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"An All-white Institution": Defending Private Practice and the Formation of the West African Medical Staff

RYAN JOHNSON*

Introduction

At the turn of the twentieth century, many politicians and businessmen with interests in West Africa considered that,

> The systematic application, by highly trained and specially qualified officers, of the principles of modern tropical medicine and hygiene to West Africa ... must result in great improvement in the healthiness of these regions, with consequent increase in their material prosperity and economic development.[1]

The efficient recruitment of physicians "specially qualified" in the principles of "modern tropical medicine and hygiene" proved, however, to be a difficult task. To address this problem, the Secretary of State for the Colonies, Joseph Chamberlain, organized a committee in 1901 to draw up plans for amalgamating the six medical departments of British West Africa. Their primary goal was to devise incentives to attract a greater number of physicians for service in the infamous "white man's grave". As a result, the West African Medical Staff (WAMS) was created and officially announced with the publication of the 1902 pamphlet, *Information for the use of candidates for appointments in West African Medical Staff*.[2]

When the WAMS was publicized in 1902 it was the only department in the empire that was explicitly racist: it formally excluded West Africans—or any physician not of "European parentage"—from joining its ranks.[3] In 1915 the governor of the Gold Coast,

* Ryan Johnson, PhD, History Department, University of Strathclyde, McCance Building, 16 Richmond Street, Glasgow, G1 1XQ, UK; e-mail: ryan.johnson@strath.ac.uk

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[1] Anon., 'Report of the Departmental Committee on the West African Medical Staff', *Lancet*, 1909, **i**: 249.

[2] National Archives, Kew (hereafter NA), CO/96/403, *Information for the use of candidates for appointments in the West African Medical Staff: Colonial Office, African (West), No. 678*, Jan. 1902. For an excellent history of the establishment and work of the East African Medical Service (EAMS), see Anna Crozier, *Practising colonial medicine: the Colonial Medical Service in East Africa*, London, I B Tauris, 2007.

[3] Despite the common practice of exclusion based on race, no department in the Colonial Service, as of 1902, had made it official policy through Whitehall. Following close on the precedent set by the WAMS, in 1904 the Malayan Civil Service (MCS) formally declared that recruits must be of European parentage; and it was not until 1925 that the East African Medical Service (EAMS) officially barred candidates of non-European descent from applying. See Crozier, op. cit., note 2 above; and Lenore Manderson, *Sickness and the state: health and illness in colonial Malaya, 1870–1940*, Cambridge University Press, 1996.

Hugh Clifford, criticizing policies of exclusion established by the 1901 Colonial Office committee, stated that,

> The question ... really is whether or no the Governments of the West African Colonies are to ... maintain a colour bar such as no Government of any Crown Colony in the Empire, with which I am acquainted, has attempted to establish, for the purpose of keeping the West African Medical Staff an all-white institution.[4]

While most colonial state departments were racist in practice, they did not make it official policy. Many medical departments, such as the Indian Medical Service (IMS), relegated indigenous practitioners to a subordinate service; however, officially, Indians could still attempt to join the regular staff, even if it was highly unlikely that they would be admitted. In addition, it was always possible for West Africans to work as attorneys, accountants, clerks and in other professional capacities for the colonial state. Just prior to the formation of the WAMS, West Africans were regularly employed in medical departments, even rising to senior posts, including that of chief medical officer.[5] An important question this article addresses, therefore, is why did the WAMS emerge as a formally racist institution and not simply maintain the practice of informal racism? Why was it considered necessary to make the organization explicitly racist?

Historians who have investigated the formation of the WAMS typically argue that it was simply British racism backed up by scientific racism[6] which explains its formation as a racist institution.[7] However, on its own, racism is an empty analytical device for understanding how and why the WAMS, in 1902, became the only department in the dependent empire that was openly racist through official policy. I argue that the West African Medical Staff was founded as "an all-white institution" to enhance the recruitment of white European medical officers and defend their interests in the lucrative but extremely competitive private practice that existed in the region. The economic imperative of private practice has not previously been considered by historians as a possible motive for the institutional racism of the WAMS. This does not deny the importance of racism itself, which provided the necessary conceptual framework to justify the exclusion of West Africans from medical service. None the less, I will demonstrate in this

[4] National Archives of Ghana (hereafter NAG), ADM/12/5/143, Hugh Clifford to Lewis Harcourt, 21 Jan. 1915.

[5] West African John Farrell Easmon, who is discussed further below, was appointed chief medical officer of the Gold Coast Colony in 1893. See Adell Patton Jr, 'Dr John Farrell Easmon: medical professionalism and colonial racism in the Gold Coast, 1856–1900', *Int. J. Afr. Hist. Stud.*, 1989, **22**: 601–36.

[6] See Nancy Leys Stepan, *The idea of race in science: Great Britain 1800–1900*, London, Macmillan, 1982; George Stocking Jr, *Victorian anthropology*, London, Collier Macmillan, 1987; Henrika Kuklick, *The savage within: the social history of British anthropology 1885–1945*, Cambridge University Press, 1991; Elazar Barkan, *The retreat of scientific racism: changing concepts of race in Britain and the United States between the world wars*, Cambridge University Press, 1993; Saul Dubow, *Scientific racism in modern South Africa*, Cambridge University Press, 1995.

[7] See Adeloya Adeloye, *African pioneers of modern medicine: Nigerian doctors of the nineteenth century*, Ibadan, University Press, 1985; Patton, op. cit., note 5 above; Adell Patton Jr, *Physicians, colonial racism, and diaspora in West Africa*, Gainsville, FL, University of Florida Press, 1996; Stephen Addae, *Evolution of modern medicine in a developing country: Ghana, 1880–1960*, Edinburgh, Durham Academic Press, 1997, esp. pp. 199–226; Christopher Fyfe, *Africanus Horton: West African scientist and patriot*, New York, Oxford University Press, 1972; Charles Tetty, 'Medical practitioners of African descent in colonial Ghana', *Int. J. Afr. Hist. Stud.*, 1985, **18**: 139–44.

article that racist arguments and policies were, for the most part, aggressively deployed as much for economic and political purposes as for reasons of internalized cultural constructions of racial difference.

When Chamberlain took office as Colonial Secretary in 1895, he attempted to restructure the Colonial Service and enhance its prestige relative to other services, such as the Indian Civil Service (ICS).[8] Chamberlain and the Unionists, through policies of "constructive imperialism", also wished to include the West African colonies in a system of imperial preference.[9] In addition, chambers of commerce with considerable interests in Britain's West African possessions were pressuring Chamberlain to improve the healthiness of the region both for Europeans and for their own profits,[10] and when the London and Liverpool schools of tropical medicine were established in 1899, an even greater sense of urgency arose to recruit "competent" and "suitable" candidates for service in West Africa.[11]

Along with the notorious West African climate, another significant barrier stood in the way of Chamberlain's and the Colonial Office's hopes of bolstering the recruitment and prestige of service in West Africa. Prior to 1902, white European medical officers competed with highly educated, successful and powerful West African medical officers for senior posts and private practice. From the 1850s, when a scholarship scheme was first introduced by the War Office, several West Africans had trained as physicians in Britain, subsequently rising to positions of prominence.[12] From the late nineteenth century many

[8] See Robert Heussler, *Yesterday's rulers: the making of the British colonial service*, Syracuse University Press, 1963; Anthony Kirk-Greene, *On crown service: a history of HM colonial and overseas services, 1837–1997*, London, I B Tauris, 1999.

[9] See Robert V Kubicek, *The administration of imperialism: Joseph Chamberlain at the Colonial Office*, Durham, NC, Duke University Press, 1969; Raymond E Dumett, 'Joseph Chamberlain and the new imperialism in West Africa', in Barry M Gough (ed.), *In search of the visible past*, Waterloo, ON, Wilfred Laurier University Press, 1975, pp. 51–75; Richard M Kesner, *Economic control and colonial development: crown colony financial management in the age of Joseph Chamberlain*, Oxford, Clio Press, 1981, esp. pp. 70–84; Michael Havinden and David Meredith, *Colonialism and development: Britain and its tropical colonies, 1850–1960*, London, Routledge, 1993, esp. pp. 70–114.

[10] See Raymond E Dumett, 'The campaign against malaria and the expansion of scientific medical and sanitary services in British West Africa, 1898–1910', *African Historical Studies*, 1968, **1**: 153–97, p. 161; African Trade Section of the Incorporated Chamber of Commerce of Liverpool, *Health and sanitation, West Africa to the Right Hon. J. Chamberlain, M.P. (H.M. Secretary of the State for the Colonies), at the Colonial Office*, Liverpool, 1901.

[11] The history of the new or Mansonian tropical medicine has been extensively documented. See Michael Worboys, 'The emergence of tropical medicine: a study in the establishment of a scientific specialty', in Gerard Lemaine (ed.), *Perspectives on western medicine and the experience of scientific disciplines*, The Hague, Mouton, 1976, pp. 75–98; *idem*, 'Manson, Ross, and colonial medical policy: tropical medicine in London and Liverpool, 1899–1914', in Roy MacLeod and Milton Lewis (eds), *Disease, medicine, and empire: perspectives on western medicine and the experience of European expansion*, London, Routledge, 1988, pp. 21–37; *idem*, 'Tropical diseases', in W F Bynum and Roy Porter (eds), *Companion encyclopedia of the history of medicine*, 2 vols, London, Routledge, 1993, vol. 1, pp. 512–36; *idem*, 'Germs, malaria, and the invention of Mansonian tropical medicine: from "diseases in the tropics" to "tropical diseases"', in David Arnold (ed.), *Warm climates and western medicine,* Amsterdam, Rodopi, 1996, pp. 181–207; June Jones, 'Science utility and the "second city of empire": the sciences and especially the medical sciences at Liverpool University, 1881–1925', PhD thesis, University of Manchester, 1989; John Farley, *Bilharzia: a history of imperial tropical medicine*, Cambridge University Press, 1992, esp. pp. 13–30; Helen J Power, *Tropical medicine in the twentieth century: a history of the Liverpool School of Tropical Medicine, 1898–1990*, London, Kegan Paul International, 1999, esp. pp. 11–46; Lise Wilkinson and Anne Hardy, *Prevention and cure: the London School of Hygiene & Tropical Medicine, a 20th century quest for global public health*, London, Kegan Paul International, 2001, esp. pp. 1–21.

[12] Throughout the nineteenth century, West Africans had held senior posts in colonial administrations. See David Kimble, *A political*

of these physicians, such as John Farrell Easmon and Benjamin Quartey-Papafio, gained the confidence not only of high ranking British officials, but also of local traders and merchants. In addition, given their year round residence in large coastal cities such as Accra, Cape Coast and Freetown, and their association with government service, they built up a large clientele of white European and West African fee paying patients, as well as holding contracts with merchant and shipping companies operating along the coast.

While the issue of private practice amongst government medical officers was not unique to British West Africa, the limited private practice in the region constituted a significant source of income, as well as tension. In 1913, for instance, a group of medical officers in the WAMS sent a list of grievances to the Secretary of State for the Colonies, Lewis Harcourt. Their main objection was the possible drafting of a policy that would exclude senior medical officers from participating in private practice. The 1913 "memorialists" stated that, "Private practice was, with many of us, the determining factor in entering the service."[13] They further declared that, "We feel it to be an interference, which in addition to being unjustifiable, is—and we use the words advisedly—quite intolerable ... To express ourselves with less emphasis would be to misrepresent our convictions." Finally, they stated, "We would respectfully inform you that it is the considered opinion of your memorialists that without the prospect of private practice the West African Medical Staff is not worth entering as a life's career."[14]

In 1901, however, when recruitment for service in West Africa was much more difficult, Chamberlain and the Colonial Office realized the importance of private practice to the recruitment process. The committee which drafted the rules of the new service was also composed of the highest ranking white European medical officers from West African medical departments, who would have been well aware of the economic function of private practice, and at one time in competition with West African physicians in government employ. Thus the defence of private practice to bolster the recruitment and prestige of service in West Africa emerged as an integral factor in the foundation of the WAMS as an "all-white institution".

West African Physicians

From the late fifteenth century, western medicine had reached a small number of West Africans along the coast predominantly through European trading posts. Portuguese physicians were amongst the first to establish European medical facilities; and early English, Danish, Dutch and German (Brandenburger) explorers and traders also brought European medical men and supplies in train.[15] By the eighteenth century, contact with western medicine often occurred through European surgeons attached to

history of Ghana: the rise of Gold Coast nationalism, 1850–1928, Oxford, Clarendon Press, 1965.

[13] NAG/ADM/12/3/20, On the subject of discontent and unrest at present unhappily prevailing among members of the West African Medical Staff: Private Practice, 16 Mar. 1914.

[14] Ibid.

[15] See Addae, op. cit., note 7 above, pp. 8–28.

slave ships, whose primary duty was to maximize profits by attending to the health of crew members and captured slaves.[16] Adell Patton Jr has also cited the dispensary system as one of the chief means through which West Africans were introduced to western medicine in the later eighteenth century. For instance, in about 1795 the Sierra Leone Company sent the West African John Macaulay Wilson, the son of a chief, to England for training as an apothecary. Upon his return Wilson worked for the company, and later the crown.[17]

Missionaries were also successful disseminators of western medical practice. According to Ralph Schram, as early as 1504 Catholic missionaries built a hospital on St Thomas Island, off the coast of Nigeria; and by the nineteenth century the Basel Mission, the Bremen Missionary Society, the Roman Catholic Mission, the Wesleyan Mission and the Church Missionary Society (CMS) were among the largest missionary societies providing basic western medical care to local West African populations.[18] In addition to missionaries, colonial surgeons in the British Army were engaged in western medical practice along the coast, with military health care facilities established at Dixcove, Cape Coast, Anomabu, Accra and Keta by the 1850s.[19]

Following the death of the governor of Sierra Leone, Charles MacCarthy, in 1824 at the hands of Ashanti landlords, and with constant high rates of European morbidity and mortality, Parliament began seriously to consider the abandonment of Britain's West African possessions.[20] None the less, despite the region's unpopularity, the British government continued to strengthen its holdings in West Africa. It was compelled—as much for reasons at home as in West Africa—to send increasing numbers of officials and troops to consolidate control and respond to growing Ashanti aggression. However, recruitment for service in West Africa was a perennial problem given the high death toll among European migrants. According to Christopher Fyfe, "To attract doctors into such an unattractive service, a double medical staff had to be maintained at great expense."[21] As a result, it was agreed that training West Africans in the tenets of western medicine was a sensible solution.[22] By the

[16] Richard B Sheridan, *Doctors and slaves: a medical and demographic history of slavery in the British West Indies*, Cambridge University Press, 1985; Robin Haines and Ralph Shlomowitz, 'Explaining the mortality decline in the eighteenth-century British slave trade', *Econ. Hist. Rev.*, 2000, **53**: 262–83; Richard H Steckel and Richard A Jensen, 'New evidence on the causes of slave and crew mortality in the Atlantic slave trade', *J. Econ. Hist.*, 1986, **46**: 57–77.

[17] Patton, op. cit., note 7 above, p. 62.

[18] Ralph Schram, *A history of the Nigerian health services*, Ibadan University Press, 1971, p. 20.

[19] Addae, op. cit., note 7 above, p. 16.

[20] Talk of abandoning interests in West Africa began with the abolition of the slave trade in 1807, and came to a head with the publication of the *Report of the Select Committee on Africa (Western Coast)*. The report recommended Britain's gradual withdrawal from the Gold Coast; however, because of continuing economic and political pressures it was never a viable option. Havinden and Meredith, op. cit., note 9 above, p. 57.

[21] Fyfe, op. cit., note 7 above, p. 29.

[22] Also influential in the decision to train West Africans in western medicine were the disastrous Niger expeditions between 1832 and 1842, which had suffered notoriously high morbidity and mortality rates—particularly Buxton's 1841–2 expedition. According to Philip Curtin, "The monthly mortality for Europeans on the Niger expedition of 1841 had been 167 per thousand and had raised such a public furor that the advance up the Niger was temporarily abandoned." Philip D Curtin, *Disease and empire: the health of European troops in the conquest of Africa*, Cambridge University Press, 1998, p. 89.

mid-nineteenth century western medical consensus held that West Africans were immune to many of the diseases laying waste to British troops, traders, merchants, government officials and missionaries. A scholarship scheme was thus introduced in 1853 by the then Deputy Secretary of War, Benjamin Hawes, to recruit "suitable" West Africans to study medicine in Britain, and thereafter serve as army medical officers in West Africa.[23] The War Office looked to Freetown, Sierra Leone and the CMS grammar school to provide suitable candidates for the scheme. In 1855 three men, Samuel Campbell, William Broughton Davies and James Beale Horton (who later added the title Africanus to his name when registering for medical school in Edinburgh) were sent to Britain to attain the degree of MD.[24] Horton is perhaps the best known West African physician prior to the establishment of the WAMS, given his legacy of numerous letters, publications and accomplishments.[25]

Other prominent physicians emerging from the Sierra Leone "nexus" during this period included Nathaniel King (1847–1884), who had also benefited from connections with the CMS.[26] Like Horton, King graduated from King's College, London, and the University of Edinburgh, where he gained the degree of MD.[27] The Yoruba physician Obadiah Johnson (1849–1920) also attended King's College, London, and like his predecessors achieved several prizes and distinctions.[28] Johnson subsequently served as assistant colonial surgeon in Lagos, when he ended his career in 1897 after being repeatedly passed over for pay increases and promotion. Like many of his fellow West African colleagues, Johnson consistently received favourable reports from both official and civilian European patients.[29]

Perhaps the most important African physician in terms of this article is John Farrell Easmon (1856–1900). Easmon, born in Freetown, studied at University College, London, and received his MD in Brussels with distinction. Easmon was a distant cousin of William MacCormack, who, at the time of Easmon's graduation, was president of the Royal College of Surgeons. In about 1880 he was offered the appointment of house surgeon at St George's Hospital, London, which could have led to an assistantship; however, he rejected the offer.[30] Instead, Easmon accepted a post in the Gold Coast Medical Service in about 1885. In 1893 he was promoted to chief medical officer, the highest ranking position in the department. During this time Easmon also contributed to the research and study of tropical diseases, and has been credited with coining the term "blackwater fever" in 1884.[31] Easmon was eventually removed from his post in 1897 on charges of

[23] Patton also notes the importance of the precedent set by the former physician and governor of Sierra Leone, William Fergusson—who was of African descent—on the formation of the scholarship scheme. Patton, op. cit., note 7 above, p. 75.

[24] Fyfe, op. cit., note 7 above, p. 33.

[25] Among James A B Horton's publications are the following: *The medical topography of the West Coast of Africa*, London, 1859; *Geological constitution of Ahanta, Gold Coast*, Freetown, 1862; *Political economy of British Western Africa*, London, W S Johnson, 1865; *Physical and medical climate and meteorology of the west coast of Africa*, London, 1867; *Guinea worm, or dracunculus*, London, 1868; *Letters on the political condition of the Gold Coast*, London, 1870; and *The diseases of tropical climates and their treatment*, London, 1874.

[26] For a discussion of the Sierra Leone "nexus" and the numerous physicians it produced, see Patton op. cit., note 7 above, pp. 59–92.

[27] Adeloye, op. cit., note 7 above, p. 48.

[28] Ibid., p. 78.

[29] Ibid., pp. 80–5.

[30] Patton, op. cit., note 7 above, p. 99.

[31] Addae, op. cit., note 7 above, p. 19.

engaging in private practice—something which the chief medical officer was barred from doing. It is, however, suggestive of his skills and the respect he commanded as a physician in the region that he was offered, and accepted, a £1,000 retainer by the merchants at Cape Coast upon his departure.[32] Throughout his career, Easmon also consistently received praise for his medical service from both European officials and former patients.[33] Indeed, the Gold Coast governor, William Brandford Griffith (1885–1895), stated that,

> His [Easmon's] successful treatment of local diseases, his frequent visits and unremitting attention to his patients, his courage in difficult cases combined with gentleness as a man and a singular power of raising the spirits of his patients and making them more and more hopeful each hour he visits them[,] are qualities which have attracted and attached people to him, and [are] invaluable at Accra where the European population has increased so much.[34]

Just prior to the formation of the WAMS, another West African, Benjamin W Quartey-Papafio, the first Ghanaian physician, received similar praise. For example, he was graciously thanked by Captain W R Reeve-Tucker, the commanding officer of the Gold Coast Constabulary at Elmina, for the quality of care he provided. Reeve-Tucker stated, "I never experienced greater kindness or attention from anyone than I did from you during the time I was ill and I am very grateful indeed to you. I expect I owe my life to you."[35] Additional praise came from A J Chalmers, former medical officer in the Gold Coast and registrar of the Ceylon Medical College. Responding to the assumption that Tamil and Sinhalese doctors formed a better class of "native" doctor than West Africans, Chalmers confided, "I always understood that Europeans very much appreciated Dr Easmon ... and I also understood that they very much appreciated Papafio, and I also understood that they appreciated some others of them." He further noted, "Dr Papafio did quite good work when I was there."[36] As these and other testimonies reveal,[37] West African physicians had in many cases earned the acceptance and confidence of both European officials and military officers, as well as of missionaries and various mining and mercantile interests.[38] Despite such support, the 1901 Colonial Office committee justified the exclusion of West Africans on the basis that they did not, in fact, enjoy such support and confidence.

[32] Tetty, op. cit., note 7 above, p. 141.

[33] For an overview of Easmon's career and difficulties, see Patton, op. cit., note 7 above, esp. pp. 93–122.

[34] NAG/ADM/1/2/46, W B Griffith to Lord Knutsford, 16 July 1892.

[35] NAG/ADM/12/5/143, W R Reeve-Tucker to B W Quartey-Papafio, 6 June 1894.

[36] NA/CO/879/99, Departmental Committee on the West African Medical Staff: minutes of evidence, African (West), NO. 922 Part II, Mar. 1909, p. 85.

[37] See Adeloye, op. cit., note 7 above; Tetty, op. cit., note 7 above, pp. 139–44.

[38] Many letters, for instance, were written by European officials and military officers in support of Quartey-Papafio and other West African physicians in an attempt to challenge their exclusion from the WAMS. NAG/ADM/12/5/143, Employment of native medical men, 27 Dec. 1888 to 17 Dec. 1918.

The Making of "An All-white Institution"

Following Chamberlain's overhaul of the Colonial Service and the opening of the schools of tropical medicine in 1899, the consolidation of the West African medical departments was considered a next logical step. In December 1901 a committee was formed by Chamberlain and the Colonial Office to offer advice on the amalgamation of the departments and to devise incentives to attract new recruits.[39] The Colonial Office committee, led by Herbert Read, was asked to consider and revise a series of preliminary proposals compiled by Chamberlain, which had initially been informed by a report drafted by the British Medical Association.[40]

Members of the Colonial Office committee, besides Read, included William R Henderson, chief medical officer of the Gold Coast, who had replaced John Farrell Easmon in 1897; R Allman, chief medical officer of Southern Nigeria; D K McDowell, chief medical officer of Northern Nigeria; and Edward H Marsh, one of Chamberlain's junior assistant private secretaries.[41] According to the report: "[T]he committee were informed by the Colonial Office that Mr Chamberlain's attention had been called to the difficulty which was experienced in obtaining a sufficient number of competent medical officers for service in West Africa, and that he had come to the conclusion that the conditions of service must be revised."[42]

The committee first responded to a proposed system of grading and pay scales drafted by Chamberlain and the British Medical Association. They approved the rank of primary medical officer—replacing that of chief medical officer—although they disagreed with the proposed salaries. They felt £800, up to a maximum of £1,000, was sufficient for Sierra Leone, Lagos, and the Gambia, but that this should be increased to £1,000, up to a maximum of £1,200, for the primary medical officers of the Gold Coast and Southern and Northern Nigeria.[43] Because primary medical officers, like all medical officers, enjoyed long leaves of absence, the committee also recommended that the grade of deputy primary medical officer be introduced, starting at £700 and rising to a maximum of £800.

The committee rejected the suggested rank of assistant medical officer and a probationary period of three years. According to the committee, "The use of the term 'assistant' (or 'probationary') 'medical officers' would not . . . be regarded with satisfaction; and the necessity of remaining on probation for three years might deter many suitable candidates from offering themselves for employment."[44] Instead, they recommended that all new medical officers receive a salary of £400, which, after a

[39] NA/CO/879/72/6, Report of the committee appointed to discuss a scheme for the amalgamation of the medical services in the West African colonies and protectorates, Jan. 1902.

[40] NA/CO/879/72, British Medical Association to the Colonial Office, 10 Dec. 1901.

[41] The primary medical officer of Sierra Leone and the senior medical officer of the Gambia were not in attendance, probably due to the small number of medical officers posted to these regions. Kubicek notes that Marsh's primary task at the Colonial Office was to interview potential candidates for professional and minor civilian posts in West Africa, explaining his assignment to the committee. Kubicek, op. cit., note 9 above, p. 56.

[42] NA/CO/879/72/6, Report of the committee appointed to discuss a scheme for the amalgamation of the medical services in the West African colonies and protectorates, Jan. 1902, p. 1.

[43] It must have been convenient that the highest ranking medical officers in Sierra Leone, Lagos and the Gambia were not present to protest their lower salary. Ibid., p. 4.

[44] Ibid.

year's probationary period, would be raised by increments of £20 to a maximum of £500.

Private practice was a sensitive issue for the committee. They did not consider banning or restricting private practice, except in the case of primary medical officers, but they agreed that the "privilege" should be taken away from individual medical officers if they abused it, or let it interfere with their government work. None the less, they argued that, "MOs [medical officers] should be permitted to take private practice, on the ground that there are few, if any, European doctors on the coast other than those in the service of the government, and that it is desirable, in the interests of humanity, that private persons on the coast should be able to obtain the best medical advice possible".[45] This proposal, by promoting private practice along the lines of a "civilizing mission", neglected an important aspect of medical service throughout the empire: high incomes could be generated from private practice in certain regions. Despite this, the committee did not recommend advertising a hypothetical amount that medical officers could expect to earn. Private practice was abundantly available in some posts, while completely lacking in others.

The second issue pondered by the committee was whether or not to include West African physicians, or any physician not of "European descent", in the new service. They unanimously decided that non-Europeans, especially West Africans, should not be allowed to join its ranks. Rather than acknowledge the competent and dedicated work of several West African, West Indian and East Indian physicians, the committee justified their exclusion on grounds of inherent racial qualities that supposedly manifested in inferior medical skills. They stated that they were "strongly of the opinion that it is generally inadvisable to employ natives of West Africa as Medical Officers in the Government Service. [It is] the duty of British Governments in West Africa to provide the best medical assistance for their European employees."[46] As discussed below, they also cited the problem of "social conditions" and military service, especially in Southern and Northern Nigeria, and the undesirability of West African medical officers outranking European military officers.[47]

As we have seen, despite multiple examples proving otherwise—especially in terms of the professional capabilities of non-European physicians—these carefully crafted and selected claims were used by the committee to argue that the new service should be open to subjects of European parentage only. In order to accommodate existing West African, West Indian and East Indian physicians working in medical departments, they recommended that a "subordinate" medical staff be established at significantly lower pay and placed on a separate roster.[48] Retaining West African physicians in some capacity was considered wise, in order to deal with increasing numbers of poor, non-fee-paying West African patients. The committee also recommended that candidates be required to enrol and successfully complete an eight-week diploma course in tropical medicine at either the London or the Liverpool School of Tropical Medicine. This

[45] Ibid.

[46] Ibid., p. 5.

[47] These were the reasons cited in dispatches from the governor of the Gold Coast, Frederick M Hodgson, and the high commissioner of Northern Nigeria at the time, Frederick J D Lugard (who later became the influential governor general of Nigeria). Ibid.

[48] Ibid.

move made it still more difficult for West Africans to join the new service, and provided further justification for not employing them in the first place.

The last order of business was advertisement for and recruitment of potential medical officers. It was agreed that the best method would be to have a certain number of nominations filled by recommendation from the largest medical schools in London, Dublin and Edinburgh; and that all candidates should be placed on one list and appointed to a region when posts became vacant. Finally, with these recommendations and revisions in hand, Chamberlain wasted little time approving conditions of the new service, which was announced with the publication of the pamphlet, *Information for the use of candidates for appointments in the West African Medical Staff* in January 1902.[49]

Following the dispatch of letters and pamphlets to the largest medical schools in Great Britain and Ireland, Alexander R Simpson, dean of the faculty of medicine at the University of Edinburgh, replied to the Colonial Office noting that some of his students were requesting further clarification on the stipulation that candidates must be of "European parentage". Simpson pointed out that the terms, as they existed, would "leave the door open to French, German, Italian and other Europeans ... whilst it would exclude qualified candidates hailing from the various Colonies of the British Empire".[50] He then reminded the committee that,

> Many medical men pass through our University who have come from India, and the West Indies, and from East, West, and South African Colonies, as well as from Canada, Australia, and other Colonies populated by the Anglo-Saxon race. When such Colonials have done well in their various classes, and have proved themselves fully qualified in their professional examinations, it would seem a hardship that they should be excluded from official services in any part of His Majesty's Empire because of their parentage.[51]

Simpson also forwarded a letter, which had prompted his contact with the Colonial Office, written by seven West African medical students currently studying at the University of Edinburgh, who voiced their disappointment over the racist terms of the new service, pointing out that it was a complete reversal of previous policy in the West African medical departments.[52] The students questioned the clause that excluded them from service, asking Simpson "to approach the Senatus Academicus with the object of soliciting their aid in making such presentations to the Colonial Office as may lead to the revision of the ... paragraph". They went on to point out the obvious hypocrisy of the policy, arguing that, "as citizens of the British Empire, West Africans have for over a hundred years enjoyed the full rights and privileges of British citizenship", and that, "under the enlightened rule of Great Britain almost every civil post of West Africa has in the past, been accessible to competent West Africans". The students then pointed to the careers of Horton and Davies. In

[49] NA/CO/96/403, *Information for the use of candidates for appointments in the West African Medical Staff: Colonial Office, African (West), No. 678*, Jan. 1902.

[50] NA/CO/96/403, A R Simpson to Under Secretary of State, 10 Mar. 1902.

[51] Ibid.

[52] The students included G O Marke, Kwesi A O Quainoo, William A Taylor, Ayodeji Oyejola, M B Hebron, B J Odunmbaku Hoare, and Frederick Victor Nanka-Bruce. NA/CO/96/403, University of Edinburgh West African Medical Student Letter of Protest, 19 Mar. 1902.

particular they recalled Horton's many contributions to western medicine in both Britain and in West Africa. Horton's example, they argued, had encouraged many West Africans to send their children to Britain for education as doctors. And, overall, they noted how, "British Governments have ... availed themselves of the services of these men and at present there are over a score of these men engaged by the Colonial Governments of West Africa." The students also recalled how the Colonial Office, in 1895, had defended the employment of government physicians of West African descent against protests by British merchants and traders. Why, now, they wondered, had "policy been reversed without any reasonable explanation for the reversal"?[53]

The students further pointed out that the WAMS was financed by taxes paid by West Africans who were "Citizens of the British Empire", and that the policy was in "flagrant violation ... of the essentially British principle of taxation with representation".[54] They also lamented the fact that white Europeans who were not British subjects, according to the wording of the pamphlet, would have the opportunity for employment in the WAMS. The students concluded by asking the Colonial Office that they be judged on their scientific work and medical qualifications only—pointing out that this was in line with the principles of science itself—and not by the colour of their skin. After reviewing the students' arguments, the Colonial Office's response was not to change the policy, but to qualify it.

Even before the letter was sent to the Colonial Office, Read and Chamberlain's assistant under-secretary, Reginald Antrobus, were aware of the Edinburgh students' questioning of the policy. Read, responding to the suggestion that the wording "European parentage" be changed to "British subjects of European descent", agreed that "the intention in using the term 'European parentage' was to exclude natives of India and West Africa, and West Indians of African descent, but not Canadians, Australians ... The term proposed ... is certainly better, though I am afraid it won't satisfy the Edinburgh University".[55] Antrobus, however, shrugged off the complaints: "The pamphlet has already been distributed widely and it would be very inconvenient to get every copy altered."[56] In subsequent pamphlets however, the wording was changed as suggested, stating that candidates must be "British subjects of European parentage".[57]

The new service proved to be a success, attracting a steadily increasing number of medical officers up to the First World War.[58] The WAMS was also repeatedly cited as a model service for other colonial medical departments to emulate; despite the existence

[53] Ibid.

[54] Ibid.

[55] NA/CO/96/403, Herbert Read to Reginald Antrobus concerning the term "European parentage" in the West African Medical Staff pamphlet, 14 Mar. 1902.

[56] NA/CO/96/403, Reginald Antrobus to Herbert Read concerning the term "European parentage" in the West African Medical Staff pamphlet, 16 Mar. 1902.

[57] NA/CO/879/72, *Information for the use of candidates for appointments in the West African Medical Staff: Colonial Office*, 7th ed., Nov. 1906.

[58] In 1901 there were 82 medical officers in West African medical departments, including West African physicians. Two years after the formation of the WAMS, the number had increased to 125, and by 1914 the number of medical officers in the WAMS stood at approximately 214. NA/CO/241/171/941, *Colonial Office lists 1898–1914*.

of considerable structural problems and widespread discontent within it.[59] Although there were a few dissenting, often anonymous, voices in the British medical profession,[60] among West African governors such as Hugh Clifford and William MacGregor and several wealthy West African families, few seriously questioned the racist policies of the WAMS. Even after all the medical departments of the dependent empire, including the WAMS, were unified in 1934, the racist policies of exclusion in the West African medical departments remained intact.

The West African Medical Staff and Policies of Discrimination

In April 1895, a European shipping agent operating in West Africa forwarded a telegram to the Liverpool Chamber of Commerce concerning the employment of West African physicians on the Gold Coast. The agent voiced his displeasure that West African doctors "stand the climate better than Europeans, thereby seniority gives advantage and the lives of Europeans are at their mercy", prompting the Liverpool Chamber of Commerce to contact the Colonial Office.[61] Read reacted by informing the Colonial Secretary, Lord Ripon, that "it would appear that there is a grievance against native doctors, apparently because they live longer".[62] The Liverpool Chamber of Commerce followed up the telegram by requesting information on all West African physicians employed in government service, along with the character and composition of West African medical departments. Read forwarded the information desired; however, he also reminded the Secretary of the Liverpool Chamber of Commerce that,

> The Government of the Colony [Gold Coast] has found the services of the native medical officers of great value, as is evidenced by the fact that the appointment of the Chief Medical Officer was recently conferred upon a native, whose performance of his duties as an Assistant Colonial Surgeon had given universal satisfaction. And that it is an advantage that they do not require to take leave to the same extent as European Officers.[63]

The particular appointment cited by Read was that of Easmon, who, as noted above, was chief medical officer of the Gold Coast at the time.

Despite this declaration of confidence in the competency of West African physicians in 1895, the 1901 Colonial Office committee, only six years later, stated that they did

[59] Two years after its formation, a steady stream of grievances from medical officers serving in the WAMS appeared in the medical press. They cited numerous structural problems that inhibited them from carrying out even the most basic public health programmes. In 1907, a group of medical officers in the WAMS, led by the primary medical officer of Southern Nigeria, Henry Strachan, protested conditions of service. Alongside continuing scathing portrayals of the service in the medical press, and an outbreak of plague in Accra, Strachan's "memorialists" had prompted its significant reform by 1908. None the less, many of the same problems persisted, and with the onset of the First World War, they were not addressed until the 1930s and 1940s. Ryan Johnson, 'Networks of imperial tropical medicine: ideas and practices of health and hygiene in the British empire, 1895–1914', DPhil thesis, University of Oxford, 2009, pp. 284–324.

[60] For example, see anon., 'The West African Medical Staff', *J. Trop. Med.*, 1909, **12**: 321–2; and anon., 'The West African Medical Staff', *J. Trop. Med.*, 1909, **12**: 230–2.

[61] NA/CO/96/266, Herbert Read to Lord Ripon, requests for information as to British and native doctors, 5 Apr. 1895.

[62] Ibid.

[63] NA/CO/96/266, Herbert Read to the Liverpool Chamber of Commerce, 15 Apr. 1895.

not believe "that in professional capabilities West African native doctors are on par . . . with European doctors, or that they possess the confidence of European patients on the coast".[64] As noted earlier, several carefully chosen examples were provided by the committee to back up this statement. For instance, they cited the provision of medical care to white European women. Frederick Lugard noted, "There are many men who, with a life long sympathy with the negro, would yet regard it as intolerable that their wives should be attended—say in child birth—by a negro practitioner. I myself am such a man."[65] A West African possibly outranking a European military officer was also considered unacceptable. With increased military presence in the Gold Coast, and in Southern and Northern Nigeria, it was argued that British soldiers and officers would neither accept medical treatment from West Africans nor share meals and accommodation with them while on campaign.[66] The most frequent justification cited, however, was that West Africans could not become competent medical officers given their supposedly inferior race. According to the senior medical officer of the Gambia, Thomas Hood, it was "inherent racial qualities of the Coast negro that is against him"; therefore, "much more reliance is placed on the advice of the European doctor".[67] Lugard reasoned similarly, and also felt that West African physicians were "unreliable and incapable of assimilating that high and disinterested standard for which we look in the European".[68] "Inherent racial qualities" was again the term used to argue that West Africans could not properly utilize tropical medical education received in Britain, which was now a requirement. For example, Lugard considered "residence in Europe is bad for Africans. He [the African] returns at best an insufferable prig; at worst a very objectionable person".[69] The primary medical officer of the Gold Coast, T E Rice, also considered the exclusion of West Africans justified on the grounds that they could not cultivate and refine the medical skills learned in Britain. Even if they took courses in tropical medicine and hygiene at the London or Liverpool School of Tropical Medicine, this knowledge, given their allegedly inferior mental capabilities, would be lost if they did not routinely return to Britain—something which they could not easily do. Rice argued that,

> It is only by constant application and close study . . . that the knowledge acquired by a medical student . . . can be built into his character and fit him for his life's work. The African when he returns to his native country finds no environment fitted for such a purpose . . . I honestly believe that this is the explanation of his failure to make good, his deterioration in character and the almost invariable deterioration that characterizes his work.[70]

Since all members of the WAMS were required to attend a course at either the London or Liverpool School of Tropical Medicine, and be registered to practise in Britain, it was not financially practical to hire West Africans.

[64] NA/CO/879/72/6, Report of the committee appointed to discuss a scheme for the amalgamation of the medical services in the West African colonies and protectorates, Jan. 1902, p. 5.

[65] NAG/ADM/12/5/143, Frederick Lugard to B Law, 7 June 1915.

[66] NA/CO/879/72, British Medical Association to the Colonial Office, 10 Dec. 1901, p. 5.

[67] NAG/ADM/12/5/143, Thomas Hood to Hugh Clifford, 8 Apr. 1915.

[68] NAG/ADM/12/5/143, Frederick Lugard to B Law, 7 June 1915.

[69] NAG/ADM/12/5/143, Minute by Sir Frederick Lugard, 25 Apr. 1913.

[70] NAG/ADM/12/5/143, Copy of minute by Primary Medical Officer, 17 Dec. 1918.

The Colonial Office committee highlighted many examples of the incompetence of West African physicians, but made little reference to the many European practitioners who routinely engaged in drunken behaviour and were often derelict in their duties as medical officers.[71] For instance, in 1913 the primary medical officer of the Gold Coast ironically noted that he had never seen "the half drunken celibate Europeans ... and it is a gross slander to make such a statement".[72] Examples include T E Bayfield, medical officer in the WAMS, who was "generally lazy and inefficient in his professional duties and addicted to ... alcoholic stimulation".[73] A Dr Croly had devoted the bulk of his working hours to "playing billiards, poker or bridge, even when native cases of gravity such as accidents occur".[74] E Mayfield Boyle, a West African who had graduated from Howard University Medical School in 1902, put the problem of drunken European medical officers more bluntly. Responding to the policy of West African exclusion, Boyle found it shameful that the 1901 Colonial Office committee had not also excluded "English doctors from attending West Africans ... and save[d] some of my people from some of those frightful alcohol sodden spectres which sometimes terrorize their bedside."[75]

No doubt many qualified and competent European medical officers served in the WAMS, but as these and several further examples demonstrate, there were a good number of incompetent ones. In general, the medical services in West Africa were plagued by marginal European physicians. For instance, in 1908 the secretary of the London School of Tropical Medicine, Pietro J Michelli, responding to questions about the quality of medical officers in the WAMS, confided, "I do not say they are worse, but they are still criticised adversely as being not quite up to the mark ... A little below the average professionally I gather"; and "I am sorry to say I fear their medical attainments are criticised harshly sometimes."[76]

The argument that West African physicians were, on the whole, professionally inferior to white European medical officers is not compatible with the available evidence. While members of the 1901 Colonial Office committee, subsequent West African governors, medical officers and other European officials might have sincerely believed in their racist rhetoric, other factors, primarily the issues of senior posts and private practice, were central to the exclusion of West Africans from the WAMS. As noted above, private practice was the primary catalyst for Easmon's removal from his post as chief medical officer of the Gold Coast in 1897, and the episode is illustrative of the tension and competition that surrounded private practice.[77] After Chamberlain's attention focused on the West African colonies from 1895, the number of European officials increased steadily up to the First World War, and the number of non-official Europeans also rose sharply from

[71] Richard Knowlton and Virginia Berridge, 'Constructive imperialism and sobriety: evidence of alcoholism among candidates for the British colonial service from 1898–1904', *Drugs Educ. Prev. Polic.*, 2008, **15**: 439–50.

[72] NAG/ADM/12/3/18, Minute by Francis Hopkins, 23 Apr. 1913.

[73] NAG/ADM/12/3/17, Drunken behaviour of Dr T E Bayfield, 1 Mar. 1911.

[74] NAG/ADM/12/3/18, Report on Dr Croly, 17 Jan. 1912.

[75] NA/CO/ 879/102, Dr E Mayfield Boyle to Colonial Office, 4 Jan. 1910.

[76] NA/CO/879/99, Departmental Committee on the West African Medical Staff: minutes of evidence, African (West), NO. 922 Part II, Mar. 1909, p. 85.

[77] Patton, op. cit., note 7 above, esp. pp. 113–22.

1899.[78] The West African elite and the majority of Chiefs and other wealthy local men and women also continued to generate a significant amount of private income for physicians.

After Easmon had left government service, he was, like Quartey-Papafio, able to resume a successful private practice. However, both initially built their reputations through government service.[79] They also, for the most part, remained in West Africa year round, which caused considerable anxiety amongst European medical officers. West Africans, as the European trading agent had pointed out, supposedly had an unfair advantage in being adjusted to the climate and able to live in West Africa permanently, unlike white Europeans. "Inherent racial qualities" and the standard of the Africans' work were not really the issue. Given that so many European medical officers on the coast were considered the "dregs" of the profession, or below par at best, it was feared that if more West Africans of the quality of Horton, Davies, Easmon and Quartey-Papafio were to train as physicians and enter the service, West Africans, not Europeans, would control private practice and occupy senior posts. At a time when Chamberlain and the Colonial Office were hoping to recruit a greater number of European medical officers for service in West Africa, and posts needed to be filled at the new schools of tropical medicine, such a development was considered unacceptable.

The issue of private practice amongst European medical officers, therefore, should not be underestimated. The 1913 "memorialists" and their fierce opposition to the possibility of senior medical officers being restricted from taking private practice, are a prime example of its importance as a motivating factor for joining the West African Medical Staff. Medical officers in the WAMS reacted with immediate hostility to the suggestion that private practice should be more tightly regulated in West Africa because of the considerable income that could be generated by it. As the governor of Southern Nigeria, Walter Egerton, noted, "There are a good many stations in Southern Nigeria where the private practice is worth a good deal."[80] When asked in 1908 what an "ordinary" medical officer could make from private practice, Thomas Hood answered, "Anything up to one thousand pounds". He went on to note that Sherbro, a "biggish" town in Sierra Leone, was "worth about £500 a year". He qualified these statements, however, by noting that not all posts in West Africa were "necessarily lucrative ... there are some stations where you cannot make a pound a year".[81] Chalmers put it most simply: "[T]here is a certain amount of practice in certain towns that is well known; and, on the other hand, you know quite well when you send a man to a certain up-country station that it is physically impossible for him to make a penny."[82]

William Claridge, a medical officer in the Gold Coast, who was instrumental in organizing the 1913 memorialists, rejected the promotion to senior medical officer

[78] For instance, the white European population for officials and non-officials in 1897 was 522, rising to 2,645 by 1914, with an even greater number of itinerant men and women attached to shipping, trading, and missionary institutions. Rhodes House, University of Oxford, Colonial Annual Reports (CAR), *Gold Coast 1897–1913*, Colonial Office.

[79] Patton, op. cit., note 7 above, esp. pp. 93–122.

[80] NA/CO/879/99, Departmental Committee on the West African Medical Staff: minutes of evidence, African (West), NO. 922 Part II, Mar. 1909, p. 118.

[81] Ibid., p. 5.

[82] Ibid., p. 84.

when it was proposed that holders of this position should be barred from engaging in private practice. He argued,

> It is of course well known that the stations where private practice is obtainable are few in number, and it has fairly and rightly been the custom ... that these, the more important stations, should be allotted to the senior men. It is therefore, as a general rule, only within a short period of being offered promotion that a medical officer has been able to derive any benefit from his right to private practice.[83]

As this and the other examples demonstrate, intense competition for private practice existed throughout British West Africa, and the factors that determined appointment to the best stations were seniority and length of service. Given that an individual's income could double in any given year through private practice, medical officers jealously guarded the privilege. Yet because their tour of service lasted only twelve months, with five months' leave in Britain, it was difficult to maintain control over their fee paying clientele, especially if West African colleagues were to remain in the region year round. The importance of private practice as a motive for the institutionalized racism of the West African Medical Staff, is illustrated by a protest drafted by the Gold Coast Anti-Slavery and Aborigines Protection Society (ASAPS). Expressing their disbelief at the continued exclusion of West Africans from the WAMS, the ASAPS noted how, prior to the formation of the organization,

> [T]he relations between the European and Native Sections of the Medical Staff were harmonious cordial and fellow-feeling. That such was the happy feeling between the two sections of the medical staff and the community generally until, suddenly, for no reason ... Mr. Chamberlain's Colonial Administration appointed a committee consisting ... [of] Colleagues with whom Native Medical Officers had been in keen competition for private practice at the time, and afterwards, sitting in judgement over them to consider the question of the employment of Native Doctors in the Medical Service with the result that the 'West African Medical Staff' was created, and to which ... only Medical men of European parentage are eligible for appointments thereby closing the door practically against Doctors of colour.[84]

Lugard, defending the WAMS as an "all-white institution", insisted that it was not formed "to retain all the best and most lucrative appointments for the European".[85] The fact that he even addressed this issue suggests that it probably was. Lugard and other officials also continually emphasized that qualified West Africans still had the right to engage in private practice.[86] They did not mention that medical officers in the WAMS held certain distinct advantages that allowed a monopoly on private practice.

Among these advantages was the ability to purchase government supplies for use in private practice. In this respect, one complainant noted that "private practitioners are at a disadvantage as compared with government Medical Officers in the matter of local

[83] NAG/ADM/1/2/90, William Claridge to Frederick Harcourt, 12 Dec. 1913.

[84] NAG/ADM/12/5/143, ASAPS to Frederick Harcourt, 13 Jan. 1913.

[85] NAG/ADM/12/5/143, Minute by Sir Frederick Lugard, 25 Apr. 1913.

[86] Ibid.

purchase of drugs".[87] Medical officers in the WAMS were "permitted to purchase, in bulk, drugs, surgical dressings, and medical comforts at current market (invoice) prices plus 25 per cent for freight and expenses". Physicians not associated with the WAMS did not have this advantage. And when it was suggested that private practitioners also be afforded this luxury, the primary medical officer of the Gold Coast felt that "it would not be advisable to allow private practitioners to use the drugs ... from the Government store".[88] Although medical officers were charged an additional 25 per cent for freight, it was still cheaper, quicker and more efficient to purchase directly from government stores than to secure supplies through normal retail channels.

Another advantage conferred by government service was a stable income. For example, the primary medical officer of the Gold Coast Francis Hopkins, referring to his experience of West Africans employed in government service prior to the formation of the WAMS, stated that they took "no real interest in their Government work and look upon their appointment as assured income to prosecute private practice".[89] While Hopkins was referring to West Africans, his comment was equally applicable to European medical officers. Setting up a private medical practice was an expensive and risky proposition; and training as a physician generally incurred a considerable expense. Government medical officers, however, were at least guaranteed a modest salary that could see them through hard times, or assist in the purchase of drugs and other supplies. After 1902, without the assurance of employment in government service, and given that European medical officers were already in fierce competition for private practice, very few West Africans had the incentive to train as physicians, let alone set up practice along the coast.

Finally, government service conferred authority and status. The medical officer often served in the capacity of district commissioner and was frequently the sole individual in charge. He could often dictate and control medical practice in his region. Along with access to government drugs and a stable income, government service went a long way in attracting private patients, both European and African. For these reasons, West African physicians, as a source of competition for private practice, were virtually eliminated.

Conclusion

Internalized constructions of racial difference are important factors when trying to understand the institutional racism of the WAMS; however, they do not tell us the whole story. In 1901, government service was associated with loyalty and devotion to Crown and Country, and the exclusion of West Africans on grounds of race would have been seen as infinitely more acceptable than the more personal and prosaic financial reality. To admit that West Africans were barred from joining the WAMS because they cut into the income of white European medical officers, and therefore

[87] NAG/ADM/12/3/18, Purchase of government medical supplies, H Bryan to Frederick Harcourt, 9 Sept. 1912.

[88] Ibid.

[89] NAG/12/3/18, Minute by Francis Hopkins on the subject of the employment of native medical men, 10 Apr. 1913.

damaged the recruitment process, would have caused a much greater scandal than their exclusion on grounds of racial inferiority. Similarly, several imperial and colonial historians have invoked British racism to explain the racist policies of the colonial past. While not denying the importance of racism as an analytical category, this case study of the West African Medical Staff has demonstrated that the emergence of racist policies often had a more complex causation, and that thorough analysis of the political and economic circumstances surrounding imperial policies of racial exclusion is required.

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