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Women Medical Doctors in South Africa: Transcultural and Other Influences Before, During and After Apartheid

The influences governing the career possibilities and entry into the medical profession of women, especially for African women until recently, have included well studied phenomena, such as sexism and racism. Yet there are other important factors affecting a woman's place in medicine. For a long time the recent cliché of feminist literature "the glass ceiling" was not appropriate for South African women doctors, because rather than a glass ceiling they experienced a concrete ceiling, hard to miss and painful to hit. Sexism and racism have had influences on this profession in unexpected ways, although at first sight one may expect a patriarchal and racist society to deny opportunity at all levels to women striving both to enter a profession and to attain high levels of responsibility within it. In South Africa the monopolistic professional organisation of the medical fraternity and the abominable concept of separate development both had a profound influence on women in medicine that finally allowed some good to result.

To begin to unravel the complex interaction of these several influences in a multicultural society, it is necessary to sketch the relevant background, but only an outline will be given of those factors well known to this audience and frequently commented on by others. For many centuries the practice of medicine in Western communities did not have the prestige and authority it enjoys today, even though throughout the ages some of the greatest and most influential minds,

such as Aristotle, wrote about medical practice and theory. Until the last century, or so, doctors understood few diseases and had few cures. Surgery was particularly crude, often maiming and killing its patients through shock and infection. Yet women frequently performed medical and surgical functions in the Middle Ages and this is not generally known. However education for them declined because of the influence of male dominated State and Church rulers. Also the church gradually stifled medical knowledge, emphasising that saints' relics would cure all ills. Yet those remaining women practitioners often knew relevant anatomy and were shrewd psychotherapists. In the 12th century educated monks were prevented from the practice of medicine by a formal decree of the church. So barbers, quacks and others without any university education then could practise freely. However, from the 14th century many European cities began to restrict medical practice to those with university degrees, so automatically debarring women. But the rural and urban poor continued to use the services of local wisewomen and other non qualified practitioners. This was usually to their benefit, for at that time patients were killed as often by the cures as by the diseases. Sydenham, probably the greatest physician of the 17th century, recognised this in saying "many poor men owed their lives to their inability to afford conventional treatment." (1) By the time that scientific bases of modern medicine (the principles of bacterial infection, antisepsis, anaesthesia, etc.) were understood and taught in the 19th century, Western formal medicine was already a rigid monopoly maintained along class and sex lines. But doctors now understood many causes of disease and the resulting cures were based on principles of physiology and other sciences. Also surgery was now much safer and more effective. This success contributed to an increasing demand for medical care from doctors, which in turn resulted in a more rigid training, incidentally still with the virtually complete exclusion of women. In some ways that situation was little different from that of the latter part of the 20th century when medical doctors in Western society are principally a well educated elite, greatly respected and well paid for their function, which is to define and treat disease. Except for the last two centuries women had an important role in this field, which is only slowly now being regained. These developments in European and British medicine were reflected in South African practice, with an important difference for black women here. Incorporation of black

Africans into medicine, whether as doctors or far more frequently as trained nurses, was, until the 1930s, mainly the result of missionaries' efforts to assist black patients. They had great influence on the practice of medicine in South Africa for many decades and in the words of Dr James McCord, an influential pioneer missionary doctor, "the work of a medical missionary is two fold: first to relieve suffering; and the second is to combat superstition and open the way for the Gospel" (2). So there are clear transcultural influences on black medical practitioners from their earliest days, which were unknown for doctors in Britain or Europe, however similar were the organisation of their medical professions.

In modern times in Britain and elsewhere in the Western world, there has been an extension of doctors' power into spheres apart from those associated with medicine, such as the preserves of the family, the church and the legal system. Medicine is an archetypal profession, having a well defined body of knowledge and assertion of a monopoly of competence in its specific occupation. The firm control of medical practice by its own practitioners enhanced their own economic power and social status and for many years their domination was such that the interests of other health workers were subordinated to those of medical doctors. In both Britain and South Africa the medical establishment became an important institution, and is of interest to sociologists, for it well demonstrates the relation between technological innovation and professionalisation. Such institutions reflect the wider social, sex and class divisions of their society. So although there is discrimination against women in South African medicine, this is part of the value system of the wider society in which it occurs. Two of the central colonial "ideologies of Victorian England — that of the weakness of the white woman and that of the sexual savagery of the black man," (3) had a great influence on the practice of medicine in South Africa, especially in the nursing of black males by white nurses. British influence in the structure, organisation and practice of the South African health services and the part played by women was overwhelming. Medical doctors were all powerful and the barriers to women studying medicine and to nurses encroaching on their territory were all but impenetrable. In the late 19th century many British doctors opposed the registration of nurses and

midwives, because this was thought to be a threat to their practice of medicine. (Incidentally, the British doctors were supported by Florence Nightingale). This is one rare situation where the medical establishment's attitudes in South Africa differed from those in Britain, for in the Cape control of medical practice was so firmly in the hands of doctors that there was no opposition to registration of nurses, as allowed in the 1891 Cape Medical and Pharmacy Act. Nurses usually worked away from the urban areas where doctors normally practised among their affluent patients, so the doctors, mainly British-trained, middle class, white males, had little to fear from competition of nurses (4). This complete control by South African doctors over all aspects of medical practice had important consequences in later years, ensuring that there were no second class doctors with lesser training, when greater numbers of women and blacks began to study medicine.

For many years nursing and teaching were virtually the only professions open to black women in South Africa. Still today members of the nursing profession far outnumber all other black women professionals and semi-professionals. They suffer under the well known double disadvantage, for in South Africa, "the vast cleavages of race and class . . . are paralleled by the equally vast one of sex. The legal system, wages, access to positions of power and authority, are all structural mechanisms whereby a hierarchical, unequal relationship between men and women is perpetuated" (5).

Racism in South Africa, as elsewhere, originated from several sources, including a belief in superiority and economic factors combined with a desire to retain power. South Africa has a particularly complex society structure. Two important constituents are a mainly impoverished, poorly educated, African (black) majority and a white minority which retained power until 1994, and mainly comprised two European groups, with British and Calvinistic Dutch/Huguenot French origins (Afrikaners). South Africa suffered redefinition of its racial and gender boundaries in the early 20th century as part of a healing process after the Anglo-Boer War. So fears of both political disintegration and sexual subversion had their effect on the practice of medicine.

In the southern USA there was similar racial segregation. Blacks there found a solution for health care problems with a network of black hospitals, for training as well as medical care. This was not possible in South Africa because of the lack of resources and personnel. One of the first African doctors to practise in South Africa was Dr SM Molema, who received his medical degree in Scotland. In 1927 the entire (white) nursing staff, including the matron, of the Victoria Hospital in Mafeking resigned when Dr Molema was appointed and admitted white patients to the hospital. They objected "to being ordered about by any native doctor and to have to stand by while he conducted operations on white women." Dr Molema sued the nurses and won, but the local community raised funds to pay the nurses' costs (6). Black women's first entry into the health services was through nursing in the early 20th century and this was followed by black doctors some decades later. If they were not employed in public hospitals there was little friction. Two other important factors affected the rate of entry of blacks into the health professions. Firstly in both rural and urban regions there was a significant deterioration of Africans' health in the late 1920s. Various government commissions considered the matter and training for larger numbers of Africans in medicine and nursing was thought to be the solution. The combined effects of both the strongly entrenched medical profession, which insisted on maintaining academic standards, and the architects of apartheid in the Broederbond and Purified National Party, who did not wish white women to care for black male patients, had important consequences on black members of the medical professions. These will be considered below. However, apartheid continued to exert restrictive effects for a long time. In 1947 a report which suggested that there be no colour bar in planned primary health care centres was bitterly opposed by the (white) nursing establishment, on the grounds that white nurses should not receive orders from black doctors, whether male or female. Even in 1957 the situation had not totally changed, when black nurses still could not give orders to lower rank white nurses, except in an emergency. However, black doctors could now give such orders. This illustrates again the power exerted by the South African medical fraternity (4). The mechanism of apartheid, like all social systems, does not depend solely on coercion, but through the consent of many in the system, who are encouraged to believe that there is a

natural power order. With apartheid still in full force in the early 1980s there was again much discussion of the increasing needs for primary health care facilities for blacks, both in rural and urban settings. Little was done in this direction, until the post apartheid era. However, in 1981 a new law permitted nurses to perform many of the functions of doctors in remote black areas if doctors were "unavailable." Since no apparent threat resulted to doctors' incomes, this law was accepted by all parties, although "unavailable" was never defined.

Although much has been written about women and their interactions with various professions, little work has been reported on the effects of race on women in medicine. The history of black entry into medicine in South Africa is long, for the first black South African medical professional was Dr John Nembula, who graduated MD from Chicago in 1891 (7). But someone far better remembered is Cecilia Makawane, who in 1907 became the first black South African state registered nurse. A large hospital in the Eastern Cape, with close ties to the University of Cape Town's medical school, is named after her. She was a member of an elite African Christian family and although an important pioneer, was not typical of her generation. (8) Several decades elapsed before the first woman black doctor graduated. This was Margaret Xaane in 1942 (9). By the 1920s nursing had become a very prestigious occupation for the Westernised African women, who formed their society's upper echelon. Soon after this period rapid industrialisation and urbanisation were accompanied by deterioration of the health status of South Africa's black workforce, to such an extent that the economy became threatened (10). Policy decisions to counteract this trend benefited blacks, initially nurses and later, as part of separate development, black doctors. In South Africa, and in many other countries until recently, ethnic minorities were treated like women in terms of entry into the higher status professions (*e. g.* medicine, law, accountancy, engineering and architecture) and the higher the status, the more likely it was to be exclusively male and middle class. In this sense blacks in South Africa were treated as an ethnic minority. Ministerial permission was required for blacks to attend the traditional "white" universities to study medicine from 1959 until recently. However, as part of the grand apartheid structure the medical school of the University of Natal was reserved for races other than white and a

new black medical faculty, the Medical University of South Africa, MEDUNSA, was founded and produced its first 12 medical graduates (with MB, ChB) in 1982. Four women were among them. At the liberal University of the Witwatersrand medical school the first black women medical students were admitted in 1981, a year after the first black male. This was of course under the aegis of governmental apartheid restrictions.

An articulate and prominent South African black woman doctor, who is now a university administrator, Mamphela Ramphela, acknowledges that her womanhood is an important constituent of her view of herself and South Africa, but challenges her community's patriarchal claims that motherhood is a woman's reason for being. She is oppressed and dehumanised by being expected simply to be a mother. Hence her message to her country is that a greater empowerment of women is necessary with fuller recognition of their human potential (11). This will certainly be attained in part by the greater participation of women in medicine.

The need for women doctors is now recognised as being so critical that women today comprise the majority of entrants into medical schools in a large range of countries, including the USA (Harvard, Yale, Johns Hopkins and Texas) (12), South Africa, Israel (13) and the former USSR (14). In many other nations women are being accepted into medical schools in steadily increasing numbers. In spite of these encouraging trends, there remain real problems for women in the medical profession. Most important are the ways personal and family life encroach upon a woman's professional career. For example, the times for specialist training and childbearing usually coincide. This adds to the woman's stresses, for time spent with her family is often to the detriment of a career. Many studies have been published on women in medicine, usually by analysing questionnaires. More rarely these investigations have been based on case studies and in one well esteemed novel (15). This latter work, whose author is a mother and paediatrician, is in effect a detailed case study of a contemporary New York paediatrician. The problems facing a woman medical practitioner include those typical of all professional women, such as suffering sex discrimination,

even if unintentional, the absence of suitable role models in formative years, women doctors often having a minority or token professional status, the role conflict between occupational and traditional gender roles, in addition to all the stresses associated with the work itself which are shared by medical males. The types of work and specialities most commonly taken up by medical women reflect all these influences. Women most frequently specialise in the lower status and traditionally nurturant fields, or "soft" specialities. Already in the USA women paediatricians-in-training outnumber men, yet over 90% of paediatric departments there are headed by men (16). In South Africa a very recent report described the criticisms by women paediatricians-in-training of their employers' discriminatory practices, for both hospital authorities and academic institutions (17). Other favourite callings for medical women are towards dermatology, internal medicine, psychiatry, primary care, anaesthetics, radiology and pathology (18). These are women's most frequently supported medical disciplines in both Britain (18) and South Africa (19), for similar reasons. Apart from fields of study, the attitude and performance of women practitioners in a clinical setting show clear differences from men. They usually show more versatility, spend more time with each patient in longer interviews, talk more to them and employ more generally patient-centred strategies than their male counterparts. It is hardly surprising therefore that patients of women doctors are more actively engaged in their patient-doctor interactions and simply talk more (20). A sign of the resulting success of this is that women have proportionally far fewer malpractice suits than men in the USA, presumably due to their better personal relations and possibly to greater skills (21).

As elsewhere, in South Africa until very recently the male dominated medical profession exerted complete control over all aspects of medical practice. Their influence on government decisions shaped the standards, training and function of the medical and allied health professions. The desire to protect the interests of medical doctors was normally couched in terms of maintaining standards for the benefit of their patients, who were usually those urban dwellers able to afford a private practitioner. Medical doctors, apart from dedicated staff of mission hospitals and a few others, rarely worked in rural areas where they were needed by blacks, because their incomes would be low. (Only

in the last few months have attempts been made to redress this lack, with compulsory service for newly graduating doctors.) In 1928 the Loram Committee on Medical Training for Natives proposed a state subsidised training programme for African doctors, to alleviate this need, and the concurrent establishment of rural health units (22). At about the same time the South African Under Secretary for Public Health returned from a visit to colonial French West Africa where he was greatly impressed by the work there of "Medical Auxiliaries" and "Native Nurses." These were in effect lower grade "doctors" and "nurses" who received a shorter, simplified training and worked amongst the poor black communities. Such practice still continues, notably in the People's Republic of China, where "Barefoot Doctors" work effectively in rural regions. The power of the South African medical fraternity was such that these benevolent, practical and cost effective proposals were not accepted. In the Cape "equal standards" was the argument against its adoption. This had the ultimate effect of ensuring that each black (and every other) doctor in South Africa satisfied the Medical Council's high academic standards.

The problems of South African women doctors have paralleled those elsewhere in the Western world, with the additional constraints imposed by legalised racism and transcultural influences. Since the overthrow of apartheid much has been said about the needs of women and previously disadvantaged minorities and many corrective appointments have been made and remedial programmes initiated. But years must pass before the medical establishment is no longer dominated by white males. The current Minister of Health, Dr Nkosazana Zuma, is a black woman doctor with British qualifications and her Chief Director, also a black woman, has a doctorate in community medicine from the USA. Slowly the effects of their new policy, that of de-emphasising tertiary medicine in the public service while greatly increasing the availability of primary health care facilities, are becoming apparent. Women medical students are now the norm and in some medical schools form a slight majority of entering classes. But this has taken a long time to achieve. In the University of the Witwatersrand, one of South Africa's most liberal educational institutions, the ratio of men to women studying

medicine has steadily dropped from about 10, in 1930, to about 2, in 1984 and to about 1 today.

“Many training programmes in South Africa do not have formal plans for coping with pregnancies among residents (trainee specialists), but treat each case by crisis management”. (23) Even in very prestigious medical schools elsewhere, the same problems are encountered. For example, at Harvard, 80% of its associated specialist programmes have no policy for maternity leave. (23) The lack of “women filling the most important teaching roles in the clinical departments of the medical schools . . . reinforces among medical students the stereotype of women as ‘second class’ doctors.” (19) South African women doctors do not shirk responsibility and are well represented in essential communal work, typically maintaining immunisation services, clinics for black patients, blood transfusion centres and the out-patient departments of hospitals. It is to be noted that important though such work is, it is of lower status, with a lower salary and in general is rejected by male doctors. (19) Mamphela Ramphele has often challenged the past “vicious racism of apartheid, but also the more insidious and pervasive injustices of patriarchy.” (11) She is necessarily a feminist and understanding this is part and parcel of a strategy still needed to bring justice to the South African woman doctor.

As the practice of medicine expanded into new technological fields after the late 1950s, more and more skills in intensive care, paediatrics, surgery, public health, etc. were required. Training for whites of course greatly outnumbered that for blacks, but the basic principles of apartheid’s separate development ensured that some facilities were made available for black doctors and nurses. The few black women among the doctors also benefited. Knowledge that training standards and qualifications were the same for all South African medical graduates, allowed increasing acceptance of black and women doctors having skills equal to those of their white counterparts. There was a similar move towards placing blacks in positions of responsibility and authority, in their homeland health services. Such changes accelerated in the 1970s. There was no benevolence or altruism in this process. It coincided with the apartheid state’s desire to form, and obtain the

collaboration of, a skilled and secure black middle (and also working) class who would be a bulwark against an expanding black militancy. This was a stupid and vain hope.

Even a cursory consideration of the history of women doctors in South Africa shows that the need for women's rights was central. Yet the advent of democracy in 1994 is not the end of their struggle. All women doctors suffer from the continuing male domination of their profession, but black women doctors continue to experience additional social and cultural problems which may result from African traditional law (as recognised in the new constitution) and so can have an effect on their professional lives. These transcultural influences do not necessarily vanish when a woman has tertiary education and a Westernised life style, even though many of the important goals of South African feminists have been achieved: there are more women in Parliament, women have greater control over their fertility and, together with the greater community, awareness exists of the need for greater protection from violence and rape. In contrast to these advances polygamy and its associations present problems, for under current law there are few resulting rights for women in a polygamous or monogamous "customary union" marriage, as defined by the Black Administration Act of 1927. They have virtually no rights after divorce or the death of a husband. In particular, they cannot then inherit (a principle of customary law recently upheld by the Supreme Court of South Africa), receive life insurance benefits, or even in principle the custody of children. Polygamy cannot simply be legalised, for customary law also makes women depend on husbands for the owning of land. Another important aspect of traditional law, still much practised even by elite families, is "*lobola*", now a bride-price. Its original purpose, a gift of cattle in a symbolic ritual accompanying the binding together of two families, has changed. One estimate of its incidence today is over 90%. (24) Current values for a well educated daughter are about Rd 20,000. This custom, apart from being considered degrading by educated wives, often results in no right of refusal for sex or preventing the husband from taking a second wife. Here there is a dilemma. African feminists wish to assert women's rights but instinctively they wish to defend African traditions. Objections to polygamy may exist, but there is greater antipathy to the

condemnation of it by white missionaries, who described it as barbaric. Even the deputy Speaker in the South African Parliament could not prevent her father from obtaining *lobola* when she married, in spite of her objections. Arguments against dropping African traditions come mainly from chiefs and traditional leaders, who are almost all men with possible vested interests in its maintenance. They maintain they defend African tradition against the imposition of Western neo-imperialist values. Perhaps one way to approach this problem is to acknowledge that customary law has not kept up with social transformation and to consider its modification, for South Africa is now the most urbanised country in Africa (with 50% urbanisation, compared with an continental average of 30%). These momentous changes have not been accompanied by appropriate changes in traditional law (24).

There is a great necessity for more medical personnel in South Africa, if the needs of patient care, education and research are to be met. The engaging of Cuban doctors, the compulsory community service for newly graduated South African doctors and the extension of powers offered to suitably trained nurses, only partially fill this need. Under 30% of currently registered doctors are women. This proportion should be increased and barriers for their postgraduate training should be dispersed. The aptitude of women doctors for personal understanding of their patients is a further cause for this action. Most public medical effort is now being directed towards of the poorest parts of the South African community and transcultural communication barriers will be lessened if more black women are encouraged to take up medicine.

Apart from affirmative recruitment, women have other needs to be able to fulfil their potential in medicine. Support systems, such as child care facilities, must be provided, modification of training conditions and emphasis on management training are also necessities. Role models for future leadership positions are necessary for women doctors. The present Minister of Health Dr Zuma should be accompanied by others, especially in the academic environment. Better than legislation and strident tactics to achieve all these ends, are mutual respect and professionalism. These appear to be currently favoured means.

South African women have lived in a multicultural society with unparalleled and prolonged legalised racism, subject to unique transcultural pressures. Their different subgroups, including their professionals, have been subject to influences from the colonial British, Calvinist Dutch and the traditions of Africa. Important influences on women medical doctors have been especially sexism and racism, a heritage of the two European groups who have ruled the country. Their effects on women doctors have been analogous to those experienced in the medical profession of other countries. Less well recounted have been important sequelae of the domination by white males of the medical and allied professions. For many years there was grudging acceptance for women to enter the profession, but once admitted they always were educated to the same level, in spite of later difficulties in postgraduate training. Some positive effects on women medical doctors, especially black women, also accrued from separate development and consequences of both these restrictive influences have rarely been considered in the literature to date. In spite of the democratisation of the last two years, much remains to be done to provide equal opportunities for women in medicine, for they had fallen so far behind. All current efforts and trends appear to be in the right direction. *On est optimiste.*

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