

## 1 The argument

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Not since the origins of mankind has East Africa been so important to the world as it is today. The special importance comes from the AIDS epidemic, and particularly from the role of East African doctors in charting the epidemiology of heterosexually transmitted AIDS and devising control strategies adopted in many other parts of the world. Yet we know almost nothing about these doctors<sup>1</sup> and the relationship between their response to AIDS and their historical experience, the crises affecting medical systems in all three East African countries in the late twentieth century, or the parallel crises within the medical profession there. East African doctors have not only fought AIDS; they also carried out, in Kenya in 1994, one of the longest doctors' strikes the world has seen.

This book is not a contemporary sociology of the East African medical profession, much as that is needed. It is a collective biography of East African doctors, covering many aspects of their experience since Africans first practised modern medicine in the region during the 1870s. These doctors were a picked group of gifted people in whose lives many of the main trends of modern East African history intersected. Their training drew the region's education upwards to university level. Their contribution to research and intellectual life was the most important by any group in the region. They were long the 'cream of the cream', the core of East Africa's modern educated elite. They were prominent in politics, especially in Uganda. They were among the first East Africans to enter international affairs as equals. Their experience after independence displayed many of Africa's dilemmas in the quest for stability and prosperity. To write their collective biography offers a much-needed fresh perspective on modern East African history. It also offers an opportunity to explore what Africans of great skill and responsibility have tried to do with political freedom.<sup>2</sup> A collective biography, however, is not the same as a history of medicine. The book deals only with black Africans. It neglects many specialities, notably psychiatry, dentistry, ophthalmology, and leprology. It goes beyond qualified doctors to include the first generation of dressers and auxiliaries who pioneered the African practice of modern medicine before Makerere

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College began formal medical training in 1924, but thereafter it neglects auxiliaries and nurses, which is particularly unfortunate because doctors have been so predominantly male. The emphasis on African doctors may appear to depreciate the role in research and treatment of other races and cadres, but that is not the intention; rather, only separate studies could do justice to them.<sup>3</sup> Even within its limits, the book is no more than a first sketch of its subject, written without specialist medical knowledge and based on sources which are often incomplete, although they are enough, it is hoped, to show that a more definitive history will be possible when East Africans themselves have carried out the necessary further research.

The chief aims are, therefore, to chart the main lines of the doctors' history and to provide background understanding of their role in the late twentieth century. The story divides into four stages. The first concerns the initial entry of East Africans into modern medical practice between the 1870s and the 1920s. A few were trained as auxiliaries, but most were allocated purely menial functions and learned by practical apprenticeship. The earliest were freed slaves and the great majority were of low social status. But they inherited an indigenous medical tradition by which young apprentices could qualify as independent practitioners. As they struggled to gather modern skills, some auxiliaries enlarged their role into an honourable career. This attracted men of higher social status into medical employment. It also encouraged European governments and missionaries to supplement practical apprenticeship by formal schooling. That combination of practice and theory was the key to effective medical education.<sup>4</sup> It was institutionalised from 1924 at Makerere College, whose medical school became the nursery of a medical profession, as was the normal pattern of professionalisation in the Third World.<sup>5</sup>

Once the Makerere Medical School existed, the history of East African doctors entered a second stage: the struggle to achieve professional status. The notion of a profession is central to this book, which argues that professionalisation has been seriously misunderstood in East Africa, much to the disadvantage of medical practice there. The idea of a profession first emerged in Britain and the United States, where the major professions of medicine and law grew up outside the universities or state employment.<sup>6</sup> Early analyses argued that the essence of a profession was a body of specialised knowledge which justified its holders in claiming to monopolise and regulate their occupation in return for observance of an ethical code of competence and altruistic service.<sup>7</sup> During the 1960s, however, sociologists pointed out that many groups possessing specialised knowledge – social workers, schoolteachers, nurses, airline pilots – had not achieved institutionalised self-regulation. The true definition of a profession, the sociologists claimed, was not knowledge but power: the power to control both its

members' own occupation and everything else within their sphere, as doctors controlled not only their own work but the duties of nurses, the behaviour of patients, and even the definition of disease.<sup>8</sup> Such power could be socially pernicious. This view of professionalism as power was applied in the 1970s to the Third World, where Terence Johnson, in particular, argued that, except perhaps in colonies of white settlement, no true professions had come into being in former colonies, because the occupations concerned had not grown up and organised themselves from below, as they had in Britain and America, but had been created and controlled by colonial states and their successors. Third World 'professionals' possessed only the powerless trappings of professionalism.<sup>9</sup>

This book contests such an analysis, for four reasons. First, the wider discussion of professions has moved beyond the dispute between a first generation of triumphalists and a second generation of cynics. The third generation, as so often, consists of social historians who have studied professionalisation in other parts of the world and stressed its complexity.<sup>10</sup> It is no longer helpful to see the essence of professionalism as either knowledge or power or something else. The essence of professionalism is ambiguity. It embraces specialised knowledge, altruistic service, thirst for power, and blatant self-interest. That is why it has been such a potent idea in East Africa, attracting the professionals by the promise of power and profit while attracting the poor by the promise of altruism and trustworthy care. That is why all sides in the strike of 1994 appealed to it. Second, the Anglo-American model of a profession never truly existed even in Britain or America, and certainly does not exist today. Most professionals in both countries – including some doctors but almost all engineers and many other groups – have been employees and therefore not truly autonomous.<sup>11</sup> Many of their 'self-regulating' organisations have depended on state support. As Eliot Freidson put it, 'The profession's privileged position is given by, not seized from, society, and it may be allowed to lapse or may even be taken away.'<sup>12</sup> The notion that relations between professions and the state must be a zero-sum struggle in which one must lose anything the other gains is precisely the myth that has had such damaging effects in East Africa. In reality, professions and the state are in large measure symbiotic. That leads to the third point. The model of a profession which Johnson applied to the Third World was extraordinarily Anglocentric. In so far as it was true of Britain and America, it was – like so much else about those countries – an exceptional case with little relevance elsewhere. In Continental Europe, for example, professions generally grew up under the control of the state or state-dominated universities. The French medical profession, perhaps the first to secure a legal monopoly of practice, was given it in 1803 by the Napoleonic state, which claimed exclusive power to license practitioners.<sup>13</sup>

In Germany the higher state bureaucracy was itself one of the first professional groups, while both law and medicine were strictly regulated for much of the nineteenth century. As Charles McClelland has written, 'The German experience of professionalization, with its complicated tangle of private sphere and bureaucratically controlled dimensions, may prove more typical of professionalization throughout the twentieth-century world than the Anglo-American "model" from which much of the social-science theory of professions has been derived.'<sup>14</sup> Japanese experience reinforces that, for there the modern medical profession was under substantial state control until 1945.<sup>15</sup> So the fourth objection to Johnson's analysis is that in colonial East Africa medical professionalisation took place through this uneasy symbiosis with the state, rather than failing to follow an idealised Anglo-American model of conflict with it. It is true that colonial states created medical services and some professional institutions. But not only did the colonial medical profession include many Asian private practitioners in all East African countries and European private practitioners in Kenya, but even the medical services were far from pure bureaucracies. In particular, the Director of Medical Services (DMS), the state's senior medical officer in each colony, was to a large extent the doctors' representative in government, often writing of making proposals to 'the Government' as though he did not belong to it, sometimes violently at odds with the political administration, and periodically engaged in bizarre negotiations between the state and its medical staff via their trade union, the British Medical Association, in London. This ambivalent symbiosis with the colonial state applied also to emerging African doctors. They saw themselves as locked in struggle with the government for professional recognition and equality, as indeed they were; professionalisation was in this sense an aspect of African nationalism. Yet African doctors also depended on the state not only for their training and employment but for their protection, both against rival practitioners and against popular disorder, as Uganda's doctors learned during disturbances in 1949.

This symbiosis between profession and state continued into the third stage of the doctors' history. At independence East Africa's doctors interpenetrated with the state, although their power over medical policy varied from country to country. During the next thirty years, however, their power and status certainly declined. It would be easy to see this, as Roger Jeffery saw it in India,<sup>16</sup> as a process of deprofessionalisation, which he attributed to the failure of India's modern doctors either to monopolise medical treatment, much of which remained with practitioners of indigenous Indian medicine, or to prevent the state rather than the profession from regulating medical practice. Deprofessionalisation is how many East African doctors see their experience since independence, but they are probably wrong

because, like Jeffery, they have a misleading Anglo-American notion of a profession. It will be argued that modern doctors in East Africa have not been seriously threatened by competition from indigenous medicine, largely because in East Africa, unlike India or China, that medicine lacked a literate tradition to provide a basis for its modernisation. The real threat to professional medicine has come from the illicit sale of modern drugs for self-medication, an outgrowth of the dominant position which chemotherapy has gained within modern medicine.<sup>17</sup> More importantly, what chiefly damaged the power and status of East African doctors after independence was not the *power* of the state but the *weakening* of the state in the face of population growth, economic crisis, commercialisation, and (in Uganda) political collapse. It was the states' inability to preserve free public-health systems, pay doctors a living wage, give them acceptable working conditions, or protect their monopoly privileges against lay practitioners that most seriously threatened the medical profession. This is the crucial reason why notions of deprofessionalisation and Anglo-American models are inapplicable to East Africa. Nevertheless, although the modern profession was weakened after independence, it remained the chief component of East Africa's late twentieth-century medical systems. These consisted of five main, often discordant, elements. First, the modern doctors who controlled state medical services dominated public health, preventive medicine, and the most sophisticated forms of curative care; thanks to modern communications and international bodies like the World Health Organisation (WHO) they held quite strictly to orthodox modern medicine, without the syncretism which had taken place in the past when Greek medicine was exported to the Islamic world or Buddhist medicine to China,<sup>18</sup> which was one reason to follow the modern doctors in seeing their medicine as distinctive and calling it modern.<sup>19</sup> Second, the bulk of doctors in public service had entered a trade union relationship with the state and were beginning to rethink the very notion of a profession. Third, most modern doctors were private practitioners, either openly or covertly, in response to urbanisation, social differentiation, and the decline of state services. Fourth, much routine medication came from drug-sellers and medical auxiliaries in private practice. Fifth, indigenous medicine was largely a residual activity, with some efforts towards self-modernisation. These five elements jostled one another, revealing as yet no clear trajectory for East African medicine as a whole.

The fourth stage in the modern doctors' history was the AIDS epidemic. Their historical experience profoundly shaped their responses. First, East Africa's doctors played a major part in uncovering the epidemiology of heterosexually transmitted AIDS, drawing on a tradition of epidemiological research first developed at Makerere in the 1940s. Second, they had sub-

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stantial responsibility for devising strategies to control the epidemic in Third World countries; here they were hampered by the weakening of East Africa's states and medical systems, but the doctors' blend of rationalism and nationalism enabled them to counsel openness and to encourage experiment without sacrificing national dignity. Third, the doctors shared in the burden of care for AIDS patients, protected to some degree by the detachment which they had cultivated in the face of East Africa's disease environment, but nevertheless at their best showing the compassion which had moved those who first pioneered modern medicine in the region.

## 2 Pioneers

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Africans began to practise modern medicine in East Africa from the 1870s. They owed little in a direct sense to the region's indigenous medicine, but they inherited its entrepreneurial character as a career open to talent and most learned their modern medicine through an apprenticeship not unlike that of indigenous healers. As apprentices in a menial task, the modern African pioneers had ambition but little status. Most were of lowly birth, initially indeed former slaves, and they generally lacked compensating modern education. But by their own efforts they converted menial work into a respectable career, while a few, through talent and long service at mission stations, gained positions of medical responsibility which Africans would not achieve again until the late 1920s. The majority, however, remained menials, especially in government employment. It was only on the eve of the First World War that practical medical training began to be linked to formal education in the way needed to lay the foundations of a medical profession.

### **Disease and medicine in nineteenth-century East Africa**

Although the first East African practitioners of modern medicine seldom came from families with an indigenous medical tradition, and although the professional structures they entered could scarcely have been less like indigenous structures, there were nevertheless more subtle legacies from the old medicine to the new. The most obvious was the disease environment. It is difficult today to imagine the extent of ill-health and suffering endured in the nineteenth century, as everywhere in the world during the 'age of agony' which preceded modern medicine. Early European doctors occasionally described it:

The Teso turned up in large force for medicine, and I saw nearly four hundred cases in the two days . . . Amongst others there were over forty lepers, with fingers and toes dropping off, some blind, alas! and others just starting the fell disease, including one a child of only eight or nine. Many had huge ulcers, with a lump of

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cow-dung clapped on by way of medicine. There were babies with malarial spleens. Enormous hydroceles, which in many cases reached the size of a child's head, or even bigger, were common. On Saturday we operated on thirty-one of these, on Sunday afternoon on forty-seven.<sup>1</sup>

One thing that modern doctors were to share with their indigenous predecessors was their value to a world of suffering.

Most of this ill-health was due to endemic complaints arising from environment and poverty. Broadly speaking, East Africa divided into damp lowlands (especially on the Indian Ocean coast and around the Great Lakes), arid savanna covering most of modern Tanzania and the north of Kenya and Uganda, and damp highland blocks thrusting out of the savanna (notably the homelands of the Kikuyu and Kalenjin of Kenya, the Chagga and Shambaa of northern Tanzania, and the mountain peoples of western Uganda).<sup>2</sup> The dominant endemic disease of the damp lowlands and the savanna, especially among children, was malaria, which African mosquitos transmitted with unique efficiency to peoples living below 1,000–1,500 metres. It accounted for one-quarter of all the early cases at Mengo Hospital in Buganda, on the northern shore of Lake Victoria.<sup>3</sup> Damp lowlands also fostered diarrhoea (especially in infants), dysentery, helminthic conditions which caused widespread anaemia, leprosy, trachoma (an eye complaint), the hideous tropical ulcers whose victims occupied so many beds in early colonial hospitals, the equally horrible and widespread sores due to yaws, and (especially on the coast) the water-transmitted urinary complaint of bilharzia.<sup>4</sup> These diseases were somewhat less prevalent in the savanna, where yaws might give place to the closely related endemic (non-venereal) syphilis.<sup>5</sup> Diarrhoea, yaws, ulcers, helminthic conditions, and leprosy were also common in many damp highlands, but here the absence of malaria was balanced by special susceptibility to pneumonia and other respiratory complaints, including a tuberculosis which was less fatal than that introduced under European rule.<sup>6</sup> Nor were East Africans spared diseases often thought peculiar to industrial countries. Within five years of arriving in Uganda in 1897, Dr Albert Cook had diagnosed cancer and leukemia, benign tumours, and several heart conditions. Epilepsy was greatly feared, often thought to be contagious, and brutally treated, as were other mental illnesses with frightening symptoms.<sup>7</sup>

Among epidemic diseases, the strain of bubonic plague which had caused Justinian's Plague in North Africa in AD 541–2 survived in East Africa's wild rodents and bred sporadic human epidemics, especially in Buganda, where people fled their homes at its appearance.<sup>8</sup> Smallpox, although common, was less feared in its relatively mild indigenous form, but long-distance trade introduced more virulent Asian or European strains which caused terrible epidemics during the last thirty years of the nineteenth



century.<sup>9</sup> Trade also brought four major cholera epidemics from India during the nineteenth century, with especially dreadful mortality in Zanzibar.<sup>10</sup> Traders probably also introduced gonorrhoea and venereal syphilis, although the similarity between their symptoms and those of yaws and endemic syphilis makes these diseases especially puzzling.<sup>11</sup>

Not only did East Africa's first modern doctors inherit a disease environment from their indigenous predecessors, but they also inherited their patients and the patients' expectations, which were for a largely curative (rather than preventive) therapy chiefly in the form of medicines, an emphasis which was to survive throughout the twentieth century. Adults probably ignored much minor illness. 'Most people in Kenya regard a certain amount of abdominal worms as a natural, indeed necessary, condition to normal health', a Kenyan medical anthropologist has written.<sup>12</sup> Illness in children probably caused more alarm, for their vulnerability was widely recognised – 'one who wants to bring up a child needs medicine', said a Luganda proverb – but modern study suggests that children, like adults, were generally treated first with home remedies.<sup>13</sup> 'The patient first tries out all the medicines known to him before he calls the healer', a well-informed observer of the Shambaa explained.<sup>14</sup> When domestic remedies failed, the next recourse was probably to an elderly neighbour or relative with a purely local reputation for treating a particular complaint.<sup>15</sup> Only when these options were exhausted did the patient turn to an expert, an *mganga* (in Swahili) or *omusawo* (in Luganda).

East Africa's indigenous healers were diverse and did not form a coherent profession. There was generally a broad distinction between divination (or diagnosis) and treatment. In some areas, as in Buganda, the same expert often performed both functions, but elsewhere they were frequently separated.<sup>16</sup> Both types of practitioners were mostly male, but there were women diviners (generally using spiritual techniques) and women who specialised in midwifery or in treating women's and children's complaints.<sup>17</sup> Although expertise often ran in families, the diviner also generally needed a spiritual calling, through dreams, sickness, spirit possession, or solitary wandering in the bush.<sup>18</sup> Like pre-modern doctors elsewhere, diviners relied less on examination than on observation, shrewd questioning, and psychological insight. They might also seek spiritual guidance or manipulate material objects: the patterns formed by powder sprinkled on water or seeds scattered from a basket, for example, or the flow of blood and condition of the organs of a slaughtered beast or fowl, to quote common techniques used in the Bunyoro kingdom bordering Buganda.<sup>19</sup> The diviners' role was to diagnose the deeper causes of misfortune – for illness was only one of the many misfortunes on which they were consulted – and to prescribe a course of action, which might be not a medical treatment but a

ritual or countermeasures against a sorcerer. In the last resort, the only test of a divination was whether the course of action worked.<sup>20</sup>

By contrast, the most common medical practitioner, the herbalist, generally learned his trade through apprenticeship, which appears to have provided a model and set of expectations for many of the first young people who studied modern medicine. Only two accounts of formal apprenticeship exist. One, for the Shambaa, describes a young man apprenticing himself to an expert by a blood oath promising mutual support and secrecy regarding the master's medicines. After initial instruction, the apprentice spent a year practising alone among neighbouring peoples, paid a fee, assisted his master for a period, made a second iteration, paid a final fee, and qualified.<sup>21</sup> The second account, for the Nyamwezi of western Tanzania, describes formal initiation into a secret society of healers, followed by a period of close service and observation with a master before receiving the *gnu's tail of office*.<sup>22</sup> Normally, however, apprenticeship was less formal. Most herbalists appear to have specialised in certain conditions or medicines and to have worked part time, mainly at their homesteads, but there were also itinerant specialists.<sup>23</sup> Herbs were applied to external injuries or drunk for internal conditions. Most herbalists claimed magical as well as chemical efficacy for their potions, which often had genuine, if mild, medicinal properties.<sup>24</sup> In addition to herbal remedies, practitioners treated fever by stimulating perspiration, countered mental and other complaints by inducing trance, and used the cupping-horn to encourage bleeding or cautery to stop it. Experts treated snake-bite, set bones, or healed wounds.<sup>25</sup> There is evidence, especially in the Great Lakes region, of surgical skill in repairing mutilations and in such agonising emergency surgery as trepanning and perhaps caesarean delivery, although – as in other pre-modern cultures – surgery was practised only in emergencies.<sup>26</sup>

Although indigenous medicine was chiefly curative, healers also had protective and preventive functions. For protection they supplied amulets, medicines, and potions, especially for children. Nyoro also inoculated their children with endemic syphilis, while inoculation with pus from an active smallpox case was known in the eighteenth century and spread widely in the nineteenth.<sup>27</sup> Healers also had important public-health functions which they were to lose under colonial rule. Kamba diviners in modern Kenya were expected to foresee approaching epidemics and place charms against them on paths approaching villages. In Buganda the priest of the plague god, Kawumpuli, sent agents to cleanse areas attacked by plague, distribute amulets, and treat and nurse the sick.<sup>28</sup> In important kingdoms the royal doctors were powerful men at court. During the 1880s the King of Bunyoro deputed a renowned healer to find a cure for plague, supplying victims for experimental purposes. Other rulers intervened more directly. The Hehe