 1998 from one shaft of the President Steyn gold mine in the Free State, when the shaft was shut down for economic reasons.

One hundred and seventy-two of the 187 men affected (92%) had been employed on rock drills for an average 6.5 years. It was reported that: “the statement made by Dr Irvine that out of 93 males who died of chest disease at the Johannesburg Hospital over 50% were miners is full of significance.” The report is quite short, only 22 pages, but the section headed ‘SILICOSIS’ is worth copying in full (pages XIX-XXII). “The disease known as Miners’ Phthisis, or more correctly as Silicosis, has been shown to be a chronic fibrosis of the lung, i.e. the inhalation of fine angular dust suspended in the mine atmosphere causes irritation which produces an enormous development of the delicate fibrous tissue in the lung; bands and patches of solid useless material gradually encroach on the normal breathing apparatus and interfere seriously with the respiratory functions – this alteration in the lung tissue is well depicted in the coloured prints attached to this report.

The large amount of silicious particles inhaled, which remain in the lung, can be distinctly felt by cutting into the same; further, chemical analysis shows that the quantity of silica in some of the lungs examined amounted to 24.4 per cent, which amount almost entirely represents foreign matter that has been introduced [there is little or no silica in the lung of individuals who have not worked in silica containing dust].
It is a matter of regret that we are unable to state with sufficient accuracy the percentage of miners in the Witwatersrand who are suffering from the disease. The fact that attention has but recently been directed to the presence of the disease [a reason which 21st century mining companies could not advance with any chance of being taken seriously], the outbreak of hostilities [there has been peace, of a sort, in South Africa, since 1945] and the reluctance on the part of many miners to present themselves for examination, have all tended to defeat our efforts in this direction.

The report of the Transvaal Medical Society shows that the disease was present to a very great extent among the miners who were examined by members of the committee. This statement has since been amply borne out by the statistical returns obtained from the mining companies, and is supported by the weight of evidence tendered by the individual witnesses.

Corroborative evidence on this point is also to be found in the Annual Report of the Government Mining Engineer for the year 1902. It is there stated that from data gathered by the inspectors of mines it is estimated that out of 1,377 rock drill miners employed in the Witwatersrand mines prior to the war, 225 or 16.34 per cent., had died during the two and a half years preceding the outbreak of hostilities.

The average age of the diseased miners is low, and the remark of Dr. Frazer, one of the witnesses, that ‘he believed every miner who has worked for a year or two on rock drills is affected,’ is pregnant with meaning.

Practically all the evidence given on this point tends to show that the inhalation of minute particle of inorganic matter is the primary and exciting cause of the disease. Whilst the various mining operations, such as drilling dry holes, blasting, shoveling, and breaking rock, are in progress, aciculiform [like little needles] dust is discharged into the atmosphere, and analyses have proved that the air breathed by the miners is impregnated with such dust to a more or less extent, according to the nature of their working places and the conditions for the time being under which they may be placed.

The drawings [appended] illustrating the character of this dust fully explain how it is that extremely fine, sharp, needle-like foreign material constantly brought in contact with delicate lung tissues produces such serious organic changes.

Dr. Pakes (whose opinions have weighed with us considerably in arriving at our conclusions) confirms the medical evidence, which is unanimous, that bad ventilation, air vitiated by gases produced by explosions, miss-fire or otherwise, lower the power of resistance in the miner and tend therefore to render him more liable to pulmonary diseases, Miners’ Phthisis included. The ill effects produced by drinking water contaminated by excreta are too well known to need further special reference.

Pulmonary complaints are contracted and accentuated by the miner being exposed whilst in his wet working clothes to the cold air on the surface after leaving the warm atmosphere of the mine.

CONCLUSIONS

From the foregoing report it will therefore be seen that it is urgently necessary:-

1. To prevent the discharge of the minute hard particles of dust already referred to into the mine atmosphere, and which are largely produced by blasting and rock drill operations.

2. To supply the working places throughout the mine with air in sufficient quantities and in such a manner as to render harmless and sweep away all vitiated atmosphere.

3. To maintain underground workings in every mine in a clean condition, and to provide for this purpose a suitable sanitary system.

4. To provide change houses, suitably warmed and within reasonable distance from each shaft, where the miners can dry and change their clothes.

5. To avoid the use of low flash point lubricants
in the air cylinders of compressors, and to provide that the air intake be outside the engine house, so as to ensure a pure supply.”

The central issues in this report are the quality of mine air and the nature of the lung disease of miners. The interest is in skilled white imported miners. Black labourers are ignored apart from an appendix giving an account of five cases of silicosis amongst natives – the ones who came to autopsy are cases of silicosis with tuberculosis and the return of sick workers to the labour-sending areas is a prominent part of the story. The analyses of mine air are interesting – dust measurements are in grains per cubic foot. The account of a compressor accident is also interesting.

SOME OF THE EVIDENCE

Mr Thomas Pryce Rosser is part of my family folklore. He gave evidence to the commission on 25 February 1903 and died in Zambia in 1905. His son Billy became an electrical engineer and worked for the Johannesburg City Council. Billy and his wife were good friends of my parents, and their daughter almost my exact contemporary. Billy became the first male Pryce Rosser, so the story goes, to turn 40 years of age for several generations. If my parents are to be believed it was an occasion for a memorable party. Tom Pryce Rosser’s evidence is worth reading.

He was asked (para 1041): “In your opinion is it quite possible to allay all the dust in a mine? – I think so, simply by meeting it on the spot where it is created.” This succinct summary is echoed by General Gorgas, a little over ten years later, who said: “The hygiene of this disease [silicosis] is obvious, that of laying the dust.” And in one of the most recent academic dissertations at Wits on the subject, just submitted to the examiners, the author states in the final two sentences: “The key to successfully combating exposure to dust is to combat it at source. Any and all efforts should be directed towards this goal as anything else will be regarded as compromise.”

The evidence of Mr WCC Pakes is relevant if only because he is careful to make the distinction between silicosis and tuberculosis very clear, and restricts his use of the word phthisis to mean pulmonary tuberculosis. He is also at pains to clarify the confusion around cause and the influence of aggravating factors. The dialogue between Pakes and the commissioners is interesting for the exchange of views and the search for accurate explanations. The report of a former mines inspector is also interesting.

Short of writing at great length, what more needs to be said? Just this – thoughtful reading of the report of the Milner Commission, written more than a hundred years ago, is both interesting and humbling given the current state of South African miners’ lungs.

OUTCOME – MORE THAN THIRTY YEARS OF ACTIVITY

Between 1903 and 1930 there were ten Commissions and Committees appointed to report on various aspects of safety and health in the mining industry and it would be presumptuous to try to précis them after reading them for the first time. It is clear from the papers submitted to the International Silicosis Conference that medical practitioners, engineers, scientists, mine officials and the government’s officials were involved in, and served on, these bodies and that the contents of the respective reports were read with care and insight, and in modern parlance internalised.


The report incorporated “by permission, work of the Department of Mines; the Transvaal Chamber of Mines Committee on Mine Air; the
gold mining industry; the Miners' Phthisis Medical Bureau; the South African Institute for Medical Research; contributors to the International Silicosis Conference; [and] scientific and technical societies.” Appendix No. 2 of the report is a chronological table which begins with a list of the committees and commissions which deliberated and reported between 1902 and 1937. This is set out in full to demonstrate the sustained activity which, when combined with the scientific, technical and statistical information from the range of sources listed above, formed the body of the 1937 report.

1902-1903 ‘Miners’ Phthisis Commission’ (Transvaal), also known as the ‘Milner Commission’. Enquired chiefly into the cause of Miners’ Phthisis.

1907-1910 ‘Mining Regulations Commission’ (Transvaal) enquired chiefly into the regulations necessary for prevention.

1911-1912 ‘Miners’ Phthisis (Medical) Commission’, enquired chiefly into the prevalence of Miners’ Phthisis and provisions for compensation.


1920 ‘Miners’ Phthisis Commission’ dealt largely with legislation for compensation; also reviewed preventive measures.

1922-1925 ‘Joint Committee on the Ventilation of Dead Ends’.

1926 to present ‘Miners’ Phthisis Prevention Committee’ (Second).

A chronology of the changes (since 1886) relative to blasting and exposure to fumes and dust caused by blasting; progress in the application of water; progress in ventilation; changes in design of rock drills; dust traps and filters; measurement of dust; and other aspects including general cleanliness and hygiene, above and below ground; labour etc. follows. The report covers nearly 300 pages and is illustrated with tables and explanatory diagrams and serves very well to consolidate the accumulated knowledge and demonstrate progress.

The medical insights and conclusions resulting from the deliberations of the committees and commissions prior to 1937 are conveniently summarised at the end of Chapter IX of the report. There is, in my opinion, something to be gained by reading the original wording of what amounts to a consensus document, put together by a wide range of stakeholders – thus this very long quotation. The objective is not to attempt to convince anyone that our predecessors were always correct, or frequently wrong, but to illustrate a rational and coherent process leading to realistic confidence that, in general, they were on the right path.

“To sum up the evidence adduced in this chapter, it may fairly be claimed that the measures adopted to prevent silicosis in the mines of the Witwatersrand have achieved a very substantial success. The main features may be indicated in summary form:-

1. There has been an immense reduction in the concentration of dust in the mine air as measured by the only comparative index we possess, that namely of gravimetric determinations.

2. There has been a very substantial corresponding reduction in the incidence of silicosis, as evidenced not merely by the decline in ‘overall’ production rates, but more accurately by the marked decrease in the liability to contract the disease shown amongst miners working at each consecutive year of exposure to underground conditions. Amongst the body of working miners taken as a whole, that liability in the cases detected in 1934-35 had fallen by 64 per cent. below the similar liability shown in cases detected in 1920-23, and by an amount of the order of 80 per cent. below that shown in the cases detected in 1918-20. Even in 1934-35 the
great majority of the cases occurred in men who had commenced work at dates prior to 1916. The effect of the ‘technical’ and ‘medical’ measures of prevention which have been operative since 1916 is shown in the low liability to contract the disease amongst the ‘New Rand Miners’. That liability is less by 90 per cent than that shown over an equal duration of years of underground work by ‘All Miners’ in 1920-23; nevertheless the incidence of the disease amongst the ‘New Rand Miners’ who have worked for 15 years or more underground has become significant.

3. When further one compares the very severe type of silicosis seen in the first decade of the century with that of the cases now arising, it is no less evident that a marked progressive amelioration has occurred in the prevalent type of the disease and there is evidence also of an amelioration in its rate of progression in those who now contract it.

4. Our experience regarding the incidence of simple tuberculosis shows that amongst European miners (and also amongst mine natives), the incidence of this condition is not excessive when compared with the standards of European countries. The conclusion to which this experience leads is that the factor of facilitation of tuberculosis does not become significant, until the local or general concentration of silicious dust in the lung is sufficient to have produced or to be capable of producing a histologically detectable silicotic fibrosis, and that the tuberculosis risk is then manifested rather in the production of the mixed silicotic and infective lesions of tubculo-silicosis than in the form of simple tuberculosis. There has been in recent years a substantial reduction of the incidence of simple tuberculosis alike amongst European miners and mine natives.”

LOSING DIRECTION AND FOCUS

To attempt to condense the seven reports of Commissions appointed between 1932 and 1981, or even to refer briefly to each, would be boring and pointless. It would seem that the major areas of interest were compensation, and the functions of the Silicosis Medical Bureau, and that the emphasis on dust was slowly replaced by concern with cooling as the mines went deeper.

THE LEON COMMISSION – HEAR THE WORKERS’ VOICES

The Marais Commission (1963) reported on only one of its terms of reference. In the opening pages of the report of the [Leon] Commission of Inquiry into Safety and Health in the Mining Industry this event is referred to in terms which are intended to draw attention to the failure of that commission to complete its task, and to the fact that many of the findings and recommendations remained valid when the Leon Commission began its work.

The Leon Commission was the first at which a predominantly black trade union was represented, and for which the major portion of the evidence was prepared by experts acting on behalf of the workers – they were worker advocates.

The Leon Commission completed and reported on its work very efficiently as a result of governance by an experienced and hardworking chairman, Mr Justice RN Leon, and the careful and comprehensive preparation of expert evidence by the National Union of Mineworkers (NUM). The opening chapter contextualises the commission as the first for more than thirty years, and as heir to the failed Marais Commission in respect of the need for changes in the law governing the regulation and inspection of mines.

The second chapter continues the careful description of the events leading to the establishment of the commission.

“The NUM first called for the establishment of this Commission in 1991 in discussion at the Mining Industry Summit. After investigation and lengthy discussions the Chamber of Mines (COM) agreed to join employee organizations
in formulating proposals for the Commission in 1992. The NUM made extensive preparations following the announcement in 1993 that a Commission would be established, and submitted a wide range of papers bearing on health and safety to the Commission.

Attention is drawn to the relevance of the health and safety campaigns organised by the NUM since its formation in 1982. Its submissions “clearly demonstrate the concern and determination of the union to obtain better standards of health and safety for the workforce in the mining industry”. Specific mention was made at this early stage in the design of the report to the evidence of experience, as working miner, of the Deputy President of the NUM, Mr Senzeni Zokwana, and to “Professor [Francis] Wilson’s opinion, which was not seriously challenged, that the rise of the NUM had brought about the biggest single change in the mining industry. It had introduced different priorities into the collective bargaining ...” Included in this chapter is a statement lifted from the submission on mining accidents by the NUM: “the loss of life and the destruction of health as a result of mining is staggering”.

HEALTH AND DISEASE

Health at work in the mining industry is the subject of Chapter Four of the report, from which the rest of this discussion will be lifted, without quotation marks or subtitles, and without regard to the order in which the extracts appeared in the original text. Sustained action to ensure a safe working environment, and to demonstrate the absence of adverse health effects among the workforce, is required over long periods of time. It may also be necessary to introduce effective control measures for diseases which are common in the community at large, including those which occur as a result of the conditions under which workers live, or to modify lifestyle in order to ensure the well-being of workers. Carefully designed protocols for the collection of essential data are required, and expertise in epidemiological and bio-statistical techniques is indispensable, if trends are to be accurately monitored. The evidence presented demonstrated clearly the general failure to collect and use data effectively. The original submission by the Chamber of Mines, on behalf of the major mining companies who are its members, restricted comment on health in the mining industry to two and a half pages. No major mining company participated in the discussions of occupational lung disease, either in writing or in person. As a result there is uncertainty even among experts as to the reliability of the numerators and denominators used to calculate the incidence, the prevalence or the severity of diseases. A critical issue is to detect the earliest evidence of disease – or of deviation from the ‘normal’ – and for this there must be standardized measurement techniques using calibrated instruments, standardized methods of analysis and interpretation of the results. Concern was expressed about a number of important but neglected matters such as the existence of multiple but conflicting data sets, the deteriorating quality of statutory reports, the abandonment of annual medical reports by the majority of mining houses, and the fact that no method had been developed for linking environmental measurements to individual workers or homogeneous risk groups.

Dust measurements, which prior to 1937 were made most often with gravimetric devices, were made more and more commonly from 1916 onwards using a konimeter. Eventually the konimeter became the standard measurement instrument until, in 1985, the instrument and the dust measurement strategy that went with it were abandoned. As a result of his own work, on the basis of dust measurements made between 1956 and 1960, Beadle concluded that there was little evidence of a decline in the dust levels between 1938 and 1969. On the basis of the work done by King and Du Toit, the commission concluded that dust levels had remained roughly the same over a period of about fifty years. Evidence submitted by the Workplace Information Group stated: “Dust levels on South African mines continue to pose a risk to workers. Existing regulations and systems have proved ineffective in adequately
reducing the levels of dust. If workers’ health on the mines is to be adequately protected there is need for a comprehensive dust abatement programme … .”

The key to the control of occupational diseases lies in the control of the working environment, and the identification of a case or cases of occupational disease should lead to an examination of the workplaces in which the particular worker was exposed. It may, and probably will, be said that today’s disease is the result of past exposures – this point has been made repeatedly in this report, as has the point that stabilisation of the work force is leading to longer exposures. If successive generations of workers are not to continue to be damaged at work, then the identification of an index case must be followed by a re-examination of the conditions which may have given rise to the disease.

In South Africa no discussion of occupational disease is complete without taking into account the link between the migrant labour system and the long lag period between exposure in the workplace and the manifestation of overt disease. Large numbers of workers will develop work-related disease after they have returned to their rural homes, where appropriate facilities for investigation and diagnosis may be non-existent. In the absence of well equipped and appropriately staffed diagnostic or recognition centres, which are accessible to retired miners, there will be serious under ascertainment and the social costs will be carried by the spouse and children, or by the extended family, or by the community at large. The importance of under ascertainment in determining attitudes towards the problem of occupational disease cannot be over emphasised, and should be borne in mind throughout the reading of the report. Current figures for the extent and severity of the problem of occupational disease among miners are certainly an underestimate.

When the commission began its work, and prior to the completion of the report, little or nothing was known about occupational lung disease among miners who had returned to their rural homes. A study of the social consequences of industrial accidents among permanently disabled miners who had returned to Lesotho, completed in 1993, had shown that their quality of life was poor, mainly as a result of inadequate compensation. The commission expressed regret that both those who gave expert evidence to the commission, and the commissioners listening to such evidence, were not able to define occupational risk by class of mine or mineral or by location of workplace within a mine. Of the references cited by White at the end of his written submission, 40% were reports of work done by staff of the Medical Bureau for Occupational Diseases or the National Centre for Occupational Health. Only 10% originated from the mining industry. The deliberations of the commission generated a long list of research questions, and the commission concluded that a great deal of research was required. Effective tripartite management of research resources was recommended.

CONFIRMATORY RESEARCH FINDINGS

Since the Leon Commission reported three investigations have been done into the health of miners who have returned to their rural homes. In the light of the evidence on the adverse effects of the migrant labour system, and the opinion of Professor Francis Wilson that the mining industry had produced wealth in the urban areas and poverty in the rural areas simultaneously, the findings of these studies are important. Apart from measuring the prevalence and severity of occupational lung disease they also validate the conclusions of the commission that occupational lung disease had become a major problem in the mines. Suffice it to say that the findings are concordant for returned miners in Botswana, the Eastern Cape and Lesotho, and that the prevalence of pneumoconiosis, tuberculosis, or both together is unacceptable. The Leon Commission accepted that the pleas for
urgency in adopting remedial action to reduce the scale of death, injury and disease in the industry, made on behalf of the National Union of Mineworkers, were well founded, and support for this comes from the conclusions of the latest of these three studies\textsuperscript{10} which reads: “A heavy burden of silicosis, tuberculosis and COPD was present in this group of former goldmines. Intensification of workplace dust control measures and [tuberculosis] and HIV prevention activities are needed on South African gold mines. In labour sending communities investment is needed in silicosis and tuberculosis surveillance as well as HIV treatment and care.”

IMPORTANT COMMONALITIES

By way of distilling a message, can we say that the Milner Commission and the Leon Commission share important characteristics? The first and most obvious is that both completed their business, and reported, promptly. The second and most important is the background work which preceded the sittings of the commissions. In the first case, the prevalence survey showed that the problem was serious, the report of the Transvaal Medical Society demonstrates professional concern, and the inclusion of working miners, mine medical officers, the manager of the dynamite factory and the chief chemist and mines inspectors, among the witnesses indicates a focus on the realities. In the second case the preparatory work was thorough and set out the medical and engineering aspects of the health and safety problems in detail, and evidence from a working miner and a social economist added vital information. The Department of Mines participated actively. The notable absence in both commissions was evidence in person from owners and managers. (The manager of a coal mine presented valuable evidence to the Leon commission.) Both arranged for complete transcripts of the oral evidence. The realistic conclusion in 1937 that progress was being made, and the sense that underlying this was a powerful sense of purpose, was replaced in 1995 by almost unrelenting criticism about the neglect of health and safety. Almost all the criticisms made by the Leon Commission have since been substantiated.

THE ROLE OF NGOS

Part of the background work was done by Non Government Organisations over the two decades prior to the sitting of the Leon Commission, among which were the Technical Advice Group, the Industrial Health Research Group, the Workplace Information Group, and others whose titles now elude me. It would be a serious omission not to acknowledge their role.

REFERENCES

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ORIGINS

I was born on 5 July 1932 at Haaskraal, a farm outside Potchefstroom. I am the third and last child of Lydia Mokhobo. My mother left me at the age of two years with her sister, Mrs Martha Mpitse, whilst she went to work as a domestic servant in the northern suburbs of Johannesburg. I spent my early childhood at Von Abosville, a farm outside Bothaville, where I started school at the age of ten years. The farm owner had required me to keep his son, Crawford, company until he reached school-going age of six years. Events in the family resulted in my returning to my maternal grandfather at Mooibank, a farm near Potchefstroom, from where I attended school in the nearby township. I escaped the ‘fate’ of many ‘piccanins’ who, after four years of schooling, would be indentured as workers on Von Abos farms permanently.

LATER SCHOOLING

Through a system of promotions, I was able to write the external examination, Standard 6, in 1946, and Junior Certificate (JC) in 1949. I completed JC in two and half years, as there was a six months break to work on a farm near Fochville. Both examinations were passed in the first class. The JC results of 1949 encouraged the secondary school principal to experiment with nine students for matriculation, with only a few teachers and no laboratory facilities, no library and not enough books. Much innovation was needed in teaching especially zoology and botany. Eventually five candidates were presented for the final Joint Matriculation Examination examinations in 1951. This was to be the first and for many years the last matriculation class at the school. My matriculation results, a first class pass with a distinction in zoology, created much publicity. Much was made of the conditions under which this achievement was possible. It was also reported that I had personally taken care of my financial needs by doing garden work and caddying at golf after school. A local businessman, Mr Hugh Calderbank, reading the story, offered to sponsor this aspirant medical student. This was to be at Fort Hare Native College, which had an arrangement with the University of the Witwatersrand (Wits). Professor Teddy [Theodore] Gillman, [subsequently first Professor of Physiology at the new medical faculty of the University of Natal], assured me that I would be admitted to the Wits Medical School should I obtain the required credits in the four basic science courses. Indeed, in 1952 I got the credits in all subjects, even though I had encountered physics and chemistry for the first time at university. I next was awarded a loan scholarship offered by the African Medical Students Trust Fund (established by voluntary contributions of Wits medical students). Mr Calderbank’s benevolence had seen me through Fort Hare, with clothes, fees, train fare and pocket money. Though thankful, I was somewhat relieved not to continue receiving financial help directly from a white man, as I was now a card carrying member of the ANC Youth League. The political events of 1952, especially the defiance campaign, had also made an impact on me.

THE WITS MEDICAL SCHOOL YEARS

Admission into second year was in 1953. The largest ever number of black students had been
admitted into first year at the Milner Park campus in 1952, almost all of whom unfortunately failed to qualify for admission into the second year. The atmosphere at Wits, and in Johannesburg in general, was a far cry from the harsh racism of Potchefstroom. Even the emphasis on academic non-segregation (by implication endorsing/accepting social segregation) was not hard to live with. Douglas Smit House was a ‘non-white’ residence, occupied almost exclusively by Africans (with an occasional ‘coloured’ or two). The cadavers in the dissection hall were all African bodies. There was a separate ‘non-white’ float during Rag. There was no official quota system, but somehow, ‘non-white’ numbers per class always remained at twelve maximum. In the lecture room, there was an identifiable ‘non-white corner’ to which questions were seldom directed by the lecturers.

In the autopsy room, ‘non-whites’ were not to see a white corpse, and would be politely invited back to view the internal organs later (having been politely asked to leave, when belatedly, it was discovered that the body under the white sheets was that of a white person). The clinical teaching was unequal throughout. Our white colleagues received teaching at all hospitals, whilst we were confined to black patients only, and also never met the clinical professors who were based at the Johannesburg General Hospital. The strict social segregation was, however, broken by some white students at personal risk, by inviting blacks to their homes. Africans also were usually running the risk of being arrested for a ‘night special’ on the way back to Douglas Smit House at night.

Graduation was a multi-racial affair in the Great Hall, and my benefactor, Mr Calderbank was my guest with my wife. Unfortunately my mother could not attend as we were allowed...
only two guests. The six years at Wits were tolerably smooth, except for the irritating phenomenon of forever being ‘seen and never heard’ as a fully fledged student, a situation very different from Fort Hare. Besides being spoken ‘on behalf of’, the presence of ‘non-white’ students at Wits seemed to have divided the white student body as the ‘non-white’ issue was always an election issue, as were the broader political issues off campus.

The scholarship allowance was enough for basic needs and included pocket money. It was the practice for many Africans to leave Douglas Smit House after third year in order to find cheaper accommodation and get more change for use as more pocket money. Hence I went to stay in Sophiatown until I graduated at a house where African journalists also stayed (Can Themba and group): an interesting experience. The murder of medical student J J Jabavu at a shebeen made headline news during this time.

INTERNSHIP, THE FIRST BARAGWANATH STINT

I had many lucky breaks up the ladder. My relocation to the Transvaal [now Gauteng] in 1944 was the result of a family tragedy, and I escaped permanent farm life. Continuing with secondary education after Standard 6 at Potchefstroom was also a chance occasioned by another family mishap, for after Standard 6, I went to work for six months with an uncle at a farm near Fochville. The matriculation experiment of 1950 was a divine gift, because after junior certificate the next step would probably have been to find work. The ‘exaggerated’ publicity about my matriculation results did the almost penultimate, crowned by the wonderful gesture of Mr Calderbank. Perhaps even admission to second year at Wits may have been facilitated by the misfortune of the many Africans who failed the first year courses. I could have had to find the means to complete a BSc degree, as one or two Africans had done when they could not gain admission after BSc 1 courses. Drs Motlana and Mji timeously exploded the anomaly whereby Africans were not allowed do internship at Baragwanath, an African hospital, purely in order to conform to the apartheid ideology of white superiority. So when we qualified in 1957, Baragwanath Hospital had opened to receive black interns. The white nursing sisters had been removed from the wards to ensure that they did not have to take orders from black doctors. They received accelerated promotions en bloc. My lucky break therefore, was that I did not have to go to some other province for internship (usually a mission hospital in Natal or Eastern Cape). Social segregation was the norm at Baragwanath, with separate tea rooms and, of course, separate living quarters. Unequal teaching continued even at this level, i.e., ‘non-white’ interns missed the pleasure of cases being discussed with our seniors over a cup of tea. The physical arrangements were such that, after the ward rounds, we left by separate doors.

GENERAL PRACTITIONER, 1959-1961

For this step, there was no lucky break. Under Section 10(d) of the Urban Bantu Act, I could not legally stay in Soweto, as was my intention and wish. In fact, I had identified a place in Mofolo South for this purpose. However, numerous degrading visits to the pass office, at No. 80 Albert Street, were fruitless and frustrating. There was no difficulty getting into Benoni, a smaller town with the newly established township of Daveyton, set up according to the classical Verwoerdian concept of separate tribal sections. I was thus readily accommodated by default. I was the second African doctor after Dr E M Dotwana (a Wits graduate). The experience as a general practitioner turned out to be quite a challenge. The township was a collection of displaced farm labourers and others from the nearby other townships in the East Rand which were part of resettlements. The socio-economic conditions were primitive. Unemployment was high, poverty, malnutrition and disease were rampant. After a year practicing alone, Dr Dumisani Mzamane joined me in partnership. We also did part-time sessions at the local clinic. The little we charged could not be afforded by many. Treatment demanded was standardised,
namely, regardless of the diagnosis, you had to dispense an injection, a supply of pills and a bottle of the most bitter medicine. We also befriended traditional healers and worked with them on common problems. Many of our debts were written off. The rooms operated for twenty four hours a day, and we took alternate weekends off. There were home visits for the very ill and for deliveries, the latter often done by candle light on the floor in primitive home environments. We innovated many a time and applied several unconventional methods of treatment (operative and medical). Boksburg-Benoni Hospital was our referral hospital. It, however, seemed to commonly provide a hostile reception for our patients (either the doctors or the system, and we came to witness such on many occasions). We would thus attempt to treat pneumonias at home, which entailed at least two home visits per day (with or without payment). The hospital attitude became friendly after the arrival Dr Ivor Kaplan (a Wits graduate), for there was now a colleague one could reach, though on the medical side only. The other challenge was the community pressure on us to provide the badly needed leadership within the apartheid structures. The concept of ‘can’t beat them, join them’ started here. For the people’s sake, one got involved in school committees and school boards. The people were happy, as the doctor was regarded as the natural leader, a constant ray of hope for the future, and an expert on all matters (social worker, marriage counsellor and political leader). As a founder member of the Pan African Congress, one had to treacherously engage in the local political activities. The Special Branch police officers were among my patients. They would thus oblige with ‘advice’, for example by warning me when I was under ‘quarantine’ (being watched), and that I must consider attending my political meetings by thumbing a lift and not use my car. This may have helped, as hard evidence to nab me was seemingly hard to come, or my SB patients protected me. Thus with the swoop on members of our cell, I ‘escaped’ (1960). My ambition to specialise was getting stronger, and I was now also becoming restless. I had no choice but to leave, to the disappointment of my many patients, for Baragwanath Hospital, in 1961.

THE SECOND BARAGWANATH STINT, 1962-1967

Following a high powered interview by clinical heads and TPA (Transvaal Provincial Administration) officials, I was offered a Senior House Officer post in paediatrics, which was my first choice. I was made to feel like a freak or a novelty for wanting to be a specialist. The signals were evident at the interview and subsequently all round the hospital. The heads of paediatrics did not do much to encourage me, so I switched to Internal Medicine, where the head, a conservative Englishman, Dr V H Wilson, was keen to sponsor this ambitious black. I thus worked for a year as SHO. I had a very difficult time being courteous and diplomatic, as my white registrars were young, inexperienced and not very much more knowledgeable. Registrarship was automatic for white colleagues two years after qualifying. I was qualified for five years when I ultimately got the post of medical registrar and, as when I was a student at Wits, I ignored all else, took everything in my stride and focused on the primary purpose for which I had come. My appointment as the first African registrar in any department at the hospital was a historic event, and was celebrated at a public function organised by the hospital nurses. My relatives attended and I made a speech of sorts. The training and teaching of registrars was a replica of the Wits pattern. We all shared the clinical material at Baragwanath, but I could not join the others for the sessions at the Johannesburg Hospital. Gradually, as University of Natal graduates came for internships, the atmosphere at Baragwanath became more accommodating. Teaching as registrar was a joy for me. I fell in love with academic medicine in the process.

The joy of academic life somehow insulated me against the discomfort of daily train trips from Benoni, and travel by Putco bus from Johannesburg Park Station. The routine became the norm. The regularly rude white train ticket officer at Benoni station made no impact, as he was just a fool to be ignored. There was overnight accommodation for when I was on call, but weekend calls I took from home,
coming in for ward rounds on Saturday and Sunday mornings. There was no transport allowance. My salary of R120.00 per month was 60% that of white colleagues. There were no other perks. In the registrars’ rotation system among different firms, there was always a scramble for the best firm. I managed to get into the powerful teaching firm of Ward 16 and eventually passed my fellowship examination 1966, another ‘first”.

By this time a number of Natal graduates were general practitioners in the East Rand townships. There were no academic meetings for ‘non-whites’ because the MASA held meetings at venues where multiracial audiences were not allowed. As a fulltime employee, I found time to form and organise the South African Medical Discussion Group for academic sessions and also as a platform where the general practitioners could talk to one another, especially to get to know what competitive private practice entailed, as this was a new experience for many. The discussion group continued to prosper and award scholarships to deserving black students. Subsequently NAMDA was formed, but had a different, more dramatic focus.

It soon dawned on me that being a pioneer did not always guarantee progress. YES, I had the qualifications and was desirous to go up the maturation ladder as a specialist and an academic, especially in cardiology. When I applied for a permanent post, the TPA informed me that the province had no permanent posts for ‘Bantu Specialists’. There were no more lucky breaks; I was now a ‘misfit’. To add to my woes, one Blackie Swart, a special branch policeman frequented me too often in my house in Benoni. Indeed in 1967, my innocent sister-in-law, Mrs Thelma Masemola, on a family visit from London, was collected in the early hours one morning from my house in Daveyton, locked up for weeks on suspicion of being on an underground ANC mission. She was subsequently released and she returned to join her exiled husband. I found myself jobless, feeling vulnerable and isolated (many of my friends and comrades were in exile). Thus I left with my family and sufficient personal belongings in two cars, hard cash in pounds hidden under seats, on travel documents, and in search of green pastures. After languishing in Botswana for about a month, Dr Allen Nxumalo (classmate, Wits graduate), became Minister of Health in the newly independent Swaziland. He answered my knock at his door, unannounced, positively. Here comes another first: I was appointed a specialist physician in the country, FCPSA, 1st part MRCP (I could not go back in 1968 for the second part, as the passport had to be handed back, and my deposit refunded).

THE JOURNEY IN THE WILDERNESS: A RURAL MEDICAL SPECIALIST IN THE MAKING. SWAZILAND

This was a country with scenic beauties. The excitement of uhuru was infectious and enviable. I got my children into good local schools (Mbabane and Waterford). The hospital environment was jovial, the average Swazi was friendly and the work looked challenging. Culture shock came in various forms, however, the language, the local mores, and the British colonialists’ maneuverings to survive post-independence. The South Africans were in fair numbers in the civil service, mostly as teachers. The British, however, regarded any educated South African as a threat to their positions, thus they tried hard to ferment negative sentiments against us. At some stage I had to sign up allegiance at some village with a chief, in order to show my bona fides as an African who may one day become a citizen or try to secure a home for the children. This was a process called to ‘khonta’, a process required only of foreign Africans. It was a weird experience for a foreigner, but nevertheless I did it for potential future survival.

My work was expected to cover anything and not internal medicine only. Shortages of staff, drugs and suboptimal supportive facilities posed a daunting challenge. Outside medicine, I learned to help with anaesthesia whenever I could. I had never given general anaesthetics. I learned from the general practitioners. In time, I soon became popular as Physician to royalty, prominent Swazis, and was preferred by fellow South
Africans. I quickly learned to improvise and innovate in order to function despite shortages of sometimes very basic items. The common response to my requests was ‘kute dokotela’ (none doctor), and the nurse would throw up her hands nonchalantly, as if this was the accepted norm. For example, I would economise on dialysis fluid by leaving it inside longer than the conventional time, or decrease drug dosages or lengthen intervals, or decide many times on empiric treatments, on minimal criteria. I would be called to theatre to assist with autotransfusion for a ruptured ectopic pregnancy. Even the writing of clinical notes on the small cards provided as patients’ files called for an innovative style by printing and using space frugally. Medical practice in an under-resourced southern African environment was faced full square. Task shifting (which is now spoken of) started then. I had to teach and train nurses and other level workers so as to share in the demanding work, putting up drips, taking bloods and doing ECGs.

Harry’s Angels, led by Dr David Cohen, a programme financed by Mr Harry Oppenheimer, started a flying doctor service. This was the highlight of my stay. It was a special privilege to be part of those mercy trips, select cases suitable for locally doable interventions and to provide after care after they had left. History unfolded rapidly especially after an historic and successful closed mitral valvulotomy was done by Mr Paul Marchand and his trainee, Dr Rob Kinsley. Not one error occurred in the choice of cases, the diagnoses made purely on good, sound clinical judgment. I had fortunately brought along my own ECG machine. The hospital had none. The X-ray pictures were of reasonable quality, though they dried up in the sun in the early period.

My stay was very enjoyable socially, satisfying professionally, but one never felt certain of permanent acceptance locally (some laws were passed which raised uncertainties for foreigners). The local attitude was quite conservative. The rural specialist was then recruited for Lesotho, on what sounded like better prospects for the future and the hope that maybe the grass would be greener.

**LESOTHO**

If Swaziland was poorly resourced, Lesotho was destitute. This independent country had emerged from major political turmoil following their last elections. This background added its own dimension to the social and health problems. The reception for me and my family was superb. The language was familiar, many of the Basothos now back home had been with us in the ‘Republic’. In fact one had assumed some were South Africans, only to meet them in their independent country. One was captivated by their infectious laughter and very loud conversations even at close range. The dry mountains, devoid of vegetation, had their own beauty. Shopping was done just across the border or in Bloemfontein. The trips in that direction were enjoyable to the extent that they made one tolerant of the invariable, uncalled for harassment on the South African side of the border post.

The health services were dire. Regularly, every three months of the financial year drugs would run out. A consignment of WHO donations would arrive, but many of these drugs (especially antibiotics), would be about to expire or had expired. They were used, nevertheless, in the absence of anything else, and patients got better. Innovation, compromise and broken rules of conventional forms of treatment again became the order of everyday practice. The pioneer physician now welcomed the company of the Mosotho neuropsychiatrist (first in southern Africa, Wits graduate), an expatriate general surgeon and a South African qualified gynaecologist. Later, an Israel trained ophthalmologist (Mosotho), and a British trained psychiatrist (another Mosotho), with a part trained paediatrician wife, also arrived. Academic life improved a lot but facilities remained poor. The other welcome developments I became part of included the formation of a Medical Association, the establishment of a Medical Council, and the publication of a medical journal, of which I was editor. I successfully organised the first ever conference, to which I
invited a number of South African physicians to deliver papers. A memorable time was to be the period spent in Denmark on a WHO cardiology sponsorship. I travelled on a borrowed Lesotho passport. Being a valued physician to VIPs facilitated this illegal gesture. It did not seem to anger the ‘Republic’ authorities. On my return, my fears of interrogations or detention, as I had to touch down on South African territory, were not fulfilled, especially as I had met my comrades during my stay abroad; spies were known to be ubiquitous.

At work, the call was still for sound basic clinical skills with little extra-clinical support, with delegated skills to share the load, like in Swaziland. The spectrum of clinical cardiology differed somewhat from the Swaziland experience. There was more hypertension, diabetes, dilated cardiomyopathy, less rheumatic heart disease, but surprisingly common was constrictive pericarditis, most likely post-tuberculous. Cases for Dr Carl Beckerling, cardio-thoracic surgeon working with a flying doctor service, Anton Rupert’s Angels, were chosen and operated on locally with success. Not one mistake was made on these patients, diagnosed entirely on clinical grounds plus a basic ECG and a routine chest X-ray. This was a compliment, considering the close similarities between pericarditis and dilated cardiomyopathy.

Lesotho was more Africa orientated, and one had opportunity to meet East African physicians, and contribute articles to East and West African journals. However, a feeling of uncertainty about the future never disappeared completely, though much was done to make us feel welcome. There was no modern law to back up this gesture and the Republic was too close for comfort. With the development of some personal problems, I decided not to renew my contract. I applied to Medunsa, and a letter of rejection was déjà vu. It simply said: No Posts for Bantu Specialists ‘yet’. Nevertheless, I left and a patient of mine who had followed me everywhere, Chief Lucas Mangope, invited me to Mafikeng, and the bait was tempting.

MAFIKENG, BOPHUTHATSWANA, 1975

Bophelung Hospital was a 900 bed hospital: 70% of the patients were there for chronic psychiatric care. There was one full time psychiatrist who had been with the hospital from its beginning. My task as Physician was to facilitate the creation of this into the main general medical hospital in the self-governing state. I was temporarily accommodated in a garage at the South African Commissioner-General’s home, but I later moved out to rent a place in a village near the hospital. In both these dwellings, conditions were primitive. Chief Mangope moved fairly swiftly to have three houses built on the hospital grounds for black senior staff. The other existing houses on the premises were for whites only. A wall was even erected separating the two residential areas. This was another adventure for this first black physician, with an all white senior staff, i.e., administrative, nursing, with a former missionary doctor as superintendent. These people were all conservative Afrikaners. The notices on toilet doors read ‘Bantu males’ and ‘Bantu females’. Tea rooms were racially separated. A parking for my car was found and designated ‘Psycian’ in a suitably separate area. The works person, a jovial Mr Wium, like everybody, was not familiar with ‘physician’ and did not ask. A psychiatrist was a known specialist locally for all those years. The hospital conversion process, though daunting, got under way quickly. The psychiatric patients were a hotchpotch of dumped cases, many of them were from outside South Africa. They were dispatched by any transport possible. No sooner, independence arrived, and developments were fast. Chief Mangope, now President, appointed me the Medical Superintendent. The hospital was physically changing, only 200 beds were designated for chronic psychiatric care for Bophuthatswanians only. The whites either left of their own accord or were replaced by blacks. The racial wall came down, some senior black staff who now began to arrive occupied houses on the premises as they were vacated. I moved into the double storey four bedroomed house previously occupied by the unmarried psychiatrist. The newly appointed Director of Health and Social Welfare, Dr J R Kriel, angrily tore down the
offending notices and forcibly integrated the multi-racial staff. The hospital started receiving interns of all races, the blacks being homeland bursary holders, and a community much happier than across the border in South Africa blossomed. The facilities developed quickly to a satisfactory level (money was no problem); in fact it was now luxury compared to the previous two countries. Many doctors (medical officers) came mainly from Uganda (refugees), one or two from West Africa, and missionaries from Europe. One or two foreign specialists came, registered in Bophuthatswana by the Department of Health. Doctors were also recruited subsequently from Israel on a government to government agreement. I, throughout, kept a firm hand in clinical practice, ensuring the development of medical facilities. There was even an attempt, before the arrival of sufficient senior doctors for other specialities, at establishing a progressive medical care pattern by using nurse practitioners as basic staff. This involved dividing major disciplines into a medical cluster (including gynaecology) and surgical cluster (anything operative). I had started a nurse practitioner course, which I single handedly devised and taught. Professor Lucy Wagstaff later accepted the invitation to help with the paediatric component on weekends. This course was so successful that it was subsequently adopted and made a certificated qualification by the South African Nursing Council during the tenure of Professor Charlotte Searle.

The language of independence sounded correct at the beginning. There was talk of greater independence to come. The Physician-

Superintendent felt happy to accept co-option into cabinet as a technocrat cum Minister of Health. A further reason for taking the bait was the realisation that the health department’s top brass was inexperienced and professionally junior (ex-missionaries) and did not share my vision (the rural specialist). I now took up the challenge of implementing primary health care as close as possible to the Alma Ata philosophy as I recognised it as the answer to the prevailing health needs. So, previous mission hospitals were renamed, functionally re-organised, the clinical nurses programmes expanded. Bophelong Hospital became the training centre, satellite clinics were organised, health education programmes started, and community participation pursued. Extra help came from Israel in various forms, both medical and relating to welfare matters. The Minister of Health buttressed his vision by legislation where appropriate, e.g. the Anti-smoking Act was passed. The idea of a medical school was rejected outright by the minister, and the one hospital he built was designed to physically reflect the concept of PHC and district health service organisation. This was at Lehurutshe. The minister continued all this time to do clinical work, teach interns, train nurses with assistance (using own graduate nurses as trainers), do all procedures (dialysis, organ biopsies etc), and conduct combined clinical discussions. The work was challenging and enjoyable. However, the political aspect was constantly uncomfortable on matters relating to integrity, professional independence and the generally perceived status in the greater South African society. The initial rationale that health services to the innocent majority becoming mandatory regardless became an unbearably long wait. After probably the longest six years of my career, I resigned from Mangope’s government and set up specialist private practice in Mafikeng town (another pioneering jump in the now chequered path).

MAFIKENG PHYSICIAN SPECIALIST

This adventure was an unintended fulfillment of a rural specialist profile. The immediate trail behind me was something to be proud of as
Bophelong Hospital prospered. It became popular with interns and other career doctors, a private hospital in town came into being, primary health care in the public sector was a marvel for anyone to appreciate and had been exported to other parts of third world South Africa.

It was during my stint in private practice that Louw Olivier, Head of Cardiology at Medunsa, invited me to be a part time lecturer, 1985-1989. By now, one had reflected on the mixture of joy, pain, and disadvantages or otherwise, of being a pioneer. On the rural specialist path, certainly much of one’s true academic/professional make-up had been lost. I was touched by the compliments in George Cohen’s article (British Museum Journal, 1972 (4) pp 288-290) and Bob Hitchcock’s book, Harry’s Angels, about my potential.

My clientele came from the far Western Transvaal and Botswana. It was a pleasant surprise that patients were multi-racial, including a substantial group of Afrikaans-sprekendes from Zeerust and nearby conservative towns. Now for a brief word on the powers of survival, academically and politically.

INNER STUFF

Don Cindi (MBBCh Wits, 1951), a friend of our secondary school principal, was a regular speaker at our year end functions. This was one source of inspiration. Dr A H Bismillah (just recently passed away in Canada), MBBCh (Wits, 1949), was the first ‘son of Potch’ to qualify as a ‘non-white’ doctor, and came to give general practice a welcome and humane face in Potchefstroom at the doorstep of the township. The general practitioners in town were providing inferior separate rooms and Africans would be seen last regardless. This planted the seeds further for a career in medicine. Dr Bismillah also formed a political group among high school students, The Society of Young Africa, a youth wing of the Unity Movement (NEUM), a multi-racial body. We joined. Then came the three gentlemen from Wilberforce Institute, Evaton, with a more appealing philosophy of the ANC Youth League.

By the time I went to Fort Hare, I had switched affiliations. At Fort Hare, the Africanists provided a straightforward message, uncomplicated, simple, namely that oppression was purely colour based, not based on economics. We embraced this. Small wonder that I was to be a foundation member of the PAC in 1959. Robert Sobukwe, however, seemed to pity the youthful looking cadre, and assigned him to head the fund raising committee (a bit of a peripheral and harmless role). The flirtations with the school committees and school boards (apartheid structures), and the homeland system, contextualised a belief in being a doctor first for people under ‘tolerable’ circumstances. This essential pragmatism also facilitated my joining Medunsa, the concept I had vehemently opposed when Professor H W Snyman went around trying to sell it to African doctors in the 1960s. The wilderness did not stop this rural medicine specialist from publishing from any location, even if it meant conforming by using self-derogatory titles (such as Bantu, for example), as Dr P J von Biljon insisted. Pragmatism dictated that the voice had an important message. The stigma was immaterial.

MEDUNSA AND BEYOND TO THE PRESENT, THE REST IS HISTORY (POPULAR CLICHÉ)

This rural specialist arrived late at the cherished destination. I was wiser, and richer in experience from third world South African environments. The erstwhile unwanted apartheid set-up had gone off the intended purpose, and there was perhaps room for a different contribution. A
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A meteoric rise from Senior Specialist, through Associate Professor of Cardiology, to Head of Medicine and Cardiology (encouraged by the Vice Chancellor, Professor E M Mokgokong, himself a belated Medunsa arrival 1980), sort of crowned the rough past retrospectively. Indeed, there was much room for an enormous contribution, with one’s unique flavour, both inside and outside Medunsa. It was a pleasure to be wedged into what was nascent black academic development. The challenge was to deliver as teacher, role model, leader and a black exponent of excellence. There would be one or two hiccups and the need for quick adaptation. For example, in the very first year as Head of Medicine, I personally failed 30% of the students. My style of teaching also took time to be accepted. It was suspected to be condescending and too simplistic. I knew it emanated from first hand insight. My instruction to staff was to mark students on content and not language. For candidates coming from the still very disadvantaged backgrounds, for whom English is not their first language, this was a necessary innovation. This requirement I also took up at a higher level, when I was Dean of the Faculty. There was never any difficulty for me as external examiner at other medical schools. I conformed. At postgraduate level, however, there was no compromise. In fact in the Fellowship examinations, or MMed, my expectations were probably excessive.

With my long cherished academic ambitions somewhat revived, serving in the various committees of the Colleges of Medicine seemed to be a given. I was disappointed that from 1966 (when I broke the ice), and for over thirty years, not much had happened to accelerate the production of African specialists. There are many theories and speculations on this deficiency. Even now, superspecialists are a rare breed. Further gratifying contributions were called for towards and during the birth of true independence. It was an honour to serve in the Interim Medical Council, the Moodley Commission on Academic Health Centres, be chairperson of the EDL committee and literally drafting the first issue alone when the academics and skeptics stalled, chair the committee that compiled PMB lists for the Medical Schemes Act, be a member of the Hoffenberg Committee on postgraduate medical education (including revised internship rules and the concept of community service), and be on the ministerial advisory committee on organ transplantation. I was in the first and subsequent teams to recruit Cuban doctors (I selected internal medicine candidates). I served on the Medical Schemes Appeal Board, the SAMA Research and Ethics Committee, and published under not easy conditions. The top of the socio-medical ladder was unobtrusively reached as a co-architect in the development of health delivery systems in one’s beloved country.

I bowed out of Medunsa as the law required 1998, had a stint as advisor to the Gauteng MEC for Health (two years), lectured in cardiology to the Medunsa Family Medicine postgraduate students, went back to clinical medicine and cardiology at Natalspruit Hospital, and then Tembisa Hospital. Next I was back to interventional cardiology in private practice (Sunninghill Clinic, Sunward Clinic in Boksburg, Aarwyp in Kempton Park), and sessional work at No. 1 Military Hospital.

My superb health and perpetual youthfulness have accompanied me back home, where, as Principal Cardiologist at a level 1-2 Potchestroom Hospital, on a one year contract at a time. The atmosphere is pleasant, the work challenging, as there is just a tinge of *déjà vu* about under-resourced areas of yesteryear. I feel I can still be of much use for a number of years yet. I lord over five children (none went for medicine as a profession), nine grandchildren and four great grandchildren.
It is always interesting to walk into a museum, any museum, and view an exhibition from which we learn, which engages us on many levels, is visually appealing and leaves us feeling enriched by the experience. In the past, museum exhibitions tended to be about ‘history’ – whether social, political, art, medical or any other discipline. Museums avoided addressing current issues, often because exhibitions can be costly to produce and, if they become outdated very quickly as contemporary events unfold, have to be replaced – at a cost. Museums were also regarded as neutral or uncontested spaces, and therefore controversy was to be avoided – at all costs.

The modern view is that museums are seen as sites of public discourse and experimentation, partners in public education and deepening democracy in societies, therefore engaging with their visitors in much more complex and challenging ways. Traditional disciplinary boundaries of museums have been challenged – it should therefore be no surprise for visitors to Wits Medical School to see the small but growing collection of artworks enhancing the walls of the entrance and foyer. The art collection is driven by the curators of the Adler Museum of Medicine, traditionally a direction driven by art museums rather than medical history/technological museums. The modern museum also addresses social, political and, in our case, health issues which are impacting on citizens today.

International Museum Day was created in 1977 by the International Council of Museums (ICOM). Its aim is to make the general public aware of how important museums are in developing society. ICOM has declared the theme of International Museum Day 2010 as: Museums for social harmony. As ICOM describes it: “The basis of social harmony lies in dialogue, tolerance, co-existence and development, based on pluralism, difference, competition and creativity. Fundamentally social harmony is to agree but to stand out, to look for common ground but to keep the difference.”

Does this mean that in interpreting such a role, museums must accept that social harmony is the goal, and any controversial stances must be avoided? And how do we, as museum curators, know which statements or artefacts or exhibitions are likely to be controversial and which not? Museums should also, in exhibiting contemporary events or issues, show the controversy surrounding them without being prescriptive or judgmental. However, they cannot be expected to avoid controversy by being so neutral or politically correct that what is presented makes them agents of conformity.

As Amareswar Galla says:

If we accept that [social harmony] infers a degree of political and social conservatism, then we must also accept that there is an inherent risk in the notion. Blind acceptance that social harmony is a goal that must be pursued at all costs, if made by museums, would mean that their roles have evolved into agents of conformity. A role, I hope, few would want to accept.

If museums are generally seen as civic spaces where all members, ideally of a civil society, may come together, albeit
in different configurations, they should be sufficiently flexible to accommodate the diversity that is naturally part of society as a whole. This, hopefully, is not just about being so bland as to be generally innocuous, but about engaging curiosity: visitors may not agree, may not be comfortable, but so long as they are entertained and informed while also feeling that they are respected, or not patronised, this is another important starting point as a site to consider important social issues.2

An Laishun has this to say: “Cultural diversity is an historical and contemporary social reality irrespective of where one is located in the world. It is the common heritage of humanity. Museums have a part to play in nurturing social harmony, and confronting the issues of alienation that are destructive to the environment and conducive to cultural conflicts.”3

To get back to an earlier statement: museums were regarded as neutral or uncontested spaces, and therefore controversy was to be avoided. How then was the Adler Museum of Medicine to deal with an exhibition about HIV and AIDS? It is not a neutral and uncontested area: infections which are transferred primarily from sexual encounters are rarely viewed in a dispassionate way. If the exhibition had opened in 2003, when Thabo Mbeki was the president of South and who is reported to have said the words: “Personally, I don't know anybody who has died of Aids”,4 would this have changed the way we presented the information in the interest of social harmony? The origin of HIV is still contested, despite a huge body of scientific research pointing to Africa as the origin of the infection, and stigmatisation of those infected remains rife throughout the world, stirring homophobic and other prejudices deeply entrenched even in the 21st century. The language we have used in the exhibition is not without controversy and we had to be mindful of every word we wrote. For example, we asked ourselves (and others): should we speak about homosexuals, gays or men who sleep with men? Should we speak about HIV/AIDS, or HIV and AIDS, HIV+ people or people living with AIDS? None of these terms are neutral.

And let us recall the controversy caused when the Minister of Arts and Culture, Lulu Xingwana, walked out of an exhibition held at Constitution Hill, Johannesburg, in August 2009, which included work by the acclaimed photographer Zanele Muholi depicting lesbians. The Minister, whose department had partly funded the exhibition entitled Innovative Women, left before she was due to speak, having been offended by these photographs. She is reported as having said that her department was mandated to promote “social cohesion and nation building”. How did she think that the exhibition did not address this very issue? Her comments left many of the artists feeling that there was no place for them in South Africa and that their artworks would be more appreciated overseas!5

And so we as curators at the Adler Museum of Medicine have grappled for what seems like an age to try and present a balanced, historical account of HIV and AIDS, without avoiding the controversies but also knowing that what the public will see will stir passions in many viewers. What message did we want to leave viewers with? That AIDS is a chronic medical condition which can be as easily managed as, say, diabetes, implying that young people in particular have nothing to fear about life style choices, or did we scare the living daylights out of visitors, showing the terrible and painful progression of the infection from HIV to full blown AIDS in graphic detail?

The forthcoming HIV and AIDS exhibition will make it clear that after apartheid it was not all plain sailing and that we have a new and painful issue with which we have to come to terms.
By the time the December 2010 issue of the Adler Museum Bulletin is printed, readers will have had the opportunity of visiting the Museum to see what choices we made, and give us their views on those decisions.

An important aspect of social harmony entails coming to terms with both past and present issues. The exhibition: Health and Health Care under Apartheid, currently on view in the Museum, does much more than record the damage done by political doctrine – it succeeds in setting two streams in parallel. These might be seen as one attempting to control liberalisation and the other as the inevitable progress towards health (and political) equity. The control stream is illustrated by press cuttings describing, by implication, the political figures of the time and some of their more outrageous dictates. The liberalising forces are portrayed by stylish portraits and punctuated by scenes illustrating the needs of the people. The whole gathers together an informative story of the triumph of good over evil.

REFERENCES
5 Mail & Guardian online. 5 March 2010.

Letter to the Editors

Dear Editors

Even so long after the article’s publication, I wish to add another, albeit minor, footnote to the career, prematurely and tragically cut short, of Dr Dumisani Mzamane. The article in question1 named Dr Mzamane as one of the six doctors who petitioned the Supreme Court in the issue of Steve Biko’s homicide and medical neglect in the face of the injuries he suffered.

Mzamane and I were internal medicine consultants in the department of the late Professor Leo Schamroth at Baragwanath Hospital in the mid 1970s. The descending hierarchical order of medical specialists in the hospitals of the then Transvaal Provincial Administration was Chief Physician (one in number - Schamroth), Principal (myself - one of a number), Senior (Mzamane - one of a number) and Physician.

In a rearrangement of the department Dr Mzamane was promoted to be head of a unit. Professor Schamroth asked me to become Mzamane’s deputy in the new unit. Of course one instantly agreed to be subordinate to so able and gentlemanly a colleague earning a deserved promotion.

Was this situation a minor first in the annals of hierarchical reversals?

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REFERENCE
I found this book a difficult read. The text did not ‘flow’ so that the picture that I imagined, that of a modest man, a devoted family man, a man clearly of genius (or he would likely never have achieved Nobel status), was lost in page after page of mathematical and physics analysis.

Since my own level of mathematics and physical science was that of 1944 high school and matriculation, I did not understand large parts of the mathematics, including diagrams, illustrations and graphs: these were over my head.

Clearly this work was not intended for those at my level, thus raising the question, who is the readership that this book is aimed at? If it is aimed at those with higher levels of technical education, I found it disappointing to encounter typographical, grammatical and informational errors, let alone disappointment that it will be aimed at a very limited readership. Of the numerous workers whose contributions to the creation of the CAT scanner eventually produced the final product, I remain largely uninformed as to who produced what.

A final bit of nitpicking: the acronym CAT is from Computerised Axial Tomography (not computerised assisted tomography – even though it fits both).
Adler Museum Bulletin publishes papers in the field of historical research in medicine and allied health sciences. The Museum welcomes original contributions and letters for publication but reserves the right to edit, abridge, alter or reject any material. Manuscripts should not exceed 5 000 words. Longer articles may be divided into parts and published in successive issues of the Bulletin. Authors are responsible for the factual correctness of their articles. All articles are sent for refereeing. Authors wishing to reserve copyright to themselves should stipulate this at the time of submission of a manuscript.

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References are listed at the end of the manuscript and should be indicated in the text by superior numbers and listed at the end of the paper in numerical order. Do not list references alphabetically. References should be set out in the Harvard style, and only approved abbreviations of journal titles should be used. ‘Personal communications’ and work that is ‘in preparation’ may be cited in the text, but not in the reference list. However, formal theses and dissertations, even though unpublished, may be listed provided full details are supplied, including the institution where the master copy is lodged. Do not indent or otherwise format each entry. Note that this is a reference list and should not be formatted as footnotes.

Reference examples

Dr Frack had been a member of the 1919 Class, the Tin Templers.¹

It did not, however, include anything about osteology, for bones would have doubled the size of The Pocket Gray.²

Direct quotes should be in italics or in inverted commas

Military medicine, surgery, and nursing were matters too important to be left to private charity, however well intended….³

“The tenth edition of Aids to Anatomy appeared in 1940…. It had been edited by Professor Stibbe, who, sadly, in 1923 left the University of the Witwatersrand.”⁴

References


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