

# **Against the Odds: A Social History of African Women Medical Doctors in South Africa, 1940s-2000s.**

**By  
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## *Abstract*

This thesis focuses on the lives of six women medical doctors of African ethnicity, from the 1940s to the 2000s. These women are of different generations and were all born in South Africa. They trained in South Africa and have worked in a variety of institutions across the country. It investigates how the profession of medicine has evolved over time and what role a changing political climate has had on the development of the medical profession; particularly in terms of race and gender. It considers the broad historical context within which South Africa's general medical training and professional development took place during the nineteenth and early twentieth centuries. It then looks at the early lives of the six interviewees, which include their childhood and later motivations to study medicine. It also investigates the medical training experiences of these African women doctors. The lives and experiences of black women doctors after they graduated from medical school with a Bachelor of Medicine (MBChB) degree, during the apartheid period, is also discussed. Their training experiences, internship experiences and the experiences of their working lives in post-apartheid South Africa is a focus of this study too. Finally, it considers the impact of recent political transformation on the racial, gendered and class dimensions of the medical profession.

## **Chapter One: Introduction**

This thesis focuses on the lives of six women medical doctors of African<sup>1</sup> ethnicity, from the 1940s to the 2000s. These women make up different generations as they are of different ages and were born in South Africa. They have also been trained and have worked in a variety of institutions in South Africa. Although scholarly works do exist on women in medicine in South Africa, there is very little written on the specific experiences of African women during these years.<sup>2</sup> In addition, I aim to investigate how the profession of medicine has evolved over time and what role a changing political context has had on the development of the profession, especially in its racial and gendered dimensions.

My interest in the topic of African women in medicine began in my first year of postgraduate study at university. My interest grew even more when I did my mini dissertation on nurses as cultural brokers in South Africa, a biography of the life of a nurse, Marriet Duduzile Rehman.<sup>3</sup> This interest in African women in medicine, expanded for my master's thesis into African women medical doctors in South Africa. It became apparent to me in my previous studies that women, especially African women, were historically discouraged to become doctors. If women entered the medical field, they were rather encouraged to enter the nursing profession, not only in South Africa, but also internationally.<sup>4</sup>

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<sup>1</sup> A note on terminology used in this thesis: In this thesis, the term 'African' refers exclusively to those people of African ethnicity. The term 'Bantu' was used as a classificatory name from the 1950s to replace the word 'Native' during the apartheid era in South Africa. The Department of Native Affairs became the Department of Bantu Administration and Development. Africans were not pleased with the word 'Bantu', as it represented the apartheid systems discriminatory treatment. From the late 1970s, the term 'Bantu' was slowly replaced by 'black'. The term 'black' meant anybody who was not white i.e. Africans, Indians and Coloureds. Therefore, when using the term 'black' I mean a term to refer to people classified under apartheid as 'non-white' generally, and when using the term 'African', I am referring to those born of African ethnicity.

<sup>2</sup> Liz Walker. "The Colour White: Racial and Gendered Closure in the South African Medical Profession" *Ethnic and Racial Studies* 28, no. 2 (2005): 348-375.

<sup>3</sup> See Amanda-Bea Rehman. "Nurses as Cultural Brokers: A Biography of a South African Nurse, Marriet Duduzile Rehman, 1940-2010." (University of KwaZulu-Natal, Pietermaritzburg: Honours Dissertation in History, 2014).

<sup>4</sup> Michael Gelfand. *Christian Doctor and Nurse: The History of Medical Missions in South Africa From, 1799-1976* (Sandton: Aitken family, 1984), Simonne Horwitz. "'Black Nurses in White': Exploring Young Women's Entry into the Nursing Profession at Baragwanath Hospital, Soweto, 1948-1980". *Social History of Medicine* 20, no. 1 (2007): 135, C. Searle. *The History of the Development of Nursing in South Africa, 1652-1960* (Cape

I have also found that an analysis of the history of African women doctors would be an interesting topic to examine as this has not been a major focus in South African history. When looking at South African medical scholarship, it has focused more on the racial exclusion of black people during the apartheid era, as well as the gendered exclusion of white women. It has not focused on the racial and gendered exclusions of African women doctors.<sup>5</sup> This thesis does not focus on the individual life story of one person, but rather provides an in-depth analysis of the lives of several different African women who were trained and who worked as medical doctors in South Africa. The people I chose to focus on in this study are of diverse ages. This is done to investigate change over time and to offer a comparative dimension when looking at their experiences as healthcare professionals in South Africa.

An examination of the intersection between race, gender and class issues is significant in this thesis as their overlapping influences have led to inequalities that have affected African women's lives.<sup>6</sup> Whether these women's professional statuses as doctors reduced their experiences of racial and gender discrimination in South Africa, and if this changed over time, will also be examined.<sup>7</sup>

However, my thesis does not only consider the apartheid period. Looking ahead to the post-apartheid period, I will also consider how the situation has changed with a growing number of women accepted into medical training in recent years. Indeed, scholars have argued that certain disciplines, and even the profession itself, has been increasingly feminised by the larger number of women who have entered it.<sup>8</sup> I will therefore examine what effects the

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Town: Struik, 1965): 124 and Shula Marks, *Divided Sisterhood: Race, Class and Gender in the South African Nursing Profession*. (New York: St Martin's Press, 1994).

<sup>5</sup> Walker, "The Colour White": 349.

<sup>6</sup> Bell Hooks, "Black Women: Shaping Feminist Theory" in K. Bhavani (ed.), *Feminism and Race*, (New York: Oxford University Press, 2001).

<sup>7</sup> Anne Digby. "The Medical History of South Africa: An Overview." *History Compass* 6, no. 5 (2008).

<sup>8</sup> Daniel J. Ncayiyana. "Feminism of the South African Medical Profession-Not yet Nirvana for Gender Equity." *South African Medical Journal* 101, no. 1 (2011): 204.

growing acceptance of women into the profession has had on the South African medical profession itself over the years.

### The Historiography of Women in Medicine

During the last twenty to thirty years a number of international scholars have examined medicine as a gendered profession, which was influenced by patriarchal views and values. These scholars have shown how women in the USA and Europe, for example, experienced a range of difficulties around gaining access to and working within the medical profession. Indeed, many unequal patriarchal ideas about a woman's "proper place" existed in male-dominated societies.<sup>9</sup> When women were included in medicine they were pushed into professions that were regarded as more feminine, such as nursing and teaching.

In her book, *The Secret Life of Dr. James Barry: Victorian England's Most Eminent Surgeon*, Rachel Holmes tells about the first female doctor in Britain in 1812, Dr James (Miranda) Barry.<sup>10</sup> Dr Barry used an unconventional and unexpected method to train, qualify and work as a doctor, at a time when female doctors in Britain were unheard of. As medicine was regarded as a profession suitable for males, Barry was forced to disguise herself as a man to achieve her educational and professional goals.

It was only in the mid-nineteenth century USA, after a long struggle to gain admission into medical schools that women could train as doctors.<sup>11</sup> However, their hardships continued as they had to endure much gender discrimination. In her book, *Elizabeth Blackwell: The First Woman Doctor*, F. Sabin tells the story of Dr Elizabeth Blackwell. It took forty years after graduating from medical school, i.e. until 1889, for her to be recognised as a doctor (the first

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<sup>9</sup> Elianne Riska and Katarina Wegar. *Gender, Work, and Medicine: Women and the Medical Division of Labour* (London: Sage Publications, 1993).

<sup>10</sup> Rachel Holmes. *The Secret Life of Dr. James Barry: Victorian England's Most Eminent Surgeon*. (United Kingdom: Tempus Publishers Ltd, 2007).

<sup>11</sup> Regina Markell Morantz-Sanchez. *Conduct Unbecoming a Woman: Medicine On Trial in Turn-of-the-Century*. Brooklyn (New York: Oxford University Press, 1999), Carolyn Skinner, *Women Physicians and Professional Ethos in Nineteenth-Century America* (Illinois: Southern Illinois University Press, 2014), Judith Bellafaire and Mercedes Graf. *Women Doctors in War* (Texas: Texas A & M University Press, 2009).



in her country, in fact) as she could not obtain a residency training and a work position after completing medical school. Her medical progress was deterred by a male medical fraternity who simply refused to work with her.<sup>12</sup>

Most European universities did not permit women to receive medical degrees until the 1870s and 1880s. Jo Manton tells the story of the first female to be recognised and to train as a doctor in Britain in her book *Elizabeth Garret Anderson*. Elizabeth Garret Anderson decided she wanted to become a doctor after meeting Dr Elizabeth Blackwell in 1859, when she visited the USA to deliver a number of lectures. After studying for several years at London's Middlesex Hospital, Anderson then went on to pass her medical exams and qualified in 1865. However, soon after this the Society of Apothecaries (a society that determined whether medical practitioners in England received a medical license) changed its rules to ban women from its medical schools and prevent other women from entering the profession this way until several years later.<sup>13</sup>

Judith Lorber discusses in her book *Women Physicians: Careers, Status and Power*, that women entering medicine in the nineteenth century were at a low quantity. This can be explained by sex-role socialisation.<sup>14</sup> Sex-role socialisation was a theory stating that women were encouraged to enter professions that were more “feminine” in nature, such as nursing. They were discouraged from having careers in socially-defined “masculine” professions, such as medicine. The work of Regina Morantz-Sanchez is important as it contributes to the literature written on professionalization in terms of gender.<sup>15</sup> She discusses the history of women physicians in the United States from the mid-nineteenth century to the early twentieth century. The history of the entrance of women into the medical profession and the struggles

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<sup>12</sup> F. Sabin. *Elizabeth Blackwell: The First Woman Doctor*. (New York: Troll Communications, 1982).

<sup>13</sup> Jo Manton. *Elizabeth Garrett Anderson*. (UK: Methuen Publishing, 1987).

<sup>14</sup> Judith Lorber, *Women Physicians: Careers, Status, and Power* (New York: Tavistock Publications, 1984).

<sup>15</sup> Regina Morantz-Sanchez. *Sympathy and Science. Women Physicians in American Medicine* (New York and Oxford: Oxford University Press. 1985) and Regina Morantz-Sanchez. *Conduct Unbecoming a Woman: Medicine on Trial in Turn-of-the-Century Brooklyn*. (New York and Oxford: Oxford University Press, 1999).

they went through to become productive members of that community, is key in her work. She also discusses the difficulties they experienced balancing marriage, family and their professional lives. Author Lillian Furst discusses the social limitations that discriminated against women. She focuses on women healers in the late nineteenth century, and their struggle to overcome deep set attitudes and beliefs about women's capabilities and primary family responsibilities to gain acceptance in the medical profession.<sup>16</sup>

During the late nineteenth century, women in the USA continued battling to secure admission to medical schools and hospitals, but also professional medical societies. This was discussed by Mary Roth Walsh in *Doctors Wanted: No Women Need Apply*.<sup>17</sup> Walsh argues that even though a few hospitals, such as Johns Hopkins, opened their doors to women in the 1890s, a series of setbacks started in the second decade of the twentieth century to outshine the earlier progress made. Indeed, male practitioners found new ways of preventing the number of women entering the medical field, by introducing, for example, internships as mandatory for aspiring doctors. Most approved internship hospitals refused to consider applications submitted by women.<sup>18</sup>

Sociologist, Stephen Cole has examined the growing numbers of women entering medical schools in the USA in the twentieth century. He considers how from around 1929, the Association of American Medical Colleges started gathering and publishing statistics on applicants and entrants who entered medical school. His research shows that between 1929 and 1970, increased numbers were seen for both women who applied to medical schools and those who were admitted.<sup>19</sup> By 1941, six medical schools in the country did not accept women. By

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<sup>16</sup> Lillian R. Furst, ed. *Women Healers and Physicians: Climbing a Long Hill*. (United States: University Press of Kentucky, 1999) and Kary L. Moss. *Man-Made Medicine: Women's Health, Public Policy, and Reform*. (United States: Duke University Press, 1996).

<sup>17</sup> Mary Roth Walsh. *Doctors Wanted, No Women Need Apply: Sexual Barriers in the Medical Profession, 1835-1975* (New Haven: Yale University Press, 1977).

<sup>18</sup> Walsh, *Doctors Wanted, No Women Need Apply*: 186-187

<sup>19</sup> Stephen Cole. "Sex Discrimination and Admission to Medical School, 1929-1984". *American Journal of Sociology* (1986): 549

the 1970s, his figures highlight a large increase in the number of women applying and the number of women gaining admission, between 1971 and 1977. He explains how during the post-World War II period, medical school admissions committees did not practice explicit discrimination against women applicants, which he argues related to changes of societal attitudes towards women in medicine.<sup>20</sup>

The work of Rosemary Pringle is also significant to mention in this literature review. In her book, *Sex and Medicine: Gender, Power and Authority in the Medical Profession*, Pringle speaks about how women doctors in Australia and Britain in the twentieth century had to deal with the difficulties of balancing time-consuming work responsibilities as physicians, with their “traditional” roles as mothers and wives.<sup>21</sup> Pringle shows how many women who chose to have careers and families were negatively affected in the profession. In a male-dominated profession, women found that being married or having children became a restricting factor in their desire for professional growth and career advancements. Some were discouraged from continuing their medical careers, while others were pushed into “softer” or less demanding (more controllable) disciplines such as dermatology or general practice.<sup>22</sup>

In addition to gender inequalities, racial exclusion was a great obstacle in the career aspirations and achievements of Africans in medicine.<sup>23</sup> James McCune Smith was the first African American to qualify as a doctor. He was born into slavery in New York in 1813. After obtaining his freedom, he travelled to the UK to train as a doctor at the University of Glasgow in Scotland, as African Americans found it difficult to enter medical schools in the USA at the time. He graduated in 1837.<sup>24</sup> The first African American woman to become a physician was

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<sup>20</sup> Cole. “Sex, Discrimination and Admission to Medical School”: 555.

<sup>21</sup> Ann Game and Rosemary Pringle. *Gender at Work*. (Sydney: Allen & Unwin, 1983). And Rosemary Pringle. *Sex and Medicine: Gender, Power and Authority in the Medical Profession*. (Cambridge: Cambridge University Press, 1998).

<sup>22</sup> Pringle. *Sex and Medicine: Gender, Power and Authority in the Medical Profession*: 101

<sup>23</sup> Todd Lee Savitt. *Race and Medicine in Nineteenth- and Early-Twentieth-Century America* (Kent, OH: Kent State University Press, 2007).

<sup>24</sup> James McCune Smith and John Stauffer. *The Works of James McCune Smith: Black Intellectual and Abolitionist*. (Oxford University Press, USA, 2006): 367

Rebecca Lee Crumpler. Achieving this accomplishment in the USA in 1864, she graduated in Boston at the New England Medical College. This was a women's only college, which closed in 1873. Crumpler was the only African American woman to graduate from this college.<sup>25</sup> The intense and intimidating racial period of the late nineteenth century America was a key reason for the exclusion of blacks when they tried to enter the medical profession.<sup>26</sup>

Black medical schools were built to accommodate those seeking to train in the USA. The main issue was financial as there was poor funding, and this limited many black schools from providing a high quality medical education for their students. Black professional organisations began to rise between the 1860s and 1880s due to African American physicians being excluded from mainly white medical societies and associations. Vera B. Thurmond also analyses African Americans in the medical profession of the USA between 1896 and 1965 and the difficulties that they went through, at a time when healthcare was influenced by racial segregation and Jim Crow laws, especially in the southern states.<sup>27</sup> By the 1970s, Wilbur Watson argues that, African Americans were still underrepresented amongst the ranks of physicians in the United States; while African-American women were even more underrepresented than black men among physicians during this period.<sup>28</sup>

Turning our attention to the larger African context, the present historiography on practitioners within the broader medical field in Africa is a big one. Scholars such as Michael Gelfand have written about the experiences of European doctors (most of whom were men) who had trained in Europe but worked in Africa as colonial missionary doctors.<sup>29</sup> Gelfand, but

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<sup>25</sup> Sarah Kovatch and Rebecca Lee Crumpler. *Rebecca Lee Crumpler*. (Columbus, OH: Zaner-Bloser, 2005).

<sup>26</sup> Savitt. *Race and Medicine in Nineteenth- and Early-Twentieth-Century America*: 260-265

<sup>27</sup> Vera B. Thurmond. "Against the Odds: Blacks in the Profession of Medicine in the United States". *The Journal of the American Medical Association* 282, no. 13 (1999): 1293.

<sup>28</sup> Wilbur H. Watson. *Against the Odds: Blacks in the Profession of Medicine in the United States*, (New Brunswick USA: Transaction Publishers, 1999) and Thurmond, "Against the Odds: Blacks in the Profession of Medicine in the United States":1293

<sup>29</sup> Michael Gelfand. *Christian Doctor and Nurse* (Sandton: Aitken Family, 1984) and Karen Flint. *Healing Traditions: African Medicine, Cultural Exchange, and Competition in South Africa, 1820-1948*. (Ohio: Ohio University Press, 2008.)

also other scholars such as Sheryl Nestel discuss how nurses in the late 1800s were usually brought to the colonies through Christian missionary bodies.<sup>30</sup> Nursing, by this stage, a quintessentially female profession, was greatly influenced by the Victorian ideals of femininity. Many scholars examined matters involving the training, employment and work of nurses in European colonies. Some even saw European nurses as useful “Tools of Empire” due to their work which helped advance imperial missions in the colonies.<sup>31</sup>

In time and due to increasing pressures on European doctors and nurses to serve a growing number of African patients, Africans were increasingly trained in biomedicine (or western scientific medicine). As was the case in Europe, African women in European colonies were pushed into nursing. The introduction of formal education to Africans was usually done by missionaries. As a result, they were often the first to introduce biomedical training to Africans.

A number of scholars have analysed the historical development of racially unequal medical training in Africa. John Iliffe’s work, *East African Doctors: A History of the Modern Profession*, focuses on the East African region and the training and work of African medical practitioners during British rule and after independence in Uganda, Kenya, and Tanzania.<sup>32</sup> On the eve of the First World War in these racially discriminatory colonial environments, Iliffe analyses how European missionaries and colonial doctors encouraged the training of Africans as subordinate categories of healers, such as medical assistants and auxiliaries. These racially “segmented societies”, as well as skepticism about the ability of Africans to competently practice medicine, were key reasons for the exclusion of Africans from achieving a full qualification in medicine.<sup>33</sup> In his book, *Illicit Union: Scientific Racism in Modern South*

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<sup>30</sup> Sheryl Nestel. “(Ad)ministering Angels: Colonial Nursing and the Extension of Empire in Africa.” *Journal of Medical Humanities* 19, no. 4 (1998): 257-277.

<sup>31</sup> Nestel, “(Ad)ministering Angels”: 258

<sup>32</sup> John Iliffe. *East African Doctors: A History of the Modern Profession*. (United Kingdom: Cambridge University Press, 1998).

<sup>33</sup> Iliffe. *East African doctors: A History of the Modern Profession*: 8-13

*Africa*, Saul Dubow also discusses how there were racist ideas in circulation during the early twentieth century about the medical capacities of Africans in the colonies, particularly what many Europeans regarded as their intellectual inferiority and resulting inability to take on such arduous professional medical training.<sup>34</sup> Illife focuses on the struggles of Africans to secure comprehensive biomedical training and the resulting professional status. This training was only attained in the second half of the twentieth century.<sup>35</sup>

Other scholars have focused their attention on the West African region. Similar to the East African situation, G.N. Chavunduka explains that in the nineteenth century, there were two key providers of western trained doctors to the West African coast. These were the British Army Medical Service and the Colonial Office.<sup>36</sup> In his book, *Physicians, Colonial Racism and Diaspora in West Africa*, Adell Patton shows how West Africans received training in biomedicine as assistants or helpers in European pharmacies and clinics in Freetown (in Sierra Leone) and elsewhere.<sup>37</sup> However, the rates of mortality of the European physicians developed into an issue for the public health in the 1800s. By the 1850s the British sent Africans educated by missionaries to British medical schools for full medical training.<sup>38</sup> These individuals became some of the first born in Africa to receive a full biomedical training.<sup>39</sup> Maryinez Lyons also discusses the unequal training offered to Africans in the Belgian Congo and Uganda in the

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<sup>34</sup> Saul Dubow. *Illicit Union: Scientific Racism in Modern South Africa*. (Johannesburg: Cambridge University Press, 1995).

<sup>35</sup> Illife. *East African Doctors: A History of the Modern Profession*: 3

<sup>36</sup> G.L. Chavunduka. (eds.) *The Professionalisation of African Medicine*. (Manchester: Manchester University Press, 1986).

<sup>37</sup> Adell Patton, Jr. *Physicians, Colonial Racism and Diaspora in West Africa*. (Gainesville: University Press of Florida, 1996): 2

<sup>38</sup> Steven Feierman. "The Social Roots of Health and Healing in Modern Africa", *African Studies Review* 28, no. 2-3 (June-September 1985): 73-148 and Hibba Abugideiri. *Gender and the Making of Modern Medicine in Colonial Egypt*. (Farnham, Surrey, England: Ashgate 2010).

<sup>39</sup> David Killingray. *Africans in Britain* (Portland, OR: F. Cass, 1994).

early days in her article, “The Power to Heal: African Medical Auxiliaries in Colonial Belgian Congo and Uganda”.<sup>40</sup>

A number of scholars have also analysed the history of medical practitioners in South Africa. Although these works will be discussed in more detail when laying out the broader historical context pertaining to the development of medical training for African women in South Africa in my next chapter, it is important to note the key areas of their contributions in this section. Scholars such as Karin Shapiro in “Doctors or Medical Aids: The Debate over the Training of Black Medical Personnel for the Rural Black Population in South Africa in the 1920s and 1930s”, Anne Digby in “The Mid-Level Health Worker in South Africa: The In-Between Condition of the ‘Middle’” and Vanessa Noble in “Health is Much Too Important a Subject to be Left to Doctors”, have analysed the early training of Africans as medical assistants and medical aides.<sup>41</sup> As in East and West Africa, their training was encouraged due to the growing numbers of African patients seeking biomedical treatment. These scholars show how subordinate medical assistants experienced much discrimination both racially and professionally.

Scholars such as Anne Digby and Bruce Murray have analysed the early decades of the twentieth century and the difficulties Africans experienced getting into South African medical schools in the Cape and Johannesburg around this time.<sup>42</sup> Other scholars have looked at the difficulties of training black students in medicine during the later apartheid years. Phillip V.

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<sup>40</sup> Maryinez Lyons. “The Power to Heal: African Medical Auxiliaries in Colonial Belgian Congo and Uganda” in *Contesting Colonial Hegemony: State and Society in Africa and India*, edited by Dagmar Engels and Shula Marks. (London: British Academic Press, 1994).

<sup>41</sup> Vanessa Noble. “Health is Much Too Important a Subject to be Left to Doctors’: African Assistant Health Workers in Natal during the Early Twentieth Century.” *Journal of Natal and Zulu History* 24, no 1 (2007), Karin A. Shapiro, “Doctors or Medical Aids – the Debate over the Training of Black Medical Personnel for the Rural Black Population in South Africa in the 1920s and 1930s,” *Journal of Southern African Studies* 13, no. 2 (1987) and Anne Digby. “The Mid-Level Health Worker in South Africa: The in-between Condition of the ‘Middle’” in Ryan Johnson and Amna Khalid. *Public Health in the British Empire: Intermediaries, Subordinates, and the Practice of Public Health* (New York & London, Routledge, 2012): 171-92.

<sup>42</sup> B.K. Murray. “Wits as an ‘Open’ University 1939–1959: Black Admissions to the University of the Witwatersrand.” *Journal of Southern African Studies* 16, no. 4 (1990): 649-676.

Tobias focuses on the challenges faced by black students particularly in the 1940s and 1950s. He discusses, as does Bruce Murray, a short period from the early 1940s to the late 1950s when the Universities of the Witwatersrand (Wits) and Cape Town (UCT) allowed small numbers of black students into their medical schools.<sup>43</sup> They discuss these students' racial and social experiences of discrimination before these universities were required by the apartheid state to close these training opportunities to black students.

From the 1950s, black students were increasingly funneled into black medical schools as part of the state's "separate development" policies. These included the University of Natal's "non-European" medical school, which Vanessa Noble discusses in her book, *A School of Struggle*,<sup>44</sup> and the Medical University of South Africa (MEDUNSA) in the 1970s, which Anne Digby discusses in her article, "Black Doctors and Discrimination in South Africa."<sup>45</sup> Both authors discuss the many hardships black students experienced, such as having to live far from the medical school or training in overcrowded and poorly resourced hospitals for black patients. In her work, *Doctors in a Divided Society* Mignonne Breier also examines the many training and work challenges experienced by black South African medical students, as well as the shifts that have influenced the training of medical students in the post-apartheid period.<sup>46</sup>

Although there is literature on the training and work experiences of black doctors in South Africa, very few scholars have considered the difficulties and specific hardships experienced by the small numbers of African women who made it into the medical profession in the mid-twentieth century. One exception is the work of Liz Walker.<sup>47</sup> Walker discusses the

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<sup>43</sup> Phillip V. Tobias. "Apartheid and Medical Education: The Training of Black Doctors in South Africa." *Journal of the National Medical Association* 72, no. 4 (1980).

<sup>44</sup> Vanessa Noble. *A School of Struggle: Durban's Medical School and the Education of Black Doctors in South Africa*. (Pietermaritzburg: University of KwaZulu-Natal Press, 2013).

<sup>45</sup> Anne Digby. "Black Doctors and Discrimination under South Africa's Apartheid Regime," *Medical History* 57, no. 2 (2013).

<sup>46</sup> Mignonne Breier and Angelique Wildschut. *Doctors in a Divided Society: The Profession and Education of Medical Practitioners in South Africa* (Cape Town: HSRC Press, 2006).

<sup>47</sup> Liz Walker. "The Colour White: Racial and Gendered Closure in the South African Medical Profession." *Ethnic and Racial Studies* 28, no. 2 (2005).



experiences of white women doctors in South Africa during the apartheid period. She analyses how white women experienced much discrimination in the medical profession and formed the South African Society of Medical Women (SASMW) to fight for their rights. However, this discrimination was based on their status as women, not their race. Although, Walker recognises that black women had to deal with the double oppression caused by race and gender discrimination in the South African medical profession, she does not go into detailed analysis of this issue.<sup>48</sup>

The hardships experienced by African women medical students and doctors in South Africa have not been looked at in detail. My research seeks to fill this gap by focusing on the medical training and work experiences of African women doctors and what effect the change over time in the social and political climate (i.e. from the apartheid to the post-apartheid period) had on the presence and African women's' contributions on the medical profession in South Africa.

### Theoretical Framework

#### Social History

The social history theoretical framework is used in this thesis.<sup>49</sup> Social history emerged out of the Marxist tradition. A key tenet of Marxism is the consideration of larger structural, economic issues and class divisions that influenced the development of unequal relationships between elite groups and the working class in societies.<sup>50</sup> Many Marxists emphasise the importance of structural forces over individuals as actors.

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<sup>48</sup> Walker., "The Colour White": 349

<sup>49</sup> Georg G. Iggers, "American Traditions of Social History", in *Historiography in the Twentieth Century: From Scientific Objectivity to the Postmodern Challenge* (Hanover: Wesleyan University Press, 1997): 41-50

<sup>50</sup> Karl Marx, *The German Ideology*. Part 1 (New York, International Publishers, 1998); Eric J. Hobsbawm. "Karl Marx's Contribution to Historiography." *Diogenes* 16, no. 64 (1968): 37-56; and Geoff Eley. 'Marxist Historiography' in *Writing History: Theory and Practice*, edited by Stefan Berger, Heiko Feidner and Kevin Passmore (London: Arnold, 2003).

The 1960s witnessed the emergence of “social history” and this framework confronted dominant historical narratives at the time, especially those focused on politics and the state.<sup>51</sup> In the 1960s and 1970s, “social history” captured the thoughts of a generation of young historians. It was centered in their thinking and prioritised the study of different kinds of topics, such as the stories of disregarded societies and individuals. Social historians sympathised with the causes (as they saw them) of marginalised people, popular movements, and the concerns of the working class.

“Social history” represents a progression in the development of historical scholarship. The focus of history, which was on the elite and those possessing authority, shifted to writing history in a way that involved people from other social groups, as well as individuals who had been previously ignored in earlier writings. The emphasis on “history from below”<sup>52</sup> highlighted the writing of histories of the masses, which were in the lower ranks or classes of society. This therefore encouraged a more extensive or wider social understanding of the past.<sup>53</sup>

British Marxist social historians, such as E.P. Thompson undertook an important in-depth study of the experiences of ordinary people and those who were marginalised. In *The Making of the English Working Class*, Thompson writes, at the start of the book, that he sought; “to rescue the poor stockinger, the Luddite cropper, the obsolete hand-loom weaver, the utopian artisan, and even the deluded follower of Joanna Southcott from the enormous condescension of posterity”.<sup>54</sup> Up to the point of Thompson’s writing in the 1960s, the voices of English working class people were too often silenced and ignored. Social historians began investigating these silences and used, where possible, the personal experiences of these historically ignored

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<sup>51</sup> Iggers, “American Traditions of Social History”: 16.

<sup>52</sup> Peter Burke. *New Perspectives on Historical Writing*. (University Park, PA: Pennsylvania State University Press, 1992): 24-41.

<sup>53</sup> Miles Fairburn. *Social History: Problems, Strategies, and Methods*. (New York: St. Martin's Press, 1999).

<sup>54</sup> E.P. Thompson. *The Making of the English Working Class* (New York: Vintage Books, 1966):12

people to write more on the issues that had enjoyed very little focus in mainstream history at the time.<sup>55</sup>

Thompson was a Marxist but, wrote against the structural determinisms of many who regarded themselves as Structural Marxists. These scholars, according to Thompson, gave too much power to economic structural forces in determining people's lives and did not focus enough on an individual's abilities to influence their own life. For Thompson, the purpose of writing in the social history framework was to emphasise agency, especially individual agency, as a driver of history.<sup>56</sup> One of his key concerns entailed giving recognition to the voices and the experiences of marginalised people.

African women were not elites in the South African political contexts of racial segregation and apartheid. Although it could be argued that their eventual status as medical professionals would ultimately place them within a more elite class position in South Africa, the hierarchical race-divided context of this country complicated any simple designation of "elite". Indeed, as we shall see, their experiences of racial and gender inequality oppressions always overlapped to influence their subordinate socio-economic status in apartheid South Africa. When studying, and writing history within the broader framework of social history, it helps one understand South African history better, especially the history of those excluded from the official archives, including African women doctors. I will use the social history framework to show the agency of African women doctors who lived, trained and worked under the apartheid system.

### Gender, Race and Class: Intersectionality in Social History

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<sup>55</sup> Gayatri Spivak. "Can the Subaltern Speak?" in Cary Nelson and Lawrence Grossberg et al (eds). *Marxism and the Interpretation of Culture* (Chicago: University of Illinois Press, 1988): 271-313 and Guha Ranjit and Gayatri Spivak. *Selected Subaltern Studies*. (New York: Oxford University Press, 1988).

<sup>56</sup> Thompson, *The Making of the English Working Class*: 14

In addition to social history, gender theorists have also impacted the framework of this thesis.<sup>57</sup> From the 1960s, under the influence of second wave feminism, a number of scholars focused on the roles and contributions of women in history. Influenced by social historians, their scholarship showed how women (as a subject matter) were marginalised, ignored or made invisible and subsumed under the universal category of men; similar to how the English working class was marginalised under the authority of the elite and powerful in E.P Thompson's texts.<sup>58</sup>

A number of scholars, such as Joan Wallach Scott and Helen Bradford, have shown how women have either been methodically left out of official historical records or have not been given credit for their contributions historically, which has often resulted in an androcentric bias in historical writings.<sup>59</sup> Furthermore, women had mostly been viewed as only being good at or suitable for the roles of "wife, sister, mistress, nurse or nanny" and labelled as the "other sex". Joan Wallach Scott raises these points in her article, "Women in the Making of the English Working Class." In this article, Scott takes on Thompson for the masculine bias of his working-class focus.<sup>60</sup> Feminist scholars such as these have played an important role in examining the largely male-dominated focus in the writing of history and have paved the way for writing women into history.

One of the significant themes that have influenced the writing of history including social and gender histories, is the issue of "race". Although it is important to recognise race as a socially constructed category, the designation of people into different racial groups has had very real socio-economic and political effects on people's lives in many parts of the

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<sup>57</sup> J.W. Scott (ed.), *Gender and the Politics of History* (New York: Columbia University Press, 1999).

<sup>58</sup> Helen Bradford, "Women, Gender and Colonialism: Rethinking the History of the British Cape Colony and its Frontier Zones, c.1806-70" in *Journal of African History*, 37 (1996): 353.

<sup>59</sup> Joan Wallach Scott, "The Problem of Invisibility" in S.J. Kleinberg (ed.), *Retrieving Women's History*, (New York: Berg Publishers Ltd, 1988): 5.

<sup>60</sup> Joan Wallach Scott, "Women in the Making of the English Working Class" in J.W. Scott (ed.), *Gender and the Politics of History* (New York: Columbia University Press, 1999): 72.

world.<sup>61</sup> Scholars such as Stephen Jay Gould and Michael Banton have done much work on race theories, looking at how and why racialised ideologies have emerged. Gould has examined the theory of evolution postulated by Charles Darwin, as well as the historical development of scientific racism where science was used to construct a scale of racial types. This scale led to the ranking of some racial groups as less intelligent and inferior to others, while some European societies even went so far as to use physical appearance and skull analysis to try to prove these ideas.<sup>62</sup>

Gender theorists tried to push the scholarship forward in the 1980s and 1990s by considering the issue of “intersectionality”. Intersectionality is not merely a theoretical concept, but describes the way multiple oppressions have been experienced and how they might still be experienced by people today. African American feminist theorists such as Bell Hooks, Patricia Hill Collins, Evelyn Brooks Higginbotham and Kimberlé Williams Crenshaw have argued for the importance of recognising an overlapping influence of race, class and gender issues in people’s lives.<sup>63</sup> Women have had many experiences of oppression in different degrees of intensity due to their gender in patriarchal societies, but also because of their race and class positions in their societies. Crenshaw states that black women experience discrimination in ways that are not a part of “racism” or “sexism” separately but as a combination of these elements.<sup>64</sup> Indeed, Bell Hooks, has argued that feminist activism needed to develop differently for white and black women because of racial and class privileges white women experienced, while black women dealt with worse forms of multiple oppressions.<sup>65</sup>

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<sup>61</sup> Dubow, *Illicit Union: Scientific Racism in Modern South Africa*: 12

<sup>62</sup> Stephen Jay Gould. *The Structure of Evolutionary Theory*. (Cambridge: Harvard University Press, 2002).

<sup>63</sup> Kimberle Williams Crenshaw. “Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Colour”, *Stanford Law Review*, 43, no. 6 (1991): 1241–1299 and Patricia Hill Collins. *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment* (New York: Routledge, 2000).

<sup>64</sup>Crenshaw. “Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Colour”: 1252.

<sup>65</sup> Bell Hooks. *A’int I A Woman: Black Women and Feminism*. (United States: South End Press, 1981) and Bell Hooks. *Feminist Theory: From Margin to Centre*. (United States: South End Press, 1984).

This is key when analysing the lives of African women in medicine in South Africa, as I will examine how intersecting oppressions influenced these women's lives and the difficulties they experienced in studying and practicing medicine. In South Africa, black people had been mistreated and discriminated against for centuries due to the colour of their skin, which led to an oppressed class position too. Yet, South Africa also developed as a patriarchal society and this historically led to gender discrimination experienced by women.<sup>66</sup> This, in turn, resulted in African women experiencing a triple form of oppression, namely discrimination on the grounds of race, class and gender.

### Research Methods and Methodology

For my study, I have used a qualitative research approach. Qualitative research focuses on understanding lived experiences and not broader trends. Qualitative research is valuable as it gives in-depth insights into the experiences of individuals or groups of people. The deeper meaning of these experiences is important. The size of the sample is a small one, and the selection of the respondents is meant to achieve a certain amount. Data collection methods in qualitative research differ and the use of unstructured or semi-structured methods is preferred. Methods involve the use of focus groups, interviews with individuals, observation of the interviewees and different types of sampling techniques such as purposive and snowballing sampling as methods of obtaining interviewees.<sup>67</sup>

I used both archival materials and oral interviews in writing this thesis. I had to search far and wide to find any mention of women medical students or doctors in the archives and I had to travel to use many different archives. Often, material found was not specifically about African women doctors, but, there was some archival material generally on black doctors.

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<sup>66</sup> Belinda Bozzoli. "Marxism, Feminism and South African Studies." *Journal of Southern African Studies* 9, no. 2 (April 1983): 141

<sup>67</sup> Anselm Strauss and Juliet Corbin. *Basics of Qualitative Research Techniques and Procedures for Developing Grounded Theory*. (UK: Sage Publications, 1998).

In terms of archival materials, I have used documentary sources to write this thesis. I found material on mostly white women doctors in the South African Society of Medical Women (SASMW) collection that was donated to the Wits University Library. The material there included interviews, financial papers, meeting minutes and mostly lists of women who were members of the SASMW.

I also found material on grants of overseas medical scholarships for black students in 1935 and documents on the appointment of African district surgeons in 1954. Documents on the training of black doctors in medical schools for black students and health inspectors were also found and documents on non-European medical schools from the National Archives Repository of South Africa in Pretoria. I also found material on the employment of African women doctors and on medical training facilities from the National Archives of South Africa.

From the Cape Town Provincial Archives Repository, which have proven useful too, material on admission of non-European medical students to hospitals for clinical study, which was sent to the Cape Town Hospital Board in 1932, was found. Documents on two books written in 1961 and 1963 about woman doctors titled “Woman Doctor”; and an application for permission to publish a book titled “Removal of Black Students from the Only Medical School” in 1977 also proved helpful. These texts were all sent to the Publications Board, which was the South African Board of Publications in Cape Town which either approved or rejected the request to publish a book. Applications for publication permission for all the above-mentioned texts were rejected as they were seen as “prejudicial to the safety of the state general welfare and peace and good order”, per the rejection document.

I also used published surveys done by the South African Institute of Race Relations between 1970 and 2004, which were found at the Alan Paton Centre and Struggle Archives in Pietermaritzburg. This helped me to see how many doctors were employed annually. However,

they did not specify whether these were black or white doctors. I also found a photograph of the first black woman doctor in South Africa at the Alan Paton Centre and Struggle Archives.

Newspaper and magazine cuttings from *Speak* (a South African history magazine) were found online. One such *Speak* article was an interview with a woman doctor, Mamphela Ramphele. Insightful photographs were found on the South African Medical Association's website of the South African Medical Congress between 1908 and 1992. The Medical Association had only white male members; by 1992 there are only two white female members.

Although it is sometimes difficult to find relevant documents related to your research project in an archive, archival research is important, and worth the effort. Combined with secondary literature and interviews, archival research can strengthen the quality and findings of a historical study.<sup>68</sup> However, researchers must also be critical of how they use archival sources. Ann Laura Stoler has argued that archives are not neutral objective entities but are socially constructed entities.<sup>69</sup> Some archives, especially state archives, have been viewed by some scholars as the products of "state machines".<sup>70</sup> This is because they have served those in power, which has influenced what material has been kept and what has been discarded. Michel Rolph Trouillot speaks of "silences" within the archives and how these silences can say a lot about a subject. He speaks of how elites have often created and used archives for their own purposes. Material retrieved from the state archive includes, the segregation and apartheid eras in South African history testified to a biased representation of black peoples. Furthermore, archives were also patriarchal when it came to what was kept and what was not, hence the fact

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<sup>68</sup> Carolyn Hamilton, Verne Harris, Michele Pickover, Graeme Reid, Razia Saleh and Jane Taylor, eds. *Refiguring the Archive* (Cape Town, South Africa: David Philip, 2002).

<sup>69</sup> Ann Laura Stoler. "Colonial Archives and the Arts of Governance: On the Content in the Form." *Archival Science* 2, no. 1-2 (2002): 87-109

<sup>70</sup> Achille Mbembe. "The Power of the Archive and its Limits" in *Refiguring the Archive*. Edited by Carolyn Hamilton, Verne Harris, Jane Taylor, Michelle Pickover, Graeme Reid and Razia Saleh. (Cape Town, South Africa: David Philip, 2002): 19-27.



that there was little on women doctors. These authors all highlight that one must understand that archival material does not always tell the full story.<sup>71</sup>

The issue of authenticity is also a significant issue to reflect on and is based on whether the document/evidence is what it claims to be. The historian or researcher must seek three things: “A) internal consistency b) confirmation from other sources, c) potential bias.”<sup>72</sup> This means that one must always be critical of all archival material and question who wrote the document, as well as when and why they wrote it because all archives have gaps, biases and silences that need to be considered.<sup>73</sup>

Oral interviews have also informed this thesis. Oral history is based on the usage of oral interviews in order to write about people and events of the past. Interviews have become an important tool and method for historians when doing research, especially since the 1960s, when it developed in parallel with social history.<sup>74</sup> Interviews with human beings are important as they try to understand the experiences of a person’s history.

With regards to interview data used in this thesis, face-to-face interviews were conducted by the author with six women doctors. Participants were between the ages of thirty-two and sixty years when I interviewed them, were born and trained in South Africa, and are of African ethnicity. Some women asked to remain anonymous and I have used pseudonyms when referring to them in this thesis. Three of the women are active medical practitioners while the other three no longer work as medical doctors. Of those that are working, one works in the public sector and two work in the private sector.

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<sup>71</sup> Michel-Rolph Trouillot. *Silencing the Past: Power and the Production of History* (Boston, MA: Beacon Press, 1995).

<sup>72</sup> Paul Thompson. *The Voice of the Past: Oral History*. (Oxford: Oxford University Press on Demand, 2000): 102

<sup>73</sup> Antoinette Burton. “Introduction: Archive Fever, Archive Stories.” In *Archive Stories: Facts, Fictions and the Writing of History* (London: Duke University Press, 2005): 1-24.

<sup>74</sup> Paul Thompson, “Evidence” in *The Voice of the Past: Oral History*. (Oxford: Oxford University Press, 2000): 14

A number of factors influenced my sample size. Firstly, I had some difficulty finding practicing African women doctors who were available and willing to be interviewed for this research project because of their busy schedules. Secondly, I experienced difficulty obtaining gatekeeper permission from the KwaZulu-Natal Provincial Department of Health to interview its employees who work in the public sector. Thus, it is significant to note upfront that my sample size is skewed towards retired women doctors and those working in the private sector. My sample consists of participants found through the snowballing method, which relies on referrals. Two participants are family acquaintances and they were referred to me by other participants.

The interviews I conducted were in-depth and semi-structured in nature. This allowed for issues not covered in my question list to be discussed. All interviews were analysed to identify and discuss common themes that affected the participants, but also to consider variations among the individuals. My sample of interviewees included women who were single and some who were married which allowed me to analyse the difference in their experiences. It also includes interviewees who studied at and/or worked at different facilities. Furthermore, interviews with African women doctors already collected by other researchers in earlier time periods have been used to supplement the interviews I did in order to assist me with my own findings when it came to comparisons and focus on changes over time. These interviews were obtained from the O'Malley Archives online and from the Wits Historical Papers Archive collection. The O'Malley Archives contain two decades worth of research, which include evaluations, chronologies, interviews and historical documents collected by Pdraig O'Malley. These materials are part of the Nelson Mandela Centre of Memory.

However, as with archival sources, researchers need a critical lens when using oral sources.<sup>75</sup> Oral interviewing has certainly added life to various written accounts of history allowing people who experienced an event or occasion and who are still alive, to tell the researcher their particular experience around a given topic. What is more, depending on the history being written, the information interviewees share with a researcher may assist in filling historical gaps and silences in archival records.<sup>76</sup> This has been particularly important for those working on African history and gender history.

Yet, when doing an interview, the interviewee and interviewer must have an understanding that the product of the interview is a result of the goals or aims brought forward by both the researcher and the interviewee. Both were active participants in the process.<sup>77</sup> The ethical issues must be carefully addressed and if interviewees know the rights concerning the person being interviewed and feel comfortable during their interviews then their information might be easier to obtain as the relationship between interviewer and interviewee will be a more productive one.

Furthermore, memory tends to be selective. An individual can remember some things and forget others and it is not “just a recall of past events and experiences in an unproblematic and untainted way.”<sup>78</sup> Memory has an enormous role to play in interviews, and has a large influence on the outcome because of the restriction that it holds. It often involves a process of remembering images, experiences, and emotions from our past and putting them into order. From this, we tell them as a narrative or story and tell them in a way that is influenced by our

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<sup>75</sup> Philippe Denis and Radikobo Ntsimane (eds). *Oral History in a Wounded Country: Interactive Interviewing in South Africa* (Scottsville: University of KwaZulu-Natal Press, 2008); Donald A. Ritchie. *Doing Oral History*. (Oxford: Oxford University Press, 2014); Robert Perks and Alistair Thomson. *The Oral History Reader*. (London: Routledge 1998) and Sean Field. *Oral History, Community and Displacement*. (New York: Palgrave Macmillan. 2012).

<sup>76</sup> Thompson, “Evidence”: 119.

<sup>77</sup> Donald Moore and Richard Roberts, “Listening for Silences” in *History in Africa* 17 (1990): 321.

<sup>78</sup> Paul Thompson. *The Voices of the Past: Oral History*. (Oxford and New York: Oxford University Press, 1978): 105-220.

social and cultural contexts.<sup>79</sup> Some of my interviewees had very clear memories of medical school and working in medical institutions, while others could not remember details, for example, of their classmates or events. I found that not all my interviewees who were of the same age group agreed on certain subjects. Issues of bias in opinion, agendas that motivated the points made and so on are all key to consider. Also, learning to “listen to the silences, in both dominant and muted channels or in both the available and untold history, allows the interviewer to extract the details”.<sup>80</sup> What the interviewee does not say can provide a much clearer understanding of how the situation affected them. Therefore, we cannot only rely on oral interviews, but instead should use the information we obtain from them in order to support archival research.<sup>81</sup>

Other issues the researcher needs to consider is the dialogue dynamic established on the day(s) of the interview; the race, class and gender background of the interviewer and interviewee; and the questions asked by the interviewer. They all are key when influencing the outcome of the interview. Thus, the final interview transcript depends on the relationship between interviewer and interviewee.

The issue of insider vs. outsider in the interview encounter may influence the product of the interview too. The interviewee may give more information to an outsider as there is no personal relationship between them and so there is more freedom. Of course, they could give more information to someone more similar to them because a sense of empathy is perceived. I felt I received more information in some interviews due to the fact that I am an African female and I could relate to some of the issues they mentioned because of this. Some felt comfortable

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<sup>79</sup> Lynn Abrams. *Oral History Theory* (London: Routledge, 2010).

<sup>80</sup> Kathryn Anderson and Dana C. Jack, *Learning to Listen: Interview Techniques and Analyses* (London: Routledge, 1991): 14

<sup>81</sup> Robert Perks and Alistair Thomson. *The Oral History Reader*. (London; New York: Routledge Press, 2006), p.20-49; Denis and Ntsimane, *Oral History in a Wounded Country*; Ritchie, *Doing Oral History*; Perks and Thomson, *The Oral History Reader* and Field, *Oral History, Community and Displacement*.

telling me their life stories because they felt that I understood some of the racial and gendered contexts of their experiences.

Finally, I have also used autobiographies written by white and black women doctors such as *Skin Deep* by Jean Walker, *The Mind is not the Heart* by Eva Salber, *Reminiscences of a Lady Doctor* by Pauline Klenerman, *Coolie Doctor* by K. Goonam and *Across Boundaries* by Mamphela Ramphele to write this thesis.<sup>82</sup> Autobiographies are important as they are another useful type of primary source which are written by particular individuals about their different personal experiences as women doctors.

### Structure of Thesis

This thesis is divided into six chapters. Witnessed in this chapter, I have focused on outlining my research, placing my research within a broader literature review on the subject of women in medicine and African history and provided the theoretical and methodological framework for this thesis.

In the next chapter, Chapter Two, I will provide more historical context/background to developments in South Africa's medical history up to the mid-twentieth century, focusing on medical training and the development of the profession, and how gender, race and class affected the entry of women into the profession.

Chapter Three considers the early lives of my interviewees, all of whom were born and trained in South Africa during the apartheid period. It considers what motivated them to study

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<sup>82</sup> Jean Walker. *"Skin Deep": The Autobiography of a Woman Doctor*. (Cape Town: Dr J.F. Midgley J.P., 1977); Eva J. Salber. *The Mind is Not the Heart: Recollections of a Woman Physician*. (Durham and London: Duke University Press, 1989); Pauline Klenerman. *Reminiscences of a Lady Doctor*. (Johannesburg: Pauline Klenerman, 1993); K. Goonam. *Coolie Doctor: An Autobiography*. (Durban: Madiba Publications, 1991) and Mamphela Ramphele. *Across Boundaries: The Journey of a South African Woman Leader*. (New York: Feminist Press, 1995).

medicine, their financial constraints, where they trained, their academic and personal difficulties and challenges leading up to admission to medical school and at medical school.

Chapter Four deals with my interviewees' working lives as medical doctors during apartheid. This includes their intersecting gender, race and class experiences in apartheid South Africa. It considers what disciplines/specialties they chose to work in and what influenced their choices, their working experiences in different practices and their experiences of balancing their work responsibilities and having families.

Chapter Five focuses on the training, working lives and experiences of women doctors in the post-apartheid years. The differences between the older and younger generations of women will be compared. It considers what challenges they face currently in South Africa and whether these are similar to or different from those their predecessors faced. Finally, I will analyse what influence African women doctors have had on the medical profession.

Lastly, Chapter Six, the conclusive chapter sums up significant themes, issues and key points about African women in the South African medical profession.

## **Chapter Two: Some Historical Background on the Training and Work of African Women in Medicine in South Africa**

This chapter lays out the broader historical context within which South Africa's general medical training and professional development took place. Gender and racial discrimination, as well as the limited access Africans and women had to enter the medical profession are important topics in this section. The nineteenth and early twentieth centuries were times of change for the medical profession in some parts of the world. There were opportunities that allowed groups that were seen as inferior because of their race or gender to embrace even the smallest opportunities to pursue a career in medicine, even if these options were in subordinate positions.

Medicine in Europe, the UK and their colonies in the nineteenth and early twentieth centuries, developed as a gendered profession. Men were encouraged to work outside the home as the primary breadwinners while women were encouraged to stay at home and focus on caring for their families. In the medical field, men were encouraged to become doctors.<sup>83</sup> Women who chose to work outside the home and wanted to enter medicine usually went into the nursing profession. During this period nursing was viewed as primarily a female occupation.<sup>84</sup> In her book, *Divided Sisterhood*, Shula Marks discusses the view of nursing as “women’s work” since the days of Florence Nightingale, and much less popular as a profession amongst men in the UK and Europe because of its gender-specific connotations.<sup>85</sup> In their African colonies too, nursing became a popular professional choice for European women during the twentieth

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<sup>83</sup> Elianne Riska and Katarina Wegar. *Gender, Work, and Medicine: Women and the Medical Division of Labour* (London: Sage Publications, 1993): Part Two.

<sup>84</sup> Anne Witz. *Professions and Patriarchy*. (London: Routledge, 1992): 46-52

<sup>85</sup> Shula Marks. *Divided Sisterhood: Race, Class and Gender in the South African Nursing Profession* (Johannesburg: University of Witwatersrand Press, 1994) and Shula Marks. “The Gender Dilemma in Nursing History: The Case of the South African Mine Hospitals.” 2001: 44, <http://www.nursing.manchester.ac.uk/ukchnm/publications/seminarpapers/genderdilemma.pdf> [Accessed: 11 April 2014]

century.<sup>86</sup> It allowed women to have prospects outside of the home, and this allowed them to pursue paid work careers, and it fitted well within the socially acceptable conventions about women's work being that of a caregiver.

The character of the medical profession in the region of what today forms the country of South Africa, was similar to that in Britain or other parts of its empire. During the nineteenth century, most doctors who practiced in South Africa were born in Britain and had trained in Britain. Most had come to the Cape Colony due to the expansion of imperial control and the opportunities this offered them.<sup>87</sup> There were no medical schools in South Africa during this period and doctors were overwhelmingly male and white. Women doctors were rare. Although, by the late nineteenth century European women were allowed to enter British medical schools to train as doctors, their numbers remained small. They continued to experience many difficulties in this male dominated training and working environment as many men felt that they were not capable of or suitable to work in this demanding profession.<sup>88</sup>

Doctor James Barry is an extraordinary example of the measures one woman took to be accepted and respected as one of the best "male" (in appearance anyway) surgeons of her generation. Barry, an early nineteenth century British doctor, who is mentioned earlier in this thesis, arrived in Cape Town sometime between 1815 and 1817 to take up duties as a regimental surgeon in the local garrison stationed there. Barry with "his" bright red hair was said to be a very odd character. "He" had narrow shoulders and was five feet tall (one hundred and forty-seven centimetres). This was below average height even in that period. "He" had a high voice and had no facial hair, at a time when facial hair was common in men. In death, James Barry

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<sup>86</sup> Mazo Sybil T. MaDlamini Buthelezi. *African Nurse Pioneers in KwaZulu-Natal- 1920- 2000*. (Canada: Trafford Publishing, 2006).

<sup>87</sup> Elizabeth Van Heyningen. "Agents of Empire: The Medical Profession in the Cape Colony, 1880-1910." *Medical History* 33, no. 4 (1989): 452.

<sup>88</sup> Harriet Deacon. "Midwives and Medical Men in the Cape Colony before 1860." *The Journal of African History* 39, no. 2 (1998): 278 and Harriet Deacon. "Cape Town and 'country' doctors in the Cape Colony during the first half of the Nineteenth Century." *Social history of medicine* 10, no. 1 (1997): 25-52.



proved to be as provocative as “he” was alive. The woman who laid out his corpse claimed that Barry was a “perfect female” and had stretch marks which meant that “she” had given birth at a very young age.<sup>89</sup>

Research shows that Barry was born Margaret Ann Bulkley in 1789 to a family that was well-connected. Impoverished by her father who mismanaged their family’s finances, her mother Mrs Bulkley and her uncle Mr James Barry, as well as some of their liberal friends decided to help create a male identity (disguise) for Margaret so that she could pursue her medical studies in Britain. This was uncommon for women in those days. Disguised as a man and using her uncle’s name (he had died shortly before she entered medical school), the new “James Barry”, completed her medical training at the University of Edinburgh Medical School in 1812. She then took the exam for the Royal College of Surgeons of England and qualified as a regimental surgeon in 1813. She became a hospital surgeon for the British Army and served in India and in Cape Town, South Africa, between 1815 and 1817. In 1840 she became a chief medical inspector for the Cape Colony where she performed the first Caesarean Section in Africa in which both mother and baby survived. She also achieved the rank of Inspector General of Military Hospitals in 1857, which was the highest medical rank obtainable in the British Army. In 1864, Barry retired and went back to England. During her time in the colonies, Barry mastered her disguise so well that nobody suspected that “he” was a woman.<sup>90</sup>

Women doctors, practicing as women in the region of southern Africa, were rare. Between 1880 and 1910, only ten women put their names on the Cape register to practice medicine in this British colony. One of these women was Jane Waterston. Born in 1843 and having grown up in a conservative, middle-class Scottish family, she struggled to gain access

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<sup>89</sup> Rachel Holmes. *The Secret Life of Dr James Barry: Victorian England's Most Eminent Surgeon*. (United Kingdom: Tempus Publishers Ltd, 2007).

<sup>90</sup> Michael Du Preez and Jeremy Dronfield. “Dr James Barry: The Woman Who Fooled the RCS and Deceived the World,” *The Bulletin of the Royal College of Surgeons of England* 98, no. 9 (2016).

to education and the medical profession. She came to South Africa in 1866 to work as a missionary under the guidance of Dr James Stewart who worked for the Free Church of Scotland in the Southern Cape. Many European women who came to this area in the late nineteenth or early twentieth centuries came as part of missions from Britain, Europe or the United States to escape the professional limitations in their country that resulted from the patriarchal systems that they were governed by.<sup>91</sup> Waterston became the first principal of the Lovedale Girls' School in the Cape in 1866, and held this position 1873 when she fought for the education of African girls in South Africa. Eventually she gained admission to the London School of Medicine for Women in Britain and completed her studies in 1874. After qualifying, Waterston returned to work in the Cape Colony. She worked mostly with the poor, and later went into private practice in Cape Town where she worked with mothers and helped train women as midwives. As scholar Jacklyn Cock argues, Waterston was “a feminist pioneer” and became a doctor at a time when the profession was still largely closed to women.<sup>92</sup>

Only in the early twentieth century, were two medical schools eventually opened in South Africa. These schools opened at the University of Cape Town (UCT) and the University of the Witwatersrand in Johannesburg (Wits) in 1910 and 1920 respectively. They were opened to start training medical students in the country for the first time.<sup>93</sup> Of course, race in general and whiteness in a racially-segregated context, determined women's access to the medical profession in South Africa. Indeed, white South African women were allowed to enter the medical profession with much less of a struggle than in other countries, specifically because of the official exclusion of black students (men and women) from educational medical

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<sup>91</sup> Michael Gelfand, *Christian Doctor and Nurse: The History of Medical Missions in South Africa* (Sandton: Mariannahill Mission Press, 1984): 312

<sup>92</sup> Jacklyn Cock. “What is Progressive Feminism? Questions Raised by the Life of Jane Waterston (1843-1932).” *Agenda*, 5, no. 5 (1989): 6.

<sup>93</sup> Bruce K. Murray. *Wits the Early Years: A History of the University of the Witwatersrand Johannesburg and its Precursors, 1896–1939* (Johannesburg: Witwatersrand University Press, 1982); Vanessa. Noble. *A School of Struggle: Durban's Medical School and the Education of Black Doctors in South Africa*. (Scottsville: University of KwaZulu-Natal Press, 2013) and Howard Phillips. *The University of Cape Town 1918-1948: The Formative Years*: (Cape Town: University of Cape Town Press, 1993).

institutions.<sup>94</sup> Women could get medical education in South Africa seventy some years after Elizabeth Blackwell first did. By this time, in a global setting, many battles had already been won by women interested in the medical profession to ensure their place in the profession.

This, however, did not mean that it was easy for women. While being white did help, white women gain access to the medical profession, gender obstacles were still problematic. For these early generations of medical women, but also extending to affect the experiences of women in later years, there was much “institutionalised sexism” that they had to face in medical schools. For example, lecturers and clinical teaching staff often said demeaning, offensive and sexualised comments and the hospital environment, headed by male doctors, could be very discriminatory. Women were often treated as interlopers and seen as doing a man’s job or taking a man’s role and encouraged to give up.<sup>95</sup>

For black South African men and women, racial discrimination was the primary factor that limited access to the medical profession. During the early twentieth century, many laws were passed to segregate South Africa’s different “race groups”. For example, the Natives Land Act of 1913 reserved most of the land in South Africa for whites and prevented Africans (who made up two-thirds of South Africans) from purchasing or owning land. Across the country, black South Africans were also required to live in “their own” residential areas to keep the races separate. In terms of the African population, the state’s policies aimed to keep most Africans in rural “reserve” areas rather than the cities, granting only those with jobs in urban areas with the necessary permits to live and work in these areas. However, between the wars (World War I and World War II), the so-called homelands (due to deteriorating conditions in

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<sup>94</sup> Elizabeth Walker. “The South African Society of Medical Women, 1951–1992: Its Origins, Nature and Impact on White Women Doctors”. (Unpublished PhD thesis, University of the Witwatersrand, Johannesburg, 1999): 13.

<sup>95</sup> Jean Walker. “*Skin Deep*”: *The Autobiography of a Woman Doctor*. (J.F. Midgley J.P., 1977); Pauline Klenerman. *Reminiscences of a Lady Doctor*. (Johannesburg: University of Witwatersrand, 1993); Liz Walker. “Conservative Pioneers: The Formation of the South African Society of Medical Women”. *The Society for the Social History of Medicine*. 14, no.3. (2001).

these reserves and the number of Africans migrating to the cities to find work illegally) increased dramatically. The number of Africans living in cities tripled over thirty years from 1904 to 1936. This growth resulted in intensified segregation. These Africans lived in terrible conditions in the cities. Housing was scarce, healthcare services were poor and transport sporadic and inferior. For many decades, most of these African households had no electricity.<sup>96</sup> Many scholars have seen apartheid simply as an intensification of segregation.<sup>97</sup>

During the early twentieth century, white medical schools were closed to black South Africans. The worries over the intellectual capacity of blacks to master a difficult subject like medicine, fear that their admission into the profession would cause the standards to drop, and that medical schools lacked clinical training facilities for black trainees are just a few of the reasons why Africans were excluded from entering medical school.<sup>98</sup> In addition, there were fears that academic socialising might lead to racial mixing at these schools, and there was the potential economic threat black doctors would pose to white doctors once in practice.

Furthermore, during this period, education opportunities for black families living in South Africa were limited. Although a few black children were able to attend missionary schools (the main form of education provided for black children during the nineteenth and early twentieth centuries) if their families were part of Christian communities living on mission stations or reserves, it was not an easy feat achieving a primary and secondary education.<sup>99</sup> Culturally and educationally, those at mission schools had to adapt to a Western-dominated view of the world, and were required to master a high level of formal Western education presented in a 'foreign' language (mostly English). Of course, because of patriarchal gender stereotypes in operation in both missionary and African societies at the time, it was mostly

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<sup>96</sup> Anthony John Christopher. "Apartheid and urban segregation levels in South Africa." *Urban Studies* 27, no. 3 (1990): 421-44

<sup>97</sup> William Beinart and Saul Dubow. *Segregation and Apartheid in Twentieth Century South Africa*. (London: Routledge, 1995).

<sup>98</sup> Noble, *A School of Struggle*: 152.

<sup>99</sup> Gelfand, *Christian Doctor and Nurse*: 147-8.

boys who received this education. The Christian view of girl children's capabilities resulted in girls being expected to focus on domestic responsibilities, child care and so on, as African societal views about African women's proper place and responsibilities were mainly maternal and in the home.<sup>100</sup>

Furthermore, until the 1940s, if black students were able to – despite the odds – matriculate with passes in the prerequisite science and mathematics subjects necessary to study medicine at the university level, tertiary facilities in South Africa either did not accept black students in their programmes, or those built to accommodate black students, such as the South African Native College of Fort Hare, which opened in 1916, did not offer students the option of a medical degree.<sup>101</sup>

Black South Africans experienced many economic hardships, regarding subordinate class status, during the segregationist and later apartheid era. This made it impossible for some families to even send their children to school, while those who did, often could not do so for more than a handful of years i.e. they could not afford to send their children to school for the many years it took a child to matriculate. This led to increasing high dropout rates as those who attended school as pupils left school earlier to start working sooner, often taking whatever jobs they could find, to help their families financially.<sup>102</sup>

During the apartheid period, the educational opportunities for African families were limited too. Many of my interviewees went to Bantu Education schools and experienced a poor quality, under-resourced and segregated type of education. The Bantu Education system came into effect from the mid-1950s after the government passed the Bantu Education Act in 1953. This piece of legislation gave the apartheid government control over the education of Africans, including most missionary schools (which they viewed as to “bookish” or academic in nature),

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<sup>100</sup> Gelfand, *Christian Doctor and Nurse*: 138.

<sup>101</sup> Noble, *A School of Struggle*: 22

<sup>102</sup> Peter Kallaway. *Apartheid and Education: The Education of Black South Africans*. (Johannesburg: Ravan Press, 1984): 89-92

and extended apartheid principles to black schools.<sup>103</sup> Dilapidated school buildings with no electricity, overcrowded classrooms, poorly trained teachers, and a lack of textbooks were just some characteristics of Bantu Education.<sup>104</sup> Bantu Education belittled black people's history, culture, and identity and further limited them when it came to entry into the medical field.<sup>105</sup> This had a large impact on Africans, especially African women who had attended these schools because not only did they offer poorer quality education that were segregated from white schools, but girls were seen as less capable of achieving academically in these schools compared to their male counterparts. The patriarchal element in the schools added even more pressure and discouragement to African females.

Black South African students who wanted to enter the medical profession had three options. Firstly, African men, but also women, were encouraged to train in subordinate categories of auxiliary healthcare services as assistants to white doctors in their practices.<sup>106</sup> Indeed, during the early twentieth century Christian missionaries were some of the first groups in Africa and South Africa to train black medical assistants for their hospitals and clinics as most medical services for the majority of the country's mostly African population were controlled by European doctors and nurses from various missionary bodies. Missionary doctors and nurses who set up early clinics and hospitals, viewed biomedicine and Christianity as a partnership to help heal and convert people but also to undermine what they viewed as "dangerous" and "primitive" "traditional healing" methods and beliefs that had existed in the country before they arrived.<sup>107</sup>

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<sup>103</sup>Kallaway. *Apartheid and Education: The Education of Black South Africans*, 89-92

<sup>104</sup> K. B. Hartshorne. *Crisis and Challenge: Black Education 1910-1990*. (Cape Town: New York: Oxford University Press, 1992).

<sup>105</sup> Kallaway. *Apartheid and Education: The Education of Black South Africans*: 96.

<sup>106</sup> Bruce K. Murray. *Wits the 'Open' Years: A History of the University of the Witwatersrand, Johannesburg, 1939-1959* (Johannesburg: Witwatersrand University Press, 1997): 172-174 and Shula Marks. *Divided Sisterhood: Race, Class and Gender in the South African Nursing Profession* (Johannesburg: Witwatersrand University Press, 1994).

<sup>107</sup> Anne Digby. *Diversity and Division in Medicine: Health Care in South Africa from the 1800s*. (Oxford: Peter Lang, 2006): Chapter 7

In the province of Natal, Dr. James McCord was one of the first medical missionaries to train and employ auxiliary African health care workers to help him with his African patients. In his autobiography, *My Patients were Zulus*, he explained how he recruited some of his African medical assistants from amongst his former patients.<sup>108</sup> Katie Makanya, an example of an early woman auxiliary health care worker trained by McCord, tells in her biography of her decision to work with this doctor. Her family had a long commitment to Christianity which dated back to the pioneer missionary era.<sup>109</sup>

The African auxiliary healthcare personnel in missionary clinics were able to help white doctors with the general African distrust of and skepticism towards the practices of western biomedicine. However, these medical assistants were always subordinate to the white doctors (and nurses) with whom they worked.<sup>110</sup> Early missionary medical assistants also provided health education to patients who were in the clinics' waiting areas and they also assisted with the language barriers acting as interpreters for the missionary doctors and nurses and their African patients. Digby and Sweet called such intermediaries "cultural brokers" as they assisted with the communication and mediation between these groups.<sup>111</sup> As cultural brokers, they were involved in settings where western (biomedicine) and African (indigenous) healing beliefs and methods often stood in conflict.<sup>112</sup> At first, western forms of religion and healing were resisted but as time passed and because of the work these cultural brokers did, many patients were won over to biomedical forms of healing.

During the late 1920s, the South African government adjusted policy with regards to providing better health care services and medical education for Africans. Up until then, the

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<sup>108</sup> James Bennett McCord and John Scott Douglas. *My patients were Zulus*. (New York: Rinehart, 1951).

<sup>109</sup> Margaret McCord. *The Calling of Katie Makanya*. (Johannesburg: David Philip, 1995).

<sup>110</sup> Vanessa Noble. "Health is Much Too Important a Subject to Be Left to Doctors': African Assistant Health Workers in Natal during the Early Twentieth Century". *Journal of Natal and Zulu History*, no. 24 & 25 (2006-2007).

<sup>111</sup> Anne Digby and Helen Sweet, "Nurses as Culture Brokers in Twentieth-Century South Africa", in *Plural Medicine, Tradition and Modernity, 1800–2000*, ed. Waltraud Ernst (London and New York: Routledge, 2001).

<sup>112</sup> Noble. "Health is Much Too Important a Subject to Be Left to Doctors": 102.

government left the provision of healthcare services to the rural black population to missionaries. By the 1920s, a central concern was the shortage of African medical personnel to serve the growing number of Africans in the rural and urban areas of South Africa. Another set of key issues centered around a concern for protecting the health of workers in the mining industry and other white commercial enterprises that employed cheap black labourers, and to try stop the spread of infectious diseases from black communities to white communities.

A government committee known as the Loram Committee met in 1928 to consider the following points: whether African doctors should be trained rather than more white doctors; whether to provide training of the same standard for black and white South Africans; or whether to provide an unequal medical qualification for Africans. Firstly, the Loram Committee argued that it was impossible to provide for the health care needs of the country's black population with white doctors only. Secondly, it felt that the encouragement of future black medical graduates to work in the government's segregated medical service was needed and that they should receive a lower salary than white doctors. Lastly, it saw the opening of medical training in South Africa as "a new avenue for the satisfaction of the natural aspirations of the Native to serve and elevate his people".<sup>113</sup>

Furthermore, the Committee suggested that if blacks were going to be trained in medicine at all, they would have to be trained at one of the existing medical schools, and that no new schools should be started. The recommendations to provide separate facilities for black students at these medical schools and the restrictions on African doctors to be employed by government matched the system of racial separation. However, these suggestions did not materialise at the time. Instead, the government decided in the 1930s to provide black students with a cheaper, shortened, professionally inferior "medical aide" training, provided by the University of Fort Hare to qualify them to practice as medical assistants working under the

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<sup>113</sup> Gish, *Alfred B. Xuma: African, American, South African*: 224.



supervision of white doctors in rural government service.<sup>114</sup>

Secondly, Shula Marks shows how black students, especially African women who wanted to enter the broader health care profession were encouraged to go into nursing.<sup>115</sup> Although an informal training of African women as nurses was pioneered by missionaries in the nineteenth century, the formal training of black nurses in South Africa only really started during the early 1900s, and was a slow process. This training helped encourage the image of women as nurturers and helpmates to male doctors, but also allowed African women a chance at independence and betterment through education.<sup>116</sup> However, as was the case with doctors' training, the effects of segregation was strongly felt in the nursing profession. In hospitals where white and black nurses worked together, black nurses were placed in subservient positions to white nurses and were required to take orders from them and (mostly male) doctors. Over time, and especially during the apartheid era, the replacement of white nurses in black hospitals by black nurses who treated "their own people" became the norm and black women were only permitted to train at, and work at, black hospitals. African women nurses were paid the lowest wages, often worked in poorly staffed and under-resourced healthcare facilities, and experienced much discrimination because of their race in apartheid South Africa.<sup>117</sup> As the number of black nurses increased, the apartheid state's control over the profession increased too. For example, in 1957 the Nursing Amendment Act rigidly legislated racial segregation into the nursing profession. This law required the South African Nursing Council to keep separate statistics and nursing registers for black and white nurses.

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<sup>114</sup> Karin A. Shapiro, "Doctors or Medical Aids: The Debate over the Training of Black Medical Personnel for the Rural Black Population in South Africa in the 1920s and 1930s", *Journal of Southern African Studies* 13, no. 2 (January 1987).

<sup>115</sup> Sheryl Nestel "(Ad)ministering Angels: Colonial Nursing and the Extension of Empire in Africa," *Journal of Medical Humanities* 19, no. 4 (1998): 257-277 and Marks, *Divided Sisterhood*: 264.

<sup>116</sup> Gelfand, *Christian Doctor and Nurse*: 148.

<sup>117</sup> Shula Marks. *Divided Sisterhood: Race*, Chapter 2 and T.G. Mashaba. *Rising to the Challenge of Change: A History of Black Nursing in South Africa*. (Cape Town: Juta & Company Limited, 1995).

Black women who entered the nursing profession have shown how they could not only manage careers, households and marriages, if they chose to get married or have children, but they could also be professionals who worked hard to make a difference in their lives and the lives of their black patients. By doing this, they became role models, whether purposefully or not, for many women who followed after them. Yet, analysis of their lives also highlights overlapping race and gender oppressions that led to increased difficulties for them.<sup>118</sup>

Thirdly, they could go abroad to study to become doctors.<sup>119</sup> Black South Africans saw the medical profession as an opportunity to improve black healthcare, but also as a good way to make a living with the hope of achieving a comfortable lifestyle. Indeed, unlike other tightly controlled occupations that Africans could enter in early twentieth century South Africa, private medical practice afforded the possibility of achieving some freedom and independence.<sup>120</sup>

However, there were only a few who were lucky enough to receive university scholarships or whose families could afford to send them to such institutions in other countries. The great distances and high expenses involved proved to have strong restrictions. A handful of students did manage to succeed in doing this, such as Alfred B. Xuma who qualified as a doctor at Northwestern University in Chicago during the 1920s and Dr. K. Goonam, a South African Indian woman who received her medical training in Edinburgh during the late 1920s and early 1930s.<sup>121</sup>

Dr Kesaveloo Goonaruthnum Naidoo (or Dr Goonam as she was known) was born in 1906 in Durban, where she grew up in the Grey Street area. As a young girl, she had

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<sup>118</sup> Helen Sweet and Anne Digby. *Race, Identity and the Nursing Profession in South Africa. New Directions in the History of Nursing: International Perspectives*. (London, UK: Routledge 2005): 119.

<sup>119</sup> Anne Digby. "Early black doctors in South Africa", *Journal of African History* 46, no. 3 (November 2005): 429 and Phillip V. Tobias, "Apartheid and medical education: The training of black doctors in South Africa", *The Leech* 60, no. 1 (March 1991): 96-97

<sup>120</sup> Anne Digby. "Early Black Doctors in South Africa." *The Journal of African History* 46, (2005): 427-454.

<sup>121</sup> Steven Gish. *Alfred B. Xuma: African, American, South African* (New York: New York University Press, 2000) and K. Goonam. *Coolie Doctor: An Autobiography*. (Durban: Madiba Publications, 1991).

ambitions to become a medical doctor, which was unheard of in the Indian community in which she grew up. After persuading her father to allow her to embark on such a training because of her commitment to this idea, and her excellent academic record, and because there were no medical schools open to Indian women in South Africa at the time, Goonam was forced to travel to Scotland in 1928 to study at Edinburgh University. After eight years living overseas, she qualified and became South Africa's first Indian female doctor to graduate overseas. She returned home in 1936 and started a practice in the Grey Street Complex in Durban.<sup>122</sup>

Dr Goonam's biography touches much on combined issues she experienced of both racism and sexism. The racial and sexist challenges faced by Indian women in their attempts to study medicine and work as medical doctors during the segregation era,<sup>123</sup> but also the apartheid era, are very similar to the challenges faced by African women, as we shall see a bit later in this thesis.

During the early 1940s, a national level debate affecting the ability of black students to study in South Africa changed. This debate favoured providing full biomedical training for African, Indian and Coloured students. This was enabled by the more politically liberal climate of World War II. After much debate, the pre-apartheid Jan Smuts government agreed to allow a small number – basically token numbers – of black students to study medicine at Wits and UCT.<sup>124</sup> Rarely did they make up more than five or six percent of the total medical student intake at these universities. Black students faced many difficulties at these institutions, such as not being allowed to live in an official university residences.<sup>125</sup> This led to higher expenses for black students as they had to travel far between these universities and the townships where they

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<sup>122</sup> K. Goonam. *Coolie Doctor: An Autobiography*. (Durban: Madiba Publications, 1991).

<sup>123</sup> D. Govinden. "Sister Outsiders" *The Representation of Identity and Difference in Selected Writings by South African Indian Women*. (Pretoria: University of South Africa Press, 2008): 146

<sup>124</sup> William Beinart. *Twentieth-Century South Africa*. (Oxford and New York: Oxford University Press, 1994).

<sup>125</sup> Noble, *A School of Struggle*: 39.

lived. Academically, black medical students were allowed to attend the same classes as white students though they were not allowed to stay when white patients were demonstrated upon, yet white students could examine black and white patients.<sup>126</sup> Furthermore, the hospitals where black students could train and work had inferior facilities and equipment and they were overcrowded and short-staffed.<sup>127</sup> Wits and UCT sought to make it appear that they provided equal academic training for black and white students yet black students experienced much discrimination at these institutions.<sup>128</sup>

The first black doctors graduated from these medical schools at the end of 1945. This training went on until 1959 when more restrictive apartheid era government legislation closed these universities to applicants from black students once again, unless they first obtained ministerial permission.<sup>129</sup>

Few black women trained in these medical schools in the 1940s. In addition to racial forms of discrimination, black women medical students had to deal with gender discrimination issues too.<sup>130</sup> There was a small number of black women medical graduates and the first two black women graduated as doctors from the UCT and the Wits in 1947. These women were: Mary Susan Malahlela (later Xakana) an African woman who graduated from Wits in 1947 of whom I found a photograph in the Alan Paton Centre and Struggle Archives, and Rawa Patel an Indian woman who graduated from UCT. Even though there were women that graduated as doctors at these universities between the late 1940s and late 1950s, Wits and UCT remained training facilities primarily for male medical students at this time. Amongst this small group of women doctors Indians greatly outnumbered Africans. The same gender discriminations

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<sup>126</sup> Murray, *Wits, the Early Years*: 174

<sup>127</sup> Noble, *A School of Struggle*: 42.

<sup>128</sup> Simone J. Horwitz, "A Phoenix Rising?: A Social History of Baragwanath Hospital, Soweto, South Africa, 1942–90" (DPhil diss., Oxford University, 2006): 242

<sup>129</sup> Bruce K. Murray, "Wits as an 'open' university 1939–59: Black admissions to the university of the Witwatersrand", *Journal of Southern African Studies* 16, no. 4 (December 1990): 206-207

<sup>130</sup> Shapiro "Doctors or Medical Aids".

experienced by white women medical students that were discussed earlier in this chapter were also experienced by black women.

The year 1951 saw the establishment of the South African Society of Medical Women (SASMW). SASMW was one of the first organizations which were created to advance and improve the positions and status of medical women by fighting professional discrimination and inequality.<sup>131</sup> This organisation's purpose was to "promote the interests of women doctors and to combat gender inequality in the medical profession."<sup>132</sup> The first temporary committee of the SASMW was formed in 1951 by a group of white women doctors who lived in Johannesburg. It was soon followed by another group in Cape Town. Members of both groups argued that the Society should, as a group, affiliate to the primarily white Medical Association of South Africa (MASA) as they believed that it would increase "legitimacy, credibility and recognition" to their aims. It also meant, however, that the SASMW was subject to MASA policies and procedures. In the 1950s and early 1960s the SASMW had two campaigns, which were successful. One was to increase the age of retirement of medical women, working in the public sector; from fifty-five to sixty years, like their male colleagues. The other measure was to remove the marriage bar. The marriage bar made it mandatory for women working in the public service to resign once married. They also fought for other issues, such as equal salaries and benefits for equal work done by male and female doctors.

Even though the SASMW was successful over time in improving women doctors' positions in the profession, those who benefitted most were the white women doctors whom it represented, not black women doctors.<sup>133</sup> Indeed, the members of the Society were middle and upper class women and in terms of its racial composition, the white medical profession was

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<sup>131</sup> Elizabeth Walker, "The South African Society of Medical Women, 1951–1992: Its Origins, Nature and Impact on White Women Doctors" (unpublished Ph.D. thesis, University of the Witwatersrand, 1999): 7–9 and 26–33.

<sup>132</sup> Walker, "The South African Society of Medical Women": 99

<sup>133</sup> Belinda. Bozzoli, "Marxism, Feminism and South African Studies", *Journal of Southern African Studies*, 9, no. 2 (1983): 140–2.

more generally reflected. This organisation was viewed by black female doctors to be essentially “white” and “elitist” and did not meet the needs of black medical women. It would take many more decades for black women in South Africa to be placed on an equal footing with white male and female doctors.

In the same year that the SASMW was established, the Durban Medical School was opened as a separate faculty controlled by the historically white University of Natal. One of the reasons for this was that the newly elected apartheid government funded this institution as part of its “separate development” programme. This medical school was established not for whites, but for the training of African, Indian and Coloured medical students specifically.<sup>134</sup> Furthermore, from the late 1950s to the 1970s, Wits and UCT were forced by the apartheid state to close their doors to black students, as the state no longer wanted black and white students mixing in medical schools. Thus, until the black Medical University of South Africa (MEDUNSA) was opened in 1976, the Durban Medical School was the only institution available to train black doctors. Comparatively, during the 1950s and 1960s, white students had a free choice of applying and being admitted to five medical schools in three provinces.

At this separate, but purportedly, equal Durban Medical School, black male and female students suffered countless hardships and shameful racial discrimination in their clinical training and residential arrangements, which I will discuss by drawing on the opinions and experiences of my interviewees, in the next chapter.<sup>135</sup> However, as we shall see, racial inequalities were not the only concerns. Gender inequalities were key too. For example, between 1957 and 1994, the Natal Medical Faculty had less than one in four women (which was only twenty-three per cent) in its graduate classes.<sup>136</sup> Anne Digby also provides similar statistics. In her article “Black Doctors and Discrimination under South Africa’s Apartheid

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<sup>134</sup> Noble, *A School of Struggle*, Chapter 2.

<sup>135</sup> Noble, *A School of Struggle*, 13

<sup>136</sup> Vanessa Noble. “Doctors Divided: Gender, Race and Class Anomalies in the Production of Black Medical Doctors in Apartheid South Africa, 1948 to 1994” (PhD dissertation, University of Michigan, 2005)

Regime”, she argues that: “between 1947 – when the first black medical woman graduated – and 1981, fifty-three such women had graduated at Natal and fifteen at Wits. (This total was higher than in the competing profession of law where only thirty-three females had qualified nationwide by 1982)”.<sup>137</sup> As we shall see in the next chapter, black women medical students experienced intersecting forms of oppression during the apartheid period, which affected the numbers who trained in medicine and their experiences of medical school.

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<sup>137</sup>Anne Digby. “Black doctors and Discrimination under South Africa’s Apartheid Regime.” *Medical History* 57, no.2 (2013): 284

## **Chapter Three: Early Lives and Medical Training during the Apartheid Period**

An individual's life is influenced by their past. Childhood, upbringing, societal setting and schooling are some of the things that inform the choices we make and the paths that we choose to take. This chapter discusses the early lives of my interviewees, how they grew up and their motivation for studying medicine. It will also consider the medical training experiences of these African women doctors who completed their education during the apartheid period. This chapter will start with a brief discussion of some biographical details of each of the African women I will focus on in this chapter. The details of these women's lives will be discussed in order of age, from the eldest to the youngest. Following on from the biographical detail, which considers each woman individually, I then draw comparisons between these women, while referencing interviews with additional African women conducted by other researchers and relevant secondary sources in an attempt to highlight their shared experiences, but also their differences.

### **Biographical Details**

#### **Dr Mputsang May Mashego Mkhize**

Dr Mputsang May Mashego Mkhize was born in 1956 in a small farming town called White River which is situated today in the province of Mpumalanga just north of the city of Nelspruit in South Africa. When she grew up, White River was a rural area with no electricity. Her mother was a housewife and her father worked as a bricklayer though he had also worked as a cook in a hotel. Dr Mkhize received her primary schooling at Embonisweni Primary School and completed her high school education at Ekhumbula Secondary School, both of which were



public schools. Dr Mkhize started medical school in 1976 at the University of Natal Medical School and graduated in 1982.<sup>138</sup>

#### Dr Nokukhanya Magubane

Dr Nokukhanya Magubane was born in 1967 in a small rural village called Nkandla, in what is today northern KwaZulu-Natal. During the late 1960s it formed a part of the KwaZulu Bantustan. Her mother went to school up to Standard One (Grade Three) and her father reached Standard Six (Grade Eight). Her father was one of the few people in their village who had a car and her mother sold tobacco to help support her family. Dr Magubane is the fourth child of eight. She did her primary schooling, up to Standard Seven (Grade Nine) in Nkandla. Her family then moved to Umlazi Township, an urban residential area created for Africans in Durban where she attended Makhumubuza Secondary School and eventually matriculated at Vukuzakhe High School.<sup>139</sup> Dr Magubane began her medical training at the Medical University of Southern Africa (MEDUNSA) in 1986 and graduated from this institution in 1991.

#### Dr Vela Ntuli

Dr Vela Ntuli was born in 1978 in Umtata in the Eastern Cape. At the time, Umtata was the capital of the Transkei Bantustan. The Transkei was another area created by the apartheid government as a separate homeland for Xhosa-speaking Africans. De Ntuli's primary schooling was completed at Roman Catholic schools in Umtata after which she attended Umtata High School. The primary breadwinner in Dr Ntuli's family, her mother, worked as a nurse. Dr Ntuli began her medical training in 1995, only a year after South Africa became a democratic country, at the University of Transkei (UNITRA), which is now the Walter Sisulu University. She graduated from this institution in 2000.<sup>140</sup>

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<sup>138</sup> Interview with Dr Mputsang May Mashego Mkhize Recording 1, August 24, 2016

<sup>139</sup> Interview with Dr Nokukhanya Magubane, Recording 6, October 1, 2016.

<sup>140</sup> Interview with Dr Vela Ntuli (Pseudonym). Recording 2, September 6, 2016.

### Dr Ayanda Penelope Khumalo

Dr Ayanda Penelope Khumalo was born in 1980 at McCord Hospital in Durban on the east coast of South Africa. She grew up in Umlazi Township. Her father was a police officer and her mother, a house wife. She did her primary schooling until Standard Five (Grade Seven) in Umlazi in J Section (which is one of the areas Umlazi is divided into), and from Standard Six (Grade Eight) up until Matric (Grade Twelve) she attended Durban Girls High School (DGHS) in Glenwood for her secondary schooling. Dr Khumalo began her medical training in 1998 at the University of Natal in Durban and graduated in 2003.<sup>141</sup>

### Dr Sthembile Ngidi

Dr Sthembile Ngidi was born in 1984 at Port Shepstone Hospital, in Port Shepstone, a coastal town, some 120 kilometres south of Durban along the KwaZulu-Natal coast. She grew up in Gamalakhe, an African township situated in the Port Shepstone area. During the apartheid era, her father worked as a social worker for the KwaZulu government and her mother was a primary healthcare nurse in the township. In the early 1990s, when Dr Ngidi first started school, she attended Port Shepstone Indian Primary School followed by Port Shepstone Junior Primary School (where there were only three black children in the whole school), and then Port Shepstone Senior Primary School. For her secondary education, she attended Port Shepstone High School. Dr Ngidi began her medical training at the University of Natal in Durban in 2002 and graduated in 2006.<sup>142</sup>

### Dr Mosele Kheswa

Dr Mosele Kheswa, was born in the early 1980s in South Africa. She is an African woman and currently resides in South Africa. She did her medical training at the University of

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<sup>141</sup> Interview with Dr Ayanda Penelope Khumalo Recording 3a, September 14, 2016.

<sup>142</sup> Interview with Dr Sthembile Ngidi, Recording 4, September 14, 2016.

Natal Medical School. She was not prepared to talk about her family background in the research and preferred to focus only on her later working experiences as a doctor. As such, her experiences in medical practice will be discussed in the latter chapters of this thesis.<sup>143</sup>

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### **Early Lives during Apartheid**

All my interviewees were born and raised in apartheid era South Africa. Apartheid was a political system of racial discrimination in South Africa, which began in 1948 when the Afrikaner Nationalist Party government came to power. This system remained in effect until 1994. The apartheid regime was built using earlier laws, which were based on institutionalised racism and segregation but it made racial segregation more entrenched with the passing of a barrage of additional laws. Most of the interviewees grew up in areas that were designated for non-white South Africans. Some grew up in urban township areas created for Africans within or just outside the municipal boundaries of major cities, while others grew up in rural Bantustans or homeland areas which were created by the apartheid government.

From the 1950s, but particularly during the 1960s and 1970s, most of South Africa's African population were moved to these rural areas in order to prevent the so called "Bantu" people from residing in South Africa's urban areas, as this was where whites lived. The aim of this separate development policy was to separate blacks from whites in all aspects of their lives, including where people lived, and allowed Africans to run their own independent governments in these separate homeland areas. This policy aimed to deny Africans citizen rights and protections in South Africa. Thus, Bantustans were established for the permanent removal of the black population from white South Africa.<sup>144</sup> Over time, the homelands and townships

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<sup>143</sup> Interview with Dr Mosele Kheswa (Pseudonym). Recording 5, October 1, 2016

<sup>144</sup> Jeffrey Robert Butler and John Adams. *The Blacks Homelands of South Africa: The Political and Economic Development of Bophuthatswana and KwaZulu*. (Berkeley: University of California Press, 1978).

became overcrowded and poverty stricken areas due to the high number of people living in these areas that were unemployed. During apartheid, the living standards were very poor for Africans. Residentially, segregation caused extra hardship for Africans. Poor transport, long distances that had to be travelled to and from work, a lack of electricity and harassment around carrying passes (South Africans were made to carry pass books – similar to passports – in order for the government to control where African movements and settlement); were just a few of the difficulties Africans faced.

Growing up under the apartheid system was influential for all of my interviewees. Most of the women grew up in areas which were part of the segregated system of apartheid and had come from communities where poverty was rife. Some of them were aware of the different policies that the apartheid system applied for black and white South Africans, but some thought it was the norm as it was simply the only way of life they knew.

Dr Ntuli told me that she was “obliviously unaware”<sup>145</sup> of the laws of apartheid in the 1980s whilst growing up, but now when she looks back she realises that they influenced her way of life in numerous ways. This is evident in the fact that her mother was only able to receive an education when Dr Ntuli was in high school as she had to do paid work from a young age to help her family survive poverty. Dr Ntuli grew up living in a small home with tight living conditions:

“I grew up in an environment where everyone was the same. ... You didn’t feel any different from the people around you. We spent a lot of time living in a one bedroom house in Elangilizwe, but you didn’t see anything wrong with it because I think your parents made it feel like it was normal.”<sup>146</sup>

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<sup>145</sup> Interview with Dr Vela Ntuli. Recording 2, September 6, 2016.

<sup>146</sup> Interview with Dr Vela Ntuli. Recording 2, September 6, 2016.

As a child who grew up in a township along the south coast, Dr Ngidi also remembered hurtful race-related incidents that she and her family endured when they ventured into largely white urban areas:

“I’m from the south coast which was extremely racial. We would only go to town to maybe do shopping here and there. And Margate particularly, we used to avoid going to this town during the November/December holidays because that’s when all the Afrikaner people would come down from the Free State for holiday. They would throw eggs at us and you know, horrible things.”<sup>147</sup>

Dr Khumalo also recalled how the apartheid laws affected her family growing up. Since her father worked as a policeman in the township of Umlazi during the 1980s, her family was often targeted by local people who believed that her father was a collaborator working for the apartheid government against his own people:

“What I remember in 1986 when I was six years old, when my father was with the police, at that time if you were a policeman people said you were a spy for the white government. They hated you and so we were exposed to riots quite a lot. They used to attack and we had to move around from house to house.”<sup>148</sup>

Women growing up under these conditions during apartheid did not receive attention when it came to their primary and secondary education. Many were not encouraged to go to school and limited family resources that were available were instead spent on sons, whom families hoped would in turn later provide for them. African women also grew up in communities where patriarchal ideas were strong. Women had inferior roles to men and were seen as the helpers of men. This also continued into the decisions of whether women could get work outside of the home, what kind of work they could choose to do and their schooling.<sup>149</sup>

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<sup>147</sup> Interview with Dr Sthembile Ngidi. Recording 4, September 14, 2016.

<sup>148</sup> Interview with Dr Ayanda Penelope Khumalo, Recording 3a, September 14, 2016.

<sup>149</sup> Belinda Bozzoli. "Marxism, Feminism and South African Studies." *Journal of Southern African Studies* 9, no. 2 (April 1983): 141

The problematic nature of her Bantu Education training was captured by Dr Mkhize who remembered an important limitation at her high school that later affected her training at medical school:

“If you were an African child in high school you would be there but there were no laboratories where you would do experiments. Instead, when you were taught chemistry, if you were lucky, the teacher would perform the experiments for you because there was so little in the way of equipment for us to do it ourselves”.<sup>150</sup>

The racial inequalities brought about by the apartheid government and the financial difficulties of some of the families of black women doctors made their primary and secondary schooling a difficult journey. This racist educational system bolstered South Africa's unequal social hierarchy, by creating a system where educational inequalities in turn led to economic inequalities because of restricted job opportunities available, mostly in unskilled or semi-skilled jobs, for black South Africans.

And, if black children showed academic promise in their schooling, despite the odds, they were still limited in terms of their choices. Dr Mkhize told me in her interview that they had to think about serving “their own people”, while young black girls tended to be pushed into less ambitious and “more feminine” career choices, such as teaching or nursing:

“Just look at Bantu education, I think they were just helping us to go to school and learn so we could communicate with them [whites]. Yes, if you had done well in your biology you could go and become a nurse and I also believe that they were training us really, more to allow us to go for that profession (nursing) because we will look after our own. Who was going to be nursing African people? You were not going to be nursing a white patient. I think we were closed within that space. ... The scope wasn't big, your choice was limited to that”.<sup>151</sup>

It is important to note that some African women doctors came from less impoverished family backgrounds, with parents who had higher paying, and sometimes professional jobs.<sup>152</sup> As a result, these parents could send their children to better schools. A good example of this is

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<sup>150</sup> Interview with Dr Mputsang May Mashego Mkhize. Recording 1, August 24, 2016.

<sup>151</sup> Interview with Dr Mputsang May Mashego Mkhize, Recording 1, August 24, 2016.

<sup>152</sup> Vanessa. Noble. *A School of Struggle: Durban's Medical School and the Education of Black Doctors in South Africa*. (Scottsville: University of KwaZulu-Natal Press, 2013): 104.

the case of Dr Albertina Luthuli, who was born in the late 1930s and studied to become a doctor at the Durban Medical School in the early 1950s. Her father was a teacher at Adam's College and her mother was a teacher at Inanda Seminary, in Newton in Inanda. She was born into a Christian family on the Groutville Mission Station up the north coast of Natal. She was the second child in a family of seven. Even though the area they lived in was rural, education was regarded as very important in this Christian African family since both her parents were teachers. She was educated at a Roman Catholic-run high school in Mariannhill with a high-quality education that earned her a place at medical school.<sup>153</sup>

### **Motivations to Study Medicine**

This section will analyse a variety of motivations that encouraged African women to study medicine, especially at times when African women were not encouraged to enter such a profession.

In her interview, Dr Mkhize told me that an important motivation for her to study medicine was that, from a young age, she enjoyed looking after people who were unwell, which included family members, such as her siblings, but also friends and neighbours. Dr Mkhize also remembered being encouraged by some of her teachers to go into medicine, especially her principal, Mr. E.J. Mabuza, who saw that she had good marks in subjects that were needed to study medicine. He had assisted another student who had wanted to become a doctor. Because of the poor quality science education offered at her local White River high school, she then had to complete a bridging course in science at Dlangezwa High School in Empangeni in KwaZulu-Natal to prepare her to study medicine after she completed high school.<sup>154</sup>

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<sup>153</sup> Interview with Albertina Luthuli, 10 January 1993, conducted by Pdraig O'Malley, <https://www.nelsonmandela.org/omalley/index.php/site/q/031v00017/041v00344/051v00730/061v00737.htm>

<sup>154</sup> Interview with Dr Mputsang May Mashego Mkhize, Recording 1, August 24, 2016.

In Dr Magubane's case, she recalled being influenced by two people. One person she remembered very clearly was a white foreign-born female doctor who helped her, her family, and her neighbours in a local hospital in the area she grew up in:

“At Nkandla where I grew up, there was a white female doctor in our local hospital. I had never seen a black female doctor so I just thought it was a thing for whites. So, even though I liked her a lot, I had never imagined myself being a doctor. I thought that if you are white and you are not from South Africa then you can be a doctor.”<sup>155</sup>

Another person who influenced Dr Magubane was her eldest brother, who practiced as a doctor in South Africa when she was thinking about possible career options in her Matric year. Her brother's motivation was unlike that of most men in isiZulu-speaking communities in the 1980s who would rather have encouraged women to focus on family duties or encouraged them to work in feminine jobs such as domestic work. Instead, he encouraged his younger sister, who did well at school, to aspire to achieve a professional career in medicine. In fact, she remembers that he actually filled in her application and sent it to MEDUNSA for her. This shows how some African men believed in equal opportunities for men and women at a time when gender remained a defining factor in women's career choices.

Dr Ntuli grew up in Umtata, which like many of the rural areas that Africans were forcibly removed to, did not have much in the way of career choices, especially for young black women. The limited career choices for academically astute young women was usually nursing or teaching during the apartheid era. She told me that she was inspired to study medicine because she wanted to do something outside these limited career choices, and to help people because there were so few doctors working in the Transkei when she grew up.<sup>156</sup>

Dr Ngidi's motivation to study medicine was linked to being a sickly child who suffered from severe asthma. She remembers how her mother used to take her regularly to the local

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<sup>155</sup> Interview with Dr Nokukhanya Magubane Recording 6, October 1, 2016

<sup>156</sup> Interview with Dr Vela Ntuli. Recording 2. September 6, 2016.



clinic and sometimes to Port Shepstone Provincial Hospital when her asthma became severe. Thus, from a young age, she found herself in a medical environment where she spent much time waiting to be seen by doctors, as well as watching doctors in action during their ward rounds, which influenced her decision to become a doctor.<sup>157</sup>

### **Choice of Medical Schools and Paying for Medical Training**

Black students were also influenced by what medical schools were available to them. For the older generations of women doctors, as students, they had limited options in terms of medical schools they could attend in apartheid South Africa as racial segregation influenced their higher education choices too.

From the late 1950s until the late 1970s when Wits and UCT medical schools effectively closed their doors to black students (especially African students) without ministerial permission, black students interested in studying medicine had limited choices. Indeed, until the late 1970s when another segregated, state-funded, medical training facility – the Medical University of South Africa (MEDUNSA) – opened its doors to train black students in Garankuwa, north of Pretoria, and the University of the Transkei (UNITRA) in Umtata opened a medical school for African students in 1985, the University of Natal’s “non-European” medical school in Durban was really the only school available to train black, including African medical students. Four of my six interviewees attended the University of Natal’s Medical School, though Drs Magubane and Ntuli attended MEDUNSA and UNITRA respectively, at a later point in time when these institutions were available as choices to black students.

Looking at the apartheid years, payment options for medical school varied for black students. Some, though very few, had parents who could pay for their children to go to medical school. Although some black students had parents who had professional qualifications and

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<sup>157</sup> Interview with Dr Sthembile Ngidi, Recording 4, September 14, 2016.

jobs, as black South Africans they earned much lower salaries than their white counterparts and thus most could not afford to pay for medical school which entailed a long six or seven years of training depending on where their children studied.<sup>158</sup>

Some students who achieved excellent marks in high school did manage to secure scholarships from businesses and other private organisations. For example, Dr Mkhize applied and received an Anglo-American bursary to assist her as she and her family did not have the financial means to pay for her studies.<sup>159</sup> This bursary covered most of her tuition and accommodation costs, though she still had to rely on her parents for money to assist her with transport and other sundry expenses.

Most African students who attended medical school relied on the assistance of the government's bursary-loan scheme as their families could not afford to pay the fees. These bursary-loans were given by the various homeland governments on a competitive basis annually to African students from their areas who did well at school and wanted to study medicine.<sup>160</sup> The scheme aimed to train more African doctors to work in their own apartheid "separate development" communities so that the desperate shortage amongst Africans in the country could be dealt with. Hence, when the Durban Medical School opened in 1951, the state made fifteen bursary loans available every year for selected African candidates in each of the seven years of study to cover their academic and residence fees.

However, the conditions were strict as students had to ensure that they passed each year, and agreed to either pay back this funding once they started working, or agreed to work for that homeland government in the public service sector for several years after graduating. This point was made by Dr Mkhize in her interview. According to Dr Mkhize, as a black student in

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<sup>158</sup> Noble. *A School of Struggle*: 114.

<sup>159</sup> Interview with Dr Mputsang May Mashego Mkhize, Recording 1, August 24, 2016.

<sup>160</sup> Noble. *A School of Struggle*: 64.

apartheid South Africa, she knew that once she graduated, as well as those of her colleagues who received government bursary-loans, she would not have freedom to choose to work where white doctors could work. Indeed, she could not:

“work anywhere my services were required as I knew very well that I was only going to be limited to working within the black community and I would have to start from where I came from. It wasn’t like I could go to Joburg and work in a white community where a doctor was wanted because we were very restricted...I knew that.”<sup>161</sup>

Despite the strict conditions, many black students applied for these bursary-loans as they could not afford to pay for themselves. This point was made by Dr Luthuli. She argued that this was an essential way that black students like herself could pay for their studies, though it was highly competitive because of limited bursaries and limited space at training institutions such as the Durban Medical School in the early 1950s:

“... black students couldn't afford to pay for medical school for themselves so the arrangement was made with the government to provide scholarships. You had to win a government scholarship to enter medical school and the number was limited, they could only finance so many and at any rate the facilities were limited at the beginning [the school could take about 35 students.]”<sup>162</sup>

She also made it clear in her interview that it was even harder for black women because out of the 35 per annum who received bursary-loans in the first two years of her studies in Durban, “very few women”, such as only “three women out of 35” received this funding, though the number of women funded did slowly increase as time went on.<sup>163</sup>

### **Experiences at Medical School**

This section focuses on some of the experiences the interviewees, who studied during apartheid, had at medical school and how these experiences impacted on their time at medical school. While the journey to medical school was a difficult one, many more hurdles lay ahead once they gained admission to medical school.

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<sup>161</sup> Interview with Dr Mputsang May Mashego Mkhize, Recording 1, August 24, 2016

<sup>162</sup> Interview with Albertina Luthuli, 10 January 1993, conducted by Pdraig O’Malley.

<sup>163</sup> Interview with Albertina Luthuli, 10 January 1993, conducted by Pdraig O’Malley.

Between the 1950s and late 1970s when most black students went to the University of Natal, many had to travel great distances, coming from across the country, to reach their Durban destination. A good example of such a student was Dr Mkhize, who travelled over seven hundred kilometres from her rural home of White River to study in Durban.

Before arriving at medical school, Dr Mkhize had imagined the facility to be a beautiful place with attractive buildings, but when she arrived she encountered something different:

“In my mind, I had this situation that I saw that I’m going to university to train as a doctor and in my head, I could see the place that I was going to train in. I could even see the place which I’ll be living in. I saw a high-rise building. I come from a rural area, so I imagined a beautiful place. I imagined a different place from where I came from. There was no electricity where I came from so I thought there would be electricity, and beautiful buildings. I imagined almost like a town situation...so I’m on my way to medical school, I know I’m going to the University of Natal, they used to call it the University of Natal Black Section, to do medicine but I will be living in Alan Taylor Residence.”<sup>164</sup>

However, when she arrived in Durban and found the bus she had to take to reach the residence, she found herself on a journey to a “Coloured location” called Wentworth, near a large oil refinery, just south of Durban’s central business district. She told me:

“When I arrived, it was becoming dusk and so I thought that I must be going where the lights are because there was also an area that was completely dark. When the bus stopped, they dropped us off and instead of going towards where there was light, we got dropped off where it was dark and that was where we would be staying. Where we were staying, it used to be ex-police barracks. You couldn’t believe it was a university...but when you had gone inside, life was not as bad...the students were very welcoming and we were told that it was only black students there.”<sup>165</sup>

Alan Taylor Residence was named after Alan B. Taylor, a medical superintendent at McCord Hospital. He had pushed hard during the 1940s to open a medical school in Durban, and became the school’s first acting dean. To accommodate its black students on a segregated basis, the University of Natal had taken out a long-term lease on a World War II-era military barracks in the suburb of Wentworth. This residence was about ten kilometres away from the

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<sup>164</sup> Interview with Dr Mputsang May Mashego Mkhize, Recording 1, August 24, 2016.

<sup>165</sup> Interview with Dr Mputsang May Mashego Mkhize, Recording 1, August 24, 2016

University's Umbilo Road medical school campus and about fifteen kilometres from central Durban.<sup>166</sup>

African students faced many hardships when they came to study at this medical school. As Africans, they were worried about violating apartheid curfew laws, which restricted the movement of Africans on Durban streets after 9:00pm, which could and did result in student arrests. African students also had to carry passes to explain why they were in the Durban area if stopped by the police. Police harassment and arrest was a constant fear that these students faced.<sup>167</sup>

At medical school, black students also remember experiencing racial discrimination in their classes. Many students experienced some lecturers using racist overtones in their verbal comments and some were even called hurtful and insulting names by their lecturers. Dr Mkhize also told me about some of the divisions and tensions that emerged between some Indian and African students because of their unequal school education. In a situation where Indian and Coloured students had come to the medical school from high schools with better resources than African schools, which was a consequence of their higher placement along the apartheid state's racial hierarchy, unfair comparisons could easily occur:

“Because we had been separated under apartheid, there were those who were better off than others. The African people were worse off. The Indian people had been given better study materials. At school, we would stand around and watch the teacher show us an experiment. When we arrived at Alan Taylor residence in our first year...there was a laboratory and everyone was given a space to work from but you've never really done these experiments yourself, and so we would always break some of the equipment...it was your first time using a pipette. You could have been number one at your school but here you arrive and life is not easy. But Indians, some of them had come from schools where they had experience with such equipment.”<sup>168</sup>

Students were taught in English at this medical school which made it very difficult to pass for African students who did not speak English as their mother tongue. Over the years,

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<sup>166</sup> Noble, *A School of Struggle*: 134 and 135.

<sup>167</sup> Noble, *A School of Struggle*: 9 and 27.

<sup>168</sup> Interview with Dr Mputsang May Mashego Mkhize, Recording 1, August 24, 2016.

many African graduates also felt purposely left out by some Indian students when they were required to do group work, and felt discriminated against by certain Indian lecturers whom they felt favoured Indian students.<sup>169</sup> They felt that the advantages Indian students enjoyed benefitted them with a higher pass rate at the school. Dr Mkhize recalls that African lecturers in senior positions were a rarity at the medical school during the 1970s, so there were few African role models for African students to learn from.

As mentioned in previous chapters, students were expected to treat “their own kind” during medical training, and black students were thus required to do their clinical training on black patients in black hospitals.<sup>170</sup> Since black hospitals under apartheid were often the most under-resourced facilities, black students, such as those who rotated through Durban’s “non-European” King Edward VIII teaching hospital, were forced to train in overcrowded and inferior conditions. Students and doctors also experienced personal racism during the apartheid years while based at King Edward VIII Hospital. One issue discussed repeatedly by graduates was when white nurses refused to take orders from black interns and doctors.<sup>171</sup>

Gender inequalities and discrimination were also experienced by students at medical school. Out of 690 students admitted between 1951 and 1969 at the University of Natal, only eighteen per cent were women. They were outnumbered by their male colleagues and there were very few women on the school’s academic staff. Women had to endure much discrimination such as sexist jokes by some lecturers and remarks made by some students, especially what they regarded as women students’ inferior intellectual abilities and primary responsibilities in the home.<sup>172</sup>

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<sup>169</sup> Noble, *A School of Struggle*: 152.

<sup>170</sup> Interview with Albertina Luthuli, 10 January 1993, conducted by Pdraig O’Malley. Also, see Cape Town Archives Repository. KAB H19/207. Admission to Hospitals of Non-European Medical Students for Clinical Study. 30 August 1932.

<sup>171</sup> Noble, *A School of Struggle*: 176.

<sup>172</sup> Noble, *A School of Struggle*, p152

Race and gender were overlapping issues in the lives of female African doctors in training. Dr Mkhize captures this by highlighting her experiences while training at King Edward VIII Hospital in the early 1980s:

“Even if you’re wearing a white coat, there is more belief that a man was better because I think people never thought a woman would ever be a doctor. In terms of race it was one thing for sure, we had African patients only and Indian patients but we asked for permission to deal with them. If you are a female, people don’t believe that you could do much, they would even call you a nurse. They saw a nurse when they saw you. And, if you needed to learn about a disease which was more common in white people you were taken to Addington Hospital by your lecturers, where there were white patients. But, we weren’t allowed to touch them if they didn’t want us to. For me, being allowed to look after black patients only was enough to say there was a racial issue. In terms of gender I did not feel that much discrimination, at that time, but people believed more in this doctor who was a black man rather than a black woman. Once I started working though, that’s when I really felt the gender discrimination.”<sup>173</sup>

Mamphela Ramphele, a doctor who graduated from the University of Natal Medical School in the 1970s, described how she and other women “learnt to be tough, insistent, and persistent” to survive and thrive at medical school.<sup>174</sup> Many female medical students would have felt a double pressure from their gender and race, and one UCT woman graduate, speaking of her experiences in the 1980s, when black students were allowed to study at UCT again without ministerial permission, commented: “I had not just to be good, I had to be better than good – I wanted to show them that I was equal or better”.<sup>175</sup>

Similar to the situation at the Durban Medical School, students at MEDUNSA experienced race and gender discriminations while in training. Dr Magubane began her medical training at MEDUNSA in 1986. At that time MEDUNSA had mostly African students with some Indians too. She explains how one of the major obstacles she faced was in her academics as most of her lecturers were white. Similar to racist insults that occurred at Natal’s Medical School, Magubane remembered certain lecturers calling African students “black monkeys”,

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<sup>173</sup> Interview with Dr Mputsang May Mashego Mkhize, Recording 1, August 24, 2016.

<sup>174</sup> Mamphela Ramphele, “The dynamics of gender within black consciousness organisations: a personal view”, in N.B. Pityana edited by, *Bounds of Possibility: The Legacy of Steve Biko and Black Consciousness* (Cape Town: David Philip, 1991): 219–20.

<sup>175</sup> Anne Digby. “Black Doctors and Discrimination under South Africa’s Apartheid Regime”. *Medical History Journal* 57, no.2. (2013): 283

which was hurtful and sometimes led students to rise in protest in efforts to have such lecturers driven out.<sup>176</sup>

Furthermore, she told me that although the courses were taught in English at MEDUNSA, many of the lecturers came from Afrikaans-speaking backgrounds. At the same time, most African students had come from schools where they were taught in their vernacular languages, or with just a few years of English, and now had to transition into an environment where they were forced to understand their work in another language. According to Magubane, there were poorly developed relationships with the lecturers as most of them would insult them and would get annoyed at the fact that the students did not understand the language they taught them in:

“Obviously, the teachers were white and we faced our first obstacle academically. You had been studying in a little bit of broken English, being taught by teachers who were not first language English speakers. Suddenly you go to university and for the first month you don’t hear what the lecturers are saying because they are pronouncing English in a way that you don’t understand. They would finish a book maybe in a week and you have absolutely no clue what the lecturer was saying. So, adjusting to the language was difficult.”<sup>177</sup>

Similar to the situation at the Durban Medical School, those who did their clinical training at MEDUNSA also trained on black patients at Garankuwa teaching hospital. Indeed, Dr Magubane asserted that there were no white patients as they were not allowed to touch white patients.

In her interview; Dr Magubane also informed me that there were very few females at MEDUNSA when she studied there, especially African females. Like Dr Mkhize, Dr Magubane states that she never had any African female mentors but there were senior students who they saw at medical school. They encouraged the younger women students to keep going as their seniors had. The African students usually interacted with each other and encouraged

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<sup>176</sup> Interview with Dr Nokukhanya Magubane, Recording 6, October 1, 2016.

<sup>177</sup> Interview with Dr Nokukhanya Magubane, Recording 6, October 1, 2016.



each other to work hard at their studies as there was nobody else to encourage them. There were also no African female lecturers during her time at MEDUNSA, which might have provided support for women students.

The experiences of African women doctors in medicals school in South Africa was a difficult one, with many obstacles along the way. When black students could attend medical schools, there was still segregation and discrimination at these schools. These challenges were exacerbated by gender issues as women were seen to be subservient to men. Often their hardships involved overlapping forms of discrimination, which could scupper their aspirations. Black women were a minority among black doctors, like all medical women in the South African medical profession. By the year 1960, only ten per cent of doctors were female.<sup>178</sup> Though the numbers of women entering medicine was small during the apartheid period, as will be discussed in a later chapter, their numbers would increase and their presence helped destabilise the socially constructed understandings of the profession as a traditionally masculine one.

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<sup>178</sup> Elizabeth Walker, ““They Heal in the Spirit of the Mother””: Gender, Race and Professionalisation of South African Medical Women. *African Studies*, 62, 1, (2003): 121

## **Chapter Four: Working Lives as Medical Doctors during Apartheid**

This chapter focuses on black women doctors' life experiences after they graduated from medical school with Bachelor of Medicine and Surgery (MChB) degrees. Firstly, I will analyse the interviewees' internship training experiences and what influenced their choice of hospitals to work in. Secondly, I will discuss their post-internship experiences which included either work in the private or public sectors, or in a specialisation. Thirdly, I will consider how race and gender inequalities overlapped in the women doctors' professional and personal lives. Women doctors often had to carry a double burden with work and family responsibilities, which will form the final part of this chapter.

### **Internship Experiences**

Internships involved compulsory practical training at a state recognised teaching hospital after students completed their medical degrees. During the apartheid period the internship training period usually lasted for one year and involved the rotation of an intern through major disciplines and wards at a teaching hospital to give the newly qualified doctor experience in medicine, surgery, obstetrics and gynaecology, for example. However, internships were restricted in the sense that black doctors could not just apply to any hospital to do their internship training.<sup>179</sup> Unlike white doctors who could apply to do their internships at any recognised teaching hospital, black doctors could only apply to "non-European" hospitals, which limited their choices. Since black hospitals were insufficiently supported by the state, it meant that they often had to do their internships in conditions which were overcrowded, under-staffed and under-resourced, which negatively affected their training experiences.

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<sup>179</sup> Anne Digby. "Black Doctors and Discrimination under South Africa's Apartheid Regime." *Medical History* 57, no. 2 (2013): 278.

Most medical students who graduated from Durban's Medical School trained at King Edward VIII Hospital, which was this medical school's training hospital and the Natal province's largest "non-European" public hospital. They could also train at the smaller private mission hospital, McCord Hospital, which was located about seven kilometres from King Edward VIII Hospital. Other Natal graduates could choose to train further afield in other recognised teaching hospitals, such as Edendale Hospital in Pietermaritzburg or in hospitals located in different provinces, such as Baragwanath Hospital in Johannesburg, or Garanukwa Hospital north of Pretoria (and which would, from the late 1970s, become MEDUNSA's main teaching hospital).

King Edward VIII Hospital, which is located near the Durban Medical School's academic buildings on Umbilo Road, provided black medical students with most of their practical clinical training experiences. Some graduates, such as Dr Mkhize, felt that the training students received at King Edward VIII was excellent because of the valuable experience this large, tertiary level public hospital provided her with. King Edward VIII Hospital provided Durban's aspiring black doctors with most of their hands-on clinical training. It also offered a home to students completing the final three years of their undergraduate medical training. Students had a practical base to complete a further, one-year internship training. Its location allowed for easy access for black patients coming from the Durban city centre and from the growing industrial areas around Durban, and for African and Indian students living in areas around Durban.

However, others had a different opinion. Not all black doctors who trained at this hospital enjoyed their clinical experiences there. As already mentioned, black doctors were restricted to examining and treating black patients only, whereas white doctors could learn from and work with both black and white patients at other hospitals. This was a limit to the clinical training, especially when they continued to be taught about certain diseases that mainly affected

black patients. Internship training at King Edward VIII Hospital was also very difficult for black doctors during the apartheid period. This hospital had limited space for interns to work, insufficient or outdated equipment to use because of resource restrictions, and less than desirable staff-to-patient ratios as the number of black patients grew in Natal during the 1970s and 1980s.<sup>180</sup> Overcrowding and staff shortages were major problems that made it challenging for the staff employed in this institution to find the time and energy to teach interns.<sup>181</sup>

McCord Hospital was opened in 1909 in Durban as a mission hospital that provided affordable health care services mainly for black South Africans.<sup>182</sup> It was semi-private and received some state subsidy. The faculty offered affordable health-care services, work and training opportunities to many people in Durban. James McCord made many efforts to train African doctors in South Africa by building and providing equipment for his own small, private school.

In the 1940s, McCord was one of the first hospitals to provide internship training and work opportunities for black interns and doctors from Wits in the late 1940s and later in the 1950s, from the Durban Medical School. It was considered one of the best hospitals for black doctors to do their internship training. This was due to its progressive non-racial policies, its attempts to encourage close working relationships between doctors of different races, and interns were allowed and motivated to take on more responsibility for work than they were in other hospitals.<sup>183</sup> It was a tight-knit community that was well known for its strong service ethic. They promoted the idea of the Christian family among their staff and this resulted in close working relationships between staff and students, and between black and white staff.

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<sup>180</sup> Vanessa Noble. *A School of Struggle: Durban's Medical School and the Education of Black Doctors in South Africa*. (Scottsville: University of KwaZulu-Natal Press, 2013): 174.

<sup>181</sup> Noble, *A School of Struggle*: 178.

<sup>182</sup> James B. McCord, *My Patients were Zulus* (New York and Toronto: Rinehart and Co., 1951)

<sup>183</sup> Vanessa Noble and Julie Parle. "‘The Hospital was just like a Home’: Self, Service and the ‘McCord Hospital Family’". *Medical History Journal* 58, no. 2 (2014): 192,202

McCord Hospital also tried to remove apartheid practices in the hospital, such as segregated eating and ablution facilities. In 1959, Taylor persuaded the McCord Hospital Board to vote in favour of paying all its first-year medical interns according to “white salary scale” as determined by the Natal Provincial Administration.<sup>184</sup>

As an intern at McCord Hospital, Dr Luthuli said the internship year was about the following:

“really learning the art of practising medicine. I did my internship at McCord Hospital, the missionary hospital...which was also a teaching hospital but it's more contained, more like family administering it compared to the extensive, impersonal King Edward Hospital.”<sup>185</sup>

Dr Luthuli stated that McCord Hospital was much more open-minded and that it did not really have segregation even though it was in a country where segregation was strongly present and where apartheid was the law. Patients went to McCord Hospital if they wanted to and white patients were allowed to take a private room. She described it as “a very nice hospital with a very nice atmosphere”.<sup>186</sup>

According to Dr Luthuli, the doctors were black and white at McCord Hospital. There were white doctors and doctors from overseas. This meant a very different atmosphere compared to the other public hospitals that Africans could complete their internships.

After graduating in 1982 Dr Mkhize began her internship training at Edendale Hospital, outside Pietermaritzburg, about 90 kilometres inland from Durban. Edendale Hospital, was a government funded hospital which was established for black patients in 1954. Between 1954 and 1972 Edendale employed five hundred and fifty-two doctors (including interns) full time, making it one of the largest provincial hospitals after King Edward VIII. However, only one

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<sup>184</sup> Noble and Parle, “The Hospital was just like a Home”.

<sup>185</sup> Interview with Albertina Luthuli, 10 January 1993, conducted by Pdraig O'Malley, <https://www.nelsonmandela.org/omalley/index.php/site/q/031v00017/041v00344/051v00730/061v00737.htm>

<sup>186</sup> Interview with Albertina Luthuli, 10 January 1993, conducted by Pdraig O'Malley.

hundred and fourteen of the five hundred and fifty-two doctors were black, while female doctors only amounted to forty-one (it is unclear how many of these female doctors were black).<sup>187</sup>

Dr Mkhize states that when she arrived at Edendale Hospital as an intern she did not receive the warmest response. She was one of only a handful of women doctors who were employed at Edendale Hospital in the early 1980s. Interestingly, she told me that it was not her colleagues who gave her a hard time while training as an intern, but the patients who expressed discomfort at being treated by a woman. This is evident in an incident in which she describes being mistaken for a nurse:

“I treated a person who was stabbed when I was doing my internship in Edendale Hospital. I did everything I had to do and did not consult anyone, I gave them their treatment and wrote down all I needed to write. That day I saw the patient and stitched him up myself. Then there was a case in court which involved the patient and the person that stabbed him and I was called into court and they asked me if I treated him and if he was drunk. I didn’t remember whether he was drunk or not but yes, I treated him and I was the only person that saw him...When I asked later why there was this line of questioning I was told that the patient said that he was treated by a nurse and not a doctor...So, it doesn’t matter if you’re wearing a white coat because you are a female. And at court they concluded that he was drunk when he was stabbed because he didn’t notice whether a doctor or nurse treated him.”<sup>188</sup>

Clearly, her patient assumed that she was a nurse because of her gender, regardless of whether she wore a white coat or not. Similar points were made by Dr Magubane and Dr Luthuli too. The stereotype that women were nurses and men were doctors still existed and women doctors had to face the effects of this stereotype daily. Dr Goonam, who returned to Durban to start her practice in 1936 was also rejected at King Edward VIII Hospital in Durban for a post and was

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<sup>187</sup> J. Cosnett. “Edendale Hospital Pietermaritzburg: The First Twenty-One Years”. *South African Medical Journal*. No. 49, vol. 1491 (1975).

<sup>188</sup> Interview with Dr Mputsang May Mashego Mkhize, Recording 1, August 24, 2016.

told that “white nurses would not be prepared to take orders from black doctors”.<sup>189</sup> These were some of the disadvantages that black women faced.<sup>190</sup>

Neither Dr Mkhize nor Dr Magubane mentioned much about issues of race when speaking about their internships but from Dr Luthuli’s interviews it is evident that black doctors were forced to work in “their own hospitals” meaning, they could only work in hospitals which were only for blacks. Although, Dr Luthuli worked at a hospital with more support for the interns relative to the other hospitals mentioned as it was less segregated and placed less limitations on black doctors, this was not the case for the majority of black South African junior doctors. Many faced the limitations and suppressions caused by racial segregation and resource limitations within state hospitals.

### **Post Internship Work**

After graduating and upon completion of their internships medical graduates were then required to register to practice as doctors in South Africa.<sup>191</sup> Black women doctors had a number of work choices after completing their internship training. They had the option of finding a job in the public sector, they could go into the private sector, or they could choose to specialise, which entailed training for several more years in a specific medical discipline.

Some black women doctors chose to go into the public sector because they had to pay back government bursary-loans through several years of public service. Some chose the private sector for the career flexibility this option offered, the freedom from apartheid government service conditions, and because this option offered the possibility of higher financial rewards. Those who chose to specialise did so to expand their knowledge, thus becoming experts in a

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<sup>189</sup> Goonam. *Coolie Doctor: An Autobiography*: 25-27

<sup>190</sup> Digby. “Early Black Doctors”: 442.

<sup>191</sup> S.F. Oosthuizen. “The Intern Year” in *Medical Education in South Africa: Proceedings of the Conference on Medical Education held at the University of Natal, Durban in July 1964*, edited by John V.O. Reid and Alexander J. Wilcot (Pietermaritzburg: University of Natal Press, 1965): 301 and V.K.G. Pillay, “Some thoughts on intern training”, *South African Medical Journal* (2 December 1961).

particular field, which provided them with the potential to earn a higher salary once they completed their additional degrees or diplomas.

All six of my interviewees worked in the public sector at some stage of their careers. When interviews were done in 2016 Dr Mkhize, Dr Ntuli and Dr Kheswa were no longer working as medical practitioners. Dr Mkhize was retired, Dr Ngidi worked in the public sector and Dr Magubane and Dr Khumalo worked in the private sector. Of these six interviewees, Dr Magubane, Dr Khumalo and Dr Ngidi had trained as specialists.

Black doctors experienced much racial discrimination and inequalities in the public sector during the 1980s. The working conditions were substandard, they often felt disrespected by colleagues and/or patients, earned lower salaries than white doctors and were excluded from white professional bodies. Discriminatory salaries paid to doctors in the public service in apartheid South Africa meant that Coloured and Indian doctors earned seventy to eighty-one per cent, and African doctors sixty-five to seventy-six per cent of what their white colleagues were earning.<sup>192</sup> Often, black doctors had to work long hours and cover late night shifts, while their white colleagues got more preferential day time shifts and more time off. And, the low racial status of Africans during apartheid meant that they had to endure being subordinate to white nurses.<sup>193</sup> Many graduates saw private practice as a favourable alternative to public practice as the state's pay was seen as racially discriminatory whereas in private practice earning potential was greater. Those who worked in the public sector complained of being overworked and underpaid, had limited professional access to hospitals, and had to endure limitations around the patients they could treat as they could only treat black patients.

Dr Mkhize recalled an incident that affected her. As African doctors, Dr Mkhize and her husband (who also qualified as a doctor) were sometimes not even viewed as “real doctors”

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<sup>192</sup> Seboko Monamodi. “Medical Doctors under Segregation and Apartheid: A Sociological Analysis of Professionalization among Doctors in South Africa, 1900-1980” (Indiana University, Dissertation, June 1996): 357.

<sup>193</sup> Monamodi. “Medical Doctors under Segregation and Apartheid”: 274



by people in their own families or communities. This stemmed from the carefully cultivated mentality in apartheid South Africa that Africans were inferior to whites or Indians:

“My husband and I got married immediately after qualifying in 1982 so my mother-in-law was a sickly old lady. When she was sick, they would ask her ‘Do your children help you when you’re sick?’ ... And she would say, ‘I want a real doctor’. The doctor who treated her was an Indian guy who was junior to us and was an intern but she believed in him more because he was an Indian. She would say ‘I have my own doctor; I’m not going to play around with these ones’. So, she never saw a doctor when she looked at us because it was a socialisation issue during that time, they had been made to believe that Indians were better doctors.”<sup>194</sup>

Black female doctors had to constantly prove themselves because nobody believed that they were doctors. If an Indian or white doctor made a diagnosis, people took their word for it but if an African woman diagnosed them they would not believe them. This point was illustrated by Dr Mkhize in her interview:

“When I worked at Edendale I ultimately progressed to work in paediatric out-patients and I was the senior medical officer in charge. ... When the junior doctors came, from whatever race, they would find me in the paediatric out-patients section together with a white or Indian male doctor who is an intern or junior to me. And when they sought assistance ... they would rather go get assistance from the white or Indian intern and the intern would tell them that they should ask me because I am their senior. They would assume that the best person to ask was the female or male white doctor or Indian doctor.”<sup>195</sup>

This experience confirms that even after qualifying and working as a senior medical officer, black doctors still experienced gender and racial discrimination. Unlike when patients questioned her abilities as a doctor, in her working life, junior doctors questioned her abilities too. The assumption was that white or Indian interns knew more than Dr Mkhize, who was in fact their senior and the right person to ask if assistance was needed. Anne Digby argues in her article “Black Doctors and Discrimination under South Africa’s Apartheid Regime” that African and Indian women encountered both racial and gender “power differentials” in their societies which involved both “practical and psychological barriers to professional success.”<sup>196</sup>

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<sup>194</sup> Interview with Dr Mputsang May Mashego Mkhize, Recording 1, August 24, 2016.

<sup>195</sup> Interview with Dr Mputsang May Mashego Mkhize, Recording 1, August 24, 2016.

<sup>196</sup> Digby, “Black Doctors and Discrimination under South Africa’s Apartheid Regime”: 12.

This means that African and Indian women had to deal with patriarchal views. This resulted in limitations when it came to their work opportunities but also led to inaccurate assumptions about their intellectual capacity.

Dr Magubane also experienced gender discrimination when she began working as a doctor in the private sector at her husband's practice. In this situation, where Dr Magubane worked as a general practitioner in partnership with her husband, the patients would refer to Dr Magubane's husband as doctor and when he was not there they would say that he had left his nurse behind with them (referring to her). They saw her as a nurse and saw her husband as a doctor because the idea that men were doctors and women were nurses, still existed, as she explained:

“In fact, one of my patients had said that this guy is very clever because he has trained his wife to do his job when he's not here. She's very good, she does it exactly the way that he has taught her. It never crossed their minds that I could have gone to medical school and qualified. They thought I was a home-brewed doctor.”<sup>197</sup>

In addition, Dr Magubane explained to me that it was not only male patients who had an issue with identifying and accepting her as a doctor, but also female patients. Dr Magubane found working with young female patients the most difficult. This was because they wanted, according to Magubane, to be treated by a male doctor in the hopes that they could attract a husband who was a doctor. Within their communities, people knew that doctors earned more money than most other black professionals or workers, and thus represented “a good catch” if they could attract a male doctor as a boyfriend or a spouse. Furthermore, she noted that female nurses she worked with tended not to like female doctors because many nurses married doctors and female doctors were seen as their competition. Many female nurses were thus threatened by them, which could make for difficult working relationships.<sup>198</sup>

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<sup>197</sup> Interview with Dr Nokukhanya Magubane, Recording 6, October 1, 2016.

<sup>198</sup> Interview with Dr Nokukhanya Magubane, Recording 6, October 1, 2016.

Patriarchal attitudes in the medical profession influenced women's careers in the public and private sectors. Many women were deeply affected by the apartheid government's policies that tried to limit women practicing medicine.<sup>199</sup> Within the restrictions of their gendered and racial ideology; the SASMW was successful in improving the position of white women doctors but not black women doctors in apartheid South Africa. Black women doctors were restricted by institutional blocking, such as their diagnoses of patients not being taken seriously, or the patriarchal system that existed within the profession and the state and by simple social conventions and ideologies around a woman's "proper place" in society. For example, black women were sometimes accompanied by a white doctor when seeing patients because they were still not accepted as doctors. At King Edward VIII Hospital, for example, sexist harassment such as name calling and inappropriate suggestive hints were made at women doctors. Professional invisibility was also rife, which included women doctors being regarded as nurses despite wearing a white doctor's coat, and the fact that salaries and other such benefits for female doctors were unequal. Within the South African medical profession, young medical women found patriarchal inequalities to be deeply-rooted and longstanding.

In 1991, the *South African Medical Journal* published an article entitled: "Women Doctors in South Africa: A Survey of their Experiences". In this article, the authors recorded that 80.8 per cent of doctors had replied that they "had experienced difficulties in their careers because they were female"<sup>200</sup>. When asked if their careers ever had to be halted due to domestic responsibilities, 813 women making up just over 50 per cent of the sample indicated that this had been the case they experienced, while a considerable proportion of this sample (34.4 per cent) indicated that they had "not found it easy" to return to work, whether in a full-time or part-time capacity.

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<sup>199</sup> Pauline Klenerman. *Reminiscences of a Lady Doctor* (Johannesburg, South Africa: Adler Museum of the History of Medicine, University of the Witwatersrand/SAIMR, 1993).

<sup>200</sup> A.J.D. Bradshaw, M.M.M. Benade, and S. Heath. "Women doctors in South Africa: A Survey of Their Experiences". *South African Medical Journal* 80 (1991): 561-6.

Turning to the issue of specialisation, black doctors who chose to specialise experienced a lot of discrimination too. In her research on Durban's Medical School, Vanessa Noble has shown how although many black doctors who graduated from this medical school may have wanted to specialise, the environment in which they specialised was a hostile one.<sup>201</sup> Many felt that they were not encouraged to specialise, as their Indian colleagues were, and were instead encouraged to leave the medical school and go into general practice. And, those few who were admitted into specialisation training programmes experienced racist treatment by their supervisors and colleagues, such as being shouted at or being belittled in front of other students, or they were ignored in classes and during ward rounds. Furthermore, they were unfairly pointed out and victimised when they were purposefully marked down in their clinical assessments. Racism experienced by black doctors during their specialisation training will be discussed in more detail in the next chapter.

Women doctors who wanted to specialise faced even greater obstacles. Black women were in the minority, even among black doctors, and even more of a minority of doctors who chose to specialise. They were excluded from male networking groups and were encouraged to enter specialties that paid lower salaries and were not of a prestigious status.<sup>202</sup> Women were channelled into certain disciplines, like paediatrics, rather than disciplines like plastic surgery that were seen as male disciplines. The more they chose to excel the more attempts were made to block them from succeeding. Their accomplishments affected the stereotype that women should be reserved and submissive to men. Historically, male doctors blocked the success of women doctors because they viewed them as a threat. It was easier for their male colleagues to say that women doctors were motivated to compete with men because they were part of a

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<sup>201</sup> Noble. *A School of Struggle*: 318 and 319.

<sup>202</sup> Noble. *A School of Struggle*: 181.

masculine profession, rather than accept that the profession was being feminised by women entering it.<sup>203</sup>

It is also important to note that some black doctors became involved in anti-apartheid political activities, which had significant effects on their lives. Dr Goonam is a good example, as the racial discrimination she experienced as an Indian doctor practicing in Durban during the segregation era pushed her into political involvement with the Natal Indian Congress, and later she actually became the vice-president of the NIC.<sup>204</sup> She became one of the main organizers of the Passive Resistance campaign of 1946, which protested against the Asiatic Land Tenure and Indian Representation Act or “Ghetto Act” that limited the land available to Indians to settle on and purchase. On 29 June 1946 Dr. Goonam was sentenced to six months imprisonment with hard labour, in addition to the week she had been sentenced to under the Riotous Assemblies Act. After four months the sentence was suspended. Dr Goonam remained politically active during the apartheid period too and was imprisoned seventeen times in total for her political activities.<sup>205</sup>

She is one of the pioneers of not only female Indian resistance but is viewed as a political activist for black people’s rights in South Africa. Dr. Goonam left South Africa to live in England in exile due to continual harassment from the Security Branch. She worked overseas in countries such as India, Australia and Zimbabwe and returned to South Africa in 1990, and voted in the first democratic elections in 1994.<sup>206</sup> In an interview by Rajes Pillay with her daughter, Vanitha Chetty, towards the latter years of her life, Vanitha Chetty argued that Dr Goonam had finally achieved some peace: “Since she had been so politically active from 1940 onwards, I would say I mean for her the be-all and the end-all was to see

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<sup>203</sup> Noble. *A School of Struggle*: 183.

<sup>204</sup> Goonam. *Coolie Doctor: An Autobiography*: 25-27

<sup>205</sup> Goonam. *Coolie Doctor: An Autobiography*: 25-27

<sup>206</sup> Interview with Vanitha Chetty, 13 June 2002, conducted by Rajes Pillay, <http://scnc.ukzn.ac.za/doc/audio/vor/goonamk/goonamkbackground.htm>

democracy in her lifetime. And that was the ultimate and when it happened I don't think she thought further, with regard to governance and policies and things like that".<sup>207</sup>

Anti-apartheid politics played a significant role in the lives of other black women doctors too. Some were forced to leave South Africa either during their studies, such as Nkosazana Dlamini Zuma, or after they qualified, such as Drs Luthuli and Mkhize. Dr Luthuli, left South Africa in 1970 as she and her family had taken an offer of political asylum from Amnesty International in the UK. Though a political activist in her own right, Dr Luthuli was the daughter of apartheid struggle icon; Chief Albert Luthuli, and the wife of Pascal Ngakane (also a medical doctor), who was an important political figure in the underground movement of the ANC in the 1960s. In the end they had to leave the country because living in South Africa had become impossible due to police harassment and the threat of arrest and long-term detention.<sup>208</sup> Thus, for twenty years, Dr Luthuli's medical skills were lost to South African patients because of harsh state oppression.<sup>209</sup> Like Dr Goonam, she eventually returned to South Africa in 1991 in the years just before the transition to democracy, where she was employed for a short time at Stanger Hospital along the North Coast, before opening her own private practice in Stanger.

In another case, political activism had a huge effect on the life of a married couple, both of whom were medically trained, who were involved in ANC's underground political activism in the latter years of the apartheid period. Mputsang May Mashego married Zweli Mkhize in the early 1980s after they both completed their medical degrees. During the 1980s Durban's medical campus became a key area for anti-apartheid political activity.<sup>210</sup> In her interview, Dr

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<sup>207</sup> Interview with Vanitha Chetty, 13 June 2002, conducted by Rajes Pillay, <http://scnc.ukzn.ac.za/doc/audio/vor/goonamk/goonamkbackground.htm>

<sup>208</sup> Interview with Albertina Luthuli, 10 January 1993, conducted by Padraig O'Malley.

<sup>209</sup> Anne Digby. "Early black doctors in South Africa." *Journal of African History* 46, no. 03 (2005): 443 and H.L. Watts. "Black Doctors: An Investigation of the Training and Career of Students and Graduates from the Medical School of the University of Natal" (University of Natal: Durban. 1975): 23.

<sup>210</sup> Noble. *A School of Struggle*: 247.

Mkhize told me of the difficulties her family experienced being involved in the politics of the country as her husband was forced to go into exile in Swaziland and then Zimbabwe in the late 1980s to escape imprisonment. This meant spending much time apart from her husband, as Dr Mkhize remained behind in South Africa when he went into hiding.<sup>211</sup> She had a lot of responsibility at this time.

### **Balancing Work and Family**

When women doctors got married and/or had children; they experienced many social pressures and had to deal with balancing their roles at home and at work. Their families and communities expected them to fulfil their duties as wives and mothers, regardless of whether they were part of an elite profession. However, the balancing act was a difficult one and many women had to make sacrifices, whether it be in terms of their careers, in terms of their specialisation dreams, or at home. Some found that they fell short when it came to fulfilling their demanding jobs or neglected their families because of pressures at work.

Dr Mkhize had a difficult time balancing family and career responsibilities. She became a wife and mother of three soon after qualifying in 1982. These additional family responsibilities prevented her from fulfilling her specialisation dreams. With a young family, it was a struggle to balance her working life with her family's needs. This was particularly difficult when her husband was away or in hiding because of his anti-apartheid activities, and when they left South Africa for a few years, and then missed the support of their extended family.

While in Zimbabwe Dr Mkhize began training in paediatrics. Six months into the training it was announced that the African National Congress (ANC) would be unbanned, which meant that they could return to South Africa. When she came back home her husband

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<sup>211</sup> Interview with Dr Mputsang May Mashego Mkhize, Recording 1, August 24, 2016.

encouraged her to specialise in paediatrics and she applied for a position at King Edward VIII Hospital, where she was accepted to complete this training. She had to travel daily between Pietermaritzburg and Durban because she lived in Pietermaritzburg at the time, and her children were still very young. She states that she had to balance it all, being a wife, mother and doctor and she realised that it was too much for her to also specialise.<sup>212</sup> She then decided not to specialise and focus more on her family.

Dr Mkhize states that her career did affect how much time she had with her children because the hours were long, and medicine was a very demanding profession. However, she also told me that she worked hard for them so that they could have what she never had and could live a better life. Indeed, her work contributed greatly to the benefits her children and her family had:

“When we grew up, our parents were never a part of our education system. It was a new thing that we had to be part of our children’s education system and we had to attend their sports matches and had to assist with their homework. It was worse because if you wanted to be a part of this, you couldn’t because you are a medical doctor but we survived because family was there to help. My career has made sure that they get where they want to be and I gave them all I could. They’ve never wished to be doctors. This profession takes a lot of time. My daughter was able to attain her PhD in Cape Town. We struggled but we made sure our children got all they could. Because of our political involvement, a lot of our time was taken from them but it was all done for them.”<sup>213</sup>

Being a professional influenced her socio-economic status because she could enrol her children in better schools, and she could even help to pay for the education costs of other children with poor parents in her extended family. Higher earnings also meant she could afford to live in better areas with more material things.

Dr Magubane met her husband at MEDUNSA in the late 1980s and got married in the early 1990s after completing her medical degree. She had two children. In her interview, she told me that she also found it difficult to balance her duties as wife, mother and doctor:

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<sup>212</sup> Interview with Dr Mputsang May Mashego Mkhize, Recording 1, August 24, 2016.

<sup>213</sup> Interview with Dr Mputsang May Mashego Mkhize, Recording 1, August 24, 2016.



“It was very difficult. I often regret combining these roles. As a mother, I felt like I neglected my children because I focused on being a doctor more. Even as a wife you are always tired and you’re grumpy so it does affect the relationship to a certain extent. ... My husband supported me, as long as he came first. I think he realised though that if he didn’t allow me to specialise I was going to divorce him because I had set my mind on specialising and once I have set my mind on something it was hard to stop me. Most men would like the fact that the household income has increased, as long as everyone thinks it’s because of them. African men understand the difficulties of being an African doctor and how difficult it is as an African woman but they’re also selfish.”<sup>214</sup>

She also felt that there were quite a lot of class opportunities that she received from becoming a doctor as being a doctor raised her class status. Like Dr Mkhize, she could send her children to better schools and provide a better future for them because of her profession.

Although I have spent much time considering race and gender issues in this chapter, class is also an important issue to consider when it comes to black doctors who worked in apartheid era South Africa. A medical education fostered the opportunity to escape the common fate of poverty facing most black South Africans at the time. Although salaries paid to black doctors in public service were lower than those paid to whites (for example, in 1968, Indian and Coloured doctors received 65 per cent of a white doctor’s salary, while Africans received only 55 per cent, despite having the same training and doing the same work), they were comparatively higher than the salaries earned by most black South Africans in other lines of work at the time.<sup>215</sup> This made it possible for black doctors to improve their lifestyle and living conditions. They could provide more for their families and had the resources to offer their children better opportunities, particularly when it came to schooling and living conditions. The medical profession was seen as a high-class status profession in the black communities, making black doctors an elite group.<sup>216</sup>

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<sup>214</sup> Interview with Dr Nokukhanya 5, Recording 6, October 1, 2016.

<sup>215</sup> Digby. "Black Doctors and Discrimination Under South Africa’s Apartheid Regime": 279.

<sup>216</sup> Leo Kuper. *An African Bourgeoisie: Race, Class and Politics in South Africa*. (New Haven: Yale University Press, 1965): 7-8.

The experiences of African women doctors' during internship training and the conditions that influenced their choice of hospitals to work in came with many hindrances. These African women could work in hospitals but were not respected or treated fairly compared to colleagues of other races or men. Gender discrimination continued to negatively impact their professional experiences, even after they qualified as doctors and should have been receiving the same respect as their white colleagues. The overlapping forms of gender and race discrimination still limited these doctors even when they were professionals working in the medical profession. The double burden of race and gender discrimination, which was mentioned in the previous chapter, worsened for black women as they progressed in their careers and life in general. The situation in post-apartheid South Africa will be discussed in the next chapter.

## **Chapter Five: Experiences of African Women Doctors in the Post-Apartheid Years**

This chapter focuses on the training, internship and working lives of African women medical doctors during the post-apartheid years. Four of the six interviewees (Drs Ntuli, Khumalo, Ngidi and Kheswa) trained and worked in the post-apartheid era, while Drs Mkhize and Magubane trained and worked during the apartheid period, but also worked in the post-apartheid era. This chapter seeks to understand what changed over time for African women doctors when it came to their education opportunities, working experiences, balancing family and career expectations and responsibilities between the apartheid and post-apartheid periods.

On 27 April 1994, South Africa's first democratic elections created a new political, social and economic system for the country. This period saw the emergence of the country's first democratically-elected government led by the African National Congress.<sup>217</sup> This resulted in the dismantling of apartheid laws. This included, for example the repeal of laws that segregated different racial groups residentially, such as the Group Areas Act, and laws that limited the education and social opportunities, as well as laws that restricted the movements of Africans. It has been more than twenty-three years since South Africa changed from apartheid to a constitutional democracy.<sup>218</sup> There has been progress made toward fixing the discriminatory ways that permeated all ways of life for South Africans before 1994, but the shadow of the apartheid regime still lingers in this country.

The post-apartheid period brought about significant changes for women wanting to study medicine. In the new dispensation, young girls and women have been given more opportunities than they had during the apartheid period. More young black girls were

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<sup>217</sup> G.W. Seidman. "Gendered citizenship: South Africa's democratic transition and the construction of a gendered state", *Gender and Society* 13, no. 3 (June 1999).

<sup>218</sup> Robert P. Inman, Daniel L. Rubinfeld. "Understanding the Democratic Transition in South Africa". *American Law and Economics Review* 15, no. 2 (2013): 1-38.

encouraged to go to school, even though patriarchal ideas about a woman's "proper place" in the home still exists in many families. More young women now stand up to their families and challenge longstanding patriarchal beliefs, opting to have professional careers and marrying later, if at all. With the end of the Bantu Education system, schools have become racially mixed institutions, which have encouraged more black girls and young black women to attend better schools. Thus, more women are qualifying with the minimum requirements needed to apply to medical school.

In Dr Khumalo's case, she is an example of a younger generation of medical graduate, whose education during the years leading up the democratic transition in 1994 brought educational advantages for some black students, especially those whose parents could afford to send them to better quality schools outside the Bantu Education system. She told me the following:

"Fortunately for me, what I think helped me a lot is that, my parents could afford to take me to a Model C school. So obviously, when we matriculated, my results were better. If others like my primary school mates had been exposed to the same school system I was exposed to the y would have gone far too."<sup>219</sup>

Former Model C schools were government schools in post-apartheid South Africa that received additional money to run their public schools from parents in a governing body.<sup>220</sup> Some of the country's best elite schools were a part of the Model C system, and were open to all race groups. Wealthier African parents were able to send their children to Model C schools, which provided a platform for African women to have more educational opportunities. Tuition was somewhere between private and regular government school fees. They were important in the early 1990s in the transition period to democracy as black students were slowly allowed into these historically white schools. This also assisted in the entry of young females into

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<sup>219</sup> Interview with Dr Ayanda Penelope Khumalo, Recording 3a, September 14, 2016.

<sup>220</sup> Model C schools were government schools that were funded by a governing body of parents and alumni. Some of the country's best schools fell into this category during the 1990s, and fees paid by parents were to send their children to such schools fell somewhere between private and regular government school fees.

medical schools, but of course this was not the case for all Africans. Class played a large factor in who attended these schools as most Africans were coming from impoverished homes and communities and could not afford to attend these schools. In addition, there were also some issues for black students attending Model C schools as initially black students who were allowed to attend these schools were put into separate classes due to doubts around their intellectual abilities. This did change over time and students of all races were put into the same classes.

As one of a small number of black learners admitted into a Model C school in the early 1990s, Dr Khumalo remembered facing many obstacles at the mainly white Durban Girls High School. She recalled how in her Standard Six (grade 8 year) they put all the black students in one class because the school's educators wanted to groom the students separately to reach the same educational standard as their white students. She used to excel in her classes and so this shows that this system was not necessary. When she reached Standard Seven (grade 9) her school allowed black students to be mixed with white and black students in classes because parents started to complain.

### **Choice of Medical Schools**

During the post-apartheid era, medical students had a greater choice of places to study than during the apartheid period. In the new democratic dispensation, they could choose to study at any medical school in South Africa. Indeed, historically white medical schools, such as UCT and Wits, opened their doors and accepted larger numbers of black students. However, until the early 2000s white students still outnumbered black students. And, historically black medical schools, such as Durban's Medical School and UNITRA began accepting white students. However, transformation of the admission process at the University of Natal's Medical School in the early 1990s was delayed because many black students protested the

admittance of white students into their medical school until black students were admitted in larger numbers into historically white medical schools.<sup>221</sup>

Furthermore, in the past few years South African medical schools have also received, more women applicants than they did in the past. By the year 2003, 66 per cent of all enrolments across South Africa's eight medical schools were made up of black students. African students made up 41 per cent of these enrolments.<sup>222</sup> By 2005; women formed 56 per cent of all the student enrolments. This means that by the 2000s, women represented most students admitted to medical schools.<sup>223</sup>

### **Experiences at Medical School**

This section focuses on the training experiences of four of my younger African women interviewees, namely Drs Ntuli, Khumalo, Ngidi and Kheswa. Dr Ntuli trained at UNITRA in 1995, while the other three trained at the University of Natal's Medical School in the late 1990s and early 2000s.

It is important to note from the outset that although the demographic composition of medical school student bodies became much more diverse in the post-apartheid period, because of the opening of medical schools to students of all races, relationships between different students remained frosty for some students for many years after 1994. This was evident at a number of universities.

Dr Ntuli began her medical training at UNITRA in 1995, only a year after South Africa's first democratic election. During this period, this medical school remained a predominantly black one with hardly any white students. A large bone of contention revolved

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<sup>221</sup> Vanessa. Noble. *A School of Struggle: Durban's Medical School and the Education of Black Doctors in South Africa*. (Scottsville: University of KwaZulu-Natal Press, 2013): 304.

<sup>222</sup> Breier with Wildschut, *Doctors in a Divided Society*: 101 and Mignonne Breier and Angelique Wildschut, "Changing gender profile of medical schools in South Africa", *South African Medical Journal* 98, no. 7 (July 2008): 557.

<sup>223</sup> Breier with Wildschut, *Doctors in a Divided Society*: 30.

around the belief amongst African students that Indian students, who could also study at this medical school, received preferential treatment from the staff (who were primarily Indian staff, as well as African staff who came from other African countries such as Nigeria and Uganda), and thus benefitted through unfair advantages.<sup>224</sup>

These issues, which led to divisions in UNITRA's student body, were similar to those that plagued Durban's Medical School. Indeed, carrying over from the apartheid period, Durban's Medical School faced growing tensions in the post-apartheid period around race issues. Dr Ngidi's experience of studying medicine at the Durban Medical School in the early 2000s highlights the divisions, particularly amongst African and Indian students, who represented the largest student demographic studying at that time. Dr Ngidi remembered what she and her African classmates saw as "black-on-black racism" which kept African and Indian students apart. She told me in her interview that Indian students felt superior to African students, and would often talk down to them. Other issues centred on preferential treatment, which African students thought their Indian colleagues received from their lecturers. This also divided the student body:

"I think that's when I really noticed that there is racism, at medical school. There you could see the separation, we hardly talked. The Indians felt very superior, they talked down to the African guys. They sometimes wouldn't attend lectures or tutorials but would always get higher marks, yet I was the black African that always went to class and worked the hardest. There was just open mistrust and open hatred because we thought they always cheated (the Indians). You would see that the marks got inflated for the Indians by the lecturers ...because it was Indian-run but the Africans would get failed. I remember there was a paper that I failed and I was so distraught because I had never failed anything in my life! I said to myself, 'I know I'm not dumb' and I asked for a remark for the paper because I did not believe that I had failed because I had studied well and understood the work. And when I got the remark I had passed. You found all the time at medical school that the people who always failed were not the Indians but it was the Africans who were the ones who attended lectures and were at the library. It was always about connections with the Indians, it was either their uncles or their fathers or someone that helped them ...They never studied but they got the better DPs (class marks), and the better patients and special tutorials etc."<sup>225</sup>

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<sup>224</sup> Interview with Dr Vela Ntuli, Recording 2, September 6, 2016.

<sup>225</sup> Interview with Dr Sthembile Ngidi, Recording 4, September 14, 2016.

Dr Ntuli who qualified as a doctor in the early 2000s, corroborated Dr Ngidi's opinions:

“At UNITRA, we had black on black racism, amongst the students. There was always this animosity between the Indian and African students. They always got preferential treatment, they were a minority, that's the funny thing. They were much fewer, but that is what we used to experience. They were sort of friendlier with the teachers, and that's how it was. We stayed in the background, we must not be heard but seen. It was the Indians, it was their world. We hardly had black staff, except for medical interns, but they were Nigerian or Ugandan. We thought it was just the way it was. We knew that Indian students just liked to go behind our backs and talk to the lecturers about student affairs. We didn't think there was anything we could do.”<sup>226</sup>

Another example of racial separation in the post-apartheid period was illustrated by Dr Khumalo in her interview. She studied in Durban in the late 1990s and early 2000s. For Dr Khumalo, racial segregation in seating arrangements was still a big issue when she was a student:

“When I was studying, Indians sat together and Africans sat together. There wasn't a lot of mixing when it came to that.”<sup>227</sup>

The apartheid government had aimed to keep students from different racial groups apart during apartheid, the effects which were still felt years later, even after 1994, when South Africa became a democratic state.

The medical profession has been increasingly feminised by the larger number of women who have entered it. In recent years, more women have entered the medical profession and this feminisation has affected the South African medical profession itself. The profession has evolved over time and a changing political context has greatly influenced the profession.

Female entry to medical training facilities steadily increased and by 1993, women of all races made up 56 per cent of the first-year entrants, while 30 per cent of black admissions were female the following year.<sup>228</sup> The post-apartheid period encouraged institutions and individuals to evaluate themselves and shift their policies and practices. This had many positive

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<sup>226</sup> Interview with Dr Vela Ntuli, Recording 2, September 6, 2016.

<sup>227</sup> Interview with Dr Ayanda Penelope Khumalo, Recording 3a, September 14, 2016.

<sup>228</sup> Digby, “Black Doctors under Apartheid”: 288.



outcomes for women students. For example, there are more female mentors available to act as role models and available to offer support to female students.

Dr Khumalo began her medical training in 1998 at the University of Natal in Durban. The relationships she had with the medical staff was one of enthusiasm and acceptance. She looked up to one of the female lecturers who was a dermatologist and received encouragement from senior students to continue with her medical training. There was no competition among the female medical students but instead they used to support each other, similar to Dr Ntuli's experience at UNITRA, and encouraged each other to pass. There was no competition among the African female students but instead they were supportive of each other.

However, Dr Kheswa told me that she did not have any female role models or mentors at medical school because even the African lecturers did not stand up for them in defiance to the injustices that were taking place, such as racial abuse and harassment. She also mentions how there was competition amongst the older African women doctors and their younger African medical students as the older women saw the younger students as competition when it came to career opportunities. Although policies based on race have theoretically ended, in practice, racial discriminations, but also gender discriminations still negatively affect the progression of black female doctors into post graduate study and career advancement during the post-apartheid era.<sup>229</sup>

### **Internship Experiences**

In the post-apartheid years, black doctors could train in all teaching hospitals, as they were now open to all races. This meant that black doctors, including women doctors, had a larger variety of institutions to choose from for their internships. However, even though the

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<sup>229</sup> Delese Wear. *Privilege in the Medical Academy: A Feminist Examines Gender, Race, and Power*. (New York and London: Teachers College, Columbia University, 1997).

transition to a democratic dispensation gave many hope for change, some things remained the same. For example, interns working in post-apartheid South Africa were still overworked and experienced similar difficulties to those that they had under apartheid. They had to work long hours, deal with the huge demands of such high-pressure jobs, and they were exploited by their seniors. Those who got posted to historically black hospitals still had to work in overcrowded, under-resourced and short-staffed facilities.<sup>230</sup> Those who worked in historically white hospitals had to work with an older generation of white doctors who had been comfortable with the apartheid system, and were now bitter as they were forced to recognise black doctors as their professional, equal peers.

For instance, after graduating in 2000, Dr Ntuli went to Cape Town, to do her internship. During her interview, she told me about the deep effect racism had on her practical training experience. She was the only black intern in a hospital which was in a white area.<sup>231</sup> She says the senior doctors at this hospital made it clear that they did not think highly of her abilities when she arrived. In her experience, black interns were not treated equally:

“If a black doctor did something that was mismanaged it would get blown out of proportion but if it was a white doctor did it, it would not be taken seriously. There was also a religion thing like Muslims would prefer Muslim doctors. But they didn’t prefer Muslim doctors if it was a white doctor treating them. Of course, if it was a black doctor, then the patients didn’t want them.”<sup>232</sup>

This quotation highlights that racial discrimination was still very much alive, even several years after 1994. Ntuli’s experience shows that white doctors were taken more seriously. Also, white and Indian patients preferred white doctors treating them. This shows how the attitude that was prevalent during apartheid, that African doctors were not as skilled as white and Indian doctors, was still a stumbling block. However, she remembered that

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<sup>230</sup> S.J. Reid, “Compulsory community service for doctors in South Africa – An evaluation of the first year”, *South African Medical Journal* 91 (2001), and Noble, *A School of Struggle*: 326.

<sup>231</sup> Dr Ntuli preferred not to mention the name of the hospital she interned at.

<sup>232</sup> Interview with Dr Vela Ntuli, Recording 2. September 6, 2016.

African patients were comfortable having African doctors treat them because they felt understood by them.

Dr Khumalo began her internship training in 2004 at Kalafong Hospital in Pretoria, a city in the northern part of the Gauteng Province in South Africa. During her interview, she explained how difficult it was to do her internship at this hospital as there was a lot of action taken to make the experience of African students difficult. In this hospital, most of the senior doctors were Afrikaans-speaking. This resulted in a language barrier for Dr Khumalo, as many of her colleagues and patients spoke in Afrikaans without caring whether she understood them or not. One Afrikaans registrar told her “to get a dictionary”<sup>233</sup> when she told him she did not understand something.<sup>234</sup> She felt that most of the senior doctors never really took the time to properly nurture her or her black colleagues, and even felt that the senior doctors wanted African doctors to fail.

### **Post-Internship Work**

This section will focus on the work experiences of black women doctors after their internships by looking at their experiences in the public and private sectors, as well as those who did specialist training after they completed their general MB.ChB degrees.

#### Public Service Experiences

An important change in the post-apartheid period was the requirement mandated by the Minister of Health in 1998 that all newly qualified doctors do a compulsory year of community service before they would receive their licences to practice as registered doctors in South Africa. This was done to improve the supply of doctors and health care services in South Africa,

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<sup>233</sup> Interview with Dr Ayanda Penelope Khumalo, Recording 3a, September 14, 2016.

<sup>234</sup> Interview with Dr Ayanda Penelope Khumalo, Recording 3a, September 14, 2016.

particularly in under-serviced rural areas, where the need for them was greatest.<sup>235</sup> It also helped to provide junior doctors with an opportunity to develop their skills through further practice in the public health care environment. Due to this, medical schools in South Africa have gone through essential changes in the curriculum during the 1990s and 2000s. Also, doctors were required to know and recognise patients' rights and to respect the racial, religious and cultural beliefs of their patients.<sup>236</sup>

After completing their community service requirements, some doctors chose to remain in the public sector. When comparing the experiences of black women doctors in the apartheid and post-apartheid periods, there were some changes but also many continuities.<sup>237</sup> Also, black doctors could treat patients of all races and they were no longer excluded from the country's key medical bodies, such as the Medical Association of South Africa.

However, in practice some forms of racial discrimination continued between colleagues in the public sector. Black-on-black racism was still prevalent and poor working conditions in historically black public hospitals remained a key issue because of limited government finances to improve many of these facilities. For example, in 2006 Dr Khumalo got a post for three months as a senior medical officer at Greytown Hospital, a state hospital in Greytown, a town in the KwaZulu-Natal Midlands. In her interview, she told me that ten years after the end of apartheid, this hospital was still poorly resourced and patients still died from preventable diseases.<sup>238</sup> She then went on to work at Prince Mshiyeni Hospital in the area of Umlazi in Durban. Built during apartheid as a black public hospital in an African township, this hospital, like Greytown, still had many problems in the post-apartheid era around limited resources, overcrowding and understaffing.

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<sup>235</sup> S.J. Reid, 'Compulsory community service for doctors in South Africa – An evaluation of the first year', *South African Medical Journal* 91 (2001): 329-331. Noble, *A School of Struggle*: 326.

<sup>236</sup> Noble. *A School of Struggle*: 314 and 315

<sup>237</sup> Noble. *A School of Struggle*: 314

<sup>238</sup> Interview with Dr Ayanda Penelope Khumalo, Recording 3a, September 14, 2016.

The gender experiences of women working in the public sector did undergo a shift but many issues remained. As more women graduated from medical school, more women started contributing their skills and expertise to medical work in the public sector. Many black women joined the SASMW after 1994. Records from the Wits University Library show information of African women doctors signing up and becoming members in 1997 and 1998.<sup>239</sup> This could have been a way to protect themselves from continuing gender discrimination in the medical profession. The SASMW continued to fight for the improvement of salaries, better working conditions and recognition for all women doctors, including black women. Its main aim was to protect and fight for practicing women doctors' rights in South Africa. The increasing numbers of black women doctors joining this organisation in 1990s showed the SASMW's contributions to improve the lives and working conditions of women doctors, including black women doctors in South Africa.

### Private Practice Experiences

Other qualified doctors decided to work in the private sector. I have already discussed some of Dr Magubane's experiences in private practice in the previous chapter. Dr Magubane worked for many years as a general practitioner before specialising in psychiatry later in her career. Reflecting on her experiences over the years, Dr Magubane told me that racial and gender discrimination continued into the post-apartheid period. Sometimes she is still mistaken for a nurse by her patients, and has had many difficulties being fully accepted by some of her white patients. This is particularly the case for white male patients:

“Even up to today, it is still very difficult. We are now allowed to see patients of all races and I run a practice in Newcastle where currently there are two psychiatrists. It's me and an Indian. What I realised is in the beginning, the white people would want to be seen once in six months because they could not stand being seen by a black person for a long time, but if they had a choice they would never see me. If they are going to go and tell a black female about their flaws, being white then it means they are not as

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<sup>239</sup> Wits University Library. A92725 SASMW Information on Membership, 1997.

perfect as they are portrayed. It is a race issue that is still alive and kicking post-1994.’<sup>240</sup>

### Specialisation Experiences

Some qualified doctors decided to specialise after completing their basic training in the post-apartheid period. In terms of my interviews, four of the six women doctors specialised. Dr Magubane started specialising in Psychiatry in 2005 while Dr Khumalo specialised in Anaesthesiology in 2007 and Dr Ngidi in Oncology in 2008. I will also draw on Dr Kheswa’s insights. Although she was not prepared to share personal and specific information with me to protect her identity, this black woman doctor also spent several months specialising in the early 2000s, before leaving her studies because of the discrimination she experienced.

When Dr Magubane began specialising in 2005 at the College of Medicine of South Africa, she faced many challenges. She started specialist training in Psychiatry after she had worked as a general practitioner for eleven years. In her interview, she told me that she felt much older than her peers and felt left behind in terms of technological advancements. Furthermore, she experienced black on black racism when she did her specialisation training and she felt Indians still treated African colleagues “like we were inferior” and bossed them around on the wards. For Dr Magubane; having a strong personality, with an ability to bounce back from such setbacks, helped her to succeed:

“The personality of a person really helps a lot because Indians still treated us like we were inferior. Even when we were specialising, they still want to treat you like a maid but if you have a personality that was loud, they began to realise that you’re also a doctor”.<sup>241</sup>

When Dr Khumalo began her Anaesthesiology training in Durban in 2007, she found that this specialisation, as well as many others, remained white-dominated, with mainly white

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<sup>240</sup> Interview with Dr Nokukhanya Magubane, Recording 6, October 1, 2016.

<sup>241</sup> Interview with Dr Mputsang May Mashego Magubane, Recording 6, October 1, 2016.

professors and white students, and that there was some discrimination towards Africans. One area related to language barriers, which made progression more difficult for her:

“When we had our specialist exams they were not very objective. You had to be an 80 percent candidate for them to pass you. The white English-speaking...students had papers written in their own language but we had to write these exams in another language, which was not our mother tongue, but I just persisted because I believed I could beat the odds.”<sup>242</sup>

Another area related to uncooperative supervisors. She qualified in 2012 and became the first black female doctor to qualify in Durban as an Anaesthesiologist. However, her obstacles around advancing in this specialisation continued in this department after qualifying, when she decided to do her Master’s degree at this same university:

“I wanted to pursue my masters and so who are the professors there? White professors. The professor I have now, he is just stalling. For me, I don’t have a choice I’m stuck with him, he throws tantrums and I don’t have an alternative. I even tried another department and got quite a lot of help, but in the end, he is still the final person to approve my work, so you just must just go against the odds and that’s what I told myself.”<sup>243</sup>

At the end of 2016 when I conducted my interview with Dr Khumalo, she was still waiting for her thesis to be marked by her supervisor.

Dr Ngidi started her Oncology specialisation training in 2008 in Durban. There are many examples of overlapping race and gender obstacles faced by Dr Ngidi during her training. She felt she was actively sabotaged by some of her Indian professors and colleagues:

“For me, specialising was the hardest thing in my life. It was so difficult. There it was all about race. I remember I was told that the only reason why I’m here is because I am black. There was animosity among the Indians in the department that I had gotten in because I am black and now I’m female, everything is about a black female. You must always go the extra mile and people sabotaged your work. If the mistake is done by a white person or an Indian nobody notices it.”<sup>244</sup>

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<sup>242</sup> Interview with Dr Ayanda Penelope Khumalo, Recording 3a, September 14, 2016.

<sup>243</sup> Interview with Dr Ayanda Penelope Khumalo, Recording 3a, September 14, 2016.

<sup>244</sup> Interview with Dr Sthembile Ngidi, Recording 4, September 14, 2016.

The issue of people actively sabotaging her progress was a sore point for Dr Ngidi and raised repeatedly in our interview:

“If you look at the number of African people who enter a specialisation programme ... many of them drop out. Be it sabotage, mistreatment, being demeaned in front of the nurses, being told you’re stupid, receiving no help. They can accept your entry but they’ll make sure that you don’t finish. It is the system that forces you out. You think it will improve a little bit, being a specialist, but it doesn’t. People won’t sign off on something because it’s by an African doctor.”<sup>245</sup>

To back up her story of hindrances and the lack of support she faced specialising in Durban, Dr Ngidi also told me the story of another African colleague who was failed four times in his specialist exams until he eventually passed:

“There is a specialist, an African male who was failed four times in the specialist exams. He’s one of the smartest guys I know in his field ... but they failed him because he used to fight against the injustices of the department. The head of department told him that he would not pass and she told other examiners to fail him. When he asked for a revision he had to pay for that and got a lawyer, when he got remarked he had actually passed with one of the highest marks in the country. We are on our own, when I went to my exam I prayed so hard because I was the only African person, and there was nobody to fight for me.”<sup>246</sup>

After becoming the first African female Oncologist in KwaZulu-Natal and the second in South Africa, she also decided to do her MD degree. Dr Ngidi had a similar experience to Dr Khumalo in terms of the lack of support from her supervisor for completing her degree:

“I thought myself a lot of stuff. Even now I just finished my masters and you’re supposed to have a supervisor and meet with your supervisor. I never had any of that, there was an Indian professor and he never would respond to my emails and he would shout if I asked him to respond. It was a struggle because even now my thesis has not been marked because they don’t want to mark it.”<sup>247</sup>

When I asked her why she faced this obstruction from her professors and other colleagues, Dr Ngidi asserted that she thought they saw her progress as a black woman in a predominantly white male discipline as a threat to be resisted. Factors such as these have made

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<sup>245</sup> Interview with Dr Sthembile Ngidi, Recording 4, September 14, 2016.

<sup>246</sup> Interview with Dr Sthembile Ngidi, Recording 4, September 14, 2016.

<sup>247</sup> Interview with Dr Sthembile Ngidi, Recording 4, September 14, 2016.



her profession into what she calls “a nest of vipers”, which has limited the number of Africans who specialise.<sup>248</sup>

To back up earlier points made around the difficulties black doctors experienced in their specialisation, Dr Kheswa, said that when she was specialising in 2014, African colleagues were regularly called “idiots with disdain in front of peers and colleagues”, that very few (if any) African women seemed to advance year after year through speciality training, and she even remembered witnessing an African female colleague being slapped by a senior female consultant in front of faculty members and students on one occasion.<sup>249</sup> Nothing was done about these issues despite there being many witnesses, and despite these doctors having trained in the post-apartheid democratic dispensation. As a result, she decided to abandon her specialist training. She is currently self-employed.

### **Balancing Work and Family**

Following on from the apartheid period, all the interviewees had to continue working out a way to balance work (or specialisation) and family life. The difficulties these women faced usually resulted in a lot of compromises. Each of my interviewees chose what they believed was of more value to them.

Women doctors who gave up medical work or specialisation opportunities for their families had to make sacrifices in their careers. Some did not take certain jobs or did not specialise, and opted instead to care for their families. Dr Ntuli met her husband in 2001 and got married in 2002. She has two children, the first of which she had two years after getting married. She currently resides in Durban.

“I think when I was going to specialise my husband was not coping and I was like ‘What do you mean you not coping?’ Because I am the one working running around at night while you are sleeping. He had to support my dream because I wanted it at the

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<sup>248</sup> Interview with Dr Sthembile Ngidi, Recording 4, September 14, 2016.

<sup>249</sup> Interview with Dr Mosele Kheswa, Recording 5, October 1, 2016.

time, but he was complaining a lot about the hours and I think my turning point was that he ended up knowing the kids more than I did. You end up having a unilateral life. I wanted to move and specialise in Cape Town and he moved with me. As a mother, I felt that I was missing out on time with my kids”.<sup>250</sup>

Dr Ntuli did not specialise due to family responsibilities. After an internship in Cape Town she returned to the Eastern Cape to work. She felt that she had to choose between specialising and focusing on her children and family.

This was similar to Dr Mkhize’s experience during apartheid. She believes her eldest daughter never liked her career choice because she would always be tired and thus did not inspire her to train to become a doctor. Dr Ntuli decided that she was not going to specialise because she needed time with her family. She could not see herself achieving personal growth in a clinic or hospital environment without specialising, so she came to see teaching as a better option for her. She then decided to become a lecturer at a medical university and now enjoys her work in academia. This career allows her to manage her time and pick up her children from school. She is more present in their lives and gets to help students who are currently studying at medical school.

“You help students and encourage them to get through their sixth year by showing them that they have options and they can make it.”<sup>251</sup>

Here we see the choices that Dr Ntuli made in order to be more involved in her children’s lives as she felt that they were a priority. Dr Ntuli decided that working as a lecturer was more beneficial for her when it came to spending time with her family. She had believed that specialising would have taken up her personal time with her family and had felt distant from them. She states that even though the earnings would have been higher if she had chosen to specialise, losing the time she has with her family would not have been worth it. She now

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<sup>250</sup> Interview with Dr Vela Ntuli, Recording 2. September 6, 2016.

<sup>251</sup> Interview with Dr Vela Ntuli, Recording 2. September 6, 2016

lectures in medicine, and makes a difference by helping the current generation of medical students reach their dreams of becoming doctors.

Women doctors who gave up work or specialisation opportunities often did so for the sake of their families. The shifts in society's expectations of women in the twenty-first century in terms of their work and family responsibilities, were highlighted in this chapter. Today, there are more examples of husbands managing a greater share of the family/child care responsibilities which has freed women to work and follow their career aspirations. This is also thanks to the fact that women have made a stand for equal treatment and opportunities, in terms of social and professional roles.

Dr Mkhize states that her children have learnt from her experiences. She is now retired and enjoys working with women and youths to help them uplift themselves and focus on educating themselves.

Some women doctors succeeded in balancing career and family responsibilities, thanks to help and support from their spouses. Like Dr Mkhize, Dr Magubane expects her children to educate themselves because she provided the resources for her children to excel. Her daughter aims to educate herself further because she has seen how hard her mother worked for her to enjoy opportunities she never had. She would not have allowed anything to stop her from specialising. She mentions that her husband was supportive of her, but only as long as he specialised first. By the same token, she says she would have divorced him if he had tried to stop her specialising. This demonstrates Dr Magubane's ambitious drive to reach her goals.

The demands of balancing work and family responsibilities sometimes caused personal and romantic relationships to fail for these women, in some cases it even led to divorce where a woman doctor's spouse felt neglected. These husbands were often threatened by their wives'

career success. Dr Khumalo met her fiancé in 2008 and started a relationship in 2011, and they now have a son together. She was married to another doctor from 2006 to 2009.

“My previous husband, he enjoyed being superior and when I wanted to start specialising he didn’t support me and became jealous. My achievements threatened him and he saw me as competition. My new fiancé is very supportive and encourages me to do what I want.”<sup>252</sup>

If it wasn’t for the support of her family she says that she would not have coped, especially at a time when she was specialising and going through a divorce. Her ex-husband was okay when she was inferior to him but when she decided to specialise he changed. The support of her parents and family helped her a lot.

Dr Ngidi divorced her husband when her career as a doctor became a problem. She has two children, a son and a daughter. Her ex-husband felt threatened when she decided to specialise:

“He used to say when I get home I must leave my title behind because he is the head of the house. I mustn’t think that because I am in charge at work then I am also in charge at home. I’m supposed to cook and clean and do all these types of things but I work, I am even on call 24 hours. Where am, I going to get the space to do all those things? That is why I hired a helper to do all those things and he said no, he wants me to do those things myself. He was threatened that I wanted to be a specialist and beloved, that if I got a higher education than I have now then I’ll think I’m better. There was a point where he was like ‘you see? This is the problem with women’s liberation because you don’t listen to us men anymore, our mothers never did that, they cleaned and looked after the house, but you guys want to be equal to men and have careers’. So, I decided that I have a career and I’m more than being reduced to just sitting at home, and dropping out of school so no, you have to go. To me it meant he was very short sighted because he cannot see that this was going to benefit us as a family.”<sup>253</sup>

Like Dr Khumalo, Dr Ngidi chose to divorce because she felt limited and discriminated against at home, almost as she felt at work. They were both married to doctors who felt intimidated by the furthering of their careers. They were both married to doctors and it seems that some African men did not mind their wives being doctors, but when it came to them having more qualifications and earning more money they felt intimidated and raised the point that

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<sup>252</sup> Interview with Dr Ayanda Penelope Khumalo, Recording 3a, September 14, 2016.

<sup>253</sup> Interview with Sthembile Ngidi, Recording 4, September 14, 2016.

because of their gender these women were meant to be at home and that their qualifications meant nothing when they were at home. Dr Ngidi decided that she did not want her daughter to think that just because she was female, she was limited in her choices. And, she wanted her son to grow up seeing women as his equal. These women experienced the double burden of gender and racial discrimination, and not only at work but also at home. But they chose to leave that behind and overcome these obstacles and oppressions in order to accomplish the goals that they had set for themselves.

When speaking with Dr Kheswa, she mentioned that she is happily married and is a mother. She explained that her family was her support system during the difficult times she experienced when she was beginning to specialise. Had it not been for the support of her family she would not have been able to remain positive.<sup>254</sup>

There were some class opportunities and the material benefits and advantages that working as doctors could bring for these women doctors' families in the post-apartheid era. There were class opportunities that came with the profession but Dr Ntuli does not think that she has moved into an elite league. Instead she believed that doctors are like "glorified slaves."<sup>255</sup>

"The perceptions are not necessarily true when it comes to the crunch. You earn just like everybody else and we didn't have much choices but there were better chances of funding. You sacrifice a lot, you sacrifice your family, yourself and everything."<sup>256</sup>

Dr Khumalo was able to educate her cousin and help her family financially. She was also able to choose where she wanted to live. All doctors could provide for themselves and their families. They were also able to choose a better life, not just for themselves, but also in terms of providing for their children.

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<sup>254</sup> Interview with Dr Mosele Kheswa, Recording 5, October 1, 2016.

<sup>255</sup> Interview with Dr Vela Ntuli, Recording 2. September 6, 2016.

<sup>256</sup> Interview with Dr Vela Ntuli, Recording 2. September 6, 2016.

The four interviewees who trained and worked in South Africa post-1994, all felt hopeful that their experiences in the medical profession would be different and better than those of more senior colleagues, such as Drs Mkhize and Magubane who had graduated and worked before 1994. However, they found that although some things had changed, such as there being more black students (including women) admitted to study medicine, the ideas and beliefs of apartheid still lingered in the medical profession. The older generation of black women doctors experienced difficulties in progressing because of their race and gender, both in a training and working environment, but so did the younger generation. They were still not seen by their colleagues and patients as equal to their non-African and male colleagues. They still suffered many prejudices, which hampered their career advancement. Furthermore, while there has been some change, black women doctors largely continue to carry a double burden of work and family responsibilities in the post-apartheid period, which had led to them having to make difficult decisions. These decisions influenced the advancement they experienced in their careers or stymied their careers in the interests of their families.

## **Chapter Six: Conclusion**

This thesis has analysed the social experiences of six African women medical doctors of various ages. They were all born in South Africa, and trained and worked here. In terms of the structure of this study, it started by providing a broad literature review that considered international and South African published scholarship on or around the lives and experiences of African women doctors in the nineteenth and twentieth century. It showed that although much has been written on women doctors more generally, little has been written on African women doctors specifically, particularly those who trained and worked in South Africa.

It then went on, in two chapters, to consider my interviewees' experiences during the apartheid period, drawing primarily on interviews I conducted, but also interviews done by other researchers and secondary sources. Chapter Three considered the early lives of the interviewees, what motivated them to study medicine, and the socio-economic difficulties they experienced on their way to medical school. Drawing on similar sources, Chapter Four focused on their working lives and the challenges they experienced as interns, practicing doctors and later as specialists, in cases where they chose to specialise.

Finally, Chapter Five moved the narrative forward in time and scrutinised the post-apartheid period. It examined the training and work experiences of the younger interviewees and whether the era of democracy brought significant changes or continuing problems for African women doctors. The change over time for African women doctors in terms of balancing their career aspirations with their family responsibilities, was a key component of Chapters Four and Five.

In terms of major themes, this thesis focused on a number of important issues. The earlier chapters, looked at the impact race-based apartheid policies and practices had on the lives of African women medical students and doctors. Race-based apartheid policies and practices influenced these women's lives as students and doctors as they had to face many

difficulties during this period. The South African apartheid government used many methods to validate segregated and inferior training, qualifications and career prospects for black professionals, and this reinforced an unfair, inadequate healthcare system.

Class also played an influential role in women medical doctors' personal lives and in relation to their professional aspirations. Class played a role in terms of influencing their access to and opportunities in the biomedical field. This study has shown that many African women became doctors because it was their dream and a chance to attain a better social standing, especially compared to black people in other occupations. However, even though they became, once they qualified, a part of an elite group within the black community, most black doctors under apartheid still only enjoyed a second-class status. Class influenced African women's access to the biomedical field. It influenced how many black doctors (including women) had to struggle, because of their families' subordinate socio-economic position under apartheid, which meant that most did not have the money to make it through high school, never mind medical school without bursary/scholarship or loan assistance.

Of course, gender played a pivotal role in terms of the experiences of women doctors.

Black women faced a great deal of discrimination during their training and working lives because of their gender and widespread social ideas about a woman's place being in the home.<sup>257</sup> These ideologies were prevalent even in a professional context and often led to gender discrimination against African women doctors. From sexist remarks to disrespect from colleagues and patients, families were more likely to invest financially in their sons' education, as sons, rather than daughters, were understood to be the future breadwinners. Women often also tried to discourage the educational and professional aspirations of other women, in the same way that some mothers discouraged their daughters from pursuing a professional career.

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<sup>257</sup> B. Unterhalter, "Shattering the male monopoly: The history and struggle of female doctors", *The Leech* 62 no.3 (November 1993).



This was often because these women and mothers had been influenced by the patriarchal cultures in which they lived.<sup>258</sup>

As we have seen, during the segregation and apartheid eras, African women were channelled into certain health related fields, such as nursing and were excluded from others. And, when African women were able to train as doctors, many were, over time, pushed into medical disciplines with lower remuneration packages and less opportunities for professional advancement. For example, Dermatology or Paediatrics were regarded as suitable for women but for many years experienced exclusion from disciplines such as Surgery. Discriminatory hospital environments added to the African female's professional invisibility and perpetuated unequal treatment, irrespective of these women's accomplishments in medicine and that they often beat odds in a system that seemed determined to oppose their professional medical ambitions.<sup>259</sup>

Studying and working in medicine definitely influenced their personal lives. The extent of this influence became apparent in an exploration of their relationships, personal and professional choices, as well as their belief around family values. Many of my interviewees have had family problems that could have discouraged them from advancing their professional status, but they did not let this get in their way. Instead they each chose their own path and have influenced many through their work, with some supporting and helping youth, students and fellow African women. Those who were able to overcome and challenge patriarchal beliefs and practices within the medical system and in their own communities because of their achievements, paved the way for current and future generations of black women in South Africa. They are the mentors that they never had.

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<sup>258</sup> Noble, *A School of Struggle*: 113.

<sup>259</sup> Rowena Martineau. "Women and Education in South Africa: Factors Influencing Women's Educational Progress and their Entry into Traditionally Male-Dominated Fields," *The Journal of Negro Education* 66, no. 4 (Autumn 1997).

Another major issue analysed in this thesis is the issue of change over time in the medical profession. I was particularly interested to examine whether (and in what ways) the shift from the apartheid period to the post-apartheid period influenced African women doctor's training, work experiences and career opportunities. This included looking at the struggles they went through to become productive contributors to this profession and how this has helped to create more opportunities for aspiring medical students. In post-apartheid South Africa, women can now educate themselves on a level that is on par with their male counterparts. Similarly, students from different races, social classes and backgrounds can learn and study together in all schools and learning institutions. In many families today, both the mother and father work and pursue their career aspirations and encourage their children to do the same. In some homes, however, women still battle the effects of a patriarchal belief system despite their professional status. There has been an overwhelming rise of women entering the nation's medical schools. Women are now more confident about speaking out against the prejudices that permeated academic environments during apartheid. They reprimand their lecturers when subjected to sexist remarks.<sup>260</sup>

It has taken many years to overcome the obstacles and challenges that were the effect of the ideologies of the apartheid regime. Luckily, there has been much progress too: A woman is no longer judged only by her role as a daughter, mother or wife. In fact her professional life will not be determined by the roles she chooses to take on in her personal life. More women can choose for themselves what they want to do with their lives, without seeking the permission of men. Their contributions and efforts in fighting or challenging the patriarchal system have emphasised the importance of education and advancement of women in society.

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<sup>260</sup> G.W Seidman. "Gendered citizenship: South Africa's democratic transition and the construction of a gendered state", *Gender and Society* 13, no. 3 (June 1999).

Of course, not all women have been able to improve their lives, and some women, depending on their circumstances (those in very poor families, or dependent relationships) are still trapped by their circumstances with little power to improve their lives.

### Challenges Still Facing Women in the Twenty-First Century

Although many improvements and changes have been made in the years since democracy, more than twenty years later there are still complaints about the racial discrimination that African doctors experience in the medical profession, especially if they choose to specialise. Many of the younger interviewees who specialised, or studied to specialise mentioned that once they became doctors and began studying towards their specialty, or became specialists, they experienced a lot of sabotage and racism within the departments at the institutions, they studied at. Dr Ngidi discussed how she had difficulty as a specialist as many of her colleagues and patients were racist and told her that she was only accepted into the programme because the authorities needed to meet a certain quota based on race.

It appears that within the medical profession, particularly at the level of specialisation, there are forces at work which aim to prevent African doctors from specialising. Apartheid laws may have been officially discarded but it seems that the certain racist ideas remain deeply rooted within the medical profession. Some of my interviewees felt that medical institutions and departments accepted them as general practitioners, but not if they wanted to make more money by becoming an expert in a particular discipline. Africans continue to feel obstructed by their Indian and white superiors, and heads of departments at various training facilities. Tests and projects are sabotaged, and many doctors attested to experiencing racial and gender discrimination. There is a clear disparity between the number of African doctors who apply for specialisations and of African doctors who actually complete these studies, in a given field of

specialisation. More than two decades after South Africa became a democratic state, there are only two African female Oncologists in South Africa.

### Significance of this Research

It is sometimes difficult to find relevant documents related to your research project in an archive. Combined with secondary literature and interviews, my use of different sources assisted me in writing this thesis. However, my primary contribution came from my collection, use and analysis of oral interviews. The oral interviews were very helpful and central when writing this thesis as they added a vibrant element to the archival sources and secondary sources. Oral interviewing has certainly added life to various written accounts of history allowing people who experienced an event or occasion and who are still alive, to tell the researcher their side of the story.<sup>261</sup> It also helps to fill in some historical gaps and silences that exist in archival records.

This is particularly true for this study as there is little research on African women doctors' experiences in South Africa. Doing oral interviews has enabled me to add their voices to the literature on African female doctors and their experience of training and working in South Africa. It shows that although significant progress has been made in the lives and experiences of African women doctors in South Africa, there is still much work to be done for these women to achieve true equality in both their personal and private lives. The shadows of racism and sexism still hang over African women doctors, producing challenges on a daily basis.

### Limitations of this Study

I would like to end by noting the historical limitation of this study. Firstly, my study only focuses on six African women doctors. The experiences of my interviewees are not

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<sup>261</sup> Paul Thompson, "Evidence" in *The Voice of the Past: Oral History*. (Oxford: Oxford University Press, 2000): 119.

representative of the many other women doctors in South Africa. Secondly, with oral interviews, not all participants were willing to answer all the questions. For example, some gave vibrant and detailed explanations of their experiences, and others were only willing to relay brief answers to my questions about their experiences. Some women doctors, answered only a certain section as they were entitled to their anonymity and choice of questions to answer. Interviews done by other researchers helped me to fill in the gaps however.

Another limitation was that my thesis did not include African women who trained at historically white medical schools such as Wits and UCT, thus did not include their experiences. Furthermore, most of my sample size is made up of women who trained and worked in the post-apartheid period, which meant that I had to rely on just two of my own interviews with older interviewees for the apartheid period, as well as interviews done with other researchers and secondary sources to elaborate on the experiences of those who studied and worked in the apartheid era.

Differing opinions that came out in the oral interviews, as well as the different opinions in secondary readings confirmed that there was no one common experience of being an African woman doctor. These experiences vary as different women, have different backgrounds, personalities, made different choices and went to different institutions. Where there were similarities, especially between the older and younger generations, I found that the change over time focus I had was very helpful because in some cases, even though the women came from different backgrounds and went to different schools, they had similar opinions and experiences when it came to the question of whether they experienced racism and gender in their medical careers. The answer for all of them was yes. They all experienced some form of intersecting racial and gendered oppressions in various aspects of their lives.

In fact, some of the younger interviewees experienced worse discrimination than the older generation, based on their accounts of their experiences anyway. The fact that this study

investigates and analyses an under-researched group and has produced new information on this group is very useful. It has also served to highlight the fact that the experiences of more subjects (i.e. African women doctors) need to be researched in the future to grapple more thoroughly with this complex subject matter.

### Closing Comments

These six women have demonstrated that they could juggle a demanding career with the responsibility of running a household and caring for a family. These women are all professionals who worked hard to make a difference in their lives and fulfil their passion. This makes them role models, whether intentionally or not, for many women who followed after them. The ability to choose to be a doctor without any political limitations has liberated many black women, and men, and allowed them to experience professional and financial independence and earn respect for their skills and expertise.

The many comparable experiences of black medical students and black doctors today that are very much like the experiences of black doctors and students during apartheid have provided an investigative analysis of the experiences of African women doctors in South Africa during and after the apartheid era. It has reviewed the variety of their experiences in training and practice as well as gendered and racial differentiations amongst African women before going on to discuss their careers and personal lives. It has also considered the impact of recent transformational change on their positions in the medical profession. I hope that this start will encourage other researchers to further investigate and build on this research in the future, as it is very significant when looking at medical history of South Africa, the history of gender, race and class in South Africa, and South Africa's history.

## **Bibliography**

### **Primary Sources**

#### **i. Websites**

- South African Government [www.gov.za](http://www.gov.za) :  
-B.50D-Women Empowerment and Gender Equality Bill-27 April 2014
- <http://www.nursing.manchester.ac.uk/ukchnm/publications/seminarpapers/genderdilemma.pdf> : Shula Marks. "The Gender Dilemma in Nursing History: The Case of the South African Mine Hospitals." 2001:44,

#### **ii. Oral interviews**

- Interview with Albertina Luthuli, 10 January 1993, conducted by Padraig O'Malley, <http://www.nelsonmandela.org/omalley/index.php/site/q/03lv00017.htm>
- Interview with Vanitha Chetty, 13 June 2002, conducted by Rajes Pillay, <http://scnc.ukzn.ac.za/doc/audio/vor/goonamk/goonamkbackground.htm>
- Interview with Dr Mputsang May Mashego Mkhize Recording 1, August 24, 2016
- Interview with Dr Nokukhanya Magubane, Recording 6, October 1, 2016.
- Interview with Dr Vela Ntuli (Pseudonym). Recording 2, September 6, 2016.
- Interview with Dr Ayanda Penelope Khumalo Recording 3a, September 14, 2016.
- Interview with Dr Sthembile Ngidi, Recording 4, September 14, 2016.
- Interview with Dr Mosele Kheswa (Pseudonym). Recording 5, October 1, 2016

#### **iii. Newspapers/ Magazines**

- *Speak*

#### **iv. Census / statistics reports.**

- South African Institute of Race Relations- 1970-2004

### **University of the Witwatersrand Library**

- A1073/ South African Society of Medical Women/ 1944-1966:
  - Interview transcripts, minutes, memoranda, financial papers and printed items of work done by the Association to upgrade the position of women in medicine, and its relationship with the Medical Women's International Association (MWIA)

### **National Archives Repository of South Africa (NAR)**

#### **Cape Town Archives Repository**

KAB 26746 Objectionable literature. **Ek laroe: Woman surgeon.** 1961-1962

KAB 158/63 Objectionable literature. P Baldwin. **Woman doctor 1963-1963**

KAB 166/50 Objectionable literature. P Baldwin. **Woman doctor.** 1963-1963

KAB P78/81 Wet op Publikasies. **Removal of Black Students from Only Medical School.** 1974

KAB H19/207. **Admission to Hospitals of Non-European Medical Students for Clinical Study.** 1932

Pretoria National Archives Repository

SAB U3/26/4/2. **University of Natal. Non-European Medical School, Durban.**1952

SAB 112/315 **United Transkeian Territories General Council1; Appointment of African District Surgeons.** 1954

SAB 67/3 **Grants of Medical Overseas Scholarships by General Council.** 1935

SAB 56- U3/26/4/5- **Universiteit van Natal. Building grants and loans- medical school. Non-Europeans-Durban.** 1949-1953

SAB 59-U3/26/4/28- **University of Natal. Loans and grants. Equipment for non-European medical school.** 1957-1958

Alan Paton Centre and Struggle Archives.

University of KwaZulu-Natal Pietermaritzburg.XPE1-605-84 Inscription: "The first South African-trained woman doctor relaxes"

### **Relevant unpublished research (dissertations/ theses):**

Beale, M.A. 'Apartheid and University Education, 1948–70'. PhD diss., University of the Witwatersrand, 1998.

Horwitz, Simonne. "A Phoenix Rising": A Social History of Baragwanath Hospital, Soweto, South Africa, 1942–90". DPhil diss., Oxford University, 2006.

Mindel, M.N. 'The Construction of Medical Education in An Unequal Society: A Study of the University of Cape Town Medical School, 1904–97'. PhD diss., University of London, 2003.

Monamodi, Isaac Seboko. "Medical Doctors under Segregation and Apartheid: A Sociological Analysis of Professionalization among Doctors in South Africa, 1900-1980." PhD diss., Indiana University, 1996.

Noble, Vanessa. 'Doctors Divided: Gender, Race and Class Anomalies in the Production of Black Medical Doctors in Apartheid South Africa, 1948 to 1994'. PhD diss., University of Michigan, 2005.



Rehman, Amanda-Bea. "Nurses as Cultural Brokers: A Biography of a South African Nurse, Marriet Duduzile Rehman, 1940-2010." University of KwaZulu-Natal, Pietermaritzburg: Honours Dissertation in History, 2014.

Walker, Elizabeth 'The South African Society of Medical Women, 1951-1992: Its Origins, Nature and Impact on White Women Doctors.' PhD diss., University of the Witwatersrand, 1999.

Watts, H.L. 'Black doctors: An Investigation into Aspects of the Training and Career of Students and Graduates from the Medical School of the University of Natal. Part I: The students, Part II: The graduates', Part III: The Attitudes and Opinions of Staff' University of Natal, Durban: Institute for Social Research, 1975/ 1976.

### **References: Relevant published research:**

Abrams, Lynn. *Oral History Theory*. London: Routledge, 2010.

Abugideiri, Hibba. *Gender and the Making of Modern Medicine in Colonial Egypt*. Frnham, Surrey, England: Ashgate 2010.

Allman, Jean. Susan Geiger, and Nakanyike Musisi (eds), *Women in African Colonial Histories*. Indiana University Press.

Anderson, Kathryn, and Dana C. Jack, "Learning to Listen: Interview Techniques and Analyses", London: Routledge, 1991.

Banton, Michael, *Racial Theories*. New York: Cambridge University Press, 1987.

Bateman, Chris. "Women Doctors Have a Rougher Time – New Association Born". *South African Medical Journal*. (June. 2014).

Bellafaire, Judith and Mercedes Graf. *Women Doctors in War*, Texas: Texas A & M University Press, 2009.

Beinart, William, and Saul Dubow. *Segregation and Apartheid in Twentieth Century South Africa.*, London: Routledge, 1995.

Boas, Franz "Instability of Human Types." *In the Idea of Race*. Edited by R. Bernasconi and T. L. Lott. Indianapolis, Indiana: Hackett Publishing Company, 2000.

Bozzoli, Belinda. "Marxism, Feminism and South African Studies." *Journal of Southern African Studies* 9, no. 2 (April 1983).

Bozzoli, G.R. *A Vice-Chancellor Remembers: The Memoirs of Professor GR Bozzoli*. Randburg: Alphaprint, 1995.

Bradford, Helen. "Women, Gender and Colonialism: Rethinking the History of the British Cape Colony and its Frontier Zones, c.1806-70" *Journal of African History*, 37 (1996)

Brink, A.J., D. Bradshaw, M. M. M. Benade, and S. Heath. "Women doctors in South Africa. A survey of their experience and opinions." *South African Medical Journal*, 8, (1991).

Breier, M. and Wildschut, A. 'Changing gender profile of medical schools in South Africa', *South African Medical Journal* 98, no. (7 July 2008).

Breier, M. with Wildschut, A. *Doctors in a Divided Society: The Profession and Education of Medical Practitioners in South Africa*. Cape Town: HSRC Press, 2006.

Burton, Antoinette. "Introduction: Archive Fever, Archive Stories." In *Archive Stories: Facts, Fictions and the Writing of History*, London: Duke University Press: 2005.

Butler, Jeffrey, and John Adams. *The Blacks Homelands of South Africa: The Political and Economic Development of Bophuthatswana and Kwa-Zulu*. Berkeley: University of California Press, 1978.

Chavundaka, G.L. (eds.) *The Professionalisation of African Medicine*. Manchester: Manchester University Press, 1986.

Christopher, Anthony John "Apartheid and urban segregation levels in South Africa." *Urban Studies* 27, no. 3 (1990)

Cock, Jacklyn. "What is Progressive Feminism? Questions Raised by the Life of Jane Waterston (1843-1932)." *Agenda*, 5, no. 5 (1989).

Cole Stephen. "Sex Discrimination and Admission to Medical School, 1929-1984". *American Journal of Sociology* (1986).

Cosnett, J. "Edendale Hospital Pietermaritzburg: The First Twenty-One Years". *South African Medical Journal*. No. 49, vol. 1491. (1975).

Collins, Patricia Hill. *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment*, New York: Routledge, 2000.

Cornwall, Andrea (ed), *Readings in Gender in Africa*. Indiana University Press, 2005.

Crenshaw, K.W. "Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color", *Stanford Law Review*, 43, no. 6. (1991)

Deacon, Harriet. "Midwives and Medical Men in the Cape Colony before 1860." *The Journal of African History* 39, no. 2 (1998).

Deacon., Harriet. "Cape Town and 'country' doctors in the Cape Colony during the first half of the Nineteenth Century." *Social history of medicine* 10, no. 1 (1997).

- Denis, Philippe and Radikobo Ntsimane, (Edited by). *Oral. History in a Wounded Country: Interactive Interviewing in South Africa*. University of Natal Press, 2008.
- Digby, A. and Phillips, H. with Deacon, H. and Thomson, K. *At the Heart of Healing: Grootte Schuur Hospital, 1938–2008*. Auckland Park: Jacana, 2008.
- Digby. A. "Black Doctors and Discrimination under South Africa's Apartheid Regime." *Medical History* 57, no. 02 (2013).
- Digby. A. *Diversity and Division in Medicine: Health Care in South Africa from the 1800s*. Oxford: Peter Lang, 2006.
- Digby, A. "Early black doctors in South Africa." *Journal of African History* 46, no. 03 (2005).
- Digby. A. "The Medical History of South Africa: An Overview." *History Compass* 6, no. 5 (2008).
- Dubow. S. *Illicit Union: Scientific Racism in Modern South Africa*. Johannesburg: Cambridge University Press, 1995.
- Du Preez, Michael, and Jeremy Dronfield. "Dr James Barry: The Woman Who Fooled the RCS and Deceived the World," *The Bulletin of the Royal College of Surgeons of England* 98, no. 9 (2016).
- Engels, Dagmar, Shula Marks (Edited by). *Contesting Colonial Hegemony: State and Society in Africa and India*. London: British Academic Press, 1994.
- Fairburn, Miles. *Social history: Problems, Strategies, and Methods*. New York: St. Martin's Press, 1999.
- Feierman, Steven. "The Social Roots of Health and Healing in Modern Africa", *African Studies Review* 28, no. 2-3 (June-September 1985).
- Field, Sean. *Oral History, Community and Displacement*. New York: Palgrave Macmillan. 2012.
- Flint, Karen. *Healing Traditions: African Medicine, Cultural Exchange, and Competition in South Africa, 1820-1948*, Ohio: Ohio University Press, 2008.
- Furst, Lilian R. ed. *Women Healers and Physicians: Climbing a Long Hill*. United States: University Press of Kentucky, 1999.
- Game, Ann and Rosemary Pringle. *Gender at Work*. Sydney: Allen & Unwin, 1983.
- Gelfand. Michael *Christian Doctor and Nurse: The History of Medical Missions in South Africa from 1799-1976*, Sandton: Aitken family, 1984.
- Gish, Steven, *Alfred B. Xuma: African, American, South African*. New York: New York University Press, 2000.

- Goonam, K. *Coolie Doctor: An Autobiography*. Durban: Madiba Publications, 1991.
- Gould, S.J. 'The Geometer of Race,' in *The Concept of "Race" in Natural and Social Science: Essays on the Social Construction and Reproduction of "Race."* Edited by E. Nathaniel Gates. New York: Garland Publishing Inc, 1997.
- Govinden. G. "Sister Outsiders' *The Representation of Identity and Difference in Selected Writings by South African Indian Women*. Pretoria: University of South Africa Press, 2008.
- Hamilton, Carolyn, Verne Harris, Michele Pickover, Graeme Reid, Razia Saleh and Jane Taylor, eds. *Refiguring the Archive*. Cape Town, South Africa: David Philip, 2002.
- Hartshorne. K.B, *Crisis and Challenge: Black Education 1910-1990*. Cape Town: New York: Oxford University Press, 1992.
- Higginbotham, E.B. 'African-American Women's History and the Metalanguage of Race'', *Feminism and History*, Edited by Joan Wallach Scott. New York: Oxford University Press, 1996.
- Hobsbawm, Eric J. "Karl Marx's Contribution to Historiography." *Diogenes* 16, no. 64 (1968)
- Holmes, Rachel. *The Secret Life of Dr. James Barry: Victorian England's Most Eminent Surgeon.*, United Kingdom: Tempus Publishers Ltd, 2007.
- Hooks. B. "Black Women: Shaping Feminist Theory'', *Feminism and 'Race'*, edited by Kum-Kum Bhavani. New York: Oxford University Press, 2001.
- Horwitz. Simonne. "'Black Nurses in White': Exploring Young Women's Entry into the Nursing Profession at Baragwanath Hospital, Soweto, 1948–1980". *Social History of Medicine* 20, no. 1 (2007).
- Hudson, Chris P., Jocelyne Kane-Berman and Rosemary Hickman. "Women in Medicine: A Literature Review – 1985-1996," *South African Medical Journal* 87, no. 11. (November 1997).
- Hunt, Nancy Rose et al (ed), *Gendered Colonialisms in African History*. Massachusetts: Blackwell Publishers Ltd, 1997.
- Khalid, Anna. *Public Health in the British Empire: Intermediaries, Subordinates, and the Practice of Public Health* (New York & London, Routledge, 2012): 171-92.
- Kovatch, Sarah, and Rebecca Lee Crumpler. *Rebecca Lee Crumpler*, Columbus, OH: Zaner-Bloser, 2005.
- Kuper, Leo. *An African Bourgeoisie: Race, Class and Politics in South Africa*. New Haven: Yale University Press, 1965.

Iiffe, John. *East African doctors: A History of the Modern Profession*. United Kingdom: Cambridge University Press, 1998.

Iggers, G.G. "American Traditions of Social History", in *Historiography in the Twentieth Century: From Scientific Objectivity to the Postmodern Challenge*. Hanover: Wesleyan University Press, 1997.

Inman, Robert, Daniel L. Rubinfield. "Understanding the Democratic Transition in South Africa". *American Law and Economics Review* 15, no. 2 (2013).

Kallaway, Peter. *Apartheid and Education: The Education of Black South Africans*. Johannesburg: Ravan Press, 1984.

Klenerman, Pauline. *Reminiscences of a Lady Doctor*. Johannesburg: Pauline Klenerman, 1993.

Killingray, David. *Africans in Britain*. Portland, OR: F. Cass, 1994.

Lorber, Judith. *Women Physicians: Careers, Status and Power*. New York and London: Tavistock Publications, 1984.

Louw, J.H. *In the Shadow of Table Mountain: A History of the University of Cape Town Medical School and its Associated Teaching Hospitals up to 1950, with Glimpses into the Future*. Cape Town: Struik, 1969.

Lyons, M. "The Power to Heal: African Medical Auxiliaries in Colonial Belgian Congo and Uganda." *Contesting Colonial Hegemony: State and Society in Africa and India*, London: British Academic Press, 1994.

Manton, Jo. *Elizabeth Garrett Anderson*. UK: Methuen Publishing, 1987.

Marks, S. *Divided Sisterhood: Race, Class and Gender in the South African Nursing Profession*. New York: Boston University African Studies Center, 1996.

Martineau, Rowena. "Women and Education in South Africa: Factors Influencing Women's Educational Progress and their Entry into Traditionally Male-Dominated Fields," *The Journal of Negro Education* 66, no. 4 (Autumn 1997).

Marx, Karl. *The German Ideology*. New York, International Publishers, 1998. Part1.

Mbembe, Achille. "The Power of the Archive and its Limits." in *Refiguring the Archive*. (Edited by) Carolyn Hamilton, Verne Harriss, Jane Taylor, Michelle Pickover, Graeme Reid and Razia Saleh. Cape Town, South Africa: David Philip, 2002.

McCord, Margaret. *The Calling of Katie Makanya*. Johannesburg: David Philip, 1995.

- McCord, James, and John Scott Douglas. *My patients were Zulus*. New York: Rinehart, 1951.
- Meyer-van den Heever, E. & Frantz, J.M. "Perceptions of Female Medical Students on Gender Equality Gains at a Local University." *African Journal of Health Professions Education (AJHPE)*, 3, no. 2 (2011)
- Moore, Donald, and Richard Roberts, "Listening for Silences" in *History in Africa* 17 (1990).
- Morantz-Sanchez, Regina. *Conduct Unbecoming a Woman: Medicine on Trial in Turn-of-The-Century Brooklyn*. New York and Oxford: Oxford University Press, 1999.
- Morantz-Sanchez, Regina. "Feminist theory and historical practice: Rereading Elizabeth Blackwell." *History and Theory* (1992).
- Morantz-Sanchez, Regina. *Sympathy and Science: Women Physicians in American Medicine*. Chapel Hill and London: The University of North Carolina Press, 1985, 2000.
- More, Ellen S. *Restoring the Balance: Women Physicians and the Profession of Medicine, 1850-1995*. Cambridge, Mass. and London: Harvard University Press, 1999.
- Moss, Kary L. *Man-Made Medicine: Women's Health, Public Policy, and Reform*. United States: Duke University Press, 1996.
- Murray, B.K. "Wits as an 'Open' University 1939–1959: Black Admissions to the University of the Witwatersrand." *Journal of Southern African Studies* 16, no. 4 (1990): 649-676.
- Ncayiyana, Daniel J. "Feminism of the South African Medical Profession-Not Yet Nirvana for Gender Equity." *South African Medical Journal* 101, no. 1 (2011).
- Nestel, Sheryl. "(Ad) ministering Angels: Colonial Nursing and the Extension of Empire in Africa." *Journal of Medical Humanities* 19, no. 4 (1998).
- Noble, V. *A School of Struggle: Durban's Medical School and the Education of Black Doctors in South Africa*. Pietermaritzburg: University of KwaZulu-Natal Press, 2013.
- Noble, Vanessa. "'Health is Much Too Important a Subject to be Left to Doctors': African Assistant Health Workers in Natal during the Early Twentieth Century." *Journal of Natal and Zulu History* 24, no 1 (2007)
- Oosthuizen, S.F. "The Intern Year" in *Medical Education in South Africa: Proceedings of the Conference on Medical Education held at the University of Natal, Durban in July 1964*, edited by John V.O. Reid and Alexander J. Wilcott. Pietermaritzburg: University of Natal Press, 1965.
- Patton, Jr. A. *Physicians, Colonial Racism and Diaspora in West Africa*. Gainesville: University Press of Florida, 1996.
- Perks Robert and Alistair Thomson. *The Oral History Reader*. London: Routledge 1998.

Perks Robert and Alistair Thomson. *The Oral History Reader*. London; New York: Routledge Press, 2006. Part 2

Pringle, Rosemary. *Sex and Medicine: Gender, Power and Authority in the Medical Profession*. Cambridge: Cambridge University Press, 1998.

Ramphela, Mamphela. *Across Boundaries: The Journey of a South African Woman Leader*. New York: Feminist Press, 1995.

Ramphela, Mamphela. "The dynamics of gender within black consciousness organisations: a personal view", in N.B. Pityana edited by, *Bounds of Possibility: The Legacy of Steve Biko and Black Consciousness*. Cape Town: David Philip, 1991.

Ranjit Guha and Gayatri Spivak (Edited by). *Selected Subaltern Studies*. Oxford University Press, 1988.

Reid, S.J. "Compulsory community service for doctors in South Africa – An evaluation of the first year", *South African Medical Journal* 91 (2001).

Ritchie, Donald A. *Doing Oral History*. Oxford: Oxford University Press, 2014.

Riska, Elianne and Katarina Weger, eds. *Gender, Work and Medicine: Women and the Medical Division of Labour*. London: Sage Publications, 1993.

Sabin, F. *Elizabeth Blackwell: The First Woman Doctor*. New York: Troll Communications; 1982.

Salber, Eva J. *The Mind is Not the Heart: Recollections of a Woman Physician*. Durham and London: Duke University Press, 1989.

Savitt. Todd Lee. *Race and Medicine in Nineteenth- and Early-Twentieth-Century America*. Kent, OH: Kent State University Press, 2007.

Scott. JW "Gender and the Politics of History". *Gender and Culture* edited by Carolyn G. Heilbrum and Nancy K. Miller, New York: Columbia University Press, 1988.

Scott, J.W. "The Problem of Invisibility" in S.J. Kleinberg (Edited by), *Retrieving Women's History*, New York: Berg Publishers Ltd, 1988.

Scott, J.W. "Women in the Making of the English Working Class" in J.W. Scott (Edited by), *Gender and the Politics of History* New York: Routledge Press (1988).

Searle. C. *The History of the Development of Nursing in South Africa, 1652-1960*, Cape Town: Struik, 1965.

Seidman, G.W. "Gendered citizenship: South Africa's democratic transition and the construction of a gendered state", *Gender and Society* 13, no. 3 (June 1999).

Skinner, Carolyn. *Women Physicians and Professional Ethos in Nineteenth-Century America*, Illinois: Southern Illinois University Press, 2014.

Smith, James McCune, and John Stauffer. *The Works of James McCune Smith: Black Intellectual and Abolitionist*. Oxford University Press, USA, 2006.

Smith, S. *In memory of Dr. Elizabeth Blackwell and Dr. Emily Blackwell. Academy of Medicine, New York & the Women' Medical Association of New York City*. New York: The Knickerbocker Press. 1911.

Shapiro, Karin. "Doctors or Medical Aids – the Debate over the Training of Black Medical Personnel for the Rural Black Population in South Africa in the 1920s and 1930s," *Journal of Southern African Studies* 13, no. 2 (1987)

Sharpe, J. 'History from Below' in P. Burke (Edited), *New Perspectives on Historical Writing*. Cambridge: Polity Press, 2001.

"Shattering the Male Monopoly: The History and Struggle of Female Doctors," *The Leech* 62, no. 3 (November 1993).

Spivak, Gayatri. "Can the Subaltern Speak?" University of Illinois Press, Chicago (1988).

Strauss Anselm, and Juliet Corbin. *Basics of Qualitative Research Techniques and Procedures for Developing Grounded Theory*. UK: Sage Publications, Inc: 1998.

Stoler, Ann Laura. "Colonial Archives and the Arts of Governance: On the Content in the Form." *Archival Science* 2, no. 1-2 (2002).

Sweet, Helen, and Anne Digby. *Race, Identity and the Nursing Profession in South Africa. New Directions in the History of Nursing: International Perspectives*. London, UK: Routledge 2005.

Sybil, Mazo, T. MaDlamini Buthelezi. *African Nurse Pioneers in KwaZulu-Natal- 1920- 2000*. Canada: Trafford Publishing, 2006.

Thompson, Paul. "Evidence" in *The Voice of the Past: Oral History*. Oxford: Oxford University Press, 2000.

Thompson, E.P. *The Making of the English Working Class*. New York: Vintage Books, 1966.

Thompson. Paul. *The Voices of The Past: Oral History*. Oxford and New York: Oxford University Press, 1978.



Thurmond, V.B. "Against the Odds: Blacks in the Profession of Medicine in the United States." *JAMA: The Journal of the American Medical Association* 282, no. 13 (1999).

Tobias, Phillip V. "Apartheid and medical education: the training of black doctors in South Africa." *Journal of the National Medical Association* 72, no. 4 (1980).

Trouillot, Michel-Rolph *Silencing the Past: Power and the Production of History*. Boston, MA: Beacon Press, 1995.

Unterhalter, B. "Shattering the male monopoly: The history and struggle of female doctors", *The Leech* 62 no.3 (November 1993).

Van Heyningen, Elizabeth, "Agents of Empire: The Medical Profession in the Cape Colony, 1880-1910." *Medical History* 33, no. 4 (1989):

Vertinsky, P.A. *The Eternally Wounded Woman: Women, Doctors, and Exercise in the Late Nineteenth Century*. Manchester: Manchester University Press, 1990.

Walker, Jean. "*Skin Deep*": *The Autobiography of a Woman Doctor*. Cape Town: Dr. J.F. Midgley J.P., 1977.

Walker, Liz. "'Conservative Pioneers': The Formation of the South African Society of Medical Women." *Social History of Medicine* 14, no. 3 (2001).

Walker, Liz. "The Colour White: Racial and Gendered Closure in the South African Medical Profession." *Ethnic and Racial Studies* 28, no. 2 (2005).

Walsh, Mary Roth. "*Doctors Wanted, No Women Need Apply*": *Sexual Barriers in the Medical Profession, 1835-1975*. New Haven: Yale University Press, 1977.

Watson, W.H. *Against the Odds: Blacks in the Profession of Medicine in the United States*. New Brunswick USA: Transaction Publishers, 1999.

Wear, Delese. *Privilege in the Medical Academy: A Feminist Examines Gender, Race, and Power*. New York and London: Teachers College, Columbia University, 1997.

Wirtzfeld, D.A. "The History of Women in Surgery." *Canadian Journal of Surgery* 52. No. 4 (2009).

Witz, Anne. *Professions and Patriarchy*. London and New York: Routledge, 1992.

## **Appendices**

### **Appendix 1- Interview Questions**

#### **Biographical:**

Where and when were you born? Class background, parents' occupations?

Where did you grow up?

Primary and secondary schooling?

Who/ what influenced/motivated your career choice as a doctor?

What influence did apartheid laws have on you growing up?

Obstacles faced as a young black girl (class, gender)?

#### **Earlier life and medical training:**

What was your experience of medical training academically and socially?

Where and when did you receive your medical training?

What type of relationships did you have with students? Medical staff? Did this change over time (better or worse in different places/ institutions)?

Were there any female mentors training you?

What were the obstacles faced as a woman doctor in training (racial, gender, class, professional, personal)?

Your memories of working with and your relationships with your patients?

Was there competition amongst female students?

Did racial differences play a role in influencing your experiences (e.g. with co-students, staff at different hospitals etc.)?

#### **Medical career:**

Difficulties faced as a black woman in Apartheid South Africa?

Difficulties faced as a black woman in post-Apartheid South Africa?

What did you choose to specialise in medically and why did you choose this medical specialisation?

How were the relationships you had with male co-workers? Was there competition?

How did the politics of the country influence you?

Did you participate in any politics? If yes why, if not, why not?

Were there any doctor strikes in the hospital/s you work/ed at? Did you participate in these?

What do you recall about them?

Were there support networks or mentors where you worked?

What relationships did you have with your patients?

Positives and negatives of being a black woman doctor?

Your changing relationships with doctors and other staff while in employment?

What obstacles did you face as a trained doctor (racial, gender, class, professional, personal)?

What class opportunities were there by being a member of an elite profession?

#### Family and social life:

Are you married? If not, why?

If yes, when did you meet your husband?

When and where did you get married? Where do you live?

What were the difficulties faced by being married and being a female doctor?

Do you have children? When did you decide to have children?

Being a doctor and your societal status? Professionalization and class?

Influence of being a doctor on your family and personal life?

#### Conclusion:

Quality of medical profession now and then?

Importance of education to you?

What changes have you personally experienced in the profession over time?

Are there any hardships or obstacles faced by female students and doctors today?