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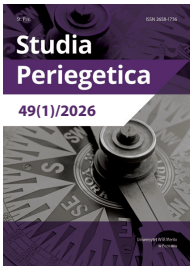

CHRISTIAN M. ROGERSON[a]

Invalidism and Historical Medical Tourism in South Africa c. 1880–1910

Abstract. During the 19th century alongside the prevalent thinking of medical science and interest in the merits of 'climatotherapy' a flourishing industry developed of health-related travels. The paper contributes a forgotten chapter in the historical development of medical tourism in South Africa. The specific focus is analysis of the 19th century development of South Africa as a health resort and vital destination for British 'consumptive invalids' afflicted by pulmonary tuberculosis. In times of Victorian Britain medical knowledge was poor about the causes and most appropriate treatment for this chronic disease. The evolution and growing popularity of climatotherapy in Britain underpins acceptance of a change of climate and encouragement of consumptive patients to travel to destinations with climatic conditions considered as favourable for treating the disease. With its healthful reputation the Cape Colony in South Africa emerged as a destination for British invalids. Source material includes 19th century guidebooks on South Africa produced in London for 'invalids', contemporary traveller narratives as well as writings by medical specialists to reconstruct the landscape of medical tourism and the challenges confronted by invalids.

Keywords: medical tourism, climatotherapy, invalidism, tuberculosis, Cape Colony, South Africa

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1. Introduction

The quest for better health is one of several factors that have shaped the historical course of travel and tourism (Kevan, 1993; Carey, 2012; Connell, 2013). As Haykowsky (2017, p. 4) asserts "travel for health or medical reasons has a long history of practice". The geographer, John Connell (2011) views medical tourism as one of the oldest forms of tourism and points out that people have been travelling

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for improving their health for millennia. Langum (2025, p. 133) avers that travel "as an escape from or cure for disease is an ancient phenomenon". Nevertheless, "while the particular forms and motivations have changed, travel for healing purposes is an enduring practice" (Langum, 2022, p. 52). Arguably, the "practice of European travel for health became well established by the mid-eighteenth century" (Janković, 2006, p. 273). For example, across much of Europe the tradition of 'taking the waters' in terms of either sea bathing or visits to mineral spas for health reasons was widespread by the 18th century (Walton, 2000, 2005; Connell, 2006, 2011; Walton, 2014).

According to Carey (2012, p. 240), health travel "has occurred for thousands of years, but it became more systematic and popular (and easier) after the eighteenth century. Whether seeking out the supposedly purifying air of the British sea coast, soaking in therapeutic spas in the Alps, or escaping to the hypothetically healthier outlying areas around Cape Town, South Africa, Europeans and later North Americans have sought out many different climates and regions to heal their maladies over the centuries". Importantly, during the 19th century alongside the prevalent thinking of medical science and interest in the merits of 'climatotherapy' there emerged a flourishing industry of health-related travels. This stream of medical tourism was grounded in the belief that "climate could facilitate both negative and positive changes in the body" (Langum, 2022, p. 58). During the nineteenth century, expanded mobilities, improved transportation networks and the growing belief in climate's impact upon health combined to boost international medical tourism (Kevan, 1993; Janković, 2006; Langum, 2022).

It is against this backdrop that the paper's aim is to examine one forgotten chapter in the historical development of 'medical tourism' in South Africa. It is acknowledged that in the burgeoning international scholarship on medical tourism no consensus exists about the definition of the term (Connell, 2013; Smith & Puczkó, 2015). Some observers prefer the terminology of 'medical travel', others of 'health tourism' as an umbrella term with medical tourism one of three sub-components, namely 'medical tourism' (surgical/clinical), 'wellness tourism' (prevention/well-being) and spa/therapeutic tourism (natural healing) (cf. Lubowiecki-Vikuk & Białk-Wolf, 2025). In a recent South African intervention Matiza and Slabbert (2020, p. 341) suggest that contemporary medical tourism be delineated as "the integration of tourism-oriented activities within the medical treatment context". Within this historical investigation our specific objective is to unpack the nineteenth century development of South Africa as a health resort and significant destination for British 'invalids'. Arguably, as the term 'tourism' was a newish word throughout the nineteenth century, medical tourists were not called as such. Instead, they were styled as 'invalids' "which was a recognized identity at

this time" (Langum, 2022, p. 53). During the 19th century most British invalids were 'consumptives', sufferers of what would later be recognized as tuberculosis. In a classic study documenting its history Helen Bynum shows the disease is of ancient origin and can be seen as a "pre-historic scourge" (Bynum, 2012, p. 5). In Victorian Britain, public health statistics confirm that tuberculosis caused more fatalities and impairment than any other disease (Tankard, 2010, 2011, 2018). More deadly than cholera and smallpox combined, the scourge of tuberculosis wrought a terrible toll on the British population at this time (Frawley, 2004).

It will be argued that 19th century South Africa — and especially the Cape Colony — emerged as a significant health destination which attracted many British invalids suffering from pulmonary tuberculosis or what was, at that time, known as consumption or phthisis. Three further sections of material are presented. The literature review explores invalidism and changes in medical science and practice concerning consumption. In addition, it analyses the mounting interest in climate cures and of climatotherapy which underpinned the surge of health travel among invalids. Following a brief overview of source material used for the study, the results section turns to document the key factors influencing the rise of the Cape Colony as a 'health resort' and specifically of its popularity for consumptive invalids. The discussion concentrates on the evolution of nineteenth century flows of medical tourists. The focus is on the pre-Union (1910) period of the late 19th and early 20th centuries when South Africa evolved into a medical tourism destination for 'invalids'. The study closes in the first decade of the twentieth century by which time a combination of changes in medical science, associated treatments for tuberculosis as well as of tuberculosis outbreaks in South Africa reduces the flows of international consumptive invalids travelling to the country.

2. Literature Review

2.1. Invalidism and Invalids

The term 'invalidism' is closely associated with the writings of Maria Frawley (2004), social historian and English literary scholar. Frawley's (2004, p. 1) exploration of Victorian invalidism unpacks the peculiar and distinctive features of 19th century culture that "made it not only possible but relatively common for people to identify themselves and others as invalids". Martin (2005) goes so far as to write of a "Victorian cult of invalidism" and Vrettos (2006, p. 178) that in the 19th century British culture invalidism was viewed "not just as a physical condition but also

a distinct identity". It was pointed out that many notables of the Victorian era 'self-identified' as invalids including Florence Nightingale and Robert Louis Stevenson. As McGeown (2025) points out, invalidism must, at one level, be understood as part of 'disability histories'.

Unquestionably, invalidism was a "dominant, if imprecisely defined, feature of nineteenth-century England's medical culture" (Frawley, 2004, p. 3). At this period, in some social circles it was even considered as "frothily fashionable" to be defined as 'invalid'; for example, Lawlor (2011, p. 25) draws attention to the fact that depression or 'melancholy' was "a condition that often seemed less of an illness and more of a blessing for the budding poet, wilting lady wishing to show off her latest nightdress, or anyone who desired to seem in the slightest bit sensitive or clever". Questions were raised, therefore, as to whether in terms of actual medical state, invalidism "was a genuine condition" (Logan, 2008, p. 970). Some even viewed the cohorts of invalids either as imposters or "at least hypochondriacs of the first order" (Frawley, 2004, p. 1). Although the term 'invalid' did not capture a homogeneous population, the vast majority of 'invalids' were genuine in searching for improvement to an existing medical ailment. Indeed, "the invalid almost by definition signified medicine's inability to ensure recovery" (Frawley, 2004, p. 5).

In Victorian Britain (1837–1901) a whole industry evolved around invalidism and invalids. To supply their needs were special invalid chairs, beds and couches, healing balms, special life assurance societies, devices such as invalid carriages as well as aid organisations targeted at particular groups of invalids such as children, women, soldiers and sailors. Invalid asylums were another institution of the era as well as invalid prayer books, hymnals and special foods. Indeed, as shown by Fig. 1 the major food companies advertised goods specially for invalids. The travel industry also was alert to the potential of this market. It catered to the invalid in search of health with the introduction of special vehicles such as the 'invalid tricycle', 'invalid carriage', and railway cars designed to accommodate the sufferer with special needs. Targeted guidebooks appeared and designed to fulfil the emerging market specifically directed at the interests and 'requirements' of the invalids. One example was Brown's (1898) guide for invalids to travel for Madeira and the Canary Islands. As a whole, there emerged a whole genre of writing about and for travel by invalids, some of which was authored by doctors/physicians who themselves were invalids (Frawley, 2004).

McGeown (2025) asserts that invalids actively shaped their public and private identities with travel to healthier destinations offering an opportunity to redefine illness on their own terms. Invalids' search for restoration and relief from their ailments involved experimentation with therapeutic treatments and the need to travel abroad. Importantly, therefore, invalids were associated with the emergence

of a culture of medical tourism. This movement was boosted by a convergence with the developing field of medical climatotherapy which encouraged invalids to leave home in the search for better health (Frawley, 2004; Janković, 2006).

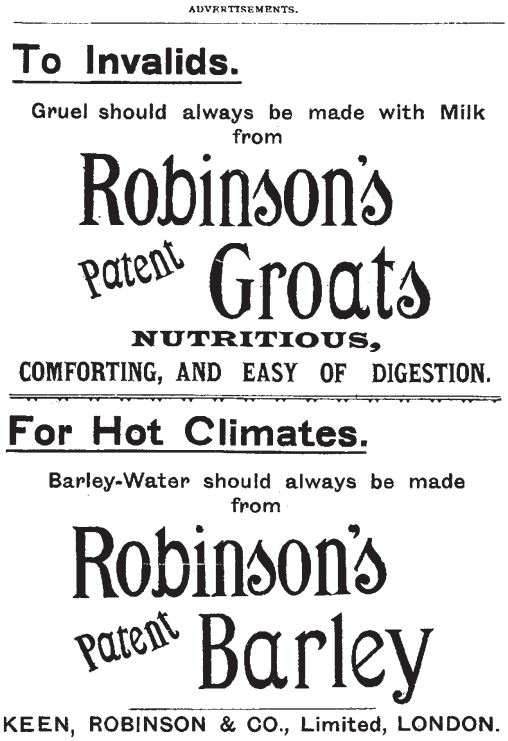


Fig. 1. Advertising to Invalids
Source: Fuller (1894)

2.2. Climate, Health and Consumption

The nexus of health and historical climatology has attracted some scholarly attention (Kevan, 1993; Janković, 2010; Carey, 2012; Rogerson & Rogerson, 2021). During the 19th century there appeared several publications which stressed the intertwined relationship between climate and health. Among others Chuchene (2020) points to the examples of Thomas Madden's *On Change of Climate: A Guide for Travellers in Pursuit of Health* and Yeo's *Climate and Health Resorts*. Sea voyages and a 'change of air' were common recommendations by medical practitioners for addressing a range of different ailments (Janković, 2006). Marks and Worboys

(1997, p. 8) point out that: "the notion that the body was influenced by its environment in medicine and Western culture was commonplace in the eighteenth and nineteenth centuries. It followed that a change of air or travel to a different area were ways to improve health, and doctors tried to match a person's constitution and illness with potential healing environment".

From the early 19th century medical practitioners evinced considerable interest in the advantages and health benefits of non-British climates and of the value of travelling abroad in search of health (Janković, 2010). According to Langum (2025, p. 133) the notion that moving climates could impact physical, mental and emotional well-being "persisted well into the eighteenth and nineteenth century". For Janković (2010, p. 123) the virtues of a change of air were considerable including travel itself deemed by some "the real pulverizer of disease". Bynum (2012) documents that during the period of the early to mid-19th century, consumption was thought of as a condition that could benefit both from rest and a change of climate. Consumption was associated with geography and of Britain's climate of prejudice. The most perilous aspects of Britain's climate were its variability, cold and moisture especially regarding pulmonary conditions (Janković, 2006, 2010). As a result, British consumptives sought health abroad because scientists in the 18th and 19th centuries considered that the climate was making them sick (Langum, 2022). The dampness and variability of British weather were thought responsible for plaguing the population with "the 'English malady' (later known as 'wear and tear' or nervousness) and pulmonary disorders, such as consumption" (Langum, 2025, p. 137). This said, it is pointed out that definitions of consumption are not easy "because until the nineteenth century there were only consumptions in the plural — a range of wasting conditions under the one name. It was only with the rise of bacteriology that consumption's modern definition of pulmonary tuberculosis came into being" (Lawlor, 2007, p. 5).

Janković (2010) explores the British preoccupation with climate and the origins of 'environmental medicine'. Importantly, medical specialists increasingly accepted that "climate could not only cause, but also cure, consumption" (Langum, 2022, p. 56). The application of 'climate therapy', however, was dependent upon the collective medical wisdom of the times (Kevan, 1993; Valen, 2022). On the advice from doctors or guidebooks middle-class and wealthy invalids sought out kinder climates than Britain (Janković, 2010). Travelling for health thus acquired great popularity in the 19th century and was associated with positive images of destinations such as Madeira and various Mediterranean resorts where streams of invalids meandered. In a seminal work Pemble (1987) writes of the 'Mediterranean Passion' of Victorian travellers which was driven by a search for healthful destinations. Undoubtedly, Madeira was a popular destination in the 19th century for wealthy British sufferers of consumption and other pulmonary diseases. It was observed

the "virtues of Madeira were touted in England not only by medical authorities but also by various travel guides and personal accounts that circulated in the nineteenth century" (Langum, 2022, p. 53). Chuchene (2020) stresses the importance of climate therapy in fuelling the passion for Mediterranean travel, including to Algeria and Tunisia.

Langum (2025) makes clear that decades before the tubercle bacillus was isolated by Robert Koch in 1882 and decades before its transmission was understood the British medical community and general public debated the best places to cure what was then known as consumption. Much uncertainty surrounded the causes of the disease, its diagnosis and best means of treatment. It is evident that throughout the 19th century there was much 'guesswork' involved in the diagnosis of consumption and disagreement as to how the disease was spread (Langum, 2025). Many scientific observers in Britain (and America) held to an explanation based on heredity (Packard, 1989a). Others began to accept a belief in contagion. In terms of treatment, physicians offered advice about lifestyle alterations, including diet, but most often about the value of travel to different climates. Carey (2012, p. 240) avers that during the 19th century medical climatology demonstrated the healing effects of certain climates and regions and "often tied to places through the early twentieth century, was thus used to heal bodies and cure diseases, especially tuberculosis".

Several medical specialists sought to systematize knowledge about healthful climates during the 19th century giving rise to the new 'science' of medical climatology which subsequently was restyled as climatotherapy (Langum, 2025). Antonelli et al. (2025) clarify that climatotherapy — a merging of the words 'climate' and 'therapy' — signifies temporary or permanent relocation to where climate (and environmental) conditions are associated with clinical improvements of certain diseases. Janković (2006, p. 271) maintains that "Victorian medical climatology held the Mediterranean in high therapeutic esteem" and was the region which "triggered climatotherapy as a medical practice" (p. 272). In the times of Victorian Britain climate cures began to enjoy elevated status among the local medical establishment. One of the leading advocates of climatotherapy was Sir James Clark, whose influence was, in great measure, because he was physician to some notable patients including Queen Victoria. Instead of 'guess work' Clark preferred a scientific basis for recommending destinations for the treatment of particular conditions (Clark, 1841). Importantly, he argued that patients should not be sent away indiscriminately to foreign climates and instead suggested such cures for consumptives only in the early stage of the disease rather than as a last resort. For much of the 19th century climatotherapy continued to garner interest with Walker (1897, p. 93) observing it was "not only claiming more and more serious attention, but is deserving of vastly more than it has thus far succeeded in obtaining".

By the mid-19th century, a change of climate was something to be recommended for many invalids often when everything else had failed (Janković, 2010). Indeed, Janković (2010, p. 122) suggests that the early appeal of medical travel "owed a great deal in particular to the failure of drugs". Flows of British invalids continued to travel abroad seeking relief from the symptoms of consumption. Of note is changing geographies of travel. Because of improved transportation, invalids began to visit not only the early popular Mediterranean destinations but also ventured farther afield to China, Russia, Crimea, and even to Western Australia and New Zealand (Bell, 1993; Langum, 2022). Further extension of the frontiers of invalid travel came when the English physician and leading authority on tuberculosis, Charles Theodore Williams undertook a wide-ranging survey of high-altitude therapeutics as potential treatment for lung diseases. By the late 19th century "there was a growing consensus about the benefits of high-altitude therapy for consumptive patients" (Tewari, 2025, p. 176). With the belief that high-elevation mountain climates could help cure the disease, Carey (2014) documents that the Peruvian Andes became a destination for tuberculosis sufferers. Along with elevated health resorts in Alpine areas, the Andes, Indian hill stations and the Rocky Mountains, localities in the elevated upland areas of South Africa also were identified as "crucial nodes in a global network of climate therapeutics" (Tewari, 2025, p. 175). By the second half of the nineteenth century therefore temporary sojourns in the 'healthful' Cape Colony were commonly recommended for British consumptive invalids (Bell, 1993; van Wyk, 2013; Rogerson & Rogerson, 2021).

3. Methods

The research commenced with a review of existing literature and a historical survey of international scholarship concerning invalidism, climate and health travel. Specific focus was on 'consumption' and invalids. As was demonstrated in the narrative literature review South Africa's appearance on the global map of medical tourism during the 19th century cannot be understood without an appreciation of the state of existing medical knowledge in Britain concerning the causes and treatment of consumptive invalids.

Second, the original research on South Africa as a health resort applied the methods of historical geographers, which include the mining of source materials from archives and the gathering of other evidence in secondary literature. The central component of the research methodology involved the collection and analysis of primary research source materials in the form of travel gazetters,

special guidebooks produced for 'invalids' The period of the 19th century John Pemble (1987, p. 7) considers was "the age of the guidebook". Drury (2026, p. 3) alerts us that historians "have increasingly recognized the usefulness and validity of guidebooks as historical sources". Likewise, Mackenzie argues (2005, p. 34) that travel "guide-books are an extremely rewarding source" for historical research in tourism. Travel guides and publicity material are useful sources for understanding the "perceptions and representations of foreign lands" (Chamekh, 2018, p. 273). Use of travel guidebooks and gazetteers can furnish insight "into the representation of tourist journeys and destinations for advisory purposes, including for 'invalids' and "looking at how the 'gaze' of the intended tourist was directed" (Walton, 2005, p. 8). However, for research in tourism, guidebooks "have remained understudied" despite their relevance and the description of places provided by their compilers (Chamekh, 2018, p. 273). Two striking exceptions are the recent utilization of guidebooks to examine resort advertising in the United Kingdom during the period of the First World War (Page & Connell, 2025) and guidebooks shaping early 20th century perceptions of Norway as a tourism destination (Drury, 2026).

According to Mackenzie (2005, p. 29) the guides on South Africa "were inevitably deeply steeped in the imperial world view" and "represent a significant element in the imperial taxonomy". In addition, to guidebooks targeted at invalids the study utilizes the reports on South Africa which appeared during the 1880s and 1890s in leading scientific medical journals produced in Britain, most significantly the *British Medical Journal* and *Edinburgh Medical Journal*, sources which have not been tapped extensively in South African tourism research. Finally, use is made of several travel writings and narratives which were produced by mainly British travellers to South Africa at this time. Such sources have been widely used in other research by historical geographers with a recognition that travellers view the world through their own cultural filters (Guelke & Guelke, 2004). Most of the guidebooks and travellers accounts used in this study are accessible through the collections of the National Library of South Africa, Cape Town depot.

Overall, the benefits of historical research approaches for tourism studies have been demonstrated by several scholars, most notably the seminal contributions made by John Walton (2000, 2005, 2014). In addition, MacKenzie et al. (2020) stress that, if used carefully, historical research methods can unmask patterns of change over time and contribute to the making of rich narratives. Recently, it has been asserted by Page and Connell (2025, p. 4) that descriptive historical research continues to have merit in tourism studies particularly as "the judicious use of primary resources creates a purposeful narrative review, creating a historical reconstruction".

4. Results

The analysis is presented of the 19th century development of South Africa as a health resort and vital destination for British 'consumptive invalids' afflicted by pulmonary tuberculosis. In times of Victorian Britain medical knowledge was poor about the causes and most appropriate treatment for this chronic disease. The argument is that the evolution and growing popularity of climatotherapy in Britain underpins the acceptance of a 'change of climate' and therefore the encouragement of consumptive patients to travel to overseas destinations where climatic conditions were considered favourable for treatment of the disease. With its healthful reputation, the Cape Colony in South Africa therefore emerged as a destination for British invalids.

The discussion is structured into four uneven sub-sections of material. First, is the foundation years when awareness arose of the 'healthful' Cape Colony which linked to its strategic geolocation in the British Empire as a stop-over between Britain and India. Second, the rise of South Africa as a health tourism destination is detailed and unpacked through the critical insights offered by travel guidebooks and reports of medical specialists. The third section explores further the growth of consumptive invalid travel in South Africa and importantly its uneven geography. Finally, in the context of changes taking place in medical knowledge concerning tuberculosis, section four analyses the emergence of growing concerns about South Africa as a destination for the treatment of British consumptive invalids.

4.1. Foundations

It is evident the evolution of South Africa as a medical tourism destination was an integral part of the 19th century international travels of invalids in response to the state of existing medical knowledge concerning the treatment of consumption. The reputation of South Africa as a 'health resort' was built upon the territory's image which developed in the early 19th century when The Cape of Good Hope played a pivotal role in Britain's Indian Ocean world as a supply depot for British troops heading to India (McAleer, 2023; Harrington, 2025).

The (renamed) Cape Colony emerged as a recuperative space for the English military from India recovering from injuries received and maladies suffered in the service of building Britain's Empire. In addition, the Cape was a popular destination also for furlough of the servants of Empire (McAleer, 2023). With its geographical location as a half-way point and stop over between Europe and India the Cape Colony was "a site of convalescence" and enjoyable "as a place of healthfulness" (McAleer, 2023, p. 33). The curative effect of spending time in the Cape was lauded

with surgeons remarking on how rapidly invalids from India rallied and recovered from their ailments (McAleer, 2023). By the mid-19th century the Cape Colony was recognized as a 'sanatorium' for officers of the Indian army. Packard (1989a, p. 39) notes "The Hotel Cogill, Drake and Rathfelder in the southern suburbs of Cape Town was a famous rendezvous".

4.2. The Rise of South Africa as Medical Tourism Destination

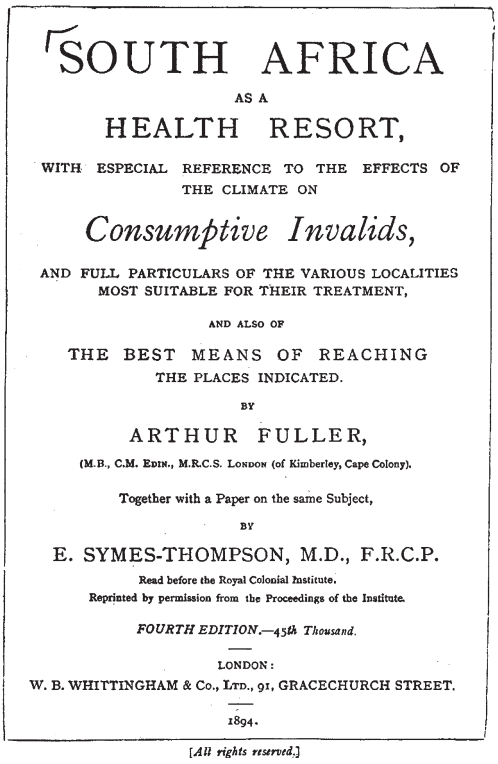
With advertisements placed in the *Illustrated London News* and articles appearing in British medical journals extolling the virtues and healthfulness of the Cape climate the "commercial exploitation of the Cape's climate had begun" by the mid-19th century (Packard, 1989a, p. 39). Essentially South Africa was marketed to the British health establishment as a country of soaking sunlight, crisp dryness and refreshing cool night winds (Rogerson & Rogerson, 2021). The core assets of South Africa as a health destination for those invalids travelling in search of cures were its "champagne air" and healing sunlight which together fostered the notion of a 'curative climate' (van Wyk, 2013). This narrative of South Africa as a health resort was magnified by the messaging in several booklets and guidebooks published in the late 19th century.

One of the most influential guidebooks in terms of building up the reputation of the Cape Colony (and South Africa) as a health resort was that produced by Arthur Fuller concerning the territory's positive impact of climate for consumptive invalids. Published in London, the first edition of Fuller's book *South Africa as a Health Resort with especial reference to the effects of the climate on Consumptive invalids* appeared in 1886. As a result of its acceptance and popularity in Britain, including by the medical community, when the sixth edition appeared in 1898 over 55 000 copies had been printed. Its overriding message was of portraying a positive image of the value of South Africa as a health resort and especially for consumptive invalids. The climatic advantages of South Africa were at the heart of Fuller's guidebook. The fourth edition published in 1894 made clear in its opening statement that: "The Climatic treatment is of all treatments the one which claims the greatest attention from the physician called upon to give advice to patients afflicted with or threatened by Phthisis, the reason of course being that although its symptoms may be palliated by the use of medicines and its onset possibly retarded by encouraging the general nutrition with various tonics and artificial foods, still there is no drug known to the Profession which exerts in any way a specific action in arresting or even checking the disease" (Fuller, 1894, p. 1). As a result, Fuller (1894, p. 1) continued "we look to climate as our great standby". For consumptive invalids the core health factors of the Cape Colony were those of the dryness of the

atmosphere, elevation of resorts above sea level, absence of crowding, a preference for a good proportion of sunshine and as little wind as possible.

Using such criteria it was asserted England was "very unsuited to consumption patients" whereas South Africa "meets perhaps as much as any climate in the world, the recuperative conditions laid down" (Fuller, 1894, p. 6 and 7). In the guidebook details were provided of the climatic conditions at various locations in South Africa, their accessibility and reports of their beneficial effects on consumptive patients. Overall, it was highlighted as follows that: "out of the many patients who seek relief in the South African climate, and who come out in the early stage of the disease very few gain no benefit at all; a goodly proportion have their life prolonged, and live in greater comfort in the dry sunny air than they could at least in Northern Europe; while a not inconsiderable number, especially of those who come out when the symptoms are first threatening, or before any actual tubercular disease is present, make a thorough recovery" (Fuller, 1894, p. 13).

Further acclamation of South Africa as a health destination appeared in a range of other guidebooks produced especially during the 1890s. The appearance of Brown's guide was part of a wave of British guidebooks mapping the empire (Mackenzie, 2013). This annual guide, a private venture compiled by two brothers, was launched in 1893 and specifically included 'invalids' in its title. Throughout the guide "a great deal of attention was devoted to the climate and healthy characteristics of southern Africa, with extensive quotations from medical men and quotations from medical works" (Mackenzie, 2005, p. 30). Typically, the 1893 guide described its rationale for invalids as follows: "The pages referring to South Africa as a Health Resort deal with a well-recognized feature of the country and comprise all the available information which may be of use to physicians in the choice of residence for their patients. The rapidly-increasing reputation of the climatic conditions of South Africa must, from an English point of view, be greatly enhanced by the fact that the country is almost entirely under British rule, that practically everywhere English is spoken and it offers the means of livelihood to those not in an independent position" (Brown, 1893, pp. ix–x). The 1896–1897 guide reaffirmed the status of South Africa as a health resort and especially the value of "the Cape climate, the excessive dryness, clearness and rarefaction of the atmosphere, with a maximum of sunlight, a series of conditions of an almost typical character are met for the treatment of pulmonary affections" (Brown and Brown, 1896, p. 36). Extensive quotations were provided from various medical specialists including the following from Dr H. Saunders that "The climatic conditions which are associated in South Africa with an altitude which confers immunity from phthisis are chiefly a temperature cold in winter and cool in summer, the winds scarcely existing in winter, and a complete pureness of air" (Brown and Brown, 1896, pp. 38–39).



SOUTH AFRICA

AS A

HEALTH RESORT,

WITH ESPECIAL REFERENCE TO THE EFFECTS OF THE CLIMATE ON

Consumptive Invalids,

AND FULL PARTICULARS OF THE VARIOUS LOCALITIES MOST SUITABLE FOR THEIR TREATMENT,

AND ALSO OF

THE BEST MEANS OF REACHING THE PLACES INDICATED.

BY

ARTHUR FULLER,

(M.B., C.M. Edin., M.R.C.S. London (of Kimberley, Cape Colony).

Together with a Paper on the same Subject,

BY

E. SYMES-THOMPSON, M.D., F.R.C.P.

Read before the Royal Colonial Institute.

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FOURTH EDITION.—45th Thousand.

LONDON:

W. B. WHITTINGHAM & Co., Ltd., 91, GRACECHURCH STREET.

1894.

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Fig. 2. Fuller's 1894 Guidebook
Source: Fuller (1894)

Among other 'influencers' was Dr Symes-Thompson (1888) who researched South Africa's capacity for "giving or restoring health" and presented the findings at gatherings of the Royal Colonial Institute in London. The significance of this work is underlined by its complete reprinting in the fourth edition of Fuller's (1894) guidebook (Fig. 2). The argument was made consistently that climate was the most important factor for the healing of the chronic disease of consumption in South Africa. According to Symes-Thompson (1888) for the treatment of patients through climatotherapy three classes could be recognized. The first were those who required 'a change of air' needing to relocate from their current surroundings for a period in order to recover from some ailment. Second, were patients who ostensibly required 'shelter' to avoid the British winter. The third class were those who had to be removed from their surroundings for years, and even on a permanent basis, if they ever wanted to recover and survive (van Wyk, 2013). For Symes-Thompson the patients in the first two classes were recommended to travel to health resorts in

Europe but for third class suffering from fast-moving consumption should look to Britain's colonies and especially the Cape. The appearance of many reports about the healthful climate of the Cape Colony — lauded as "superior to that of Italy — resulted in the rising reputation of the country as a health resort and confirming that "the South African climate possessed curative properties" (Laidler, 1940, p. 75). In 1907 the almanac for the Cape Colony produced by Burton (1907, p. 267) acknowledged once again that the climate as "one of the healthiest in the world".

The establishment of South Africa as a medical tourism destination thus was founded upon these influential guidebooks echoing the narrative that the country's dry sun-filled climate offered curative solutions for the treatment of consumption. The stature, reputation and popularity of the Cape as a health resort was strengthened by endorsements made by consumptives who had been in South Africa, recovered and prospered because of the healthful climate. For example, letters appeared in the *British Medical Journal*, including from doctors who had personal experience of the positive impacts of the healing climate and surrounds of South Africa (Arnison & Kinsey-Morgan, 1896). Many stories and statements were published about health seekers who arrived as invalids and ended up choosing to be long-term colonial settlers. Arguably, one of the most famous patrons was Cecil John Rhodes who became a mining magnate and would serve as Prime Minister of the Cape Colony from 1890 to 1896. Born the son of a vicar in Hertfordshire (England), at age 15 Rhodes was diagnosed with a severe case of consumption. He was sent to South Africa at age 16, travelling to the Cape not to be cured but simply to survive a few months longer in the belief that the climate might improve his health. However, as van Wyk (2013, p. 68) points out, "miraculously he was cured by the South African climate and lived to become South Africa's foremost capitalist".

Rhodes became a strong patron of South Africa as a health resort and contributed a preface to the guidebook authored by Scholtz (1897) publicizing the country as a destination for invalids and most especially its value for assisting pulmonary cases. In 1897 from personal experience as an invalid Rhodes declared his unquestioned endorsement of South Africa as a health resort. Rhodes stated as follows: "I honestly believe that owing to the purity and dryness of our climate, the growth of the tubercle is frequently checked, and after a period becomes entirely arrested". Further, it was argued: "Our plateau has the advantage over St Moritz and other places on the Continent, of having a dry warm climate, free from mist and cloud; and, in addition, you are not exposed to the chills which naturally occur in the shade at similar altitudes in Europe" (Letter in Scholtz, 1897 frontispiece). As a symbol of appreciation and gratitude to the country Rhodes funded the construction of a sanatorium for consumption invalids in the diamond-mining centre of Kimberley. Unquestionably, this sanatorium brought further international atten-

tion to South Africa as a destination for invalids. On her travels in South Africa the well-known British writer, social reformer and administrator, Violet Markham (1900, p. 354) highlighted that: "Every traveller to Kimberley owes Mr. Rhodes a debt of gratitude for another building he has erected. South Africa is not a land of very comfortable hotels, and in the course of many varied experiences we found the Sanatorium so delectable a spot that it came near to proving our Capua… The Sanatorium, as its name betokens, is primarily intended as a health resort for invalids, but the most robust wanderers gladly avail themselves of its many comforts *and* unlimited supply of hot water — no small consideration in a country where an occasional sponge with Schweppe's Soda is often a luxury".

4.3. Growth and Uneven Geography

Precise numbers are unavailable of the numbers of British invalids who chose South Africa as a medical tourism destination. Nevertheless, across the four decades 1870 to Union in 1910, substantive evidence exists of regular arrivals of 'invalids' from Britain disembarking in Cape Town. Since the improvement in technology with the introduction of speedier steam transport between Cape Town and Britain in the 1870s estimates were made that the numbers of invalid travellers was increasing "by at least 40 or 50 percent" (Leach, 1878, p. 754). Salter-Whiter (1892) records that amongst the "conglomerate of mankind" on the ocean steamers from Southampton to Cape Town there were many consumptives. Cohorts of British invalids were "seeking a kindlier clime where the clear dry air of South Africa will take the hectic flush out of his or her cheek, and tan it with the glow of quickly circulating health" (Packard, 1989a, pp. 10–11). For Britain, the occupying colonial power in South Africa at the time the ownership of the asset of a health resort meant that with the promotion of the Cape Colony "British invalids would visit so-called British soil, and not other European countries, and the revenue would therefore be ploughed back into British pockets" (van Wyk, 2013, p. 55). Accompanying growing medical acceptance of the 'open-air treatment' for consumption increasing numbers of patients made their way to the country "where they might spend time in the open air, away from crowds and that they had exercise in the open air" in order "to help the body recover from consumption by using climate as a form of medicine" (van Wyk, 2013, p. 54). The flow of positive reports of visits of individual travellers to South Africa boosted the territory's reputation. Illustratively, in the published diary of the traveller Frederick Baron Rothschild (1895, p. 56) describing a three-week trip to South Africa it was recorded that "Owing to the dryness of the atmosphere the Karroo has become a sanitarium (*sic!*) for persons suffering from pulmonary complaints, in which cases it sometimes effects marvellous cures".

It was acknowledged in all guidebooks as well as by most British medical specialists that not all locations in South Africa were appropriate for invalids travelling for the benefits of climatotherapy. Geography mattered. The recommendation was to avoid coastal areas and especially the climate of Cape Town which was unfavourable for consumptives; instead the need was for invalids to travel 'upcountry'. In particular, 'upcountry' meant to localities with higher altitudes and especially in the Karoo region. The Karoo region was the upland space most favoured and regularly endorsed for invalid visits because it possessed a "climate unrivalled in its general healthfulness" (Scholtz, 1897, p. 13). This was described as "a climate pleasant and salubrious at once cold and dry, with an invigorating atmosphere, rich in oxygen, and a soft balmy air stirred by refreshing breezes" (Scholtz, 1897, p. 22). A Scottish medical physician wrote that as a rule "Karroo winter days are lovely, clear, and invigorating — the so-called champagne atmosphere — with a warm sun. The nights are cold, and suitable for sleeping. There is never the great coldness in the shade that is experienced in Switzerland" (Robertson, 1904, p. 435). Another writer described the Central and Northern Karoo in the following terms: "Here is probably to be found one of the most perfect climates in the world for tuberculosis" and "I would defy the most miserable hypochondriac alive to remain uncheerful on a bright sunny day on these glorious uplands" (Creswicke, 1903, p. 168).

As a whole, British medical specialists rated the healthful benefits of the Central Karoo climate in seven factors: (1) purity of air and comparative absence of floating matter; (2) dryness of air and soil; (3) coldness of air temperature and great warmth of sun temperature; (4) rarefaction; (5) intensity of light; (6) stillness of air in winter; and (7) large amount of ozone (Brown, 1893, pp 39–40). Among the most popular health resorts situated in or surrounding the Karoo were the small towns of Aliwal North, Beaufort West, Ceres, Cradock, Graaff Reinet, Matjiesfontein and Tarkastad. The town of Cradock was described as "one of the principal Colonial health resorts" (Brown, 1893, p. 41). It was remarked as follows: "Dr Symes-Thompson speaks very highly" and "states that the air is so dry that a knife left for a year or two on the veld does not become rusty" (Brown, 1893, pp. 41–42). With good access and geographical proximity to Cape Town, Ceres and Matjiesfontein "became known as 'health resorts in their own right and were visited for health reasons as well as 'socialites' from Europe" (van Wyk, 2013, p. 246). Ceres was first recommended in the 1870s as a health resort by Dr Leach most especially for those with chest diseases; it was considered as "worth while for patients to remain in Ceres and try it for some time before proceeding to the still higher elevated portions of South Africa" (Fuller, 1894, p. 21). The concluding advice of Fuller (1894, p. 23) was "invalids not desiring to travel far are advised that in the summer months they can choose no pleasanter or healthier resort than

Ceres". Its advantages were locational and "by its easy access from Cape Town, it makes a pleasant and safe halting place for those arriving by steamer and wishing for a rest before going on to higher elevations" (Fuller, 1894, p. 23).

The colourful history of the Karoo town of Matjiesfontein becoming established as a health resort for Britain's elite merits special mention (Allen, 2015). This town was described as a little Victorian England. Its development in the 1890s from railway siding to health resort is an extraordinary tale linked to James Logan, of Scottish heritage who immigrated to South Africa in 1877 and through his business and political acumen amassed a fortune, becoming an important figure in colonial Cape society. He became styled the 'Laird of Matjiesfontein' as he transformed the railway siding with one shed into a Victorian village. Allen (2015) recounts that the village was built from scratch with materials imported from Glasgow, lamp posts from London and the 'Laird's' personal staff coming from throughout Scotland. The doctor hailed from a village close to Logan's birthplace in the Scottish Borders. Also, Matjiesfontein was distinguished by its own cricket pitch and the claim that the first English cricket side to visit South Africa played there. Attracted by its fame, eminent visitors included Lord Randolph Churchill, Cecil Rhodes (a frequent visitor), His Highness Prince Sayyid Ali (the Sultan of Zanzibar), and Rudyard Kipling. Olive Schreiner, one of South Africa's most prominent literary writers, resided at Matjiesfontein.

4.4. Concerns, Criticisms and Demise

The perceived therapeutic regenerative qualities of South Africa's climate therefore became a driver for the development of a form of international medical tourism that pre-dated the country's emergence as a leisure tourism destination (Rogerson & Rogerson, 2021). Nevertheless, growing concerns emerged as to the observed differential benefits from South Africa's climate for different classes of invalids, the multiple challenges they endured in their visits, and more widely to the impacts of their arrival for health in South Africa.

Negative reports began to surface about South Africa's renowned status as a medical tourism destination and appropriateness for 'consumptives'. One damning report was published in *The Lancet* on the experience of The Chief Medical Officer of Health to the Port of London: "I have seen invalids wandering miserably around Cape Town … whose condition indicated that no possible good could come of such a journey, because they were physically incapable of getting 'up country and into the high and dry air that alone would give them a chance of prolonged life. To send such cases out is little short of cruelty" (Leach, 1878, p. 752). It was stressed that patients needed to be well enough on arrival in South Africa to go into the

Karoo where they might be in the open air "for a great part of the day, and to take horse exercise" (Leach, 1878, p. 752). The warning was sounded by Scholtz (1897, p. 11) that the "difficulties of making a judicious selection of the most suitable locality whither the invalid should proceed on arrival in Cape Town are being seriously and rightly recognized by the medical world in the Old Country". Caution was given that British physicians should avoid the haphazard 'bundling off' of patients to inappropriate locations. As Scholtz (1897, p. 12) stated, in "change of air we have admittedly a powerful remedial agent, but that it must not be forgotten that this remedy should not be applied indiscriminately, but that judgement and discretion should be exercised in the selection of the most suitable locality".

Controversy mounted about the lack of discretion that was exercised by British medical practitioners in sending pulmonary patients to South Africa. Complaints arose surrounding "the haphazard manner whereby tuberculotics were bundled off to the Cape without regard to the phase of the disease or climatic variations within the land. Invalids lodged in boarding houses mixed with the ordinary residents, and received what attention was afforded by the local practitioner" (Laidler, 1940, p. 75). For the mid-1890s Murray (1895, p. 1158) recorded: "Of late there has been much outcry against the indiscriminate sending by English doctors of consumptives to die in South Africa". Brown's Guide of 1896–7 was forthright that "Physicians and invalids are emphatically warned that South Africa is not adapted to those who cannot, to a certain extent, shift for themselves: *To send sick people in the last stages of consumption on a fatiguing journey which leads to places where the unfortunate patient cannot procure proper attention is most certainly wrong* (emphasis in original). There is not a town or health resort in South Africa where the writer has not been requested to give the uttermost prominence to this fact" (Brown and Brown, 1896–97, p. vii). Likewise, in the *Edinburgh Medical Journal* the following account was published of a typical situation in which a patient suffering from a chest complaint would be told they should go to South Africa: "The patient would say, "Where — for South Africa is a big order — and the doctor, very often an eminent specialist, would probably say "Oh, I am not very particular so long as you go to South Africa" (Robertson, 1904, p. 434).

Although it was acknowledged that "of the clearness, dryness and general salubrity of the air there can be no doubt" (Leach, 1878, p. 752) the evidence accumulated that South Africa was not a suitable place for pulmonary patients at an advanced stage of the disease. Murray (1895, p. 1158) highlighted that whilst the main point of climate treatment was for an open-air life it was observed that "the up-country towns have numbers of young men suffering from phthisis who work in stores, banks and offices for six to eight hours daily, and who see the green veldt perhaps once a week". In addition, many instances were recorded of

incorrect advice given to patients. In one case a distinguished London physician recommending the coastal settlement of Knysna which was described as "chiefly celebrated as the district in which the Duke of Edinburgh, some years ago, shot an elephant or two, but in no way, as South Africa goes, climatically recommendable" (Leach, 1878, p. 758). Other invalids were packed off on long journeys from Cape Town to, for example, Pietermaritzburg in Natal, another non-climatically suitable destination, and "a very long journey for a weak invalid" (Leach, 1878, p. 753).

It was apparent that notwithstanding the Cape's solid reputation as a healthful destination for invalids, mortality rates were high. Many deaths were caused by the fact that across South Africa "the average colonial town is in a bad sanitary state" (Murray, 1895, p. 1158). For example, "Queen's Town, an important centre up country, has cesspools and sluits, the cleansing of which is ancient history" (Murray, 1895, p. 1158). Appearing in the influential *British Medical Journal* it was argued that the ordinary consumptive from England had a better chance of survival at Ramsgate in Kent "than at Cape Town, East London and Grahamstown". Moreover, in South Africa "there are tracts of country fifty and even a hundred miles from the coast line which compare with Westmorland for dampness and rainfall" (Murray, 1895, p. 1158). Other negative reports published in the *British Medical Journal* documented the harsh conditions endured by many invalids and the lack of improvement in their plight. In 1896 the Karoo town of Graaff Reinet was described as follows: "This is the last autumn month and now comes the winter, not a fireplace or stove in the hotel; no home comforts here" (Lush, 1896, p. 629). Furthermore, "You must not suppose that all invalids who come out here get well — very few ever do. Some remarkable cures take place of course but the majority of those I know are dead or dying" (Lush, 1896, p. 629).

The diverse experiences of consumptive invalids in South Africa was summed up as follows. Arguably, some of the consumptives arriving in South Africa "possessed the means or skills needed to establish themselves in business or take up a fresh trade. For such fortunate men of whom Cecil Rhodes was perhaps the most successful, the sunny temperate climate of South Africa proved beneficial and they remained free of the disease for the greater part of their lives. Many others, however, were not so fortunate. Some arrived too ill to work and without resources died soon after their arrival. Others who were able to work but lacked resources were forced to seek employment in low-paying, physically demanding jobs that further weakened their condition" (Packard, 1989a, p. 39). The rising mortality rates of invalids in South Africa began to attract concern which detracted from the country's reputation as a health resort. A critical problem for those invalids with insufficient funds related to "scarcity of work, whether trade, mercantile or professional" (Murray, 1895, p. 1158). Another problem surrounded quality of food and

available accommodation for invalids. The traveller Sir Frederick Young opined that across much of South Africa "hotel accommodation and adequate comfort for invalids, as regards food, quarters, attention, occupation and amusement are still most deficient" (Young, 1890, p. 161). Similarly, the *Edinburgh Medical Journal* reported "there is no doubt that for love or money it was very difficult for the invalid to get suitable food, and the surroundings, so far as hotel and boarding-house accommodation were concerned, were also far from satisfactory" (Robertson, 1904, p. 436). The staple dish was reportedly "mutton in various forms — roasted, stewed, chops, rissoles… Eggs and milk were difficult to get, and vegetables were scarce. Cooking, as a rule, bad and 'greasy'" (Robertson, 1904, p. 436).

The infectious nature of tuberculosis was only discovered in the 1880s by Robert Koch. Consumptive invalids from Britain were a source for the local spread of disease through both their work and residential arrangements in South Africa. Invalids frequently lived in cheap tenements and overcrowded boarding houses, and there became sources of infection to other residents who shared their economic condition, and eventually their disease. Many 'up-country' consumptives worked as tutors for the children of local white farmers, thereby becoming sources of infection within those families (Packard, 1989a). Although before 1895 in the Cape Colony no legislation required the registration of deaths which made it impossible to assess the impact of tuberculosis on mortality rates, following the introduction of death registrations the medical authorities of the colony recognised the high mortality rates from tuberculosis in several resort towns such as Aliwal North and Beaufort West (Packard, 1989a).

Beyond the challenges that impacted consumptive invalids and their impacts upon local populations, undoubtedly the major factor behind the late 19th century and early 20th century demise of South Africa as a medical tourism destination was advances in medical knowledge. The critical change was triggered in 1882 when Robert Koch isolated the *tubercle bacillus* as the cause of tuberculosis and thus laid the foundations for what would eventually become treatment by drugs. Despite Koch's breakthough in understanding the cause of the disease, it is argued that initially it "was not widely accepted within the western medical establishment" (Packard, 1989a, p. 40). According to Packard (1989b) from the end of the 19th century into the first decade of the 20th Western medical models of tuberculosis were in a state of flux as the hereditary paradigm, which was popular in medical models competed with Koch's germ theories. By the early 1900s, however, acceptance of Koch's aetiology of the disease was widespread and the abandonment of the open-air treatments occurred (Morris, 2018).

The retreat from climatotherapy posed significant implications for geographies of medical tourism, including for South Africa. As Janković (2006, p. 292) points out the trends in the treatment of consumption became "less and less climatologi-

cal". Accordingly, the demise of climatotherapy for consumption patients was inseparable from advances in medical knowledge. Correspondingly, there was a rise of bacteriology as well as the establishment of sanatorium facilities staffed with medical practitioners and often with open-air treatments (Janković, 2010). By the early 1900s there were established several sanatoria across South Africa with the best by reputation located at Kimberley.

5. Conclusion

This research is positioned as a modest contribution to international scholarship on medical tourism. Contemporary South Africa is considered an emerging, respected and preferred destination for medical tourism which is a topic garnering an awakened academic interest in the country albeit as yet with minimal historical context (Henama, 2014; Crush & Chikanda, 2015; Mudzanani, 2016; Matiza & Slabbert, 2020). Indeed, despite its ancestry as a form of travel, the existing state of medical tourism scholarship is dominated also by contemporary research investigations and is relatively shallow in relation to historical studies. However, as Langum (2025, p. 138) points out "travel for medical purposes became fashionable in the nineteenth century". Therefore, whilst it was lacking in any formal designation a history of medical tourism existed long before the burgeoning research interest in its nuanced contemporary manifestations (Connell, 2013; Smith & Puczkó, 2015; Puczkó, 2022; Lubowiecki-Vikuk & Białk-Wolf, 2025)

Arguably, this study is distinctive in its application of an historical approach and utilization of a range of untapped primary source material, including specialist guidebooks for invalids, traveller narratives as well as the writings of medical specialists to shed fresh insight into an early phase in the development of medical tourism in South Africa. The mining of the contents of multiple 19th century guidebooks on South Africa produced in London for 'invalids' as well as writings by medical specialists facilitated the reconstruction of the historical landscape of South Africa for medical tourists. It is contended that the culture of 'invalidism' was one important driver for the growing flow of medical tourists and most especially the search for improved health by British sufferers of consumption. During the 19th century, however, medical knowledge was poor about the causes and most appropriate treatment of this chronic disease. The evolution and growing popularity of climatotherapy in Britain explains the rising acceptance of 'a change of climate' and the associated encouragement of consumptive patients to travel to overseas destinations with climatic conditions considered as favourable for treating the disease.

Arguably, South Africa's appearance on the global map of medical tourism was part of this international trend. This early chapter in the history of South Africa as a specific type of health destination for 'consumptives' declined and subsequently closed largely due to new advances made in medical knowledge concerning the causes and treatment of tuberculosis. Accordingly, by 1910, the time of the formation of the Union of South Africa, a shift is noticeable in promotional material with a reduced focus on climate and instead much greater attention given to the country's bountiful assets of healthful medicinal springs as one vital element of the 'touristic capital' of the new nation (Rogerson & Rogerson, 2023).

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Declaration of Competing Interest

None.

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„Suchotnicy" i historyczna turystyka medyczna w Afryce Południowej ok. 1880–1910

Streszczenie. W XIX wieku, równolegle z dominującymi poglądami nauk medycznych oraz rosnącym zainteresowaniem zaletami klimatoterapii, rozwinęła się prężna branża podróży o charakterze zdrowotnym. Artykuł odsłania zapomniany rozdział w historii rozwoju turystyki medycznej w Afryce Południowej. Szczególny nacisk położono na analizę rozwoju Afryki Południowej w XIX stuleciu jako destynacji uzdrowiskowej i ważnego kierunku podróży dla brytyjskich „suchotników" cierpiących na gruźlicę płuc. W epoce wiktoriańskiej w Wielkiej Brytanii wiedza medyczna na temat przyczyn oraz sposobów leczenia tej przewlekłej choroby była niewielka. Rozwój i rosnąca popularność klimatoterapii w Wielkiej Brytanii sprzyjały akceptacji zmiany klimatu jako formy terapii oraz zachęcaniu chorych na gruźlicę do podróży do miejsc o warunkach klimatycznych uznawanych za korzystne dla leczenia tej choroby. Dzięki reputacji miejsca sprzyjającego zdrowiu, Kolonia Przylądkowa w Afryce Południowej stała się celem podróży brytyjskich gruźlików. Materiały źródłowe obejmują XIX-wieczne przewodniki po Afryce Południowej wydawane w Londynie dla „suchotników", ówczesne relacje podróżników, a także opracowania specjalistów medycznych, co pozwoliło na odtworzenie krajobrazu turystyki medycznej oraz wyzwań, z jakimi mierzyli się chorzy.

Słowa kluczowe: turystyka medyczna, klimatoterapia, suchoty, gruźlica, Kolonia Przylądkowa, Republika Południowej Afryki