

**Lunacy, Leprosy and Legislation: Medical practice and colonial control at the
Cape, c. 1820-1831.**

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COMPULSORY DECLARATION

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Introduction

On the 11th of March 1823 Dr James Barry wrote to the office of the Cape Colony's governor requesting his assistance on a matter of medical importance. Barry had been made aware of certain abuses taking place in relation to the Colony's leprosy treatment system. The masters of afflicted slaves and Khoikhoi indentured servants were reportedly withholding medical care from them in order to work them for as "long as possible."¹ Only "when they become useless in point of labour and disgusting to the sight" were they released to be institutionalised. This type of master inaction was contrary to the leper legislation of the period and Barry subsequently ordered the publishing of the details pertaining to such a law "in the Cape Courant".² By doing so he aimed to "prevent masters from having recourse to the plea of ignorance".³ Such cases of abuse were common during this era; however the reaction of the medical authority to such instances illuminates notions of colonial control and regulation in this unique colony. This case therefore positions this thesis and allows us to gain insight into some of the themes that characterised medical treatment in the early 19th century Cape.

Medical practice and care in colonial contexts is a subject of study that offers up a unique and useful focus for the exploration of specific imperial societies and their structures, whilst also being able to reveal greater empire wide trends. Indeed, David Arnold, an expert on Colonial medicine in British India, noted in 1988 that "many historians are now aware of the richness of the medical archive and its value for the study of social, political, and economic history".⁴ This is evidenced by the tangible increase in scholarship relating to this particular topic.⁵ Such studies aim to reveal how health became a highly charged field within which coloniser and colonised inhabited, thus giving rise to complex relationships of "power and authority".⁶ Yet the study of the Cape medical field has as yet received only partial examination. More specifically the 1820s in the history of the Cape Colony's medical system have largely escaped popular study and although there has been a great deal of exceptional work done by historians like Harriet Deacon, Howard Phillips and Elizabeth van Heyningen in this arena, there is still a great deal of primary source material that has yet to be fully explored.⁷ This thesis will aim to rectify some of these omissions by looking at a series of medical topics in the context of the early 19th century Cape Colony, with a specific focus on the 1820s and early 1830s. Such a focus will reveal how local and metropole authorities attempted to

¹ Dr James Barry. Letter to the Office of the Governor regarding the abuse of the leprosy system. 11 March 1823. Letter. MC vol. 27

² *Ibid.*

³ *Ibid.*

⁴ David Arnold, *Imperial Medicine and indigenous societies* (Manchester: Manchester University Press, 1988), 1.

⁵ Pati Harrison & Mark Harrison, *The Social History of Health and Medicine in Colonial India*, (Oxon: Routledge, 2009), 1.

⁶ David Arnold, *Imperial Medicine and indigenous societies*: 1.

⁷ Harriet Deacon, Howard Phillips and Elizabeth van Heyningen, *The Cape Doctor in the Nineteenth Century: A Social History*, (Amsterdam: Editions Rodopi B.V, 2004).

regulate the actions of practitioners in different fields of interest. Questions around control, regulation and power will be central throughout.⁸

This period of interest was one of tumultuous change and internal imperial struggle which resulted in various reforms of varied success. The moral issues of British Imperialism in its contemporary state were continually raised by humanitarian agitators and fiscal concerns came to dominate British colonial policy in this era.⁹ Such issues fuelled a climate of investigations and inquiries which in turn brought colonial matters to the forefront of public opinion.¹⁰ Matters of concern, as we will see throughout this thesis, were in no short supply at the Cape during this era. Intra-settler relations between the Dutch and British were characterised by tension, and the colonist's treatment of slaves as well as the indigenous population throughout the colony was without doubt, abominable.¹¹ Adding to this complex and at times, highly charged environment was the expansion of the colony, a colonial undertaking primarily motivated by the arrival of hundreds of British settlers.¹² This was also the era of Lord Charles Somerset, a man who governed the Cape as a dictator in all but name.¹³ Such factors made the Colony a unique place within the empire and a study of how its medical structures functioned in such an environment, is therefore of great interest.

Thesis structure

By investigating certain subjects in detail some of the gaps in our understanding of how certain medical conditions within the Cape Colony were viewed and treated, will be filled. These subjects include: 'lunacy', leprosy, medical malpractice, how professionals kept up to date (or in many cases didn't) with contemporary knowledge, as well as the presence of a local network of knowledge and control. In this regard chapters three, four and five will act as case studies looking at these different themes. The study of these foci can then be used to speak towards a set of wider internal imperial trends. The thesis will begin with an initial chapter that investigates the general British colonial context within which the period of interest falls. This will involve the use of secondary material which relates to the context of knowledge circulation and despotic governorship that characterised the post-Napoleonic war. For this purpose the work of historians like Zoë Laidlaw, C.A. Bayly, Catherine Hall, as well as a limited number of other experts in this field, will be essential.¹⁴ It will then proceed to look more specifically at how the Cape was directly targeted and affected by the Commission of Eastern Inquiry, an investigation that embodied the trends in Colonial governance. This chapter will therefore be central in revealing to what extent a Cape administration, and more specifically a Cape Colonial medical structure was affected by wider trends in Imperial

⁸ David Arnold, *Imperial Medicine and indigenous societies*: 1.

⁹ Zoë Laidlaw, "Investigating Empire: Humanitarians, Reform and the Commission of Eastern Inquiry", *The Journal of Imperial and Commonwealth History* 40, 5 (December 2012), 750.

¹⁰ Alan Lester, "British Settler Discourse and the Circuits of Empire", *History Workshop Journal* 54 (2002), 26.

¹¹ Randolph Vigne, *Thomas Pringle: South African pioneer, poet and abolitionist* (Boydell and Brewer Ltd, 2012), 68.

¹² *Ibid*, 48.

¹³ Randolph Vigne, *Thomas Pringle*, 126.

¹⁴ Zoë Laidlaw, "Investigating Empire", 750.

governance. The chapter will also reveal the effectiveness of policies instituted by Colonial Office officials.

The second chapter will focus more specifically on the Cape Colony and its context in the build up to the period of interest. As a result, a brief introduction and history relating to the Cape's seizure by the British will need to be conducted. The unique aspects of local governance and life within the colony for the period of the 1820s will then be more logically placed within a larger context. Having developed an understanding of both a wider imperial as well as a more local environment the thesis will then be able to begin the process of examining specifics about the medical context and structure at work. A thorough interrogation of the overarching medical system that was in operation at the Cape during the period of interest will be the natural starting point for this focus. This will involve explaining the offices of the Colonial Medical Inspector and the Supreme Medical Committee, discussing their duties, as well as investigating their roles within a larger system. Due to his role in medical matters in the 1820s the remarkable figure of Dr James Barry will be briefly explored. The positions of the various district surgeons will then be described before the place of the ordinary recognised and sanctioned medical practitioners within this era is examined. This chapter will also look at how the profession at the Cape was battling to assert itself in the 1820s. Comprehending some of these issues is essential to the chapters that follow as they evidence a number of conflicts relating to control and attempts to regulate health care. For this purpose the works of Edmund Burrows, Harriet Deacon and Howard Phillips are of great use.¹⁵

Having established what medical system and chain of command was theoretically in operation, the actions of different actors within this structure will be assessed. The first of the three case study chapters will assess the interconnected nature of the Cape medical fraternity. This will involve looking at how local medical personnel sought to establish contact with one another, in addition to how the Cape Town based authorities sought to maintain a standard of medical care throughout the colony. In this way the nature of the internal network of knowledge that permitted such interactions to take place can be assessed by looking at these specific cases. The chapter will also explore the attempts made by imperial 'metropole' based organisations, like the Royal College of Physicians, to extract certain potentially useful information from the Cape based medical profession. The dialogue that emerged in these exchanges is of particular interest due to the power dynamics and questions relating to colonial appropriation of knowledge that it raises. The structures brought up by these cases will set the scene for the next chapter which aims to indicate how flimsy and haphazard such connections were and that means of maintaining control through information were limited.

Instances of medical malpractice and issues around the enforcement of order within the Cape's medical system will form the basis for chapter four. Fortunately for the purpose of this study, although unfortunately for the patients concerned, there are a number of examples of medical negligence and misconduct to be found within this period of time. By studying

¹⁵ Edmund Burrows, *A History of Medicine in South Africa: Up to the end of the Nineteenth Century*, (Cape Town: A.A. Balkema, 1958).

these instances with a critical lens, the thesis will aim to illuminate how officials sought to maintain a certain standard (and therefore obtain some measure of respectability), a process which produced varied results. This chapter therefore relies on the prior sections of the thesis that established the structures which were in place to try and facilitate such regulations. Issues relating to space and authority within the Colony feature heavily in this section of the thesis, but it also reveals how the medical structure was influenced, and was able to influence other spheres of colonial life (largely due to the role of medical personnel in certain court trials and deaths). Such a chapter will in turn add to the context within which a series of cases relating to specific illnesses and conditions can be further explored.

Chapter five uses two case studies to discuss themes of maintaining certain standards, the power of knowledge and the lack of control present in the Colony at this point in time. The diagnosis, perception and ‘treatment’ offered to ‘lunatics’ within the period of interest will form the basis of the initial part of the fifth chapter. There are a number of interesting and at times heart-wrenching primary examples of the approach taken towards managing the Colony’s mentally insane population. The evidence obtained from these cases can in turn, be referred back to the local medical administration structures (spoken about in the previous chapter) at work. Certain particulars of this chapter will also be able to show a certain tension between the colonies medical administration and the desired application of policy intended by metropolitan colonial authorities. The second half of the fifth chapter will seek to explore how cases of leprosy were dealt with in this particular period. Like the treatment of the insane, this is a theme within this period which has largely escaped study. The approach to this topic will be similar to that taken towards the study of lunacy. Both topics in this chapter debate the themes of maintaining standards, the power of knowledge and the lack of control present in the Colony at this point in time. Further similarities relating to the Cape’s treatment of lunacy and leprosy will help draw these two conditions together in the final section of this chapter.

The conclusion evaluates the extent to which “a state centred system of scientific knowledge and power” was present in the Cape during the 1820s and early 1830s.¹⁶ The conclusion aims to critically re-assess the concepts of control and the structures of information that were explored in the body of the thesis in an effort to bring these themes together. The extent to which these topics fit into a wider context of knowledge circulation and imperial control will also be determined as part of this process. This will allow the paper to return to the broader concepts with which it started by looking at how these medical “social transformations are a product of both global patterns and local struggles”.¹⁷ It will then conclude by evaluating the unique nature of the Cape Colony and the potential for further research.

¹⁶ David Arnold, *Colonizing the Body*, 7.

¹⁷ Alan Lester, *Imperial Networks: Creating Identities in nineteenth-century South Africa and Britain*, (London: Routledge, 2001), 7.

Historiography and limitations:

It is important to note that the size constraints of a Master's thesis have restricted the scope of this study and it is by no means a comprehensive history of medical care in the Cape in the 1820s. Certain topics have not been raised, for example that of the vaccine institute, due to the word limit. This highlights the possibility for further study into this area. In addition a number of very interesting correspondence letters were not referred to in the chapters that follow as a selective process had to be charted in order to not exceed the word limit. Instead the thesis will aim through its specific focus on a select number of topics and case studies, to make some form of small contribution to a field that still awaits comprehensive study.

The nature of this focus has determined that the thesis will utilise a series of different approaches that will in turn be able to address wider themes and mitigate certain foreseeable restraints. Micro-history will be central in the way that particular examples will be drawn from the primary sources and analysed in order to critique the wider themes that may be discerned from their content. A number of recent historical works have applied such an approach to Cape historical research and by doing so the limitations of the sources have been greatly reduced.¹⁸ Kirsten McKenzie's *Scandal in the Colonies* applies such a technique in order to look at notions of respectability in both Cape Town and Sydney during the 19th century.¹⁹ In this manner she is able to reveal how certain conceptions and ideas, evident in a select number of cases, relating to social status were transmitted throughout the empire. Such examples of Cape micro-history are invaluable to this study's intent.

Yet it is also important to note the dangers of such an analytical tool. These hazards have been noted extensively due to the fact that a micro-historical approach often focuses in on unique and extraordinary events.²⁰ As has already been said, many such events are present in the thesis that follows. But, in order to try and mitigate the threat posed by such a specific focus an attempt has been made where possible to find a number of similar events that will in turn allow for some form of general trend to be mapped.

In addition to a micro historical lens, the observation of certain inclinations in governance and correspondence have been analysed with a view towards determining the presence of networks. The works of a number of contemporary historians such as Alan Lester, Kirsten McKenzie and Zoë Laidlaw have all shown the importance of observing these connections during the time period that this study focuses on. Zoë Laidlaw's *Colonial Connections* is the perfect starting point for exploring how the Colonial Office in London sought to establish more consistent and informed authority over the empire.²¹ In her work she reveals how multifaceted networks of knowledge were during this time. Alan Lester's study of how Southern Africa and in particular the Eastern Cape fitted into these structures of knowledge

¹⁸ Nigel Penn, *Murderers, Miscreants and Mutineers: Early Colonial Cape Lives*, (Sunnyside: Jacana Media (Pty) Ltd, 2015), VII.

¹⁹ Kirsten McKenzie, *Scandal in the Colonies: Sydney & Cape Town, 1820-1850*, (Carlton: Melbourne University Press, 2004), 1.

²⁰ Edward Muir, "Microhistory or Microstoria", *Encyclopaedia of Historical Writing II* (London, 1998), 616.

²¹ Zoë Laidlaw, *Colonial Connections, 1815- 1845: Patronage, the information revolution and colonial government*, (Manchester: Manchester University Press, 2005),3

and information circulation is therefore invaluable. Works like *Imperial Networks* not only provide important context, but they also offer a perfect example of how such an approach can be applied to the Cape Colony.²²

The notions of the colonial space and the limits of formal ‘state’ governance are linked to these network approaches. In particular numerous works by David Arnold have served as ideal instances from which to draw assistance. His work on colonial medicine in India has examined a number of specific topics whilst still being able to make a comment on the broader schemes at work.²³ The approach he utilises in *Colonising the Body* is able to reveal how the British sought to govern the sub-continent but his focus on medical topics addresses how their policies had to evolve in order to fit the social environment.²⁴ Arnold’s *Colonising the Body* explores themes like smallpox, cholera, plague, the adaption of British medicine to India and how such issues resulted in a particular response from authority officials. This informative and useful work does not just speak about medical conditions and their treatment. This paper has sought to adopt a similar approach. Although the paper comprises five distinct and at times disparate chapters that all deal with varied topics, when placed together they all converge on common themes. These trends centre on the primary notions of power and control therefore bringing in certain questions that surround the interconnected nature of the Cape context.

As with any study that aims to observe relationships of power, forms of authority and means of control, the work of Michel Foucault has been important. *History of Madness* explores the hidden structures at play during the treatment of the insane and the way society views the figure of the ‘lunatic’. The evolution of facilities built to separate these individuals is central, accompanied by the power dynamics represented by the ‘lunatic-doctor’ relationship.²⁵ In addition the first chapter, *Stultifera Navis*, searches for the origin of the madman in literature and in doing so finds a direct link between the representation and confinement of the ‘leper’ and the ‘lunatic’.²⁶ This is a theme raised by the fifth chapter of this thesis therefore making Foucault’s analysis of such a connection influential. *The Birth of the Clinic* works towards showing how 19th century medicine and medical care was able to rebrand itself largely through the use of language.²⁷ This therefore interrogates the dramatic shift in the way that the doctor was represented. Yet Foucault is also able to illuminate the evolution of the former entity of the medical institution, which during this period “was dissolved in favour of a generalised system of assistance”.²⁸ Through this analysis the emergence of the state as “sole administrator” of health care is revealed.²⁹ Notions of control and authority abound in *The Birth of the Clinic* which point towards the highly charged nature of the medical field. Sally

²² Alan Lester, *Imperial Networks: Creating Identities in nineteenth-century South Africa and Britain* (London: Routledge, 2001), 7.

²³ David Arnold, *Colonizing the Body*, 47.

²⁴ *Ibid.*

²⁵ Michel Foucault, *History of Madness*. Oxon: Routledge, 2006, 337.

²⁶ *Ibid.*, 8.

²⁷ Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*, New York: Vintage Books, 1975, 4.

²⁸ *Ibid.*, 18.

²⁹ *Ibid.*

Swartz has evidenced the use of Foucault's work in studies of colonial power in the field of medicine. In *The Regulation of British Colonial Lunatic Asylums and the Origins of Colonial Psychiatry*, Swartz utilises some of Foucault's conceptions to reveal how the British Colonial Office sought to maintain control over far flung institutions.³⁰ Swartz' exploration of colonial mental health care is therefore a useful example of how ideas of power and regulation, evident in *The Birth of the Clinic* and *Psychiatric Power*, can be applied to the context of the British Empire.³¹ In addition, by placing specific cases within a grander context of colonial governance, networks and reform, the thesis aims to avoid what Andrew Scull has cited as a serious issue with the micro history of medical topics like lunacy.³² Joseph Melling explains Scull's argument that the use of single cases "and community networks need to be informed by a theoretical and comparative perspective".³³ Thus by establishing a firm local context and an understanding of the state of imperial management during this period, the examples cited cannot be looked at in isolation.

Having briefly outlined the approach that will be undertaken, the work of building a substantial context is now appropriate.

³⁰ Sally Swartz, "The Regulation of British Colonial Lunatic Asylums and the Origins of Colonial Psychiatry", *History of Psychology* 13, 2 (2010), 164

³¹ *Ibid*, 169.

³² Joseph Melling & Bill Forsythe, *Insanity, Institutions and Society, 1800-1914: A social history of madness in comparative perspective*, (London: Routledge, 1999), 17.

³³ *Ibid*.

Chapter 1: Imperial knowledge circulation and control; The British Empire and the Cape, 1815-1835

Interconnected relationships

The complex entity of an empire is one that throws up certain issues with regards to historiographical approaches. Examples evident in the inquiries of the 1820s (as well as the works of Foucault) reveal that events and structures cannot be viewed in isolation due to the nature of imperial interconnectedness. Zoë Laidlaw in *Colonial Connections* sums up the relevance of such a view within the time frame of interest. She writes: “The study of networks draws attention to both individuals and structures within the empire; this is important for an era of small formal government when non-government lobbyists could play a critical part in decision making”.³⁴ A more in depth examination of such a context is therefore crucial before insight into a specific case or place is possible. As a result the state of the British Empire and trends within the imperial approach to managing the colonies needs to be explored. This understanding can then be used to explain the Cape’s position in such a complex web of control. In the narrowing of this focus to the Cape Colony, the reports of the Commissioners’ of Eastern Inquiry will be of particular use. The relation of medical regulation and control to a wider context will then be clearer.

However before any of this is possible, an understanding of what defines a network within this specific context is important. For this purpose the work of Zoë Laidlaw is invaluable as it provides insight into forms of knowledge circulation that were in use during this period. In *Colonial Connections*, Laidlaw notes that there were three forms of dialogue that allowed for information to be transmitted on a global scale.³⁵ All of these categories were heavily dependent on interpersonal communication, relationships and some form of common experience.³⁶ The first type of network is said to have been formulated “independently of the empire” and had certain restrictions on entry into its avenues of transmission.³⁷ Such networks were comprised of structures that had either arisen due to shared experiences, like war service or collective education, or were the result of family connections.³⁸ Although these sorts of associations are viewed by Laidlaw as having arisen separately from the business of empire, the role of imperial work and activity in developing some of these should be noted. For example, soldiers deployed to different garrisons and campaigns throughout the imperial possessions would have forged friendships and connections. The high degree of circulation of military personnel, especially senior officers, would mean that maintenance of these bonds would have required a flow of information in order to sustain them.³⁹ This suggests that even those attachments formed in the category of what Laidlaw sees as having

³⁴ Zoë Laidlaw, *Colonial Connections*, 1.

³⁵ *Ibid*, 16.

³⁶ *Ibid*.

³⁷ *Ibid*.

³⁸ *Ibid*.

³⁹ Alan Lester, *Imperial Networks*, 6.

been derived “independently of empire” were in some way or another linked to the activity of empire building and management.⁴⁰

The second form of network can be defined, according to *Colonial Connections*, as deriving directly from “the business of imperialism itself”.⁴¹ This category is determined as encompassing interpersonal dialogue linked to aspects of empire such as: economic activity, colonial administration and religious conversion.⁴² Laidlaw points out that the second of the three classifications of network was less exclusive in its composition, and entrance was not as strictly policed by certain exclusionary factors. Yet the most porous of the groupings is that which provided “information on colonial circumstances and societies to the Colonial Office”.⁴³ The approach to information dissemination represented by this third category was to become of great importance within the period after 1817, as will be shown later in this chapter. Although the distinction between these categories is useful, it should be pointed out that they could often overlap one another, and at times they could be inextricably linked. In this way they fed off each other and can, at times, be seen as contributing to the development of the other. Importantly, Zoë Laidlaw argues that the members of these networks were aware of their place within them.⁴⁴ As a result they were able to utilise this knowledge to their advantage. In this way a network can be revealed as a powerful tool by which influence and power could be derived and maintained with a global context. Furthermore these webs of information and consciousness fuelled the creation of unique identities. This is evidenced by Alan Lester’s work in *Imperial Networks* where he points out that such networks were not always consistent, but that they played an important role in the creation of social categories.⁴⁵

Yet these understandings of networks are reliant on conceptions of the empire itself and how it was structured. The majority of theoretical notions relating to information transmission structures make certain distinctions between transmitters and receivers. Such a representation appears to rely heavily on the hypothesis of centre and periphery. Rainald von Gizycki describes this viewpoint as holding that “a centre is a place from which influence radiates”.⁴⁶ The areas defined as the periphery are therefore reliant on the ideas and directives emanating from the centre. This flow of knowledge is as a result uneven in its nature, as the periphery is required to emulate the “structure and procedures” prominent in the centre.⁴⁷ The conceptual approach defined by von Gizycki in the article *Centre and Periphery in the International Scientific Community* is reliant on an idea that the flow of authority and knowledge is a one-way process.⁴⁸ This is problematic as it implies there is no dialogue within the framework of entities like the British Empire. In response to such unadaptable

⁴⁰ Zoë Laidlaw, *Colonial Connections*, 16.

⁴¹ *Ibid*, 16.

⁴² *Ibid*, 16.

⁴³ *Ibid*, 16

⁴⁴ *Ibid*, 16.

⁴⁵ Alan Lester, *Imperial Networks*, 7.

⁴⁶ Rainald Von Gizycki, “Centre and Periphery in the International Scientific Community: Germany, France and Great Britain in the 19th Century”, *Minerva* 11, 4 (October 1973), 474.

⁴⁷ *Ibid*, 475.

⁴⁸ *Ibid*.

perception of networks, a number of modern historians working on the British Imperial period of the early 19th century have employed heavily modified conceptions of this outdated method. Catherine Hall points to the work of James in *The Black Jacobins* as having illuminated the flaws of ‘centre-periphery’ approaches by critiquing “the assumption that causality always runs from the centre to the colony”.⁴⁹ In order to establish some form of viable alternative to the limitations of ‘centre-periphery’ theory, the concept and terminology of ‘metropole and colony’ became prominent. Such a way of viewing networks and web-like relationships aimed to point out that there are multiple sites from which influence and knowledge can emanate. Hall describes how “the colony and metropole are terms which can be understood only in relation to each other” thus indicating some sort of symbiotic relationship.⁵⁰ This conception is clearly manifested and expanded upon in Zoë Laidlaw’s *Colonial Connections* where the idea of ‘control nodes’ helps to identify multiple places and sources from which knowledge can originate.⁵¹ Her notion of nodes allows for a much more intricate image of networks to be discerned. Like Catherine Hall, Laidlaw shows the high degree of interconnectedness that existed between certain prominent internal Empire reform movements within the early 1800s.⁵² Importantly, the examples she employs also indicate that people could be vital contributors to intra-imperial networks.⁵³ Such a conception is similar to that adopted by C. A. Bayly in *Imperial Meridian* where he notes the importance of the individual person in the transmission of ideas and the implementation of certain types of authority.⁵⁴ These impressions indicate that there was in fact a more complex dialogue between parties within the British Empire than ‘centre-periphery’ assumed possible.

The ‘nodes’ identified by historians like Bayly, Laidlaw and Hall were often very different in nature and in turn produced varying contributions to the elaborate web of ideas that connected the empire. This type of approach therefore enables the analysis of networks that existed not just between the mother country and the colonies, but within particular possessions. As a result we are made aware of an even more complicated and complex nexus from which authority, influence and knowledge would have been transposed. Yet it can also help us to understand what type of dialogue was at work within a chosen area. Such a concept reveals how a particular context can relate to a much wider environment. This thesis will therefore seek to affirm the presence of a fluid, two-way dialogue between the colony and metropole, but also how there was a complex conversation within a particular possession, that being the Cape. Despite acknowledging the presence of a more diverse and even-handed exchange between metropole and dependency, modern historians of this school still note the importance of a supreme authoritarian ‘node’ in attempts to exert a particular influence over areas within the empire. Within the context of this period and scope the city of London is portrayed as being the embodiment of this unique label.⁵⁵ The reason behind this can be seen

⁴⁹ Catherine Hall, *Civilising Subjects: Colony and metropole in the English imagination, 1830- 1867*, Chicago: University of Chicago Press, 2002, 9.

⁵⁰ *Ibid*, 12.

⁵¹ Zoë Laidlaw, *Colonial Connections*, 16.

⁵² *Ibid*, 14.

⁵³ *Ibid*, 16.

⁵⁴ C.A Bayly, *Imperial Meridian: The British Empire and the World, 1780-1830*, (London: Longman, 1989),133.

⁵⁵ Zoë Laidlaw, *Colonial Connections*, 2.

to derive from the metropolis's role as the seat of established institutions of governance and administration.

It is also important to try and understand how the colony was perceived and conceived in correlation to the British 'mother country'. Catherine Hall's view that conceptions of the metropole and colony cannot be separated, needs to be further explored as it is essential to clarify the extent to which this was the case.⁵⁶ Crucially, the position of Hall indicates that there was a distinction made between what the metropole was, and what the colony was. However, one could not be understood without taking the other into consideration. Her interrogation of a Jamaica case study reveals how, at least to an extent, "colonies were thought of as offshoots of the mother country".⁵⁷ This in turn explains the attempts to replicate mainland British institutions of state, but also cultural and social structures in the colonies.⁵⁸ This trend is perfectly evidenced in Kirsten McKenzie's *Scandal in the Colonies* where colonial settlers sought to emulate positions of social standing in Britain.⁵⁹

Despite this impression of a seemingly parental relationship there was still a large disjuncture between perceptions of the two sites. Furthermore, *Civilising Subjects* suggests that this distinction was important in maintaining authority over colonial citizens. Hall's introduction attempts to explain this paradigm by indicating how "the right to colonial rule was built on the gap between metropole and colony".⁶⁰ This was in turn grounded in a stereotypical colonial image of "civilisation here, barbarism/savagery there".⁶¹ Attempts at institutional transposition to imperially controlled territories' therefore aimed to maintain a semblance of superiority for the metropole, whilst still attempting to control the way the colonies developed.⁶² Also important to note was the role of the influence that the London based government attempted to assert through the appointment of colonial officials.⁶³ Yet some of the evidence that will be referred to in this thesis could potentially challenge "the centrality of London".⁶⁴ The inability of the metropole to enforce its will upon all areas of the colony can function as a serious critique of its role in networks of authority and power. The thesis will therefore aim to point out where webs of knowledge operated and succeeded, but perhaps more importantly where they failed or where ignored. Contextually, it is also crucial to take into account the general nature of colonial administration during this time period. C.A. Bayly indicates in *Imperial Meridian* that towards the end of the 18th century the British sought to run their possessions in a highly autocratic manner.⁶⁵ This involved the use of highly

⁵⁶ Catherine Hall, *Civilising Subjects*, 12.

⁵⁷ *Ibid*, 10.

⁵⁸ Zoë Laidlaw, *Colonial Connections*, 7.

⁵⁹ Kirsten McKenzie, *Scandal in the Colonies*, 5.

⁶⁰ Catherine Hall, *Civilising Subjects*, 10.

⁶¹ *Ibid*.

⁶² Zoë Laidlaw, *Colonial Connections*, 7.

⁶³ *Ibid*, 8.

⁶⁴ Zoë Laidlaw, *Colonial Connections*, 17.

⁶⁵ C.A Bayly, *Imperial Meridian*, 10.

powerful individual positions, like that of the colonial governor, in order to maintain strict and firm control over subjects in the colonies.⁶⁶

Reasons for reform

The year 1817 saw a shift in the way that the British Empire sought to run and administer its colonies'. Yet there are multiple reasons for this adjustment in approach and they need to be looked at comparatively in an effort to determine how and why changes in policy were enacted. C.A Bayly has noted the lack of previous focus on the imperial period from the late 18th century until the 1830s.⁶⁷ However his work, accompanied by that of Catherine Hall, Alan Lester and Zoë Laidlaw helps to fill this void and illuminate the reasons behind an alteration in the strategy of empire management. A factor noted by Zoë Laidlaw as crucial in the move towards more engaged and involved policy was a feeling of profound fear. This fear arose from the loss of a portion of Britain's North American colonies during the American Revolution which concluded in 1783.⁶⁸ The fact that the full might of the British military was unable to subdue the uprising caused a panic with regards to the true ability to enforce order. Yet of greater importance and shock to the imperial mind-set was the reality that British colonial subjects could become so disenfranchised that they were willing to take up arms to remove themselves from the empire.⁶⁹

A desire to prevent such a disastrous repeat of events elsewhere in the territories was thus a central motivator behind a concerted desire to reform. Britain's period of almost continual warfare with France and her allies up until the year 1815 has been cited as central to attempted policy revisions. Zoë Laidlaw views this conflict as having had an ardent impact on "a generation of colonists, metropolitan officials and colonial administrators".⁷⁰ These individuals had grown up in the shadow of the second empire's failure, but it was the global wars with revolutionary France and their consequences that Laidlaw, argues shaped their mentalities.⁷¹ The eventual victory of the British coalition spurred a renewed national confidence and self-belief, and it was this new hope that helped shape an attempt to reinvigorate the colonies and the imperial mission.⁷² In addition, with the threat of Napoleonic France gone a new enterprise was needed to fulfil personal and national ambitions. The change in the global political climate and context brought about by victory therefore allowed the colonies to re-enter the British imagination in a place of prominence.

Yet the defeat of the French and their allied partners also saw Britain appropriate numerous overseas territories. This expansion of imperial control brought with it an increased population for which the British now found themselves responsible. This particular turn of

⁶⁶ Zoë Laidlaw, *Colonial Connections*, 40.

⁶⁷ C.A Bayly, *Imperial Meridian*, 7.

⁶⁸ Zoë Laidlaw, *Colonial Connections*, 2.

⁶⁹ *Ibid.*

⁷⁰ *Ibid.*, 2.

⁷¹ *Ibid.*, 2.

⁷² C.A Bayly, *Imperial Meridian*, 3.

events does however highlight a series of issues with regards to our conception of the colony in relation to the British mainland. These acquisitions could not as of yet be viewed “as offshoots of the mother country” as the majority of the settler population was not of English speaking origin.⁷³ Furthermore the style and approach to the management of these territories had to be moulded by a different manner of colonisation.⁷⁴ How these distinctly ‘foreign’ colonies were to be brought within the British mould of imperial authority was of great concern. This issue correlates with the trend which saw an increase in attempts to “seriously discipline and control marginal groups”.⁷⁵ These new citizens of the empire would have constituted one of the ‘marginal groups’ targeted by this process. Yet in order to exert control more information on such peoples was needed. There were also concerns with settlers who had originated from the British Isles, in addition to issues that concerned the entirety of imperial possessions. One such issue involving many British colonial subjects was that of slavery.

The context of abolition in the early 19th century has been noted as having been central to reform attempts. Alan Lester, in his journal article *British Settler Discourse and the Circuits of Empire*, explores how debates within the metropole around practices of slavery were fuelled by input from the colonies. This process he argues was responsible for establishing a multitude of “trans-imperial connections” within the British Empire.⁷⁶ The article reveals that these networks were responsible for keeping abolitionists in Britain up to date with events in the colonial possessions. The culmination of this process in 1807 came to be seen as a crucial turning point whereby the entity of the empire could be genuinely viewed as a morally righteous institution.⁷⁷ In addition, Lester’s research reveals the means abolitionists utilised to maintain such contact. These included the circulation of “books, pamphlets, prints and artefacts” across imperial spaces.⁷⁸ This is important as it indicates some of the physical manifestations that networks of knowledge circulation took during this period. He goes on to identify these links, at the end of the 18th century and beginning of the 19th, as being the precursors to another network which would be vitally important and influential in the system of knowledge circulation that emerged in the aftermath of the Napoleonic Wars. Following the abolition of the slave trade within the British Empire in 1807 a humanitarian discourse replaced and incorporated aspects of the anti-slavery cause.⁷⁹ Derek Peterson argues that the humanitarians and abolitionists were one and the same therefore drawing direct links between their ideals and modes of knowledge transmission.⁸⁰ The emergence of the ‘benevolent’ ideas of colonial control, present in the arguments of abolitionists and humanitarians, have been identified as central in influencing governance practices throughout the empire.⁸¹ The effect

⁷³ Catherine Hall, *Civilising Subjects*, 10.

⁷⁴ Zoë Laidlaw, “Investigating Empire”, 751

⁷⁵ C.A Bayly, *Imperial Meridian*, 6.

⁷⁶ Alan, Lester, “British Settler Discourse and the Circuits of Empire”, 25.

⁷⁷ Derek Peterson, *Abolitionism and imperialism in Britain, Africa, and the Atlantic*, (Ohio: Ohio University Press, 2010), 6.

⁷⁸ Alan, Lester, “British Settler Discourse and the Circuits of Empire”, 25.

⁷⁹ Zoë Laidlaw, “Investigating Empire”, 749

⁸⁰ Derek Peterson, *Abolitionism and imperialism in Britain, Africa, and the Atlantic*, 7.

⁸¹ Zoë Laidlaw, “Investigating Empire”, 752.

that such concepts had on the Cape and its medical structure is therefore important and will be explored in depth in the latter parts of the thesis.

Alan Lester suggests that Britain's previously central role in the trans-Atlantic slave trade had come to be viewed as a shameful blot on its international and moral image.⁸² Although important progress in redeeming the nation for this past evil had been achieved through abolition, there was a feeling that this could "be jeopardized if abuses" in the colonies were allowed to occur.⁸³ It is apparent that there was a direct correlation between the movements against the slave trade, and those which came to advocate a reform in colonial practices. Humanitarians relied on the numerous networks that had been established by the abolitionists. However supporters of this humane ideology also called for an increase in state surveillance practices within the colonial territories. These would serve a number of purposes, and when the Colonial Office implemented a number of these controls the humanitarians were able to influence findings on the ground. Interestingly, Laidlaw suggests that "the broadly defined 'humanitarian' or 'philanthropic' network tended to operate outside metropolitan and colonial government", yet they were still able to feed off of the operations of these institutions, whilst maintaining an ability to influence their actions.⁸⁴ It is the combination of this humanitarian discourse and post Napoleonic debates on colonial governance that Laidlaw cites in the article *Investigating Empire* as being the driving force behind a heightened desire for knowledge.

Practically speaking, the importance of human movement throughout the empire is raised as being central to the maintenance of these interconnected webs. The high degree of personnel circulation in official and unofficial imperial positions therefore points towards a tangible sign of imperial networking. These motivations for movement were also accompanied by the expansion of British trade between colonial possessions.⁸⁵ When one takes into account that these individuals would have travelled with specific conceptions and ideas, it is fair to identify this constant movement of people as a central mode for idea transference.

Yet it appears to have been the British financial state at the conclusion of the perpetual wars with France, which created a paramount feeling of panic in the metropole, and the impetus to reform with the help of knowledge networks. The Conservative government's realisation of how serious monetary issues were after victory in 1815 prompted a panicked attempt to address the root causes of these issues.⁸⁶ The costly administration of the colonial empire was therefore brought up in parliament as a drain on funds that had to be reassessed. The Colonial Office was instructed by the government to investigate how the empire could "be run more efficiently and cheaply".⁸⁷ According to Zoë Laidlaw, this move towards better financial management created what she has termed "a climate of hostility towards corruption"

⁸² Alan, Lester, "British Settler Discourse and the Circuits of Empire", 27.

⁸³ *Ibid.*

⁸⁴ Zoë Laidlaw, *Colonial Connections*, 27.

⁸⁵ C.A Bayly, *Imperial Meridian*, 104.

⁸⁶ Zoë Laidlaw, "Investigating Empire", 749.

⁸⁷ Zoë Laidlaw, *Colonial Connections*, 41.

within the mother country and in the colonies.⁸⁸ Her research has shown that clamping down on financial abuses began in Britain and radiated outwards into the colonial settings.⁸⁹ Yet in order to determine where, when and how monetary expenditure in the overseas territories could be greatly reduced, a new and more hands on approach was required. It was therefore suggested in 1817 that commissions of inquiry should be established in order to investigate a cheaper way forward for the colonies.⁹⁰ The financial problems of Britain at this stage provided the impetus for this new approach, yet the other factors previously mentioned in this chapter should not be ignored.

Commissions of Inquiry and the Cape

The establishment of a number of commissions to look into the state of specific colonies and their management was motivated by a number of issues and changes in context. But the practicalities and nature of these inquiries gives insight into the means by which the metropole attempted to exert greater control. It is necessary to highlight how the appointed commissioners went about their business, but also how they observed and reported back to their superiors on particular occurrences in the imperial possessions. One of the lengthiest inquiries was undertaken by what became known as The Commission of Eastern Inquiry. Its mission, which was approved by parliament, was to inspect and report back on the colonies of Ceylon, Mauritius, and especially important for this thesis, the Cape.⁹¹ These commissions were to be “of a very general nature” in an attempt to get a broad overview of the situation in these territories.⁹² With that being said, the report on the Cape centred on questions relating to more efficient administration and concerns around the treatment on slaves and the indigenous population.⁹³ In this regard the commissioners were permitted to “suggest such improvements as might appear to them to be expedient and practicable”.⁹⁴ Previously the Cape had been the subject of a limited number of fact finding expeditions. One such mission was undertaken by John Barrow, the secretary to the first British governor of the Cape, in 1797.⁹⁵ However, despite some comments on the local population, Barrow’s expeditions into the interior were motivated by an attempt to map the colony, a process that served as a “prelude to occupying it”.⁹⁶ Comparatively the Commissioners of Eastern Inquiry, conducting their investigations 20 years later, knew of Britain’s intention to remain at the Cape. As a result, their inquiry sought to establish how the Colony could be run more efficiently by making small alterations. These differences in intent, illuminate the shift in British colonial policy spoken about by Bayly and Laidlaw. The Commission of Eastern

⁸⁸ *Ibid*, 42.

⁸⁹ *Ibid*, 42.

⁹⁰ British House of Commons. Debate on Commission of Inquiry 25 July 1822. Cc 1801-441801. Accessed from <http://hansard.millbanksystems.com/1822/jul/25/commission-of-inquiry> on 15/07/2016.

⁹¹ Zoë Laidlaw, “Investigating Empire”, 753.

⁹² *Ibid*.

⁹³ *Ibid*.

⁹⁴ *Ibid*.

⁹⁵ Nigel Penn, *Mapping the Cape: John Barrow and the First British Occupation of the Colony, 1795-1803*, (Paper presented to the Aberdeen University African Studies Group Colloquium on ‘Maps and Africa’), 5-6 (1993), 9.

⁹⁶ Nigel Penn, *Mapping the Cape*, 9.

Inquiry embodies the trend of attempting to run colonies through more consistent and reliable information.

When looking at the men who conducted the investigation at the Cape one could argue that they too, were embodiments of this era. John Bigge and Major Colebrooke were appointed as the commissioners for the Cape section of the inquiry and arrived at the Cape in 1823.⁹⁷ Bigge was an English lawyer who had previously conducted a similar study into the state of New South Wales as well as the convict transportation system. Colebrooke was a career soldier who had served throughout the empire and would go on to conduct additional inquiries before becoming a governor in the West Indies. Both had truly transnational careers and indicate the movement of administrators during this period.⁹⁸ Their duties during this period also address the personal nature of colonial governance and intelligence gathering, thus reiterating the arguments of Laidlaw and Bayly. Kirsten McKenzie's work in *Imperial Underworld* stresses the importance of this "new breed of reforming administrators" and how their efforts were crucial in binding the Empire together.⁹⁹ The content of the Commissioners reports' at the Cape are a rich topic waiting for further in depth study. Different sections of their write-ups deal with a series of issues they came across and ranged from the state of the police service to the establishment of efficient water canals in Cape Town.¹⁰⁰ Their investigations lasted for approximately three years until they left the Colony in 1826.¹⁰¹ However, Peires indicates that the central concern of their work was to regulate Somerset and suggest ways to reorganise the Cape's administrative structures.¹⁰² This did result in some changes, but this thesis will reveal that the ability of such an administrative tool to effect quick, meaningful and sustained was severely limited.

It is now clear that the imperial context in the aftermath of the Napoleonic Wars was one of increased change and attempts at colonial reform. These trends all sought to increase control through a number of different networks that connected the Empire, yet they also sought the institution of a series of new webs. In this way, information was seen as a powerful tool which could allow for policy to be better implemented and regulation more efficiently achieved. This era of knowledge circulation and imperial interconnectedness affected the Cape which became a node in the structure. The investigations of the Commissioners into various aspects of Cape society and its administrative structures represent its incorporation. However the extent to which the practice and regulation of healthcare in the Cape was affected by such trends, is uncertain. The thesis now turns to the specifics of the Cape medical structure during this period.

⁹⁷ Randolph Vigne, *Thomas Pringle*, 48.

⁹⁸ Zoë Laidlaw, "Investigating Empire", 757.

⁹⁹ Kirsten McKenzie, *Imperial Underworld: An Escaped Convict and the Transformation of the British Colonial Order*, (Cambridge: Cambridge University Press, 2016), 6.

¹⁰⁰ George McCall Theal, *Records of the Cape Colony from February 1793 to April 1831 vol. 35*, 193.

¹⁰¹ *Ibid.*

¹⁰² J.B. Peires, "The British and the Cape, 1814- 1834", In *The Shaping of South African Society, 1652- 1840*, edited by Richard Elphick and Hermann Giliomee, (Cape Town: Maskew Miller Longman, 1989),493.

Chapter 2: The Cape's medical structure and members of the local fraternity

A better understanding of the medical structures and health care in the 1820s Cape is required before the specific case study chapters can be explored. In order to examine this topic the works of Harriet Deacon, Anne Digby, Howard Phillips and Edmund Burrows are central. Burrows' work, which was published in 1958, sought to look at South Africa's medical history until the beginning of the 1900s. Anne Digby notes that Burrows' work was "the first comprehensive account of South African medical history", however she made sure to note that its content was in many cases "focused narrowly on biomedicine with the foregrounding of white male doctors' careers".¹⁰³ The more recent academic inquiries of Harriet Deacon, Howard Phillips and Anne Digby focus on the different practices of medicine in the Cape Colony during the 19th century in a more inclusive way. As a result their works are a useful and necessary reference point for much of the content present in this section of the thesis. But in order to set the scene for a focus on medical structures, this chapter begins by looking at how the British came to control the Cape at the beginning of the 19th century. It will then explore the different medical positions that were sanctioned by the government, as well as those that were not. Although this chapter seeks to set up the context for the case studies that follow, it will also discuss attempts to establish authority and control over the Colony,

Context prior to British occupation

Prior to late 1795 the Cape had been ruled by the Dutch East India Company.¹⁰⁴ This initial period of colonisation had formally begun in 1652 when Jan van Riebeeck landed in the peninsula with the intention of establishing a half way station between Europe and the lucrative markets in the eastern seas.¹⁰⁵ Despite initial restrictions on expansion the colony steadily advanced into the interior. This resulted in a series of cultural and economic exchanges with the local Khoikhoi inhabitants. However relations quickly soured and violence became a characteristic of life at the Cape. The European settlers were able to subjugate large numbers of Khoi into a state of serfdom drastically shaping the way in which the colonial society would evolve.¹⁰⁶ Those who refused to accept the authority of the VOC and its settlers either resisted or fled further inland. In response, the European colonists relied on the commando system to enforce their will, using extreme and unrelenting violence in an attempt to break the spirit of the Khoikhoi and later the San peoples with whom they came into contact.¹⁰⁷ Yet the period of Dutch East India Company rule was also characterised by an inability to make the Colony financially viable in no small part due to the corruption of the

¹⁰³ Anne Digby, "The Medical History of South Africa: An Overview", *History Compass* 6/5 (2008), 1195.

¹⁰⁴ William Freund, "The Cape under the transitional governments, 1795- 1814", In *The Shaping of South African Society, 1652- 1840*, edited by Richard Elphick and Hermann Giliomee, (Cape Town: Maskew Miller Longman, 1989), 211

¹⁰⁵ Leonard Guelke, "Freehold farmers and frontier settlers, 1657- 1780". In *The Shaping of South African Society, 1652- 1840*, edited by Richard Elphick and Hermann Giliomee, (Cape Town: Maskew Miller Longman, 1989), 41.

¹⁰⁶ William Freund, "The Cape under the transitional governments, 1795- 1814", 212.

¹⁰⁷ *Ibid.*

local administration.¹⁰⁸ The Cape under Dutch rule was violent, ill managed and lawless, especially in the rural districts.

British rule at the Cape

It was this troubled and deeply divided colony that the British captured in 1795.¹⁰⁹ The Dutch administration was deposed and Lord George Macartney was installed as the first British Governor.¹¹⁰ He quickly ensured that a number of reforms were made to the inefficient system left in place by the dysfunctional VOC.¹¹¹ As Elphick indicates in his work, *The Cape under the transitional Governments*, these alterations in administration were not designed to help the inhabitants, but rather to ensure the new government could maintain firm control over its new subjects, whilst the metropole decided on whether to keep the Colony. British Imperial rule did not last long as political events in Europe resulted in the Cape being returned to Dutch administration under the Batavians.¹¹² This interlude was to last a mere four years before the British returned. With the intention to stay, the Colonial administrators began adapting existing institutions of control, and where necessary implementing new ones.¹¹³ These alterations were driven by the unique nature of British Imperialism which required that more authoritarian bodies were needed to achieve “prosperity and order”.¹¹⁴ This in turn translated into a restructuring of the way medical practitioners were controlled and permitted to act.

Moulding the medical field

Comparatively the VOC at the Cape had pursued a policy of maintaining “little formal control over medical practice”.¹¹⁵ As a result the British had inherited a system with little to no centralised authority or authorities who could ensure the branches of medicine were being practiced appropriately. The need to curtail irregular practice was quickly identified by the British administration due to reports that “bad medicines and Drugs” were “daily sold to the Inhabitants” of the Colony.¹¹⁶ The British government in the Cape therefore passed laws in 1807 that sought to exert a measure of influence over who could practice medicine and sell remedies. It was the enforcement of these new orders that led to the promulgation of the Supreme Medical Committee, an office that would operate from Cape Town, in the same year. A series of ‘standard operating procedures’, that would regulate the actions of the Committee, were then devised and put in writing.¹¹⁷ These included the jobs of reviewing the

¹⁰⁸ Nigel Penn, *Murderers, Miscreants and Mutineers*, XI.

¹⁰⁹ *Ibid*, X.

¹¹⁰ W. Bird, *State of the Cape of Good Hope in 1822*, (Cape Town: Struik, 1966), B.

¹¹¹ William Freund, “The Cape under the transitional governments, 1795- 1814”, 212.

¹¹² *Ibid*.

¹¹³ Harriet Deacon, “Medical Gentlemen and the Process of Professionalization before 1860”. In *The Cape Doctor in the Nineteenth Century: A Social History*, edited by Harriet Deacon, Howard Phillips and Elizabeth van Heyningen, (Amsterdam: Editions Rodopi B.V, 2004), 89.

¹¹⁴ William Freund, “The Cape under the transitional governments, 1795- 1814”, 213.

¹¹⁵ Harriet Deacon, “Medical Gentlemen and the Process of Professionalization before 1860”, 87

¹¹⁶ Edmund Burrows, *A History of Medicine in South Africa: Up to the end of the Nineteenth Century*, (Cape Town: A.A. Balkema, 1958), 72.

¹¹⁷ *Ibid*, 72.

qualifications of supposed medical practitioners and drug sellers.¹¹⁸ In addition they were to conduct random inspections to ensure that the medicines being sold throughout the Cape were not dangerous to the health of patients. To facilitate this they were granted powers that allowed them to “cancel licenses or impose alternative punishment” on offenders of the 1807 directives.¹¹⁹ The Committee was consequently established as an arm of government whose duties directly related to regulating the practice of medical care.

However, as Harriet Deacon points out in *The Cape Doctor in the Nineteenth Century* the regulations adopted by the Colony in 1807 held little power outside of Cape Town.¹²⁰ This was due to an inability to effectively enforce them in the country districts over whom the central administration clearly held very little authority. This was a trend that was not limited to this initial period of British rule and can be seen to continually re-emerge in the lead up to and throughout the 1820s. The reasons behind this lack of effective control can be linked to factors that arose due to the administrative situation within the Colony as a whole. Having only retaken control of the Cape one year previously, the Colonial government based in Cape Town was still in the process of exerting influence over all the districts under its jurisdiction. As a result ‘the state’, and therefore the medical committee, had little manpower with which to enforce the new regulations. This meant that these authorities would not have been able to conduct regular and efficient inspections in areas outside of metropolitan Cape Town. In addition the majority of physicians at the Cape, especially those in the rural counties, were not of British origin.¹²¹ This would have led to a degree of apprehension towards the new, more authoritarian rulers of the Colony. Harriet Deacon notes that the predominance in numbers of non-English speaking doctors only changed “after 1820” with “increased British immigration” to the Cape Colony.¹²² In this environment the Committee continued in its function for 14 years, although its office was progressively scaled down by the Governor until 1821 (round the beginning of our time frame of interest), when it was disbanded and replaced by a new form of office, that of the Colonial Medical Inspector.

The position of Colonial Medical Inspector

The Cape Colony came to rely solely on a single individual appointed by the Governor to oversee the effective administration of its medical services and respond with advice to any health related issues that may have arisen. The position came into existence when Governor Somerset selected Dr John Robb in 1821 as Colonial Medical Inspector of the Colony.¹²³ Yet he was quickly replaced by Dr James Barry who was to fulfil the role until it was abolished in 1825.¹²⁴ Strangely enough, the solitary position was devised in order to replace the Supreme

¹¹⁸ *Ibid*, 72.

¹¹⁹ *Ibid*.

¹²⁰ Harriet Deacon, “Medical Gentlemen and the Process of Professionalization before 1860”, 88.

¹²¹ Harriet Deacon, “Introduction: The Cape Doctor in the Nineteenth Century”, In *The Cape Doctor in the Nineteenth Century: A Social History*, edited by Harriet Deacon, Howard Phillips and Elizabeth van Heyningen, (. Amsterdam: Editions Rodopi B.V, 2004), 25

¹²² *Ibid*, 25

¹²³ Edmund Burrows, *A History of Medicine in South Africa*, 80.

¹²⁴ Harriet Deacon, “Medical Gentlemen and the Process of Professionalization before 1860”, 91.

Medical Committee, a cabinet that was made up of a number of physicians.¹²⁵ This resulted in a single person taking on an immense load that had previously been more widely distributed, and from the work conducted by Edmund Burrows, it is clear that the Inspector was to inherit all the duties of the Supreme Medical Committee.¹²⁶ This would include inspecting government institutions in order to ensure correct medical procedure was being followed.¹²⁷ In addition he was to continue to conduct reviews, as the Committee had done, of all medicines entering the colony, as well as regulating members of the recognised professions. This therefore granted the Inspector with the power to determine who could officially practice as apothecaries, doctors or surgeons.

Through this vetting practice the government attempted to ensure that the only practitioners who were deemed worthy of a certain title were graduates of European medical education institutions. Such a regulatory process indicates how the local authorities, through the office of the inspector, were attempting to maintain some level of standard and control over matters of health care. This process was also part of a move towards establishing a professional image within the Colony by putting firm parameters and boundaries upon who could claim the given labels of the profession. Yet this was all made especially difficult with the size of the colony and the lack of firm centralised authority maintained throughout the Cape. On a number of occasions the office of Barry was informed that certain ‘doctors’ were in fact charlatans. In these cases the centralised authority figure of the Colonial Medical Inspector, was reliant on tip offs from concerned members of the public in order to unearth phoney doctors. This form of ‘raising the alarm’ is evident in the case of Luis Dugui, a person living in the Calabash Kraal area.¹²⁸ He was reported by surgeon Thomas Price for “practising medicine in various parts of Koeberg and Swartland” despite not having been through the Colony’s vetting system.¹²⁹ Price’s message served to inform Dr Barry of a potential charlatan physician loose on the West Coast of the colony. This case therefore brings up the issue of space and the ability of the local administration to exert control over far flung rural regions. As has been shown by Anne Digby, the majority of licensed medical practitioners resided in the established towns of the colony which allowed them access to a considerable patient base.¹³⁰ Those practitioners who set up their offices outside of the concentrated areas were difficult to contact and thus difficult to regulate, a theme that will continue to re-emerge throughout this thesis. Furthermore, the uneven distribution of healthcare workers during the early 19th century meant that there were gaps that needed to be filled.¹³¹ People still got sick in these areas and therefore still needed treatment. As a result there was money to be made in

¹²⁵ Edmund Burrows, *A History of Medicine in South Africa*, 80.

¹²⁶ *Ibid*, 83.

¹²⁷ *Ibid*.

¹²⁸ Price, Thomas. Letter informing Barry of potential charlatan. 24 October 1825. Letter. MC vol. 7

¹²⁹ *Ibid*.

¹³⁰ Anne Digby, “Self-Medication and the Trade in Medicine within a Multi-Ethnic Context: A Case Study of South Africa from the Mid-Nineteenth to Mid-Twentieth Centuries”, *Social History of Medicine* 18, 3 (2005), 439.

¹³¹ Harriet Deacon, “Introduction: The Cape Doctor in the Nineteenth Century”, 36.

spite of regulations, so long as the unlicensed practitioner could remain out of the Inspector's reach.

Important to this context and the position of Inspector, was the fact that the Cape was heavily dominated by the military and its medical services. The large number of practitioners affiliated to the armed forces could be trusted as their training and intentions were thought to be in line with that of the Imperial state, thus putting them in a position to receive government authority. In contrast a great deal of suspicion was directed towards non-military medics who were, as Edmund Burrows describes, a "civilian medical profession in an occupied country".¹³² Their intentions were looked upon with a great deal of mistrust. The Cape's status as a former Dutch possession can be linked to the attempts to control its local professionals through offices like the Colonial Medical Inspector and Supreme Medical Committee.¹³³ The members of these bodies, who were mostly military men, "helped to draft professional legislation in 1807 and 1823".¹³⁴ This affected the nature of government policy in a way that suited the doctor, and more specifically the British physician or surgeon. The nature of Cape society also indicates why it was that medical men from the military dominated all forms of health administration in the Colony within the 1820s. Every strand of colonial government was laden with army and navy officials who drew on the particular approach to governorship desired for the Cape. This is touched on by Deacon and van Heyningen who point out that the British sought to implement "a new order on the backward and disorganised former Dutch colony" throughout the early 19th century.¹³⁵ This included the utilisation of military officials and administrators. Yet despite the duties that military physicians and surgeons had to fulfil to the army and navy in the Cape they continued to practice privately in order to treat civilians and earn an extra income.¹³⁶

It is clear that the initial powers and responsibilities of the Inspector were not divided at all, in that they were held by a single physician. Dr Barry, who was to be the longest serving of the two inspectors, came to embody the medical authority of the empire in the Colony during his tenure. The nature of the singular position of Colonial Medical Inspector raises the point as to why one person was given the monumental task of overseeing the medical system of an entire Colony. As we will later see, Barry was forced to do a staggering amount of work on his own in order to ensure health care functioned in a reasonably appropriate manner. This begs the question as to why this massive portfolio was given to one individual. Interestingly enough the creation of this job appears to have coincided with noteworthy trends within the administration of colonial territories. C.A. Bayly asserted that the early 19th century was a period of colonial despotic rule. The presence of such a management style in the Cape is confirmed by the secretary to the Governor in 1822. W. Bird's contemporary account of the *State of the Cape of Good Hope* noted: "The executive authority of the Cape is vested in one

¹³² Edmund Burrows, *A History of Medicine in South Africa*, 79.

¹³³ *Ibid*.

¹³⁴ Harriet Deacon and Elizabeth van Heyningen, "Opportunities Outside Private Practice before 1860", In *The Cape Doctor in the Nineteenth Century: A Social History*, edited by Harriet Deacon, Howard Phillips and Elizabeth van Heyningen, (Amsterdam: Editions Rodopi B.V, 2004), 135.

¹³⁵ *Ibid*, 136.

¹³⁶ *Ibid*, 135.

person, nominated by the crown”.¹³⁷ He was of course referring to the position of Governor of the Colony, yet he made sure to remark that this form of “absolute government” overseen by a supreme leader had worked incredibly well in the case of the Cape (Governor Somerset being his boss).¹³⁸ This approach to controlling departments of governance through the appointment of an authoritative figure appears to have been present in the establishment of the position that Barry was to occupy, thus indicating that such forms of control were not limited to the position of governor.¹³⁹ In addition, by appointing a single person whom he could trust (Barry and Somerset were close friends) to act according to his wishes, Somerset may have sought to maintain even stronger authority over a very important portfolio of local government.¹⁴⁰ Yet the circumstances of empire wide fiscal reform should also be noted. The way the Supreme Medical Committee was progressively downscaled until it was replaced by the position of Inspector speaks towards this trend. By decreasing the size of this regulatory body the governor could have been attempting to cut costs in line with orders from the Colonial Office. One such directive was received by Barry towards the end of 1822 and evidences the orders from London to scale back funding. It said: “Sir I am directed by His Excellency the Governor, to transmit to you, the enclosed Instructions relative to Public Expenditure; and to desire that you will be pleased to give them your serious attention, in order that you may be guided by them, in incurring, in future, any Expense, for account of the Colonial Government”.¹⁴¹

Dr James Barry

The man who fulfilled the position of Colonial Medical Inspector for almost the entirety of its existence has been an individual of great interest and scholarship. It is therefore useful to examine Dr Barry to better understand who he was in relation to the Cape medical system of the 1820s. After all, his personality and actions appear to have played a very important role in the way things were done in relation to the practice of healing at the Cape Colony. Having attended Edinburgh University in 1812 and obtaining his medical degree, Dr James Barry joined the British military health services.¹⁴² This saw him dispatched to the Cape Colony 1816 where he quickly rose from his initial position of hospital assistant in Cape Town.¹⁴³ This has been linked to the relationship (the nature of this connection is still uncertain) that he initiated with the Colony’s governor, Lord Somerset.¹⁴⁴ He was co-opted into being Somerset’s doctor, and in 1821 was appointed as the Colony’s Colonial Medical Inspector. Many of his actions during his tenure in this position will be further explored in the chapters that follow, but it is notable that many display his “assertive manner and demands for medical

¹³⁷ W. Bird, *State of the Cape of Good Hope in 1822*, 5.

¹³⁸ *Ibid.*

¹³⁹ C.A. Bayly, *Imperial Meridian*, 205.

¹⁴⁰ Rachel Holmes, *The Secret Life of Dr James Barry: Victorian England’s Most Eminent Surgeon*, (Stroud: Tempus Publishing Limited, 2007), 78.

¹⁴¹ Office of Governor Somerset. Instructions on reducing expenditure in line with CO directive. 15th of November 1822. MC vol. 7

¹⁴² Edmund Burrows, *A History of Medicine in South Africa*, 80.

¹⁴³ Kirsten McKenzie, *Scandal in the Colonies*, 3.

¹⁴⁴ Rachel Holmes, *The Secret Life of Dr James Barry*, 63.

reform”.¹⁴⁵ He was publicly accused of having an affair with Lord Somerset and even fought a duel after his (Barry’s) use of slanderous language in passing was challenged.¹⁴⁶ Such an allegation against Barry’s aggressive manner of speaking is made believable when looking at a series of records towards the end of his period of inspectorship. In the aftermath of two incidents, one relating to an alleged ‘lunatic’ and the other relating to Barry’s feeling that his jurisdiction had been infringed upon (both of which will be dealt with later in this thesis), Barry was said to have insulted numerous high ranking officials in the Cape. In a letter dated from the 1st of November Richard Plasket wrote to the Commissioners Colebrooke and Bigge of Barry’s conduct on receiving a summons.¹⁴⁷ Plasket explained how Barry had torn up the paper and thrown it into the face of the messenger.¹⁴⁸ He had then vowed that he would proceed by “cutting off the Fiscal’s ears”.¹⁴⁹ Yet this was not the only incident as in the same year Barry was reprimanded for having performed “a kind of horse whistle” as an insult whilst in the audience of Somerset and a judge from the admiralty.¹⁵⁰ Plasket went on to write that Barry had also disrespected Mr Blair, the secretary to the Commissioners, before criticising the inquiry in public.¹⁵¹ During this exchange he was alleged to have sarcastically asked Blair “whether he had ever heard the story of the Mountain and the Mouse”.¹⁵²

His personal attributes led to conflict with his subordinates and other members of government in the Cape, and his term as Medical Inspector was cut short unceremoniously in 1825.¹⁵³ Barry remained in Cape Town for another three years after which he returned to Britain.¹⁵⁴ He was thereupon despatched to the West Indies and after a lengthy post there, was sent to Canada.¹⁵⁵ Such an interesting life reveals how transnational agents, like Dr Barry, were during this time. His experiences in Britain, as well as in each of the different colonies he served would have impacted on his medical expertise and view of the world. Having completed his service in Canada, Dr Barry returned to Britain where he died in 1865.¹⁵⁶ Despite his many notable medical achievements, which included one of the first successful Caesarean sections, Barry is most known for the ambiguity that surrounds his gender. His manner of dressing and his outward bodily appearance have led many to determine that he was in fact a woman. Although now believed to have been slightly dubious in nature, the post-mortem done on his body allegedly determined that Barry was in fact a

¹⁴⁵ Kirsten McKenzie, *Scandal in the Colonies*, 3.

¹⁴⁶ Robert Ross, *Status and respectability in the Cape Colony, 1750 -1870: A tragedy of manners*,(Cambridge: Cambridge University Press, 1999), 47.

¹⁴⁷ George McCall Theal, *Records of the Cape Colony from February 1793 to April 1831 vol. 23*, 464.

¹⁴⁸ *Ibid.*

¹⁴⁹ *Ibid.*

¹⁵⁰ *Ibid*, 507.

¹⁵¹ *Ibid.*

¹⁵² *Ibid.*

¹⁵³ Harriet Deacon, “Medical Gentlemen and the Process of Professionalization before 1860”, 91.

¹⁵⁴ Kirsten McKenzie, *Scandal in the Colonies*, 3.

¹⁵⁵ Rachel Holmes, *The Secret Life of Dr James Barry*, 229.

¹⁵⁶ *Ibid*, 274.

woman who had given birth.¹⁵⁷ However this is a conclusion disputed by Rachel Holmes who stresses our inability to determine such information for certain.¹⁵⁸

Barry has often been identified as a humanitarian figure who always put his patient's welfare before his own, even if it meant fighting with his superiors.¹⁵⁹ Indeed, many of the cases involving Barry looked at during this thesis could be used to argue such a point. But it is also clear that many of Barry's actions were motivated by a very large ego and an intention to remain the sole medical authority in the Colony. This can be seen in his aggressive refusal to head up the re-established Supreme Medical Committee in 1825 after his position was abolished.¹⁶⁰ Furthermore many of his so-called humanitarian actions were prompted by orders from Somerset, an issue that will be raised in detail in chapter 5. One can see that the multi-faceted image of Dr James Barry is even more complex than may have been previously thought. Such an intricate character came to play an important role in medical care during the initial part of the 1820s and reveals how the personalities of different administrators came to affect control at the Cape.

The emergence of the Supreme Medical Committee

The end of Barry's career as the Colonial Medical Inspector in 1825, heralded the culmination of the singular position altogether with Governor Somerset opting to return to the use of the expanded Supreme Medical Committee. This body was to inherit the responsibilities and powers vested in the Colonial Medical Inspector, with the expanded size believed to increase its efficiency in regulating practice and advising government. Yet, as will be shown in the remainder of this thesis, this was not always the case. Having briefly looked at the offices that were considered to be the most senior medical positions within the colony in the lead up to, and during the 1820s, it is now appropriate to examine the professions that were subordinated to them. It is here that the distinction between practitioners who were endorsed and regulated by the state and those who were not, becomes more apparent.

The District Surgeon:

The position of the district surgeon is one that still exists today, yet in the 1820s the medical landscape of South Africa was very different. The position dated back to the rule of the Dutch East India Company where those who were given the role, were tasked with providing medical assistance to people in the rural areas of the Colony.¹⁶¹ The district surgeons were either physicians or surgeons who had been appointed to be the highest ranking medical professional in a particular area. However Harriet Deacon and Elizabeth van Heyningen indicate that there was very little regulation of these posts and they were far from being an established and respectable position. This was due to the fact that the district surgeons were theoretically "not Colonial employees" and were in effect "still independent contractors to the

¹⁵⁷ Randolph Vigne, *Thomas Pringle*, 127.

¹⁵⁸ Rachel Holmes, *The Secret Life of Dr James Barry*, 300.

¹⁵⁹ *Ibid*, 134.

¹⁶⁰ Dr James Barry. Letter to Governor refusing appointment to the SMC. 13 October 1825. Letter. MC vol. 27.

¹⁶¹ Harriet Deacon and Elizabeth van Heyningen, "Opportunities Outside Private Practice before 1860", 155.

various landdrosten” by the start of the 1820s.¹⁶² This appears to have changed to an extent with the beginning of Barry’s tenure as Colonial Medical Inspector. One of the first things that Barry set about doing once appointed, was to inform the district surgeons within the Colony what he expected of them. In this way he was able to set a type of standard by which the actions of the various district surgeons could be held to account. This particular position came with a certain amount of remuneration and perhaps in some cases respect, nevertheless it was necessary for Barry to clarify their responsibilities, but also their rights. By doing so Barry appears to have been attempting to exert a more substantial level of authority over the district surgeons by holding them to a formal written standard.

These standing orders were circulated to all the constituencies of the Cape thus evidencing a move towards establishing a colony wide mode of regulation. This document included the information that the district surgeon was “obliged” to provide “his assistance at all times either by day or by night whence and whenever called upon”.¹⁶³ Yet this was accompanied by the tariffs he was legally entitled to, after the completion of his services. The sum thereof was in turn determined by the hours it took for the district surgeon to reach the patient or scene of medical distress.¹⁶⁴ These letters provide substantial insight into how the central medical authority, embodied by Barry, sought to maintain control over rural practitioners but also establish a standard. Although in theory the district surgeons were still only answerable to the *Landrost* who employed them, the letters of the Inspector in this instance show how the British authorities were trying to increase their influence into the rural areas of the colony

In addition to attending to any sick people who called upon his services, the appointed doctor or surgeon was also required to regularly attend to the health of the inmates of the district prisons and hospitals. This is evidenced in a letter directed to Barry in 1825 by District Surgeon McCabe, a particularly interesting case that will be fleshed out in chapter 3. The district surgeon was also required to perform a number of other functions. This included acting as the constituency’s chemist and performing the appropriate vaccinations as stipulated by the authorities in Cape Town.¹⁶⁵ Both of these functions provided the district surgeon with a degree of power over the people and other doctors within his jurisdiction. Yet it was the necessity of the district surgeons function as a regional vaccinator that Deacon and van Heyningen identify in *Opportunities Outside Private Practice before 1860* as being important in formalising the position, providing a degree of prestige and allowing the colonial office to maintain contact with its citizens.¹⁶⁶ However the role of the district surgeon was not static even after Barry’s attempted formalisation of their duties.

In 1828 the reconstituted Supreme Medical Committee circulated a revised set of duties which Burrows notes as having been the first to be published on behalf of the local

¹⁶² Edmund Burrows, *A History of Medicine in South Africa*, 87.

¹⁶³ Dr James Barry. Instructions for the District Surgeon of George. 19 April 1822. Letter containing proclamation of instructions. MC vol. 7

¹⁶⁴ *Ibid.*

¹⁶⁵ Harriet Deacon and Elizabeth van Heyningen, “Opportunities Outside Private Practice before 1860”, 154.

¹⁶⁶ *Ibid.*, 160.

government.¹⁶⁷ Such a point indicates an even greater attempt by the Cape Town based officials to exert power over the medical health system through formal legislation. The description of duties provided by Barry to the District Surgeon of George indicates interesting complexities with regards to the patient-doctor relationship that existed in these areas of operation. Although the district surgeon was required to attend to any medical matter brought to his attention (and I say his as there were no officially sanctioned female physicians or surgeons in the colony), the fact that they were entitled to payment regardless of the case suggests that the system was not as humanitarian as the list of ‘duties’ implies. The physician had the right to demand payment from the patient or if they were deceased, from their families. If they did not or could not comply with the order to settle their account, then the doctor in question could bring the issue up with the landrost, or write to the Colonial Medical Inspector in order to ensure their grievance was heard. However, the patient could also appeal to the office of the Inspector if they felt they were being unfairly billed.

The Common Practitioner

Having briefly looked at the positions of Colonial Medical Inspector, the Supreme Medical Committee and the district surgeon, the role played by the majority of health practitioners who made up the health care system in the colony, can be fitted into this wider framework. Yet it is important to first note that a number of health providers were branded as unscientific or not medically sound by the government process of licensing.¹⁶⁸ As a result there is very little reference to these positions of healthcare practitioner in the written archive despite their abundance in number throughout the Cape Colony during this period. With that being said, we are still able to see evidence of the conflict that arose as the local government sought to control health care in favour of Western trained practitioners. A great deal of this process has been brought to light by the research of a select number of modern day historians. This can allow for a better understanding of overall medical care, whether it was sanctioned by the colonial government or not, within the colony. It is here that Foucault’s conceptions on the power of language and labelling is crucial.¹⁶⁹ Those deemed outsiders found themselves tagged in a certain manner and therefore excluded.

In *The Cape Doctor and the Broader Medical Market, 1800-1850*, Harriet Deacon explains how in addition to providing medical treatments to their own groups, “Khoisan and Muslim practitioners seem to have occupied a niche market among Cape settlers” in the early 19th century.¹⁷⁰ This is interesting to note especially when we take into consideration the lack of official documentation of this medical miscegenation. The fight to secure patients, be they European settlers or indigenous Khoikhoi, was therefore a great deal more competitive than the archive kept by the Colonial Office would have us believe. Despite attempts to discredit the expertise of non- Western care through a process of emphasising the scientific basis and

¹⁶⁷ Edmund Burrows, *A History of Medicine in South Africa*, 88.

¹⁶⁸ Harriet Deacon, “The Cape Doctor and the Broader Medical Market, 1800-1850”, *In The Cape Doctor in the Nineteenth Century: A Social History*, edited by Harriet Deacon, Howard Phillips and Elizabeth van Heyningen, (Amsterdam: Editions Rodopi B.V, 2004), 35.

¹⁶⁹ Michel Foucault, *The Birth of the Clinic*, 4

¹⁷⁰ Harriet Deacon, “The Cape Doctor and the Broader Medical Market, 1800-1850”, 61.

truths of European doctors, it appears to have been widely held throughout the populations of the Colony that certain practices of the Khoikhoi and San were superior in dealing with particular local issues like snake bites and poisons.¹⁷¹ Yet there was also an assertion that “creole folk medicine” practitioners had a better approach to and understanding of child birth.¹⁷² In addition to the healers of indigenous groups in the Cape, there were also settlers who despite a lack of formal Western training provided medical services in rural areas. An example of one such individual is presented in the next chapter. But it is important to note that these colonists were reliant for healing knowledge on the wisdom of “Khoisan medical techniques and eastern practices brought to the Cape by slaves”.¹⁷³

There were also a number of distinctions made between recognised ‘Western’ practitioners which in turn show just how complex the Cape medical market was during the early 19th century. The most recognised category would be that of the physician and the surgeon. Unlike the modern day health care system, a surgeon was not usually a physician who had completed an additional qualification in order to become a specialist in surgery. During the 19th century the boundaries of what constituted a doctor were, along with the image of the respectable medical man, still very much under construction. Howard Phillips indicates how the method of training undertaken by most surgeons in the early 1800s was based on an apprentice system.¹⁷⁴ This process mirrored the learning and teaching of a common trade whereby “all training therefore emanated from one man, the master” and was passed on to the apprentice.¹⁷⁵ Although some qualification licensing requirements were established in the first half of the 19th century, there was still a marked ‘learn on the job’ manner to the way surgeons and some physicians qualified.¹⁷⁶ The number of practitioners trained in this manner who were practicing in the Cape during the early 1800s is surprisingly large. The table compiled by Howard Phillips in *Home Taught for Abroad* suggests that apprentice trained surgeons were by far the majority during this period.¹⁷⁷ In contrast the majority of common physicians usually held a medical degree from a university medical school. Although there appears to have initially been a strong division made at the Cape between surgeons and physicians, they were both considered doctors.¹⁷⁸ As a result these types of doctor be they physician or surgeon, “were permitted to practice medicine (including surgery) and to prescribe drugs”.¹⁷⁹ Furthermore as time went on these sub-divisions of doctor became less notable, especially as the British administration increased legislation that distinguished them

¹⁷¹ *Ibid.*

¹⁷² *Ibid.*

¹⁷³ Harriet Deacon, “Introduction: The Cape Doctor in the Nineteenth Century”, 35.

¹⁷⁴ Howard Phillips, “Home Taught for Abroad: The Training of the Cape Doctor, 1807-1910”, In *The Cape Doctor in the Nineteenth Century: A Social History*, edited by Harriet Deacon, Howard Phillips and Elizabeth van Heyningen, (Amsterdam: Editions Rodopi B.V, 2004), 108

¹⁷⁵ *Ibid*, 108.

¹⁷⁶ *Ibid*, 108.

¹⁷⁷ *Ibid*, 116.

¹⁷⁸ Harriet Deacon, “The Cape Doctor and the Broader Medical Market, 1800-1850”, 53.

¹⁷⁹ *Ibid*, 53.

from “druggists (apothecaries, chemists and druggists), in terms of status, fees and practice”.¹⁸⁰

Such noteworthy distinctions again point towards government attempts in the Cape to both elevate the Western trained practitioner over indigenous rivals, as well as setting ‘the doctor’ apart as uniquely qualified and respectable. The positions of the Colonial Medical Inspector and the office of the Supreme Medical Committee were crucial here in asserting these divisions between types of practices.¹⁸¹ The processes of licensing performed by these bureaus sought to police and restrict who could claim the protocol and powers of a doctor.¹⁸² Yet despite official attempts many people still practiced as if they were doctors even when their licenses had not been granted.¹⁸³ These individuals were able to sidestep the attempts to regulate the professional space as long as they remained unnoticed or out of the grasp of the Cape Town based officials. The statistics available as to the numbers of practicing doctors are deceptive as these were only officially sanctioned individuals. With that being said, it is interesting to note that there were 50 fully licensed doctors in the Cape in the year of 1820.¹⁸⁴ This figure identifies the doctors over whom the local state could exercise some level of authority. In addition, Harriet Deacon’s painstakingly compiled table indicates the ratio of settlers to sanctioned doctors: One doctor to every 781 settlers in 1820.¹⁸⁵ These do not take into account the other members of the colonial community not classified as ‘settlers’ but it is clear that after Barry’s regulations of 1822 district surgeons were obliged to treat them as well. The extent to which the indigenous population and the Colony’s slaves sought out this treatment is however, hard to decipher.

Crucial to our understanding of the medical landscape in the Cape is the influx of British doctors that occurred in the 1820s.¹⁸⁶ This trend, which saw doctors from Britain go from being in the minority to the majority, has been traced by Harriet Deacon to the aftermath of the Napoleonic Wars.¹⁸⁷ Such a development appears to back up the important role that the conclusion of the conflict France had in the way that Britain’s colonies were viewed and run. Not only was there a tangible increase in the administrative attempts to reform the way the colonies were run, but there was also a circulation of medical professionals to these territories.¹⁸⁸ This alteration would have changed the flavour of the Cape medical fraternity due to the increase in doctors, as well as their particular place of training and origin. English speaking physicians were now the predominant medical force in a colony where English was barely spoken. Yet this surge must have also been crucial to the way that the local officials were able to run the colony and the medical profession. This is evidenced by a case that highlights the miscommunication that abounded between officials who spoke different

¹⁸⁰ *Ibid*, 53.

¹⁸¹ *Ibid*, 51.

¹⁸² *Ibid*, 51.

¹⁸³ *Ibid*, 54.

¹⁸⁴ Harriet Deacon, “Introduction: The Cape Doctor in the Nineteenth Century”, 30.

¹⁸⁵ *Ibid*, 30.

¹⁸⁶ Harriet Deacon, “The Cape Doctor and the Broader Medical Market, 1800-1850”, 52.

¹⁸⁷ Harriet Deacon, “The Cape Doctor and the Broader Medical Market, 1800-1850”, 52.

¹⁸⁸ C.A. Bayly, *Imperial Meridian*, 251.

languages. In 1823 an apothecary by the name of Elser wrote to Barry saying: “Sir my not speaking the English language compels me to take this mode to apologise to Dr Barry”.¹⁸⁹ The increase of English speaking doctors would have pushed those who only spoke Dutch to the periphery of the medical fraternity. Their inability to effectively communicate with the new local authorities would have increased their hesitancy to raise issues and to ask questions. Such matters, although not abounding in the archival sources, must be noted when examining the nature of Cape society and its medical profession.

It is also interesting to note and reiterate the differences in both the reputation and ability of doctors in this era, when compared to the modern day. Today a doctor is considered a highly skilled professional whose training is portrayed as having been scientifically based and supported. Their image is that of a benevolent and compassionate individual who, at least in theory, utilises their abilities for the benefit of all. Comparatively, Cape doctors in the 19th century were still reliant on many classical conceptions of illness “and did not use such modern techniques such as anaesthesia”.¹⁹⁰ Furthermore their approaches and beliefs “had much in common with folk theories of disease” and as a result there was little in their scope that actually made them unique in the field of health care.¹⁹¹ Such an understanding of their actual means of healing helps to identify why it was that doctors and members of the relevant authorities sought to distinguish the doctor via legislation from other health care workers of the period and context, as in reality there was little to define differences on the grounds of practice.

The practitioners from what was considered the ‘European tradition’ of medicine were legislated into a state of theoretical inferiority in the early 19th century. The lack of reference to these other professions in the archival records, except when their powers were being curtailed, is further evidence of the colonial state’s idea around the supremacy of the doctor as the desired practitioner for the Colony. Yet despite this exclusion from the written record these professionals did play an important role in the local health service. The category Deacon defines as the ‘druggists’ was made up of “apothecaries, chemists and druggists” who put together remedies for illnesses.¹⁹² Although the legislation of the British colonial office prevented it, many still “charged for medical advice and prescribed” the drugs they produced.¹⁹³ The threat from this profession was clearly of great importance to physicians and surgeons as evidenced by the legislation championed by doctors like Barry and those on the Supreme Medical Committee.

In addition, a large body of midwives was practicing in the Cape, but despite this fact, they too have been largely omitted from the colonial archive kept in Cape Town. This raises the issue of how gender specific the ideal medical practitioner was deemed to be in the official record and amongst the authorities. The skill of midwifery does however appear to have been admired and respected; something we can garner from the fact that many surgeons and

¹⁸⁹ Elser, CL. Apology to Dr Barry for misunderstanding. Letter. MC vol. 7.

¹⁹⁰ Harriet Deacon, “The Cape Doctor and the Broader Medical Market, 1800-1850”, 50.

¹⁹¹ *Ibid.*

¹⁹² Harriet Deacon, “The Cape Doctor and the Broader Medical Market, 1800-1850”, 53.

¹⁹³ Harriet Deacon, “Introduction: The Cape Doctor in the Nineteenth Century”, 38.

physicians were trained and “interested in practicing general midwifery” at the Cape.¹⁹⁴ Yet Harriet Deacon also indicates that there was little conflict between midwives and doctors.¹⁹⁵ This appears to have drawn from the fact that female midwives, although utilised throughout the colony, did not offer the level of financial threat posed by other types of practitioners like druggists and indigenous healers. Furthermore Kirsten McKenzie has indicated the envisioned role of women in the colonial setting which may have also played a role. She points out in *Scandal in the Colonies* that settler women were “central to a society’s civilised status”.¹⁹⁶ This in turn drew from their specific and unique “productive and reproductive labour”.¹⁹⁷ The process of childbirth was therefore deemed a female role and as a result women were permitted to play an important role in its outcome. Thus women practitioners were permitted to work alongside male practitioners, albeit in a subservient position, in this sphere of medical practice.

It can thus be seen that health care in the context of the Cape Colony during this period was a highly complex business. Although attempts at regulation were prominent, the actual success of these was varied. This resulted in the continuation of a multifaceted system of healing whereby people were still able to choose their practitioner, be they sanctioned or unsanctioned by the government. In this way the central authority of the Governor’s government could be avoided. Healthcare also found itself heavily affected by the general state of the colony as well as policy changes made in London. The administrative structures of medical care were shaped in keeping with the trends of the times, yet the role of individuals in attempting change was central. Having established both an internal and external context it is now suitable to begin the process of introducing and interrogating specific themes within this Cape medical environment and how these were, at times, affected by external actors.

¹⁹⁴ Harriet Deacon, “The Cape Doctor and the Broader Medical Market, 1800-1850”, 72.

¹⁹⁵ *Ibid*, 72.

¹⁹⁶ Kirsten McKenzie, *Scandal in the Colonies*, 165.

¹⁹⁷ *Ibid*, 165.

Chapter 3: The Cape as part of a medical network

In Chapter 2 the presence of knowledge networks was touched on in the manner by which the metropole and Cape colonial government aimed to regulate certain practices. This points towards the Colony's positioning within both an internal local and a broader external network. But it also indicates how important such connections were to any attempt at maintaining control. This chapter will delve deeper by looking at a series of examples and records which help reveal the degree of interconnectedness amongst practitioners and authority figures, as well as the recurring themes of authority and regulation that were at work. The trends identified by historians like Zoë Laidlaw, Alan Lester and C.A. Bayly appear in the survey document circulated by the Royal College of Physicians to a number of colonial possessions in 1830. As a result this chapter will begin by examining this document and the responses to its dissemination.

The 1830 inquiry of the Royal College of Physicians

The College was a regulatory body based in London and functioned in a similar manner to the Cape Supreme Medical Committee.¹⁹⁸ Its duties involved assessing licenses and monitoring the state of health care services in Britain.¹⁹⁹ Although there is virtually no secondary literature available on their foray into colonial health, the motivations for the survey of 1830 can be easily deduced. The Royal College of Physicians appears to have wanted to gain a better understanding of the medical situation throughout the Empire and felt that the best manner to do this was through the circulation of a standard survey.²⁰⁰

Such an inquiry is a prime example of attempts to further integrate the colonies, the Cape being one of them, into a wider medical network. This particular document sought to unearth and circulate ideas around science, governance, geography, demographics and healthcare in a truly transnational manner. Furthermore the interaction represented by the inquiry of the RCP was intended to be a two way dialogue, with the College posing questions and the different areas of the selected colonies replying. This reveals an assumption that the colonies might hold valuable information that could be utilised to the benefit of health in the mother country and throughout the empire. In addition the nature of the inquiry, which relied on a document being circulated, speaks to the trend of obtaining levels of control through knowledge networks prominent during this era. The Colonial Office's hunger for gathering information appears to have filtered down to other institutions based in the metropole of London. Its questions, content and the response it received, are useful. This chapter will analyse these records with the goal of determining how the Cape Colony functioned within a greater scheme of empire and health care at the time. In addition, the chapter will use this basis in order to look at whether or not there was an internal network of medical based knowledge in the Cape, and if so how it functioned.

¹⁹⁸ "History of RCP", *Royal College of Physicians*, 21 July 2016, www.rcplondon.ac.uk/about-rcp/our-history.

¹⁹⁹ *Ibid.*

²⁰⁰ James Lewis, *The Peoples Health: Public health in Australia, 1788- 1950*, (Westport: Greenwood Publishing Group: 2003), 30.

The Cape Colony in within a wider a network

The document which was sent out in 1830 consisted of 17 questions to which the College of Physicians hoped would be responded to in as much detail as possible. In response, the local medical authority at the Cape appears to have supported the Royal College of Physicians in their endeavour, as they agreed to distribute their requests for information to the different district surgeoncies' within the Colony. In response, the reaction of the district surgeons was varied. Some complied with great vigour and returned the documents packed to the brim with information on the different questions asked, whilst others did not even acknowledge the correspondence. It is clear that around the time period of 1830 when the questionnaires were distributed, that there were ten positions of district surgeon in the Cape.²⁰¹ Yet the records available reveal that only four of the district heads responded with completed surveys. This means that James Honey of Caledon, J. Fairbridge of the Cape, C. Wentworth of Uitenhage, J. Atherstone of Albany, J Younger of Somerset East and W.H. Glaeser of Worcester did not respond to the request of the Supreme Medical Committee.²⁰² This limits the extent to which we can view the available records as presenting a valid and encompassing vision of the entire Colony, as the responses that were transferred to London reveal a diversity between the districts. This raises the question as to how different the other six constituencies were in comparison.

Nevertheless, those who did reply appear to have bought into wider schemes and conceptions of knowledge production in some manner. In comparison, those who didn't respond may have viewed such an inquiry as an unwelcome intrusion into their sphere of authority that did not warrant a response. The failure of the majority of the Cape's district surgeons to answer the requests of both the Committee and the College of Physicians therefore requires an examination of their attitude before exploring the actual content of the returned surveys is possible. Their knowledge, gained through their unique experiences with their patients, was something they may have felt to be their own valuable capital that they were within their rights to dispense with and withhold as they saw fit. In response to this the Royal College of Physicians, being based in London was unable to enforce any measures of their own accord to ensure their requests were responded to. They were reliant on the local 'authority', in this case the Supreme Medical Committee, to handle the distribution of their survey. Yet this body which had now been in operation since 1825 held little means to enforce compliance, a fact that will become increasingly apparent as this paper continues.

Although this is a single case, it does indicate a degree of reluctance by numerous ground level administrators and practitioners to take part in any attempt to map the medical landscape of the wider empire. These district surgeons clearly did not see the benefit of assisting to create a better understanding of a greater public health situation. They appear to have been content with working in isolation, refusing to contribute and presumably declining any attempts from outside parties to influence their areas of jurisdiction. Such an attitude may

²⁰¹ Edmund Burrows, *A History of Medicine in South Africa*, 88.

²⁰² *Ibid.*

have drawn from their historic level of autonomy which had only recently been ended by the establishment of set positions by the local government.²⁰³ Yet the failure to respond is also linked to areas of effective colonial control within the Cape. Although the local authorities had established what Dennis Byrne terms a ‘grid’, which in many ways mirrored metropolitan means of management, they did not have the resources to effectively police such a vast geographic area.²⁰⁴

This therefore raises issues around the establishment of dialogues within empire, as in order to have a consistent and meaningful system by which information could be processed there needed to be willing participants on both sides of the network. In the case of the RCP’s attempt to gain information from the distant Cape there were not sufficient participants in the Colony’s rural areas for an adequate lattice to exist. The network was a haphazard one, and although we need to be wary of reading too much into this single case it does appear to mirror the trends and their failures identified by Zoë Laidlaw during this time frame. The difference in views between the authorities in Cape Town and the majority of those held by figures in the rural district surgeoncies’ is also crucial to note as they point towards differing conceptions of the need to remain in contact with a wider empire. The figures of the Supreme Medical Committee appear to have been intent on establishing and maintaining an image of respectability within the context of the empire. As a result they attempted to facilitate the request of the RCP, a body who could ensure that such an image was established in Britain. Comparatively, the district surgeons, who failed to respond en-masse did not share the same desire. The disparity within the Colony over notions of respectability and the place of the medical professional within the empire is apparent. The internal difference between priorities and concepts of wider networks in urban and rural areas should be acknowledged and highlighted. Those district surgeons who were unwilling to comply had little fear of the Supreme Medical Committee. In addition, the fact that they did not reply to a request for information from the very heart of the Empire demonstrates how safe they felt in their own positions within the wider context. They seem to have felt that there would be no repercussions for their lack of action, a feeling that was well founded. This episode can also be used to signal a certain degree of disjuncture with regards to medical ideas and policy at the centre, and those held and implemented in the colonies. Although responses from the districts of Stellenbosch, Swellendam, George and Graff Reinett stipulate that there was at least some form of expertise sharing, the lack of reaction from the remaining six surgeoncies’ indicates that there was not a compulsory or uniform system with regards to knowledge production and dissemination in the Cape. Action was therefore determined by the personal feelings of individuals.

²⁰³ Harriet Deacon and Elizabeth van Heyningen, “Opportunities Outside Private Practice before 1860”, 155

²⁰⁴ Tracey Banivanua Mar & Penelope Edmonds, *Making Settler Colonial Space: Perspectives on Race, Place and Identity*, (Basingstoke: Palgrave Macmillan, 2010), 105

Knowledge appropriation

Having attempted to determine why there was such a disparity in the returns of the documents, it is now possible to examine the content of those that were returned to the RCP in London. The responses from the different district surgeons varied greatly, with some displaying clear contempt and disregard for any indigenous forms of health care. Nonetheless, some like Nobert Surnbutt and Thomas Perry gathered and conveyed a wealth of knowledge on this particular topic, even displaying some degree of respect for the medicinal practices of the local population. Perry wrote in response to the question around local remedies in his district saying: “Hottentots and slaves use the roots and leaves of indigenous plants, and with some success!”²⁰⁵ He then went on to describe some of the maladies employed for particular ailments and complaints. But, he did note that the effectiveness of these medicines had “not been investigated” in addition to pointing out that upon failure of these routes the locals “have recourse to charms”.²⁰⁶ Here we see a willingness by some medical practitioners to incorporate aspects of local knowledge, whilst still maintaining an impression of superiority. By noting the fact that the genuine value of the indigenous techniques employed by locals had not been assessed, Perry was conveying that they had not been scientifically tested. His remark on the locals’ “recourse to charms” displays his perception of the limits of their care, but also his disapproval at their apparent descent into superstition.²⁰⁷ As a result he appears to have determined that these methods of care could not be fully accepted into ‘Western’ medical lore until confirmed by scientific methods. In relation to the practices of the local population, Dr Perry consequently appeared “less willing to accept their validity”.²⁰⁸ This is a trend that Harriet Deacon has attributed to an attempt to establish the respectability of the doctor within society, preferring to emphasise their connection as a profession to science as a means of securing social standing.²⁰⁹

Yet in this manner the periphery medical authority of the district surgeon was regulating what knowledge the institution of the RCP, which was situated at the heart of the colonial empire received. His opinion of what constituted valid medical knowledge was vital, but perhaps it also indicates a broader context of what was deemed sound wisdom. The answers of the Cape’s district surgeons would have been regulated what they considered appropriate yet also what they thought the physicians in London would view as valid. Their answers would need to conform to ideas of medical decency in the metropole in a way that protected or established their image as gentlemanly practitioners. It is important to keep in mind Kirsten McKenzie’s study on the notions of disjuncture between colony and mother-country.²¹⁰ Yet their attempts to emphasise their Western training also raises a slight difference with some

²⁰⁵ District Surgeon Thomas Perry. Response to Royal College of Physicians questionnaire. 12 May 1830. Completed questionnaire. MC vol.1.

²⁰⁶ *Ibid.*

²⁰⁷ *Ibid.*

²⁰⁸ Harriet Deacon, “The Cape Doctor and the Broader Medical Market, 1800-1850”, 56.

²⁰⁹ *Ibid.*, 56.

²¹⁰ Kirsten McKenzie, *Scandal in the Colonies*, 5.

practitioners elsewhere in the empire. Arnold's study of medicine in the colonial subcontinent has spoken to an ability of the profession to adapt itself to the unique context of the colony.²¹¹ He writes: "Western medicine was not merely a projection of the medicine taught and practiced in Britain but was constantly engaged in a dialogue with India".²¹² Such a process saw the incorporation of some local practices largely out of an attempt to win over more patients. Furthermore, the Indian profession was becoming more self-sufficient due to the establishment of a number of medical schools in the 19th century.²¹³ This in turn allowed for an assertion of a uniquely Indian medical character. Comparatively the Cape profession of doctors appears to have continually tried to assert its links with Britain and Europe.

The correspondence between the district surgeons and the Royal College of Physicians also reveal attempts to obtain and maintain tangible statistical based knowledge on the possessions of the empire.²¹⁴ This included their inhabitants as the nature of the questions posed reveal a fascination and interest with the different peoples that made up the Empire. For example, question four inquired: "What are the features, complexion, colour of the hair and average stature of the natives?"²¹⁵ The generic nature of this particular question also confirms that it had been compiled and distributed to a number of different colonies. It did not specify which 'natives' it was requesting information on, and as a result the district surgeons appear to have been confused as to whether they should solely describe the indigenous African population or add descriptions relating to the European inhabitants of their specific jurisdictions. This in itself indicates some of the issues that surround surveys of this nature. Due to the intended scope of their distribution, little distinction for the differences between the different colonies were made. Furthermore the fact that the district surgeons were unable to confirm the nature of the question prior to answering indicates the issues with knowledge gathering at this time. This also verifies the remote location of the district surgeoncies' within the local Cape Colonial network and can again reinforce how intelligence was mediated through context before being put into circulation.

With regards to the population of the respective district the surveys obviously reveal the differences in quantitative population statistics, but some of the responses broke their answers down into the composition of that population. For example, Graff Reinett was said to have a population of 8879: 6599 "whites", 953 "Free Blacks", and 1327 "slaves".²¹⁶ Interesting in this particular case is the categories of distinction that were used. Unlike the district of Swellendam, whose district surgeon declared it's demographic to comprise of "Christians, Hottentots, slaves, Prize Negroes and free people of colour", Graff Reinett's district surgeon utilised just three labels of classification.²¹⁷ Such a disparity raises the issues of a document

²¹¹ David Arnold, *Colonizing the Body*: 14

²¹² *Ibid.*

²¹³ David Arnold, *Colonizing the Body*: 18

²¹⁴ Zoë Laidlaw, "Investigating Empire", 753.

²¹⁵ District Surgeon of George. Response to Royal College of Physicians questionnaire. 12 May 1830. Completed questionnaire. MC vol.1.

²¹⁶ District Surgeon of Swellendam. Response to Royal College of Physicians questionnaire. 12 May 1830. Completed questionnaire. MC vol.1

²¹⁷ *Ibid.*

of this nature. The RCP would not have been able to ensure that all people replied in the manner they wanted. Yet the varied response to this particular question also indicates a lack of consistency with regards to how individual authority figures classified the different people within their communities. Thus, our attention is brought to the functioning of an internal network within the Cape Colony.

Such subtle differences indicate that a consistent dialogue between districts and the central medical authority around issues such as patient classifications was not taking place. This raises the question about the efficiency of the Cape medical system in being able to disseminate information uniformly between its ten localities. In addition the responses of the district surgeons point out the issues that surround the vague nature of the survey. The largest constituency that responded to the survey was Stellenbosch under Dr O Flinn. The data transmitted revealed that the district had a total population of 16 753 the majority being “whites, Europeans or the descendants of Europeans”.²¹⁸ The subsequent response of Dr O Flinn to the second question around “what proportion” “the annual deaths bear to the population” makes for interesting yet somewhat confusing reading.²¹⁹ His answer indicated that the population of European settlers within his jurisdiction had a better chance of survival when contrasted with that of the other free peoples of the Stellenbosch region. Yet despite indicating the presence of slaves in the area by naming them as part of the population, O Flinn did not note the proportion of their deaths to their size as a population group.²²⁰ We are only able to speculate the reasons for this, but perhaps it has something to do with who he considered a legal ‘person’ and part of his medical flock. In contrast Thomas Perry of Graff Reinett gave the total deaths occurring under his jurisdiction as 119.²²¹ He made no distinctions saying that he had no way of “ascertaining the number of deaths occurring in the different classes”, thus immediately showing a disparity in the way that records were kept between districts.²²² More striking was the response of the District Surgeon of Swellendam who informed the College that there was “no register of deaths kept”.²²³ This inconsistency again reveals the intricacies of the flow of information throughout the colony. Mainly, that there was no standard of record keeping maintained throughout the Colony therefore indicating a weak and inconsistent flow of information, in addition to the presence of bureaucratic inefficiency. One can also determine the degree of independence allowed to some members of the Cape medical system due to the nature of authority in the region.

²¹⁸ District Surgeon O Flinn. Response to Royal College of Physicians questionnaire. 12 May 1830. Completed questionnaire. MC vol.1

²¹⁹ *Ibid.*

²²⁰ *Ibid.*

²²¹ District Surgeon Thomas Perry. Response to Royal College of Physicians questionnaire. 12 May 1830. Completed questionnaire. MC vol.1

²²² District Surgeon Thomas Perry. Response to Royal College of Physicians questionnaire. 12 May 1830. Completed questionnaire. MC vol.1

²²³ District Surgeon of Swellendam. Response to Royal College of Physicians questionnaire. 12 May 1830. Completed questionnaire. MC vol.1

Networks of disease and controlling responses

Importantly, the district surgeons were asked “what diseases prevail” within their area of jurisdiction, and when these particular illnesses were found to manifest themselves.²²⁴ In this regard we can observe distinct differences between the various districts of the Cape’s medical system. The correspondence from Swellendam revealed that “inflammatory fevers, chronic rheumatism, dysentery, diarrhoea and the ring worm amongst children” were afflictions that occurred all year round, but as of yet there had been no serious outbreaks of contagious disease.²²⁵ Similarly Dr O Flinn of Stellenbosch declared that “bilious and inflammatory fever, dysentery, rheumatism, hepatic diseases” abounded but that unlike in Europe there were no cases “arising from marsh miasms, measles and small pox”.²²⁶ In contrast the area around George presented with few noteworthy illnesses the exception being “a species of leprosy” that the district surgeon indicated was confined to the Khoi population (a subject that will be dealt with in depth in chapter 5).²²⁷ Thomas Perry of Graff Reinett noted that Elephantiasis was common with the Khoikhoi under his jurisdiction, but that he had also seen two white settlers afflicted.²²⁸ In addition, he noticed the absence of, among other prevalent European illnesses, the scourge of syphilis.²²⁹ This is interesting as the sexually transmitted disease was prominent throughout the world at this point in time. Perry’s correspondence suggests that by 1830 it had not reached the region around Graff Reinett. Such an example raises questions around the Cape’s place in a different medical network, that of diseases. This in turn reveals the complexity of the ‘public health’ situation with which the local medical administration was forced to deal. From the correspondence of the various districts it is clear that some areas had notable diseases of concern which in turn would have had to be made provision for by the medical administration.

Each locality would hence have to implement its own policy with which to handle their predominant sicknesses. In addition, they would need to communicate with the other districts and the central authority in Cape Town with regards to new diseases arising in their sector. This dialogue clearly took place as is evident from the number of letters the office of the Colonial Medical Inspector and later the Supreme Medical Committee, received from its medical constituents. The case of a mysterious breakout of illness in the Koue Bokkeveld towards the end of 1829 illustrates how this transmission of knowledge was crucial in order to prevent epidemic disaster. Yet it also reveals how weak and inefficient the communication

²²⁴ District Surgeon of George. Response to Royal College of Physicians questionnaire. 12 May 1830. Completed questionnaire. MC vol.1

²²⁵ District Surgeon of Swellendam. Response to Royal College of Physicians questionnaire. 12 May 1830. Completed questionnaire. MC vol.1

²²⁶ District Surgeon O Flinn. Response to Royal College of Physicians questionnaire. 12 May 1830. Completed questionnaire. MC vol.1

²²⁷ District Surgeon of George. Response to Royal College of Physicians questionnaire. 12 May 1830. Completed questionnaire. MC vol.1

²²⁸ District Surgeon Thomas Perry. Response to Royal College of Physicians questionnaire. 12 May 1830. Completed questionnaire. MC vol.1

²²⁹ *Ibid.*

channels were within the Cape medical system, as well as between the heads of the medical districts and the inhabitants of their respective localities. A report arrived at the office of the Medical Committee after having been delivered to the Colonial Office on the 27th of October 1829. It described how “an alarming disease” had “broken out amongst some of the inhabitants in the ward KoueBokkeveld”.²³⁰ The Committee upon considering the symptoms described, decided that despite the disease being “alarming” it was “not of recent appearance” and was in fact leprosy.²³¹ They then went on to declare “it necessary that the district surgeon be ordered to visit the ward to examine and prescribe for the persons afflicted and to report to the government on the nature of the disease”.²³²

Yet this final section of the correspondence reveals that the report of this illness had not emanated from the office of the localities district surgeon as one would expect.²³³ This means that the report must have emanated from the ward where the afflicted were situated. Therefore the compilers of the report must have bypassed the authority of the district surgeon in order to go straight to the central office of governance in Cape Town. What was presumably the official channel for the dissemination of medical knowledge was therefore ignored. This example raises numerous points of interest with regards to the actions of the Committee upon receiving and interpreting the information from the specific ward.²³⁴ Without seeing the patient’s first-hand, the members of the Supreme Medical Committee gave a medical diagnosis that if incorrect, could have had far reaching consequences for the public health of the entire Cape Colony. In this instance they placed an incredible amount of faith in the descriptions and write ups provided by non-medically trained lay members of the public. By doing so they showed a willingness to trust an informal medical network.

However they also displayed a certain amount of arrogance with the evident certainty in their own opinion that such unqualified people could not successfully diagnose disease. As a result they trusted their own conclusions over those of people who had actually seen the manifestations of symptoms. Notions of power gained through recognised forms of medical training can therefore be discerned. Furthermore the orders of the Committee intended for the district surgeon highlight a refusal of recognised medical authority to engage with the general public on issues of their own health. There was no dialogue set up with the people who had sent the communication in the first place. The local network for transmission of knowledge can therefore be seen to be a one way system where people could raise issues but would not be granted a conversation on the matter at hand. Instead a decision would be made irrespective of their feelings on the matter.

Characteristics of the Cape

²³⁰ Supreme Medical Committee. Response to letter from Worcester district regarding disease outbreak. 28 October 1829. Letter. MC vol.1.

²³¹ *Ibid.*

²³² *Ibid.*

²³³ *Ibid.*

²³⁴ *Ibid.*

The imperial acquisition of knowledge relating to the natural attributes of colonial possessions is a topic that has increased in popularity over the years. William Beinart has indicated how at times scientific efforts could be “associated specifically with a project of dehumanisation and domination”.²³⁵ Although he stresses that the examples of Burchell and Spaarman provide alternatives, the majority of the time saw knowledge exploitation on a grand scale.²³⁶ Attempts to discern the medical benefits and bounty of the Cape landscape are evident in the numerous attempts made to determine the nature of local water sources. Such an instance is evident, but not limited to, the investigation of the Supreme Medical Committee into the “nature and quality of the mineral waters found at the Koegha” in June 1826.²³⁷ Yet their attempt to determine the benefits of the Cape’s water appears to have been part of a general empire wide trend. This is evidenced by the 8th question of the Royal College’s survey of 1830, which asked: “Are there any mineral springs there?” Although the different responses they received speak towards the diversity of the landscape of the Cape, this particular question points indicates a selfish manner of viewing the colonial territories. But despite the similarities between these two attempts to acquire intellectual and scientific capital from the colony, they were different in their findings due to specific limitations. The Royal College of Physicians was reliant on the willingness of the local district surgeons to share their knowledge. Furthermore they were counting on the assumption that the district surgeons had some conception of the natural waters in their area of jurisdiction. In comparison, the investigation of the Supreme Medical Committee was at an advantage due to the fact that they could travel to locations and conduct their own tests on water sites.

The advantage of spatial distance that local science endeavours had over those that were attempted from the empire metropole is, made apparent in the Supreme Medical Committee’s investigation of salt sourced from Algoa Bay. The Committee was able to receive a physical sample in order to assess its uses. The process they went about interrogating its properties is described at length in *The Cape Town Gazette, and African Advertiser* on the 15th of February 1827. Yet the lack of scientific assets available in the Colony is also apparent in their report. The Committee wrote that although they suspected they knew the benefit of the salt, they could not be sure until a full chemical study had been conducted. This was “a matter of more nicety than they have been able to institute, and would require the careful direction of an experienced Chemist” in order to provide a final verdict.²³⁸ Such an admission also raises the topic of the tension present between the Colony’s doctors and apothecaries, with the proclamation that there was not a sufficiently ‘experienced’ chemist available clearly being an insult to the Cape’s chemists. Furthermore the detail of the report published in the town newspaper mirrors that of a journal article suggesting that this was an attempt by the Committee to publish their findings. As there were few established local journals that could reach a large audience, the local gazette would have to do.

²³⁵ William Beinart, “Men, Science, travel and nature in the eighteenth and nineteenth-century Cape”, *Journal of Southern African Studies* 24, 4 (December 1998), 799.

²³⁶ *Ibid.*

²³⁷ Supreme Medical Committee. Report on the waters at Koegha. 15 June 1826. MC vol.1

²³⁸ *The Cape Town Gazette, and African Advertiser*. Cape Town, February 15th 1827.

The section of the questionnaires relating to indigenous knowledge of local plants and their medicinal properties is of interest due to the nature of its transmission and its role in a system of appropriation. For example, District Surgeon Surnbutt of Swellendam wrote that some of the peoples under his jurisdiction “make use of the bark and of the fruit of *Salanum Mammosim* and of the root and leaves of *Graphalium Mudifolium*”.²³⁹ In this instance the respondent used scientific botanist terminology to describe the plants in use. He noticeably did not use the names that the indigenous Khoikhoi would have utilised in referring to this flora. Such a response indicates how local knowledge and perceptions of local plants was being mediated in a certain way to make it palatable for a specific audience. In this manner the colonial enterprise was appropriating knowledge but altering it in a certain way. Such an example can reveal how the process of naming resident plant life became an unbalanced power relationship. Within this exchange colonial information gatherers were reliant on the indigenous population for their knowledge of medicinal plants, yet through the process of labelling they failed to acknowledge this crucial contribution.

This relates back to the presence and nature of a network of medical knowledge that required information to be altered in order to make it understandable within a different context. One can also deduce that the district surgeons who were collecting this knowledge used this specific terminology in order to enter into a scientific discourse that would give their responses authority. By using the Latin names for particular plants the validity of their work in gathering the specific information would have been viewed as sound. This indicates that they understood the parameters and requirements that governed transmission of expertise within the networks of the British Empire. A central concern of these evaluations appears to have been whether the colony had any mysterious local remedies that could be harnessed for Western usage. For example, the questionnaire asked: “what are the medicinal substances of the country and how are they prepared”.²⁴⁰ This was followed up by “what remedies do the natives employ in the diseases to which they are subject?” Such questions again point towards an attempt to extract local knowledge from the colonial territories and people with the intention of placing it into a wider context for circulation. These questions therefore allow us to place this survey in a scientific process that was hungry for information. Yet it is also interesting to note that “only two medicinal Cape plants were exported on a large scale” and it was only these same two plants, being aloe and buchu that “were incorporated into the published British pharmacopoeia” throughout the 19th century.²⁴¹ This is a reality that Harriet Deacon puts down to the manner in which Western practitioners were trained.²⁴² It was this training, which focused on the uses of Europe’s medicinal herbs and plants, which blurred the vision of Cape based practitioners. The limits of their training, coupled with their intent to avoid giving the indigenous practitioner any form of respect, combined to prevent the true wonders of the Capes flora from being distributed to a worldwide medical market.

²³⁹ District Surgeon Norbert Surnbutt. Response to Royal College of Physicians questionnaire. 12 May 1830. Completed questionnaire. MC vol.1

²⁴⁰ District Surgeon of George. Response to Royal College of Physicians questionnaire. 12 May 1830. Completed questionnaire. MC vol.1.

²⁴¹ Harriet Deacon, “The Cape Doctor and the Broader Medical Market, 1800-1850”, 58.

²⁴² *Ibid*, 59.

Professional respectability and regulation

With regards to what constituted a valid medical practice and practitioner within the Cape Colony and wider context of Empire, the 13th and 14th questions are useful. Question 13 asked: “What is the education of those who practice medicine?”²⁴³ To this all but one of the district surgeons responded “none” indicating a clear and staunch distinction between those deemed worthy of authentic patient care, and those who were charlatans.²⁴⁴ Furthermore the only district surgeon who had a different response made sure to point out that there were “three admitted practitioners”, in addition to “several black conjurors” and “a few farmers who practice medicine but do not profess to be conjurors” within his area of jurisdiction.²⁴⁵ In this case the only people deemed authentic health care workers were those of formal Western training, whilst those who were not, found themselves ‘lumped together’ under the banner of being a suspected or confirmed superstitious ‘conjuror’. Yet again the work of Harriet Deacon allows us to better understand how labelling and distinguishing became powerful tools in asserting medical authority.²⁴⁶ Yet these distinctions also reveal how the wider power of the Western medical authority was attempting to assert itself in different colonial environments.²⁴⁷ Furthermore by collecting knowledge on the prevalence of indigenous forms of health care, the RCP in London could have been determining whether or not a genuine threat was being posed to the ‘conventional’ authority of the doctor in the colonial setting.

The 14th question posed by the survey inquired as to whether local peoples had “any writings or traditions on medical subjects”, and yet again the heads of the various districts responded emphatically that they didn’t.²⁴⁸ In this regard we are made aware of a correlation between a view of valid medical knowledge and its need to be in written form. Similarly the medical process of vaccinating against known illnesses appears to have been used as a means to dismiss the services offered by ‘non-Western practitioners’. The final question and the responses to it indicate how this practice was used as an exclusionary tool by the recognised medical authorities. It asked (referring to the local population): “do they practice vaccination?”²⁴⁹ Most replied “no” whilst one displayed obvious discontent that such a question was even asked replying “certainly not”.²⁵⁰ In this way the self-affirming air of superiority granted by Western ideas of scientific practice can be seen.²⁵¹ The more in depth responses of Thomas Perry and Dr O Flinn indicate how the procedure was monopolised and protected by the recognised medical authority, again reiterating some level of concerted effort

²⁴³ District Surgeon of George. Response to Royal College of Physicians questionnaire. 12 May 1830. Completed questionnaire. MC vol.1

²⁴⁴ *Ibid.*

²⁴⁵ District Surgeon Thomas Perry. Response to Royal College of Physicians questionnaire. 12 May 1830. Completed questionnaire. MC vol.1

²⁴⁶ Harriet Deacon, “The Cape Doctor and the Broader Medical Market, 1800-1850”, 63.

²⁴⁷ *Ibid.*, 61.

²⁴⁸ District Surgeon of George. Response to Royal College of Physicians questionnaire. 12 May 1830. Completed questionnaire. MC vol.1.

²⁴⁹ *Ibid.*

²⁵⁰ *Ibid.*

²⁵¹ Harriet Deacon, “The Cape Doctor and the Broader Medical Market, 1800-1850”, 63.

to emphasise the respectable nature of the Cape doctor, and more specifically the district surgeon. O Flinn wrote that “vaccination is performed by District Surgeons solely throughout the Colony, none others are permitted to practice it”.²⁵² Similarly, Perry pointed out that he conducted numerous trips in order to vaccinate people within his jurisdiction.²⁵³ In this way, district surgeons like Perry acted as the representative of authorised medical authority and attempted to control access to power through a control over medical knowledge and practices.

He also noted that the local settler population understood its purpose and approved of its practice, but that the other local peoples “submit to its operation without understanding its object”.²⁵⁴ Here we see how medical knowledge and ideas around ‘public health’ were transmitted to some members of the local population, whilst others were excluded. This reveals how notions of medical power were forced to operate differently within different groups of colonial subjects. Settlers of European origin had to be convinced of the benefits of vaccination, and once they were assured of these they submitted to the practice. Notions of medical knowledge were employed to serve this purpose. In comparison, the medical authority did not or could not explain the scientific motivation for vaccination and presumably coerced members of the indigenous population into receiving the procedure.

The reference to the stature of the local populations indicates how cumulative statistics or at least estimates, were critical to what was conceived of as valid information. Yet again we can conclude that the compilers of the questionnaire were attempting to draw links between the physical attributes of the local population and their surrounding geographic environment. This is evident from the question regarding the features of the Cape’s peoples which immediately followed with questions regarding “the medium height of the thermometer in the summer and winter months” and the nature of the wind in the area.²⁵⁵ Due to the fact that the surveys dispatched to the Cape Colony were part of a wider project that encompassed a number of territories, it can be deduced that the College of Physicians were trying to determine trends and correlations within areas. They would then be able to contrast these statistics with those compiled from elsewhere in the Empire.

The Eagle Life Insurance Company

The interest in local diseases and factors relating to health was not confined to the questionnaires distributed on behalf of the Royal College of Physicians. The set of RCP queries is mirrored by a set of questions posed by J.B. Ebdon, a representative of Eagle Life Insurance.²⁵⁶ This company was a British one, and although there are no secondary sources on its history, we can assume from the nature of its questions, that it intended to establish

²⁵² District Surgeon O Flinn. Response to Royal College of Physicians questionnaire. 12 May 1830. Completed questionnaire. MC vol.1.

²⁵³ District Surgeon Thomas Perry. Response to Royal College of Physicians questionnaire. 12 May 1830. Completed questionnaire. MC vol.1

²⁵⁴ *Ibid.*

²⁵⁵ District Surgeon of George. Response to Royal College of Physicians questionnaire. 12 May 1830. Completed questionnaire. MC vol.1

²⁵⁶ Supreme Medical Committee. SMC reply to questions of Eagle Life Insurance Company. August 1831. Response to questions. MC vol.1

itself in the Cape. By obtaining information on the local settler population the company could assess whether an insurance venture would be financially viable in the Cape. Although the survey conducted by this insurance company was undoubtedly driven by motives of business, the types of queries it raised, help place it within the broader context of intelligence gathering that was taking place within the empire. Their questions, like those of the RCP, were handed to the Supreme Medical Committee to be answered and they in turn obliged with a very thorough and informative response. Unlike the survey of the College, the Committee answered these themselves.²⁵⁷ Again, one can see the role of the centre authority, embodied by the Supreme Medical Committee, acting as the mediator for information collected from throughout the colony. The Committee conducted its own investigation and its members decided amongst themselves what constituted valid and appropriate responses to the inquiry. The fact that this survey was prompted by an insurance company also indicates a flow of capital, as well as the medical connection to this monetary circulation. Like the queries compiled by the Royal College of Physicians, the questionnaire of the Eagle Life Insurance company was largely concerned with the life expectancy and prevalence of disease within the local white Cape population.²⁵⁸ When used together these two resources can give remarkable insight into health standards within the Cape, but can also reiterate how medical knowledge was gathered and disseminated.

Standards of living and stereotypes of the Cape's settlers

It is clear that the health benefits or potentially detrimental effects of the Cape to one's wellbeing were also being evaluated during the course of the inquiries conducted by the Royal College of Physicians. Questions were asked relating to the local temperature, winds, "nature of the soil", and prevalence of any mineral springs.²⁵⁹ The questionnaire appears to have been trying to draw a correlation between these natural factors and trends of living amongst the inhabitants of the specific district within which they occurred. In this regard the district surgeons were asked whether there were "any remarkable instances of longevity among the local inhabitants?"²⁶⁰ They were also asked about the size of the population, in addition to: "What proportion do the annual deaths bear to the local populations?"²⁶¹ In this manner, the survey appeared to be greatly concerned with the standard of living amongst imperial subjects. The response of the Supreme Medical Committee to the seventh question posed by the Eagle Life Insurance Company reiterates a substantial belief that one's life could be prolonged due to residence at the Cape. The question asked whether they believed "the lives of Europeans to be shortened or protracted by residing in this climate", to which the response was a resounding confirmation of the Cape's value in lengthening life span.²⁶² Naturally the questions posed by Eagle Life Insurance in the same year were primarily

²⁵⁷ *Ibid.*

²⁵⁸ *Ibid.*

²⁵⁹ District Surgeon of George. Response to Royal College of Physicians questionnaire. 12 May 1830. Completed questionnaire. MC vol.1

²⁶⁰ *Ibid.*

²⁶¹ *Ibid.*

²⁶² Supreme Medical Committee. SMC reply to questions of Eagle Life Insurance Company. August 1831. Response to questions. MC vol.1.

concerned with the life expectancy of the Cape settler population groups, and not the Capes indigenous inhabitants. In this regard they firstly asked the Committee: “Whether your board considers there is any difference in the health of the African and British born in this Colony affecting their longevity and if so, on which side the longevity exceeds”.²⁶³ They followed this up with a question as to whether they believed “the climate of this Colony, inferior, equal or superior to that of Great Britain as affecting the health of the inhabitants”.²⁶⁴ Such questions therefore indicate an attempt to discern some form of viable correlation between the natural environment of the Cape and patterns of life expectancy. Organisations operating from the centre of the Empire, be they the Royal College of Physicians or insurance companies, showed a growing interest in the effect that the colonial life could have on settlers. This tied into fears that the particular climate of certain colonies could negatively impact the life expectancy of Europeans. The data collected from both sets of surveys can in turn speak to actual trends of living in different parts of the Cape.

The preoccupation with the Dutch settlers of the Cape, evident in the questions posed by the Eagle Life Insurance Company, is striking. Yet even more interesting are the responses put forward by the local medical authority. One cannot help but ascertain a degree of favouritism in the correspondence of the Committee directed towards the Dutch speaking classes of the Cape. Their numerous responses appear to have been trying to dispel prominent stereotypes that had emerged around the lifestyles of the Cape Dutch. For example, question six asked: “Whether it be true that thee Dutch are often carried off suddenly by apoplexy from their habits of living- whether this disease is very frequent- amongst the Dutch inhabitants here, or rather unusual, that as to say whether it is more common here than in England?” Such conceptions emanated from a number of travel accounts; one of which was penned by John Barrow. In *Travels* Barrow described the local Dutch as villains who were guilty of exerting a brutal and inhumane control over the local Khoikhoi. He claimed that the ‘Boors’ were “unwilling to work, and unable to think” both of which were exasperated by their excessive consumption of meat and strong liquor.²⁶⁵ His description concludes: “The African peasant grows to an unwieldy size, and is carried off the stage by the first inflammatory disease that attacks him”.²⁶⁶

In response, the members of the Committee declared that although in the past this may have at times been the case due to the “old custom of drinking to great excess on birthdays and other festive occasions” but they stressed that it had “gone almost entirely out of fashion amongst them; and we can say that apoplexy has not been by any means frequent amongst them”.²⁶⁷ They made sure to report on a number of occasions that the drinking habits of the Dutch did not exceed those of the British upper classes, and that it was in fact the “lower class of the British colonist, the free blacks and the aboriginal Hottentots” who “severely

²⁶³ *Ibid.*

²⁶⁴ *Ibid.*

²⁶⁵ Nigel Penn, *Mapping the Cape*, 13.

²⁶⁶ *Ibid.*

²⁶⁷ Supreme Medical Committee. SMC reply to questions of Eagle Life Insurance Company. August 1831. Response to questions. MC vol.1.

drink to excess and are not reckoned good lives”.²⁶⁸ Furthermore, the Committee declared that the Cape Dutch were an “active and healthy race” who did not deserve higher premiums because of misconstrued conceptions around their lifestyle.²⁶⁹ These questions posed by an insurance company also help reveal medical conceptions present in the Colony around what could produce a healthy and unhealthy life.

The Committee’s answer around the lifestyle habits of the local Dutch settlers indicates that the local medical fraternity was aware of the correlation between certain illnesses, and a lack of exercise, unhealthy eating habits and excessive alcohol consumption. By declaring that the Cape’s Dutch inhabitants were no longer guilty of partaking in these gluttonous type acts, they were making it clear that they were not at risk of dying young or unexpectedly. The dialogue between the Supreme Medical Committee and the Eagle Life Insurance Company points towards the spread of certain ideas relating to life practices that could impede life quality and length. Both the Cape based committee and life insurance company, which originated from Britain, had common perceptions about how negative habits could result in specific illnesses. This indicates the presence of a network for the transmission of medical knowledge and ideas. Yet, what must be kept in mind is the unique position of the Supreme Medical Committee. All of its members resided in the port of Cape Town and as a result were presumably more able to receive updates with regards to medical knowledge. The extent to which the practitioner in the rural country district was able to receive such information is not clear from this particular source. We must look at a different case in order to reveal if medical practitioners outside of central Cape Town were kept in some form of local and international network that kept them up to date with conceptions of medical knowledge.

The set of examples about the Dutch present in the survey of the Eagle Life Insurance Company indicates how conceptions of medical normality and stereotypes around health practices were in circulation throughout the empire about the inhabitants of the Cape. Case studies have in the past shown that the Khoikhoi became widely studied out of curiosity and a number of stereotypical tropes were attributed to their bodies. The question raised by the life insurance company indicates that this was a process not isolated to the Khoi. British traveller accounts towards the beginning of the 19th century had portrayed the Cape Dutch in a very negative light. This was a trend that had continued in the report of the Commissioners of Eastern Inquiry where the local Dutch speaking population was depicted as being brutal overlords of the local and slave populations. Furthermore their reluctance to accept British rule was even more cause for concern and added to their negative depiction. It was this type of information and that of the Commissioners of Inquiry on the local Dutch that led to the end of the Burgher senate in 1828.²⁷⁰ The concerted effort made by the Committee throughout the course of their answers to improve the image of the Dutch settlers can also reveal aspects of their personal viewpoints. The composition of the committee and the attempts of the local British administration to bridge the divide between both groups of white settlers can assist with our understanding of why such a hard-line approach was taken towards the old

²⁶⁸ *Ibid.*

²⁶⁹ *Ibid.*

²⁷⁰ J.B. Peires, “The British and the Cape, 1814- 1834”, 493.

stereotypes of local Dutch life.²⁷¹ Kirsten McKenzie has noted an attempt within the Cape Colony to establish a combined settler identity. This culminated in political mobilization and calls for a form of self-government in the 1840s.²⁷² The reply of the Committee to the questions posed on the local Dutch colonists can therefore reflect this shift in local portrayals.

Internal knowledge regulation

One can again see the way in which the recognised local fraternity felt threatened by other notions of medical knowledge in the correspondence received from a Field Cornet by the name of J Bodenstein in February 1831. Bodenstein wrote to the committee saying: “Being remote from medical aid, we are in this part of the country obliged to resort to our own extinctions in cases of sickness and many of the plants in this district have been found eminently serviceable in cases which have been abandoned by the faculty- I have resided here many years and have taken some trouble in collecting medicinal plants and in watching their effects- in ten or eleven cases of Epilepsy I have supplied a remedy without a single failure of cure and consider it a duty I owe to the colony to make it generally known.”²⁷³ He went on to offer his services and expertise to the Committee so that the lore of the frontier could be fully utilised. The Committee’s response was one of interest and after receiving permission from the governor they requested Bodenstein to send “samples of the plants provided they be sent in small packages by different mails”.²⁷⁴ But their response to another letter from Bodenstein on the 24th of August evidences their hesitancy to use the remedies and flora provided by the Field Cornet. A member of the Committee explained: “I have but few opportunities of trying your new remedies, as I consider myself bound not to make experiments on my patients unless they were not to improve under usual treatment”.²⁷⁵ This was however a consideration not held towards the experiments on lepers, as will be shown in the 5th chapter.

But their refusal to test the treatments does indicate the parameters of care that were exclusionary of anyone not deemed as having undergone appropriate training. Bodenstein’s remedies were not deemed to have been adequately tested by professionals and therefore could not hope to be considered on the same level as Western approved treatments. In this way the Supreme Medical Committee acted as the gate keepers as to what knowledge was seen as officially worthy. They held sway over what they saw as the legitimate channels of medicinal ideas. Coupled with the evidence from the questionnaires distributed to the district surgeons, one can become aware of a process by which the labels of sanctioned and unsanctioned were used to distinguish the Western Medical fraternity in the Cape. By seeking to police the borders of what knowledge was deemed scientifically viable by a certain standard, the authority was able to exclude other practitioners, whilst at the same time giving the actions of its particular medic’s power.

²⁷¹ Kirsten McKenzie, *Scandal in the Colonies*, 58.

²⁷² *Ibid*, 58.

²⁷³ Field Cornet J. Bodenstein. Offering expertise to SMC with regards to medicine of the frontier. 22 February 1831. Letter. MC vol.1

²⁷⁴ Supreme Medical Committee. Acknowledgment of letter from Bodenstein. 18 March 1831. Letter. MC vol.1

²⁷⁵ Supreme Medical Committee. Letter to Bodenstein. 24 August 1831. Letter. MC vol. 1.

The offer of Bodenstein highlights an informal and underground circulation of unsanctioned medical knowledge that arose on the frontiers of the Colony. Conventional assistance was not available to settlers like Field Cornet Bodenstein and as a result they had to develop their own means of dealing with issues of a medical nature. This would have involved engaging with the local indigenous population of Khoi-San in order to obtain some understanding of therapeutic means to handle ailments and afflictions. The case of Cornet Bodenstein can confirm that there was some form of dialogue around notions of medicinal care between the settler populations, especially on the frontier, and indigenous healers. Although this discourse was clearly not looked upon favourably by the members of the Supreme Medical Committee, it does point towards the presence of an underground network of knowledge born of necessity due to the Cape's unique situation. In addition, this interesting example can reveal that settlers on the ground had a grasp of certain ailments. Bodenstein makes reference to the numerous cases of epilepsy that he was personally responsible for curing. Such a mention of epilepsy points to the transmission of notions of particular illnesses to lay settlers on the frontier. One can thus deduce that there were forms of circulating and updating ideas around diseases even on the frontier of the Cape. In particular, the reference to epileptic symptoms shows that at least amongst Bodenstein's community, such an affliction was understood as being medical in nature. The wording of Bodenstein's letter to the offices of the Committee in Cape Town also indicates a lay conception of what was an apt source of expertise.²⁷⁶ Despite the fact that Cornet Bodenstein would have been in dialogue with local Khoikhoi and San healers, he makes no mention of their contribution to his corpus of medicinal knowledge.

This failure to acknowledge the contribution of any local peoples can be attributed to both Bodenstein's own ideas of what he thought the Committee would recognise as authoritative and a sense of superiority. As is evident from the exclusionary language used in the responses by the District Surgeon's to the Royal College of Physicians, the indigenous health care practitioners were largely dismissed as being heavily superstitious. Their techniques and approaches were regarded as being without scientific basis. Bodenstein consequently took the line of passing his knowledge off as having been gathered empirically therefore giving it some potential form of validity.²⁷⁷ In this way he aimed to mediate the knowledge in order to make it more palatable for the authorities. Here we can see the presence of a tiered system that determined whose medical knowledge was valid. However, the case of Field Cornet Bodenstein, besides revealing notions around what constituted valid knowledge, points towards the more sinister nature of the knowledge network during the colonial period. The declaration about the source of his healing practices raises questions around the appropriation of local intellectual capital. Without some form of help from the indigenous people of the district, Bodenstein and his fellow colonists would surely have been unable to gain some grasp of the medicinal value of certain herbs. Yet despite this, there is no acknowledgment of their aid. In this way the webs of knowledge can be seen to have been exploited by locals (in

²⁷⁶ Field Cornet J. Bodenstein. Offering expertise to SMC with regards to medicine of the frontier. 22 February 1831. Letter. MC vol.1.

²⁷⁷ *Ibid.*

the form of Bodenstein and the Supreme Medical Committee) as well as metropole based actors like the Royal College of Physicians.

The threat of Rabies

Nevertheless these structures of dissemination were not always purely exploitative. The ability of the Cape's internal network and its incorporation of international health related concepts is evident in the response of the medical system to a specific emergency. A letter dated the 11th of October 1822 from a physician in the Stellenbosch District by the name of Dr Shand raised the concern of rabies or hydrophobia to which it was then referred to as. Upon highlighting the dangers of a potential rabies epidemic in the Colony, Dr Shand wrote a guide for members of the public to identify and treat the affliction in the absence of a medical practitioner. In his opinion it was "necessary that thought and concise directions should be laid before the public, for the benefit of those particularly residing in distant areas and who cannot on every occasion command assistance of a professional man".²⁷⁸ He made sure to explain to Barry that his 'guide' was not intended for physicians whose knowledge on the subject would far "supersede" any treatment that could be provided by lay members of the public.²⁷⁹ His proposed treatment involved washing the bite wound in hot soapy water before squeezing and vigorously irrigating the area with a syringe. Following this step the wounds "should all be cauterized/ burnt/ by a red hot iron, a wire or common long nail", after which a "feather dipped in the ace of viticol" should be applied.²⁸⁰ Upon completing the treatment of the wound the patient was to be confined to bed for "10 to 20 days" and given a "cupful of chamomile or ginger tea" every "two or three hours".²⁸¹ Dr Shand intended for his directives to be sent to the different districts of the Colony through the medium of the "Cape Paper" after they had been read by Barry.²⁸² However things did not follow in this manner, as will be later explored. But before the interesting response of Dr Barry to this proposed directive is analysed, the substance of what Shand was saying should be explored. The letter of Dr Shand to Barry is a crucial piece of evidence for analysing both the internal medical network in the Cape Colony, as well as the wider web that connected the colonies. The need for a set of instructions designed for use by the general population speaks to the lack of medical personnel distribution within the Colony.

In mid-October 1822 Dr Barry wrote with a certain amount of urgency to the district surgeons within his scope of authority. This speedy proclamation was spurred on by the letter and directives for members of the public that Barry had received earlier in the month from Dr Shand. The central topic of this letter related to the treatment of patients who had had the misfortune of being bitten by an animal. Yet, it does make certain distinctions between venomous bites, and those originating from animals suspected of having rabies, or as Barry called it: hydrophobia. The treatment, which the letter proposed for dealing with the

²⁷⁸ Dr Shand. Suggestions on the treatment of Hydrophobia for the magistrate of Stellenbosch. 11 October 1822. Letter. MC vol. 7

²⁷⁹ *Ibid.*

²⁸⁰ *Ibid.*

²⁸¹ *Ibid.*

²⁸² *Ibid.*

suspected rabid wound, called for the “excision of the bitten parts”, as according to Dr Barry, this was “the only certain remedy” that could ensure the victim did not develop rabies.²⁸³ In this way his directions were to supersede those offered by Dr Shand’s guide. He then moved on to the means by which medical professionals should go about treating patients with snake bites.²⁸⁴ In a similar manner to the hydrophobia treatment, Barry declared that it was necessary to cut “off sizable chunks” of flesh around the site of injection in order to “avoid spread”.²⁸⁵ The doctor was then to use generous amounts of brandy to wash the wound in order to prevent all manner of infection.²⁸⁶ What is interesting in this case is the evidence that Barry referenced for his directive of treatment. He declared that the method he wished the district surgeons to utilize was derived from the treatment of cobra bites that had been developed in the West Indies colonies.

This indicates the need to call on the authority of ‘international’ medical practitioners to back up certain statements of medical knowledge. It also indicates the presence of a global medical network that connected physicians and disseminated knowledge for use in different areas of the British Empire. In this way, Barry appears to have been the intermediary between the isolated district surgeons and a wider database of developing medical knowledge. In the modern day medical system, practitioners are by HPCSA law, required to keep up to date with procedures by attending Continuous Professional Development (CPD) lectures; within the Cape Colonial context of the early 1820s, Dr Barry seems to have served this function, instructing the common doctor on new developments in patient care from the wider world. Cape Town was in this instance the source from which this knowledge was circulated. But in order to do this, it had to function as a node within a wider medical network. *Scandal in the Colonies* indicates how Cape Town served as a receptor for gossip and ideas around societal respectability in this very same period.²⁸⁷ Barry’s reference to information from elsewhere in the British Empire indicates that the same was applicable for medicine.

The letters of authority figures, in this case Barry, can therefore be viewed as the initial means by which state entities attempted to exert control over the rural areas. It can be deduced that Cape Town functioned as both an internal and external receptacle node of information. However, due to the nature of letters they could be easily ignored or their contents misinterpreted. It is for this reason that Dr Barry had to become incredibly well travelled in order to ensure that his orders were enforced. Yet the correspondence from Dr Shand of the Stellenbosch district also indicates an important dialogue that existed between the rural and the urban centre of medical administration within the Colony. Barry’s proclamations to the physicians of the Cape were, in this particular case, spurred on by issues raised by a medical man who was on the ground level of the system. Dr Barry, representing the centre of the network, responded in order to standardise and prepare a response to cases of rabies and similar poison induced conditions. The same guidelines that Barry sent to the different district surgeons of the colony were also published in *The Cape Town Gazette, and*

²⁸³ Dr James Barry. Reply to Dr Shand regarding rabies directives. 15 October 1822. Letter. MC vol. 27.

²⁸⁴ *Ibid.*

²⁸⁵ *Ibid.*

²⁸⁶ *Ibid.*

²⁸⁷ Kirsten McKenzie, *Scandal in the Colonies*, 7.

African Advertiser on October the 26th 1822. All forms of public print media were controlled by the local government, and Somerset lauded over these institutions with dictatorial powers.²⁸⁸ It was only in 1829 that some level of autonomy was granted.²⁸⁹ The newspaper was another tool at the disposal of the authorities that could be used in order to disseminate medical information. By publishing the instructions for the use of the general public Barry appears to have been trying to ensure that the information was actually passed down. He does not appear to have trusted the district surgeons to have acted in accordance with his wishes, an assumption on their character that was clearly well founded.

The instances looked at during this chapter indicate the presence of a series of different networks. In determining the presence of these connections the work of Zoë Laidlaw is again useful.²⁹⁰ The first link was the connection of the Cape to the metropole and the rest of the empire. The second was the official correspondence that was utilised by the local colonial authorities in the Cape in order to stay in touch with, and maintain order over, the different practitioners that made up the haphazard health service. The final network can be identified by reading against the grain as records relating to it are scarce but it is clear from hints that it existed. This informal structure facilitated the non-sanctioned and unofficial transmission of information throughout the colony between people. It was this network that allowed for ideas to be transmitted between different groups and it was this unrecorded form of dialogue that allowed people like Field Cornet Bodenstern to acquire local medical knowledge. What is clear when analysing the state of networks is that they were not steady or well established. The information that travelled through the webs that connected different people, was mediated by personal feelings and opinions. Furthermore numerous people refused to enter into dialogue and instead opted to live out of imperial control. In addition the inability of both the local authorities and metropole officials to enforce order in the field and practice of medicine was inconsistent and weak at best. It is now possible to examine specific cases whereby regulations were contravened and the authority figures were forced to respond.

²⁸⁸ J.B. Peires, "The British and the Cape, 1814- 1834", 479.

²⁸⁹ *Ibid.*

²⁹⁰ Zoë Laidlaw, *Colonial Connections*, 14.

Chapter 4: Attempts to regulate practice and cases of malpractice

The importance of image within colonial society appears to have been central to the work of the Colonial Medical Inspector and Supreme Medical Committee. Although colonies were potentially places of new beginnings for settlers, Kirsten McKenzie has indicated how these spaces “were worlds turned upside-down, but they were endeavouring to right themselves”.²⁹¹ This relied on efforts to try and establish notions of decent and amiable conduct that were in line with British standards. Evidence of such trends is clear in the attempts made to regulate medical practice in the Cape within the period of the 1820s. This forms part of the process that was trying to define what was appropriate and proper before enforcing compliance in line with such ideals. A study of particular cases of malpractice and attempted regulation by the central authorities can act as a specific lens to attempts to establish a respectable profession and image, something McKenzie notes as having been crucial to life in colonial societies during this period.²⁹² Although the efforts to regulate entry into the profession of the doctor have been spoken about briefly in Chapter 2 (which drew heavily on the work of Harriet Deacon and Howard Phillips), the work of local medical authorities in controlling the conduct of those admitted into the ‘elite club’ has not. By examining these instances the effectiveness of the control structures as well as attempts to establish a respectable profession, will be apparent. In order to look into these cases, the networks spoken about in the previous chapters are essential. Control of these networks was seen as highly beneficial, and in some examples they were. But it will also be made apparent that the weak and inconsistent nature of these connections resulted in a decrease in order. Again, it is important to keep in mind the limitations of analysing a select number of cases that must have represented a break from the norm in order to be recorded. But they can speak towards greater trends.

Regulating medical goods

The fact that the medical offices of authority, based in Cape Town, sought to keep a firm grasp on what medical supplies were brought into the Cape Colony, is important to note. This administrative centre also attempted to regulate who was provided with drugs and medical materials, a fact that is made clear in the records of the Supreme Medical Committee and Colonial Medical Inspector. The supplies which were received in the port of Cape Town from abroad were thoroughly vetted and their contents noted. This restrictive practice can be seen as both a means to supply the different districts with the goods necessary for the care of their patients, as well as an administrative device of regulation. The medical goods needed by the colony were first brought in by ship to the central location of Cape Town and were then cross checked by the Colonial Medical Inspector, or later the Supreme Medical Committee. It was also in Cape Town that information sent by the district surgeons determined which supplies and their quantity were distributed. The maintaining of records by the district surgeons was therefore critical to the process by which the central authority could restock the supplies of the given district. Yet, evidence found in the archive shows that the district authorities did not

²⁹¹ Kirsten McKenzie, *Scandal in the Colonies*, 5.

²⁹² *Ibid*, 1.

always do so. This was the case in relation to the District Surgeon of George, Mr Somervale. Dr Barry noted in a response to a letter that he had “not been furnished with any schedule of that Gentleman’s stock of drugs” and as a result it was impossible “to determine the deficiencies either in point of quantity or quality”.²⁹³ Furthermore this example indicates that the Colonial Medical Inspector had very little means at his disposal to enforce that relevant drug records were kept up to date. This points to a haphazard system where there was no consistent means to ensure that each district was fully stocked with medical supplies.²⁹⁴ The case of Mr Somervale’s failure to declare the state of his medical supplies indicates that matters of this nature were largely governed by the personal feeling towards admin and paperwork of the local authority figure.

By controlling the entry of medical products into the Colony and in a way governing their subsequent distribution, the Committee and Inspector also sought to prevent unauthorised people practicing health care. Therefore, at least in theory, the authorities in Cape Town hoped to maintain some level of control over the health care system in the colony. With that being said, the surveys of 1830 show that there were a number of people practicing medical care without being officially supported by the colonial state. They received none of the chests that were distributed by the metropole officials and would have struggled to obtain the recognised tools of the European medical profession. This distinction would have served as another factor used to improve the image of Western trained practitioner within the Colony and separate them from the unlicensed indigenous health worker.

The regulations around who could and couldn’t be furnished with a medical chest, like the rules around who could practice as a physician or surgeon, can be seen as a trend within the wider attempt to make distinctions between what was genuine medical care and what wasn’t. In addition, it is clear that there was a level of disjuncture between attempts to professionalise the medical image by emphasising its unique knowledge as well as its reliability in times of need. When compared with the actions of numerous physicians and surgeons in the rural districts, the policies and attempts to regulate malpractice by the medical authorities, don’t match. Although there are a number of cases of country doctors reporting others for unethical actions, the disparity between urban and rural priorities is evident. Doctors and medical officials in Cape Town would have been reliant on a sound and respectable image in order to secure their position within local society. The professionalization of the ‘medical man’s’ aura was still under construction in Britain itself. Yet the attempts at regulation through legislation and proclamation at the Cape Colony show that a similar process was trying to be achieved within the colonial context. Yet again the attempts to mirror a type of order which was present in the metropole can be seen in the colonial context.²⁹⁵ Howard Philips has shown the need to propagate a sound image in order to ensure business was good in the more crowded medical market of Cape Town. In rural districts however, there was little or no competition due to the low numbers of official Western trained practitioners. As a result the need and

²⁹³ Dr James Barry. Letter regarding the medical supplies held by District Surgeon Somervale. 23 March 1822. Letter. MC vol. 27.

²⁹⁴ *Ibid.*

²⁹⁵ Kirsten McKenzie, *Scandal in the Colonies*, 1.

desire to maintain a reputable image in the countryside was not as important. This can partially explain some of the cases of medical malpractice that were brought to the attention of the authorities from the rural districts. The cases examined in this chapter tend to suggest that physicians, surgeons and district surgeons in outlying areas seem to have felt that they could act however they wanted without fear of repercussion for their livelihood. Such a trend indicates a different set of priorities to Cape Town based medics. Nevertheless it is also crucial to note the lack of consistent supervision present in the vast majority of the Cape Colony, whilst also raising the issues of personal rivalries and squabbles. Such matters may have led to a number of the cases, spoken about in this chapter, coming to light.

The use of newspapers as tools of control

The government in Cape Town appears to have tried to minimize problems of malpractice and overcharging by using the local newspaper, which it ran, in order to inform the population about what they should expect from doctors and other sanctioned medical personnel. This is epitomised in the proclamation published in *The Cape Town Gazette, and African Advertiser* on the 27th of September 1823, which was compiled by Dr Barry and signed off by Lord Somerset. In the directive, the regulations of practice were explained, after which a fixed pricing system for services rendered was given.²⁹⁶ By telling the citizens of the Cape what the medical practitioner's duties and rights were, they could look to hold them to account by a written directive. In this manner, the Cape Town based authority appears to have accepted the limits of its jurisdiction, but by providing the populace with such information it hoped that the medical system would, at least to an extent, self-regulate. This tool obviously had serious limitations, but in a colony with limited means to police legislation it was an interesting and valuable approach.

Issues hampering management

These topics directly highlight the spatial issues that hampered attempts by the centrally based authorities to maintain order amongst practitioners. Certain areas of the Colony appear to have been beyond quick, reliable contact and regulation. It is for that reason that a very informal, irregular and inconsistently dependable network of letters and rumours brought back to Cape Town, was the only means available. The difficulty in remaining in contact with rural districts also raises other important problems. Such a dispersed force of medical practitioners would have been difficult to keep up to date. As has been shown, figures like Barry attempted to keep their underlings medical knowledge in the country localities up to date. In this regard the use of the local newspapers (in addition to personal letters) appears to have been very important, as is evidenced by Barry's directives on Rabies in 1822. This is something also noted by Edmund Burrows, who mentioned Barry's "detailed control measures and treatment for publication in the press" in the case of a typhoid outbreak in 1824.²⁹⁷ However consistent and effective control would have been difficult given the obvious problems in the communication lattice that connected the central Cape Town offices to the districts. It also indicates some of the issues that would have arisen should a public

²⁹⁶ *The Cape Town Gazette, and African Advertiser*. Cape Town, September 27th 1823.

²⁹⁷ Edmund Burrows, *A History of Medicine in South Africa*, 81.

health emergency have arisen. Although the rabies example, spoken about in the previous chapter, shows us that there were attempts by local metropole medical authorities to warn district surgeons of public health threats, the bad attitudes of many of these individual figures suggests that they may have been ignored. Such issues are evident in rural districts in the 1820s when it came to determining whether or not a person had leprosy, a topic that will be spoken about at length in the next chapter. These matters reiterate many of the administrative problems inherent to the Cape context as well as the inability of the Cape Town authorities to exert an overarching influence over the constituencies.

Report back system and direct supervision

Certain examples from country districts show evidence of a required report back system in action. This was the case for the Uitenhaige 'trunk' during Barry's tenure as Colonial Medical Inspector. Yet this specific instance of a rural district surgeon sending information back to Cape Town can also give insight into the system that was supposed to be in operation throughout the Cape Colony. The district surgeon of the area, Mr S. Mc Cabe wrote to Barry saying: "Sir I have the honor to enclose you the quarterly return of the sick in the trunk to the 31st December 1824- Not having seen the form of return I have ventured to send one similar to what I have seen in the Hospital practice".²⁹⁸ Such an example indicates that Mc Cabe knew of his responsibility to send information on the state of the prisoners who were by default under his jurisdiction. This indicates the district surgeon's increasingly formalised role as a representative of the medical arm of the colonial state government, something which was heralded by Barry's directives of 1822.²⁹⁹ He was required to attend to the health of the prisoners within the state run jail, in addition to making the Cape Town authorities aware of their health. In the letter dated the 31st of January 1825 Mc Cabe informed the office of the Colonial Medical Inspector that "the Hoopeing Cough has been prevalent here during the last four months and still continues to a very violent degree".³⁰⁰ Yet the opening statements of Mc Cabe's letter of the 31st of January again points towards a disjuncture between policy and actual enforcement.³⁰¹ District Surgeon knew that he was required to send a quarterly statement to the offices in Cape Town, yet he did not have the correct form template in order to do so. It is clear that members who were directly employed by the local state had been made aware of their obligations. Yet due to the inefficiencies of the system people like District Surgeon Mc Cabe were unable to perform their duties properly.³⁰² However, it should also be noted that the reports sent in by Mc Cabe were very much anomalies in the grander scheme of the Cape's medical structure. Very few other examples of this nature can be found in the archives. This suggests that the other district surgeons were not compliant when it came to sending in their quarterly records from the institutions under their watch. Such an inconsistency can again highlight the lack of firm control exerted by the authorities from Cape Town over the country districts. This once again highlights the disparity between the regulation that was exerted by the government officials in Cape Town, and that which was

²⁹⁸ District Surgeon Mc Cabe. Quarterly return of sick at Uitenhage Tronk. 31 January 1825. Report. MC vol. 7.

²⁹⁹ Harriet Deacon and Elizabeth van Heyningen. "Opportunities Outside Private Practice before 1860", 155.

³⁰⁰ District Surgeon Mc Cabe. Quarterly return of sick at Uitenhage Tronk. 31 January 1825. Report. MC vol. 7

³⁰¹ *Ibid.*

³⁰² *Ibid.*

weakly maintained across the rest of the colony. Yet the fact that there was some form of policy in place that asked for a quarterly report on the health of prisoners points towards some level of desire from the metropole to stay up to date with the goings on in the rural areas. But, this only applied to certain bodies that were directly run by the colonial state. One can also observe the inability of officials like Barry to enforce such a regulated response. The fact that District Surgeon Mc Cabe did not have the correct form points towards a lack of a consistent two way dialogue with the Cape Town authority.

An example from the Cape Town context in 1825 illustrates the difference between the rural districts and the sector we would define as the metropole. The minutes of the Supreme Medical Committee reveal that they conducted regular visits to the two prisons situated in Rondebosch.³⁰³ The state of these institutions and of others like them in the immediate vicinity of Cape Town, appears regularly on the agenda of the Committee. Their report back from the 27th of December 1825 reveals the amount of detail and care they took during such inspections. They noted that there was not sufficient space set aside for the care of ill prisoners and that there was a “want of bedding for use of the prisoners” in these facilities.³⁰⁴ In addition they remarked on an interesting gap in the medical structure of these institutions as they observed that they had no designated medical officer or attendant.³⁰⁵ These were issues that the committee sought to remedy and they continued to conduct inspections over the coming years. Although their regular reports, present in the minutes of the Committee, at times illustrate a lack of change, the frequency of their visits do show some form of attempt to influence the conditions within the prisons. The same cannot be said for the state run institutions in the rural districts. Although there were some examples during Barry’s tenure of the medical authority making some inspections (the one to Hemel en Aarde serves as the primary example), these were few and far between. Furthermore, under the Supreme Medical Committee there appears to have been even fewer trips of investigation outside of Cape Town. This was despite the fact that the size of this regulatory body had increased exponentially having replaced the solitary position that Barry had occupied. The case of the Cape Town prisons highlights the geographic centralisation of government resources in the Cape Colony. The disparity in attempts to regulate through inspections indicates a failure, and perhaps unwillingness, to try and control the goings on outside of Cape Town.

Yet a section of the minutes held by the Supreme Medical Committee from the 29th of April 1826 illustrate that despite the frequent attempts to institute order in the local Cape Town institutions there was still little alteration. This is illustrated in the section of the report which revealed how many of the inmates were still subjected to dirty, damp and cold conditions. Such a clear failure to affect change was followed up by the admission: “Regret no alteration or improvement has taken place in this prison since the first report from the Committee”.³⁰⁶ This also evidences the expectations of the Committee whilst contrasting them with the actual

³⁰³ Supreme Medical Committee. Report on the state of Rondebosch prisons. 27 December 1825. Report. MC vol.1

³⁰⁴ *Ibid.*

³⁰⁵ *Ibid.*

³⁰⁶ Supreme Medical Committee. Minutes from meeting of the 29th of April 1826. 29 April 1826. Minutes. MC vol.1

reality of events and the situation on the ground. The Committee appears to have thought that their previous actions undertaken after the inspection of December 1825 would have translated into some form of tangible change. But their follow up in the first half of 1826 illustrates how little their authority was able to do. This in turn raises the issues of where authority could be exercised in the Colony. The case of the Cape Town prison shows that even in the areas where the offices of colonial governance were situated there was still little an inability to enforce the desired policies.

Regulating Medical Malpractice amongst Sanctioned Physicians

Various cases of medical malpractice within the Colony can be found in the records of correspondence held by the Cape Archives. These instances, which were brought to the attention of the authorities in a number of ways, can in turn indicate what level of dialogue there was in the Colony with regard to information of this nature. Furthermore, these examples can reveal how the established order sought to exert influence over those who were, at least in theory, under its control. Whilst keeping in mind the limitations of exceptional cases like these, their value should not be diminished. The reactions of different actors in the examples looked at, can indicate what was deemed normal, and the actions taken by the authorities can speak to the regulatory structures that were theoretically in operation. This in turn helps reveal the notions of power and control operating during this period.

The case of District Surgeon Becker

A particularly interesting and bizarre saga played itself out in a series of letters directed towards Dr Barry as Colonial Medical Inspector in 1823. This example raises a shocking occurrence of potential patient abuse committed by a district surgeon. Yet apart from providing a riveting and compelling read, the case also points towards specific attempts to regulate medical actions within the Colony. The instance relates to the supposed actions of Worcester's District Surgeon, Mr Becker. Charges were brought against him by the Landdrost of the constituency after it was alleged that he had provided the mother of a sick boy (both mother and child were in fact slaves) with a deadly poison which was supposed to treat his illness. The court proceedings and the apparent incident are related as part of the records held by the office of Colonial Medical Inspector and date from the 14th of May 1823 onwards. The testimony of 25 year old Irish born Dr William Munce in these records describes the series of events that led to him raising the issue before the Heemraden in Worcester. Dr Munce had gone to church on the morning of the 26th of March 1823 where after the service he was informed by a Mr Jan Mohr that the four year old son of one of his slaves was very ill.³⁰⁷ The boy, whose name was David had been sick for a lengthy period of time and Mr Mohr, informed Munce that he had previously informed the District Surgeon, Mr Becker, of his worrying condition in addition to requesting his attendance. Yet Mr Becker, despite his obligation which was clearly set out in the series of rules disseminated by Barry with the intention of governing the responsibilities and actions of District Surgeons,

³⁰⁷ Records of Worcester Court. Court Proceedings of case against District Surgeon Becker. Court records. 26 June 1823. MC vol. 7.

“had neglected to come”.³⁰⁸ As a result Dr Munce hastily accompanied Mr Mohr back to his property where he examined his paediatric patient. Although he failed to describe the specifics of the slave boy’s illness, William Munce did relate how he prescribed and administered a series of indicated drugs which he hoped would alleviate the condition. Having done so, he claimed that “the child got immediately better.”³⁰⁹ Content that the boy’s battle with illness would shortly be concluded Munce left the house and continued his normal duties.

However, after the next Sunday’s worship he returned to make sure of the child’s health but was shocked with what he discovered. Jan Mohr (the master) informed him that since his inspection (that of Munce) and departure the previous weekend, District Surgeon Becker had finally arrived, albeit on Saturday (the day before Munce’s follow up visit). He had during this call provided the child’s mother, a slave by the name of Philida, with a mysterious packet of white powder. His instructions were that half of the precipitate should be stirred into a solution, whilst the remainder was to be injected. Yet what shocked Munce, was that he strongly suspected the package to contain Cerussa Acetata which he described to be a “strong poison”.³¹⁰ After speaking to Philida in an attempt to discern some of the details regarding Becker’s instructions, Munce informed her master, Mr Mohr, to take possession of the potentially dangerous packet and refuse anyone access to it. Dr Munce described how, due to time constraints, he was unable to take “any further steps” at that point in time but that he made sure to follow up a couple of days later.³¹¹ Upon his return he was updated by Mr Mohr who explained to him that District Surgeon Becker had returned during his absence. He had allegedly asked Philida whether or not his instructions had been followed to which she replied that they had not and that the package was now in the possession of her master. This appears to have sent Becker into a rage and after bellowing at David’s mother he moved on to Mr Mohr. Surgeon Becker “repeatedly requested him to give him the powder again” perhaps suggesting that he knew he was potentially in a great deal of trouble should the package find its way into the hands of any knowledgeable authority.³¹² Munce then proceeded to weigh the substance in the presence of the town deacon and school principle (presumably as a witness). Having done this he divided the powder into two and gave one half to Mr Mohr. During the trial a portion of the substance was sealed and forwarded to the office of the Colonial Medical Inspector in Cape Town. The Chief of Justice “requested this powder be officially examined as to its nature, quantity and effects” after which a verdict on its identity could be provided to the court in Worcester.³¹³

In this case the lack of external regulation exacted over the rural district of Swellendam is apparent. Becker was the senior medical official of the region and it appears as if it was only by chance that Dr Munce had been able to unearth the suspected malpractice in which he was

³⁰⁸ *Ibid.*

³⁰⁹ *Ibid.*

³¹⁰ *Ibid.*

³¹¹ *Ibid.*

³¹² *Ibid.*

³¹³ Records of Worcester Court. Court Proceedings of case against District Surgeon Becker. Court records. 26 June 1823. MC vol. 7.

allegedly involved. Tip offs appear to have been the only means of curtailing misconduct by medical practitioners within the colony. On very rare occasions, authority figures like Barry would make trips to outlying districts to investigate suspected cases of negligence. This is evident in the story of the Hemel en Aarde leper Colony that will be dealt with in the fifth chapter. Yet inspections of this nature were clearly only made once a firm and believable accusation had reached a Cape Town office of governance from the rural district concerned. The instance of the denunciations brought against Mr Becker in 1823 is mirrored by those levelled against the District Surgeon of George in 1824 by the interesting and at times diabolical figure of Mr John Honey (the abhorrent actions of Honey in Cape Town will be dealt with in chapter 5). When these two very similar cases are placed alongside one another they can be used to indicate the lack of any consistent means by which the designated authority in Cape Town was able to control the actions of its practitioners. With that being said, the allegations against Becker did not hold up.

Dr Barry responded to the local Chief of Justice on the matter on the 1st of July 1823, clearly disturbed by the contents of the previous correspondence he had received. But it was not towards Becker that he displayed fury. Having analysed the contents of the package, Barry declared it to be acetate of lead; a form of medicine.³¹⁴ He concluded that the ill boy's mother had merely misunderstood the instructions of Becker and that he was not at fault.³¹⁵ He then proceeded to lambast the actions of Dr Munce saying: "It is painful to my feelings (but I am in duty bound so to do) to express my unfeigned horror and astonishment at the extraordinary conduct of Dr Munce the most illiberal and unprofessional that ever came under my notice".³¹⁶ He criticised Munce's slanderous accusations as both lazy and idiotic whilst having no scientific or logical grounding. Here the opinion of Dr Barry was central in the outcome of the case and it is clear that his opinion was highly valued by the court.³¹⁷ That being said, Barry's was just an opinion and the court still had the right to act as it saw fit. However, another letter written by Barry to the chief justice helps to clarify the position of the medical structure within Cape society as a whole. In 1824 the court attempted to subvert Barry's authority by publicly questioning his refusal to grant an apothecary licence to a Cape Town based trainee. Dr Barry responded to this challenge by saying that the courts could in "no way be a judge or lay down the laws respecting the medical profession in any of its branches".³¹⁸ Such a fiery response helps indicate the boundaries and jurisdiction of the healthcare field in the Cape Colony. Despite the fact that medical professionals were subject to the law and courts, as is evident in the case of Dr Becker and Dr Munce above, they did still operate within their own field and as such, were entitled to self-regulation. Barry, as the most senior medical official, felt it his duty to defend the rights of his profession by reiterating that it was his duty to determine who could and couldn't practice.

³¹⁴ Dr James Barry. Reply to Chief of Justice regarding contents of envelope. 1 July 1823. Letter. MC vol. 27.

³¹⁵ *Ibid.*

³¹⁶ *Ibid.*

³¹⁷ Dr James Barry. Letter to Brink regarding the actions of the chief of justice. 24 September 1824. Letter. MC vol. 27.

³¹⁸ *Ibid.*

What is interesting to note from the example of this particular case is the role that the Colonial Medical Inspector played in the actions of the court. A small sample of the suspect substance that was brought before the court was sent to the Dr Barry for inspection. It was his job to determine and report on what its true “nature, quantity and effects” were.³¹⁹ Dr Barry was viewed as the only figure imbued with enough knowledge and medical authority to draw conclusions as to the actual essence of the substance. In the context of networks we can observe that Barry was in fact a mobile nexus of knowledge whose officially sanctioned role as the Colony’s premier medical man placed him at the centre of the intra colony web. Such an instance indicates that the notion of ‘metropole’ can perhaps be applied to an individual whose unique position permitted their functioning as a node of both authority and information. What is also interesting is how the justice system in this instance viewed the necessity of a web in order to perform its function. Their distribution of the powder to Barry makes it evident that the *Landrost* was aware of the role that the medical fraternity needed to perform with regard to therapeutic malpractice. The legal authority utilised its connection with the office of the Colonial Medical Inspector in order to obtain the correct authority to act on a case of this nature. In this manner, the court acknowledged both the jurisdiction of medicinal practitioners as well as the means by which it was needed to be employed in order to obtain their assistance. Such a link appears to conform to Zoë Laidlaw’s conception of the “formal network” where each body recognised the role of the other in the dialogue that took place.³²⁰ Yet because this particular instance reveals how there were in fact streams of ideas and authority within a colony, the notion of ‘metropole and colony’ clearly needs some alteration. The relationship on this occasion also appears to have been more complex than simply metropole and rural. Instead there seems to have been a more intricate exchange of information.

The case relating to Mr Becker’s alleged attempt to treat the slave boy David with poison can be used to indicate the level of medical services and care available in the Cape Colony’s outlying districts. In the case of David’s illness, he had gone for an extended length of time without attention from any medical official. This was despite the fact that his master had made requests for such a service directly to the District Surgeon, in addition to the fact that the District Surgeon was supposed to be governed by a binding code to offer care no matter the time of day it was requested.³²¹ Although this lack of attendance could be attributed to Becker’s reluctance to see the boy, the fact that David’s master was only able to find another practitioner on the Sunday when people congregated for church, points towards the lack of any abundance of appropriate health care workers in the vicinity of Swellendam.

A severe head injury

The saga involving the charges brought against the District Surgeon of George by Surgeon John Honey is a lengthy one but its content is both fascinating and useful. Honey, who was a

³¹⁹ Records of Worcester Court. Court Proceedings of case against District Surgeon Becker. Court records. 26 June 1823. MC vol. 7

³²⁰ Zoë Laidlaw, *Colonial Connections*, 16.

³²¹ Dr James Barry. Instructions for the District Surgeon of George. 19 April 1822. Letter containing proclamation of instructions. MC vol. 7

ship surgeon aboard *The Mary* which made the voyage between Britain and the east, entered the colony by accident in 1824. *The Mary* was shipwrecked off the coast of Mossel Bay but Surgeon Honey was able to make it to shore where he took up temporary residence in the nearby town of Mossel Bay. It was here that he first appears in the public record after he initiated a case of negligence against the local district surgeon in the office of the Heemraden. The narrative of the subsequent court proceedings were forwarded to Cape Town, as the Landrost of George hoped that the Colonial Medical Inspector might provide him with his “medical opinion” on the testimonies included.³²² It is from these testimonies that we can determine why it was that Honey felt it necessary to report the District Surgeon, and the subsequent reply from District Surgeon Somervaille illustrates his attempted defence.

Honey’s attendance had been requested by the so-called ‘President of Mossel Bay’ Mr Acker who desired that he should inspect a wounded man whose condition had visibly deteriorated. The patient concerned, had allegedly been hit in the head by a stone that was thrown by an unnamed resident of the town. Upon Surgeon Honey’s contact with the patient he noted that he had “been labouring under a violent contusion across the forehead for a number of days from a blow receiving by some person”.³²³ He observed the presence of a very deep cut in the man’s head which resulted in the exposure of his brain matter.³²⁴ This was in addition to the discovery of a quantity of air within the wound, and the presence of rotting matter in the afflicted area. After completing his inspection he concluded that the Moor’s (the records only refer to the man as the ‘Moor’ or ‘the Moor Saubden’) life was “now in imminent danger through culpable neglect”.³²⁵

It was the words ‘culpable neglect’ which appears to have prompted the local court to take this case seriously. They sought greater clarity from Honey when he was interviewed in front of the Landrost of the area J.W. Van der Piet esq. He was asked what he meant by the phrases “culpable neglect” as well as “culpable homicide” which appeared in his report compiled on the 11th of September 1824. He explained the events according to his knowledge; beginning with the first time he was informed of the man’s wounds on the 28th of August, the day after the injury had occurred. The president of the town subsequently cancelled his request for assistance from Honey having been informed that the District Surgeon of George was in town on business. As a result he would acquire the opinion of District Surgeon Somervaille as to the condition of the Moor instead (a man who was presumably his servant or slave). Three days later Honey was again contacted by President Acker, yet this time he did not cancel his attendance. Honey declared that he had been informed by Mr Acker that Somervaille had failed to inspect the wound of the injured man and had merely placed a handkerchief over the site which was bleeding. He had then instructed Acker to leave the make shift bandage over the affected area for no less than three days.³²⁶ It was only after this allotted period of time

³²² Heemraden of George. Proceedings of case of neglect of duty brought against District Surgeon Somervaille. 3 December 1824. Court Proceedings. MC vol. 7.

³²³ *Ibid.*

³²⁴ *Ibid.*

³²⁵ *Ibid.*

³²⁶ Heemraden of George. Proceedings of case of neglect of duty brought against District Surgeon Somervaille. 3 December 1824. Court Proceedings. MC vol. 7

had passed that Honey was summoned to make his own inspection and survey the afflicted. Here he discovered the wound to be in a deplorable state with “a high degree of inflammation accompanied by a great degree of” rotting matter.³²⁷ He attributed these factors to the fact that the gaping wound had been unattended for such an extended period of time. It was due to these reasons that Honey declared the actions of Somervaile as being stained with ‘culpable neglect’. Due to the consequences of his injuries and presumably the alleged lack of treatment he had received, the Moor Laubder died shortly after Honey’s visit. Yet, further details as to the injuries sustained by the deceased patient can be found in the death certificate filed by Somervaile on the 11th of September.³²⁸

As was required by law, District Surgeon Somervaile completed the death certificate. During his inspection of the deceased man’s skull Somervaile observed that there was “a wound about two and a half inches in length upon the forehead of an oblique direction upwards and outwards”.³²⁹ Upon proceeding with his survey of the Moor’s head he discovered that there was a severe skull fracture which was pushing into the grey matter of the brain itself. Although he noted that the left side of the brain appeared to be sufficiently intact, “the right hemisphere was in a state of inflammation and ulceration” with numerous spots of gangrene visible to the naked eye.³³⁰ He finally noted that there was a “colourless fluid” to be found in the “lateral ventricles” of the brain.³³¹ This subsequent autopsy of the deceased indicates just how much Somervaile had missed in his prior interaction with the Moor on the 28th of August. Yet it was Somervaile’s court-based response to the allegations of Honey that give further insight into the details surrounding the events that culminated in the death of the Moor and the subsequent inquiry into a case of negligence.

His testimony was given in George on the 24th of September where he explained that he had been in Mossel Bay on the 28th of August “to attend to sales”.³³² It was there that he was called upon by “the Lascar in question” for assistance in the treatment of his bleeding head wound.³³³ Somervaile insisted that due to the nature of his travel arrangements he was without any adequate medical equipment to treat the wound or properly bandage it. Furthermore his personal account admits that he offered no treatment to the injured man and in fact he left the handkerchief atop his head that was already being used as an impromptu bandage. However, Somervaile noted that upon his inspection of the patient he “appeared apparently well” and as a result he felt it unnecessary to make a fuss over what seemed to be a minor and superficial injury.³³⁴ His story goes on to profess that he had put provisions in place in order for the patient to receive treatment should his condition worsen. Yet on his return to the town of Mossel Bay on the 13th of September, Somervaile was shocked to find the supposedly lightly injured Moor deceased. He then proceeded to conduct the post-

³²⁷ *Ibid.*

³²⁸ *Ibid.*

³²⁹ *Ibid.*

³³⁰ *Ibid.*

³³¹ *Ibid.*

³³² *Ibid.*

³³³ *Ibid.*

³³⁴ *Ibid.*

mortem. But sections of his account given to the court, unlike the certificate produced on the 13th, aimed to deflect any wrong doing away from his own inaction. In fact his testimony attempts to lay the blame for the death of the Moor squarely at the feet of Surgeon John Honey, the man who had accused him of negligence.

Firstly he pointed out that Honey had been provided with a medical chest by the Cape medical authorities and was better equipped to treat members of the Mossel Bay community. Secondly, he alleged that Honey was at the time living in President Acker's house and was, as a result, the most geographically convenient member of the medical fraternity able to check on the state of the injured man.³³⁵ He then proceeded to insult Honey's abilities in relation to his attempts to sew the wound closed. He remarked how his "gross inattention and apparently want of surgical skills in this case" were blatantly apparent.³³⁶ He concluded with a shameless statement which sought to brand Honey as the person solely responsible for the death of the patient saying: "it was his duty to try and as he has not done so I hold him responsible for having acted to the contrary."³³⁷ Although the response of Barry to the request for his opinion does not appear to be available, one can assume that he sided with the account put forward by Honey. This is due to the fact that Somervale's name disappears from the list of District Surgeons after this year. In addition Surgeon Honey was given a formal posting within the Colony as the Chief of the Somerset Hospital's lunatic asylum. This was despite Honey's claim that his certificates of qualification had been lost in the shipwreck of *The Mary* and that there was no means of determining whether he was in fact a genuine medical man. His attack on Somervale's conduct (or lack thereof) appears to have impressed Dr Barry to such an extent that an exception was made and he was allowed to enter into the local fraternity unchallenged.

This case again highlights the lack of medical coverage throughout the dispersed Cape Colony. Before the ship wreck of *The Mary* there would have been no permanent surgeon or physician present in the town of Mossel Bay. Although there were more than likely other health care practitioners in the area, they were not officially sanctioned to perform the required duties. District Surgeon Somervale appears to have been the only medical doctor available within riding distance of this town. The method of sending a letter requesting attendance was the only means, and a time consuming one; available to the inhabitants of particular towns. It is also interesting to note that when a medical practitioner was called away from his base area of operations to see a patient in an outlying area the rest of his jurisdiction would have had severe difficulty contacting him. Furthermore, even when there was a practitioner available, people seemed reluctant to use this service and instead opted for the treatment offered by the district surgeon even if that meant waiting.³³⁸ This indicates that the consumers of medical treatment were aware of the hierarchy present within the local

³³⁵ *Ibid.*

³³⁶ *Ibid.*

³³⁷ *Ibid.*

³³⁸ Heemraden of George. Proceedings of case of neglect of duty brought against District Surgeon Somervale. 3 December 1824. Court Proceedings. MC vol. 7

medical structure and as a result wanted their family or servants to be treated by the highest ranking physician possible.

The case of Somervale also points towards the lack of any real standard of what was deemed appropriate care and what was not. As a result the figure of Dr Barry as the Colony's preeminent medical figure, was needed in order to ensure that the correct judgment was handed down in the court. We can observe that there was little formal written standard against which the action or inaction of the practitioner could be contrasted. The only example we find is the list of directives sent by Barry to the numerous district surgeons under his command. This set of orders attempted to remind the District Surgeons in writing of their duties and we can assume that he used this written record in order to assess whether Somervale was guilty of medical neglect.

The distribution by Barry of the set of rules for district surgeons indicates an attempt to impose an outside will upon these previously untouched positions. But the actions of the district surgeons in the cases of negligence and malpractice spoken about in this chapter indicate that his will, was far from being adhered to. In addition Barry's attempted inspections to places like Hemel en Aarde in 1822 (this will be dealt with in the next chapter), indicate that the informal network of maintaining contact with the peripheries of the medical system was failing to maintain sufficient order.³³⁹ Dr Barry realised that the only means by which he could effectively regulate the actions of practitioners was to make impromptu visits. Although these inspections appear to have worked in some cases, the sheer scale of the colony meant that it was impossible for one man to keep up to date on all the medics and charlatans operating in the region. In a way Barry's attempt to regulate the actions of his subordinates and far flung institutions through inspections reflects a similar approach that was adopted by the Colonial Office in the years following the end of the Napoleonic Wars. He utilised a review process like that of commission system which saw agents like John Bigge and Colonel Colebrooke traveling to the colonies of the Empire.³⁴⁰ Yet like the commissions, his strategy was fraught with issues. The scale of his jurisdiction was too great to ensure compliance and the lack of any consistently reliable network of knowledge, meant that personal follow ups were necessary to maintain an element of fear in the previously inspected areas. It is also interesting to note that once the position of Colonial Medical Inspector was replaced by the reinstated Supreme Medical Committee, inspections into areas outside Cape Town appear to have ceased. Although the Committee made inspections within the confines of the Colony's metropole, there was little attempt to maintain Barry's method of personally visiting unsuspecting districts. Instead they relied solely on the system of 'tip-offs' and letters received from dissatisfied recipients of care or the reports of outraged practitioners to maintain some level of grasp on the goings on within the medical structure of the Colony.

³³⁹ Zoë Laidlaw, *Colonial Connections*, 16.

³⁴⁰ Zoë Laidlaw, *Investigating Empire*, 751.

“A most serious accident”

Another instance of negligence that was brought to the attention of Barry’s office in 1824 again indicates the lack of an efficiently staffed health care system in the Cape. A man by the name of H.G. Mientingh wrote a letter of complaint to Dr Barry on the 17th of November with regards to the conduct of Dr Price, a physician in the Caledon area. Mientingh described how his son had been travelling and at four o’clock on a Sunday afternoon he had arrived at the house of a Mr T.C. Fawies.³⁴¹ After his arrival at this location near what Mientingh describes as the Londer Lind River, “a most serious accident” occurred which left his son severely injured, although no specific details were given.³⁴² Mr Fawie proceeded to write a letter asking for immediate assistance from Dr Price who resided in Caledon. He then dispatched said letter via a messenger (whom Mientingh described as being a boy). Yet the desired emergency medical help did not arrive throughout the night and the messenger returned the next morning alone. He in turn described how he had arrived “between twelve and one o’clock or there about that night at Doctor Price’s house with Mr Fawies letter”.³⁴³ Price had then proceeded to read the letter after which he ordered the messenger “to make him some coffee”.³⁴⁴ The messenger was then instructed to prepare the doctor’s horse for travel. However four hours passed before Price re-emerged only to inform the messenger to return to his master and inform him that he had “gout in his knee and two of his fingers and if his master wanted him, to send a wagon”.³⁴⁵ None of the above was transmitted to Fawies in writing. Mientingh then proceeded to explain that his son had tragically succumbed to his wounds on Thursday morning at 7 o’clock of that week. It is clear that neither Dr Price nor any other medical practitioner attended to the grievously injured boy throughout the ordeal.

Yet again we find an example of a doctor in the rural district dismissing his legally defined responsibility to provide care to his constituents. This common trend must be attributed to a feeling that there would be no consequences for their refusal to perform their role. Despite the widely circulated directives emanating from the central offices of the Capes medical authority, the Colonial Medical Inspector, there was no care afforded to the mortally wounded child. The events surrounding the death of Mr Mientingh’s son like those relating to the accusations levelled against District Surgeon Becker, again suggests a lack of medical practitioners in rural districts of the Cape Colony. This equated to a lack of authorised medical control as the government sanctioned practitioner was widely dispersed. The procedure followed by Mr Fawies to request assistance shows just how difficult and timeous it was to obtain speedy treatment. The soonest that Mientingh thought it would have been appropriate for Dr Price to arrive in order to attend to his son was “4 or 5 o’clock” the morning after the accident had occurred. Such a tragic example reveals one of the central flaws that characterised the medical health system in such a remote part of the Colony.³⁴⁶ The network that could allow for the attendance of the appropriate practitioner was handicapped

³⁴¹ Mientingh, H.G. Letter to Barry reporting negligence of Dr Price. 17 November 1824. Letter. MC vol. 7

³⁴² *Ibid.*

³⁴³ *Ibid.*

³⁴⁴ *Ibid.*

³⁴⁵ *Ibid.*

³⁴⁶ *Ibid.*

by among other things distance and communication methods. Furthermore, the issues that accompanied the means of acquiring help meant that doctors who felt no need to attend to the needy could fob off the request and then deny any knowledge of the event. Because Doctor Price made no written acknowledgment that he had received a particular appeal, he could rebuff attempts to prosecute him if any authority ever got wind of a certain incident.

Master Groenewald and the death of Rachel

Yet it is not only from cases of medical malpractice and negligence committed by the systems doctors, that we can gain insight into the role and structure of the Cape health structure. A case relating to the suspected murder or death via negligence of a slave girl by the name of Rachel again reveals how the physician fitted into a wider system of prosecution and therefore society's means of controlling action.³⁴⁷ In this way we can see how the recognised medical practitioner was viewed as a necessary cog in the local judicial when it came to specific cases. This in turn helps to reveal certain aspects around the perceptions of the part that a health practitioner played in this colony's society. The case which attempted to determine how it was that a presumably healthy child slave died at such a young age was eventually brought to the attention of the Supreme Medical Committee who wrote a letter of response on the 5th of December 1825.³⁴⁸ The reaction to the particulars of the episode reveals the procedure that was followed in the course of the court proceedings but also a certain dichotomy amongst the level of authority within the medical system. It emerged that the local court of Swellendam had sought to investigate the involvement of Rachel's master Mr W Jacobus Groenewald in her death. The process followed that the local veld Cornet, a man by the name of Gabuil Le Barne, was to examine the body which he did³⁴⁹. It was his report that prompted the subsequent investigation into the conduct of the Mr Groenewald, however the Veld Cornet was not a medical official. As a result, the court called on the services of the local district surgeon T.J. Mehoney to conduct a post mortem on the body to determine the cause of the young girl's death.

In this instance the role of the medical practitioner within the society's structures of administering justice and maintaining order becomes clear. Mehoney, accompanied by the Heemraden travelled to the residence of Mr Groenewald where they ordered that the body of the deceased slave girl be exhumed from the earth.³⁵⁰ Mehoney then proceeded to conduct his autopsy and examination of the disinterred body. He noted five key points and a sixth remark on the findings from the interior dissection that were crucial before giving his judgement on the cause of death. His report reads: "1st on the left side of the forehead and outer back of the head, some scabs and wounds, 2nd on her arms the marks of having her bound, because the shin was chafed through by cord on the thong which she must have been bound, 3rd the wrist of the right hand much swelled, 4th several wounds on her posterior and legs and her loins

³⁴⁷ Secretary Court of Justice. Inquest into death of female slave child Rachel. 1 December 1825. Court Proceedings. MC vol.1

³⁴⁸ *Ibid.*

³⁴⁹ *Ibid.*

³⁵⁰ Secretary Court of Justice. Inquest into death of female slave child Rachel. 1 December 1825. Court Proceedings. MC vol.1

swelled, 5th the ankles of both legs deeply wounded before and behind, whereby the muscles were bare”.³⁵¹ His paragraph written after the dismemberment of the body, determined that there were no “internal parts found injured” but that the wounds he opened on the girls legs and posterior “were found black”.³⁵² His conclusion stated that in his professional opinion “said child died from the consequences resulting from the extensive mortification of her back and loins and the evident exhausting pain she must have suffered from the wounds upon her legs and arms”.³⁵³ It was on this account that Jacobus Groenewald was imprisoned by the local court for his presumably paramount role in the death of Rachel. Nonetheless this was not the end of this saga.

The case was forwarded to the Court of Justice in Cape Town after the findings of the local Swellendam court. Here we see both the hierarchy of the courts as well as the hierarchy of the medical system in the Cape, as the Court of Justice proceeded to send the findings of Mehoney on to the Supreme Medical Committee for their opinion. The members of the Committee, after reading the report of District Surgeon Mehoney, declared that they were “unanimously of opinion that” his conclusion was in fact incorrect.³⁵⁴ They felt that although the autopsy hinted at the prospect “that much cruelty may have been practiced on the above child”, factors such as the lack of internal injury and the length that the body had been buried amongst others meant that no definitive opinion on the matter could be reached.³⁵⁵ The Supreme Medical Committee’s rebuttal of Mehoney’s judgment indicates how the internal structures of the Cape medical system could be used to supersede the opinion of somebody who had actually seen the body first hand. Yet a letter received by the Supreme Medical Committee from Groenewald dated the 14th of March 1826 indicates that he was still imprisoned. No mention is made of the charges he was being held on, but his letter requested clemency and exemption from punishment on account of his ailing health.³⁵⁶ Despite the fact that the Supreme Medical Committee had determined that he could not be held directly responsible for the death of Rachel, Groenewald detained by the Swellendam authorities three months after the Committees professional response. This suggests that he had either been detained on other charges relating to the death of Rachel, or the local court had merely ignored the opinion of Supreme Medical Committee. Such a case indicates a level of disjuncture between the central authorities based in Cape Town and those in the outlying districts.

Internal regulation

What is interesting to note in all of the above cases is that there appears to have been, at least in theory, no distinction placed on the care that should be afforded to the medically needy. Three of the four cases involved slaves and where treatment was deemed to have been withheld by the practitioner concerned, a complaint was laid to some authority (be it the

³⁵¹ *Ibid.*

³⁵² *Ibid.*

³⁵³ *Ibid.*

³⁵⁴ *Ibid.*

³⁵⁵ *Ibid.*

³⁵⁶ Jacobus Groenewald. Letter requesting release from prison on account of health. 14 March 1826. MC. 1.

courts, the Supreme Medical Committee or Barry as Colonial Medical Inspector). Such a trend points towards the notion that there was supposed to be some form of non-biased health care provision within the Cape Colony regardless of race or social standing. No distinctions were made in Barry's directives of 1822 with regards to who was entitled to care at any time of day or night.³⁵⁷ The fact that a number of practitioners contravened such a conception is interesting. Yet the indignation and anger expressed in the correspondence to the authorities where there was a feeling that the right of a patient had been contravened, is fascinating. This fits into the emerging trends of humanitarianism that were sweeping through the Empire and the written directives of Barry in 1822 which called for a more humane regulation of health care places him within this development. In addition, the particular cases of slave mistreatment brought to the attention of authority figures, complies with the trend identified by Harriet Deacon in the 1820 period. She indicates that such cases point towards British attempts to lessen the brutalities of Cape slavery.³⁵⁸ Although the bulk of the medical maltreatment cases appear to have been raised by other physicians, the example offered up by the death of Mr Mientingh's son indicates that there was some sense of 'moral economy' amongst the common settler.³⁵⁹ Furthermore in the alleged attempt to poison the slave boy David, his master appeared to have an understanding that his illness required treatment and that he was entitled to seek it out, even if that meant contacting another physician. One therefore gets the sense that at least in some parts of the colony, people were aware of their right to medical care from sanctioned officials. The degree to which they sought such care, is another story. The action taken against Dr Price by Mr Mientingh also suggests that people knew that there could be some recourse offered by state institutions when they felt some injustice had been committed.

The prevalence of physicians reporting other physicians is interesting in a number of the accounts available in the Cape archives. This again indicates an attempt to establish a sense of respectability around the recognised medical profession. Although John Honey can hardly be seen as a man of many morals (as is indicated by his treatment of the 'lunatics' at the Somerset Hospital), the fact that he reported his superior for negligence indicates that he felt some boundary had been crossed. This is mirrored by the subsequent prosecution that Honey experienced over his brutal 'treatment' of Cape Town's insane, where he was investigated by the Medical Committee for violating a rudimentary unspoken code (This case will be dealt with in depth in the next chapter). The instance whereby Dr Munce sought to unearth the potentially criminal actions of his superior, District Surgeon Becker, also points towards some attempts by members of the fraternity to self-regulate the actions of their colleagues. Yet in all the cases involving alleged medical negligence or malpractice there was no means close by in the rural district for the Cape medical structure to self-regulate the actions of its members. It was instead either reliant on a message or rumour reaching the central offices in Cape Town, or the courts intervening and thus making it a criminal case.

³⁵⁷ Dr James Barry. Instructions for the District Surgeon of George. 19 April 1822. Letter containing proclamation of instructions. MC vol. 7

³⁵⁸ Harriet Deacon and Elizabeth van Heyningen, "Opportunities Outside Private Practice before 1860", 155

³⁵⁹ Mientingh, H.G. Letter to Barry reporting negligence of Dr Price. 17 November 1824. Letter. MC vol. 7

The role of the Cape Town medical officials in acting as the Colony's authority on medical matters is more evident in another case that was forwarded to the office Dr James Barry. Edmund Burrows makes reference to this same case in revealing how the procedure of post mortems conducted in the colony had not changed in over 100 years.³⁶⁰ Such an observation reveals a level of continuation despite the Cape's change in ownership. It could also speak towards a type of medical tradition that may have been passed down through the ages. Yet Burrows' analysis of this instance does not delve into the further drama revealed by the response of Dr Barry to certain particulars of this case.³⁶¹ His dialogue with the Stellenbosch court reveals an interesting conflict that had arisen between two practitioners in the area. The particulars of this dispute can in turn reveal aspects of the medical hierarchy present in the colony. But, yet again this case like many others highlights the lack of regulation as well as the 'free for all' nature of the Cape Colony's medical structure in the rural districts. The case which occurred in late 1822 saw two rurally based doctors (with one being the District Surgeon of Stellenbosch) fighting over whose certificate of death was most accurate for use by the local court.³⁶² Yet again the situation involved the death of a slave under dubious circumstances. The certificates of death produced by doctors Shand and Tardieux differ from one another in that the one cites a severe flogging as the cause of death.³⁶³ This disparity is compounded by the haphazard manner with which Dr Tardieux conducted his autopsy and the absurd conclusions he reached. Barry having been sent the statements of both doctors, first noted that Tardieux was not the district surgeon of the area. This he immediately cited as an issue. Due to this fact he had no place performing the autopsy. Such a duty was supposed to have been performed by Dr Shand who was the District Surgeon of Stellenbosch and the fact that Tardieux appears to have acted outside his scope of duties seems to have irked Dr Barry greatly³⁶⁴. This instance appears to again indicate the presence of some standard that should have been kept to, yet due to the nature of the medical structure it was not enforced.

The next issue cited in Barry's response, related to the fact that the dates on Tardieux's certificate did not correlate. Upon examining the evidence Barry determined that Tardieux had conducted his inspection of the deceased a full "7 or 8 days after Dr Shand's examination".³⁶⁵ Such a time difference suggests a lack of communication between practitioners but also the courts and medical personnel. Why it was that Tardieux was even permitted to conduct a post mortem so long after the initial and official one, was bizarre. However it does yet again indicate the haphazard nature of rural Cape society and the lack of effective dialogue between relevant people and offices. Yet it was his actions as a medical pathologist that appears to have caused the most problems in Barry's mind. Tardieux stated in his report that "bruises cannot occasion death only cuts" and due to this fact, he did not open

³⁶⁰ Edmund Burrows, *A History of Medicine in South Africa*, 56.

³⁶¹ *Ibid.*

³⁶² Dr James Barry. Reply to Court on the validity of certificates produced by Dr Shand and Dr Tardieux. 22 November 1822. Letter. MC vol. 27

³⁶³ *Ibid.*

³⁶⁴ Edmund Burrows, *A History of Medicine in South Africa*, 56.

³⁶⁵ Dr James Barry. Reply to Court on the validity of certificates produced by Dr Shand and Dr Tardieux. 22 November 1822. Letter. MC vol. 27

up the body.³⁶⁶ Barry's response commented on the absurdity of this claim, after which he used the example of an orange rolling on a table to illustrate his point that Tardieux was "most incorrect".³⁶⁷ He then pointed out that Tardieux's conclusion that the slave had not died as a result of the flogging but had instead succumbed to bulimia was completely irrational especially seeing as the stomach of deceased had not been opened.³⁶⁸ Dr Barry's subsequent reference to District Surgeon Shand's certificate of death was remarkably short and he concluded that his report seemed "a true and professional statement" that could be depended upon.³⁶⁹ His dismantling of Tardieux's attempt at a post-mortem left both the Doctor's image as a professional and his assertion that the slave had not died as a result of excessive abuse, in tatters. Barry's final words on Tardieux were that his report was "ignorant and contemptible if not vicious".³⁷⁰ Thus Burrow's assertion that there was a continuation of the medical autopsy procedure within the Colony, is perhaps flawed. The differences in the manner that Shand and Tardieux conducted their respective investigations into the slave's death are striking. Such a stark contrast in approaches by two practitioners within the same district to what should have been the same process, suggests the lack of an enforceable standard across the Colony.

From such cases we can see how the local authorities attempted to use the networks (previously described) to maintain a semblance of order and standard. The effectiveness of these attempts was varied and for the most part highlights the inability of the Cape Town based authority to exercise consistent order through such channels of dialogue and authority. It is also clear that there was a great degree of freedom when it came to movement. Individuals such as Surgeon Honey were able to traverse the globe despite an apparent lack of medical skill. This reiterates the degree of independence granted to certain people within the structures of the British Empire, a fact made clear in Kirsten McKenzie's examination of the *Imperial Underworld*.³⁷¹ Yet how a system within this context responded to unique types of illnesses is still uncertain. By looking at the response to two unique and feared conditions, an effort can be made to determine how the Cape medical body was able to react to issues of public health. As a result the next chapter will explore the conditions of lunacy and leprosy within the context that the thesis has established.

³⁶⁶ *Ibid.*

³⁶⁷ *Ibid.*

³⁶⁸ *Ibid.*

³⁶⁹ *Ibid.*

³⁷⁰ *Ibid.*

³⁷¹ Kirsten McKenzie, *Imperial Underworld*, 35.

Chapter 5: A case study of incompetence and neglect- Leprosy and Lunacy at the Cape during the 1820s

Mental health care

The classification and care (or lack thereof) offered to the mentally insane and deranged has been a contentious issue throughout history. The way that the ‘lunatic’ has been seen and viewed by societies appears to have been fluid and subject to alteration and evolution. In response to these very misunderstood conditions, methods of treating and managing the afflicted have arisen. Yet, how this discipline of care developed and adapted to the unique nature of the Cape Colony has been largely overlooked in the 1820s. It is appropriate to explore this topic within this period, whilst keeping in mind the factors and issues raised early in this thesis. As we will see, factors relating to power and authority factored heavily into the response of the local authorities to this type of medical condition. The specific lens on lunacy can therefore serve as a specific case study. In order to understand the state of mental care at the Cape it is important to first assess the general perceptions and treatments of lunacy within a wider context. It is consequently necessary to examine, in a very brief manner, the developments of western psychiatric knowledge and care up until the 1820s.

The context of mental health care

Despite there being forms of asylums before the enlightenment, these were very few in number and they did not seek to provide treatment or care.³⁷² Instead they functioned effectively as prisons where ‘lunatics’ who were considered especially dangerous or troublesome could be confined for the greater good of the community.³⁷³ The majority of the insane therefore remained the responsibility of their respective families.³⁷⁴ As a result, people developed their own means to handle the burden of their insane family member, yet these approaches were largely shaped by the overriding ideas that surrounded conditions of lunacy. Before the supposed ‘Age of Reason’ the afflictions of madness were considered a divine punishment in a similar manner to the way leprosy was perceived.³⁷⁵ Those who presented with symptoms of mental derangement were labelled as sinners who were deserving of their condition.³⁷⁶ In fact, Michel Foucault proposed that the idea of the ‘lunatic’ supplanted the image of the leper in European consciousness by the late medieval era.³⁷⁷ The apparent decline in the 1300s of the number of people suffering from leprosy meant that the condition could no longer stand as the ultimate representation of God’s wrath. Yet the “structures” and perceptions of this ultimate outsider still remained, and although sexually transmitted

³⁷² Edward Shorter, *A History of Psychiatry: From the era of the asylum to the age of Prozac*, (New York: Wiley, 1997), 4.

³⁷³ The terms lunatic, maniac and leper were the terms used during this time period.

³⁷⁴ Michael Macdonald, *Mystical Bedlam: Madness, anxiety and healing in seventeenth century England*, (Cambridge: Cambridge University Press, 1981), 3

³⁷⁵ Michel Foucault, *History of Madness*, 8.

³⁷⁶ Anne Digby, *Madness, morality and medicine: A study of the York Retreat, 1796- 1914* (Cambridge: Cambridge University Press, 1985), 1.

³⁷⁷ Michel Foucault, *History of Madness*, 5.

diseases temporarily filled the void, the mad were to inherit the mantle previously given to the leper.³⁷⁸ The insane man or woman was thus looked down upon with hatred and a lack of compassion. Families would often seek to confine those for whom they had the responsibility with chains, and order was enforced through the use of violence.³⁷⁹ Yet, when the family rejected their responsibility and cast the ‘lunatic’ out, they were forced to fend for themselves and consequently “swelled the streams of beggars that wandered the roads of early modern Europe”.³⁸⁰

The era of the renaissance brought some changes to the representation and perception of the mentally insane. By the 1600s, a more complex and fractured perception of insanity appears to have prevailed.³⁸¹ As opposed to being a solely religious interpretation, many started to see the affliction of madness as a combination of “magical, religious and scientific concepts”.³⁸² Such changes added further possibilities as to how and why someone could be ‘insane’. A number of historians and scholars have used contemporary literature of the renaissance period to note the change in perceptions of the insane. Despite the emergence of counter arguments to the general religious connotations of madness, treatment remained largely non-existent. But marked increases in Europe’s population presented the tradition of the mad being a familial responsibility with problems.³⁸³ In addition, the development of European economies around capitalist frameworks meant that members of the traditional family structure had to adapt in order to survive.³⁸⁴ This, according to some historians, meant that ordinary people no longer had the time to care for mentally ill relatives.³⁸⁵ As a result, the state had no option but to provide alternative accommodation for the increased numbers of mentally ill people that emerged as a by-product of the upsurge in population. The sixteenth and seventeenth centuries therefore saw a marked increase in the number of public institutions where the insane could be confined. This was accompanied by a concurrent rise in the number of private institutions where families could deposit their insane at a price.³⁸⁶ It was these new ‘asylums’ that led to the removal of the insane “from their normal social surroundings” on a grand scale.³⁸⁷ However, despite the emergence of a large number of institutions for the insane, it was only in the age of the Enlightenment that a widespread and concerted effort was made to secularise the conditions of madness.³⁸⁸ This meant that public and private asylums in the pre-Enlightenment era effectively functioned as prisons where little means of care was provided for the ‘incarcerated patients’.³⁸⁹

³⁷⁸ *Ibid*, 6.

³⁷⁹ Edward Shorter, *A History of Psychiatry*, 2.

³⁸⁰ *Ibid*.

³⁸¹ Michael Macdonald, *Mystical Bedlam*, 7.

³⁸² *Ibid*.

³⁸³ *Ibid*, 3.

³⁸⁴ Charlotte Mackenzie, *Psychiatry for the rich: A history of Ticehurst Private Asylum*, (New York: Routledge, 1992), 6.

³⁸⁵ *Ibid*, 6.

³⁸⁶ Anne Digby, *Madness, morality and medicine*, 4.

³⁸⁷ Michael Macdonald, *Mystical Bedlam*, 2

³⁸⁸ Anne Digby, *Madness, morality and medicine*, 2.

³⁸⁹ Charlotte Mackenzie, *Psychiatry for the rich*, 6.

Slowly but surely the medical view of insanity began to assert itself over religious and superstitious impressions as to the cause and treatment of madness.³⁹⁰ Doctors who were eager to claim a more respected role in society stressed the effectiveness of their ‘scientific’ approach to care.³⁹¹ In addition the medical profession went on the offensive in denouncing traditional perceptions of psychological illness.³⁹² Michael MacDonald, in his work *Mystical Bedlam*, suggests that “religious controversy and the shock of revolution” in the 17th and early 18th centuries aided the cause of the physicians.³⁹³ In his view, historical events such as the English Revolution cast doubt on views that the world could be perceived in a purely religious and ‘magical’ manner.³⁹⁴ A largely secular view of illness and insanity became viable in a world that had had its fundamental structures shaken by violence and religious strife.³⁹⁵ The increased medicalization of mental disorders meant that treatment, as opposed to mere confinement, became possible.

The Classification and ‘Care’ of the insane at the Cape Colony

This was the general context of mental health care within which the Cape Colony found itself operating. As stated elsewhere and crucial to also keep in mind, is that all authorised Cape doctors during the 1820s were trained in Europe.³⁹⁶ Their origins and that of their medical education would have played an important role in determining their views of the insane. Nevertheless, the extent to which the Colony conformed to the notions of insanity and treatment in Europe is still largely unexplored, and it is probable that the unique nature of the Cape context resulted in a different manifestation of mental care than what was present in Britain and Europe. The report into the state of the Cape Colony conducted by Commissioners Bigge and Colebrooke in the 1820s and submitted in 1828, reveals very specific and interesting details regarding the way the state sought to deal with the insane. They found that “the duty of providing for persons in this unfortunate situation has devolved upon the Local Government”.³⁹⁷ However determining who was to fall under this authority appears to have been an incredibly unregulated process. The commissioners said: “There exists no particular form of Judicial Enquiry into the condition of persons whose sanity is doubtful”.³⁹⁸ Despite this statement it is clear that in order to be committed to a government institution a person needed to be medically declared as insane. This is evident from the fact that a relative of an insane person needed to supply the court authorities with “medical certificates” declaring the insanity to be genuine.³⁹⁹ Such requirements reveal certain smaller details as to public and institutional perceptions of the ‘lunatic’ patient. The evidence

³⁹⁰ Michael Macdonald, *Mystical Bedlam*, 7.

³⁹¹ *Ibid*, 8.

³⁹² *Ibid*.

³⁹³ *Ibid*, 9.

³⁹⁴ *Ibid*.

³⁹⁵ Charlotte Mackenzie, *Psychiatry for the rich*, 7.

³⁹⁶ Howard Phillips, “Home Taught for Abroad”, 107.

³⁹⁷ George McCall Theal, *Records of the Cape Colony from February 1793 to April 1831: copied from manuscripts in the Public Record Office, London*, Volume 35, (London: Clowes Printers for the Government of the Cape Colony, 1897- 1905, 175.

³⁹⁸ *Ibid*.

³⁹⁹ *Ibid*.

suggests that the care of suspected insane people was considered the responsibility of their family up until the point where they could no longer handle them. This correlates with the trends of mental care in Europe where the patient's management was viewed as the duty of their relatives. It was only when the family felt they could no longer complete this obligation that they would transfer authority to the state. In addition, the reluctance of local Cape Courts to have suspected 'lunatics' committed reveals a reluctance to deal with the problem posed by such patients. It was only after having completed a series of required court ordered obligations that the person was then accepted into the state's apparatus.

It is also interesting to note the prominence of the court in determining who could and could not receive mental health care. Yet those having no immediate family could be institutionalised upon the word of "the Landrost or the Officers of Police".⁴⁰⁰ But the Commissioners did observe a potential issue with the way the system could be abused. They noted that a relative could merely declare a relation to be insane in an effort to gain their property.⁴⁰¹ This they hoped could be mitigated by the use of a jury whose goal would be to ascertain the true state of the person in question. Yet, in this process societal conceptions about what was normal and what wasn't would have been central in determining the fate of the suspected 'lunatic'. In addition the "Officers of Police" appear to have wielded immense power in being able to "take into custody those lunatics found at large".⁴⁰² Police had the ability to determine who was acting in an unusual manner and "disturbing the public peace".⁴⁰³ The Commissioners desired that the local Chief Justice should conduct an inspection before any alleged maniac could be moved from their present place of confinement. Yet again one can see a trend in the way the judicial arms of the colonial state in the Cape were used to determine states of insanity and normality. But the role of the Commissioners in attempting to restructure the system of determining the insane is also notable. Their conceptions of what was fair and humanitarian can be seen to contrast with the colonial norm. This represents an attempt by the metropole to alter the way madness was declared in order to be more in line with the norm in Britain. In this manner, those who embodied the imperial metropole's attempts to connect the empire moved to regulate the colonial approach of committing people as 'lunatics'.

Worryingly the report pointed out that there were few institutions in the districts outside of Cape Town able to accommodate the insane.⁴⁰⁴ It went on to indicate that Somerset Hospital was the designated and dedicated catchment for the entire Colony's 'lunatic' population.⁴⁰⁵ This highlights an approach of centralisation whereby resources could be concentrated in order to manage all the Cape's insane patients. The spatial issues of the colony, pertaining to population density and resource devotion, are thus brought to the fore once more. Furthermore, the fact that the report made a suggestion that patients who were committed should be visited "and a report of their condition and progress" compiled by "the Surgeon to

⁴⁰⁰ *Ibid*, 176.

⁴⁰¹ *Ibid*.

⁴⁰² *Ibid*.

⁴⁰³ *Ibid*.

⁴⁰⁴ *Ibid*.

⁴⁰⁵ *Ibid*.

the Courts and to the Chief Secretary to government”, suggests that such mandatory things were not being done at this stage.⁴⁰⁶ If the recommendations of the Commissioners were to be followed then the medical personnel attached to organs of the local state would function as the gate keepers to the outside world. This indicates differing opinions as to the role of the medical professional in the state structure. The external Commissioners appear to have felt that the doctor was worthy of involvement in the court system, whilst the local justice officials did not. Such a disjuncture may be due to a difference in the process of establishing the respectability of the medical profession. The suggestion that reports and inspections of such a nature were not being conducted indicates that for many at the stage of the Bigge-Colebrooke report, confinement was more than likely permanent.

The ‘lunatic’ Smith

The curious case of Aaron Smith, found in the correspondence between Dr Barry and the Colonial Office in mid-1824, again points towards a haphazard and seemingly fluid conception of what constituted insanity within the Cape Colony. Having been arrested for disturbing the peace after undertaking a spell of “hard drinking”, Mr Smith was placed in one of the town’s jails to cool off.⁴⁰⁷ Yet what seemed to be a simple case of drunkenness soon turned into a complicated and protracted debate over medical authority and the definition of insanity. Having been placed in a cell and beaten by the jailer for misbehaving, authorities began to suspect that there was more at work than mere drunken tomfoolery. Mr Smith continued to exhibit strange behaviour despite seemingly being sober. As a result the gaol authorities summoned Dr Barry to examine prisoner Smith in an attempt to discern what in fact was going on. Barry concluded that Smith was not insane but that a spell of temporary insanity had been brought about due to his over indulgence in alcohol.⁴⁰⁸ This verdict meant that Mr Smith remained accountable for his actions and as a result he was to remain locked up in the gaol. Dr Barry was certain that his condition would normalise as long as Smith was kept away from any hard liquor whilst he awaited trial. Unfortunately the saga did not end there by any means. Shortly after declaring the sanity of Mr Smith, Barry was again requested to examine him after it was reported that his condition had deteriorated considerably. Upon this second inspection Barry determined that his patient had relapsed into a “melancholy state” despite the apparent absence of any alcohol in his system.⁴⁰⁹ Dr Barry had no choice but to state that Mr Smith was in fact deranged of mind. In other words he was to be classified as a lunatic and removed from the criminal justice system and placed in the Colony’s central holding area for the insane, Somerset Hospital. The correspondence between Barry and the colonial office on this contentious issue seems to end at this point, however this series of events continued to have ramifications. In fact, this case of insanity appears to have been a pivotal event that helped end Barry’s career as medical inspector of the Cape.

⁴⁰⁶ *Ibid.*

⁴⁰⁷ Dr James Barry. Letter to Brink regarding the actions of the chief of justice. 24 September 1824. Letter. MC vol. 27

⁴⁰⁸ *Ibid.*

⁴⁰⁹ *Ibid.*

This contentious debate which indicates the subjective nature of insanity in the Cape Colony is mirrored in Barry's earlier inspection of Somerset Hospital on the 8th of March 1824. In an effort to free up space in the overcrowded wards of the hospital that were, according to Barry, "as dirty as the patients", an effort was made to re-evaluate the authenticity of the resident lunatics' states of mind.⁴¹⁰ This process came to the conclusion that two of the supposedly insane patients were in fact sound of mind, with Barry remarking that one such individual by the name of Francina was "as sane as most people".⁴¹¹ Such cases raise a number of rather troublesome questions about conceptions and diagnoses of insanity within the Cape. The most striking of these relates to why people who were not mad were being confined to the asylum. However the fact that Francina had been left in the hospital suggests that there was inadequate monitoring of those deemed and confined as lunatics by the attendants of the institution. One would hope that if somebody was not insane then those tasked with their care would be able and willing to address this issue.

Yet this apparent lack of concern highlights the state of psychological care within the colony and in particular Somerset Hospital. Prior to Barry's inspection on the 8th of March the condition of the Cape's lunatic population does not appear to have been of great interest. But the archival sources reveal that it was not Barry's own initiative that led to the visit and the eventual, but temporary, improvement of care. A letter from the office of the Colony's governor indicates that it was his concern and not Barry's that flagged the obvious issues with the level of care at Somerset. The correspondence sent from the Colonial Office on the 2nd of March 1824 ordered Dr Barry "to visit that institution" "occasionally and inform his Excellency of the condition in which you find the lunatics confined there".⁴¹² These visits were to be detailed in the form of reports that relayed "the state of health of the lunatics" in addition; proposals were to be made on improvements in care that could be implemented.⁴¹³ The deplorable state that the psychiatric patients were found and the fact that Barry had left the Colony's only asylum to its own devices for the majority of his tenure, suggests that the care of the insane was not high up on his list of priorities'. In addition, the state of Somerset Hospital's lunatics again raises the issues of insufficient communication between role players in the local health care system. Yet like the cases of the Rondebosch jail, dealt with in the previous chapter, this institution was based in Cape Town the heart of the Colony's administration. This reiterates the fact that even in neighbouring areas, there was very little consistent authority maintained over the medical structures in the Cape.

The fact that Barry was compelled by the Governor to take a more active role in the care of the insane speaks to the nature of medical authority within the Colony. The office of the Governor clearly felt no qualms about ordering Dr Barry to perform certain tasks, as is evident in this particular case. It is clear that the Colonial Medical Inspector, who was the highest ranking medical official in the Colony, played a subservient role even in matters of medical importance. With that being said the Governor's office clearly acknowledged that the

⁴¹⁰ Dr James Barry. Report on the lunatics of Somerset Hospital. 8 March 1824. Report. MC vol. 27.

⁴¹¹ *Ibid.*

⁴¹² Secretary Brink. Request from the Office of the Governor for regular reports on the state of the lunatics at the Somerset Hospital. 2 March 1824. Letter. MC vol. 7.

⁴¹³ *Ibid.*

inspection of Somerset Hospital had to be conducted by Barry due to his particular field of expertise. His opinion was therefore vital in determining the policy or action that the Governor would undertake. This can be seen in the dialogue that emerged around the potential expansion of the Lunatics' quarters at Somerset in late 1824.⁴¹⁴

Following the regular visits that he was now required to make, Barry suggested that the insane patients at the hospital were in dire need of their own separate space. The Governor accepted this recommendation, trusting the authority of Barry's qualified word, and decreed that the lunatics were to be moved as soon as possible. However, in order to ensure that the housing allotted to the mad was appropriate and 'medically' sound Governor Somerset determined that Barry was to engage in dialogue with the "members of the Burgher senate" on the matter.⁴¹⁵ In addition, Somerset ordered Dr Barry's "attendance at said hospital", "in order to meet the commissioner of their" (the hospital's) "board for the purpose stated".⁴¹⁶ In short, the Governor told Barry to utilise his position of medical authority to compel the hospital's administrators and board to open up suitable space for the neglected lunatics that were living in squalor. Furthermore, correspondence of the Colonial Office with the Burgher Senate on the 12th of November 1824 indicates how the Governor used the position and aura of medical authority that surrounded the position of medical inspector to back up his directive. The letter points out "that His Excellency called upon the Colonial Medical Inspector for his opinion as to the measures that should be adopted for enacting the Epigancies of the present moment".⁴¹⁷ Upon receiving his advice, in the form of the reports that he had ordered Barry to compile, the Governor saw fit that a number of rooms separate from the main building of the hospital were to be "appropriated".⁴¹⁸ This was to be in addition to the appointment of a resident surgeon whose duty it would be to watch over the insane. This particular case indicates the limitations of medical power at the Cape. Although the issue at hand was a medical one, being that of the treatment and confinement of the colony's 'lunatic' patients, the position of Colonial Medical Inspector appears, in this case at least, to have been a mere tool to achieve the will of the Colonial Office. The governor utilised Barry's opinion to back up his order that a number of buildings were to be "appropriated".⁴¹⁹ Dr Barry was limited to acting as an advisor with little independent will of his own.

The report that emerged from Barry's visit of the 8th of March highlights the management of the insane in the Cape Colony. As opposed to Britain where asylums had developed to provide some form of care, the Cape's single mental hospital in the early 1820s appears to have been nothing more than a dumping ground Yet such a case can also point towards the

⁴¹⁴ Office of Governor Somerset. Instructions to Barry on the inspections of the lunatics. 19 November 1824. MC vol. 15.

⁴¹⁵ *Ibid.*

⁴¹⁶ *Ibid.*

⁴¹⁷ Colonial Office. Instructions from the Colonial Office to the Burgher Senate on the situating of an asylum. 12 November 1824. MC vol. 7

⁴¹⁸ *Ibid.*

⁴¹⁹ Colonial Office. Instructions from the Colonial Office to the Burgher Senate on the situating of an asylum. 12 November 1824. MC vol. 7

unique nature of Cape mental and medical care within the wider context of the British Empire. The topic of mental care offered in the Indian colonies has been the subject of substantial research and provides an interesting point of comparison to the Cape. Waltraud Ernst's chapter on India in *Imperial Medicine and Indigenous Societies* explains how the colonial authorities had established a complex system with numerous institutions for the confinement of European and local Indian 'lunatics'.⁴²⁰ Comparatively the Cape had only one defined institution for the confinement of the insane in the 1820s. In addition the Somerset Hospital did not function as a transit institution in the way that Colonial Indian asylums for Europeans did. Ernst and Fisher-Tyne have both indicated why the return of European 'lunatics' from the subcontinent was deemed so important.⁴²¹ In order to ensure "the oft-asserted 'superiority of the European character'" colonial authorities saw it as essential to have the insane removed.⁴²² This would portray a particular image that would allow for effective governance of the colonised. In the Cape there was no such policy. Although employees of the Colonial administration may be lucky enough to be transported back to the British Isles, the majority of the Cape's 'lunatics' were reliant on the shoddy standard of 'care' described by Barry in his letter to the Governor dated the 8th of March 1824. This raises the question of why the British rulers of the Cape Colony did not feel it necessary to dispatch its settler madmen back to the metropole. The answer to this can be found in the make-up and state of the settler colony. When the British took control they inherited an indigenous population who had been decimated and subjugated by years of brutal VOC colonialism. As a result there was no longer a perceivable threat from the local population of Khoikhoi. Comparatively the Indian colonies were still deemed to contain a substantial danger in the form of the local population, a fact evidenced by both the mutiny in 1857 and the concern shown towards illness amongst the military.⁴²³ In addition, the small size of the settler population in the Cape meant that there were very few cases of insanity amongst the colonisers.

Lack of change and sustained mismanagement

A report from the Supreme Medical Committee in February 1826 reveals how badly the insane were still being treated two years after Barry's intervention. Such a report describes the feeble attempts at reform, in addition to highlighting the inability of the authorities to effect sustainable change over a period of time. The wider inspection of the Somerset institution was the direct result of "papers containing charges against W. Honey in his professional duties as resident surgeon".⁴²⁴ The allegations related directly to the atrocious conditions and care being forced upon the hospital's 'lunatics'. The Committee found that two patients in particular had been physically maltreated by Honey and his staff. The first was "the lunatic Hartwick" who was found to have been whipped "14 or 16 stripes of the

⁴²⁰ Waltraud Ernst, "The European insane in British India, 1800- 1858: a case-study in psychiatry and colonial rule", In *Imperial medicine and indigenous societies*, edited by David Arnold. (Manchester: Manchester University Press, 1988), 27

⁴²¹ *Ibid*, 30.

⁴²² *Ibid*, 30.

⁴²³ David Arnold, *Colonizing the Body*, 65.

⁴²⁴ Supreme Medical Committee. Minutes of the 4th of February 1826. 4 February 1826. Minutes. MC vol.1

horse trace”.⁴²⁵ The reason Honey provided was that he was attempting to punish the man in question as he had damaged the wall of his cell. By having such a punishment inflicted upon the man, he had supposedly hoped to prevent him from repeating any further misdemeanours. The whipping of Hartwick suggests that physical violence was integral to the confinement and control of the Colony’s insane. Furthermore, the report reveals that the patient had been placed in a cell like a criminal. This confirms that care for the insane at the Cape was still very much dominated by attempts to manage the mad rather than cure them. The second case brought against Honey and his team was that of “the female lunatic Hottentot Rachael”.⁴²⁶ Unlike the punishment given to Hartwick, Honey admitted to having lashed Rachael himself but declared it was warranted. Rachael was “charged with being sometimes noisy in the use of obscene language”.⁴²⁷

Resident Surgeon Honey and his underlings appear to have been shocked that their actions were coming into question. From Honey’s perspective, the type of physical punishment meted out under his authority was in line with “such practised in different Public Institutions under sanction of some eminent medical men”.⁴²⁸ He did not appear to back up these claims with any evidence or names. Furthermore, Honey declared that “he has himself known in several instances beneficial effects to result from such treatment”.⁴²⁹ Again these reports were not substantiated by any concrete evidence, but they do indicate that this sort of action towards the insane was common place in the Cape Colony. In response to the defence provided by Honey for the two cases, the Committee declared that they were “unanimously of opinion” that the means to maintain order over the insane should “cause least injury to the feelings either mental or corporeal”.⁴³⁰ They did however acknowledge that some form of deterrent was needed. They also admitted that some renowned physicians had used similar approaches to Honey’s, but in their opinion such actions served only to “cause or aggravate” their condition further.⁴³¹ It is clear that the Colony’s most eminent medical men, embodied by the Supreme Medical Committee, felt it inappropriate to treat the insane in the manner that Honey had done. In order to enforce the actions taken against such methods, the Committee used a journal article from Europe that declared what was the best means to approach care of the insane. The relevant portion of the article was taken from “*Dr Gregory’s Practice of Medicine*, one of the newest and most approved works in medicine”.⁴³² It stated: “the employment of severe restraint is hardly ever resorted to in the best regulated modern mad houses” as “it creates a degree of irritation of mind which impedes advancement and is at variance with that soothing and encouraging plan so necessary to ultimate success”.⁴³³ The use of this extract suggests that the Supreme Medical Committee were trying to move care in

⁴²⁵ Supreme Medical Committee. Charges brought against Surgeon Honey regarding conduct at Somerset Hospital. 6 February 1826. Report. MC vol.1

⁴²⁶ *Ibid.*

⁴²⁷ *Ibid.*

⁴²⁸ *Ibid.*

⁴²⁹ *Ibid.*

⁴³⁰ *Ibid.*

⁴³¹ *Ibid.*

⁴³² Supreme Medical Committee. Report on conduct of Surgeon Honey at Somerset Hospital. 4 March 1826. Report. MC vol.1

⁴³³ *Ibid.*

the Cape towards the standards becoming prominent and accepted in Europe. It also indicates that they were in contact with medical developments in Europe thus reiterating the presence of different networks of knowledge connecting parts of the Empire. Yet it also indicates stark contrasts between the state and aim of mental care in the Cape Colony, and that of Europe at this particular point in time. The section provided from *Dr Gregory's Practice of Medicine* confirms that European asylums had largely moved towards attempting to cure the insane. Comparatively, in the Cape, the system was still locked in the approach of attempting to confine the 'lunatics' were they would not be able to impede the rest of society. Despite the intentions of the Supreme Medical Committee treatment and perceptions largely remained unchanged.

Following the investigations into the treatment of Hartwick and Racheal, Surgeon Honey was relocated to the country to act as District Surgeon of Caledon. It appears that the Committee was mostly concerned about the fact that he had become physically involved in handing out punishment. Yet the trouble regarding the care of the insane at the Cape did not end there which suggests that Honey was merely a small cog in a bigger system of harsh 'treatment'. In July 1826 another inspection of the Somerset Hospital revealed that the insane were subjected to the cold of winter without adequate bedding to keep them warm. More worryingly was that there was a member of staff inciting trouble amongst the mad patients. The assistant to the resident surgeon, a man by the name of Gaches, was brought on a charge for displaying "extremely violent and disobedient conduct" towards his superior.⁴³⁴ But this was not his first offense as the report claimed he was "guilty of great cruelty to one of the lunatics without any authority".⁴³⁵ In addition he had been responsible for having "aggravated the insanity of one of them by making him drunk".⁴³⁶ This emphasises the lack of care provided for the mentally ill in the Cape Colony, and reveals the continued lack of appropriate authority to maintain control over the care of the 'insane'. This was despite the close proximity of the asylum to the offices of the Committee and colonial governance in the Cape.⁴³⁷ It would be thought that this miniscule distance to the authorities would have resulted in a more consistent and firm form of regulation, but this was not the case. One starts to see that it was not just the rural areas that were seemingly lawless in the arena of medical regulation. The Colony's largest hospital and only dedicated asylum was riddled with inefficiency, ghastly conditions and personal misconduct, which despite numerous attempts, continued to operate as such.

The recurrent insanity of James Thompson

The Supreme Medical Committee's inquest into the insanity of James Thompson in August 1827 reveals further details of how mental health was viewed in the Cape during this period. The Committee set about examining Thompson, an inmate in the Somerset asylum, in an

⁴³⁴ Supreme Medical Committee. Minutes from meeting of the 7 July 1826. 7 July 1826. Minutes. MC vol.1

⁴³⁵ *Ibid.*

⁴³⁶ *Ibid.*

⁴³⁷, Penelope Edmonds, *Urbanizing Frontiers: Indigenous peoples and settlers in Pacific 19th Century Rim Cities*, (Vancouver: UBC Press, 2010), 6.

attempt to decipher “whether or not his speedy recovery” was to be “expected”.⁴³⁸ They found that Mr Thompson was generally sound of mind but had fallen back into insanity on more than one occasion “from the use of spirituous liquors”.⁴³⁹ This is evidenced by reports published in the local newspaper *The Cape Town Gazette, and African Advertiser* where Mr Thompson’s demise was chronicled over the years. On the 12th of October 1822 his estate was “placed under Sequestration” “in consequence of his derangement”.⁴⁴⁰ However this notice was rescinded on the 23rd of January 1823 due to Thompson having regained a state of sound mind.⁴⁴¹ He was then recommitted to the Cape Town asylum (at Somerset Hospital) and his estate placed under administration in April 1826.⁴⁴² Nevertheless, in May of the same year he was handed back control of his affairs due to his quick recovery.⁴⁴³ This was to last just three months when he was again dispossessed of his estate and confined to hospital.⁴⁴⁴ His condition had clearly deteriorated as is evident from the decrease in time between his numerous committals. The physicians of the Committee went on to declare that Mr Thompson did not have the willpower to resist the temptations of alcohol. He was “not in a state to be trusted to his own guidance without the greatest risk of speedily relapsing into the melancholy degree of insanity under which he was labouring on admission into the hospital”.⁴⁴⁵ They concluded that he would more than likely spend the rest of his life institutionalised in hospital. The members of the Committee appear to have consequently observed a clear link between Thompson’s consumption of spirits and his bouts of insanity.

However, it is here that we can see the different classifications of ‘lunatic’ spoken about by Berrios.⁴⁴⁶ Mr Thompson was declared to be a melancholic, and we can presume he displayed signs of what we would today term depression. The way that Thompson’s symptoms and condition were described reveal a change in general perception from days when the “psychophysical malady of melancholy” was seen as a powerful motivator for “genius”.⁴⁴⁷ In addition they appear to have established that he had no control over his desire to drink alcohol, indicating that he was an alcoholic. Yet this condition had, as of yet, not been recognised as legitimate by the medical fraternity. They therefore appear to have determined that it was due to a weak constitution that Thompson was unable to withstand the allure of spirituous drinks. Time and time again he had been released from hospital only to return with the same condition after over indulging. They came to the agreement that James Thompson was to be permanently confined to the hospital in order to break the cycle. Consequently, he

⁴³⁸ Supreme Medical Committee. Report on state of mind of one James Thompson. 18 August 1827. Report. MC vol.1.

⁴³⁹ *Ibid.*

⁴⁴⁰ *The Cape Town Gazette, and African Advertiser*. Cape Town, October 12th 1822.

⁴⁴¹ *The Cape Town Gazette, and African Advertiser*. Cape Town, January 25th 1823.

⁴⁴² *The Cape Town Gazette, and African Advertiser*. Cape Town, April 21st 1826.

⁴⁴³ *The Cape Town Gazette, and African Advertiser*. Cape Town, May 26th 1826.

⁴⁴⁴ *The Cape Town Gazette, and African Advertiser*. Cape Town, September 1st 1826.

⁴⁴⁵ Supreme Medical Committee. Report on state of mind of one James Thompson. 18 August 1827. Report. MC vol.1.

⁴⁴⁶ G.E. Berrios, “Melancholia and Depression during the 19th century: A conceptual history”, *British Journal of Psychiatry* 153, (1988), 300.

⁴⁴⁷ Roy Porter, *Bodies Politic: Disease, death and doctors in Britain, 1650- 1900*, (London: Reaktion Books, 2001), 61.

was not granted power over his estate and assets again. This type of action, taken against people like James Thompson, was largely overseen by the courts and indicates how the state moved to seize control over citizens who were defined as medically incapable of looking after themselves.

But the case of Thompson's derangement was also a case of public concern as is evidenced by its advertisement in the government paper. This highlights the societal aspects of 'lunacy' in the Cape Colony. Although there were important practical aspects to publishing such advertisements, such as informing family members and debtors of the individual's descent into madness, the role of such a practice in establishing societal barriers is notable. The notice would serve to inform the community that the man or woman concerned was no longer a fully functioning member of society. As a result they were removed from the day to day notions of respectability. But the case of Thompson also points towards the capacity of the local society to, at least in theory, re-integrate people who had emerged from a period of lunacy.

Patient rights

In August 1826 the matter of patients' visitation rights in Somerset Hospital was raised before the Supreme Medical Committee. Presumably some patient's relatives or friends had complained about the lack of access they had to their relations who were confined to the hospital.⁴⁴⁸ Yet this issue reveals more about a particular theory of managing and treating mental illness in place at the Cape Colony. Dr Wehr of Somerset Hospital wrote that he had not been responsible for preventing the families of all patients from seeing their loved ones, but that he had only prevented such interactions for one patient by the name of de Jongh.⁴⁴⁹ The man in question was a diagnosed 'lunatic' and in the past, visitations had resulted in a deterioration of his condition. In an example Dr Wehr declared that at one stage "several of his brother workmen applied at once to see him".⁴⁵⁰ However Wehr concluded that "they came from curiosity" and that their visit "would injure him by useless disturbance".⁴⁵¹ As a result de Jongh's gang of colleagues was not granted access to see him. In another incident involving the same patient, Wehr had refused to allow a woman, (presumably de Jongh's girlfriend) into the hospital as she had previously supplied him with alcohol from which he became inebriated. He consequently determined that the patient was always "worse for her visits" and he was obliged to refuse her entry.⁴⁵²

Here the link between hard liquor and insanity arises again, something that has been seen in two of the other cases noted in this chapter. David Arnold has noted in *Colonizing the Body* how central alcohol was to British military life in India in the 19th century.⁴⁵³ The two Cape based 'lunatics', whose conditions appear to have developed from excessive drinking, appear

⁴⁴⁸ Supreme Medical Committee. Questions put to Dr Wehr. 26 August 1826. Questions. MC vol.1

⁴⁴⁹ *Ibid.*

⁴⁵⁰ *Ibid.*

⁴⁵¹ *Ibid.*

⁴⁵² *Ibid.*

⁴⁵³ David Arnold, *Colonizing the Body*, 82.

to mirror this and raise the importance of liquor in Cape society. Yet we can see the doctor's apparent concern for the state of mind of the 'lunatic' patient. Dr Wehr appears to have been genuinely concerned about how unscrupulous visitors would affect the mind of de Jongh. In this way their presence seems to have been viewed as a threat to Wehr's authority and, in a sense, his treatment. This case suggests that confinement may not have simply been a method of protecting normal society, instead Wehr's intentions point towards it being seen as the only viable means of curing the mind of the afflicted. We thus see a contrast between two modes of thinking and treating the insane at the Cape. Honey's revolved around controlling the patients through violence in order to keep them confined in the easiest possible manner. Despite his protests, there appears not to have been any real attempt to 'cure' the insane patients under his care. Comparatively, Dr Wehr viewed solitude in the hospital, away from the stresses and temptations of everyday life, as a viable course of action which had the potential to dispel madness from the mind of the patient. With that being said, the state of the hospital during this same time period suggests that Dr Wehr was not entirely behind the adoption of this method either. This is apparent from the lack of any form of comfort within the hospital as recorded in the minutes of the SMC on the 5th of August 1826. The report stated: "Many of the 'lunatics' have been without any kind of bed or bedding during the inclemency of the entire winter but the director, Doctor Wehr, promises for the future that they shall be provided with bed and bedding as far as his means will allow".⁴⁵⁴ Such a report indicates that Wehr's apparent concern for the state of the insane was potentially false, or that his ability to enforce positive changes was limited.

Alternatives to Somerset Hospital

The Bigge- Colebrooke report shows that Somerset was not the only space set aside by the local government in order to confine the 'maniacs' of the Colony. Their report revealed that there were 'lunatics' held on Robben Island in 1823, yet this confinement appears to have been an unofficial one. None of the local official documents appear to refer to this form of rudimentary asylum. Nevertheless, the shock at the state of the conditions of confinement they found the patient-inmates in, resulted in the Commissioners appealing to the Governor to intervene immediately in order to relocate them to the mainland. Their report indicates that the 'lunatics' were "without immediate medical assistance or superintendence" and were housed in a series of huts next to the prison on the island.⁴⁵⁵ They lived in squalor and did not have even the most basic of care provided for them. The recommendation of the Commissioners was that the eight insane patients were to be moved "into apartments in the Somerset Hospital".⁴⁵⁶ This appears to have taken place, but the reports provided after Barry's inspection of Somerset Hospital in 1824 indicate that their hopes that the insane would have "proper attention" "paid to their comfort and accommodation", did not materialise.⁴⁵⁷ This is evidenced by the cases already touched on in this chapter, where the insane were treated in a most neglectful manner. Furthermore, such trends in the way the

⁴⁵⁴ Supreme Medical Committee. Questions put to Dr Wehr. 26 August 1826. Questions. MC vol.1

⁴⁵⁵ George McCall Theal, *Records of the Cape Colony* vol. 35, 175

⁴⁵⁶ *Ibid.*

⁴⁵⁷ *Ibid.*

insane at the Cape were viewed appear to have run deep, as just a few years later the Supreme Medical Committee suggested that all of the Colony's insane should be moved to Robben Island. They declared in their report on the 2nd of March 1829, that the Island provided "a natural means of effecting the perfect seclusion of these unfortunates".⁴⁵⁸ The approach and policy of the established medical system is evident in this phrase. There was little regard for the patient and little intention to provide a form of treatment that would see the mentally insane cured or aided. Instead the process of confinement was in place in order to prevent disruptions to everyday life. The act of placing the insane on an island whose central function was to hold convicted criminals highlights how 'lunatics' were perceived. Yet the report also raises the disjuncture between how the insane were considered in the Cape and the metropole, as well as reiterating the view of power being centred in certain areas. The Commissioners were outraged with the standards with which the 'lunatics' were being housed and it is evident that they felt moving them to the mainland would allow for increased care.⁴⁵⁹ This reveals again how authority was viewed by members of the Commission.⁴⁶⁰ They deemed that the closer the convicts were to offices of government authority, the better treatment they would receive. This clearly did not happen, despite their move to the Somerset Hospital, as they continued to be kept in squalor along with the Colony's other insane.

Equality in confinement?

Interestingly enough, there does not appear to have been substantial amounts of discrimination on racial grounds with regard to who could and couldn't be given 'care'. The cases of Hartwick and Racheal which were brought to the Supreme Medical Committee were treated in a similar manner. Both people were deemed to have been wronged by the medical attendants at the asylum. Furthermore the section of the Bigge- Colebrooke report of 1823 relating to Robben Island and the individuals confined there, speaks about the conditions that the patients were found to be in.⁴⁶¹ Apart from noting that they were found to be in a "destitute state", the Commissioners noted that amongst the eight insane patients there "was an English sailor, and two women of colour of advanced ages".⁴⁶² Such a report proves that regardless of their race, insane people were grouped together in the same quarters. It seems that all peoples in the Colony were 'entitled' to the same accommodation and deplorable methods of mental health care. This is mirrored in the way that the local authorities sought to confine convicts or suspected offenders in gaols and jails at the Cape. The only factor that was used to separate prisoners was gender, and although the officials at the 'trunk' recorded the classification of inmates as "Hottentots", "Boschman", "Negro", "slave" and "European" they appear to have been lumped together in lockdown.⁴⁶³ This points to the conclusion that perhaps all those deemed a danger to society forfeited all their rights, making everyone equal

⁴⁵⁸ Supreme Medical Committee. Report on suitability of Robben Island as a leper and lunatic asylum. 2 March 1829. Report. MC vol.1

⁴⁵⁹ *Ibid.*

⁴⁶⁰ George McCall Theal, *Records of the Cape Colony vol. 35*, 175.

⁴⁶¹ *Ibid.*

⁴⁶² *Ibid.*

⁴⁶³ W. Bird, *State of the Cape of Good Hope in 1822*, 21.

before the law. In this manner insanity, like criminality appears to have been an equalising factor within the Cape.

Such a means of confinement sets the Cape apart from means of treating the insane elsewhere in the empire. It has already been touched on that there was a policy of repatriation for European ‘lunatics’ in place across the Indian subcontinent. However, this was only done after a certain period of time and as a result there were lunatic asylums established to house the settler insane. In these institutions “racial segregation” was exercised in addition to the separation of patients along the lines of class.⁴⁶⁴ This approach to ordering the insane is something that was not taking place concurrently in the Cape. Such a disparity evidences the lack of a coherent empire wide means of handling the insane. In addition, Waltraud Ernst has pointed out that European ‘lunatics’ in India were afforded a far greater degree of personal freedom, something that was not afforded to any of the Cape’s ‘insane’ patients, let alone the European inmates.⁴⁶⁵

One can thus see how mental care and confinement was moulded to fit the unique context of the Cape Colony during this period. The local factors and structures that were dealt with in the previous chapters played an important role in this process. In addition, the inability of metropole officials to maintain a consistent dialogue with the Cape also resulted in the inhumane forms of rudimentary psychological management that manifested themselves. Yet, as will be shown in the remainder of this chapter, the treatment of leprosy was characterised by similar issues.

Leprosy in the context of the Cape Colony, 1820-1830

In a similar manner to ‘lunatics’, lepers have been subject to a plethora of negative connotations and tropes throughout history. The assessment of the extent to which the treatment of the Cape’s ‘lunatics’ and lepers throughout the course of the 1820s was similar, is therefore useful.

Situating leprosy

Leprosy appears throughout history and across accounts as a disease largely unparalleled in the fear and scorn it induced. The leper and the image of the leper has been the subject of disdain in countless representations. These have included references in scripture where the

⁴⁶⁴ Waltraud Ernst, “The European insane in British India”, 35.

⁴⁶⁵ *Ibid*, 28.

character of the leper surfaces often. Out of fear and an attempt to control the disease, those suffering from the dreaded affliction were thrown out of society and forced to live beyond its fringes. Joan Lane notes that in the Medieval era, the leper “was attended but kept away from the rest of society”.⁴⁶⁶ As a result institutions were set up in order to facilitate the confinement of those often said to have been cursed by God.⁴⁶⁷ But towards the end of the Middle Ages the number of leprosy sufferers appears to have declined in Europe, and although there were still cases of the infection, the number of infected was nowhere near that of earlier times. Yet events at the Cape in the 19th century indicate that the illness was far from dead, and the reactions towards its manifestation, were far from progressive.

Initial attempts to regulate leprosy at the Cape

The years preceding the 1820s saw a dramatic increase in the concern shown towards cases of suspected leprosy in the Cape Colony. Edmund Burrows noted that prior to the arrival of the British there had been only one single confirmed case of leprosy in the Colony’s history.⁴⁶⁸ This changed in 1807 when an instance was brought to the attention of the authorities in Stellenbosch.⁴⁶⁹ Following this suspected surfacing of the disease there appears to have been a flurry of interest shown within the Colony. This set in motion an investigation which determined that the scourge was “wide-spread among the” Khoikhoi of the Cape.⁴⁷⁰ The means by which this inquiry was conducted and the validity of its conclusions are difficult to assess, however the stance taken by the medical authorities does suggest some genuine basis for concern. In 1813, the local colonial government made it the duty of each district to care for their afflicted constituents at their own expense.⁴⁷¹ Each of the localities attempted to establish their own institution within which to house their lepers. Yet the number of cases appears to have been so high that the different districts were unable to house them all. This raises interesting questions as to the nature of the supposed ‘leprosy epidemic’ that was sweeping through the Cape’s Khoikhoi population. The noteworthy lack of cases evident in the local archival records up until 1807 makes the supposed explosion of the illness suspicious. How was it that leprosy suddenly emerged amongst the Khoikhoi in the early 19th century? This is a question that is very difficult to find logical answers, especially given the nature of the primary material available. It may be suggested that the scourge had only arisen at this point in time. Yet the fact that the illness was supposedly restricted solely to the Khoikhoi population of the Cape Colony suggests that it was not a pandemic. Instead the work of David Arnold in *Imperial Medicine and Indigenous Societies* can potentially provide answers.⁴⁷² His work has observed a trend in colonial societies in “the association of diseases like smallpox, plague, cholera and malaria with the indigenous population”.⁴⁷³ This

⁴⁶⁶ Joan Lane, *A Social History of Medicine: Health, Healing and Disease in England, 1750- 1950*, (Oxon: Routledge, 2001), 3.

⁴⁶⁷ *Ibid.*

⁴⁶⁸ Edmund Burrows, *A History of Medicine in South Africa*, 103.

⁴⁶⁹ *Ibid.*

⁴⁷⁰ *Ibid.*

⁴⁷¹ *Ibid.*

⁴⁷² David Arnold, *Imperial Medicine and indigenous societies*, 8.

⁴⁷³ *Ibid.*

attempted correlation was fuelled by and in turn fuelled “European suspicions”.⁴⁷⁴ Such a process appears to have been a factor that contributed to the allegations levelled against the Khoi regarding the condition of leprosy.

The birth of Hemel en Aarde

Having failed to set up an effective system whereby the districts remained responsible for the lepers within their geographic jurisdiction, a new solution was needed. It was determined that all of the Colony’s lepers were to be centralised in a place that would be conducive to the easing of the suffering involved with their illness. Hemel en Aarde (near modern day Hermanus) was selected as a perfectly secluded spot where the diseased could be placed at a considerable distance away from the population dense parts of the Colony.⁴⁷⁵ The institution therefore fell under the jurisdiction of Caledon, but its expenses were “to be borne equally by the seven drostdys”.⁴⁷⁶ This is confirmed by the fact that a “Leper Tax for 1820” was taken up in Graff Reinet, and presumably the other Drostdies, in order to meet the cost of the new leper asylum.⁴⁷⁷ Such a levy placed on the inhabitants of the districts is fascinating in relation to the interconnected nature of the colony. The authorities in Cape Town had realised the need for an expanded health care system in order to cope with the presently afflicted and prevent a spreading of the disease to the rest of the Colony’s population. Yet the fact that the various different districts had to contribute financially in order to fit the bill of this new leper institution indicates the lack of external assistance provided by the colonial authorities in London. It also suggests that when it came to financial matters, the Cape Town based authorities were suddenly able to exert enough influence over their rural constituencies. This is evidenced by the tax taken in Graff Reinet and the subsequent establishment of the institution at Hemel en Aarde, which would presumably have been set up, only if all districts had paid their dues. However the funds raised through the levy of 1820 appear not to have been put to good use as the letters and correspondence of Dr James Barry reveal in late 1822.

Barry had been informed of the dire condition of the leper institution near the present day town of Hermanus and decided that an inspection was needed in order to assess the situation.⁴⁷⁸ This set in motion a saga that would last until the abrupt ending of Barry’s tenure at the Cape. Yet this narrative speaks volumes about the response to leprosy in the Colony, as well as the haphazard nature of the local medical system and its connections with a wider network. Dr Barry was joined in his assessment by Reverend Dr Thom, the resident religious man of the area.⁴⁷⁹ Barry had also requested that the institutions medical officer, Dr O Flynn, be in attendance but due to travel problems as a result of “bad weather”, he was unable to attend.⁴⁸⁰ Upon arrival, Dr Barry was shocked and disgusted with the deplorable state of the institution. He quickly set about identifying the many problems that were at work within the

⁴⁷⁴ *Ibid.*

⁴⁷⁵ Edmund Burrows, *A History of Medicine in South Africa*, 104.

⁴⁷⁶ *Ibid.*

⁴⁷⁷ *The Cape Town Gazette, and African Advertiser*. Cape Town, March 8th 1827.

⁴⁷⁸ Dr James Barry. Report on Hemel en Aarde. 4 November 1822. Report. MC vol. 27.

⁴⁷⁹ *Ibid.*

⁴⁸⁰ *Ibid.*

isolated leper colony. These included a lack of good nutrition amongst the patients, an absence of any form of warm clothing and bedding, in addition there were no activities for the patients to pass the time.⁴⁸¹ Yet the paramount issue for Barry appears to have been the lack of management by the officials who were tasked with the running of the Leper colony. Not only was the man in charge of the day to day running of Hemel and Aarde neglecting the most basic of his duties, but Dr O Flynn who was supposed to attend to the lepers, was not doing so.⁴⁸² In fact, he lived so far from the institution that it took him over a day to get there. This O Flynn cited as the reason for only visiting the lepers of Hemel en Aarde once every fourteen days.⁴⁸³

Barry was scathing of the way all three of the establishment's authorities: The doctor, the steward and the priest, refused to take responsibility for the state of the patients. In his report, Dr Barry wrote that "the steward complained that he was bullied and obliged to do all the Dr's work" and as a result he had tendered his resignation.⁴⁸⁴ The reverend explained that he "lives 4 hours ride from the leper institution" and therefore could not make regular visits.⁴⁸⁵ Furthermore the reverend accused the steward and doctor of structuring the schedule of the lepers so as to not allow for religious teaching. In addition, these two individuals had allegedly "damned and otherwise insulted him".⁴⁸⁶ The rather upsetting findings of this visit were placed by Barry into a report which was directed towards Governor Somerset. Yet it is also clear that Barry used his position as an agent of the Governor to back up his attempts to improve conditions at Hemel en Aarde. For example Dr Barry noted in his report: "From my personal knowledge of Lord Charles Somerset, I have used the liberty in the name of his excellency to order an augmentation of the present rations and an addition of the necessary articles".⁴⁸⁷ Apart from suggesting that Barry drew on his personal relationship with the Governor to assist him in his work, the above statement suggests the limitations of the Colonial Medical Inspector's powers. He appears to have had to use the threat of his connection to the Governor in order to ensure that his desired changes were made. This reaffirms the role of the Colonial Medical Inspector as an agent of the local governor but also highlights the limitations of the position's powers.

After this first shocking visit, Barry appears to have taken a special interest in the improvement of the leprosy colony, making regular inspections to ensure his orders were being followed. Yet this case illuminates a trend within the Cape Colonial medical system of the time, which has been continually raised in this thesis. Whenever there was a lack of supervision, or at least an absence of the threat of supervision, institutions like the leper colony at Hemel en Aarde appear to have fallen into disrepute. Those tasked with the day to day running of things did as they pleased if there did not appear to be any obvious threat from superiors. However Barry's inspection and his continued monitoring of the situation at Hemel

⁴⁸¹ *Ibid.*

⁴⁸² *Ibid.*

⁴⁸³ *Ibid.*

⁴⁸⁴ *Ibid.*

⁴⁸⁵ *Ibid.*

⁴⁸⁶ *Ibid.*

⁴⁸⁷ *Ibid.*

en Aarde clearly brought about changes in the short term. This instance indicates how crucial face to face interaction and regular check-ups were in maintaining order over the different institutions that made up the Colony's medical service.

Control through centralisation

The approach that the colony took towards centralising its care for lepers is particularly interesting in that it mirrors the structure presently used in the Western Cape health care system. The previously used method of each district dealing with its own lepers did not last long and the catchment system developed out of the need to handle the problem. Yet the fact that this approach was only adopted after the overwhelming failure of another system speaks to how the administrators in the Cape could at times, change things when the need become ignorable. Such a case emphasises other attempts within the Cape to centralise resources and institutions in a single place. This same approach can be seen in the way the medical offices responsible for overseeing certain duties throughout the Colony, were clustered in Cape Town. It is also evident in the method that was adopted in order to concentrate the 'lunatics' of the Cape at Somerset Hospital and Robben Island. In the means used to try and handle the confinement and care of 'lunatics' and lepers we can observe how the local government realised its inability to exert substantial influence over far flung institutions. As a result it determined that centralising its resources for handling these populations was going to be the most effective strategy, thus mirroring the suggestion of the Commissioners in relation to the Cape's insane.

Terror and stereotyping

The fear of leprosy and the prospect that it may spread in an unrestricted manner appears to have captivated the minds of the Colony from time to time. As we have already seen, an apparent upsurge in leprosy cases amongst the Khoikhoi had resulted in a leper tax in 1820.⁴⁸⁸ Such action indicates a degree of panic and terror that the disease might increase if left unchecked, yet fear of this disease was not isolated to 1820. The correspondence and minutes of the Supreme Medical Committee indicate a persistent panic that leprosy may become endemic to the Cape in the latter half of the 1820s. Measures to control, treat and isolate it safely therefore dominate many of the official accounts following the reconstitution of the Committee. Furthermore, the disease appears to have been a scapegoat for any form of unknown disease reported to the Supreme Medical Committee. This evidence reveals that the fear of leprosy within the Colony predated the establishment of the Robben Island leper institution in 1846.⁴⁸⁹ One can deduce that contrary to scholarship which cites the period around the mid- part of the 19th century as the years that saw an upsurge in leprosy fears, there was a sustained panic from the beginning of the 1800s.

Despite the conception of leprosy being a disease of the Khoikhoi, white sufferers were seemingly placed into the same category destined for separation from mainstream society. As

⁴⁸⁸ *The Cape Town Gazette, and African Advertiser*. Cape Town, March 8th 1827.

⁴⁸⁹ Rod Edmond, *Leprosy and Empire: A Medical and Cultural History*, (Cambridge: Cambridge University Press, 2006), 156.

a result, like in the case of ‘lunatics’, few racial distinctions can be found in the records we have at our disposal. Although there was a premise that the Khoi were more susceptible to the illness, there were still white sufferers. Rod Edmund writes that before “compulsory segregation was finally introduced in 1892” amongst the Cape’s leper populations the predominantly financially destitute white sufferers were viewed in a similar manner to their Khoikhoi counterparts.⁴⁹⁰ One can therefore draw links between the class positions of these unfortunate individuals. Despite being of European descent, these lepers experienced little preferential treatment. Furthermore, the fact that Edmund suggests it was only poor whites who suffered from leprosy allows us to draw correlations between the contraction of the condition.⁴⁹¹ The Khoikhoi population of the Cape had by the early 19th century been reduced to a state of serfdom. As a result they were largely economically destitute and forced to live in poverty across the Colony. The suggestion of Rod Edmund that it was only underprivileged white European settlers who suffered from leprosy points towards a common factor of acquiring the illness in the Cape context. In addition, the financial state of the white sufferers may have played an important role in their comparative image with the Khoi afflicted.

Camps Bay as a new institution

In 1826 the committee was tasked with determining the suitability of different areas for the placement of a new leper institution. On the 16th of August, they inspected the area of Camps Bay and found that it would have been a very promising option, if not for some rather important issues.⁴⁹² Unlike the hard to reach Hemel en Aarde colony, the potential location of Camps Bay offered convenience which would allow it “to be more immediately under the eye of Government”.⁴⁹³ This accessible positioning had previously been taken advantage of by Lord Somerset “as a place for sea bathing”, a fact comically evident in the official records of the Cape.⁴⁹⁴ In addition, the proximity of the institution would allow for “the trial of medicine” under close observation.⁴⁹⁵ Yet there were downsides to the proposal of turning Camps Bay into a leper treatment centre. The members of the committee noted that the inhabitants of Cape Town would more than likely not stand for such a move due to the disease “being generally considered an infectious and contagious complaint”.⁴⁹⁶ They felt that were the institution to be created then “great alarm and discontent would be excited” amongst Capetonians.⁴⁹⁷ It was this fear of local ill sentiment that deterred any attempts to appropriate the area of Camps Bay for use as a leper settlement.

The scrapping of what was described as a very promising location for a centralised institute raises concerns within the Colony around space, respectability and medical ignorance which

⁴⁹⁰ Rod Edmond, *Leprosy and Empire*, 157.

⁴⁹¹ *Ibid.*

⁴⁹² Supreme Medical Committee. Report on suitability of Camps Bay as a new leper colony. 16 August 1826. Report. MC vol.1.

⁴⁹³ *Ibid.*

⁴⁹⁴ George McCall Theal, *Records of the Cape Colony*, Volume 23, 86.

⁴⁹⁵ *Ibid.*

⁴⁹⁶ *Ibid.*

⁴⁹⁷ *Ibid.*

are mirrored by previous examples. The positives offered by the position of a leper establishment in Camps Bay were clearly outweighed by the negative public backlash that the medical officials were bound to receive should the proposal go ahead. Such a level of fear expressed by the Supreme Medical Committee shows how low the care of their leprosy patients ranked on their list of priorities. Their report of the 16th of August 1826 clearly described the numerous benefits which would accompany the placement of a leper colony in Camps Bay. Yet the assistance that would be offered to the Cape's lepers was not worth the trouble and loss of respect that the Committee members would need to endure should the proposal be followed through with. Such an example can again illustrate how the wellbeing of the patient was not paramount in the minds of many medical practitioners in the Cape Colony. Furthermore, in the mentioning of the positives that would accompany the location of the new institution, the Committee appears to have been enamoured with how they could benefit from it. They noted that the positioning of the colony would allow for the observation of the effects that new untested trial drugs would have on lepers. This would in turn be of a potential positive "result to the science and practice of medicine".⁴⁹⁸ The advancement of their careers through the possibility of making a medical and scientific breakthrough was of primary importance when identifying a location. This example yet again points towards the tensions present within the Cape medical administration. Ideas around humane care were overshadowed by other factors determined by personal desires and the realities of the local Cape context. It is clear that there were conceptions around benevolent treatment of lepers originating from the British metropole, yet the translation of these ideas into reality within the specific Cape Colonial context had issues.

Perceptions of the illness

The section on the potential establishment of the Camps Bay leper colony also illuminates perceptions of the disease. The members of the Committee describe in the minutes from August 1826 how the general population viewed the condition of leprosy, as well as how they felt that it could be transmitted. The authors of the report pertaining to the potential Camps Bay location described how the condition of leprosy was "generally considered an infectious and contagious complaint" by the vast majority of Cape Town's population.⁴⁹⁹ This raises the theme of cleanliness and space within this unique colonial context. The fact that leprosy came to be considered as a disease spread exclusively by the Khoikhoi is also very interesting with these themes in mind. Such a correlation could therefore serve as further justification for the oppression of the Khoi.⁵⁰⁰ Here we see how important it was to place those who were deemed to be a threat outside the vicinity of the respectable inhabitants of Cape Town.⁵⁰¹ This is mirrored by the earlier establishment of Hemel en Aarde whose positioning far from any major settlement was crucial to its selection as an appropriate site. Such insight allows us to better understand what can be described as a general panic at the threat of a leprosy

⁴⁹⁸ Supreme Medical Committee. Report on suitability of Camps Bay as a new leper colony. 16 August 1826. Report. MC vol.1

⁴⁹⁹ *Ibid.*

⁵⁰⁰ Penelope Edmonds, *Urbanizing Frontiers*, 10.

⁵⁰¹ Supreme Medical Committee. Report on suitability of Camps Bay as a new leper colony. 16 August 1826. Report. MC vol.1

pandemic, sweeping through the Colony. This feeling of general fear amongst people throughout the Cape is palpable in the level of attention given to the condition in the minutes of the Supreme Medical Committee throughout the second half of the 1820s.

Yet the Committee also went on to describe their own views of the leprosy condition in the report of August 1826 and those which followed. These records are illuminating as the dichotomy between the different practitioners perceptions of the condition, is evident throughout the subsequent minute records. The Committee declared, with regards to leprosy, that “many modern authors of high repute consider it as non-contagious”.⁵⁰² They then went on to profess that their stance as a collective, was in line with this belief. This contrast is yet further evidence of the fact that there was very little standard of knowledge and approach towards treating illness maintained in the Colony at this point in time. Despite the Committee’s professed belief that the condition of leprosy was not contagious, they still advocated resolutely for the separation of afflicted patients from those presenting with other illnesses. This position was due to two factors. Firstly the Committee continually reiterated the need to prevent panic in the general population. They described how the visual ascetics of the condition and its “incurable nature” were too much for normal people to handle.⁵⁰³ This was despite the position of the Committee, thus evidencing the lack of scientific surety and knowledge available on the condition in this context. But secondly the Committee’s personal feelings on the transmission of the disease drove their call for what was essentially permanent quarantine. Although the members of the Committee felt that the disease was not contagious under normal circumstances, they determined that transmission occurred as a result of genetics. By separating the affected patients, not just from the general public, but from the opposite gender of other sufferers, they felt they could eradicate the problem that was of such concern. It was due to these two reasons that the Committee attempted to find a “detached building” at Somerset Hospital where the lepers could be kept, prior to their transportation to the Hemel en Aarde facility.⁵⁰⁴

Despite their earlier stance on the contagious nature of leprosy, the Committee were forced to backtrack just five months later in their report to the Governor on the state of leprosy in the Colony. They admitted that “in the present state of” their understanding there was no definitive way of declaring leprosy to be non-contagious.⁵⁰⁵ This was of course the correct decision as modern day medicine has determined the ability of leprosy to be passed on through contact.⁵⁰⁶ It appears as if some instances had been brought to their attention in the period since their report on suitability of Camps Bay as a leper colony which changed their position on the illness. In this regard they wrote: “Some melancholy cases have occurred in respectable Dutch families in this colony where it could not be traced to hereditary taint, and

⁵⁰² Supreme Medical Committee. Report on suitability of Camps Bay as a new leper colony. 16 August 1826. Report. MC vol.1

⁵⁰³ Supreme Medical Committee. Recommendation regarding the accumulation of lepers at Somerset Hospital. 9 January 1827. Report/Recommendation. MC vol.1

⁵⁰⁴ *Ibid.*

⁵⁰⁵ Supreme Medical Committee. Update on the state of leprosy in the Colony. 7 May 1827. Report. MC vol.1.

⁵⁰⁶ John Launcer, “Hansen’s Disease”, *QJ Med* 100(2007), 1.

in who it was suspected to have originated from contact with leprous persons”.⁵⁰⁷ Such an interesting turn around in the position of the Committee shows how unstable the standard of medical knowledge was in the Colony. This case indicates that what was considered medically sound theory, was fluid within the Cape context.

The Committee’s preoccupation with the leprosy threat is evidenced continually with specific cases forwarded to their office from the rural districts. This indicates an interesting notion of the Cape Town office being the central hub of information. The fact that some rurally based practitioners requested diagnostic assistance from the members of the Committee is striking in that it is proof that some felt that there was some form of knowledge network to which they could refer. This framework would in turn be able to give a more ‘educated’ opinion on the specific case. One such instance involved the diagnosis of a slave man with an unknown illness. The Committee upon reviewing the case were “unanimously of opinion that his disease is of the nature of that species of leprosy called elephantiasis”.⁵⁰⁸

As has already been raised, the case pertaining to the proximity of the lepers to Cape Town highlights the link between themes of cleanliness, distance and disease in the minds of the local colonists. Such concerns appear frequently in the issues brought before the Committee and the prior position of Medical Inspector pertaining to the positioning of institutions that could pose a potential public health hazard. Another instance similar in nature can be seen in the minutes of the 26th of May 1826. These records show how the Committee’s opinion was for asked by the Secretary of Government regarding the establishment of “privies in the barrack yards by making excavation to a certain depth in the earth”.⁵⁰⁹ The reason their feelings on the matter were asked, was due to the fear that such action would pose a hazard to the health of Cape Town’s population.⁵¹⁰ This same issue relating to the proximity of things that were deemed to have been potential health hazards is also evident in the debate around burials. The Committee advised on the 16th of June 1826 that a proposed burial site should be moved to “a more distant spot for both the hospital and town now extending in the direction that the one proposed”.⁵¹¹ They also raised issue with the practice of burying the dead “in vaults under the church” as a number of “incalculable mischiefs may possibly ensue”.⁵¹² The evidence for this proposal was backed up the Committee who cited a case whereby “a pregnant lady and her daughter while at devotions by an accident of this kind were precipitated into the midst of one”.⁵¹³ Here we can see how the Committee do not always count on medical evidence as to the dangers of a particular practice in order to have it outlawed. Instead they used a particularly alarming case of structural weakness to back up their assertions that the cemeteries should be moved further outside of town. The issues around policing the boundaries of the town are again made apparent. Such concerns with

⁵⁰⁷ Supreme Medical Committee. Update on the state of leprosy in the Colony. 7 May 1827. Report. MC vol.1

⁵⁰⁸ Supreme Medical Committee. Reply of SMC relating to case of unknown illness. 23 December 1826. Letter. MC vol. 1

⁵⁰⁹ Supreme Medical Committee. Update on the state of leprosy in the Colony. 7 May 1827. Report. MC vol.1

⁵¹⁰ Supreme Medical Committee. Update on the state of leprosy in the Colony. 7 May 1827. Report. MC vol.1

⁵¹¹ Supreme Medical Committee. Minutes from meeting of the 16 June 1826. 16 June 1826. Minutes. MC vol.1.

⁵¹² *Ibid.*

⁵¹³ *Ibid.*

notions relating to the public space, cleanliness and disease are mirrored in the issues raised by Barry pertaining to the positioning of the town's abattoirs. These same topics were brought up by the commissioners of inquiry and raised on a much greater scale to the Colonial Office in London.

The panic caused by a general conception that a leprosy pandemic was on the verge of spreading resulted in the Committee attempting to establish an "inquiry into the state of leprosy throughout the colony".⁵¹⁴ The findings were to be brought "before government" once finished.⁵¹⁵ This was done quickly and the results, which were made available on the 7th of May 1827 make for very interesting reading. Firstly, the Committee declared that Hemel en Aarde was no longer performing any of its intended functions. They pointed out that the institution was "neither a hospital for treating leprous cases with a view to cure, nor is it a place for seclusion of those affected with leprosy to prevent dissemination of the disease by hereditary descent (the only certain way it is known to be communicated and kept up)".⁵¹⁶ Such a statement makes it clear that the Committee realised the inability of anyone in Cape Town to ensure the efficient and proper running of an institution so far away. It also serves as an admission that the medical systems approach towards of lepers was lacking in both key areas, being prevention and cure.

But the debate around Camps Bay's suitability also raises questions regarding methods of medical treatment which drew on conceptions of transmission. As a result there appears to have been two modes of thinking with regards to the disease's longevity as a threat to the health of the colony. On one hand doctors were concerned with developing means to cure the illness once and for all and on the other they attempted to find ways to prevent its transmission and eliminate it as a threat through isolation. It was the latter of the two approaches that institutions like Hemel en Aarde sought to adopt, yet the correspondence around Camps Bay's eligibility as a leper colony suggests a move towards forms of actual treatment. By having a population of lepers so close to the administrative and medical hub of the colony, a number of potential cures could be tested over an extended period of time. The Committee's attempts to find cures for leprosy was an agenda that they clearly tried to imbue amongst their underlings. This is evidenced in their correspondence with the notorious figure of Surgeon Honey in 1830. Honey had since been relocated to the area of Caledon to act as district surgeon there in the aftermath of the scandal involving his treatment of the Somerset Hospital 'lunatics'.⁵¹⁷ The fact that he was sent to Caledon by the Committee as a form of punishment, emphasises how the different areas of the Colony were viewed. Despite essentially being promoted to the position of district surgeon, his relocation to a rural constituency was a form of penance. A posting to the Colony's capital town can thus be viewed as a more respectable and admirable position within the local colonial society. In comparison, being placed in the countryside to administer services to a much larger geographic area offered little hope of promotion or upward social mobility in the grander

⁵¹⁴ Supreme Medical Committee. Recommendation regarding the accumulation of lepers at Somerset Hospital. 9 January 1827. Report/Recommendation. MC vol.1

⁵¹⁵ *Ibid.*

⁵¹⁶ Supreme Medical Committee. Update on the state of leprosy in the Colony. 7 May 1827. Report. MC vol.1

⁵¹⁷ Edmund Burrows, *A History of Medicine in South Africa*, 90.

scheme of things. This is evidenced in Burrow's short section relating to this interesting figure where it is explained that District Surgeon Honey remained in Caledon until 1842 when he was "forced into retirement by infirmity".⁵¹⁸ Such a dichotomy in status is again evidenced by the works of Howard Phillips and Edmund Burrows. In *A History of Medicine in South Africa* Edmund Burrows explores the formation of the South African Medical Society in 1827. His brief section on the Society shows that during this period there was a tangible distinction made between practitioners who worked in Cape Town, and those who operated in the rural districts.⁵¹⁹

The correspondence of the Committee with the intrepid Mr Honey (in 1830) shows that he was, once again, not following procedure. As the District Surgeon of Caledon it was his duty to oversee the medical needs of the lepers at Hemel en Aarde (yet another reason to view his relocation as a punishment). The minutes of the Committee note that they reprimanded his requests for more medicines due to the fact that he had not documented how much of each drug he still had in his medical chest. As a result they informed him "that in future he should state the quantities remaining".⁵²⁰ This would allow the members of the Committee to keep up to date with whether Honey was in fact requiring the medicines he was applying for. The suspicions of the Committee are further evidenced in their declaration that Honey's request for one particular strand of medicine was "exorbitant".⁵²¹ Furthermore there were better remedies that could be prepared for application to the lepers' wounds. They went on to instruct him of their wishes that he conduct "the trial of a weak solution of the chloride of lime".⁵²² This solution would then need to be applied to the lesions of the lepers under his care. Such an instruction forms part of the trend within the Cape metropole to conduct medical trials.

Scientific research and respectability

This trend links to the attempts of professional men to further the image of the profession by emphasising their scientific expertise and their worth to society. Such an example ties into a greater development identified amongst the doctors of Britain during the same period. There was a concerted effort to "identify doctors as gentlemen of high social status" within Britain, which in turn filtered down to colonies like the Cape.⁵²³ The attempt to make medical breakthroughs and assert the scientific basis of the medical profession was crucial to this grander scheme. This push by the Supreme Medical Committee reveals the intra-Imperial trends of establishing a credible and respected image of the doctor in the 19th century. But despite the intentions of the central authorities, the lack of documented medical trials in the rural districts is notable. The positioning of the colony's principal leper treatment and confinement centre meant that it was outside of the grasp of the Committee and its intent to

⁵¹⁸ *Ibid.*

⁵¹⁹ *Ibid.*, 130.

⁵²⁰ Supreme Medical Committee. Examination of District Surgeon Honey's request for medicines. 15 October 1830. Report. MC vol.1

⁵²¹ *Ibid.*

⁵²² *Ibid.*

⁵²³ Harriet Deacon, "Introduction: The Cape Doctor in the Nineteenth Century", 33.

conduct experimental tests. It was this issue that primarily led to their desire to relocate the leprosy facility to a part of the colony closer to Cape Town. Such concerns were clearly not present in the original effort to have the primary facility placed at Hemel en Aarde. This disparity over a matter of years, indicates a move by authority figures to establish a more conducive scientific research environment with regards to leprosy. Without the relocation of the Cape Colony's chief leprosy facility, the members of the Medical Committee were reliant on the very weak authority which they exercised over Surgeon Honey, to carry out long term trials.

Nevertheless the intentions of some medical authorities cannot and should not be taken as an indication of an overall move towards the Cape becoming a place of scientific advancement. This view is due to the opinion offered by Barry in 1824 where he remarked that "the Cape was not a School for Medicine."⁵²⁴ This accompanied his attempts to ban the apprenticeship of apothecaries within the Colony as he felt the Cape was not ready to be a producer of medical trainees.⁵²⁵ Such actions would therefore seek to keep the Colony as a subservient member of a medical knowledge network whereby it would continue to be reliant on Europe for all its practitioners. In contrast, the SMC who succeeded Barry displayed a concerted effort to make the Cape a producing member of the empire wide network. Although Barry did perform one of the first documented successful caesarean sections in the world, his knowledge of the event was gained from European studies and previous attempts.⁵²⁶ Furthermore, Barry does not appear to have advocated widespread trials and tests of medicines in the same way that the Medical Committee did. This was despite the fact that he personally experimented with local plant remedies.⁵²⁷ The Committee also undid Barry's prior ban placed on the training of local apothecaries.⁵²⁸ This may seem to have been an attempt to prevent reliance on chemists from abroad. However Harriet Deacon indicates that this move was motivated by an internal attempt to solidify the image of the physician within Cape society by decreasing that of the apothecary. She writes: "The insistence on European training for doctors helped to maintain their social status".⁵²⁹ This would emphasise their uniqueness within Cape society and work towards emphasising and enhancing their prestige.

The attempt to find an effective means within the Colony of curing leprosy appears to have been very high on the agenda, as it was raised again. Such a consistent attempt seems to indicate a move towards not being entirely reliant on external knowledge. Rather, the moves of the Committee display vigour for knowledge production and an endeavour to contribute to a wider framework of scientifically based expertise. The report of the 7th of May 1827 compiled by the Committee on leprosy reveals the efforts they had made to test out iodine's effects on the lepers awaiting transport to Hemel en Aarde. They declared: "These trials have been exceedingly favourable and that most of the cases in which it has been used have been

⁵²⁴ Dr James Barry. Letter to Brink regarding the actions of the chief of justice. 24 September 1824. Letter. MC vol. 27.

⁵²⁵ Harriet Deacon, "Medical Gentlemen and the Process of Professionalization before 1860", 91.

⁵²⁶ Rachel Holmes, *The Secret Life of Dr James Barry*, 149.

⁵²⁷ Harriet Deacon, "The Cape Doctor and the Broader Medical Market, 1800-1850", 58.

⁵²⁸ Harriet Deacon, "Medical Gentlemen and the Process of Professionalization before 1860", 91.

⁵²⁹ *Ibid*, 91.

benefited and some even appear to have been cured by it”.⁵³⁰ With that being said, they made sure to note that they had not been able to observe the effects of the drug for an extended period of time, therefore justifying their attempt to have an institution established closer to Cape Town.⁵³¹ They concluded the third point of their report by calling for iodine to be “tried in all the leprous cases in the Colony”.⁵³² More importantly they wished to instruct District Surgeon Honey that he should put all the lepers under his care upon a course of iodine “for at least 6 months”.⁵³³ This was a result of his access to the highest concentration of lepers. However their proposed duties for Honey which were intended to advance the science of medicine, ignored two important factors. The first was Honey’s complete disregard for authority made blatantly obvious in the records following his shipwreck off Mossel Bay. The second was the distance between Honey’s primary base of operations in Caledon and the leper institute at Hemel en Aarde. The inspection of Dr Barry in 1822 revealed just how big an issue this geographic spacing was. This would have impacted Honey’s ability to make regular observations as to the effects of the iodine over the intended period. The side effects and intricacies of the medication’s influence on the body could thus not be sufficiently deduced. This case clearly shows how the Committee was trying within its unique colonial context, to not be mere passive consumers of new medical ideas and drugs.

Yet it is also clear that the Committee was trying to use all the means at its disposal in order to test the new drug iodine and produce valid and authentically tested knowledge on its effects. This is evident in the fact that they intended to have District Surgeon Honey test the new drug on all his leprous patients, but also their intentions for the other districts in the Colony. They informed the Governor in 1827 that they were “happy to draw up instruction” for the use of iodine, which would then be distributed (along with the drug) to the different districts.⁵³⁴ It would appear that the transportation of all lepers in the different constituencies had ceased in favour of the former means of confinement within the general area of origin. The potential attributes of iodine meant that the respective district surgeons would then be able to provide treatment of a kind to the lepers under their control. Here we can again see how the written instruction was the only feasible means by which medical knowledge and new regulations could be circulated to the different parts of the geographically dispersed Colony. But, the directions they intended to pass on to the district surgeons sought to have them contribute to a wider database which would in turn be funnelled back to the local hub of Cape Town. Their envisioned directives for the district surgeons involved reports “quarterly on the number, nature and progress of their cases and on the effects of the iodine upon them or of any other remedy that they may use”.⁵³⁵ Such a set of instruction displays the Committee’s aim of receiving quantifiable data from a number of sources which could then be collated and interpreted. A concrete conclusion of iodine’s use in leprosy cases could then be discerned and disseminated on both a local and intra-imperial level.

⁵³⁰ Supreme Medical Committee. Update on the state of leprosy in the Colony. 7 May 1827. Report. MC vol.1

⁵³¹ *Ibid.*

⁵³² *Ibid.*

⁵³³ *Ibid.*

⁵³⁴ *Ibid.*

⁵³⁵ *Ibid.*

They opportunistically attempted to do their own personal trials of iodine despite the lack of a sizeable leper population in Cape Town. This can be seen in the case of an afflicted slave girl on whom they tested the effects of iodine with permission from the governor, in Somerset Hospital on the 23rd of May 1827.⁵³⁶ As well as evidencing again that the Committee needed the permission of the governor to test new drugs, the particular case points to their concerted effort to collect data wherever they could on iodine and its effects. This emphasis on iodine and leprosy is striking and once more draws our attention to the agenda of the Committee and their particular intentions to contribute to a wider network of health related information. They appear to have identified certain factors and problems unique to their local context before attempting to find a scientific approach in order to make their findings on these issues palatable for a wider medical audience abroad.

The theme of conducting scientific research in the context of the Cape Colony was not limited to the condition of leprosy.⁵³⁷ Edmund Burrows notes in his work from the 1950s that the era under Charles Somerset's governorship saw a dramatic increase in locally based attempts at scientific progress.⁵³⁸ This translated into a number of medical experiments some of which were bizarre. One such instance was brought to the attention of the Supreme Medical Committee in 1829. The Committee wrote with urgency to the local Colonial Office on the matter, revealing their fears about the outcome of the proposed treatment. Their communication reads: "the Supreme Medical Committee beg to return the enclosed communication on the efficacy of train oil as a remedy for the bites of serpents, and the Committee will not fail to seek further information on the subject, at the same time they much fear the reported remedy will be found a fallacious one".⁵³⁹ Such a peculiar instance of an attempt to further the medical sciences, raises a number of interesting features relating to the practice and advancement of the practice of medicine in the Cape. Although the Committee was quick to try and suppress the proposed use of train oil to treat cases of snake bites, the fact that it was even proposed indicates the scholastic environment that was present in the Colony. Such an instance shows that for some budding scientific physicians no substance was off limits. The attempted use of an industrial material suggests an endeavour to try and understand other uses of these newly popularised substances and whether or not they could have uses in the medical context. Furthermore, the proposal that they could be used as a treatment for poisonous snake bites suggests an effort to find new ways to treat medical problems specific to the Cape context.

Robben Island

The intentions of the Committee in finding a closer location for a leper institution continued after the Camps Bay report, with the members of the Committee deciding on Robben Island

⁵³⁶ Supreme Medical Committee. Acknowledgement of receipt of letter from government dated 18th inst. 23 May 1827. Receipt. MC vol.1

⁵³⁷ Saul Dubow, *A Commonwealth of Knowledge: Science, Sensibility and White South Africa 1820- 2000*, (Oxford: Oxford University Press, 2006), 166.

⁵³⁸ Edmund Burrows, *A History of Medicine in South Africa*,130

⁵³⁹ Supreme Medical Committee. Response to letter regarding efficacy of train oil for use in snake bite cases. 10 December 1829. Letter. MC vol.1.

as the most appropriate site. This would be close enough for regular inspections and the observation of medical trials, in addition to being sufficiently removed from the general population of Cape Town who feared leprosy sufferers. It was in their report of the 7th of May 1827 that “extinction of the disease will be forwarded by removing the institution to Robben Island and making it at once a hospital and a place of quarantine for the cases affected”.⁵⁴⁰ This would replace the failing Hemel en Aarde colony and serve as the catchment for the entire colony. Yet despite their identification of an appropriate site, their ability to have their plans actioned, appears to have been minimal. The topic only re-merges in the records two years later where the Committee sought to provide their opinion on the state of the island and its conduciveness to housing leprosy and mental patients.⁵⁴¹ This collectivising of these two categories of undesirable patients is important as it indicates a link between how they were perceived. Their reply to a letter from the Colonial Secretary Bell stated that they still thought the location to be “peculiarly well adapted for such establishments”.⁵⁴²

Apart from allowing for their adequate separation from any settlement of people, the weather was stressed to be complementary and the patients would “have access to sea bathing”, an opportunity that was evidently “much recommended in leprosy”.⁵⁴³ The location would also make supply and inspection easy. This seems to have been of great importance given the problems with exerting authority over far flung institutions like Hemel en Aarde. The building specifications suggested by the Committee for the intended leper and maniac establishment give some indication of the extent to which these two conditions prevailed in the Cape during this time. The Committee determined that “accommodation for 24 maniacs and 120 lepers” would be needed. However the make-up of these two populations posed a problem that needed special attention.⁵⁴⁴ No mention is made of race, but the report reveals that “the establishment for the male cases would require to be larger than that for the females by about one fourth, as they find that in both mania and leprosy the average numbers of males affected exceeds that of females nearly in that proportion”.⁵⁴⁵ This underlines how the Committee was collecting and interpreting data that they were receiving from throughout the Colony. This interpretation of the information that they had accumulated regarding these two conditions, shows how policy suggestions and inactions were impacted by data collected from the different corners of the Colony. Yet, as we have seen throughout this study there was very little regular and effective contact between the locally based administrators in Cape Town, and the physicians and patients in the rural districts. As the Robben Island institution was intended to act as the sole leper and ‘lunatic’ colony in the Cape it can be seen that these were the numbers of the two conditions that the Committee had knowledge of. Attempts to set up a colony wide policy in order to deal with these problems, was therefore reliant on incomplete information.

⁵⁴⁰ Supreme Medical Committee. Update on the state of leprosy in the Colony. 7 May 1827. Report. MC vol.1

⁵⁴¹ Supreme Medical Committee. Report on suitability of Robben Island as a leper and lunatic asylum. 2 March 1829. Report. MC vol.1

⁵⁴² *Ibid.*

⁵⁴³ *Ibid.*

⁵⁴⁴ *Ibid.*

⁵⁴⁵ *Ibid.*

Again, the lack of regard for patient welfare and the prioritisation of other factors raises its head in the document forwarded to the Governor's office. The Committee stated that their previous recommendations had called for the intended institute to be reserved for male leper patients only. The female sufferers would then remain in the district of residence where it would be the responsibility of the local district surgeon to quarantine them. But the Committee rethought this strategy and suggested that all lepers, with no exception, should be removed to the single location of Robben Island, should it be confirmed as the Colony's new institution. This they stated would save money, in addition to being "more congenial to the feelings of the public (who have a great horror this disease)".⁵⁴⁶ They would then need to seclude the two genders from one another in order to prevent "cohabitation between the sexes" thus allowing for the condition to become extinct through quarantine and the prevention of the condition being passed down in a hereditary manner.⁵⁴⁷ The fact that this seclusion also applied to the maniacs is also interesting as it indicates a rudimentary understanding of genetics and how mental illness could be passed down from parent to child. The emphasis of the general population's feelings towards the illnesses intended for seclusion on Robben Island accompanied by the move to save money again highlights the lack of regard the medical fraternity held for these patients.

⁵⁴⁶ Supreme Medical Committee. Report on suitability of Robben Island as a leper and lunatic asylum. 2 March 1829. Report. MC vol.1

⁵⁴⁷ *Ibid.*

Conclusion

The response of the medical fraternity to these two medical conditions comes to epitomise the trends in governance present both within the Cape and across the Empire during this period. The presence of an internal and external network is apparent when looking at such cases; however these were not uniform structures that functioned seamlessly. It is clear that individual actors, like Dr Barry and Surgeon Honey, with personal motives often manipulated these flimsy connections to serve their own ends. This can be seen in the lack of compliance received from rurally based practitioners despite directives from the officials. With that being said, it was the authorities who appear to have seen networks as the most efficient tool in order to maintain a standard and some semblance of order. Time and time again we have seen how the establishment in Cape Town sought to implement and use networks of information in order to try to maintain order within the medical field. Here, attempts at control abounded yet these were characterised by an inability to enforce the intention behind them. This resulted in a system that had varying levels of authority in different areas, as well as a great deal of disorder. Although the constraints of this thesis have prevented a more in depth study of medical care in the Cape (for example the fascinating case of Somerset Hospital which has been briefly viewed), the sheer lack of health care uniformity is apparent. Events in this colonial example therefore mirror the attempts of contemporary metropole officials based in London who tried to reform and maintain surveillance through networks of knowledge. This comparison allows us to see how tools of control filtered down into local colonial governance structures. However, it also indicates how structures were altered and reformed in order to try and increase efficiency. In addition, the failures of such observation and control methods is apparent in both cases, as seen by the numerous malpractice cases in the colony and the metropole's move away from individual based governance and surveillance in 1835.

Yet it is also clear that the Cape Colony did play a role in a web of medical information and control. It received a great deal of medical expertise and trained professionals from Europe and in addition drew conceptions of health field based respectability and hierarchy from this dialogue with the mother country. These notions were in turn emphasised through the local network that utilised proclamations and authoritative threats to try and disseminate such ideas. Such conceptions were in turn used to try and maintain some form of standard despite the lack of manpower to ensure compliance. But it is important to note that this was not a passive process. At times the Colony was actively engaged in discussion with the metropole over certain health related ideas, and although this conversation should not be over emphasised, it was still present. Attempts were made at producing scientifically based knowledge in the unique Cape context indicating that the intent was there, amongst some practitioners. However the disjuncture between the urban and rural areas in this regard became apparent which in turn reiterates the inability of the Cape Town authority to enforce its agenda over such a geographically dispersed region. It appears as if such issues of enforcing order may have prompted attempts at internal reform when in late 1831 the position of Cape District Surgeon was abolished, and the Supreme Medical Committee's duties were

handed to the South African Medical Society.⁵⁴⁸ In this way the Cape authorities appear to have pre-empted the Colonial Office's realisation in 1835 that present structures of interpreting information and methods of reforming and enforcing order, were failing.⁵⁴⁹

It is consequently apparent that health care and attempts to regulate those who practiced it in the 1820s Cape, did not function in isolation. Structures of control and management were heavily influenced by the trends of governance prominent at the time. Committees, Commissioners and inquiries abounded during this time and the external factors of empire did impact medical care within the Cape Colony. In addition, medical knowledge was received and disseminated in the Colony. Yet it is also clear that the Colony was unique within the context of the empire. The Cape's intricate past which was characterised by different forms of colonial rule, as well as complex local factors like a distinctive geography and political set-up, resulted in a particularly haphazard response to certain medical conditions and the practice of healthcare. As a result the Colony did not always conform to conventions of the era. Consequently it can be confirmed that a focused lens on medical topics in the Cape can give insight into the Colony's history and its place within a grander context.

⁵⁴⁸ Edmund Burrows, *A History of Medicine in South Africa*, 132.

⁵⁴⁹ Zoë Laidlaw, *Colonial Connections*, 179

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