

The Expulsion of South Africa and Rhodesia from the Commonwealth Medical Association, 1947–70

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Abstract: In 1970 the medical associations of South Africa and Rhodesia (now, Zimbabwe) were expelled from the Commonwealth Medical Association. The latter had been set up, as the British Medical Commonwealth Medical Conference, in the late 1940s by the British Medical Association (BMA). These expulsions, and the events leading up to them, are the central focus of this article. The BMA's original intention was to establish an organisation bringing together the medical associations of the constituent parts of the expanding Commonwealth. Among the new body's preoccupations was the relationship between the medical profession and the state in the associations' respective countries. It thus has to be seen as primarily a medico-political organisation rather than one concerned with medicine per se. Although, there were also tensions from the outset regarding the membership of the Southern African medical associations. Such stresses notwithstanding, these two organisations remained in the BMA-sponsored body even after South Africa and Rhodesia had left the Commonwealth. This was not, however, a situation which could outlast the growing number of African associations which joined in the wake of decolonisation; and hardening attitudes towards apartheid. The article therefore considers: why the BMA set up this Commonwealth body in the first place and what it hoped to achieve; the history of the problems associated with South African and Rhodesian membership; and how their associations came to be expelled.

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Introduction

In November 1948 *The Medical Journal of Australia* carried a leading article entitled 'A British Commonwealth Medical Conference'. This described a meeting which had taken place at the headquarters of the British Medical Association (BMA) in London

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in September attended by delegates from Australia, Canada, Ceylon (Sri Lanka), Eire (Republic of Ireland), Great Britain, India, New Zealand, Pakistan, South Africa and Southern Rhodesia (later Rhodesia, now Zimbabwe). The article concluded that the idea behind this meeting had ‘much to commend it’. Its advantages included ‘bringing about closer union among the component nations’ and it was a sign to the world that ‘there are within the several units of the Commonwealth groups of persons with scientific training and a knowledge of humanity to whom tradition and cohesion are indispensable’.¹

Other similar journals also took an upbeat approach. The *Canadian Medical Association Journal*, likewise in a leading article, suggested that the new body had been formed because of ‘a general desire for a closer linking between the various medical associations of the Commonwealth’. And while its remit was restricted and its structure informal, nonetheless ‘it may reasonably be expected that, among a number of men with the common ties and interests which will exist in this group, there will at least grow up a most desirable sense of unity’.² The Pakistan association’s standpoint was articulated by its journal’s editor, Dr N. Ahmed. After commenting on the discussion of the British National Health Service (NHS) which had taken place, Ahmed turned to the future. The British, he suggested, knew that their Empire, or at least ‘its objectionable imperialistic tendencies and designs’, was gone. But its ‘direct and indirect beneficial activities’ could promote mutually positive improvement if carried out in ‘the spirit of mutual co-operation and equal partnership of the commonwealth countries’. His own association had been born in an ‘absolute independent atmosphere’ but had chosen to ‘become a member of the Commonwealth family and will continue to remain one as long as the circumstances permit us to do so’.³

These articles celebrated the creation of the British Commonwealth Medical Conference (BCMC), reconstituted in the early 1960s as the Commonwealth Medical Association (CMA), which, despite the enthusiasm with which the original body was greeted, has received scant attention in the existing historiography.⁴ The rest of this piece examines in particular the tensions around the membership of the Southern African associations and how, after a long and fraught period of membership, these tensions came to be resolved. To do so, the origins and aims of the BCMC/CMA are analysed in order to illustrate its self-perceived role as a medico-political organisation. More broadly, this Commonwealth body can be seen as part of a broader trend to ‘internationalise’ health care and information about health care after the Second World War. While far from a new phenomenon, nonetheless the immediate post-war period saw the creation of a number of important institutions, for instance the World Health Organization (WHO). This article thus also contributes to our growing understanding of international and transnational health initiatives post-1945.⁵

¹ ‘A British Medical Conference’, *The Medical Journal of Australia*, II, (1948), 639–40.

² ‘The British Medical Conference’, *Canadian Medical Association Journal*, 60, 4 (1949), 410.

³ N. Ahmed, ‘British Commonwealth Medical Conference’, *Journal of the Pakistan Medical Association*, 1, 2 (1949), 26–7.

⁴ There is a passing reference in Peter Bartrip, *Themselves Writ Large: The British Medical Association 1832–1966* (London: BMJ Publishing Group, 1996), 292–3. See also Terence Johnson and Marjorie Caygill, ‘The British Medical Association and Its Overseas Branches: A Short History’, *The Journal of Imperial and Commonwealth History*, 1, 3 (1973), 303–29.

⁵ For the foundation of the WHO, James A. Gillespie, ‘Social medicine, social security and international health, 1950–60’, in Esteban Rodríguez-Ocaña (ed.), *The Politics of the Healthy Life: An International Perspective* (Sheffield: EAHMH, 2002), 219–39. For British health care in its international context, John Stewart, ‘Healthcare systems in Britain and Ireland in the nineteenth and twentieth centuries: the national, international and sub-national contexts’, in Donnacha Seán Lucey and Virginia Crossman (eds), *Healthcare in Ireland and Britain*

It should be acknowledged that much of the material utilised comes from British-based sources and archives. Many of these have been under- or unexplored by historians of medical politics in Britain and further afield. The focus on British material in part reflects the availability of material to which the author had access. So, for instance, it has not been possible to track down much about the internal dynamics of the medical association of Rhodesia, a search of the *Central African Medical Journal* notwithstanding. Indeed, it may be significant in itself that this publication had little to say about the events discussed and analysed in this article. Nonetheless, the paucity of existing secondary literature on the BCMC/CMA suggests the need for, *inter alia*, a platform for further research in this area as well as an articulation of its historical significance. It is thus to be hoped that the present piece will stimulate further investigation into Commonwealth medical networks, and not least from non-metropolitan perspectives.

Founding the British Commonwealth Medical Conference

The late 1940s was a challenging era in medical, domestic and world politics. As the BCMC was coming into being, the BMA was engaged in an acrimonious dispute with Britain's Labour government over the creation of the NHS, a dispute which saw the BMA back down at the last minute in summer 1948. The BMA was acutely conscious, too, of the still simmering conflict between its New Zealand branch and that country's Labour government; and of an almost contemporaneous dispute between its Australian branch and its Labor government. What united these disputes was the hostility of the medical profession, especially in the so-called 'White Dominions', to socialised medicine and state intervention.⁶

Resistance to socialised medicine was also manifested in the founding in 1946 of the World Medical Association (WMA) with BMA sponsorship. As James Gillespie shows, the WMA, too, was 'part of a wider campaign against state medicine' despite a close relationship with the WHO, a body which contained more radical elements. Initially dominated by the British, from 1948 the WMA came increasingly under the influence of the American Medical Association, vigorous opponent of socialised medicine. Although in some respects constrained by the more collectivist tendencies of, for example, many of its European members, the WMA nonetheless continued to insist that health was essentially a matter for the individual.⁷ More pertinently for this article, though, and as we shall see, the WMA was also to have problems with South Africa in the last quarter of the century.⁸

Returning to the late 1940s, it was almost certainly the case by this point that the BMA envisaged a new Commonwealth body as both more sympathetic to its own ambitions and world view and more tractable than the WMA, as well as being able to build on much vaunted commonalities in training, language and medical cultures. The broader

from 1850: *Voluntary, Regional and Comparative Perspectives* (London: Institute of Historical Research, 2014), 61–78. For international organisations founded prior to 1939 see, for instance, Iris Borowy, *Coming to Terms with World Health: The League of Nations Health Organisation, 1921–46* (Frankfurt am Main: Peter Lang, 2009). On the importance of Britain's empire to Irish doctors, at least until after 1945, Greta Jones, '“A Mysterious Discrimination”: Irish Medical Emigration to the United States in the 1950s', *Social History of Medicine*, 25, 1 (2012), 139–56.

⁶ On New Zealand, Linda Bryder and John Stewart, '“Some Abstract Socialistic Ideal or Principle”: British Reactions to New Zealand's 1938 Social Security Act', *Britain and the World*, 8, 1 (2015), 51–75.

⁷ Gillespie, *op. cit.* (note 5), 231–3.

⁸ Mandisa Mbali, '“A Matter of Conscience”: The Moral Authority of the World Medical Association and the Readmission of the South Africans, 1976–94', *Medical History*, 58, 2 (2014), 257–77.

context is also important. On the international stage by the late 1940s, the Cold War was intensifying while Britain's Labour government was seeking to consolidate links with the Empire and especially with the Dominions.⁹ And, of particular importance for this article, in 1948 South African voters installed the National Party in power and the new, Afrikaner, government was soon vigorously to pursue its racially discriminatory policy of apartheid while remaining, until 1961, a Commonwealth member. Even before the advent, apartheid South Africa's racial policies had been denounced by India at the United Nations in 1946, although in the country itself the immediate post-war period was one of liberal optimism. As Saul Dubow remarks, the late 1940s were thus 'an interregnum'. Liberal optimism was still possible while the 'intentions and strength of the new apartheid government still remained uncertain'.¹⁰ All this, though, soon changed and it is against a background of increasing international hostility to apartheid that the commitment of its medical association to remain a member of the Commonwealth organisation needs to be seen.

Turning specifically to the BCMC, in July 1947 the BMA's Secretary, Charles Hill, wrote to what were described as the 'Commonwealth Medical Associations' (CMAs), the national medical bodies of the countries noted by *The Medical Journal of Australia*. Some of these organisations were still branches of the BMA. Others were independent, for example that of South Africa, which had declared its own autonomous organisation in 1945 while remaining a BMA affiliate.¹¹ This ongoing relationship with a 'British' organisation by the Medical Association of South Africa (MASA) is revealing in itself. As Conway and Leonard point out, Britons in South Africa had 'always existed in liminal spaces' in contrast to other 'old' Commonwealth countries, such as New Zealand, where they had a 'foundational place'. And to this can be added the further complicating factor of Afrikaner hostility to Britain and its empire.¹² Hill's letter explained that BMA Council had recently resolved to encourage closer links between Commonwealth doctors and their associations.¹³

Hill's approach was well received. So, for example, MASA's medical secretary, A.H. Tonkin, wrote that his federal council had approved the proposal, which, at a recent MASA dinner, had been further received 'with enthusiasm'.¹⁴ The Canadian Medical Association was slightly more circumspect, notwithstanding the editorial noted above. Its general secretary expressed concerns, for instance, about a possible conflict of interest with the WMA, a potentially undesirable outcome from the Canadian point of view. The end result was again an expression of interest and an agreement to 'co-operate' in its establishment.¹⁵ Canadian concerns about the role of the Conference and its successor recurred in the

⁹ John Darwin, *The Empire Project: The Rise and Fall of the British World System, 1830–1970* (Cambridge: Cambridge University Press, 2009), 543.

¹⁰ Saul Dubow, *A Commonwealth of Knowledge: Science, Sensibility, and White South Africa, 1820–2000* (Oxford: Oxford University Press, 2006), 248–9.

¹¹ See Johnson and Caygill, *op. cit.* (note 4).

¹² Daniel Conway and Pauline Leonard, *Migration, Space and Transnational Identities: The British in South Africa* (Basingstoke: Palgrave Macmillan, 2014), 181 and *passim*.

¹³ Archives of the British Medical Association (hereafter, BMA), CMA/1/1, letter, 18 July 1947, Charles Hill to Commonwealth Medical Associations (hereafter CMAs).

¹⁴ BMA, CMA/1/1, letter, 18 November 1947, A.H. Tonkin, Medical Association of South Africa (hereafter MASA), to Hill.

¹⁵ BMA, CMA/1/1, letter, 5 November 1947, T.C. Routley, general secretary of the Canadian Medical Association, to Hill; Archives of the Canadian Medical Association (hereafter, ACMA), Minutes of a Meeting of the Executive Committee, October 1947. I am grateful to the Association's archivist for locating this material.

coming decades, part of Canada's broader desire to resist too close involvement with the Commonwealth and to align itself more closely with the United States.¹⁶ Here we have an early sign that the dynamics of Commonwealth relationships were going to change significantly in the next two decades. This was to affect the BCMC/CMA not only with respect to Canada, but also in terms of the place of the Southern African associations within it. Overall, such changes can be attributed to the changing composition of the BCMC/CMA as, on the one hand, decolonisation took place and, on the other, the 'White Dominions' slowly began to weaken their links with Britain.

Nonetheless, the organising of the inaugural conference went ahead. A meeting of representatives of the BMA's Overseas Branch was told by Hill in the summer of 1948 that Council felt that 'the time had come to establish a body which was in a sense superior to the medical associations or branches in the Dominions'. What was to be the inaugural conference would take place in London later that year and the invitation to it 'had been accepted with alacrity by practically every Dominion'. It was thus hoped that the new body would 'effect a liaison between the Dominions in term of complete equality'.¹⁷ This notion of complete equality was part of a broader reshaping of the relationship between Britain and the Dominions and seen as a key component of the Commonwealth medical network.

In advance of the meeting three papers were sent out in addition to the proposed agenda. The first dealt with another BMA initiative to bind Commonwealth medical associations closer together, the Empire Medical Bureau. Set up in 1947, the Bureau's purpose was to answer queries from doctors from other parts of the Commonwealth and to help such doctors when visiting Britain.¹⁸ The second paper dealt with the proposed constitution and specifically claimed that, for example, there would be no conflict of interest with the WMA. The rationale for the new body was, as might be expected, that the participating medical associations not only 'share common ideals and traditions which are peculiar to the peoples of the Commonwealth, but they are faced with similar problems and difficulties in the sphere of medical service'.¹⁹ Just what such 'problems and difficulties' might be was flagged up in the title of the third document, 'The Medical Revolution in Great Britain', an account of the BMA's negotiations with the government over the NHS.²⁰ This was, to say the least, a somewhat one-sided depiction of what had taken place.²¹ But, as the Canadian delegate reported to his association's executive, the ensuing discussion 'provoked a great deal of interest and indeed sharp criticism from those outside Great Britain', the latter presumably over the BMA's purported capitulation to the government. The British delegates had, though, 'quite stoutly defended the scheme in general' while indicating disagreement 'on particular points or principles'.²²

¹⁶ In this context it is significant that, as Bartrip, *op. cit.* (note 4), 292 notes, Canada was 'never a BMA stronghold'.

¹⁷ 'Overseas Conference', *BMJ: Supplement*, II (1948), 39.

¹⁸ For the Bureau's origins and activities see, for example, letters from H.A. Sandiford, 'Medical Director of the Empire Medical Advisory Bureau, to the Editor', *New Zealand Medical Journal*, 48, 259 (1948), 273–4, and 49, 263 (1949).

¹⁹ BMA, CMA/1/1, British Commonwealth Medical Council, 'Inaugural Meeting to Be Held on 15 September, 1948: Document 2, Constitution of the Council: Notes Submitted for Discussion', 2, 1.

²⁰ BMA, CMA/1/1, British Commonwealth Medical Council, 'Inaugural Meeting to Be Held on 15 September, 1948: Document 3, 'The Medical Revolution in Great Britain', 1, 11.

²¹ See Charles Webster, *The Health Services Since the War: Volume I, Problems of Health Care* (London: HMSO, 1988).

²² ACMA, Minutes of a Meeting of the Executive Committee, October 1948, J.F.C. Anderson, 'A Report of a Meeting of Representatives of British Commonwealth Associations'.

All this alerts us to two important characteristics of the BCMC and, later, the CMA. First, attendance was limited to a small number of delegates, for the most part senior figures in their respective medical associations. These individuals had spent much of their later careers formulating and negotiating their associations' policies on health care organisation. They were thus medical politicians primarily devoted to advancing what they saw as their profession's interests. The idea was that these senior figures, after discussions and exchange of information at Commonwealth level, would return home and disseminate conference findings more widely. Second, papers at these meetings were predominantly of two types: first, and of paramount interest to members, on the profession's relationship with the state; second, issues in medical science and clinical practice.

As noted, the BCMC's creation had been welcomed by Commonwealth medical opinion. In Britain, too, it was acclaimed by the profession's leaders. Alfred Cox, another veteran BMA negotiator, used the commonly expressed notion of the Commonwealth as a 'family', claiming that the BMA had thus taken, through the BCMC and the Empire Bureau, a considerable step in promoting familial solidarity.²³ Commenting on the Inaugural Meeting a *BMJ* leading article reiterated the notion of the 'common link between medical men and women in the Commonwealth'. Overseas doctors drew 'inspiration' from Britain and often returned 'home' to pursue, for instance, postgraduate education. All Commonwealth doctors spoke 'a common tongue' and all were equal partners in the BCMC. And, in a passage which hints at a broader unease about the tense nature of global politics, it was hoped that 'common association and common aims (might) stem the forces of disintegration so painfully manifest' in the world. The piece concluded by noting the venues of future conferences, including South Africa in 1951.²⁴ The BMA can thus be seen as contributing to the 'Commonwealth of Knowledge' identified by Dubow.²⁵

Southern Africa

But a political issue which was to prove increasingly troublesome within the organisation itself was South African and Rhodesian membership. As noted, a conference had been scheduled to take place in South Africa in 1951 and, as was to become the practice, this was to be timed to run alongside the BMA's annual meeting. But neither of these meetings took place and the underlying issue was the South African government's commitment, since 1948, to apartheid. As *The Medical Journal of Australia* reported, an initial attempt by BMA Council, the body which ran the Association and generally consisted of members of the medical elite, to withdraw from the events planned for Johannesburg had been rejected by a meeting of the Association's representative body. The latter had a broader base than Council and was thus more attuned to the views of doctors in general. This was not the last time these two bodies would be at odds over Southern Africa. More immediately, though, MASA had approached the Minister of the Interior seeking assurances that there would be no obstacles to any BMA member seeking to enter South Africa. The Minister had declined to give such an assurance. Without it ever being made explicit, it is clear that the issue here was doctors from the Indian sub-continent and the hostility they might face if, for instance, they sought to enter segregated areas. As the journal put it, BMA Council 'could not continue in a course of action which might expose members to affront or

²³ Letter from Alfred Cox, *BMJ*, II, (1948), 690.

²⁴ Leading article, 'Medicine in the Commonwealth', *BMJ*, II, (1948), 606.

²⁵ Dubow, *op. cit.* (note 10), *passim*.

discourtesy or other unpleasantness'. The piece concluded that Australian BMA members 'will affirm their feelings of kinship and cordiality towards members of the Association in all other countries and towards members of associations affiliated with it in different parts of the British Commonwealth'.²⁶ Given that their country was vigorously pursuing a 'White Australia' policy at the time, and had a poor track record in its treatment of Aboriginals, this might be seen as rather self-serving, although possibly sincere enough in its own terms.

The BMA also received support from other BCMC members. The Executive Committee of the Canadian Association, for example, wrote to BMA Secretary Angus Macrae that it 'fully appreciates the necessity of these decisions and concurs in the action taken' – namely, that the meeting should be cancelled.²⁷ But the issue had not gone away. In late 1951 Tonkin wrote to BMA headquarters in London about his proposed attendance at the next BCMC meeting, to be held in Calcutta in 1952. Tonkin noted the 'somewhat strained diplomatic relations which exist between India and South Africa', although correspondence with the Indian Medical Association had resulted in reassurances over the issue of his entry.²⁸ To put Tonkin in his broader context, and as background to his speeches at BCMC meetings, it has been argued that 'the language and debates of MASA under apartheid came to reflect a conservative, white, male profession comfortable within a racist society'. There was, therefore, and unsurprisingly, on its part 'no questioning of disastrous impact of apartheid policies on the majority of South Africans'.²⁹ Vanessa Noble similarly sees the South African body at that time as 'largely white and apartheid aligned'.³⁰ It is worth noting as well that only two years previously Johannesburg had hosted the African Regional Scientific Conference with around one hundred delegates from Africa, Europe and the United States as well as observers from United Nations organisations such as the WHO.³¹ So, in these two years we can discern a hardening of attitudes on both sides over apartheid.

In the event, Tonkin did attend the Calcutta meeting, as did a delegate from Southern Rhodesia. Tonkin also addressed the conference in its opening session, noting his pleasure at bringing greetings to the Indian Medical Association from his own association. The latter had many Indian members, Tonkin continued, and 'I bring special greetings from them to you'. Despite the tense relations between their two countries, he concluded, 'I can assure you that members of the Indian Medical Association would be cordially received in my country, just as I have been received in India'.³² But the Calcutta meeting posed another problem for vexed BMA officials in London, for Southern Rhodesia's medical association offered to host the next BCMC, in 1955. Macrae wrote to his Rhodesian counterpart shortly afterwards. After admitting his personal unfamiliarity with 'conditions in your country' he noted first the cancellation of the Johannesburg conference. He then continued that

²⁶ 'Cancellation of Meetings in South Africa', *The Medical Journal of Australia*, I, (1951), 341.

²⁷ BMA, CMA/1/4, letter, 6 March 1951, A.D. Kelly, assistant secretary of the Canadian Medical Association, to BMA secretary, Angus Macrae.

²⁸ BMA, CMA/1/4, letter, 19 November 1951, A.H. Tonkin, medical secretary of MASA, to Macrae, BMA.

²⁹ Laura Baldwin-Ragaven, Leslie London and Jeanelle De Gruchy, *An Ambulance of the Wrong Colour: Health Professionals, Human Rights and Ethics in South Africa* (Cape Town: University of Cape Town Press, 1999), 148.

³⁰ Vanessa Noble, *A School of Struggle: Durban's Medical School and the Education of Black Doctors* (Scottsville, South Africa: University of KwaZulu-Natal Press, 2013), 267.

³¹ Dubow, *op. cit.* (note 10), 247, 249.

³² *Journal of the Indian Medical Association*, XXI, (1952), 44.

he knew ‘that there is no Government racial policy in Southern Rhodesia in any way comparable with that of the Union of South Africa’. Nonetheless Macrae sought assurance that there was ‘nothing in the social customs of your country which would give any cause to India, Pakistan and Ceylon to hesitate to send delegates . . . or which would be likely to cause the slightest embarrassment to such delegates if they did attend’.³³ The Rhodesian association then withdrew its offer on the grounds of problems of accommodation.³⁴ While accommodation may indeed have been a problem, it is not unreasonable to infer that the association was also deliberately avoiding a potentially embarrassing dispute.

Up to and including the Calcutta conference, one characteristic of BCMC meetings had been that the majority of papers had been given by delegates from the host country. But in 1953 Tonkin suggested a change in format for the next conference, to take place in Toronto in 1955. Writing to Macrae, he remarked that each participant must have problems of medical practice unique to it but which ‘may be of interest to the representatives of other countries’. So, he continued, ‘it occurs to me that it might interest members of the Conference to know something of what is being done for the vast non-European population’ in South Africa.³⁵ Further correspondence ensued and Tonkin wrote again to Macrae just under a year later to inform him of what had so far occurred. Apart from the South Africans, the only association to take up his suggestion had been Canada’s. In his view, though, the matter should not be allowed to rest there. It would be useful to hear about Australia’s Aborigines and New Zealand’s Maoris. Tonkin then raised the stakes. ‘I think more might be told to us’, he went on, ‘regarding the care of under-privileged persons in India, Pakistan and Ceylon.’ This would contribute to mutual knowledge of the participating countries ‘as I do feel that a reasonable estimate of the value of a country’s health services can be got from a knowledge of the work that is done for its so-called submerged peoples’.³⁶

It is difficult to know conclusively whether Tonkin was being naïve, or malicious or was genuinely interested in this issue (although discussion below yields some clues), but it certainly gave Macrae cause for concern. As he told a Canadian colleague, A.D. Kelly, in advance of the Toronto meeting, while he was not concerned with Tonkin and the use of the expression ‘native populations’, he was ‘thoroughly scared’ about what the South Africans might say. Macrae’s inclination was to ask Tonkin to confine his comments ‘strictly to the medical care of native African populations in South Africa’ (emphasis in original). Were he to include Indians with Africans under the general rubric of ‘non-Europeans’, this would be bound to ‘give offence to our colleagues from the East’, that is delegates from the Asian associations. Macrae further suggested that, while it would be acceptable for Australian and New Zealand delegates to make contributions on the topic, those from India and Pakistan ‘might resent any reference to “submerged races” in these countries’.³⁷ Given that both India and Pakistan had only recently gained independence from British colonial rule, Macrae’s concern not to cause offence is understandable.

Having received reassurance from Kelly that he was at one with his proposal, Macrae then wrote directly to Tonkin. He observed that there was no reason why, in the course

³³ BMA, CMA/1/5, letter, 19 August 1952, Macrae to J.E.A. David, honorary secretary of the Medical Association of Southern Rhodesia (British Medical Association).

³⁴ BMA, CMA/1/4, letter, 18 September 1952, M.H. Webster, Medical Association of Southern Rhodesia, to Macrae.

³⁵ BMA, CMA/1/5, letter, 6 October 1953, Tonkin to Macrae.

³⁶ *Ibid.*, letter, 20 September 1954, Tonkin to Macrae.

³⁷ *Ibid.*, letter, 7 January 1955, Macrae to A.D. Kelly, Canadian Medical Association.

of discussion, Australian and New Zealand delegates could not talk about Aborigines and Maoris. He then pointed out that in India and Pakistan 'the native race is the ruling race' and that it would thus be 'inappropriate' to invite those countries' representatives to talk about 'submerged peoples'. Moving on to Tonkin's own contribution, Macrae suggested that he would be 'well advised' to talk only of 'the native African races in South Africa' (emphasis in original). The last thing desired in 'our friendly little conference' was a 'bitter controversy about the racial policy of the South African Government', a clear reference to apartheid. Including Indians, Macrae concluded, 'with Africans under the general heading of non-Europeans . . . might cause grave offence to our colleagues from the East'.³⁸ Tonkin responded that he had no intention of including 'Asiatics' in his speech, although he would respond to any questions on the subject, and that in any event most of them received private medical care, with the rest being treated 'in the same way as all indigents . . . regardless of race, colour or creed'. He had no fears about dealing with this although, revealingly, he recalled 'the Ceylon delegate, Professor da Silva, asking a very provocative question at the last meeting in Canada'.³⁹ The last point further suggests that Southern African racial politics were of some concern to at least some BCMC members and they were certainly recognised as such by the London leadership.

The Toronto conference welcomed delegates from eleven countries – Australia, British Guiana, Canada, Ceylon, India, the Republic of Ireland, New Zealand, Pakistan, South Africa, Southern Rhodesia and the UK.⁴⁰ During the session on 'Medical Care of Native Populations' some rather misleading, if not downright erroneous, claims were made. The Southern Rhodesian delegate, for instance, argued that Africans were 'at liberty to seek advice from the private practitioner but had been provided with a non-contributory health scheme by the Government and the local authorities'. Services in the countryside involved a 'system of outlying dispensaries under the control of a district physician, and the urban services included dispensaries, clinics and hospitals of a high standard'. Tonkin's contribution started with an historical overview claiming that in 1857 the Cape governor had 'sought to bring the benefits of European medicine to the Africans and had established Grey's Hospital in (King William's Town) in an attempt to counteract the witchcraft which was still a powerful influence today'. He stressed the role of the missionaries and the army in promoting health and claimed that health services developed by the gold industry were 'probably second to none in the world'. Nowadays it was generally the case that 'medical services provided for the African . . . differed little from those provided for the rest of the community'. Increasing numbers of African nurses were being trained 'to care for their own people, and the new medical school in Durban was designed particularly to meet the needs of the African people'.⁴¹ These were highly sanitised accounts of Southern Africa's medical history.⁴²

We have no record of the response to these claims, although it is unlikely to have been uniformly positive, but overt tensions over the membership of South Africa and Rhodesia

³⁸ *Ibid.*, letter, 27 January 1955, Macrae to Tonkin.

³⁹ *Ibid.*, letter, 2 February 1955, Tonkin to Macrae.

⁴⁰ 'Commonwealth Conference and Annual Meeting', *Canadian Medical Journal*, 73, 1 (1955), 52–3.

⁴¹ BMA, CMA/1/5, 'British Commonwealth Medical Conference, Report of the Fourth Conference, Toronto, 1955', 6–7.

⁴² For recent scholarly discussions of South African medical history, Anne Digby, 'The Medical History of South Africa: An Overview', *History Compass*, 6, 5 (2008), 1194–210; and Julie Parle and Vanessa Noble, 'New Directions and Challenges in Histories of Health, Healing and Medicine in South Africa', *Medical History*, 58, 2 (2014), 147–65.

appear to have abated for around fifteen years. Not that this was a period of unchanging calm in either the BCMC or the Commonwealth. The former reconstituted itself as the Commonwealth Medical Association in the early 1960s. During the relevant discussions, Tonkin suggested that the new body did not need a constitution as the

common bond of affection is stronger than a written constitution in the Commonwealth. Family ties grow stronger with independence and the same holds good in the international field. The bond of affiliation of the South African Medical Association is stronger now than it was when it was a branch of the British Medical Association.⁴³

This was an important re-statement of South African views, once again stressing familial, organic and professional connections between Commonwealth members while highlighting the longstanding relationship between doctors in South Africa and in Britain.

The Expulsion of South Africa and Rhodesia

With further decolonisation, the number of associations represented continued to grow and this brought changes in the dynamics of the Commonwealth, as did changing attitudes among existing CMA members. On the latter point, for example, a leading figure in the Medical Association of New Zealand wrote to the leading CMA official in London in 1968 suggesting that his country's ties with the 'Old World' were loosening while those with Asia and the Pacific were becoming ever closer. The BMA's response again invoked the 'common heritage and common aims' of Commonwealth doctors, hence the essential need to meet collectively every two years to discuss 'matters of mutual interest'.⁴⁴ But a key aspect of concerns such as those expressed from New Zealand was Britain's own changing relationship with the Commonwealth as she moved nearer to Europe, in the first instance economically through membership, from 1973, of the European Economic Community. Nonetheless, the 1968 meeting, held in Canberra, recorded delegates from twelve associations, including that of South Africa, and observers from fourteen more. For technical reasons, the Rhodesian association had to reapply for full membership and this was proposed by the South African and Canadian delegates and unanimously agreed upon. The Ghanaian delegate noted that his association had considered Rhodesia's application and had taken no exception to it.⁴⁵

The broader context is crucial. Tonkin's 'bond of affiliation' speech came in the same year, 1961, as South Africa's exit from the Commonwealth and less than a year after the Sharpeville massacre.⁴⁶ By this point, as Stuart Ward puts it, the idea of 'South African "Britishness"' had long since lost credibility'.⁴⁷ But, as we have seen, a purported intimate relationship was a central part of Tonkin's argument and was to remain so. Re-confirmation of Rhodesia's membership, meanwhile, came three years after that country's Unilateral Declaration of Independence. And yet there was no attempt to terminate CMA membership of either association. Tonkin had also engaged in an extensive correspondence about his

⁴³ BMA, CMA/1/7, 'British Commonwealth Medical Conference: Sixth Conference, Auckland, 1st to 4th February, 1961', 3.

⁴⁴ BMA, CMA/1/11, letter, 25 January 1968, Adrian Webb, honorary general secretary of the Medical Association of New Zealand, to D.P. Stevenson, honorary secretary-treasurer, CMA; and letter, 6 February 1968, Stevenson to Webb.

⁴⁵ *BMJ*, II, (1968), 427–9.

⁴⁶ Shula Marks, 'Southern Africa', in Judith M. Brown and William Roger Louis (eds), *The Oxford History of the British Empire, Volume IV: The Twentieth Century* (Oxford: Oxford University Press, 1999), 567.

⁴⁷ Stuart Ward, 'Imperial identities abroad', in Sarah Stockwell (ed.), *The British Empire: Themes and Perspectives* (Oxford: Blackwell, 2008), 238.

inability to attend the Karachi meeting in 1966, but this was to do with visa problems – Pakistan and South Africa did not have diplomatic relations – rather than unwillingness to attend on his part or exclusion by the CMA.⁴⁸ But that year also saw the beginning of a chain of events which was to lead to the expulsion of South Africa and Rhodesia in 1970.

In early summer 1966, D.P. Stevenson, the BMA secretary, began a correspondence with John Chadwick, director of the Commonwealth Foundation, which resulted in the latter contributing £1,250 to enable delegates from India, Ceylon, Ghana, Malaysia and Singapore to attend the Karachi meeting.⁴⁹ This was one of the Foundation's earliest awards.⁵⁰ On the initiative of the British government, which felt that tensions within the Commonwealth were posing a threat to the latter's existence, the Commonwealth Foundation had been set up in 1965 with the agreement of Commonwealth heads of government. It sought to encourage co-operation and interaction between professionals and professional bodies within the Commonwealth. In principle an autonomous organisation, and a registered charity, the Foundation was by 1971 funded by twenty-eight Commonwealth governments and had an annual income of £350,000. Although medical organisations were by no means the only recipients of Foundation grants, in its first five years over a fifth of its disposable grant income went to the field of medicine, including to the CMA.⁵¹ Immediately prior to the Karachi conference, a meeting took place in London between the Commonwealth Foundation and the BMA. Chadwick, while unable to give a definite commitment, nonetheless suggested that 'it was more than possible' that applications to fund future CMA events 'would receive sympathetic consideration'.⁵² As we shall see, though, there would be conditions attached.

External events also flesh out the context. In the spring of 1969, the BMA, along with journalists, medical members of parliament and the Labour Party-affiliated Socialist Medical Association (SMA), received briefing notes from the UK-based Anti-Apartheid Movement (AAM). As the latter's annual report noted, this intervention had been prompted by the strike in April by African, Indian and coloured doctors in South Africa in pursuit of pay equality with their white counterparts. This dispute centred on the Durban Medical School, which played an important part in the struggle against apartheid. As a result of the AAM's approaches, the dispute had received coverage in the medical and general press.⁵³ So, for instance, the AAM's executive secretary, Ethel de Keyser, wrote to Labour MP and leading SMA member, David Kerr, asking him if he would approach the Medical Practitioners' Union (MPU) and 'if you think it worthwhile . . . the British Medical Association, asking for support for the African, Indian and Coloured doctors'. The MPU was a trade union, affiliated to the Trades Union Congress, and as such could

⁴⁸ See the correspondence in BMA, CMA/1/10.

⁴⁹ BMA, CMA/1/10, letter, 1 July 1966, John Chadwick, Commonwealth Foundation, to D.P. Stevenson, BMA.

⁵⁰ John Chadwick, 'The Commonwealth Fund: Developing Professional Standards', *The Round Table*, 57, 226 (1967), 177–82.

⁵¹ The Commonwealth Foundation, *The Commonwealth Foundation: The First Five Years, 1966–71* (London: The Commonwealth Foundation, 1971), 4, 10, 32ff; and John Chadwick, *The Unofficial Commonwealth: The Story of the Commonwealth Foundation, 1965–80* (London: George Allen and Unwin, 1982), chs 3–6.

⁵² BMA, CMA/1/10, 'Note for File DLG/JAF: Commonwealth Foundation', 2.

⁵³ Archives of the Anti-Apartheid Movement, Bodleian Library, University of Oxford (hereafter, Bodleian), MSS.AAM 13, typescript, 'Annual Report, August 1968/August 1969', 8. On the neglect of this issue by MASA, see Baldwin-Ragaven *et al.*, *op. cit.* (note 29), 150–1. On the Durban Medical School, Noble, *op. cit.* (note 30), ch. 6, 'The 1950s and 1960s: medical students and the anti-apartheid struggle in Durban'.

adopt a much more militant stance than the BMA. Among her other correspondents were leading MPU activist, H.C. Faulkner, and another prominent SMA member, Harry Keen.⁵⁴

This agitation appears to have had some effect. In June, a *BMJ* leading article deprecated the South African practice of medical remuneration according to race. ‘Salary scales which are based on distinctions which are an offence to biology as much as humanity’, it observed, ‘must seem peculiarly irksome to medical men and women’, a point which was to be reiterated the following year. The recent disturbances among non-white medical staff were therefore ‘not surprising’. Medicine transcended ‘national frontiers’ and, more specifically, there were numerous ‘friendly links’ between British and South African doctors. Many of the latter trained in Britain and their respective medical organisations were both members of bodies such as the WMA and the CMA. The South African body had long opposed apartheid in medicine and a recent issue of the *South African Medical Journal* had reaffirmed this position.⁵⁵ Given the impending South African rugby union and cricket tours, the politically contentious issue of British arms sales to South Africa and Rhodesia’s declaration of a republic, the late 1960s and early 1970s was thus an era when Southern Africa featured heavily in British political consciousness.⁵⁶ It is also worth recalling that, in reality, MASA did little to oppose apartheid, whatever its own claims and indeed those of the BMA.⁵⁷

It was against this background that the build-up for the August 1970 CMA meeting, to be held in Kuala Lumpur and Singapore, took place. In April, the Malaysian Medical Association informed the BMA that it appeared unlikely its government would admit Rhodesian or South African delegates, that the Singapore government had already denied access to Rhodesians and that it might also do the same to South Africans.⁵⁸ Because of visa problems, the Rhodesian delegate duly pulled out. However P.D. Combrink, MASA associate secretary, informed the BMA that he had obtained a visa and planned to attend.⁵⁹ Three months before the meeting was due to take place, Stevenson wrote to all CMA members stressing the desirability of a good attendance. This was on account of recent discussions with the Commonwealth Foundation with regard to an advisory role which the CMA might be able to perform for the former, which would both benefit the CMA and ‘which we hope would be supported by funds from the Foundation’. No mention was made, though, of any conditions which the latter might attach.⁶⁰

When the conference convened it became clear from the outset, as an Australian observer subsequently reported, that the ‘membership of South Africa and Rhodesia would come under attack’.⁶¹ At the first, closed, session in Kuala Lumpur, the Ghanaian delegate complained that the representative from his country who had supported Rhodesia’s membership in 1968 had not been speaking on behalf of his association and requested that this be minuted. The delegate from Tanzania – along with Jamaica, Fiji and Sierra

⁵⁴ Bodleian, MSS.AAM 114, ‘General Correspondence on Health Matters’, letters, Ethel de Keyser, 28 April 1969, to David Kerr MP and 30 April to H.C. Faulkner, MPU, and Harry Keen, SMA.

⁵⁵ ‘Payment by Colour’, *BMJ*, II, (1969), 586–7.

⁵⁶ Brian Harrison, *Finding a Role? The United Kingdom, 1970–90* (Oxford: Oxford University Press), 38ff.

⁵⁷ Baldwin-Ragaven *et al.*, *op. cit.* (note 29), ch. 7, *passim*.

⁵⁸ BMA, CMA/1/12, letter, 23 April 1970, Malaysian Medical Association to Stevenson, BMA.

⁵⁹ *Ibid.*, letter, 2 June 1970, R.D. Martin, Rhodesian Medical Association, to Stevenson, BMA; and letter, 5 June 1970, P.D. Combrink, MASA, to Stevenson, BMA.

⁶⁰ *Ibid.*, letter, 7 May 1970, Stevenson to Honorary Secretaries, CMA member associations.

⁶¹ D.J. Brennan, ‘The Commonwealth Medical Association’s Council Meeting, 1970: Observations of an Observer’, *The Medical Journal of Australia*, II, (1970), 1210.

Leone, a new Association member – then thanked the CMA for accepting his association's membership application, but, he continued, it would have thought twice had it known of South African and Rhodesian membership. Those countries' racial policies were 'thoroughly inconsistent with the noble principles laid down in the CMA Constitution'. In fact, and unsurprisingly, there had been no mention of 'race' when the Association had been set up, although the delegate's reference may have been to the frequently alluded to idea of equality of status within the CMA and its predecessor. There was, the Tanzanian continued, no possibility of fostering better relationships because no relationship existed in the first place. He therefore urged Rhodesia and South Africa's immediate expulsion. The chairman responded that he had anticipated problems over this issue, but asked that the matter be deferred until a letter from the Commonwealth Foundation had been reviewed. By a majority vote, it was agreed to revisit the subject in Singapore. A discussion of CMA finances then ensued and their reliance on Commonwealth Foundation monies became apparent. The Foundation, Stevenson reported, had offered further funding of £30,000 over three years if the CMA could broaden its membership, as it had recently done. There were only two requirements attached to this award, one of which was that it would not be available if the South African and Rhodesian associations remained members. After discussion, it was agreed to accept Stevenson's financial statement and to send a message 'expressing appreciation for the Foundation's very generous offer of assistance'.⁶²

When the meeting re-convened in Singapore, the Canadian delegate, Dr Kippen, optimistically, if illogically, suggested that the issues of the Commonwealth Foundation offer and that of membership be kept separate. However, the Ghanaian and Tanzanian representatives put forward a motion proposing that the CMA constitution be amended to exclude South Africa and Rhodesia. This was justified on various grounds, including Commonwealth Foundation funding, but the key factor was that Rhodesian and South African membership was not 'consistent with the concept of the multi-racial character of the Commonwealth for which reasons (sic) precisely both South Africa and Rhodesia have ceased to belong to the family of Commonwealth of nations'.⁶³ There then followed, as the Australian observer put it, 'a vehement and intense debate'.⁶⁴

Combrink was invited to take the floor. He expressed surprise that 'politics had been allowed to enter the discussions of this professional association'. His organisation held the same values as the CMA; namely, the 'promotion of medical and allied sciences, and the interests of the medical profession'. Pointing out that South Africa and Rhodesia had both continued as CMA members after leaving the Commonwealth, he suggested that what members had in common was language, roots in the BMA and adherence to the 'British School of Medicine'. Again, these were ideas which had been much proclaimed since the late 1940s. He was not there, Combrink continued, to defend his government's policies, his association did not support apartheid, its membership was open to all and it was in dispute with the government over various issues. The Indian delegate, Dr Bhoose, in supporting the motion, claimed that apartheid also affected the South African medical profession. One of the BMA representatives then suggested that expelling South Africa could harm

⁶² BMA, CMA/1/12, 'Commonwealth Medical Association: Minutes of 5th Council Meeting', 2–5. There is also an edited and abbreviated, although substantially accurate, account of these events in 'Commonwealth Medical Association: Fifth Biennial Council Meeting', *BMJ*, III, (1970), 516–18. A brief account of what the CMA did with this grant can be found in The Commonwealth Foundation, *Commonwealth Co-operation and the Role of Professional Associations: Occasional Paper XXVIII* (London: The Commonwealth Foundation, 1974), 22–3.

⁶³ BMA, *op. cit.* (note 62), 6–7.

⁶⁴ Brennan, *op. cit.* (note 61), 1210.

those it was seeking to help, non-white doctors, and indeed their patients. Opposition to expulsion also came from the Australian delegate, while Dr Mulcahy, from the Irish association, suggested that the position of 'coloured people' was improving fast through their own and others' efforts. Concerned about loss of contacts, Mulcahy suggested that Irish Republic's own 'severance' from Britain had been a mistake. Others, for instance the Malaysian delegate, expressed doubts about the constitutionality of what might take place. A compromise amendment was proposed which sought information from MASA and the setting up of a postal ballot to determine the future of South Africa and Rhodesia within the CMA.⁶⁵ To put this part of the discussion in context, by the early 1970s Africans had had access to medical training in South Africa for a quarter of a century, but only 252 had qualified and, while there was one African doctor per 44 000 Africans, the white doctor to patient ratio was one to 400.⁶⁶

Back at the meeting, not everyone was prepared to take a conciliatory line. Even before the amendment was tabled, the Jamaican delegate accused Combrink of obfuscation, while Dr Mamujee from Tanzania pointed to the number of South African refugees entering his country and the evidence they brought of racial discrimination. Tanzanians thus knew that 'the best way to improve the situation was to force South Africa to accept world pressure. The best thing to do was to boycott South Africa from all civilized contacts'.⁶⁷ The amendment was duly put, losing six votes to nine. The original motion was then passed by twelve votes for, none against and four abstentions.⁶⁸ As the rather terse, and somewhat misleading, press statement put it, the meeting had resolved that 'as the conditions appertaining in the Medical Associations of South Africa and Rhodesia were inconsistent with the aims and objectives of the CMA they should cease their membership forthwith'. The constitution had been duly amended to this effect.⁶⁹ Reflecting on the meeting, which he had chaired, Professor A.A. Sandosham noted the presence of more African and Caribbean members 'who are in close touch with the evil effects of apartheid and segregation policies on the medical profession' and that this made it inevitable that South Africa and Rhodesia's membership would come into question. A compromise had been defeated on the grounds that if immediate action were not taken then the CMA might break up, and Sandosham further speculated that some Commonwealth medical associations had held back from joining because of the continuing presence of the South African and Rhodesian associations.⁷⁰ The latter observation calls into question the Tanzanian delegate's claim that he had not known in advance of South African and Rhodesian membership.

'Race and Commonwealth'

The BMA quickly made its own position clear. The same edition of *BMJ* which reported on the Kuala Lumpur and Singapore meetings carried the leading article 'Race and Commonwealth'. This started with a brief account of the CMA's formation, noting that MASA had been included from the outset, that this had survived South Africa's exit

⁶⁵ BMA, *op. cit.* (note 62), 8–10.

⁶⁶ T.R.H. Davenport and Christopher Saunders, *South Africa: A Modern History*, 5th edn (Basingstoke: Macmillan, 2000), 661.

⁶⁷ BMA, *op. cit.* (note 62), 8.

⁶⁸ BMA, *op. cit.* (note 62), 10.

⁶⁹ BMA, CMA/1/12, 'Final Press Statement: 5th Council Meeting Commonwealth Medical Association'.

⁷⁰ BMA, CMA/1/12, clipping from *The Medical Journal of Malaya*, XXV, 3 (1971), 166–7.

from the Commonwealth and that the CMA had unanimously accepted the Rhodesian association's re-application in 1968. The piece continued that this indicated that 'deep political differences between countries were not alone enough' to lead to any member's exclusion, although of course this was precisely what had happened. Rushing over whether the recent exclusion was 'political', it was then argued that 'racial discrimination is an evil that bites deep. The judgements made under its influence set it apart not merely as something uncivilized but as an offence to humanity'. Doctors found such discrimination 'peculiarly repugnant' since 'their training and their daily relationship with their patients recognise the falsity of the doctrine it embodies'. In the particular case of South Africa, its government's racial policy undoubtedly affected the whole of society. Combrink's refusal to answer for his government was positively recognised. It was acknowledged, too, that MASA did not operate any form of discrimination in its membership; that it criticised, for example, racially differentiated salaries; and that if it challenged apartheid head on, it 'would not survive a day'. Nonetheless, Combrink had not adequately explained separate training schools for white and non-white medical students. Such criticisms could be extended, the leader continued, to practices such as segregated wards and waiting rooms. The WMA's code of ethics, which forbade the doctor-patient relationship to be affected by factors such as race, was then invoked. No mention was made, though, of the Commonwealth Foundation's highly conditional support for the CMA and its activities.⁷¹

BMA Council, in its subsequent annual report, expressed concern at the way in which the expulsion of the Southern African associations had taken place, and in particular that the issue had not been flagged up before the meeting. Nonetheless, it continued, there had been no actual contravention of the CMA's constitution and the link of affiliation between the BMA and the South African association meant that communication between the two bodies would continue. Without relating the two issues, the Commonwealth Foundation's grant was also noted, and this would 'further co-operation in medical affairs throughout the Commonwealth'.⁷²

Combrink and MASA, however, were not content to leave matters as they stood. In a contribution to the *South African Medical Journal*, editorially described as a 'factual report', Combrink described the BCMC/CMA's origins and noted that, historically, it had been funded principally by the BMA. Moving on to more recent events, he remarked first that in 1968 Rhodesia had gained (in fact, regained) membership and that Zambia, Kenya and Mauritius had signalled their intentions to apply. Combrink then cited a letter from the Commonwealth Foundation to the BMA which clearly stated that any further funding of the CMA would not happen while the South African and Rhodesian associations remained members. Discussing the 1970 meeting, Combrink gave an account of his own contribution to the debate, which had explicitly attributed the expulsions to the Commonwealth Foundation's stance. Among the other key points he had raised were that MASA could not be held accountable for its government's policies, that a CMA meeting was not the place to discuss these and that there had been no questioning of South African membership when the CMA had come into being, notwithstanding that South Africa was by this stage no longer a Commonwealth member. Combrink then reported that he had been subjected to 'torrid' questioning during which his honesty had been disputed by some supporters of expulsion and that 'he was obliged to enter into acrimonious individual debates with certain of (my) questioners'. He concluded by noting that MASA's expulsion

⁷¹ 'Race and Commonwealth', *BMJ*, III, (1970), 475-6.

⁷² *Supplement to the BMJ*, II, (1971), 79.

would not affect its affiliation to either the BMA or the Canadian Medical Association, and good links with certain other Commonwealth professional bodies would be maintained.⁷³

MASA Federal Council, meanwhile, in its report for 1970, commented on the expulsions, which it attributed, as had Combrink, to Commonwealth Foundation demands. It was regrettable that a CMA 'Founder Member' had been treated in this way 'at the hands of newer members', and that 'we were not given the opportunity to withdraw so that the Association could have accepted the Commonwealth Foundation's offer without embarrassment to anyone'.⁷⁴ The last point was a new one as it does not appear to have been raised by Combrink at the meeting itself. A number of *BMJ* correspondents also deprecated the CMA's decision, finding it a matter of 'deep regret', a 'tragedy' which would dishearten the Rhodesian medical profession – 'one of the largest liberal minded groups in that country' – and potentially 'disastrous' and 'unwholesome'.⁷⁵ Criticisms were expressed, too, at the BMA's 1971 Annual Representative Meeting, which was 'concerned that the constitution of the Commonwealth Medical Association allows the expulsion of member associations without prior notice of such motions being given to members'. BMA Council was therefore instructed to amend the constitution appropriately.⁷⁶

However, the most trenchant critic was *BMJ* correspondent George W. Gale. Born in Durban, Gale had, in the course of a long and varied career, gained his medical training in Edinburgh and Liverpool, founded a Church of Scotland hospital in Natal in the late 1920s, been Secretary for Health in the South African government from 1946 to 1952, and acted as founding Dean of the Durban Medical School from 1952 to 1955. Thereafter, he had held professorial posts in Uganda, Thailand and Malaysia before retiring to Britain in 1969.⁷⁷ Certainly at the start of his career, Noble suggests, Gale was a 'person of liberal political leanings' who had left his government post on account of the 'reactionary views and policies' being promoted in the Department of Health by National Party officials.⁷⁸ It seems unlikely, then, that he would have been a wholehearted supporter of apartheid.

Gale started his letter by pointing out that nothing MASA had done was at odds with CMA objectives. The latter had thus committed an act of 'gross injustice' against one of its members. Combrink had been forced into discussing an issue – training facilities for 'non-Whites' – about which he had no first-hand knowledge and no opportunity to consult with those who did. The South African association itself did not practice apartheid except when 'compelled to do so by the legal *force majeure* of the Government'. Indeed it had opposed the Government on not some 'but on all applications of apartheid to medical men or their patients that are inimical to the true interests of either' (emphasis in original). Gale made various other points in defence of the South African association before challenging the BMA to tackle the UK government on its 'racially discriminatory

⁷³ P.D. Combrink, 'Report on the Expulsion of the Medical Association of South Africa from the Commonwealth Medical Association: The History of the Commonwealth Medical Association with Particular Reference to the Membership Thereof of the Medical Association of South Africa', *South African Medical Journal*, 19 September 1970, 1067–9.

⁷⁴ E.W. Turton, 'Report of the Chairman of the Federal Council for the Year Ended 31 December 1970', *South African Medical Journal*, 6 March 1971, 269.

⁷⁵ Letters from J. Stallworthy, *BMJ*, III, (1970), 527. Brian Beach, *BMJ*, III, (1970), 648; and Victor Russell, H. Vincent Corbett, *BMJ*, III, (1970), 706.

⁷⁶ *Supplement to the BMJ*, IV, (1971), 20–1.

⁷⁷ Michael Gelfand, *Christian Doctor and Nurse: The History of Medical Missions in South Africa from 1799–1976* (Sandton, RSA: privately printed, 1984), 7, 135.

⁷⁸ Noble, *op. cit.* (note 30), 66.

policy on immigration' and its renewed sale of arms to South Africa. The latter helped bolster the present regime 'morally perhaps even more than materially, against external attack from non-White countries infuriated beyond endurance'. Should the BMA fail to do so then it should be expelled by the CMA, as should any other association failing to protest against its government's discriminatory policies, of which Gale claimed there were two.⁷⁹

Of course, not all *BMJ* readers supported such views. Barry Lewis, another recipient of correspondence from the AAM, questioned the idea, based on his contacts with Rhodesia over nine years, that its medical profession was notably liberal. While some Rhodesian Medical Association members were, commendably, anti-racist, the association had made 'no effective protest at the innumerable ways in which racial discrimination in Rhodesia influences medical practice'. Concluding, Lewis suggested that when racial issues were as clear cut 'as in Southern Africa, not to protest it is to acquiesce'.⁸⁰ Nonetheless, it was those who objected to the expulsion of the South African and Rhodesian associations who shouted loudest, at least in the *BMJ*.

The next CMA meeting, held at Accra and thus the first to take place in Africa, was attended by representatives of over twenty member associations with new recruits including Kenya, Nigeria and Swaziland. There was much discussion of finance and, as the Australian delegate put it, a 'lively debate' on a British proposal that the CMA should not be influenced by 'national or international political considerations'. The proposal was, he continued, 'regarded as being related to the expulsion of Rhodesia and South Africa'. In the event, only the Australian and one other delegate, presumably the Briton, supported the motion.⁸¹ This was effectively the end of the matter, at least in the short term. A few years later, South Africa was forced to leave the WMA before being controversially re-admitted. One consequence of all this was that the BMA broke off its relationship with MASA and left the WMA.⁸²

Conclusion

What conclusions can we draw from these events stretching over two decades? First, the founding of the BCMC has to be understood in the context of an unstable world in which the British medical profession felt threatened by the onset of socialised medicine, a concern shared by doctors in, notably, New Zealand, Canada and Australia. This was, then, and notwithstanding the claims of its members, a political body, with further proof being afforded by the principal focus of this article, the ultimate expulsion of the Rhodesian and South African associations. Delegates to BCMC, and subsequently CMA, meetings were the leaders of the profession in their respective countries – medical politicians, much of whose working lives were now largely bound up with negotiations with civil servants and senior politicians. It is thus ironic that at the Accra meeting the BMA sought, albeit unsuccessfully, to de-politicise such events, although of course any de-politicisation would, of itself, be 'political'.

Second, another factor behind the BMA's initiative in setting up the BCMC was its apparent belief that it would be a more cohesive and amenable body than the WMA. Its

⁷⁹ G.W. Gale, 'Race and Commonwealth', *BMJ*, III (1970), 705–6.

⁸⁰ B. Lewis, 'Race and Commonwealth', *BMJ*, III, (1970), 774. For his contact with the AAM, see the reference in Bodleian, MSS.AAM 114, letter, 30 April 1969, Ethel de Keyser to H.C. Faulkner.

⁸¹ *Medical Journal of Australia*, I, (1972), 1263.

⁸² See Mbali, *op. cit.* (note 8), *passim*.

members would be bound together by a common language, medical culture and methods of training and practice. The BMA and its fellow BCMC/CMA members clearly felt that there was indeed what Combrink claimed in his association's last involvement at such events, a 'British School of Medicine'. Of course, on one level this might be seen, especially after the late 1950s, as wishful thinking, particularly on the part of the BMA. Even at the beginning the Canadians were somewhat detached, while by the late 1960s the profession in what had long been seen as the most 'loyal' dominion, New Zealand, was questioning the relevance of its own CMA membership. The sought-after cohesion was thus highly contingent, and once again the membership of the Southern African associations was ultimately very disruptive.

There does, nonetheless, seem to have been a sense of Commonwealth solidarity. As the Singapore delegate put it at the Colombo meeting in 1962:

Within the commonwealth, we have the advantage of language which seems to be understood by all of us. We have also systems of medical education which have arisen from a common stem of origin, and therefore, retain many points of similarity. We have been, too, in the past, united politically, and there are still many traditional linkages existing amongst individual members.

Equally revealing, he concluded that associations such as his own looked to the 'more senior members for guidance and for moral and physical support' and not least on issues such as 'socialised medicine, political propaganda against a particular professional group, and legislations which may encroach on the realms of medical ethics'.⁸³ Once again, the bogey of socialised medicine had made an appearance and again undermines the notion that bodies such as the CMA were non-political.

Third, the BCMC/CMA was never, even at the outset, a 'white man's club' and became even less so over time, although it has to be conceded that at least in its early days it was dominated by the BMA itself, abetted by the powerful associations of the 'White Dominions'. Nonetheless, even at this point, the racial politics of Southern Africa were undoubtedly problematic and were to be an ever more infected running sore over the next two decades. This surfaced within a few years of the BCMC's foundation through, for example, the need to cancel the 1951 Johannesburg meeting, concerns over what Tonkin would say in his speech in Toronto, and various instances of problems over visas. Nonetheless, the issue took a remarkably long time to result in a showdown, given South Africa's exit from the Commonwealth and then Rhodesia's declaration of independence. Indeed, when the BCMC was reconstituted as the CMA, the latter's first meeting specifically noted that membership was open to Commonwealth medical associations (thus including at this stage Rhodesia) and those of South Africa and the Republic of Ireland. This meeting, it is worth remarking, was attended by delegates from, *inter alia*, Ceylon, Ghana, India, Malaya, Pakistan and Singapore, suggesting that the strength of professional ties, at least at this point, overrode more overtly political concerns.⁸⁴ But an eventual confrontation was inevitable for at least three reasons: increasing African membership of the CMA in the wake of decolonisation, the stipulations of the Commonwealth Foundation and the ongoing international campaign against apartheid – British and American resistance to economic sanctions notwithstanding.⁸⁵

⁸³ BMA, CMA/1/8, 'British Commonwealth Medical Conference: Seventh Conference and British Commonwealth Medical Association: First Meeting of Council, Ceylon 21–24 November, 1962', 17–18.

⁸⁴ *Ibid.*, 1, 6.

⁸⁵ On the last point, Marks, *op. cit.* (note 46), 567.

Fourth, the charge of hypocrisy laid at the BMA's door by Gale has to be acknowledged as containing elements of truth. As he rightly noted, Britain had recently resumed arms sales to South Africa and operated discriminatory immigration policies. Nor should the racially-questionable policies which long persisted in other BCMC/CMA members' countries be ignored – 'White Australia' and 'White New Zealand' being obvious cases in point. But to imply some sort of moral equivalence between racial politics in Britain and those in South Africa is stretching the point. Gale would, though, appear to be on firmer ground in his argument that South Africa's medical profession did not initiate apartheid. This was true enough, although, as Davenport and Saunders point out, even medical opponents of apartheid had 'been obliged to comply with its laws – as most did – or artfully evade them'. The Truth and Reconciliation Commission was later to criticise the medical association for its 'lack of concern over human rights' and the profession came out very badly in episodes such as the cover up of the causes of Steve Biko's death in 1977.⁸⁶ And, as we have seen, other historians have been sceptical about MASA's self-proclaimed opposition to apartheid.

Finally, what can we make of the BMA's conduct more generally? It has been argued that the Association's motives in setting up, in the first instance, the BCMC were primarily political. On another level, though, the BMA might be commended for creating what was clearly going to be a multi-ethnic organisation, and one whose membership would become increasingly diverse as time passed. Of course, neither the BMA nor anyone else anticipated the speed of, in particular, African decolonisation in the late 1950s and 1960s. Nonetheless, from this perspective its aims were reasonably honourable, and considerable time and resources were devoted to advancing the Commonwealth cause. The BMA also showed determination in ensuring that doctors from the Indian sub-continent should not be offended or poorly treated on any visit to Southern Africa. It was thanks to this stance that such meetings did not take place. And editorials such as 'Race and Commonwealth' took a fairly robust line, although there is also the sense that external pressures played their part in precipitating such pieces. But apartheid could be, and was, rejected on a broad scientific basis as well as by the medical profession's view of its own work as scientifically grounded.

Having said that, it has already been noted that a decision over South Africa and Rhodesia took many years to come about and their membership was an issue which could have been addressed much earlier. The matter was especially poorly handled when expulsion actually took place. On the one hand, it was surely right to argue that it was unconstitutional to expel what were at that point legitimate members in such a way, or at best very bad practice. On the other, the BMA cannot have been unaware of the hostility of other BCMC/CMA members from the outset, something acknowledged by the manoeuvrings to avoid insult to Asian members, and especially after South Africa's Commonwealth exit and Rhodesia's declaration of independence. From the moment it started engaging with the Commonwealth Foundation, furthermore, it must have been apparent that that body was not going to fund any organisation with South African and Rhodesian membership. And yet Rhodesian membership was reaffirmed in 1968 and with no suggestion that either that country's or South Africa's status was under challenge. The 1970 meeting itself was clearly not well run and the attempt to separate out the issue of membership from Commonwealth Foundation funding either naïve or disingenuous.

⁸⁶ Davenport and Saunders, *op. cit.* (note 66), 661–2; also Mbali, *op. cit.* (note 8).

This would also suggest that the nature of the Foundation's potential funding offer to the BMA leadership in London had not been adequately communicated to the hosts of the 1970 conference, which in turn would have left those hosts unprepared for what transpired. The BMA leadership were experienced medical politicians, but appear to have been more and more out of their depth when faced by a situation they appear not to have fully comprehended.

To conclude: after the alarums and excursions of the early 1970s, the CMA, its numerically increased membership notwithstanding, went into a period of sharp decline, although it was subsequently revived. The history of the first two decades of the BCMC/CMA, though, illustrate the shifting dynamics within the Commonwealth, particularly as decolonisation took place and the political and intellectual tide increasingly turned against the racial policies of South Africa and Rhodesia. Medical politics and international medical networks, as practised and exemplified by the BMA and its Commonwealth organisations, were far from immune from these trends. For one thing, the scientific basis of medicine played its part in shaping the BMA response to growing criticism of the Rhodesian and South African regimes and their racial policies. External pressures, too, played their part. These included the agitation of bodies such as the AAM, the increasing detachment of some of the original members of the BCMC/CMA, and the flexing of its financial muscle by the Commonwealth Foundation. Added to this, we can clearly see how new members of the BCMC/CMA were more and more reluctant to accept the rather complacent status quo which accepted Rhodesian and South African membership even after those countries had left the Commonwealth. Racial politics were certainly not at the forefront of the BMA's mind when it took its Commonwealth initiatives in the late 1940s, but, as we have seen, they could not be avoided, whatever appeals were made to notions such as the 'British School of Medicine' and a purported broad commonality of interests.